



COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

July 1, 2008

MEDICAID MANUAL – VOLUME XIII

TRANSMITTAL #89

The following acronyms are used in this transmittal:

- AC – Aid Category
- ADAPT – Application Benefit Delivery Automation Project
- ABD – Aged, Blind, Disabled
- BCCPTA – Breast and Cervical Cancer Prevention and Treatment Act
- CBC – Community-based Care
- CNNMP – Categorically Needy Non-Money Payment
- DDS – Disability Determination Services
- DMHMRSAS – Department of Mental Health, Mental Retardation & Substance Abuse Services
- F&C – Families and Children
- FAMIS – Family Access to Medical Insurance Security Plan
- FIPS – Federal Information Processing Standard
- LDSS – Local Department of Social Services
- LIFC – Low-income Families with Children
- LTC – Long-term Care
- MED-UP – Medicaid Unemployed Parent
- MI – Medically Indigent
- MMIS – Medicaid Management Information System
- MN – Medically Needy
- PACE – Program for All-Inclusive Care for the Elderly
- PASS – Plan for Achieving Self-Support
- SLH – State-Local Hospitalization
- SOF – Statement of Facts
- SPARK – Services Programs Answers Resources Knowledge
- SSDI – Social Security Disability Insurance
- SSI – Supplemental Security Income
- SSN – Social Security Number
- USCIS – United States Citizenship and Immigration Services
- WIA - Workforce Investment Act

Medicaid Transmittal #89 contains new and revised Medicaid eligibility policy as outlined within this letter.

New Policy

This transmittal contains Medicaid policy on two new groups of qualified aliens, Afghan and Iraqi Special Immigrants, who are admitted to the U.S. for permanent residency. Effective December 26, 2007, Afghan and Iraqi Special Immigrants, their spouses, and their children under age 21 who live in the home became eligible for full Medicaid benefits for **six months**, beginning with the month of entry in the U.S. or after conversion to special immigrant status, if they did not enter the U.S. with that status. Effective January 28, 2008, the period of eligibility for **Iraqi Special Immigrants only** was extended to include **eight months**, beginning with the month of entry into the U.S. or after conversion to special immigrant status, if they did not enter the U.S. with that status. Eligibility for full Medicaid coverage cannot be granted for periods prior to the effective dates of the laws granting benefits to these immigrants. Within the applicable time period, these Special Immigrants are eligible for the full package of Medicaid benefits available to the covered group they meet, provided that they meet **all** other Medicaid eligibility requirements.

The alien status policy for Afghan and Iraqi Special Immigrants also applies to FAMIS, FAMIS MOMS and SLH. After the 6 or 8-month period, Afghan and Iraqi Special Immigrants are treated as lawful permanent residents for FAMIS, FAMIS MOMS and SLH eligibility when they have documents indicating lawful permanent residency. For FAMIS and FAMIS MOMS, lawful permanent residents are not eligible for the first 5 years they reside in the U.S.

Revised Policy

The SSN requirements exception for voluntarily entrusted foster care children is removed in this transmittal. The Social Security Administration district offices are accepting the voluntary entrustment as validation for the public or private child-placing agency representative to apply for the child's SSN. Effective July 1, 2008, a voluntarily entrusted child must provide an SSN or proof of an SSN application to be eligible for Medicaid.

The foster care policy regarding a trial visit's duration has been changed from three months to six months.

Plan First policy was revised to add a new requirement to screen a Plan First application for full benefit Medicaid eligibility before determining Plan First eligibility. Based on the Plan First application and information in the applicant's case record (if any), the worker is required to screen the applicant(s) for possible full benefit Medicaid eligibility and give the applicant(s) the opportunity to provide any additional verifications necessary to determine full benefit Medicaid eligibility.

The policy on PACE is revised in this transmittal. PACE is the state's community model for the integration of acute and long-term care. Previously, a model "pre-PACE" program operated solely in the Hampton Roads area. The full PACE model has been implemented in several locations around the state. Under the full PACE model, Medicaid and Medicare coverage/funding are combined. PACE provides the entire spectrum of acute and long-term care services to enrollees without limitations on the duration of services provided or the dollars spent. Participation in PACE is in lieu of CBC and is voluntary. PACE is NOT a CBC Waiver; however, the preadmission screening, financial eligibility and post eligibility requirements for individuals enrolled in PACE are based on the LTC policies contained in Chapter M14. Additional information about PACE is contained in Broadcast #4600.

Clarifications

Clarifications to policy contained in this transmittal include additional information regarding the following:

- Pre-release planning application procedures for DMHMRSAS and Department of Corrections individuals;
- Instructions regarding when a disability determination is required for a child;
- Definitions and policy regarding foster care and adoption assistance children;
- Policy that defines available income for the retroactive period as income actually received, and for the application and subsequent months as the average monthly income that is expected to be received;
- Income policy that states that third party payments made in lieu of support are not counted as income for Medicaid, FAMIS and FAMIS MOMS;
- Extended Medicaid policy that states that verification of dependent care expenses is not required when reporting earnings at the required intervals;
- Resource policy that states that the contractual amount of payments under the Tobacco Quota Buy-Out Program are a countable resource.

Additionally, the policies on the burial fund exclusion in subchapter M1130 and the policies on the resource assessment for an institutionalized spouse in subchapter M1480 were reorganized and clarified.

Updates

This transmittal contains the ABD, F&C MI, and FAMIS income limits that were previously announced in Broadcast #4727. The income limits were effective January 23, 2008 for individuals without Social Security income and for those being evaluated for FAMIS, and March 1, 2008 for Social Security recipients. This transmittal also contains the July 1, 2008, 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 have been updated in ADAPT.

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, 2008.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
VDSS Volume XIII Medicaid Eligibility Manual Table of Contents, pages i-iii	VDSS Volume XIII Medicaid Eligibility Manual Table of Contents, pages i-iii	Updated the main Medicaid Manual VDSS Volume XIII Medicaid Eligibility Manual Table of Contents.
Chapter M01 Title Page Table of Contents	Chapter M01 Title Page Table of Contents	Updated the Chapter M01 title page and the Table of Contents.
Chapter M01, Subchapter 10 Title Page Table of Contents	Chapter M01, Subchapter 10 Title Page Table of Contents	Updated the Chapter M01, Subchapter 10 title page and Table of Contents.
Subchapter M0110 pages 7-11	Subchapter M0110 pages 7-13	Updated the subchapter title page. Page 7 is reprinted. On pages 8-10, clarified workers' responsibilities to applicants and enrollees regarding voter registration. Pages 11-13 are runover pages.
Subchapter M0120 Title Page Table of Contents page 8a pages 9-15	Subchapter M0120 Title Page Table of Contents pages 9-16	Updated the subchapter title page and Table of Contents. On page 9, clarified that the Application for Benefits cannot be used to apply for Plan First or BCCPTA. On page 10, clarified use of the ADAPT SOF for Medicaid applicants and added the Application for Adult Medical Assistance. Pages 11-12, and 15-16 are runover pages. On pages 13 and 14, clarified the pre- release planning policy and procedures for applicants in DMHMRSAS and Corrections facilities.
Subchapter M0130 Title Page Table of Contents pages 3, 4 pages 9-11	Subchapter M0130 Title Page Table of Contents pages 3, 4 pages 9-11	Updated the subchapter title page and Table of Contents. Pages 4, 10 and 11 are runover pages. On page 3, clarified that retroactive coverage can be requested after the application is filed and that eligibility for all months in the retroactive period are determined. On page 9, clarified entitlement to medical assistance.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Chapter M02 Table of Contents, pages i, ii	Chapter M02 Table of Contents, pages i, ii	Updated page i of the Table of Contents. Page ii is reprinted.
Subchapter M0220 Table of Contents pages 1, 2 pages 4s, 4t pages 7-12 pages 14a-14d pages 15-20 page 22a Appendix 1, page 1 Appendix 3, page 3	Subchapter M0220 Table of Contents pages 1, 2 pages 4s, 4t pages 7-12 pages 14a-14d pages 15-20 page 22a Appendix 1, page 1 Appendix 3, page 3	Updated the Table of Contents. Page 1 is reprinted. On page 2, clarified that individuals entitled to Medicare are exempt from the citizenship and identity documentation requirements. On page 4s, added information on Afghan/Iraqi Special Immigrants. Page 4t is a runover page. On page 7, added Afghan/Iraqi Special Immigrants to the list of full benefit aliens. Pages 8 and 9 are reprinted. On pages 10 and 11, updated the immigration agency's name. On page 12, added the definition of an Afghan/Iraqi Special Immigrant. On page 14a, added policy on Afghan/Iraqi Special Immigrants. On pages 14b and 14c, changed item designations. On page 14d, removed the policy on grandfathered aliens who were in LTC because there are no longer any individuals eligible for Medicaid in this group. On pages 15 and 16, updated the immigration agency's name. On pages 17 and 19, reordered sections for clarity. On page 18, added policy on Afghan/Iraqi Special Immigrants. On page 20, clarified that non-immigrant aliens living in Virginia with a valid visa are not Virginia residents while the visa is valid. On page 22a, added instructions for enrolling Afghan/Iraqi Special Immigrants in MMIS. In Appendix 1, updated the address for USCIS. In Appendix 3, removed the information on grandfathered aliens who were in LTC and added information on Afghan/Iraqi Special Immigrants.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0230 Table of Contents pages 1-6	Subchapter M0230 Table of Contents pages 1-7	Updated the Table of Contents. On pages 1 and 2, moved the policies on specific prohibitions and disputed residency from page 6 and included them in the policy principles. On page 3, clarified that non-immigrant aliens living in Virginia with a valid visa are not Virginia residents. On pages 4 and 7, clarified state residency for non-IV-E foster care and adoption assistance children, and children in adoptive placements. Pages 5 and 6 are runover pages.
Subchapter M0240 Table of Contents pages 1-2	Subchapter M0240 Table of Contents pages 1-3	Updated the Table of Contents. On pages 1-3, removed the reference to special SSN requirements for foster children in voluntary entrustments and added follow-up requirements for enrollees who apply for SSNs.
Subchapter M0310 Table of Contents pages 5-6a pages 11, 12 pages 21, 22 pages 25, 26 pages 29, 30	Subchapter M0310 Table of Contents pages 5-6a pages 11, 12 pages 21, 22 pages 25, 26 pages 29-30a	Updated the Table of Contents. On pages 5-6a, clarified the adoption assistance definition. On page 11, reformatted the text in M0310.111 A for improved clarity and consistency. On page 12, reformatted the text under M0310.111 C.1 for improved clarity. Page 21 is a runover page. On page 22, clarified when a disability determination is needed for previous SSDI/SSI recipients and children. On page 25, removed incorrect reference to a form. Page 26 is reprinted. On pages 29-30a, added independent living, non-custodial and parental agreements and clarified the definitions of IV-E and Non-IV-E foster children.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
<p>Subchapter M0320 Table of Contents pages 1, 2 pages 13, 14 pages 45, 46 pages 46e, 46f pages 49-50c pages 51-60</p>	<p>Subchapter M0320 Table of Contents pages 1, 2 pages 13, 14 pages 45, 46 pages 46e, 46f pages 49-50c pages 51-60</p>	<p>Updated the Table of Contents. On page 1, changed the LIFC section number to M0320.304. Page 2 is reprinted. On page 13, corrected the age range for Protected Widows and Widowers to age 50 through 64. Page 14 is reprinted. On page 45, clarified the asset transfer policy reference. On page 46, removed the term “aged” from the nonfinancial requirements for MEDICAID WORKS. On page 46e, clarified the introduction to the Families & Children Categorically Needy section. On page 46f, changed the LIFC section number to M0320.304. On pages 49 and 50, added the requirement for full-benefit Medicaid eligibility determination when the Plan First applicant appears to be eligible in a full-benefit Medicaid covered group. Pages 50a-50c are runover pages. On pages 51-59, changed the LIFC section number, clarified the LIFC assistance unit, the IV-E children, Individuals Under Age 21, and Special Medical Needs covered group requirements. Page 60 is reprinted.</p>
<p>Subchapter M0330 pages 23-27</p>	<p>Subchapter M0330 pages 23-27</p>	<p>On pages 23-27, reformatted section M0330.304, and clarified the MN covered groups of Individuals Under Age 21 and Special Medical Needs Adoption Assistance.</p>
<p>Subchapter M0710 Table of Contents pages 1-4 pages 9-13 Appendix 1 Appendix 3 Appendix 5 Appendix 6 Appendix 7</p>	<p>Subchapter M0710 Table of Contents pages 1-4 pages 9-13 Appendix 1 Appendix 3 Appendix 5 Appendix 6 Appendix 7</p>	<p>Updated the Table of Contents. On pages 1 and 2, clarified verification of income. On pages 2 and 3, clarified that gross income actually received is used in the retroactive period and average gross income is used in the application and ongoing months. Page 4 is a runover page. On pages 9-13, clarified the</p>

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		<p>exclusion of WIA income and/or other earned income of a child under age 19 who is a student. On page 11, deleted reference to MED-UP. In Appendix 1, updated the LIFC 185% of standard of need income limits. In Appendix 3, updated the categorically needy 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.</p>
<p>Subchapter M0715 Table of Contents pages 1-3</p>	<p>Subchapter M0715 Table of Contents pages 1-3</p>	<p>Updated the Table of Contents. On pages 1 and 2, updated the headers. On page 3, clarified that third party payments made in lieu of child support are not counted as income for F&C Medicaid eligibility purposes.</p>
<p>Subchapter M0730 pages 1, 2 pages 7-10</p>	<p>Subchapter M0730 pages 1, 2 pages 7-10</p>	<p>Pages 2, 9 and 10 are runover pages. On page 1, clarified that gross income actually received is used in the retroactive period and average gross income is used in the application and ongoing months. Page 7 is reprinted. On page 8, re-ordered child support policy sections. On page 8a, clarified that third party payments made in lieu of child support are not counted as income for F&C Medicaid eligibility purposes, and added policy for counting child support payments received for a child who does not live in the home.</p>
<p>Subchapter M0810 Table of Contents pages 1, 2 pages 23, 24</p>	<p>Subchapter M0810 Table of Contents pages 1, 2 pages 23, 24</p>	<p>Updated the Table of Contents. Pages 1 and 23 are reprinted. On page 2, updated the MI and MN income limits. On page 24, clarified that PASS is not evaluated by the eligibility worker.</p>

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0820 pages 37, 38	Subchapter M0820 pages 37, 38	Page 37 is reprinted. On page 38, removed reference to PASS.
Subchapter S1130 Table of Contents, pages i, ii pages 27-38 pages 49-52 pages 59, 60	Subchapter S1130 Table of Contents, pages i, ii pages 27-38 pages 49-52 pages 59, 60 Appendix 3	Updated pages i and ii of the Table of Contents. On pages 27-37, reorganized and clarified the policy on burial fund exclusions. Page 38 is a runover page. On page 49, revised the reference to PASS. On page 50, revised the section number. Page 51 is a runover page. On page 52, added policy on the Tobacco Quota Buy-Out Program. On pages 59, revised the reference for PASS. Page 60 is reprinted. Appendix 3 is added.
Subchapter M1310 page 5	Subchapter M1310 page 5	On page 5, added the definition of “spenddown eligibility.”
Chapter M14 Table of Contents, pages i, ii	Chapter M14 Table of Contents, pages i, ii	Updated the Table of Contents.
Subchapter M1410 Table of Contents pages 1, 2 pages 7-20 Appendices 1-5	Subchapter M1410 Table of Contents pages 1, 2a pages 7-15	Updated the Table of Contents. On pages 1 and 2, clarified when an individual meets the definition of institutionalization. Page 2a is a runover page. Page 7 is reprinted. On pages 8 and 15, added information on PACE. On pages 9-15, removed policy on who can sign the application because it is in subchapter M0120. The appendices were removed and links to the on-line forms on SPARK and other web sites were added to pages 11, 12 and 14.
Subchapter M1420 Table of Contents pages 3-6 Appendices 1-4	Subchapter M1420 Table of Contents pages 3-6 Appendices 1-3	Updated the Table of Contents. On page 3-5, added information about PACE. On page 5, added link to the on-line version of the DMAS-96 Form. Page 6 is a runover page. Removed Appendix 1, the DMAS-96, and renumbered the remaining Appendices.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M1430 pages 3, 4	Subchapter M1430 pages 3, 4	On page 3, clarified financial eligibility requirements for individuals in nursing facilities. Page 4 is reprinted.
Subchapter M1440 pages 3, 4 pages 11, 12	Subchapter M1440 pages 3, 4 pages 11-12a	On page 3, clarified the financial eligibility requirements for individuals in CBC. Pages 4 and 11 are reprinted. On pages 12 and 12a, added information about PACE.
Subchapter M1450 Table of Contents pages 31, 32 pages 39, 40 Appendix 1	Subchapter M1450 Table of Contents pages 31, 32 pages 39, 40a Appendix 1	Updated the Table of Contents. Page 31 is reprinted. On page 32, added reference to M1450, Appendix 1. On pages 39 and 40, clarified the procedures for using the Asset Transfer Hardship Claim Form on SPARK. A link to the form was added and it was removed from the appendices. Page 40a is a runover page. The new Appendix 1, Average Monthly Private Nursing Facility Cost Prior to October 1, 1996, replaced the old Appendix 1.
Subchapter M1460 pages 9, 10 pages 13, 14 pages 37-40	Subchapter M1460 pages 9, 10 pages 13, 14 pages 37-40	On pages 9, 13 and 14, clarified the requirements for the 300% SSI covered group. Page 10 is a runover page. Page 37 is reprinted. On pages 38-40, updated the AC codes and clarified the ACs used for institutionalized children.
Subchapter M1470 Table of Contents, pages 9-12 pages 27, 28 pages 35-38 pages 49-52 pages 57-60	Subchapter M1470 Table of Contents, pages 9-12 pages 27, 28 pages 35-36a pages 37, 38 pages 49-50b pages 51, 52 pages 57-60	Updated the Table of Contents. On page 9, clarified the definition of an old bill. Pages 10 and 11 are reprinted. On page 12, updated the address for DMAS. On page 27, clarified the definition of an old bill. Page 28 is reprinted. On pages 35-37, added patient pay policy for PACE. Pages 38 and 49 are reprinted. On pages 50-50a and 51, added spenddown policy for PACE. Page 50b is a runover

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page. Pages 52 and 57 are reprinted. On pages 58 and 59, clarified that the date of death is a covered day for hospice patients. Page 60 is reprinted.

Updated the Table of Contents. On page 5, clarified the definition of “likely to remain in an institution.” Page 6 is reprinted. On page 7, clarified when reverse mortgages reduce home equity value. On page 8, section M1480.020 about undue hardship was removed and relocated to pages 17-18a. Page 8a is a runover page. On page 8b, clarified when the resource assessment is completed. Page 13 is reprinted. On page 14, added procedures to be followed when the individual is not resource eligible. Pages 17-18a contain the policy on undue hardship. On pages 18b and 18c, clarified the entitlement policy for an institutionalized spouse. Pages 19 and 20a are runover pages. On page 20, clarified when the protected resource amount is determined. On pages 29-33, reorganized, consolidated and revised the policies on the institutionalized spouse’s protected period and the community spouse resource allowance for improved comprehension and clarity, and links were added to the “Intent to Transfer Assets to the Community Spouse” and the “Institutionalized Spouse Resource Eligibility Worksheet” forms on SPARK. Page 34 is a runover page. Due to the consolidation of some policies, pages 35-46 were deleted and are not being replaced in this transmittal. On page 47, the policy on suspension procedures was clarified. Page 48 is a runover

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		<p>page. Pages 49 and 52 are reprinted. On pages 50 and 51, revised the appendix number. On pages 55-58, added spenddown policy for PACE. Pages 58a and page 65 are runover pages. Page 67 is reprinted. On page 66, updated the monthly maintenance needs standard and the excess shelter standard. On pages 68, 69, 75 and 76 added patient pay policy for PACE. On page 70, added the EDCD Waiver to the list of waivers that have the special earnings allowance. Pages 77 and 91 are reprinted. On pages 78, 92 and 93, added policy on patient pay for MN PACE recipients. Pages 94 and 95 are runover pages. On page 96, added information about where to send the DMAS-122 form for PACE recipients. Because links to the forms were added to the policy, Appendices 4 and 5 were removed, and Appendix 6 was renamed Appendix 4.</p>
Chapter M15 Table of Contents	Chapter M15 Table of Contents	Updated the Table of Contents for chapter M15.
Subchapter M1510 Table of Contents pages 1, 2 pages 7, 8 pages 13-16	Subchapter M1510 Table of Contents pages 1-2a pages 7, 8 pages 13, 14	Updated the Table of Contents. Pages 2 and 2a are runover pages. On page 1, clarified entitlement. On page 7, deleted automatic enrollment of pregnant women in family planning services. Page 8 is a runover page. Page 13 is reprinted. On page 14, removed the reference to special SSN requirements for foster care children in voluntary entrustments and moved the SSN follow-up procedures to subchapter M0240.
Subchapter M1520 pages 1, 2 pages 5-8 pages 15-18	Subchapter M1520 pages 1, 2 pages 5-8 pages 15-18	Pages 1, 8 and 17 are reprinted. On page 2, clarified the role of the worker in the program integrity process. On page 5, added SSN

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M1550 Appendix 1	Subchapter M1550 Appendix 1	follow-up to renewal requirements. On page 6, clarified the procedures for referring a child about to turn age 19 to DDS. Page 7 is a runover page. On pages 15, 16 and 18, removed the requirement to verify dependent care expenses for Extended Medicaid.
Subchapter M17 Table of Contents pages 1-6 Appendix 2, pages 1, 2	Subchapter M17 Table of Contents pages 1-6 Appendix 2, pages 1, 2	Added facilities and the FIPS codes to the list of DMHMRSAS facilities in Appendix 1. Updated the Table of Contents. On pages 1 and 3, revised regulatory citations. Pages 2 and 4 are reprinted. On pages 5 and 6, revised the contact information for reporting fraud and non-fraud recoveries to DMAS. Revised page 1 of Appendix 1 to collect additional information. Clarified the instructions on page 2 of Appendix 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	Chapter M20 pages 3-6 pages 15, 16 Appendix 1, page 1 Appendix 2, page 1 Appendix 3, page 1 Appendix 4, page 1	On pages 3, 6, and 15, updated the resource limits for Extra Help. Pages 4, 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.
Chapter M21 Table of Contents pages 1-10 page 15 Appendix 1 Appendix 3	Chapter M21 Table of Contents pages 1-10a page 15 Appendix 1 Appendix 3	Updated the Table of Contents. Page 1 is reprinted. Pages 5-7, 10 and 10a are runover pages. On page 2, added information about Afghan and Iraqi special immigrants and clarified that alien status must be verified. On page 3, clarified that grandfathered aliens under age 19 and emergency services only coverage for unqualified aliens are not applicable to FAMIS. On page 4, renumbered items. On page 8,

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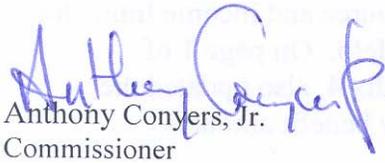
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clarified that gross income actually received is used in the retroactive period and average gross income is used in the application and ongoing months. On page 9, numbered the items in section B. On page 15, clarified that FAMIS Select is available only to families who have a child enrolled in FAMIS. Updated the FAMIS income limits in Appendix 1. On page 1 of Appendix 3, added Afghan and Iraqi Special Immigrants; pages 2 and 3 are runover pages.

Updated the Table of Contents. On page 3, added the Afghan and Iraqi Special Immigrants policy. Pages 4 and 5 are runover pages. On pages 6 and 7, clarified the family unit and countable income policy. Pages 8-10 are runover pages. Updated the FAMIS MOMS income limits in Appendix 1.

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


Anthony Conyers, Jr.
Commissioner

Attachment

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CHAPTER M01

APPLICATION FOR MEDICAL ASSISTANCE

SUBCHAPTER 10

GENERAL INFORMATION

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M01 APPLICATION *FOR* MEDICAL ASSISTANCE

M0110.000 GENERAL INFORMATION

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- I. Family Substitute Representative** means a spouse *age 18 or older* or designated relative *age 18 or older* who is willing and able to take responsibility for the individual's personal or financial affairs. Designated relatives other than the spouse who may be substitute representatives are, in this preferred order, the individual's child, parent, sibling, grandchild, niece or nephew, aunt or uncle.
- J. Guardian** means a person appointed by a court of competent jurisdiction to be responsible for the personal affairs of an incapacitated individual, including responsibility for making decisions regarding the person's support, care, health, safety, habilitation, education, and therapeutic treatment, and if not inconsistent with an order of commitment, residence.
- K. Incapacitated Individual** means an individual who, pursuant to an order of a court of competent jurisdiction, has been found to be incapable of receiving and evaluating information effectively or responding to people, events, or environments to such an extent that the individual lacks the capacity to (1) meet the essential requirements of his health, care, safety, or therapeutic needs without the assistance or protection of a guardian; or (2) manage property or financial affairs or provide for his or her support or the support of his legal dependents without the assistance or protection of a conservator.
- L. Legal Emancipator of a Minor** means a minor who has been declared emancipated by a court of competent jurisdiction. A married minor is not emancipated unless a court has declared the married minor emancipated from his parents.
- M. Medical Assistance** *means any program administered by DMAS jointly with the Department of Social Services (DSS) that helps individuals or families pay for medical, dental and related health services. These programs are Medicaid, State and Local Hospitalization (SLH), Family Access to Medical Insurance Security (FAMIS) and FAMIS MOMS.*

M0110.300 Availability of Information

A. Information Required to be Given to the Applicant

- 1. Explanation of Medicaid Program** The agency must inform the applicant about Medicaid eligibility requirements, covered services, use of the Medicaid card, recovery (3rd party, lawsuits and estate) of funds paid, and the applicant's rights and responsibilities. This information must be given to the applicant in written form and verbally, if appropriate.

The following materials must be given to the individuals specified below:

- The booklet "Virginia Social Services Benefit Programs," form # 032-01-002, contains information about the Medicaid Program and must be given to all applicants;

- The Division of Child Support Enforcement (DCSE)'s booklet "Child Support and You," form #032-01-945 must be given to applicants who are applying on behalf of a child who has an absent parent; *and*
- The "Virginia Medicaid Handbook" must be given to all recipients and must be given to others upon request.

Applicants may also be given Medicaid Fact Sheets as appropriate.

2. Early Periodic Screening, Diagnosis and Treatment (EPSDT)

All Medicaid applicants who are under age 21 are eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. Information on the availability and benefits of EPSDT must be provided for all applicants under age 21 within 60 days of the date that eligibility is determined. EPSDT information is included in the booklet "Virginia Social Services Benefit Programs."

3. Voter Registration

The National Voter Registration Act of 1993 (NVRA) requires local social services agencies to offer each TANF, Food Stamp, and Medicaid applicant an opportunity to apply to register to vote at initial application and at each review of eligibility. Additionally, voter registration application services must be provided any time a change of address is reported in person to the local agency.

In complying with the requirements of the NVRA, local agency staff must provide each applicant and *enrollee* the same degree of assistance in completing his/her voter registration application as they do in completing the application for public assistance.

a. Exceptions to Offering Voter Registration

The only exception to offering voter registration application services is when the *individual*:

- has previously indicated that he is currently registered to vote where he lives,
- there is a completed agency certification form in the *individual's* case record indicating the same, and
- the *individual* has not moved from the address where he stated that he was registered to vote.

b. Prohibitions

Local social services agencies and agency staff are prohibited from the following activities when providing voter registration application services:

- *seeking to influence an individual's political preference;*
- *displaying any political preference or party affiliation;*

- *making any statement to the or taking any action the purpose or effect of which is to discourage the individual from applying to register to vote; or*
- *making any statement to an individual or taking any action the purpose of which is to lead the individual to believe that a decision to register or not register has any impact on the individual's eligibility for assistance or the benefit level that they may be entitled to receive.*

c. Voter Registration Services

Each local social services agency must provide the following voter registration services:

- *distribution of voter registration application forms;*
- *assistance to individuals in completing the registration application form, unless such assistance is refused, and ensuring that all spaces on the form are completed;*
- *ensuring that the certification statement on the application for benefits or statement of facts is completed; and*
- *acceptance of voter registration application forms for transmittal to the local general registrar.*
 - 1) *Each completed registration application must be submitted to the local general registrar every Friday (if Friday is a holiday, the forms must be forwarded to the local registrar on the last working day before Friday.) Completed forms are to be forwarded to the local registrar in an envelope, notated with an "A" in the upper left-hand corner and listing the number of completed registration applications included in the envelope.*
 - 2) *For split/combined agencies, all voter registration applications are to be transmitted to the general registrar in the locality where the local social services agency is located.*
 - 3) *If the individual chooses, he may take a voter registration application to be mailed to the State Board of Elections at his own cost.*

d. Voter Registration Application

In Virginia, one voter registration application form will be used to serve a twofold purpose:

- *the voter registration application will be completed by the individual with necessary assistance from local agency staff during the*

application/review process and left at the local agency for transmittal to the local general registrar; or

- *for individuals who do not wish to complete the voter registration during the application process, they may take a voter registration form for mail-in registration.*

e. Individuals Required to be Offered Voter Registration Services

In order to be offered voter registration services, an individual must:

- *be a member of the Medicaid family unit.*
- *be at least 18 years old by the next general election. General elections are held in all localities on the Tuesday after the first Monday in November or on the first Tuesday in May to fill offices regularly scheduled by law to be filled at those times.*

If any question arises as to whether the individual will turn 18 before the next general election, complete the registration application and the local registrar will determine if the individual may be registered.

- *be present in the office at the time of the application or renewal interview if an interview takes place, or when a change of address is reported in person. If a change of address is not reported in person, a registration application will be sent to the individual upon request. Any change in the Medicaid family unit composition that does not occur concurrent with an application, renewal or change of address will be handled at the next scheduled renewal.*

Any individual accompanying the applicant/enrollee to the local agency who is not a member of the assistance unit (including payees and authorized representatives) will not be offered voter registration services by the local agency. However, a registration application is to be provided to the non-unit member upon request.

Any request for a mail-in application for assistance must include a mail-in voter registration application. When an authorized representative is applying on another individual's behalf, the local agency is to offer a mail-in voter registration application. In both situations, the bottom of the certification form is to be completed accordingly.

f. Voter Registration Application Sites

Local social services agencies are required to offer voter registration application services at each local office (including satellite offices) for applicants/recipients of TANF, Food Stamp, and Medical Assistance. Voter registration application services are also offered by out-stationed staff taking Medicaid applications at hospitals or local health departments and by

Medicaid staff at the state's Mental Health, Mental Retardation, and Substance Abuse facilities.

B. Information Made Available to the Public in General

1. Availability of Manual

Federal regulations require copies of the State Plan and eligibility rules and policies to be available in agency offices and other designated locations. Policy manuals must be made available in agency offices and other designated locations to individuals who ask to see them.

Upon request, copies of program policy materials must be made available without charge or at a charge related to the cost of reproduction. Copies of manual pages may be made at the local departments of social services, or Medicaid manuals may be ordered from:

Virginia Department of Social Services
Division of General Services
7 North Eighth Street,
Richmond, Virginia 23219

2. Medicaid Handbook and Fact Sheets

Federal regulation 42 CFR 435.905 requires the state agency to publish bulletins or pamphlets describing eligibility in easy to understand language. The "Virginia Medicaid Handbook" includes basic information about the program and provides a listing of rights and responsibilities. To supplement the "Virginia Medicaid Handbook," fact sheets that explain specific policy areas are available to local social services agencies from the state department of social services. The "Virginia Medicaid Handbook" will be given to all recipients at initial approval and to other individuals upon request. The handbook is also available on the internet at www.dmas.state.va.us.

C. Inquiries

1. General Inquiries

The following information has been developed to give guidance to employees of the State and local departments of social services about how to respond to inquiries:

- Limit verbal and written information to explaining the written materials provided. Those written materials may include copies of manual pages, the "Virginia Medicaid Handbook," or fact sheets. The individual may also be referred to the Virginia Department of Social Services website at www.dss.state.va.us and the Virginia Department of Medical Assistance Services website at www.dmas.state.va.us for additional information.
- Do not go beyond the scope of the written materials. Questions about hypothetical situations, such as (but not limited to) "what would happen if a certain value of resources were transferred?" or "what would be the effect on Medicaid if a trust were written in a certain way?" *should not* be answered.

Medicaid rules and policies are applied to the facts of a specific application after an application is received. Prior to receipt, do not give hypothetical advice or answers to hypothetical questions to applicants, their attorneys or anyone applying on behalf of the applicant. Answering hypothetical questions is inappropriate for two reasons:

- Until a complete application is received, the local agency cannot be sure it has all the relevant facts. An attempt to be helpful could be futile or lead to incorrect advice. In the event of a dispute, the applicant may then assert that the agency is bound by the incorrect advice. The applicant or other persons affected by the applicant's actions (such as those affected by a property transfer or those otherwise responsible for the care of the applicant) may attempt to hold the agency employee or employees involved individually liable for damages suffered as a result of alleged negligent advice.
- Providing responses to hypothetical questions may under some circumstances constitute the practice of law. The practice of law includes advising another for compensation, direct or indirect, in any matter involving the application of legal principles to facts or purposes or desires. Local agency workers, regional Medicaid consultants, and central office Medicaid employees, even if they are attorneys, are not functioning as legal counsel and must not give legal advice which may affect the rights of applicants, recipients, or others who may not be applying or eligible for Medicaid.

All Medicaid staff are bound by these guidelines for the dissemination of information. Do not refer inquiries from attorneys, applicants or others acting on behalf of the applicant to regional or state Medicaid staff.

2. Case Specific Inquiries

Send questions that occur as a direct result of the receipt of an application to the regional Medicaid consultant. Do not refer questions from attorneys (or legal questions in general) to the Regional Assistant Attorney General. These attorneys are responsible for providing legal advice to the regional Medicaid consultant and are not authorized to give legal advice to the public.

M0110.400 Retention of Case Information

A. Introduction

The agency must maintain case records that contain information necessary to support the facts essential to the determination of initial and continuing eligibility as well as any basis for discontinuing or denying assistance. The case record shall consist of a hard (i.e. paper) record, an electronic record, or a combination of the two. Records of active cases must be maintained for as long as the client receives benefits, while closed records must be maintained for a minimum of three years from the date of closure.

B. Policy

Case records must contain the following elements:

- the date of application,
- the date of and basis for the disposition of the application,

- facts essential to the determination of initial and continuing eligibility,
- the provision of medical assistance (i.e. enrollment),
- the basis for discontinuing medical assistance,
- the disposition of income and eligibility verification information, and
- the name of the agency representative taking action on the case and the date of the action.

The agency must include in each applicant's case record documentation to support the agency's decision on his application and the fact that the agency gave recipients timely and adequate notice of proposed action to terminate, discontinue or suspend their eligibility or to reduce or discontinue services they may receive under Medicaid. Types of documentation that support the agency's decision include evaluations of eligibility, case narratives, and permanent verifications.

The case record must contain a duplicate, either electronically or in writing, of all notices sent to the client. Copies of the documents used for verification of citizenship and identity, such as birth certificates, must also be maintained within the case record.

Active cases may be purged with the exception of documentation that supports the information shown in the paragraphs above. Agencies may wish to retain other information used in future eligibility determinations, such as resource assessments and burial contracts. Closed cases are required to be retained by the agency for a period of no less than three years from the date of closure.

The case record shall be organized as to enable audit and program integrity entities to properly discharge their respective responsibilities for reviewing the manner in which the Medicaid program is being administered.

CHAPTER M01
APPLICATION FOR MEDICAL ASSISTANCE

SUBCHAPTER 20

MEDICAL ASSISTANCE APPLICATION

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B. 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, *except Plan First and BCCPTA*, can be determined with this application form.
- 2. Application/Redetermination For SSI Recipients**

The Application/Redetermination for Medicaid for SSI Recipients, form #032-03-091 (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) is used for SSI recipients. If the applicant is not eligible for Medicaid in the SSI recipients covered group, his eligibility in other Medicaid covered groups, for FAMIS and for SLH can be determined using this application form.
- 3. Medicaid Application/Redetermination For Medically Indigent Pregnant Women**

The Medicaid Application/Redetermination for Medically Indigent Pregnant Women, form #032-03-040 (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) is acceptable if submitted for pregnant women. If any additional information is necessary (individual requires a resource evaluation for medically needy spenddown or for SLH), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant.
- 4. Health Insurance For Children and Pregnant Women**

The Health Insurance for Children and Pregnant Women, form FAMIS-1 (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) is an application form for children and/or pregnant women. If any additional information is necessary (individual requires a resource evaluation for medically needy spenddown or for SLH), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant.

5. **BCCPTA Medicaid Application** The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application, form #032-03-384, is used only by women screened under the Breast and Cervical Cancer Early Detection Program. **This form is not to be given to applicants by the local departments of social services** (M0120, Appendix 2 is provided for reference purposes only).
6. **ADAPT Statement of Facts** A signed ADAPT Statement of Facts (SOF) *is a valid application for anyone in an ADAPT case, including ABD Medicaid applicants who are in an ADAPT case, EXCEPT for Plan First and BCCPTA. The SOF cannot be used as a Plan First or BCCPTA application.* If any additional information is necessary (individual requires a resource evaluation), the appropriate pages from an Application for Benefits or Eligibility Review Form Part B if that form was obtained for Food Stamps can be used to collect the *additional* information. The pages must be signed by the applicant and attached to the SOF.
7. **Title IV-E Foster Care & Medicaid Application/Redetermination** The Title IV-E Foster Care & Medicaid Application/Redetermination, form #032-03-636 (available at: <http://www.localagency.dss.state.va.us/divisions/bp/me/forms/general.cgi>) is used for foster care or adoption assistance children who are eligible under Title IV-E of the Social Security Act. If any additional information is necessary (individual requires a resource evaluation for medically needy spenddown or for SLH), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant's guardian.
- For a *IV-E* FC child whose custody is held by a local department of social services or a private FC agency, or for a *IV-E* adoption assistance (AA) child, the Title IV-E Foster Care & Medicaid Application/Redetermination, form #032-03-636, is used to determine if the child meets *Medicaid* IV-E eligibility requirements. This form is also used to determine Medicaid eligibility for IV-E FC and *IV-E* AA children, and *for* non-IV-E FC children in the custody of a local agency in Virginia. This form is **not** used for children in non-custodial agreement cases or non-IV-E AA. When a child enters care through a non-custodial agreement, or *when a child* is a non-IV-E AA child, a separate Medicaid application must be completed and signed by the parent or guardian.
- For IV-E FC children in the custody of another state's social services agency and *for* IV-E AA children, a separate Medicaid application is not required. The worker must verify the IV-E maintenance payment (for FC) or the IV-E status (for AA). Virginia residency (by declaration) and current third party liability (TPL) information must be obtained. This information may be supplied by the foster/adoptive parent or obtained from the agency that entered into the FC or AA agreement.
8. **Application for Adult Medical Assistance** *The Application for Adult Medical Assistance is intended for adults who are aged, blind or disabled or who need long-term care. It is available online at:*
<http://www.localagency.dss.state.va.us/divisions/bp/me/forms/general.cgi>

- 9. Auxiliary Grant (AG)** An application for AG is also an application for Medicaid. A separate Medicaid application is not required.
- 10. Plan First Application Form** The Plan First Application is for men and women who wish to apply for Medicaid coverage of family planning services only. Individuals who wish to apply for family planning services must complete and sign the Plan First Application. The Plan First Application form is available on the VDSS intranet at: <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.
- 11. SLH Application Form** The following form has been prescribed as the application form for SLH:
- Application for Benefits, form #032-03-824, also referred to as the Combined Application.

M0120.400 Place of Application

- A. Principle** The place of application is ordinarily the office of the local social service department serving the locality in which the applicant resides. Verification of residence is not required. Medicaid applications are also taken at designated hospitals and health clinics (Medicaid outstationed sites). If an applicant is homebound and needs assistance with completing the application, the agency, upon request, must arrange to have the application taken where he resides or is a patient.

A child whose residence is divided between two custodial parents living in different localities is considered to reside in the locality in which he attends school. If the child is not enrolled in school, the parents must decide which locality is the child's residence for Medicaid application/ enrollment purposes.

B. Foster Care, Adoption Assistance, Department of Juvenile Justice

- 1. Foster Care** Responsibility for taking applications and maintaining the case belongs as follows:

a. Title IV-E Foster Care

Children in the custody of a Virginia local department of social services or private foster care agency who receive Title IV-E maintenance payments apply at the agency that holds custody.

Title IV-E foster care children in the custody of another state's social services agency apply in the Virginia locality where they reside.

b. State/Local Foster Care

Non-Title IV-E (state/local) children in the custody of a Virginia local department of social services or a private child placing agency apply at the agency that holds custody.

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

2. Adoption Assistance

Children receiving adoption assistance through a Virginia local department of social services apply at the agency that made the adoption assistance agreement.

Children receiving adoption assistance through another state's social services agency apply at the local department of social services where the child is residing.

3. Virginia Department of Juvenile Justice/Court (Corrections Children)

Children in the custody of the Virginia Department of Juvenile Justice or who are the responsibility of a court (corrections children) apply at the local agency where the child is residing.

C. Institutionalized Individual (Not Incarcerated)

When an individual of any age is a resident or patient in a medical or residential institution, except DMHMRSAS facilities and the Virginia Veteran's Care Center, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in Virginia in which he last resided outside of an institution.

Exception: If the applicant is applying for or receives Food Stamps, responsibility for processing the Medicaid application and determining Medicaid eligibility rests with the department of social services in the locality in which the institution where he is receiving care is located.

If the individual did not reside in Virginia prior to entering an institution, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in which the institution where he is receiving care is located.

D. Individuals in DMHMRSAS Facilities

1. Patient in a DMHMRSAS Facility

If an individual is a patient in a state DMHMRSAS institution, is not currently enrolled in Medicaid, and is eligible in an Aged, Blind or Disabled (ABD) covered group, responsibility for processing the application and determining eligibility rests with the state department of social services' eligibility technicians located in DMHMRSAS facilities. A listing of facilities and technicians as well as further information on the handling of cases of Medicaid applicants and recipients in DMHMRSAS facilities is located in Subchapter M1550.

If an individual is a patient in a State DMHMRSAS Institution, is not currently enrolled in Medicaid, and is eligible in a Families and Children's (F&C) covered group, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in Virginia in which he last resided outside of an institution.

**2. Patient
Pending
Discharge
(Pre-release
Planning)**

a. General Policy

For DMHMRSAS facility patients who will be discharged, local agencies will take the applications received on behalf of these patients and process them within the established time frames. Eligibility will be determined based on the type of living arrangement to which the patient will be discharged.

If the patient was not Medicaid eligible in the DMHMRSAS facility but Medicaid eligibility in the patient's new circumstances needs to be determined, an application must be sent to the appropriate *local* department of social services. The facility physician or discharge planning authority must attach a written statement that includes the following information:

- the date of the proposed discharge,
- the type of living arrangement and address to which the patient will be discharged (nursing facility, adult care residence, private home, relative's home, etc.), and
- the name and title of the person who completed the statement.

The discharge planner or case manager must follow up the application and statement with a telephone call to the agency worker on or after the patient's actual discharge to confirm the discharge date and living arrangement. The agency cannot enroll the patient without the confirmation of the discharge date and living arrangement.

b. Pending Discharge to a Facility

If a patient who was not Medicaid eligible in the DMHMRSAS facility is being discharged to an assisted living facility or nursing facility, an application for Medicaid will be filed with the department of social services in the locality in which the patient last resided prior to entering an institution.

c. Pending Discharge to the Community

If a patient who was not Medicaid eligible in the DMHMRSAS facility will live outside of an institution, the responsibility for processing the application and determining eligibility rests with the locality in which he will be living.

d. Eligibility Determination and Enrollment

The local agency determines the patient's Medicaid eligibility BEFORE actual discharge, based on the type of living arrangement to which the patient will be discharged. If the patient is found eligible for Medicaid in the locality, he is not enrolled in Medicaid until the day he is discharged from the DMHMRSAS institution.

When the individual is discharged, the DMHMRSAS discharge planner, or the individual, may call the local agency worker on the discharge date. The worker can then enroll the patient in the MMIS and give the enrollee number to the discharge planner.

**E. Individuals In
Virginia Veteran's
Care Center**

Medicaid applications for patients in the Virginia Veteran's Care Center in Roanoke may be filed, processed and maintained at the Roanoke City Department of Social Services.

**F. Incarcerated
Individuals Pre-
release Planning**

Inmates of state correctional facilities may apply for Medicaid as part of pre-release planning. Responsibility for processing the application and determining eligibility rests with the local department of social services in the locality where the inmate was living prior to incarceration. Applications are to be processed in the same manner and within the same processing time standards as any other Medicaid application, but if the incarcerated individual is found eligible, he is **not** enrolled in the Medicaid program until after he has been released from the correctional facility.

Applications are not to be refused because an applicant is an inmate of a public institution at the time of application.

a. Department of Corrections Procedures

The following procedures will be followed by correctional facility staff when an inmate in a Virginia Department of Corrections facility will require placement in a nursing facility upon release:

- The correctional facility staff will complete the Medicaid application and, if a disability determination is needed, the disability report and medical release forms. The correctional facility staff will notify the assigned Medicaid consultant and mail the forms to the local department of social services in the locality where the inmate was living prior to incarceration.
- The correctional facility staff will request a pre-admission screening for nursing home *or community-based* care from the health department or local department of social services in the locality where the correctional facility is located. This screening is to be done simultaneously with the determination of disability and determination of Medicaid eligibility. The staff will coordinate with nursing facilities in order to secure a placement.

b. Eligibility Determination and Enrollment

The local department of social services determines the patient's Medicaid eligibility BEFORE actual release, based on the type of living arrangement to which the applicant will be released. If the applicant is found eligible for Medicaid in the locality, he is not enrolled in Medicaid until the day he is released from the Department of Corrections facility.

The Corrections facility's pre-release planner or the individual may call the local agency worker on the release date. The worker can then enroll the eligible applicant in the MMIS and provide the enrollee number.

M0120.500 Receipt of Application

A. General Principle

An applicant or authorized representative may submit a written application for Medicaid only or may apply for Medicaid in addition to other programs.

An applicant may be assisted with completing the various aspects of the application by an individual(s) of his choice and may designate in writing that such individual(s) may represent him in subsequent contacts with the agency.

B. Qualified Individuals (QI)

Eligibility for Medicaid as a QI begins the first day of the application month, and ends December 31 of the calendar year, if funds are still available for this covered group. A QI must submit a new Medicaid application on or after January 1 of each year in order to receive continued coverage. Applications for QI coverage for an upcoming year may not be taken until January 1 of that year (see M0320.208).

C. Application Date

The application date is the earliest date the signed, written application for Medicaid or the Request for Assistance is received by the local agency, an outstationed site, or an entity contracted with DMAS to accept applications. The application must be on a form prescribed by DMAS and signed by the applicant or person acting on his behalf. The application may be received by mail, fax, or hand delivery. The date of delivery to the agency must be stamped on the application. If an application is received after the agency's business hours, the date of the application is the next business day.

The date of application for foster care children in the custody of a local department of social services is the date the application is received by the eligibility worker.

If an application for a pregnant woman or child is denied due to excess income, the applicant must be given the opportunity to complete an Application for Benefits in order to request a medically needy evaluation. If the Application for Benefits is submitted within 10 days of the date the notice of denial was mailed, the application date is protected, and the date of application is the date the denied application was received.

M0120.600 When An Application Is Required

A. New Application Required

A new application is required when there is:

- an initial request for medical assistance, or
- a request to add a person to an existing case.

When an application is received because there is a new person in the family for whom medical assistance is requested, the annual renewal for the existing enrollees is done using the same application form. See subchapter M1520 for renewal policy and procedures.

**B. Application NOT
Required**

A new application is not required when an individual is already an active Medicaid enrollee or is enrolled in another medical assistance program. Changes in the enrollee's circumstances do not require a new application. Changes that do not require a new application include, but are not limited to, the following:

- a change in the case name,
- a change in living arrangements, and
- a change in income.

A change in living arrangements may require a partial review of the individual's eligibility when the change results in a change to the assistance unit. Whenever the change requires verifications that can be used to complete a renewal, the annual renewal should be completed at the time the change is reported.

CHAPTER M01
APPLICATION FOR MEDICAL ASSISTANCE
SUBCHAPTER 30

APPLICATION PROCESSING

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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 retroactive period* - 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.

There is no administrative finality on determining retroactive eligibility if eligibility for the months in the retroactive period has not been determined. 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 *entire retroactive period* – all three months prior to the application month – *even if a covered medical service was received in only one retroactive month*. The applicant must provide all verifications necessary to determine eligibility during *the retroactive 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 *retroactive* 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 electronically or in the case record 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,

Eligibility decisions are made following a prescribed sequence:

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

Subchapter M0210 contains the general principles of Medicaid Eligibility determination.

B. Hierarchy of Covered Group

An applicant must be evaluated for eligibility in all potential covered groups and enrolled in the group that is the most beneficial to the applicant. First, evaluate under covered groups offering full coverage and if the applicant is not eligible, evaluate under groups offering *limited* coverage. Further specific instructions regarding the determination of covered group are contained in chapter M03.

C. Applicant's Choice of Covered Group

An individual who meets more than one covered group may choose the covered group under which he wishes his eligibility determined. Appropriate policy used is based on that individual's choice. If the choice is not clear on the application/redetermination form, the individual must state his covered group choice in writing. If the applicant does not make a choice, enroll him in the covered group that is the most beneficial.

D. Application Disposition

1. General Principle

Each application must be disposed of by a finding of eligibility or ineligibility as supported by the facts in the case record, unless the application is withdrawn or terminated (see M0130.400).

If an applicant dies during the application process, his eligibility can only be established for the period during which he was alive.

2. Entitlement and Enrollment

a. Entitlement

Entitlement to medical assistance is based on the application month. However, entitlement cannot begin prior to an individual's date of birth, and cannot continue after an individual's date of death. See section M1510.100 for detailed entitlement policy and examples.

b. Enrollment

Medicaid *enrollees* must be enrolled in the Medicaid Management Information System (MMIS). Effective June 16, 2003, a new MMIS system was implemented. The Medicaid Eligibility Manual contains enrollment instructions based on the former MMIS. Some terminology and procedures used in the current MMIS differ from those used with the former MMIS. When following enrollment instructions in this manual, please note the following changes:

- The program designation (PD) is now known as aid category (AC). The AC is now the former PD prefaced by the digit “0.” (e.g. AC 051).
- Coverage types are no longer used to enroll limited periods of coverage. Coverage is determined by begin and end dates.
- The former cancel reasons are now prefaced by the digit “0” (e.g. cancel reason 007).

When enrolling an individual in the MMIS, the appropriate aid category (AC) for the applicant’s covered group must be used. Enrollment procedures

and a list of ACs are found in the MMIS Users’ Guide for DSS, that can be accessed from the DSS local agency intranet at:

http://localagency.dss.virginia.gov/divisions/bp/me/vammis_documents.cgi.

3. Notification to Applicant

The Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs (NOA), form #032-03-008 (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) must be used to notify the applicant when:

- the application has been approved, including the effective date(s) of his Medicaid coverage;
- the retroactive Medicaid coverage was approved, including the effective dates;
- the application has been denied, including the specific reason(s) for denial cited from policy;
- retroactive Medicaid coverage was denied, including the specific reason(s) for denial cited from policy;
- there is a reason for delay in processing his application;
- a request for re-evaluation of an application in spenddown status has been completed; and
- a child has been approved or denied (including the specific reason for denial cited from policy) for FAMIS (see M21).

A copy of the notice must also be mailed to the individual who has applied on behalf of the applicant.

E. Notification for Retroactive Entitlement

There are instances when an applicant is not eligible for ongoing eligibility but is eligible for retroactive benefits or a change in the applicant's situation during the application process results in the applicant being eligible for only a limited period of time. Only one NOA is sent to the applicant covering both actions. Statements of the exact dates of eligibility, the date of ineligibility, and the reason(s) for ineligibility must be included on this notice.

M0130.400 Applications Denied Under Special Circumstances

- A. General Principle** When an application is withdrawn or the applicant cannot be located, the application is denied. The reason for the denial must be recorded in the case record, and a Notice of Action on Medicaid must be sent to the applicant's last known address.
- B. Withdrawal** An applicant may withdraw his application at any time. The request must be written and documented in the record. When the applicant withdraws an application, the eligibility worker must send a Notice of Action on Medicaid. An applicant may voluntarily withdraw only his application for retroactive coverage by signing a statement specifically indicating the wish to withdraw the retroactive coverage part of the application.
- C. Inability to Locate** The agency must send a letter to the last known address informing the applicant of the agency's attempt to locate him and asking that he contact the office. For applicants who are documented as homeless, maintain all correspondence at the local agency. If the applicant does not respond within 45 days of the date of application, deny the application.
- D. Duplicate Applications** Applications received requesting Medicaid and/or FAMIS for individuals who already have an application recorded or who are currently active will be denied due to duplication of request. A Notice of Action on Medicaid will be sent to the applicant when a duplicate application is denied.

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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 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, and
- documentation of 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. *Individuals entitled to or enrolled in Medicare, Social Security Disability Insurance (SSDI) beneficiaries and SSI recipients currently entitled to SSI payments (this does NOT include 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 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, is deemed eligible for Medicaid as a "certain newborn" through age one as long as the child continues to reside with his mother and the mother and child continue to reside in Virginia. See M0320.301.

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.

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).

Afghan and Iraqi immigrants admitted to the U.S. under a Special Immigrant Visa will have either (1) a Form I-551 or (2) a passport or I-94 form indicating categories SI1, SI2, SI3, QQ1, SQ2, or SQ3 and bearing the Department of Homeland Security stamp or notation.

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.

M0220.300 FULL BENEFIT ALIENS**A. Policy**

A “full benefit” alien is

- an alien who receives SSI (M0220.305);
- an American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (INA) apply, or a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)) (M0220.306);
- a “qualified” alien (defined in M0220.310 below) who entered the U.S. before 8-22-96;
- a qualified alien refugee, asylee, deportee, Amerasian, Cuban or Haitian entrant, or victim of a severe form of trafficking who entered the U.S. on or after 8-22-96, but only for the first 7 years of residence in the U.S. (M0220.313 C);
- *a qualified Afghan or Iraqi immigrant admitted to the U.S. on a Special Immigrant Visa, but only for six months (Afghan nationals) or eight months (Iraqi nationals) beginning with the month of entry into the U.S. or the date of conversion to Special Immigrant status, if not admitted under that status.*
- a qualified lawful permanent resident who entered the U.S. on or after 8-22-96 who has at least 40 qualifying quarters of work, but only **AFTER** 5 years of residence in the U.S. (M0220.313 B);
- a qualified alien who meets the veteran or active duty military requirements in M0220.311 below; or
- a “grandfathered” alien who meets the requirements in M0220.314 below.

A full benefit alien is eligible for full Medicaid benefits if he/she meets all other Medicaid eligibility requirements.

Aliens who are not “full benefit” aliens are “emergency services” aliens and may be eligible for emergency Medicaid services only if they meet all other Medicaid eligibility requirements. See section M0220.400 for emergency services aliens.

B. Procedure**1. Step 1**

First, determine if the alien receives SSI. Section M0220.305 describes this group of aliens who receive SSI.

If the alien does NOT receive SSI, go to Step 2.

If the alien receives SSI, go to Step 6.

2. Step 2

Second, determine if the alien is an American Indian born in Canada or a member of an Indian tribe as defined in section 4(e) of the Indian Self-

Determination and Education Assistance Act (25 U.S.C. 450b(e)). Section M0220.306 describes this group of aliens.

If NO, go to Step 3. If YES, go to Step 6.

3. Step 3

Third, determine if the alien is a “qualified” alien eligible for full benefits (a full benefit qualified alien).

- Section M0220.310 defines “qualified” aliens.
- Section M0220.311 defines qualified veteran or active duty military aliens.
- Section M0220.312 describes qualified aliens who entered the U.S. before 8-22-96.
- Section M0220.313 describes qualified aliens who entered the U.S. on or after 8-22-96.

If the alien is NOT a qualified alien eligible for full benefits, go to step 4.

If the alien is a qualified alien eligible for full benefits, go to step 6.

4. Step 4

Fourth, determine if the alien is a “grandfathered” alien. Section M0220.314 defines the grandfathered aliens.

If the alien is NOT a grandfathered alien, go to Step 5.

If the alien is a grandfathered alien, go to Step 6.

