



COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

September 1, 2010

MEDICAID MANUAL – VOLUME XIII

TRANSMITTAL #94

The following acronyms are used in this transmittal:

- ADAPT – Application/Benefit Delivery Automation Project
- CBC – Community-based Care
- DDS – Disability Determination Services
- DMAS – Department of Medical Assistance Services
- FAMIS – Family Access to Medical Insurance Security
- FAC – Federal Additional Compensation
- HIPP – Health Insurance Premium Payment
- ID – Intellectual Disabilities
- IMD – Institution for Treatment of Mental Diseases
- LDSS – Local Departments of Social Services
- MCO – Managed Care Organization
- MMIS – Medicaid Management Information System
- MR – Mental Retardation
- PACE – Program of All-inclusive Care for the Elderly
- QI – Qualified Individual
- SOLQ-I – State On-line Query-Internet
- SPARK – Services Programs Answers Resources Knowledge
- SSA - Social Security Administration
- SSI – Supplemental Security Income
- SSN – Social Security Number
- SVES – State Verification Exchange System
- TPL – Third Party Liability
- U.S. – United States
- VDSS – Virginia Department of Social Services

This transmittal includes revised eligibility policy and procedures for Medicaid fraud and recovery of misspent funds, as well as policy revisions regarding the eligibility of Iraqi and Afghan special immigrants. Other revised and clarified policies are included in this transmittal that are effective on September 1, 2010, unless another date is indicated for the revision.

Revised Policy

The policy on Medicaid coverage for individuals admitted to the United States under an Afghan and Iraqi Special Immigrant Visa has been revised. The Department of Defense Appropriations Act of 2010, enacted on December 19, 2009, provides that individuals admitted to the U.S. under an Afghan or Iraqi Special Immigrant visa are eligible for Medicaid and FAMIS benefits through the first seven years after entry into the U.S.—to the same extent and for the same time period as refugees—provided that all other Medicaid eligibility requirements are met. The new legislation supersedes prior legislative authority that limited Medicaid coverage for these individuals to eight months from the date of entry.

This change applies to Iraqi and Afghan special immigrants who arrived in the U.S. before the December 19, 2009, effective date of the law AND to those who enter the country after that date. However, this change is **not** retroactive. Iraqi and Afghan special immigrant whose eight-month eligibility expired **prior** to December 19, 2009, must reapply for benefits to receive additional Medicaid coverage. Currently enrolled Iraqi and Afghan special immigrants who were approved prior to December 19, 2009, will remain eligible for the first seven years after their entry into the U.S. Their coverage must not be terminated due to the previous 8-month time limit. Any Iraqi or Afghani special immigrant whose Medicaid or FAMIS coverage was canceled **after** December 19, 2009, because of the 8-month time limit, is eligible for Medicaid or FAMIS if all other eligibility requirements continue to be met. FAMIS-eligible Iraqi and Afghan Special Immigrants are eligible without regard to time limitations. If these individuals' Medicaid or FAMIS coverage was canceled because of the 8-month time limit, the Iraqi or Afghan Special immigrant must re-apply for Medicaid/FAMIS. This policy change was originally posted in Broadcast #6245, dated May 12, 2010.

The policy on alien status for SSI recipients has been revised. Certain disabled “seven-year” aliens, including refugees, are now eligible to receive a two-year extension of SSI benefits, for a total of nine years of SSI benefits. Individuals receiving extended SSI payments are considered full-benefit aliens for the purposes of Medicaid eligibility. This policy revision was originally posted in Broadcast #6377, dated July 20, 2010.

The policy on FAC payments to certain individuals receiving Unemployment Compensation has been revised. The American Recovery and Reinvestment Act of 2009 (P.L. 111-5) authorized increased FAC payments of \$25.00 per week to certain individuals receiving Unemployment Compensation payments. FAC increased payments are authorized for Unemployment Compensation payments made through December 4, 2010, provided that the initial claim for compensation was filed on or before May 23, 2010. Claims filed after May 23, 2010 are not subject to the increased payments. FAC increased payments are excluded from countable income. If the individual's Unemployment Compensation claim was filed on or before May 23, 2010, exclude the first \$25.00 of Unemployment Compensation for payments made through December 4, 2010. If the claim was filed after May 23, 2010, the individual does not receive the additional weekly \$25.00. DO NOT exclude the FAC payments from countable income. This policy revision was originally posted in Broadcast #6353, dated July 7, 2010.

The spenddown policy for QIs has been revised to more closely follow the spenddown policies for the other Medicare Saving Program covered groups. A QI enrollee who meets all other Medicaid eligibility requirements for Medicaid as a Medically Needy individual is to be placed on continuous spenddowns, two at a time, as long as the enrollee's Medicaid coverage remains open. The spenddown periods will be based on the initial application date, rather than the QI coverage renewal, which is due by December 31 for all QI individuals regardless of the application date.

The Mental Retardation Waiver was renamed the Intellectual Disabilities/Mental Retardation Waiver. The references to the MR Waiver throughout Chapter M14 have been updated with the new name.

Chapter M17, Medicaid Fraud and Recovery of Misspent Funds, was significantly revised for improved clarity. The responsibilities of the LDSS for reporting cases in which the individual erroneously received Medicaid coverage for any reason have been more clearly delineated. The policies regarding when a referral to the DMAS Recipient Audit Unit must be made and the referral process were also clarified. The Notice of Recipient Fraud/Non-fraud Overissuance form has been revised to provide more comprehensive information from the LDSS to DMAS. The form has been placed on the SPARK ME Forms page at <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.html>.

Clarified Policy

The use of the SVES or SOLQ-I to verify SSA records is clarified.

Policy is clarified to allow “early” denial or cancellation actions to be made under certain circumstances. When the deadline date falls on a weekend or holiday, a denial or cancel action may be taken on the last business day before the deadline date if all necessary verifications have not been received, provided the LDSS re-opens the application or renewal if the individual provides the requested information by the deadline date.

The policies and procedures on making referrals to DDS for disability determinations were significantly reorganized and expanded for improved clarity. Additional information was added regarding how a disability determination is made, and a sequential flow chart was added to aid in determining whether or not a DDS referral is necessary. The procedures used when reopening an application that was previously denied because disability was not met have been more explicitly clarified.

The policies regarding pursuit of support from an absent parent is clarified for pregnant women. An unmarried pregnant woman cannot be denied medical assistance for failure to cooperate with support if she meets the medical assistance cooperation requirements, even if she is ineligible for another program because of failure to cooperate with support.

Additional clarifications contained in this transmittal include:

- delineated procedures to follow when SSA match is unable to verify the individual’s citizenship and identity;
- added procedures for verifying an SSN that is provided by an individual applicant;
- when certain Huff-Cook burial insurance policies reduce the burial fund exclusion;
- when the penalty period for uncompensated asset transfers begins;
- when a claim of undue hardship related to an uncompensated asset transfer can be made; and
- the procedures to be followed when an individual in a nursing facility does not make his patient pay available to the facility.

Electronic Version

Transmittal #94 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 M0110 pages 2, 3	On pages 2 and 3, revised the information regarding releasing information to medical providers.
Subchapter M0120 pages 8, 8a	On page 8, changed the heading in item A.2. On page 8a, added information about the federal government's model Application for Medicare Premium Assistance form.
Subchapter M0130 pages 2-6, 8	On pages 2 and 5, clarified that when a deadline date falls on a weekend or holiday, early denial action may be taken. Page 3 is a runover page. On pages 4, 6 and 8, clarified that verification from SSA can be from either SVES or SOLQ-I, except when verification of the individual's name in SSA records is required. On page 6, changed the instructions for entering a pseudo SSN for enrollees who have applied for SSNs; "888" as the first three digits is accepted in MMIS and ADAPT, because the "APP" in the first three digits is no longer required in ADAPT.
Subchapter M0220 pages 3-3b, 7-9, 14a-14d, 18, 21, 22a, 23 Appendix 1 Appendix 3, page 3	On pages 3-3b, clarified the procedures for notifying the enrollee when the SSA is unable to verify citizenship and identity via the computer data match. On pages 7, 14a-14c, 18, 22a, 23 and Appendix 3, page 3, revised the policy on the qualified alien status of Afghan and Iraqi special immigrants for Medicaid eligibility purposes. Page 8 is a runover page. On page 9, added the revised alien policy for SSI recipients. Page 14d is a runover page. On page 21, removed the reference to the HIPP requirement. In Appendix 1, updated the address of the U.S. Citizenship & Immigration Services office where LDSS send requests.
Subchapter M0240 Table of Contents pages 1-6	Updated the Table of Contents. On pages 1 and 2, clarified that verification from SSA can be from either SVES or SOLQ-I, except when verification of the individual's name in SSA records is required. On page 3, clarified that when an individual meets the application for an SSN requirement, it is met in the retroactive period. On page 3, changed the instructions for entering a pseudo SSN for enrollees who have applied for SSNs; "888" as the first three digits is accepted in MMIS and ADAPT, because the "APP" in the first three digits is no longer required in ADAPT. Page 4 is a runover page. On pages 5 and 6, added a new section containing procedures for verifying SSNs provided by individuals, which includes procedures for working the SSN and Citizenship Update Report.
Subchapter M0250 pages 3-5	On page 3, clarified that an unmarried pregnant woman cannot be denied medical assistance for failure to cooperate with support if she meets the medical assistance cooperation requirement, even if she is ineligible for another program because of failure to cooperate with support. Pages 4 and 5 are runover pages.

Pages Changed	Significant Changes
Subchapter M0280 Page 1	On page 1, clarified that psychiatric residential treatment centers for children and adolescents are considered IMDs.
Subchapter M0310 pages 21-27c, 28	On pages 21-27c, reorganized, expanded, and clarified the policy on referrals to DDS and a referral to DDS is appropriate. Page 28 is a runover page.
Subchapter M0320 pages 49-50b	On page 49, removed the history of Plan First. On page 50, added the MMIS action taken when TPL is detected on the enrollee's record. On pages 50a and 50b, added policy about the Plan First post-sterilization extension of coverage from Broadcast #5599.
Subchapter M0720 pages 5, 6	On page 5, added policy that states that salaries from corporations owned or partially owned by an individual are not self-employment income. Page 6 is a runover page.
Subchapter M0730 pages 7, 8	On pages 7 and 8, revised the policy on the special \$25.00 weekly exclusion from countable income for certain individuals receiving Unemployment Compensation Payments
Subchapter S0830 page 29	On page 29, revised the policy on the special \$25.00 weekly exclusion from countable income for certain individuals receiving Unemployment Compensation Payments
Subchapter S1130 pages 20, 20a, 28-29a	On pages 20 and 29, added information about Huff-Cook life/burial insurance policies. Pages 20a, 28 and 29a are runover pages.
Subchapter S1340 page 6	On page 6, clarified the language regarding when old bills can be applied to a future consecutive spenddown.
Subchapter M1370 Table of Contents pages 1-5	Updated the Table of Contents. On pages 1, 2, 4 and 5, added policy and procedures for placing Qualified Individuals on a spenddown. Page 3 is a runover page.
Subchapter M1410 pages 6, 7, 13	On pages 6, 7 and 13, changed the MR Waiver references to ID/MR Waiver.
Subchapter M1420 Table of Contents pages 3-5 Appendix 3	Updated the Table of Contents. On pages 3-5 and in Appendix 3, changed the MR Waiver references to ID/MR Waiver.
Subchapter M1440 Table of Contents pages 13, 16, 18b, 19-22	Updated the Table of Contents. On pages 13, 16, 18b and 19-22, changed the MR Waiver references to ID/MR Waiver.

Pages Changed	Significant Changes
Subchapter M1450 Table of Contents pages 36-37a, 39-44	Updated the Table of Contents. On page 36 and 37, clarified when the penalty period begins for uncompensated asset transfers on or after February 8, 1996. On pages 39 and 41, clarified when an undue hardship claim may be made. On page 42, clarified that an individual in CBC cannot be eligible for Medicaid in the 300% of SSI covered group during a penalty period. On pages 42 and 43, clarified the content of the notices. Pages 37a, 40 and 44 are runover pages.
Subchapter M1460 page 4a	On page 4a, changed the MR Waiver references to ID/MR Waiver.
Subchapter M1470 Table of Contents pages 1, 1a, 3, 3a, 11, 12, pages 19, 20, 24, 28, 31	Updated the Table of Contents. On pages 1 and 1a, added the procedures for nursing facilities and LDSS when the individual does not pay his patient pay. On page 3, clarified that the Survivor's Benefit Plan deductions from military pensions are not countable toward patient pay. Page 3a is a runover page. On pages 11 and 12, clarified that Medicare Part D premiums can be deducted from patient pay for the month of admission into a nursing facility. On pages 19 and 20, changed the MR Waiver references to ID/MR Waiver. On pages 24, 28 and 31, clarified that patient pay allowances for non-covered medical expenses do not have to be approved by DMAS for CBC and PACE enrollees.
Subchapter M1480 pages 64, 66, 69, 70	On page 64, added the missing phrase at the end of the page. On page 66, clarified that there was no change to the Monthly Maintenance Needs Standard and Excess Shelter Standard for 2010. On pages 69 and 70, changed the MR Waiver references to ID/MR Waiver.
Subchapter M1510 pages 2a, 8-8a	On page 2a, clarified that when an individual meets the application for an SSN requirement, it is met in the retroactive period. On pages 8 and 8a, clarified procedures to follow when re-opening an application that was denied because disability not met.
Subchapter M1520 Table of Contents pages 3, 4b, 5, 6-6a, 10 Appendix 1 was removed	Updated the Table of Contents. On pages 3, 4b, 6a and 10 clarified that verification from SSA can be from either SVES or SOLQ-I, except when verification of the individual's name in SSA records is required. On page 5, clarified the deadline date for returning renewals is at least 10 calendar days from date the renewal form is sent to the enrollee, and that early cancellation actions may be taken before the deadline date when the deadline falls on a weekend or holiday. Page 6 is a runover page.

Pages Changed	Significant Changes
Chapter M17 Title Page Table of Contents pages 1-7 Appendix 1 Appendix 2	Updated the Title Page and the Table of Contents. On pages 1-7, clarified when a referral to the DMAS Recipient Audit Unit must be made and clarified the referral process. Appendix 1, the Notice of Recipient Fraud/Non-fraud Recovery, was removed and placed on SPARK. The former Appendix 2 was renumbered as Appendix 1. A new form, the MCO Capitation Fees Recovery Form, was added as Appendix 2.
Chapter M18 page 12	On page 12, changed the MR Waiver references to ID/MR Waiver.
Chapter M21 page 3 Appendix 3, pages 1, 2	On page 3 and Appendix 3, pages 1 and 2, revised the policy on the qualified alien status of Afghan and Iraqi special immigrants for FAMIS eligibility purposes.
Chapter M22 page 3	On page 3, revised the policy on the qualified alien status of Afghan and Iraqi special immigrants for FAMIS MOMS eligibility purposes.

Please retain this transmittal letter for future reference. Should you have questions about information contained in this transmittal, please contact Stephanie Sivert, Manager, Medical Assistance Programs, at 804-726-7660 or stephanie.sivert@dss.virginia.gov.



Martin D. Brown
Commissioner

Electronic Attachment

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TN #93	01/01/10	page iii
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M15 ENTITLEMENT POLICY & PROCEDURES

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M20 EXTRA HELP – MEDICARE PART D LOW-INCOME SUBSIDY

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(FAMIS)**

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M0110 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/2010	Pages 2, 3
TN #93	01/01/2010	pages 1, 6

- the processing of claims and making payments to medical providers, and
- the recovery of Medicaid expenditures in appropriate cases. Suspected applicant fraud is a combined responsibility of both DMAS and DSS.

2. DSS

The responsibilities of DSS are:

- the determination of initial and continuing eligibility for Medicaid and
- the enrollment of eligible persons in the Medicaid program.

3. Confidentiality

Medicaid applicants and recipients are protected by federal and state confidentiality regulations, 42 CFR 431.300 and 12VAC30-20-90. These regulations were established to protect the rights of clients to confidentiality of their Medicaid information.

a. Release of Client Information

Except as otherwise indicated, no person shall obtain, disclose or use, authorize, or permit the use of any client information that is directly or indirectly derived from the records, files or communications of the agency, except for purposes directly connected with the administration of the Medicaid program, which includes but is not limited to:

- establishing eligibility,
- determining the amount of medical assistance,
- providing services for recipients, and
- conducting or assisting in an investigation, prosecution or a civil or criminal proceeding related to the administration of the program.

b. Release of Information to Medical Providers

Although certain individuals are authorized to receive information about an applicant's/recipient's case, only the minimum data necessary to respond to the request is to be released. Federal regulations stipulate that the disclosure of information about an applicant or recipient can only be for purposes related to administration of the Medicaid State Plan.

Information in the case record related to an individual's medical treatment, or method of reimbursement for services may be released to Virginia Medicaid providers by DMAS without the applicant's/enrollee's consent. Enrollee consent is not needed for the DSS agency to provide confirmation of an individual's eligibility, the dates of eligibility, and any patient pay responsibility *if the medical provider is unable to*

obtain that information from the member verification system or from DMAS staff. The provider **is not** entitled to specific information about an applicant's/recipient's income or resources without a release of information because the provider does not need that information for medical treatment or payment.

Provider contractors, such as application assistance companies, operate under the authority of the provider. A patient's consent is not required for the agency to provide the contractor with information related to reimbursement for services rendered or medical treatment. Provider contractors **are not** entitled to receive detailed financial or income information contained in an applicant's or recipient's case record without the person's *consent to release the* information.

Local agencies may release Medicaid enrollee identification numbers to medical providers by telephone if the provider cannot contact the DMAS provider/recipient verification telephone number. This procedure does not conflict with federal or State confidentiality regulations, if the local agency is satisfied that the number is being released to an identifiable provider.

c. Release to Authorized Representatives

Individuals not determined to be incapacitated by a court can designate whomever they choose to be their authorized representatives, including a provider or a provider's contractor (such as an application assistance company). The designation must be in writing, with the applicant or recipient specifying the information to be released to the authorized representative. It is not sufficient to indicate that any information in the case record may be released; the designation must state the specific information to be released (i.e. notices, the ability to make application or provide information necessary to determine eligibility, and what, if any, other information can be released to the authorized representative). The authorized representative designation is valid for the life of the application.

d. Safeguarding Client Information

All information associated with an applicant or recipient that could disclose the individual's identity is confidential and shall be safeguarded. Such information includes but is not limited to:

- name, address, and all types of identification numbers assigned to the client;
- medical services provided to the client;
- social and economic conditions or circumstances of the client;
- agency evaluation of the client's personal information;

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M0120 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/2010	pages 8, 8a
TN #93	01/01/2010	pages 1, 7, 9-16
Update (UP) #1	07/01/2009	page 8
TN #91	05/15/2009	page 10

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

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

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

E. Unsigned Application

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

F. Invalid Signature

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

M0120.300 Medical Assistance Application Forms

A. General Principle – Application Required

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

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

1. Exception for Certain Newborns

EXCEPTION: A child born to a mother who was Medicaid eligible at the time of the child's birth (including a child born to an emergency-services-only alien mother) is deemed to have applied and been found eligible for Medicaid on the date of the child's birth (see M0320.301). An application for the child is not required. The child remains eligible for Medicaid to age 1 year.

If the child was born to a mother who was covered by Medicaid outside Virginia at the time of the child's birth, verification of the mother's Medicaid coverage must be provided by the parent or authorized representative or an application must be filed for the child's eligibility to be determined in another covered group.

2. Forms That Protect the Application Date

a. ADAPT Request for Assistance

The Request for Assistance – ADAPT, form #032-03-875 available at: <http://localagency.dss.virginia.gov/divisions/bp/files/fs/forms/general/032-03-0875-08-eng.pdf> may be used to establish and preserve the

application date for 30 calendar days, but a signed application must be submitted within 30 calendar days in order for eligibility to be determined.

b. Model Application for Medicare Premium Assistance Form

*The model Application for Medicare Premium Assistance is a form developed by the federal Centers for Medicare & Medicaid Services (CMS) that states can choose to use for the Medicare Savings Program applicants. The model application is **NOT** a prescribed Virginia Medicaid application form at this time.*

Should a local department of social services (LDSS) receive a model application form, the agency is to send a Virginia Application for Adult Medical Assistance (form # 032-03-0022), or an Application for Benefits (form #032-03-0824), to the applicant with a request that it be completed, signed, and returned to the agency within 30 calendar days. The date of application on the model Application for Medicare Premium Assistance is to be preserved as the application date for purposes of Medicaid entitlement.

The processing time for the LDSS begins when the agency receives the Virginia application form back from the applicant. If the Virginia application form is not returned within 30 days, no further action is necessary on that application. The agency does not send a Notice of Action because no Virginia application was received. The model application date is not preserved beyond 30 calendar days. Should the person later submit a valid Virginia application, the date the Virginia application is received by the LDSS is the application date.

The model application form may be viewed on the SSA web site at: <http://www.socialsecurity.gov/prescriptionhelp/MSP-Model-Application-ENG.pdf>.

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M0130 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/2010	pages 2-6, 8
TN #93	01/01/2010	pages 4-6, 8
Update (UP) #2	08/24/2009	pages 8, 9

immediately and the applicant must be notified of the decision within 10 working days of the agency's receipt of the application.

If a decision cannot be made within 10 working days of receipt of the BCCPTA application, the worker must send a NOA on the 10th day stating why action has not been taken, specifying what information is needed, and a deadline for submitting the information.

If all necessary verifications are not received, the application continues to pend until the 45-calendar-day processing time limit is reached.

2. 45/90 Day Requirement

Applications, including requests for retroactive coverage, must be processed within 45 calendar days for all applicants other than pregnant women, women in the BCCPTA covered group, or individuals needing a disability determination.

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 (see M0310.112 E.2). 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).

The time standard begins with the date of receipt of a signed application and ends with the date of enrollment or the date the notification of denial of Medicaid is mailed to the applicant. The applicant must be informed of the agency's time standards.

The eligibility worker must allow at least 10 *calendar* days to receive the necessary verifications. If all necessary verifications are not received, the application continues to pend until the 45-day processing time limit is reached.

2. Early Denial Before Deadline Date

When the 45-day processing deadline date falls on a weekend or a holiday, the LDSS may deny an individual's application on the last business day before the deadline date if all necessary verifications have not been received. If the early denial action is taken, however, the LDSS must re-open the application if the individual provides the necessary information on or before the 45th day deadline.

If the individual's application is re-opened and he is determined eligible, the LDSS must enroll the individual and send a notice to the individual notifying him of the approval and the begin date of coverage.

