



COMMONWEALTH of VIRGINIA

May 15, 2009

DEPARTMENT OF SOCIAL SERVICES

MEDICAID ELIGIBILITY MANUAL – VOLUME XIII

TRANSMITTAL #91

The following acronyms are used in this transmittal:

- ABD – Aged, Blind, Disabled
- AC – Aid Category
- ARRA – American Recovery and Reinvestment Act of 2009 (P.L. 111-5)
- CBC – Community-based Care
- DMAS – Department of Medical Assistance Services
- DDS – Disability Determination Services
- EDCD – Elderly and Disabled with Consumer Direction
- F&C – Family and Children's
- LDSS – Local Department of Social Services
- LTC – Long-term Care
- MMIS – Medicaid Management Information System
- PACE – Program of All-inclusive Care for the Elderly
- SPARK – Services Programs Answers Resources Knowledge
- SSN – Social Security Number
- QDWI – Qualified Disabled and Working Individual
- VDSS – Virginia Department of Social Services

The purpose of this transmittal is to provide revised and clarified eligibility policies for the Medicaid Program. Unless otherwise indicated, the provisions included in this transmittal are effective for all eligibility determinations completed on or after May 15, 2009.

Revised Policy

Life Estates

The Medicaid eligibility policy regarding the treatment of life estates was revised in this transmittal due to the recent enactment of the ARRA, commonly known as the Economic Stimulus bill. The ARRA provided for increased federal funding for the Medicaid program if the eligibility standards, methodologies or procedures under the Medicaid State Plan are not more restrictive than the eligibility standards, methodologies or procedures that were in effect as of July 1, 2008. States with Medicaid State Plans that are more restrictive now than they were on July 1, 2008 will not qualify for the increased amount of federal funding. To qualify for the enhanced federal funding available through the ARRA, Virginia has rescinded the life estate policies that were enacted in September 2008.

The life estate policy revision was announced in Broadcast 5451. Consequently, the policy that is applied to a life estate now differs based on the date the life estate was created, as summarized below:

- Life estates created on or after February 24, 2009 are not counted as resources, except when determining eligibility for QDWI.
- Life estates that were created between August 28, 2008 and February 23, 2009 are to be treated in the same manner as real property, including the application of real property exclusions, if any.
- Life estates created prior to August 28, 2008 are not counted as resources, except when determining eligibility for QDWI.

The transfer of a life estate must be evaluated under the asset transfer policy regardless of whether or not the life estate was counted or excluded as a resource.

Unemployment Compensation Payments

The ARRA also authorized an increase in weekly Unemployment Compensation payments of \$25 per week for certain individuals. This increase is authorized for Unemployment Compensation payments made through June 26, 2010. However, the individual's entitlement to Unemployment Compensation is not affected—the individual will only receive the number of payments to which the individual would normally be entitled.

To be entitled to the \$25 increase in payments, the individual must have received Unemployment Compensation on or after February 28, 2009 and be entitled to a weekly Unemployment Compensation payment of at least \$1.00. Because the Virginia Employment Commission did not immediately implement the increased payments, these individuals are subject to receiving a one-time lump sum retroactive payment as well as an additional \$25 per week prospectively until the individual's Unemployment Compensation benefits are discontinued.

The retroactive lump sum payment is entirely excluded as countable income or as a resource. For individuals who were receiving Unemployment Compensation payments as of February 28, 2009, the first \$25 of each weekly payment is excluded from countable income.

MMIS Patient Pay Process

This transmittal also contains revisions made to Medicaid policies and procedures for LTC patient pay. Patient pay is now calculated in MMIS using the MMIS Patient Pay process. The eligibility worker is responsible for entering and updating the patient pay information in MMIS when the enrollee's patient pay changes, or at least once every 12 months. The worker no longer completes a paper DMAS-122 form to relay patient pay information to the provider. The provider has access to patient pay information through the Automated Response System and MediCall System, and will be responsible for verifying patient pay through those systems. The worker no longer completes and sends the Notice of Obligation for LTC Costs. MMIS generates and sends the Notice of Obligation directly to the patient or authorized representative.

The DMAS-122 form is obsolete and should no longer be used for any reason. The DMAS-122 form was replaced by the Medicaid LTC Communication Form (DMAS-225), which is used by both the local agency and the provider as necessary to make the agency and provider aware of changes in the patient's Medicaid eligibility status, as well as changes that may impact the patient's eligibility or patient pay. The patient pay amount, however, is not to be relayed via the Medicaid LTC Communication Form.

DDS Referrals for Expedited Disability Determinations

The procedures for sending an expedited referral for a disability determination to DDS have changed and are included in this transmittal. DDS conducts disability determinations on an expedited basis for hospitalized individuals who, due to the severity of their injuries, urgently require placement in a rehabilitation facility. The hospital sends the LDSS an application for Medicaid and sends DDS a completed Disability Report. When the LDSS receives an application flagged as "expedited," the LDSS sends a completed DDS Referral Form to DDS to verify that a Medicaid application has been filed.

In October, 2008, DDS decentralized its operations, requiring non-expedited referrals to be sent to the particular DDS regional office serving the local agency. As of March 9, 2009, LDSS are to send both expedited and non-expedited disability referrals to the appropriate DDS regional office that services the LDSS. This change in procedures was announced in Broadcast 5449.

Afghan Special Immigrants

Afghans with Special Immigrant visas meet the alien status requirements for full Medicaid coverage for a limited amount of time. The Omnibus Appropriations Act (P.L. 111-08), which was signed into law on March 10, 2009, extended the eligibility period from six months to eight months, beginning with the month of entry into the United States or conversion to Special Immigrant status. Afghan Special Immigrants, including those enrolled in Medicaid as of March 10, 2009, are eligible for Medicaid coverage for eight months if all other Medicaid eligibility requirements are met. Afghan Special Immigrants who arrived in the United States after July 10, 2008 and whose six-month period of eligibility ended may reapply for services under the new law to be covered for no more than two additional months. It is not necessary to reinstate coverage for Afghan Special Immigrants whose coverage was canceled at the end of the six-month period unless they reapply for Medicaid and are determined to be eligible for the additional two months.

Hospice Covered Groups

Individuals who have elected to receive hospice care and who are enrolled in either the F&C Hospice covered group or the ABD Hospice covered group may also simultaneously receive services that are offered under the EDCD Waiver, such as personal care services, provided that the individual meets the level of care criteria for the service. An individual who is "deemed" to be disabled for the purposes of meeting the ABD Hospice covered group does not need to have a disability determination to receive EDCD Waiver services and remains enrolled under AC 054. Individuals who receive hospice care in a nursing facility are subject to patient pay. Similarly, individuals who receive both hospice and EDCD Waiver services are subject to patient pay for the EDCD Waiver services.

Clarifications

This transmittal contains clarified policy about the SSN requirement for aliens who are not eligible for full Medicaid coverage. Per section 1137(f) of the Social Security Act (the Act), individuals who are seeking medical assistance for the treatment of an emergency medical condition under section 1903(v)(2) of the Act are not required to provide or apply for an SSN. These individuals include

undocumented or “illegal” aliens and qualified aliens who are in a mandatory period of ineligibility for full Medicaid benefits (eligible for emergency services only).

The F&C and ABD earned income exclusions sections are revised in this transmittal to clarify that income paid by the U.S. Census Bureau to temporary employees specifically hired for the 2010 census is not counted when determining eligibility for medical assistance.

Other clarifications contained in this transmittal include:

- Premiums for dental insurance are allowable as patient pay deductions.
- The amount of the premium for a Medicare Part D Prescription Drug Plan that is in excess of the national standard amount is allowable as a patient pay deduction.
- Individuals who reside in an assisted living facility and receive an Auxiliary Grant are not eligible for PACE.

Electronic Version

Transmittal #91 is available electronically on SPARK and the VDSS public web site. It has not been printed for distribution. The electronic version is the transmittal of record. Significant changes to the manual are as follows:

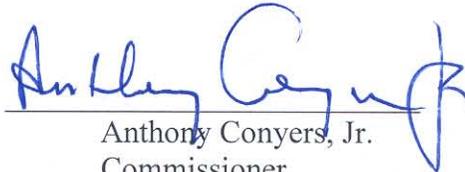
Pages Changed	Significant Changes
Subchapter M0120 page 10	On page 10, updated the link to the revised Title IV-E Foster Care & Medicaid Application/Redetermination form and added the link to the online Application for Adult Medical Assistance.
Subchapter M0220 page 7 pages 14a, 14b page 18 page 20 Appendix 3, page 3	On pages 7, 14a, and 18, revised the time limit for eligibility for Afghan Special Immigrants. Page 14b is a runover page. On page 20, clarified the SSN requirement for emergency-services-only aliens. On Appendix 3, page 3, revised the time limit for eligibility for Afghan Special Immigrants.
Subchapter M0240 pages 1, 2	On pages 1 and 2, clarified the SSN requirement for emergency-services-only aliens.
Subchapter M0310 pages 23-25 Appendix 4 Appendix 5	On pages 23 and 25, updated the references to the DDS Referral Forms. Page 24 is a runover page. In Appendix 4, added information about the DDS Regional Offices. In Appendix 5, clarified that both expedited and non-expedited disability referrals are forwarded to the appropriate DDS regional office.
Subchapter M0320 pages 31-34 pages 65-68	On page 31, 33 and 34, clarified that individuals in the ABD Hospice covered group may also receive services under the EDCD Waiver. Pages 32, 65 and 67 are runover pages. On pages 66 and 68, clarified that individuals in the F&C Hospice covered group may also receive services under the EDCD Waiver.

Pages Changed	Significant Changes
Subchapter M0720 page 11	On page 11, added the exclusion of income earned from temporary U.S. Census Bureau work for the 2010 census.
Subchapter M0730 Table of Contents pages 7-8a	Updated the Table of Contents. On pages 7 and 8, added policy regarding the special weekly \$25 increase in Unemployment Compensation payments. Page 8a is a runover page.
Subchapter S0820 Table of Contents pages 29, 30	Updated the Table of Contents. On page 29, added the exclusion of income earned from temporary U.S. Census Bureau work for the 2010 census. On page 30, renumbered the items in section A.
Subchapter S0830 Table of Contents, page i page 29	Updated page i of the Table of Contents. On page 29, added policy regarding the special weekly \$25 increase in Unemployment Compensation.
Subchapter S1110 pages 14-16	On page 14, clarified the policy for counting life estates as a resource. Pages 15 and 16 are runover pages.
Subchapter S1130 page 13	On page 13, clarified that a life estate created on or after August 28, 2008 but before February 24, 2009 may be excluded under reasonable effort to sell provisions.
Subchapter S1140 pages 11-12a	On pages 11 and 12, clarified the policy for counting life estates as a resource. Page 12a is a runover page.
Subchapter M1410 pages 11-14	On pages 11-14, replaced the references to the DMAS-122 form with references to the DMAS-225 form and/or MMIS. On pages 12 and 13, also clarified where to send the DMAS-225 form. Page 15 was deleted.
Subchapter M1440 Table of Contents page 12 pages 17-18c	Updated the Table of Contents. On page 12, removed the information about PACE. Page 12a is deleted. Page 17 is a runover page. On pages 18 and 18a, added a new section for PACE. Pages 18b and 18c are runover pages.
Subchapter M1450 pages 41, 42	On pages 41 and 42, replaced the references to the DMAS-122 form with references to the DMAS-225 form.
Subchapter M1460 pages 23, 24	On pages 23 and 24, replaced the references to the DMAS-122 form with references to the DMAS-225 form.
Subchapter M1470 Table of Contents pages 1-56 Appendix 1	Updated the Table of Contents. Throughout the subchapter, the numerous references to the DMAS-122 form were replaced with references to the DMAS-225 form or MMIS, as appropriate. These changes are italicized in the revised subchapter. Additional changes to the subchapter, including runover pages, are listed below.

Pages Changed	Significant Changes
	<p>On page 1, added information about the Automated Response System and the MediCall System. On pages 2 and 3, clarified the treatment of advance payments to LTC providers. On pages 3-5, clarified the deduction of the facility personal needs allowance. On page 6, clarified when the dependent child allowance is given and added dental insurance premiums to allowable deductions from patient pay. On page 7, clarified the treatment of membership fees for organizations that sponsor insurance. On pages 7 and 8, clarified the treatment of Medicare Part A and Part B premiums as patient pay deductions.</p> <p>On page 9, clarified the treatment of Medicare Part D premiums. On pages 9-11, clarified the treatment of LTC insurance premiums. Page 12 is a runover page. On page 13, updated the address for DMAS. On pages 14 and 15, clarified the treatment of the home maintenance deduction. On page 16, moved the policy for LTC provider changes from M1470.320 to M1470.920 and renumbered the section regarding facility stays of less than 30 days. On pages 17, 18 and 19, revised text for improved clarity. On pages 20 and 21, revised the example. On page 22, clarified the treatment of membership fees for organizations that sponsor insurance. On pages 23 and 24, revised the example and clarified the treatment of Medicare Part D and LTC insurance premiums. Page 25 is a runover page.</p> <p>On pages 26 and 27, clarified the treatment of Medicare Part D copayments. Page 28 is a runover page. On page 29, revised the example. On page 30, revised text for improved clarity. On page 31, moved the policy for LTC provider changes from M1470.520 to M1470.920 and renumbered the section regarding PACE. On page 31, also clarified that Auxiliary Grant recipients are not eligible for PACE. On page 32, clarified the policy on Medically Needy coverage for individuals in an institution for mental disease. Pages 33-37 are runover pages. On page 38, revised the example. On page 39, clarified the treatment of spenddown for CBC patients. On page 40, updated the reference to the CBC waiver. On page 41, revised text for improved clarity. Page 42 is a runover page. On pages 43 and 44, clarified when the DMAS-225 form is used. On pages 45-46, revised text for improved clarity.</p> <p>On page 47, clarified when the Notice of Obligation is sent. On pages 48 and 49, clarified the procedures to use when the LTC provider changes within a month. On page 50, clarified the procedures to use when the individual dies or is discharged from LTC. Pages 51-54 are runover pages. On pages 55 and 56, revised text for improved clarity. Pages 57-66 were deleted. Appendix 1, Sample Notice of Obligation for LTC Costs Generated by MMIS, was added to the subchapter.</p>
Subchapter M1480 pages 67, 68 pages 76-93	On page 67, removed the policy for the DMAS-122 form and added policy for the new MMIS Patient Pay process. Page 68 is a runover page. On pages 76 and 77, removed references to the DMAS-122 form.

Pages Changed	Significant Changes
	Pages 78, 79, 84, 89 and 91 are runover pages. On pages 80-83, 85-88, 90, 92 and 93, deleted the references to the DMAS-122 form and updated the examples to reflect current MMIS enrollment procedures. Pages 94-96 were deleted.
Subchapter M1510 page 14	On page 14, the DMAS-122 reference and the LDSS responsibility for sending a Notice of Obligation policy are replaced by references to the new MMIS Patient Pay process.
Subchapter M1550 Appendix 1	Appendix 1 is updated.
Chapter M18 page 2 pages 5, 6 page 8	On pages 2 and 8, replaced the reference to the DMAS-122 form with the DMAS-225 form. On pages 2 and 6, updated the DMAS web site address. On page 5, changed the aid category acronym to "AC" and updated the intranet title.

Questions about this transmittal should be directed to Stephanie Sivert, Manager, Medical Assistance Programs, at 804-726-7660 or stephanie.sivert@dss.virginia.gov.


 Anthony Conyers, Jr.
 Commissioner

- 1. 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).
- 2. 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.
- 3. Title IV-E Foster Care & Medicaid Application/Redetermination**

The Title IV-E Foster Care & Medicaid Application/Redetermination, form #032-03-636 (available at: <http://spark.dss.virginia.gov/divisions/dfs/fc/files/forms/032-03-0636-02-eng.doc>) 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. The paper form is available online at: www.localagency.dss.state.va.us/divisions/bp/me/forms/general.cgi. The online application is available at: <https://jupiter.dss.state.va.us/VDAMedicaid>.

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 **eight months** 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. *Note that effective 3-10-09, the time limit for Afghan Special Immigrants changed from six months to eight months, beginning with the date of entry into the U.S. or the date of conversion to Special Immigrant Status. This includes individuals enrolled as of 3-10-09.*
- 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-

- 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 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. *Effective March 10, 2009, the period of eligibility for Afghan Special Immigrants, including those enrolled as of March 10, 2009, was also 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

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 *only* 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. *Effective March 10, 2009, both Iraqi and Afghan 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. This includes Afghan Special Immigrants enrolled in Medicaid as of March 10, 2009.*
- 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.

M0220.500 ALIENS ELIGIBILITY REQUIREMENTS

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

1. Residency the Virginia residency requirements (M0230);

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

2. Social Security Number (SSN) the SSN provision/application requirements (M0240);

NOTE: An alien eligible only for Medicaid payment of emergency services does not have to apply for or provide an SSN. This includes emergency-services-only aliens as defined in M0220.410 and unqualified aliens as defined in M0220.411.

	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 T1	Emergency Only T2	Emergency Only T3
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 U1	Emergency Only U2	Emergency Only U3
V	Illegal aliens – aliens not lawfully admitted or whose lawful admission status has expired	Emergency Only V1	Emergency Only V2	Emergency Only V3
W	Visitors (non-immigrants): tourists, diplomats, foreign students, temp. workers, etc. [I-688B – 274a.12(b)(1)-(20); I-94; I-185: I-I186; SW-434; I-95A]	Emergency Only W1	Emergency Only W2	Emergency Only W3
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 Y1	Full Benefits Y2	Full Benefits Y3

	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	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]	From 12-26-07 – 3-9-09, 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>Beginning 3-10-09, full benefits for EIGHT (8) MONTHS beginning with month of entry or date of conversion to SIV status. Includes individuals enrolled as of 3-10-09.</i>	Emergency Only	See Line Items B and C on page 1 of this appendix.
Z	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-551 or passport/ I-94 indicating categories S11, S12, S13, QQ1, SQ2, or SQ3 and bearing Department of Homeland Security stamp or notation]	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. Beginning 1-28-08, full benefits for EIGHT (8) MONTHS beginning with month of entry or date of conversion to SIV status.	Emergency Only	See Line Items B and C on page 1 of this appendix.

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 alien who is eligible only for Medicaid payment of emergency services, as defined in subchapter M0220, 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. Emergency-Services-Only Alien

an alien *eligible for Medicaid payment of emergency services only*, as defined in M0220.410 and M0220.411; an *emergency-services-only* 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. Emergency-Services-Only Alien

an alien *eligible for Medicaid payment of emergency services only*, as defined in M0220.410 and M0220.411; an *emergency-services-only* 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."

The DDS makes a determination of disability when the:

- applicant alleges a disabling condition and has never applied for a disability from SSA or has not been denied disability within the past 12 months;
- SSA has not made a decision on a pending SS/SSI claim; or
- applicant alleges a disabling condition which is different from that considered by SSA or is in addition to that considered by SSA.

1. Hospital Referrals to DDS for Expedited Disability Determination

The 2004 Budget Bill mandated DDS make a disability determination within seven (7) working days of receipt of a referral from DSS when the Medicaid applicant is hospitalized and needs to be transitioned to a rehabilitation facility. To identify those hospitalized individuals who require an expedited disability determination, the following procedures have been established:

a. Hospital staff will:

- send DSS the Medicaid application and a cover sheet (see Appendix 4 for an example of the cover sheet); and simultaneously
- send DDS the medical documentation (disability report, authorizations to release information and medical records) needed to make the disability determination and a copy of the cover sheet.

b. DDS must:

- make a disability determination within seven (7) working days; and
- fax the result of the disability decision to the DSS.

c. DSS must:

- fax a completed DDS Referral *Form* (#032-03-0095, #032-03-0096, #032-03-0097, or #032-03-0098) for the appropriate region, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>, to the appropriate DDS Regional Office, verifying receipt of the Medicaid application;
- give priority to processing the applications and immediately request any verifications needed;
- process the application as soon as the DDS disability determination and all necessary verifications are received; and
- notify the hospital contact identified on the cover sheet of the action on the application and provide the Medicaid enrollee number, if eligible.

Should DDS be unable to render a decision within 7 working days, DDS will send a communication to the DSS advising that the disability determination has been delayed.

2. DSS Referral to DDS Required When Disability Determination Has Not Been Made

The DDS must make a determination of disability when the applicant alleges a disability and a disability determination has not been made by SSA or the RRB. The DDS must make a disability determination within a time frame that will allow the DSS to process the application within 90 days, provided all medical information has been submitted. Follow the procedure in E. 1. below for making a referral to DDS except when a hospital has initiated an expedited disability determination (see D.1. above).

3. DSS Referral to DDS Required When SSA Denied Disability Within Past 12 Months

SSA decisions made within the past 12 months are final decisions for Medicaid purposes unless:

- a. The applicant alleges a condition that is new or in addition to the condition(s) already considered by SSA,

OR

- b. The applicant alleges his condition has changed or deteriorated causing a new period of disability, AND
- he no longer meets the SSI financial requirements but might meet Medicaid financial requirements, or
 - he applied to SSA for a reconsideration or a reopening and SSA has refused to reconsider or reopen his case.

If the conditions in a. or b. exist, DDS must make a disability determination. The eligibility worker must follow the procedure in E. 1. below to make a referral to DDS. Information regarding the new, changed and/or deteriorated condition(s) must be identified and sent to DDS using the procedure in E. 1. below.

If the conditions in a. or b. do not exist, the SSA denial of disability is final for Medicaid purposes. Do not make a referral to DDS for a disability determination.

4. Referral to DDS When SSA Denied Disability More Than 12 Months Ago

If the applicant alleges a disability and SSA denied the disability more than 12 months ago, the eligibility worker must follow the procedure in E. 1. below to make a referral to DDS.

E. DSS Procedures When a Disability Determination is Required

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, #032-03-0096, #032-03-0097, or #032-03-0098) for the appropriate region, available on SPARK 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 the **DDS** Regional Office to which the local DSS agency is assigned. The addresses for the DDS Regional Offices and their assigned local agencies are contained in M0310, Appendix 5.