5. Step 5

*The alien is an “**emergency services**” alien. Go to Section M0220.400 which defines emergency services aliens, then to M0220.500 which contains the eligibility requirements applicable to all aliens, then to M0220.700 which contains the entitlement and enrollment policy and procedures for emergency services aliens.*

6. Step 6

*Use Section M0220.500, which contains the Medicaid eligibility requirements applicable to all aliens, to determine the alien’s Medicaid eligibility. Then use Section M0220.600, which contains the entitlement and enrollment procedures for **full benefit** aliens, to enroll an eligible full benefit alien.*

M0220.305 ALIENS RECEIVING SSI

A. Policy

An SSI recipient meets the Medicaid full benefit alien status requirements. Some SSI recipients who are aliens would have lost SSI and Medicaid eligibility. The Balanced Budget Act of 1997 restored SSI eligibility for certain groups of aliens:

- *a legal alien who was receiving SSI on August 22, 1996, may continue to receive SSI if he/she meets all other SSI eligibility requirements.*

- an alien who was blind or disabled on August 22, 1996, and who is residing legally in the U.S. may receive SSI in the future if he/she meets all other SSI eligibility requirements.
- a legal alien who is receiving SSI for months after July 1996 on the basis of an SSI application filed before January 1, 1979, is exempted from the SSI legal alien requirements, and is eligible for SSI if he/she meets all other SSI eligibility requirements.

B. Procedure

Verify the alien's SSI current payment status on the SDX or through SVES. If the alien currently receives SSI, and/or received SSI during the period for which Medicaid coverage is requested, the alien meets the alien status requirements for Medicaid with no further development.

Determine the alien SSI recipient's Medicaid eligibility using the policy and procedures for full benefit aliens in section M0220.600 below.

M0220.306 CERTAIN AMERICAN INDIANS**A. Policy**

An alien who is

- an American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (INA) apply, or
- a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)),

meets the Medicaid full benefit alien status requirements.

B. Procedure

Verify the status of an American Indian born in Canada from *USCIS* documents that the individual presents, or via the SAVE system.

Verify the status of a member of an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)) from official documents that the individual presents.

M0220.310 QUALIFIED ALIENS DEFINED**A. Qualified Aliens Defined**

A qualified alien is an alien who, at the time he applies for, receives or attempts to receive Medicaid is:

1. Lawful Permanent Resident

an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act.

2. Refugee

an alien who is admitted to the U.S. under the Immigration and Nationality Act as a **refugee under section 207 of the INA**, or an alien

who is admitted to the U.S. as **an Amerasian immigrant** pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act 1988 (as contained in section 101(e) of Public Law 100-202 and amended by the 9th proviso under MIGRATION AND REFUGEE ASSISTANCE in title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1989, Public Law 100-461, as amended).

The refugee will have a Form I-94 identifying him/her as a refugee under section 207 of the INA. The Amerasian immigrant will have an I-94 coded AM1, AM2, or AM3, or an I-551 coded AM6, AM7, or AM8.

3. Conditional Entrant

an alien who is granted conditional entry pursuant to section 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980.

Aliens admitted to the United States as conditional entrants pursuant to 203(a)(7) of the Immigration and Nationality Act (INA) (8 USC 1153(a)(7)) have an *USCIS* Form I-94 bearing the stamped legend "Refugee - Conditional Entry" and a citation of the INA section.

NOTE: Section 203(a)(7) of the INA was made obsolete by the Refugee Act of 1980 (P.L.96-212) and replaced by section 207 of the INA effective April 1, 1980.

4. Asylee

an alien who is granted asylum under section 208 of the Immigration and Nationality Act. Aliens granted asylum will have a Form I-94 and a letter.

5. Parolee

an alien who is paroled into the U.S. under section 212(d)(5) of the Immigration and Nationality Act for a period of at least 1 year. Aliens in this group will have a Form I-94 indicating that the bearer has been paroled pursuant to section 212(d)(5) of the INA.

**6. Deportee--
Deportation
Withheld**

an alien whose deportation is being withheld under section 243(h) of the INA (as in effect immediately before the effective date of section 307 of division C of Public Law 104-208) or section 241(b)(3) of the INA (as amended by section 305(a) of division C of Public Law 104-208). These aliens will have an order from an immigration judge showing that deportation has been withheld under section 243(h) or section 241(b)(3) of the INA and/or a Form I-94.

**7. Cuban or
Haitian
Entrant**

an alien who is a Cuban and Haitian entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980. A Cuban or Haitian Entrant is a person from Cuba or Haiti who

- has been granted parole by *USCIS* for humanitarian or public interest reasons, unless a final order of deportation or exclusion has been issued;
- has an application for asylum pending with *USCIS*, unless a final order of deportation or exclusion has been issued;

- is subject to *USCIS* exclusion or deportation proceedings, unless a final order of deportation or exclusion has been issued.

a. Humanitarian, Public Interest, Application for Asylum

To meet the humanitarian, public interest or application for asylum status, the Cuban or Haitian entrant must be from Cuba or Haiti and must have an I-94 with one or more of the following notations:

- humanitarian parole;
- public interest parole;
- section 212(d)(5);
- parole; or
- Form I-589 filed.

Contact *USCIS* if there is reason to believe that a final order of exclusion or deportation has been issued.

b. Subject to Exclusion or Deportation

To be subject to exclusion or deportation proceedings, the Cuban or Haitian entrant must be from Cuba or Haiti and must have letters or notices which indicate ongoing exclusion or deportation proceedings that apply to the individual. Contact *USCIS* if there is reason to believe that a final order of exclusion or deportation has been issued.

8. Battered Alien

an alien, and/or an alien parent of battered children and/or an alien child of a battered parent who is battered or subjected to extreme cruelty while in the U.S. who meets the following requirements:

- a. the perpetrator is a spouse, parent or other household member of the spouse or parent's family who was residing in the home at the time of the incident but is no longer in the home. The alien must not now be residing in the same household as the individual responsible for the battery or extreme cruelty, and
 - the alien was battered or subjected to extreme cruelty while in the U.S. by a spouse or a parent, or by a member of the spouse or parent's family residing in the same household as the alien, and the spouse or parent consented to or acquiesced in such battery or cruelty;
 - the alien's child was battered or subjected to extreme cruelty while in the U.S. by a spouse or a parent of the alien (without the active participation of the alien in the battery or cruelty), or by a member of the spouse or parent's family residing in the same household as the alien, and the spouse or parent consented or acquiesced to such battery or cruelty and the alien did not actively participate in such battery or cruelty; or

- the alien child resides in the same household as a parent who has been battered or subjected to extreme cruelty while in the U.S. by that parent's spouse, or by a member of the spouse's family residing in the same household as the parent and the spouse consented or acquiesced to such battery or cruelty.
- b. the agency providing benefits determines (according to the guidelines to be issued by the U.S. Attorney General) that there is a substantial connection between the battery or cruelty and the need for benefits; and
- c. the alien has a petition approved by or pending with *USCIS* for one of the following:
 - status as an immediate relative (spouse or child) of a U.S. citizen;
 - classification changed to immigrant;
 - status as the spouse or child of a lawful permanent resident alien (LPR); or
 - suspension of deportation and adjustment to LPR status based on battery or extreme cruelty by a spouse or parent who is a U.S. citizen or LPR alien.

**9. Afghan or
Iraqi Special
Immigrant**

an alien who is lawfully admitted into the U.S. on a Special Immigrant Visa (SIV) for permanent residency. Aliens in this group include the principal SIV holder, his spouse, and his children under age 21 living in the home. Afghan and Iraqi Special Immigrants will have either (1) a Form I-551 or (2) a passport or I-94 form indicating categories SI1, SI2, SI3, QQ1, SQ2, or SQ3 and bearing the Department of Homeland Security stamp or notation.

M0220.311 VETERAN & ACTIVE DUTY MILITARY ALIENS

**A. Veterans or Active
Duty Military
Aliens**

An alien lawfully residing in the state (not here illegally) is always eligible for full Medicaid benefits (if he/she meets all other Medicaid eligibility requirements) **regardless of the date of entry into the U. S.**, if he or she meets one of the following conditions:

1. he/she is a qualified alien and is a veteran discharged honorably not on account of alienage, and who fulfills the minimum active-duty service requirements of section 5303A(d) of title 38, United States Code;
2. he/she is a qualified alien and is on active duty (other than active duty for training) in the Armed Forces of the United States (not in the Armed Forces Reserves),
3. he/she is the
 - a) spouse or the unmarried dependent child of a living (not deceased) qualified alien who meets the conditions of 1. or 2. above, or

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

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

- B. Services Available To Eligibles** A qualified alien who entered the U.S. before 8-22-96 and who meets all other Medicaid eligibility requirements is eligible for the full package of Medicaid covered services available to the alien's covered group.
- C. Entitlement & Enrollment of Eligibles** The Medicaid entitlement policy and enrollment procedures for eligible qualified aliens who entered the U.S. before 8-22-96 are found in section M0220.600 below.

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

- A. First 6/8 Months of Residence in U.S.** *Two laws, P.L. 110-16 effective December 26, 2007, and P.L. 110-181, effective January 28, 2008, granted limited eligibility for full Medicaid benefits to qualified Afghan or Iraqi Special Immigrants, their spouses, and their children under age 21 who live in the home. For a limited time, these Special Immigrants are eligible for full Medicaid benefits available to the covered group they meet (if they meet all other Medicaid eligibility requirements).*

*Effective December 26, 2007, Afghan and Iraqi Special Immigrants became eligible for full Medicaid benefits for **six months** beginning with the month of entry in the U.S. or the date of conversion to Special Immigrant status, if not admitted under that status. Effective January 28, 2008, the period of eligibility for **Iraqi Special Immigrants only** was extended to include **eight months** beginning with the month of entry into the U.S. or the date of conversion to Special Immigrant status. Eligibility for full Medicaid coverage cannot be granted for periods prior to the effective dates of the laws granting benefits to these immigrants.*

After the applicable limited time period expires, individuals aged 19 years and older are no longer eligible for full-benefit Medicaid and are eligible for Medicaid payment of emergency services only unless the requirements in M0220.313 B for Lawful Permanent Residents are met. Children under age 19 who are Lawful Permanent Residents meet the requirements in M0220.314 B.1 for "grandfathered aliens."

- B. First 7 Years of Residence in U.S.** During the first seven years of residence in the U.S., four groups of qualified aliens (as defined in M0220.310 above) who entered the U.S. on or after 8-22-96 are eligible for the full package of Medicaid benefits available to the covered group they meet (if they meet all other Medicaid eligibility requirements). These 4 groups of qualified aliens who entered the U.S. on or after 8-22-96 are:

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

Refugee status is usually adjusted to Lawful Permanent Resident status after 12 months in the U.S. For the purposes of establishing Medicaid eligibility, such individuals may still be considered refugees. To determine former Refugee status of a Lawful Permanent Resident, check the coding on the I-551 for codes RE-6, RE-7, RE-8, or RE-9.

2. **Asylees**
Asylees under section 208 are full benefit aliens for 7 years from the date asylum in the U.S. is granted. Once 7 years have passed from the date the alien is granted asylum in the U.S., the asylee becomes an “emergency services” alien.
3. **Deportees**
Deportees whose deportation is withheld under section 243(h) or section 241(b)(3) are full benefit aliens for 7 years from the date withholding is granted. After 7 years have passed from the date the withholding was granted, the deportee becomes an “emergency services” alien.

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

4. **Cuban or Haitian Entrants**
Cuban and Haitian entrants as defined in section 501(e) of the Refugee Education Assistance Act of 1980 are full benefit aliens for 7 years from the date they enter the U.S. After 7 years have passed from the date they entered the U.S., a Cuban or Haitian entrant becomes an “emergency services” alien.
5. **Victims of a Severe Form of Trafficking**
Victims of a severe form of trafficking as defined by the Trafficking Victims Protection Act of 2000, P.L. 106-386 are full benefit aliens for 7 years **from the date they are certified or determined eligible** by the Office of Refugee Resettlement (ORR). Victims of a severe form of trafficking are identified by either a letter of certification (for adults) or a letter of eligibility (for children under age 18 years) issued by the ORR (see Appendix 5 of this subchapter). **The date of certification/eligibility specified in the letter is the date of entry for a victim of a severe form of trafficking.** After 7 years have passed from the certification/eligibility date, a victim of a severe form of trafficking becomes an “emergency services” alien unless his status is adjusted.

- C. **AFTER 5 Years of Residence in U.S.**
After five years of residence in the U.S., one group of qualified aliens (as defined in M0220.310 above) who entered the U.S. **on or after 8-22-96** is eligible for the full package of Medicaid benefits available to the covered group they meet (if they meet all other Medicaid eligibility requirements). This group of qualified aliens who entered the U.S. on or after 8-22-96 is the **lawful permanent resident who has at least 40 qualifying quarters of work.**

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

Note: If the LPR had prior Refugee status, he may be considered to have Refugee status for the purposes of Medicaid eligibility. To determine former Refugee status of a Lawful Permanent Resident, check the coding on the I-551 for codes RE-6, RE-7, RE-8, or RE-9. Refer to M0220.313 A.1.

AFTER 5 years have passed from the date of entry into the U.S., Lawful Permanent Residents who have at least 40 qualifying quarters of work are “full

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

2. Qualifying Quarter

- A qualifying quarter of work means a quarter of coverage as defined under Title II of the Social Security Act which is worked by the alien and/or
- all the qualifying quarters worked by the spouse of such alien during their marriage and the alien remains married to such spouse or such spouse is deceased, and all of the qualifying quarters worked by a parent of such alien while the alien was under age 18 years.

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

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

D. AFTER 7 Years of Residence in U.S.

After seven years of residence in the U.S., the qualified refugee, Amerasian, asylee, deportee, Cuban or Haitian entrant, or victim of a severe form of trafficking (as defined in M0220.310 above) who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an “emergency services” alien.

E. Services Available To Eligibles

1. Refugee, Amerasian, Asylee, Deportee, Cuban or Haitian Entrant, Victim of a Severe Form of Trafficking

A qualified refugee, Amerasian, asylee, deportee, Cuban or Haitian entrant, or victim of a severe form of trafficking (as defined in M0220.310 above) who entered the U.S. on or after 8-22-96 and who meets all other Medicaid eligibility requirements is eligible for the full package of Medicaid covered services available to the alien’s covered group during the first 7 years of residence in the U.S. After 7 years of residence in the U.S., the refugee, Amerasian, asylee, deportee, Cuban or Haitian entrant, or victim of a severe form of trafficking who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and is eligible for **emergency services only**.

2. LPR With 40 Work Quarters

After five years of residence in the U.S., a lawful permanent resident alien with 40 or more qualifying quarters of work who entered the U.S. on or after 8-22-96 is eligible for the **full package of Medicaid benefits** available to the covered group he/she meets if he/she meets all other Medicaid eligibility requirements.

F. Entitlement & Enrollment of Eligibles

The Medicaid entitlement policy and enrollment procedures for full benefit qualified aliens who entered the U.S. on or after 8-22-96 are found in section M0220.600 below.

The Medicaid entitlement policy and enrollment procedures for emergency services qualified aliens who entered the U.S. on or after 8-22-96 are found in section M0220.700 below.

M0220.314 GRANDFATHERED ALIENS *UNDER AGE 19*

- A. Grandfathered Aliens Under Age 19** Aliens who are under age 19 years and who would be eligible for full Medicaid benefits if the alien requirements prior to July 1, 1997, were still in effect, are eligible for full benefits. The alien status requirements that were in effect prior to July 1, 1997, are in section B. below.
- B. Alien Status Requirements in Effect Prior to 7-1-97 (*Applicable to Aliens Under Age 19*)** Prior to 7-1-97, aliens who had an immigration status as identified below were eligible for full Medicaid benefits if they met all other Medicaid eligibility requirements:
- 1. Lawful Permanent Resident** an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act.
 - 2. Refugees** an alien who is admitted to the U.S. under the Immigration and Nationality Act as a refugee under any section of the INA. The refugee will have a Form I-94 identifying him/her as a refugee under the INA.
 - 3. Conditional Entrant** an alien who is granted conditional entry pursuant to section 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980. Aliens admitted to the United States as conditional entrants pursuant to 203(a)(7) of the Immigration and Nationality Act (INA) (8 USC 1153(a)(7)) have an *USCIS* Form I-94 bearing the stamped legend "Refugee - Conditional Entry" and a citation of the INA section.

NOTE: section 203(a)(7) of the INA was made obsolete by the Refugee Act of 1980 (P.L.96-212) and replaced by section 207 of the INA effective April 1, 1980
 - 4. Asylee** an alien who is granted asylum under the Immigration and Nationality Act. These are, generally, aliens who would be otherwise deported. However, effective with the Refugee Act of 1980, asylum may be granted to an alien if it is determined that the alien is a refugee. Such asylum may be terminated if the Attorney General determines that the alien is no longer a refugee due to a change in the circumstances in the alien's country. Aliens granted asylum will have a Form I-94 and a letter.
 - 5. Parolee** parolees are:
 - aliens paroled into the United States, including Cuban/Haitian entrants, pursuant to section 212(d)(5) of the INA (8 USC 1182(d)(5));

- admitted to the United States for similar reasons as a refugee, i.e., humanitarian. However, this group, unlike refugee status, does not grant legal residence status. Parole status allows the alien temporary status until an *USCIS* determination of his/her admissibility has been made, at which time another status may be granted.

Aliens in this group will have a Form I-94 either indicating that the bearer has been paroled pursuant to section 212(d)(5) of the INA or stamped "Cuban/Haitian Entrant (Status Pending) Reviewable [date]" "Employment authorized until [date]." Possession of a properly annotated Form I-94 constitutes evidence of permanent residence in the U.S. under color of law, regardless of the date the Form I-94 is annotated.

6. Deportation Withheld

an alien with "deportation withheld" status is

- an alien granted a stay of deportation by court order, statute or regulation, or by individual determination of *USCIS* pursuant to section 245 of the INA (8 USC 1253 (a)) or *USCIS* Operations Instruction 245.3 whose departure *USCIS* does not contemplate enforcing, or
- an alien who is in deportation proceedings but deportation has been withheld because of conditions similar to those leading to a granting of refugee status, i.e., fear of persecution.

Aliens in this group have been found to be deportable, but *USCIS* may defer deportation for a specific period of time due to humanitarian reasons. These aliens will have an order from an immigration judge showing that deportation has been withheld under section 245(h) of the INA (8 USC 1253(h)) and/or a Form I-94.

7. Indefinite Voluntary Departure

aliens residing in the United States pursuant to an indefinite voluntary departure.

- Aliens in this group are in the midst of deportation proceedings and *USCIS*, using its discretion, has allowed the alien to depart the United States voluntarily without a deportation order.
- Aliens in this group will have a letter and/or a Form I-94 form indicating that the alien has been granted voluntary departure for an indefinite time period.

8. Immediate Relative Petition

aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition, who are entitled to voluntary departure (under 8 CFR 242.5(a)(2)(vi)) and whose departure *USCIS* does not contemplate enforcing. An immediate relative for *USCIS* purposes is: husband, wife, father, mother, or unmarried child under age 21.

- Aliens in this group are the immediate relatives of an American citizen or a lawful permanent resident and have had filed on their behalf a Form I-130 petition for issuance of an immigration visa. If this petition has been approved, a visa will be prepared, which will allow the alien to remain in the United States permanently.

- b. Aliens in this group will have a Form I-94 and/ or I-210 Letter. These documents will indicate that the alien is to depart on a specified date (usually 3 months from date of issue), however, *USCIS* expects the alien's visa to be available within this time. If it is not, extensions will be granted until the visa is ready. Also indicated on these documents is the authorization for employment.

**9. Status
Adjustment
Applicants**

aliens who have filed applications for adjustment of status pursuant to section 245 INA (8 USC 1255) that *USCIS* has accepted as "properly filed" (within the meaning of 8 CFR 242.5(a) or (b)) or has granted, and whose departure the *USCIS* does not contemplate enforcing.

- a. Aliens in this group have filed for lawful permanent resident status.
- b. Aliens in this group will have a Form I-181 or their passports will be stamped with either of the following: "adjustment application" or "employment authorized during status as adjustment applicant."

**10. Voluntary
Departure
Granted**

Aliens granted voluntary departure pursuant to 8 USC 1252(b) (section 242(b) of the INA) or 8 CFR 242.5 whose departure *USCIS* does not contemplate enforcing.

- a. Aliens in this group are awaiting a visa.
- b. Such aliens are provided Forms I-94 and/or I-210 which indicate a departure within 60 days. This may be extended if the visa is not ready within the time allotted.

**11. Deferred
Action Status**

Aliens granted deferred action status pursuant to *USCIS* operating instructions.

- a. Aliens in this group are similar to those under an order of supervision except there have been no formal deportation proceedings initiated.
- b. Aliens in this group will have a Form I-210 or a letter indicating that the alien's departure has been deferred.

**12. Deportation
Suspended**

Aliens granted suspension of deportation pursuant to section 244 of the INA (8 USC 1254) whose departure the *USCIS* does not contemplate enforcing.

- a. Aliens in this group have been found deportable, have met a period of continuous residence and have filed an application for *USCIS* to suspend deportation in an effort to be granted lawful permanent resident status.
- b. If the suspension is granted, the alien must wait through two full sessions of the Congress. If the Congress does not take action on the application, *USCIS* will grant the alien lawful permanent residence.
- c. These aliens will have a letter/order from the immigration judge and a Form I-94 with employment authorized for 1 year. After lawful permanent residence is granted, the alien will have a Form I-551, or I-151.

M0220.400 EMERGENCY SERVICES ALIENS

- A. Policy** Any alien who does NOT meet the requirements for full benefits as described in section M0220.300 through 314 above is an “emergency services” alien and is eligible for emergency Medicaid services only, if he or she meets all of the Medicaid nonfinancial and financial eligibility requirements.
- B. Procedure** Section M0220.410 describes the qualified aliens who entered the U.S. on or after 8-22-96 who are emergency services aliens.
- Section M0220.411 defines “unqualified” aliens.
- Section M0220.500 contains the Medicaid eligibility requirements applicable to full benefit and emergency services aliens.
- Section M0220.700 contains the entitlement and enrollment procedures for emergency services aliens.

M0220.410 EMERGENCY-SERVICES-ONLY QUALIFIED ALIENS WHO ENTERED U.S. ON OR AFTER 8-22-96

- A. First 5 Years of Residence in U.S.** During the first five years of residence in the U.S., four groups of qualified aliens (as defined in M0220.310 above) who entered the U.S. on or after 8-22-96 are eligible for **emergency Medicaid services only** provided they meet all other Medicaid eligibility requirements.
- 1. Lawful Permanent Residents (LPRs)** An LPR who enters the U.S. on or after 8-22-96 is an “emergency services” alien during the first 5 years the LPR is in the U.S., regardless of work quarters.

Note: If the LPR had prior Refugee status, he may be considered to have Refugee status for the purposes of Medicaid eligibility. To determine former Refugee status of a Lawful Permanent Resident, check the coding on the I-551 for codes RE-6, RE-7, RE-8, or RE-9. Refer to M0220.313.A.1.
 - 2. Conditional Entrants** A qualified Conditional Entrant who enters the U.S. on or after 8-22-96 is an “emergency services” alien.
 - 3. Parolees** A qualified parolee who enters the U.S. on or after 8-22-96 is an “emergency services” alien.
 - 4. Battered Aliens** A qualified battered alien who enters the U.S. on or after 8-22-96 is an “emergency services” alien.
- B. AFTER 5 Years of Residence in U.S.** **AFTER** 5 years have passed from the date of entry into the U.S., the following groups of aliens who entered on or after 8-22-96 are eligible for emergency services only:
- 1. Lawful Permanent Residents Without 40 Work Quarters** Lawful Permanent Residents who DO NOT have at least 40 qualifying quarters of work remain emergency services aliens after residing in the U.S. for 5 years. Lawful Permanent Residents who have at least 40 qualifying quarters of work become full benefit aliens after 5 years of residing in the U.S.

- 2. Conditional Entrants** A qualified Conditional Entrant who enters the U.S. on or after 8-22-96 is an “emergency services” alien.
- 3. Parolees** A qualified parolee who enters the U.S. on or after 8-22-96 is an “emergency services” alien.
- 4. Battered Aliens** A qualified battered alien who enters the U.S. on or after 8-22-96 is an “emergency services” alien.
- C. AFTER 7 Years of Residence in U.S.**
- 1. Refugees** After 7 years of residence in the U.S., a refugee or Amerasian immigrant who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an “emergency services” alien.
- 2. Asylees** After 7 years have passed since asylum was granted, an asylee who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an “emergency services” alien.
- 3. Deportees** After 7 years have passed since deportation was withheld, a deportee who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an “emergency services” alien.
- 4. Cuban or Haitian Entrants** After 7 years of residence in the U.S., a Cuban or Haitian Entrant who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an “emergency services” alien.
- D. Afghan and Iraqi Special Immigrants** *Medicaid coverage for Afghan and Iraqi Special Immigrants who are eligible in a Medicaid covered group cannot begin earlier than December 26, 2007. Afghan Special Immigrants are eligible for full Medicaid benefits for **six months** beginning with the month of entry in the U.S. or the date of conversion to Special Immigrant status, if not admitted under that status. From December 26, 2007 through January 27, 2008, Iraqi Special Immigrants are eligible for full Medicaid benefits for **six months** beginning with the month of entry in the U.S. or the date of conversion to Special Immigrant status. Effective January 28, 2008, Iraqi Special Immigrants are eligible for full Medicaid benefits for **eight months** beginning with the month of entry in the U.S. or the date of conversion to Special Immigrant status.*
- After the applicable limited time period expires, individuals become “emergency services” aliens unless the requirements in M0220.313 B. or M0220.314 are met.*
- E. Services Available To Eligibles** An emergency services alien who meets all Medicaid eligibility requirements is eligible for Medicaid coverage of emergency services only.
- F. Entitlement & Enrollment of Eligibles** The Medicaid entitlement policy and enrollment procedures for emergency services aliens are found in section M0220.700 below.

M0220.411 UNQUALIFIED ALIENS

- A. Unqualified Aliens** Aliens who do not meet the qualified alien definition M0220.310 above and who are **NOT** “grandfathered” aliens (M0220.314 above) are “unqualified” aliens and are eligible for emergency services only if they meet all other Medicaid eligibility requirements. Unqualified aliens include illegal and non-immigrant aliens.
- B. Illegal aliens** Illegal aliens were never legally admitted to the U.S. or were legally admitted for a limited period of time and did not leave when that period expired. If an alien remains in the U.S. after his visa expires, he becomes an illegal alien.
- C. Non-immigrant Aliens** Aliens who are lawfully admitted to the U.S. for a temporary or limited period of time, and the limited period has **not** expired, are non-immigrant aliens. Non-immigrants, such as visitors, tourists, some workers, and diplomats, are not eligible for Medicaid because of the temporary nature of their admission status (they do not meet the state residency requirement). Non-immigrants have the following types of *USCIS* documentation:
- Form I-94 Arrival-Departure Record,
 - Form I-185 Canadian Border Crossing Card,
 - Form I-186 Mexican Border Crossing Card,
 - Form SW-434 Mexican Border Visitor's Permit,
 - Form I-95A Crewman's Landing Permit.
- NOTE: If the alien remains in the U.S. after the limited time period (visa) is over, he becomes an illegal alien.
- Non-immigrants include:
1. **Visitors** visitors for business or pleasure, including exchange visitors;
 2. **Foreign Government Representative** foreign government representatives on official business and their families and servants;
 3. **Travel Status** aliens in travel status while traveling directly through the U.S.;
 4. **Crewmen** crewmen on shore leave;
 5. **Treaty Traders** treaty traders and investors and their families;
 6. **Foreign Students** foreign students;
 7. **International Organization** international organization representatives and personnel, and their families and servants;
 8. **Temporary Workers** temporary workers including some agricultural contract workers;
 9. **Foreign Press** members of foreign press, radio, film, or other information media and their families.

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

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

1. Residency

the Virginia residency requirements (M0230);

Aliens who are visitors (non-immigrants) *with valid visas* do not meet the *Virginia* state residency requirements because their visas will expire on a definite date. *See M0230 for state residency policy for a non-immigrant alien whose visa has expired.*

2. Social Security Number (SSN)

the SSN provision/application requirements (M0240);

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

M0220.600 FULL BENEFIT ALIENS ENTITLEMENT & ENROLLMENT

- A. Policy** An alien who is determined eligible for full Medicaid benefits and who meets all Medicaid eligibility requirements (including covered group requirements) is eligible for all Medicaid-covered services available to the recipient's covered group.
- B. Application & Entitlement**
- 1. Application Processing** The eligibility worker must take the application and develop it in the same manner as any other individual's application. All eligibility requirements, including covered group requirements must be met.
 - 2. Entitlement** If the applicant is found eligible for Medicaid, ongoing eligibility may exist unless the recipient is on a spenddown.
 - 3. Spenddown** Spenddown provisions apply to medically needy individuals who have excess income.
 - 4. Notice** Appropriate notice must be sent to the applicant of the status of his application and of his Medicaid eligibility.
- C. Enrollment Procedures** Once a full benefit alien is found eligible for Medicaid, he must be enrolled on the Medicaid computer (MMIS) using the following data:
- 1. Cty** In this field, Country of Origin, enter the code of the alien's country of origin.
 - 2. CI** In this field, Citizenship code, enter the MMIS citizenship code that applies to the alien. Next to the MMIS code is the corresponding Alien Code from the Alien Code Chart in Appendix 3 to this subchapter. Eligible alien codes are:

R = refugee (Alien Chart codes F1, F2, G1, G2); *also used for Afghan and Iraqi Special Immigrants (Alien Chart Code Z) during six- or eight-month period of full eligibility.*
E = entrant (Alien Chart code D1).
P = full benefit qualified aliens (Alien Chart codes A1, A2, A3, B1, B3, C1, E1, H1, H2, I1, J1, J2).
I = grandfathered aliens only (Alien Chart codes Y1, Y2, Y3)
 - 3. Entry date** **THIS FIELD MUST BE ENTERED.** Enter the date on which the alien entered the U.S., except for asylees and deportees. For asylees, enter the date asylum was granted. For deportees, enter the date deportation withholding was granted.
 - 4. App Dt** In this field, Application Date, enter the date of the alien's Medicaid application upon which the eligibility coverage period is based.
 - 5. Covered Dates Begin** In this field, coverage begin date, enter the date the alien's Medicaid entitlement begins.

UNITED STATES CITIZENSHIP AND IMMIGRATION SERVICES (USCIS) OFFICE

Effective April 15, 2008, all agencies needing to correspond with USCIS are to use the following address:

*USCIS
4th Floor, Crystal Plaza VI
2221 South Clark Street
Arlington, VA 22201-3745*

(phone: 1-800-375-5283).

	UNQUALIFIED ALIEN GROUPS (cont.)	Arrived Before 8-22-96	Arrived On or After 8-22-96	
T	Aliens granted suspension of deportation pursuant to Section 244 of the INA and whose deportation the <i>USCIS</i> does not contemplate enforcing [Immigration Judge Court Order]	Emergency Only <i>T1</i>	Emergency Only <i>T2</i>	Emergency Only <i>T3</i>
U	Any other aliens living in the US with the knowledge and permission of the <i>USCIS</i> whose departure the agency does not contemplate enforcing [<i>USCIS</i> Contact]	Emergency Only <i>U1</i>	Emergency Only <i>U2</i>	Emergency Only <i>U3</i>
V	Illegal aliens – aliens not lawfully admitted or whose lawful admission status has expired	Emergency Only <i>V1</i>	Emergency Only <i>V2</i>	Emergency Only <i>V3</i>
W	Visitors (non-immigrants): tourists, diplomats, foreign students, temp. workers, etc. [I-688B – 274a.12(b)(1)-(20); I-94; I-185: I-1186; SW-434; I-95A]	Emergency Only <i>W1</i>	Emergency Only <i>W2</i>	Emergency Only <i>W3</i>
GRANDFATHERED ALIENS				
Y	Unqualified aliens or emergency services qualified aliens under age 19 years who meet the alien status requirements that were in effect before 7-1-97	Full Benefits <i>Y1</i>	Full Benefits <i>Y2</i>	Full Benefits <i>Y3</i>

	AFGHAN AND IRAQI SPECIAL IMMIGRANTS	First Six/Eight Months after Entry into U.S.	Greater than Six/Eight Months after Entry into U.S., first 5 years	Greater than Six/Eight Months after Entry into U.S., after 5 years
Z	<i>Afghan Special Immigrants admitted on a Special Immigrant Visa (SIV), including the spouse and children under age 21 living in the home with the principal visa holder.</i> [I-551 or passport/ I-94 indicating categories S11, S12, S13, QQ1, SQ2, or SQ3 and bearing Department of Homeland Security stamp or notation]	<i>Full Benefits for SIX (6) MONTHS beginning with month of entry or date of conversion to SIV status. Coverage cannot begin prior to 12-26-07.</i>	<i>Emergency Only</i>	<i>See Line Items B and C on page 1 of this appendix.</i>
Z	<i>Iraqi Special Immigrants admitted on a Special Immigrant Visa, including the spouse and children under age 21 living in the home with the principal visa holder.</i> [I-551 or passport/ I-94 indicating categories S11, S12, S13, QQ1, SQ2, or SQ3 and bearing Department of Homeland Security stamp or notation]	<i>From 12-26-07 – 1-27-08, full Benefits for SIX (6) MONTHS beginning with month of entry or date of conversion to SIV status. Coverage cannot begin prior to 12-26-07.</i> <i>Beginning 1-28-08, full benefits for EIGHT (8) MONTHS beginning with month of entry or date of conversion to SIV status.</i>	<i>Emergency Only</i>	<i>See Line Items B and C on page 1 of this appendix.</i>

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M0230.000 VIRGINIA RESIDENCY REQUIREMENTS**M0230.001 POLICY PRINCIPLES****A. Policy**

An individual must be a Virginia resident in order to be eligible for Medicaid, but is not required to have a fixed address. This subchapter, M0230, explains in detail how to determine if an individual is a Virginia resident.

An individual placed by a Virginia government agency in an institution is considered a Virginia resident for Medicaid purposes even when the institution is in another state (section M0230.203 below).

For all other individuals, Virginia residency is dependent on whether the individual is under age 21 years or is age 21 or older (sections M0230.201 and 202 below).

B. Retention of Residency

Residence is retained until abandoned. Temporary absence from Virginia with subsequent return to the state, or intent to return when the purposes of the absence have been accomplished, does not interrupt continuity of Virginia residence.

C. Non-immigrant Aliens

Aliens who are non-immigrants (visitors, temporary workers) with valid (unexpired) visas do not meet the Virginia residency requirements.

If a non-immigrant alien's visa has expired, ask the individual "Where do you intend to live now that your visa has expired?" If the individual states in writing that he "intends to reside in Virginia now that his visa has expired," then the non-immigrant alien may meet the Virginia residence eligibility requirement for Virginia Medicaid.

D. Cross-Reference to Intra-State Transfer

Procedures for handling cases where individuals who are Virginia residents move from one Virginia locality to another are described in subchapter M1520.

E. No Fixed Address

The agency cannot deny Medicaid to an eligible Virginia resident just because the resident has no fixed address. A Virginia resident is not required to have a fixed address in order to receive Medicaid.

For an eligible Virginia resident who does not have a fixed address, use the local social services department's address for the Medicaid card and inform the resident that he must come to the social services department to receive his card until he obtains a fixed address.

F. Length of Residency

The agency may not deny Medicaid eligibility because an individual has not resided in Virginia for a specified period of time.

G. Residency in Virginia Prior to Admission to Institution

The agency may not deny Medicaid eligibility to an individual in an institution who meets the Virginia residency requirements previously identified in this subchapter, because the individual did not establish residence in Virginia before entering the institution.

- H. Temporary Absence** The agency may not deny or terminate Medicaid eligibility because of that individual's temporary absence from Virginia if the individual intends to return to Virginia when the purpose of the absence has been accomplished, UNLESS another state has determined that the individual is a resident there for Medicaid purposes.
- I. Disputed or Unclear Residency** If state residency is unclear or is in dispute, contact the regional specialist for help in resolution. When two or more states cannot resolve the residency, the state where the individual is physically located becomes the state of residence.

M0230.100 DEFINITION OF TERMS

- A. Introduction** For purposes of this subchapter only, the terms in this section have the following meanings:
- B. 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**.
- For purposes of state placement of an individual, the term "institution" also includes foster care homes approved by the state and providing food, shelter and supportive services to one or more persons unrelated to the proprietor.
- C. 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.
- D. Incapable of Indicating Intent** An individual is incapable of declaring his intent to reside in Virginia or any state if the individual:
- has an I.Q. of 49 or less or has a mental age of 7 or less, based on tests acceptable to the Virginia Department of Mental Health Mental Retardation & Substance Abuse Services (DMHMRSAS);
 - is judged legally incompetent; or
 - is found incapable of declaring intent to reside in a specific state based on medical documentation obtained from a physician, psychologist, or other professional licensed by the State in the field of mental retardation.
- E. Virginia Government Agency** A Virginia government agency is any state or local government agency, and any entity recognized by State law as being under contract with a Virginia state or local government agency.

M0230.200 RESIDENCY REQUIREMENTS**M0230.201 INDIVIDUALS UNDER AGE 21****A. Under Age 21
NOT In An
Institution****1. Blind or
Disabled**

For any individual under age 21

- who is not residing in an institution (as defined above in M0230.100)
AND
- whose Medicaid eligibility is based on blindness or disability,

the state of residence is the state in which the individual is living. If the individual lives in Virginia, he/she is a Virginia resident.

**2. Other
Individuals
Under Age 21**

An individual under age 21 who is **not** in an institution is considered a resident of Virginia if he/she:

- a. is married or emancipated from his/her parents, is capable of indicating intent and is residing in Virginia with the intent to remain in Virginia permanently or for an indefinite period;
- b. is presently living in Virginia on other than a temporary basis;
- c. lives with a caretaker who entered Virginia as a result of a job commitment or a job search (whether or not currently employed) and is not receiving assistance from another state;
- d. is a non-IV-E (state/local) foster care child whose custody is held by Virginia (see M230.204 C. and D.);
- e. is a non-IV-E child adopted under an adoption assistance agreement with Virginia (see M230.204 C. and D.);
- f. is a non-IV-E foster care child whose custody is held by a licensed, private foster care agency in Virginia, regardless of the state in which the child physically resides;
- g. is under age 21 and is residing in another state for temporary period (for reasons such as medical care, education or training, vacation, (or visit) but is still in the custody of his/her parent(s) who reside in Virginia.
- h. is living with a parent(s) who is a non-immigrant alien (admitted to the U.S. for a temporary or limited time) *whose visa has expired* when the parent has declared his intent to reside in Virginia permanently or for an indefinite period of time, *and no other information is contrary to the stated intent. If the non-immigrant parent's visa is still valid, the parent and the child are NOT Virginia residents for Medicaid eligibility purposes.*

B. Under Age 21 In An Institution**If the individual was placed in the institution by a state government agent, go to section M0230.203 below.**

An institutionalized individual (who was not placed in the institution by a state government) who is under age 21 and is not married or emancipated, is a resident of Virginia if:

1. the individual's parent or legal guardian was a Virginia resident at the time of the individual's institutional placement;
2. the individual's parent or legal guardian who applies for Medicaid is a Virginia resident and the individual is institutionalized in Virginia; or
3. the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, the individual is institutionalized in Virginia, and the party who files the Medicaid application resides in Virginia.
4. for an individual under 21, if a legal guardian has been appointed for the child and parental rights have been terminated, the guardian's state of residence is used instead of the parent's to determine residency.

C. Under Age 21, Custody or Adoption Agreement with Another State

When another state's child-placing agency has custody of a child who lives in Virginia with a foster family, the child is NOT a Virginia resident unless the child is eligible as a IV-E Foster Care child and receives a IV-E Foster Care maintenance payment.

1. IV-E Eligible Children

A Title IV-E Foster Care child who lives in Virginia and who receives a Title IV-E maintenance payment from another state meets the Virginia residency requirements for Medicaid.

A Title IV-E Adoption Assistance child who lives in Virginia and has a Title IV-E Adoption Assistance agreement in effect with another state's child-placing agency meets the Virginia residency requirements for Medicaid.

2. Non-IV-E Foster Care

A non-IV-E Foster Care child placed in Virginia from another state does NOT meet the Virginia residency requirements for Medicaid.

3. Non-IV-E Adoption Assistance and Adoptive Placement

A child who lives in Virginia with an adoptive family is considered to be living with a parent, regardless of whether a final order of adoption has been entered in court. When his adoptive parent is a Virginia resident, the child is a Virginia resident for Medicaid eligibility purposes. A Non-IV-E Adoption Assistance child whose adoption assistance agreement is signed by another state's child-placing agency is a Virginia resident when the child lives in Virginia with the adoptive parent(s).

M0230.202 INDIVIDUALS AGE 21 OR OLDER**A. Introduction**

For an individual age 21 or older, the determination of state residency depends on

- whether or not the individual is in an institution, and
- whether or not the individual is capable of indicating his or her intent to reside in the state.

B. Age 21 Or Older NOT In An Institution

For any individual age 21 or older NOT residing in an institution, the state of residence is Virginia when:

- the individual is living in Virginia with the intention to remain in Virginia permanently or for an indefinite period;
- the individual is incapable of indicating intent and the individual is living in Virginia; or
- the individual is living in Virginia and entered the state with a job commitment or seeking employment (whether or not currently employed).

C. Age 21 Or Older In An Institution

If the individual was placed in the institution by a state government agent, go to section M0230.203 below.

1. Capable of Stating Intent

An individual in an institution who is age 21 or over and who is capable of declaring his intent to reside in Virginia, is a resident of Virginia if the individual is in an institution in Virginia with the intent to remain permanently or for an indefinite period.

2. Became Incapable Before Age 21

An individual in an institution who is age 21 or over and who became incapable of stating intent before age 21 is a Virginia resident if:

- a. regardless of the physical location where the individual actually resides, Virginia is the individual's state of residence when the individual's legal guardian or parent who files the Medicaid application resides in Virginia;
- b. the individual's parent or legal guardian was a Virginia resident at the time of the individual's institutional placement;
- c. the individual's parent or legal guardian who applies for Medicaid resides in Virginia and the individual is institutionalized in Virginia; or
- d. the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, the individual is institutionalized in Virginia and the party who files the Medicaid application resides in Virginia.

If a legal guardian has been appointed for the individual and parental rights have been terminated, the guardian's state of residence is used instead of the parent's to determine residency.

3. **Became Incapable At or After Age 21** An individual in an institution who is age 21 or over and who became incapable of stating intent at or after age 21 is a Virginia resident if he or she is residing in Virginia and was not placed here by another state.

M0230.203 STATE PLACEMENT IN INSTITUTION

A. Policy

Any agency of the state, including an entity recognized under state law as being under contract with the state for such purposes, that arranges for an individual to be placed in an institution located in another state, is recognized as acting on behalf of the state in making the placement. The state arranging or actually making the placement is considered the individual's state of residence. When an individual is placed by state or local government in an institution in another state, the individual remains the responsibility of the placing state unless the state or local government agency in the other state assumes responsibility for the individual's care or Medicaid eligibility.

When an individual is placed by a Virginia government agency in an institution in another state, the individual remains the responsibility of Virginia unless

- a state or local government agency in the other state assumes responsibility for the individual's care or Medicaid eligibility,
- the individual is a child who receives a IV-E foster care or adoption assistance payment, or
- the individual is a child who receives **non-IV-E adoption assistance** and the state in which he is placed is a reciprocal state under the interstate compact, verified by the central office Deputy Compact Administrator, Adoption Unit, Division of Family Services, Virginia Department of Social Services (DSS).

B. State Placement

Placement by a state government agency is any action taken by the agency, beyond providing general information to the individual and *his* family, to arrange admission to an institution for the individual. The following actions do not constitute state placement:

- providing basic information to individuals about other states' Medicaid programs or about the availability of health care services and facilities in other states;
- assisting an individual, who is capable of declaring intent and who independently decides to move out-of-state, in locating an institution in another state.

1. Lack Of Facilities

When a placement is initiated by a state because the state lacks a sufficient number of appropriate facilities to provide services to its residents, the state making the placement is the individual's state of residence for Medicaid purposes.

2. Individual Leaves Facility

When a competent individual leaves the facility in which he was placed by a state, that individual's state of residence for Medicaid purposes is the state where the individual is physically located.

- C. Individual Placed Out-of-State by Virginia Government** An individual can leave Virginia and retain Virginia residency if he is placed in an institution outside Virginia by a Virginia government agency. Out-of-state placement into a long-term care facility must be preauthorized by the Director of the Virginia Department of Medical Assistance Services for Virginia Medicaid to pay for the institutional care.

When a competent individual voluntarily leaves the facility in which Virginia placed him, he becomes a resident of the state where he is physically located.

M0230.204 CASH ASSISTANCE PROGRAM RECIPIENTS

- A. Introduction** Certain individuals are considered residents of Virginia for Medicaid purposes if they live in Virginia and receive a cash assistance payment specified below in this section. Some recipients of cash assistance from a Virginia social services agency who do NOT reside in Virginia are considered residents of Virginia for Medicaid purposes, as specified below.
- B. Auxiliary Grants Recipients** An individual receiving an Auxiliary Grants (AG) payment from a locality in Virginia is considered a Virginia resident.
- An individual who receives a State Supplement of SSI payment from another state is considered a resident of the state making the State Supplement payment.
- C. IV-E Payment Recipients** For an individual of any age who receives federal foster care or adoption assistance payments under Title IV-E of the Social Security Act, the state of residence for Medicaid eligibility is the state where the child lives.
- D. Non-IV-E Foster Care Payment Recipients** The non IV-E (state/local) foster care payment recipient is a resident of the state that is making the non IV-E payment.
- E. Non-IV-E Adoption Assistance Payment Recipients** *The non IV-E (state/local) Adoption Assistance recipient is a resident of the state in which the child's adoptive parent(s) resides, regardless of whether a final order of adoption has been entered in court.*

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M0240.000 SOCIAL SECURITY NUMBER REQUIREMENTS

M0240.001 GENERAL PRINCIPLES

A. Policy

1. Medicaid

To be eligible for Medicaid, an individual must provide his Social Security number (SSN) as well as the SSN of any *person* for whom Medicaid is requested, or must provide proof of application for an SSN, **UNLESS** the applicant

- is an illegal alien as defined in subchapter M0220 *who is eligible only for Medicaid payment of emergency services, or*
- *is a child under age one born to a Medicaid-eligible mother, as long as the mother would still be eligible for Medicaid had the pregnancy not ended and the mother and child continue to live together (see M0320.301 B. 2.).*

An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

2. FAMIS & FAMIS MOMS

*To be eligible for FAMIS or FAMIS MOMS, an individual is **not** required to provide or apply for an SSN.*

B. Failure to Meet SSN Requirement

Any Medicaid family unit member for whom an application for an SSN has not been filed or for whom the SSN is not furnished is **not eligible** for Medicaid EXCEPT for:

1. Child Under Age 1

a child under age one born to a Medicaid-eligible mother; a newborn is deemed to have applied and been found eligible for Medicaid as long as the mother remains Medicaid-eligible (or would be eligible if she were pregnant) and they continue to live together, whether or not the eligibility requirements, including SSN, have actually been met.

2. Illegal Alien

an illegal alien as defined in Section M0220; an illegal alien does not have to provide or apply for an SSN.

C. Relationship to Other Medicaid Requirements

An applicant who cannot provide documentation that he is a citizen or legally present at the time of application must sign an affidavit under oath attesting that he is a U.S. citizen or legally present in the U.S. in order to temporarily meet the requirement for proof of legal presence (see M0210.150). **Submission of the affidavit without proof of application for an SSN does NOT meet the SSN requirement.**

D. Verification

The individual's SSN must be verified by the Social Security Administration (SSA).

E. Procedure

Section M0240.100 below explains in detail how to determine if an individual meets the SSN requirements when the individual or child does not have an SSN.

M0240.100 APPLICATION FOR SSN

A. Policy

If an SSN has not been issued for the individual or the individual's child(ren), the applicant must cooperate in 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 verified and entered in the Medicaid Management Information System (MMIS).

1. Newborns

In the case of a newborn child, the applicant/recipient may satisfy this requirement by requesting that an SSN be applied for by hospital staff in conjunction with the filing of the birth record at the time of the child's birth. Form SSA-2853 will be given to the mother by hospital staff as verification of application for the child's SSN.

2. Failure to Apply for SSN

Applicants who refuse to furnish an SSN or to show proof of application for a number are ineligible for Medicaid.

B. Exceptions

Any Medicaid family unit member for whom an SSN has not been applied **is not eligible** for Medicaid EXCEPT for:

1. Child Under Age 1

a child under age one born to a Medicaid-eligible mother, *who meets the definition in M0320.301 of a newborn "deemed" eligible for Medicaid.* A newborn is deemed to have applied and been found eligible for Medicaid as long as the mother remains Medicaid-eligible (or would be eligible if she were pregnant) and they continue to live together, whether or not the eligibility requirements including SSN, have actually been met. See M0320.301 for a newborn's eligibility as a child under age 1.

2. Illegal Alien

an illegal alien as defined in Section M0220. An illegal alien does not have to apply for an SSN.

M0240.200 FOLLOW-UP REQUIREMENTS FOR SSN

A. Policy

When an applicant who has applied for an SSN is determined eligible for medical assistance, he is enrolled with a pseudo-SSN. The worker must obtain the enrollee's SSN when it is assigned and enter it into the enrollee's records.

B. Procedures

1. Documentation

If the applicant does not have an SSN, the agency must document in the record the date he applied for an SSN.

2. Entering Computer Systems

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.

When enrolling an eligible individual in MMIS, use the date the individual applied for an SSN, or the individual's date of birth, preceded by "888."

3. Follow-up

a. Follow-up in 90 Days

After enrollment of the eligible individual, the agency must follow-up within 90 days of the Social Security number application date or 120 days if application was made through hospital enumeration.

b. Check for Receipt of SSN

Check the MMIS and ADAPT records for the enrollee's SSN. If the SSN still has "888" or "APP" as the first 3 digits, contact the enrollee to obtain the enrollee's SSN verbally or by mail.

c. Verify SSN

Verify the SSN by a computer system inquiry of the SSA records.

d. Enter Verified SSN in Systems

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.

4. Renewal Action

If the enrollee's SSN has not been assigned by the 90-day follow-up, the worker must follow-up no later than the enrollee's annual renewal, by checking the systems for the enrollee's SSN and by contacting the enrollee if necessary.

a. Check for Receipt of SSN

Before or at renewal, the SSN must be entered into MMIS and ADAPT. 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 or by mail, or on the renewal form if a renewal form is required.

c. Verify SSN

Verify the SSN by a computer system inquiry of the SSA records.

d. Enter Verified SSN in Systems

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.

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parents who adopt "hard to place" foster care children who were in the custody of a local department of social services or a child placing agency licensed by the state of Virginia.

1. Residing in Virginia

Adoption assistance children are children who reside in Virginia who are adopted under a Title IV-E or Non-IV-E (state-local) adoption assistance agreement with a department of social services or in conjunction with a child-placing agency.

2. Child-placing Agency Definition

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. When Adoption Assistance Is Effective

A child under 21 is *usually considered* an adoption assistance child when the adoption assistance agreement is signed, even if the interlocutory or judicial decree of adoption has not been issued or adoption subsidy payments are not being made. *The adoptive parents are considered to be the adoption assistance child's parent(s) as of the date the adoption agreement is signed.*

If the child is not eligible because of the adoptive family's income, treat the adoption assistance child as a foster care child until the interlocutory or judicial decree of adoption has been issued. As a foster child, the child's assistance unit consists of one person and the adoptive parent's income is not deemed to the child.

NOTE: if the child is a foster child for income eligibility, the child must be treated as a foster child for all other Medicaid eligibility criteria including Virginia residence. A non-IV-E foster care child who is in the custody of another state is NOT a Virginia resident. See M0230.

B. IV-E and Non-IV-E

1. IV-E Adoption Assistance

a. Definition

The following children meet the IV-E adoption assistance definition:

- 1) Children adopted under a IV-E adoption assistance agreement with a Virginia local department of social services or in conjunction with a private child placing agency, who reside in Virginia. Eligibility begins when the IV-E adoption assistance agreement is signed even if an interlocutory or judicial decree of adoption has not been issued, or subsidy payments are not being made.
- 2) Children adopted under a IV-E adoption assistance agreement with another state's department of social services, who now reside in Virginia.

b. IV-E Adoption Assistance payment not required

The IV-E adoption assistance definition is met when the adoption assistance agreement specifies that *cash and medical assistance is required or that* the only assistance required is medical assistance. *Receipt of cash assistance is not required to meet the Adoption Assistance definition.*

**2. Non-IV-E
Adoption
Assistance**

a. Non-IV-E definition

The following children meet the Non-IV-E adoption assistance definition:

- 1) *Children who reside in Virginia who are adopted under a Non-IV-E adoption assistance agreement with a Virginia local department of social services or in conjunction with a Virginia private child placing agency.*
- 2) *“Special Medical Needs” children adopted under a Non IV-E Adoption Assistance agreement with a Virginia local department of social services or a Virginia private, non-profit child placement agency in conjunction with a local department of social services, in accordance with policies established by the State Board of Social Services.*

b. Special Medical Needs definition

A child with “special medical needs” is a child who was determined unlikely to be adopted because of:

- a physical, mental or emotional condition that existed prior to adoption; or
- a hereditary tendency, genetic defect, congenital problem or birth injury leading to a substantial risk of future disability.

c. Agreement must specify “special medical need(s)”

The adoption assistance agreement must specify that the child has a special medical need; the agreement does NOT need to specify a particular diagnosis or condition.

d. Virginia Medicaid coverage for Special Medical Needs children

Medicaid coverage is to be provided to any child who has been determined to be a Non-IV-E Special Medical Needs *adoption assistance* child for whom there is in effect an adoption assistance agreement between a *local Virginia department of social services (LDSS) or a Virginia child-placing agency* and an adoptive parent(s).

Virginia Medicaid coverage MAY be provided to a special medical needs child for whom there is in effect an adoption assistance agreement between another state’s child-placing agency and an adoptive parent(s) IF the other state reciprocates with Virginia per the Interstate Compact on Adoption and Medical Assistance (ICAMA).

3. Verification

a. Adoption assistance agreement with Virginia agency

A child's status as an adoption assistance child is verified by the LDSS agency foster care/adoption assistance worker. Documentation of the child's *IV-E* or *Non-IV-E* adoption assistance eligibility must be part of the Medicaid case record.

Verification of a child's status as a Virginia *IV-E*, *Non-IV-E* or *Special Medical Needs* adoption assistance recipient is obtained through the local agency's Service Programs Division.

b. IV-E adoption assistance agreement with another state

When the *IV-E* adoption assistance agreement is with another state and the *IV-E* child resides in Virginia, verification of the child's status as a Title *IV-E* adoption assistance recipient is verified through the Deputy Compact Administrator, Adoption Unit, Division of Family Services, Virginia Department of Social Services.

c. Non-IV-E adoption assistance agreement with another state

Verification of the child's *Non-IV-E* adoption assistance status with another state, and the state's reciprocal agreement under the Interstate Compact on Adoption and Medical Assistance (*ICAMA*), is obtained through the Deputy Compact Administrator, Adoption Unit, Division of Family Services, Virginia Department of Social Services.

If the state that signed the non-IV-E adoption assistance agreement does NOT reciprocate Non-IV-E adoption assistance eligibility with Virginia, then the Non-IV-E Adoption Assistance child is not eligible for Virginia Medicaid in the Adoption Assistance classification of the "Individuals Under Age 21" covered group.

M0310.103 AFDC

A. Aid To Families With Dependent Children (AFDC)

AFDC is the short name of the Aid to Families With Dependent Children cash assistance program that was operated in Virginia prior to the February 1, 1997, implementation of TANF (Temporary Assistance to Needy Families). It was a federally funded assistance program under Title IV-A of the Social Security Act. In Virginia, AFDC was replaced by TANF on February 1, 1997.

B. Procedure

AFDC is defined here because of the occasional references in Medicaid policy to the AFDC program that was in effect on July 16, 1996. There are no current recipients of AFDC because the AFDC program no longer exists.

M0310.104 AG

A. Auxiliary Grants (AG)

"AG" is the short name for the Auxiliary Grants Program. AG is Virginia's assistance program that supplements the federal Supplemental Security Income (SSI) assistance program. AG is Virginia's "State Supplementation of SSI." AG is available only to ABD financially eligible individuals who reside in licensed Adult Care Residences (ACRs).

B. Procedure

Check the local agency records of AG recipients. If the individual is eligible for and receiving an AG payment, he is an AG recipient for Medicaid purposes.

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:

- 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 *or in the month* he attains age 19; **AND**

NOTE: The above definition of a full-time student does NOT apply when determining student status for the student earned income exclusion. See sections M0720.500 B.2 and M0720.510 for the student income exclusion requirements.

- **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 the child 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, or adoption terminates relationship to the biological relatives.

2. Child's Father

Virginia law considers a man who is legally married to the mother of a child on the date of the child's birth to be the legal father of the child **UNLESS** DCSE or a court has determined that another man is the child's father. NOTE: The mother's marriage at the time of the child's birth does not require verification; the mother's declaration is sufficient.

The man listed on the application form as the child's father is considered the father when:

- the mother was not married to another man on the child's birth date, or
- the mother was married to another man on the child's birth date but DCSE or a court determined that the man listed on the application is the child's father

unless documentation, such as the child's birth certificate, shows that another man is the child's father.