3. Processing Priority

Application processing priority must be given to applicants who are in need of Medicaid coverage for nursing facility or community-based long-term care, hospice care, or who are in emergent need of other covered services. These applications must be processed as quickly as possible.

4. Time Standard Exceptions

The specified time standards apply unless the agency cannot reach a decision within the time standard because of one of the following reasons:

- the applicant's inability to furnish necessary information for a reason beyond his/her control,

- a delay in receipt of information from an examining physician,
- a delay in the disability determination process,
- a delay in receiving DMAS decision on property transfer undue hardship claim, or
- an administrative or other emergency beyond the agency's control.

If action is not taken within the time standard, the case record must show the cause for the delay and the applicant must be notified in writing of the status of his application, the reason for the delay, and his right of appeal.

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

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

C. Application for Retroactive Coverage

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

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

There is no administrative finality on determining retroactive eligibility if eligibility for the months in the retroactive period has not been determined. Retroactive coverage can be requested at any time subsequent to an application even if the application was denied or the applicant signed a statement saying he did not want retroactive coverage. The retroactive period is based on the application month regardless of whether the application was denied or approved.

If the application was denied, the application is reopened for determination of eligibility in the entire retroactive period – all three months prior to the application month – even if a covered medical service was received in only one retroactive month. The applicant must provide all verifications necessary to determine eligibility during the retroactive period.

If the applicant is found eligible for retroactive coverage and a Medicaid-covered medical service was received over one year prior to the date the

retroactive eligibility is determined, the applicant must be given an "Eligibility Delay" letter to give to the medical provider so that Medicaid will pay the claim (use the sample letter on the intranet at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>). Once retroactive eligibility is established, Medicaid coverage begins the first day of the earliest retroactive month in which *retroactive* eligibility exists.

M0130.200 Required Information and Verifications

A. Identifying Information

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

1. Name

The name entered in the official case record and computer enrollment systems for an applicant must match the applicant's name on his Social Security card or Social Security Administration (SSA) records verification. *This is important because of the Medicare Buy-in and other computer matches the Medicaid Management Information System (MMIS) performs with SSA. At the time of the initial Medicaid application, the State Verification Exchange System (SVES) must be used to verify the SSA record of the individual's name because SVES verifies the spelling, etc., of the individual's name in the SSA records. For subsequent reapplications, the State Online Query-Internet system (SOLQ-I) may be used.*

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

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

2. SSN

The SSN of an individual for whom Medicaid or other medical assistance is requested must be provided by the applicant and verified by the worker through SSA. *SVES or SOLQ-I may be used to verify the individual's SSN.*

B. Required Verifications

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

The eligibility worker must allow at least 10 days for receipt of the necessary verifications, but additional time may be allowed depending on the type of information requested. The specific information requested and the deadline for receipt of the verifications must be documented in the case record.

1. Copy Verification Documents

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

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

2. Information Not Provided

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

When the deadline date falls on a weekend or holiday, LDSS may choose to deny the application (or cancel coverage) before the deadline date. However, if the early denial or cancel action is taken, LDSS must re-open the application if the individual provides the necessary information on or before the original deadline date. If the individual's application is re-opened and he/she is determined eligible, the LDSS must send a notice to the individual notifying him of the changed action.

C. Verification of Nonfinancial Eligibility Requirements

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

1. Verification Not Required

Verification is not required for:

- Virginia state residency,
- application for other benefits.

2. Verification Required

The following information must be verified:

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

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

D. Social Security Numbers

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

1. **SSN Verification** *SVES or SOLQ-I may be used to verify the individual's SSN. However, to verify the SSA record of the individual's name at the initial Medicaid application, SVES must be used because SVES verifies the spelling, etc., of the individual's name in the SSA records.*

 2. **Exceptions to SSN Requirements** *Children under age one born to Medicaid-eligible mothers are deemed to have applied and been found eligible for Medicaid, whether or not eligibility requirements have actually been met. A child eligible in this covered group does not need a Social Security number.*

Illegal aliens who are eligible only for Medicaid payment of emergency services are not required to provide or apply for SSNs (see M0220).

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

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

When entering the individual in ADAPT, MMIS or MedPend, use the date the individual applied for an SSN, or the individual's date of birth, preceded by "888" as the individual's SSN. For example, an individual applied for an SSN on October 13, 2006, enter "888101306" as the individual's SSN.
- E. Legal Presence (Effective January 1, 2006)** *Effective January 1, 2006, Section 63.2-503.1 of the Code of Virginia requires most applicants for or recipients of public assistance who are age 19 or older to provide proof of citizenship or legal presence in the U.S. Applicants or recipients age 19 or older for whom medical assistance is requested must prove their citizenship or legal presence.*

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

TPL code for that benefit, the worker must email the information to the DMAS TPL Unit at TPLUnit@dmass.virginia.gov, or send the information to:

DMAS Third Party Liability Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

G. Health Insurance Premium Payment (HIPP) Program

The HIPP program is a cost-savings program for individuals enrolled in Medicaid which may reimburse some or all of the employee portion of the employer group health insurance premium. Eligibility for HIPP is determined by the HIPP Unit at DMAS. Participation in HIPP is voluntary.

The local DSS agency must give each applicant or enrollee who reports that he or someone in his family is employed more than 30 hours each week and is eligible for health insurance coverage under an employer's group health plan must be given a HIPP Fact Sheet, which provides a brief description of the program and the contact information for the HIPP Unit at DMAS. The HIPP Fact Sheet is available on-line at: <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>.

If the health insurance policy holder lives outside of the home, a HIPP Consent Form must be completed by both the policy holder and the parent/authorized representative so the DMAS HIPP Unit can process the HIPP application. If the form is required, the DMAS HIPP Unit will send it to the applicant for completion.

H. Verification of Financial Eligibility Requirements

The eligibility worker must verify the following financial eligibility requirements:

- the value of all countable, non-excluded resources;
- all earned and unearned income; and
- asset transfer information for individuals in need of long-term care services, including the date of transfer, asset value, and compensation received.

Social Security and/or Supplemental Security Income must be verified through SSA. The State Data Exchange (SDX) system should only be used as an alternate method when the SVES *or* SOLQ-I is not available.

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

M0130.300 Eligibility Determination Process

A. Evaluation of Eligibility Requirements

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

The evaluation of eligibility requirements must be documented in writing for cases not processed in the ADAPT system. The Evaluation of Eligibility

M0220 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/2010	pages 3-3b, 7-9, 14a-14d, 18, 21, 22a, 23 Appendix 1 Appendix 3, page 3
Update (UP) #3	03/01/2010	pages 1-3a
TN #93	01/01/2010	Table of Contents pages 7-8 page 14a pages 14c-14d pages 15-20 page 22a Appendix 1 Appendix 3, page 3 Appendix 4, pages 1 and 2 Appendix 6, page 2
TN #92	05/22/2009	Table of Contents pages 1-6a Appendix 8 (18 pages) pages 4a-4t were removed and not replaced.
TN #91	05/15/2009	page 7 pages 14a, 14b page 18 page 20 Appendix 3, page 3

1. Exceptions to Verification Requirements

The following groups of individuals are NOT required to provide verification of C&I. Document in the case record why an individual is exempt from verifying C&I:

- a. All foster care children and IV-E Adoption Assistance children;
- b. Individuals born to mothers who were eligible for Medicaid in any state on the date of the individuals' birth;
- c. Individuals entitled to or enrolled in Medicare, individuals receiving Social Security benefits on the basis of a disability and SSI recipients currently entitled to SSI payments. Former SSI recipients are not included in the exemption. The local department of social services (LDSS) must have verification from the Social Security Administration (such as a SVES response) of an individual's Medicare enrollment, benefits entitlement or current SSI recipient status.

When an individual loses an exception status and his C&I has not previously been verified, the individual must be given a reasonable opportunity to provide C&I.

NOTE: A parent or caretaker who is applying for a child, but who is NOT applying for Medicaid for himself, is NOT required to verify his or her C&I.

2. Verification Required One Time

Once verification of C&I has been provided, it is not necessary to obtain verification again. Documentary evidence may be accepted without requiring the individual to appear in person. C&I documentation must be stored in the case record.

3. Enroll Under Good Faith Effort

If an individual meets all other Medicaid eligibility requirements and declares that he is a citizen, *he is to be enrolled under a good faith effort. Do not request verification of C&I from the applicant, and do not delay or deny application processing for proof of C&I.* If the applicant meets all other Medicaid eligibility requirements, approve the application and enroll the applicant in Medicaid, but specify on the Notice of Action that the individual may have to provide documentation of C&I if it cannot be obtained by other means.

The individual remains eligible for Medicaid while the agency attempts to verify C&I through the data matching process described in M0220.100 D. below, or if necessary, requests verification from the individual. The same good faith effort requirements apply should an individual lose his exemption from providing C&I verification.

D. Procedures for Documenting C&I

CHIPRA allows the option for verification of C&I for individuals newly enrolled in Medicaid or Family Access to Medical Insurance Security Plan (FAMIS) using a data match with SSA to confirm the consistency of a declaration of citizenship with SSA records in lieu of presentation of original documentation. This option, implemented in March 2010, allows for a

monthly exchange of data between the Medicaid Management Information System (MMIS) and SSA for the documentation of C&I for individuals enrolled in the Medicaid and FAMIS programs. *In order for this process to be used to verify citizenship and identity, the individual's SSN must be verified by SSA (see M0240).*

1. MMIS Data Matches SSA

If the information in the MMIS matches the information contained in the SSA files, the MMIS will be updated to reflect the verification of C&I. No further action is needed on the part of the eligibility worker, and the enrollee will not be required to provide any additional documentation, if the SSA match code in MMIS shows that SSA verified the individual's C&I.

2. MMIS Data Does Not Match SSA

If the information in the MMIS does not match the information in the SSA files, a discrepancy report will be generated monthly listing the inconsistent information. Eligibility staff are expected to review the report to see if the report lists any enrollees who were rejected because SSA could not verify the enrollee's citizenship and identity.

a. SSA Cannot Verify C&I

If the SSA data match result does not verify the individual's C&I, eligibility workers must review the information in the MMIS or ADAPT to determine if a typographical or other clerical error occurred. If it is determined that the discrepancy was the result of an error, steps must be taken to correct the information in the MMIS or ADAPT so that SSA can verify C&I when a new data match with SSA occurs in the future.

If the inconsistency is not the result of a typographical or other clerical error, *the individual must be given a reasonable opportunity period of 90 days to either resolve the issue with SSA or provide verification of C&I.* The eligibility worker must send a written notification to the enrollee that informs the enrollee of the discrepancy and gives him 90 calendar days from the date of the notice to either resolve the discrepancy with the SSA and to provide written verification of the correction, OR provide acceptable documentation of C&I to the LDSS.

The notice must specify the date of the 90th day, and must state that, if the requested information is not provided by the 90th day, the individual's Medicaid coverage will be canceled. Include with the notice the "Proof of U.S. Citizenship and Identity for Medicaid" document available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/citizenship/index.cgi#forms>. Acceptable forms of documentation for C & I are also included in Appendix 8 to this subchapter.

b. Individual Does Not Provide Verification in 90 Days

If the individual does not provide the information necessary to meet the C&I documentation requirements *by the 90th day, his coverage must be canceled.* Send an advance notice, and cancel coverage at the end of the month in which the 90th day occurs.

c. Discrepancy Resolved With SSA Within 90 Days

If written verification is received that corrects the SSA discrepancy within the 90 days, update the MMIS accordingly so that the enrollee's information will be included in a future data match for C&I verification. The individual continues to remain enrolled pending the results of the subsequent data match.

If this subsequent data match with SSA results in verified C&I, MMIS will automatically enter code "CV" in the Cit Lvl and Identity fields in the individual's MMIS record. No further match will be done with the SSA files for C&I verification.

d. Verification of C&I Provided Within 90 Days

If the individual provides acceptable verification of his C&I within the 90 days, update the appropriate demographic fields in MMIS (and ADAPT, if the case is in ADAPT) with the appropriate codes. No further match will be done with the SSA files for C&I verification.

3. Subsequent Applications

If the individual who lost coverage for failure to provide C&I documentation files a subsequent application, a new reasonable opportunity period is not granted. The individual must provide acceptable documentation of C&I prior to approval of the re-application.

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; victim of a severe form of trafficking; *or a qualified Afghan or Iraqi immigrant admitted to the U.S. on a Special Immigrant Visa*; 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 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 legal immigrant child under age 19 who meets the requirements in M0220.314 below.

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

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

B. Procedure**1. Step 1**

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

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

If the alien receives SSI, go to Step 6.

2. Step 2

Second, determine if the alien is an American Indian born in Canada or a member of an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)). Section M0220.306 describes this group of aliens.

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

- 3. Step 3** Third, determine if the alien is a “qualified” alien eligible for full benefits (a full benefit qualified alien).
- Section M0220.310 defines “qualified” aliens.
 - Section M0220.311 defines qualified veteran or active duty military aliens.
 - Section M0220.312 describes qualified aliens who entered the U.S. before 8-22-96.
 - Section M0220.313 describes qualified aliens who entered the U.S. on or after 8-22-96.
- If the alien is NOT a qualified alien eligible for full benefits, go to step 4.
- If the alien is a qualified alien eligible for full benefits, go to step 6.
- 4. Step 4** Fourth, determine if the alien is a legal immigrant child under age 19. Section M0220.314 defines a legal immigrant child under age 19.
- If the alien is NOT a legal immigrant child under age 19, go to Step 5.
- If the alien is a legal immigrant child under age 19, go to Step 6.
- 5. Step 5** The alien is an “**emergency services**” alien. Go to Section M0220.400 which defines emergency services aliens, then to M0220.500 which contains the eligibility requirements applicable to all aliens, then to M0220.700 which contains the entitlement and enrollment policy and procedures for emergency services aliens.
- 6. Step 6** Use Section M0220.500, which contains the Medicaid eligibility requirements applicable to all aliens, to determine the alien’s Medicaid eligibility. Then use Section M0220.600, which contains the entitlement and enrollment procedures for **full benefit** aliens, to enroll an eligible full benefit alien.

M0220.305 ALIENS RECEIVING SSI

A. Policy

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

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

- B. SSI Extension for Elderly and Disabled Refugees Act** *The SSI Extension for Elderly and Disabled Refugees Act (P.L. 110-328), enacted on September 30, 2008, allows elderly or disabled aliens subject to the seven-year time limit for receiving SSI to receive up to two additional years of SSI benefits. Although the Social Security Administration makes the determination of eligibility for the SSI extension, the categories of seven-year aliens to which the SSI extension may apply are listed in M0220.313 A.1 through A.4.*

Individuals receiving SSI benefits on the basis of the SSI extension also meet the alien status requirement for full-benefit Medicaid eligibility.

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

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

M0220.306 CERTAIN AMERICAN INDIANS

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

meets the Medicaid full benefit alien status requirements.

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

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

M0220.310 QUALIFIED ALIENS DEFINED

- A. Qualified Aliens Defined** A qualified alien is an alien who, at the time he applies for, receives or attempts to receive Medicaid is:

- 1. Lawful Permanent Resident** an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act.

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

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

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

- A. First 7 Years of Residence in U.S.** During the first seven years of residence in the U.S., *six (6)* 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 6 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.

6. Afghan or Iraqi Immigrant Admitted to the U.S. on a Special Immigrant Visa

The Department of Defense Appropriations Act of 2010, enacted on December 19, 2009, provides that Iraqi and Afghan Special Immigrants are eligible for Medicaid benefits to the same extent and for the same time period as refugees. The legislation supersedes prior legislative authority that limited Special Immigrants to benefits for an 8-month time period. Provided that all other eligibility requirements are met, Iraqi and Afghan Special Immigrants are eligible for Medicaid benefits for the first seven years after entry into the United States (U.S.).

7. After 7 Years Residence in U.S.

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

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

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

1. Lawful Permanent Residents (LPRs)

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

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

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

2. Qualifying Quarter

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

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

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

C. Services Available To Eligibles

1. Refugee, Amerasian, Asylee, Deportee, Cuban or Haitian Entrant, Victim of a Severe Form of Trafficking; Afghan or Iraqi Special Immigrant

The following immigrants:

- qualified refugee,
- Amerasian,
- asylee,
- deportee,
- Cuban or Haitian entrant,
- victim of a severe form of trafficking, *or*
- *Afghan or Iraqi Special Immigrant (as defined in M0220.310 above),*

who entered the U.S. on or after 8-22-96 and who meets all other Medicaid eligibility requirements is eligible for the full package of Medicaid covered services available to the alien's covered group during the first 7 years of residence in the U.S. After 7 years of residence in the U.S., the refugee, Amerasian, asylee, deportee, Cuban or Haitian entrant, victim of a severe form of trafficking, or Afghan or Iraqi Special Immigrant who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and is eligible for emergency services only.

2. LPR With 40 Work Quarters

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

D. Entitlement & Enrollment of Eligibles

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

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

M0220.314 LEGAL IMMIGRANT CHILDREN UNDER AGE 19

A. Policy

Section 214 of CHIPRA of 2009 gives states the option to provide Medicaid coverage to certain individuals who are lawfully residing in the United States and are otherwise eligible for assistance. Virginia has elected to cover children under the age of 19 who are lawfully residing in the U.S.

Children who are in one of the legal immigrant children alien groups must have their immigration status verified at the time of the initial eligibility determination and at each annual renewal of eligibility to ensure that the children are lawfully residing in the U.S. and that their immigration status has not changed.

B. Eligible Alien Groups

Non-citizen children under 19 who are legal immigrants meet one of the following alien groups:

1. Lawful Permanent Resident

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

2. Refugees

an alien who is admitted to the U.S. under the Immigration and Nationality Act as a refugee under any section of the INA. The refugee will have a Form I-94 identifying him/her as a refugee under the INA.

3. Conditional Entrant

an alien who is granted conditional entry pursuant to section 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980. Aliens admitted to the United States as conditional entrants pursuant to 203(a)(7) of the Immigration and Nationality Act (INA) (8 USC 1153(a)(7)) have an USCIS Form I-94 bearing the stamped legend "Refugee - Conditional Entry" and a citation of the INA section.

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

4. Parolee

parolees are:

aliens paroled into the United States, including Cuban/Haitian entrants, pursuant to section 212(d)(5) of the INA (8 USC 1182(d)(5)); or

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

- 1. Lawful Permanent Residents Without 40 Work Quarters**

Lawful Permanent Residents who DO NOT have at least 40 qualifying quarters of work remain emergency services aliens after residing in the U.S. for 5 years. Lawful Permanent Residents who have at least 40 qualifying quarters of work become full benefit aliens after 5 years of residing in the U.S.
 - 2. Conditional Entrants**

A qualified Conditional Entrant who enters the U.S. on or after 8-22-96 is an “emergency services” alien.
 - 3. Parolees**

A qualified parolee who enters the U.S. on or after 8-22-96 is an “emergency services” alien.
 - 4. Battered Aliens**

A qualified battered alien who enters the U.S. on or after 8-22-96 is an “emergency services” alien.
- C. AFTER 7 Years of Residence in U.S.**
- 1. Refugees**

After 7 years of residence in the U.S., a refugee or Amerasian immigrant who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an “emergency services” alien.
 - 2. Asylees**

After 7 years have passed since asylum was granted, an asylee who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an “emergency services” alien.
 - 3. Deportees**

After 7 years have passed since deportation was withheld, a deportee who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an “emergency services” alien.
 - 4. Cuban or Haitian Entrants**

After 7 years of residence in the U.S., a Cuban or Haitian Entrant who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an “emergency services” alien.
 - 5. 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. *After 7 years of residence in the U.S., Afghan and Iraqi Special Immigrants are no longer eligible for full Medicaid benefits and become “emergency services” aliens.*

- | | |
|---|---|
| 3. Assignment of Rights and Pursuit of Support from Absent Parents | the assignment of rights to medical benefits requirements (M0250); |
| 4. Application for Other Benefits | the requirements regarding application for other benefits (M0270); |
| 5. Institutional Status | the institutional status requirements (M0280); |
| 6. Covered Group | the covered group requirements (chapter M03); |
| 7. Financial Eligibility | <p>the asset transfer requirements (see subchapter M1450) apply.</p> <p>Resources must be within the resource limit appropriate to the individual's covered group. (Chapter M06 for F&C covered groups; Chapter S11 for ABD covered groups).</p> <p>Income must be within the income limit appropriate to the individual's covered group. (Chapter M07 for F&C covered groups; Chapter S08 for ABD covered groups). Spenddown provisions apply to these individuals. All medical expenses count toward meeting the spenddown, but once an entitlement date is determined after the individual meets the spenddown, only emergency services rendered on or after the entitlement date and which are within the period of coverage on the Emergency Medical Certification form are covered for emergency services aliens.</p> |
| B. Emergency Services Certification--Not Applicable to Full Benefit Aliens | <p>Certification that the service provided was an emergency service is an additional eligibility requirement for emergency services aliens (not applicable to full benefit aliens). LDSS can certify emergency services coverage for pregnancy-related labor and delivery services for limited, specified periods of time. DMAS must certify emergency services coverage for all other requests and determine the period of coverage.</p> |
| 1. LDSS Certification for Pregnancy-Related Labor and Delivery Services | <p>LDSS can certify emergency services payment for pregnancy-related labor and delivery services, including inpatient hospitalizations that did not exceed:</p> <ul style="list-style-type: none"> • 3 days for a vaginal delivery, or • 5 days for a cesarean delivery. |

M0220.600 FULL BENEFIT ALIENS ENTITLEMENT & ENROLLMENT

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

R = refugee (Alien Chart codes F1, F2, G1, G2); also used for Afghan and Iraqi Special Immigrants (Alien Chart Code Z1).
E = entrant (Alien Chart code D1).
P = full benefit qualified aliens (Alien Chart codes A1, A2, A3, B1, B3, C1, E1, H1, H2, I1, J1, J2).
I = legal immigrant children under age 19 only (Alien Chart codes Y1, Y2, Y3)
 - 3. Entry Date** **THIS FIELD MUST BE ENTERED.** Enter the date on which the alien entered the U.S., except for asylees and deportees. For asylees, enter the date asylum was granted. For deportees, enter the date deportation withholding was granted.
 - 4. Appl/ Dt** In this field, Application Date, enter the date of the alien's Medicaid application upon which the eligibility coverage period is based.
 - 5. Coverage Begin Date** In this field, Coverage Begin Date, enter the date the alien's Medicaid entitlement begins.

- 6. **Coverage End Date** Enter data in this field only if eligibility is a closed period of eligibility in the past. Enter the date the alien's Medicaid entitlement ended.
- 7. **AC** Enter the AC code applicable to the alien's covered group.