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.

SAMPLE

Cover Sheet for Expedited Referral to DDS and DSS

This is an example of a cover sheet that is used when a Medicaid Disability Determination is required to transition a hospitalized patient to a rehabilitation facility. The address, phone number and fax number for the appropriate Regional DDS Office will be included in the cover letter.

Patient: _____

SSN: _____

This individual appears to satisfy the severity and duration requirements contained in Section 223(d) and Section 1614(a) of the Social Security Act.

DISABILITY is defined as:

The inability to do any substantial gainful work, because of a severe, medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or is expected to last for a continuous period of not less than 12 months.

The Medicaid Application has been sent to this Dept. of Social Services:

Agency Name: _____

Agency Address: _____

Date Mailed: _____

The information checked below is being faxed/overnighted to:

Disability Determination Services, Medicaid Unit

_____ (DDS Regional Office Address)

_____ (DDS Regional Office Phone & Fax #)

_____ Form SSA-3368 Disability Report Form

_____ SSA-827 Authorization to Disclose Information

_____ Medical Reports

_____ Medical History & Physical, including consultations

_____ Clinical findings (such as physical/mental status examination findings)

_____ Laboratory findings (such as latest x-rays, scans, pathology reports.)

_____ Diagnosis.

_____ A physician's statement providing an opinion about the individual's expected response to treatment and prognosis of residual capacity one year from onset.

Specific Clinical and Laboratory Findings Generally Required to Support Diagnosis and Assess Impairment Severity:

- medically acceptable imaging - X-rays/scans/MRIs
- spirometry, DLCO (diffusing capacity of lungs for carbon monoxide), AGBS (arterial blood gas studies)
- EKGs, cardiac catheterization, echocardiogram, Doppler studies
- pathology reports
- psychological test reports

Name of Hospital: _____ Date Completed: _____

Hospital Contact Person: _____ Telephone: (____) _____

Please Print

Fax: (____) _____

DDS Regional Offices

Send all *expedited and* non-expedited disability referrals to the DDS Regional Office to which the local DSS agency is assigned, as indicated in the table below.

DDS Regional Office	Local DSS Agency Assignments
<p>Central Regional Office Disability Determination Services 9960 Mayland Drive, Suite 200 Richmond, Virginia 23233</p> <p>Phone: 800-523-5007 804-367-4700 FAX: 866-323-4810</p>	<p>Amelia, Brunswick, Buckingham, Charles City, Charlotte, Chesterfield, Colonial Heights, Cumberland, Danville, Dinwiddie, Emporia, Essex, Goochland, Greenville, Halifax, Hanover, Henrico, Hopewell, King and Queen, King William, Lancaster, Lunenburg, Mecklenburg, Middlesex, New Kent, Northumberland, Nottoway, Petersburg, Pittsylvania, Powhatan, Prince Edward, Prince George, Richmond County, Richmond City, South Boston, Surry, and Sussex</p>
<p>Tidewater Regional Office Disability Determination Services 5850 Lake Herbert Drive, Suite 200 Norfolk, Virginia 23502</p> <p>Phone: 800-379-4403 757-466-4300 FAX: 866-773-0244</p>	<p>Accomack, Chesapeake, Franklin, Gloucester, Hampton, Isle of Wight, James City, Mathews, Newport News, Norfolk, Northampton, Portsmouth, Poquoson, Southampton, Suffolk, Courtland, Virginia Beach, Williamsburg, York</p>
<p>Northern Regional Office Disability Determination Services 11150 Fairfax Boulevard, Suite 200 Fairfax, Virginia 22030</p> <p>Phone: 800-379-9548 703-934-7400 FAX: 866-843-3075</p>	<p>Albemarle, Alexandria, Arlington, Augusta, Caroline, Charlottesville, Clarke, Culpepper, Fairfax City, Fairfax County, Falls Church, Fauquier, Fluvanna, Frederick, Fredericksburg, Greene, Harrisonburg, Highland, King George, Loudoun, Louisa, Madison, Manassas City, Orange, Page, Prince William, Rappahannock, Rockingham, Shenandoah, Spotsylvania, Stafford, Staunton, Warren, Waynesboro, Westmoreland, and Winchester</p>
<p>Southwest Regional Office Disability Determination Services 111 Franklin Road, S.E., Suite 250 Roanoke, Virginia 24011</p> <p>Phone: 800-627-1288 540-857-7748 FAX: 866-802-5842</p>	<p>Alleghany, Amherst, Appomattox, Bath, Bedford City, Bedford County, Bland, Botetourt, Bristol, Buchanan, Buena Vista, Campbell, Carroll, Covington, Craig, Dickenson, Floyd, Franklin, Galax, Giles, Grayson, Henry, Lee, Lexington, Lynchburg, Martinsville, Montgomery, Nelson, Patrick, Pulaski, Radford, Roanoke County, Roanoke City, Rockbridge, Russell, Salem, Scott, Smyth, Tazewell, Washington, Wise, and Wythe</p>

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

2. Not QMB

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

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

E. Ineligible In This Covered Group

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

M0320.205 ABD HOSPICE

A. Policy

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

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

Individuals receiving hospice services in the ABD Hospice Covered group may also receive services under the Elderly and Disabled with Consumer Direction (EDCD) Waiver, if the services are authorized by the Department of Medical Assistance Services (DMAS) (see M1440.101).

The individual must elect hospice care. Election of hospice care is verified either verbally or in writing from the hospice. If the verification is verbal, document the case record. Eligibility in the Hospice covered group is ongoing as long as the individual continues to receive hospice care, subject to a renewal of eligibility at least once every 12 months. The eligibility worker must verify that the hospice agreement is current at the time of the annual Medicaid renewal.

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

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

Individuals who meet the Hospice covered group may have their eligibility determined using the same financial requirements as institutionalized individuals.

B. Nonfinancial Eligibility

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

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

C. Financial Eligibility

1. Asset Transfer

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

2. Resources

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

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

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

a. Unmarried Individual

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

b. Married Individuals

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

3. Income

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

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

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

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

D. Entitlement

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

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

E. Enrollment

Eligible individuals must be enrolled in the appropriate aid category (AC). If the individual is aged, blind, or disabled as defined in M0310, he is enrolled under that AC. AC (054) is used for "deemed-disabled" individuals only. *Use the appropriate Hospice AC when the individual is also authorized to receive EDCD Waiver services.*

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

1. ABD Individual

a. Dual-eligible As QMB

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

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

b. Not QMB

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

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

2. "Deemed" Disabled Individual

An individual who is "deemed" disabled based on the hospice election is enrolled using AC 054. Individuals in this AC who have also been approved to receive services under the EDCD Waiver do not need a disability determination.

E. Post-eligibility Requirements (Patient Pay)

A patient pay must be calculated for individuals who receive hospice services in a nursing facility (see subchapter M1470). Individuals who receive hospice services outside of a nursing facility do not have a patient pay.

Individuals who have elected hospice services and who also receive Medicaid Long-term Care services available under the EDCD Waiver must have a patient pay calculation for the EDCD services (see subchapter M1470).

F. Ineligible In This Covered Group

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

M0320.206 QMB (QUALIFIED MEDICARE BENEFICIARY)

A. Policy

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

A QMB is an individual who:

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

has income that does not exceed 100% of the federal poverty limits.

B. Nonfinancial Eligibility

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

1. Entitled to Medicare Part A

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

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

2. Individual Not Currently Enrolled In Medicare Part A

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

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

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

3. Income

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

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

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

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

D. Entitlement & Enrollment

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

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

1. Dual-eligible As QMB

If the individual is also a Qualified Medicare Beneficiary (QMB) – the individual has Medicare Part A and has countable income within the QMB income limit - the AC is "062."

2. Not QMB

If the individual is NOT a Qualified Medicare Beneficiary (QMB) – the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - the AC is "060."

E. Ineligible In This Covered Group

If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy spenddown. For unmarried individuals, redetermine resources using the F&C medically needy policy in chapter M06. Do not recalculate resources of a married individual.

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

M0320.311 F&C HOSPICE**A. Policy**

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

Individuals receiving hospice services in the F&C Hospice Covered group may also receive services under the Elderly and Disabled with Consumer Direction (EDCD) Waiver, if the services are authorized by DMAS (see M1440.101).

To be eligible in the hospice covered group, the individual must file an election statement with a particular hospice which must be in effect for 30 or more consecutive days. Eligibility in the Hospice covered group is ongoing as long as the individual continues to receive hospice care, subject to a renewal of eligibility at least once every 12 months. The eligibility worker must verify that the hospice agreement is current at the time of the annual renewal.

The 30-day requirement begins on the effective date of the hospice care election. Once the hospice election has been in effect for each of 30 consecutive days, the 300% of SSI income limit is used to determine Medicaid eligibility. If the individual's income is within the limit, eligibility begins the effective date of the hospice election.

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

B. Nonfinancial Eligibility

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

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

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

C. Financial Eligibility

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

1. Asset Transfer

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

2. Resources

a. Resource Eligibility - Unmarried Individual

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

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

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

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

c. Resource Eligibility - Married Individual

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

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

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

3. Income

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

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

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

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

D. Entitlement & Enrollment

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

1. Entitlement

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

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

2. Enrollment

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

E. Post-eligibility Requirements (Patient Pay)

Individuals who receive hospice services in a nursing facility have a patient pay calculation (see subchapter M1470). *Individuals who receive hospice services outside of a nursing facility do not have a patient pay.*

Individuals who have elected hospice services and who also receive Medicaid Long-term Care services available under the EDCD Waiver must have a patient pay calculation for the EDCD services (see subchapter M1470).

F. Ineligible In This Covered Group

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

- B. Earned Income Exclusions**
- Income exclusions are applied, in the following order, to earned income for family unit/budget unit (FU/BU) members as appropriate to the covered group.
- See Families and Children (F&C) Earned Income Exclusions chart in Appendix 1 to this subchapter.
1. **Workforce Investment Act Income**
Earned income of an eligible child (less than 18, or 18 and expected to graduate prior to 19) derived from employment in a program under the Workforce Investment Act is excluded. Do not request verification of income from employment under the Workforce Investment Act.
 2. **Student Income**
Earned income of an individual under age 19 who is a student is excluded. Do not request verification of student income.

For this exclusion, a student is any individual under age 19 who is attending any type or level of school, part-time or full-time. Do not verify school attendance; declaration of school attendance is sufficient.
 3. **2010 Census Income**
Income paid by the U.S. Census Bureau to temporary employees specifically hired for the 2010 census is NOT counted when determining eligibility for medical assistance.
 4. **Standard Work Exclusion**
A standard work exclusion of the first \$90 of gross monthly earned income is excluded for each employed member of the FU/BU whose income is not otherwise exempt. For LIFC, the standard work exclusion is not allowed in the 185% screening. See M0720.520.
 5. **\$30 Plus 1/3 Earned Income Exclusion**
For the LIFC covered group only, \$30 plus 1/3 of the remaining monthly earned income is excluded for 4 consecutive months from the total earnings (other than those specified above) and from self-employment of each employed member of the FU/BU. The \$30 plus 1/3 earned income exclusion is not allowed in the 185% screening. See M0720.525.
 6. **\$30 Earned Income Exclusion**
For the LIFC covered group only, \$30 per month earned income is excluded for 8 consecutive months following the receipt of 4 months of the \$30 plus 1/3 earned income exclusion from total earnings (other than those specified above) and from self-employment of each employed member of the FU/BU. The \$30 earned income exclusion is not allowed in the 185% screening. See M0720.526.
 7. **Child Care/Incapacitated Adult Care Exclusion**
Monthly anticipated child care expenses or incapacitated adult care expenses, up to the appropriate maximums, which are paid for by the caretaker-relative must be excluded. For LIFC, the child care/incapacitated adult care exclusion is not allowed in the 185% screening. See M0720.540.

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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

1. General 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.

2. Special \$25 Weekly Exclusion

The American Recovery and Reinvestment Act of 2009 (P.L. 111-5) authorized an increase in Unemployment Compensation payments of \$25 per week for certain individuals. This increase is authorized for Unemployment Compensation payments made through June 26, 2010. However, the individual's entitlement to Unemployment Compensation is not affected—the individual will only receive the number of payments to which the individual would normally be entitled.

To be entitled to the \$25 weekly increase in payments, the individual must have received Unemployment Compensation on or after February 28, 2009 and be entitled to a weekly Unemployment Compensation payment of at least \$1.00.

Because the Virginia Employment Commission did not immediately implement the increased payments, these individuals are subject to receiving a one-time lump sum retroactive payment as well as an additional \$25 per week prospectively until the individual's Unemployment Compensation benefits are discontinued.

a. Lump sum payment

The lump sum retroactive payment is excluded from countable income.

b. Prospective payments

If the individual received Unemployment Compensation on or after February 28, 2009, disregard the first \$25 of the weekly payment from income.

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 \$100 of support collected in a month on behalf of the TANF assistance unit to that unit. (If the total support collected is less than \$100, 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 amount to the TANF assistance unit. That excess amount is counted as unearned income.

2. **\$100 Pass Through** Child support collected by DCSE and paid to a TANF assistance unit as a \$100 (or less) pass-through of child support, is income to the Medicaid family/budget unit when the pass-through check exceeds \$50.00 per month. The amount of the monthly pass-through check that exceeds \$50.00 is counted for Medicaid eligibility.
 3. **Amount in Excess of the 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.

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C. Procedure

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

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

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

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

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

EARNED INCOME EXCLUSIONS

M0820.500 GENERAL

A. Policy

- 1. General**

The source and amount of all earned income must be determined, but not all earned income counts when determining Medicaid eligibility.
- 2. Other Federal Laws**

First, income is excluded as authorized by other Federal laws.
- 3. 2010 Census Income**

Income paid by the U.S. Census Bureau to temporary employees specifically hired for the 2010 census is NOT counted when determining eligibility for medical assistance.

4. Other Earned Income

Then, other income exclusions are applied, in the following order, to the rest of earned income in the month:

- a. Federal earned income tax credit payments.
- b. Up to \$10 of earned income in a month if it is infrequent or irregular.
- c. For 2008, up to \$1,550 per month, but not more than \$6,240 in a calendar year, of the earned income of a blind or disabled student child.

For 2009, up to \$1,640 per month, but not more than \$6,600 in a calendar year, of the earned income of a blind or disabled student child.
- d. Any portion of the \$20 monthly general income exclusion which has not been excluded from unearned income in that same month.
- e. \$65 of earned income in a month
- f. Earned income of disabled individuals used to pay impairment-related work expenses.
- g. One-half of remaining earned income in a month
- h. Earned income of blind individuals used to meet work expenses
- i. Any earned income used to fulfill an approved plan to achieve self-support.

5. Unused Exclusion

Earned income is never reduced below zero. Any unused earned income exclusion is never applied to unearned income.

Any unused portion of a monthly exclusion cannot be carried over for use in subsequent months.

6. Couples

The \$20 general and \$65 earned income exclusions are applied only once to a couple, even when both members (whether eligible or ineligible) have income, since the couple's earned income is combined in determining Medicaid eligibility.

B. References

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

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

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

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M0830.230 UNEMPLOYMENT *COMPENSATION* BENEFITS

A. Definition **Unemployment *Compensation*** payments *are* received under a State or Federal unemployment law and additional amounts paid by unions or employers as unemployment benefits.

B. Procedures

1. General Procedures Unemployment *Compensation* benefits are *counted as* unearned income

2. Special \$25 Weekly Exclusion *The American Recovery and Reinvestment Act of 2009 (P.L. 111-5) authorized an increase in Unemployment Compensation payments of \$25 per week for certain individuals. This increase is authorized for Unemployment Compensation payments made through June 26, 2010. However, the individual's entitlement to Unemployment Compensation is not affected—the individual will only receive the number of payments to which the individual would normally be entitled.*

To be entitled to the \$25 weekly increase in payments, the individual must have received Unemployment Compensation on or after February 28, 2009 and be entitled to a weekly Unemployment Compensation payment of at least \$1.00.

Because the Virginia Employment Commission did not immediately implement the increased payments, these individuals are subject to receiving a one-time lump sum retroactive payment as well as an additional \$25 per week prospectively until the individual's Unemployment Compensation benefits are discontinued.

a. Lump sum payment

The lump sum retroactive payment is excluded from countable income. Any amount retained in the month following the month of receipt is a countable resource.

b. Prospective payments

If the individual received Unemployment Compensation on or after February 28, 2009, disregard the first \$25 of the weekly payment from income.

S0830.235 WORKERS' COMPENSATION

A. Introduction Workers' compensation (WC) payments are awarded to an injured employee or his/her survivor(s) under Federal and State WC laws, such as the Longshoremen and Harbor Workers' Compensation Act. The payments may be made by a Federal or State agency, an insurance company, or an employer.

B. Policy

1. Income **a. General**

The WC payment less any expenses incurred in getting the payment is unearned income.

M1110.515 OWNERSHIP IN FEE SIMPLE OR LESS THAN FEE SIMPLE

A. Definitions

1. Fee Simple

Fee simple ownership means absolute and unqualified legal title to real property. The owner(s) has unconditional power of disposition of the property during his or her lifetime. Upon his or her death, property held in fee simple can always pass to the owner's heirs. Fee simple ownership may exist with respect to property owned jointly or solely.

2. Less than Fee Simple Ownership

a. Life Estate

A life estate confers upon one or more persons (grantees) certain rights in a property for his/her/their lifetimes or the life of some other person. A life estate is a form of legal ownership and usually created through a deed or will or by operation of law. See B. below.

b. Equitable Ownership

An equitable ownership interest is a form of ownership that exists without legal title to property. It can exist despite another party's having legal title (or no one's having it). See C. below.

B. Description--Life Estate

1. Rights of Life Estate Owner

a. What Owner Can Do

Unless the instrument (will or deed) establishing the life estate places restrictions on the rights of the life estate owner, the owner has the right to possess, use, and obtain profits from the property and to sell his or her life estate interest.

Whether the value of a life estate is counted as a resource depends on when the life estate was created.

- The value of a life estate created prior to August 28, 2008 is **not** counted as a resource.
- *The value of a life estate created on or after August 28, 2008 but before February 24, 2009 is a countable resource to the owner of the life estate unless the life estate is excluded under one of the real property exclusions contained in Chapter S11.*
- The value of a life estate created on or after February 24, 2009 is **not** counted as a resource.

Exception: The value of a life estate owned by a QDWI enrollee is countable, regardless of the date on which it was created. See M1140.110 for additional information.

b. What Owner Cannot Do

A life estate owner owns the physical property only for the duration of the life estate. The owner generally can sell only his or her interest; i.e., the life estate. The owner cannot take any action concerning the interest of the remainderman.

2. Remainder Interest

a. Future Interest in Physical Property

A life estate instrument often conveys property to one person for life (life estate owner) and to one or more others (remaindermen) upon the expiration of the life estate. A remainderman has an ownership interest in the physical property but without the right to possess and use the property until termination of the life estate.

b. Sale of Remainder Interest

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

3. Example

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

C. Policy--Equitable Ownership Interest

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

1. Unprobated Estate

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

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

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

2. Trust

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

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

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

**3. Equitable
Home
Ownership**

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

D. References

The following references pertain to trust situations:

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

**S1110.520 PROPERTY RIGHTS WITHOUT OWNERSHIP OF THE
PROPERTY**

A. Introduction

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

B. Definitions

1. Leasehold

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

**2. Incorporeal
Interests**

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

M1130.140 REAL PROPERTY FOLLOWING REASONABLE BUT UNSUCCESSFUL EFFORTS TO SELL

A. Policy Principles

1. Exclusion

Real property, including a life estate in real property *created on or after August 28, 2008 but before February 24, 2009*, that an individual has made reasonable but unsuccessful efforts to sell, will continue to be excluded for as long as:

- the individual continues to make reasonable efforts to sell it; and
- including the property as a countable resource would result in a determination of excess resources.

This exclusion is effective the first of the month in which the most recent application was filed or up to three months prior if retroactive coverage is required.

B. Operating Procedure

The "current market" value (CMV) of real property located in Virginia is the tax assessed value of the property. For property located outside of Virginia the CMV is determined by applying the tax assessed value of the property to the local assessment rate, if the rate is not 100%.

1. Initial Effort Established

The following criteria define reasonable efforts to sell. The listing price must not exceed 100% of CMV.

A reasonable effort to sell is considered to have been made:

- a. As of the date the property becomes subject to a realtor's listing agreement if, it is listed at current market value, **AND** the listing realtor verifies that it is unlikely to sell within 90 days of listing given particular circumstances involved; for example
 - owner's fractional interest;
 - zoning restrictions;
 - poor topography;
 - absence of road frontage or access;
 - absence of improvements;
 - clouds on title;
 - right of way or easement;
 - local market conditions; or
- b. When at least two realtors refuse to list the property. The reason for refusal must be that the property is unsalable at CMV (other reasons are not sufficient); or

M1140.110 OTHER PROPERTY RIGHTS

A. Introduction

1. **Mineral Rights** Mineral rights represent ownership interest in natural resources such as coal, oil, or natural gas, which normally are extracted from the ground.
2. **Timber Rights** Timber rights permit one party to cut and remove free standing trees from the property of another property.
3. **Easements** An easement gives one party the right to use the land of another party for a special purpose.
4. **Leaseholds** A leasehold gives one party control over certain property of another party for a specified period. In some States, a "lease for life" can create a life estate under common law. See M1140.110A.6 for life estates.
5. **Water Rights** Water rights usually confer upon the owner for riverfront or storefront property the right to access and use the adjacent water.
6. **Life Estates**
 - a. **General**

A life estate conveys to the individual to whom it is given certain property rights for the duration of his or her life, or someone else's life. In some cases, it may be conditional: e.g., for life or until remarriage.