See M0310.123 for the definition of a parent.

M0310.112 DISABLED

A. Introduction

The Social Security Administration (SSA) defines disability for an individual who is age 18 or older as the inability to do any substantial gainful activity (work) because of a severe, medically determinable physical or mental impairment which has lasted or is expected to last for a continuous period of not less than 12 continuous months, or which is expected to result in death.

SSA defines disability for a child under age 18 as having a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than 12 months. However, a child cannot be found disabled if, at application, the child is performing substantial gainful activity and is not currently entitled to SSI benefits.

The Disability Determination Services (DDS) is a division of the Virginia Department of Rehabilitative Services (DRS). DDS is charged with making the determinations of medical eligibility for disability or blindness benefits under Social Security (SS), Supplemental Security Income (SSI), and Medicaid. DDS works in partnership with the SSA, the Department of Medical Assistance Services (DMAS), and the Department of Social Services (DSS) in processing disability and blindness claims and makes its determinations of “disabled” or “not disabled” based upon federal regulations. The same definitions of disability and blindness and the same evaluation criteria are used for all three programs.

The Railroad Retirement Board (RRB) makes disability determinations for railroad employees. “Total” disability determinations mean the individual is disabled for all regular work. “Occupational” disability means the individual is disabled for regular railroad occupation, but not “totally” disabled. Individuals who receive a “total” disability determination are disabled using the same criteria as the SSA.

The Medicaid disability definition is the same as the SS, SSI, and the Railroad Retirement (RR) total disability definition.

B. Policy

Individuals who have been determined disabled or blind by DDS for Medicaid or for SSA, without a subsequent decision by SSA reversing the disability determination and individuals who have been determined disabled by the RRB meet the Medicaid covered group requirement of being “disabled.”

C. Who Meets the Medicaid Disability Definition

An individual meets the Medicaid disability definition if he:

- receives SS/SSI as a disabled individual, or RR total disability benefits; or
- has been found to be disabled by the DDS without a subsequent decision by SSA reversing the disability decision.

An applicant who received SS/SSI disability benefits or RR total disability benefits in one or more of the 12 months preceding the Medicaid application and whose benefits were terminated for a reason other than no longer meeting the disability or blindness requirement continues to meet the disability or blindness definition.

An applicant who *previously received SS/SSI benefits but* has not received SS/SSI disability benefits or RR total disability benefits in one or more of the 12 months preceding the Medicaid application must reapply for a disability determination.

1. Individual Has Been Determined Disabled and receives Benefits From SSA

If an applicant alleges that he has been found to be disabled and is receiving SS/SSI disability benefits, verify his disability status through a SVES (State Verification Exchange System) request or through documentation provided to the applicant by the SSA.

If the individual applies for retroactive coverage and the SSI decision or the SVES SSI information do not specify a disability onset date that covers the Medicaid application's retroactive period, refer the individual to DDS for a disability determination using the procedures in E. 1. below.

2. Individual Has Been Determined Totally Disabled by RRB

If an applicant alleges that he has been found to be totally disabled and is receiving RR benefits, verify his disability by contacting the RRB at 804-771-2997 or 1-800-808-0772, or through documentation provided to the applicant by the RRB.

3. Individual Has Been Determined Disabled by DDS

If the applicant alleges that he has been found to be disabled by the DDS but there is no disability determination on file, verify his status by contacting the DDS at 1-800-578-3672.

D. DDS Disability Determinations- General Information

An individual *age 19 years or older* who is claiming to have a disabling condition and does not receive SS/SSI disability benefits, or RR total disability benefits and has not been denied disability or has not had disability determined by DDS, must have his disability determined by DDS.

A child under age 19 who is claiming to have a disabling condition must have his disability determined by DDS:

- *if he is not eligible for FAMIS Plus or FAMIS, or*
- *if it is 90 calendar days prior to his 19th birthday.*

Do not refer a disabled child under age 19 to DDS for the sole purpose of the Health Insurance Premium Payment (HIPP) program.

1. DSS Referrals to DDS

The following forms must be completed and sent to DDS when DSS is requesting a disability determination:

- [Disability Report Adult SSA-3368-BK](#) (see Appendix 1 to this subchapter) or the [Disability Report Child SSA-3820-BK](#), (see Appendix 2 to this subchapter); and
- a minimum of 5 signed, original forms: [Authorization to Disclose Information to the Social Security Administration form SSA-827-02-2003](#) (see Appendix 3 to this subchapter) **or** 1 for each medical provider if more than 5; and
- a DDS Referral Form #032-03-0095, available on the intranet at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.

NOTE: the applicant may have a hard (printed) copy of an on-line Disability Report used to apply for Social Security benefits. A hard copy of the SSA on-line Disability Report for Adults (3368PRO) or Children (3820) may be accepted in lieu of the SSA-3368-BK or SSA-3820-BK; however, an individual cannot submit an actual on-line Disability Report to DDS for Medicaid disability determination purposes.

When the SSA disability report and the Authorization to Disclose Information to the Social Security Administration forms must be sent to the applicant for completion, send the request immediately, giving the applicant 10 calendar days to return the completed forms. When the completed forms are returned, mail them along with the DDS Referral form to:

Disability Determination Services Medicaid Unit
9960 Mayland Drive, Suite 203
Richmond, Virginia 23233-1463

Do not send referrals to DDS via the courier.

The eligibility worker must request the necessary verifications needed to determine eligibility so that the application can be processed as soon as the decision on the disability determination is received.

If the completed forms are not returned by the applicant within 45 *calendar* days from the date of application, the applicant is considered not to meet the covered group, and the Medicaid application must be denied.

2. Nonfinancial Requirements

For individuals who require a disability determination to meet the covered group requirement, the time standard for processing an application is 90 calendar days. Other non-financial requirements, however, must be met and verified by the 45th calendar day, or the application must be denied and DDS must be notified to stop action on the disability determination. Exception: allow up to the full 90 calendar days when the individual or agency is unable to obtain documentation of citizenship and/or identity within 45 calendar days of the application date. See M0220.100 D.9 for additional information.

F. Communication Between Agency and DDS

1. Agency

The *agency* must make every effort to provide the DDS with complete and accurate information. Report all changes in address, medical condition, and earnings to the DDS on pending applications.

If the *agency* is aware of changes in the applicant's situation that would make him ineligible for Medicaid even with a favorable disability determination, the information must immediately be provided to the DDS so that office will not complete a disability determination. The fact that an individual has excess resources is not a reason for DDS to stop the development of a disability claim (see M0130.100.B.4).

When an application is denied for a nonfinancial reason not related to the disability determination, DDS must be notified immediately.

2. DDS Responsibilities

The DDS will advise the agency of the applicant's disability status as soon as it is determined by either SSA or the DDS. For hospitalized individuals who meet the requirements for an expedited (within 7 working days) disability determination, DDS will fax the outcome of the disability determination decision to the *agency*. For all other disability determinations, DDS will send the *agency* a notice to be sent to the applicant advising him of the outcome of his disability determination.

A disability determination cannot be completed within the allotted time when there is missing or incomplete medical information. In the event that this situation occurs, the DDS will notify the applicant directly of the delay and/or the need for additional information. A copy of the DDS's notice to the applicant will be sent to the agency so the *agency* can send a Notice of Action to extend the pending application.

DDS will notify the agency if it rescinds its denial of an applicant's disability to continue an evaluation of the individual's medical evidence. If the Medicaid application has been denied, the agency must reopen the application and notify the applicant of the action. The application continues to pend until notification is received from DDS of the disability determination. If an appeal has been filed with DMAS, the agency must notify the DMAS Appeals division so that the appeal may be closed (see M1650.100).

G. Notice to the Applicant

The eligibility worker must complete the Medicaid eligibility determination immediately after receiving notification of the applicant's disability status and send the client both the DDS's notification of the disability determination and a Notice of Action of the agency's decision on the Medicaid application.

H. Applicant is Deceased

When an individual who applies for a disability determination and Medicaid dies or when the applicant is deceased at the time of the Medicaid application, the DDS will determine if the disability requirement for Medicaid eligibility was met. The *agency* must immediately notify DDS of the individual's death and provide a copy of the death certificate, if available.

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:

- a local board of social services;
- a licensed private, non-profit child placement agency;
- the Department of Juvenile Justice; or
- the child's parent(s), under a non-custodial agreement.

Federal regulations define "foster care" as "24-hour substitute care for children placed away from their parents or guardians and for whom the State agency has placement and care responsibility" (45 C.F.R. §1355.20). Transfer of the legal custody of the child is not a component when determining if a child is considered to be in foster care. The federal definition is based upon the child being placed outside of the home and who has placement and care responsibility for the child. If a child is placed outside of the home and LDSS is the case manager with placement and care responsibility, then the federal government considers the child to be in foster care. For the federal government, the term "placement and care" means that LDSS is legally accountable for the day-to-day care and protection of the child through either a court order or a voluntary placement agreement.

1. Custody

Custody may be given to an agency by the court or may be retained by the parent(s) or guardian when a non-custodial agreement is involved. If custody is retained by the parent under a parental agreement with the Community Policy and Management Team (CPMT), the child is NOT in foster care.

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. Independent Living

A foster care child who is under age 21, who is in an Independent Living arrangement and receives full or partial support from a local social services agency, continues to meet the foster care definition and may be eligible in the covered group of Individuals Under Age 21.

4. Non-custodial and Parental Agreements

a. Non-custodial Agreement

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

Non-custodial agreements are used when LDSS serves as the case manager and has placement and care responsibilities to place a child outside of his home for treatment.

Children with non-custodial agreements are considered to be in foster care for Medicaid eligibility purposes.

b. Parental Agreement

A parental agreement is an agreement between the child's parent or guardian and an agency other than DSS which is designated by the CPMT. The other agency designated by the CPMT has placement and care responsibility for the child and agrees to provide financial assistance and/or services to the child, such as placement in and payment for residential facility services.

Parental agreements are used when an agency other than LDSS is designated by the CPMT as case manager and the child is placed outside of the home for treatment.

Children with parental agreements ARE NOT considered to be in foster care for Medicaid eligibility purposes.

c. Placement

Federal Title IV-E funds can only be claimed if LDSS has placement and care responsibility for the child and the child is placed by LDSS outside the child's home. If the LDSS has placement and care responsibility for the child and the child is placed in the child's home, the child is not eligible for Title IV-E funds and is a Non-IV-E foster child for Medicaid eligibility purposes.

5. Department of Juvenile Justice

A child in the custody of the Virginia Department of Juvenile Justice or who is the responsibility of a court is a "Department of Juvenile Justice (DJJ) child."

B. Procedures

1. IV-E Foster Care

Children who are eligible for and receive Title IV-E (AFDC-FC) foster care maintenance payments are IV-E Foster Care for Medicaid eligibility purposes. A child who is eligible for IV-E Foster Care but who does not receive a IV-E Foster Care maintenance payment is considered a "Non-IV-E Foster Care" child.

Children in the custody of another state's social services agency, who are eligible for *and receive* 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 who are eligible for *but do not receive IV-E maintenance payments or who are eligible for* Non-IV-E (state/local) Foster Care (*whether or not they receive a Non-IV-E payment*), and who reside in Virginia are Non-IV-E Foster Care for Medicaid eligibility purposes.

3. Non-IV-E Children in Another State's Custody

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

4. Trial Home Visits

A foster care or DJJ child continues to meet the foster care definition when placed by the agency in the child's own home for a trial period of up to six months. Do not redetermine Medicaid eligibility during the 6 month trial home visit.

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.

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M0320.000 CATEGORICALLY NEEDY GROUPS

M0320.001 GENERAL POLICY PRINCIPLES

A. Overview

A State Plan for Medicaid must include the mandatory federal categorically needy (CN) groups of individuals. Most of the CN groups are mandatory; some are optional which Virginia has chosen to cover in its Medicaid state plan.

Two of the Virginia Medicaid “subclassifications,” the “categorically needy non-money payment (CNNMP)” and the “medically indigent (MI),” are actually categorically needy covered groups according to the federal Medicaid law and regulations. This subchapter divides the covered groups which are classified as CN into “protected,” “ABD” and “F&C” groups.

B. Procedure

Determine an individual’s eligibility first in a categorically needy covered group. If the individual is not eligible as categorically needy, go to the medically needy groups in subchapter M0330.

The following sections in this chapter contain the policy and procedures for determining whether an individual meets a Medicaid categorically needy covered group:

- M0320.100 Protected Covered Groups
- M0320.101 Former Money Payment Recipients August 1972
- M0320.102 Conversion Cases
- M0320.103 Former SSI/AG Recipients
- M0320.104 Protected Widows or Widowers
- M0320.105 Qualified Severely Impaired Individuals (QSII-1619(b))
- M0320.106 Protected Adult Disabled Children
- M0320.107 Protected SSI Disabled Children

- M0320.200 ABD Categorically Needy Groups
- M0320.201 SSI Recipients
- M0320.202 AG Recipients
- M0320.203 ABD In Medical Institution, Income \leq 300% SSI
- M0320.204 ABD Receiving Waiver Services
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- M0320.305 IV-E Foster Care & IV-E Adoption Assistance
- M0320.307 Individuals Under Age 21
- M0320.308 Special Medical Needs Adoption Assistance
- M0320.309 F&C In Medical Institution, Income ≤ 300% SSI
- M0320.310 F&C Receiving Waiver Services
- M0320.311 F&C Hospice
- M0320.312 Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)

M0320.100 PROTECTED COVERED GROUPS

A. Legal base Federal law and regulations require that the Medicaid eligibility status of certain groups of persons be protected even though they may not meet current eligibility requirements. These groups, and the applicable eligibility requirements, are described in this section.

- B. Procedure**
- M0320.101 Former Money Payment Recipients August 1972
 - M0320.102 Conversion Cases
 - M0320.103 Former SSI/AG Recipients
 - M0320.104 Protected Widows or Widowers
 - M0320.105 Qualified Severely Impaired Individuals (QSII)-1619(b)
 - M0320.106 Protected Adult Disabled Children
 - M0320.107 Protected SSI Disabled Children.

M0320.101 FORMER MONEY PAYMENT RECIPIENTS AUGUST 1972

A. Policy 42 CFR 435.114 and 42 CFR 435.134--The agency must provide Medicaid to individuals who meet the following conditions:

- 1. Entitled to OASDI In August 1972 & Received Cash Assistance**
- In August 1972, the individual was entitled to OASDI and
- he was receiving AFDC, Old Age Assistance (OAA), Aid to the Blind (AB), or Aid to the Permanently and Totally Disabled (APTD); or
 - he would have been eligible for one of those programs if he had applied and the Medicaid plan covered this optional group. The Virginia plan covered this group; or
 - he would have been eligible for one of those programs if he was not in a medical institution or intermediate care facility and the Medicaid plan covered this optional group. The Virginia plan covered this group.
- 2. Would Currently Be Eligible If Increase Were Excluded**
- The individual *would meet the F&C income limits for LIFC* or currently eligible for SSI or AG except that the increase in OASDI under P.L. 92-336 raised his income over the *F&C income limits or SSI*. This includes an individual who
- meets all *LIFC* requirements or current SSI requirements except for the requirement to file an application; or

The cost-of-living increase(s) is not excluded when determining income eligibility in ANY other covered group. However, these individuals must be identified for possible future CNNMP protection as the SSI and AG income limits increase.

C. 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 former SSI or AG recipients in this group are classified as categorically needy non-money payment (CNNMP). Program designation is

- 021 for an aged individual;
- 041 for a blind individual;
- 061 for a disabled individual.

D. Eligibility for Non-Protected Family Members

The amount of an SSA cost-of-living increase that must be excluded when determining eligibility for a former SSI recipient **cannot** be excluded when determining Medicaid eligibility of the individual's non-protected spouse and/or children living with the former SSI recipient.

The former SSI recipient is included in his/her non-protected spouse's unit if the non-protected spouse is aged, blind, or disabled.

The former SSI recipient is included as a member of the family unit when determining a child's eligibility in an F&C covered group. All of the protected recipient's income, including the cost-of-living increase(s), is counted.

M0320.104 PROTECTED WIDOWS OR WIDOWERS

A. Policy

Two groups of disabled widow(er)s who lost SSI eligibility because of receipt of or increase in Title II disabled widow(er)s' or Title II widow(er)s' benefits have their Medicaid categorically needy eligibility protected. The first group consists of disabled widow(er)s who would be eligible for SSI except for the increase in disability benefits resulting from elimination of the reduction factor under P.L. 98-21 in January 1984. The second group consists of disabled widow(er)s age 50 through 64 who would be eligible for SSI except for early receipt of Social Security benefits.

B. July 1989 Protected Widow(er)s

42 CFR 435.137 - A "July 1989 protected widow(er)" is an individual who became entitled to SSA benefits when he/she had attained age 50 but not age 60 years, and

- who applied for Medicaid before July 1, 1989,
- was entitled to monthly OASDI benefits under Title II of the Social Security Act for December 1983,
- were entitled to and received widow's or widower's disability benefits under section 202(e) or 202(f) of the Social Security Act for January 1984,
- lost SSI and/or AG because of the January 1984 increase in disabled widow(er)'s benefits due to elimination of the reduction factor,
- has been continuously entitled to an SSA widow(er)'s disability benefit under section 202(e) or 202(f) of the Social Security Act since the first month that increase was received, and
- would be eligible for SSI or AG if the amount of the increase and any subsequent COLAs in the widow(er)s' SSA benefits were excluded.

1. Nonfinancial Eligibility

Determine the widow(er)'s eligibility using the procedures below. The widow(er):

- a. meets the nonfinancial eligibility requirements in chapter M02;
- b. applied for Medicaid as a protected individual prior to July 1, 1989;
- c. was entitled to and received a widow's or widower's benefit based on a disability under Section 202 (e) or (f) of the Social Security Act, for January 1984;
- d. became ineligible for SSI and/or AG payments because of the increase in the amount of his/her widow(er)'s benefit and:
 - the increase resulted from the elimination of the reduction factor for disabled widow(er)s entitled before age 60,

C. Financial Eligibility

1. **Asset Transfer** Asset transfer policy *only applies to individuals in long-term care. See 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:

- 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 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.

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 NEEDED

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, or BCCPTA definition, *or must have applied for Plan First.*

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 Plan First--Family Planning Services (FPS);
- M0320.303 MI Child Under Age 19 (FAMIS Plus);
- M0320.304 Low Income Families With Children (LIFC);
- M0320.305 IV-E Foster Care & IV-E Adoption Assistance;
- 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 level (FPL). 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 so long as the child resides with the mother, they reside in Virginia, and the mother remains eligible for Medicaid or would be eligible if she were still pregnant (with the newborn).

a. Eligible To Age 1

A child no longer meets this covered group effective the end of the month in which the child reaches age 1, provided he was under age 1 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 1. Any child born a Medicaid-eligible woman will continue to be eligible up to age 1 as long as the following conditions are met:

- 1) the child remains in the home with the mother,
- 2) the child and mother reside in Virginia, and

M0320.302 PLAN FIRST - FAMILY PLANNING SERVICES (FPS)

A. Policy

Since October 2002, family planning services (FPS) have been available to eligible women up to 24 months after the receipt of a Medicaid-covered pregnancy related service.

Effective January 1, 2008, a new family planning services health program known as Plan First is available to **uninsured** men and women who have countable income within 133% FPL and have not had a sterilization procedure. The previous requirements for receipt of a Medicaid-paid pregnancy-related service by women and the time limitations have been eliminated from the Plan First requirements.

The Plan First Application Form must be submitted for eligibility to be determined in this covered group. Exception: the application requirement for this covered group is different for women whose coverage in the MI Pregnant Woman covered group ended on or before December 31, 2007 or who were enrolled in FPS prior to January 1, 2008.

1. MI Pregnant Woman Coverage Ended On or Before December 31, 2007 or Already Enrolled in FPS as of January 1, 2008

Women who were eligible in the MI Pregnant Woman covered group and received a pregnancy-related service paid for by Medicaid became automatically eligible for FPS following the end of the 60-day postpartum period **when the postpartum period ended on or before December 31, 2007**. A separate eligibility determination was not required.

Changes in income do not affect eligibility for FPS for 12 months following the end of the pregnancy when:

- the woman was eligible in the MI Pregnant Woman covered group and received a pregnancy-related service paid for by Medicaid, and the postpartum period ended on or before December 31, 2007, or
- the woman was already enrolled in FPS as of January 1, 2008.

For FPS coverage to continue after the twelfth month, a redetermination of eligibility for Plan First, using the Plan First Application Form, must be completed.

2. Plan First Applications Taken On or After January 1, 2008

Uninsured men and women who have countable income within 133% FPL and have not had a sterilization procedure may be eligible for Plan First. **A Plan First application form is required** for initial eligibility and for each annual renewal. There is no automatic eligibility for Plan First other than the exception noted in A.1 above.

Plan First coverage cannot begin earlier than January 1, 2008.

Retroactive coverage is NOT available in the Plan First covered group.

3. Determine Medicaid Eligibility First

a. Application Indicates Potential Full-benefit Medicaid Eligibility

If the information contained in the Plan First application indicates potential eligibility in a full-benefit Medicaid covered group (e.g., the

applicant has a child under 18 in the home and has income within the LIFC income limit for the family unit size), the worker must determine whether eligibility for full benefit Medicaid coverage exists before the individual(s) can be determined eligible for Plan First.

b. Additional Information Needed For Full Benefit Medicaid

If additional information is needed to complete the eligibility determination for a full-benefit Medicaid covered group, the applicant must be given the opportunity to provide the additional information needed. If the additional information is not provided by the deadline, the worker will determine the applicant's eligibility for Plan First only.

c. Applicant Eligible for Plan First Only

If the applicant is not eligible for full benefit Medicaid but is eligible for Plan First, enrollment in Plan First must be made directly in the MMIS. ADAPT will not enroll eligible individuals in Plan First, even if the eligibility determination for full benefit Medicaid was done in ADAPT.

B. Nonfinancial Requirements

1. General Nonfinancial Requirements

Men and women in this covered group must meet the following Medicaid nonfinancial requirements in chapter M02:

- citizenship/alien status (emergency services aliens described in M0220.700 are not eligible);
- Virginia residency;
- Social Security number;
- assignment of rights to medical benefits;
- application for other benefits; and
- institutional status.

Men and women who have been determined eligible for a full benefit Medicaid covered group are not eligible for this covered group.

DCSE services are available to all Medicaid recipients, but cooperation with DCSE is not a condition of eligibility for this covered group.

2. Creditable Health Insurance Coverage

Plan First men and women must **not** have creditable health insurance coverage. Creditable health insurance coverage includes:

- church plans and governmental plans;
- health insurance coverage, either group or individual insurance;
- military-sponsored health care;
- a state health benefits risk pool;
- the federal Employees Health Benefits Plan;
- a public health plan; and
- any other health benefit plan under section 5(e) of the Peace Corps Act.

The definition of creditable coverage includes short-term, limited coverage.

Creditable health insurance coverage does not include:

- accident only;
- credit or disability insurance;
- 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.

3. Sterilization Procedure

Individuals who have had a sterilization procedure (such as tubal ligation, hysterectomy, vasectomy) are **not** eligible for Plan First. Information regarding receipt of a sterilization procedure is collected on the Plan First application/renewal form.

If an individual enrolled in this covered group receives a sterilization procedure paid for by Medicaid, DMAS will take action to cancel the coverage and send the appropriate notice.

C. Financial Eligibility

1. Assistance Unit

Use the assistance unit policy in chapter M05 to determine the FPS financial eligibility.

2. Asset Transfer

The asset transfer rules do not apply to the FPS covered group.

3. Resources

There is no resource limit.

4. Income

The income requirements in chapter M07 must be met for this covered group. The income limits are 133% FPL and are found in subchapter M710, Appendix 6.

5. Spenddown

Spenddown does not apply to this covered group.

D. Entitlement and Enrollment

1. Entitlement

Eligibility in the Plan First covered group begins the first day of the month in which the Plan First application is filed, if all eligibility factors are met in the month. Retroactive coverage is NOT available in the Plan First covered group.

Coverage for Plan First can begin no earlier than January 1, 2008.

Completion of a Plan First application is required at each renewal.

2. Enrollment

The AC for Plan First enrollees is “080.”

M0320.303 MI CHILD UNDER AGE 19 (FAMIS PLUS)

A. Policy

Section 1902(a)(10)(A)(i)(VI) and 1902 (l)(1)(C) of the Act - The federal Medicaid law requires the Medicaid State Plan to cover children from birth to age 6 years whose countable income is less than or equal to 133% of the federal poverty limit (FPL). Section 1902(a)(10)(A)(i)(VII) and 1902 (l)(1)(D) of the Act - The federal Medicaid law requires the Medicaid State Plan to cover children who have attained age 6 years but are under age 19 years whose countable income is less than or equal to 100% of the FPL and allows states to cover children at higher income limits.

Virginia has elected to cover children from age 6 to age 19 with countable income less than or equal to 133% of the FPL. The federal law allows the State Plan to cover these children regardless of their families’ resources; Virginia has chosen to waive the resource eligibility requirements for these children. Coverage under the MI Child Under Age 19 covered group is also referred to as FAMIS Plus.

B. Nonfinancial Eligibility

The child must meet the nonfinancial eligibility requirements in chapter M02.

The child must be under age 19 years. The child's date of birth must be provided, but birth verification is not required. Any child under age 19 years can be eligible in this covered group regardless of the child’s living arrangements or the child’s mother’s Medicaid eligibility.

A child no longer meets this covered group effective the end of the month in which the child reaches age 19 years, provided he was under age 19 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 19.

NOTE: a child who does not meet a Medicaid non-financial eligibility criterion AND who has excess income for Medicaid may be evaluated for FAMIS eligibility.

C. Financial Eligibility

1. Assistance Unit

Use the assistance unit policy in chapter M05 to determine the child’s financial eligibility.

2. Asset Transfer

The asset transfer rules in subchapter M1450 apply to institutionalized MI individuals.

3. Resources

There is no resource limit.

- 4. **Income** The income requirements in chapter M07 must be met by the child. The income limits are 133% of the FPL and are found in subchapter M0710, Appendix 6.

- 5. **Income Changes** Any changes in an MI child’s income that occur after his eligibility has been established affect eligibility. Recalculate income and compare to the MI 133% FPL income limits.

- 6. **Income Exceeds MI Limit** A child under age 19 whose income exceeds the MI income limit may be eligible for Virginia’s Title XXI program, Family Access to Medical Insurance Security (FAMIS). The income limit for FAMIS is 200% FPL. See chapter M21 to determine FAMIS eligibility.

Spenddown does not apply to the medically indigent. If the child’s income exceeds the medically indigent limit, he/she is not eligible as medically indigent regardless of medical expenses. Eligibility as medically needy (MN) must then be determined in order for spenddown to apply, and all medically needy eligibility requirements must be met, including resource limits.

D. Entitlement

Eligible MI children are entitled to full Medicaid coverage beginning the first day of the child’s application month if all eligibility requirements are met in that month, but no earlier than the date of the child’s birth. Retroactive coverage is applicable to this covered group; however, the income limit for children age 6 – 19 cannot exceed 100% FPL for any period prior to September 1, 2002.

Eligible MI children are entitled to all Medicaid covered services as described in chapter M18.

E. Enrollment

The ACs for the MI child are:

AC	Meaning
090	MI child under age 6; income greater than 100% FPL, but less than or equal to 133% FPL
091	MI child under age 6; income less than or equal to 100% FPL
092	<ul style="list-style-type: none"> • MI child age 6-19; insured or uninsured with income less than or equal to 100% FPL; • MI child age 6-19; insured with income greater than 100% FPL and less than or equal to 133% FPL
94	MI child age 6-19; uninsured with income greater than 100% FPL and less than or equal to 133% FPL

Do not change the AC when a child’s health insurance is paid for by Medicaid through the HIPP program.

M0320.304 LOW INCOME FAMILIES WITH CHILDREN (LIFC)

A. Policy

Section 1931 of the Act - The federal Medicaid law requires the State Plan to cover dependent children under age 19 and parents or caretaker-relatives of dependent children who meet the financial eligibility requirements of the July 16, 1996 AFDC state plan. In addition, Medicaid covers dependent children and parents or caretaker-relatives of dependent children who participate in the Virginia Initiative for Employment not Welfare (VIEW) component of the Virginia Independence Program (VIP) and meet the requirements of the 1115 waiver. This covered group is called "Low Income Families With Children" (LIFC).

B. Nonfinancial Eligibility

The individual must meet all the nonfinancial eligibility requirements in chapter M02.

The child(ren) must meet the definition of a dependent child in M0310.111. The adult with whom the child lives must be the child's parent or must meet the definition of a caretaker-relative of a dependent child in M0310.107. A child or adult who lives in the household but who is not the dependent child's parent or caretaker-relative may be eligible as LIFC if he/she meets the definition of an EWB in M0310.113.

C. Financial Eligibility

1. Assistance Unit

The assistance unit policy in subchapter M0520 applies to the LIFC covered group. The assistance unit's financial eligibility is determined first. If the family unit has income that cannot be verified or that exceeds the amount for the individual's covered group, the family unit is divided into budget units, if appropriate.

If the LIFC individual is living with his/her spouse or child who is aged, blind, or disabled, two different financial calculations must be completed for the unit if the family unit does not meet the LIFC income limits, because of the different resource and income limits used in the F&C and ABD determinations.

2. EWB

An EWB meets the LIFC covered group only when the dependent child's family has income within the LIFC income limits and the family is eligible for Medicaid as LIFC.

When the LIFC household includes an individual who meets the EWB definition, the EWB's income eligibility is determined in a separate assistance unit. See M0520.103.

3. Resources

There is no resource test for the LIFC covered group.

4. Income

a. Non-VIEW Participants

The income requirements in chapter M07 must be met by the LIFC group. The income limits are in M0710.002.

b. VIEW Participants

The income requirements in chapter M07 must be met by VIEW participants. The method for determining income eligibility is different for VIEW participants and is found in M0710.730 D. The income limits are in M0710.002.

5. Income Exceeds CNNMP Limit

Spenddown does not apply to the CNNMP income limits. If the family/budget unit's (FU/BU's) income exceeds the F&C CNNMP income limit, the unit is not eligible as CNNMP LIFC and cannot spenddown to the CNNMP limit. If resources are within the medically needy limit, the unit may be placed on spenddown if at least one member meets an MN covered group, such as MN children under age 18.

D. Entitlement

Entitlement to Medicaid as an LIFC individual begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

E. Enrollment

The ACs for individuals in the LIFC covered group are:

- 081 for an LIFC individual in a family with one or no parent in the home;
- 083 for LIFC individuals in a two-parent household.

M0320.305 IV-E FOSTER CARE OR IV-E ADOPTION ASSISTANCE RECIPIENTS

A. Policy

42 CFR 435.145---The federal Medicaid law requires the State Plan to cover children who are eligible for foster care or adoption assistance payments under Title IV-E of the Social Security Act.

B. Children Who Receive SSI

Foster care or adoption assistance children who receive SSI meet the eligibility requirements for IV-E foster care or adoption assistance. They cannot receive both SSI and IV-E payments, so most of them elect to receive the higher SSI payment. These children are enrolled in Medicaid as SSI recipients.

C. Nonfinancial Eligibility Requirements

The child must be under age 21 years and must meet the IV-E foster care or IV-E adoption assistance definition in M0310.115 or M0310.102. *The child meets the age requirement until the end of the month in which the child turns age 21.*

The child must meet all the nonfinancial eligibility requirements in chapter M02. The IV-E eligibility determination meets the Medicaid requirements for Virginia residency and cooperation in pursuing support. Check the following nonfinancial requirements:

- citizenship or alien status (M0220);
- Social Security account number (M0240);
- assignment of rights (M0250);
- application for other benefits (M0270);
- institutional status (M0280).

NOTE: IV-E eligible foster care or adoption assistance recipients meet the Medicaid institutional status requirements when they live in a public residential facility if the facility has less than 25 beds.

D. IV-E Foster Care

42 CFR 435.145---The federal Medicaid law requires the State Plan to cover children who are eligible for foster care *maintenance* payments under Title IV-E of the Social Security Act.

The child must meet the IV-E foster care definition in M0310.115 *and must be receiving IV-E foster care maintenance payments*. The IV-E eligibility determination meets the Medicaid requirements for Virginia residency and cooperation in pursuing support.

NOTE: IV-E eligible foster care *maintenance payment* recipients meet the Medicaid institutional status requirements when they live in a public *child care institution* if the facility has less than 25 beds, *or if they live in a publicly operated community residence that has no more than 16 beds*. See section M0280.100 for definitions of public institutions.

E. IV-E Adoption Assistance

42 CFR 435.145--The federal Medicaid law requires the State Plan to cover children who are eligible for adoption assistance under Title IV-E of the Social Security Act *and for whom a IV-E adoption assistance agreement between the LDSS and the adoptive parent(s) is in effect*.

The child must meet the IV-E adoption assistance definition in M0310.102. *The child does not have to receive a IV-E Adoption Assistance payment in order to meet the IV-E Adoption Assistance definition*.

The IV-E *Adoption Assistance* eligibility determination meets the Medicaid requirements for Virginia residency and cooperation in pursuing support.

F. Financial Eligibility

A separate Medicaid financial eligibility determination is not made for IV-E eligible foster care or IV-E adoption assistance children, regardless of the state that makes the IV-E payment. Verify the child's IV-E payment eligibility via agency records.

G. Entitlement

1. IV-E Foster Care Child

Entitlement to Medicaid as a IV-E Foster Care child begins the first day of the month of commitment or entrustment if a Medicaid application is filed within 4 months of commitment or entrustment. Retroactive entitlement prior to the month of commitment or entrustment is not allowed.

If the Medicaid application is filed more than 4 months after entrustment or commitment, entitlement may be retroactive up to 3 months prior to application if the child met all Medicaid eligibility requirements in the retroactive months. However, Medicaid entitlement cannot go back to the month of entrustment or commitment when the application is filed more than 4 months after entrustment or commitment.

2. IV-E Adoption Assistance Child

Entitlement to Medicaid as a IV-E Adoption Assistance child begins the first day of the application month if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

H. Enrollment

The *aid category (AC)* for IV-E *foster care and adoption assistance* children is “074.”

M0320.307 INDIVIDUALS UNDER AGE 21

A. Policy

42 CFR 435.222 – The federal Medicaid law allows the State Plan to cover reasonable classifications of individuals under age 21 years who do not receive cash assistance but who meet the income requirements of the state’s July 16, 1996 AFDC State Plan. *However, children under age 19 must first have eligibility determined in the FAMIS Plus covered group of children because the income limits are higher for that group. Individuals ages 19 and 20 should be evaluated in the Individuals Under Age 21 covered group when they are not eligible for Medicaid in any other full-benefit covered group.*

The reasonable classifications of individuals under age 21 are:

- *IV-E eligible foster care children who do NOT receive a IV-E maintenance payment,*
- *Non-IV-E foster care children,*
- *Department of Juvenile Justice (DJJ) children,*
- *Non-IV-E Adoption Assistance children,*
- *Children in intermediate care nursing facilities (ICF), and*
- *Children in intermediate care facilities for the mentally retarded (ICF-MR).*

B. Nonfinancial Eligibility Requirements

The individual must be under age 21 and meet the nonfinancial requirements in chapter M02.

C. Reasonable Classifications

The individual under age 21 must meet one of the following classifications:

1. Non IV-E Foster Care

Children who meet the foster care definition in M0310.115 but do not receive a IV-E maintenance payment are “individuals in foster homes, private institutions or independent living arrangements for whom a public or private nonprofit child-placing agency is assuming full or partial financial responsibility.” This group also includes DJJ children.

a. Children Living In Public Institutions

Non-IV-E foster care recipients meet the Medicaid institutional status requirements when they live in a public child care institution if the facility has less than 25 beds, or if they live in a publicly operated community residence that has no more than 16 beds. See section M0280.100 for definitions of public institutions.

When these children are placed in public residential institutions, the facility must not have capacity for more than 16 children (see M0280).

b. Child in Independent Living Arrangement

A child in an independent living arrangement is eligible for Medicaid in this covered group if the child is *receiving services from* the local social services agency.

**2. Non-IV-E
Adoption
Assistance**

Children under age 21 who meet the adoption assistance definition in M0310.102 for whom a Non-IV-E adoption assistance agreement between the local department of social services (LDSS) and the adoptive parent(s) is in effect are “individuals in adoptions subsidized in full or in part by a public agency.” If the child receives a *Non-IV-E* adoption assistance payment, or if the child was adopted under an adoption assistance agreement *and is not eligible as a IV-E Adoption Assistance child*, then the child meets the “*Non-IV-E* adoption assistance” definition.

Non IV-E adoption assistance children who have “special medical needs” have additional requirements. See section M0320.308 for the Special Medical Needs Adoption Assistance requirements.

**3. In ICF or ICF-
MR**

Children under age 21 who are patients *in either an ICF or ICF-MR meet the classification of “individuals in an ICF or ICF-MR” in the Individual Under Age 21* covered group.

D. Assistance Unit

**1. Non-IV-E Foster
Care Children
(Includes DJJ)**

The child is an assistance unit of one effective the date the child is removed from the home and placed in foster care. Each child in foster care is evaluated as a separate assistance unit, even if the child is living with his/her siblings in a foster care home.

A foster care *or DJJ* child continues to be a single person unit during a trial visit *in his own home*. A “trial visit” is no longer than *six months* for this section’s purposes.

**2. Adoptive
Placement**

While in adoptive placement, the child may continue to be treated as a foster care child. However, once the interlocutory or the final order of adoption is entered, the child must be treated as a Non-IV-E adoption assistance child; see 3. below.

3. Non-IV-E Adoption Assistance-Interlocutory or Final Order Entered Financial eligibility is determined using the assistance unit procedures in subchapter M0520, which require the inclusion of the child's adoptive parent(s) and sibling(s). *An adoption assistance child must have his/her eligibility determined by counting or deeming (as appropriate) his/her parent's and sibling's income.*

4. Child in ICF or ICF-MR *A child in an ICF or an ICF-MR is an institutionalized individual in a medical facility when he meets the definition of "institutionalized individual" in section M1410.010 B.2. When he meets the institutionalized individual definition, he is an assistance unit of one person.*

E. Resources There is no resource test for the *categorically needy non-money payment (CNNMP)* Individuals Under Age 21 covered group.

F. Income

1. Income Limits *For the Individuals Under Age 21 covered group, the income limit is the F&C 100% income limit found in chapter M0710, Appendix 3.*

The foster care or adoption subsidy payment is excluded when determining the unit's income eligibility.

Foster care and Adoption Assistance children in residential facilities do not have a different income limit. For a foster care/adoption assistance child living outside the State of Virginia, the income limit for the assistance unit is the income limit for the Virginia locality which holds custody, pays the adoption subsidy, or signed the adoption assistance agreement.

2. Income Exceeds F&C 100% Income Limit *For foster care (including DJJ) and adoption assistance children whose income exceeds the F&C 100% income limit, determine the child's Medicaid eligibility as a medically needy Individual Under Age 21 (see M0330.304).*

For children who are institutionalized in an ICF or ICF-MR and whose income exceeds the *F&C 100% income limit, determine the child's Medicaid eligibility* in the 300% SSI covered group (see M0320.309).

G. Entitlement & Enrollment

1. Entitlement Entitlement to Medicaid begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

2. Enrollment

The *aid category (AC)* for individuals in the CNNMP covered group of Individuals Under Age 21 are:

- 076 for a non-IV-E Foster Care child;
- 075 for a Department of Juvenile Justice child;
- 072 for a Non-IV-E Adoption Assistance child;
- 082 for a child *under age 21* in an ICF or ICF-MR.

M0320.308 SPECIAL MEDICAL NEEDS ADOPTION ASSISTANCE CHILDREN

A. Policy

42 CFR 435.227 - The federal Medicaid law allows the State Plan to cover an individual under age 21 years:

- for whom a non-IV-E adoption assistance agreement between the state and the adoptive parent(s) is in effect;
- who cannot be placed with adoptive parents without Medicaid because the child has special needs for medical or rehabilitative care; and
- who was enrolled in Medicaid under any covered group before the adoption assistance agreement was entered into OR who would have been eligible for Medicaid before the adoption assistance agreement was entered into if the eligibility requirements and standards of the IV-E foster care program were used, without employing the threshold title IV-A eligibility determination.

If the child was not enrolled in Medicaid or would not have been eligible for Medicaid prior to the adoption assistance agreement being entered into, the child is **not** eligible for Medicaid in the covered group of “Special Medical Needs.” *The child may be eligible as a Non-IV-E Adoption Assistance child in the CNNMP Individuals Under Age 21 covered group. See section M0320.307.*

B. Nonfinancial Eligibility Requirements

The child must

- be under age 21,
- meet the “special medical needs” adoption assistance definition in M0310.102, and
- meet the nonfinancial requirements in chapter M02.

C. Financial Eligibility Requirements

1. Assistance Unit

The assistance unit consists of only the child if the child was eligible for Medicaid prior to the adoption assistance agreement being entered into. The adoptive parent(s)’ income and resources are **not** counted or deemed; only the *Special Medical Needs* child’s own income and resources are counted.

2. **Asset Transfer** The asset transfer rules *apply to Special Medical Needs children who are in long-term care. See subchapter M1450.*

3. **Resources** *There is no resource test for the Special Medical Needs Adoption Assistance Children covered group.*

4. **Income** Adoption assistance children in residential facilities do not have a different income limit. The F&C 100% *standard of need* income limit for one person in the child’s locality is used to determine eligibility *in the Special Medical Needs covered group*. For a *Virginia Special Medical Needs* adoption assistance child living outside the State of Virginia, the income limit for the unit is the income limit for the Virginia locality that signed the adoption assistance agreement.

The adoption subsidy payment is excluded when determining the child’s financial eligibility.

If the child’s countable income exceeds the *F&C 100% standard of need* income limit, evaluate the child in the medically needy covered group of “special medical needs adoption assistance” in subchapter M0330.

D. Entitlement & Enrollment

Entitlement to Medicaid begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

The AC for individuals in the CNNMP covered group of Special Medical Needs Adoption Assistance children is “072.”

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M0320.309 F&C IN MEDICAL INSTITUTION, INCOME ≤ 300% SSI

A. Policy

42 CFR 435.236 - The State Plan includes the covered group of individuals who meet a families & children definition who are in medical institutions and who

- meet the Medicaid resource requirements; and
- have income that does not exceed 300% of the SSI individual payment limit (see M0810.002 A. 3.).

B. Nonfinancial Eligibility

An individual is eligible in this covered group if he/she meets the nonfinancial requirements in M1410.020.

C. Entitlement & Enrollment

Children who become eligible after meeting a spenddown are entitled to full medically needy Medicaid coverage beginning the day the spenddown was met. Retroactive coverage is applicable to this covered group.

Eligible children in this group are classified as medically needy (MN), aid category "088."

M0330.304 INDIVIDUALS UNDER AGE 21

A. Policy

42 CFR 435.308(b) - A state may choose to provide medically needy coverage to reasonable classifications of individuals under 21 years of age who *are* not eligible for coverage as categorically needy but who meet the medically needy resource and income requirements.

Virginia has chosen to cover the following reasonable classifications of individuals under age 21:

- *Non-IV-E Foster Care children*
- *Department of Juvenile Justice (DJJ) children,*
- *Non-IV-E Adoption Assistance children,*
- *Children in intermediate care nursing facilities (ICF), and*
- *Children in intermediate care facilities for the mentally retarded (ICF-MR).*

NOTE: the ICF-MR services are **not** covered for medically needy individuals, but other Medicaid covered services such as prescription drugs, physicians, inpatient and outpatient hospital services are covered for medically needy patients in ICF-MRs.

B. Nonfinancial Eligibility

The individual must be under age 21 and meet the nonfinancial requirements in chapter M02. *The child meets the age requirement until the end of the month in which the child turns age 21.*

C. Reasonable Classifications

The individual under age 21 must meet one of the following classifications:

1. Non IV-E Foster Care

Children who meet the foster care definition in M0310.115 but do not receive a IV-E maintenance payment are "individuals in foster homes, private institutions or independent living arrangements for whom a public or private nonprofit child-placing agency is assuming full or partial financial responsibility." This group also includes DJJ children.

a. Children Living In Public Institutions

Non-IV-E foster care children meet the Medicaid institutional status requirements when they live in a public child care institution if the facility has less than 25 beds, or if they live in a publicly operated community residence that has no more than 16 beds. See section M0280.100 for definitions of public institutions.

When these children are placed in public residential institutions, the facility must not have capacity for more than 16 children (see M0280).

b. Child in Independent Living Arrangement

A child in an independent living arrangement is eligible for Medicaid in this covered group if the child is receiving services from the local social services agency.

**2. Non-IV-E
Adoption
Assistance**

Children under age 21 who meet the adoption assistance definition in M0310.102 for whom a Non-IV-E adoption assistance agreement between the local department of social services (LDSS) and the adoptive parent(s) is in effect are “individuals in adoptions subsidized in full or in part by a public agency.” If the child receives a *Non-IV-E* adoption assistance payment, or if the child was adopted under an adoption assistance agreement *and is not eligible as a IV-E Adoption Assistance child*, then the child meets the “*Non-IV-E* adoption assistance” definition.

Non IV-E adoption assistance children who have “special medical needs” have additional requirements. See section M0330.305 for the medically needy Special Medical Needs Adoption Assistance requirements.

**3. In ICF or ICF-
MR**

Children under age 21 who are patients *in either an ICF or ICF-MR meet the classification of “individuals in an ICF or ICF-MR” in the Individual Under Age 21* covered group.

C. Assistance Unit

**1. Non-IV-E Foster
Care Children
(Includes DJJ)**

The child is an assistance unit of one effective the date the child is removed from the home and placed in foster care. Each child in foster care is evaluated as a separate assistance unit, even if the child is living with his/her siblings in a foster care home.

A foster care or DJJ child continues to be a single person unit during a trial visit in his own home. A “trial visit” is no longer than six months for this section’s purposes.

**2. Adoptive
Placement**

While in adoptive placement, the child may continue to be treated as a foster care child. However, once the interlocutory or the final order of adoption is entered, the child must be treated as a Non-IV-E adoption assistance child; see 3. below.

**3. Non-IV-E
Adoption
Assistance-
Interlocutory or
Final Order
Entered**

Financial eligibility is determined using the assistance unit procedures in subchapter M0520, which require the inclusion of the child’s adoptive parent(s) and sibling(s). *An adoption assistance child must have his/her eligibility determined by counting or deeming (as appropriate) his/her parent’s and sibling’s income.*

4. Child in ICF or ICF-MR

A child in an ICF or an ICF-MR is an institutionalized individual in a medical facility when he meets the definition of “institutionalized individual” in section M1410.010 B.2. When he meets the institutionalized individual definition, he is an assistance unit of one person.

D. Resources

The resource limit and requirements are found in chapter M06.

If the resources exceed the limit, the child is not eligible for Medicaid. If the child is under age 19, determine the child’s eligibility as *FAMIS Plus* because that classification has no resource limits.

E. Income

The MN income requirements are found in *subchapter M0710*.

1. Income Limits

For the MN Individuals Under Age 21 covered group, the income limit is the medically needy income limit found in chapter M0710, Appendix 5.

The foster care or adoption subsidy payment is excluded when determining the unit’s income eligibility.

Foster care or adoption assistance children in residential facilities do not have a different income limit. For a foster care/adoption assistance child living outside the State of Virginia, the MN income limit for the unit is the income limit for the Virginia locality which holds custody, pays the adoption subsidy, or signed the adoption assistance agreement.

2. Income Exceeds MN Income Limit

If the unit’s resources are within the medically needy limit, but the income exceeds the medically needy income limit, the unit is placed on a spenddown. All medical expenses of the unit members are used to meet the spenddown. Once the spenddown is met, only the child and family members who meet an MN covered group and who applied for Medicaid are enrolled in Medicaid.

F. Entitlement & Enrollment

1. Entitlement

Entitlement to Medicaid begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. If the individual is eligible after meeting a spenddown, entitlement begins the date the spenddown was met and ends after the last day of the spenddown period.

Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

2. Enrollment

The *aid category* for *medically needy* individuals in the MN covered group of *Individuals Under Age 21* are:

- 086 for an MN Non-IV-E foster care, MN Non-IV-E adoption assistance,
- 085 for an MN Juvenile Justice Department child;
- 098 for an MN child under age 21 in an ICF or ICF-MR.

M0330.305 SPECIAL MEDICAL NEEDS ADOPTION ASSISTANCE

A. Policy

42 CFR 435.308(b) - A state may choose to provide medically needy coverage to a child under age 21 years

- for whom a non-IV-E adoption assistance agreement between the state and the adoptive parent(s) is in effect;
- who cannot be placed with adoptive parents without Medicaid because the child has special needs for medical or rehabilitative care; and
- who was enrolled in Medicaid under any covered group before the adoption assistance agreement was entered into OR who would have been eligible for Medicaid before the adoption assistance agreement was entered into if the eligibility requirements and standards of the IV-E foster care program were used, without employing the threshold title IV-A eligibility determination.

If the child was not enrolled in Medicaid and would not have been eligible for Medicaid prior to the adoption assistance agreement being entered into, the child is **not** eligible for Medicaid in the MN covered group of “special medical needs adoption assistance children.” *The child may be eligible in the MN Non-IV-E Adoption Assistance classification of Individuals Under Age 21 in section M0330.304.*

B. Nonfinancial Eligibility

The child must

- be under age 21,
- meet the “special medical needs” adoption assistance definition in M0310.102, and
- meet the nonfinancial requirements in chapter M02.

C. Financial Eligibility

1. Assistance Unit

The assistance unit consists of only the child if the child was eligible for Medicaid prior to the *special medical needs* adoption assistance agreement being entered into. The adoptive parent(s)’ income and resources are **not** counted or deemed; only the *Special Medical Needs* adoption assistance child’s own income and resources are counted.

A child in an ICF or an ICF-MR is an institutionalized individual in a medical facility when he meets the definition of “institutionalized individual” in section M1410.010 B.2. When he meets the institutionalized individual definition, he is an assistance unit of one person. The child’s eligibility is determined in the CNNMP F&C 300% SSI covered group in M0320.309.

2. Asset Transfer The asset transfer rules *apply to an institutionalized child. See subchapter M1450.*

3. Resources The resource limits and requirements are found in chapter M06.

If the resources exceed the limit, the child is not eligible for Medicaid *as medically needy*. If the child is under age 19, determine the child’s eligibility as F&C medically indigent because that classification has no resource limits.

4. Income Adoption assistance children in residential facilities do not have a different income limit. The MN income limit for one person in the child’s locality is used to determine the child’s MN eligibility. For an adoption assistance child living outside the State of Virginia, the income limit for the child is the income limit for the Virginia locality which signed the adoption assistance agreement.

The adoption subsidy payment is excluded when determining the child’s financial eligibility.

If the child’s countable income exceeds the MN income limit, the child is placed on a spenddown. Only the child’s medical expenses are used to meet the spenddown. Once the spenddown is met, the special medical needs adoption assistance child is enrolled in Medicaid.

D. Entitlement & Enrollment

Eligible individuals in this MN 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. Individuals who become eligible after meeting a spenddown are entitled to full Medicaid coverage beginning the day the spenddown was met and ending the last day of the sixth month in the spenddown period. Retroactive coverage is applicable to this covered group.

The AC for individuals in the MN covered group of special medical needs adoption assistance children is “086.”

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M0710.000 GENERAL-- F&C INCOME RULES

M0710.001 OVERVIEW

- A. Introduction** Medicaid is a needs based program. Two financial criteria, income and resources, are used to determine if a person is in need and is financially eligible for Medicaid. This section addresses how to determine an individual's income eligibility.
- B. Use of Family Units/Budget Units** Family Units (FUs) are formed to establish whose income and resources are counted in determining financial eligibility. If financial eligibility does not exist at the family unit level for one or more persons for whom Medicaid was requested and if budget unit (BU) rules permit, form BUs.
- Financial eligibility is determined at the BU level for each person for whom Medicaid was requested and who was financially ineligible in the FU determination. Eligibility is not determined for an individual who was found eligible in the FU determination.
- See M0520 for F&C Family Unit/Budget Unit (FU/BU) policy and procedures.
- C. Individual Income Eligibility** An individual's income eligibility is based on the total countable income available to his/her FU/BU.
- Each source of income received by a member of the FU/BU is evaluated and the countable amount determined based on the policy in this chapter. The countable amount of each FU/BU member's income is added to the countable amount of the income of all other FU/BU members. That total is used to determine the income eligibility of each individual within that FU/BU. The FU/BU's total countable income is compared to the income limit that is applicable to the individual's classification and to the number of members in the FU/BU.
- D. Policy Principles**
- 1. Income** Everything an individual owns and all monies received are assets. Monies received are income in the month received when the monies are cash or its equivalent.
- Income may be either earned or unearned. See M0720 for earned income and M0730 for unearned income.
- 2. Verification** All income other than Workforce Investment Act and the earned income of a student under age 19 must be verified. When attempts to verify income are unsuccessful because the person or organization who is to provide the information *cannot be located or refuses to provide the information to both the applicant/recipient and the eligibility worker*, a third party statement, a collateral contact, *or as a last resort, the applicant's/recipient's written statement can be used as verification* and to determine the amount of

Failure of the applicant/enrollee to verify his income results in the agency's inability to determine Medicaid eligibility and the applicant/enrollee's Medicaid coverage must be denied or canceled.

- 3. Converted Income**

For the ongoing evaluation period, all income received more frequently than monthly must be converted to a monthly amount.

 - Weekly income is multiplied by 4.3
 - Bi-weekly income is multiplied by 2.15
 - Semi-monthly income is multiplied by 2.

- 4. Available Income**

Retroactive period –available income is the gross income actually received in each month in the retroactive period.

Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months. The applicant's actual gross income received in the application month may be used if the application is processed after the month has passed and the person is eligible only when using the actual gross income for the month.

- 5. MI, CN, CNNMP Monthly Income Determination Period**

An income eligibility determination is made for each calendar month for which eligibility is being evaluated in the Medically Indigent (MI), Categorically Needy (CN), and Categorically Needy Non-Money Payment (CNNMP) classifications.

- 6. MN - Ongoing 6 Month Income Determination Period**

Medically Needy (MN) income eligibility for the ongoing period is based on income that is anticipated to be received within the six month period beginning with the month of application.

- 7. MN - Retro 3 Month Income Determination Period**

MN income eligibility for the retroactive period is based on income that was actually received in the three-month period immediately prior to the month of application.

- 8. Countable Income**

Assets that meet the definition of income minus the exclusions allowed by policy are countable income. Only countable income is used to determine income eligibility. See M0720 Earned Income, M0730 Unearned Income.

- 9. Whose Income is Counted**

The total countable income of all FU members is used in determining the income eligibility of each FU member. The total countable income of all BU members is used in determining the income eligibility of each BU member.

- 10. Income Eligibility**

If the total amount of the FU/BU's countable income is equal to or less than the income limit for the evaluation period, income eligibility exists.

- 11. Excess Income**

When an FU has countable income totaling more than the allowable CN, CNNMP, or MI income limit for the evaluation period, eligibility at the FU level does not exist. If ineligible at the FU level and policy permits breaking the FU into BUs, a BU evaluation must be completed.

When a BU has countable income totaling more than the allowable CN, CNNMP, or MI income limit for the evaluation period, eligibility as CN, CNNMP, or MI does not exist. Evaluate the BU's as Medically Needy eligibility if one or more of the BU members meets a MN covered group. If no members of the BU meet a MN covered group, the BU is not eligible for Medicaid because of excess income.

12. Excluded Income

State and federal policy require that certain types of income or portions of income be excluded (not counted) when determining income eligibility. See:

- Earned Income Exclusions, M0720.500
- Unearned Exclusions, M0730.099

M0710.002 INCOME LIMITS

A. Introduction

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

B. Income Limits

1. CN and CNNMP

Refer to M0710, Appendix 1 for the LIFC 185% of the Standard of Need Chart, M0710, Appendix 2 for the grouping of localities, and M0710, Appendix 3 for the F&C 90% and 100% Income Limit Charts.

2. MN

Refer to M0710, Appendix 2 for the grouping of localities and M0710, Appendix 5 for the MN income limits.

3. MI

Refer to M0710, Appendix 6 for the MI income limits.

M0710.003 NET COUNTABLE INCOME

A. Policy Principle

Income is

- cash, or
- its equivalent unless specifically listed in M0715 as not being income.

B. Available Income

Retroactive period –available income is the gross income actually received in each month in the retroactive period.

Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months. The applicant's actual gross income received in the application month may be used if the application is processed after the month has passed and the person is eligible only when using the actual gross income for the month.

C. Net Countable Income

Net countable income is all money, both earned and unearned, which is available to the members of the FU/BU, *after* portions specifically excluded and all amounts that are not income *are subtracted*.