M0220.700 EMERGENCY SERVICES ALIENS ENTITLEMENT & ENROLLMENT

A. Policy Unqualified aliens, and qualified aliens eligible for emergency services only (see M220.500), are eligible for Medicaid coverage of emergency medical care only. This care must be provided in a hospital emergency room or as an inpatient in a hospital.

B. Entitlement-Enrollment Period If the applicant is found eligible and is certified for emergency services, eligibility exists only for the period of coverage certified by the LDSS or DMAS staff on the Emergency Medical Certification form, # 032-03-628 (see Appendix 4 of this subchapter).

Once an eligibility period is established, additional requests for coverage of emergency services within 6 months will not require a new Medicaid application. However, each request for Medicaid coverage of an emergency service or treatment requires a new, separate certification and a review of the alien's income and resources and any change in situation that the alien reports.

An emergency services alien must file a new Medicaid application after the 6-month eligibility period is over if the individual receives an emergency service and wants Medicaid coverage for that service.

C. Enrollment Procedures Once an emergency services alien is found eligible for coverage of emergency services, the individual must be enrolled in MMIS using the following data:

1. **Country** In this field, Country of Origin, enter the code of the alien's country of origin.

2. **Cit Status** In this field, Citizenship *Status* code, enter :

A = Emergency services alien (Alien Chart codes B2, C2, C3, D2, D3, E2, E3, F3, G3, H3, I2, I3, codes J3 through V3, Z2) other than dialysis patient.

D = Emergency services alien who receives dialysis.

V = Visitor, non-immigrant alien (Alien Chart codes W1, W2, W3).

The Alien Codes Chart is found in Appendix 3 to this subchapter.

NOTE: Foreign visitors are not usually eligible for Medicaid because usually they do not meet the Medicaid Virginia state residency requirement.

UNITED STATES CITIZENSHIP AND IMMIGRATION SERVICES (USCIS) OFFICE

All agencies needing to correspond with USCIS are to use the following address:

*Attn: Immigration Status Verification Unit
US Citizenship and Immigration Services
10 Fountain Plaza, 3rd Floor
Buffalo, NY 14202*

	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 USCIS 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 USCIS whose departure the agency does not contemplate enforcing [USCIS 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
LEGAL IMMIGRANT CHILDREN UNDER AGE 19				
Y	Non-citizen (alien) children under the age of 19 lawfully residing in the U.S. who meet the requirements in M0220.314.	N/A	Full Benefits	Full Benefits

	AFGHAN AND IRAQI SPECIAL IMMIGRANTS	<i>First 7 Years after Entry into U.S.</i>	<i>After 7 Years</i>
Z	Afghan <i>and</i> Iraqi Special Immigrants admitted on a Special Immigrant Visa (SIV), including the spouse and children under age 21 living in the home with the principal visa holder. [I-551 or passport/ I-94 indicating categories SI1, SI2, SI3, QQ1, SQ2, or SQ3 and bearing Department of Homeland Security stamp or notation]	<i>Full Benefits</i> Z1	<i>Emergency Only</i> Z2

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M0240 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/2010	pages 1-5
TN #93	01/01/2010	pages 1-4
Update (UP) #1	07/01/2009	pages 1, 2
TN #91	05/15/2009	pages 1, 2

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M0240.000 SOCIAL SECURITY NUMBER REQUIREMENTS

M0240.001 GENERAL PRINCIPLES

A. Policy

1. Medicaid

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

- is an 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, 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

1. Name

The name entered in the official case record and computer enrollment systems for an applicant must match the applicant's name on his Social Security card or Social Security Administration (SSA) records verification. It is important to spell the name correctly so that when the Medicaid

Management Information System (MMIS) sends the enrollee information to SSA for the Medicare Buy-in or the citizenship and identity match, the enrollee can be matched to SSA records.

At the time of the initial Medicaid application, the State Verification Exchange System (SVES) must be used to verify the SSA record of the individual's name because SVES verifies the spelling, etc., of the individual's name in the SSA records. For subsequent reapplications, the State Online Query-Internet system (SOLQ-I) may be used.

2. SSN

The individual's SSN must be verified. The worker may use the SOLQ-I or SVES to verify an individual's SSN.

3. Verification Systems - SVES & SOLQ-I

SVES verifies the individual's SSN, name spelling, entitlement to SSA benefits and the amount of the benefit, entitlement to SSI and the amount, and entitlement to Medicare & the Medicare premium amounts. SVES tells the worker what is wrong with the name, if the name is incorrectly spelled.

The SOLQ-I verifies the individual's SSN, entitlement to SSA benefits and the amount of the benefit, entitlement to SSI and the amount, and entitlement to Medicare & the Medicare premium amounts. SOLQ-I does not verify the individual's name according to the SSA records.

Workers may use either the SOLQ-I or SVES to verify the individual's SSN and entitlement to Social Security benefits and Medicare. However, to verify the SSA record of the individual's name at the initial application, SVES must be used.

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.

3. Retroactive Eligibility

An individual who provides proof of application for an SSN after he applies for medical assistance, meets the application for SSN requirement in the three months retroactive to his medical assistance application.

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, 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 APPLICATION

A. Applicant Applied for SSN

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. Follow-Up 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, MMIS or MedPend, use the date the individual applied for an SSN, or the individual’s date of birth, preceded by “888.”

For example, an individual applied for an SSN on October 13, 2006. Enter “888101306” as the individual’s SSN.

3. Follow-up

a. Follow-up in 90 Days

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

b. Check for Receipt of SSN

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

c. Verify SSN

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

d. Enter Verified SSN in Systems

Enter the enrollee's SSN in MMIS, and in ADAPT if the enrollee is in ADAPT. If the enrollee is in an active Medicaid case in ADAPT, and his pseudo SSN is not changed to a valid SSN at renewal, ADAPT will determine him ineligible for Medicaid.

4. Renewal Action

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

a. Check for Receipt of SSN

Before or at renewal, the SSN must be entered into MMIS and ADAPT. Check the MMIS and ADAPT records for the enrollee's SSN. If the SSN has "888" as the first 3 digits, contact the enrollee to obtain the enrollee's SSN verbally or by mail, or on the renewal form if a renewal form is required.

b. Verify SSN

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

c. Enter Verified SSN in Systems

Enter the enrollee's SSN in MMIS, and in ADAPT if the enrollee is in ADAPT. If the enrollee is in an active Medicaid case in ADAPT, and his pseudo SSN is not changed to a valid SSN at renewal, ADAPT will determine him ineligible for Medicaid.

d. SSN Not Provided by Renewal Deadline

The worker must assist the enrollee in obtaining the applied-for SSN. The worker will ask the enrollee for the assigned SSN at the first renewal, and give a deadline date for the enrollee to provide the SSN.

If the enrollee does not provide the SSN by the deadline, the worker will ask the enrollee why it was not provided to the worker:

- Did the enrollee ever receive the SSN from SSA?
- If not, why not?

If the problem is an SSA administrative problem, such as a backlog of SSN applications causing the delay in issuing an SSN to the enrollee, the enrollee continues to meet the Medicaid SSN eligibility requirement. The worker will assist the enrollee with obtaining the SSN and will periodically check with the computer systems and the enrollee.

If the problem is **not** an SSA administrative problem, the worker must cancel Medicaid coverage for the enrollee whose SSN is not provided.

M0240.300 SSN Verification Requirements

- A. SSN Provided By Individual** *The individual's SSN must be verified. When the individual provides his SSN, the worker may use the SOLQ-I or SVES to verify the individual's SSN. The individual is not eligible for Medicaid and cannot be enrolled in MMIS if his SSN is not verified.*
- B. Procedures**
- 1. Enter Verified SSN in Systems** *Enter the eligible enrollee's verified SSN in MMIS, and in ADAPT if the enrollee's Medicaid eligibility is determined in ADAPT.*
 - 2. SSN and Citizenship Update Report** *When an individual's SSN is entered into MMIS, the SSN and identifying data is transmitted on the 21st of the month to SSA for SSN verification. If SSA does not verify the individual's SSN, the individual will be listed on the SSN and Citizenship Update Report (RS-O-485A) that is posted on SPARK, Medicaid Management Reports.*
 - 3. Review Report Each Month** *Eligibility staff is expected to review the report to see if the report lists any enrollees who were rejected because their SSN, name or date of birth did not match the information in the SSA records. If an enrolled individual is listed on the report with an "SSN Status" that is not verified, the worker must attempt to resolve the discrepancy.*
 - 4. Resolving Unverified SSN Discrepancies**
 - a. Data Entry Error Caused Discrepancy**
If it is determined that the discrepancy was the result of an error made while entering the SSN in the system, steps must be taken to correct the information in the MMIS and/or ADAPT so that a new data match with SSA can occur in the next month.
 - b. Discrepancy Not Caused by Data Entry Error**
If the discrepancy is not the result of a typographical or other data entry error, the individual must be given a period of 10 days to resolve the issue or provide written verification from SSA of the individual's correct SSN. The eligibility worker must send a written notification to the enrollee that informs the enrollee of the SSN discrepancy and gives him 10 calendar days from the date of the notice to either resolve the discrepancy with the SSN or to provide

written verification of his correct SSN to the worker. The notice must inform the individual that if he does not verify his SSN by the deadline, his Medicaid coverage will be canceled.

c. Individual Provides SSN Verification

If verification of the SSN is received within the 10 days, update the MMIS (and ADAPT if appropriate) accordingly so that the enrollee's information will be included in a future data match.

d. SSN Verification Not Provided

If verification of the SSN is NOT received within the 10 days, send the individual an advanced notice of proposed cancellation and cancel the individual's coverage in MMIS.

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M0250 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/2010	Pages 3-5

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

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

1. Waiver of Cooperation

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

2. Documentation

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

M0250.300 PURSUIT OF MEDICAL SUPPORT FROM THE ABSENT PARENT

A. Policy

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

A pregnant woman is not required to cooperate with DCSE when requesting assistance for herself and her child(ren) born out of wedlock. If she is or was married, she is required to cooperate in pursuing medical support for her legitimate child(ren) from the legitimate child(ren)'s absent father.

*A married pregnant woman who meets the medical assistance support requirement **cannot be denied** medical assistance for failure to cooperate in pursuing support even when ineligible for another program because of failure to cooperate with pursuit of support.*

B. Definition of Cooperation

1. Application

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

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

2. Ongoing

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

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

C. Local DSS Agency Responsibility

1. Applicants

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

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

2. Enrollees

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

a. Enrollees who were approved before January 1, 2007

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

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

If the enrollee who applied for Medicaid on/after January 1, 2007, chooses to apply for DCSE services and DCSE opens a case for the applicant, the enrollee must cooperate with DCSE in the pursuit of medical support from

the absent parent, unless there is good cause for not cooperating. If the agency is notified by DCSE that the enrollee is not cooperating, the agency worker must take appropriate action on the enrollee's Medicaid coverage; the child(ren)'s eligibility for Medicaid is NOT affected.

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

D. DCSE

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

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

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M0280 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/2010	page 1
TN #93	01/01/2010	page 13

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

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

B. Procedure

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

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

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

A child care institution is a

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

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

B. Facility for the Mentally Retarded

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

C. Institution

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

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

An IMD is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, to persons with mental diseases. *A psychiatric residential treatment facility for children and adolescents is an IMD. An ICF-MR or other facility for individuals with intellectual disabilities is NOT an IMD.*

E. Medical Facility

A medical facility is an institution that:

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

M0310 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/10	pages 21-27c, 28
TN #93	01/01/10	page 35 Appendix 5, page 1
Update (UP) #2	08/24/09	Table of Contents page 39
TN #91	05/15/09	pages 23-25 Appendix 4, page 1 Appendix 5, page 1

M0310.112 DISABLED

A. Introduction

For individuals who meet no other full-benefit covered group and claim to have a disabling condition, Medicaid eligibility uses the same definition of “being disabled” that the Social Security Administration (SSA) uses.

1. Definition of a Disabled Individual

For an individual 18 or older, the SSA defines “being disabled” as an individual’s inability to do any substantial gainful activity (SGA) or work because of a severe, medically determinable physical or mental impairment or combination of impairments. This impairment(s) has lasted or is expected to last for a continuous period of not less than 12 months, or the impairment is expected to result in death.

For a child under 18, the SSA defines “being disabled” as having a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations. These limitations must have lasted or be expected to last for a period of not less than 12 continuous months, or the impairment is expected to result in death. However, a child cannot be found disabled if, at application, the child is performing SGA and is not currently entitled to Supplemental Security Income (SSI) benefits.

2. Disability Determination Services

Disability Determination Services (DDS) is a division of the Virginia Department of Rehabilitative Services (DRS). DDS is charged with making disability determinations for individuals who allege they are disabled for the purpose of qualifying for Social Security Disability Insurance (SSDI) and/or Supplemental Security Income (SSI) disability or blindness benefits, and/or Medicaid. An individual must file separate applications for SSDI/SSI benefits with SSA and for Medicaid with LDSS.

The Department of Medical Assistance Services (DMAS) contracts with DRS to have DDS process disability and blindness claims and make determinations of “disabled” or “not disabled” based upon federal regulations. DDS uses the same definitions of disability and blindness and the same evaluation criteria for all three programs. See M0310.106 for the definition of blindness.

3. Factors Involved in a Disability Decision

The LDSS does not determine whether or not an individual meets the disability requirements. DDS determines whether or not an individual is disabled as defined by the SSA by evaluating a series of factors in sequential order. The following information is intended to provide a general overview for the LDSS worker of this sequential process and does not provide a complete explanation of the disability determination process:

a. Engaged in Substantial Gainful Activity (SGA)?

***Is the individual currently engaged in substantial gainful activity (SGA)?** SGA means work that: (1) involves doing significant and productive physical or mental duties and (2) is done (or intended) for pay or profit and (3) earnings are above a certain amount. If an individual is working and earning SGA, a finding must be made that the person is not disabled, and no medical evaluation is done. If the individual is not earning SGA, DDS proceeds to the next step.*

b. Severe Impairment?

Does the individual have a severe impairment, as defined by SSA, that meets the durational requirement (i.e. has lasted or is expected to last for a continuous period of not less than 12 months, or which is expected to result in death)? If no, the person is not disabled. If yes, DDS will proceed to the next step.

c. Impairment Equals Severity Requirements?

Does the individual have an impairment that meets or equals the severity requirements of a medical condition contained in the Social Security Listing of Impairments? If yes, a finding of disability is made. If no, DDS will proceed to the next step.

d. Prevents Performing Past Relevant Work?

Does the individual have an impairment that prevents him from performing past relevant work? If the individual can perform past relevant work, the person will be found not disabled. If the individual cannot perform past relevant work, DDS will proceed to the next step.

e. Prevents Performing Any Work?

Does the individual have an impairment that prevents him from performing any substantial gainful employment? If the individual cannot perform any work, the person will be found disabled. If the person has the capacity to adjust to other types of work, the person will be found not disabled. Age, education, training and skills acquired in past work are considered in making this determination.

**4. Other Benefits
Related to
Disability**

a. Benefits Administered by the SSA

The SSA uses the SSA disability definition in the determination of eligibility for SSDI and SSI benefits.

b. Benefits Administered by the Railroad Retirement Board (RRB)

The RRB makes disability determinations for railroad employees who have applied for the Railroad Retirement (RR) disability benefits. A determination of “total” disability means the individual is disabled for all regular work. “Occupational” disability means the individual is disabled for regular railroad occupation, but is not “totally” disabled. Individuals who receive a “total” disability determination are disabled using the SSA criteria.

B. Policy

*The following individuals meet the definition of being disabled for the purposes of meeting a Medicaid covered group and are **not to** be referred to DDS:*

- *individuals who receive SSDI or SSI as a disabled individual or receive RR **total** disability benefits.*

- *individuals who received SSDI or SSI disability benefits or RR total disability benefits in one or more of the 12 months preceding the Medicaid application and whose benefits were terminated for a reason **other than no longer meeting the disability or blindness requirements.***
- *individuals who have been determined disabled or blind by DDS for Medicaid or for SSA, without a subsequent decision by SSA reversing the disability determination, and*
- *individuals who have been determined “totally” disabled by the RRB.*

C. Procedures for Verifying Disability Status

1. Receives SSDI/SSI Disability Benefits

Verify SSDI/SSI disability status through a SVES (State Verification Exchange System) or SOLQ (State Online Verification Query) request or through documentation provided to the applicant by the SSA.

2. Receives RRB Disability Benefits

Verify RRB disability by contacting the RRB at 804-771-2997 or 1-800-808-0772, or through documentation provided to the applicant by the RRB.

3. Determined Disabled by DDS

*If disability status cannot be ascertained **after** reviewing SVES or SOLQ, contact your regional DDS office to verify disability status (see Appendix 5 to this subchapter for DDS Regional Offices).*

D. When a DDS Disability Determination is Required

- *The DDS makes a disability determination for Medicaid when the individual alleges a disabling condition and has never applied for disability benefits from SSA or has not been denied disability within the past 12 months; **or***
- *the individual alleges a disabling condition and SSA has not yet made a determination on a pending SSDI/SSI claim; **or***
- *the individual alleges a disabling condition which is different from that considered by SSA or is in addition to that considered by SSA.*

1. Individual Age 19 Years or Older

An individual age 19 years or older must have his disability determined by DDS if he:

- *is claiming to have a disabling condition but does not receive SS/SSI disability benefits or RR total disability benefits, **and***
- *has not been denied SSDI or SSI disability benefits in the past 12 months.*

2. Individual Under Age 19

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

- *if he is not eligible for FAMIS Plus or FAMIS, **or***

- if it is 90 calendar days prior to his 19th birthday.

Do **NOT** refer a disabled child under age 19 to DDS for the sole purpose of participation in the Health Insurance Premium Payment (HIPP) program

E. When an LDSS Referral to DDS is Required

1. 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 LDSS to process the application within 90 days, provided all medical information has been submitted.

2. SSA Denied Disability Within the 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 requested SSA reopen or reconsider his claim **AND** has refused to do so or denied it for non-medical reasons. Proof of decision made by SSA is required.

If the conditions in a. or b exist, DDS must make a disability determination.

If the conditions in a or b above do not exist, the SSA denial of disability is final for Medicaid purposes. **Do NOT make a referral to DDS for a disability determination. Deny the Medicaid application because SSA denied the applicant's disability and the applicant meets no other covered group.**

3. 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 M0310.112 G. below to make a referral to DDS.

F. Decision Pathway for DDS Referrals

When determining whether or not a referral to DDS is required, the worker should ask the following questions:

Has the individual applied for SSDI or SSI?

If no, refer to DDS.

If yes and a decision **has not** been made, refer to DDS.

*If yes and a decision **has** been made, was the disability allowed or denied?*

If allowed, refer to M0310.112 B, because another determination of disability may not be necessary.

If denied, look at the date of the last determination.

If the last SSA denial determination was made more than 12 months in the past, refer to DDS.

If the last SSA denial determination was made less than 12 months in the past, and there is a new condition that has not been evaluated by SSA, refer to DDS.

If the last SSA denial determination was made less than 12 months in the past, and there has not been a worsening of a condition already evaluated by SSA, do not refer to DDS.

If the last SSA denial determination was made less than 12 months in the past, but there is a worsening of a condition already evaluated by SSA, ask if the individual has filed for a reconsideration or reopening of his case with SSA.

If yes and the case is currently under reconsideration, do not refer to DDS. The SSA decision remains binding unless SSA reverses the decision.

If yes and the SSA refused to reconsider his case because he does not meet the SSI eligibility requirements, refer to DDS.

*If no, do **NOT** refer to DDS. The individual must initiate an appeal of his denial with SSA. Unless SSA refuses the appeal request or turns it down for non-disability related reasons, the disability determination remains binding for 12 months.*

**G. LDSS Procedures
When a Disability
Determination is
Required**

There are two types of DDS referrals for the purposes of Medicaid eligibility: non-expedited and expedited. Most referrals are non-expedited. Expedited referrals are limited to individuals who are hospitalized and require a Medicaid disability determination so they can be transitioned directly from the hospital to a rehabilitation facility.

For both types of referrals, the eligibility worker must request the necessary verifications needed to determine eligibility so that the application can be processed when the disability determination is received.

1. LDSS Referrals to DDS for Non-expedited Cases

- a. Send the following forms to the applicant for completion immediately, giving the applicant 10 calendar days to return the completed forms:
- a copy of the *Frequently Asked Questions—Disability Determinations for Medicaid* (form #032-03-0426), available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>, explaining the disability determination process and the individual's obligations;
 - the *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).
 - a minimum of 3 signed, original forms: *Authorization to Disclose Information to the Social Security Administration form SSA-827 (4-2009)* (see Appendix 3 to this subchapter) **or** a form for each medical provider if more than 3.
- b. Complete the DDS Referral Form, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi> Use the DDS Referral Form that corresponds with the DDS Regional Office to which the LDSS has been assigned (#032-03-0095, #032-03-0096, #032-03-0097, or #032-03-0098). To the form, attach the following:
- the completed Disability Report
 - the signed copies of the *Authorization to Disclose Information*
 - copies of paystubs, if the applicant is currently working.

If the individual's application was filed with the assistance of a hospital-based eligibility assistance organization, a copy of the consent to release information to the organization must be included with the referral so DDS staff can communicate with them, if necessary.

Mail the DDS Referral form and attachments to the appropriate DDS Regional Office. See Appendix 2 to this subchapter for the locality assignments and addresses for DDS Regional Offices.

Do not send referrals to DDS via the courier.

2. Expedited Referrals for Hospitalized Individuals Awaiting Transfer to a Rehabilitation Facility

The 2004 Budget Bill mandated that DDS make a disability determination within seven (7) working days of the receipt of a referral from the LDSS when the Medicaid applicant is hospitalized and needs to be transferred directly to a rehabilitation facility. To ensure that the DDS is able to make the disability determination within the mandated timeframe, the procedures below shall be followed:

a. *Hospital staff shall simultaneously send:*

- *the Medicaid application and a cover sheet (see Appendix 4 for an example of the cover sheet) to the LDSS or the hospital outstationed eligibility worker*
- *the medical documentation (disability report, authorizations to release information and medical records) and cover sheet to the DDS.*

b. *LDSS shall immediately upon receipt of the Medicaid application:*

- *fax a completed DDS Referral Form (#032-03-0095, #032-03-0096, #032-03-0097, or #032-03-0098) to the appropriate DDS region, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>, to verify receipt of the Medicaid application; and*
- *give priority to processing the applications and immediately request any verifications needed; and*
- *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.*

c. *DDS shall make a disability determination within seven (7) working days and fax the result of the disability decision to the LDSS. DDS is not responsible for notifying either the applicant or the hospital of the outcome of the disability determination.*

If DDS is unable to render a decision within 7 working days, DDS will send a communication to the LDSS advising that the disability determination has been delayed.