The owner of a life estate can sell the life estate but does not have title to the property and thus normally cannot sell it or pass it on as an inheritance.

b. Life Estate Created Prior to August 28, 2008

The value of a life estate created prior to August 28, 2008 is not counted as a resource. Exception: The value of a life estate owned by a QDWI enrollee is countable, regardless of the date on which it was created.

c. Life Estate Created On or After August 28, 2008 but Before February 24, 2009

The value of a life estate created on or after August 28, 2008 *but before February 24, 2009* is a countable resource to the owner of the life estate unless the life estate is excluded under one of the real property exclusions contained in Chapter S11. Exception: The value of a life estate owned by a QDWI enrollee is countable, regardless of the date on which it was created.

The value of a life estate in real property on which the individual resides and considers to be his home is excluded. If the individual leaves the property but retains a life estate, and the property is not occupied by a spouse or dependent child, the value of the life estate becomes a countable resource unless it is excluded under one of the real property exclusions contained in Chapter S11.

d. Life Estate Created on or after February 24, 2009

The value of a life estate created on or after February 24, 2009 is not counted as a resource. Exception: The value of a life estate owned by a QDWI enrollee is countable, regardless of the date on which it was created.

7. Remainder Interests

When the owner of property gives it to one party in the form of a life estate, and designates a second party to inherit it upon the death of the life estate holder, the second party has a remainder interest in the property.

B. Development and Documentation

1. General

Treat the items in A. above as real property and develop ownership and value per S1140.100. See 4. below for additional instructions regarding life estates and remainder interests.

2. Mineral Rights

a. Ownership of Land and Mineral Rights

If the individual owns the land to which the mineral rights pertain, the CMV of the land can be assumed to include the value of the mineral rights. Additional development is unnecessary.

b. Ownership of Mineral Rights Only

If the individual does not own the land to which the mineral rights pertain, obtain a CMV estimate from a knowledgeable source. Such sources include, in addition to those listed in S1140.100 D.2.c.:

- the Bureau of Land Management;
- the U.S. Geological Survey;
- any mining company that holds leases.

3. Lease for Life

Refer any "lease for life" agreement and related information to the regional coordinator for a determination of whether it creates a life estate under State law.

4. Value of Life Estate or Remainder Interest

a. General

The value of a life estate created on or after August 28, 2008 *but before February 24, 2009* is a countable resource to the owner of the life estate unless the life estate is excluded under one of the real property exclusions contained in Chapter S11.

b. Calculate Value of Life Estate

To determine the countable value of a life estate, use the table in S1140.120. Multiply the CMV of the property by the life estate or remainder interest decimal that corresponds to the individual's age. Record the result.

If there is more than one life estate, divide the equity value of the real property by the number of people having a life estate interest. Multiply the prorated equity value of the property by the life estate or remainder interest decimal that corresponds to the individual's age. Record the result.

c. Life Estate Affects Property Value

Any countable equity value of real property would be affected if it is:

- subject to someone else having life estate interest, or
- the applicant/recipient transfers their real property retaining a life estate interest, thus affecting the value for evaluation of transfer of assets.

See S1140.120, Life Estate and Remainder Interest Tables to determine CMV of real property owned by an applicant or recipient.

screening is not required (See M1420.400). If an individual is receiving private-pay *home health services*, 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.

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

The *Medicaid Long-term Care Communication Form (DMAS-225)* notifies the LTC provider of changes to an enrollee'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 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 & FAMIS (#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 is sent to the applicant/enrollee or the authorized representative to notify them of the amount of patient pay responsibility. *The form is generated and sent by the Medicaid Management Information System (MMIS) on the day the patient pay information is entered into MMIS. The report of all Notices sent by MMIS each day is posted by FIPS code on SPARK in the Medicaid Management Reports.*
- 3. Medicaid LTC Communication Form (DMAS-225)**

The Medicaid Long-term Care (LTC) Communication Form is available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi. *The form is used by LTC providers and local departments of social services (LDSS) to exchange information, other than patient pay information, such as:*

 - *the Provider National Provider Identifier (NPI)/Atypical Provider Identifier(API) number;*
 - *the enrollee's physical residence, if different than the LDSS locality;*
 - *changes in the enrollee's income, resources or deductions;*
 - *admission, death or discharge to an institution or community-based care service;*
 - *changes in eligibility status; and*
 - *changes in third-party liability.*

Do not use the DMAS-225 to relay the patient pay amount. Providers are able to access patient pay information through the Department of Medical Assistance Services (DMAS) provider verification systems.

a. When to Complete the DMAS-225

The EW completes the DMAS-225 at the time *initial patient pay information is added to MMIS, when there is a change in the enrollee's situation or when a change affects an enrollee's Medicaid eligibility.*

b. Where to Send the DMAS-225

- 1) *For hospice services patients, send the original form to the hospice provider*
- 2) For facility patients, send the *original form* to the *nursing facility*.
- 3) For PACE recipients, send the original *form* to the PACE provider.
- 4) *For Medicaid CBC, send the original form to the following individuals:*
 - the case manager at the Community Services Board, for the MR and DS waivers;
 - *the case manager* (support coordinator), for the DD Waiver,
 - *the personal care provider, for agency-directed EDCD personal care services and other services,*
 - the service facilitator, for consumer-directed EDCD services,
 - *the case manager, for any enrollee with case management services, and*
 - The case manager at DMAS, for the Tech Waiver, at the following address:

*Department of Medical Assistance Services
Division of LTC, Waiver Unit,
600 E. Broad St,
Richmond, VA 23219.*

Retain a copy of the completed DMAS-225 in the case record.

4. Advance Notices of Proposed 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 when:

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

b. Notice of Obligation for Long-Term Care Costs

When a change in the patient pay amount is entered in MMIS, a “Notice of Obligation for Long-term Care Costs” will be generated and sent by MMIS as the advanced notice to the applicant/recipient or the authorized representative.

Patient pay must be entered into MMIS no later than close-of-business on the 15th day of the month, to meet the advance notice requirement.

Do not send the “Advance Notice of Proposed Action” when patient pay increases.

**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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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.

M1440.106 ALZHEIMER’S ASSISTED LIVING WAIVER

A. General Description The Alzheimer’s Assisted Living (AAL) Waiver is available only to individuals who are Auxiliary Grants (AG) recipients. 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 on this waiver do not have Medicaid eligibility determined as institutionalized individuals, and there are no post-eligibility requirements.**

The AAL waiver serves persons who are:

- Auxiliary Grants (AG) recipients,
- have a diagnosis of Alzheimer’s or a related dementia and no diagnosis of mental illness or mental retardation, and
- age 55 or older.

B. Eligibility Rules 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 enrollment and notification procedures used with non-institutionalized Medicaid recipients are followed (see M0130.300).

C. Services Available Services available under the AAL waiver are:

- 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. Assessment and Service Authorization Local 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.

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

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

This waiver serves persons who:

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

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

B. Eligibility Rules

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

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

C. Services Available

Services available under the DD waiver are:

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

D. Assessment and Service Authorization

The initial assessment and development of the plan is conducted by qualified individuals under contract with DMAS. DMAS staff will review the contractor's plan and authorization.

M1440.108 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

A. General Description

PACE is NOT a CBC Waiver, but rather is the State's community model for the integration of acute and long-term care. PACE 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.

B. Targeted Population

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.

C. Eligibility Rules

For Medicaid to cover PACE services, the individual must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid eligible in a medical institution. The resource and income rules are applied to PACE-eligible individuals as if the individuals were residing in a medical institution.

The income limit used for PACE is 300% of the SSI limit (see M0810.002 A. 3.) or the MN income limit and spenddown.

PACE is not available to individuals who reside in an assisted living facility (ALF) and receive Auxiliary Grant (AG) payments. Individuals who reside in an ALF may be enrolled in PACE if they meet the functional, medical/nursing, and financial requirements, but they will not be permitted to receive an AG payment.

D. Services Available

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.

E. Assessment and Service Authorization

*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.*

Eligibility for PACE must begin on the first day of a month and end on the last day of a month.

M1440.200 COVERED SERVICES

A. Introduction

This section provides general information regarding the LTC services provided under the waivers. This is just for your information, understanding, and referral purposes. The information does not impact the Medicaid eligibility decision.

B. Waiver Services Information

Information about the services available under a waiver is contained in the following sections:

- M1440.201 Personal Care/Respite Care Services
- M1440.202 Adult Day Health Services
- M1440.203 Case Management Services
- M1440.204 Private Duty Nursing Services

- M1440.205 Nutritional Supplements
- M1440.206 Environmental Modifications
- M1440.207 Residential Support Services
- M1440.208 Personal Assistance Services
- M1440.209 Assistive Technology Services
- M1440.210 Day Support Services
- M1440.211 Supported Employment Services
- M1440.212 Therapeutic Consultation Services
- M1440.213 Personal Emergency Response System (PERS)
- M1440.214 Prevocational Services

M1440.201 PERSONAL CARE/RESPIRE CARE SERVICES

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

M1440.202 ADULT DAY HEALTH CARE SERVICES

- A. What Is Adult Day Health Care** Adult Day Health Care (ADHC) is a congregate service setting where individuals receive assistance with activities of daily living (e.g., ambulating, transfers, toileting, eating/feeding), oversight of medical conditions, administration of medications, a meal, care coordination including referrals to rehabilitation or other services if needed, and recreation/social activities. A person may attend half or whole days, and from one to seven days a week, depending on the patient's capability, preferences, and available support system.

- B. Relationship to Other Services** ADHC centers may provide transportation and individuals may receive this service, if needed, to enable their attendance at the center. An individual may receive ADHC services in conjunction with Personal Care or Respite Care services as needed.
- C. Who May Receive the Service** An individual must meet the EDCD Waiver criteria to qualify for ADHC services.

M1440.203 CASE MANAGEMENT SERVICES

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

M1450.800 AGENCY ACTION

- A. Policy** If an institutionalized individual's asset transfer is not allowable by policy, the individual is eligible for Medicaid but is not eligible for Medicaid payment of long-term care services. The individual, the service provider, and the Department of Medical Assistance Services (DMAS) must be notified of his/her ineligibility for Medicaid payment of long-term care services.
- B. Procedures** The procedures used for notifying the recipient, the provider and DMAS are in sections M1450.810, 820, and 830 below.

M1450.810 APPLICANT/RECIPIENT NOTICE

- A. Policy** Whenever an institutionalized individual is not eligible for Medicaid payment of long-term care services because of an asset transfer, the form which notifies him/her of Medicaid eligibility must include the penalty period during which Medicaid will not cover LTC services for the individual.
- B. Notice Contents** The Notification of Action on Medicaid sent to the individual must specify:
- the individual is eligible for Medicaid beginning (the appropriate date) and
 - Medicaid will not pay for nursing facility or CBC waiver services for the months (state the begin and end dates of the penalty period) because of the uncompensated asset transfer(s) that occurred (date/dates).
 - the penalty period may be shortened if compensation is received.
- C. Advance Notice** When an institutionalized Medicaid recipient is found no longer eligible for Medicaid payment of long-term care services because of an asset transfer, the Advance Notice of Proposed Action must be sent to the individual at least 10 days before cancelling coverage of LTC services, and must specify:
- the individual is eligible for Medicaid.
 - Medicaid will not pay for long-term care services for the months (state the penalty period begin and end dates) because of the asset transfer(s) that occurred (date/dates).
 - The penalty period may be shortened if compensation is received.

M1450.820 PROVIDER NOTICE

- A. Introduction** Use the *Medicaid LTC Communication Form (DMAS-225)* to notify the provider of the individual's Medicaid eligibility and ineligibility for Medicaid payment of long-term care services.

**B. Medicaid LTC
Communication
Form (DMAS-225)**

The *DMAS-225* should include:

- the individual's full name, Medicaid and Social Security numbers;
- the individual's birth date;
- the patient's Medicaid coverage begin date; and
- that the patient is not eligible for Medicaid payment of nursing facility/CBC waiver services for the months (state the penalty period begin and end dates) because of an asset transfer(s).

M1450.830 DMAS NOTICE

A. Introduction

The worker must notify DMAS that the recipient is not eligible for LTC services payment because of an asset transfer. DMAS must input the code in the MMIS that will deny payment of LTC services claims.

The worker notifies DMAS via a copy of the *DMAS-225* sent to the provider.

B. Copy of *DMAS-225*

The copy of the *DMAS-225* that is sent to DMAS must contain the following information, in addition to the information on the provider's copy of the *DMAS-225*:

- date(s) the asset transfer(s) occurred;
- the uncompensated value(s); and
- penalty period(s) (begin and end dates) and computation of that period(s).

C. Send DMAS Notice

The agency worker must send a copy of the *DMAS-225* to:

Program Delivery Systems
Long-Term Care Unit
Department of Medical Assistance Services
600 E. Broad St., Suite 1300
Richmond, VA 23219.

The copy of the *DMAS-225* must be signed and dated by the worker, and must show the worker number and the local agency's FIPS code.

Any information the agency receives about the individual's subsequent receipt of compensation which shortens the penalty period must be sent to the Long-Term Care Unit at the above address.

b. F&C Covered Groups

- 1) Excluded Resources (section M0630.100).
- 2) Reasonable Effort To Sell (CN, CNNMP) (section M0630.105).
- 3) Reasonable Effort To Sell For the Medically Needy (section M0630.110).

F. Home No Longer Excluded

If the individual's home property is no longer excluded and the individual has excess resources, cancel Medicaid because of excess resources when the individual does not have Medicare Part A. If the individual has Medicare Part A, evaluate the individual's eligibility as ABD MI, which has more liberal resource requirements and limits.

1. Individual Has Medicare Part A

When the individual has Medicare Part A:

- a. compare income with the ABD MI limits; if the income is below one of the ABD MI income limits, then
- b. evaluate the resources using ABD MI policy as found in Chapter S11, Appendix 2.
- c. If eligible as ABD MI only, Medicaid will not pay for nursing facility or CBC waiver services costs. Do the following:
 - prepare and send an Advance Notice of Proposed Action to the recipient;
 - cancel the recipient's coverage in the MMIS, then reinstate the recipient to ABD MI limited coverage;
 - send a *Medicaid LTC Communication Form (DMAS-225)* to the provider, stating that the recipient is no longer eligible for full Medicaid coverage because of excess resources, but is eligible for limited ABD MI coverage; beginning (specify the date following the cancel date of the recipient's full coverage), Medicaid will not pay for the individual's care.
- d. If NOT eligible as ABD MI because of resources and/or income, cancel the recipient's Medicaid. Do the following:
 - prepare and send an "Advance Notice of Proposed Action" to the recipient;
 - cancel the recipient's Medicaid coverage in the MMIS because of excess resources or income;

- send a *DMAS-225* to the provider, stating that the recipient's Medicaid will be canceled because of excess resources (and/or income) and the effective date of cancellation.

2. Individual Does Not Have Medicare Part A

When the individual DOES NOT have Medicare Part A:

- a. cancel the recipient's Medicaid coverage in the MMIS because of excess resources;
- b. prepare and send an Advance Notice of Proposed Action to the recipient;
- c. send a *DMAS-225* to the provider, stating that the recipient's Medicaid will be canceled because of excess resources, and the effective date of cancellation.

M1460.540 SUSPENSION PROCEDURES

A. Policy

This section applies ONLY to Medicaid recipients:

- who are enrolled in ongoing Medicaid coverage and
- whose patient pay exceeds the Medicaid rate.

B. Procedures

If a Medicaid recipient's patient pay exceeds the Medicaid rate and his resources go over the Medicaid resource limit, take the following actions:

1. For Recipients Who Have Medicare Part A

a. Resources Less Than or Equal to ABD MI Resource Limit

If the recipient's resources are less than or equal to the higher ABD MI resource limit, **determine** if the recipient's income is less than or equal to the QMB, SLMB, or QI income limit.

- 1) When the recipient's income is less than or equal to the QMB, SLMB, or QI income limit:
 - a) prepare and send an advance notice to reduce the recipient's Medicaid coverage from full benefits to limited benefits (specify the appropriate QMB, SLMB, or QI coverage). Write a note on the notice telling the recipient that:
 - the limited (QMB, SLMB, or QI) benefits will NOT pay for long-term care services, and
 - if he verifies that his resources are less than or equal to the \$2,000 resource limit, he should request reinstatement of full Medicaid benefits.

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M1470.000 PATIENT PAY-POST-ELIGIBILITY TREATMENT OF INCOME

M1470.001 OVERVIEW

- A. Introduction** “Patient pay” is the amount of the LTC patient’s income which must be paid as his share of the LTC services cost. This subchapter provides basic rules regarding the post-eligibility determination of the amount of the LTC patient’s income which must be paid toward the cost of his care.
- B. Policy** The state’s Medicaid program must reduce its payment to the LTC provider by the amount of the eligible patient’s monthly income, after allowable deductions. Patient pay is calculated after an individual has been determined eligible for Medicaid and for Medicaid LTC services. A Medicaid recipient who is admitted to a nursing facility, ICF-MR or Medicaid waiver services for less than 30 days must have a patient pay determined for the month(s) in which the recipient is in the facility or waiver services. The provider collects the patient pay from the patient or his authorized representative. *Patient pay information is pulled from the Medicaid Management Information System (MMIS) to the Automated Response System (ARS) and the MediCall Systems for provider verification of patient pay. These systems report the amount of patient pay and the date of service to the provider responsible for collecting patient pay.*
- C. MMIS Patient Pay Process** *The patient pay calculation is completed in MMIS. Refer to the MMIS User’s Guide for DSS for information regarding data entry into MMIS. MMIS allows the patient pay to be calculated for up to three months to capture changes in allowances due to the Medicare buy-in, etc. For ongoing enrollees whose patient pay is being entered in MMIS for the first time, or for new enrollees whose patient pay will not change after the first month, it is not necessary to complete the patient pay calculation beyond the first month. The patient pay must be updated in MMIS whenever the patient pay changes, but at least once every 12 months.*
- The MMIS Allowance and Medically Needy Workbook is available to facilitate the calculation of certain allowances that must be computed outside of MMIS and to calculate patient pay for Medically Needy determinations. The workbook is available at: http://www.vcu.edu/vissta/bps/bps_resources/ltc_medicaid.htm.*
- D. Patient Notification** *The patient or the authorized representative is notified of the patient pay amount on the Notice of Obligation for Long-term Care Costs. MMIS will generate and send the Notice of Obligation for LTC Costs. M1470, Appendix 1 contains a sample Notice of Obligation for LTC Costs generated by MMIS.*
- The provider’s failure to collect the patient pay, or the patient’s failure to pay the patient pay, does not affect the patient’s Medicaid eligibility. However, if the patient pay is not paid to or collected by the provider, the EW must review the patient’s resources each month to determine if the resources are within the Medicaid limit.

M1470.100 AVAILABLE INCOME FOR PATIENT PAY

- A. Gross Income** Gross monthly income is considered available for patient pay. Gross monthly income is the same income used to determine an individual’s eligibility in the 300% SSI income group. It includes types and amounts of income which are excluded when determining medically needy eligibility.

- 1. 300% SSI Group** If the individual is eligible in the 300% SSI group, to determine patient pay start with the gross monthly income calculated for eligibility. Then add and deduct any amounts that are listed in subsection C. below.
- 2. Groups Other Than 300% SSI Group** If the individual is eligible in a covered group other than the 300% SSI group, determine the individual's patient pay income using subsections B. and C. below.
- B. Income Counted For Patient Pay** All countable sources of income for the 300% SSI group listed in section M1460.611 are considered income in determining patient pay. Any other income NOT specified in C. below is counted as income for patient pay.
- 1. Aid & Attendance and VA Pension Payments** Count the total VA Aid & Attendance payments and/or VA pension payments in excess of \$90.00 per month as income for patient pay when the patient is:
- a veteran who does not have a spouse or dependent child, or
 - a deceased veteran's surviving spouse who does not have a dependent child.
- Do not count any VA Aid & Attendance payments and/or VA pension payments when the patient is:
- a veteran who has a spouse or dependent child, or
 - a deceased veteran's surviving spouse who has a dependent child.
- NOTE: This applies to all LTC recipients, including patients who reside in a Veterans Care Center.
- 2. Non-Refundable Advance Payments To LTC Providers** Advance payments and pre-payments paid by a recipient to the LTC provider that will not be refunded are counted as income for patient pay. *M1470.1100 contains instructions for calculating the patient pay when an advance payment has been made to reduce resources within a month.*
- C. Income Excluded For Patient Pay** Income *from sources* listed in subchapter M1460.610 "What is Not Income" is not counted when determining patient pay, **EXCEPT** for the VA Aid & Attendance and VA pension payments to veterans which are counted in the patient pay calculation (see B. above). *Additional* types of income excluded from patient pay are listed below.
- 1. SSI & AG Payments** All SSI *and Auxiliary Grants (AG)* payments are excluded from income when determining patient pay.
- 2. Certain Interest Income**
- a. Interest or dividends accrued on excluded funds which are set aside for burial are not income for patient pay.
 - b. Interest income when the total interest accrued on all interest-bearing accounts is less than or equal to \$10 monthly is not income for patient pay. Interest income that is not accrued monthly must be converted to a monthly amount to make the determination of whether it is excluded.
 - Verify interest income at application and each scheduled redetermination.

- If average interest income per month exceeds \$10.00 and is received less often than monthly, it must be treated as a lump sum payment for patient pay purposes. Refer to Section M1470.1000 of this subchapter for procedures and instructions.

3. **Repayments** Amounts withheld from monthly benefit payments to repay prior overpayments are not income for patient pay (the patient or his representative should be advised to appeal the withholding).
4. **CBC Additional Care** Additional care purchased outside of a CBC recipient's plan of care is not counted as income available for patient pay if it is purchased by someone other than the recipient. This additional care may be purchased from any source including the agency providing the CBC.
5. **Refundable Payments to LTC Facilities** The family of a prospective Medicaid patient or other interested party may make an advance payment on the cost of facility care prior to or during the Medicaid application process to assure the patient's admission and continued care. The individual may have been promised that the advance payment will be refunded if Medicaid eligibility is established.

Advance payments made by a person other than the patient *and* which are expected to be reimbursed once Medicaid is approved, *as well as* payments made by outside sources to hold the facility bed while the patient is hospitalized, are **not counted as income** in determining eligibility or patient pay.