Sometimes, *countable* income includes more or less *money* than *is* actually received. For example, gross earnings *before deductions are counted when determining eligibility for FAMIS; no deductions or exclusions are subtracted from the gross earnings.*

M0710.004 INCOME EXCLUSIONS

- A. Introduction** Medicaid eligibility is based on countable income. See M0710.003 for the definition of countable income. In determining countable income, apply any income exclusions. Some exclusions totally negate the amount of income received. Other exclusions reduce the amount counted.
- B. Definition** Excluded income is an amount which is income but does not count in determining eligibility.
- C. Policy Principles** Some Federal laws other than the Social Security Act prohibit counting some income for Medicaid purposes. Section 402(a) of the Social Security Act provides for several income exclusions in determining countable income for Medicaid purposes.
- D. References**
- Earned income exclusions, M0720.500
 - Unearned income exclusions, M0730.099

M0710.010 RELATIONSHIP OF INCOME TO RESOURCES

- A. Policy** In general, anything received in a month from any source is income to an individual, subject to the definition of income in M0710.003.
- Anything the individual owns in the month under consideration is subject to the resource counting rules.
- An item received in the current month is income for the current month only. If held by the individual until the following month, that item is subject to resource counting rules.
- B. References**
- Definition of Resources, M0610.100
 - Conversion or sale of a resource, M0715.200
 - Casualty property loss payments, M0630.650
 - Lump sums, M0730.800

M0710.015 TYPES OF INCOME

- A. Policy Principle** Income is either earned or unearned, and different rules apply to each.
- B. Types of Income**
- 1. Earned Income** Earned income consists of the following types of payments:
- wages;
 - salaries, and/or commissions;
 - profits from self employment; or
 - severance pay.

1. **Unearned Income** All unearned income specifically excluded per M0730.099;
2. **Earned Income** Earned income is excluded in the following order:
 - standard work exclusion of the first \$90 of gross earned income for each employed member of the assistance unit whose income is not otherwise exempt per M0720.520;
 - child care/incapacitated adult care exclusion per M0720.540

D. Income Eligibility If the countable income (gross income minus above exclusions) is equal to or less than the MI income limit for that covered group, the members of the FU/BU meeting that classification are income eligible. If the countable income exceeds the income limit, the FU/BU is not eligible as MI.

Determine if any members of the FU/BU would be eligible as CNNMP or MN.

M0710.730 CATEGORICALLY NEEDY NON-MONEY PAYMENT (CNNMP)

The following procedures apply to the Categorically Needy Non-Money Payment (CNNMP) classification:

- A. **Individuals under 21 in Nursing Facilities or ICF/MR** Individuals under 21 in nursing facilities or ICF/MR are evaluated as individuals in medical facilities and their income is screened at 300% of SSI (see M0810.002 A. 3.).
- B. **Individuals under 21 in Foster Care/Adoption Assistance** Individuals under 21 in foster care or receiving adoption assistance are evaluated as Medically Indigent if they are under age 19 or pregnant. If they are not eligible as MI, evaluate their eligibility as CNNMP using the following procedures:
 1. **Step 1- 185% Screen** The child's countable income is the total gross earned income, other than Workforce Investment Act income and/or other earned income of a child under age 19 who is a student. It also includes unearned income, other than the unearned income listed in M0730.099.

Screen income at LIFC 185% of the standard of need. Refer to M0710, Appendix 1 for the LIFC 185% of Standard of Need Chart.

If the countable income exceeds the LIFC 185% standard of need, the child is not eligible as an Individual Under 21 in FC/Adoption Assistance. If the income is equal to or less than LIFC 185% standard of need, proceed to Step 2.

**2. Step 2 -
100 % Screen**

Once the total countable income of the child is determined to be less than or equal to LIFC 185% standard of need, the child's income must be screened at F&C 100% income limit in the locality where the child resides outside an institution. Refer to M0710, Appendix 2 for the grouping of localities and M0710, Appendix 3 for F&C 100% Income Limit for one person.

Total gross income is all earned income, other than Workforce Investment Act income and/or *other earned* income of a child under age 19 who is a student. It also includes unearned income of the child, including contributions. The following income is excluded when income is screened at 100%:

- a. All unearned income specifically excluded in M0730.099;
- b. Earned income is excluded in the following order:
 - standard work exclusion of the first \$90 of gross earned income for each employed member of the family/budget unit whose income is not otherwise exempt per M0720.520;
 - child care/incapacitated adult care exclusion per M0720.540.

If the countable income (gross income minus above exclusions) is equal to or less than the F&C 100% income limit, the child is eligible as an Individual Under 21 in FC/Adoption Assistance.

If the countable income exceeds F&C income limit, evaluate eligibility as MN.

C. LIFC (Non-View)

**1. Step 1 –
185% Screen**

In order to meet the income requirements for Medicaid in the Low Income Families with Children (LIFC) covered group, the family/budget unit's countable income must be screened at LIFC 185% standard of need and the F&C 90% income limit (prospective determination) to determine the family/budget unit's eligibility. If the income of the assistance unit is equal to or less than LIFC 185% of the standard of need, income is then screened at the F&C 90% income limit, allowing income exclusions, when appropriate. Refer to M0710, Appendix 1 for LIFC 185% Standard of Need Chart.

Total gross income for this purpose includes all gross earned income, other than Workforce Investment Act income and/or *other earned* income of a child under age 19 who is a student. It also includes unearned income, such as net countable support, benefits, etc., and any income deemed available to the family/budget unit.

The following income is excluded when income is screened at 185%:

- a. All unearned income specifically excluded per M0730.099;
- b. Unemployment compensation benefits received by either parent.

If the countable income (gross income minus above exclusions) is equal to or less than LIFC 185% of the standard of need proceed to Step 2.

If the countable income is in excess of LIFC 185% standard of need, the FU/BU is not eligible as CNNMP. Determine if any members of the FU/BU would be eligible as MN.

**2. Step 2 -
90% Screen**

Once the total gross countable income of the family/budget unit is determined to be less than or equal to LIFC 185% standard of need, income must then be screened at the F&C 90% income limit. Refer to M0710, Appendix 2 for the grouping of localities and M0710, Appendix 3 for the F&C 90% income limits.

Total gross income includes all gross earned income, other than Workforce Investment Act income and/or *other earned* income of a child under age 19 who is a student. It also includes unearned income of all FU/BU members and any income deemed available to the family/budget unit. The following income is excluded when income is screened at 90%:

- a. All unearned income specifically excluded per M0730.099;
- b. Earned income is excluded in the following order:
 - standard work exclusion of the first \$90 of gross earned income for each employed member of the family/budget unit whose income is not otherwise exempt per M0720.520;
 - \$30 plus 1/3 exclusion and the \$30 monthly earned income exclusion if an FU/BU member received LIFC Medicaid in any one of the preceding four months per M0720.525 and M0720.526; and
 - child care/incapacitated adult care exclusion per M0720.540.

If the countable income (gross income minus above exclusions) is equal to or less than F&C 90% income limit, the individuals in the FU/BU that meet a CNNMP covered group are income eligible.

If the countable income is in excess of the F&C 90% income limit, the FU/BU is not eligible as CNNMP. Determine if any members of the FU/BU would be eligible as MN.

**D. VIEW
Participants**

VIEW participants' income eligibility in the LIFC covered group is determined by comparing all of the FU's gross earned income, other than Workforce Investment Act and/or *other earned* income of a child under age 19 who is a student, to the 100% Federal Poverty Limit (FPL) and unearned income to the F&C 90% income limit. If the earned income of the FU is equal to or less than 100% of the FPL, then the unearned income is screened as the F&C 90% income limit for the locality. If the FU's unearned countable income is equal to or less than the F&C 90% income limit, income eligibility for VIEW participants in the LIFC covered group is established.

If the FU's earned or unearned income exceeds the limits, the FU is not eligible as VIEW participants in the LIFC covered group. BU policy does not apply to the VIEW participant income eligibility determination. Determine if any family members are eligible as LIFC (non-VIEW) or in any other covered group.

**1. Step 1 -
Earned
Income**

Determine the total gross earned income, other than Workforce Investment Act income and/or *other earned* income of a child under age 19 who is a student, of all required FU members. Compare the total gross earned income to the 100% FPL Chart (see subchapter M0710, Appendix 6) for the income limit for the appropriate FU size.

Total gross income for this purpose includes all gross earned income of both adults and children in the FU.

If the gross countable earned income is equal to or less than 100% FPL for the FU, proceed to Step 2.

If the gross earned income is greater than 100% FPL for the FU, the FU is not eligible in the LIFC covered group. Determine if any family members are eligible in any other covered group.

**2. Step 2 -
Unearned
Income**

Once the earned income is determined to be equal to or less than 100% FPL, unearned income must be screened at the F&C 90% income limit. Refer to M0710, Appendix 2 for the grouping of localities and M0710, Appendix 3 for the F&C 90% income limit.

Total unearned countable income includes all unearned income of all family unit members and any unearned income deemed available to the FU. Exclude all unearned income in listed in M0730.099.

If the countable unearned income is equal to or less than the F&C 90% income limit, the individuals in the FU meet the income requirements for the LIFC covered group and are eligible.

If the countable unearned income is greater than the F&C 90% income limit, the individuals in the FU do not meet the income requirements for the LIFC covered group. Determine if any member of the FU is eligible in any other covered group.

M0710.740 MEDICALLY NEEDED (MN)

The following procedures apply to the Medically Needed (MN) classification:

- A. Locality Grouping and Income Limits** The countable income, allowing income exclusions when appropriate, is compared to the Medically Needed (MN) income limits for the locality and the number of members in the FU/BU.
- Refer to M0710, Appendix 2 for the grouping of localities and M0710, Appendix 5 for the Medically Needed income limits.
- B. Gross Income** Total gross income includes all gross earned income, other than Workforce Investment Act income and/or *other earned* income of a child under age 19 who is a student. It also includes the unearned income of all FU/BU members and any income deemed available to the family/budget unit.
- C. Excluded Income** The following income is excluded when income is compared to MN limits:
- 1. Unearned Income** All unearned income specifically excluded per M0730.099;
 - 2. Earned Income** Earned income is excluded in the following order:
 - standard work exclusion of the first \$90 of gross earned income for each employed member of the assistance unit whose income;
 - is not otherwise exempt per M0720.520;
 - child care/incapacitated adult care exclusion per M0720.540.
- D. Income Eligibility** If the countable income (gross income minus above exclusions) is equal to or less than the appropriate MN limit for the locality and the number of members in the FU/BU, the FU/BU is income eligible as MN. If the countable income is in excess of the MN limit, the FU/BU must be placed on an MN spenddown following policy in chapter M13.

**LIFC 185% OF STANDARDS OF NEED (MAXIMUM MONTHLY
INCOME)
EFFECTIVE 7/01/08**

Family/Budget Unit Size	GROUP I	GROUP II	GROUP III
1	<i>\$330.80</i>	<i>\$394.27</i>	<i>\$550.60</i>
2	<i>518.89</i>	<i>582.34</i>	<i>740.94</i>
3	<i>668.44</i>	<i>729.65</i>	<i>890.54</i>
4	<i>811.22</i>	<i>874.67</i>	<i>1035.55</i>
5	<i>956.26</i>	<i>1035.55</i>	<i>1228.19</i>
6	<i>1071.81</i>	<i>1153.39</i>	<i>1343.76</i>
7	<i>1212.32</i>	<i>1291.62</i>	<i>1484.25</i>
8	<i>1364.16</i>	<i>1441.21</i>	<i>1631.64</i>
Each additional person add	<i>138.19</i>	<i>138.19</i>	<i>138.19</i>

F&C Monthly Income Limits Effective 7/01/08

Group I

Family/Budget Unit Size	100%	90%
1	\$178.81	\$160.43
2	280.47	253.51
3	361.31	324.56
4	438.49	394.39
5	516.90	465.44
6	579.35	523.01
7	655.31	590.38
8	737.37	662.64
Each additional person add	74.69	68.56

Group II

Family/Budget Unit Size	100%	90%
1	\$213.12	\$192.28
2	314.78	282.93
3	394.39	356.42
4	472.78	425.01
5	559.76	501.01
6	623.44	560.98
7	698.18	627.12
8	779.02	700.63
Each additional person add	74.69	68.56

Group III

Family/Budget Unit Size	100%	90%
1	\$297.62	\$269.46
2	400.51	360.10
3	481.37	433.60
4	559.76	502.20
5	663.88	597.73
6	726.35	654.07
7	802.29	722.67
8	881.95	796.18
Each additional person add	74.69	68.56

MEDICALLY NEEDY INCOME LIMITS EFFECTIVE 7-01-08

# of Persons in Family/Budget Unit	GROUP I		GROUP II		GROUP III	
	Semi-Annual	Monthly	Semi-Annual	Monthly	Semi-Annual	Monthly
1	\$1,592.39	\$265.39	\$1,837.38	\$306.23	\$2,389.59	\$398.26
2	2,027.57	337.92	2,262.85	377.14	2,880.04	480.00
3	2,388.59	398.09	2,633.58	438.93	3,246.05	541.00
4	2,694.83	449.13	2,939.81	489.96	3,552.27	592.04
5	3,001.06	500.17	3,246.05	541.00	3,858.51	643.08
6	3,307.29	551.21	3,552.27	592.04	4,164.74	694.12
7	3,613.52	602.25	3,858.51	643.08	4,470.97	745.16
8	3,981.00	663.50	4,225.98	704.33	4,777.21	796.20
Each addt'l person add	411.56	68.59	411.56	68.59	411.56	68.59

MEDICALLY INDIGENT CHILD UNDER AGE 19 (FAMIS PLUS) INCOME LIMITS FEDERAL POVERTY LEVEL (FPL) EFFECTIVE 1-23-08 ALL LOCALITIES		
# of persons in Family/Budget Unit	100% FPL Monthly Limit	133% FPL Monthly Limit
1	\$ 867	\$1,153
2	1,167	1,552
3	1,467	1,951
4	1,767	2,350
5	2,067	2,749
6	2,367	3,148
7	2,667	3,547
8	2,967	3,946
Each additional person add	300	399

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

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

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

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

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

MEDICALLY INDIGENT PREGNANT WOMAN INCOME LIMITS 133% FPL EFFECTIVE 1-23-08 ALL LOCALITIES	
# of persons in Family/Budget Unit	<i>133% FPL Monthly Limit</i>
2	<i>\$1,552</i>
3	<i>1,951</i>
4	<i>2,350</i>
5	<i>2,749</i>
6	<i>3,148</i>
7	<i>3,547</i>
8	<i>3,946</i>
Each additional person add	<i>399</i>

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

TWELVE MONTH EXTENDED MEDICAID INCOME LIMITS 185% of FEDERAL POVERTY LIMITS EFFECTIVE 1-23-08 ALL LOCALITIES	
# of Persons in Family Unit/Budget Unit	185% FPL Monthly <i>Limit</i>
1	\$1,604
2	2,159
3	2,714
4	3,269
5	3,824
6	4,379
7	4,934
8	5,489
<i>Each additional person add</i>	555

AC 081 – LIFC one parent or caretaker in home

AC 083 – LIFC both parents in home

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M0715.000 F&C WHAT IS NOT INCOME

M0715.001 WHAT IS NOT INCOME – GENERAL

A. Introduction Some items that an individual receives are not income because they do not meet the definition of income and others are income but are excluded by federal statutes. In making income determinations, the eligibility worker must distinguish between an asset that is income and an asset which is not income by definition. This subchapter addresses assets that are not income based on federal regulation. Only those items specifically listed in the law and regulations can be excluded from income.

B. Policy An asset received is not income if it is not cash or its equivalent (check, money order, etc.), or if it is listed in this subchapter.

C. Documentation Document the receipt of the assets described in this subchapter and the determination that they are not income.

Verification is limited to establishing that the monies received is of a type listed in this chapter. Verify that the money received is one of the types listed in this subchapter.

M0715.050 REIMBURSEMENTS

A. Policy Reimbursements for out-of-pocket expenses are not countable income.

B. Types of Reimbursements Reimbursements may include, but are not limited to, reimbursement for travel expenses such as mileage, reimbursement to the caretaker of a child for child care expenses, reimbursement for expenses incurred as a volunteer, etc.

Payments from the Department of Medical Assistance Services to Medicaid registered drivers or Health Insurance Premium Payment (HIPP) participants are reimbursements and are not income.

M0715.100 MEDICAID RECIPIENT IS AN AGENT

A. Policy Money which belongs to another person that is handled by an individual to pay expenses for that other person is not income to the individual. The individual is acting as an agent for the other person.

B. Examples **Example 1:**

Mrs. C. has a son in the Army who is currently in Germany. He sends her \$250 a month to pay his car payment of \$250 a month. None of this money is considered as income to Mrs. C.

Example 2:

Mrs. X and Mrs. Y live in the same house which is rented in Mrs. X's name. Mrs. Y gives Mrs. X an established portion of the rent each month. Mrs. X adds her portion to Mrs. Y's and pays the rent. Since this is a shared shelter arrangement, Mrs. Y's portion of the rent is not considered income to Mrs. X.

M0715.200 CONVERSION OR SALE OF A RESOURCE

A. Policy Receipts from the sale, exchange, or replacement of a resource are not income, but are resources that have changed their form.-

This includes cash or in-kind items that are provided to replace or repair a resource that has been lost, damaged, or stolen.

B. Reference Casualty Property Loss Payments, M0630.130

M0715.270 INCOME TAX REFUNDS

A. Policy Income tax refunds (including Earned Income Tax Credit payments and refunds) are not income.

B. Tax Withheld Prior to Application Date Income tax refunds are not income even if the income from which the tax was withheld or paid was received in a period prior to application for Medicaid.

M0715.350 PROCEEDS OF A LOAN

A. Introduction Proceeds of a loan are not income to the borrower because of the borrower's obligation to repay the loan.

B. Policy

1. Loan Not Income All bona fide loans, regardless of the intended use, are not income. This includes loans obtained for any purpose and may be from a private individual as well as from a commercial institution.

2. Documentation of Bona Fide A simple statement signed by both parties indicating that the payment is a loan and must be repaid is sufficient to verify that a loan is bona fide.

3. Loan Not Bona Fide If an individual indicates that money received was a loan but does not provide required verification, the money is to be treated as unearned income in the month received and a resource thereafter.

4. Interest on a Loan Interest earned on the proceeds of a loan while held in a savings account, checking account, or other financial instrument will be counted as unearned income in the month received and as a resource thereafter.

M0715.370 SHELTER CONTRIBUTED

- A. Policy** Shelter that is contributed is not income.
- B. Exception** Pending establishment of a child support obligation by the District Child Support Enforcement Office, payments for shelter made to a third party such as a rental agency in lieu of or in addition to child support, whether based on a court order or a mutual voluntary agreement between the Medicaid applicant/*enrollee* and the responsible person, must be counted as unearned income to the family/budget unit. The \$50 disregard is not applicable to third party shelter payments.
- Once the support order is established and payments are made to a third party for shelter in lieu of child support these payments are third party payments for shelter and are not income.
- C. Reference** Child/Spousal Support, M0730.400

M0715.400 BILLS PAID BY A THIRD PARTY

- A. Policy** Bills paid by a third party directly to a supplier are not income.
- EXAMPLE:** A church pays the electric company for Mrs. Brown's electric bill. This is a bill paid by a third party and is not income to Mrs. Brown.
- B. Exceptions** Pending establishment of a child support obligation by the District Child Support Enforcement Office, payments made to a third party such as a day care provider or telephone company in lieu of or in addition to child support, whether based on a court order or a mutual voluntary agreement between the Medicaid applicant/recipient and the responsible person, *are NOT* counted as unearned income to the family/budget unit.
- Third party payments made by an absent spouse in lieu of spousal support are treated as contributions in kind *and are not counted as income*.
- C. Reference** Child/Spousal Support, M0730.400

GENERAL**M0730.001 INTRODUCTION TO UNEARNED INCOME**

- A. Policy - General** Unearned income is all income received by members of the family/budget unit that is not earned income. Unearned income consists of:
- benefits, including public assistance benefits received from another state
 - royalties
 - child/spousal support
 - dividends and interest
 - some rental income
 - gifts
 - some home energy assistance
 - contributions
 - lump sums
- B. Policy - When to Count Unearned Income** Unearned income is counted as income in the earliest month it is:
- received by the individual;
 - credited to the individual's account; or
 - set aside for the individual's use.
- C. Available Income** *Retroactive period –available income is the gross income actually received in each month in the retroactive period.*
- Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months. The applicant's actual gross income received in the application month may be used if the application is processed after the month has passed and the person is eligible only when using the actual gross income for the month.*
- D. Policy - What Amount of Unearned Income is Counted** The amount of unearned income received is counted as income.
- EXCEPTION: When the Medicare Part B premium is deducted from the Social Security or Railroad Retirement benefits, that amount must be added to the actual benefit being received.
- E. Verifications** Verify the amount of the unearned income by an award letter or notice, a benefit payment check, or through contact with the source of the unearned income, unless the source of the unearned income is listed in M0730.099 B. Verification of unearned income that is totally excluded is not required.
- F. References** What is income, M0710.003
What is not income, M0715.050
When income is counted, M0710.030
How to estimate income, M0710.610

UNEARNED INCOME EXCLUSIONS - GENERAL**M0730.050 OVERVIEW OF EXCLUSIONS**

- A. Definitions** An exclusion is an amount of income that does not count in determining eligibility.

- B. Policy** Exclusions never reduce unearned income below zero. No unused unearned income exclusion may be applied to earned income.
- C. Procedure** First determine whether what is received is income. Next apply any appropriate exclusions of unearned income listed in this subchapter.
- D. Reference** What is not income, M0715.050

M0730.099 GUIDE TO EXCLUSIONS

- A. Introduction** The following provides a list of exclusions of unearned income:
- B. List of unearned income exclusions**
- 1. Home Produce** Home produce of the individual utilized for his/her family's own consumption is excluded.
 - 2. Food Stamps** Benefits under the Food Stamp Program *are* excluded.
 - 3. Commodities** The value of foods donated under the U.S.D.A. Commodity Distribution Program, including those furnished through school meal programs, is excluded.
 - 4. Federal Relocation Assistance** Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 is excluded.
 - 5. Nutrition Program for the Elderly** Any benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965, as amended, are excluded.
 - 6. Grant or Loan Administered by U.S. Secretary of Education** Any grant or loan to any undergraduate student for educational purposes made or insured under any program administered by the U.S. Secretary of Education is excluded. Programs that are administered by the U.S. Secretary of Education include: Pell Grant, Supplemental Educational Opportunity Grant, Perkins Loan, Guaranteed Student Loan, including the Virginia Educational Loan, PLUS Loan, Congressional Teacher Scholarship Program, College Scholarship Assistance Program, and the Virginia Transfer Grant Program.
 - 7. College Work Study Programs** Any funds derived from the federal College Work Study Program or any other college work study programs are excluded.
 - 8. Educational Scholarships and Grants** All educational scholarships and grants are excluded.

B. Definitions

- 1. Annuity** 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.
- 2. Pensions and Retirement Benefits** Pensions and retirement benefits are payments to a worker following his retirement from employment. These payments may be paid directly by a former employer, by a trust fund, an insurance company, or other entity.
- 3. Disability Benefits** Disability benefits are payments made because of injury or other disability.

C. List of Benefits

The following are examples of benefits:

Social Security Benefits
VA Payments
Worker's Compensation
Railroad Retirement
Black Lung Benefits
Civil Service Payments
Military Pensions
VIEW Transitional Payments

D. Procedure

Verify entitlement amount and amount being received by documents in the applicant/enrollee's possession, such as an award letter or benefit payment check, or by contact with the entitlement source.

M0730.200 UNEMPLOYMENT COMPENSATION

A. Policy

Unemployment Compensation received by an individual is counted as unearned income. The amount counted is the gross benefit before any taxes or deductions.

B. Procedures

Count Unemployment Compensation as unearned income for all covered groups, but do not count it in the 185% income screening for LIFC.

Exclude Unemployment Compensation in the 185% income screening for LIFC. Count Unemployment Compensation in the 90% income screening.

M0730.210 TRADE ADJUSTMENT ASSISTANCE ACT INCOME

A. Policy

The Trade Adjustment Assistance Act is administered by the Virginia Employment Commission. The Act allows qualified unemployed individuals to receive additional weeks of Unemployment Compensation (UC). UC benefits are counted as unearned income. The amount counted is the gross benefit before any taxes or deductions.

B. Procedure

See M0730.200, above, for procedures to use in counting UC benefits.

M0730.400 CHILD/SPOUSAL SUPPORT

- A. Policy** Support received by an individual, whether it comes directly from the provider or is redirected to the individual by DCSE, is unearned income. The support received by the individual is subject to the \$50 Support Exclusion.
- B. TANF Recipients**
- 1. Distribution of Support** As a condition of eligibility for Temporary Assistance to Needy Families (TANF), an individual is required to assign to the State any rights to support from an absent parent of a child receiving TANF.

The State, through the Division of Child Support Enforcement (DCSE), sends the first \$50 of support collected in a month on behalf of the TANF assistance unit to that unit. (If the total support collected is less than \$50, the entire amount is sent to the unit.) Any remaining amount of support is kept by the State as reimbursement of TANF payments made to the family. If DCSE collects more support than the State is entitled to keep as reimbursement for TANF paid, it will forward the excess to the TANF assistance unit. That excess amount is counted as unearned income.
 - 2. \$50 Pass Through** Child support collected by DCSE and paid to a TANF assistance unit as a \$50 (or less) pass-through of child support is not income to the Medicaid family/budget unit.
 - 3. Amount in Excess of the \$50 Pass-Through** Child support collected by DCSE and forwarded to a TANF family because the support exceeds the amount which the State is entitled to keep as reimbursement for TANF is a payment of child support and is *counted as* unearned income.
 - 4. Retained by State** Child support collected by a State and retained as reimbursement for TANF payments is not income to a Medicaid *applicant/enrollee*.
 - 5. After TANF Stops** If the Medicaid *enrollee* has been removed from the TANF unit and is no longer included in the money payment, the assignment of rights to support for that individual is no longer valid (except with respect to any unpaid support obligation that has accrued under the assignment). From that point forward, the Medicaid *enrollee* is entitled to receive from the State his or her share of any support collected on his behalf. Any support received is unearned income in the month received.
- C. Individual Not Receiving TANF**
- 1. Direct Child/Spousal Support** Support collected by DCSE and paid to the Medicaid family/budget unit is unearned income in the form of child support to the family/budget unit. Support paid directly to the Medicaid family/budget unit by an absent parent or spouse is unearned income in the form of child/spousal support to the family/budget unit.

**2. Support
Exclusion**

The first \$50 of total child or child and spousal support paid to the family/budget unit is excluded. The \$50 exclusion is only applicable current child/spousal support payments received each month. The \$50 exclusion does not apply to alimony that is not commingled with child support.

**D. Payments Made to
Third Party (Other
Than DCSE)**

Pending establishment of a child support obligation by the District Child Support Enforcement Office, payments made to a third party such as a rental agency in lieu of or in addition to child support, whether based on a court order or a mutual voluntary agreement between the Medicaid applicant/*enrollee* and the responsible person, *are NOT* counted as unearned income to the child *or to the parent-caretaker*.

**E. Payments Received
for Child Not Living
in Home**

Child support payments received by a parent-caretaker for a child who is not living in the home are counted as income to the parent-caretaker if the parent-caretaker does NOT give the payment to the child when it is received.

M0730.500 DIVIDENDS AND INTEREST

- A. Policy** Dividends and interest are only counted as unearned income when earned on a countable resource. Dividend and interest income payments on countable resources are counted as income in the month received or anticipated to be received (even if paid quarterly, annually, etc.), unless the interest is earned on an excluded savings account for education, home purchase or establishing a business per M0630.125.
- B. Definition** Dividends and interest are returns on capital investments such as stocks, bonds, certificates of deposit, or savings accounts.
- C. Procedure** Verify the amount that is received or is anticipated to be received by documents in the applicant/recipient's possession or through contact with the financial institution where the account or other financial instrument is located.

M0730.505 RENTAL/ROOM AND BOARD INCOME

- A. Policy** Net rental/boarder income from the rental of real property, or rooms, or board paid when the applicant/recipient is not engaged in a business enterprise or actively involved in management is unearned income. Rental/room and board income is counted in the month in which it is received.
- B. Definitions**
- 1. Rent** Rent is a payment which an individual received for the use of real or personal property, such as land or housing.
 - 2. Net Rental Income** Net rental income is the total amount received less the allowable costs.
 - 3. Board** Board is the amount paid for the provision of meals only.
 - 4. Room** Room is the amount paid to rent a room only.
 - 5. Room and Board** Room and board is the amount paid for room rent and the provision of meals.
- C. Calculation of Net Rental/Boarder Income**
- 1. Real or Personal** The net rental income is the total amount received less the tax on the property.

Verify the anticipated income by documents in the applicant's possession or by a statement from the tenant.

Verify the anticipated cost by a tax receipt for the property owned.

2. Room Rent

The net rental income is 65% of the total rent received if heating fuel is furnished by the applicant/recipient. The net rental income is 75% of the total rent received if heating fuel is not furnished.

Verify the rent paid by documents in the applicant/recipient's possession or a statement from the tenant.

3. Boarders

The net rental income is the total board received less the standard food allowance for one person at 100% per boarder. Contact your Medicaid Consultant for the current standard food allowance.

Verify anticipated income from documents in applicant/recipient's possession or statement from boarder.

**4. Roomer/
Boarders**

The net rental income is the total rent received less the standard food allowance for one person at 100% per boarder AND the room rental costs: 65% of the total rent received if heating fuel is furnished or 75% of the total rent received if heating fuel is not furnished.

Verify anticipated income by documents in the applicant/recipient's possession or by a statement from the boarder.

M0730.520 GIFTS**A. Policy**

The first \$30 received by each individual in the assistance unit per calendar quarter for special occasions, such as birthdays, Christmas, etc., is excluded.

B. Definition

Calendar quarters are:

January - March;
April - June;
July - September;
October - December.

C. Procedure

Any amount in excess of the \$30 per calendar quarter anticipated to be received will be counted as unearned income in the month in which it is anticipated to be received.

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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	2008 Monthly Amount	2007 Monthly Amount
1	\$637	\$623
2	956	934
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size	2008 Monthly Amount	2007 Monthly Amount
1	\$424.67	\$415.33
2	637.33	622.67

**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	2008 Monthly Amount	2007 Monthly Amount
1	\$1911	\$1,869

**4. Medically
Needy**

a. Group I		
Family Unit Size	Semi-annual	Monthly
1	\$ 1,592.39	\$ 265.39
2	2,027.57	337.92
b. Group II		
Family Unit Size	Semi-annual	Monthly
1	\$ 1,837.38	\$ 306.23
2	2,262.85	377.14
c. Group III		
Family Unit Size	Semi-annual	Monthly
1	\$ 2,389.59	\$ 398.26
2	2,880.04	480.00

**5. ABD Medically
Indigent**

**For:
ABD 80% FPL,
QMB, SLMB, &
QI without Social
Security (SS) and
QDWI, effective
1/23/08;
ABD 80% FPL,
QMB, SLMB, &
QI with SS,
effective 3/01/08;
and MEDICAID
WORKS,
effective 1/23/08**

ABD 80% FPL	Annual	Monthly
1	\$8,320	\$ 694
2	11,200	934
QMB 100% FPL	Annual	Monthly
1	\$10,400	\$ 867
2	14,000	1,167
SLMB 120% of FPL	Annual	Monthly
1	\$12,480	\$1,040
2	16,800	1,400
QI 135% FPL	Annual	Monthly
1	\$14,040	\$1,170
2	18,900	1,575
QDWI and MEDICAID WORKS 200% of FPL	Annual	Monthly
1	\$20,800	\$1,734
2	28,000	2,334

- d. **Analysis:** The time deposit interest and savings interest are received only once (or less) per quarter. Therefore they are both infrequent. The \$7 gift is irregular income. Since the total of the irregular/infrequent income received by the couple in 9/92 does not exceed \$20 (\$10 + \$2.50 + \$7), the income from these sources may be excluded.

Both the checking interest and the title II benefit are paid monthly. Therefore, neither type of income is excludable as infrequent or irregular.

NOTE: The frequency with which interest is **compounded** is not material to how often it is paid. Daily, monthly, or quarterly compounding are methods of **computing** (not paying) interest.

**3. Infrequent/
Irregular
Income--
Amount
Exceeds Limit**

- a. **Situation:** The recipient owns a savings account which pays interest of no more than \$8 in the first month of each quarter. Also in the first month of every quarter, the recipient's sister gives her \$16 in cash to help her pay utility bills.
- b. **Analysis:** Although both the income from her savings account and the income from her sister are received infrequently, the total of the infrequent income exceeds \$20 in a month. Therefore, none of the income is excludable under this provision.

Note that were the sister to give the recipient \$16 in the second or third month of every quarter (i.e., not in the same month the interest income is received), **both** types of income could be excluded under the infrequent income provision.

H. References

Relation of the infrequent/irregular exclusion to other income exclusions, S0830.050.

S0810.420 \$20 PER MONTH GENERAL INCOME EXCLUSION

A. Policy

- 1. Unearned Income**

We exclude the first \$20 per month of any unearned income other than income based on need (IBON).

Do not increase the dollar amount of this exclusion when both an eligible individual and his/her eligible spouse have income. An eligible couple receives one \$20 exclusion per month.
- 2. Income Based on Need**

Income based on need is a benefit that uses financial need as measured by income as a factor to determine eligibility.

The \$20 exclusion does **not** apply to a benefit based on need that is totally or partially funded by the Federal Government or by a nongovernmental agency.
- 3. Earned Income**

If an individual (or couple) has less than \$20 of unearned income (other than IBON) in a month and also has earned income in that month, the remainder of the \$20 exclusion reduces the amount of the earned income.

B. References

- Income Based On Need (IBON), S0830.170
- Assistance Based On Need (ABON), S0830.175

M0810.430 PLAN FOR ACHIEVING SELF-SUPPORT (PASS)

A. Policy

Income, whether earned or unearned, of a blind or disabled recipient may be excluded if such income is needed to fulfill a plan for achieving self-support (PASS). The Social Security Administration determines if an SSI recipient is entitled to a PASS exclusion.

This exclusion does not apply to a blind or disabled individual age 65 or older, unless he/she was receiving SSI or State disability or blind payments for the month before he/she became age 65.

B. How PASS Works In Brief

PASS is an income and resource exclusion that allows a disabled or blind person to set aside income and/or resources for a work goal such as education, vocational training, or starting a business. Individuals can *also* set aside funds to purchase work-related equipment.

PASS can help an individual establish or maintain SSI eligibility and can also help increase or help maintain the individual's SSI payment amount. *The PASS exclusion applies to the individual's SSI eligibility and is not evaluated by the Medicaid eligibility worker.*

C. References

- IRWE and PASS exclusions both apply, S0820.545 B.3.

3. **IRWE Used for Other Daily Activities** Any expense may meet the criteria for an IRWE even if it also is used for daily activities other than work.
4. **Application of Exclusion**
- a. The IRWE exclusion only applies to earned income. IRWE in excess of the earned income an individual receives during the month are never deducted from unearned income. (See S0820.560 for allocating expenses.)
 - b. The IRWE exclusion is applied to earned income in the sequence below:
 - immediately **after** deducting:
 - any portion of the general income exclusion which has not been deducted from unearned income; **and**
 - the \$65 earned income exclusion; **and**
 - immediately **before** deducting one-half of the remaining earned income.

M0820.545 WORK EXPENSES – INTERACTION WITH OTHER POLICIES

A. Introduction This section discusses the interaction of other policies with work expenses.

**B. Policy-Items
Deductible Under
Other Provision**

- 1. Self-Employment** If the cost of an item has been deducted in figuring net earnings from self-employment (NESE) as described in S0820.200, it cannot be deducted as a work expense.
- 2. Community Residence** When an individual resides in a community residence, the individual's payments for work related attendant care can be used to reduce countable earnings.
- 3. PASS**
 - a. A PASS permits an individual to set aside income and resources for a limited period of time in order to reach a work goal. (For a more comprehensive discussion on PASS, see M0810.430)
 - b. Income used to pay for a particular work-related item may not be excluded from countable income under the PASS and the BWE or IRWE provisions simultaneously.
 - c. Unlike BWE or IRWE, a PASS may be used to reduce countable unearned income and resources.

C. Policy – Deeming In determining how much of an ineligible spouse's or parent's income is subject to deeming, earnings which are used to meet work expenses are not counted, if the ineligible spouse or parent is blind or disabled. Accept the individual's allegation of blindness or disability. Work expenses should be documented and verified according to S0820.550.

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M1130.410 BURIAL FUNDS EXCLUSION

A. Policy Principle

Up to \$3,500 of burial funds may be excluded for each member of the ABD assistance unit (i.e., the individual and the individual's spouse, if living together).

NOTE: Burial funds exclusion is separate and apart from burial space exclusion.

For QDWI, see Appendix 1 to chapter S11.

B. Definitions

1. Burial Funds

Burial funds are resources that have been specifically set aside and clearly designated in writing for the cremation or other burial-related expenses of the individual or the individual's spouse.

Burial funds may be:

- irrevocable burial trusts established on or after August 11, 1993 (*irrevocable burial trusts established **before** August 11, 1993 are not countable based on the law in effect at that time*);
- revocable burial trusts;
- revocable burial contracts;
- other revocable burial arrangements (including the value of certain installment sales contracts for burial spaces);
- cash;
- financial accounts (e.g., savings or checking accounts);
- other financial instruments with a definite cash value (e.g., stocks, bonds, certificate of deposit, life insurance policies, etc.); or

Property other than that listed in this definition will not be considered burial funds and may not be excluded under the burial funds provisions. For example, a car, real property, livestock, etc., are **not** burial funds.

NOTE: The entire amount of an irrevocable trust established on or after 8/11/93 by a funeral director for an individual for the purpose of paying for funeral and burial expenses is excluded if the following two step process is followed:

- 1) *the individual signs a pre-need contract with a funeral home director promising prepayment in return for specific funeral merchandise and services and pays the agreed upon amount in the form of a direct cash payment or purchase of a life insurance policy or annuity to the funeral director, and*
- 2) *the funeral home director in turn places the money, life insurance policy or annuity into a trust.*

2. Expenses for Burial Funds Exclusion Purposes

a. Expenses Included

Expenses included for burial funds exclusion purposes are generally those related to preparing a body for burial and any services prior to burial.

They usually include, for example: transportation of the body, embalming, cremation, flowers, clothing, services of the funeral director and staff, etc.

b. Expenses Not Included

Usually, expenses for items used for interment of the deceased's remains are not included for burial funds exclusion purposes. Such items may be subject to the burial space exclusion (M1130.400). However, items that do not qualify for the burial space exclusion, e.g., a space being purchased by installment contract, may be excluded under the burial fund exclusion.

**C. Policy--
General**

**1. Amount of
Funds That
Can Be
Excluded**

a. Maximum Exclusion

We can exclude up to \$3,500 each in funds set aside for:

- the burial expenses of the individual; and
- the burial expenses of the individual's spouse (eligible or ineligible).

This exclusion is separate from and in addition to the burial space exclusion.

- Funds paid on an installment contract do not qualify for the burial space exclusion.
- Funds paid on an installment contract for burial spaces may qualify for the burial fund exclusion.

b. Reductions in Maximum Exclusion

The maximum \$3,500 that can be excluded from countable resources is reduced by:

- *the face value of life insurance (not including term policies) owned by and insuring the individual and/or the individual's spouse, if the cash surrender value of such policies has been excluded from countable resources (cash surrender value of life insurance is excluded when the total face value per insured individual aged 21 or over does not exceed \$1,500), and*
- *the face value of an irrevocable burial trust established before 8/11/93 (not including the value of burial space items), regardless of whether the arrangement is owned by the individual or some one else, and*
- *the face value of burial insurance, regardless of whether the burial insurance is owned by the individual or some one else, and*
- *the face value of burial contracts (not counting the value of burial space items), regardless of whether the contract is owned by the individual or someone else.*

EXAMPLE:

Mrs. Brown has the following burial resources:

\$2,000 designated savings account
\$ 200 irrevocable burial contract

\$3,500 maximum exclusion
- 200 irrevocable burial contract
\$3,300 available exclusion
- 2,000 excluded burial funds
\$1,300 still available for exclusion

Treatment - We exclude the \$2,000 savings account. Two years later, Mrs. Brown wants to add to her designated burial savings account which now has a balance of \$2,150 due to accumulated interest. She can increase the amount of excluded funds in the account by up to \$1,300. **Note that when determining the amount still available for exclusion, we disregard the amount of interest which accumulated in the account.**

c. Subsequent Purchase of Excluded Life Insurance or Irrevocable Burial Contract

A subsequent purchase of an excluded life insurance policy or an irrevocable burial contract reduces the amount of the available burial funds exclusion as described in b. above. The reduction is effective the month after the month in which the life insurance or the irrevocable burial contract was purchased.

d. Burial Insurance

Burial insurance policies are not life insurance policies (see **M1130.300** for a definition of burial insurance). For Medicaid purposes, burial insurance is an irrevocable arrangement whose face value reduces the maximum burial funds exclusion by the policy's face value.

e. Increases in Value of Burial Funds

Any appreciation in the value of excluded burial funds is excluded from resources (and from income), even if the total of the burial funds thus excluded exceeds the \$3,500 maximum. This includes interest earned by burial funds, provided the interest is left to accumulate as part of the funds.

2. Increases in Amount of Excluded Burial Funds

a. Designated Amount is \$3,500

Interest earned on excluded burial funds and appreciation in the value of excluded burial arrangements are excluded from resources if left to accumulate and become part of the separate burial fund.

b. Designated Amount is Less than \$3,500

Until \$3,500 (or such other lesser amount established in accordance with C.1.b.) in burial funds has been designated, additional amounts can be excluded under the burial funds provision if the individual designates them for burial expenses. Interest on excluded burial funds is not included in determining if the \$3,500 maximum has been reached.

c. Designated Amount is greater than \$3,500

While an individual may designate greater than \$3,500 for burial, only up to \$3,500 may be excluded for burial. The remainder of the designated amount will be evaluated as a countable resource. If the individual is determined eligible, interest and appreciation that accumulates on the excluded portion of the burial fund will be excluded. Interest and appreciation that accrue over time on the non-excluded portion will be evaluated as a countable resource.

3. Burial Funds Must Be Kept Separate from Non-burial-Related Assets

a. If burial funds are commingled with nonburial-related assets, the exclusion does not apply.

b. Examples

A single burial contract for \$4,500 of burial services and \$2,000 in burial spaces does not have to be separated into 2 contracts since the whole amount is burial-related, even though we can only exclude \$3,500 of the contract as a burial fund.

A bank account containing \$1,200, \$500 of which is designated for burial and \$700 of which is other funds the individual uses for living expenses, is **not** allowable and the \$500 may **not** be excluded as a burial fund. If the \$500 is moved to a separate account, the exclusion may be applicable the month in which the funds are separated.

4. Funds Used for Another Purpose

a. General

If some or all of the excluded funds were withdrawn and used for another purpose, the funds withdrawn may have been either transferred or retained as a resource. If the funds were transferred, the asset transfer policies in subchapter M1450 are applicable. If the funds have been retained as a resource, the resource policies in Chapter S11 are applicable. Any excluded funds remaining in the designated burial fund continue to be excluded.

b. Change of Form

Transferring excluded burial funds from one form to another (e.g., from a certificate of deposit to a burial contract) is not use for another purpose.

c. Examples - Use for Another Purpose

A loan against the cash surrender value (CSV) of a life insurance policy that has been designated for burial expenses **is not** use for another purpose **if** the loan is for the purchase of another burial fund.

Use of a burial fund as collateral for a loan **is** use for another purpose because the loan creates an encumbrance on the funds. Since the funds are not available for the individual's burial as long as they are encumbered, the funds cannot be considered set aside for the individual's burial.

5. When to Develop Use for Another Purpose

Determine if excluded burial funds have been used for some purpose other than as burial funds only if:

- there is some indication that excluded funds may have been used for another purpose, and
- the sum of the excluded funds (including any that may have been spent) and countable resources exceeded the applicable (individual or couple) resources limit as of the month in which the excluded funds may have been used for another purpose, and
- the individual was eligible for the month in which the excluded burial funds may have been used for another purpose.

6. How to Develop Use for Another Purpose

If the criteria in 1. above indicate a need to pursue the issue of use for another purpose:

- obtain the individual's signed statement as to whether any of the funds were so used and, if so, the amount;
- obtain any pertinent evidence, including signed statements from other individuals who may know about the funds in question.
- follow resource policy if funds have been retained as a resource.
- follow asset transfer policy if funds were transferred.

7. Deeming Considerations

If the individual is a blind or disabled child under age 21 who lives with his parent, resources (and income) of the parent are deemed to the child. The burial funds exclusion applies to resources that belong to the parent and are designated as set aside for the burial expenses of the parent and/or his or her spouse.

D. Designation of Burial Funds

1. How Designation May Be Made

Burial funds may be designated by the applicant at the time of application or during the initial application processing period or by an enrollee at any time after eligibility has been determined. Burial funds may be designated by:

- an indication on the burial fund document (e.g., the title on a bank account); or
- a signed statement.

See Appendix 3 for a sample burial funds designation form. A printable version of the form is located on the Virginia Institute for Social Services Training Activities (VISSTA) web site at:

http://www.vcu.edu/vissta/bps/bps_resources/medicaid/burial_fund_designation.pdf.

2. Signed Statement Designating Burial Funds

A signed statement must include:

- the value and owner of the resources;
- for whose burial the resources are set aside;
- the form(s) in which the resources are held (burial contract, bank account, etc.); and
- the date the individual first considered the funds set aside for the burial of the person specified.

3. Date of Intent

We accept the individual's allegation as to the date he or she first considered the funds set aside for burial unless there is evidence that the funds were used and replaced after that date.

4. Effective Date of Exclusion

Once the date that burial funds were considered set aside for burial has been established, the first month for which the exclusion affects resource determination is the latest of:

- the month in which the funds were considered to have been set aside, or
- the month of application, if the funds were considered set aside before the month (or first month of retroactive period, if retroactive coverage is requested).

5. Designating Life Insurance as a Burial Fund

When designating a countable life insurance policy as a burial fund, the policy itself is designated. However, because the countable value of the policy is its cash surrender value, it is the cash surrender value at the time of designation that is applied toward the burial funds exclusion when determining countable resources.

*If life insurance is designated as a burial fund, the individual can also designate any dividend accumulations on the life insurance policy (M1130.300 A.5.b.) as a burial fund. Dividend accumulations are a separate resource (i.e. **not** considered as an increase in the value of the CSV) and must be designated as burial funds separate from the life insurance policy itself.*

6. Designation Remains

Once a burial fund is designated, it remains a burial fund until:

- *eligibility terminates or*
- *the individual states in writing that the funds are no longer set aside for burial.*

E. Procedure-Initial Applications Development and Documentation

1. Ask About Burial Funds

Unless the individual is ineligible for a reason other than resources, inquire to determine the presence of excluded burial funds.

NOTE: Make sure the individual understands what we mean by a burial fund and the effect a burial fund could have on countable resources and income.

- 2. Verify Form and Separation of Funds** Verify that the funds meet the definition of burial funds in B.1. above and that the funds are separated from all other non-burial-related assets (C.3. above). Burial funds must meet both of these requirements before we can exclude them. *If funds cannot be excluded, tell the individual why (e.g., if the funds are not separate from non-burial assets).*
- 3. Determine Date Funds Set Aside for Burial** If an individual alleges having set aside funds for burial, determine the date they were first considered as set aside and document the file with supporting evidence.
- If the funds are already clearly designated (e.g., by the title of a savings account), accept any official record which shows the title of the account and which establishes that the designation was in effect prior to the month of application.
 - If the funds are **not** already clearly designated, obtain the statement described in D. above.
 - See D.4. above regarding effective date of the exclusion for funds considered set aside for burial prior to filing.
- 4. Verify Value of Funds** Verify the value of any burial funds to be excluded, using the instructions that apply to the specific resources in question.
- 5. Determine Amount of Exclusion Available** Document the file with evidence of:
- the face value of life insurance owned by and insuring the individual or the individual's spouse if the cash surrender value of such policies has been excluded from countable resources (cash surrender value of life insurance is excluded when the total face value per insured individual age 21 or over does not exceed \$1,500), and
 - the face value of an irrevocable burial trust established before 8/11/93 (not including the value of burial space items) whether the arrangement is owned by the individual or some one else, and
 - the face value of burial insurance whether owned by the individual or some one else, and
 - the face value of burial contracts (not counting the value of burial space items) whether the contract is owned by the individual or someone else.

Should the \$3,500 maximum exclusion be reduced by life insurance, any irrevocable arrangement including an irrevocable burial trust established before 8/11/93, burial insurance, or a burial contract, document the amount by which the exclusion will be reduced, including the computation of the amount. To make this computation, you may use the electronic Burial Funds Exclusion Worksheet located on the VCU-VISSTA website:

http://www.vcu.edu/vissta/bps/bps_resources/medicaid/abd_medicaid/master_bfe_worksheet.xls

**F. Procedures-
Renewal or a
Reported Change**

**1. Verify Funds
Already
Excluded**

If the case record shows excluded burial funds, verify the current amount. *When \$3,500 or less was initially designated as a burial fund, increases in the burial fund due to appreciation or accumulated interest are excluded even if they result in the total burial fund exclusion exceeding the \$3,500 maximum.*

If more than \$3,500 was initially designated for burial funds exclusion, interest and appreciation that have subsequently accrued on the excluded portion of the burial fund are excluded. Interest and appreciation that have subsequently accrued on the countable portion are countable. To calculate the countable value of a burial fund at renewal or when a change is reported you may use the electronic "BFE Increased Value Determination Worksheet". The worksheet is located on the Virginia Institute for Social Services Training Activities (VISSTA) web site at:

http://www.vcu.edu/vissta/bps/bps_resources/medicaid/abd_medicaid/master_bfe_increased_value_determination_worksheet.xls.

Also, inquire whether designated burial funds continue to be maintained separately from non-burial-related assets (C3. above).

If the funds have decreased, see G. below.

**2. Enrollee Wishes
to Designate
Funds**

If an enrollee wishes to designate funds for burial, proceed as you would for an initial application. This applies whether no funds are currently excluded or less than \$3,500 (excluding appreciation or accumulated interest) is currently excluded.

**3. Apply Burial
Funds-Related
Income/
Resources
Exclusions**

See H. below.

**G. Procedure-Burial
Funds Are Used for
Another Purpose**

**1. When to
Evaluate Use
for Another
Purpose**

Determine if excluded burial funds have been used for some other purpose only if:

- there is some indication that excluded funds may have been used for another purpose, *and*
- the sum of the excluded funds (including any that may have been spent) and countable resources exceeded the applicable (individual or couple) resources limit as of the month in which the excluded funds may have been used for another purpose, *and*
- the individual was eligible for the month in which the excluded burial funds may have been used for another purpose.

2. How to Evaluate Use for Another Purpose

If the criteria in 1. above indicate a need to pursue the issue of use for another purpose:

- obtain the individual's signed statement as to whether any of the funds were so used and, if so, the amount;
- obtain any pertinent evidence, including signed statements from other individuals who may know about the funds in question.

H. Procedure-- Posteligibility Application of Burial Fund - Related Income/Resource Exclusions

1. Recipient Is Eligible for All Months During Period of Review

If the individual remained eligible throughout the period of review:

- exclude from income any interest earned on the excluded burial funds if that interest has been allowed to accumulate as part of such funds; and
- exclude from resources, in addition to the funds previously excluded, any interest on such excluded burial funds that has been excluded from income and any appreciation in the value of such excluded funds.

I. References

Burial space exclusion, M1130.400.
 Prepaid burial contracts, M1130.420.
 Burial insurance, M1130.300.
 Interest on excluded burial funds, S0830.501.
 Insurance funded burial contracts, M1130.425.

**M1130.411 BURIAL FUNDS EXCLUSION--
 JULY 1, 1988 THROUGH JULY 31, 1994**

A. Introduction

The instructions in **M1130.410** apply to the burial funds exclusion for July 1, 1988 through June 30, 1994 with the exceptions noted below.

B. Policy

1. Form of Burial Funds

For months prior to August 1, 1994 burial funds could be in the form of **any** resource, liquid or nonliquid.

2. Commingled Funds

For months prior to August 1, 1994, burial funds could be commingled with other resources (burial-related or nonburial-related), but the funds had to be separately identifiable in order to be excluded (S1130.700).

M1130.420 PREPAID BURIAL CONTRACTS

- A. Definition** A prepaid (or preneed) burial contract is an agreement whereby the buyer pays in advance for a burial that the seller agrees to furnish upon the death of the buyer or other designated individual.
- B. Policy--General**
- 1. Contract Is a Resource** If a burial contract is revocable or salable, it is a resource. However:
- any portion of the contract that clearly represents the purchase of burial spaces may be excludable, regardless of value (**M1130.400**); and
 - some or all of any remaining value of the contract may be excludable as burial funds (**M1130.410**).
- 2. Contract Is Not a Resource**
- a. Contract Not Saleable**
- When a burial contract is funded totally by an irrevocable trust, irrevocably assigned life insurance policy or annuity, the contract is NOT saleable. Do not develop the prepaid burial contract further. Determine whether the trust, the life insurance policy or annuity is a resource using the following policy:
- trusts in sections M1120.200 through 202, M1140.400 through 404.
 - life insurance in sections M1130.300 and M1140.310.
- b. Contract Issued in Another State**
- If a burial contract is issued in another State and cannot be revoked or be sold without significant hardship, it is not a resource. However:
- any portion of the contract that represents burial **funds** reduces the \$3,500 maximum otherwise available for the burial funds exclusion; but
 - any portion that represents the purchase of burial spaces has no effect on the burial funds exclusion.
- 3. Contract Revocability** State law determines whether a contract is revocable. Some burial contracts may be partly revocable. For example, if the total value of an otherwise irrevocable contract exceeds the limit set for irrevocability by State law, the excess is revocable.
- 4. Burial Insurance and Burial Trusts** Prepaid burial contracts do not include burial insurance as defined in **M1130.300** or burial trusts as described in M1120.200.

5. **Provider Places Funds in Trust** If an individual contracts with a provider of burial services and the **provider** places the funds in trust with the funeral provider named as the grantor on the trust document, this individual has purchased a preneed contract; this is a compensated "transfer" of funds.

C. Policy --Evaluations Contracts

1. **Conditions for Liquidation** A prepaid burial contract may have conditions attached to its liquidation or revocation. If either of the following conditions exists, the contract is not a resource.

- Significant hardship may result from the conditions required for selling or revoking a contract. Significant hardship means an unrealistic demand on the buyer; e.g., having to move out of state. If an EW determines that such would be the case, the file must contain a determination to that effect.
- State law or contractual terms may require **mutual consent** of buyers and seller in order to sell or revoke a contract. If the seller will not consent, or will consent only under conditions that would pose a significant hardship to the buyers, the file must reflect those facts.

NOTE: If a condition creating hardship or some other obstacle to liquidation is not evident on the face of the contract, assume it is revocable or salable and, therefore, a resource. The burden is on the applicant/recipient to provide evidence to the contrary.

2. **Value of Contract as a Resource** If a burial contract is a resource, use as its value:

- the amount payable to the owner upon revocation; or
- if the contract is not revocable but is salable, its CMV.

3. **Single Purpose Burial Space Contracts** a. **General** Apply the burial space exclusion to any single-purpose burial space contract that is a resource **if:**

- the contract lists all of the burial spaces **and** either includes a value for each space or the total value of all the spaces combined; and
- the seller's obligation to provide those items is not contingent on further payment (as in certain installment contracts); i.e., the items are actually being held for the individual's future use.

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**C. Policy--
Limitations On
Development**

It is not necessary to develop for the exclusion of property essential to self-support if:

- the combined value of the self-support property and other countable resources does not exceed the applicable resource limit;
- the value of other countable resources (including any equity over \$6,000 when B.1.b. or c. is involved) exceeds the applicable resource limit;
- the individual is ineligible for a **nonfinancial** reason; or
- the property was excluded under the State plan in effect for October 1972 and the individual meets the "grandfathering" criteria.

D. Related Policies

**1. Home
Property**

When an individual uses home property to perform self-support activities, the property is excluded under S1130.100, regardless of its value, rate of return, or current use.

**2. Plan For
Achieving Self-
Support
(PASS)**

The primary differences between the exclusion of property essential to self-support and the exclusions provided for under a PASS (see *M0810.430*) are that the PASS exclusions:

- cover income as well as resources;
- apply to the blind and disabled, but not to the aged;
- have a time limit; and
- do not have an inherent dollar limit.

Consider the overall resource situation to ensure that the individual receives the benefit of the most advantageous exclusion for him or her.

**M1130.501 ESSENTIAL PROPERTY EXCLUDED REGARDLESS OF VALUE
OR RATE OF RETURN**

A. Policy Principles

- 1. The Exclusion** The properties described in 2, 3, and 4 below are excluded as essential to self-support regardless of value or rate of return. However, they must be in current use or, if not in use for reasons beyond the individual's control, there must be a reasonable expectation that the required use will resume.