**3. Application
Processing When
DDS Referral is
Pending**

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 application must be denied.

Individuals who require a disability determination must meet all non-financial requirements other than covered group, within 45 calendar days or the application must be denied. If these requirements are met, the application timeframe may be extended to 90 days while DDS is making the disability determination. If any non-financial requirement other than covered group is not met by the 45th calendar day, his application must be denied and DDS must be notified of the denial.

DDS does NOT stop the disability determination process when the individual meets all non-financial requirements, but has excess resources (see M0130.100 B.4) because he might reduce his resources while the.

application is pending for the disability determination. DDS does NOT stop the disability determination when the individual has excess income because of possible spenddown eligibility

**4. LDSS
Responsibilities
for
Communication
with DDS**

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

**H. Notification of DDS
Decision to LDSS**

The DDS will advise the agency of the applicant's disability status as soon as it is determined by either SSA or the DDS. For hospitalized individuals who meet the requirements for an expedited disability determination, DDS will fax the outcome of the disability determination directly to the LDSS responsible for processing the application and enrolling the eligible individual.

**1. Hospitalized
Individuals**

**2. Individuals Not
Hospitalized**

For all other disability determinations, DDS will mail the determination to LDSS responsible for processing the application and enrolling the eligible individual. If the claim is denied, DDS will also send a personalized denial notice to be sent to the applicant explaining the outcome of his disability determination.

**3. Disability
Cannot Be
Determined
Timely**

A disability determination cannot be completed within the allotted time when there is missing or incomplete medical information. In the event that this situation occurs, the DDS will notify the applicant on or about 75 days from the application date of the delay and/or the need for additional information. A copy of the DDS's notice to the applicant will also be sent to the LDSS. The LDSS shall send the applicant a Notice of Action to extend the pending application.

**4. DDS Rescinds
Disability Denial**

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

**I. LDSS Action &
Notice to the
Applicant**

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

**J. Applicant is
Deceased**

When a Medicaid applicant who has been referred to DDS dies or when the applicant is deceased at the time of the Medicaid application, DDS will determine if the disability requirement for Medicaid eligibility was met. The LDSS must immediately notify DDS of the individual's death and make every effort to provide a copy of the death certificate.

**K. Subsequent SSA or
RRB Disability
Decisions**

When SSA or the RRB make a disability decision subsequent to the Medicaid decision which differs from the Medicaid decision, the SSA or RRB decision must be followed in determining Medicaid eligibility unless one of the conditions in M0310.110 D. 2 above applies.

**1. SSA/RRB
Approval**

If SSA approves disability or the RRB approves total disability, the disability definition is met. If DDS initially denied disability and the decision is reversed, re-evaluate the denied Medicaid application. The individual's Medicaid entitlement is based on the Medicaid application date, including the retroactive period, if all eligibility requirements were met during the retroactive period. However, eligibility as a disabled individual cannot begin prior to the disability onset date (month) established by SSA. Do not send the claim back to DDS for an earlier onset date.

Disability Approved More Than 12 Months Past

If, based upon the re-evaluation, the individual is determined to be eligible and more than 12 months have passed since the application was filed, complete an eligibility renewal to determine whether or not the individual remains eligible.

Spenddown

If, based upon the re-evaluation, the individual is determined not eligible for Medicaid but met the requirements in Chapter M13 for placement on a spenddown, a first prospective and additional 6 month spenddown budget periods may be established to cover the period of time between the date of application and the date action is taken on his case. A new application is not required for each 6 month spenddown budget period leading up to the date of processing, however, verification of all income and resources for those time periods must be obtained.

**2. SSA Denial or
Termination
And Appeal**

If SSA denies disability, the disability definition is not met. If the individual has been enrolled in Medicaid as disabled and is not eligible in another covered group, send an advance notice to the enrollee to cancel Medicaid.

*If the individual appeals the SSA's disability decision timely (within 60 calendar days from the SSA notification or with good cause for exceeding 60 days) and SSA agrees to reconsider the decision, the Medicaid coverage must be reinstated until the final decision on the SSA appeal is made. **The individual must provide verification that he filed the appeal and SSA agreed to reconsider the case.** The individual must also provide verification of the decisions made at all levels of appeal in order for Medicaid to continue during the process. The Medicaid coverage will continue until a final decision is made and the individual has no right to further SSA appeals.*

The levels of administrative review are in the following order:

- a. reconsideration,*
- b. the hearing before an administrative law judge (ALJ), and*
- c. the Appeals Council*

For example: An individual is enrolled in Medicaid as disabled. However, his SSA claim is denied at the ALJ hearing level. If the individual fails to appeal the ALJ decision to the Appeals Council and the Appeals Council does not decide on its own to review the case, the ALJ decision becomes the final decision once the 60-day deadline for requesting further review has passed. Because the individual no longer meets the disabled definition for another covered group, his Medicaid coverage must be canceled.

**3. RRB Denial,
Termination
and RRB
Appeal**

If RRB denies disability, the disability definition is not met. If the individual has been enrolled in Medicaid as disabled and is not eligible in another covered group, send an advance notice to the recipient to cancel Medicaid.

Persons who believe that their claims have not been adjudicated correctly may ask for reconsideration by the Board's Office of Programs. If not satisfied with that review, the applicant may appeal to the Board's Bureau of Hearings and Appeals. Further, if the individual timely appeals the RRB disability decision, Medicaid coverage must be reinstated until the final decision on the RRB appeal is made. The individual must provide verification that he filed a timely appeal with RRB and must provide verification of the decisions made at all levels of appeal in order for Medicaid to continue during the process.

M0310.113 EWB

A. Essential to The Well-Being (EWB)

EWB is the short name for a person who is “essential to the well-being” of a child in the household. An EWB who is living in the household and who is providing services which are essential to the well-being of the dependent, deprived child(ren) in the household may be eligible for Medicaid in the LIFC covered group, if the individual

- does not meet any other Medicaid covered group, and
- the individual to whom the EWB provides the service(s) is eligible for Medicaid in the CNNMP LIFC covered group. Services which are essential to the well-being of the dependent, deprived child(ren) in the household are listed in item B.

B. Services Essential to Well-Being

Services which are essential to the well-being of the dependent, deprived child(ren) in the household are limited to:

- provision of care for an incapacitated family member in the home;
- provision of child care which enables the caretaker to work on a full-time basis outside the home;
- provision of child care which enables the caretaker to receive training full-time;
- provision of child care which enables the caretaker to attend high school or GED classes full-time;
- provision of child care for a period not to exceed 2 months to enable the caretaker to participate in employment search.

C. Procedure

Section M0320.306 contains the detailed requirements for the LIFC covered group in which an EWB can be eligible for Medicaid.

M0310.114 FAMILIES & CHILDREN (F&C)

A. Families & Children (F&C)

"Families & Children (F&C)" is the group of individuals that consists of

- eligible members of families with dependent children,
- pregnant women, and
- specified subgroups of children under age 21.

M0320 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/2010	pages 49-50b
UP #3	03/01/2010	pages 34, 35, 38, 40, 42a, pages 42b, 42f
TN #93	01/01/2010	pages 11-12, 18, 34-35, 38 pages 40, 42a-42d, 42f-44, 49 pages 50c, 69-71
UP #2	08/24/2009	pages 26, 28, 32, 61, 63, 66
Update (UP) #1	07/01/2009	pages 46f-48
TN #91	05/15/2009	pages 31-34 pages 65-68

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

A. Policy

Plan First, Virginia's family planning services health program, is available to uninsured men and women who have countable income within 133% FPL and have not had a sterilization procedure.

To be enrolled in Plan First, individuals cannot be eligible for a full-benefit Medicaid covered group.

1. Plan First Applications

Uninsured men and women who have countable income within 133% FPL and have not had a sterilization procedure may be eligible for Plan First.

The Plan First Application Form *or the Application for Benefits form* **must be submitted for eligibility to be determined in this covered group.** *There is no automatic eligibility for Plan First.*

An application is *required* for initial eligibility and for each annual renewal. *Ex parte renewals are not allowed.*

Retroactive coverage is NOT available in the Plan First covered group. *Eligibility begins the first day of the month in which the application form was received by the agency, provided all eligibility requirements were met in that month.*

2. Determine Medicaid Eligibility First

a. Application Indicates Potential Full-benefit Medicaid Eligibility

If the information contained in the application indicates **potential** eligibility in a full-benefit Medicaid covered group (e.g., the applicant has a child under 18 in the home and has income within the LIFC income limit for the family unit size), the worker must determine whether eligibility for full benefit Medicaid coverage exists before the individual(s) can be determined eligible for Plan First.

b. Additional Information Needed For Full Benefit Medicaid

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

c. Applicant Eligible for Plan First Only

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

B. Nonfinancial Requirements

**1. General
Nonfinancial
Requirements**

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

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

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

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

**2. Creditable Health
Insurance
Coverage**

Men and women *who* have creditable health insurance coverage *are not eligible for Plan First, even when the health insurance does not cover family planning services*. Creditable health insurance coverage includes:

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

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

Creditable health insurance coverage does not include:

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

MMIS will cancel coverage (cancel reason 052), and send an advance notice of the cancellation to the enrollee, in the month that it detects the following TPL:

- *M = Major/Medical-Comprehensive*
- *L = Managed Care (HMO/PPO)*
- *B = Medicare Part B.*

- 3. Sterilization Procedure** Individuals who have had a sterilization procedure (tubal ligation *or* vasectomy), *or a woman who has had a hysterectomy*, are **not** eligible for Plan First *because they do not require family planning services*. Information regarding receipt of a sterilization procedure is collected on the Plan First application/renewal form, *as well as on the Application for Benefits*.

C. Financial Eligibility

- 1. Assistance Unit** Use the assistance unit policy in chapter M05 to determine financial eligibility.
- 2. Resources** There is no resource limit.
- 3. Income** The income requirements in chapter M07 must be met for this covered group. The income limits are 133% FPL and are found in subchapter M0710, Appendix 6.
- 4. Spenddown** Spenddown does not apply to this covered group.

D. Entitlement and Enrollment

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

Completion of a Plan First *or Application for Benefits* application is required at each renewal.

- 2. Enrollment** The AC for Plan First enrollees is “080.”

- 3. Coverage Extension Post-Sterilization** If an individual enrolled in this covered group receives a sterilization procedure paid for by Medicaid, DMAS will take action to cancel the coverage and send the appropriate notice *after an extension of coverage for 90 days following the date the sterilization consent form was signed*.

Plan First coverage is extended for 90 days to allow time for a post-sterilization procedure follow-up visit. MMIS will automatically cancel the individual’s coverage in AC 080 in the 3rd month post-sterilization.

*Individuals may obtain **one** additional month of coverage provided a follow-up visit has been scheduled for that additional month. Workers should accept the individual’s declaration that he or she has scheduled an appointment.*

Prior to reinstating the Plan First coverage, the eligibility worker must notify DMAS that the PLAN FIRST IND field in MMIS needs to be changed

from “N” to “Y.” Use the MMIS Coverage Correction Request form and email it to: enrollment@dmass.virginia.gov. DMAS staff will notify the worker when the change has been made in MMIS. Once the change has been made, the worker can reinstate the Plan First coverage for one month only.

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

A. Policy

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

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

B. Nonfinancial Eligibility

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

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

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

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

C. Financial Eligibility

1. Assistance Unit

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

2. Asset Transfer

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

3. Resources

There is no resource limit.

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M0720 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/2010	pages 5, 6
TN #91	05/15/2009	page 11

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

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

M0720.200 INCOME FROM SELF-EMPLOYMENT

A. **Policy** Self-employment is defined as a business, farming or commercial enterprise in which the individual receives income earned by his own efforts, including his active engagement in management of property. Self-employment situations include, but are not limited to, domestic workers, day care providers including babysitters, and chore and companion service providers.

1. **Salary from Corporation Owned by Individual** *If an individual has incorporated a self-employment enterprise either alone or with other persons (such as an "S-corporation"), and he draws a salary from the corporation, the wages drawn are regular earned income; they are NOT self-employment income. In such a situation, the person's share of the net worth of the corporation is a resource.*

2. **Profit is Earned Income** The profit from self-employment is earned income. Profit from self-employment means the total income received, less the allowable business expenses directly related to producing the goods or services and without which the goods or services could not be produced.

B. Business Expenses

1. **Definition** Business expenses are expenses directly related to producing goods or services and without which the goods or services could not be produced. *Allowable business expenses include, but are not limited to, the following:*

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

3. **Expenses NOT Included** Business expenses **do not** include:

- payments on the principal of the purchase price of, and loans for, capital asset, such as real property, equipment, machinery and other goods of a durable nature;

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

C. Verification

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

M0720.250 INCOME FROM REAL PROPERTY

A. Policy

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

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

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

B. Profit

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

M0720.260 INCOME FROM ROOM AND BOARD

A. Policy

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

B. Procedure

1. Verify Gross Income

Verify gross income received by self-employment bookkeeping records.

M0730 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/2010	pages 7, 8
TN #93	01/01/2010	page 2
TN #91	05/15/2009	Table of Contents pages 7-8a

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 *increased* payments, called *Federal Additional Compensation (FAC)*, of \$25.00 per week to certain individuals receiving Unemployment Compensation payments. *FAC* increased payments are authorized for Unemployment Compensation payments made through *December 4, 2010, provided that the initial claim for compensation was filed on or before May 23, 2010. Claims filed after May 23, 2010 are not subject to the increased payments.*

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.

FAC increased payments are excluded from countable income. If the individual's Unemployment Compensation claim was filed on or before May 23, 2010, exclude the first \$25.00 of Unemployment Compensation for payments made through December 4, 2010.

If the claim was filed after May 23, 2010, the individual does not receive the additional weekly \$25.00. DO NOT exclude the FAC payments from countable 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

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S0830 Changes

Transmittal Number	Effective Date	Pages Changed
TN #94	09/01/2010	page 29
TN #93	01/01/2010	Table of Contents, page iv pages 28, 67, 119-120 pages 122-125
TN #91	05/15/2009	Table of Contents, page i page 29

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 *increased* payments, called *Federal Additional Compensation (FAC)*, of \$25.00 per week to certain individuals receiving Unemployment Compensation payments. *FAC* increased payments are authorized for Unemployment Compensation payments made through *December 4, 2010*, provided that the *initial claim for compensation was filed on or before May 23, 2010*. *Claims filed after May 23, 2010 are not subject to the increased payments.*

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.

FAC increased payments are excluded from countable income. If the individual's Unemployment Compensation claim was filed on or before May 23, 2010, exclude the first \$25.00 of Unemployment Compensation for payments made through December 4, 2010.

If the claim was filed after May 23, 2010, the individual does not receive the additional weekly \$25.00. DO NOT exclude the FAC payments from countable 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.

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S1130 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/2010	pages 20, 20a, 28-29a
TN #93	01/01/2010	pages 63-65 pages 70, 74, 75
TN #91	05/15/2009	page 13

B. Policy

1. Life Insurance as a Resource

A life insurance policy owned by the individual is a resource if it generates a CSV. Its value as a resource is the amount of the CSV.

A life insurance policy which is irrevocably assigned to another person is not a resource to the individual, but it needs to be evaluated as an asset transfer (subchapter M1450). When the life insurance policy is irrevocably assigned to a funeral home or trust to fund the individual's burial contract, go to section M1130.425.

2. Limited Exclusion

A life insurance policy is an excluded resource, **for individuals age 21 and over**, if its FV and the FV of any other life insurance policies the individual owns on the same insured total \$1,500 or less. However, the FV of some policies does not count toward this \$1,500 total (see 3. below). **Life insurance policies on individuals under age 21 are excluded from resource evaluations.**

We do **not** include the FV of dividend additions in determining whether a policy is a countable or excludable resource. If the policy is a countable resource, we include the **CSV** of dividend additions in determining the resource value of the policy.

3. FV of Burial and Certain Term Insurance Not Counted

In determining whether the total FV of the life insurance policies an individual owns on a given insured is \$1,500 or less, the FV of the following are not taken into account:

- burial insurance policies; and
- term insurance policies that do not generate a CSV.

4. Relation to Burial Fund Exclusion

The maximum of \$3,500 that can be excluded as set aside for the burial expenses of an individual must be reduced by the FV of:

- any burial insurance policy for the burial expenses of the individual;

Exceptions: Huff-Cook Mutual Burial Association life insurance policies (which may be designated as Care Plans on the policy) sold prior to April 7, 1993 do not reduce the \$3,500 burial fund exclusion. Huff Cook life insurance policies sold from April 7, 1993 through November 30, 1993 reduce the burial fund exclusion. Huff-Cook/Settlers life insurance policies sold on or after December 1, 1993 do not reduce the \$3,500 burial fund exclusion unless they are assigned to pay for a pre-need funeral contact.

- any insurance policy on the life of the individual that is excluded under the life insurance exclusion in B.2. above;

- a life insurance policy of any value that was assigned to a funeral provider or of which a funeral provider has been made the irrevocable beneficiary, if the policy owner has irrevocably waived his or her right to, and cannot obtain, any CSV the policy may generate. The amount by which the \$3,500 exclusion is reduced equals the face value of the policy MINUS the total cost of burial space items identified in the contract.

(See **M1130.410** for instructions regarding the burial fund exclusion and **M1130.410 C.1.d.** for more discussion of burial insurance.)

**5. Eligibility for
Other Benefits**

a. Supplementary Contracts

Supplementary contracts normally provide for an annuity. We treat such contracts in accordance with the instructions on filing for other benefits, for any benefit with choices about method of payment.

b. Accelerated Life Insurance Payments

Accelerated payments are not "benefits" for purposes of the Medicaid "filing for other benefits" provision. We do not require a policyholder to apply for accelerated payments as a condition of obtaining or retaining Medicaid eligibility.

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

b. Expenses Not Included

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

C. Policy--General

1. Amount of Funds That Can Be Excluded

a. Maximum Exclusion

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

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

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

Funds paid on an installment contract do **NOT** qualify for the **burial space exclusion**.

Funds paid on an installment contract for burial spaces may qualify for the burial fund exclusion.

b. Reductions in Maximum Exclusion

The maximum \$3,500 that can be excluded from countable resources is reduced by:

- the face value of life insurance (not including term policies) owned by and insuring the individual and/or the individual's spouse, if the cash surrender value of such policies has been excluded from countable resources (cash surrender value of life insurance is excluded when the total face value per insured individual aged 21 or over does not exceed \$1,500), and
- the face value of an irrevocable burial trust established before 8/11/93 (not including the value of burial space items), regardless of whether the arrangement is owned by the individual or someone else, and
- the face value of burial insurance, regardless of whether the burial insurance is owned by the individual or someone else, and
- the face value of burial contracts (not counting the value of burial space items), regardless of whether the contract is owned by the individual or someone else.

c. Exceptions Related to Huff-Cook/Settlers Policies

Huff-Cook Mutual Burial Association life insurance policies (which may be designated as Care Plans on the policy) sold prior to April 7, 1993 do not reduce the \$3,500 burial fund exclusion.

Huff-Cook life insurance policies sold from April 7, 1993 through November 30, 1993 reduce the burial fund exclusion.

Huff-Cook/Settlers life insurance policies sold on or after December 1, 1993 do not reduce the \$3,500 burial fund exclusion unless they are assigned to pay for a pre-need funeral contact.

d. EXAMPLE – Burial Fund Exclusion

Mrs. Brown has the following burial resources:

\$2,000 designated savings account
\$ 200 irrevocable burial contract

\$3,500 maximum exclusion
- 200 irrevocable burial contract
\$3,300 available exclusion
-2,000 excluded burial funds
\$1,300 still available for exclusion

Treatment - We exclude the \$2,000 savings account. Two years later, Mrs. Brown wants to add to her designated burial savings account, which now has a balance of \$2,150 due to accumulated interest. She can increase the amount of excluded funds in the account by up to \$1,300. Note that when determining the amount still available for *burial fund* exclusion, we disregard the amount of interest which accumulated in the account.

e. Subsequent Purchase of Excluded Life Insurance or Irrevocable Burial Contract

A subsequent purchase of an excluded life insurance policy or an irrevocable burial contract reduces the amount of the available burial funds exclusion as described in b. above. The reduction is effective the month after the month in which the life insurance or the irrevocable burial contract was purchased.

f. Burial Insurance

Burial insurance policies are not life insurance policies (see **M1130.300** for a definition of burial insurance). For Medicaid purposes, burial insurance is an irrevocable arrangement whose face value reduces the maximum burial funds exclusion by the policy's face value.

Exceptions: *Huff-Cook Mutual Burial Association life insurance policies sold prior to April 7, 1993 do not reduce the \$3,500 burial fund exclusion.*

Huff-Cook/Settlers life insurance policies sold on or after December 1, 1993 do not reduce the \$3,500 burial fund exclusion unless they are assigned to pay for a pre-need funeral contact.

e. Increases in Value of Burial Funds

Any appreciation in the value of excluded burial funds is excluded from resources (and from income), even if the total of the burial funds thus excluded exceeds the \$3,500 maximum. This includes interest earned by burial funds, provided the interest is left to accumulate as part of the funds.

**2. Increases in
Amount of
Excluded
Burial Funds**

a. Designated Amount is \$3,500

Interest earned on excluded burial funds and appreciation in the value of excluded burial arrangements are excluded from resources if left to accumulate and become part of the separate burial fund.

b. Designated Amount is Less than \$3,500

Until \$3,500 (or such other lesser amount established in accordance with C.1.b.) in burial funds has been designated, additional amounts can be excluded under the burial funds provision if the individual designates them for burial expenses. Interest on excluded burial funds is not included in determining if the \$3,500 maximum has been reached.

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M1340 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/2010	page 6
TN #93	01/01/2010	page 18

1. **Beneficiary NOT In Medicare PDP on Date of Service**
If the Medicare beneficiary was not enrolled in a Medicare PDP on the date of the prescription drug service, allow the prescription drug cost that is the responsibility of the beneficiary as a spenddown deduction.
2. **Beneficiary in Medicare PDP on Date of Service**
If the Medicare beneficiary was enrolled in a Medicare PDP on the date of service, allow the prescription drug cost (deductible, co-pays and/or coverage gap) that is the responsibility of the beneficiary as a spenddown deduction.
3. **PDP Denies Drug Coverage**
If a Medicare PDP denies coverage of a prescription drug, 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.
 - Do NOT allow the charge if the drug charge appears on the statement as a denial and no exception was requested.
 - Allow the charge if the drug charge appears on the statement as a denial, and an exception was requested and denied.

Medicare beneficiaries who are enrolled in a Medicare PDP should be advised to keep their statements and other related documentation for consideration under spenddown.