The facility must reimburse any payment contributed toward the cost of patient care pending a Medicaid eligibility determination once Medicaid eligibility is established.

M1470.200 FACILITY PATIENTS - ALLOWABLE DEDUCTIONS FROM INCOME

- A. **Introduction** Sections M1470.210 through 240 are the only *allowable* deductions from a facility patient's gross monthly income when calculating patient pay in the month of entry and subsequent months when the patient does not have a community spouse..

If the individual is married and his spouse is in a nursing facility, then there is no community spouse and each spouse is treated as an unmarried individual for patient pay purposes. When the patient is an institutionalized spouse with a community spouse, as defined in subchapter M1480, go to subchapter M1480 to determine the institutionalized spouse's patient pay.
- B. **Order of Patient Pay Deductions** Deductions from gross monthly income are subtracted in the order presented below. *Deductions are made only to the extent that income remains after a prior deduction has been subtracted. Therefore*, if the patient has no income remaining after a deduction, no *additional* deductions can be made.
 1. **Personal Needs** See section M1470.210 "Facility Personal Needs Allowance."

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|---------------------------------------|---|
| 2. Dependent Child Allowance | See section M1470.220 "Dependent Child Allowance." |
| 3. Noncovered Medical Expenses | See section M1470.230 "Facility - Noncovered Medical Expenses." |
| 4. Home Maintenance Deduction | See section M1470.240 "Facility - Home Maintenance Deduction." |
- C. Appeal Rights** The patient or his representative has the right to appeal the patient pay determination, the amounts used in the calculation and denial of any request for adjustment. If a recipient or his representative appeals the patient pay, the EW or Medicaid Technician who made the decision prepares the appeal summary and attends the hearing.

M1470.210 FACILITY PERSONAL NEEDS ALLOWANCE

- A. Policy** The personal needs allowance is calculated according to the instructions in this section for the month of entry and subsequent months. The amount of the personal needs allowance depends on whether or not:

- the patient has a guardian or conservator who charges a fee; or
- the patient has earnings from employment that is part of the treatment plan.

The personal needs allowance is the sum of the basic personal allowance plus the guardianship fee and/or special earnings allowance, if applicable.

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|------------------------------------|--|
| 1. Basic Personal Allowance | Deduct \$40 per individual, effective July 1, 2007. The <i>basic</i> personal allowance for prior months is \$30. |
| 2. Guardianship Fee | Deduct an amount up to 5% of the patient's gross monthly income (including amounts not counted as income and excluded income) for guardianship fees, if the patient has a legally appointed guardian or conservator AND the guardian or conservator charges a fee. The guardianship filing fees CANNOT be deducted from the individual's income. Document how it was determined that the guardian/conservator charges a fee and the amount of the fee. |

No deduction is allowed for representative payee or "power of attorney" fees or expenses.

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|--------------------------------------|--|
| 3. Special Earnings Allowance | Working patients are allowed a higher personal needs allowance if they meet the following criteria. These patients will be identified by the facility. The patient must regularly participate in vocational activity which is a planned habilitation program and is carried out as a therapeutic work program, such as: <ul style="list-style-type: none"> • sheltered workshops • vocational training • pre-vocational training. |
|--------------------------------------|--|

Deduct a special earnings allowance if the patient participates in a work program as part of treatment. The special earnings allowance is deducted from earned income only. Subtract:

- the first \$75 of gross monthly earnings, PLUS
- ½ the remaining gross earnings,
- up to a maximum of \$190 per month.

The special earnings allowance cannot exceed \$190 per month.

**4. Example -
Calculation of
Personal Needs
Allowance**

A patient in the nursing facility is employed as a telephone salesperson as part of his plan of care in the facility. He has a legally appointed guardian who charges a 2% fee. His only income is gross earnings of \$875 per month. *The patient receives deductions for the basic allowance, the guardianship fee, and the special earning allowance.*

His special earnings allowance is calculated first:

\$875	gross earned income
<u>- 75</u>	first \$75 per month
800	remainder
<u>÷ 2</u>	
400	½ remainder
<u>+ 75</u>	first \$75 per month
\$475	which is > \$190

His personal needs allowance is computed as follows:

\$ 40.00	basic allowance
+190.00	special earnings allowance
<u>+ 17.50</u>	guardian fee (2% of \$875)
\$247.50	personal needs allowance

M1470.220 DEPENDENT CHILD ALLOWANCE

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

An unmarried individual, or married individual without a community spouse, who has a minor dependent child(ren) under age 21 in the community, can have a dependent child allowance. When the individual verifies that he/she has a dependent child(ren) in the community:

- Calculate the difference between the appropriate monthly medically needy income limit (MNIL) for the child's locality for the number of minor dependent children in the home, and the child(ren)'s gross monthly income. If the child lives outside of Virginia, use the Group III MNIL.
- The result is the dependent child allowance. If the result is greater than \$0, deduct it from the patient's monthly income as the dependent child allowance. If the result is \$0 or less, there is NO dependent child allowance.

The dependent child allowance cannot be given when the dependent child(ren)'s gross monthly income exceeds the monthly MNIL for the number of children in the child(ren)'s locality, if money is not made available or he does not accept the monthly income allowance.

Do NOT deduct any allowance for other family member(s).

1. Example--One Dependent Child (Based on July 2008 figures)

Mrs. K is a married individual who is now residing in a nursing facility. Her spouse is in another medical facility. Their dependent child lives with her sister in a Group II locality. The child receives a \$95.00 of Social Security income per month.

The allowance for the dependent child is calculated as follows:

$$\begin{array}{r} \$ 265.39 \text{ MN limit for 1 (Group II)} \\ - \underline{95.00} \text{ child's SSA income} \\ \$ 170.39 \text{ dependent child's allowance} \end{array}$$

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

2. Example--Two Dependent Children (Based on July 2008 figures)

Mr. H is a single individual with gross monthly income of \$920, living in a nursing facility. He is divorced and has two children under age 21 who live with his ex-wife in Group I. His two children each receive \$75 of monthly Social Security income.

The allowance for the dependent children is calculated as follows:

$$\begin{array}{r} \$ 337.92 \text{ MN limit for 2 (Group I)} \\ - \underline{150.00} \text{ children's total monthly SSA income} \\ \$ 187.92 \text{ dependent children's allowance} \end{array}$$

M1470.230 FACILITY - NONCOVERED MEDICAL EXPENSES

A. Policy

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

B. Health Insurance Premiums

1. Private or Commercial Insurance

Payments for medical/health insurance, *including dental insurance*, which meet the definition of a health benefit plan are deducted from patient pay when:

- the premium amount is deducted from the patient's benefit check;
- the premium is paid from the patient's own funds; OR
- the premium is paid by a relative (other than a spouse or parent for minor child) when that relative receives a benefit payment (income) which includes a benefit amount for the patient.

The amount deducted is the amount of the **monthly** premium. If the patient pays the premium less often than monthly, such as quarterly, prorate the amount paid by the number of months covered by the payment to obtain the monthly amount to deduct in the patient pay calculation.

“Health benefit plan” means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA (Multiple Employer Welfare Arrangement) or plan provided by another benefit arrangement.

Health benefit plan does not mean accident only, credit, or disability insurance; long-term care insurance; 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 a 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 (14VAC5-234-30).

Income protection insurance (indemnity) policy premiums are not medical expenses and are not deducted from the patient pay.

Membership fees for an organization that sponsors or provides the health insurance are not part of the premium and are not deductible.

2. Medicare Part A and/or B Premiums

Medicare Part B premiums and/or Medicare Part A premiums are paid by Medicaid *for eligible individuals*. The premiums are paid by Medicaid via the “buy-in” and are not usually deducted from patient pay. However, Medicaid does not start paying the premiums immediately for all eligible patients, so the Medicare premium(s) must be deducted from patient pay in those months for which Medicaid does not pay the premium.

*For CNNMP and MN recipients, the Medicare buy-in is effective **2 months after the begin date** of Medicaid coverage. If the begin date of coverage is other than the first day of a month, the buy-in is effective the first of the month in which the 60th day occurs. Part B premiums (and Part A premiums if the recipient must pay the Part A premium) must be deducted from patient pay in the month(s) in which the buy-in is not effective.*

Deduct the Medicare premium(s) for the first two months of coverage for the following recipients:

- CNNMP individuals who are not dually eligible QMB,
- MN recipients who are not dually eligible QMB.

The Medicaid Medicare buy-in does NOT pay for Medicare premiums in closed periods of coverage for LTC patients who are on spenddown and whose eligibility is for a closed period. Deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from patient pay in the month(s) in which the buy-in is NOT effective.

For cash assistance and QMB (either just QMB or dually-eligible) *enrollees*, the buy-in is effective with the begin date of Medicaid coverage. Therefore, do NOT deduct Medicare premiums in the patient pay determination for months in the retroactive and ongoing coverage periods.

Do not deduct Medicare premiums in retroactive and ongoing coverage periods for the following recipients:

- SSI recipients,
- AG recipients,
- ABD 80% FPL recipients,
- IV-E cash assistance recipients,
- QMB eligible recipients (either dually-eligible or just QMB).

The Medicaid Medicare buy-in pays for Medicare premiums in retroactive coverage and closed periods of coverage EXCEPT for LTC patients who are on spenddown. DO NOT deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from the patient pay in the month(s) in which the buy-in is effective for LTC patients who are NOT on spenddowns.

3. Example--Dual Eligible QMB

Mrs. Q has Medicare coverage and SSA income of \$580 per month. Her Medicare premiums are deducted from her SSA check. She was admitted to the nursing facility on September 9. Her daughter filed a Medicaid application for her on September 10.

Mrs. Q is eligible in the CNNMP 300% SSI group in September and is eligible as QMB. Her Medicare premiums are not deducted for September because they will be paid by Medicaid.

4. Example--Not Dual Eligible QMB

Mr. A was admitted to a nursing facility on March 5. He applied for Medicaid on June 2. His monthly income is \$1,295, and his Medicare Part B premium is deducted from his SSA check. He is determined to be eligible in the CNNMP 300% SSI covered group effective March 1.

His patient pay for March (the month of entry) includes a deduction for the Medicare premium. Because he is not QMB eligible, the buy-in is effective in May, the second month following the month in which his ongoing Medicaid coverage began. The cost of his Medicare Part B premium is deducted from his patient pay for the months of March and April, as his buy-in will be in effect beginning with the month of May.

If the buy-in is delayed for any reason, the individual will be reimbursed by SSA for premiums deducted after the second month.

5. Medicare Part D Premiums

The federal government sets a yearly “benchmark” premium for Medicare Part D Prescription Drug Plans (PDP). An individual who is eligible for Medicare and Medicaid is entitled to premium-free enrollment in a Medicare Part D basic

prescription drug plan (PDP) with a “benchmark” premium. However, the individual may elect enrollment in a basic plan with a premium above the benchmark or in an enhanced plan, which offers additional benefits.

Individuals who enroll in a higher-premium basic plan or an enhanced plan are responsible for that portion of the premium attributable above the benchmark rate. When a full-benefit Medicaid enrollee is enrolled in a higher-premium PDP, the portion of the premium that remains the individual’s responsibility is an allowable deduction from patient pay.

The benchmark premium for 2009 is \$30.36.

6. LTC Insurance

a. Deduct LTC premium in admission month only

When an individual has an LTC insurance policy, the individual stops paying premiums beginning the month after he is admitted to LTC. The premium paid for the policy in the admission month can be deducted from the admission month’s patient pay only. The LTC insurance premium is not deducted from patient pay for the months following the admission month.

b. LTC insurance benefits

LTC insurance benefits are treated as TPL. If the individual receives the payment from the insurance company, the payment is not income for patient pay or eligibility determinations. The individual should assign it to the nursing facility. If the individual cannot do this, or the policy prohibits assignment, the LTC insurance 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 provider is unable to accept payment directly from the individual, the individual must send the insurance payment to:

DMAS Fiscal Division, Accounts Receivable
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

**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 M1470.230 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 or the patient' authorized representative *of the denial of the request* using the *Notice of Action*.

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 (see M1470.230 C.5). 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.

e. Medicare Part D

Individuals who:

- qualify for Medicare Part D,
- are NOT enrolled in a Medicare PDP, and
- are NOT Medicaid eligible at the time of admission to a nursing facility,

will be fully responsible for their drug costs until Medicaid eligibility is determined and the Medicare Part D PDP enrollment process is completed. The individual remains responsible for any drugs purchased prior to the effective date of the PDP enrollment; Medicaid cannot pay for these drugs. The cost of drugs purchased before the PDP begin date can be deducted from patient pay.

Medicaid-enrolled nursing facility patients who are enrolled in a Medicare Part D PDP are **not** responsible for the payment of deductibles or co-pays, nor will they be subject to a coverage gap in their Part D benefits. Do NOT deduct from patient pay any Medicare PDP deductibles, co-pays or coverage gap costs.

If a full-benefit Medicaid/Medicare recipient was subject to PDP co-pays prior to his admission to a nursing facility, he may continue to be assessed co-pays until the PDP is notified of his admission to the nursing facility. Once DMAS has identified him as a nursing facility patient, the PDP will reimburse him for co-pays incurred during the month(s) in which he was in a nursing facility.

If an individual is enrolled in Part D and is in a nursing facility but was not eligible for Medicaid at the time of admission to the nursing facility, he may continue to be charged co-pays or deductibles until the PDP is notified of his eligibility as a full-benefit Medicaid enrollee. The PDP will reimburse him for co-pays or deductibles incurred during the months in which he was determined to be a full-benefit Medicaid enrollee.

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 to:

*Health Care Compliance Program Analyst
Division of Program Operations, Customer Service Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219*

Do not send requests for adjustments to DMAS when the patient has no available income for patient pay. Refer to M1470.230 C.5.c 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 using the MMIS Patient Pay process.
- 2) If the adjustment request is denied, DMAS prepares the notification.

b. DMAS Approval Not Required

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

- 1) Upon receipt of the requested documentation, determine the amount of the bill that is a valid deduction. Do not deduct more than the available income that remains after the personal needs, dependent child allowance(s), and health insurance premiums are deducted.

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

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

c. Notice Procedures

Upon the final decision to allow the deduction, use the MMIS Patient Pay process to adjust the patient pay. MMIS will generate and send the Notice of Obligation for LTC Costs.

M1470.240 FACILITY - HOME MAINTENANCE DEDUCTION

A. Policy

A single institutionalized individual can be allowed a deduction for the cost of maintaining a home for not more than six months, if a physician has certified he or she is likely to return home within that period.

Home maintenance means that the individual has the responsibility to pay shelter costs on his former place of residence in Virginia, such as rent, mortgage, utilities, taxes, room and board, or *assisted living facility (ALF)* payments, and that the home, apartment, room or bed is being held for the individual's return to his former residence in Virginia. *Individuals who have no responsibility to pay shelter costs are not permitted a home maintenance deduction. If responsibility for shelter costs is questionable, documentation must be requested and provided.*

EXEPTION: For an individual admitted to a nursing facility from an ALF, deduct a home maintenance allowance for the month of entry even if the admission to the nursing facility is not temporary.

Only one spouse of an institutionalized married couple (both spouses are in a medical facility) is allowed the deduction to maintain a home for up to six months, if a physician certifies that he is likely to return home within that period.

- B. Temporary Care** Temporary care is defined as not exceeding 6 months of institutionalization, beginning the **month** of admission to the medical facility. A physician's written statement, including a DMAS-96, that the individual is expected to return to his home within 6 months of admission is required to certify temporary care. When the temporary care period ends, the home maintenance deduction must be discontinued.
- C. Amount Deducted** The home maintenance deduction is the MN income limit for one person in the individual's locality of residence. See Appendix 5 to subchapter M0710 or section M0810.002 A. 4 for the MN income limits.

M1470.300 FACILITY PATIENTS

- A. Overview** This section provides policy and procedures for calculating patient pay for the facility patient.
- B. Policy and Procedures** Policy and procedures for determining patient pay in the most common admission situations are contained in the following sections:
- Facility Admission From A Community Living Arrangement (M1470.310)
 - Medicaid CBC Recipient Entering A Facility (M1470.320)
 - Facility Admission From Another Facility (M1470.340)

M1470.310 FACILITY ADMISSION FROM A COMMUNITY LIVING ARRANGEMENT

- A. Policy** The policy in this section describes the procedures for calculating patient pay for the month of admission and ongoing months for all persons admitted to an LTC facility except:
- persons who received Medicaid CBC in the community during the admission month;
 - persons who were admitted from another facility;
 - persons admitted to a facility from a state institution.
- B. Procedures** To determine patient pay for the admission month, use the procedures in this subsection.

1. **All Covered Groups Except MN Spenddown** For an individual admitted to a facility (except an individual who meets a spenddown), take the following steps in the order presented, *to the extent that income remains*:
 - a. Count all income received in the admission month (M1470.100).
 - b. Deduct a personal needs allowance:
 - \$40.00 basic personal needs;
 - additional amount for guardianship fees, if appropriate;
 - additional amount for special earnings allowance, if working.
 - c. Deduct a dependent child allowance, if appropriate (M1470.220).
 - d. Deduct the Medicare premium withheld if the applicant is a Medicare recipient and was not receiving Medicaid prior to admission (see M1470.230).
 - e. Deduct other health insurance premiums, deductibles or co-insurance charges, if appropriate (M1470.230).
 - f. Deduct other allowable noncovered medical expenses, if appropriate (M1470.230).
 - g. Deduct the home maintenance (MNIL) deduction **if appropriate**, if a doctor has certified that the individual is likely to return home within a six-month period (see M1470.240). For recipients who are admitted for a stay that has been for less than 30 days, a physician certification of length of stay is NOT required.
 - h. Any remainder is the patient pay for the month(s).
2. **MN Spenddown Individual in Facility for Less than 30 Days** For a medically needy individual on a spenddown who is in a facility for less than 30 days, see section M1470.350 B. for procedures.
3. **MN Spenddown Individual In Facility For More Than 30 Days** For an institutionalized medically needy individual, see Section M1470.600 for procedures.

M1470.320 PATIENT PAY FOR FACILITY STAY OF LESS THAN 30 DAYS

- A. **All Covered Groups Except MN Spenddown** To determine patient pay for a non-institutionalized individual admitted to a facility for less than 30 days (except an individual who meets a spenddown), use the procedures in subsection M1470.310 B.1 for the admission month and for the subsequent month when the facility stay continues into the month after admission.

**B. Non-
Institutionalized
Individuals on MN
Spendedown**

A non-institutionalized MN individual who is on a spenddown is not eligible for Medicaid until the spenddown is met. Non-institutionalized MN individuals on a three-month retroactive or six-month ongoing spenddown.

**1. Individual Who
Meets the
Spendedown**

For a non-institutionalized MN individual who meets the spenddown on a date that is within the dates of facility service, take the following steps to determine patient pay:

- a. Add together the number of days in the facility stay that are NOT covered by Medicaid. Multiply the result by the facility's private pay daily rate.
- b. Determine the remaining balance of the spenddown prior to applying the bill that caused the spenddown to be met.
- c. Add the amount in a. above to the figure obtained in b. above. The total is the individual's patient pay for the part of the facility stay that occurs in the spenddown coverage period.
- d. Enter patient pay into MMIS.

**2. Example –
Spendedown Met**

Mr. B, an unmarried 70 year-old individual living in a Group II locality, filed an initial application for Medicaid on October 5, 1999. He had excess income and was placed on a spenddown of \$2000 for the period October 1, 1999 through March 31, 2000. On October 8, 1999, he was admitted to a nursing facility for temporary care that is expected to be less than 30 days.

On November 10, 1999, his authorized representative asks for his spenddown to be re-evaluated due to his admission to the nursing facility. The representative also submits medical bills incurred before October 8, 1999, that the worker determines leave a spenddown balance of \$500 as of October 8, 1999. The nursing facility charges him \$120 per day; the Medicaid per diem is \$85. His spenddown is determined:

\$2000	spenddown liability October 1, 1999-March 31, 2000
- 1500	old bills incurred prior to October 1, 1999
500	spenddown balance on October 1, 1999
- 50	doctor's charge on October 5, 1999 (after TPL pays)
- 120	private pay rate on October 8, 1999
330	spenddown balance beginning October 9, 1999
- 120	private pay rate on October 9, 1999
210	spenddown balance beginning October 10, 1999
- 120	private pay rate on October 10, 1999
90	spenddown balance beginning October 11, 1999
- 120	private pay rate on October 11, 1999
\$ 0	spenddown met on October 11, 1999

Mr. B met his spenddown on October 11, 1999. *Medicaid coverage begins on October 11, 1999 and ends on March 31, 2000, the end of the six month spenddown budget period.*

He is discharged from the nursing facility to his home without CBC on November 1, 1999. He was in the nursing facility for less than 30 days. His patient pay for the October 8, 1999 through November 1, 1999 stay is determined:

a) 3 number of days in the nursing facility that are NOT covered by the individual's Medicaid coverage period (October 8 through October 10)
 $\times 120$ facility private pay daily rate
\$ 360 amount of the spenddown liability for which the individual is responsible.

b) \$90 is the spenddown balance on the date the spenddown was met, therefore, the individual is responsible to pay the \$90 to the nursing facility. Medicaid will pay the remainder of the cost.

c) \$360 amount of the spenddown liability for which the individual is responsible (October 8 - October 10)
 $+ 90$ spenddown balance on October 11; begin date of coverage
\$450 individual's patient pay for October 11 through October 31

If his dates in the nursing facility include part of a second month, his patient pay for the second month would be \$0.

3. Individual Who Does Not Meet Spenddown

An individual who meets the spenddown on a date after the date he left the facility has full responsibility for the days he was in the facility. Send the individual a Notice of Action showing the dates of Medicaid coverage and that the facility care was not covered by Medicaid. Send the provider a DMAS-225 regarding the individual's eligibility status.