- 2. Trade Or Business Property** Property essential to self-support used in a trade or business is excluded from resources regardless of value or rate of return effective 5/1/90.

- 3. Government Permits** Government permits represent authority granted by a government agency to engage in income producing activity. Examples are commercial fishing permits granted by a State Commerce Commission and tobacco crop allotments issued by the U.S. Department of Agriculture.

- 4. Personal Property Used by an Employee** Personal property used by an employee for work is excluded from resources. Excluded items include tools, safety equipment, uniforms, etc.

B. Development and Documentation-- General

The rules in C., D., and E. below apply unless development can be eliminated in accordance with S1130.500 C.

C. Development and Documentation -- Property Used in a Trade or Business

- 1. Trade or Business Not Being Excluded** When an individual alleges owning trade or business property not already being excluded, consider if a valid trade or business exists, and if the property is in current use (see S1130.504). Obtain a statement giving the information below. Absent evidence to the contrary, accept the responses to items a.-d. Verify e. with the business tax returns.
 - a. a description of the trade or business;
 - b. a description of the assets of the trade or business;
 - c. the number of years it has been operating (see 4. below);
 - d. the identity of any co-owners;
 - e. the estimated gross and net earnings of the trade or business for the current tax year (see 3. below).

- 2. Redetermination of Excluded Trade or Business Property** Consider current use of the property in the trade or business. Obtain and verify the individual's allegations as to the estimated gross and net earnings of the trade or business for the current tax year for income purposes (see S0820.230).

3. Use of Tax Returns

a. Use Most Recent Tax Return

Obtain a copy of the business tax return (i.e., Form 1040 and the appropriate schedules) for the tax year prior to the application or redetermination. Use the return to determine the net earnings from self-employment and validity of the trade or business. The following can be particularly helpful:

- Schedule C, Profit or Loss from Business or Profession;
- Schedule SE, Computation of Social Security Self-Employment;
- Schedule F, Farm Income and Expenses;
- Form 4562, Depreciation and Amortization; and
- Form 1065, U.S. Partnership Return of Income.

b. Current Tax Return Not Available

If the current tax return is not available, obtain a copy of the latest tax return available.

4. Questionable Trade or Business

If a trade or business has operated a year or less, or there is a question of bona fides, develop to determine whether a trade or business actually exists.

5. Liquid Resources Used in a Trade or Business

Effective May 1, 1990, all liquid resources used in the operation of a trade or business are excluded as property essential to self-support. Obtain an individual's signed allegation that liquid resources are used in the trade or business.

D. Development and Documentation Government Permits

1. Individual's Statement

Permit Alleged

If an individual alleges owning a government license, permit, or other property that represents government authority to engage in an income producing activity, and that has value as a resource, obtain his or her signed statement as to:

- the type of license, permit or other property;
- the name of the issuing agency, if appropriate;
- whether the law requires such license, permit, or property for engaging
- in the income producing activity at issue; and
- how the license, permit, or other property is being used; or
- if it is not being used, why not.

If the property is not being used, see S1130.504 for development.

2. Supporting Evidence

Have the individual submit a copy of the license, permit and/or other pertinent documents. For example, an individual engaged in fishing in Alaska would have to have a permit. In North Carolina, a person growing flue-cured tobacco would

have to have a "marketing sales card" to sell it. If the individual cannot submit the necessary evidence, verify his or her allegations with the issuing agency. Do this by telephone if possible.

3. Common Government Permits

a. Alaska Limited Entry Fishing Permit (ALEFP)

An ALEFP is one of the two most commonly encountered types of property representing required government authority to engage in an income producing activity. Alaska's Commercial Fisheries Entry Commission first issued ALEFP's in 1973 to control commercial salmon fishing. These permits are required for individuals who engage in the fishing trade.

b. Tobacco Crop Allotment (TCA)

The TCA is the other most commonly encountered type of property representing government authority to engage in an income producing activity. It is issued by the U.S. Department of Agriculture's (USDA) Agricultural Stabilization and Conservation Services. It is required for the growing and selling of flue-cured tobacco, which is grown mostly in the southeastern United States. Do not confuse a TCA with a price support or subsidy, or a soil bank program.

Exclude a TCA only when the grower who has it is restricted to growing a certain quantity of the crop.

c. Tobacco Quota Buy-Out Program

The Tobacco Quota Buy-Out Program is administered by the USDA. The program involves a contract between the USDA and the land owner and/or the producer (the individual, other than the land owner, who grows the crop) and provides payments to the land owner and/or producer for their tobacco "base" or quotas. The unpaid balance of the contract is a countable resource.

E. Development and Documentation -- Personal Property Used by an Employee

1. Individual's Statement

If an individual alleges owning items that are used in his or her work as an employee, obtain his or her statement to include:

- the name, address, and telephone number of the employer;
- a general description of the items;
- a general description of his or her duties; and
- whether the items are currently being used.

If the individual is temporarily not working (e.g., job loss, seasonal employment), or the property is not otherwise in current use, see S1130.504.

2. Supporting Evidence

Absent evidence to the contrary, accept the individual's statement.

- 5. Change of Intent** If, after property has been excluded because an individual intends to resume self-support activity, the individual decides not to resume such activity, the exclusion ceases to apply as of the date of the change of intent. Thus, unless excluded under another provision, the property is a resource for the following month.

**D. Procedure --
Disabling
Condition**

- 1. Individual's Statement** If an individual alleges that self-support property is not in current use because of a disabling condition, obtain the individual's signed statement as to:
- the nature of the condition;
the date he or she ceased the self-support activity; and
when he or she intends to resume the activity, if at all.
- 2. Special Review** Prepare a special review as to whether up to an additional 12 months will be allowed for resuming use of the property.

NOTE: Medical review is not an indicator of an individual's intent or ability to do at least some work.

**S1130.510 RESOURCES SET ASIDE AS PART OF A PLAN FOR ACHIEVING
SELF-SUPPORT**

- A. Introduction** A plan for achieving self-support (PASS) allows blind and disabled (but not aged) individuals to set aside income and/or resources necessary for the achievement of its goals.
- B. Policy Principle** Resources set aside as part of an approved PASS are excluded.
- C. Development and Documentation** PASS resources are determined by SSI. See *M0810.430 for additional information about PASS.*

M1130.520 TRUSTS ESTABLISHED BETWEEN JULY 1, 1993 AND AUGUST 10, 1993

- A. Introduction** Trusts established between July 1, 1993 and August 10, 1993 can have up to \$25,000 disregarded from countable resources.
- B. Definitions**
- 1. MQT** A trust or similar legal device (SLD) is a legal instrument established other than by a will which:
- Is established by an individual or spouse (also includes trusts established by a guardian or representative payee for an incompetent adult or any child);
 - The individual may be beneficiary of all or part of the funds;
 - Is either revocable or irrevocable;
 - Trustees have discretion (whether or not the discretion is actually exercised) in distributing funds to the beneficiary;
 - May or may not be established for purposes other than to enable the beneficiary to qualify for medical assistance.
- 2. "SLD"** An "SLD" is a legal instrument:
- Under which the individual transfers or surrenders property to another individual;
 - In which a second individual has legal responsibility to manage the property for the first individual;
 - Which can include oral trusts, constructive trusts, and trusts created in law, in addition to trusts created by a written legal document; and
 - Which may not be labeled a "trust" but seems to meet all of the MQT criteria listed above.
- C. Policy** Some trusts have provisions which place limits on the discretion of the trustee either directly or indirectly to make payments from the trust to the grantor when the grantor makes a Medicaid application, or requires medical, hospital, or long-term care services. **Any restricting clauses in trusts created after July 1, 1993, are void if they limit the discretion of the trustee when the grantor applies for Medicaid or needs medical, hospital, or long-term care services.**
- 1. Trusts Less Than \$25,000** **Trust(s) Less than \$25,000 created after July 1, 1993 and before August 11, 1993**
- None of the principle is counted as a resource for single or multiple trusts created after July 1, 1993 and before August 11, 1993 when corpus or corpora is less than \$25,000. The maximum amount of income payable from the trust according to its terms is considered available income whether or not it is actually paid to the applicant or recipient.

Burial Fund Designation

CASE NAME
CASE NUMBER

I hereby designate the funds described below for burial.

RESOURCE DESIGNATED		OWNER	
Description <small>(Include name of financial institution, insurance company, location, account number or policy number, etc.)</small>	Designated for Whom	Date First Considered Designated	Value

RESOURCE DESIGNATED		OWNER	
Description <small>(Include name of financial institution, insurance company, location, account number or policy number, etc.)</small>	Designated for Whom	Date First Considered Designated	Value

RESOURCE DESIGNATED		OWNER	
Description <small>(Include name of financial institution, insurance company, location, account number or policy number, etc.)</small>	Designated for Whom	Date First Considered Designated	Value

SIGNATURE	DATE
-----------	------

- 21. Re-application** Re-application means any Medicaid medically needy spenddown application which is filed after the initial application.
- 22. Retroactive Spenddown Budget Period** The retroactive spenddown budget period is the retroactive period in which the individual is on a spenddown. The retroactive spenddown budget period is the 3 months immediately prior to the application month, when none of the months overlap (was included in) a previous MN spenddown budget period in which spenddown eligibility was established.
- When some of the months overlap a previous MN spenddown budget period in which spenddown eligibility was established, the retroactive spenddown budget period is shortened (prorated) to include only the month(s) which were not included in the previous MN spenddown budget period in which spenddown eligibility was established.
- 23. Spenddown** Spenddown is the process through which countable income is compared to the MNIL for the budget period and incurred expenses are deducted from excess countable income.
- 24. Spenddown Budget Period** A spenddown budget period is the budget period during which the individual's or family's countable income exceeds the MNIL for the budget period and during which the individual or family is placed on a spenddown.
- 25. Spenddown Eligibility** *Spenddown eligibility means the individual established eligibility by meeting a spenddown within a spenddown budget period.*
- 26. Spenddown Liability** The spenddown liability is the amount by which the individual's or family's countable income exceeds the MNIL for the budget period.
- 27. State or Territorial Public Program** A state or territorial public program is a public health program that is wholly or partially funded and administered by a state or territory, including a political subdivision thereof (i.e., SLH, GR, AG and CSB services).
- 28. State or Territorially-Financed Program** A state or territorially-financed program is a state or territorial public program whose funding, except for deductibles and coinsurance amounts required from program beneficiaries, is either:
- appropriated by the state or territory directly to the administering agency, or
 - transferred from another state or territorial public agency to the administering agency.

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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 days begins with the day of admission to the medical institution or receipt of Medicaid CBC. The date of discharge into the community (not in LTC) or death is **NOT** included in the 30 days.*

The institutionalization provisions may be applied when the individual is already in a medical facility at the time of the application, or the individual has been screened and approved to receive LTC services and it is anticipated that he is likely to receive the services for 30 or more

consecutive days. If it is known at the time the application is processed that the individual did not or will not meet the 30 consecutive day requirement, the individual is not to be treated as an institutionalized individual.

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). *This allows the agency to begin the evaluation of the applicant in the 300% SSI covered group for institutionalized individuals and to use the special rules for married institutionalized individuals who have a community spouse, if appropriate. However, prior to approval of the individual for Medicaid payment of LTC services, the worker must have received the DMAS-96 that was signed by the supervising physician or the signed Waiver Level of Care form. Applicants must be evaluated as non-institutionalized individuals for the months prior to the month in which the completed form is dated.*

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

CBC Waiver applicants cannot receive Medicaid payment of CBC services prior to the date the DMAS-96 was signed by the supervising physician. For applicants for whom a Waiver Level of Care form is the appropriate authorization document, Medicaid payment of CBC services cannot begin prior to the date the form has been signed.

For purposes of this definition, continuity is broken by 30 or more consecutive day's absence from a medical institution or by non-receipt of waiver services. For applicants in a nursing facility, if it is known at the time of application processing that the individual left the nursing facility and did not stay for 30 consecutive days, the individual is evaluated as a non-institutionalized individual. Medicaid recipients without a community spouse who request Medicaid payment of LTC services, except MN individuals, and are in the nursing facility for less than 30 consecutive days will have a patient pay determination (see M1470.350).

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**

6. Individual and Family Developmental Disabilities Support Waiver (DD Waiver)

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

The services provided under this waiver include:

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

7. Day Support Waiver for Individuals with Mental Retardation

The Day Support Waiver for Individuals with Mental Retardation (DS Waiver) is targeted to provide home and community-based services to individuals with mental retardation who have been determined to require the level of care provided in an ICF/MR. These individuals may currently reside in an ICF/MR or may be in the community at the time of assessment for DS Waiver services. Only those individuals on the urgent and non-urgent waiting lists for the MR Waiver are considered for DS Waiver services. Individuals may remain on the MR Waiver waiting list while receiving DS Waiver Services.

The services provided under this waiver include:

- day support
- prevocational services

8. Alzheimer's Assisted Living Waiver

The Alzheimer's Assisted Living (AAL) Waiver is available only to individuals who are Auxiliary Grants (AG) recipients, have a diagnosis of Alzheimer's Disease or a related dementia, no diagnosis of mental illness or mental retardation, and who are age 55 or older. The AAL Waiver allows for the provision of services to individuals in approved assisted living facilities who, without the waiver, might require nursing home placement.

Individuals in this waiver do not have Medicaid eligibility determined as institutionalized individuals, and there are no post-eligibility requirements.

The services provided under the AAL waiver include:

- assistance with activities of daily living
- medication administration by licensed professionals

- nursing services for assessments and evaluations
- therapeutic social and recreational programming which provides daily activities for individuals with dementia.

**D. Children’s Mental Health Program—
Not Medicaid CBC**

Children’s Mental Health Program services are home and community-based services to children who have been discharged from psychiatric residential treatment facilities. **Children’s Mental Health Program services are NOT Medicaid CBC services.** See M1520.100 E. for additional information.

E. Program for All-Inclusive Care for the Elderly (PACE)

PACE is the State’s community model for the integration of acute and long-term care. Under the PACE model, Medicaid and Medicare coverage/funding are combined to pay for the individual’s care. PACE is centered around the adult day health care model and provides the entire spectrum of acute and long-term care services to enrollees without limitations on the duration of services or the dollars spent. Participation in PACE is in lieu of the EDCD Waiver and is voluntary. PACE serves individuals aged 55 and older who (1) meet the nursing facility level of care criteria and (2) reside in their own communities. PACE provides all of an individual’s health care and medical long-term care needs.

PACE is NOT a CBC Waiver; however, the preadmission screening, financial eligibility and post eligibility requirements for individuals enrolled in PACE are the same as those for individuals enrolled in the EDCD Waiver.

M1410.050 FINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

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

B. Asset Transfer

The asset transfer policy is found in subchapter M1450.

C. Resources

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

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

D. Income

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

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

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

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

M1410.100 LONG-TERM CARE APPLICATIONS

- A. Introduction** The general application requirements applicable to all Medicaid applicants/recipients found in chapter M01 also apply to applicants/recipients who need LTC services. This section provides those additional or special application rules that apply only to persons who meet the institutionalization definition.

- B. Responsible Local Agency** The local social services department in the Virginia locality where the institutionalized individual (patient) last resided outside an institution retains responsibility for receiving and processing the application.

If the patient did not reside in Virginia prior to admission to the institution, the local social services department in the county/city where the institution is located has responsibility for receiving and processing the application.

Community-Based Care (CBC) applicants apply in their locality of residence.

ABD patients in state Department of Mental Health Mental Retardation and Substance Abuse Services (DMHMRSAS) facilities for more than 30 days have eligibility determined by Medicaid technicians located in the state DMHMRSAS facilities. When an enrolled ABD Medicaid recipient is admitted to a state DMHMRSAS facility, the local department of social services transfers the case to the Medicaid technician after the recipient has been in the facility for 30 days or more. See section M1520.600 for case transfer policy.

C. Procedures

- 1. Application Completion** A signed application is received. 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), *available on SPARK at:*

http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi.

- 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. *If it is known at the time of application processing that the individual did not or will not receive LTC services, do not determine eligibility as an institutionalized individual.*

M1410.300 NOTICE REQUIREMENTS

A. Introduction

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

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

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

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

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

Individuals in the AAL Waiver have Medicaid eligibility determined in the AG covered group (see M0320.202) and do not have Medicaid eligibility determined as institutionalized individuals. There are no post-eligibility requirements. The DMAS-122 is not completed for individuals in the AAL Waiver. The enrollment and notification procedures used with non-institutionalized Medicaid recipients are followed (see M0130.300).

B. Forms to Use

1. **Notice of Action on Medicaid (#032-03-0008)**

The EW must send the Notice of Action on Medicaid, *available on SPARK at:* <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>, to the applicant/ recipient and the person who is authorized to conduct business for the Applicant to notify him of the Agency's decision on the initial Medicaid application, and on a redetermination of eligibility when a recipient starts LTC services.

2. **Notice of Obligation for Long-Term Care Costs (#032-03-0062)**

The Notice of Obligation for Long-term Care Costs, *available on SPARK at:* <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>, is sent to the applicant/recipient and the person managing the applicant's affairs to notify them of the amount of patient payment responsibility. *The Patient Pay Workbook, located on the VISSTA web site at:* http://www.vcu.edu/vissta/bps/bps_resources/medicaid/ltc_medicaid/master_patient_pay_workbook_eff_010708.xls, also contains an electronic version of the Notice of Obligation form.

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

3. **Patient Information (DMAS-122)**

The Patient Information Form (DMAS-122) is available on the DMAS web site at: <http://www.dmas.virginia.gov/downloads/forms/DMAS-122.pdf>. *The Patient Pay Workbook, located on the VISSTA web site at:* http://www.vcu.edu/vissta/bps/bps_resources/medicaid/ltc_medicaid/master_patient_pay_workbook_eff_010708.xls, also contains an electronic version of the DMAS-122.

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

a. When to Complete the DMAS-122

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

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

b. Where to Send the DMAS-122

1) Facility Patients

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

2) Medicaid CBC Waiver patients *and* PACE participants

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

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

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

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

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

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

f) *For PACE recipients, send the DMAS-122 to the PACE provider.*

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

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

4. Advance Notices of Proposed Adverse Action

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

a. Advance Notice of Proposed Action (#032-03-0018)

The Advance Notice of Proposed Action, *available on SPARK at:* <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>, must be used for an adverse eligibility action when:

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

b. Notice of Obligation for Long-Term Care Costs (#032-03-0062)

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

The Notice of Obligation for Long-term Care Costs is available on SPARK at: <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>. The Patient Pay Workbook, located on the VISSTA web site at: http://www.vcu.edu/vissta/bps/bps_resources/medicaid/ltc_medicaid/master_patient_pay_workbook_eff_010708.xls, also contains an electronic version of the Notice of Obligation form.

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

**5. Medicaid
Redetermination For Long-
term Care
(#032-03-0369)**

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

The Medicaid Redetermination for Long-Term Care Form is available on SPARK at:

http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi.

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- Peninsula AIDS Foundation
 - Northern Virginia AIDS Project
 - INOVA System/Office of HIV
 - Council of Community Services
 - AIDS Support Group, Inc.
 - Whitman Walker Clinic of Northern Virginia
5. **Individual and Family Developmental Disabilities Support (DD) Waiver** DMAS and the Virginia Health Department child development clinics are authorized to screen individuals for the DD waiver.
6. **Alzheimer's Assisted Living (AAL) Waiver** Local *screening committees or teams* and hospital screening committees or teams are authorized to screen individuals for the AAL waiver; however, a copy of the pre-admission screening is not required for the Medicaid eligibility record.
7. **Day Support Waiver for Individuals with Mental Retardation (DS) Waiver** Local CSB and DMHMRSAS case managers are authorized to screen individuals for the DS waiver. Final authorizations for DS waiver services are made by DMHMRSAS staff.
8. **Program for All-Inclusive Care for the Elderly (PACE)** *Local screening committees or teams and hospital screening committees or teams are authorized to screen individuals for PACE. If the individual is screened and approved for LTC, the committee/team will inform the individual about any existing PACE program that serves the individual's locality. Participation in PACE is in lieu of the EDCD Waiver and is voluntary.*

M1420.300 COMMUNICATION PROCEDURES

- A. Introduction** To ensure the eligibility determination process takes place simultaneously with screening decisions so that nursing facility placement or receipt of CBC services may be arranged as quickly as possible, prompt communication between screeners and eligibility staff must occur.
- Each agency shall designate an appropriate eligibility staff member for screeners to contact. Local social services staff, hospital social services staff, and DRS staff shall be given instructions on how to contact that person.
- B. Procedures**
1. **Screeners** Screeners must inform the agency eligibility worker that the screening process has been initiated.
2. **EW Action** The eligibility worker must begin to process the individual's Medicaid application when informed that the screening process has begun.

- 3. Provider Involvement** If the individual is found eligible and verbal assurance of approval by the screening committee has been received, the EW must provide, without delay, the facility or CBC provider with the recipient's Medicaid ID number.
- 4. Designated DSS Contact** The local DSS agency should designate an appropriate eligibility staff member for screeners to contact. Local social services staff, hospital social services staff and DRS staff should be given the name of, and instructions on how to contact, that person. This will facilitate timely communication between screeners and the eligibility determination staff.

M1420.400 SCREENING CERTIFICATION

- A. Purpose** The screening certification authorizes a local DSS to determine financial eligibility using the more liberal rules for institutionalized individuals and verifies qualification for special personal maintenance allowances for temporary stays in long-term care facilities. The screening certification is valid for one year.
- B. Procedures**
- 1. Exceptions to Screening** Pre-admission screening is NOT required when:
- the individual is a patient in a nursing facility at the time of application or has been a patient in a nursing facility for at least 30 consecutive days;
 - the individual received Medicaid LTC in one or more of the preceding 12 months and whose LTC was terminated for a reason other than no longer meeting the level of care;
 - the individual is no longer in need of long-term care but is requesting assistance for a prior period of long term care;
 - the individual enters a nursing facility directly from the EDCD, *PACE* or AIDS waiver;
 - *an individual who was screened and approved for LTC services prior to entering a nursing facility leaves the nursing facility and begins receiving EDCD, PACE or AIDS waiver services; or*
 - the individual enters a nursing facility from out-of-state.
- 2. Documentation**
- a. If the individual has not been institutionalized for at least 30 consecutive days, the screener's certification of approval for Medicaid long-term care must be substantiated in the case record.
- b. Substantiation is by:
- a DMAS-96;
 - a MR Waiver Level of Care Eligibility Form;
 - a DS Waiver Level of Care Eligibility Form; or
 - a DD Waiver Level of Care Eligibility Form.

- c. The screening certification is valid for one year.

3. DMAS-96

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

The DMAS-96 is available on the DMAS web site at:

<http://www.dmas.virginia.gov/downloads/forms/DMAS-96.pdf>.

**4. EDCD Waiver
Authorization
for Consumer-
Directed
Services**

When an individual has been screened and approved for the EDCD waiver, the local DSS must determine his eligibility as an institutionalized individual and if eligible, enroll him in Medicaid. DMAS or its contractor must give final authorization for consumer-directed services. If the services are not authorized, the Service Facilitator will notify the LDSS, and the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

**5. MR Waiver
Level of Care
Eligibility Form**

For an individual who has been screened and approved for the MR waiver, the "MR Waiver Level of Care Eligibility Form" will be signed and dated by the DMHMRSAS representative. The "MR Waiver Level of Care Eligibility Form" will include the individual's name, address and the date of DMHMRSAS approval. See Appendix 1 for a copy of the "MR Waiver Level of Care Eligibility Form."

**6. DS Waiver Level
of Care
Eligibility Form**

For an individual who has been screened and approved for the DS waiver, the "DS Waiver Level of Care Eligibility Form" authorizing Medicaid waiver services will be signed and dated by the DMHMRSAS representative. The "DS Waiver Level of Care Eligibility Form" will include the individual's name, address and the date of DMHMRSAS approval. See Appendix 2 for a copy of the "DS Waiver Level of Care Eligibility Form."

**7. DD Waiver
Level of Care
Eligibility Form**

For an individual who has been screened and approved for the DD waiver, a "DD Waiver Level of Care Eligibility Form" authorizing Medicaid waiver services will be signed and dated by a DMAS Health Care Coordinator. The form letter will include the individual's name, address and the date of approval for waiver services. See Appendix 3 for a copy of the "DD Waiver Level of Care Eligibility Form."

**8. LTC
Authorization
Not Received**

If the form is not available when placement needs to be made, verbal assurance from a screener or DMAS that the form approving long-term care will be mailed or delivered is sufficient to establish the Medicaid pre-authorization. The date of receipt of such assurance and the name of the person providing the information must be entered in the case record.

Prior to approval of the individual for Medicaid payment of LTC services, the worker must have received the DMAS-96 that was signed by the supervising physician or the signed Waiver Level of Care form.

If a pre-admission screening is required and the documented or verbal assurance of screening and approval is not received, Medicaid eligibility for an individual who is living in the community must be determined as a community resident using the rules applicable to a non-institutionalized Medicaid applicant.

**9. LTC
Authorization
Rescinded**

The authorization for Medicaid-funded long-term care may be rescinded by the physician or by DMAS at any point that the individual is determined to no longer meet the level of care criteria for Medicaid-funded long-term care.

When an individual is no longer eligible for a CBC Waiver service, the EW must re-evaluate his/her eligibility as a non-institutionalized individual.

Continue to use the institutional eligibility criteria for persons who are in a medical institution even though they no longer meet the level of care criteria. If eligible, Medicaid will not make a payment to the facility for the care.



COMMONWEALTH of VIRGINIA

*Department of
Mental Health, Mental Retardation and Substance Abuse Services
Post Office Box 1797
Richmond, Virginia 23218-1797*

RICHARD E. KELLOGG
COMMISSIONER

Telephone (804) 786-3921
Voice/TDD (804) 371-8977
www.state.va.us/dmhmrzas/welcome.htm

MR Waiver Level of Care Eligibility Form

Name: _____

Address: _____

City: _____ VA. Zip Code: _____

Date of Approval by DMHMRSAS: _____

This person has met the level of care requirements for Medicaid waiver services and needs a Medicaid eligibility determination completed. This person is authorized to have eligibility determined using the special institutional rules.

DMHMRSAS Representative: _____

Date: _____

Phone: _____



COMMONWEALTH of VIRGINIA

*Department of
Mental Health, Mental Retardation and Substance Abuse Services
Post Office Box 1797
Richmond, Virginia 23218-1797*

DS Waiver Level of Care Eligibility Form

Name: _____

Address: _____

City: _____ VA. Zip Code: _____

Date of Approval by DMHMRSAS: _____

This person has met the level of care requirements for Medicaid waiver services and needs a Medicaid eligibility determination completed. This person is authorized to have eligibility determined using the special institutional rules.

DMHMRSAS Representative: _____

Date: _____

Phone: _____

Confidentiality Statement: This document contains confidential health information that is legally privileged. This information is intended only for the use of the individuals or entities listed above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of this document is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of this document.



COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

Suite 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
804/225-4612 (Fax)
804/343-0634 TDD)

DD Waiver Level of Care Eligibility Form

Name: _____

Address: _____

City: _____ VA. Zip Code: _____

Date of Approval by DMAS: _____

This person has met the level of care requirements for Medicaid waiver services and needs a Medicaid eligibility determination completed. This person is authorized to have eligibility determined using the special institutional rules.

DMAS Health Care Coordinator: _____

Date: _____

Phone: _____

M1430.100 BASIC ELIGIBILITY REQUIREMENTS

- A. Overview** To be eligible for Medicaid payment of long-term care, an individual must be eligible for Medicaid. The Medicaid non-financial eligibility requirements in *chapter M02* apply to all individuals in long-term care. The eligibility requirements and the location of the manual policy are listed below in this section.
- B. Citizenship/
Alienage** The citizenship and alien status policy is found in subchapter M220.
- C. Virginia Residency** The Virginia state resident policy specific to facility patient is found in subchapter M0230 and section M1430.101 below.
- D. Social Security
Number** The social security number policy is found in subchapter M0240.
- E. Assignment of
Rights** The assignment of rights is found in subchapter M0250.
- F. Application for
Other Benefits** The application for other benefits policy is found in subchapter M0270.
- G. Institutional
Status** The institutional status requirements specific to long-term care in a facility are in subchapter M0280 and section M1430.102 below.
- H. Covered Group
(Category)** The Medicaid covered groups eligible for LTC services are listed in M1460. The requirements for the covered groups are found in chapter M03.
- I. Financial
Eligibility** *An individual who has been a patient in a medical institution (such as a nursing facility) for at least 30 consecutive days of care or who has been screened and approved for LTC services is treated as an institutionalized individual for the Medicaid eligibility determination. Financial eligibility for institutionalized individuals is determined as a one-person assistance unit separated from his/her legally responsible relative(s).*

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). If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has 30 days from the date on the Notice of Action to begin services.

For unmarried individuals and for married individuals without community spouses, the resource and income eligibility criteria in subchapter M1460 is applicable.

For married individuals with community spouses, the resource and income eligibility criteria in subchapter M1480 is applicable.

The asset transfer policy in M1450 applies to all facility patients.

M1430.101 VIRGINIA RESIDENCE

- A. Policy** An individual must be a resident of Virginia to be eligible for Virginia Medicaid while he/she is a patient in a medical facility. There is no durational requirement for residency.
- B. Individual Age 21 or Older** An institutionalized individual age 21 years or older is a resident of Virginia if:
- the individual is in an institution in Virginia with the intent to remain permanently or for an indefinite period; or
 - the individual became incapable of declaring his intention to reside in Virginia at or after becoming age 21 years, he/she is residing in Virginia and was not placed here by another state government agency.
- 1. Determining Incapacity to Declare Intent** An individual is incapable of declaring his/her intent to reside in Virginia if:
- he has an I.Q. of 49 or less or has a mental age of less than 7 years;
 - he has been judged legally incompetent; or
 - medical documentation by a physician, psychologist, or other medical professional licensed by Virginia in the field of mental retardation supports a finding that the individual is incapable of declaring intent to reside in a specific state.
- 2. Became Incapable Before Age 21** An institutionalized individual age 21 years or older who became incapable of stating intent before age 21 is a resident of Virginia if:
- the individual's legal guardian or parent, if the parents reside in separate states, who applies for Medicaid for the individual resides in Virginia;
 - the individual's legal guardian or parent was a Virginia resident at the time of the individual's institutional placement;
 - the individual's legal guardian or parent who applies for Medicaid for the individual resides in Virginia and the individual is institutionalized in Virginia; or
 - the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, the individual is institutionalized in Virginia, and the person who files the individual's Medicaid application resides in Virginia.

D. Financial Eligibility

An individual who has been screened and approved for CBC services is treated as an institutionalized individual for the Medicaid eligibility determination. Financial eligibility is determined as a one-person assistance unit separated from his legally responsible relative(s) with whom he lives.

If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has 30 days from the date on the Notice of Action to begin receiving CBC services.

For unmarried individuals and for married individuals without community spouses, the resource and income eligibility criteria in subchapter M1460 is applicable.

For married individuals with community spouses, the resource and income eligibility criteria in subchapter M1480 is applicable.

The asset transfer policy in M1450 applies to all CBC waiver services recipients.

M1440.020 INSTITUTIONAL STATUS

A. Introduction

To be eligible for Medicaid, an individual approved for CBC waiver services must meet the institutional status requirement. A CBC waiver services recipient usually is not in a medical institution; most CBC recipients live in a private residence in the community. However, an individual who resides in a residential facility such as an adult care residence (ACR) may be eligible for some CBC waiver services.

This section contains the Medicaid institutional status policy, inmate of a public institution policy and procedures for determining whether a CBC waiver services patient meets the institutional status eligibility requirement.

B. Definitions

1. 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.

2. Public Institution

A **public institution** is an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

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

- a medical facility, including a nursing facility;
- a publicly operated community residence that 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 accomodates no more than 25 children;

- an institution certified as an ICF-MR for individuals with mental retardation or related conditions.

**3. Publicly
Operated
Community
Residence**

A **publicly operated community residence** is a public residential facility (institution) 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 they serve no more than 16 residents:

- residential facilities located on the grounds of, or adjacent to, any large 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.

NOTE: An individual residing in a public educational or vocational training institution for purposes of securing education or vocational training is NOT an inmate of a public institution, and therefore may be eligible for Medicaid, even though the educational or training facility is not a publicly operated community residence that serves no more than 16 residents.

**4. 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

justice system?

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

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

M1440.100 CBC WAIVER DESCRIPTIONS

- A. Introduction** This section provides a brief overview of the Medicaid CBC waivers. The overview is a synopsis of the target populations, basic eligibility rules, available services, and the assessment and service authorization procedure for each waiver.
- The eligibility worker does not make the determination of whether the individual is eligible for the waiver services; this is determined by the pre-admission screener or by DMAS. The policy in the following sections is only for the eligibility worker's information to better understand the CBC waiver services.
- B. Definitions** Term definitions used in this section are:
- 1. Financial Eligibility Criteria** means the rules regarding asset transfers; what is a resource; when and how that resource counts; what is income; when and how that income is considered.
 - 2. Non-financial Eligibility Criteria** means the Medicaid rules for non-financial eligibility. These are the rules for citizenship and alienage; state residence; social security number; assignment of rights and cooperation; application for other benefits; institutional status; cooperation with spousal support and DCSE; and covered group and category requirements.
 - 3. Patient** an individual who has been approved by a pre-admission screener to receive Medicaid waiver services.

M1440.101 ELDERLY OR DISABLED WITH CONSUMER-DIRECTION WAIVER

- A. General Description** The *Elderly or Disabled with Consumer-Direction (EDCD)* Waiver is targeted to provide home and community-based services to individuals age 65 or older, or who are disabled, who have been determined to require the level of care provided in a medical institution and are at risk of facility placement.
- Recipients may select agency-directed services, consumer-directed services, or a combination of the two. Under consumer-directed services, supervision of the personal care aide is furnished directly by the recipient. Individuals who are incapable of directing their own care may have a spouse, parent, adult child, or guardian direct the care on behalf of the recipient. Consumer-directed services are monitored by a Service Facilitator.*

B. Targeted Population

This waiver serves persons who are:

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

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

C. Eligibility Rules

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

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

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

D. Services Available

LTC services available through this waiver include:

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

E. Assessment and Service Authorization

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

F. Program for All-Inclusive Care for the Elderly (PACE)

PACE serves individuals aged 55 and older who (1) meet the nursing facility level of care criteria and (2) reside in their own communities. PACE provides all of their health care and long-term care medical needs. Individuals who meet the criteria for the EDCD Waiver may be enrolled in PACE in lieu of the EDCD Waiver.

PACE is NOT a CBC Waiver, but rather is the State's community model for the integration of acute and long-term care. The pre-PACE model previously operated in the Hampton Roads area covered only the individual's Medicaid services and did not incorporate Medicare coverage. The current full PACE model combines Medicaid and Medicare funding.

PACE provides the entire spectrum of acute and long-term care services to enrollees without limitations on the duration of services or the dollars spent and is centered on an adult day health care model.

The following services are provided through PACE:

- *adult day care that offers nursing, physical, occupational, speech and recreational therapies;*
- *meals and nutritional counseling; social services;*
- *medical care provided by a PACE physician; personal care and home health care;*
- *all necessary prescription drugs;*
- *access to medical specialists such as dentists, optometrists and podiatrists; respite care;*
- *hospital and nursing facility care when necessary; and*
- *transportation.*

*Participation in PACE is **voluntary**. The nursing home pre-admission screening team will advise the individual of the availability of PACE and will facilitate enrollment if the Medicaid enrollee chooses PACE. The PACE team is responsible for authorizing as well as providing the services.*

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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 *dividing* the uncompensated value of the assets transferred on or after the look-back date, 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 the following Northern Virginia localities: Arlington, Fairfax, Loudoun and Prince William counties and the cities of Alexandria, Fairfax, Falls Church, Manassas and Manassas Park. 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 the Northern Virginia localities and all other Virginia localities *effective October 1, 1996*.

D. Average Monthly Private Nursing Facility Cost

<u>Application Date</u>	<u>Average Monthly Private Nursing Facility Cost*</u>	
	<u>Northern Virginia</u>	<u>All Other Localities</u>
10-1-96 to 9-30-97	\$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 to 9-30-07	\$5,403	\$4,060
10-1-07 and after	\$6,654	\$4,954

*Figures provided by Virginia Health Information.

See M1450, Appendix 1 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.

**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 UNDUH 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. *If the applicant/recipient chooses to make a claim of an undue hardship, documentation regarding the transfer and the applicant/recipient's circumstances must be sent to the Department of Medical Assistance Services (DMAS) for an undue hardship determination prior to the eligibility worker taking action to impose a penalty period.* 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.

Applicants, recipients, or authorized representatives, may request an undue hardship evaluation. Additionally, the Deficit Reduction Act of 2005 authorized nursing facilities to act on behalf of their patients, when necessary, to submit a request for undue hardship. The nursing facility must have written authorization from the recipient or his authorized representative in order to submit the claim of undue hardship.

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.
- b. A copy of the Asset Transfer Hardship Claim Form, *available on the VDSS local agency intranet at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi*, must be included with the letter. The individual must be given 10

calendar days to return the completed form to the local agency.

If undue hardship is claimed, the eligibility worker must *send a copy of the undue hardship claim form, the documentation regarding the transfer and a brief summary of the applicant/recipient's current living situation* to DMAS at the following address:

DMAS, Division of Policy and Research
Eligibility Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Retain a copy of all documentation for the case record.

- 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 all of the following information 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 and verification of their value at the time of the transfer;
- Include documents such as deeds, wills and bank statements;
- A statement from an independent third party substantiating the reason(s) for the transfer;
- Evidence of the efforts made to recover the asset(s) and/or documentation from all parties of why no recovery is possible;
- 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 **agency** 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

**Average Monthly Private Nursing Facility Cost
Prior to October 1, 1996**

Application Date	Average Monthly Cost (All Localities)
7-1-1988 to 6-30-1989	\$2,029
7-1-1989 to 12-31-1990	\$2,180
1-1-1991 to 9-30-1993	\$2,230
10-1-1993 to 9-30-1996	\$2,554

c. Individuals Under 21 in NF or ICF-MR

Individuals under age 21 who meet the resource and income requirements of the July 16, 1996, AFDC State Plan are eligible for Medicaid if they are in a nursing facility or intermediate care facility for the mentally retarded. See section M0320.307 for details about this covered group.

M1460.220 CNNMP 300% SSI COVERED GROUP

A. Description

These are ABD or F&C individuals in medical facilities or who receive Medicaid CBC waiver services, who meet the appropriate CNNMP resource requirements and resource limit and whose income is less than or equal to 300% of the SSI payment limit for an individual.

Individuals who have been screened and approved for Medicaid LTC services may be evaluated in this covered group. If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has 30 days from the date on the Notice of Action to begin services.

B. ABD Groups

Aged, blind or disabled individuals institutionalized in medical facilities, or who require institutionalization and are approved to receive Medicaid CBC waiver services are those who:

- meet the Medicaid ABD resource requirements; and
- have gross income, determined according to the ABD income requirements, that does not exceed 300% of the SSI individual payment limit.

See sections M0320.203 and 204 for details about these covered groups.

C. F&C Groups

Individuals who meet an F&C definition (children under age 19, foster care or adoption assistance children under age 21, parents or caretaker-relatives of dependent children, and pregnant women) in medical facilities, or who require institutionalization and who are approved to receive Medicaid home and community-based care (CBC) waiver services, are those who:

- meet the F&C CNNMP resource requirements if unmarried, (married individuals must meet the ABD resource requirement); and
- have gross income, determined according to the **ABD income** requirements, that does not exceed 300% of the SSI individual payment limit.

See sections M0320.309 and 310 for details about these covered groups.

M1460.225 ABD 80% FPL COVERED GROUP

A. Description

The ABD 80% FPL covered group includes aged, blind and disabled

individuals who have income less than or equal to 80% FPL and countable resources that do not exceed the SSI resource limits. See M0320.210 for details about this covered group.

B. Policy

1. **Nonfinancial** Evaluate the non-financial Medicaid eligibility rules in section M1410.020.
2. **Asset Transfer** Determine if the recipient meets the asset transfer policy in subchapter M1450.
3. **Resources** Determine countable resources using the policy in chapter S11 and Appendix 2 to chapter S11. The resource limit is \$2,000.

The home property resource exclusion for individuals in the ABD 80% FPL covered group includes the home and ALL contiguous property as long as the individual lives in the home or, if absent, intends to return to the home (see Appendix 2 to chapter S11). When the ABD 80% FPL individual leaves his home property, obtain a signed statement from the individual as to:

- when and why he left the home;
- whether he intends to return; and
- if he does not intend to return, when that decision was made.

The 6-month home property resource exclusion for institutionalized individuals does NOT apply to this covered group.

4. **Income** Income is determined using the policy in chapter S08, and countable income must not exceed 80% FPL. Spenddown does not apply to this covered group.

M1460.230 MEDICALLY NEEDED COVERED GROUPS

A. Description The medically needy (MN) classification applies to those groups of aged, blind, disabled (ABD) individuals who do not meet the ABD CN or CNNMP resource or income requirements, but who meet the ABD MN resource and income requirements. The medically needy (MN) classification also applies to those groups of families and children (F&C) who do not meet the F&C CN or CNNMP resource or income requirements, but who meet the F&C MN resource and income requirements.

- B. ABD Groups**
1. Aged individuals age 65 years or older; see section M0330.201.
 2. Blind individuals; see section M0330.202.
 3. Disabled individuals; see section M0330.203.
 4. Individuals who were Blind or Disabled MN recipients in December 1973, who continue to meet the MN eligibility requirements in the December 1973 plan, but do not meet the current blindness or disability criteria; see section M0330.204.

Yes: eligible as CN; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay. (Remember to review asset transfer to evaluate whether Medicaid payment may be made for LTC services).

No: Go to B below.

B. Covered Group

Is person already enrolled in Medicaid in a covered group eligible for LTC services?

Yes: Go to E "Resources" below.

No: Is person F&C?

Yes: Determine if he meets F&C MI group first (section M1460.240) go to D "Income" below.

No: Go to C below.

C. Is person ABD?

Yes: Go to D "Income" below.

No: Is person in Hospice?

Yes: Determine as Hospice; see section M0320.205.

No: ineligible for Medicaid, does not meet a covered group; STOP. Go to section M1460.660 for notice procedures.

D. Income (See M1460.600)

1. Person is F&C MI

Determine countable income using chapter M07.

Compare income to appropriate F&C MI income limit.

Is income within F&C MI limit?

Yes: eligible as F&C MI, STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

No: not eligible as F&C MI, go to item 2 below.

2. Person Is Not F&C MI

(1) Is person ABD and (2) does person meet the definition of institutionalization in M1410.010?

Yes: Determine if gross income is less than or equal to the 300% SSI income limit using chapter S08 and section M1460.600 below to determine gross income.

Is gross income less than or equal to 300% SSI income limit?

Yes: Go to section E "Resources" below.

No: Go to section M1460.410 "Steps for Determining MN Eligibility" below.

No: Does person meet the F&C 300% SSI or Hospice covered group (*does person meet the definition of institutionalization in M1410.010*)?

Yes: Go to item 3 “Determine 300% SSI income” *below*.

No: Go to section M1460.410 “Steps for Determining MN Eligibility.”

3. Determine if Gross Income is Less Than or Equal to 300% SSI

Determine if gross monthly income is less than or equal to the 300% SSI income limit using chapter S08 and section M1460.600 below for **ABD and F&C** individuals.

Is gross income less than or equal to 300% SSI income limit?

Yes: go to section E “Resources” below.

No: go to section M1460.410 “Steps for Determining MN Eligibility” below.

E. Resources (See M1460.500)

1. Determine CN/CNNMP Resources

a. ABD groups

1) Unmarried Individual or Married Individual with no Community Spouse

a) 300% SSI group: Determine ABD countable resources using chapter S11.

Compare to ABD CN/CNNMP resource limit = \$2,000 for 1 person.
If the individual is not eligible due to excess resources, evaluate eligibility in the ABD 80% FPL covered group. See item b) below.

b) ABD 80% FPL group: Using chapter S08 and M1460.600, determine if countable income is within the ABD 80% FPL income limit contained in M0810.002.A.5. If countable income is less than or equal to 80% FPL, determine countable resources using chapter S11 and Appendix 2 to chapter S11. **NOTE:** the 6-month home exclusion does not apply to this covered group.

Compare to ABD CN/CNNMP resource limit = \$2,000 for 1 person.

2) Married Individual with Community Spouse

Determine ABD countable resources using chapter S11 and subchapter M1480.

Compare to ABD CN/CNNMP resource limit = \$2000 for 1 person

b. F&C groups

1) Unmarried Individual or Married Individual with no Community Spouse

- Determine F&C CN/CNNMP countable resources using chapter M06 for the unmarried institutionalized individual.

- Compare to F&C CN/CNNMP resource limit = \$1,000.

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 *aid category (AC)* as follows:
1. CN
 - a. Supplemental Security Income (SSI) recipients EXCEPT AG recipients, regardless of living arrangements.
 - 011 Aged
 - 031 Blind
 - 051 Disabled
 - b. All Auxiliary Grant (AG) recipients, including those who receive SSI.
 - 012 Aged
 - 032 Blind
 - 052 Disabled
 - c. IV-E foster care (AFDC-FC) or IV-E adoption assistance (AFDC-AA) child who is IV-E eligible.
 - 074
 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.
 - 021 Aged
 - 041 Blind
 - 061 Disabled
 - 081 Low Income Families With Children (LIFC)
 - 083 LIFC--Unemployed/underemployed parent deprivation
 - b. Child age 19 or 20 in intermediate care facility or ICF-MR, *not determined blind or disabled*.
 - 082
 - c. Non-IV-E (state/local) Adoption Assistance child & Special Medical Needs Adoption Assistance child under age 21.
 - 072
 - d. Child under age 21, responsibility of Juvenile Justice Department.
 - 075

- e. Non-IV-E (state/local) foster care child under age 21
076

3. ABD 80% FPL

ABD individuals with income less than or equal to 80% FPL
029 Aged
039 Blind
049 Disabled

4. F&C MI

- a. Pregnant woman w/income less than or equal to the 133% FPL
091
- b. Child under age 6 w/income less than or equal to the **100% FPL**
091
- c. Child under age 6, income greater than the **100% FPL** but less than or equal to the **133% FPL**
090
- d. Child age 6 to 19
 - **insured or uninsured** w/income less than or equal to the **100% FPL**;
 - **insured** w/income greater than 100% and less than or equal to the **133% FPL**
092
- e. **Uninsured** child age 6 to 19 w/income greater than 100% FPL and less than or equal to the **133% FPL**
094

5. Complete & Send Notice

Complete a “Notice of Action on Medicaid *and* FAMIS to notify the individual of his Medicaid eligibility and coverage begin date. Go to subchapter M1470 to determine the individual’s patient pay.

B. Eligible--300% SSI Group

If the individual’s gross income is less than or equal to the 300% SSI income limit, determine patient pay according to the policy and procedures found in Subchapter M1470.

1. 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 AC:

- **022** Aged
- **042** Blind
- **062** Disabled.

If the income is over the QMB limit, enroll the recipient with the appropriate CNNMP AC:

- **020** Aged
- **040** Blind
- **060** Disabled.

2. Individual Does Not Have Medicare Part A

If the individual does NOT have Medicare Part A, enroll the **ABD patient** with the appropriate CNNMP aid category:

- **020** Aged
- **040** Blind
- **060** Disabled.

Enroll the **F&C patient** with the appropriate CNNMP AC:

060 Institutionalized F&C individual who does not meet the “Individuals Under Age 21 in an ICF or ICF/MR” covered group, who has not been determined blind or disabled and does not have Medicare

082 Institutionalized child under age 21 in an ICF or ICF-MR who has not been determined blind or disabled.

NOTE: Children under age 19 who are eligible in the MI Child Under Age 19” covered group should be enrolled in the appropriate MI AC.

3. Complete & Send Notice

Complete and send a “Notice of Action on Medicaid” to the individual notifying him of his Medicaid eligibility and coverage begin date. Go to subchapter M1470 to determine the individual’s patient pay.

B. Income Exceeds 300% SSI Limit

If income exceeds the 300% SSI limit, evaluate as MN. If the individual meets an MN covered group, re-calculate countable income for MN.

Subtract the income exclusions listed in sections M1460.610 and 611 that apply to the individual’s MN covered group. Go to section M1460.700 below.

If the individual does NOT meet an MN covered group, he is not eligible for Medicaid; go to subsection C. below.

C. Ineligible--Notice

Complete and send a “Notice of Action on Medicaid and FAMIS” to the individual notifying him that he is not eligible for Medicaid and of his appeal rights.

M1460.700 MEDICALLY NEEDY INCOME & SPENDDOWN

A. Policy

Institutionalized individuals whose income exceeds the 300% SSI income limit must be placed on a monthly medically needy (MN) spenddown if they meet a medically needy (MN) covered group and have countable resources that are less than or equal to the MN resource limit. Countable income for the medically needy (MN) is different than countable income for the 300% SSI covered group. Recalculate income using medically needy income principles.

For individuals who were within a spenddown budget period prior to the month in which they become institutionalized, prorate and shorten the spenddown budget period for the months prior to admission to long-term care services.

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**C. Non-covered
Medical/Dental
Services**

Deductions for the cost of a patient's medically necessary medical or dental services not covered by Medicaid, other insurance (such as Medicare), or another person are subtracted from income to determine patient pay. Some deductions for noncovered services must be approved by DMAS before they can be subtracted from the patient's income.

Services that are covered by Medicaid in the facility's per diem rate cannot be deducted from patient pay as a noncovered service. See C.3. for examples of services that are included in the facility per diem rate.

**1. Zero Patient
Pay
Procedures**

If deductions from patient pay cannot be allowed because the recipient has no income remaining after deducting the personal needs allowance, dependent child allowance(s) and health insurance premiums, or the recipient has no income available for patient pay, deny the request.

Notify the patient (and the patient's representative, if appropriate) using the "Notice of Obligation for LTC Costs". This form provides notice of the right to appeal the agency's decision.

If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service has been approved, notify the patient or his authorized representative that the deduction for the new noncovered service will be made after the first noncovered service deductions are completed.

**2. Allowable
Non-covered
Expenses**

When a patient has income available for patient pay, the following can be deducted as noncovered expenses:

a. Old Bills

"Old bills" are deducted from patient pay as noncovered expenses. "Old bills" are unpaid medical, dental, or remedial care expenses which:

- were incurred prior to the Medicaid application's retroactive period, *or during the retroactive period if the individual was not eligible for Medicaid in the retroactive period or the service was not a Medicaid-covered service;*
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met; **and**
- remain a liability to the individual.

"Old bills" do not require approval from DMAS in order to be deducted in the patient pay calculation even when the amount of the "old bill" exceeds \$500.

b. Medically Necessary Covered Services Provided By A Non-participating Provider

Medically necessary medical and dental services that are covered by Medicaid, but that the enrollee received from a provider who does not participate in Virginia Medicaid, are deducted from patient pay as non-covered services.

c. Covered Services Outside of Medicaid's Scope

Medically necessary medical and dental services exceeding Medicaid's amount, duration, or scope can be deducted from patient pay.

d. Other Allowable Noncovered Services

- 1) The following medically necessary medical and dental services that are NOT covered by Medicaid can be deducted from patient pay by the local department of social services without DMAS approval when the cost does NOT exceed \$500. **If the service is not identified in the list below and/or the cost of the service exceeds \$500, send the request and the documentation to DMAS for approval.** DMAS will advise the eligibility worker if the adjustment is allowable and the amount that is to be allowed.
 - routine dental care, necessary dentures and denture repair for recipients 21 years of age and older. **Pre-approval for dental services that exceed \$500 must be obtained from DMAS prior to receipt of the service;**
 - routine eye exams, eyeglasses and eyeglass repair;
 - hearing aids (when medically necessary), hearing aid batteries and hearing aid repair;
 - batteries for power wheelchairs or other power mobility items owned by the recipient, not to exceed four batteries in a 12-month period;
 - chiropractor services, except for Medicare recipients (Medicare covers chiropractor services and Medicaid covers the Medicare deductible and coinsurance amounts);
 - dipyridamole (Persantine) and other prescription medications not covered by Medicaid but ordered by the recipient's physician;
 - **transportation to medical, dental or remedial services not covered by Medicaid.**
- 2) Services received by a Medicaid *enrollee* during a period of limited Medicaid eligibility (e.g., LTC services not covered because of a property transfer) can be deducted in the patient pay calculation by the local agency without DMAS approval even when the amount of the service exceeds \$500.

3. Services NOT Allowed

Types of services that CANNOT be deducted from patient pay include:

- a. medical supplies and equipment that are part of the routine facility care and are included in the Medicaid per diem, such as:
 - diabetic and blood/urine testing strips,
 - bandages and wound dressings,
 - standard wheelchairs,
 - air or egg-crate mattresses,
 - IV treatment,
 - splints,
 - certain prescription drugs (placebos).
- b. TED stockings (billed separately as durable medical supplies),
- c. acupuncture treatment,
- d. massage therapy,
- e. personal care items, such as special soaps and shampoos,
- f. ancillary services, such as physical therapy, speech therapy and occupational therapy provided by the facility or under arrangements made by the facility.

4. Documentation Required

a. Requests For Adjustments From A Patient or Authorized Representative

Request the following documentation from the patient or his representative:

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

The local agency can make the adjustment for services identified in subsection C. 2. b. through d.1), above providing the cost of the service does not exceed \$500. If the cost of the service is not identified in subsection C. 2. b. through d. 1), or exceeds \$500, send the documentation to DMAS to obtain approval *and the allowable amount of the adjustment (reimbursement is limited to the prevailing Medicaid or Medicare rate).*

b. Requests For Adjustments From LTC Providers

If the request for an adjustment to patient pay to deduct one of the above expenses is made by a nursing facility, ICF-MR, long-stay hospital, or DMHMRSAS facility, the request must be accompanied by:

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

If the request from a facility does not include all the above documentation, return the request to the facility asking for the required documentation.

When the cost of the service cannot be authorized by the local department of social services and/or exceeds \$500, send the request and the documentation to DMAS to obtain approval for the adjustment and the allowable amount of the adjustment (reimbursement is limited to the prevailing Medicaid or Medicare rate). DMAS must be notified of the name and address of the recipient's spouse, POA or guardian so that proper notification of the decision can be given.

5. Procedures

a. DMAS Approval Required

Requests for adjustments to patient pay for services not included in subsection C.2. b. through d.1) above, or for any service which exceeds \$500, must be submitted by the provider to the DSS worker. The DSS worker sends the request and documentation, along with the most recent copy of the DMAS-122 to:

DMAS-122 Program Support Technician Sr.
Customer Service Unit,
Division of Program Operations
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

NOTE: Do not send requests for adjustments to DMAS when the patient has no available income for patient pay. Refer to c. below for notification procedures to be followed by the local worker.

When a request for an adjustment is approved or denied by DMAS, the local DSS worker will receive a copy of the letter sent to the recipient by DMAS:

- 1) If approved, adjust the patient pay. Prepare a new DMAS-122. See the notice requirements in c. below.
- 2) If the adjustment request is denied, DMAS prepares the notification.

1. Zero Patient Pay Procedures

If deductions from patient pay cannot be allowed because the recipient has no income remaining after deducting the personal maintenance allowance, dependent child allowance(s) and health insurance premiums, or the recipient has no income available for patient pay, **deny** the request.

Notify the patient (and the patient's representative, if appropriate) using the "Notice of Obligation for LTC Costs". This form provides notice of the right to appeal the agency's decision.

If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service has been approved, notify the patient or his authorized representative that the deduction for the new non-covered service will be made after the first noncovered service deductions are completed.

2. Allowable Non-covered Expenses

When a patient has income available for patient pay, the following can be deducted as noncovered expenses:

a. Old Bills

Old bills are deducted from patient pay as non-covered expenses. Old Bills are unpaid medical, dental or remedial care expenses which:

- were incurred prior to the Medicaid application's retroactive period, *or during the retroactive period if the individual was not eligible for Medicaid in the retroactive period or the service was not a Medicaid-covered service;*
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and
- remain a liability to the individual.

b. Medically Necessary Covered Services Provided By A Non-participating Provider

Medically necessary medical and dental services that are covered by Medicaid, but that the recipient received from a provider who does not participate in Virginia Medicaid, are deducted from patient pay as non-covered services.

c. Covered Services Outside of Medicaid's Scope

Medically necessary medical and dental services that can be deducted from patient pay are:

- services exceeding Medicaid's amount, duration, or scope;
- services rendered during a prior period of Medicaid eligibility (i.e., LTC services not covered because of a property transfer).

d. Other Allowable Non-covered Services

Medically necessary medical and dental services that are NOT covered by Medicaid and can be deducted from patient pay include:

- 1) medical supplies, such as antiseptic solutions, incontinent supplies (adult diapers, pads, etc.), dressings, EXCEPT for patients under the Technology-assisted Individuals Waiver (Medicaid covers these services for Technology-assisted Individuals Waiver patients).