M1340.600 OLD BILLS

- A. Policy**
- Old bills are any unpaid medical, dental and/or remedial care expenses incurred prior to the retroactive period based on an initial application. Unpaid medical, remedial, and dental care expenses incurred prior to a re-application and its retroactive period may also be deducted as old bills provided that:
- they were not incurred during a prior spenddown budget period, in which spenddown eligibility was established,
 - they were not fully deducted from any previous spenddown that was met, and
 - they remain the liability of the individual.

Old bills may include medical bills that were paid by a state or local program.

An unused portion of an old bill which is still the liability of the individual may be *applied to a future consecutive* spenddown budget period(s) only if there is no break in spenddown eligibility. If there is a break in spenddown eligibility, only current payments made on old bills based on a prior spenddown application can be deducted in the current budget period. The old bill from a prior application is no longer an “old bill” as defined in section M1310.300. Only the amount of any “current payment” made on that expense in the current budget period can be deducted. Go to section M1340.800 for current payments policy and procedures.

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M1370 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/2010	Table of Contents pages 1-5

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M13 SPENDDOWN

M1370 SPENDDOWN - ABD MEDICALLY INDIGENT (EXCLUDING ABD 80% FPL)

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**M1370.000 SPENDDOWN - ABD MEDICALLY INDIGENT
(EXCLUDING ABD 80% FPL)****M1370.100 SPENDDOWN - ABD MEDICALLY INDIGENT****A. Introduction**

This policy applies to aged, blind or disabled (ABD) medically indigent (MI) enrollees in one of the following groups:

- Qualified Medicare Beneficiaries (QMBs),
- Special Low-income Medicare Beneficiaries (SLMBs),
- Qualified Individuals (QIs), and
 - Qualified Disabled Working Individuals (QDWIs).

These ABD MI enrollees are eligible for only a limited package of Medicaid services. They do not receive full Medicaid coverage, therefore they must be evaluated to determine if they could become eligible for full Medicaid coverage as medically needy (MN) by meeting a spenddown.

This policy does not apply to individuals in the ABD 80 % FPL covered group. Individuals in the ABD 80% FPL covered group receive full Medicaid coverage.

1. Placement on Spenddown

At application and redetermination, QMB, SLMB, and QDWI MI enrollees who meet the MN covered group and resource requirements are placed on two six-month spenddown budget periods within the 12 month *renewal* certification period. They may also be eligible for retroactive MN spenddown eligibility.

QI enrollees who meet the MN covered group and resource requirements are placed on two six month spenddown budget periods at a time, beginning with the month of application. Spenddown budget periods continue to run consecutively, with no new application required, as long as the individual remains QI eligible.

When only one spouse of an ABD couple is eligible as ABD MI (i.e., one spouse has Medicare and the other does not), the couple is an assistance unit of two for spenddown purposes and placed on two six-month spenddowns.

2. QMB, SLMB, and QDWI

If an enrolled QMB, SLMB, or QDWI does not meet the spenddown, he continues to be eligible as ABD MI. If he remains eligible as ABD MI, the ABD Medicaid Renewal form (#032-03-0186) may be used as an application for establishing additional spenddown budget periods. The Eligibility Review Part A (#032-03-729A) and the Eligibility Review Part B (#032-03-729B) forms should only be used when they are required by another program under which the individual is receiving benefits.

The spenddown budget period is based on the application date. At renewal, the new spenddown budget period begins the month following the end of the previous spenddown budget period if the renewal is filed in the last month of the spenddown budget period or the following month. If the renewal is filed two or more months after the end of the last spenddown budget period, the new spenddown budget periods (retroactive or prospective) are based on the

date the renewal form was received in the LDSS. Do not complete an early renewal on a spenddown case because the spenddown period must not be shortened by the completion of an early renewal.

3. QI

The QI medically indigent enrollees who meet the MN covered group and resource requirements are placed on a MN spenddown. If an enrolled QI medically indigent enrollee does not meet the spenddown, he continues to be eligible as QI for the calendar year, or as long as the program is funded.

QI coverage can be renewed for the following year as long as the QI completes and returns the ABD Medicaid Renewal form (#032-03-0186) and the renewal is completed by December 31 of each year. If the renewal form is not returned and the QI renewal is not completed by December 31, the individual must reapply for Medicaid for the coverage to resume.

Spenddown budget periods for QIs are based on the initial application month. Unless the individual applied in January, his spenddown budget periods will not coincide with the renewal certification period. Spenddown budget periods continue to run consecutively, with no new application required, as long as the QI's Medicaid coverage remains open.

4. QI Spenddown Procedures

a. New Applications

At the time of initial application, the agency will calculate two spenddown periods. When the second spenddown period expires, the agency will continue to calculate additional spenddown periods, two at a time, without a new application as long as the person remains active in Medicaid. The worker shall send a Notice of Action containing the information about the new spenddown periods each time the worker calculates another two spenddown periods.

b. QIs who were enrolled and on a spenddown as of July 1, 2010

When the QI's current spenddown period ends, the agency will continue to calculate additional spenddown periods, two at a time, without a new application as long as the person remains active in Medicaid. The worker shall send a Notice of Action containing the information about the new spenddown periods each time the worker calculates another two spenddown periods.

When bills are submitted, the worker shall contact the individual to see if living situation, income or resources have changed. If changes have occurred, verification must be provided and a re-evaluation must be completed.

The spenddown cycle does not affect the QI renewal cycle—QI renewals will be due in December regardless of when the person applied for Medicaid.

C. References

The spenddown eligibility determination and enrollment procedures for an ABD MI enrollee are contained in the following sections:

- M1370.200 Qualified Medicare Beneficiaries (QMBs), Special Low-income Medicare Beneficiaries (SLMB), & Qualified Disabled Working Individuals (QDWIs).
- M1370.300 Qualified Individuals (QI).

M1370.200 QMBs, SLMBs & QDWIs**A. Policy**

QMBs are eligible only for Medicaid coverage of their Medicare premiums, the Medicare deductible and coinsurance charges for Medicare covered services. Medicare does not cover all of the services that Medicaid covers. For example, Medicare does not cover non-emergency transportation.

SLMBs and QDWIs are eligible only for Medicaid coverage of their Medicare premiums.

B. Entitlement After Meeting Spenddown

When an enrolled QMB, SLMB or QDWI meets a medically needy spenddown, he is eligible for Medicaid as medically needy beginning the date the spenddown was met and ending the last day of the spenddown budget period.

C. Enrollment Procedures

The MMIS enrollment must be canceled and then reinstated in order for the individual to receive the full scope of Medicaid services for the portion of the spenddown budget period in which he is eligible as medically needy. Take the following actions:

1. Cancel ABD MI Coverage

Cancel the enrollee's current coverage line that has the medically indigent aid category (AC).

- a. Cancel date is the date **before** the date the spenddown was met.
- b. Cancel reason is "024".

2. Reinstatement MN Coverage

Reinstate the enrollee in the appropriate medically needy aid category (AC).

- enter the eligibility begin date as the date the spenddown was met.
- enter the eligibility end date - the date the spenddown budget period ends.

Be sure that the application date is the first month in the spenddown budget period. The MMIS will cancel eligibility effective the end date entered.

D. Continuing Eligibility and Enrollment After Spenddown Ends

When the spenddown budget period ends, reinstate the enrollee's Medicaid eligibility as medically indigent beginning the day after the MN spenddown budget period eligibility cancel date. Use the original Medicaid application date. ABD MI eligibility resumes the first day of the month following the end of the spenddown budget period. The month in which the spenddown budget period ends is considered the month in which the agency determines the enrollee's ABD MI eligibility.

To establish a new spenddown budget period, use the ABD Medicaid Renewal form (#032-03-669). The Eligibility Review Part A (#032-03-729A) and Eligibility Review Part B (#032-03-729B) forms should only be used when they are required by another program under which the individual is receiving benefits. When the annual redetermination is filed, new spenddown budget periods are established. Eligibility for each spenddown budget period is evaluated.

E. Example--QMB Meets Spenddown

EXAMPLE #1: Mr. B is 69 years old. He has Medicare Parts A & B. He applied for Medicaid on July 14, 2005. Resources are within the medically needy limit. His income exceeds the medically needy limit, but is less than the QMB limit. His eligibility is determined on August 1, 2005. He is enrolled in Medicaid QMB coverage effective September 1, 2005, the month following the month the agency determined his QMB eligibility. He is placed on two consecutive 6-month spenddown budget periods, July 1, 2005 through December 31, 2005 and January 1 through June 30, 2006. The agency enrolls him in the MMIS with an eligibility begin date of September 1, 2005, AC 023.

On September 15, 2005, he brings in prescription drug bills. He meets the spenddown on September 13, 2005. On September 25, 2005, the agency cancels his QMB coverage (AC.023) effective September 12, 2005. He is reinstated with MN Medicaid eligibility as AC 028 (dual-eligible medically needy aged) with a begin date of September 13, 2005, an application date of July 14, 2005, and an end date of December 31, 2005.

His spenddown eligibility ends December 31, 2005. On January 1, 2006, the agency worker reinstates his QMB-only Medicaid coverage with a begin date of January 1, 2006, AC 023, application date July 14, 2005. He remains on a spenddown for the spenddown budget period January 1, 2006 through June 30, 2006.

M1370.300 QUALIFIED INDIVIDUALS (QI)

A. Introduction

QIs are eligible only for limited Medicaid payment of their Medicare premiums. They are NOT eligible for any other Medicaid-covered services.

If all eligibility factors are met in the application month, eligibility for Medicaid as QI begins the first day of the application month and ends December 31 of the calendar year, if funds are still available. *QI coverage can be renewed for the following year if the renewal form is submitted by December 31 of each year. If the renewal form is not returned by December 31, the individual must reapply for Medicaid for the coverage to resume.*

- B. Entitlement After Meeting Spenddown** When an enrolled QI meets a spenddown, he is eligible for Medicaid as medically needy. MN eligibility begins the date the spenddown was met and ends the last day of the spenddown budget period.
- C. Enrollment Procedures**
- The MMIS ABD MI enrollment must be canceled and the MN coverage reinstated in order for him to receive the full scope of Medicaid services for the portion of the spenddown budget period in which he is MN-eligible. Take the following actions:
1. **Cancel QI Coverage**

Cancel the enrollee's current eligibility in the QI aid category.

 - a. Cancel date is the date before the date the spenddown was met.
 - b. Cancel reason is "024".
 2. **Reinstate MN Coverage**

Reinstate the enrollee in the appropriate MN AC (**NOT dual-eligible**).

 - enter the eligibility begin date as the date the spenddown was met.
 - enter the end date as the last date of the spenddown budget period.

Be sure that the application date is the first month in the spenddown budget period. The MN coverage will end the last date of the spenddown budget period.
- D. Continuing Eligibility and Enrollment After Spenddown Ends** When the spenddown budget period ends, reinstate the enrollee's Medicaid eligibility as medically indigent QI beginning the day after the MN spenddown eligibility cancel date. Use the initial Medicaid application date. The QI medically indigent coverage begin date is the first day of the month following the end of the spenddown budget coverage period.
- E. Example- QI Meets Spenddown** **EXAMPLE #2:** Mr. P. is 69 years old. He has Medicare Parts A & B, and applied for Medicaid on May 14. Resources are within the medically needy limit. His income exceeds the medically needy limit, but is less than the QI limit. His eligibility is determined on June 1. He is enrolled in Medicaid QI coverage beginning May 1. He is placed on a spenddown for the budget period May 1 through October 31. The agency enrolls him in the MMIS with an eligibility begin date of May 1, AC 056.
- On July 15 he brings in prescription drug bills. He meets the spenddown on July 13. On July 25 the agency cancels his QI (AC 056) coverage effective July 12. His Medicaid eligibility as MN is reinstated using AC 018 (medically needy aged) with an application date May 14, eligibility begin date of July 13, and eligibility end date of October 31.
- His spenddown eligibility ends October 31. On November 1, the agency worker reinstates his QI Medicaid coverage with a begin date of November 1, AC 056, application date May 14. *Because his coverage was uninterrupted, he is placed on two additional spenddowns, November 1 through April 30 of the following year and May 1 through October 31 of the following year. He completes an ABD Renewal form and returns it to the agency in December, and his QI coverage is also renewed for the following year.*

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M1410 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/2010	pages 6, 7, 13
TN #93	01/01/2010	pages 1, 7, 9, 12
TN #91	05/15/2009	pages 11-14

2. Intellectual Disabilities/Mental Retardation Waiver

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

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

3. AIDS Waiver

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

Services available to recipients of the AIDS Waiver include:

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

4. Technology-Assisted Individuals Waiver

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

The services provided under this waiver include:

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

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

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

The services provided under this waiver include:

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

6. Day Support Waiver for Individuals with Intellectual Disabilities/Mental Retardation

The Day Support Waiver for Individuals with *Intellectual Disabilities/Mental Retardation* (DS Waiver) is targeted to provide home and community-based services to individuals with mental retardation who have been determined to require the level of care provided in an ICF/MR. These individuals may currently reside in an ICF/MR or may be in the community at the time of assessment for DS Waiver services. Only those individuals on the urgent and non-urgent waiting lists for the *ID/MR* Waiver are considered for DS Waiver services. Individuals may remain on the *ID/MR* Waiver waiting list while receiving DS Waiver Services.

The services provided under this waiver include:

- day support
- prevocational services.

7. Alzheimer's Assisted Living Waiver

The Alzheimer's Assisted Living (AAL) Waiver is available only to individuals who are Auxiliary Grants (AG) recipients, have a diagnosis of Alzheimer's Disease or a related dementia, no diagnosis of mental illness or mental retardation, and who are age 55 or older. The AAL Waiver allows for the provision of services to individuals in approved assisted living facilities who, without the waiver, might require nursing home placement.

Individuals in this waiver do not have Medicaid eligibility determined as institutionalized individuals, and there are no post-eligibility requirements.

The services provided under the AAL waiver include:

- assistance with activities of daily living
- medication administration by licensed professionals.

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 *ID/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.

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M1420 Changes

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3. ***Intellectual Disabilities/Mental Retardation (ID/MR) Waiver*** Local Community Mental Health Services Boards (CSBs) and the Department of Rehabilitative Services (DRS) are authorized to screen individuals for the *ID/MR* waiver. Final authorizations for *ID/MR* waiver services are made by DBHDS staff.
4. **AIDS Waiver** Local and hospital screening committees or teams are authorized to screen individuals for the AIDS waiver.
5. **Individual and Family Developmental Disabilities Support (DD) Waiver** DMAS and the Virginia Health Department child development clinics are authorized to screen individuals for the DD waiver.
6. **Alzheimer's Assisted Living (AAL) Waiver** Local screening committees or teams and hospital screening committees or teams are authorized to screen individuals for the AAL waiver; however, a copy of the pre-admission screening is not required for the Medicaid eligibility record. Documentation of the verbal assurance by the screeners must be included in the case record.
7. **Day Support Waiver for Individuals with *Intellectual Disabilities/Mental Retardation (DS) Waiver*** Local CSB and DBHDS case managers are authorized to screen individuals for the DS waiver. Final authorizations for DS waiver services are made by DBHDS staff.

- D. **PACE** Local screening committees or teams and hospital screening committees or teams are authorized to screen individuals for PACE. If the individual is screened and approved for LTC, the committee/team will inform the individual about any existing PACE program that serves the individual's locality.

M1420.300 COMMUNICATION PROCEDURES

- A. **Introduction** To ensure that nursing facility/PACE placement or receipt of Medicaid CBC services are be arranged as quickly as possible, there must be prompt communication between screeners and eligibility staff.
- B. **Procedures**
1. **LDSS Contact** The LDSS agency should designate an appropriate staff member for screeners to contact. Local social services staff, hospital staff and DRS staff should be given the name and contact information for that person to facilitate timely communication between screeners and eligibility staff.
2. **Screeners** Screeners must inform the individual's eligibility worker when the screening process has been initiated and completed.

- 3. Eligibility Worker (EW) Action** The EW must inform both the individual and the provider once eligibility for Medicaid payment of LTC services has been determined. If the individual is found eligible for Medicaid and verbal or written assurance of approval by the screening committee has been received, the eligibility worker must give the LTC provider the enrollee's Medicaid identification number.

M1420.400 SCREENING CERTIFICATION

- A. Purpose** The screening certification authorizes the local DSS to determine financial eligibility using the more liberal rules for institutionalized individuals, including the 300% SSI covered group and the special rules for married institutionalized individuals with a community spouse. The screening certification is valid for one year.
- B. Exceptions to Screening** Pre-admission screening is NOT required when:
- the individual is a patient in a nursing facility at the time of application;
 - the individual received Medicaid LTC in one or more of the preceding 12 months and LTC was terminated for a reason other than no longer meeting the level of care;
 - the individual is no longer in need of long-term care but is requesting assistance for a prior period of long term care;
 - the individual enters a nursing facility directly from the EDCD/AIDS waiver or PACE;
 - the individual leaves a nursing facility and begins receiving EDCD/AIDS waiver services or enters PACE and a pre-admission screening was completed prior to the nursing facility admission; or
 - the individual enters a nursing facility from out-of-state.
- C. Documentation** If the individual has not been institutionalized for at least 30 consecutive days, the screener's certification of approval for Medicaid long-term care must be substantiated in the case record by one of the following documents:
- Medicaid Funded Long-term Care Service Authorization Form (DMAS-96) for nursing facilities, PACE and EDCD, Tech and AIDS Waivers (see Appendix 1);
 - Technology Assisted Waiver Level of Care Eligibility Form (see Appendix 2);
 - ID/MR Waiver Level of Care Eligibility Form (see Appendix 3);
 - DS Waiver Level of Care Eligibility Form (see Appendix 4); or
 - DD Waiver Level of Care Form (see Appendix 5).

Medicaid payment for CBC services cannot begin prior to the date the screener's certification form is signed and prior authorization of services for the individual has been given to the provider by DMAS or its contractor.

1. Nursing Facility/PACE

Individuals who require care in a nursing facility or elect PACE will have a DMAS-96 signed and dated by the screener and the supervising physician.

The "Medicaid Authorization" section will have a number in the box that matches one of the numbers listed under the "Pre-admission Screening" section. These numbers indicate which of these programs was authorized. Medicaid payment of PACE services cannot begin prior to the date the DMAS-96 is signed and dated by the supervising physician and prior-authorization of services for the individual has been given to the provider by DMAS.

2. EDCD Waiver

Individuals screened and approved for the EDCD waiver must have a DMAS-96 signed and dated by the screener and the physician.

If the individual elects consumer-directed services, DMAS or its contractor must give final authorization. If services are not authorized, the service facilitator will notify the LDSS, and the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

3. Tech Waiver

Individuals screened and approved for the Tech Waiver will have either a DMAS-96 signed and dated by the screener and physician, or a Technology Assisted Waiver Level of Care Eligibility Form signed and dated by a DMAS representative.

4. ID/MR Waiver Level of Care Eligibility Form

Individuals screened and approved for the ID/MR waiver will have the ID/MR Waiver Level of Care Eligibility Form signed and dated by the DBHDS representative. The ID/MR Waiver Level of Care Eligibility Form will include the individual's name, address and the date of DBHDS approval.

5. DS Waiver Level of Care Eligibility Form

Individuals screened and approved for the DS waiver will have the DS Waiver Level of Care Eligibility Form signed and dated by the DBHDS representative. The DS Waiver Level of Care Eligibility Form will include the individual's name, address and the date of DBHDS approval.

6. DD Waiver Level of Care Eligibility Form

Individuals screened and approved for the DD waiver will have the DD Waiver Level of Care Eligibility Form signed and dated by a DMAS Health Care Coordinator. The form letter will include the individual's name, address and the date of approval for waiver services.

D. Authorization for LTC Services

If the form is not available when placement needs to be made, verbal assurance from a screener or DMAS that the form approving long-term care will be mailed or delivered is sufficient to determine Medicaid eligibility as an institutionalized individual. However, the appropriate form must be received prior to approval and enrollment in Medicaid as an institutionalized individual.



COMMONWEALTH of VIRGINIA

Department of
Behavioral Health and Developmental Services
Post Office Box 1797
Richmond, Virginia 23218-1797

JAMES REINHARD
COMMISSIONER

Telephone (804) 786-3921
Voice/TDD (804) 371-8977
www.dbhds.virginia.gov

ID/MR Waiver Level of Care Eligibility Form

Name: _____

Address: _____

City: _____ VA. Zip Code: _____

Date of Approval by DBHDS: _____

This person has met the level of care requirements for Medicaid waiver services and needs a Medicaid eligibility determination completed. This person is authorized to have eligibility determined using the special institutional rules.

DBHDS Representative: _____

Date: _____

Phone: _____

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TN #94	09/01/2010	Table of Contents pages 13, 16, 18b, 19-22
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M1440.102 *INTELLECTUAL DISABILITIES*/MENTAL RETARDATION WAIVER

- A. General Description** The *Intellectual Disabilities*/Mental Retardation (*ID/MR*) Waiver program is targeted to provide home and community-based services to individuals with mental retardation and individuals under the age of six years at developmental risk who have been determined to require the level of care provided in an *intermediate care facility for the mentally retarded* (ICF/MR).
- B. Targeted Population** The targeted population groups of individuals who have been determined to require the level of care provided in an intermediate care facility for the mentally retarded are:
- individuals with diagnosis of *an intellectual disability* or mental retardation;
 - individuals under the age of six who are at developmental risk and who have been determined to require the level of care provided in an ICF/MR. At age 6, these individuals must be determined to be *intellectually disabled* or mentally retarded in order to continue to receive CBC waiver services.
- C. 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 individual were residing in a medical institution.
- The income limit used for this waiver is 300% of the current SSI payment standard for one person. 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.
- D. Services Available** Services available under the *ID/MR* waiver include:
- *day support*
 - *supported employment*
 - *residential support*
 - *therapeutic consultation*
 - *agency-directed and consumer-directed personal assistance services*
 - *agency-directed and consumer-directed respite care*
 - *nursing services*
 - *environmental modification*
 - *assistive technology*
 - *agency-directed and consumer-directed adult companion services*
 - *crisis stabilization*
 - *prevocational services*
 - *Personal Emergency Response System (PERS)*
 - *therapeutic consultation.*
- E. Assessment and Service Authorization** The individual's need for CBC is determined by the Community Mental Health Services Board (CSB) or Department of Rehabilitative Services (DRS) case manager after completion of a comprehensive assessment.

- nutritional supplements
- medical supplies and equipment not otherwise available under the Medicaid State Plan.

E. Assessment and Service Authorization

The initial assessment and development of the plan of care is conducted by DMAS staff.

The following entities are authorized to screen for the Technology-Assisted Individuals Waiver:

- DMAS Health Care Coordinator.