M1470.400 MEDICAID CBC PATIENTS - ALLOWABLE DEDUCTIONS FROM INCOME

A. Introduction

Sections M1470.410 through 430 are the only *allowable* deductions from a Medicaid CBC patient's gross monthly income when calculating patient pay when the patient does not have a community spouse. *If* the patient has a community spouse, go to subchapter M1480 to determine patient pay.

Medicaid CBC patients are not allowed a home maintenance deduction because shelter costs are included in the personal maintenance allowance.

B. Procedure

Subtract the deduction(s) from gross monthly income in the order presented below:

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

C. Appeal Rights

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

M1470.410 MEDICAID CBC - PERSONAL MAINTENANCE ALLOWANCE

A. Individuals

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

The total amount of the PMA cannot exceed 300% SSI.

1. Basic Maintenance Allowance

a. Elderly or Disabled with Consumer-Direction (EDCD) Waiver, Mental Retardation (MR) Waiver, Technology-Assisted Individuals Waiver, Individual and Family Developmental Disabilities Support (DD) Waiver and Day Support (DS) Waiver

Patients receiving Medicaid CBC under the following waivers are allowed a monthly basic PMA:

- EDCD Waiver,
- MR Waiver,
- Technology-Assisted Individuals Waiver
- DD Waiver, and
- DS Waiver

The PMA is:

- January 1, 2008 through December 31, 2008: \$1,051.
- January 1, 2009 through December 31, 2009: \$1,112.

Contact a Medical Assistance Program Consultant for the *PMA* in effect for years prior to 2008.

b. AIDS Waiver

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

2. Guardianship Fee

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

The guardianship **filing** fees CANNOT be deducted from the individual's income. Document how it was determined that the guardian/conservator charges a fee and the amount of the fee.

No deduction is allowed for representative payee or "power of attorney" fees or expenses.

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

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

- 1) for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (\$2,022) per month.
- 2) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI (\$1,348) per month.

4. Example - Special Earnings Allowance (Using January 2009 figures)

A working patient receiving EDCD waiver services is employed 18 hours per week. His income is gross earnings of \$928.80 per month and SSA of \$300 monthly. His special earnings allowance is calculated by comparing his gross earned income (\$928.80) to the 200% of SSI maximum (\$1,348.00). His gross earned income is less than 200% of SSI; therefore, he is entitled to a special earnings allowance. His personal maintenance allowance is computed as follows:

$$\begin{array}{r} \$ 1,112.00 \text{ CBC basic maintenance allowance} \\ + \quad 928.80 \text{ special earnings allowance} \\ \hline \$ 2,040.80 \text{ PMA} \end{array}$$

Because the PMA may not exceed 300% of SSI, the PMA for the patient in this example must be reduced to \$2,022.00.

B. Couples

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

M1470.420 DEPENDENT CHILD ALLOWANCE

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

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

- Calculate the difference between the appropriate MN income limit for the **child's** home locality for the number of children in the home and the child(ren)'s gross monthly income. If the children are living in different homes, the children's allowances are calculated separately using the MN income limit for the number of the patient's dependent children in each home.
- The result is the dependent child allowance. If the result is greater than \$0, deduct it from the patient's income as the dependent child allowance. If the result is \$0 or less, do not deduct a dependent child allowance.

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

Do not deduct an allowance for any other family member.

**1. Example--Two
Dependent
Children In One
Home (Using
January
2009 Figures)**

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

The allowance for his dependent children is calculated as follows:

\$ 337.92 MN limit for 2 (Group I)
- 150.00 children's SSA income
\$ 187.92 dependent children's allowance

**2. Example--Three
Dependent
Children In Two
Homes (Using
January 2009
Figures)**

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

The allowance for the dependent children is calculated as follows:

\$ 306.23 MN limit for 1 (Group II)
- 95.00 child's SSA income
\$ 211.23 child's allowance

\$ 480.00 MN limit for 2 (Group III)
- 190.00 children's SSA income
\$ 290.00 children's allowance

\$ 211.23 *child's allowance*
+ 290.00 *children's allowance*
\$ 501.23 total dependent children's allowance

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

M1470.430 MEDICAID CBC - NONCOVERED MEDICAL EXPENSES

A. Policy

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

**B. Health Insurance
Premiums**

Payments for medical/health insurance which meet the definition of a health benefit plan, *including dental insurance*, are deducted from patient pay when:

- the premium amount is deducted from the patient's benefit check;

- the premium is paid from the patient's own funds; OR
- the premium is paid by a relative (other than a spouse or parent for minor child) when that relative receives a benefit payment (income) which includes a benefit amount for the patient.

The amount deducted is the amount of the monthly premium. If the patient pays the premium less often than monthly, such as quarterly, prorate the amount paid by the number of months covered by the payment to obtain the monthly amount to deduct in the patient pay calculation.

“Health benefit plan” means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA (Multiple Employer Welfare Arrangement) or plan provided by another benefit arrangement.

Health benefit plan does not mean accident only, credit, or disability insurance; long-term care insurance; 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 a 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 (14VAC5-234-30).

Income protection insurance (indemnity) policy premiums are not medical expenses and are not deducted from the patient pay.

Membership fees for an organization that sponsors or provides the health insurance are not part of the premium and are not deductible.

1. Medicare Part A and/or Part B Premiums

For CNNMP and MN recipients, the Medicare buy-in is effective **2 months after the begin date** of Medicaid coverage. If the begin date of coverage is other than the first day of a month, the buy-in is effective the first of the month in which the 60th day occurs. Part B premiums (and Part A premiums if the recipient must pay the Part A premium) must be deducted from patient pay in the month(s) in which the buy-in is not effective.

Deduct the Medicare premium(s) for the first two months of *coverage* eligibility for the following recipients:

- CNNMP individuals who are not dually eligible QMB,
- MN recipients who are not dually eligible QMB.

The Medicaid Medicare buy-in does NOT pay for Medicare premiums in closed periods of coverage for LTC patients who are on spenddown and whose eligibility is for a closed period. Deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from patient pay in the month(s) in which the buy-in is NOT effective.

For cash assistance and QMB (either just QMB or dually-eligible) enrollees, the buy-in is effective with the begin date of Medicaid coverage. Therefore, do NOT deduct Medicare premiums in the patient pay determination for months in the retroactive and ongoing coverage periods.

Do not deduct Medicare premiums in retroactive and ongoing coverage periods for the following recipients:

- SSI recipients,
- AG recipients,
- ABD 80% FPL recipients,
- IV-E cash assistance recipients,
- QMB eligible recipients (either dually-eligible or just QMB).

The Medicaid Medicare buy-in pays for Medicare premiums in retroactive coverage and closed periods of coverage EXCEPT for LTC patients who are on spenddown. DO NOT deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from the patient pay in the month(s) in which the buy-in is effective for LTC patients who are NOT on spenddowns.

**2. Example -
Medicare Buy-
in (Using
January 2009
Figures)**

Mr. A is 80 years old and started receiving CBC on February 15. He applied for Medicaid on February 2. His only income is \$1500 per month. He has no Medicare Part A premium. His Part B premium is withheld from his SSA benefit. Therefore, his gross SSA entitlement is actually \$1596.40. He is CNNMP eligible, but he is not dually-eligible as QMB.

Mr. A submitted bills for January and met a retroactive spenddown in January. Ongoing Medicaid began in February because he began receiving Medicaid CBC in February and became CNNMP. The Medicare Buy-in begins on April 1.

His Medicare Part B premium is deducted in February's and March's patient pay. April and subsequent months will not include a deduction for the Medicare premium.

**3. Medicare Part
D Premiums**

The federal government sets a yearly "benchmark" premium for Medicare Part D Prescription Drug Plans (PDP). An individual who is eligible for Medicare and Medicaid is entitled to premium-free enrollment in a Medicare Part D basic prescription drug plan (PDP) with a "benchmark" premium. However, the individual may elect enrollment in a basic plan with a premium above the benchmark or in an enhanced plan, which offers additional benefits.

Individuals who enroll in a *higher-premium basic plan* or an enhanced plan are responsible for that portion of the premium attributable above the benchmark rate. When a full benefit Medicaid enrollee is enrolled in a *higher-premium PDP*, the portion of the premium that remains the individual's responsibility is an allowable deduction from patient pay.

The benchmark premium for 2009 is \$30.36.

**4. LTC
Insurance**

a. Deduct LTC premium in admission month only

When an individual has an LTC insurance policy that covers long-term care services received in the home, the individual stops paying premiums beginning the month after he is admitted to the home-based LTC. The premium paid for the policy in the LTC admission month can be deducted from the admission month's patient pay only. The LTC insurance premium is not deducted from patient pay for the months following the admission month.

b. LTC insurance benefits

LTC insurance benefits are treated as TPL. If the individual receives the payment from the insurance company, the payment is not income for patient pay or eligibility determinations. The individual should assign it to the waiver services provider. If the individual cannot do this, or the policy prohibits assignment, the LTC insurance payment should be given directly to the provider. The provider should report the payment as a third party payment on its claim form.

If the provider is unable to accept payment directly from the individual, the individual must send the insurance payment to:

DMAS Fiscal Division, Accounts Receivable
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

**C. Noncovered
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.

See M1470.430 B.6 for the procedures used to deduct Medicare Part D prescription drug co-pays for patients who have Medicare.

**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 *or* the patient's representative using the *Notice of Action*.

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). For Medicaid CBC recipients who have Medicare Part B, 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.

e. Medicare Part D copays

Individuals who:

- *qualify for Medicare Part D,*
- *are NOT enrolled in a Medicare PDP, and*
- *are NOT Medicaid eligible at the time of admission to CBC*

will be fully responsible for their drug costs until Medicaid eligibility is determined and the Medicare Part D PDP enrollment process is completed. The individual remains responsible for any drugs purchased prior to the effective date of the PDP enrollment; Medicaid cannot pay for these drugs. The cost of drugs purchased before the PDP begin date can be deducted from patient pay.

Full benefit Medicaid enrollees who have Medicare, are receiving Medicaid CBC services, and are enrolled in a Medicare Part D PDP are responsible for the payment of co-pays, but are not subject to payment of deductibles or a coverage gap in their Part D benefits.

1) Monthly Statements

PDPs must issue a periodic (at least monthly) statement to the beneficiary explaining all benefits paid and denied. Part D drugs that are not covered by the PDP may not be covered by Medicaid and, absent other drug coverage, remain the responsibility of the individual. When a PDP denies coverage of a prescription, the beneficiary has the right to request an exception for coverage of the drug. The beneficiary is notified in writing of the decision on any exception requested.

2) *Verifying Allowable Co-pays*

To determine whether or not prescription expenses can be deducted from patient pay, apply the following rules:

- *If the drug expense appears on the statement as a denial, and no exception was requested, **do not** allow the expense.*
- *If the drug expense appears on the statement as a denial, and an exception was requested and denied, allow the expense.*

Enrollees should be advised to maintain these monthly statements if they wish to request patient pay adjustments for Medicare Part D co-pays and for drugs for which the PDP denied coverage.

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

4. **Documentation Required**

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

Request the following documentation from the patient or his representative:

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

b. Requests For Adjustments From CBC Providers

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

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

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

5. Procedures

a. Determine Deduction

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

- 1) Upon receipt of the requested documentation, determine the amount of the bill that is a valid deduction. Do not deduct more than the available income that remains after the personal needs, dependent child allowance(s), and health insurance premiums are deducted.

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

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

b. Notice Procedures

Upon the final decision to allow the deduction, use the MMIS Patient Pay process to adjust the patient pay. MMIS will generate and send the Notice of Obligation for LTC Costs.

**D. Example--CBC
Deduction of
Noncovered
Services (Using
January 2009
Figures)**

An aged, single individual, with no dependent child and no guardian or conservator, who lives in Group II, applied for Medicaid for the first time in June. He is approved by the screener for long-term care under the *EDCD* waiver. His gross income is \$950 Civil Service Annuity (CSA) and \$500 SSA. His resources are within the Medicaid limit. He has Medicare and federal employee's health insurance (Medicare is withheld from his SSA check at the rate of \$96.40 per month and \$80 is withheld from his CSA for the Health Insurance). Because his income is less than 300% of the SSI income limit, he meets the 300% SSI group.

He is denied retroactive eligibility because he had no Medicaid covered service in the retroactive period. He owes \$1,500 on a hospital bill he incurred the prior September *and is making payments*. His patient pay for June is determined in the following steps:

Step 1. gross income:

\$ 950	CSA
<u>+ 500</u>	SSA
\$1,450	total gross income

Step 2. deduct the correct personal maintenance allowance:

\$ 1,450	total gross income
<u>- 1,112</u>	personal maintenance allowance
\$ 338	remaining income

Step 3. deduct the appropriate medical expense deductions in the correct sequential order:

\$ 338.00	remaining income
<u>- 176.40</u>	96.40 Medicare + 80.00 health insurance premium
161.60	remaining income
<u>- 161.60</u>	non-covered medical expenses (\$1,500-161.60=\$1,338.40)
\$ 0	patient pay for June

The \$1,338.40 balance remaining from the \$1,500 hospital bill that was not deducted from the June patient pay can be deducted in subsequent month(s) as long as it remains a liability.

M1470.500 MEDICAID CBC PATIENTS

A. Overview

This section is only for unmarried individuals and or married individuals who have no community spouse. For married patients who have a community spouse, go to subchapter M1480 for patient pay determination.

This section provides policy and procedures for calculating Medicaid CBC recipients' patient pay.

B. Policy and Procedures Policy and procedures for determining Medicaid CBC admission month patient pay in the most common admission situations are contained in the following sections:

- Community Living Arrangement Admission to Medicaid CBC (M1470.510)
- *PACE (M1470.520)*

M1470.510 COMMUNITY LIVING ARRANGEMENT ADMISSION TO MEDICAID CBC WAIVER SERVICES

A. Policy The policy in this section describes the procedures for calculating patient pay for the month of admission and ongoing months for **all** persons residing in the community who are screened and approved for Medicaid CBC waiver services.

B. Procedures

1. All Covered Groups Except MN Spenddown

For an individual admitted to Medicaid CBC waiver services (EXCEPT an individual who meets a spenddown), use these procedures:

- a. Count all income received in the admission month (M1470.100).
- b. Deduct a personal needs allowance (M1470.410):
 - basic maintenance allowance based on the waiver;
 - guardianship fees, if *any*;
 - special earnings allowance, if *any*.
- c. Deduct a dependent child allowance, if *any* (M1470.420).
- d. Deduct the Medicare premium withheld if the individual is a Medicare recipient and was not receiving Medicaid prior to admission, if *any* (see M1470.430).
- e. Deduct other health insurance premiums, deductibles or co-insurance charges, if *any* (M1470.430).
- f. Deduct other allowable noncovered medical expenses, if *any* (M1470.430).
- g. Any remainder is the patient pay for the month(s).

2. MN Individual Who Meets Spenddown

An MN individual who is on a spenddown is not eligible for Medicaid until the spenddown is met. If an individual is screened and approved for Medicaid waiver services, he is considered “institutionalized” and his eligibility for Medicaid is determined as an institutionalized individual. If the individual’s income exceeds the 300% SSI income limit, he must meet an MN institutionalized individual monthly spenddown.

Go to section M1470.600 below to determine patient pay for a CBC patient who is on a spenddown.

M1470.520 PACE

A. Policy

The Program of 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. *Individuals who are enrolled in Medicaid as Auxiliary Grant recipients (Aid Categories 012, 032, and 052) are not eligible for PACE.* See M1440.108 for additional information about PACE.

Individuals enrolled in PACE have a patient pay obligation.

B. 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 a 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.

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.

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 *under 22 years of age receiving inpatient psychiatric services* in an IMD (Institution for Treatment of Mental Diseases) whose income exceeds 300% of SSI may be eligible for Medicaid as MN if he meets the spenddown liability.

Coverage in an IMD is not part of the Medicaid benefit package for any other MN individuals who are eligible for Medicaid while in an IMD, including individuals age 65 years or older. Individuals under age 22 years who are not receiving inpatient psychiatric services and all individuals over age 22 years but under age 64 years are not eligible for Medicaid while in an IMD (see M0280.201).

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 (M1470.210),
 - b. a dependent child allowance, if appropriate (M1470.220),
 - c. any allowable noncovered medical expenses (M1470.230), not including the facility cost of care,
 - d. a home maintenance deduction, if appropriate (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.

C. Examples

1. **Facility--MN And Patient Pay Income Are The Same (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:

$$\begin{array}{r}
 \$1,600 \text{ monthly MN income} \\
 - \quad \underline{20} \text{ exclusion} \\
 1,580 \text{ countable MN income} \\
 - \quad \underline{325} \text{ MN limit for 1 (Group III)} \\
 \$1,255 \text{ spenddown liability for month}
 \end{array}$$

The facility’s Medicaid rate is \$45 per day, or \$1,395 for a projected 31-day month. By projecting the month’s cost of facility care, he meets his spenddown because his spenddown liability is less than the Medicaid rate. He is eligible effective the first day of the month and for the whole month of April. Because his spenddown liability is less than the Medicaid rate, Mr. Cay will have ongoing Medicaid eligibility. His patient pay for April is determined:

\$1,600	total patient pay gross income
<u>- 1,255</u>	spenddown liability
345	
- 110	personal needs allowance (basic plus guardian fee)
- 50	health insurance premium
<u>- 25</u>	noncovered medical expense incurred April 2
160	remaining income
<u>+1,255</u>	spenddown liability (his responsibility to pay)
\$1,415	contributable income for patient pay (April)

Compare the contributable income for patient pay (\$1,415) to the facility's Medicaid rate for April, \$1,395. The facility can collect no more than the Medicaid rate. Because the Medicaid rate is less than the contributable income for patient pay, Mr. Cay's patient pay for April is the Medicaid rate of \$1,395. Any income retained by Mr. Cay is a resource in May.

**2. Facility--MN
 And Patient
 Pay Income
 Are Different
 (Using July
 1999 Figures)**

Mr. Day is a disabled individual who applied for Medicaid in July 1999. He was admitted to the facility in November 1998. He has a monthly CSA benefit of \$1,500 and a monthly Seminole Indian payment of \$235. He last lived outside the facility in a Group III locality. His income of \$1,735 exceeds the CNNMP 300% of SSI income limit. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His MN eligibility is determined for July 1999. The MN determination results in a spenddown liability of \$1,155:

\$1,500	monthly MN income (Seminole Indian payment excluded)
<u>- 20</u>	exclusion
1,480	countable MN income
<u>- 325</u>	MN limit for 1 (Group III)
\$1,155	spenddown liability for month

He has an old bill of \$250 incurred in December 1998, which was not used to meet a spenddown, and a health insurance premium of \$50 monthly plus a noncovered medical expense of \$25 that he incurred on July 2. The facility's Medicaid rate is \$40 per day, or \$1,240 for a projected 31-day month. By projecting the month's cost of facility care, he meets his spenddown because his spenddown liability is less than the Medicaid rate. He is eligible for full month's coverage. His patient pay for July is determined:

\$1,500	CSA
<u>+ 235</u>	Seminole Indian payment (not excluded for patient pay)
1,735	patient pay gross income
<u>- 1,155</u>	spenddown liability
580	
- 30	personal needs allowance
- 50	health insurance
- 250	old bill from December 1998
<u>- 25</u>	non-covered medical expense incurred July 2
\$ 225	remaining income
<u>+1,155</u>	spenddown liability (his responsibility to pay)
\$1,380	contributable income for patient pay (July)

Compare the contributable income for patient pay to the facility's Medicaid rate for July. The facility can collect no more than the Medicaid rate. Because the Medicaid rate is less than the contributable income for patient pay for July, Mr. Day's patient pay for July is the Medicaid rate of \$1,240. Any income that is retained becomes a resource the following month.

3. Facility-Not Eligible in Admission Month, Eligible in Following Month (Using April 2000 Figures)

Mr. C first applied for Medicaid on April 25. He was admitted to the facility on April 22. He last lived outside the facility in a Group III locality. He is a 40-year-old disabled individual with one dependent child age 10 years; the child lives with his sister in a Group II locality. He has a monthly CSA benefit of \$1,700; the child has a CSA benefit of \$150 per month. Mr. C has a guardian who charges a 5% guardian fee. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period.

Mr. C's income exceeds the CNNMP 300% of SSI income limit, so he is not eligible as CNNMP. He has a carry-over expense of \$200 incurred in the retroactive period. He has a monthly health insurance premium of \$50 paid on the 15th of the month plus a \$25 noncovered medical expense he incurred on April 2. His MN eligibility is determined for April. The MN determination results in a spenddown liability of \$1,355:

\$1,700	monthly MN income
<u>- 20</u>	exclusion
1,680	countable MN income
<u>- 325</u>	MN limit for 1 (Group III)
\$1,355	spenddown liability for month

The facility's Medicaid rate is \$45 per day, or \$405 for April 22 - 30 (9 days), the admission month. He does not meet his spenddown by projecting the cost of care at the Medicaid rate for the admission month because his spenddown liability (\$1,355) exceeds the Medicaid rate of \$405 for the admission month. Therefore, his spenddown cannot be met by projecting the nursing facility costs at the Medicaid rate. His spenddown eligibility must be determined retrospectively using the private pay rate for the number of days of facility care to reduce his spenddown liability. The private pay rate is \$50 per day, or \$450 for the days April 22 - 30. After subtracting all allowable expenses, he does not meet his spenddown in April and is not eligible for Medicaid in April.

His eligibility for May is determined. His April facility expenses are not deducted because he paid them in April. His \$200 January bill is not deducted as a carry-over expense, but any current payments on that bill can be deducted. He incurred a noncovered medical expense on May 2, and paid \$65 on his January medical bill.