NOTE: For Medicaid CBC recipients who have Medicare Part B, medical supplies and equipment are often covered by Medicare Part B. The coinsurance or deductible is covered by Medicaid when these supplies/equipment are obtained from a Medicare/Medicaid enrolled supplier. Do not deduct the cost of supplies/equipment obtained from a Medicare/Medicaid supplier since the supplier receives direct payment from Medicare and Medicaid.

- 2) routine dental care, necessary dentures and denture repair for recipients 21 years of age and older;
- 3) routine eye exams, eyeglasses and eyeglass repair;
- 4) hearing aids (when medically necessary), hearing aid batteries and hearing aid repair;
- 5) batteries for power wheelchairs or other power mobility items owned by the recipient, not to exceed four batteries in a 12-month period;
- 6) chiropractor services, except for Medicare recipients (Medicare covers chiropractor services and Medicaid covers the Medicare deductible and coinsurance amounts);
- 7) dipyridamole (Persantine) and other prescription medications not covered by Medicaid but ordered by the recipient's physician;
- 8) *copayments for prescription drugs obtained under Medicare Part D.*

3. Services NOT Allowed

Types of services that CANNOT be deducted from patient pay include:

- a. medical supplies covered by Medicaid, or Medicare when the recipient has Medicare, such as:
 - diabetic and blood/urine testing strips,
 - bandages and wound dressings,
 - standard wheelchairs,
 - air or egg-crate mattresses,
 - IV treatment,
 - splints,
 - certain prescription drugs (placebos).

a revised DMAS-122 to the facility.

Compare the recipient's patient pay amount for the discharge month to the facility's cost, which is the facility's Medicaid per diem rate multiplied by the number of days the patient was in the facility that month. NOTE: Do not count the date of discharge when determining how many days the patient was in the facility.

b. Patient Pay Exceeds Facility Cost

When the patient pay exceeds the facility cost:

- 1) the facility cost (Medicaid per diem multiplied by number of days) is the patient pay in the facility for that month. Complete and send a revised DMAS-122 to the facility.
- 2) the remaining balance is the countable income used to determine patient pay for the CBC waiver admission month. From the remaining balance deduct the basic waiver maintenance allowance based on the type of waiver minus the total PNA (which may have included guardianship fees and special earnings allowance) allowed while in facility. Do not deduct the guardianship fee and special earnings allowance again.

Any remainder is the CBC patient pay for the admission month only. If the remainder is zero or less, the DMAS-122 will show zero patient pay for the admission month. Complete and send the DMAS-122 to the CBC waiver provider showing no patient pay for the admission month and showing the regular patient pay for the month(s) following the admission month.

c. Facility Patient Pay Less Than Facility Cost

When the patient pay amount is less than the facility cost, the facility patient pay for that month does not change. Do not send a revised DMAS-122 to the facility.

The patient pay for the CBC wavier admission month is \$0. Complete and send a DMAS-122 to the CBC waiver provider showing no patient pay for the admission month and showing the regular patient pay amount effective the month(s) following the admission month.

M1470.530 PACE

A. Introduction

The Program for All-inclusive Care for the Elderly (PACE) serves individuals aged 55 and older who (1) meet the nursing facility level of care criteria and (2) reside in their own communities. PACE provides all of an individual's health care and long-term care medical needs. PACE is not a CBC Waiver; individuals who meet the criteria for the EDCD Waiver may be enrolled in PACE in lieu of the EDCD Waiver. See M1440.101.F for additional information about PACE.

B. Policy

Individuals enrolled in PACE have a patient pay obligation, with the exception of PACE recipients who reside in assisted living facilities and receive Auxiliary Grant (AG) payments. PACE recipients also receiving AG payments do not have a patient pay.

C. Procedures

The patient pay for an individual enrolled in PACE who is not Medically Needy is calculated using the procedures in M1470.400 through M1470.520 for an individual in CBC, with the exceptions listed below.

1. Medicare Part D Premiums

PACE recipients are not responsible for Medicare Part D premiums because their prescriptions are provided through PACE and they are eligible for the full Medicare Part D subsidy. Therefore, the cost of the Medicare Part D premium is not allowable as a deduction from patient pay.

2. Covered Medical Expenses

Because PACE includes most medically-necessary services the individual needs, the allowable medical expense deductions differ from the allowable medical expense deductions for CBC.

The following services are provided through PACE:

- *adult day care that offers nursing, physical, occupational, speech and recreational therapies;*
- *meals and nutritional counseling; social services;*
- *medical care provided by a PACE physician; personal care and home health care;*
- *all necessary prescription drugs;*
- *access to medical specialists such as dentists, optometrists and podiatrists; respite care;*
- *hospital and nursing facility care when necessary; and*
- *transportation.*

Any medical expenses incurred by the individual for the services listed above are not allowable patient pay deductions. With the exception of the services listed above, the non-covered expenses listed in M1470.430 C.2 are allowable for PACE recipients.

3. PACE Recipient Enters Nursing Facility

Because PACE is a program of all-inclusive care, nursing facility services are part of the benefit package for PACE recipients who can no longer reside in the community. When a PACE recipient enters a nursing facility, the PACE provider or the individual has 60 days from the date of admission to notify the eligibility worker of the individual's placement in the nursing facility and the need for a recalculation of the patient pay.

*After notification of the individual's entrance into a nursing facility, the eligibility worker will take action to recalculate the individual's patient pay prospectively for the month following the month the 10 day advance notice period ends. **There is NO retroactive calculation of patient pay back to the date the individual entered the facility.** When the change is made, the individual is entitled to a personal needs allowance of \$40 per month. **The DMAS-122 will be sent to the PACE provider, who will continue to collect the patient pay.***

M1470.600 MN PATIENTS - SPENDDOWN LIABILITY

A. Policy

This section is for unmarried individuals or married individuals who have no community spouse. **DO NOT USE this section** for a married individual with a community spouse, go to subchapter M1480.

Medically needy (MN) individuals have a spenddown liability that must be met before they are eligible for Medicaid because their monthly income exceeds 300% of SSI, which exceeds the MN income limits. When an MN individual meets the spenddown, he is eligible for Medicaid (see section M1460.700 for spenddown determination policy and procedures). Patient pay for **each** month in which the individual meets the spenddown must be determined.

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

- patients age 65 years or older
- patients age 22 – 64
- patients under age 22 years (children), unless the child is receiving inpatient psychiatric care.

NOTE: Patients in IMDs who are under age 65 are not eligible for Medicaid because they do not meet the nonfinancial institutional status requirement, unless they are under age 22 and in inpatient psychiatric care.

B. Definitions

The following definitions are used in this section and subsequent sections of this subchapter:

1. Medicaid Rate

The Medicaid rate for facility patients is the facility's Medicaid per diem multiplied by the number of days in the month. For the month of entry, use the actual number of days that care was received or is projected to be received. For ongoing months, multiply the Medicaid per diem by 31 days.

The Medicaid rate for CBC patients is the number of hours per month actually provided by the CBC provider multiplied by the Medicaid hourly rate.

PACE has a capitated monthly rate that is due and payable on the first day of the month. The monthly PACE rate is available from the PACE provider.

2. Remaining Income

Remaining income is the amount of the patient's total monthly countable income for patient pay, minus all allowable patient pay deductions.

3. Spenddown Liability The spenddown liability is the amount by which the individual's countable income exceeds the medically needy income limit.

C. Procedures The subsections identified below contain the procedures for determining patient pay when an LTC patient meets a spenddown liability and is determined eligible for Medicaid.

1. Facility Patients Patient pay determination procedures are different for medically needy facility patients, depending on whether the spenddown liability is less than or equal to or greater than the Medicaid rate. To determine patient pay for MN facility patients:

- a. Determine the individual's spenddown liability using the policy and procedures in subchapter M1460.
- b. Compare the spenddown liability to the Medicaid rate.
- c. If the spenddown liability is less than or equal to the facility Medicaid rate, go to section M1470.610 below to determine patient pay.
- d. If the spenddown liability is greater than the facility Medicaid rate, go to section M1470.620 to determine patient pay.

2. Medicaid CBC Patients Medicaid CBC patient pay determination procedures are different from facility procedures. For CBC patients with a spenddown liability, go to section M1470.630.

3. PACE Recipients *For PACE recipients with a spenddown liability, go to section M1470.640.*

M1470.610 FACILITY PATIENTS--SPENDDOWN LIABILITY LESS THAN OR EQUAL TO MEDICAID RATE

A. Policy This section is applicable **ONLY** to an unmarried individual, or a married individual without a community spouse. **DO NOT USE this section** for a married individual with a community spouse; go to subchapter M1480.

An MN facility patient whose spenddown liability is less than or equal to the Medicaid rate is eligible for Medicaid effective the first day of the month, based on the projected facility Medicaid rate for the month. Medicaid must **NOT** pay any of the recipient's spenddown liability to the provider. In order to prevent any Medicaid payment of the spenddown liability, the spenddown liability is added to available income for patient pay.

B. Procedures Determine patient pay for the month using the procedures below.

1. Patient Pay Gross Monthly Income Determine the recipient's patient pay gross monthly income according to M1470.100 (including any amounts excluded in determining MN countable income and the spenddown liability).

2. **Subtract Spenddown Liability** From the individual's gross monthly income for the month, subtract the spenddown liability. The result is the remaining income.
3. **Subtract Allowable Deductions** Deduct the following from the remaining income:
 - a. a personal needs allowance (per M1470.210),
 - b. a dependent child allowance, if appropriate (per M1470.220),
 - c. any allowable noncovered medical expenses (per M1470.230), not including the facility cost of care,
 - d. a home maintenance deduction, if appropriate (per M1470.240).The result is the **remaining income**.
4. **Add Spenddown Liability** Add the spenddown liability to the remaining income (**because the individual is responsible to pay his spenddown liability to the facility**). The result is the **contributable income** for patient pay.
5. **Patient Pay** Compare the contributable income to the facility's Medicaid rate for the month. The patient pay is the lesser of the two amounts.
2. **Complete and Send DMAS-122** Complete and send the DMAS-122 to the facility showing the patient pay for the month(s) (see section M1470.800). The DMAS-122 has space for 3 months of patient pay. In the admission month, show the patient pay amount for the admission month and the regular patient pay amount effective the month(s) following the admission month.
7. **Complete and Send "Notice of Obligation for LTC Costs"** Complete and send the "Notice of Obligation for LTC Costs" to the patient or his representative informing him of his financial responsibility to the facility (his patient pay).

C. Examples

1. **Facility--MN And Patient Pay Income Are The Same** **EXAMPLE #14 (Using April 2000 figures):** Mr. Cay first applied for Medicaid in April. He was admitted to the facility a year earlier. He has a monthly Civil Service Annuity (CSA) benefit of \$1,600. He last lived outside the facility in a Group III locality. His income exceeds the CNNMP 300% SSI income limit. He has no old bills, but he has a health insurance premium of \$50 monthly plus a \$25 noncovered medical expense he incurred on April 2, and a guardian who charges a guardian fee of 5% of Mr. Cay's income. His MN eligibility is being determined for April. The MN determination results in a spenddown liability of \$1,255:

**6. CBC with
Special
Earnings
Allowance**

EXAMPLE #20: (Using January 2000 figures)

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

His monthly countable earnings for January are determined:

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

His spenddown liability is calculated:

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

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

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

His January patient pay is calculated as follows:

\$2,800.00	total gross monthly income
<u>-2,048.00</u>	personal maintenance allowance
\$ 752.00	remaining income for patient pay for (January)

The worker compares the Medicaid rate for CBC waiver services of \$1,627.50 (155 hours in January multiplied by \$10.50 per hour) to the remaining income of \$752. Because the remaining income is less than the Medicaid rate, Mr. R's patient pay for January is \$752.

M1470.640 PACE RECIPIENTS WITH SPENDDOWN LIABILITY

A. Policy

*This section is applicable ONLY to an unmarried individual, or a married individual without a community spouse. **DO NOT USE this section** for a married individual with a community spouse; go to subchapter M1480.*

1. Monthly Spenddown Determination

PACE recipients who have income over the CNNMP 300% of SSI income limit are placed on a monthly spenddown as institutionalized individuals because they have been screened and approved for LTC services.

Unlike CBC, PACE has a capitated monthly rate that is due and payable on the first day of the month. The monthly PACE rate is available from the PACE provider. When an MN individual is in PACE, the amount of allowed PACE expenses is the rate that is due as of the first day of each month.

*PACE recipients are not responsible for Medicare Part D premiums, which are included in the monthly PACE rate. **Therefore, the cost of the Medicare Part D premium cannot be used to meet a spenddown and must be subtracted from the monthly PACE rate when determining if the spenddown has been met.***

The individual's spenddown liability and the PACE monthly rate (minus the Medicare Part D premium) establish whether the spenddown eligibility determination can be projected or must be determined retrospectively.

2. Projected Spenddown Determination

If the MN individual's spenddown liability is less than or equal to the monthly PACE rate (minus the Medicare Part D premium), the individual is eligible for Medicaid. As long as the individual's spenddown liability and the PACE monthly rate do not change, the individual is enrolled in ongoing coverage effective the first day of the month in which the spenddown is initially met.

3. Retrospective Spenddown Determination

If the MN individual's spenddown liability exceeds the monthly PACE rate (minus the Medicare Part D premium), he is not eligible for Medicaid until he actually incurs medical expenses that meet the spenddown liability within the month. The monthly medical expenses are determined retrospectively; they cannot be projected for the spenddown budget period.

Retrospective spenddown eligibility determinations are made monthly after the month has passed and the expenses have actually been incurred. The PACE rate (minus the Medicare Part D premium) along with other allowable medical and dental expenses are deducted daily and chronologically as the expenses are incurred. The individual's income and resources must be verified each month before determining if the spenddown has been met. See M1470.530 for allowable medical deductions.

When incurred medical expenses equal or exceed the monthly spenddown liability, the individual is eligible for the full month of Medicaid coverage beginning the first day of the month and ending the last day of the month.

3. *Patient Pay*

a. *Projected Spenddown Eligibility Determinations*

Medicaid must NOT pay any of the individual's spenddown liability to the provider. In order to prevent any Medicaid payment of the spenddown liability, the spenddown liability is added to available income for patient pay. Follow the instructions in M1470.610 for calculating spenddown and patient pay when spenddown liability is less than or equal to the PACE rate (minus the Medicare Part D premium).

b. *Retrospective Spenddown Eligibility Determinations*

Because the spenddown eligibility determination is completed after the month in which the PACE services were received and expenses are not projected, the spenddown liability is NOT added to the available income for patient pay. Follow the instructions in M1470.630 for calculating the spenddown and patient pay when the spenddown liability exceeds the monthly PACE rate (minus the Medicare Part D premium).

M1470.800 COMPLETING THE DMAS-122 FORM

A. Introduction

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

B. Purpose

Use the DMAS-122 to keep the provider informed on a current basis of the amount to be paid by or on behalf of the patient for care (the patient pay). The DMAS-122 must be completed and sent to the provider who collects the patient pay no later than 45 days from the date of application and 30 days from the date of a reported change. If the recipient has more than one provider, the DMAS-122 is sent to the provider as specified in 2. below.

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

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

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

The EW must update the DMAS-122 and send it to the provider at least once per year (even if the patient pay does not change). *If the patient pay does not change, the updated DMAS-122 can be sent* when the annual redetermination is completed.

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

a. Facility Patients

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

b. CBC Waiver Patients

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

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

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

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

CBC Unit
DMAS Division of Appeals & Long-term Care
600 E. Broad Street
Richmond, VA 23219.
- 7) *For PACE recipients, send the DMAS-122 to the PACE provider.*

M1470.810 MEDICARE PART A SNF COVERAGE

A. Introduction

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

B. Medicare Part A SNF Coverage

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

1. QMB Only Recipients

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

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

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

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

2. All Other Recipients

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

a. Medicare & Medicaid Only

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

b. Medicare and Medicare Supplement Health Insurance

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

C. Example

EXAMPLE #21: A QMB-only Medicaid recipient from a Group III locality is admitted to a SNF directly from a hospital on June 4. He remains QMB-only because his resources exceed \$2,000 but are less than the \$4,000 QMB resource limit. He has a Medicare supplement health insurance policy. His only income is \$678 SS. He is already on the Medicare Buy-in.

The DMAS-122 for June and July is completed and the boxes stating the patient "is eligible for QMB Medicaid only", "has Medicare Part A" and "other health insurance" are checked. No patient pay information is entered.

M1470.910 *RETROACTIVE ADJUSTMENTS FOR PRIOR MONTHS*

A. Retroactive Adjustment

If a change was reported timely and the patient pay for prior months is incorrect, adjust the patient pay for the prior months only in the following situations:

1. a deceased individual had health insurance premiums or noncovered medical expenses that should have reduced patient pay;
2. a community spouse is owed money for a spousal allowance and the institutionalized spouse is deceased or no longer in long-term care. However, if the community spouse had decreased income and did not report the change in a timely manner, do NOT adjust the patient pay.

In these situations, adjust the DMAS-122s retroactively for the prior months in which the patient pay was incorrect. In all other situations when a change is reported timely, do NOT adjust the DMAS-122 retroactively.

B. Notification Requirements

Changes to patient pay require notice to the individual responsible for making the payment to the LTC provider using the Notice of Obligation for LTC Costs form, and notice to the LTC provider using the DMAS-122 form. See section M1410.300 for specific notification requirements.

M1470.920 LTC PROVIDER CHANGE WITHIN A MONTH

A. Policy

A change in LTC providers requires a review of patient pay to determine if a patient pay amount needs to be paid to the new provider. When a recipient changes LTC providers within a month, send a DMAS-122 to the new provider and a revised DMAS-122 to the former provider, when necessary.

B. CBC Provider Change to New CBC Provider

1. If the monthly patient pay exceeds the cost of care received from the old CBC provider, send a revised DMAS-122 for the month to the old provider showing the patient pay for the month as the actual number of hours received multiplied by the Medicaid hourly rate. Obtain the hours and rates from the provider.

The patient pay to the new CBC provider for the month is the amount remaining after subtracting the revised patient pay amount from the “regular” patient pay amount. Show the ongoing patient pay effective the following month.

2. If the monthly patient pay is less than the cost of care received from the former provider, **do not** send a revised DMAS-122 to the former provider.

The DMAS-122 to the new provider will show no patient pay for the month in which the patient changed providers and will show the regular patient pay amount effective the following month.

**C. Facility Provider
Change to New
Facility**

1. If the monthly patient pay exceeds the cost of care received from the former facility, send a revised DMAS-122 for the month to the former facility showing the patient pay for the month as the actual number of days in the facility multiplied by the facility's Medicaid per diem rate. the patient pay for the month in the new facility is the amount remaining after subtracting the former facility's revised patient pay amount from the "regular" patient pay amount. Show the ongoing patient pay effective the following month.
2. If the monthly patient pay is less than the cost of care received from the former facility, **do not** send a revised DMAS-122 to the old facility.

The DMAS-122 to the new facility will show no patient pay for the month in which the patient changed facilities and will show the regular patient pay amount effective the following month.

M1470.930 DEATH OR DISCHARGE FROM LTC

A. Death

When a patient dies, recalculate patient pay for the month in which the patient died.

1. Determine the Medicaid rate for the month:
 - for a facility patient, *other than a hospice patient*, the monthly rate is the facility's per diem rate multiplied by the actual number of days the patient was in the facility in the month; do NOT include the date of death. *The date of death is a covered day for hospice patients.*
 - for a Medicaid CBC patient, the monthly rate is the provider's hourly rate multiplied by the actual number of hours of services provided to the patient in the month.
2. Compare the Medicaid rate to the patient pay for the month.
3. If the patient pay is higher than the Medicaid rate, adjust the patient pay to the Medicaid rate. Send a revised DMAS-122 to the provider for the month showing the Medicaid rate as the patient pay.
4. If the patient pay is less than or equal to the Medicaid rate, do not adjust the patient pay.

B. LTC Discharge

When a patient is discharged from LTC to another living arrangement which does not include LTC services, recalculate patient pay for the month of discharge.

1. Determine the Medicaid rate for the discharge month:

- for a facility patient, *other than a hospice patient*, the monthly rate is the facility's per diem rate multiplied by the number of days in the month that the patient received services in the facility; do NOT include the discharge date (the discharge date is not a covered day). The date of discharge is a covered day for hospice patients.
 - for a Medicaid CBC patient, the monthly rate is the provider's hourly rate multiplied by the number of hours of services provided to the patient in the month.
2. Compare the Medicaid rate to the patient pay for the discharge month.
 3. If the patient pay is higher than the Medicaid rate, adjust the patient pay to the Medicaid rate. Send a revised DMAS-122 to the provider for the discharge month showing the Medicaid rate as the patient pay.
 4. If the patient pay is less than or equal to the Medicaid rate, do not adjust the patient pay.

M1470.1000 LUMP SUM PAYMENTS

A. Policy

Lump sum payments of income or accumulated benefits are counted as income in the month they are received. Patient pay must be adjusted to reflect this income change *for the month following the month in which the 10-day advance notice period expires*. Any amount retained becomes a resource in the following month.

B. Lump Sum Defined

Income such as interest, trust payments, royalties, etc., which is received regularly but is received less often than quarterly (i.e., once every four months or three times a year, once every five months, once every six months or twice a year, or once a year) is treated as a lump sum for patient pay purposes.

NOTE: A conversion of a resource from one type of resource into another type of resource is NOT income.

EXCEPTION: Income that has previously been identified as available for patient pay, but which was not actually received because the payment source was holding the payment(s) for some reason or had terminated the payment(s) by mistake, is **NOT** counted again when the corrective payment is received.

See section M1470.1030 below for instructions for determining patient pay when a lump sum is received.

M1470.1010 LUMP SUM REPORTED IN RECEIPT MONTH

A. Lump Sum Available

Lump sum payments reported in the month the payment was received are counted available for patient pay effective the first of the month following the month in which the 10-day advance notice period expires.

If the individual is no longer in the facility and is not receiving Medicaid CBC, adjust the DMAS-122 for the lump sum receipt month if the money is still available.

- B. Lump Sum Not Available** If the money is not available, the EW must complete and send a referral to DMAS, Division of Program Operations, Recipient Audit Unit.

M1470.1020 LUMP SUM NOT REPORTED TIMELY

- A. Effective Date** Lump sum payments reported AFTER the month in which the payment was received are not reported timely. Evaluate total resources including the lump sum. If the resources are within the limit, determine availability for patient pay. See B. & C. below. If they exceed the resource limit, go to section M1470.1100 below.

- B. Lump Sum Not Available** If the money is not available, the EW must complete and send a referral to DMAS, Division of Program Operations, Recipient Audit Unit.

- C. Lump Sum Available**
1. If the money is still available and the individual is no longer in the facility and is not receiving Medicaid CBC, adjust the DMAS-122 retroactively for the lump sum receipt month.
 2. If the money is still available and the individual is still in the facility or is still receiving Medicaid CBC, adjust the patient pay according to procedures in section M1470.1030 below.

M1470.1030 PATIENT PAY DETERMINATION FOR LUMP SUMS

- A. Policy** When a lump sum payment is received, the patient pay for the month in which the 10-day advance notice period expires must be adjusted using the procedures in this section.

B. CNNMP Procedures

1. **Total Income** Add the lump sum to the patient's regular monthly income; the result is total income for the month.
2. **Less Than Or Equal To 300% of SSI** If the total gross income (including the lump sum) is equal to or less than the 300% of SSI income limit, adjust the patient pay. None of the lump sum remains to be evaluated.
3. **Greater Than 300% of SSI** If the total gross income (including the lump sum) exceeds the 300% of SSI income limit, adjust the patient pay. Compare the income available for patient pay to the Medicaid rate for the month.

If the income available for patient pay is less than or equal to the Medicaid rate, *the available income is the patient pay.*

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15. Institutionalized Spouse

means an individual who:

- is in a medical institution, or who is receiving Medicaid waiver services, or who has elected hospice services;
- is likely to remain in the facility, or to receive waiver or hospice services for at least 30 consecutive days; and
- who is married to a spouse who is NOT in a medical institution or nursing facility.

NOTE: An institutionalized spouse receiving Medicaid CBC Waiver services can also be a community spouse if his spouse is in a medical facility or is receiving Medicaid CBC Waiver services.

16. Likely to Remain in an Institution

means a reasonable expectation based on acceptable medical evidence that an individual will receive *LTC services* for 30 consecutive days, *unless it is known prior to processing the application that the 30-day requirement has not been met or will not be met. If it is known at the time the application is processed that the individual did not or will not meet the 30 consecutive day requirement, the individual is not to be treated as an institutionalized individual.*

17. Maximum Spousal Resource Standard

means the maximum amount of the couple's combined countable resources established for a community spouse to maintain himself in the community (\$60,000 in 1989). This amount increases annually by the same percentage as the percentage increase in the Consumer Price Index (CPI) for all urban consumers between September 1988 and the September before the calendar year involved. [1924(f)(2)(A)(ii)].

See section M1480.231 for the current maximum spousal resource standard.

18. Minimum Monthly Maintenance Needs Allowance (MMMNA)

The minimum monthly maintenance needs allowance [1924(d)(3)(A)] is the monthly maintenance needs standard, plus an excess shelter allowance if applicable, up to a maximum [1924(d)(3)(C)]. The minimum monthly maintenance needs allowance is the amount to which a community spouse's income is compared in order to determine the community spouse's monthly income allowance.

The monthly maintenance needs standard and monthly maintenance needs allowance maximum change each year. See section M1480.410 below for the current standard and maximum.

19. Minor Child

means a child under age 21 years, of either spouse, who lives with the community spouse and who may be claimed as a dependent by either member of the couple for tax purposes pursuant to the Internal Revenue Service Tax Code. Tax dependency is verified by a verbal or written statement from either spouse.

- 20. Monthly Maintenance Needs Standard** The monthly maintenance needs standard is 150% of 1/12 of the federal poverty level for a family of two in effect on July 1 of each year [Section 1924(d)(3)(A)(i)].
- See section M1480.410 below for the current monthly maintenance needs standard.
- 21. Otherwise Available Income or Resources** means income and resources which are legally available to the community spouse and to which the community spouse has access and control.
- 22. Promptly Assess Resources** means within 45 days of the request for resource assessment, unless the delay is due to non-receipt of documentation or verification, if required, from the applicant or from a third party.
- 23. Protected Period** means a period of time, not to exceed 90 days after an initial determination of Medicaid eligibility. During the protected period, the amount of the community spouse resource allowance (CSRA) will be excluded from the institutionalized spouse's countable resources IF the institutionalized spouse expressly indicates his intention to transfer resources to the community spouse.
- 24. Resource Assessment** means a calculation, completed by request or upon Medicaid application, of a couple's combined countable resources at the beginning of the **first** continuous period of institutionalization of the institutionalized spouse beginning on or after September 30, 1989.
- 25. Spousal Protected Resource Amount (PRA)** means at the time of Medicaid application as an institutionalized spouse, the greater of:
- the spousal resource standard in effect at the time of application;
 - the spousal share, not to exceed the maximum spousal resource standard in effect at the time of application;
 - the amount actually transferred to the community spouse by the institutionalized spouse pursuant to a court spousal support order; or
 - the amount of resources designated by a DMAS Hearing Officer.
- 26. Spousal Resource Standard** means the minimum amount of the couple's combined countable resources (\$12,000 in 1989) necessary for a community spouse to maintain himself in the community. This amount increases each calendar year after 1989 by the same percentage increase as in the Consumer Price Index (CPI). [1924(f)(2)(A)(i)].
- See section M1480.231 for the current spousal resource standard.

- 27. Spousal Share** means ½ of the couple's combined countable resources at the beginning of the **first** continuous period of institutionalization, as determined by a resource assessment.
- 28. Spouse** means a person who is legally married to another person under Virginia law.
- 29. Waiver Services** means Medicaid-reimbursed home or community-based services covered under a 1915(c) waiver approved by the Secretary of the United States Department of Health and Human Services.

M1480.015 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LONG-TERM CARE

A. Applicability The policy in this section applies to nursing facility and CBC patients who meet the requirements for LTC on or after January 1, 2006. The policy does not apply to recipients approved for LTC prior to January 1, 2006 who maintain continuous Medicaid eligibility.

- 1. Approved for LTC Before 01-01-2006** If the enrollee's eligibility for LTC was approved **before** January 1, 2006, do not apply this policy at the next renewal of Medicaid eligibility. If the individual becomes ineligible for Medicaid and subsequently re-applies for Medicaid LTC, the substantial home equity policy must be evaluated when determining Medicaid eligibility based on the new application.
- 2. Approved for LTC On/After 01-01-2006** If the enrollee's eligibility for LTC was approved **on or after** January 1, 2006, **but before July 1, 2006**, apply this policy at the next renewal of Medicaid eligibility.

If the enrollee's eligibility for LTC was approved **on or after** January 1, 2006, and eligibility is processed **on or after July 1, 2006**, apply this policy immediately. Take appropriate action if the individual is ineligible for Medicaid payment of LTC because of substantial home equity.

B. Policy Individuals with equity value in home property that exceeds \$500,000 are NOT eligible for Medicaid payment of long-term care (LTC) services unless the home is occupied by:

- a spouse,
- a dependent child under age 21 years, or
- a blind or disabled child of any age.

Individuals with substantial home equity may be eligible for Medicaid payment of other covered services if they meet all the other Medicaid eligibility requirements.

- 1. Reverse Mortgages** Reverse mortgages **do not** reduce equity value until *the individual begins receiving* the reverse mortgage payments from *the lender*.

- 2. Home Equity Lines of Credit** A home equity line of credit **does not** reduce the equity value until credit line has been used or payments from the credit line have been received
- B. Verification Required** Do not assume that the community spouse is living in the home. Obtain a statement from the applicant indicating who lives in the home. If there is no spouse, dependent child under age 21, or blind or disabled child living in the home, verification of the equity value of the home is required.
- C. Notice Requirement** If an individual is ineligible for Medicaid payment of LTC services because of substantial home equity exceeding \$500,000, the Notice of Action must state why he is ineligible for Medicaid payment of LTC. The notice must also indicate whether the applicant is eligible for other Medicaid covered services.
- D. References** See section M1120.225 for more information about reverse mortgages.

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

The spousal share is used in determining the institutionalized individual's resource eligibility. A resource assessment must be completed when a married institutionalized individual with a community spouse *who*

- is in a nursing facility, *or*
- is screened and approved to receive nursing facility or Medicaid CBC waiver services, *or*
- has elected hospice services

applies for Medicaid. The resource assessment is completed when the applicant is screened and approved to receive nursing facility or Medicaid CBC services *or within* the month of application *for Medicaid*, whichever is later.

The following table contains examples that indicate when an individual is treated as an institutionalized individual for the purposes of the resource assessment:

Screened and Approved in:	In a Facility?	Application Month	Resource Assessment Month	Processing Month	Month of Application/ ongoing as Institutionalized	Retroactive Determination as Institutionalized (in a medical facility)
January	no	January	January	January	yes	no
January	no	February	February	February	yes	no
N/A	yes	January	first continuous period of institutionalization	February	yes	yes
January	no	March	March	April	yes	no
April	no	March	April	Whenever	no, but yes for April	no

c. Both Spouses Request Medicaid CBC

When both spouses request Medicaid CBC, one resource assessment is completed. The \$2,000 Medicaid resource limit applies to each spouse.

C. Responsible Local Agency

The local department of social services (DSS) in the Virginia locality where the individual last resided outside of an institution (including an ACR) is responsible for processing a request for a resource assessment without a Medicaid application, and for processing the individual's Medicaid application. If the individual never resided in Virginia outside of an institution, the local DSS responsible for processing the request or application is the local DSS serving the Virginia locality in which the institution is located.

The Medicaid Technicians in the Department of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS) facilities are responsible for processing a married patient's request for a resource assessment without a Medicaid application, and for processing the patient's Medicaid application.

b. When the Assessment Is Completed

Both spouses and the guardian, conservator, or authorized representative must be notified in writing of the assessment results and the spousal share calculated. Use the form Notice of Medicaid Resource Assessment (#032-03-817). Attach a copy of the Medicaid Resource Assessment form (#032-03-816) to each Notice. A copy of all forms and documents used must be kept in the agency's case record.

M1480.220 RESOURCE ASSESSMENT WITH MEDICAID APPLICATION

A. Introduction

This section applies to married individuals with community spouses who are inpatients in medical institutions or nursing facilities, who have been screened and approved to receive Medicaid CBC waiver services, or who have elected hospice services. If a married individual with a community spouse is receiving private-pay home-based services, he **cannot** have a resource assessment done without also filing a concurrent Medicaid application.

B. Policy

1. Resource Assessment

If a resource assessment was **not completed** before the Medicaid application was filed, the spousal share of the couple's total countable resources that existed **on 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, is calculated when processing a Medicaid application for a married institutionalized individual with a community spouse.

If a resource assessment was completed before the Medicaid application was filed, use the spousal share calculated at that time in determining the institutionalized spouse's eligibility.

2. Use ABD Resource Policy

For the purposes of the resource assessment and spousal share calculation, countable and excluded resources are determined for all covered groups using the ABD resource policy in Chapter S11, **regardless of the individual's covered group and regardless of community property laws or division of marital property laws**, except for the following resources which are excluded as indicated below when completing the resource assessment and spousal share:

- the home and **all** contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SS & SSI payments received on or after 11/01/05 for nine (9) calendar months following the month in which the individual receives the benefits. For retroactive SSI and SS benefits received **before** 11/01/05, exclude from resources for six (6) calendar months; and
- up to **\$1,500** of burial funds for each spouse (NOT \$3,500).

Resources owned in the name of one or both spouses are considered available regardless of whether either spouse agrees to sell or liquidate the resource, and regardless of whether either spouse refuses to make the resource available. The resource assessment is not affected by the amount disregarded in the eligibility determination as a result of a Partnership Policy.

C. Appeal Rights

When the resource assessment is completed as part of a Medicaid application and eligibility determination, the spousal share calculation can be appealed pursuant to the existing Client Appeals regulations (VR 460-04-8.7).

D. Eligibility Worker Responsibility

Each application for Medicaid for a person receiving LTC services who has a community spouse requires the completion of a resource assessment to determine the spousal share used in determining eligibility.

The EW must provide the applicant with a written request for verification of:

- all reported countable resources owned by the couple **on the first moment of the first day of the first month** of the first continuous period of institutionalization,
- all reported countable resources owned by the couple on the first moment of the first day of the month of application, and
- all reported countable resources owned by the couple as of the first moment of the first day of each retroactive month for which eligibility is being determined.

To expedite the application processing, the EW may include a copy of the "Intent to Transfer Assets to A Community Spouse" form, available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi with the request for verifications.

The same verification requirements as for all Medicaid applications apply to the resource assessment.

If the applicant reports to the EW that he cannot obtain certain verifications, the EW must determine why he cannot obtain them and what the EW can do to assist the applicant.

E. Procedures

The resource assessment is only a part of the eligibility determination process. The spousal share is calculated as a result of the resource assessment. The spousal share is used in the calculation of the spousal protected resource amount (PRA) and the institutionalized spouse's countable resources.

1. Forms

The applicant or his representative does not complete a Medicaid Resource Assessment Request form. The Medicaid application is the resource assessment request.

Either the Medicaid Resource Assessment form (#032-03-816) or the electronic Resource Assessment and Eligibility Workbook may be used to complete the assessment of resources and spousal share calculation at the time of the first continuous period of institutionalization. The workbook is located on the VISSTA web site at:

http://www.vcu.edu/vissta/bps/bps_resources/ltc_medicaid.htm.

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

\$131,000 Total Value of Couple's Countable Resources
\$ 65,500 Spousal Share

In the eligibility evaluation, the worker uses the spousal share amount (\$65,500) as one factor to determine the spousal protected resource amount (PRA) that is subtracted from the couple's current resources to determine the institutionalized spouse's resource eligibility.

F. Notice Requirements

Do not send the Notice of Medicaid Resource Assessment when a resource assessment is completed as a part of a Medicaid application.

Include a copy of the Medicaid Resource Assessment form with the Notice of Action on Medicaid that is sent when the eligibility determination is completed.

M1480.225 INABILITY TO COMPLETE THE RESOURCE ASSESSMENT-UNDUE HARDSHIP

A. Policy

Federal law states that a resource assessment must be completed on all Medicaid applications for institutionalized individuals who have a community spouse. On occasion, however, it is difficult to comply with this requirement because the applicant is unable to establish his marital status or locate a separated spouse, or the community spouse refuses or fails to provide information necessary to complete the resource assessment. In situations where the applicant is unable to provide information necessary to complete the resource assessment, undue hardship can be claimed if each of the following criteria is met:

1. The applicant establishes by affidavit specific facts sufficient to demonstrate (a) that he has taken all steps reasonable under the circumstances to locate the spouse, to obtain relevant information about the resources of the spouse, and to obtain financial support from the spouse; and (b) that he has been unsuccessful in doing so;

Absent extraordinary circumstances, determined by DMAS, the requirements of A.1 (a) cannot be met unless the applicant and spouse have lived separate and apart without cohabitation and without interruption for at least 36 months.

2. Upon such investigation as DMAS may undertake, no *relevant* facts are revealed that refute the statement contained in the applicant's affidavit, as required by paragraph A.1.

3. The applicant has assigned to DMAS, to the full extent allowed by law, all claims he or she may have to financial support from the spouse; and
4. The applicant cooperates with DMAS in any effort undertaken or requested by DMAS to locate the spouse, to obtain information about the spouse's resources and/or to obtain financial support from the spouse.

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 an undue hardship, he must provide a written statement requesting an undue hardship evaluation. The applicant 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 to locate the estranged spouse by the EW alone is not sufficient to complete the undue hardship evaluation. When it is reported that the applicant has a medical condition that prevents participation in the process, then a physician's statement must be provided documenting the medical condition.

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.

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 *or his* representative must sign, have notarized and return to the agency.

M1480.230 RESOURCE ELIGIBILITY OF INSTITUTIONALIZED SPOUSE

A. Introduction

This section contains the resource rules that apply to the institutionalized spouse's eligibility.

If the community spouse applies for Medicaid, do not use the rules in this subchapter to determine the community spouse's eligibility. Use the financial eligibility rules for a non institutionalized person in the community spouse's covered group.

B. Policy

An institutionalized spouse meets the resource eligibility requirements for Medicaid if the difference between the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined and the spousal protected resource amount (PRA) is equal to or less than \$2,000.

In initial eligibility determinations for the institutionalized spouse, the spousal share of resources owned by the couple **at 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, remains a constant factor in determining the spousal PRA.

*For the purposes of determining eligibility of an institutionalized spouse with excess resources, an institutionalized spouse **cannot** establish resource eligibility by reducing resources within the month. The institutionalized spouse may become eligible for Medicaid payment of LTC services when the institutionalized spouse's resources are equal to or below the \$2,000 CNNMP/MN resource limit as of the first moment of the first day of a calendar month.*

1. Use ABD Resource Policy

For the purposes of eligibility determination, countable and excluded resources are determined for all covered groups using the ABD resource policy in Chapter S11, **regardless of the individual's covered group and regardless of community property laws or division of marital property laws**, except for the following resources which are excluded as indicated below when determining eligibility of the institutionalized spouse:

- the home and all contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SS & SSI payments received on or after 11/01/05 for nine (9) calendar months following the month in which the individual receives the benefits; and
- up to \$3,500 of burial funds for each spouse.

Resources owned in the name of one or both spouses are considered available in the initial month for which eligibility is being determined regardless of whether either spouse agrees to sell or liquidate the resource, and regardless of whether either spouse refuses to make the resource available.

2. After Eligibility is Established Once an institutionalized spouse has established Medicaid eligibility as an institutionalized spouse, count only the institutionalized spouse’s resources when determining the institutionalized spouse’s Medicaid eligibility. Do not count or deem the community spouse’s resources available to the institutionalized spouse.

If an institutionalized spouse’s Medicaid coverage was cancelled and he reapplies as an institutionalized individual, use only the resources of the institutionalized spouse for his eligibility determination.

C. “Institutionalized Spouse Resource Eligibility Worksheet” Use the “Institutionalized Spouse Resource Eligibility Worksheet,” available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi, or the electronic Resource Assessment and Eligibility Workbook located at http://www.vcu.edu/vissta/bps/bps_resources/ltc_medicaid.htm to determine the institutionalized spouse’s resource eligibility.

M1480.231 SPOUSAL RESOURCE STANDARDS

A. Introduction This section provides the amounts and the effective dates of the standards used to determine an institutionalized spouse’s initial and ongoing resource eligibility. Use the standard in effect on the date of the institutionalized spouse's Medicaid application. Definitions of the terms are found in section M1480.010.

B. Spousal Resource Standard	\$20,880	1-1-08
	\$20,328	1-1-07

C. Maximum Spousal Resource Standard	\$104,400	1-1-08
	\$101,640	1-1-07

M1480.232 INITIAL ELIGIBILITY DETERMINATION PERIOD

A. Policy The initial eligibility determination period begins with the month of application. If the institutionalized spouse is eligible for the month of application, the initial eligibility determination period will both begin and end with that month.

If the applicant is not eligible in the month of application, the initial eligibility determination period continues until the first month in which the institutionalized spouse is eligible. NOTE: Established application processing procedures and timeframes apply.

An institutionalized spouse meets the resource eligibility requirements for Medicaid if the difference between the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined, the community spouse's protected resource amount (PRA) and the institutionalized spouse's partnership policy disregard amount (see M1460.160) is equal to or less than \$2,000.

1. First Application

Use the procedures in item B below for the initial resource eligibility determination for an institutionalized spouse's first application for Medicaid in a continuous period of institutionalization that began on or after 9-30-89.

2. Subsequent Applications

a. Medicaid Eligibility For LTC Services Achieved Previously

If an individual achieved Medicaid eligibility as an institutionalized spouse during a period of institutionalization that began on/after 9-30-89, regardless of whether the period of institutionalization is the same continuous period covered by the previous application(s), **do not consider the couple's resources. Use only the institutionalized spouse's resources.** Use the policy and procedures in section M1480.255 to determine the institutionalized individual's financial eligibility.

b. Medicaid Eligibility For LTC Services Not Previously Achieved

If an individual has never achieved Medicaid eligibility as an institutionalized spouse, **treat the application** as an "initial eligibility" determination.

- Determine countable resources for the application month (see item B below);
- Deduct the spousal PRA from the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined.
- Deduct a dollar amount equal to the Partnership Policy disregard, if any.

B. Procedures

Use the following criteria to determine Medicaid eligibility for any month in the initial eligibility determination period.

NOTE: The initial eligibility determination period begins with the month of application. If the institutionalized spouse is not eligible in that month, the initial eligibility determination period continues until the first month in which the institutionalized spouse is eligible.

1. Couple's Total Resources

Verify the amount of the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined.

NOTE: When a loan or a judgment against resources is identified, send the documents pertaining to the loan and/or judgment to DMAS for review before taking action on the application. 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

2. Deduct Spousal Protected Resource Amount (PRA)

Deduct the spousal protected resource amount (PRA) from the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined. The PRA is the greatest of the following:

- the **spousal share** of resources as determined by the resource assessment, provided it does not exceed the maximum spousal resource standard in effect at the time of application. **If the spousal share exceeds the maximum spousal resource standard, use the maximum spousal resource standard.** If no spousal share was determined because the couple failed to verify resources held at the beginning of the first continuous period of institutionalization, the spousal share is \$0. The spousal share does not change; if a spousal share was previously established and verified as correct, use it;
- the **spousal resource standard** in effect at the time of application;
- an amount **actually transferred** to the community spouse from the institutionalized spouse under a **court spousal support order**;
- an amount designated by a DMAS Hearing Officer.

If the individual does not agree with the PRA, see subsection F. below.

Once the PRA is determined, it remains a constant amount for the current Medicaid application (including retroactive months). *If the application is denied and the individual reapplies, the spousal share remains the same but a new PRA must be determined.*

3. Deduct Partnership Policy Disregard Amount

When the institutionalized spouse is entitled to a Partnership Policy disregard, deduct a dollar amount equal to the benefits paid as of the month of application.

**4. Compare
Remainder**

Compare the remaining amount of the couple's resources to the appropriate Medicaid resource limit for one person.

a. Remainder Exceeds Limit

When the remaining resources exceed the limit *and the institutionalized spouse does not have Medicare Part A*, the *institutionalized spouse* is not eligible for Medicaid coverage because of excess resources.

*If the institutionalized spouse has Medicare Part A, he may be eligible for limited coverage QMB, SLMB or QI Medicaid (which will not cover the cost of the LTC services) because the resource requirements and limits are different. **The resource policies in subchapter M1480 do not apply to limited-coverage Medicaid eligibility determinations.** Follow the procedures for determining resource eligibility for an individual in Chapter S11. More information about the QMB, SLMB, and QI covered groups is contained in subchapter M0320.*

Note: The institutionalized spouse cannot be eligible for QDWI Medicaid.

b. Remainder Less Than or Equal to Limit

When the remaining resources are equal to or less than the Medicaid limit, the institutionalized spouse is resource eligible in the month for which eligibility is being determined:

**Initial Eligibility
Determination
Month**

February 1998

Step 1: The couple's total resources as of September 1, 1992 (the first moment of the first day of the first continuous period of institutionalization) were \$200,000.

Step 2: $\$200,000 \div 2 = \$100,000$. The spousal share is \$100,000.

Step 3: The couple's total countable resources as of February 1, 1998 (the month for which eligibility is being determined) are \$90,000.

Step 4: Determine the PRA: Once the PRA is determined, it remains the same for all retroactive months and for months in the initial eligibility determination period.

The PRA is \$80,760 (See Step 4 in the retroactive determine for December 1997 above).

Step 5: Deduct the PRA from the couple's combined countable resources on February 1, 1998 (the first moment of the first day of the month for which eligibility is being determined):

$\$90,000$	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
$- \quad 80,760$	Step 4 PRA
$\$9,240$	countable resources in month for which eligibility is being determined.

\$ 9,240 countable resources for Mr. B.

Step 6: Since \$9,240 exceeds the \$2,000 limit, Mr. B is not eligible for Medicaid in February 1998 (the month for which eligibility is being determined).

Note: The initial eligibility determination period continues until the individual is found eligible. If Mr. B reapplies, he will still be in the initial eligibility determination period.

M1480.240 INTENT TO TRANSFER - PROTECTED PERIOD

A. Policy

After the initial eligibility determination, an institutionalized spouse who has resources in his name which exceed the Medicaid resource limit may have his Medicaid resource eligibility "protected" for a period of time if all of the following criteria are met:

- *resources in the community spouse's name are less than the PRA at the time of application,*

- *the amount of resources that may be transferred to bring the community spouse up to the PRA will reduce the resources in the institutionalized spouse's name to no more than \$2,000, and*
- *the institutionalized spouse has expressly indicated in writing his intent to transfer resources to the community spouse.*

The protected period is designed to allow the institutionalized spouse time to legally transfer some or all of his resources to the community spouse.

Resources in the institutionalized spouse's name are excluded only for one 90-day period.

If the institutionalized spouse does not transfer resources to the community spouse within the 90-day period, all of the institutionalized spouse's resources will be counted available to the institutionalized spouse when the protected period ends. If the institutionalized spouse loses eligibility after the 90-day protected period is over, and then reapplies for Medicaid, he CANNOT have resource eligibility protected again and a PRA is NOT subtracted from his resources.

B. Protected Period Is Not Applicable

A protected period of eligibility is not applicable to an institutionalized spouse when:

- *the institutionalized spouse is not eligible for Medicaid;*
- *the institutionalized spouse previously established Medicaid eligibility as an institutionalized spouse, had a protected period of eligibility, became ineligible, and reapplies for Medicaid; or*
- *at the time of application, a community spouse has title to resources equal to or exceeding the PRA.*

C. Intent to Transfer Resources To Community Spouse

*The institutionalized spouse or authorized representative must expressly indicate **in writing** his intention to transfer resources to the community spouse. If not previously obtained, send an "Intent to Transfer Assets to A Community Spouse" form, available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi, to the institutionalized spouse or authorized representative, allowing 10 days from the date of mailing for return of the form.*

If the completed Intent to Transfer Assets form is not returned by the time the application is processed, no protected period of eligibility may be established. All resources in the institutionalized spouse's name must be counted in his eligibility determination beginning with the month following the initial eligibility determination period. If eligible, enroll the institutionalized spouse for a closed period of coverage beginning with the retroactive period and ending with the last day of the month of the initial eligibility period.

If the institutionalized spouse submits a new application for Medicaid payment of long-term care services, the process starts again and a new Intent to Transfer form must be mailed.

When the community spouse is a Medicaid recipient, the eligibility worker must inform the couple that the transfer of resources to the community spouse could impact the community spouse's Medicaid eligibility.

D. How to Determine the Protected Period

The 90-day protected period begins with the date the local agency takes action to approve the institutionalized spouse's initial eligibility for Medicaid LTC services, if the institutionalized spouse or his authorized representative *has signed the Intent to Transfer Assets form.*

E. Protected Period Ends

Set a special review for the month in which the 90-day period ends. When the protected period of eligibility is over, all resources owned in the institutionalized spouse's name are counted available to the institutionalized spouse. Extension of the protected period is NOT allowed.

F. Institutionalized Spouse Acquires Resources During the Protected Period of Eligibility

If the **institutionalized spouse** obtains additional resources during the protected period of eligibility, the additional resources shall be excluded during the protected period if:

- the new resources combined with other resources that the institutionalized spouse intends to retain do not exceed the appropriate Medicaid resource limit for one person, OR
- the institutionalized spouse intends to transfer the new resources to the community spouse during the protected period of eligibility and the total resources to be transferred do not exceed the balance remaining (if any) of the PRA.

NOTE: Some assets, such as inheritances, are income in the month of receipt. Be careful to count only those assets that are resources in the month of receipt, and to count assets that are income as a resource if retained in the month following receipt.

M1480.241 COMMUNITY SPOUSE RESOURCE ALLOWANCE (CSRA)

A. Policy

When the Intent to Transfer form has been completed, the institutionalized spouse's eligibility is protected for 90 days to allow time for resources in the institutionalized spouse's name to be transferred to the community spouse for the community spouse's support.

The community spouse resource allowance (CSRA) is the amount of the resources in the institutionalized spouse's name (including his share of jointly owned resources) which can be transferred to the community spouse to bring the resources in the community spouse's name up to the PRA. This amount is disregarded in the institutionalized spouse's Medicaid eligibility determination during the protected period.

B. CSRA Calculation Procedures

Use the following procedures for calculating the CSRA. The “Institutionalized Spouse Resource Eligibility Worksheet,” available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi, or the electronic Resource Assessment and Eligibility Workbook located at http://www.vcu.edu/vissta/bps/bps_resources/ltc_medicaid.htm may be used to determine countable resources and the CSRA.

1. Determine Community Spouse's Resources

Determine the amounts of the couple's total resources which are in the community spouse's name only and the community spouse's share of jointly owned resources owned as of the first moment of the first day of the initial month for which eligibility was established.

2. Determine Institutionalized Spouse's Resources

Determine the amounts of the couple's total resources which are in the institutionalized spouse's name only and the institutionalized spouse's share of jointly owned resources owned as of the first moment of the first day of the initial month for which eligibility was established. If the institutionalized spouse's resources changed during initial month (after the first moment of the first day of the initial month which eligibility was established) verify the institutionalized spouse's resources owned as of the first moment of the first day of the month following the initial month.

3. Calculate CSRA

To calculate the *Community Spouse Resource Allowance* (CSRA):

a. Determine PRA

Find the spousal PRA (determined in section M1480.232 above).

b. Subtract CS Resources from the PRA

Subtract from the PRA an amount equal to the resources in the community spouse's name only and the community spouse's share of jointly owned resources as of the first moment of the first day of the initial month in which eligibility was established.

c. Remainder

The remainder, if greater than zero, is the CSRA and the amount to be disregarded in the institutionalized spouse's Medicaid eligibility determination during the protected period. This is the amount to be transferred to the community spouse during the protected period.

If the remainder is \$0 or a negative number, the CSRA = \$0. The community spouse does not have a CSRA.

**C. Example
 CSRA Calculation**

EXAMPLE #9: (Using January 2008 figures)

Mrs. Tea applied for Medicaid on *May 21, 2008*. She was admitted to the nursing facility on *January 20, 2008*. She is married to Mr. Tea who lives in their community home. This is her first application for Medicaid as an institutionalized spouse. The first day of the first month of the first continuous period of institutionalization is *January 1, 2008*. Eligibility is being determined for May 2008. *Mrs. Tea signs the Intent to Transfer form June 1, 2008.*

Step 1:

Determine the PRA

The couple's total countable resources as of *January 1, 2008* (the first moment of the first day of the first continuous period of institutionalization) were \$50,000.

- \$25,000 spousal share ($\$50,000 \div 2$), *not to exceed the maximum spousal resource standard of \$104,400, eff. 01-01-2008*
- \$20,880 spousal resource standard in effect on January 1, 2008
- \$0 (amount actually transferred as court-ordered spousal support);
or
- \$0 (DMAS hearing decision amount).

Since \$25,000 is the greatest of the above, \$25,000 is the PRA.

Steps 2. and 3:

Subtract CS Resources from the PRA to Determine CSRA

The couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined are \$26,500. The community spouse has \$7,000 in his name. The institutionalized spouse has \$19,500 in her name. From the PRA of \$25,000, deduct the community spouse resource amount of \$7000. The remaining \$18,000 is the CSRA that can be transferred to the community spouse and disregarded in the institutionalized spouse' Medicaid eligibility determination during the protected period.

$$\begin{array}{r}
 \$25,000 \text{ PRA} \\
 - \underline{7,000} \quad \text{Resources in the CS name} \\
 \hline
 \$18,000 \quad \text{CSRA (amount that can be transferred to CS)}
 \end{array}$$

D. Community Spouse Acquires Additional Resources During Protected Period

If the **community spouse** obtains additional resources during the protected period of eligibility, the institutionalized spouse's eligibility is NOT affected. The community spouse's new resources are not counted when determining the institutionalized spouse's eligibility during or after the protected period of eligibility. **Do NOT recalculate the CSRA.**

E. Reviewing Resource Eligibility

When reviewing the institutionalized spouse's resource eligibility at the end of the protected period and at scheduled redeterminations, the community spouse's resources are NOT counted available.

H. Asset Transfers

Instructions for treatment of asset transfers are found in subchapter M1450.

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M1480.260 SUSPENSION PROCEDURES

A. Policy

This section applies to institutionalized individuals who:

- *are enrolled in ongoing Medicaid coverage,*
- *have Medicare Part A,*
- *have a patient pay that exceeds the Medicaid rate, and*
- *have resources between \$2,000 and \$4,000.*

B. Procedures

If the conditions above are met, take the following actions:

1. Prepare and Send Advance Notice

Prepare and send an advance notice to reduce the recipient's full Medicaid coverage to the appropriate MI ABD covered group. Specify the effective date, which is the last day of the month in which the 10-day advance notice period expires. Write a note on the notice telling the recipient that if he verifies that his resources are less than or equal to the \$2,000 resource limit before the specified date (specify the date which is 3 months from the cancel effective date), he should request reinstatement of Medicaid coverage.

2. Suspend Case Administratively

Suspend the case administratively for a maximum of 3 months; do not close the case statistically. The suspension effective date is the effective date of the Medicaid cancellation in the MMIS. The case is counted as a "case under care" while suspended. While suspended, the case remains open for a maximum of 3 months.

If, by the end of 3 months from the suspension effective date, the individual provides verification that his resources have been reduced to or below the resource limit, update the latest application or redetermination form in the individual's case record. Reinstatement his Medicaid coverage in the MMIS effective the first day of the month in which his resources are less than or equal to the resource limit.

If the individual does NOT provide verification within 3 months of the suspension effective date that his resources have been reduced to or below the resource limit, close the case administratively and statistically. Do not take any action on his enrollment in the MMIS, because his coverage has already been canceled. The individual will have to file a new Medicaid application.

M1480.300 INCOME ELIGIBILITY OF INSTITUTIONALIZED SPOUSE

A. Introduction The income rules in this section apply only to the institutionalized spouse's eligibility.

The rules in this section supersede all other manual chapters and sections wherever those chapters or sections conflict with these rules. The ABD income policy rules in Virginia DSS Volume XIII, Chapter S08 are used to determine income eligibility for married institutionalized individuals.

- 1. When Applicable** **The income rules apply to an institutionalized spouse regardless of when the continuous period of institutionalization began.**

- 2. When Not Applicable** If the institutionalized spouse no longer meets the definition of an institutionalized spouse in section M1480.010, the income rules in this subchapter do not apply effective the first day of the first full calendar month following the month in which he no longer meets the definition of an institutionalized spouse.

These rules NEVER apply when determining the eligibility of the community spouse. The income rules applicable to non-institutionalized individuals, found in other sections and chapters of the manual, apply to the community spouse.