M1440.105 DAY SUPPORT WAIVER

A. General Description

The Day Support (DS) Waiver is targeted to provide home and community-based services to individuals with *intellectual disabilities* or mental retardation who have been determined to require the level of care provided in an ICF/MR. These individuals may reside in an ICF/MR or may be in the community at the time of the assessment for DS Waiver services.

B. Targeted Population

Only those individuals on the urgent and non-urgent waiting lists for the ID/MR Waiver are considered for DS Waiver services. Individuals may remain on the ID/MR Waiver waiting list while receiving DS Waiver Services.

C. 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 individual were residing in a medical institution.

The income limit used for this waiver is 300% of the current SSI payment standard for one person. 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.

D. Services Available

Services available under the DS Waiver include:

- day support
- prevocational services.

E. Assessment and Service Authorization

The individual's need for CBC is determined by the CSB or DBHDS case manager after completion of a comprehensive assessment. All recommendations are submitted to DBHDS staff for final authorization.

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

M1440.201 PERSONAL CARE/RESPITE 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 ID/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** AIDS Waiver patients may not be initially authorized to receive Case Management services alone. Case Management must be provided as an adjunct to the other direct waiver services. These other services are: personal care, nursing, nutritional supplements and respite care. An AIDS Waiver patient could, at some point after admission to the Waiver, be closed to a direct service and continue to receive Case Management.
- C. Who May Receive the Service** An individual must meet the AIDS Waiver criteria to qualify for Case Management services.

M1440.204 PRIVATE DUTY NURSING SERVICES

- A. What is Private Duty Nursing** Private Duty Nursing services are called "nursing services" in the *ID/MR* waiver. These services are offered to medically fragile patients who require substantial skilled nursing care. Patients receive nursing services from Registered Nurses or Licensed Practical Nurses. Services are offered as needed by the patient, but always exceed what is available through the Home Health program.
- For example, in the Technology-Assisted waiver, most patients receive 8 hours or more of continuous nursing services at least four times per week. AIDS waiver patients usually need this service in lieu of home health services for monitoring the administration of potent intravenous drugs. *ID/MR* Waiver patients may need the service for either routine nursing or in lieu of Home Health nursing.
- B. Relationship to Other Services** There are no requirements that other waiver services be or not be received.
- C. Who May Receive the Service** An individual must meet the AIDS waiver criteria, Technology-Assisted waiver criteria, or be eligible under the *ID/MR* waiver for nursing services. A Medicaid recipient who qualifies under EPSDT (Early & Periodic Screening, Diagnosis & Treatment) to receive private duty nursing services may also receive private duty nursing.

M1440.205 NUTRITIONAL SUPPLEMENTS

- A. What are Nutritional Supplements** Studies have indicated that the nutrition of a person with AIDS or HIV+ is one of the most important factors in maintaining their health and avoiding costly health care. Nutritional Supplements (enteral nutrition products) are provided through DME (durable medical equipment) providers for patients in the AIDS or Technology-Assisted waiver who have an identified nutritional risk. Nutritional supplements are ordered by the individual's physician to cover a six-month period and Medicaid payment is authorized by the pre-admission screener or DMAS.

- B. Relationship to Other Services** There are no requirements that other waiver services be or not be received.
- C. Who May Receive the Service** Individuals who qualify under the AIDS or Technology-Assisted waiver may receive nutritional supplements.

M1440.206 ENVIRONMENTAL MODIFICATIONS

- A. What is Environmental Modification** Environmental modification provides physical adaptations or modifications to the recipient's house or place of residence, work site or vehicle. The adaptations or modifications are needed to ensure the recipient's health or safety and enable him/her to live and function in a non-institutional setting.
- B. Relationship to Other Services** This service is available to patients who are receiving at least one other waiver service along with Case Management services.
- C. Who May Receive the Service** The service is available to individuals who qualify under the *ID/MR* waiver.

M1440.207 RESIDENTIAL SUPPORT SERVICES

- A. What is Residential Support** Residential Support services consist of training, assistance, and/or specialized supervision provided primarily in a recipient's home or in a licensed/certified residence considered to be his or her home. This cannot include room and board costs.
- These services can be provided in the individual's own home or in a licensed Adult Care Residence or with a certified Foster Care/Family Care provider. The services may be provided by the ACR, the foster family or by an external provider.
- B. Relationship to Other Services** This service cannot be offered to an individual who receives assisted living services in an ACR.
- C. Who May Receive the Service** This service is available to *ID/MR* Waiver patients.

M1440.208 PERSONAL ASSISTANCE SERVICES

- A. What is Personal Assistance Services** Personal Assistance services are available to recipients who do not receive Residential Support services, and for whom training and skills development are not primary objectives or are received in another service or program. Assistance is provided with bathing, dressing, eating, personal hygiene, activities of daily living, medication and/or other medical needs, and monitoring health status and physical condition.

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

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

M1440.209 ASSISTIVE TECHNOLOGY SERVICES

- A. What is Assistive Technology** Assistive Technology (AT) is any device or environmental modification that increases the independence, safety or comfort of an individual.

AT ranges from simple devices such as a jar opener or eyeglasses to complex devices such as a voice synthesizer or a powered wheelchair.

- B. Relationship to Other Services** This service is available only to persons who are receiving at least one other waiver service along with Case Management.

- C. Who May Receive the Service** This service is provided only to recipients of the *ID/MR* Waiver.

This service may be provided in residential and/or non-residential settings.

M1440.210 DAY SUPPORT SERVICES

- A. What is Day Support** Day Support services are provided primarily in non-residential settings, separate from the home or other community residence, to enable a person to acquire, improve, and maintain maximum functional abilities. This service includes a variety of training, support, and supervision. Prevocational training for patients who previously resided in a Medicaid-certified facility is included under this service.

- B. Relationship to Other Services** This service is available only to persons who are receiving at least one other waiver service along with Case Management.

- C. Who May Receive the Service** This service is available only to recipients of the DS and *ID/MR* waivers.

M1440.211 SUPPORTED EMPLOYMENT SERVICES

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

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

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

M1440.212 THERAPEUTIC CONSULTATION SERVICES

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

M1440.213 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

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

M1440.214 PREVOCATIONAL SERVICES

- A. What are Prevocational Services** Prevocational Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Prevocational services are provided to individuals who are not expected to be able to join in the

M1450 Changes

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TN #93	01/01/2010	Table of Contents pages 3, 17-18, 29 Appendix 2, page 1
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- have the penalty period, or the remaining time in the penalty period, divided between the spouses, or
- assign the penalty period or remaining penalty period to one of the two spouses.

When one spouse is no longer subject to the penalty, such as one spouse is no longer institutionalized or one spouse dies, the remaining penalty period applicable to **both** spouses must be applied to the remaining spouse.

EXAMPLE #18: Mr. A. enters a nursing facility and applies for Medicaid. Mrs. A. transfers an asset that results in a 36 month penalty period for Mr. A. 12 months into the penalty period, Mrs. A. enters a nursing facility and is eligible for Medicaid. The penalty period against Mr. A. still has 24 months to run. Because Mrs. A. is now in a nursing facility and a portion of the penalty period remains, the penalty period is reviewed. Mr. and Mrs. A. decide to have the penalty period divided between them. Therefore, both Mr. A. and Mrs. A. are ineligible for Medicaid payment of LTC services for 12 months beginning the first day of Mrs. A's Medicaid eligibility.

After 6 months, Mr. A. leaves the facility and is no longer institutionalized. Mrs. A. remains institutionalized. Because Mr. A is no longer subject to the penalty, the remaining total penalty period for the couple, 12 months (6 months for Mr. A. and 6 months for Mrs. A.), must be imposed on Mrs. A. If Mr. A. becomes institutionalized again before the end of the 12 months, the remaining penalty period is again reviewed and divided or applied to one spouse, depending on the couple's choice.

M1450.630 PENALTY PERIOD FOR TRANSFERS ON OR AFTER FEBRUARY 8, 2006

A. Policy

The policy in this section applies to actions taken on applications, renewals or changes processed on or after July 1, 2006 for transfers made on or after February 8, 2006. The DRA enacted significant changes to the implementation date of the penalty period. When the transfer is made prior to the request for Medicaid LTC, the penalty period does not begin until the individual is eligible for Medicaid LTC. Penalty periods are assessed for fractional portions of a month. The number of months is not rounded down; therefore, the penalty period may end on a day during the month.

B. Penalty Date

*The date that the penalty period begins for asset transfers made on or after February 8, 2006 is **not** based on the date of the transfer. When the transfer of an asset made on or after February 8, 2006, affects eligibility, the period of ineligibility for Medicaid payment for LTC cannot begin until the person would otherwise be eligible for the Medicaid payment of LTC services were a penalty period not being imposed.*

1. **Medicaid LTC Not Received at Time of Transfer** *If the individual is not receiving Medicaid-covered LTC services at the time of the asset transfer, the penalty period begins on the date the individual is eligible for Medicaid and would otherwise be eligible for the Medicaid payment of LTC services but for the application of the penalty period, as long as the date does not fall into another period of ineligibility imposed for any reason.*
 2. **Medicaid LTC Received at Time of Transfer** *If the individual is receiving Medicaid-covered LTC services either at the time of the asset transfer or at the time that the agency learns of the asset transfer, the penalty period begins the first day of the month following the month in which the asset transfer occurred.*
 3. **Penalty Periods Cannot Overlap** *When multiple asset transfers result in multiple penalty periods, the penalty periods cannot overlap. One penalty period must be completed prior to the beginning of the next penalty period.*
 4. **Nursing Facility** *If the individual in a nursing facility meets all Medicaid eligibility requirements, he is eligible for Medicaid payment of all other covered services.*
 5. **CBC** *If the individual has been screened and approved for or is receiving Medicaid CBC services, he cannot be eligible for Medicaid in the 300% of SSI covered group or for the Medicaid payment of LTC services in any other covered group.*
- C. Penalty Period Calculation**
- The penalty period is the number of months, including any fractional portion of a month that an individual will be ineligible for the Medicaid payment of LTC services.
- The period is calculated by taking the uncompensated value of the assets transferred on or after the look-back date, divided by the average monthly cost of nursing facility services to a private-pay patient in his locality at the time of the application for Medicaid. The remainder is divided by the daily rate (the monthly rate divided by 31).
- When the uncompensated value of an asset transfer is less than the monthly nursing facility rate, go to step #4 in E below to calculate the partial month penalty period.
- D. Average Monthly Nursing Facility Cost**
- See M1450.620.D for the average monthly nursing facility cost for the locality in which the individual is physically located at the time of application for Medicaid.
- E. Partial Month Transfer**
- The following example shows how to compute a penalty period for an uncompensated transfer that occurred on or after February 8, 2006 and involving a partial month.
- Example #19:** An individual makes an uncompensated asset transfer of \$30,534 in April 2006, the same month he applies for Medicaid. The uncompensated value of \$30,534 is divided by the average monthly rate of \$4,060 and equals 7.52 months. The full 7-month penalty period runs from

April 2006, the month of the transfer, through October 2006, with a partial penalty calculated for November 2006. The partial month penalty is calculated by dividing the partial month penalty amount (\$2,114) by the daily rate. The calculations are as follows:

Step #1 \$30,534.00 uncompensated value of transferred asset
 $\div 4,060.00$ avg. monthly nursing facility rate at time of application
 $= 7.52$ penalty period (7 full months, plus a partial month)

Step #2 \$ 4,060.00 avg. monthly nursing facility rate at time of application
 $\times 7$ seven-month penalty period
\$28,420.00 penalty amount for seven full months

Step #3 \$30,534.00 uncompensated value
 $- 28,420.00$ penalty amount for seven full months
\$ 2,114.00 partial month penalty amount

**C. Example #21
Partial
Compensation
Received**

Example #21: Ms. H. applied for Medicaid on November 2, 2004, after entering a nursing facility on March 15, 2004. On October 10, 2004, she transferred her non-home real property worth \$40,000 to her son and received no compensation in return for the property. Ms. H's Medicaid application was approved, but she was ineligible for Medicaid payment of long-term care services for 9 months beginning October 1, 2004 and continuing through June 30, 2005.

On December 12, 2004, the agency verified that Ms. H's son paid her \$20,000 for the property on December 8, 2004. The agency re-evaluated the transfer and determined a remaining uncompensated value of \$20,000 and a penalty period of 4 months, beginning October 1, 2004, and continuing through January 31, 2005.

The \$20,000 payment must be evaluated as a resource in determining Ms. H.'s Medicaid eligibility for January 2005.

M1450.700 CLAIM OF UNDUE HARDSHIP

A. Policy

The opportunity to claim an undue hardship must be given when the imposition of a penalty period affects Medicaid payment for LTC services. An undue hardship may exist when the imposition of a transfer of assets penalty period would deprive the individual of medical care such that the individual's health or life would be endangered or he would be deprived of food, clothing, shelter, or other necessities of life. An undue hardship may be granted when documentation is provided that shows:

- that the assets transferred cannot be recovered, and
- that the immediate adverse impact of the denial of Medicaid coverage for payment of LTC services due to the uncompensated transfer would result in the individual being removed from the institution or becoming unable to receive life-sustaining medical care, food, clothing, shelter or other necessities of life.

Applicants, recipients, or authorized representatives may request an undue hardship evaluation. Additionally, the Deficit Reduction Act of 2005 authorized nursing facilities to act on behalf of their patients, when necessary, to submit a request for undue hardship. The nursing facility must have written authorization from the recipient or his authorized representative in order to submit the claim of undue hardship.

A claim of undue hardship can be made only by or on behalf of an individual for which there is an open Medicaid case or pending Medicaid application. An undue hardship claim cannot be made on a denied Medicaid application.

B. Procedures

If the individual chooses to make a claim of an undue hardship, documentation regarding the transfer and the individual's circumstances

must be sent to the Department of Medical Assistance Services (DMAS) for an undue hardship determination **prior** to the eligibility worker taking action to impose a penalty period.

The individual has the burden of proof and must provide written evidence to clearly substantiate what was transferred, the circumstances surrounding the transfer, attempts to recover the asset or receive compensation, and the impact of the denial of Medicaid payment for LTC services.

1. Eligibility Worker

The eligibility worker must inform the individual of the undue hardship provisions and, if an undue hardship is claimed, send the claim and supporting documentation to DMAS for evaluation.

The eligibility worker must send a letter to the individual informing him of each asset transfer and the corresponding penalty period, as well as the right to claim an undue hardship. An Asset Transfer Hardship Claim Form, available on the VDSS local agency intranet at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi, must be included with the letter. The Asset Transfer Hardship Claim Form serves as the request for an undue hardship evaluation.

a. Undue Hardship Claimed - Required Documentation

When requesting an undue hardship, the individual must provide the following documentation:

- the reason(s) for the transfer;
- attempts made to recover the asset, including legal actions and the results of the attempts;
- notice of pending discharge from the facility or discharge from CBC services due to denial or cancellation of Medicaid payment for these services;
- physician's statement that inability to receive nursing facility or CBC services would result in the applicant/recipient's inability to obtain life-sustaining medical care;
- documentation that individual would not be able to obtain, food, clothing or shelter;
- list of all assets owned and verification of their value at the time of the transfer if the individual claims he did not transfer resources to become Medicaid eligible; and
- documents such as deeds or wills if ownership of real property is an issue.

b. 10 Days to Return Undue Hardship Claim

The individual must be given 10 calendar days to return the completed form and documentation to the local agency. *If the form and documentation are not returned within 10 calendar days, the penalty period must be imposed.*

c. Documentation for DMAS

If an undue hardship is claimed, the eligibility worker must send to DMAS:

- a copy of the undue hardship claim form
- a description of each transfer:
 - what was transferred
 - parties involved and relationship
 - uncompensated amount
 - date of transfer
- the penalty period(s)
- a brief summary of the applicant/recipient's current eligibility status and living arrangements (nursing facility or community), and
- other documentation provided by the applicant/recipient

Send the documentation to DMAS at the following address:

DMAS, Division of Policy and Research
Eligibility Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

A copy of all documentation submitted with the undue hardship claim must be retained in the case record.

d. When Applicant/Recipient Was Victim

If the applicant/recipient was a victim of an individual who is not the individual's attorney in fact, guardian, conservator or trustee and undue hardship is claimed, the **agency** must provide a statement documenting the facts and what actions were taken by the agency with regard to their findings. If the transfer was by a court-appointed guardian or conservator, documentation of any bond insurance that would cover the loss must be provided.

e. Undue Hardship Not Claimed or Not Granted by DMAS

If undue hardship is not claimed or if a penalty period must be imposed per DMAS, follow the procedures in M1450.800 through M1450.830 for notifying the individual and DMAS of the action. The individual must be

informed that a denial of a claim for undue hardship may be appealed in accordance with the provisions of 12 VAC 30-110. If the individual meets all other eligibility requirements, he is eligible for Medicaid payment of all covered services other than LTC.

2. DMAS

DMAS will review the documentation provided with the undue hardship claim to determine if an undue hardship may be granted and send written notification to the eligibility worker. *If additional documentation is needed to support the Undue Hardship claim, DMAS will notify the agency and provide a time frame for submitting the documentation.* A copy of the decision must be retained in the individual's case record.

3. Subsequent Claims

If DMAS is unable to render a decision about a claim of undue hardship because sufficient supporting documentation was not submitted, the claim must be denied. No further decision on a claim of undue hardship related to the same penalty period will be made by DMAS, should the individual reapply for Medicaid coverage of LTC services.

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 notice to the individual must contain the following:*

1. Notice Includes Penalty Period

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.

2. Individual In Facility - Eligible

An individual in a nursing or other medical facility continues to meet the definition of an institutionalized person. If the individual meets all other Medicaid eligibility requirements, he is eligible for Medicaid in the 300% SSI covered group, except for payment for LTC services.

3. Individual Not in Facility - Not Eligible

*An individual outside a medical facility (i.e. living in the community) **does not** meet the definition of an institutionalized person if he is not receiving Medicaid covered CBC services. Therefore, an individual for whom a penalty period is imposed cannot be eligible for Medicaid unless the individual is eligible for Medicaid outside the 300% SSI covered group.*

B. Notice Contents

The Notice of Action on Medicaid sent to the individual must specify that:

- 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 on (date/dates);
- the penalty period may be shortened if compensation is received.

The notice must also specify that either:

- the individual is eligible for Medicaid coverage of services other than nursing facility or waiver services beginning (the appropriate date); *or*
- *the individual is ineligible for Medicaid in any covered group, citing M1450.810 A.3, above.*

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.

M1460 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/2010	page 4a
TN #93	01/01/2010	pages 28, 35
TN #91	05/15/2009	pages 23, 24

- provide inflation protection:
 - under 61 years of age, compound annual inflation protection,
 - 61 to 76 years of age, some level of inflation protection, or
 - 76 years or older, inflation protection may be offered, but is not required.

Obtain a copy of the Partnership Disclosure Notice and the LTC Partnership Certification Form (See M1460, Appendices 1 and 2) for verification of the requirements noted above. Also, verification of the amount of benefit paid to or on behalf of an individual as of the month of application must be obtained. This can be found on the Explanation of Benefits statement or by calling the insurance carrier.

Partnership Policies that are issued in other states may or may not meet Virginia's requirements. Please contact your Medicaid Consultant to verify reciprocity with Virginia.

Verifications and documentation regarding a Partnership Policy must be kept with other permanent verifications in the case record.

See M1470.820 for data entry procedures for MMIS.

M1460.200 DETERMINATION OF COVERED GROUP

A. Overview

An individual in LTC who meets the Medicaid non-financial eligibility requirements in M1410.010 must also meet the requirements of at least one covered group in order to be eligible for Medicaid and Medicaid payment of LTC services.

1. Covered Groups Eligible for Long Term Care Services

The covered groups whose benefit packages include long-term care services are the following groups:

- a. All categorically needy (CN) covered groups.
- b. All categorically needy non-money payment (CNNMP) covered groups.
- c. ABD with income \leq 80% FPL (ABD 80% FPL).
- d. All medically indigent (MI) Families & Children (F&C) covered groups:
 - pregnant women and newborns under age 1 year,
 - children under age 19.
- e. All medically needy (MN) covered groups; however, Medicaid will not pay for the following services for MN individuals:
 - *services in an intermediate care facility for the mentally retarded (ICF-MR),*
 - *services in an institution for the treatment of mental disease (IMD),*
 - *Intellectual Disabilities/Mental Retardation (ID/MR) Waiver services, and*
 - *Individual and Family Development Disability Support (DD) Waiver services.*

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M1470 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/2010	Table of Contents pages 1, 1a, 3, 3a, 11, 12, pages 19, 20, 24, 28, 31
TN #93	01/01/2010	pages 9, 13, 19-20, 23, 43, 44
TN #91	05/15/2009	Table of Contents pages 1-56 Appendix 1

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APPENDIX

Sample Notice of Obligation for LTC Costs Generated by MMIS Appendix 1 1

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 is the only entity with the authority to take action when residents do not pay their patient pay amount. If a resident, or his authorized representative is negligent in paying his patient pay amount to the provider, the provider will provide written documentation regarding the requirement to pay the patient pay amount to the resident or authorized representative and follow the provider’s collection procedures to collect the funds. The provider will report the resident’s negligence in paying the patient pay amount to the LDSS.

The provider’s failure to collect the patient pay, or the patient’s failure to pay the patient pay, does not *itself* affect the patient’s Medicaid eligibility. However, the

EW must review the patient's resources each month to determine if the resources are within the Medicaid limit.

If the individual resides in a nursing facility and the above attempts to collect the patient pay amount are unsuccessful, DMAS has advised that the facility may take one of the following options:

1. Facility Option #1

The facility will notify the LDSS no later than 120 days from the due date of the payment. The facility will include in this notification a copy of the third collection statement, a written notification of the situation, documentation of contacts made with the resident or authorized representative, and the reasons why payment has not been made.

The LDSS will take the following steps:

- *Upon receipt of the written notice from the facility, the local DSS will review the case to determine if the individual's resources are within Medicaid eligibility limits or if a transfer of assets has occurred.*
- *If the individual alleges that he does not receive sufficient income to pay his patient pay, the eligibility worker will review the patient pay amount and make any necessary adjustments.*

2. Facility Option #2

Discharge or transfer the resident, including transferring the resident within the facility, except as prohibited by the Virginia State Plan for Medical Assistance Services.

Prior to discharge or transfer, the facility must provide reasonable and appropriate notice of the required patient pay, and the resident or authorized representative must be given at least 30 days written notice prior to the discharge or transfer, which shall include appeal rights. If the resident or authorized representative does not agree with this action, he may submit an appeal request to DMAS. The individual will be allowed to continue residing in the facility during the appeal process.