The facility's Medicaid rate is \$45 per day, or \$1,395 for a projected 31-day month. By projecting the cost of care at the Medicaid rate, he meets his spenddown on the first of the month (May) because his spenddown liability of \$1,355 is less than the Medicaid rate (\$1,395). His patient pay for May is determined:

\$1,700	total patient pay gross income
<u>- 1,355</u>	spenddown liability
345	
- 105	personal needs allowance (basic plus guardian fee)
- 100	dependent child allowance (\$250-150=100)
- 50	health insurance premium
<u>- 25</u>	noncovered medical expense incurred May 2
65	
<u>- 65</u>	current payment on January medical bill
0	remaining income
<u>+1,355</u>	spenddown liability (his responsibility)
\$1,355	contributable income for patient pay (May)

Compare the contributable income for patient pay to the facility's Medicaid rate for May. The facility can collect no more than the Medicaid rate. Because the contributable income for patient pay is less than the Medicaid rate, Mr. C's patient pay for May is his contributable income of \$1,355.

M1470.620 FACILITY PATIENTS--SPENDDOWN LIABILITY GREATER THAN THE 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.

1. Retrospective Determination

An MN facility patient whose spenddown liability exceeds the Medicaid rate is not eligible for Medicaid until he actually incurs medical expenses that meet the spenddown liability within the month. ALL of these determinations are made monthly, retrospectively, **after** the month has passed and the expenses have actually been incurred. The individual's resources and income must be verified each month before determining if the spenddown has been met.

2. Full Month's Coverage If Spenddown Met

When incurred expenses equal or exceed the spenddown liability, the individual is eligible for the full month of Medicaid coverage beginning the first day of the month in which the spenddown was met, and ending the last day of the month in which the spenddown was met. See subchapter M1460 for procedures to determine spenddown eligibility for these individuals. Patient pay for the month in which the spenddown was met is calculated after determining that the spenddown was met.

3. Patient Pay

Medicaid must not pay any of the recipient's spenddown liability to the provider. Because the spenddown determination is completed after the month and expenses are not projected, the spenddown liability is NOT added to remaining income for patient pay. Use the following procedures to calculate the patient pay for the month in which the spenddown was met.

B. Patient Pay Procedures

1. **Patient Pay Gross Monthly Income** Determine the recipient's patient pay gross monthly income according to section M1470.100 (including any amounts excluded in determining MN countable income and the spenddown liability).

2. **Calculate Remaining Income For Patient Pay** Calculate remaining income for patient pay by deducting the following from gross patient pay income:
 - a. a personal needs allowance (M1470.210),
 - b. a dependent child allowance, if appropriate (M1470.220),
 - c. any allowable noncovered medical expenses (M1470.230) **NOT** including the facility cost of care, and
 - d. a home maintenance deduction, if appropriate (M1470.240).

The result is individual's **remaining income**.

3. **Patient Pay** Compare the remaining income to the facility's Medicaid rate for the month. The patient pay is the lesser of the two amounts.

C. Example—In a Facility, Spenddown Liability Exceeds Medicaid Rate; No Dependent (Using July 1999 Figures)

Ms. Day is an institutionalized individual with no dependents who filed an initial application for Medicaid on November 13, 1999. She was admitted to the facility on November 12, 1999. She has a monthly CSA benefit of \$1,700 and a monthly payment of \$225 from the Seminole Indians Land Trust. She has a \$75 old bill incurred in July 1998, and she has a health insurance premium payment of \$50 per month paid on the 20th of the month. She does not have Medicare. She last lived outside the facility in a Group II locality. Her income exceeds the 300% SSI income limit. Her MN eligibility is determined for November 1999. The MN determination results in a spenddown liability:

\$1,700	monthly MN income (Seminole Indians payment excluded)
- 20	exclusion
1,680	countable MN income
- 250	MN limit for 1 (Group II)
\$1,430	spenddown liability for November

The facility's Medicaid rate is \$40 per day, or \$760 for the 19 days in November, the admission month. Because her spenddown liability of \$1,430 exceeds the \$760 Medicaid rate for the admission month of November, Ms. Day is not eligible until she actually incurs medical expenses, including the private facility rate, on or before November 30 that equal or exceed the spenddown liability of \$1,430. The private rate is \$65 per day. The old bill of \$75 is deducted on November 1. She incurs \$1,235 for 19 days of care and the \$50 insurance premium on November 21; she incurs no other expenses. She does not meet the spenddown in the admission month of November. She paid her all of her November medical expenses in November.

Her eligibility for December (the month following the admission month) is determined. The Medicaid rate of \$40 per diem is projected for a 31-day month and equals \$1,240. The spenddown liability for the month is compared to the Medicaid rate before deducting any incurred medical expenses. Because the monthly spenddown liability of \$1,430 exceeds the Medicaid rate, eligibility must be determined, retrospectively, after the actual facility care costs have been incurred.

In January, to determine if the spenddown was met in December, the worker compares the spenddown liability to the private cost of care for December. The private daily rate of \$65 per day is multiplied by 31 days in December to determine the private monthly cost of care. Because the monthly spenddown liability of \$1,430 is less than the private monthly cost of care of \$2,015, Ms. Day met her spenddown in December and is eligible for the full month of December. She is enrolled for a closed period of eligibility, beginning 12-01-99 and ending 12-31-99. On December 3, she made a payment of \$75 on her July 1998 medical expense. Her patient pay for December is calculated as follows:

\$1,700	CSA
+ 225	Seminole Indians payment (not excluded for patient pay)
1,925	gross income for patient pay
- 30	personal needs allowance
- 75	12/3/99 current payment on medical bill from July 1998
- 50	health insurance premium paid on the 21st
\$1,770	remaining income for patient pay (December)

The eligibility worker compares the remaining income to the Medicaid rate (\$1,240) for December. The facility can collect no more than the Medicaid rate. Because the Medicaid rate is less than the remaining income for patient pay, Ms. Day's patient pay for December is the Medicaid rate of \$1,240. Since she paid the nursing facility the private rate of \$2,015 for December, the facility will reimburse her after receiving the Medicaid payment for December. If she retains this money, it becomes a resource to her in the month in which she receives the reimbursement (January at the earliest). Her countable resources must be verified for January before determining if her January spenddown was met.

M1470.630 CBC PATIENTS 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. Retrospective Determination

Community Based Care (CBC) patients who have income over the 300% of SSI income limit are placed on a monthly spenddown as institutionalized individuals because they have been screened and approved for waiver services. The monthly CBC 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 CBC expenses, along with other allowable medical and dental expenses, are deducted

daily and chronologically as the expenses are incurred. The individual's resources and income must be verified each month before determining if the spenddown has been met.

2. Full Month's Coverage If Spenddown Met

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.

Patient pay for the month in which the spenddown was met is calculated after determining that the spenddown was met.

3. Patient Pay

Medicaid must not pay any of the recipient's spenddown liability to the provider(s). Because the spenddown is completed after the month and expenses are not projected, the spenddown liability is NOT added to the available income for patient pay. Use the following procedures to calculate the patient pay for the month in which the spenddown was met.

B. Patient Pay Procedures

1. Patient Pay Gross Monthly Income

Determine the CBC recipient's patient pay gross monthly income according to section M1470.100 (including any amounts excluded in determining MN countable income and the spenddown liability).

2. Calculate Remaining Income for Patient Pay

Calculate remaining income for patient pay by deducting the following from gross patient pay income:

- a. a personal needs allowance (M1470.410),
- b. a dependent child allowance, if appropriate (M1470.420),
- c. any allowable noncovered medical expenses (M1470.430) including any old bills, carry-over expenses and other noncovered expenses that were used to meet the spenddown, but NOT including the cost of CBC care.

The result is the individual's **remaining income** for patient pay.

3. Patient Pay

Compare the remaining income to the Medicaid rate (hours of CBC waiver services multiplied by the Medicaid hourly rate) for the month. The patient pay is the lesser of the two amounts.

4. Example--CBC Spenddown Met (Using January 2000 Figures)

Ms. G. lives in Group III and filed an initial application for Medicaid in January. She is approved by the screener for the *EDCD* Waiver in January. She has no community spouse or dependent child. Her monthly income of \$1800 SSA and a \$200 private pension and exceeds the CNNMP 300% SSI limit. Her monthly spenddown liability is determined:

\$1,800	SSA
+ 200	private pension
\$2,000	total monthly income
- 20	exclusion
\$1,980	countable income
- 325	MNIL for Group III
\$1,655	monthly spenddown liability

Her January application is denied and she is placed on a monthly spenddown during the 12-month certification period of January through December.

In February she submits bills to determine if her January spenddown has been met. Her spenddown eligibility is evaluated first by comparing the private cost of care to her spenddown liability. The private cost of care is \$15 per hour, 4 hours per day, or \$60 per day. She received care on 20 days in January at the private rate of \$60 per day. The private cost of care for January was \$1,200. Because the private cost of care was less than her spenddown liability, her spenddown eligibility must be determined on a daily basis. She has old bills of \$600 incurred prior to the retroactive period, a health insurance premium of \$100 paid on the first of the month, and prescription costs of \$500 incurred January 2. Her spenddown eligibility is determined:

\$1,655	spenddown liability
- 600	old medical bills incurred prior to retroactive period
- 100	medical insurance premium paid January 1
- <u>60</u>	cost of care incurred January 1
895	balance beginning January 2
- 500	prescription costs incurred January 2
- <u>60</u>	cost of care incurred January 2
335	balance beginning January 3
- <u>300</u>	cost of care incurred January 3 -7 (5 days)
35	spenddown liability balance at beginning of January 8
- <u>60</u>	cost of care incurred on January 8
\$ 0	spenddown met on January 8

Because she met the spenddown on January 8, she is eligible for *full* Medicaid coverage beginning January 1 and ending January 31. Her patient pay for January is calculated as follows:

\$1,800	SSA
+ 200	private pension
- 512	personal maintenance allowance
- 600	old bill incurred prior to retroactive period
- <u>100</u>	medical insurance premium paid January 1
\$ 788	remaining income for patient pay (January)

The worker compares the remaining income for patient pay to the Medicaid rate for Medicaid CBC waiver services. The Medicaid hourly rate of \$10.50 is multiplied by the 80 hours of CBC waiver services received in January. Because her remaining income (\$788) is less than the Medicaid rate (\$840), Ms. G's patient pay for January is the remaining income of \$788.

The following month, Mrs. G submits bills to determine if and when her February spenddown was met. Her February spenddown eligibility is evaluated as follows:

\$1,655	spenddown liability
- 100	medical insurance premium paid February 1
- 60	cost of care incurred on February 1
1,495	spenddown balance beginning February 2
-1,140	cost of care for remainder of February (19 days)
\$ 355	spenddown balance on February 29

Mrs. G does not meet her spenddown for the month of February, so she is not eligible for February and no patient pay is calculated. In March and subsequent months, Mrs. G might have additional medical expenses which could enable her to meet her spenddown liability and establish eligibility.

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 M1470.520 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.

4. 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 COMMUNICATION BETWEEN LOCAL DSS AND LTC PROVIDER

A. Introduction

Certain information related to the individual's eligibility for and receipt of Medicaid LTC services must be communicated between the local agency and the LTC provider. The Medicaid LTC Communication Form (form DMAS-225) is used by both the local agency and LTC providers to exchange information.

B. Purpose

The DMAS-225 is available on SPARK at: http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi. The form is used to:

- *notify the LTC provider of a patient's Medicaid eligibility status;*
- *reflect changes in the patient's income, resources or deductions;*
- *document admission, death or discharge of a patient to an institution or community-based care services;*
- *provide information on health insurance, LTC insurance or VA contract coverage, and*

- *provide other information unknown to the provider that might cause a change in eligibility status or patient pay amount.*

Do not use the DMAS-225 to relay the patient pay amount. Providers are responsible for obtaining patient pay information from the ARS/MediCall verification systems.

C. *When to Complete the DMAS-225*

Complete the DMAS-225 at the time of eligibility determination and/or the recipient's entry into LTC. Complete a new DMAS-225 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.

Additionally, complete a DMAS-225 for an ongoing enrollee whose patient pay has been initially transitioned into MMIS to notify the provider that the patient pay information is available through ARS/MediCall.

D. *Where to Send the DMAS-225*

Refer to M1410.300 B.3.b to determine where to send the form.

M1470.900 ADJUSTMENTS AND CHANGES

A. Policy

The Medicaid recipient or his authorized representative is responsible to report any changes in his or her situation within 10 days of the day the change is known. In situations where the patient pay amount is less than the Medicaid rate the patient pay must be adjusted within 30 days of notification or discovery of the change. This section contains the procedures for when and how to adjust patient pay.

There are situations when the EW **cannot increase** the patient pay, such as when the current patient pay amount equals the Medicaid rate for the month. In this situation, an adjustment that results in an increase in patient pay cannot be made and a referral to the DMAS Recipient Audit Unit must be completed following the procedures in D.3.c.1) below.

B. Action When A Change Is Reported

Upon receipt of notice that a change in an enrollee's income or deductions has occurred, the EW must evaluate continued income eligibility (see subchapter M1460). If eligibility no longer exists, follow the procedures for LTC medically needy income and spenddown (see M1460.700). If eligibility continues to exist, the EW must:

1. Recalculate the patient pay.
2. If the patient pay remains the same, send written notification to the person handling the patient's income that the patient pay is unchanged.
3. If the patient pay decreases, follow the instructions found in Item C. below. If the patient pay increases, follow the instructions found in Item D. below.

**C. Patient Pay
Decreases**

**1. When to
Adjust**

Reflect a patient pay decrease using the MMIS Patient Pay process effective the month following the month in which the change was reported when:

- the patient's income decreases;
- an allowable deduction is added or increased;
- the patient did not receive, or no longer receives, some or all of his income.

Adjust the patient pay for the month following the month in which the change was reported. DO NOT adjust patient pay retroactively, unless the patient meets a condition specified in section M1470.910 below.

2. Procedures

Using the MMIS Patient Pay process, take the following steps to reflect a decrease in patient pay:

- a. Verify the decrease.
- b. Calculate the new patient pay based on the change(s).
- c. Subtract the “new” patient pay from the “old” patient pay amount; the result is the reduced amount.
- d. Multiply the reduced amount by the number of months in which the reduced amount should have been effective; the result is the total reduction.
- e. Subtract the total reduction from the next month’s (the month following the month in which the worker is taking this action) patient pay. If the total reduction exceeds the patient pay, the patient pay amount will be zero until the total reduction has been subtracted from the patient pay.

**3. Example-
Patient Pay
Decrease**

Mr. F is an institutionalized individual who had been receiving a SSA payment of \$1,000 and a workman’s compensation payment of \$400 each month. On June 30, he reported he received his final worker’s compensation payment on June 15. The EW requested verification of the termination of the worker’s compensation and received the verification on August 22. His patient pay had been \$1,370 per month. His new patient pay is calculated to be \$960 per month. The “new” patient pay of \$960 is subtracted from the “old” patient pay of \$1,370. The monthly amount is reduced by \$410. Since Mr. F reported the change in June, the patient pay must be adjusted for July and subsequent months. The reduction of \$410 is multiplied by 2 months (July and August) and totals \$820. The EW *adjusts Mr. F's September patient pay* to reflect the decreased monthly income for July and August. *MMIS shows a September patient pay of \$140 and also shows a patient pay of \$960 for October and subsequent months.*

**D. Patient Pay
Increases**

Using the *MMIS Patient Pay* process, reflect a patient pay increase effective the month following the month in which the 10-day advance notice period ends when:

- the patient's income increases;
- an allowable deduction stops or decreases.

**1. Prospective
Month(s)**

Calculate the new patient pay based on the current income and make the change effective the month following the month in which the 10-day advance notice period ends. This will be the new ongoing patient pay.

**2. Current and
Past Month(s)**

Determine the amount of the recipient underpayment when:

- the income counted was less than the income actually received; or
- an allowable deduction stopped or decreased.

Do not revise the *patient pay* retroactively for the current and past month(s) unless the requirements in section M1470.910 below are met.

3. Procedures

a. Determine the amount of the underpayment(s):

- 1) Calculate the new monthly patient pay based on the change(s), beginning with the month in which the change occurred.
- 2) Subtract the "old" monthly patient pay from the "new" monthly patient pay amount. The result is the amount of the recipient's underpayment for that month.
- 3) Add the monthly underpayment(s) together to determine the total amount of the recipient's underpayment. If the underpayment is less than \$500, follow the procedures in "b" below. If the underpayment is \$500 or more, follow the procedures in "c" below.

b. Total underpayment of less than \$500

To adjust the patient pay obligation for the month following the month in which the 10-day advance notice period ends, take the following steps:

- 1) Add the total underpayment to the new ongoing patient pay. This is the total patient pay obligation.
- 2) Compare the total patient pay obligation to the provider's Medicaid rate.
 - a) If the total patient pay obligation is less than the provider's Medicaid rate, the total amount of the patient's underpayment can be collected in one month. The total patient pay obligation is the patient pay for the month following the month in which the 10-day advance notice period ends.

- b) If the total patient pay obligation exceeds the provider's Medicaid rate, determine the difference between the ongoing patient pay and the provider's Medicaid rate. The difference is the amount of the underpayment that can be collected the first month. The patient pay for the first month (current patient pay and a portion of the underpayment) will equal the Medicaid rate. The balance of the underpayment must be collected in subsequent months. Repeat these procedures for subsequent months until the total amount of the underpayment has been reduced to zero.

c. Total underpayment of \$500 or more

- 1) Underpayment amounts totaling \$500 or more must be referred to the DMAS Recipient Audit Unit for collection.

- a) Complete and send a "Notice of Recipient Fraud/Non-Fraud Overissuance" (see Appendix 1 to chapter M17) to:

Recipient Audit Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

- b) Complete and send a "Notice of Action on Medicaid" (available at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) informing the patient of the referral to DMAS for collection of the underpayment.

- 2) Prospective months' patient pay

MMIS will automatically generate and send a "Notice of Obligation for LTC Costs" to the patient or the patient's representative for the month following the month in which the 10-day advance notice period ends.

**4. Example--
Patient Pay
Increase -Total
Underpayment
Less than \$500**

Mr. S is an aged individual who has received Medicaid covered CBC services for two years. His "old" monthly patient pay was \$300. On February 25, he reports his pension increased \$50 per month in February. On March 22 the EW recalculated the patient pay based on the current income. His new monthly patient pay is \$350. Because of the 10-day advance notice requirement the change could not be made for April and must be made for May 1.

His "old" patient pay is subtracted from his "new" patient pay for February, March and April to determine his underpayment for those months. The \$50 underpayment for three months (\$150) is added to his "new" ongoing patient pay (\$350) and the total patient pay obligation (\$500) is compared to the Medicaid rate of \$1700. Since the total patient pay obligation of \$500 is less than the Medicaid rate of \$1700, the patient pay for May is \$500. The ongoing patient pay starting in June is \$350.

**5. Example--
Patient Pay
Increase -Total
Underpayment
\$500 or More**

Mr. M is an institutionalized individual. On February 25, he reports his pension increased \$200 per month in February. On March 22 the EW recalculated the patient pay based on the current income. His new monthly patient pay is \$1400. His "old" monthly patient pay was \$1200.

Because of the 10-day advance notice requirement the change could not be made for April and must be made for May 1. His "old" patient pay is subtracted from his "new" patient pay for February, March and April to determine his underpayment for those months. The \$200 underpayment for three months totals \$600. Since the total underpayment exceeds \$500, a patient pay adjustment can not be made. A referral must be made to the DMAS Recipient Audit Unit for collection and the recipient must be notified of the referral (see M1470.900 D. 3. c).

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; *or*
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 patient pay retroactively using *MMIS Patient Pay process* 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 patient pay retroactively.**

**B. Notification
Requirements**

MMIS automatically generates and sends the Notice of Obligation for LTC Costs.

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, *revise the patient pay* if necessary.

B. Procedures

This procedure applies to the following changes in LTC Providers during a month:

- *CBC Provider to CBC Provider;*
- *Nursing Facility Provider to Nursing Facility Provider;*
- *CBC Provider to Nursing Facility Provider; and*
- *Nursing Facility Provider to CBC Provider*

Refer to Chapter G in the *MMIS User's Guide for DSS*, available at: http://www.dmas.virginia.gov/dss_mmis_manual.htm, for patient pay data entry procedures for change in provider during a month.

**1. CBC to CBC;
NF to NF;
CBC to NF**

- a. Contact the former Medicaid provider to obtain the actual Medicaid cost of services received for the month in which the transfer occurred.
- b. Compare the Medicaid monthly patient pay amount for the month of admission to the current provider to the actual cost of the Medicaid services received under the former provider.
- c. If the actual Medicaid cost for the former provider for the month of admission to the current provider is greater than or equal to the amount of patient pay, do not revise the patient pay amount to the former provider. Patient pay for the current provider is zero for the month of admission. Show the ongoing patient pay to the current provider effective the following month.
- d. If the actual Medicaid cost for the former provider is less than the amount of patient pay, subtract the actual cost from the amount of patient pay. The actual cost is the patient pay to the former provider. For the month of admission to the current provider, the patient pay to the current provider is the difference between the amount paid to the former provider and the monthly patient pay amount. Show the ongoing patient pay to the current provider effective the following month.

2. NF to CBC

- a. Contact the NF to obtain the actual Medicaid cost of services received for the month in which the transfer occurred.
- b. Compare the Medicaid monthly patient pay amount for the month of admission to CBC to the actual cost of the Medicaid services received from the NF.
- c. If the actual Medicaid costs in the NF for the month of admission to CBC are greater than or equal to the amount of patient pay, do not revise the patient pay amount to the NF. Patient pay for the CBC provider is zero for the month of admission. Show the ongoing patient pay to the CBC provider effective the following month.
- d. If the actual Medicaid cost for the NF is less than the amount of patient pay, subtract the actual cost from the amount of patient pay. The actual cost is the patient pay to the NF. For the month of admission to CBC, the remaining balance of the patient pay obligation is considered income for patient pay for CBC services.
- e. Determine patient pay to the CBC provider for the month of admission. From the remaining patient pay balance, subtract the PMA, which is determined as follows:

The PMA equals the waiver's basic allowance minus the NF PNA (including any Special Earnings Allowance and/or guardianship fee). The Special Earnings Allowance and guardianship fee may only be deducted once and are included in the NF PNA.

Show the ongoing patient pay to the CBC provider effective the following month.