B. Policy

An institutionalized spouse's income shall be determined as follows without regard to state laws governing community property or division of marital property:

1. Income From Non-trust Property

Unless a DMAS Hearing Officer determines that the institutionalized spouse has proven to the contrary (by a preponderance of the evidence):

- a. income paid to one spouse belongs to that spouse;
- b. each spouse owns one-half of all income paid to both spouses jointly;
- c. each spouse owns one-half of any income which has no instrument establishing ownership [1924(b)(2)(C)];
- d. income paid in the name of either spouse, or both spouses and at least one other party, shall be considered available to each spouse in proportion to the spouse's interest. When income is paid to both spouses and each spouse's individual interest is not specified, consider one-half of their joint interest in the income as available to each spouse.

2. Income From Trust Property

Ownership of income from trust property shall be determined pursuant to regular income policy, except as follows:

- a. Income is considered available to each spouse as provided in the trust.
- b. If a trust instrument is not specific as to the ownership interest in the trust income, ownership shall be determined as follows:
 - 1) Income paid to one spouse belongs to that spouse.
 - 2) One-half income paid to both spouses shall be considered available to each spouse.
 - 3) Income from a trust paid in the name of either spouse or both spouses, and at least one other party, shall be considered available to each spouse in proportion to the spouse's interest in the trust principal. When income from a trust is paid to both spouses and each spouse's individual interest in the trust principal is not specified, consider one-half of their joint interest in the income as available to each spouse.

3. Income Deeming

Do not deem a community spouse's income available to an institutionalized spouse for purposes of determining the institutionalized spouse's Medicaid eligibility for any month of institutionalization (including partial months). For the month of entry into institutionalization and subsequent months, only the institutionalized individual's income is counted for eligibility and patient pay purposes.

The community spouse's income is used only to determine the community spouse monthly income allowance, if any. If the community spouse is not entitled to a monthly income allowance from the institutionalized spouse, the community spouse may have an expected contribution to the institutionalized spouse. See Appendix 4 to this subchapter to determine the community spouse's expected contribution.

4. Income Determination

For purposes of the income eligibility determination of a married institutionalized spouse, regardless of the individual's covered group, income is determined using the income eligibility instructions in section M1480.310 below and chapter S08.

For individuals who are within a spenddown budget period prior to the month in which they become institutionalized, prorate and shorten the spenddown budget period to include months **prior to admission** to long-term care services. A separate monthly budget period is established for each month of receipt of long-term care services.

5. Post-eligibility Treatment of Income

After an institutionalized spouse is determined eligible for Medicaid, his or her patient pay must be determined. See the married institutionalized individuals' patient pay policy and procedures in section M1480.400 below.

M1480.310 300% SSI AND ABD 80% FPL INCOME ELIGIBILITY DETERMINATION

A. Introduction

This section provides those income requirements specific to determinations of eligibility for Medicaid participation in payment of long-term care services.

For ABD individuals, first determine the individual's eligibility in the 300% SSI covered group. If the individual is ineligible in the 300% SSI covered group due to excess resources, determine the individual's eligibility in the ABD 80% FPL covered group.

For purposes of this section, we refer to the ABD covered group and the F&C covered group of "individuals in medical facilities who have income less than or equal to 300% of the SSI individual payment limit" and "individuals receiving Medicaid waiver services who have income less than or equal to 300% of the SSI individual payment limit" as one covered group. We refer to this one group as "institutionalized individuals who have income within 300% of SSI" or the "300% SSI group."

B. 300% SSI Group

The income limit for ABD and F&C individuals in the 300% SSI group is 300% of the SSI individual payment limit (see M0810.002.A.3).

1. Gross Income

Income sources listed in section M1460.610 are not considered as income.

Income sources listed in section M1460.611 ARE counted as income.

All other income is counted. The institutionalized spouse's gross income is counted; no exclusions are subtracted.

D. Expected Contributions From Legally Responsible Relative

An expected contribution from a legally responsible relative is not counted unless it is actually contributed to the institutionalized child or spouse. If a separated spouse has income over the spousal maximum maintenance standard (see M1480.410) or a higher amount set by hearing officer or judge, an expected contribution of income is determined using the scale in Appendix 4 to this subchapter. However, the contribution is not counted as income available to the institutionalized spouse for patient pay or the eligibility determination unless it is actually made available to the institutionalized spouse from the separated spouse.

The separated spouse has no expected contribution if his income is less than or equal to the spousal maximum maintenance standard in subchapter M1480 (or a higher amount determined by a DMAS hearing officer or court judge as necessary for the separated spouse's maintenance needs) or if the separated spouse receives an allowance from the institutionalized spouse's income.

M1480.315 THIRD PARTY & LONG-TERM CARE INSURANCE PAYMENTS

A. Payments Made by Another Individual

Payment of an individual's bills (including Medicare supplementary medical insurance or other medical insurance premiums) by a third party directly to the supplier is not income.

Payments made directly to the service provider by another person for the individual's private room or "sitter" in a medical facility are NOT income to the individual. Refer all cases of Medicaid eligible enrollees in nursing facilities who have a "sitter" to DMAS, Division of Long-term Care, for DMAS review to assure that DMAS is not paying the facility for services provided by the sitter.

B. LTC Insurance Policy Payments

The LTC insurance policy must be entered into the recipient's TPL file on MMIS. The insurance policy type is "H" and the coverage type is "N." When entered in MMIS on the TPL system, MMIS will not pay the nursing facility's claim unless the claim shows how much the policy paid.

If the patient receives the payment from the insurance company, it is **not** counted as income. The patient should assign it to the nursing facility. If the patient cannot do this, or the policy prohibits assignment, the payment should be given directly to the nursing facility. The facility should report the payment as a third party payment on its claim form.

If the patient received the payment and cannot give it to the facility for some reason, then the patient should send the insurance payment to:

DMAS Fiscal Division, Accounts Receivable
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

M1480.320 RETROACTIVE MN INCOME DETERMINATION

- A. Policy**
- The retroactive spenddown budget period is the three months immediately prior to the application month, when none of the months overlap (was included in) a previous MN spenddown budget period in which spenddown eligibility was established. When some of the months overlap a previous MN spenddown budget period in which spenddown eligibility was established, the retroactive spenddown budget period is shortened (prorated) to include only the month (s) which were not included in the previous MN spenddown budget period.
- 1. Institutionalized**
For the retroactive months in which the individual was institutionalized, determine income eligibility on a **monthly basis** using the policy and procedures in this subchapter. A spenddown must be established for a month during which excess income existed.
 - 2. Individual Not Institutionalized**
For the retroactive months in which the individual was NOT institutionalized, determine income eligibility for ABD groups using the ABD policy and procedures in chapter S08. Determine income eligibility for F&C groups using policy and procedures in chapter M07. A spenddown must be established for a month(s) during which excess income existed.
 - 3. Retroactive Entitlement**
If the 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 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.
- The countable income is compared to the appropriate income limit for the retroactive month, if the individual was CNNMP in the month. **For the institutionalized MN individual, Medicaid income eligibility is determined monthly.**
- 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 applicant had excess income in the retroactive period and met his spenddown, he is enrolled beginning the first day of the month in which his retroactive spenddown was met. For additional information refer to section M1510.101.
- D. Retroactive Example**
- EXAMPLE #15:** A disabled institutionalized spouse 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. His countable resources are less than \$2,000 in April, May and June. The income he received in April and May is counted monthly because he was institutionalized in each month.

- 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**.
- 4) 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 section M0810.002 for the current QMB limit):
- a) When income is less than or equal to the QMB limit, enroll using the appropriate AC that follows:
- Aged = **028**
 - Blind = **048**
 - Disabled = **068**
- b) When income is greater than the QMB limit, enroll using the appropriate PD that follows:
- Aged = **018**
 - Blind = **038**
 - Disabled = **058**
- 5) Patient Pay: Determine patient pay according to section M1480.400 below.

d. SD Liability Is Greater Than Medicaid Rate

If the spenddown liability is **greater than** the facility's Medicaid rate, the institutionalized spouse is NOT eligible unless he incurs medical expenses which meet the spenddown liability in the month. To determine if the spenddown is met, go to section M1480.335 below.

2. Medicaid CBC Waiver Patients

The institutionalized spouse meets the definition of "institutionalized" when he is screened and approved for Medicaid waiver services and the services are being provided. An institutionalized spouse who has been screened and approved for Medicaid waiver services and whose income exceeds the CNNMP 300% SSI income limit is not eligible for Medicaid until he meets the monthly spenddown liability.

To determine if the spenddown is met, go to section M1480.335 below.

3. PACE Recipients

The individual's spenddown liability and the PACE monthly rate (minus the Medicare Part D premium) establish whether the spenddown eligibility determination can be projected or must be determined retrospectively.

To determine if the spenddown is met, go to section M1480.340 below.

**M1480.335 FACILITY PATIENTS WITH SPENDDOWN LIABILITY
GREATER THAN MEDICAID RATE & ALL MN CBC PATIENTS**

- A. Facility Patients--
SD Liability Is
Greater Than
Medicaid Rate**
- An MN institutionalized spouse whose spenddown liability is greater than the facility's Medicaid rate is not eligible for Medicaid until he incurs medical expenses that meet the spenddown liability within the month. These determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred. The institutionalized spouse's resources and income must be verified each month before determining if the spenddown was met.
- To determine if the institutionalized spouse met the spenddown, use the following procedures:
- 1. Calculate
Private Cost of
Care**

Multiply the facility's **private** per diem rate by the number of days the institutionalized spouse was actually in the facility in the month. Do not count any days the institutionalized spouse was in a hospital during the month.

The result is the private cost of care for the month.
 - 2. Compare to
Spenddown
Liability**

Compare the private cost of care to the institutionalized spouse's spenddown liability for the month.
 - 3. Cost of Care
Greater Than
Spenddown
Liability**

When the private cost of care is **greater than** the institutionalized spouse's spenddown liability, the institutionalized spouse meets the spenddown in the month because of the private cost of care. He is entitled to **full-month coverage** for the month in which the spenddown was met.

Enroll the institutionalized spouse in Medicaid with the begin date of the first of the month, the end date the last day of the month. Go to section M1480.350 below for enrollment procedures. Determine patient pay according to section M1480.440 below.
 - 4. Cost of Care
Less Than or
Equal To
Spenddown
Liability**

When the private cost of care is less than or equal to the institutionalized spouse's spenddown liability, **determine spenddown on a day-by-day basis** in the month by deducting allowable incurred expenses from the spenddown liability.

To determine spenddown eligibility:

 - Go to section M1480.341 below if the institutionalized spouse was NOT previously on a spenddown.
 - Go to section M1480.342 below if the institutionalized spouse was previously on a spenddown.

B. All MN CBC Patients

An MN institutionalized spouse who has been screened and approved for Medicaid CBC waiver services is not eligible for Medicaid until he actually incurs medical expenses that meet the spenddown liability within the month. These determinations are made monthly, retrospectively, **after** the month has passed and the expenses have actually been incurred. The private cost of his home-based medical care is deducted on a day-by-day basis as a noncovered medical expense, along with any other incurred medical expenses.

The institutionalized spouse's resources and income must be verified each month before determining if the spenddown was met. To determine if the institutionalized spouse met the spenddown:

- Go to section M1480.341 below if the institutionalized spouse was NOT previously on a spenddown.
- Go to section M1480.342 below if the institutionalized spouse was previously on a spenddown.

M1480.340 MN PACE RECIPIENTS

A. Policy

1. Monthly Spenddown Determination

PACE recipients who have income over the CNNMP 300% of SSI income limit are placed on a monthly spenddown as institutionalized individuals because they have been screened and approved for LTC services.

Unlike CBC, PACE has a capitated monthly rate that is due and payable on the first day of the month. The monthly PACE rate is available from the PACE provider. When a MN individual is in PACE, the amount of allowed PACE expenses is the rate that is due as of the first day of each month.

*PACE recipients are not responsible for Medicare Part D premiums, which are included in the monthly PACE rate. **Therefore, the cost of the Medicare Part D premium cannot be used to meet a spenddown and must be subtracted from the monthly PACE rate when determining if the spenddown has been met.***

The individual's spenddown liability and the PACE monthly rate (minus the Medicare Part D premium) establish whether the spenddown eligibility determination can be projected or must be determined retrospectively.

2. Projected Spenddown Determination

If the MN individual's spenddown liability is less than or equal to the monthly PACE rate (minus the Medicare Part D premium), the individual is eligible for Medicaid effective the first day of the month in which the spenddown is met. As long as the individual's spenddown liability and the PACE monthly rate do not change, the individual is enrolled in ongoing coverage.

3. Retrospective Spenddown Determination

If the MN individual's spenddown liability exceeds the monthly PACE rate (minus the Medicare Part D premium), he is not eligible for Medicaid until he actually incurs medical expenses that meet the spenddown liability within the month. The monthly medical expenses are determined retrospectively; they cannot be projected for the spenddown budget period.

Retrospective spenddown eligibility determinations are made monthly after the month has passed and the expenses have actually been incurred. The PACE

rate(minus the Medicare Part D premium) along with other allowable medical and dental expenses are deducted daily and chronologically as the expenses are incurred. The individual's income and resources must be verified each month before determining if the spenddown has been met. See M1470.530 for allowable medical deductions.

When incurred medical expenses equal or exceed the monthly spenddown liability, the individual is eligible for the full month of Medicaid coverage beginning the first day of the month and ending the last day of the month.

M1480.341 NOT PREVIOUSLY ON SPENDDOWN

A. Procedure

To determine eligibility in the one-month budget period for an institutionalized spouse who has NOT previously been on a spenddown, take the following actions:

- deduct old bills,
- deduct carryover expenses from the retroactive period,
- deduct medical/remedial care expenses incurred within the budget period (month).

Use the "Medical Expense Record-Medicaid" found in Appendix 1 to subchapter M1340 to document expenses and file it in the case record.

If the institutionalized spouse was on a spenddown in the retroactive period, whether or not the retroactive spenddown was met, go to section M1480.342 below.

B. Old Bills

Old bills for medical, dental, or remedial care services received prior to the retroactive period based on the initial application that can be deducted are:

1. Paid by Public Program

Expenses for medical services for which the applicant was legally liable received on or after December 22, 1987, which were provided, covered, or paid for by a public state or local government program, can be deducted. The amount deducted is the amount that the applicant would have been liable for if the service had not been covered by a public program, up to the spenddown liability amount.

2. Legally Liable

Expenses incurred for medical services that the applicant is legally liable to pay are deducted. For the expense to be deducted:

- the applicant must still owe the service provider a specific amount for the service and present current verification of the debt;
- the expense (or remainder of the expense) must not have been forgiven or written-off by the provider; and

a claim for the expense must have been submitted to the liable third party and the applicant must provide evidence of the third party's payment denial or the amount paid for the expense.

- 3. Amount Deducted** The amount deducted is the balance of the old bills owed by the applicant as of the first day of the first prospective budget period, less any portion of the amount that was used to meet the retroactive spenddown.
- 4. When Deducted** Allowable old bills are deducted on the first day of the budget period.
- C. Carry-over Expenses from Retroactive Period** Paid or unpaid expenses incurred during the retroactive period of an initial application can be deducted IF:
- the individual established eligibility in the retroactive budget period **without having to meet a spenddown**, AND
 - the expenses are allowable by kind of service.
- 1. Amount Deducted** The amount deducted is the amount of the expense owed as of the beginning of the budget period, up to the spenddown liability amount.
- 2. When Deducted** Allowable expenses carried over from the retroactive period are deducted on the first day of the one-month budget period.
- D. Expenses Incurred Within the Budget Period** Allowable expenses incurred on or after the beginning of the one-month budget period that can be deducted are:
- 1. Paid By Public Program** Allowable incurred expenses for medical or remedial care which the applicant received after the beginning of the budget period which were provided, covered, or paid for by a public state or local government program can be deducted. The incurred expense amount that can be deducted is the amount that the applicant would have been liable for if the service had not been covered by a public program, up to the spenddown liability amount.
- 2. Legally Liable** Allowable expenses (paid or unpaid) incurred during the budget period for which the applicant is legally liable are deducted. To be deducted, the claim for the expense must have been submitted to the liable third party. The applicant must provide evidence of the third party's payment denial or the 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**

<i>\$1,750.00</i>	<i>7-1-08</i>		
<i>\$1,711.25</i>	<i>7-1-07</i>		
- C. Maximum Monthly Maintenance Needs Allowance**

<i>\$2,610.00</i>	<i>1-1-08</i>		
<i>\$2,541.00</i>	<i>1-1-07</i>		
- D. Excess Shelter Standard**

<i>\$525.00</i>	<i>7-1-08</i>		
<i>\$513.38</i>	<i>7-1-07</i>		
- E. Utility Standard Deduction (Food Stamps)**

<i>\$252</i>	<i>1 - 3 household members</i>	<i>10-1-07</i>	
<i>\$317</i>	<i>4 or more household members</i>	<i>10-1-07</i>	
<i>\$281</i>	<i>1 - 3 household members</i>	<i>10-1-06</i>	
<i>\$352</i>	<i>4 or more household members</i>	<i>10-1-06</i>	

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 *or* PACE. 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 and
PACE**

a. Basic Maintenance Allowance

Deduct the appropriate maintenance allowance for one person *as follows*:

- 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, Day Support (DS) Waiver *or PACE*:

Prior to September 1, 2006, the personal maintenance allowance was equal to the monthly SSI payment limit for one person. Effective September 1, 2006, the personal maintenance deduction is equal to 165% of the monthly SSI payment limit for one person. The personal maintenance deduction is:

- January 1, 2007 through December 31, 2007: \$1,028
- January 1, 2008 through December 31, 2008: \$1,051.

Contact a Medical Assistance Program Consultant for the SSI amount in effect for years prior to 2007.

- 2) For the AIDS Waiver: the personal maintenance allowance is equal to 300% of the SSI limit for one person (\$1,911).

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 *EDCD*, DD, DS and MR Waivers

[EXAMPLE #19 was deleted]

For *EDCD*, 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 (\$1,911) per month.
- b) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI (\$1,274) per month.

The total of the basic maintenance allowance, the guardianship fee and the special earnings allowance cannot exceed 300% SSI.

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

4. Deduct Family Member's Allowance Deduct the family member(s)' monthly income allowance(s) from the institutionalized spouse's patient pay income. Do NOT deduct the family member's allowance if the family member does not accept the allowance.

5. Example-- Family Member's Allowance **EXAMPLE #23: (Using July 2000 figures)**
 The couple's minor child lives with the community spouse. The child has no income. The child's family member maintenance allowance is 1/3 of \$1,406.25 which is \$468.75.

The community spouse's father lives with the community spouse and receives \$300 per month SSA, which is his only income. The monthly family member allowance for the father is calculated as follows:

\$1,406.25	monthly maintenance needs standard
<u>- 300.00</u>	father's income
\$1,106.25	remainder
<u>÷ 3</u>	(divide by 3)
\$ 368.75	family member maintenance allowance for father

The institutionalized spouse's income is \$1,200. The community spouse has no community spouse monthly income allowance in this example, so the institutionalized spouse's patient pay is calculated as follows:

\$1,200.00	institutionalized spouse's patient pay income
<u>- 30.00</u>	personal needs allowance
1,170.00	
<u>- 468.75</u>	child's family member's income allowance
701.25	
<u>- 368.75</u>	father's family member's income allowance
\$ 332.50	patient pay

F. Noncovered Medical Expenses Incurred medical and remedial care expenses recognized under State law, but not covered under the Medicaid State Plan and not subject to third party payment are deducted from patient pay after all allowances are deducted.

See section M1470.230 for facility patients, section M1470.430 for Medicaid CBC waiver patients *or section M1470.530 for PACE recipients* for specific instructions in determining allowable noncovered medical expense deductions from patient pay.

G. Home Maintenance Deduction 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.

H. Patient Pay Compare the **remaining income** (patient pay gross monthly income minus allowable deductions) to the Medicaid rate for the month. The patient pay is the lesser of the two amounts.

- I. DMAS-122** Complete and send a DMAS-122 form to the facility or Medicaid CBC/PACE provider showing the patient pay for the month(s). The DMAS-122 has space for three months of patient pay.

- J. Notice of Obligation** Complete and send a “Notice of Obligation for Long-term Care” to the recipient and/or his authorized representative showing the individual’s patient pay for the month(s).

- K. Example--300% SSI Group Patient Pay** **EXAMPLE #25: (Using July 2000 figures)**
Mrs. Bay is a disabled institutionalized spouse who first applied for Medicaid for long term care services in July. She was admitted to the facility in June, but she is not eligible for Medicaid in the retroactive months because of excess resources. She has a monthly SSA benefit of \$1,000 and a monthly private pension payment of \$400. She has Medicare Parts A & B and private Medicare supplement health insurance which costs \$75 per month. Her spouse, Mr. Bay, still lives in their Group II home with their dependent son, age 19 years. Mr. Bay has income of \$1,500 per month from CSA. Their son has no income. Mrs. Bay’s income is less than the CNNMP 300% SSI income limit, so she is eligible for ongoing Medicaid coverage beginning July 1. She is enrolled in Medicaid *in AC 060*.

Her patient pay for July and subsequent months is determined. The community spouse monthly income allowance is calculated first:

\$1,406.25	monthly maintenance needs standard
<u>+ 200.00</u>	excess shelter allowance
1,606.25	MMMNA (minimum monthly maintenance needs allowance)
<u>-1,500.00</u>	community spouse’s gross income
\$ 106.25	community spouse monthly income allowance

The family member monthly income allowance for their son is calculated:

\$1,406.25	monthly maintenance needs standard
<u>- 0</u>	son’s income
1,406.25	amount by which the standard exceeds the son’s income
<u>÷ 3</u>	
\$ 468.75	family member’s monthly income allowance

Mrs. Bay has old bills totaling \$200, dated the prior January. She has no noncovered expenses from the retroactive period because she paid the nursing facility in full through June. She is eligible in the CNNMP 300% SSI group and is not a QMB; therefore, her Medicare premium is deducted from her patient pay for the first two months of Medicaid coverage (July and August). Her patient pay for July is calculated as follows:

\$1,000.00	SSA
<u>+ 400.00</u>	private pension
1,400.00	total gross income

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

Her patient pay for August is calculated as follows:

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

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

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

The worker completes a DMAS-122 showing her patient pay for July, August and September and sends it to the facility. The worker completes and sends a "Notice of Obligation" to Mr. Bay showing Mrs. Bay's patient pay for July, August and September and each month's patient pay calculation.

M1480.440 MEDICALLY NEEDY PATIENT PAY

A. Policy

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

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

1. Patient Pay Deductions

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

2. When Patient Pay Is Not Required

Intermediate Care Facility for the Mentally Retarded (ICF-MR) and Institution for Mental Diseases (IMD) services are not covered for medically needy (MN) eligible recipients. Therefore, a patient pay determination is not required when a MN enrolled recipient resides in an IMD or ICF-MR.

B. Patient Pay Procedures

Determine an MN institutionalized spouse's patient pay using the policy and procedures in the sections below:

- Facility Patient Pay - Spenddown Liability Less Than or Equal to Medicaid Rate (section M1480.450)
- Facility Patient Pay - Spenddown Liability Greater Than Medicaid Rate (section M1480.460)
- CBC - MN Institutionalized Spouse Patient Pay (section M1480.470)
- PACE - MN Institutionalized Spouse Patient Pay (section M1480.480).

\$2,000.00	SSA
<u>+ 500.00</u>	monthly private pension
2,500.00	total monthly income
<u>- 20.00</u>	exclusion
2,480.00	countable MN income
<u>- 250.00</u>	MN limit for 1 (Group II)
\$2,230.00	spenddown liability for month

She is placed on a monthly spenddown for each month in the 12-month certification period beginning *July 1*. On *August 2*, she submits expenses for *July*. The private CBC rate is \$14 per hour, 5 hours per day or \$70 per day, for a total of \$2,170 for *July* (31 days). The private cost of care, \$2,170, is less than her spenddown liability of \$2,230. Therefore, the worker must complete a day-by-day calculation to determine Mrs. Bly's eligibility for *July*:

\$2,230.00	spenddown liability 7-1
<u>- 140.00</u>	CBC private pay rate for 7-1 & 7-2 @ \$70 per day.
2,090.00	spenddown balance on 7-3
- 145.50	45.50 Medicare + 100.00 health ins. premium paid 7-3
<u>- 1,890.00</u>	private pay for 27 days @ \$70 per day 7-3 through 7-29
54.50	spenddown balance at beginning of 7-30
<u>- 70.00</u>	CBC private pay for 7-30
\$ 0	spenddown met on 7-30

Mrs. Bly met her spenddown on *July 30*. On *August 3*, the worker enrolls her in Medicaid with the begin date of *July 1* and end date *July 31*, application date *July 1*. To determine her patient pay, the community spouse monthly income allowance is calculated:

\$1,406.25	monthly maintenance needs standard
<u>+ 525.00</u>	excess shelter allowance
1,931.25	MMMNA (minimum monthly maintenance needs allowance)
<u>- 1,800.00</u>	community spouse's gross income
\$ 131.25	community spouse allowance

Mrs. Bly's patient pay for *July* is calculated as follows:

\$2,000.00	SSA
<u>+ 500.00</u>	private pension
2,500.00	gross patient pay income
- 512.00	maintenance allowance
<u>- 131.25</u>	community spouse allowance
1,856.75	
<u>- 145.50</u>	noncovered 45.50 Medicare + 100.00 health ins. premium
\$1,711.25	remaining income

Mrs. Bly's remaining income of \$1,711.25 is greater than the Medicaid rate for *July* of \$1,705, so her patient pay for *July* is the Medicaid rate of

\$1,705. The worker notifies her of her Medicaid coverage dates and her patient pay for July, and sends a DMAS-122 to the CBC provider for July only.

From her July income of \$2,500, Mrs. Bly must pay the Medicaid rate of \$1,705 to the CBC provider. Medicaid will not pay for any of her CBC care in July because she is responsible for the whole Medicaid rate; Medicaid will cover all other medical services except her Medicare & health insurance premiums. She has \$795 left with which to meet her maintenance needs (\$512), pay the community spouse allowance, and pay her Medicare and health insurance premiums, a total of \$788.75. She has \$6.25 left from her July income. Medicaid will assume responsibility for \$525 of her spenddown liability (\$2,230 - 1,705 patient pay = \$525).

On August 25, she requests evaluation of her spenddown for August. She was reimbursed \$465 on August 22 by the CBC provider, which was deposited into her bank account. The worker verifies that her resources exceed the Medicaid resource limit in August. The worker sends her a notice denying Medicaid for August because of excess resources, and stating that she must reapply for Medicaid if she reduces her resources and wants to be placed on spenddown again.

M1480.480 PACE – MN INSTITUTIONALIZED SPOUSE PATIENT PAY

A. Policy

An institutionalized spouse who is screened and approved for PACE services, and whose income exceeds the 300% SSI income limit, is placed on a monthly spenddown. The individual's spenddown liability and the PACE monthly rate (minus the Medicare Part D premium) establish whether the spenddown eligibility determination can be projected or must be determined retrospectively. The instructions for determining spenddown eligibility for MN institutionalized spouse PACE recipients is in M1480.340

If the spenddown is met, Medicaid coverage begins the first day of the month in which the spenddown is met and a patient pay for the month is calculated. If spenddown eligibility is projected, the patient pay is not calculated monthly as long as the monthly PACE rate (minus the Medicare Part D premium), income and allowances remain the same. If spenddown eligibility is determined retrospectively, the patient pay is calculated month-by-month.

Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay his personal needs, community spouse and family member allowances, and noncovered expenses. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability. Payment of part or all of the spenddown liability is permitted under Section 1924 (d) of the Social Security Act.

B. Procedures

The institutionalized spouse's spenddown eligibility was determined in section M1480.340 above. His patient pay must be determined using the procedures below.

1. Calculate Available Income for Patient Pay

a. Determine Gross Monthly Patient Pay Income

Determine the institutionalized spouse's patient pay gross monthly income according to section M1480.330 (including any amounts excluded in determining MN countable income and the spenddown liability).

b. Subtract Allowable Deductions

Deduct the following from the patient pay gross monthly income, in the following order as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.

- 1) a personal maintenance allowance (per section M1480.430 C.),*
- 2) a community spouse monthly income allowance, if appropriate (per section M1480.430 D.),*
- 3) a family member's monthly income allowance, if appropriate (per section M1480.430 E.),*
- 4) allowable noncovered medical expenses (per section M1470.530) including any old bills, carry-over expenses and other noncovered expenses that were used to meet the spenddown, but NOT including the cost of the community-based care.*
- 5) a home maintenance deduction, if appropriate (per section M1480.430 G.).*

The result is the remaining income for patient pay.

2. Patient Pay

Compare the remaining income for patient pay to the monthly PACE rate (minus the Medicare Part D premium) for the month. The patient pay is the lesser of the two amounts.

3. DMAS-122

Complete and send a DMAS-122 form to the PACE provider. For retrospectively-determined spenddowns, indicate the individual's begin and end date of Medicaid coverage in the month, and the patient pay for the month.

4. Notice of Obligation

Complete and send a "Notice of Obligation for Long-term Care" to the recipient and/or his authorized representative indicating the patient pay. For retrospectively-determined spenddowns, indicate the individual's begin and end date of Medicaid coverage in the month, and the patient pay for the month.

M1480.500 NOTICES AND APPEALS

M1480.510 NOTIFICATION

A. Notification

Send written notices to the institutionalized spouse, the authorized representative and the community spouse advising them of:

- the action taken on the institutionalized spouse’s Medicaid application and the reason(s) for the action;
- the resource determination, the income eligibility determination, and the patient pay income, spousal and family member allowances and other deductions used to calculate patient pay;
- the right to appeal the actions taken and the amounts calculated.

B. Forms to Use

1. Notice of Action on Medicaid (form #032-03-0008)

The EW must send the “Notice of Action on Medicaid (Title XIX) and Children’s Medical Security Insurance Plan (Title XXI Program)” to the applicant/recipient and the person who is authorized to conduct business for the applicant to notify him of the Agency's decision on the initial Medicaid application, and on a redetermination of eligibility when a recipient starts Medicaid-covered LTC services.

2. Notice of Obligation for Long-Term Care Costs (#032-03-0062)

The “Notice of Obligation for Long-term Care Costs” notifies the patient of the amount of patient pay responsibility. The “Agency” copy of the form should be signed and returned by the person to whom it is sent to acknowledge notification of his responsibility to pay the LTC provider.

Failure to return a signed form has no impact on the individual’s eligibility status. Processing of the application shall not be delayed pending the return of the signed form. This form is a voluntary agreement only.

3. Patient Information DMAS-122

The Patient Information form DMAS-122 is a two-way communication form designed to facilitate communication between the local agency and the LTC services provider. Sometimes, the DMAS-122 is initiated by the local agency; sometimes, the form is initiated by the LTC provider.

The DMAS-122 form

- notifies the LTC provider of a patient’s Medicaid eligibility status;
- provides confirmation of the amount of income an eligible patient must pay to the provider toward the cost of care;
- reflects changes in the patient's level of care;
- documents admission or discharge of a patient to an institution or community-based care services, or death of a patient;

- provides other information known to the provider that might cause a change in eligibility status or patient pay amount.

a. When to Complete A DMAS-122

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

The EW must update the DMAS-122 and send it to the provider at least once per year (even if the patient pay does not change). If the patient pay does not change, the updated DMAS-122 can be sent when the annual redetermination is completed.

b. Where To Send A DMAS-122

1) Facility Patients

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

2) Medicaid CBC Waiver Patients

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

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

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

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

d) For DD waiver recipients, send the DMAS-122 to the Case Manager.

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

health provider. If the patient receives both personal care and adult day health, send the DMAS-122 to the personal care provider.

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

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

c. Revising DMAS-122 Forms

DMAS-122 forms are not revised retroactively (after the month in question has passed) EXCEPT when

- the patient dies, or
- the patient moves to another facility or changes LTC providers.

Go to subchapter M1470 for detailed instructions for completing and revising the DMAS-122 form.

4. Resource Assessment Forms

The forms used for a resource assessment when no Medicaid application is filed are described in section M1480.210 (above). The resource assessment form that is used with a Medicaid application is described in section M1480.220 (above). Copies of the forms are included in Appendix 1 and Appendix 2 to this subchapter.

M1480.520 APPEALS

A. Client Appeals

The institutionalized spouse, the community spouse, or the authorized representative for either, has the right to appeal any action taken on a Medicaid application. The Medicaid client appeals process applies.

B. Appealable Issues

Any action taken on the individual's Medicaid **application** and receipt of Medicaid services may be appealed, including:

- spousal share determination,
- initial resource eligibility determination,
- spousal protected resource amount (PRA),
- resource redetermination,
- community spouse resource allowance (CSRA),
- income eligibility determination,
- patient pay and/or allowances calculations.

SEPARATED SPOUSE EXPECTED CONTRIBUTION SCALE - INSTITUTIONALIZED RECIPIENTS

1. Determine the number of dependent children living with the institutionalized individual's separated spouse who are not "other family members" (as defined in Subchapter M1480). The separated spouse counts as 1 dependent. Only the separated spouse's own child(ren), whose other parent is not the institutionalized spouse, can be a dependent for this scale's purposes.
2. Determine the separated spouse's gross monthly income. If the income falls between two numbers on the scale, use the next lower figure. If the spouse has court-ordered support or an allowance from the institutionalized spouse, the separated spouse does not have an expected contribution.
3. Locate the separated spouse's gross income in the first column; locate the expected contribution under the column indicating the number of dependents. (The scale does not differ for the locality groupings because the spousal maintenance standard is a statewide standard and geographical differentials are not allowed). For monthly income over \$4,900, add \$10 to the last contribution amount on the scale for each additional \$100 of monthly income.

Gross Monthly Income	# of dependents in household				
	1	2	3	4	5
\$1,900	0	0	0	0	0
\$2,000	15	0	0	0	0
\$2,100	25	15	0	0	0
\$2,200	35	25	15	0	0
\$2,300	45	35	25	15	0
\$2,400	55	45	35	25	15
\$2,500	65	55	45	35	25
\$2,600	75	65	55	45	35
\$2,700	85	75	65	55	45
\$2,800	95	85	75	65	55
\$2,900	105	95	85	75	65
\$3,000	115	105	95	85	75
\$3,100	125	115	105	95	85
\$3,200	135	125	115	105	95
\$3,300	145	135	125	115	105
\$3,400	155	145	135	125	115
\$3,500	165	155	145	135	125
\$3,600	175	165	155	145	135
\$3,700	185	175	165	155	145
\$3,800	195	185	175	165	155
\$3,900	205	195	185	175	165
\$4,000	215	205	195	185	175
\$4,100	225	215	205	195	185
\$4,200	235	225	215	205	195
\$4,300	245	235	225	215	205
\$4,400	255	245	235	225	215
\$4,500	265	255	245	235	225
\$4,600	275	265	255	245	235
\$4,700	285	275	265	255	245
\$4,800	295	285	275	265	255
\$4,900	305	295	285	275	265

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M1510.000 ENTITLEMENT POLICY & PROCEDURES

M1510.100 MEDICAID ENTITLEMENT

- A. Policy** If an individual meets all eligibility factors within a month covered by the application, eligibility exists for the entire month *unless the individual became eligible by meeting a spenddown.*
- 1. Spenddown Met** If the applicant had excess income and met the spenddown within the month, he remains responsible for his spenddown liability and his coverage begin date cannot be any earlier than the date he met the spenddown.
- 2. Applicant Dies** *If an applicant dies during the application process, his eligibility is determined only for the days he was alive. He must have been eligible for Medicaid while he was alive in order to be entitled to enrollment in Medicaid. Any changes in the individual's resources or income after his death do not affect the eligibility determination.*
- Example: An individual applies on July 23 for retroactive and ongoing Medicaid. The worker determines that the individual had excess resources(cash value of life insurance) throughout the retroactive period and the application month. The individual dies on August 5. The family asserts that he no longer owned the life insurance policies on August 5 and meets the resource requirements for the month of August. The worker determines that the individual owned the policies on the date of his death, the countable value exceeded the resource limit and he was not eligible for medical assistance on or before the date of his death.*
- B. SSI Entitlement Date Effect on Medicaid** SSI payments for eligible individuals are effective the first day of the month following the month in which the SSI application was filed. Medicaid coverage for eligible individuals is effective the first day of the month in which the Medicaid application is filed. When the Medicaid application is filed in the same month as the SSI application, the applicant is not eligible for Medicaid as an SSI recipient until the month in which his SSI entitlement began - the month following the application month. His eligibility for Medicaid in the application month must be determined in another covered group.
- C. Procedures** The procedures for determining an eligible individual's Medicaid coverage entitlement are contained in the following sections:
- M1510.101 Retroactive Eligibility & Entitlement
 - M1510.102 Ongoing Entitlement
 - M1510.103 Disability Denials
 - M1510.104 Foster Care Children
 - M1510.105 Delayed Claims

M1510.101 RETROACTIVE ELIGIBILITY & ENTITLEMENT

A. Definitions

- 1. Retroactive Period** The retroactive period is the three months immediately prior to the application month. Within this retroactive period, the individual may be CN, CNNMP or MI in one or two months and MN in the third month, or any other combination of classifications.
- 2. Retroactive Budget Period** The "budget period" is the period of time during which an individual's income is calculated to determine income eligibility. The retroactive budget period depends on the individual's covered group.

B. Policy

An application for Medicaid or Auxiliary Grants (AG) is also an application for retroactive Medicaid coverage whenever the applicant reports that he/she received a Medicaid-covered service in retroactive period. Eligibility for retroactive coverage is determined at the same time as the ongoing eligibility is determined, using the same application.

If the applicant reports receipt of a hospital service within the month immediately preceding the application month, the application date is within 30 days of the hospital service, and the applicant is not eligible for retroactive Medicaid, the applicant's eligibility for SLH must be determined.

When an applicant reports that he/she, or anyone for whom he/she is applying, received a Medicaid covered service in any one of the three retroactive months, determine the applicant's eligibility for all three retroactive months, regardless of the service date. Determine nonfinancial, resource and income eligibility for each month in the retroactive period.

C. Budget Periods By Classification

- 1. CN, CNNMP, MI** The retroactive budget period for categorically needy (CN), categorically needy non-money payment (CNNMP) and medically indigent (MI) covered groups (categories) is one month.

CN, CNNMP or MI eligibility is determined for each month in the retroactive period, including a month(s) that is in a prior spenddown that was not met. Do not determine eligibility for a retroactive month that was included in a previous Medicaid coverage period; the applicant has already received Medicaid for that month.

NOTE: There is never any retroactive eligibility or entitlement as a Qualified Medicare Beneficiary (QMB) only. An individual who is eligible as Special Low-income Medicare Beneficiary (SLMB) or Qualified Disabled & Working (QDWI) can have retroactive coverage as an SLMB or QDWI.
- 2. Medically Needy (MN)** In the retroactive period, the **MN budget period is always all three months** in the retroactive period. Unlike the CN, CNNMP or MI, the retroactive MN budget period may include a portion of a prior Medicaid coverage or

spenddown period, and may also include months in which he is eligible as CN, CNNMP or MI.

D. Verification

The applicant must verify all eligibility requirements in a retroactive month in order to be eligible for Medicaid coverage in that month.

If the applicant fails to verify any required eligibility factor for a retroactive month, coverage **for that month** must be denied because of failure to verify eligibility. If he verifies all eligibility factors for the other months in the retroactive period, he may be eligible for CN, CNNMP or MI retroactive coverage for those months.

EXAMPLE #1: Ms. A applied for Medicaid for herself and her children on July 8. She reported receiving a Medicaid covered service in each retroactive month. The retroactive period is April 1 through June 30. She currently receives Unemployment Compensation; she lost her job in May. She provided all required verification for May and June, but did not provide income verification for April. Their application was approved for MI Medicaid coverage beginning May 1; April coverage was denied because of failure to verify income for April.

his local agency a Medicaid application which is received on August 18. The facility's statement notes that he will be discharged on September 17 to ABC Nursing Home, a nursing facility. The agency completes the determination on August 27 and finds that he will be eligible once he is discharged to the nursing facility.

The agency does not enroll Mr. A until the discharge is confirmed. The CSB case manager calls the agency on September 21 and informs the agency that the patient was discharged to the ABC Nursing Home on September 18. The patient is enrolled in Medicaid with a begin date of September 18.

B. Coverage End Date

Medicaid entitlement ends the last day of the month in which the recipient fails to meet all of the Medicaid eligibility requirements, unless the recipient is an MI pregnant woman or is age 21-64 and admitted to an IMD or other ineligible institution (see below).

Medicaid coverage is canceled on the last day of the month in which the agency determines that the recipient no longer meets the eligibility requirements IF the agency can send an advance notice to the recipient at least 11 days before the last day of the month. If the agency cannot send the notice at least 11 days before the end of the month, coverage is canceled effective the last day of the next month.

1. MI Pregnant Woman

For an eligible MI pregnant woman, entitlement to Medicaid continues after eligibility is established regardless of any changes in family income, as long as she meets the pregnant category (during pregnancy and the 60-day period following the end of pregnancy) and all other non-financial criteria.

2. Individual Age 21-64 Admitted to Ineligible Institution

a. Entitlement - applicants

For a Medicaid enrollee age 21-64 years, entitlement to Medicaid begins on the first day of the application month and ends on the date following the date he is admitted to an IMD or other ineligible institution. When enrolling the individual in the MMIS, enter the begin date and the end date of coverage.

b. Cancel procedures for ongoing enrollees

Cancel coverage as soon as possible after learning of the enrollee's admission to an ineligible institution. **DO NOT cancel coverage retroactively.** Cancel coverage in the MMIS effective the date the cancel transaction is done in the MMIS, using cancel reason code "008."

c. Notice

An Advance Notice of Proposed Action is not required. Send a Notice of Action to the enrollee or his authorized representative informing him of the cancel date and the reason.

**3. Spenddown
Enrollees**

Medicaid entitlement ends on the last day of the last month in the spenddown budget period, unless the individual's or family's circumstances change before that date.

**C. Ongoing Entitle-
ment After
Resources Are
Reduced**

When an applicant has excess resources throughout the application month, he is not eligible for Medicaid for the month of application. An applicant who reduces excess resources during the month of application or a subsequent month before action is taken on the application may become eligible in the month in which the value of his resources is reduced to, or below, the Medicaid resource limit. In order to reduce resources, the resources must actually be expended and the expenditure documented. (For example: a receipt, a canceled check, or a bank statement).

Reduction of resources is an asset transfer and must be evaluated under asset transfer policy (subchapter M1450).

When excess resources are reduced, entitlement to ongoing Medicaid may begin no earlier than the first day of the month in which the resources were reduced to the Medicaid limit. When retroactive coverage is requested, policy in M1510.101 above must be followed.

M1510.103 DISABILITY DENIALS

A. Policy

When an individual concurrently applies for SSI or SS and Medicaid as disabled, and either the DDS or the Social Security Administration (SSA) denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.

When an individual applies for Medicaid as disabled or concurrently applies for SS/SSI and Medicaid as disabled, and DDS denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.

B. Procedures

**1. Subsequent
SSA/SSI
Disability
Decisions**

The SSA disability decision takes precedence over a DDS decision (DDS will make a decision before SSA if SSA does not take action within the 90-day Medicaid application processing time). If SSA denies disability and the decision is appealed and subsequently reversed, reopen and re-evaluate the denied Medicaid application. The original application is used as long as the application was denied because the individual was not disabled and the subsequent disability onset date is within 90 days of the application. If the re-evaluation determines that the individual is eligible, entitlement is based on the date of the Medicaid application and the disability onset date. If the denied application is more than 12 months old, a redetermination using current information must also be completed.

be included in the TPL section of the *MMIS* eligibility file maintained by the Department of Medical Assistance Services.

b. Applicants Who Cannot Produce a Claim Number

In the event the applicant either does not have a Medicare card or does not know his claim number, inquire SSA via the SVES (State Verification Exchange System) using the applicant's own SSN.

If the applicant has never applied for Medicare, complete the Referral to Social Security Administration Form DSS/SSA-1 (form #032-03-099) and write in, "Buy-In" on the upper margin. Mail the form to the Social Security Office serving the locality in which the applicant resides. The SSA office will provide the correct claim number if the individual is on their records. Should the (local/area) SSA office have no record of an application for Medicare, a representative will contact the applicant to secure an application.

Should the applicant be uncooperative (not wish to apply) or be deceased, the Social Security Office will contact the local social services department and ask that agency to file the Medicare application in his behalf. A local department of social services must also submit an application for Medicare on behalf of an individual who is unable or unwilling to apply. When the local department must file a Medicare application, the local Social Security office will advise the local department of the procedure to follow.

4. Buy-in Begin Date

Some individuals have a delay in Buy-in coverage:

Classifications	Buy-in Begin Date
Category Needy Cash Assistance	1st month of eligibility
ABD MI (includes dually-eligible)	1st month of eligibility
Categorically Needy Non-money Payment and Medically Needy who are dually-eligible (countable income \leq 100% FPL and Medicare Part A)	1st month of eligibility
Categorically Needy Non-money Payment and Medically Needy who are not dually-eligible (countable income $>$ 100% FPL or no Medicare Part A)	3 rd month of eligibility

If the medically needy coverage begin date is other than the first day of a month, Buy-in is effective the first day of the month in which the 60th day after the begin date occurs.

D. Other Third Party Liability

When the agency identifies another third party which has responsibility to pay for a recipient's medical bill, the agency must report the third party to:

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

Examples of other third parties include liability insurance settlements, trust funds established for the recipient's medical care, awards resulting from liability lawsuits, and persons ordered by the court to pay for the recipient's medical care.

E. Pursuing Third Party Liability and Medical Support

In order to continue to be eligible for Medicaid, an individual who is required to assign rights to, and cooperate in, pursuing medical support and third party liability must continue to cooperate with the local agency and DMAS. See subchapter M0250 for details.

M1510.302 SOCIAL SECURITY NUMBERS

A. Policy

Applicants must provide the Social Security number (SSN) of any person for whom they request Medicaid, or must apply for a Social Security number if he/she does not have one. An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

When an individual has applied for an SSN and is determined eligible for medical assistance, the worker must take follow-up action to obtain the individual's SSN.

B. Procedures

See subchapter M0240 for the SSN application follow-up procedures required after enrolling an eligible individual who has applied for an SSN.

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.

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). *The individual may be eligible for the limited benefit family planning services covered group, Plan First. A Plan First Brochure or a Plan First Fact Sheet, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>, must be included with the Advance Notice of Proposed Action. Eligibility for Plan First is not determined unless the individual submits a Plan First application.*

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 *and the DMAS Recipient Audit Unit*). 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 *to follow up by requesting the appropriate verifications and/or sending advance notice, if necessary*, 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.

- 2. Renewal For SSI Recipient** The renewal for an SSI recipient who has no countable real property can be completed by verifying continued receipt of SSI through SVES and documenting the case record. The ex parte process cannot be used for an SSI recipient who owns non-exempt real property. He is subject to a resource evaluation and the agency has no internal means to verify all his resources.
- 3. Coordination With Other Benefit Programs** When an ongoing F&C Medicaid enrollee applies for Food Stamps or TANF, the income information obtained for the application can be used to complete an early Medicaid renewal and extend the Medicaid renewal to coincide with the Food Stamp certification period. However, failure to complete an early renewal must not cause ineligibility for Medicaid.
- 4. Medicaid Renewal Form Required** When a Medicaid Renewal form is required, the form must be sent to the enrollee no later than the 11th month of eligibility. The Medicaid Renewal form can be completed by the worker and sent to the enrollee to sign and return or can be mailed to the enrollee for completion. The eligibility worker must allow at least 10 days for receipt of the necessary verifications, but additional time may be allowed depending on the type of information requested. The specific information requested and the deadline for receipt of the verification must be documented.

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

- 6. SSN Follow Up** *If the enrollee's SSN has not been assigned by renewal, the worker must obtain the enrollee's assigned SSN at renewal in order for Medicaid coverage to continue. See subchapter M0240 for detailed procedures for obtaining the SSN.*

C. Special Requirements for Certain Covered Groups

- 1. Pregnant Woman** A renewal of eligibility of an MI pregnant woman is not required during her pregnancy. Eligibility as a pregnant woman ends effective the last day of the month in which the 60th day following the end of her pregnancy occurs.

When eligibility as a pregnant woman ends, determine if the woman meets the definition for another Medicaid covered group (see M0310.002). If the woman meets the definition of a full-benefit covered group, determine if an ex parte renewal can be completed or if a renewal form is required and take appropriate action.

If the woman does not meet the definition and/or the income requirements for another full-benefit covered group, she may be eligible for the limited benefit family planning services covered group, Plan First. A Plan First Brochure or a Plan First Fact Sheet, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>, must be included

with the Advance Notice of Proposed Action. Eligibility for Plan First is not determined unless the woman submits a Plan First application.

Do not use change transactions to move an individual between full and limited coverage.

2. Plan First (FPS) Review Requirements

Effective January 1, 2008, a Plan First application/renewal form must be filed for individuals (men and women) who request Medicaid coverage for family planning services only (see M0320.302). The application/renewal form is available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.

The ex parte renewal process cannot be used for this covered group.

3. Newborn Child Turns Age 1

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

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

4. Child Under Age 19 (FAMIS Plus)

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

When an enrolled FAMIS Plus child no longer meets the MI income limits, evaluate the child for the Family Access to Medical Insurance Security Plan (FAMIS) using the eligibility requirements in chapter M21. If the child is eligible for FAMIS, send the family an Advance Notice of Proposed Action that Medicaid will be cancelled effective the last day of the month in which the 10-day advance notice expires and the FAMIS coverage will begin the first day of the month following the Medicaid cancellation. Use cancel reason "042" when the child loses eligibility in Medicaid and is reinstated in FAMIS and there is no break in coverage.

Do not use change transactions to move a child between Medicaid and FAMIS.

If the child is not eligible for FAMIS, the worker must provide an opportunity for the child to be evaluated as medically needy prior to sending an advance notice and canceling the child's Medicaid coverage.

5. FAMIS Plus Child Turns Age 19

When a FAMIS Plus child turns age 19, redetermine the child's continuing Medicaid eligibility in other covered groups.

If information in the case record indicates that the child is disabled or may be disabled, verify the child's SSI benefits through SOLQ-I or SVES. If the child does not receive SSI, complete a referral to Disability Determination Services (DDS) following the procedures in M0310.112. The referral to DDS should be made at least 90 calendar days prior to the child's 19th birthday.

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

- 6. Child Turns Age 21**
- When an enrollee who is enrolled as a child under age 21 attains age 21, determine from the case information if the enrollee meets a definition for another covered group, such as blind, disabled, or pregnant woman.
- 7. IV-E FC and AA and Special Medical Needs AA Children From Another State**
- For FC or AA children placed by another state's social services agency, verification of continued IV-E eligibility status or non-IV-E special medical needs status, current address, and TPL can be obtained from agency records, the parent or the other state.
- 8. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)**
- The BCCPTA Redetermination, form #032-03-653, is used to redetermine eligibility for the BCCPTA covered group. The renewal form is available online at: <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.html>. The enrollee must provide a statement from her medical provider verifying continued treatment for breast or cervical cancer. There are no Medicaid financial requirements for the BCCPTA covered group.
- 9. SSI and QSII (1619(b)) Covered Group Recipients**
- For recipients enrolled in the SSI and QSII Medicaid covered groups, the ex parte renewal consists of verification of continued SSI or 1619(b) status by inquiring SOLQ-I or SVES.
- If the individual is no longer an SSI recipient or no longer has 1619(b) status and the information needed to determine continued eligibility is not known to the agency, a Medicaid Renewal, form #032-03-699, must be completed and necessary verifications obtained to allow the eligibility worker to evaluate the individual's eligibility in all other covered groups prior to canceling his Medicaid coverage.
- D. Recipient Becomes Institutionalized**
- When a recipient is admitted to long-term care in a medical facility or is screened and approved for Medicaid waiver services, eligibility as an institutionalized individual must be determined using the policies and procedures in chapter M14.
- E. LTC**
- LTC recipients, other than those enrolled in the Medicaid SSI covered group, must complete the Medicaid Redetermination for LTC, form #032-03-369 available at <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi> for the annual renewal. The DMAS-122 must be updated at least every 12 months even when there is no change in the patient pay.
- Ongoing eligibility for LTC recipients enrolled in the Medicaid SSI covered group can be established through an ex parte renewal, i.e., SVES inquiry.

M1520.400 MEDICAID CANCELLATION OR SERVICES REDUCTION

M1520.401 NOTICE REQUIREMENTS

A. Policy

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

The Advance Notice of Proposed Action is available on the intranet at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.

B. Change Results in Adverse Action

1. Services Reduction

When information is secured that results in a reduction of Medicaid services to the *enrollee* or a reduction in the Medicaid payment for the *enrollee*'s services (when the patient pay increases), the "Advance Notice of Proposed Action" must be sent to the *enrollee* at least 10 days plus one day for mail, before the adverse action is taken.

If the *enrollee* requests an appeal hearing before the effective date, the *enrollee* 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 *enrollee*, 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). If the *enrollee* requests an appeal hearing before the effective date of the action *and the DMAS Appeals Division* notifies the local agency *that the enrollee's coverage must be reinstated during the appeal process, reinstate the enrollee's coverage in the MMIS. Do not reinstate coverage until directed to do so by the DMAS Appeals Division.*

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

2. Adverse Action Resulting from Computer Matches

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

Medicaid coverage will terminate if the child(ren) in the family turns age 18, or turns age 19 if the child is in school.

The family unit must be instructed to retain verifications of all earnings received during each month of the extension, and to send the "Medicaid Extension Earnings Report" and attach verifications of the first three-month period's earnings to the agency by the 21st day of the fourth month in the extension period.

The names of the three months in the three-month period must be written out on the notice form and the report form whenever either form is sent to the family unit.

2. Third Month of Extension

In the third month of extension, the unit must be notified that it must return the "Medicaid Extension Earnings Report", with the earnings verifications attached, to the agency by the 21st of the following month (the fourth month).

This notice will be sent automatically by the Medicaid computer if the correct follow-up code and effective date of the 12-month extension are entered in the base case information fields. If the code and effective date are not entered correctly or in a timely manner, the agency must manually send the notice.

The notice will state that if the earnings report and verifications are not received by the 21st day of the fourth month, Medicaid coverage will be canceled effective the last day of the sixth month, and that the family will not be eligible for any additional Medicaid extension.

3. Fourth Month of Extension

If the first three-month period's report is not received by the 21st day of the fourth month, the family is not eligible for the additional six-month extension. Medicaid must be canceled effective the last day of the sixth month in the extension period.

a. Notice Requirements

The Medicaid computer will send the advance notice and automatically cancel coverage at the end of the sixth month if the initial follow-up code and extension effective date were entered correctly, and the code is not updated because the report was not received on time. If the code was not entered correctly, the agency must manually send the advance notice of Medicaid cancellation and must cancel the family's coverage in the computer after the Medicaid cut-off date in the fifth month. The effective date of cancellation will be the last day of the sixth month in the extension period.

b. Determine Child(ren)'s Eligibility

The child(ren)'s eligibility for Medicaid *in* another covered group or for FAMIS must be determined before canceling coverage. Contact the recipient and request current verification of the family's total income, including earned and unearned income. If the child is eligible, change the

child's enrollment to the appropriate aid category **before the cut-off date** of the sixth extension month. If not eligible, leave the child's enrollment (and the base case follow-up code and follow-up date fields) as it is and the computer will cancel the child's coverage.

If the child(ren)'s eligibility is not reviewed by the **cut-off date** of the sixth extension month, the computer will cancel coverage. The agency must then reopen the child(ren)'s Medicaid if the child(ren) is determined eligible and must notify the recipient of the reopened coverage.

c. Report Received Timely

If the first three-month period's report is received by the 21st day of the fourth month, and the family continues to include a child, entitlement to extended Medicaid continues. The follow-up code must be changed in the Medicaid computer base case information when the report is received in order for Medicaid to continue. No action is taken on the first three-month period's earnings and the extension continues.

4. Sixth Month of Extension

In the sixth month of extension, the unit must be notified that it must return the "Medicaid Extension Earnings Report" for the previous three-month period (the fourth through the sixth month) with the earnings verifications for those three months attached, to the agency by the 21st day of the seventh month of extension.

The notice must state that if this three-month period's report and verifications are not returned by the 21st day of the seventh month, Medicaid coverage will be canceled effective the last day of the eighth month of extension.

The Medicaid computer will automatically send this notice if the follow-up code in the base case information is correct. If it is not correct, the agency must manually send this notice.

5. Seventh Month of Extension

If the second three-month period's report and verifications are not received by the 21st of the seventh month, the family's Medicaid coverage must be canceled after an Advance Notice of Proposed Action is sent. The Medicaid computer will send the advance notice and automatically cancel coverage if the report is not received on time and the code is not changed.

Medicaid coverage must be canceled unless the family establishes good cause for failure to report on a timely basis. Examples of good cause for failure to report timely are, illness or injury of family member(s) who is capable of obtaining and sending the material; agency failure to send the report notice to the family in the proper month of the extension.

a. Determine Child(ren)'s Eligibility

The child(ren)'s eligibility for Medicaid in another covered group or for FAMIS must be determined before canceling coverage. Contact the recipient and request current verification of the family's total income, including earned and unearned income. If the child is eligible, change the child's enrollment to the appropriate aid category before the **cut-off date** of the eighth extension

month. If not eligible, leave the child's enrollment (and the base case follow-up code and follow-up date fields) as it is and the computer will cancel the child's coverage.