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.

- 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.
6. ***Survivor's
Benefit Plan
Deductions
from Military
Pensions*** *Any portion of a military retiree's pension that is withheld as a contribution to participate in the Survivor's Benefit Plan (SBP) is not income for patient pay. To participate in SBP in conjunction with their retirement, military members must elect to receive reduced retirement pay for their lifetime so that a percentage of their retirement pay can continue to be paid to their survivors following their death. Once SBP is elected, retirees cannot discontinue the deductions from their pensions.*

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."

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 *beyond the month of admission into the nursing facility.*

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. *Deduct PDP co-pays incurred during the month of admission to the nursing facility only.*

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. *Deduct PDP co-pays incurred during first month of Medicaid eligibility in the nursing facility only.*

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.

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, Intellectual Disabilities/Mental Retardation (ID/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,
- ID/MR Waiver,
- Technology-Assisted Individuals Waiver
- DD Waiver, and
- DS Waiver

The PMA is:

- January 1, 2010 through December 31, 2010: \$1,112 (no change for 2010)
- January 1, 2009 through December 31, 2009: \$1,112.

Contact a Medical Assistance Program Consultant for the PMA in effect for years prior to 2009.

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 **filig** 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, ID/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:
- a. for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (\$2,022 *in 2010*) per month.
 - b. for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI (\$1,348 *in 2010*) 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:

\$ 1,112.00 CBC basic maintenance allowance
 + 928.80 special earnings allowance
 \$ 2,040.80 PMA

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.

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.3 for the procedures used to deduct Medicare Part D prescription drug co-pays for patients who have Medicare.

DMAS approval is not required for deductions of noncovered services from patient pay when the individual receives CBC services, regardless of the amount of the deduction.

**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.

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

*When the individual receives CBC services, DMAS approval is **not required** for deductions of noncovered services from patient pay, regardless of the amount of the 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.

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 (AG) 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 noncovered expenses listed in M1470.430 C.2 are allowable for PACE recipients. *DMAS approval is not required for deductions of noncovered services from patient pay for PACE recipients, regardless of the amount of the deduction.*

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.

M1480 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/2010	pages 64, 66, 69, 70
TN #93	01/01/2010	Table of Contents, page ii pages 3, 8b, 18, 18c, 20a pages 21, 31, 50, 51, 66, pages 69, 70, 93 Appendix 4 was removed.
Update (UP) #1	07/01/2009	page 66
TN # 91	05/15/2009	pages 67, 68 pages 76-93

\$1,920.00 total monthly income
 - 20.00 general income exclusion
 1,900.00 countable income
 - 216.67 MNIL for 1 month for 1 person in Group I
 \$1,683.33 spenddown liability

The facility's private rate is \$58 per day; the Medicaid rate is \$45 per day.
 The facility Medicaid rate for the admission month is calculated as follows:

\$ 45 Medicaid per diem
 x 27 days
 \$1,215 Medicaid rate admission month

Her spenddown liability of \$1,683.33 is greater than the Medicaid rate of \$1,215. Therefore, she is not eligible until she has actually incurred medical bills that equal or exceed her spenddown liability in January. The worker is processing the application on February 2. Mrs. Was was in the facility from January 5 through January 31. The facility's private cost is calculated:

\$ 58 private per diem
 x 27 days in facility in January
 \$1,566 private cost of care in January

The private cost of care for January, \$1,566, is less than Mrs. Was's spenddown liability of \$1,683.33. Therefore, her spenddown eligibility for January must be determined on a daily basis. The prospective budget period is January 1 through January 31, 2000. Since she had a break in spenddown eligibility, only the current payments she is making on the August 1998 bills can be deducted from her spenddown liability. She paid the hospital \$50 and the physician \$50 each (\$100 total) on January 5, 2000. Her spenddown eligibility is determined:

\$1,683.33 prospective spenddown liability
 - 388.00 carry-over expense (balance of 11-13-99 outpatient expense)
 - 100.00 current payment Aug, 1998 hospital & physician bills 1-1-00
 1,195.33 spenddown balance on 1-1-00
 - 812.00 14 days private rate @ \$58 per day (1-5 through 1-18)
 383.33 spenddown balance on 1-19-00
 - 348.00 6 days private rate @ \$58 per day (1-19 through 1-23)
 35.33 spenddown balance on 1-23-00
 - 58.00 private cost of care for 1-24-00
 \$ 0 spenddown balance on 1-24-00

Mrs. Was met her spenddown on January 24, 2000. On February 3, the worker enrolls Mrs. Was in Medicaid as medically needy with eligibility begin date 1-1-2000 and end date 1-31-2000. The worker sends her a "Notice of Action on Medicaid" stating her Medicaid coverage dates and asking her to bring or send in her medical bills for February if she wants her *February spenddown eligibility evaluated*.

After eligibility is established, the usual reporting and notification processes apply. Send the “Notice of Action on Medicaid” for the month(s) during which the individual establishes Medicaid eligibility. MMIS will generate the “Notice of Obligation for LTC Costs” and it will be sent to the individual or his authorized representative.

M1480.400 PATIENT PAY

- A. Introduction** This section contains the policy and procedures for determining an institutionalized spouse’s (as defined in section M1480.010 above) patient pay in all covered groups.
- B. Married With Institutionalized Spouse in a Facility** For a married LTC patient with an institutionalized spouse in a facility, **NO** amount of the patient’s income is deducted for the spouse’s needs in the patient pay calculation.

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

- A. Introduction** This subsection contains the standards and their effective dates that are used to determine the community spouse’s and other family members’ income allowances. The income allowances are deducted from the institutionalized spouse’s gross monthly income when determining the monthly patient pay amount. Definitions of these terms are in section M1480.010 above.
- B. Monthly Maintenance Needs Standard**

\$1,821.25	7-1-09	<i>(no change for 2010)</i>
\$1,750.00	7-1-08	
- C. Maximum Monthly Maintenance Needs Allowance**

\$2,739.00	1-1-10	<i>(no change for 2010)</i>
\$2,739.00	1-1-09	
- D. Excess Shelter Standard**

\$546.38	7-1-09	<i>(no change for 2010)</i>
\$525.00	7-1-08	
- E. Utility Standard Deduction (SNAP Stamps Program)**

\$302	1 - 3 household members	10-1-09
\$381	4 or more household members	10-1-09
\$290	1 - 3 household members	10-1-08
\$365	4 or more household members	10-1-08

M1480.420 PATIENT PAY FOR ABD 80% FPL AND 300% SSI INSTITUTIONALIZED SPOUSE

- A. Policy** After a 300% SSI or ABD 80% FPL institutionalized spouse has been found eligible for Medicaid, determine his patient pay (post-eligibility treatment of income).

\$875 gross earned income
- 75 first \$75 per month
800 remainder
± 2
400 ½ remainder
± 75 first \$75 per month
\$475 which is > \$190

His personal needs allowance is calculated as follows:

\$ 40.00 basic personal needs allowance
+190.00 special earnings allowance
+ 17.50 guardianship fee (2% of \$875)
\$247.50 personal needs allowance

**2. Medicaid CBC
Waiver
Services and
PACE**

a. Basic Maintenance Allowance

Deduct the appropriate maintenance allowance for one person as follows:

- 1) For the Elderly or Disabled with Consumer Direction Waiver (EDCD Waiver), *Intellectual Disabilities/Mental Retardation (ID/MR)* Waiver, Technology-Assisted Individuals Waiver, Individual and Family Developmental Disabilities Support (DD) Waiver, Day Support (DS) Waiver or PACE:

- January 1, 2010 through December 31, 2010: \$1,112 (no change for 2010).
- January 1, 2009 through December 31, 2009: \$1,112.

Contact a Medical Assistance Program Consultant for the SSI amount in effect for years prior to 2009.

- 2) For the AIDS Waiver: the personal maintenance allowance is equal to 300% of the SSI limit for one person (\$2,022).

b. Guardian Fee

Deduct the actual fee a guardian or conservator charges, up to a maximum of 5% of the patient's actual gross income (including amounts not counted as income and excluded amounts) for guardianship fees, IF:

- the patient has a legally appointed guardian or conservator AND
- the guardian or conservator charges a fee.

Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

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

c. Special Earnings Allowance For EDCD, DD, DS and ID/MR Waivers

[EXAMPLE #19 was deleted]

For EDCD, DD, DS and ID/MR Waivers, deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

- 1) for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (\$2,022 in 2010) 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 in 2010) per month.

The total of the basic maintenance allowance, the guardianship fee and the special earnings allowance cannot exceed 300% SSI.

EXAMPLE #20: (Using January 2000 figures)

A working patient in the ID/MR Waiver is employed 18 hours per week. He has gross earnings of \$928.80 per month and SS of \$300 monthly. His special earnings allowance is calculated first:

\$ 928.80	gross earned income
- 1,024.00	200% SSI maximum
\$ 0	remainder

\$928.80 = special earnings allowance

His personal maintenance allowance is calculated as follows:

\$ 512.00	maintenance allowance
+ 928.80	special earnings allowance
\$1,440.80	personal maintenance allowance

M1510 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/2010	Pages 2a, 8-8a
TN #93	01/01/2010	page 6
Update (UP) #2	08/24/2009	page 11
TN #91	05/15/2009	page 14

spenddown period, and may also include months in which he is eligible as CN, CNNMP or MI.

D. Verification

The applicant must verify all eligibility requirements in a retroactive month in order to be eligible for Medicaid coverage in that month.

An individual who provides proof of application for an SSN, after he applies for medical assistance, meets the application for SSN requirement in the three months retroactive to his medical assistance application.

If the applicant fails to verify any required eligibility factor for a retroactive month, coverage **for that month** must be denied because of failure to verify eligibility. If he verifies all eligibility factors for the other months in the retroactive period, he may be eligible for CN, CNNMP or MI retroactive coverage for those months.

EXAMPLE #1: Ms. A applied for Medicaid for herself and her children on July 8. She reported receiving a Medicaid covered service in each retroactive month. The retroactive period is April 1 through June 30. She currently receives Unemployment Compensation; she lost her job in May. She provided all required verification for May and June, but did not provide income verification for April. Their application was approved for MI Medicaid coverage beginning May 1; April coverage was denied because of failure to verify income for April.

**3. Spenddown
Enrollees**

Medicaid entitlement ends on the last day of the last month in the spenddown budget period, unless the individual's or family's circumstances change before that date.

**C. Ongoing
Entitlement After
Resources Are
Reduced**

When an applicant has excess resources throughout the application month, he is not eligible for Medicaid for the month of application. An applicant who reduces excess resources during the month of application or a subsequent month before action is taken on the application may become eligible in the month in which the value of his resources is reduced to, or below, the Medicaid resource limit. In order to reduce resources, the resources must actually be expended and the expenditure documented. (For example: a receipt, a canceled check, or a bank statement).

Reduction of resources is an asset transfer and must be evaluated under asset transfer policy (subchapter M1450).

When excess resources are reduced, entitlement to ongoing Medicaid may begin no earlier than the first day of the month in which the resources were reduced to the Medicaid limit. When retroactive coverage is requested, policy in M1510.101 above must be followed.

M1510.103 DISABILITY DENIALS

A. Policy

When an individual concurrently applies for SSI or SS and Medicaid as disabled, and either the DDS or the Social Security Administration (SSA) denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.

When an individual applies for Medicaid as disabled or concurrently applies for SS/SSI and Medicaid as disabled, and DDS denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.

B. Procedures

**1. Subsequent
SSA/SSI
Disability
Decisions**

The SSA disability decision takes precedence over a DDS decision (DDS will make a decision before SSA if SSA does not take action within the 90-day Medicaid application processing time). If SSA denies disability and the decision is appealed and subsequently reversed, reopen and re-evaluate the denied Medicaid application.

**2. Use Original
Application**

The original application is used as long as the application was denied because the individual was not disabled and the subsequent disability onset date is within 90 days of the application.

3. Entitlement

If the re-evaluation determines that the individual is eligible, *the individual's Medicaid entitlement is based on the Medicaid application date including the retroactive period if all eligibility requirements were met during the retroactive period. However, eligibility as a disabled individual*

cannot begin prior to the disability onset date when the disability onset date falls after the application date.

**4. Redetermination
Required When
More Than 12
Months Have
Passed**

If, based upon the re-evaluation, the individual is determined to be eligible and more than 12 months have passed since the application was filed, complete a redetermination to determine whether or not the individual remains eligible.

5. Spenddown

*If, based upon the re-evaluation, the individual is determined **not** eligible but met the requirements for placement on a spenddown in chapter M13, he is placed on only **one** six-month spenddown period beginning with the month of application. The individual is not placed on additional spenddown periods to cover the disability appeal period unless another Medicaid application was filed during the disability appeal period.*

M1510.104 FOSTER CARE CHILDREN

A. Policy

Entitlement begins the first day of the month of commitment or entrustment IF a Medicaid application is filed within 4 months of the commitment or entrustment date.

If the Medicaid application is filed more than 4 months after entrustment or commitment, entitlement begins the first day of the application month if retroactive coverage is NOT requested.

**B. Retroactive
Entitlement**

If the Medicaid application is filed within 4 months of entrustment or commitment, retroactive eligibility exists only if the child met another covered group and all other Medicaid eligibility requirements in the

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M1520 Changes

Changed With	Effective Date	Pages Changed
TN #94	9/01/2010	Table of Contents Pages 3, 4b, 5, 6-6a, 10 Appendix 1 was removed.
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Update (UP) #2	08/24/2009	pages 1, 2, 13, 14, 17, 18
Update (UP) #1	07/01/2009	page 3

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**D. Covered Group
Changes**

1. Newborn Child

When a child is born to a Medicaid-eligible woman (including an emergency services alien certified for Medicaid payment for labor and delivery), the only information needed to enroll the child in Medicaid (Child Under One covered group) is the child's name, gender and date of birth.

This information may be reported through any reliable means, such as the hospital where the child was born, the medical practitioner, or the mother's managed care organization. The agency may not require that only the mother make the report.

An eligibility determination for a child born to a Medicaid eligible pregnant woman (including an emergency services alien certified for Medicaid payment for labor and delivery) is not required until the month in which the child turns one year old, unless there is an indication that the child no longer meets the Virginia residency requirements in M0230. If the child continues to reside in Virginia, an application and an eligibility determination must be completed prior to MMIS cut-off in the month the child turns one year old.

**2. Child Turns
Age 6**

When a child who is enrolled as an MI child turns age 6, the child's Aid Category (AC) in MMIS will automatically be changed to 092 or 094. No action is required when the child is enrolled as AC 092. If the child is enrolled as AC 094, a partial review must be completed to determine if the child has creditable health insurance coverage. If the child does not have creditable health insurance, no additional action is required. If the child has creditable health insurance, the eligibility worker must cancel the child's enrollment in AC 094 effective the end of the month and reinstate coverage in AC 092 effective the first day of the following month. Do not use change transactions to move a child to or from AC 094.

**3. SSI Medicaid
Enrollee
Becomes a
Qualified
Severely
Impaired
Individual
(QSII) –
1619(b)**

When an SSI Medicaid enrollee loses eligibility for an SSI money payment due to receipt of earned income, continued Medicaid eligibility under the Qualified Severely Impaired Individual (QSII) -1619(b) covered group may exist. A partial review to determine the individual's 1619(b) status via the State Verification Exchange System (SVES) *or* the State Online Query-Internet system (SOLQ-I).

To identify a 1619(b) individual, check the "Medicaid Test Indicator" field on the SOLQ-I or SVES screen. If there is a code of A, B, or F, the individual has 1619(b) status. The eligibility worker must change the AC to the appropriate AC.

complete them for another program under which he is receiving benefits. These forms are available on the intranet at:
<http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.

B. Renewal Requirements and Time Standard

The agency must make all reasonable efforts to obtain relevant information from Medicaid files and other sources (subject to confidentiality requirements) in order to conduct eligibility renewals.

An evaluation of the information used to determine continued eligibility must be completed and included in the case record. The enrollee must be informed of the findings of the renewal and the action taken using the Notice of Action when continued eligibility exists. The Advanced Notice of Proposed Action must be used when there is a reduction of benefits or termination of eligibility. Renewals must be completed prior to cut-off in the 12th month of eligibility.

1. Ex Parte Renewal Process

The agency must utilize on-line systems information verifications that are available to the agency without requiring verifications from the individual or family and make efforts to align renewal dates for all programs. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps) and TANF records, some wage and payment information, information from SSA through the SVES, *SOLQ-I*, SDX and Bendex, and child support and child care files.

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

2. Income Verification Required

Income verification no older than 6 months old may be used unless the agency has reason to believe it is no longer accurate. It is not necessary to retain a copy of verifications of income in the case record. If a copy is not retained, the worker must document the date and method used to obtain the information (viewed, telephone call, etc.), the type of verification, the source and a description of the information.

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

3. Renewal For SSI Recipient

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

- 4. Coordination With Other Benefit Programs**

When an ongoing F&C Medicaid enrollee applies for SNAP or TANF, the income information obtained for the application can be used to complete an early Medicaid renewal and extend the Medicaid renewal to coincide with the Food Stamp certification period. However, failure to complete an early renewal must not cause ineligibility for Medicaid.
 - 5. Medicaid Renewal Form Required**

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

If the enrollee's SSN has not been assigned by renewal, the worker must obtain the enrollee's assigned SSN at renewal in order for Medicaid coverage to continue. See subchapter M0240 for detailed procedures for obtaining the SSN.
 - 7. *Renewal Not Completed***

If information necessary to redetermine eligibility is not available through online information systems that are available to the agency and the enrollee has been asked but has failed to provide the information, the renewal must be denied and the coverage cancelled due to the inability to determine continued eligibility.
 - 8. *Action Taken Before Cutoff***

When the enrollee fails to return the renewal form and verifications by the requested date and cutoff falls on a weekend or holiday, cancel the individual's coverage on the last business day before Medicaid cutoff, and send advance notice of the cancellation to the enrollee. However, if the early cancel action is taken, LDSS must re-open the renewal if the individual provides the necessary information by the last day of the month in which the renewal is due.

If the individual's renewal is re-opened and he is determined eligible, the LDSS must reinstate the individual's coverage and send a notice to the individual notifying him of the reinstatement and continued coverage.
- C. Special Requirements for Certain Covered Groups**
- 1. Pregnant Woman**

Do not initiate a renewal of eligibility of an MI pregnant woman, or a pregnant woman in any other covered group, during her pregnancy. Eligibility in a pregnant woman covered group ends effective the last day of the month in which the 60th day following the end of her pregnancy occurs.

When eligibility in a pregnant woman covered group ends, determine if the woman meets the definition for another Medicaid covered group (see

M0310.002). If the woman meets the definition of a full-benefit covered group, determine if an ex parte renewal can be completed or if a renewal form is required and take appropriate action.

If the woman does not meet the definition and/or the income requirements for another full-benefit covered group, she may be eligible for the limited benefit family planning services covered group, Plan First. If the worker manually cancels the pregnant woman's Medicaid coverage before cut-off in the 60th-day month, a Plan First Brochure or a Plan First Fact Sheet, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>, must be included with the Advance Notice of Proposed Action. Eligibility for Plan First is not determined unless the woman submits a Plan First application.

Do not use change transactions to move an individual between full and limited coverage.

**2. Plan First (FPS)
Review
Requirements**

Effective January 1, 2008, a Plan First application/renewal form must be filed for individuals (men and women) who request Medicaid coverage for family planning services only (see M0320.302). The application/renewal form is available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.

The ex parte renewal process cannot be used for this covered group.

**3. Newborn Child
Turns Age 1**

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

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

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

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

When an enrolled FAMIS Plus child no longer meets the MI income limits, evaluate the child for the Family Access to Medical Insurance Security Plan (FAMIS) using the eligibility requirements in chapter M21. If the child is eligible for FAMIS, send the family an Advance Notice of Proposed Action that Medicaid will be cancelled effective the last day of the month in which the 10-day advance notice expires and the FAMIS coverage will begin the first day of the month following the Medicaid cancellation.

Use cancel reason “042” when the child loses eligibility in Medicaid and is reinstated in FAMIS and there is no break in coverage.

Do not use change transactions to move a child between Medicaid and FAMIS. If the child is not eligible for FAMIS, the worker must provide an opportunity for the child to be evaluated as medically needy prior to sending an advance notice and canceling the child’s Medicaid coverage.

**5. FAMIS Plus
Child Turns Age
19**

When a FAMIS Plus child turns age 19, redetermine the child's continuing Medicaid eligibility in other covered groups.

If information in the case record indicates that the child is disabled or may be disabled, verify the child’s SSI benefits through SVES *or* SOLQ-I. If the child does not receive SSI, complete a referral to Disability Determination Services (DDS) following the procedures in M0310.112. The referral to DDS should be made at least 90 calendar days prior to the child’s 19th birthday.

2. Death of Recipient

The eligibility worker must take the following action when it is determined that an enrollee is deceased:

If the enrollee has an SSN, the worker must verify the date of death. The worker must run a SVES *or* SOLQ-I request to verify the date of death. SVES will display an “X” and the date of death in the “SSN VERIFICATION CODE” field on Screen 1.

If the recipient does not have an SSN, or if SOLQ-I or SVES does not return information showing that the recipient is deceased, contact the parent/caretaker relative or authorized representative to obtain the date of death. Information from a medical professional/facility is also acceptable.

The worker must document the case file. Send adequate notice of cancellation to the estate of the enrollee at the enrollee’s last known address and to any authorized representative(s) using the “Notice of Action on Medicaid.”

Cancel coverage in MMIS using cancel code “001.” The effective date of cancellation is the date of death.

3. End of Spenddown Period

When eligibility terminates at the end of a six-month spenddown period, advance notice is not required. The individual is notified of the limited period of spenddown eligibility on the Notice of Action sent at the time the spenddown application is approved. Explanation of this limitation and information relative to re-application is provided at the time of the spenddown eligibility determination and enrollment.

M1520.402 CANCELLATION ACTION OR SERVICES REDUCTION

A. Introduction

1. MMIS Transaction

An enrollee’s coverage must be canceled in MMIS prior to the date of the proposed action. The change to the MMIS enrollee file must be made after system cut-off in the month the proposed action is to become effective. For example, if the Notice of Action specifies the intent to cancel coverage on October 31, a change to MMIS is made prior to cut-off in October.

In the event the proposed action is not taken, the enrollee’s coverage must be immediately reinstated. If the enrollee files an appeal prior to the proposed date of action, the DMAS Appeals Division will notify the agency if the enrollee’s coverage should be reinstated.