3. **PACE** *Enrollment in PACE begins on the first day of a month and ends on the last day of a month. Patient pay for PACE participants is not adjusted due to provider changes within a month.*

M1470.930 DEATH OR DISCHARGE FROM LTC

- A. Policy** *The LTC provider may not collect an amount of patient pay that is more than the Medicaid rate for the month. When a patient dies or is discharged from LTC to another living arrangement that does not include LTC services, do not recalculate patient pay for the month in which the patient died or was discharged. The provider is responsible for collecting an amount of patient pay for the month of death or discharge that does not exceed the Medicaid rate for the month.*
- B. Procedure** *Refer to Chapter G in the MMIS User's Guide for DSS for procedures regarding death or discharge from LTC. Send a DMAS-225 to the provider regarding the eligibility status of the patient. Send a notice to the patient or the patient's representative that reflects the reduction or termination of services.*

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.*

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 patient pay for the lump sum receipt month if the money is still available.

- B. Lump Sum Not Available** *If the money is not available, complete and send a "Notice of Recipient Fraud/Non-Fraud Overissuance" to the DMAS, 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, complete and send a "Notice of Recipient Fraud/Non-Fraud Overissuance" to the DMAS, 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, complete and send a "Notice of Recipient Fraud/Non-Fraud Overissuance" to the DMAS, Recipient Audit Unit.
 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. If the income available for patient pay exceeds the Medicaid rate, adjust the patient pay to equal the Medicaid rate for the month.

Evaluate the difference between the Medicaid rate and the available income as a resource for the next month. If the patient's total countable resources exceeds the resource limit, take appropriate action to cancel the patient's Medicaid.

C. MN Procedures

1. Facility Patients-- Spenddown Liability Less Than or Equal To Medicaid Rate

For facility patients who have a spenddown liability that is less than or equal to the facility Medicaid rate and who are enrolled in ongoing Medicaid coverage:

- a. add the lump sum to the patient's regular monthly income; the result is total gross income for the month;
- b. subtract the correct personal needs/maintenance allowance and any other allowable deductions; the remainder is the income available for patient pay for the month
- c. compare the spenddown liability to the Medicaid rate for the month:
 - if the available income for patient pay is less than or equal to the Medicaid rate, the available income is the patient pay.
 -
 - if the available income for patient pay is **greater than** the Medicaid rate, adjust the patient pay to the Medicaid rate for the month. Evaluate the difference between the Medicaid rate and the available income as a resource for the next month. If the patient's total countable resources, including the remainder of the available income, exceed the resource limit, take appropriate action to cancel the patient's Medicaid.

2. Facility Patients With Spenddown Liability Greater Than Medicaid Rate, & All Medicaid CBC Patients

For facility patients who have a spenddown liability that is greater than the facility Medicaid rate, and for ALL Medicaid CBC patients whose eligibility and patient pay are determined retrospectively:

a. Spenddown Eligibility & Patient Pay Previously Determined

If the individual's spenddown eligibility for the month has been determined without including the lump sum amount and the individual was enrolled for the month:

- 1) add the lump sum to the patient's regular monthly income in the month the lump sum was received; the result is total gross income for the month;
- 2) subtract the correct personal needs/maintenance allowance and any other allowable deductions; the remainder is the revised patient pay for the month;
- 3) compare the revised patient pay to the patient pay that was previously determined and sent to the provider:
 - if the revised patient pay is **greater than** the previously determined patient pay, adjust the patient pay to the revised patient pay amount or the Medicaid rate, whichever is less. If the Medicaid rate is less, evaluate the difference between the Medicaid rate and the revised amount as a resource for the next month.

- if the revised patient pay is **less than or equal to** the previously determined patient pay, DO NOT adjust the patient pay.

Note: If the patient's total countable resources, including the remainder of the available income, exceed the resource limit, take appropriate action to cancel Medicaid eligibility the next month because of excess resources.

b. Spenddown Eligibility & Patient Pay NOT Previously Determined

If the individual's spenddown eligibility for the month has not yet been determined:

- 1) Recalculate the individual's spenddown liability by adding the lump sum to the patient's regular monthly income in the month the lump sum was received; determine spenddown eligibility by policy and procedures in section M1460.700.
- 2) If the individual meets the revised spenddown, determine patient pay by using the policy and procedures in section M1470.620 or 630.

M1470.1100 REDUCTION OF EXCESS RESOURCES

A. Policy

Medicaid policy allows for a full month of eligibility if the resource limit is met at anytime during the month. LTC patients whose patient pay is less than the Medicaid rate can choose to reduce excess resources by expending the excess for the cost of LTC services.

**B. Resource
Reduction Defined**

A decrease in property value, such as an official reassessment or a lien placed against property, is not a reduction of resources. It is a decrease in the value of the resource.

In order to reduce resources, a resource must be transferred out of the patient's possession. Liquid resources such as bank accounts and prepaid burial accounts must actually be expended or encumbered. Non-liquid resources must be liquidated and the money expended.

A reduction of resources is an asset transfer and must be evaluated under asset transfer policy in subchapter M1450.

C. Procedures

**1. Required
Contact**

When a Medicaid-enrolled LTC recipient is found to have excess resources, evaluate whether an adjustment to patient pay by using the excess toward the cost of care will allow continued eligibility in the month in which the 10-day advance notice period expires. Do not assume that the recipient or the recipient's representative will agree to use the excess resources to pay an increased patient pay.

Prior to initiating the following procedures, contact the individual or his authorized representative and tell him of the alternatives available. In the case record, document the conversation and the decision made. If unable to make contact by phone, send the Advance Notice of Proposed Action for cancellation due to excess resources.

2. Reduce Excess Resources

When the patient agrees to use the excess resources toward the cost of care, take the following steps for the month in which the 10-day advance notice period expires:

Step 1

Determine amount of excess resources (total resources minus the resource limit).

Step 2

Determine the monthly Medicaid rate:

- for a facility patient, the monthly rate is the facility's Medicaid per diem rate multiplied by 31 days.
- for a CBC patient, the monthly rate is each CBC service provider's hourly rate multiplied by the number of hours of services provided to the patient in the month.

Step 3

Add the amount of excess resources to the current patient pay.

Step 4

If the result of Step 3 is less than the monthly Medicaid rate obtained in Step 2, adjust the patient pay for one month to allow the excess resources to be reduced.

Step 5

If the result of Step 3 is more than the monthly Medicaid rate obtained in Step 2, the patient is ineligible due to excess resources. Send an "Advance Notice of Proposed Action" to cancel Medicaid coverage due to excess resources.

**D. Example--
Recipient Reduces
Resources**

An institutionalized Medicaid recipient's resources accumulate to \$2,200 in February. His monthly income is \$500 from Social Security (SS) and \$100 VA Compensation. His patient pay *of \$560* is less than the Medicaid rate. He pays the amount of his excess resources (\$200) to the nursing facility as part of his March patient pay, so he remains eligible.

\$ 500	SS
<u>+ 100</u>	VA Compensation
\$ 600	total gross income
<u>- 40</u>	personal needs allowance
\$ 560	current patient pay (prior to adding excess resources)

\$ 560	current patient pay
<u>+ 200</u>	excess resources
\$760	patient pay for March only

His patient pay for April and subsequent months is calculated:

\$ 500	SS
+ 100	VA Compensation
\$ 600	total gross income
- 40	personal needs allowance
\$ 560	patient pay for April and subsequent months

M1470.1200 INCORRECT PAYMENTS TO PROVIDER

A. Introduction There may be instances when the amount of patient pay collected by an LTC provider is less than the amount *determined* available for payment. This situation is most likely to occur when some other person is the payee for the patient's benefits.

B. Procedures This section provides policy and procedures used to determine patient pay when the provider collects less than the patient pay *amount*. Patient pay can be adjusted *according to whether* certain criteria, specified in sections *M1470.1210 and M1470.1220* below, are met.

M1470.1210 ADJUSTMENTS NOT ALLOWED

A. Policy The facility or CBC provider is responsible to collect the patient pay from the patient or the person handling the patient's funds. When the provider is not successful in collecting the patient pay, the EW **cannot** adjust the patient pay.

B. Do Not Adjust Patient Pay The patient pay *reported in ARS/MediCall* is considered available by Medicaid. Do not adjust the patient pay when:

1. the patient directly receives his benefits and is considered to be competent but does not meet his patient pay responsibility; or
2. the amount of patient pay in question is from the patient's own funds which have been withheld by a payee or other individual receiving the patient's funds and have not been paid toward the cost of the patient's care, as specified by policy in this chapter and by the "Notice of Obligation for LTC Costs" sent to the individual.

Should the situation indicate that a change in payee is necessary, contact the program which is the source of the benefit payment and recommend a change. *Additionally*, be alert to situations that may require a referral to Adult Protective Services for an evaluation of exploitation.

C. Entitlement Benefits Adjustment For an ongoing case, if benefits from entitlement programs (such as Social Security) are not received because the program is holding the check(s) for some reason, but the benefits will be paid some time in the future in a lump sum, do not adjust the patient pay for the months the benefits are not received.

When the lump sum payment is received, do **not** count the lump sum payment and do **not** follow instructions for lump sum payments as found in this subchapter because the patient must use the lump sum to pay the previous months' remaining patient pay amounts the patient still owes to the provider.

M1470.1220 ADJUSTMENTS ALLOWED

A. Adjust Patient Pay

Adjust the patient pay when:

- the income counted in the patient pay calculation was not actually received because the source did not pay; *and*
- the income will not be paid some time in the future; and
- documentation of the change in income is received by the worker.

See section M1470.900 for instructions on adjusting patient pay.

B. Adjustment Allowed Due To Income Changes

Some examples of when income is not received and will not be paid in the future are:

1. Rental Income

Rental income is no longer received because the property was not rented for a period of time, or the renter did not pay. Be aware that if property no longer produces income, the resource exclusion may be affected. Evaluate *the individual's* continued eligibility.

2. Contribution Not Received

A contribution from a responsible relative or other source is not received. Advise the responsible relative of his legal responsibility. If there is a legal responsibility to support the individual, advise the responsible relative that continued failure to meet that responsibility may result in a non-support petition being filed with the appropriate court.

3. Income Source Exhausted

Interest income is not received because the source of income was exhausted or is no longer available.

4. Trust Income

Income from a trust fund is not received because the trustee did not make it available and/or will no longer make it available.

5. Policy/Benefits Ran Out

Payment from an insurance company or organization is not paid because the policy is no longer in force, benefits ran out, the organization refuses to or cannot pay, etc.

Sample Notice of Obligation for Long-term Care Costs Generated by MMIS

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

NOTICE OF OBLIGATION FOR LONG-TERM CARE COSTS

TO: _____

Local Agency: _____

Address: _____

Local Agency Phone #: _____

Provider #: _____

Provider: _____

Recipient Name: _____

Recipient ID#: _____

This form serves as your notice of patient pay which is the amount of your income that must be paid to the provider every month for the cost of long-term care services you receive. If you are a current recipient of long-term care services, this will serve as the 10-day advance notice when your patient pay amount is increased. Please contact your eligibility worker if you have questions.

For individuals assigned to a VALTC Managed Care Organization (MCO), notification of the name of the provider to which you are to make payment will be given to you by your MCO's Care Coordinator.

You must report any changes in income or resources to the local agency. Failing to report changes or providing false or misleading information may result in your prosecution for fraud.

Patient Pay Calculation

Effective Date of Patient Pay

Reason

Income

SSA

Other Unearned Income

Total Earned Income

Total Gross Income

Minus Spenddown Liability (SDL)

Remaining Income

Allowances

The amounts below were deducted from your income to determine your patient pay.

Personal/Maintenance Needs

Spousal

Child/Family Member

Non-covered Medical Expense

Home Maintenance

Income Remaining After Allowances

Spenddown Liability

Contributable Income

Medicaid Rate for Month

Patient Pay

Patient pay may be the lesser of the SDL amount, contributable income amount (income remaining after deductions plus the SDL), remaining income or the Medicaid Rate, whichever is applicable to the individual's circumstances. Patient pay will not exceed the Medicaid Rate.

Eligibility Worker: _____

Date of Notice: _____

If you disagree with the patient pay calculation you may appeal this decision within 30 days of receipt of this notice. If you appeal an increase in patient pay within 10 days of receipt of this notice, the increase will not take effect until a hearing decision is made. If the decision upholds the increase, you will have to pay the increased amount and the amount that was not paid during the appeal process. Appeals should be in writing and should be sent to Client Appeals, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, Virginia 23219. Please read below for additional information about Appeals and Fair Hearings.

APPEALS AND FAIR HEARINGS

A fair hearing provides you the opportunity to review the way the amount of your patient pay for Medicaid was determined. The fair hearing is a private, informal meeting with you and anyone you wish to bring as a witness or to help you tell your story, such as a lawyer or a friend. The Medicaid Technician or a representative of the local agency and possibly other staff who know about your case will be present to tell how the amount of patient pay was reached. Also present will be a hearings officer. The hearings officer, who is the official representative of the Department of Medical Assistance Services, will make a decision on your appeal.

In addition to filing an appeal, you have the right to request a conference with your Medicaid Technician or local agency at which time the Medicaid Technician or local agency must give you an explanation of the proposed change in patient pay. You will be given the opportunity to present any information on which your disagreement with the proposed patient pay is based. At the conference you have the right to have your story presented by an authorized representative, such as a friend, relative, or lawyer. If you request the conference within 10 days of receipt of this notice and the proposed action is to increase your patient pay, the proposed action will not be taken until a decision is made at your conference.

If you are not satisfied with the explanation you receive at the conference and want your present patient pay to continue until a hearing decision on the increase in patient pay is received, you must file an appeal within two days following the date of the conference. If you do not request a conference but file an appeal within 10 days of this notice, your present patient pay will be continued until a hearing decision is reached. If your present patient pay continues and the action to increase patient pay is upheld, you will be required to pay the patient pay that was not paid during the appeal process. If you do not file an appeal within two days of the conference, the increase in your patient pay will occur but you can still appeal the action within 30 days of the date of this notice.

If you wish to request a hearing, follow the instructions on the front of this form. You will be notified of the date and time for your hearing at a location agreeable to you and the Medicaid Technician or local agency. If you cannot be there on that day, call the Medicaid Technician or local agency immediately.

At the hearing, you and/or your representative will have the opportunity to:

- 1) Examine all documents and records which are used at the hearing;
- 2) present your case or have it presented by a lawyer or by another authorized representative;
- 3) Bring witnesses;
- 4) Establish pertinent facts and advance arguments; and
- 5) Question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

The decision or recommendation of the hearing officer shall be based exclusively on evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In such an event, you and the Medicaid Technician or the local agency representative would be given the opportunity to question or refute this additional information. You will be notified of the decision in writing within 90 days of the date your Medicaid appeal is received by the Department of Medical Assistance Services.

It is **YOUR RIGHT TO APPEAL** decisions. If you want more information or help with an appeal, you may contact the local agency or Medicaid Technician. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you desire free legal advice, you may contact your local legal aid office.

- 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. MMIS Patient Pay Process** *The patient pay is calculated in the Medicaid Management Information System (MMIS) using the Patient Pay process. The patient pay must be updated in MMIS whenever the patient pay changes, but at least once every 12 months. Refer to the MMIS User Guide for information regarding data entry into MMIS.*
- The MMIS Allowance and Medically Needy Workbook is available to facilitate the calculation of certain allowances that must be computed outside of MMIS and to calculate patient pay for Medically Needy determinations. The workbook is available at:*
http://www.vcu.edu/vissta/bps/bps_resources/ltc_medicaid.htm
- The Automated Response System (ARS) and the MediCall System convey the necessary patient pay information to the provider.*

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.

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:

**I. 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
<u>+ 400.00</u>	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
<u>+ 400.00</u>	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 *the MMIS Patient Pay process* for July, August and September. *MMIS generates 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).

M1480.450 FACILITY PATIENT PAY - SPENDDOWN LIABILITY LESS THAN OR EQUAL TO MEDICAID RATE

A. Policy **An MN institutionalized spouse in a facility whose spenddown liability is less than or equal to the Medicaid rate is eligible for a full month's Medicaid coverage effective the first day of the month,** based on the projected Medicaid rate for the month. Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay his community spouse and family member allowances, and his personal needs and noncovered expenses not used to meet the spenddown. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability to the provider.

B. Procedures Determine patient pay for the month in which the spenddown is met using the procedures below.

1. Patient Pay Gross Monthly 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).

- 2. Subtract Patient Pay Deductions** Subtract 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.
- a. a personal needs allowance (per section M1480.430 C.),
 - b. a community spouse monthly income allowance, if appropriate (per section M1480.430 D.),
 - c. a family member’s income allowance, if appropriate (per section M1480.430 E.),
 - d. any allowable noncovered medical expenses (per section M1470.230) **including** any old bills and carry-over expenses,
 - e. a home maintenance deduction, if appropriate (per section M1480.430 G.).

The result is the **remaining income** for patient pay.

- 3. Patient Pay** Compare the remaining income for patient pay to the Medicaid rate for the month. The patient pay is the lesser of the two amounts.

C. Example—Facility Spenddown Liability Less Than Medicaid Rate, Community Spouse Allowance

EXAMPLE #24: (Using July 2000 figures)

Mr. Hay is an institutionalized spouse who applied for Medicaid in July. He was admitted to the facility the prior November. He has a monthly CSA benefit of \$1,700 and a monthly Seminole Indian payment of \$235. He has Medicare Parts A & B and Federal Employees Health Insurance which costs \$75 per month. He last lived outside the facility in a Group III locality. His wife, Mrs. Hay, still lives in their home; she has income of \$500 per month from CSA. They have no dependent family members living with Mrs. Hay. Mr. Hay’s total income exceeds the CNNMP 300% of SSI income limit. His MN eligibility is determined for July. The MN determination results in a monthly spenddown liability of \$1,355:

\$1,700	monthly MN income (Seminole Indian payment excluded)
- 20	exclusion
1,680	countable MN income
- 325	MN limit for 1 (Group III)
\$1,355	spenddown liability for month

The facility’s Medicaid rate is \$45 per day, or \$1,395 for a 31-day month. By projecting the month’s cost of facility care, Mr. Hay meets his spenddown effective the first day of the month and is eligible for Medicaid effective July 1. He is enrolled in Medicaid effective July 1 in AC 018.

The community spouse monthly income allowance is calculated:

\$1,406.25	monthly maintenance needs standard
+ <u>0</u>	no excess shelter allowance
1,406.25	MMMNA (minimum monthly maintenance needs allowance)
- <u>500.00</u>	community spouse's gross income
\$ 906.25	community spouse monthly income allowance

His patient pay is calculated as follows:

\$1,700.00	CSA
+ <u>235.00</u>	Seminole Indian payment (counted for patient pay)
1,935.00	total patient pay gross income
- 30.00	PNA (personal needs allowance)
- <u>906.25</u>	community spouse monthly income allowance
998.75	
- 45.50	Medicare premium (not paid by Medicaid)
- <u>75.00</u>	health insurance premium
\$ 878.25	remaining income for patient pay (July)

The facility's Medicaid rate for July is \$1,395. Because Mr. Hay's remaining income for patient pay is less than the Medicaid rate for July, his patient pay for July is \$878.25. From his July income of \$1,935, Mr. Hay must pay \$878.25 patient pay to the facility, leaving him \$1,056.75 from which he can pay the community spouse income allowance of \$906.25, his personal needs allowance of \$30 and his Medicare and health insurance premiums of \$120.50 (total of \$1,056.75). Medicaid will pay \$476.75 of his spenddown liability (\$1,355 spenddown liability - 878.25 patient pay = \$476.75). **This is allowed under section 1924 of the Social Security Act (Special Treatment For Married Institutionalized Spouses).**

D. Example-Facility Spenddown Liability Less Than Facility Rate, Community Spouse & Family Member Allowance

EXAMPLE #25: (Using July 2000 figures)

Mrs. Zee is a disabled institutionalized spouse who 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 month because of excess resources. She has a monthly SSA benefit of \$1,200 and a monthly private pension payment of \$600. She has Medicare Parts A & B and private Medicare supplement health insurance which costs \$75 per month. Her spouse, Mr. Zee, still lives in their Group II home with their dependent son, age 19 years. Mr. Zee has income of \$1,500 per month from CSA. Their son has no income. Mrs. Zee's income exceeds the CNNMP 300% SSI income limit. Her MN eligibility is determined for July. She has old bills totaling \$300 dated the prior January. The MN determination results in a spenddown liability of \$1,530:

\$1,200.00	SSA
<u>+ 600.00</u>	monthly private pension
1,800.00	total monthly income
<u>- 20.00</u>	exclusion
1,780.00	countable MN income
<u>- 250.00</u>	MN limit for 1 (Group II)
\$1,530.00	spenddown liability for July

The facility's Medicaid rate is \$55 per day, or \$1,705 for the month. By projecting the month's cost of facility care, she meets the spenddown effective the first day of the month. Mrs. Zee is eligible for Medicaid, effective July 1. She is enrolled in Medicaid in AC 058.

The community spouse monthly income allowance is calculated:

\$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

Her patient pay for July is calculated as follows:

\$1,200.00	SSA
<u>+ 600.00</u>	private pension
1,800.00	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
1,195.00	
- 120.50	Medicare premium & health insurance premium
<u>- 300.00</u>	old bills
\$ 774.50	remaining income for patient pay (July)

The facility's Medicaid rate for July is \$1,705. Because Mrs. Zee's remaining income for patient pay is less than the Medicaid rate, her patient pay for July is \$774.50. From her July income of \$1,800, she must pay \$774.50 to the facility, leaving her \$1025.50 left to pay her personal needs, community spouse and family member's monthly income allowances, the old

bills and her medical insurance premiums, totaling \$1025.50. Medicaid will pay \$755.50 of her spenddown liability (\$1,530 spenddown liability - 774.50 patient pay = \$755.50). This is allowed under section 1924 of the Social Security Act (Special Treatment For Married Institutionalized Spouses).