If the child(ren)'s eligibility is not reviewed by the **cut-off date** of the eighth extension month, the computer will cancel coverage. The agency must then reopen coverage and notify the recipient if the child is found eligible.

b. Cancellation Effective Date

Cancellation is effective the last of the eighth month of extension.

c. Report Received Timely

If the second three-month period's report is received by the 21st of the seventh month, change the base case follow-up code in the Medicaid computer immediately upon receipt of the report and verifications. The family will continue to be eligible for extended Medicaid coverage unless:

- 1) no child under age 18, or under age 19 if in school, lives with the family;
- 2) the family disenrolls from a group health plan that DMAS has determined cost-effective or fails to pay the premium to maintain the group health plan;
- 3) the caretaker/relative had no earnings in one or more of the previous three months, unless the lack of earnings was due to the caretaker/relative's involuntary lay-off, the business closed, etc., the caretaker/relative's illness or injury, or other good cause (such as serious illness of child in the home which required the caretaker/relative's absence from work); or
- 4) the family unit's average gross monthly **earned** income (earned income only; unearned income is not counted) less costs for child care that was necessary for the employment of the caretaker/relative, during the preceding three-month period exceeds the 185% poverty income limit appropriate to the family unit size.

See subchapter M0710, Appendix 7 for the 185% poverty income limits.

d. Calculate Family's Gross Earned Income

- 1) The "family's" gross earned income means the earned income of all family unit members who worked in the preceding three-month period. "Gross" earned income is total earned income before any deductions or disregards. All earned income must be counted, including students' earned income, JTPA earned income, children's earned income, etc. No disregards are allowed.
- 2) Child care costs that are "necessary for the caretaker/relative's employment" are expenses that are the responsibility of the caretaker/relative for child care that if not provided would prevent the caretaker/relative from being employed.

3) To calculate average gross monthly income:

- add each month's cost of child care necessary for the caretaker/relative's employment; the result is the three-month's cost of child care necessary for the caretaker/relative's employment.
- add the family unit's total gross earned income received in each of the 3 months; the result is the family's total gross earned income.
- subtract the three-months' cost of child care necessary for the caretaker/relative's employment from the family's total gross earned income.
- divide the remainder by 3; the result is the average monthly earned income.
- compare the average monthly earned income to the monthly 185% poverty limit for the appropriate number of family unit members.

e. Family No Longer Entitled To Extended Medicaid

- 1) If the family is not entitled to further Medicaid coverage because of one of the reasons in item 5.c. above, each family member's eligibility for Medicaid *in* another covered group must be determined before canceling coverage.

Contact the recipient and request current verification of the family's total income, including earned and unearned income. If eligible, change the enrollment to the appropriate aid category before cut-off in the eighth extension month.

- 2) If the family is ineligible because of excess income, cancel Medicaid coverage. If any of the family members are eligible for FAMIS or FAMIS MOMS, enroll them in FAMIS or FAMIS MOMS, and transfer the case to the FAMIS Central Processing Unit (CPU).
- 3) If any of the ineligible family members meet a medically needy covered group definition, send an Application for Benefits to the family giving them the opportunity to apply for spenddown.

f. Family Remains Entitled To Extended Medicaid

If the family remains eligible for the extension, no action is required until the ninth month of extension, except to be sure that the follow-up code was updated in the computer when the income report was received.

6. Ninth Month of Extension

In the ninth month of extension, the unit must be notified that it must return the "Medicaid Extension Earnings Report" with earnings verifications attached, for the previous three-month period (seventh through

**DMHMRSAS Facilities
Medicaid Technicians**

NAME	LOCATION	WORK TELEPHONE	CASELOAD
Brenda Wolhfert, Supervisor	Central Virginia Training Center Medicaid Office Madison Heights, VA Mail to: P. O. Box 1098 Lynchburg, VA 24505	434-947-2754 cell 434-906-0024	CVTC-caseload-A-H
Mary Lou Spiggle	Central Virginia Training Center Medicaid Office Madison Heights, VA Mail to: P. O. Box 1098 Lynchburg, VA 24505	434-947-6256	CVTC-caseload-I-Z PGH-caseload-H-Z WSH-caseload-all NVMHI-caseload-all SVMHI-caseload-all
Janet Benton	Central State Hospital Medicaid Office P. O. Box 4030 Petersburg, VA 23803	804-524-7582	SSVTC-caseload-all Hiram-Davis-caseload-all PGH-caseload-A-G
Debra J. Quesenberry	Catawba Hospital Medicaid Office P. O. Box 200 Catawba, VA 24070	540-375-4350	Catawba-caseload-all NVTC-caseload-all
Frances Jones	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0841	SWVTC-caseload-all ESH-caseload-A-J
Terri Neel-Kinder	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0842	SEVTC-caseload-all ESH-caseload-K-Z SWVMHI-caseload-all

NOTE: Because the Medicaid Technicians handle various hospitals in their caseloads, LDSS staff should send transferred case records directly to the Medicaid Technician who requested the case record. In the case record transfer request, the Medicaid Technician will give specific instructions about where to send the case record.

DMHMRSAS Facilities:

<i>FIPS</i>	<i>Facility Initials and Full Name</i>
997	Catawba – Catawba Hospital
990	CVTC – Central Virginia Training Center
994	ESH – Eastern State Hospital
988	NVMHI – Northern Virginia Mental Health Institute
986	NVTC – Northern Virginia Training Center
993	PGH – Piedmont Geriatric Hospital
985	SEVTC – Southeastern Virginia Training Center
989	SSVTC – Southside Virginia Training Center
983	SVMHI – Southern Virginia Mental Health Institute
992	SWVMHI – Southwestern Virginia Mental Health Institute
984	SWVTC – Southwestern Virginia Training Center
991	WSH – Western State Hospital

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M1700 MEDICAID FRAUD AND RECOVERY

M1700.100 INTRODUCTION

A. Administering Agency The Department of Medical Assistance Services (DMAS) is responsible for the investigation and referral of fraudulent and erroneous payments made by the Medicaid Program. DMAS can recover any payment erroneously made for services received by a Medicaid recipient or former Medicaid recipient. Recovery can be made from the recipient or the recipient's income, assets, or estate, unless such property is otherwise exempted from collection efforts by State or Federal law or regulation.

A. Utilization Review Recipients' utilization of all covered services is monitored regularly by DMAS. Whenever the utilization of services is unusually high, the claims for services are reviewed for medical necessity. If some services are considered not medically necessary, the recipient will be contacted by the DMAS Recipient Monitoring Unit.

DMAS also reviews hospital claims prior to payment to determine if the 21-day limit is exceeded or if the length of stay regulations are met. All provider claims are reviewed and audited after payment.

M1700.200 FRAUD

A. Definitions Fraud is defined as follows:

"Whoever obtains, or attempts to obtain, or aids and abets a person in obtaining, by means of a willful false statement or representation, or by impersonation, or other fraudulent device, assistance or benefits from other programs designated under rules and regulations of the State Board of Social Services or State Board of Health to which he is not entitled, or fails to comply with the provisions of 63.2-522, 32.1-321.1, 32.1-321.2, 1-112, shall be deemed guilty of larceny..." (Code of Virginia, §63.1-124).

"If at any time during the continuance of assistance there shall occur any change, including but not limited to, the possession of any property or the receipt of regular income by the recipient, in the circumstances upon which current eligibility or amount of assistance were determined, which would materially affect such determination, it shall be the duty of such recipient immediately to notify the local department of such change, and thereupon the local board may either cancel the assistance, or alter the amount thereof." (Code of Virginia, §63.1-112).

B. DMAS Responsibilities

1. Recipient Fraud DMAS has sole responsibility for handling cases of suspected fraud by Medicaid recipients when eligibility for a public assistance payment is not involved (Medicaid only cases). Medicaid cases involving suspected fraud must be

referred to DMAS, Recipient *Audit* Unit, 600 E. Broad Street, Suite 1300, Richmond, Virginia 23219, using the format for the Recipient Fraud/Non-Fraud Referral in Appendix 1 to this chapter. The following information must be provided:

- recipient's name and Medicaid number;
- recipient's social security number;
- reasons for and exact dates of ineligibility for Medicaid;
- *applicable Medicaid applications or review forms for the referral/ineligibility period;*
- *address and telephone number of any attorney-in fact, authorized representative, or other individual who assisted in the application process;*
- *relevant covered group, income, resource, and/or asset transfer documentation;*
- *any record of communication between the agency and the client or representative, such as case narratives, letters, and notices; and*
- *information obtained from the agency's fraud investigation, including names and addresses of knowledgeable individuals for testimony and/or interviews.*

This format has been specifically designed to be used in conjunction with the DMAS Fraud Abuse Information Reporting System and the format must not be altered.

The current threshold for Administrative Recoveries of Medicaid fraud is \$300.00. It is not feasible for DMAS to pursue cases with losses less than this threshold. If there is a question regarding the amount of the loss of Medicaid funds, the local agency must submit a Medicaid Claims Request (see Appendix 2 to this chapter) to DMAS and obtain the amount of the loss. The local agency should allow a three-week turnaround for the documents. There may be exceptional circumstances when claims can be provided within a shorter time, i.e. expedited trial dates. The local agency must send the Recipient Fraud/Non-Fraud Referral to DMAS *with the Medicaid Claims Request form.*

There is **no** threshold for any case with criminal intent to defraud Medicaid.

2. Provider Fraud

Cases of suspected fraud involving enrolled providers of medical services to Medicaid recipients must be referred to the Medicaid Fraud Control Unit in the Office of the Attorney General. A copy of the information sent to the Medicaid Fraud Control Unit in the Office of the Attorney General must be sent to the Provider Review Unit, Department of Medical Assistance Services.

- 3. Suspected Fraud Involving Recipients of Public Assistance**
- a. Temporary Assistance for Needy Families (TANF) and Auxiliary Grant (AG) Cases**

Cases of suspected fraud involving ineligibility for a TANF or AG payment are the responsibility of the local department of social services. The local agency determines the period of ineligibility for Medicaid, and the DMAS Recipient Audit Unit provides the amount of Medicaid payments made. The amount of misspent Medicaid funds must be included in the TANF or AG fraud cases, whether the action results in prosecution or in voluntary restitution. The final disposition on all money payment fraud cases must be communicated to the Recipient Audit Unit, DMAS, no later than 5 business days after disposition for inclusion in federal reporting.

b. Food Stamps, General Relief (GR), Fuel, etc.

For suspected fraud involving Food Stamps, GR, Fuel, or other such assistance which does not directly relate to the provision of Medicaid, the local agency must notify the Recipient Audit Unit of the agency's action on the other assistance case so that Medicaid can take concurrent action if necessary.

C. Medicaid Ineligibility Following Fraud Conviction

1. Period of Eligibility

When an individual has been convicted of Medicaid fraud by a court, that individual will be ineligible for Medicaid for a period of 12 months beginning with the month of fraud conviction. Action to cancel the individual's Medicaid coverage must be taken in the month of conviction or in the month the agency learns of the conviction, using cancel reason 014 (*42 United States Code §1320a-7b.(a)(6)(ii); 12 Virginia Administrative Code 30-10-70*).

2. Who is Ineligible

a. TANF or Families and Children (F&C) Cases

In a TANF or F&C Medicaid case, only the parent/caretaker will be ineligible for Medicaid when the parent/caretaker has been convicted of Medicaid fraud. The TANF payment for the caretaker may not be affected.

b. Aged, Blind, Disabled (ABD) or Pregnant Women Cases

In an ABD or pregnant woman case, only the individual found guilty of Medicaid fraud will be ineligible. If only one spouse of a married couple is convicted, the eligibility of the innocent spouse is not affected.

3. Family Unit

If both spouses of an eligible couple are found guilty of fraud, neither is eligible for Medicaid. If only one member of a family unit is convicted of fraud, only that member's Medicaid coverage is canceled. The fraud conviction does not affect the composition of the family unit or the treatment of the family unit's income or resources. The convicted individual is included in the family unit according to Medicaid policy, but is not eligible for Medicaid coverage and is not enrolled.

M1700.300 NON-FRAUD RECOVERY

- A. Definition** The Virginia State Plan for Medicaid defines Non-Fraud Recovery as: "Investigation by the local department of social services of situations involving eligibility in which there is no reason to suspect that there has been deliberate misrepresentation by an applicant/recipient with intent to defraud." These cases are referred to DMAS when there is reason to suspect that an overpayment has occurred. (42 CFR§431).
- B. Recovery of Misspent Funds** DMAS has the authority to investigate cases and recover expenditures made for services received by ineligible enrollees without fraudulent intent. The situations in which recovery of expenditures are possible include, but are not limited to:
- when eligibility errors are due to recipient misunderstanding,
 - when agency errors are made, or
 - when medical services are received during the appeal process and the agency's cancellation action is upheld.
- C. Recovery of Funds Correctly Paid** Within specific restrictions, DMAS may recover funds correctly paid for medical services received by eligible recipients
- 1. Deceased Recipient's Estate** Under federal regulations and state law, DMAS may make a claim against a deceased enrollee's estate when the recipient was age 55 or over. The recovery can include any Medicaid payments made on his/her behalf. This claim can be waived if there are surviving dependents. **(42 CFR §433.36; Va. Code §32.1-326.1 and 32.1-327).**
- Section 1917(b)(1)(C)(ii) of the Social Security Act was amended by the Deficit Reduction Act of 2005 to exempt assets disregarded under a "qualified" Long-term Care (LTC) Partnership Policy from estate recovery, as defined in clause (iii) of 1917(b)(1)(C). The same amount of assets that was disregarded in the Medicaid eligibility determination for an individual under an LTC Partnership Policy will be protected during estate recovery.*
- 2. Uncompensated Property Transfers** DMAS may seek recovery when a Medicaid *enrollee* transferred property with an uncompensated value of more than \$25,000. The transferees (recipients of the transfer) are liable to reimburse Medicaid for expenditures up to the uncompensated value of the property or resource. The property transfer must have occurred within 30 months of the recipient (transferor) becoming eligible for or receiving Medicaid. **(Va. Code §20-88.02).**
- 3. Local DSS Referral** When an agency discovers a Medicaid case involving property transfers, a "Notice of Medicaid Fraud/Non-fraud Overissuance" (form # DMAS 751R; see M1700, Appendix 1) must be completed and sent to:

Supervisor
 Recipient Audit Unit
 Department of Medical Assistance Services
 600 East Broad Street, Suite 1300
 Richmond, Virginia 23219

Estate recoveries *and cases involving insurance-related recoveries* must be referred to:

Department of Medical Assistance Services
Attn: Third Party Recovery Unit
600 East Broad Street, Suite 1300
Richmond, VA 23219

or by e-mail to TPLunit@dmas.virginia.gov.

M1700.400 RESPONSIBILITY OF THE LOCAL DSS

A. Introduction

DMAS shares an interagency agreement with the *Virginia* Department of Social Services (VDSS) which lists specific responsibilities. Local departments of social services are responsible for referring and reporting the following situations to DMAS:

- Investigations "by the local department of social services of situations involving eligibility in which there is no reason to suspect that there has been deliberate misrepresentation by an applicant/recipient with intent to defraud"; and
- Instances where there is evidence that fraud may exist.

B. VDSS Responsibilities

To assist in the prevention of receipt of non-entitled services by enrollees, VDSS must use the "Notice of Medicaid Fraud/Non-fraud Overissuance" to:

- Notify DMAS of every known instance relating to a non-entitled individual's use of Medicaid services, regardless of the reason for non-entitlement;
- Cancel the eligibility of all persons convicted of public assistance fraud or medical assistance fraud to the extent allowable under federal and state regulations, using the cancel code for fraud convictions (Cancel Code 014);
- Notify DMAS of all instances in which a Medicaid recipient is a beneficiary of a discretionary trust and the trustee refuses to make the assets available for the medical expenses of the recipient, or when a Medicaid recipient has been found to be ineligible for Medicaid benefits as a result of a transfer of assets; and
- Include Medicaid expenditures in the computation of misspent funds, where a withholding or a deliberate misrepresentation of a pertinent fact has taken place and where a local social service agency will exercise jurisdiction in regard to prosecution of the case.

C. Recipient Audit Reporting

*The Recipient Audit Unit has two prevention efforts for reporting fraud and abuse of Medicaid services. Either may be used by DSS for reporting fraud and abuse **in conjunction with** the “Notice of Medicaid Fraud/Non-fraud Overissuance.”*

- *Referrals may be made through the web address, recipientfraud@dmas.virginia.gov.*
- *Referrals may also be made through the Recipient Audit fraud and abuse hotline. Both a local and a toll free number are available 24 hours daily for reporting suspected fraud and abuse: local (804) 786-1066; and toll free (866) 486-1971.*

D. Statute of Limitations

There is no "statute of limitations" for Medicaid fraud; cases that are referred for fraud should be flagged to ensure that the information is not purged. Cases cannot be properly investigated without specific documents, i.e. signed applications, bank statements, burial or insurance information. DMAS will notify the agency of the results of the fraud investigation.



COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services
Medicaid Claims Request

PATRICK FINNERTY
DIRECTOR

600 EAST BROAD STREET
RICHMOND, VA. 23219
PHONE: (804) 786-7933
FAX: (804)225-4512

Date: _____

Agency: _____

Worker's Name: _____

Phone No: _____

Recipient Audit Unit Supervisor
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Dear Supervisor:

I am conducting an investigation of the person(s) listed below for the time period indicated. Please forward proof of claims paid by Medicaid during the investigative period, if claims exceed the \$300.00 threshold (worker will be notified by telephone if claims are below the threshold).

Custodian Certificate/Claims needed? Y/N
Written referral following? Y/N
Expected Date to the CA: _____
Expected Court Date: _____

I will keep you informed of additional progress and of the outcome of this investigation.

Case Name: _____ Base ID#: _____

(a) _____ Recipient ID#: _____

Period of suspected fraud/overpayment: _____

(b) _____ Recipient ID#: _____

Period of suspected fraud/overpayment: _____

(c) _____ Recipient ID#: _____

Period of suspected fraud/overpayment: _____

(d) _____ Recipient ID#: _____

Period of suspected fraud/overpayment: _____

Sincerely,

CLAIMS REQUEST FORM INSTRUCTIONS

FORM NUMBER - DMAS 750R (7/08)

PURPOSE:

This form serves as a multi-purpose form. It can be used to receive certified claims from DMAS reporting the total expended amount of Medicaid services for the period of time in question. These claims are used in court testimony, as evidence against the defendant. Restitution is ordered based on the amount of claims in the form of a custodian certificate that is submitted by the supervisor of the Recipient Audit Unit. This information is notarized, and is attesting to the fact that the information is accurate and that the supervisor serves as the keeper of the records for DMAS. It can also be used if the agency would like to know if the claims exceed the Recipient Audit Unit amount of \$300.00 for Medicaid-Only referrals. This is helpful in determining whether or not the case should be referred to the Recipient Audit Unit for investigation.

NOTE: Providers have up to one year to bill for services, therefore the amount of claims may not be accurate or complete at the time of prosecution or inquiry. It is suggested that the Commonwealth's Attorney be advised of this information, should additional claims develop at a later time and additional restitution be requested by DMAS.

USE OF FORM – Request of recipient claims for any investigation conducted by the local agency as it relates to person(s) receiving a money grant under the Temporary Assistance for Needy Families and Food Stamp program(s). Also, request for an estimate of claims when determining whether or not the Medicaid-Only case meets the RAU threshold requirements.

NUMBER AND DISTRIBUTION OF COPIES – **Prepare original; make a copy for the agency record before sending to the Recipient Audit Unit at DMAS.**

INSTRUCTIONS FOR PREPARATION OF FORM – The form should contain the case name, the base case ID number, each recipient ID number and the period of suspected fraud/overpayment for each recipient. Each recipient should be listed separately as shown on the form by the letters (a) through (d). Should there be additional recipients on the same base case ID, a second page should be attached.

The requestor must complete the *four* questions in the lower left corner of the form in order for DMAS to determine the priority of the request. *Failure to complete the questions will result in a delay of claims processing.*

The recipient(s) should be referred to DMAS if there was a period of time when the recipient was not eligible to receive benefits and the agency is unsure of how to handle the case.

**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 \$10,490 (or if he is married and living with a spouse, they have countable resources of no more than \$20,970), 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 \$10,490 for one person and \$20,970 for a married couple. Resources at or below \$6,290 for an individual and \$9,440 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 \$11,990 for an individual and \$23,970 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 \$10,490 for one person and \$20,970 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 \$11,990/\$23,970;
 - 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 \$11,990/\$23,970;
 - 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 \$1,300.00 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 \$11,990 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 \$ 1,750.00 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 \$23,970 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 \$1,170 for one person or \$1,575 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	\$1,170	\$1,575	< \$1,300.00	< \$1,750.00	< \$2,200.00	< \$2,650.00
Resources	\$4,000	\$6,000	\$10,490	\$20,970 (C)	\$10,490 (S) \$20,970 (C)	\$10,490 (S) \$20,970 (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 1/23/08 MONTHLY GUIDELINES					
FAMILY SIZE	PERCENT OF FEDERAL POVERTY LEVEL (FPL)				
	100%	135%	140%	145%	150%
1	<i>\$866.67</i>	<i>\$1,170.00</i>	<i>\$1,213.33</i>	<i>\$1,256.67</i>	<i>\$1,300.00</i>
2	<i>1,166.67</i>	<i>1,575.00</i>	<i>1,633.33</i>	<i>1,691.67</i>	<i>1,750.00</i>
3	<i>1,466.67</i>	<i>1,980.00</i>	<i>2,053.33</i>	<i>2,126.67</i>	<i>2,200.00</i>
4	<i>1,766.67</i>	<i>2,385.00</i>	<i>2,473.33</i>	<i>2,561.67</i>	<i>2,650.00</i>
5	<i>2,066.67</i>	<i>2,790.00</i>	<i>2,893.33</i>	<i>2,996.67</i>	<i>3,100.00</i>
6	<i>2,366.67</i>	<i>3,195.00</i>	<i>3,313.33</i>	<i>3,431.67</i>	<i>3,550.00</i>
7	<i>2,666.67</i>	<i>3,600.00</i>	<i>3,733.33</i>	<i>3,866.67</i>	<i>4,000.00</i>
8	<i>2,966.67</i>	<i>4,005.00</i>	<i>4,153.33</i>	<i>4,301.67</i>	<i>4,450.00</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	\$212.33
COUPLE	318.67

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%
≤ \$6,290	A	C	D	E	F
> \$6,290 to ≤ \$10,490	B	C	D	E	F
> \$10,490	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%
≤ \$9,440	A	C	D	E	F
> \$9,440 to ≤ \$20,970	B	C	D	E	F
> \$20,970	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	\$2.25/\$5.60	N	\$0
B	100%	\$56	15%	N	\$2.25/\$5.60
C	75%	\$56	15%	N	\$2.25/\$5.60
D	50%	\$56	15%	N	\$2.25/\$5.60
E	25%	\$56	15%	N	\$2.25/\$5.60
F (No subsidy)	0%	\$275	25%	Y	@5%

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M2100.000 FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS)

M2110.100 FAMIS GENERAL INFORMATION

A. Introduction

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program, enacted as Title XXI of the Social Security Act, to provide funds to States to enable them to initiate the provision of child health insurance to **uninsured low-income children**.

FAMIS 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 Department of Medical Assistance Services (DMAS) will notify the Department of Social Services (DSS) Central Office if funds for this program run out.

Initial eligibility for FAMIS is determined by local DSS, including DSS outstationed sites, or by the FAMIS Central Processing Unit (CPU). Children found eligible for FAMIS receive benefits described in the State's Title XXI Child Health Insurance Program. Eligible children are enrolled for benefits effective the first day of the child's application month if all eligibility requirements are met in that month, but no earlier than the date of the child's birth.

Retroactive coverage is only available to an eligible child who was born within the 3 months prior to the FAMIS application month. Eligibility for FAMIS coverage will be effective retroactive to the child's date of birth if the child would have met all eligibility criteria during that time.

Case management and ongoing case maintenance, and selection for managed care, are handled by the FAMIS CPU.

B. Legal Base

The 1998 Acts of Assembly, Chapter 464, authorized Virginia's Children's Health Insurance Program by creating the Children's Medical Security Insurance Plan for uninsured children under 19 years of age. In August 2001, the program was revised and renamed the Family Access to Medical Insurance Security Plan (FAMIS).

C. Policy Principles

FAMIS covers uninsured low-income children under age 19 who are not eligible for FAMIS Plus (children's Medicaid) and whose gross family income is less than or equal to 200% of the federal poverty level (FPL) for the family size (see M2130.100 for the definition of the FAMIS assistance unit and Appendix 1 for the income limits).

A child is eligible for FAMIS if all of the following are met:

- he is **not** eligible for FAMIS Plus *and he has income in excess of the FAMIS Plus limits;*
- he is under age 19 and a resident of Virginia;

- he is uninsured;
- he 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 2 to this chapter);
- he is **not** a member of a family who has dropped health insurance coverage on him within 4 months of the application without good cause;
- he is **not** an inmate of a public institution;
- he is **not** an inpatient in an institution for mental diseases;
- he meets the Medicaid Nonfinancial Eligibility Requirements in Chapter M02 with certain exceptions; and
- he has gross family income less than or equal to 200% FPL.

M2120.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

The child must meet, with certain exceptions, the Medicaid Nonfinancial Eligibility Requirements in chapter M02 and the nonfinancial eligibility requirements imposed by FAMIS.

B. M02 Requirements

The Medicaid Nonfinancial Eligibility Requirements in Chapter M02 that must be met are:

- citizenship and alienage requirements, *including Afghan and Iraqi special immigrants in M0220.313 A*, with the exceptions noted in M2120.100 C.1. below;
- Virginia residency requirements;
- institutional status requirements regarding inmates of a public institution.

C. M02 Exceptions

The exceptions to the Medicaid Nonfinancial Eligibility Requirements in Chapter M02 are:

1. Alienage Requirements

Alien status must be verified. Refer to sections M0220.200, M0220.201 and M0220.202 for information about verifying alien status.

FAMIS alienage requirements are different from the Medicaid alienage requirements. Qualified aliens who entered the U.S. before August 22, 1996 meet the alienage requirements and are not subject to time limitations.

- a. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **without regard to time limitations**:
 - refugees or Cuban-Haitian Entrants (see M0220.310 A. 2 and 7),
 - 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).

- b. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **after five years of residence in the United States**:
 - lawful permanent residents (LPR),
 - conditional entrants-aliens admitted pursuant to 8 U.S.C.1153(a)(7),
 - aliens, other than Cuban-Haitian Entrants, paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA, and
 - battered aliens, alien parents of battered children, alien children of battered parents.

2. No Grandfathered Aliens

The Medicaid policy for grandfathered aliens under age 19 does NOT apply to FAMIS.

3. No Emergency Services Only For Unqualified Aliens

Unqualified aliens, including illegal and non-immigrant aliens, do not meet the alienage requirements *and are not eligible for FAMIS.*

4. Alien Eligibility Chart

Appendix 3, FAMIS Alien Eligibility Chart, lists alien groups that meet or do not meet the alienage requirements.

5. SSN

A Social Security number (SSN) or proof of application for an SSN (M0240) is **not** a requirement for FAMIS.

6. Assignment of Rights

Assignment of rights to payment for medical care from any liable third party is a condition of eligibility for the child.

- 7. HIPP** Application requirements for the Health Insurance Premium Payment (HIPP) program (M0290) do not apply to FAMIS.
- D. FAMIS Nonfinancial Requirements** The child must meet the following FAMIS nonfinancial requirements:
- 1. Age Requirement** The child must be under age 19 for at least one day during the month. No verification is required.
- A child no longer meets the age requirements for FAMIS effective the end of the month in which the child reaches age 19 years, provided he was under age 19 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 19.
- 2. Uninsured Child** The child must be uninsured, that is, he must not be covered under any health insurance plan offering hospital and medical benefits. See M2120.200.
- 3. State Employee Prohibition** A child is ineligible for FAMIS if he is a member of a family eligible for health insurance coverage under any Virginia State Employee Health Insurance Plan on the basis of the family member's employment with a State agency.
- 4. IMD Prohibition** The child cannot be an inpatient in an institution for mental diseases (IMD).

M2120.200 HEALTH INSURANCE COVERAGE

- A. Introduction** The intent of FAMIS is to provide health coverage to low-income uninsured children. Eligibility for this program is prohibited when creditable health insurance coverage is dropped within 4 months of the application for FAMIS unless good cause for discontinuing the insurance is demonstrated, or the child is pregnant.
- B. Definitions**
- 1. Creditable Coverage** For the purposes of FAMIS, creditable coverage means coverage of the individual under any of the following:
- church plans and governmental plans;
 - health insurance coverage, either group or individual insurance;
 - military-sponsored health care;
 - a state health benefits risk pool;
 - the federal Employees Health Benefits Plan;
 - a public health plan; and

- any other health benefit plan under section 5(e) of the Peace Corps Act.

The definition of creditable coverage includes short-term limited coverage.

2. Family Member

When determining whether the child is eligible for coverage under a State Employee Health Insurance Plan, or whether the discontinuance of health insurance affects the child's eligibility, family member means:

- parent(s) with whom the child is living, and
- a stepparent with whom the child is living if the stepparent claims the child as a dependent on his federal tax return.

3. Health Benefit Plan

"Health benefit plan" is defined in the Virginia Bureau of Insurance Regulations (14VAC5-234-30) and means:

- "any accident and health insurance policy or certificate,
- health services plan contract,
- health maintenance organization subscriber contract,
- plan provided by a Multiple Employer Welfare Arrangement (MEWA)".

Health benefit plan does not mean:

- Medicare, Medicaid, FAMIS Plus, or State/Local Hospitalization;
- accident only;
- credit or disability insurance;
- 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.

4. Insured

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

5. Uninsured

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

C. Policy

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

- have creditable health insurance coverage;

- have coverage under a group health plan (TRICARE, federal employee benefit plan, private group insurance such as Anthem, etc.);
- be a member of a family eligible for health benefits coverage under a State Employee Health Insurance Plan (a full-time, salaried, classified State employee or a permanent, full-time, salaried State education institution faculty member) [see Appendix 2 to this chapter], or

without good cause (see item E. below), have had creditable health insurance coverage terminated within 4 months prior to the month of application.

D. Health Insurance Coverage Discontinued

If the child's insurance coverage was discontinued by a parent or other individual who does NOT live with the child, the discontinuance of the insurance does NOT affect the child's eligibility for FAMIS.

A child is ineligible for FAMIS coverage if creditable health insurance coverage was terminated by a family member, as defined in M2120.200 B.3, above, without good cause within four months prior to the month for which eligibility is being established, unless the child was pregnant at the time of application.

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

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

E. Good Cause for Dropping Health Insurance

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

1. Employment Stopped

The family member who carried insurance changed jobs or stopped employment, and no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.

2. Employer Stopped Contributing

The employer stopped contributing to the cost of family coverage and no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.

3. **Insurance Company Discontinued Insurance** The child's coverage was discontinued by an insurance company for reasons of uninsurability, e.g., the child has used up lifetime benefits or the child's coverage was discontinued for reasons unrelated to payment of premiums. Verification is required from the insurance company.
4. **Discontinued By Family Member** Insurance was discontinued by a family member who was paying the full cost of the insurance premium under a COBRA policy AND no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
5. **Discontinued By Other Contributor** Insurance on the child is discontinued by someone other than the child (if 18 years of age), or, if under age 18, the child's parent or stepparent, e.g. the insurance was discontinued by the child's grandparent, aunt, uncle, godmother, etc. Verification is not required.
6. **Discontinued Because Cost Exceeds 10% of Income** Insurance on the child is discontinued because the cost of the health insurance premiums for all family members exceeds 10% of the family's GROSS monthly income or exceeded 10% of the family's GROSS monthly income at the time the insurance was discontinued.

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

- a. Use the applicant's month-prior-to-application gross income verification.
- b. Calculate 10% of the family's gross monthly income.
- c. Compare to total amount of monthly premiums.
- d. If monthly premium is less than or equal to 10% of current gross monthly income:
 - 1) Ask applicant "what was your family's gross income in the month in which you discontinued the health insurance (include all amounts of income received in that month)?" Document the applicant's statement in the record.
 - 2) Calculate 10% of the family's gross monthly income (in the month in which the insurance was discontinued).
 - 3) Compare to total amount of monthly premiums.
 - i If monthly premiums are less than or equal to 10% of this gross monthly income, good cause is NOT met. The children are not eligible for 4 months following the discontinuance of the insurance.

- ii If monthly premiums are more than 10% of this gross monthly income, good cause is met and there is no waiting period for FAMIS.

M2120.300 NO CHILD SUPPORT REQUIREMENTS

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

M2130.100 FINANCIAL ELIGIBILITY

A. Financial Eligibility

1. FAMIS Assistance Unit

The FAMIS assistance unit consists of:

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

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

2. Asset Transfer

Asset transfer rules do not apply to FAMIS.

3. Resources

Resources are not evaluated for FAMIS.

4. Income

a. Countable Income

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

b. Available Gross Income

Retroactive period (for newborns only) – available income is the gross income actually received in each month in the retroactive period.

Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months.

c. Income Limits

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

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

M2140.100 APPLICATION and CASE PROCEDURES

- A. **Application Requirements** The Health Insurance for Children and Pregnant Women application is the application form for FAMIS. The Application for Benefits or the ADAPT Statement of Facts are also acceptable application/renewal forms for FAMIS. These forms are available on the intranet at:
<http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.

The parent, legal guardian, authorized representative age 18 or older, an adult relative age 18 or older with whom the child lives, or the child if age 18, must sign the application. The adult relative must be related by blood or marriage. Accept declaration of relationship; documentation of the relationship is not required. The child's parent or legal guardian may designate in writing an authorized representative age 18 or older to complete and sign the application. The date of the application is the date the application is received at the local DSS, including DSS outstationed sites, or at the FAMIS CPU.

Applications can be mailed to the local DSS or the CPU. A face-to-face interview is not required.

- B. **Eligibility Determination** When an application is received and the child is not eligible for FAMIS Plus due to excess income, determine eligibility for FAMIS. In order to complete an eligibility determination, both the FAMIS nonfinancial requirements in M2120.100 and the financial requirements in M2130.100 must be met. Income must be verified.

1. **Notice** The applicant/enrollee must be notified in writing of the required information and the deadline by which the information must be received. Applications must be acted on as soon as possible, but no later than 45 days from the date the signed application was received at the local DSS or the FAMIS CPU.

2. **Transfer Approved Cases** Cases approved for FAMIS must be transferred to the FAMIS CPU for case management and ongoing case maintenance.

- C. **Entitlement and Enrollment**

1. **Begin Date** Children determined eligible for FAMIS are enrolled for benefits in the Medicaid Management Information System (MMIS) effective the first day of the child's application month if all eligibility requirements are met in that month, **but no earlier than the date of the child's birth.**

2. Retroactive Coverage For Newborns Only

Retroactive FAMIS coverage is effective with applications received on or after September 1, 2006.

Retroactive coverage is available ONLY to an eligible child who was born within the 3 months prior to the FAMIS application month. Eligibility for FAMIS coverage will be effective retroactive to the child's date of birth if the child was born within the retroactive period and would have met all eligibility criteria during the retroactive period.

The following eligibility requirements must be met in order for a newborn child to be enrolled in FAMIS for retroactive FAMIS coverage:

- a. Retroactive coverage must be requested on the application form or in a later contact.
- b. The child's date of birth must be within the three months immediately preceding the application month (month in which the agency receives the signed application form for the child).
- c. The child must meet all the FAMIS eligibility requirements during the retroactive period.

3. FAMIS Aid Categories

The aid categories (ACs) for FAMIS are:

AC	Meaning
006	child under age 6 with income > 150% FPL and ≤ 200% FPL
007	child 6 – 19 with income > 150% FPL and ≤ 200% FPL
008	child under age 6 with income > 133% FPL and ≤ 150% FPL
009	child 6 – 19 with income > 133% FPL and ≤ 150% FPL

4. Separate FAMIS and FAMIS Plus MMIS Case Numbers

Because FAMIS Plus and FAMIS are separate programs, FAMIS Plus eligible individuals and FAMIS eligible children cannot share the same case number in the MMIS. When a child is determined eligible for FAMIS and the child has family members enrolled in FAMIS Plus in the MMIS, the FAMIS child must be given a new case number when enrolled in the MMIS. Only children eligible for the same program can share the same base case number in the MMIS.

After the child is enrolled in the MMIS, the local DSS worker must change the MMIS worker number to V0000 to transfer the case to the FAMIS CPU.

The local DSS worker must not change the FIPS code or make any other change to the case after the case has been transferred to FAMIS in the MMIS.

D. Notification Requirements

The local DSS worker must send a Notice of Action on Medicaid and FAMIS to the family informing them of the action taken the application. The notice must include the eligibility determination for both FAMIS Plus and FAMIS.

If the child is eligible for FAMIS, the notice must inform the family that the case has been transferred to FAMIS and that further information on the program will come from FAMIS.

If the child is ineligible for both FAMIS Plus and FAMIS, the family must be sent a notice that the child is not eligible for either program and must be given the opportunity to have a Medicaid medically needy evaluation. Along with the notice, send the Application for Benefits to the family and advise them that if the signed application is returned within 10 calendar days, the original application date will be honored.

**E. FAMIS Case
Transfer
Procedures**

1. ADAPT Cases

a. Electronic Case Transfer

If the application is processed in ADAPT, individuals approved for FAMIS are enrolled in MMIS by ADAPT. ADAPT will automatically transfer the FAMIS enrollees' data to the FAMIS CPU.

If a family has both Medicaid (including FAMIS Plus) FAMIS-eligible individuals, a separate FAMIS case is created in MMIS via the ADAPT "Medicaid Authorization" (AEAUTM) screen. When granted, ADAPT changes the worker number to V0000 on the FAMIS case in the MMIS and automatically transfers the FAMIS case and enrollee data to the FAMIS CPU. The LDSS has responsibility for ongoing case maintenance of the FAMIS Plus case.

Do not send a paper case file to the FAMIS CPU when the case is automatically transferred by ADAPT. The LDSS retains the original application, verifications and notices.

b. Resolve Enrollment Rejections BEFORE Granting

It is important that workers resolve any MMIS Enrollment Rejections immediately when they are received. ADAPT will NOT transfer a FAMIS-

- answer non-policy related questions regarding transferring or closing cases, and
- change worker number V0000 to M0000 when necessary.

The DMAS FAMIS Plus workers will not provide policy clarification and will not handle client complaints. Please continue to contact your supervisor or Medical Assistance Program Consultant for assistance with policy clarifications, computer system problems, and client complaints.

Please note that the DMAS FAMIS Plus workers' telephone numbers are for the LDSS workers only and **are not to be given to clients**. The CPU has a separate toll-free FAMIS helpline number (1-866-87FAMIS or 1-866-873-2647) designated for client use. This toll-free FAMIS telephone number is **not** for use by LDSS workers.

K. FAMIS Select

Under the FAMIS program, a family, *whose child(ren) are determined eligible for FAMIS and* who has access to health insurance through an employer or wishes to purchase a private policy, has the option of enrolling the family in that health plan. "FAMIS Select" allows the choice of the private or employer's insurance instead of FAMIS. Children enrolled in FAMIS whose families have access to private or employer sponsored health insurance coverage may qualify to have the State pay part of the family's share of the health insurance premium.

Once a child is enrolled in FAMIS, the FAMIS CPU will identify if the family is interested in more information about FAMIS Select. Families who have access to health insurance will receive information from DMAS about the benefits of enrolling in the FAMIS Select component of FAMIS and information about how to participate in the program. Participation in the FAMIS Select component is voluntary.

L. 12-Month Continuous Coverage

Children under age 19 who are enrolled in FAMIS are entitled to 12 months of continuous coverage provided the family continues to reside in Virginia and the family income is less than or equal to 200% of the FPL.

Children enrolled in FAMIS who subsequently apply for FAMIS Plus or Medicaid and are found eligible must have their FAMIS coverage cancelled so they can be reinstated in FAMIS Plus or Medicaid.

M2150.100 REVIEW OF ADVERSE ACTIONS

A. Case Reviews

An applicant for FAMIS may request a review of an adverse determination regarding eligibility for FAMIS. FAMIS reviews follow the procedures established by Medicaid for client appeals (see chapter M16).

The payment of medical services on the part of any child or any right to participate in the program is not subject to review if funds for FAMIS are exhausted.

<p align="center">FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS) INCOME LIMITS ALL LOCALITIES EFFECTIVE 1/23/08</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	<i>\$15,600</i>	<i>\$1,300</i>	<i>\$20,800</i>	<i>\$1,734</i>
2	<i>21,000</i>	<i>1,750</i>	<i>28,000</i>	<i>2,334</i>
3	<i>26,400</i>	<i>2,200</i>	<i>35,200</i>	<i>2,934</i>
4	<i>31,800</i>	<i>2,650</i>	<i>42,400</i>	<i>3,534</i>
5	<i>37,200</i>	<i>3,100</i>	<i>49,600</i>	<i>4,134</i>
6	<i>42,600</i>	<i>3,550</i>	<i>56,800</i>	<i>4,734</i>
7	<i>48,000</i>	<i>4,000</i>	<i>64,000</i>	<i>5,334</i>
8	<i>53,400</i>	<i>4,450</i>	<i>71,200</i>	<i>5,934</i>
Each additional, add	<i>5,400</i>	<i>450</i>	<i>7,200</i>	<i>600</i>

FAMIS ALIEN ELIGIBILITY CHART

QUALIFIED ALIEN GROUPS	ARRIVED BEFORE AUGUST 22, 1996	ARRIVED ON OR AFTER AUGUST 22, 1996	
		1 ST 5 YEARS	AFTER 5 YEARS
Qualified aliens who are Veterans or Active Military (includes spouses/dependent children); certain American Indians Form DD 214-veteran	Eligible	Eligible	Eligible
Permanent Resident Aliens (Aliens lawfully admitted for permanent residence), except Amerasians I-151; AR-3a; I-551; I-327; I-688B-274a.12(a)(1)	Eligible	NOT Eligible	Eligible
Conditional entrants-aliens admitted Pursuant to 8 U.S.C. 1153(a)(7), section 203(a)(7) of the INA I-94	Eligible	NOT Eligible	Eligible
Aliens, other than Cuban or Haitian Entrants, paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA I-94; I-688B – 274a(12)(c)(11)	Eligible	NOT Eligible	Eligible
Battered aliens, alien parents of battered children, alien children of battered parents U.S. Attorney General	Eligible	NOT Eligible	Eligible
AFGHAN AND IRAQI SPECIAL IMMIGRANTS	First Six/Eight Months after Entry into U.S.	Greater than Six/Eight Months after Entry into U.S., first 5 years	Greater than Six/Eight Months after Entry into U.S., after 5 years
<i>Afghan Special Immigrants admitted on a Special Immigrant Visa (SIV), including the spouse and children under age 21 living in the home with the principal visa holder. [I-551 or passport/I-94 indicating categories S11, S12, S13, QQ1, SQ2, or SQ3 and bearing Department of Homeland Security stamp or notation]</i>	<i>Eligible for SIX (6) MONTHS beginning with month of entry or conversion to SIV status. Coverage cannot begin prior to 12-26-07.</i>	NOT Eligible	Eligible
<i>Iraqi Special Immigrants admitted on a Special Immigrant Visa (SIV), including the spouse and children under age 21 living in the home with the principal visa holder. [I-551 or passport/I-94 indicating categories S11, S12, S13, QQ1, SQ2, or SQ3 and bearing Department of Homeland Security stamp or notation]</i>	<i>From 12-26-07 to 1-27-08, eligible for SIX (6) MONTHS beginning with month of entry or conversion to SIV status. Coverage cannot begin prior to 12-26-07. Beginning 1-28-08, eligible for EIGHT (8) MONTHS beginning with month of entry or conversion to SIV status.</i>	NOT Eligible	Eligible

QUALIFIED ALIEN GROUPS	ELIGIBLE REGARDLESS OF ENTRY DATE OR LENGTH OF RESIDENCE
Aliens granted asylum pursuant to section 208 of the INA I-94; I-688B – 274a.12(a)(5)	Eligible
Aliens admitted as refugees pursuant to section 207 of the INA, or as Cuban or Haitian Entrants as defined in section 501(e) of the Refugee Education Assistance Act of 1980 {including those under section 212(d)(5)} I-551; I-94; I-688B	Eligible
Aliens whose deportation has been withheld pursuant to Section 243(h) or 241(b)(3) of the INA I-688-B – 274a.12(a)(10) Immigration Judge’s Order	Eligible
Victims of a severe form of trafficking pursuant to the Trafficking Victims Protection Act of 2000 (P.L. 106-386) [ORR certification/eligibility letter]	Eligible

UNQUALIFIED ALIEN GROUPS NOT ELIGIBLE REGARDLESS OF ENTRY DATE OR LENGTH OF RESIDENCE
Aliens residing in the US pursuant to an indefinite stay of deportation (I-94; Immigration Letter)
Aliens residing in the US pursuant to an indefinite voluntary departure (I-94; Immigration Letter)
Aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition who are entitled to voluntary departure under 8 CFR 242.5(a)(2)(vi) and whose departure the INS does not contemplate enforcing (I-94; I-210)
Aliens who have filed an application for adjustment of status pursuant to §245 INA that the INS has accepted as properly filed and whose departure the INS does not contemplate enforcing (I-181; Endorsed Passport)
Aliens granted stay of deportation by court order, statute or regulation, or by individual determination of the INS whose departure the agency does not contemplate enforcing (I-94; Court Order; INS Letter)
Aliens granted voluntary departure pursuant to section 242(b) of the INA whose departure the INS does not contemplate enforcing (I-94; I-210; I-688B – 247a.12(a)(11) or (13))
Aliens granted deferred action status pursuant to INS Operations Instruction 103.1(a)(ii) prior to 6/15/84 or 242.1a22 issued 6/15/84 and later (I-210; INS Letter)
Aliens residing in the U.S. under orders of supervision (I-220B)
Aliens who entered before January 1972 and have continuously resided in the U.S. since January 1972 (Case Record)

UNQUALIFIED ALIEN GROUPS**NOT ELIGIBLE REGARDLESS OF ENTRY DATE OR LENGTH OF RESIDENCE**

Aliens granted suspension of deportation pursuant to Section 244 of the INA and whose deportation the INS does not contemplate enforcing (Immigration Judge Court Order)

Any other aliens living in the US with the knowledge and permission of the INS whose departure the agency does not contemplate enforcing (INS Contact)

Illegal aliens – aliens not lawfully admitted or whose lawful admission status has expired

Visitors (non-immigrants): tourists, diplomats, foreign students, temporary workers, etc.
(I-688B – 274a.12(b)(1)-(20); I-94; I-185: I-I186; SW-434; I-95A)

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- conditional entrants-aliens admitted pursuant to 8 U.S.C.1153(a)(7),
- aliens paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA, and
- battered aliens, alien parents of battered children, alien children of battered parents.

- d. *Afghan and Iraqi special immigrants who meet all other eligibility requirements for FAMIS MOMS are eligible for a limited period of time from the date they enter the U.S. or the date their immigrant status is converted to Special Immigrant Visa (SIV) status. See section M0220.313 A and Appendix 3 to Chapter M21 for the limited time periods and details about these special immigrants. When the limited time period (6 or 8 months, beginning with the month of entry or status conversion to SIV) is over, these special immigrants are no longer eligible for FAMIS MOMS because of their lawful permanent resident (LPR) status. LPRs are not eligible for FAMIS MOMS for the first 5 years they reside in the U.S.*
- e. Appendix 3 to Chapter M21 contains a FAMIS Alien Eligibility Chart that lists the alien groups that meet or do not meet the FAMIS MOMS alienage requirements.

3. No Emergency Services for Unqualified Aliens

Unqualified aliens, including illegal and non-immigrant aliens do not meet the alienage requirements. FAMIS MOMS does not provide any emergency services eligibility for unqualified aliens.

4. SSN not Required

The applicant is not required to provide an SSN or proof of an application for an SSN.

5. HIPP not Applicable

Application requirements for the Health Insurance Premium Payment (HIPP) program (M0290) do NOT apply to FAMIS.

D. FAMIS MOMS Covered Group Requirements

1. Verification of Pregnancy

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

2. Must be Uninsured

The pregnant woman must be uninsured; that is, she must not be covered under any creditable health insurance plan offering hospital and medical benefits. If a pregnant woman has creditable health insurance that does not cover pregnancy, labor and/or delivery services, the pregnant woman is ineligible for FAMIS MOMS because she is insured.

3. **IMD Prohibition** The pregnant woman cannot be an inpatient in an institution for mental diseases (IMD).
4. **State Employee Health Benefits Prohibition** A pregnant woman is ineligible for FAMIS MOMS if she is eligible for health insurance coverage under any Virginia State Employee Health Insurance Plan on the basis of her or a family member's employment with a State agency. A woman who cannot be enrolled until an open enrollment period is not prohibited from FAMIS MOMS coverage.

See Appendix 2 to Chapter M21 for a list of state government agencies.

M2220.200 HEALTH INSURANCE COVERAGE

- A. **Introduction** The intent of FAMIS MOMS is to provide health coverage to low-income uninsured pregnant women. A pregnant woman who has creditable health insurance coverage is not eligible for FAMIS MOMS.

B. Definitions

1. **Creditable Coverage** For the purposes of FAMIS MOMS, creditable coverage means coverage of the individual under any of the following:
- church plans and governmental plans;
 - health insurance coverage, either group or individual insurance;
 - military-sponsored health care;
 - a state health benefits risk pool;
 - the federal Employees Health Benefits Plan;
 - a public health plan; and
 - any other health benefit plan under section 5(e) of the Peace Corps Act.

The definition of creditable coverage includes short-term limited coverage.

2. **Employer-Sponsored Dependent Health Insurance** Employer-sponsored dependent health insurance means the employer pays a portion of the premium payment. COBRA coverage in which the employer makes no contribution to the payment of the premium is not employer-sponsored insurance.
3. **Family Member** ONLY when determining whether the pregnant woman is eligible for coverage under a State Employee Health Insurance Plan, "family member" means the pregnant woman's spouse with whom she lives, or her parent(s) with whom she lives when the pregnant woman is unmarried and is under age 23. "Family member" includes the pregnant woman's stepparent with whom she is living if the pregnant woman is under age 21 and her stepparent claims the pregnant woman as a dependent on his federal tax return. State employee health benefits are available to the state employee's unmarried **dependent** child or stepchild under age 23 years.

4. Health Benefit Plan

“Health benefit plan” is defined in the Virginia Bureau of Insurance Regulations (14VAC5-234-30) and means:

- any accident and health insurance policy or certificate,
- health services plan contract,
- health maintenance organization subscriber contract,
- plan provided by a Multiple Employer Welfare Arrangement (MEWA)”.

Health benefit plan does NOT mean:

- Medicare, Medicaid or State/Local Hospitalization;
- accident only;
- credit or disability insurance;
- 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). *The unborn child(ren) is counted as part of the family unit.*

- 2. Asset Transfer** Asset transfer rules do not apply to FAMIS MOMS.

- 3. Resources** Resources are not evaluated for FAMIS MOMS.

- 4. Income** *a. Countable Income*

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).

b. Available Gross Income

For the application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months. There is no retroactive coverage in FAMIS MOMS.

c. Income Limits

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).

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.

For applicants under the age of 18, the parent, legal guardian, authorized representative, or an adult relative with whom the child lives must sign the application. The adult relative must be related by blood or marriage.

Documentation of the relationship is not required. The child's parent or legal guardian may designate in writing an authorized representative to complete and sign the application.

For applicants age 18 or older, the applicant, family substitute relative, authorized representative or the guardian can sign the application.

B. Eligibility Determination

1. Pregnant Teenager Under Age 19

When an application is received for a pregnant teenager who is under age 19, is not eligible for Medicaid and has income in excess of the Medicaid limits, process her eligibility in the following order:

- a. first, process eligibility as a Medicaid MI child under age 19; if not eligible because of excess income, go to item b.
- b. second, process eligibility as a Medicaid MI pregnant woman; if not eligible because of excess income, go to item c.

- c. third, process eligibility as a FAMIS child under age 19; if not eligible because of excess income, go to item d.
- d. fourth, process eligibility as a FAMIS MOMS pregnant woman. In order to complete the eligibility determination, the FAMIS MOMS nonfinancial requirements in M2220.100 and the financial requirements in M2230.100 must be met. If she is not eligible for FAMIS MOMS because of excess income, she must be given the opportunity to have a medically needy evaluation completed.

2. 10-day Processing

Applications for pregnant women must be processed as soon as possible, but no later than 10 working days from the date the signed application was filed. If all necessary verifications are not received, the application continues to pend until the 45 day processing time limit is met.

3. Notice Requirements

The applicant/recipient must be notified in writing of the required information and the deadline by which the information must be received.

The agency must have all necessary verifications within 10 working days in order to determine eligibility. If all verifications are not received within 10 working days, a Notice of Action on Medicaid and FAMIS Programs (NOA), form #032-03-008 (see subchapter M0130, Appendix 1) must be sent to the applicant. The NOA must state why action on the application could not be taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 calendar days to submit the verification.

Once all necessary verifications for the pregnant woman are received, an eligibility determination must be made immediately and the applicant must be notified of the decision.

C. Case Setup Procedures for Approved Cases

Because Medicaid and FAMIS MOMS are separate programs, Medicaid eligible individuals and FAMIS MOMS eligible individuals cannot share the same base case number in the Virginia Medicaid Management Information System (MMIS). Only individuals eligible for the same program (Medicaid or FAMIS/FAMIS MOMS) can share the same base case number in the MMIS.

When an individual is determined eligible for FAMIS MOMS and the individual has family members enrolled in Medicaid, the FAMIS MOMS individual must be given a new MMIS base case number when enrolled.

The local DSS worker cannot change the FIPS code or make any other change to the case after the case has been transferred to the FAMIS CPU in MMIS.

D. Entitlement and Enrollment

- 1. Begin Date of Coverage** Pregnant women determined eligible for FAMIS MOMS are enrolled for benefits in the Virginia Medicaid Management Information System (MMIS) effective the first day of the application month, if all eligibility requirements are met in that month.
- 2. No Retroactive Coverage** There is no retroactive coverage in the FAMIS MOMS program.
- 3. Aid Category** The FAMIS MOMS aid category (AC) is “005.”

E. Notification Requirements

Notice must be sent to the pregnant woman informing her of the action taken on the application. The notice must include the eligibility determination results for both Medicaid and FAMIS MOMS.

If the pregnant woman is eligible for FAMIS MOMS, the notice must inform the pregnant woman that the case has been transferred to the FAMIS CPU and that further information on the program will come from the FAMIS CPU.

If the pregnant woman is ineligible for both Medicaid and FAMIS MOMS due to excess income, she must be sent a notice that she is not eligible for either program and must be given the opportunity to have a Medicaid medically needy evaluation completed. Send the notice and an Application for Benefits to the pregnant woman and advise her that if the signed application is returned within 10 days the original application date will be honored.

NOTE: The ADAPT NOA meets the notification requirements. When a NOA is generated by ADAPT, do not send the NOA form #032-03-008.

F. Transfer Case to FAMIS CPU

Once the enrolled FAMIS MOMS case is transferred in MMIS and the notice is sent to the family, the case must be transferred to the FAMIS CPU for ongoing case maintenance.

See chapter M21, section M2140.100 E for the procedures to use when transferring a FAMIS MOMS case to the FAMIS CPU.

G. Transitions Between Medicaid And FAMIS MOMS (Changes and Renewals)

See chapter M21, sections M2140.100 F through J for the procedures to use when an enrollee transitions between Medicaid and FAMIS MOMS.

H. Application Required for Newborn

The newborn child born to a FAMIS MOMS enrollee is not deemed eligible for FAMIS or Medicaid. The newborn’s parent, guardian or authorized representative must file an application for medical assistance for the newborn to have the newborn’s eligibility determined for Medicaid and/or FAMIS.

M2250.100 REVIEW OF ADVERSE ACTIONS

An applicant for FAMIS MOMS may request a review of an adverse determination regarding eligibility for FAMIS MOMS. FAMIS MOMS follows the procedures established by Medicaid for client appeals (see Chapter M16).

The payment of medical services on the part of any pregnant woman or any right to participate in the program is not subject to review if the reason for denial or cancellation is that funds for the FAMIS MOMS program are exhausted.

FAMIS MOMS INCOME LIMITS ALL LOCALITIES		
EFFECTIVE 01/23/2008		
# of Persons in FAMIS MOMS Assistance Unit	FAMIS MOMS 185% FPL	
	Annual Limit	Monthly Limit
2	\$25,900	\$2,159
3	32,560	2,714
4	39,220	3,269
5	45,880	3,824
6	52,540	4,379
7	59,200	4,934
8	65,860	5,489
Each additional, add	6,660	555