M1480.460 FACILITY PATIENT PAY - SPENDDOWN LIABILITY GREATER THAN MEDICAID RATE

A. Policy

An MN facility institutionalized spouse whose spenddown liability is greater than the Medicaid rate is not eligible for Medicaid unless he incurs additional medical expenses that meet the spenddown liability within the month. If he meets the spenddown liability, his Medicaid coverage begins the first day of the month in which the spenddown is met, and ends on the last day of that month. A patient pay for the month is calculated.

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. Because he met the spenddown in the month, he is enrolled in a closed period of coverage for the full month. His patient pay for the month must be determined using the procedures below.

1. Calculate Remaining 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 needs 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 M1470.230) 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 facility care, and
- 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 Medicaid rate for the month. The patient pay is the lesser of the two amounts.

C. Example--Facility Spenddown Liability Greater Than Medicaid Rate, Less Than Private Cost of Care

EXAMPLE #26: (Using July 2000 figures)

Mr. L is an institutionalized spouse who applied for Medicaid in July. He was admitted to the facility the prior December. He has a monthly CSA benefit of \$1,900 and a monthly Seminole Indian payment of \$200. He has Medicare Parts A & B and Federal Employees Health Insurance which costs him \$75 per month. He last lived outside the facility in a Group III locality.

His wife, Mrs. L, still lives in their home with their dependent child age 20 years. Mrs. L has income of \$500 per month from CSA. Their child has no income. Mr. L's income exceeds the CNNMP 300% SSI income limit. His MN eligibility is determined for July. The MN determination results in a spenddown liability of \$1,555:

\$1,900	monthly MN income (Seminole Indian payment excluded)
- 20	exclusion
1,880	countable MN income
- 325	MN limit for 1 (Group III)
\$1,555	spenddown liability for month

The facility's Medicaid rate is \$45 per day, or \$1,395 for a month. The private pay rate is \$80 per day. By projecting the month's Medicaid rate, he does not meet his spenddown in July. He has no old bills. He is placed on a monthly spenddown of \$1,555 for each month in the 12-month certification period beginning July 1.

On July 31, he submits expenses for July. The worker verifies that his resources were below the limit in July. His spenddown liability of \$1,555 is compared to \$2,480, the private rate for July (\$80 per diem x 31 days). Because the private cost of care for July is greater than his spenddown liability for July, he met his spenddown in July. He is eligible for the full month of July. On August 1, the worker enrolls him in Medicaid with coverage beginning July 1 and ending July 31.

His patient pay is determined. The community spouse and family member allowances are calculated first:

\$1,406.25	monthly maintenance needs standard
+ 0	no excess shelter allowance
<u>1,406.25</u>	MMMNA (minimum monthly maintenance needs allowance)
- 500.00	community spouse's gross income
\$ 906.25	community spouse monthly income allowance
\$1,406.25	monthly maintenance needs standard
- 0	child's income
<u>1,406.25</u>	amount by which standard exceeds child's income
÷ 3	
\$ 468.75	child's family member monthly income allowance
\$1,900.00	CSA income
+ 200.00	Seminole Indian payment (not excluded for patient pay)
<u>2,100.00</u>	total patient pay gross income
- 30.00	personal needs allowance
- 906.25	community spouse monthly income allowance
- 468.75	family member allowance
<u>695.00</u>	
- 45.50	noncovered Medicare Part B premium
- 75.00	noncovered health insurance premium
\$ 574.50	remaining income (July)

The facility's Medicaid rate for July is \$1,395. Because Mr. L's remaining income for patient pay is less than the Medicaid rate for July, his patient pay for July is \$574.50.

From his July income of \$2,100, he must pay the patient pay of \$574.50. He has \$1,525.50 left with which to meet his personal needs (\$30), pay the community spouse and family member allowances, and pay his Medicare and health insurance premiums, a total of \$1,525.50. In accordance with Section 1924 of the Social Security Act, Medicaid will assume responsibility for \$980.50 of his spenddown liability (\$1,555 - 574.50 patient pay = \$980.50).

D. Example—Facility Spenddown Liability Greater Than Medicaid Rate and Private Cost of Care

EXAMPLE #27: (Using July 2000 figures)

Mrs. Bee is an institutionalized individual who files an initial application for Medicaid on July 6. She has a monthly SSA benefit of \$2,000 and a monthly private pension payment of \$500. She has Medicare Parts A & B and private Medicare supplement health insurance which costs her \$100 per month. Mrs. Bee last resided outside the facility in a Group II locality. Her spouse, Mr. Bee, still lives in their home. He has income of \$1,800 per month from CSA. Mrs. Bee's income exceeds the CNNMP 300% SSI income limit.

Her MN eligibility is determined for July. The MN determination results in a spenddown liability of \$2,230:

\$2,000.00 SSA
+ 500.00 monthly private pension
 2,500.00 total monthly income
- 20.00 exclusion
 2,480.00 countable MN income
- 250.00 MN limit for 1 (Group II)
 \$2,230.00 spenddown liability for month

The facility's Medicaid rate is \$55 per day, or \$1,705 for a month. By projecting the month's Medicaid rate, she does not meet her spenddown. 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 facility rate is \$70 per day, or \$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. Bee's spenddown eligibility for July:

\$2,230.00 spenddown liability 7-1
- 140.00 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
- 1,890.00 private pay for 27 days @ \$70 per day 7-3 through 7-29
 54.50 spenddown liability balance at beginning of 7-30
- 70.00 private pay for 7-30
 \$ 0 spenddown met on 7-30

Mrs. Bee met her spenddown on July 30. On August 3, the worker enrolls her in Medicaid with a begin date of July 1 and end date of July 31. To determine her patient pay, the community spouse monthly income allowance is calculated:

\$1,406.25 monthly maintenance needs standard
+ 525.00 excess shelter allowance
 1,931.25 MMMNA (minimum monthly maintenance needs allowance)
- 1,800.00 community spouse's gross income
 \$ 131.25 community spouse allowance

Mrs. Bee's patient pay for July is calculated as follows:

\$2,000.00 SSA
+ 500.00 private pension
 2,500.00 gross patient pay income
- 30.00 personal needs allowance
- 131.25 community spouse allowance
 2,338.75
- 145.50 noncovered Medicare & health ins. premium
 \$2,193.25 remaining income (July)

Mrs. Bee's remaining income for patient pay in July is \$2,193.25, which is greater than the Medicaid rate for of July \$1,705. The facility can only collect the Medicaid rate; therefore, her patient pay for July is the Medicaid rate of \$1,705.

From her July income of \$2,500, she must pay the Medicaid rate of \$1,705. Medicaid will not pay for any of her facility 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 personal needs (\$30), pay the community spouse allowance, and pay her Medicare and health insurance premiums, a total of \$306.75. She has \$488.25 left from her July income. Medicaid will assume responsibility for \$525 of her spenddown liability (\$2,230 - 1,705 Medicaid rate = \$525).

Since Mrs. Bee paid the private rate of \$2,170 to the facility in July, the facility is responsible to reimburse her for the difference between the private rate and the Medicaid rate (\$465). On August 25, she requests evaluation of her spenddown for August. She was reimbursed \$465 on August 20, which was deposited into her patient fund 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.

M1480.470 CBC - MN INSTITUTIONALIZED SPOUSE PATIENT PAY

A. Policy

When the Medicaid community-based care (CBC) institutionalized spouse has been screened and approved for waiver services and has **income less than or equal to 300% of the SSI income limit** for one person, he is eligible for Medicaid as CNNMP and entitled to Medicaid for full-month, ongoing Medicaid coverage.

An institutionalized spouse who is screened and approved for waiver services, and whose income **exceeds the CNNMP 300% SSI income limit**, is placed on a monthly spenddown. **The monthly CBC costs cannot be projected** for the spenddown budget period. The CBC costs, along with any other spenddown deductions, are deducted daily and chronologically as the costs are incurred. If the spenddown is met any day in the month, Medicaid coverage begins the first day of the month in which the spenddown is met, and ends on the last day of that month. A patient pay for the month is calculated.

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. Because he met the spenddown in the month, he is enrolled in a closed period of coverage for the full month. His patient pay for the month must be determined for the month 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 *any* (per section M1480.430 D.),
- 3) a family member's monthly income allowance, if *any* (per section M1480.430 E.),
- 4) *any* allowable noncovered medical expenses (per section M1470.430) 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 *any* (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 Medicaid rate for the month. The patient pay is the lesser of the two amounts.

C. Example--CBC Institutionalized Spouse on Spenddown

EXAMPLE #28: (Using July 2000 figures)

Mr. T is an institutionalized spouse who applied for Medicaid in July. He was screened and approved for Medicaid E & D waiver services on July 1, and began receiving those services on that date. He has a monthly CSA benefit of \$1,900 and a monthly Japanese-American Restitution payment of \$200. He has Medicare Parts A & B and Federal Employees Health Insurance which costs him \$75 per month. He last lived outside the facility in a Group III locality.

His wife, Mrs. T, lives in their home with Mr. T and their dependent child age 18 years. Mrs. T has income of \$500 per month from CSA. Their child has no income. Mr. T's income exceeds the CNNMP 300% of SSI income limit. His MN eligibility is determined for July. The MN determination results in a spenddown liability of \$1,555:

\$1,900	monthly MN income (Japanese-American Restitution payment excluded)
- <u>20</u>	exclusion
1,880	countable MN income
- <u>325</u>	MN limit for 1 (Group III)
\$ 1,555	spenddown liability for month

He has no old bills. He is placed on a monthly spenddown of \$1,555 for each month in the 12-month certification period beginning July 1.

On July 31, he submits expenses for July. The worker verifies that his resources were below the limit in July. His spenddown liability of \$1,555 is compared to \$2,400, the total private rate for July (\$16 per hour private rate x 5 hours per day x 31 days = \$2,480). Because the private cost of CBC care for July is greater than his spenddown liability for July, he met his spenddown in July. He is eligible for the full month of July. On August 1, the worker enrolls him in Medicaid beginning July 1 and ending July 31.

His patient pay is then calculated. The community spouse and family member allowances are calculated first:

\$1,406.25	monthly maintenance needs standard
+ <u>0</u>	no excess shelter allowance
1,406.25	MMMNA (minimum monthly maintenance needs allowance)
- <u>500.00</u>	community spouse's gross income
906.25	community spouse monthly income allowance
\$1,406.25	monthly maintenance needs standard
- <u>0</u>	child's income
1,406.25	amount by which standard exceeds child's income
÷ <u>3</u>	
\$ 468.75	family member monthly income allowance
\$1,900.00	CSA income
+ <u>200.00</u>	Japanese-American Restitution payment (not excluded for patient pay)
2,100.00	total patient pay gross income
- 512.00	personal maintenance allowance
- 906.25	community spouse monthly income allowance
- <u>468.75</u>	family member allowance
213.00	
- 45.50	noncovered Medicare Part B premium
- <u>75.00</u>	noncovered health insurance premium
\$ 92.50	remaining income for patient pay

The CBC provider’s Medicaid rate is \$9.50 per hour, 5 hours per day or \$47.50 per day, a total of \$1,472.50 for July (31 days). Because Mr. T’s remaining income is less than the Medicaid rate, his patient pay for July is \$92.50.

From his July income of \$2,100, Mr. T must pay the patient pay of \$92.50. He has \$2,007.50 left with which to meet his maintenance needs (\$512), pay the community spouse and family member allowances, and pay his Medicare and health insurance premiums, a total of \$2,007.50. In accordance with Section 1924 of the Social Security Act, Medicaid will assume responsibility for \$1,462.50 of his spenddown liability (\$1,555 - 92.50 patient pay = \$1,462.50). Because he paid all of his income to the CBC provider in July, his resources are within the limit in August.

D. Example-CBC Institutionalized Spouse on Spenddown

EXAMPLE #29: (Using July 2000 figures)

Mrs. Bly is an aged individual who files an initial application for Medicaid on July 1. She was screened and approved for Medicaid E & D waiver services on July 1, and began receiving those services on July 1. She has a monthly SSA benefit of \$2,000 and a monthly private pension payment of \$500. She has Medicare Parts A & B and private Medicare supplement health insurance which costs her \$100 per month. Mrs. Bly resides in a Group II locality. Her spouse, Mr. Bly, lives with her in their home. He has income of \$1,800 per month from CSA. Mrs. Bly’s income exceeds the CNNMP 300% of SSI income limit.

Her MN eligibility is determined for July. The MN determination results in a spenddown liability of \$2,230:

\$2,000.00	SSA
+ 500.00	monthly private pension
2,500.00	total monthly income
- 20.00	exclusion
2,480.00	countable MN income
- 250.00	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
- 140.00	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
- 1,890.00	private pay for 27 days @ \$70 per day 7-3 through 7-29
54.50	spenddown balance at beginning of 7-30
- 70.00	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
+ 525.00	excess shelter allowance
<u>1,931.25</u>	MMMNA (minimum monthly maintenance needs allowance)
- 1,800.00	community spouse's gross income
<u>\$ 131.25</u>	community spouse allowance

Mrs. Bly's patient pay for July is calculated as follows:

\$2,000.00	SSA
+ 500.00	private pension
<u>2,500.00</u>	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
<u>\$1,711.25</u>	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.

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 are 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 *any* (per section M1480.430 D.),
- 3) a family member's monthly income allowance, if *any* (per section M1480.430 E.),

4) *any* 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 *any* (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.

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

The "Notice of Obligation for Long-term Care Costs" notifies the patient of the amount of patient pay responsibility. *The form is generated and sent by MMIS when the patient pay is used entered or changed.*

3. Medicaid LTC Communication Form (DMAS-225)

The *Medicaid Long-term Care (LTC) Communication Form (DMAS-225)* is used to facilitate communication between the local agency and the LTC services provider. The form may be initiated by the local agency or the provider. The form is available on SPARK at:
http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi.

The *DMAS-225*:

- notifies the LTC provider of a patient's Medicaid eligibility status;
- 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.

Do not use the DMAS-225 to relay the patient pay amount. Providers will be able to access the patient pay amount via the verification systems available to providers.

a. When to Complete the *DMAS-225*

Complete the *DMAS-225* at the time of eligibility determination and/or the recipient's entry into LTC. Complete a new *DMAS-225* 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.

b. Where To Send the *DMAS-225*

Refer to M1410.300 B.3.b to determine where the form is to be sent.

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. 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.

- 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 INFORMATION

- 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, *the worker enters the information in MMIS. MMIS sends the "Notice of Obligation for Long-Term Care Costs" to the enrollee or the enrollee's authorized representative.*

- B. Procedure** When patient pay increases, the *MMIS "Notice of Obligation for Long-Term Care Costs" is sent in advance of the date the new amount is effective.*

**DMHMRSAS Facilities
Medicaid Technicians**

NAME	LOCATION	WORK TELEPHONE	CASELOAD
Brenda Wolkfert, Supervisor (T006)	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 SSVTC-All
Mary Lou Spiggle (T003)	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-all WSH-caseload-all NVMHI-caseload-all SVMHI-caseload-all SSVTC-back-up
Debra J. Quesenberry (T002)	Catawba Hospital Medicaid Office P. O. Box 200 Catawba, VA 24070	540-375-4350	Catawba-caseload-all NVTC-caseload-all Hiram Davis-caseload-all
Frances Jones (T004)	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0841	SWVTC-caseload-all ESH-caseload-A-J
Vacant(Back-up Frances Jones) (T005)	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:

FIPS	Facility Initials and Full Name
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
996	Hiram Davis Medical Center

2. Nursing Facility Patients

Patients in long-term nursing facilities receive Medicaid cards. The nursing facility also receives a computer-generated list at the first of the month which lists all eligible Medicaid patients in that facility. Each patient's name, Medicaid number, and medical resources code is included on this listing.

This listing reflects only those Medicaid-eligible patients for whom the nursing facility has submitted an "admission packet" to Medicaid, and whom Medicaid has entered on its Long-Term Care Information computer subsystem.

DMAS staff enters the patient information into the subsystem and assigns a patient control number to the facility for use in billing Medicaid for the patient's care.

When a patient dies or is discharged from the facility, the facility is responsible for notifying DMAS and the LDSS of the date of discharge or death. Long-term care providers have been instructed to notify the LDSS of death or discharge via the *Medicaid Long-term Care Communication Form (DMAS-225)*.

M1820.100 SERVICE PROVIDERS

A. Enrollment Requirement

Providers of medical services must be enrolled by DMAS to receive Medicaid payment for their services. Lists of enrolled providers are available to local departments of social services *and enrollees* from DMAS and are available online at www.dmas.virginia.gov.

B. Out-of-State Providers

1. Covered Services

Medicaid will cover medical services rendered by out-of-state providers when the use of such providers is:

- a. the general custom of the eligible individual (e.g., a recipient living near the border of another state),
- b. needed by a non IV-E Foster Care child placed outside Virginia,
- c. necessitated when an eligible person is temporarily outside Virginia and has a medical emergency, or
- d. indicated because of referral to an out-of-state facility when preauthorized by DMAS.

- newly eligible Medallion II enrollees who are in their third trimester of pregnancy and who request exclusion by the 15th of the month in which their MCO enrollment becomes effective. Exclusion may be granted only if the member's obstetrical provider (physician or hospital) does not participate with any of the state-contracted MCOs. The enrollee, MCO, or obstetrical provider can make exclusion requests. Following end of pregnancy, these individuals shall be required to enroll in Medallion II to the extent they remain eligible for full Medicaid benefits.
- recipients who have been pre-assigned to the MCO but have not yet been enrolled, who have been diagnosed with a terminal condition, and whose physician certifies a life expectancy of six (6) months or less may request exclusion from Medallion II. Requests must be made during the pre-assignment period.
- recipients who are inpatients in hospitals, other than those listed above, at the scheduled time of enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge.
- Certain children between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (IDEA) and who meet DMAS review.

**1. Foster Care/
Adoption
Assistance
Children**

All Foster Care and Adoption Assistance children enrolled in MMIS with an Aid Category (AC) of 072, 074, 076, or 086 or enrolled through ADAPT are automatically excluded from participating in managed care. Foster Care/Adoption Assistance children who are enrolled outside ADAPT under any other AC can be exempted from Medicaid managed care programs. If a worker finds that a Foster Care/Adoption Assistance child is enrolled in a managed care program, the worker may request that the child be removed from managed care and placed in fee-for-service Medicaid through the following process:

- Complete the Foster Care Child-Exemption from Managed Care form available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>. The custody order, emergency removal order, or a statement on agency letterhead signed by the director or foster care supervisor verifying the child is in the agency's custody and the date the agency received custody must be attached to the form in order to have the child exempted from managed care.
- Fax the form to (804) 786-5799.

Exemption requests may take up to 5 business days to complete. Disenrollment is effective at the end of the month of notification (not retroactively). The LDSS can verify disenrollments by checking the MMIS Managed Care Assignment screen for a managed care end date.

2. Other Exempt Recipients

Recipients who are exempt from enrollment in managed care are excluded based on information supplied to MMIS at the time of enrollment.

C. Choice of Managed Care Programs/PCPs

Recipients who are required to participate in a managed care program will be notified within 15 - 45 days of enrollment in Medicaid and asked to choose either a MEDALLION PCP or one of the Medallion II MCOs operating in the recipient's geographical region. A list of MCOs operating in each region can be obtained online at www.dmas.virginia.gov or by contacting the Managed Care Helpline at 1-800-643-2273 to request a comparison chart.

D. Good Cause

MEDALLION

The MEDALLION program has an annual open enrollment period of 90 days that applies to individuals in MEDALLION only areas. During the open enrollment period, MEDALLION enrollees may change Primary Care Physicians (PCPs). If an enrollee wishes to change his PCP outside of the open enrollment period, he must make a good cause request to DMAS.

MEDALLION II

In the Medallion II program, good cause consists of a pre-defined set of operational conditions that allows an enrollee to change from one Managed Care Organization (MCO) to another. In areas where there is only one MCO, an enrollee may change from either MEDALLION or the MCO to the other program. The good cause provision applies only after the initial 90-day enrollment period has ended.

If a good cause reason exists, the enrollee must write a letter to the DMAS Managed Care Division providing supporting documentation. All written correspondence should be directed to the following address and/or fax number:

Department of Medical Assistance Services
Managed Care Division
600 East Broad Street, 11th Floor
Richmond, VA 23219
(fax) 804-786-5799

M1840.100 UTILIZATION REVIEW AND CLIENT MEDICAL MANAGEMENT

A. Utilization Review

Federal regulations require the Department of Medical Assistance Services (DMAS) to regularly review recipients' use and need for the covered medical services they receive. Regulations require that Medicaid pay only for medically necessary covered medical services. Medicaid cannot pay for duplicate services since they are not necessary.

DMAS staff in the Long Term Care and Quality Assurance Division reviews provider claims and recipient utilization histories for medical necessity. If it is determined that services were not medically necessary, providers are obligated to reimburse DMAS for any Medicaid payment they have received.

Recipients in long-term care are reviewed at least once every six months to determine the continued need for long-term care. Their treatment and level of functioning is compared to the Medicaid long-term care regulations for nursing care. If a recipient no longer meets the regulations for long-term care, DMAS notifies the provider and the recipient at least 10 days in advance that Medicaid payment for the care will stop. The recipient has the right to appeal this decision. Long-term care providers have been instructed to notify the LDSS of discharge via the *DMAS-225 form*.

B. Client Medical Management Program

Recipients' utilization of Medicaid cards for physicians' services and pharmaceutical services is monitored regularly by DMAS. Whenever the utilization of one or both of these services is unusually high, the services will be reviewed for medical necessity. If some services are considered not medically necessary, recipients who are not enrolled in a managed care program will be placed in the Client Medical Management Program and required to select a primary physician and/or pharmacy or both.

Recipients identified as high utilizers will receive a letter of notification with instructions about selecting primary providers and identifying those providers to DMAS. The local agency service worker will be asked to interview the recipient and gather information for DMAS. Following receipt of that information by DMAS, the recipient's MMIS record will have the names and provider numbers of the selected physician and pharmacy on it. Recipients who do not respond to the letter within the specified time will have their primary physician and pharmacy designated by DMAS.