CHAPTER M17

MEDICAID FRAUD AND *NON-FRAUD* RECOVERY

Virginia DSS, Volume XIII

M17 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/10	Title Page Table of Contents pages 1-7 Appendix 1 Appendix 2
TN #93	01/01/10	page 3

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M1700 MEDICAID FRAUD AND NON-FRAUD RECOVERY

M1700.100 INTRODUCTION

A. Administering Agency The Department of Medical Assistance Services (DMAS) *investigates and accepts referrals regarding* fraudulent and *non-fraudulent* erroneous payments made by the Medicaid Program. DMAS *has the authority to* recover any payment erroneously made for services received by a Medicaid recipient or former Medicaid recipient. Recovery *may* be made from the recipient or the recipient's income, assets, or estate, unless such property is otherwise exempted from collection efforts by State or Federal law or regulation.

B. Utilization Review Recipients' utilization of all covered services is monitored regularly by DMAS. Whenever utilization of services is unusually high, claims for services are reviewed for medical necessity. If some services are *determined not to be* medically necessary, the recipient will be contacted by the DMAS Recipient Monitoring Unit.

DMAS also reviews hospital claims prior to payment to determine if the 21-day limit is exceeded or if the length of stay regulations are met. All provider claims are reviewed and audited after payment.

M1700.200 FRAUD

A. Definitions Fraud is defined as follows:

"Whoever obtains, or attempts to obtain, or aids and abets a person in obtaining, by means of a willful false statement or representation, or by impersonation, or other fraudulent device, assistance or benefits from other programs designated under rules and regulations of the State Board of Social Services or State Board of Health to which he is not entitled, or fails to comply with the provisions of 63.2-522, 32.1-321.1, 32.1-321.2, 1-112, shall be deemed guilty of larceny..." (Code of Virginia, §63.1-124).

"If at any time during the continuance of assistance there shall occur any change, including but not limited to, the possession of any property or the receipt of regular income by the recipient, in the circumstances upon which current eligibility or amount of assistance were determined, which would materially affect such determination, it shall be the duty of such recipient immediately to notify the local department of such change, and thereupon the local board may either cancel the assistance, or alter the amount thereof." (Code of Virginia, §63.1-112).

B. DMAS Authority

1. Recipient Fraud DMAS has sole *authority over* cases of suspected Medicaid fraud when eligibility for a public assistance payment is not involved (Medicaid only cases). The local department of social services (LDSS) *shall* refer all Medicaid cases involving suspected fraud to the DMAS Recipient Audit Unit, 600 E. Broad Street, Suite 1300, Richmond, Virginia 23219, using the Notice of Recipient Fraud/Non-Fraud Recovery (form #DMAS 751R) located on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.

The information listed below shall be provided, using the following format:

- *confirmation that ongoing eligibility has been reviewed (in relation to the allegation) with evaluation results attached;*
- *reasons for and exact dates of ineligibility for Medicaid;*
- *the recipient's name and Medicaid enrollee identification number;*
- *the recipient's Social Security Number;*
- *applicable Medicaid applications or review forms for the referral/ineligibility period;*
- *address and telephone number of any attorney-in fact, authorized representative, or other individual who assisted in the application process;*
- *relevant covered group, income, resource, and/or asset transfer documentation for the time period in question;*
- *any record of communication between the agency and the client or representative, such as case narratives, letters, and notices; and*
- *information obtained from the agency's fraud investigation, including names and addresses of knowledgeable individuals for testimony and/or interviews.*

**2. Fiscal
Threshold
Removed**

The fiscal threshold for Administrative Non-fraud Recovery (previously \$300) has been removed. There is no fiscal threshold of any case with criminal intent to defraud Medicaid.

In order to determine the amount of the loss of Medicaid funds related to the enrollee's Temporary Assistance for Needy Families (TANF) Medicaid eligibility, the local agency must submit a Medicaid Claims Request (see Appendix 1 to this chapter) to DMAS and obtain the amount of the loss. The local agency should allow a three-week turnaround for the documents. There may be exceptional circumstances when claims can be provided within a shorter time, i.e., expedited trial dates. Once the information is received and the agency determines that it will not make a joint TANF/Medicaid criminal prosecution referral, the local agency must send to DMAS the Notice of Recipient Fraud/Non-Fraud Recovery. DMAS will determine if administrative non-fraud recovery is appropriate and request restitution.

For those cases where Medicaid claims only include Managed Care Organization (MCO) capitation fees, the MCO Capitation Fees Recovery Form will be included with the claims and the custodian certificate (see Appendix 2 to this chapter). The MCO Capitation Fees Recovery Form provides an explanation of the MCO capitation fees submitted and paid as claims on the recipient's behalf during the recovery period. The TANF/Medicaid related claims information should be included with this form.

2. **Provider Fraud** Cases of suspected fraud involving enrolled providers of medical services to Medicaid recipients *shall* be referred to the Medicaid Fraud Control Unit in the Office of the Attorney General, *and a copy of the referral correspondence shall be sent to the Provider Review Unit, Department of Medical Assistance Services.*

3. **Suspected Fraud Involving Recipients of Public Public Assistance Cash Payments**
- a. **Auxiliary Grant (AG) Cases**
- Individuals who receive AG payments also receive Medicaid coverage. Cases of suspected fraud involving AG payments are the responsibility of the local department of social services. For AG cases, the LDSS shall determine whether the enrollee would have been eligible for Medicaid had he not been receiving AG. If the individual was eligible for Medicaid solely due to his AG eligibility, the agency shall determine the period of ineligibility for Medicaid. The LDSS shall report any period of ineligibility. The DMAS Recipient Audit Unit will determine the amount of Medicaid payments made.*

The amount of misspent Medicaid funds *shall* be included in the AG fraud case, whether the action results in prosecution or in voluntary restitution. The final disposition on all money payment fraud cases *shall* be communicated to the Recipient Audit Unit, DMAS, no later than 5 business days after disposition for inclusion in federal reporting.

- b. **Cases in which Medicaid is received with TANF, SNAP, GR, Energy Assistance, etc.**

For suspected fraud involving cases *with combined Medicaid and TANF, Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), General Relief (GR), Energy Assistance, or other such assistance which does not directly relate to the provision of Medicaid, the local agency shall notify the Recipient Audit Unit of the agency's action on the other assistance case so that Medicaid may take concurrent action, if necessary.*

C. **Medicaid Ineligibility Following Fraud Conviction**

1. **Period of Eligibility** *An individual who has been convicted of Medicaid fraud is ineligible for Medicaid for a period of 12 months beginning with the month of fraud conviction. Action to cancel the individual's Medicaid coverage shall be taken in the month of conviction or in the month the agency learns of the conviction, using cancel reason 014 (42 United States Code §1320a-7b.(a)(6)(ii); 12 Virginia Administrative Code 30-10-70).*

2. **Who is Ineligible**
- a. **TANF or Families and Children (F&C) Cases**

Only the parent/caretaker of a TANF/Medicaid or F&C Medicaid case is ineligible for Medicaid when the parent/caretaker has been convicted of Medicaid fraud. The TANF payment made to the caretaker on a child's behalf shall not be affected.

b. Aged, Blind, Disabled (ABD) or Pregnant Women Cases

In an ABD or pregnant woman case, only the individual found guilty of Medicaid fraud will be ineligible. If only one spouse of a married couple is convicted, the eligibility of the innocent spouse is not affected.

3. Family Unit

If both spouses of an eligible couple are found guilty of fraud, neither is eligible for Medicaid. If only one member of a family unit is convicted of fraud, only that member's Medicaid coverage is canceled. The fraud conviction does not affect the composition of the family unit or the treatment of the family unit's income or resources. The convicted individual is included in the family unit according to Medicaid policy, but is not eligible for Medicaid coverage and is not enrolled.

M1700.300 NON-FRAUD RECOVERY**A. Definition**

The Virginia State Plan for Medicaid defines Non-Fraud Recovery as: "Investigation by the local department of social services of situations involving eligibility in which there is no reason to suspect that there has been deliberate misrepresentation by an applicant/recipient with intent to defraud." These cases are referred to DMAS when there is reason to suspect that an overpayment has occurred. (42 CFR§431).

B. Recovery of Erroneous Payments

DMAS has the authority to investigate cases and recover expenditures made for services received by ineligible enrollees without fraudulent intent. *Examples of when recovery of expenditures is possible include, but are not limited to:*

- eligibility errors due to recipient misunderstanding,
- agency errors, or
- medical services received during the appeal process, *if* the agency's cancellation action is upheld.

C. Recovery of Correctly Paid Funds

Within specific restrictions, DMAS may recover funds correctly paid for medical services received by eligible recipients.

1. Deceased Recipient's Estate

Under federal regulations and state law, DMAS may make a claim against a deceased enrollee's estate when the recipient was age 55 or over. The recovery *may* include any Medicaid payments made on his/her behalf. This claim *may* be waived if there are surviving dependents. (**42 CFR §433.36; Va. Code §32.1-326.1 and 32.1-327**).

Section 1917(b)(1)(C)(ii) of the Social Security Act was amended by the Deficit Reduction Act of 2005 to exempt assets disregarded under a "qualified" Long-term Care (LTC) Partnership Policy from estate recovery, as defined in clause (iii) of 1917(b)(1)(C). The same amount of assets that was disregarded in the Medicaid eligibility determination for an individual under an LTC Partnership Policy will be protected during estate recovery.

2. Uncompensated Asset Transfers

DMAS may seek recovery when a Medicaid enrollee transferred *assets* with an uncompensated value of more than \$25,000. The transferees (recipients of the transfer) are liable to reimburse Medicaid for expenditures up to the *amount of funds spent on the enrollee or the amount of the uncompensated asset transfer, whichever is less*. The *asset transfer* must have occurred within 30 months of the recipient (transferor) becoming eligible for or receiving Medicaid. (**Va. Code §20-88.02**).

D. Insurance Settlements and Similar Recoveries

Settlements related to personal injuries are a form of third party liability (TPL). When a Medicaid enrollee has received an insurance settlement or similar settlement from a law suit related to a medical condition or injury, DMAS may seek recovery of any amount of medical assistance expended on the enrollee prior to the receipt of the settlement. Generally, the insurance company notifies DMAS of the settlement; however, if an agency discovers that an enrollee received a settlement, the agency shall report it to DMAS. An insurance settlement that is sent directly to a recipient, in his name only, should be reviewed for its impact on the recipient's eligibility.

E. LDSS Referral

When an agency discovers a Medicaid case involving property transfers, the Notice of Medicaid Fraud/Non-fraud Recovery *shall* be completed and sent to:

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

or the form may be faxed to 804-371-8891.

For cases involving estate recoveries and/or TPL (insurance-related) recoveries, the completed recovery form shall be sent to:

Department of Medical Assistance Services
Attn: Third Party Recovery Unit
600 East Broad Street, Suite 1300
Richmond, VA 23219

or the form may be sent by e-mail to TPLunit@dmass.virginia.gov.

M1700.400 RESPONSIBILITY OF THE LDSS

A. VDSS/LDSS Responsibilities in Loss Prevention Efforts

VDSS Medicaid operates under an interagency agreement with DMAS which lists specific responsibilities of VDSS and, by extension, the LDSS, for active participation in loss prevention efforts. The responsibilities of the LDSS fall under the interagency agreement and are neither optional nor discretionary for the LDSS. VDSS shall supervise the programmatic activities of the LDSS to ensure compliance.

B. LDSS Requirements

*It is the responsibility of LDSS to determine and review ongoing or current recipient eligibility. **The DMAS RAU does not determine ongoing recipient eligibility, but rather reviews recipient eligibility in relation to allegations of fraud.** LDSS shall participate in the identification, tracking, and correction of eligibility errors. LDSS shall:*

**1. Report
Individuals**

Report to DMAS RAU every known instance relating to a non-entitled individual's use of Medicaid services, regardless of the reason for non-entitlement including, but not limited to:

- Instances where evidence of fraud may exist;
- Errors involving eligibility discovered by the LDSS in which there is no reason to suspect that there has been deliberate misrepresentation by an applicant/recipient with intent to defraud;
- Eligibility errors discovered by the LDSS, independent of other audit or quality control functions, including cases in which the individual was enrolled incorrectly, added in error, not cancelled timely, allowed to remain on Medicaid during the conviction sanction period or when information known to the agency would render ineligibility;
- Cases in which the LDSS discovers that the enrollee failed to report information that impacts eligibility; and
- Long-term Care patient pay underpayments resulting from any cause.

**2. Corrective
Action**

Report to DMAS RAU corrective action taken on all discovered eligibility errors. Corrective action is a function of the loss prevention process. All corrected errors shall be reported to DMAS.

**3. Cancel
Coverage**

Cancel the eligibility of all persons convicted of public assistance fraud or medical assistance fraud to the extent allowable under federal and state regulations, using the cancel code for fraud convictions (Cancel Code 014).

**4. Discretionary
Trust
Beneficiaries**

Notify DMAS of all instances in which a Medicaid recipient is a beneficiary of a discretionary trust and the trustee refuses to make the assets available for the medical expenses of the recipient, or when a Medicaid recipient has been found to be ineligible for Medicaid benefits as a result of a transfer of assets.

The LDSS shall use the Notice of Recipient Fraud/Non-Fraud Recovery (form # DMAS 751R), located on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>, to report the information listed above. Include in the report any corrective action that has been or will be taken by the LDSS, as well as the name of the supervisor of the person submitting the form. The supervisor's signature is not required.

Include Medicaid expenditures in the computation of misspent funds, where a withholding or a deliberate misrepresentation of a pertinent fact has taken place when the LDSS has jurisdiction in regard to prosecution of the case because a public assistance payment program is involved.

C. DMAS Response

The RAU shall send a written verification of the error to the individual making the referral, including the amount of misspent funds, as well as any further action required of the LDSS.

D. Recipient Audit Reporting

The RAU has two prevention efforts for reporting fraud and abuse of Medicaid Services by individuals within the community. Both referral methods should be given to the individual by the LDSS, along with a copy of the Notice of Medicaid Fraud/Non-fraud Recovery. If an individual wishes to make an anonymous referral, the report may be made through.

- the web address, recipientfraud@dmas.virginia.gov.
- the Recipient Audit fraud and abuse hotline. Both a local and a toll free number are available 24 hours daily for reporting suspected fraud and abuse: local (804) 786-1066; and toll free (866) 486-1971.

E. Statute of Limitations

There is no "statute of limitations" for Medicaid fraud; cases that are referred for fraud *shall* be flagged to ensure that the information is not purged. Cases cannot be properly investigated without specific documents, i.e. signed applications, bank statements, burial or insurance information. DMAS will notify the agency of the results of the fraud investigation.



COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services
Medicaid Claims Request

CYNTHIA JONES
ACTING DIRECTOR

600 EAST BROAD STREET
RICHMOND, VA. 23219
PHONE: (804) 786-7933
FAX: (804)225-4512

Date: _____

Agency: _____

Worker's Name: _____

Phone No: _____

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

Dear Supervisor:

I am conducting an investigation of the person(s) listed below for the time period indicated. Please forward proof of claims paid by Medicaid during the investigative period.

Custodian Certificate/Claims needed? Y/N

Written referral following? Y/N

Expected Date to the CA: _____

Expected Court Date: _____

I will keep you informed of additional progress and of the outcome of this investigation.

Case Name: _____ Base ID#: _____

(a) _____ Recipient ID#: _____

Period of suspected fraud/overpayment: _____

(b) _____ Recipient ID#: _____

Period of suspected fraud/overpayment: _____

(c) _____ Recipient ID#: _____

Period of suspected fraud/overpayment: _____

(d) _____ Recipient ID#: _____

Period of suspected fraud/overpayment: _____

Sincerely,

CLAIMS REQUEST FORM INSTRUCTIONS

FORM NUMBER - DMAS 750R

PURPOSE:

This form serves as a multi-purpose form. It can be used to receive certified claims from DMAS reporting the total expended amount of Medicaid services for the period of time in question. These claims are used in court testimony, as evidence against the defendant. Restitution is ordered based on the amount of claims in the form of a custodian certificate that is submitted by the supervisor of the Recipient Audit Unit. This information is notarized, and is attesting to the fact that the information is accurate and that the supervisor serves as the keeper of the records for DMAS. The claims inquiry will also assist the agency in determining whether to include the Medicaid claims with a joint criminal referral. If the agency determines that a joint criminal referral will not be made, the worker/investigator must send the Recipient Fraud/Non-Fraud Referral to DMAS. DMAS determine if non-fraud recovery is appropriate and request restitution.

NOTE: Providers have up to one year to bill for services, therefore the amount of claims may not be accurate or complete at the time of prosecution or inquiry. It is suggested that the Commonwealth's Attorney be advised of this information, should additional claims develop at a later time and additional restitution be requested by DMAS.

USE OF FORM – Request of recipient claims for any investigation conducted by the local agency as it relates to person(s) receiving a money grant under the Temporary Assistance for Needy Families and Food Stamp program(s). Also, request for an estimate of claims when determining whether or not the Medicaid-Only case *will be included with a joint criminal referral.*

NUMBER AND DISTRIBUTION OF COPIES – Prepare original; make a copy for the agency record before sending to the Recipient Audit Unit at DMAS.

INSTRUCTIONS FOR PREPARATION OF FORM – The form should contain the case name, the base case ID number, each recipient ID number and the period of suspected fraud/overpayment for each recipient. Each recipient should be listed separately as shown on the form by the letters (a) through (d). Should there be additional recipients on the same base case ID, a second page should be attached.

The requestor must complete the *four* questions in the lower left corner of the form in order for DMAS to determine the priority of the request. Failure to complete the questions will result in a delay of claims processing.

The recipient(s) should be referred to DMAS if there was a period of time when the recipient was not eligible to receive benefits and the agency is unsure of how to handle the case.

COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services, Recipient Audit Unit

MANAGED CARE ORGANIZATION (MCO) CAPITATION FEES
RECOVERY FORM

Date: _____

Agency: _____

Worker's Name: _____

Phone No: _____

Recipient ID#: _____

Recipient Name: _____

Period of Overpayment: _____

Amount of Overpayment: _____

Dear Recipient:

The above named agency has conducted an investigation of the person(s) listed above and determined that Medicaid ineligibility existed. Medicaid paid Managed Care Organization (MCO) capitation fees on your behalf for the time period indicated and recovery of those fees is requested. The Code of Virginia §32.1-321.2 authorizes the recovery of those fees.

Managed Care Organization capitation fees are monthly insurance premiums paid to the MCO to ensure that you have medical coverage. These premiums, or capitation fees, are paid by Medicaid to the MCO every month even if you do not utilize medical services. These premiums are considered losses to the program and can be recovered if you are determined ineligible for any prior period. If you are found to be ineligible for prior months of coverage due to your failure to report truthful information or changes in your circumstances to your caseworker, you may be liable to repay these monthly premiums.

If your repayment for services includes a benefit administered through your local agency, your payment arrangements will be administered through that agency. However, if these arrangements are not made, and you are repaying only Medicaid services, please make a check or money order payable to the Department of Medical Assistance Services. Include your Medicaid number on the check, and send it to the following address:

*Department of Medical Assistance Services
Financial Management Division, FAR
600 E. Broad St., 8th Floor
Richmond, VA 23219
Attn: LaVera Land, 804-786-5431*

Thank you for your cooperation in this matter.

DMAS 752RMCO (9/09)

MCO CAPITATION FEES RECOVERY FORM INSTRUCTIONS

FORM NUMBER - DMAS 752R (9/09)

PURPOSE:

This form serves as a multi-purpose form. It is used to accompany the certified claims from DMAS reporting the total expended amount of Medicaid capitation fees for the period of time in question. These claims are used in court testimony, as evidence against the defendant. Restitution is ordered based on the amount of claims in the form of a custodian certificate that is submitted by the supervisor of the Recipient Audit Unit. This information is notarized, and is attesting to the fact that the information is accurate and that the supervisor serves as the keeper of the records for DMAS. The form also provides an explanation of the MCO capitation fees submitted and paid as claims on the recipient's behalf during the recovery period.

USE OF FORM – *Request of recipient claims for any investigation conducted by the local agency as it relates to person(s) receiving a money grant under the Temporary Assistance for Needy Families and Food Stamp program(s). The form is used to accompany the recipient's request letter where the claims only include MCO capitation fees paid by DMAS on the recipient's behalf during the recovery period.*

NUMBER AND DISTRIBUTION OF COPIES – *An original MCO fact sheet will be forwarded to the agency along with the completed claims request. Prepare original; make a copy for the agency record and a copy for the Recipient Audit Unit at DMAS.*

INSTRUCTIONS FOR PREPARATION OF FORM – *The form should contain: the agency of record; eligibility worker/fraud investigator's name and phone number; case/recipient name, the base case/recipient ID number; the period of suspected fraud/overpayment and the amount of the overpayment. A separate fact sheet should accompany each recovery letter to the recipient.*

The recipient(s) should be referred to DMAS if there was a period of time when the recipient was not eligible to receive benefits and the agency is unsure of how to handle the case or if there are questions regarding the recovery of capitation fees.

M18 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/10	page 12
TN #93	01/01/10	pages 4, 5
TN #91	05/15/09	page 2 pages 5, 6 page 8

Explanations of some covered services are provided below:

**1. Children's
Mental Health
Program
Services**

Intensive community-based services for children and youth who have been in a psychiatric residential treatment facility may be provided. The services available are:

- respite,
- in-home residential supports,
- companion services,
- training and counseling for unpaid caregivers,
- environmental modifications, and
- consultative clinical and therapeutic services.

2. Clinic Services

Covered clinic services include therapeutic, rehabilitative, or palliative items or services, and renal dialysis furnished to an outpatient by or under the direction of a physician, in a certified facility which is organized and operated to provide medical care to outpatients.

**3. Community-
Based Care
Waiver Services**

Virginia provides services under community-based care (CBC) waivers to specifically targeted individuals. These services are not available to all Medicaid recipients. The CBC waivers are:

- Acquired Immunodeficiency Syndrome (AIDS) Waiver,
- Elderly or Disabled With Consumer Direction (EDCD) Waiver,
- *Intellectual Disabilities*/Mental Retardation (*ID/MR*) Waiver,
- Technology Assisted Individuals Waiver,
- Individual and Family Developmental Disabilities Support (DD) Waiver,
- Day Support (DS) Waiver, and
- Alzheimer's Assisted Living (AAL) Waiver.

Services covered under the waivers are listed in M1410.040.

**4. Community
Mental Health
and Mental
Retardation
Services**

Certain mental health and mental retardation services are covered for Medicaid-eligible recipients when provided by Medicaid-enrolled mental health providers. Examples of community mental health services are mental health case management, psychosocial rehabilitation, mental health support, day treatment/partial hospitalization, therapeutic day treatment for children and adolescents, intensive in-home services for children and adolescents, and crisis intervention services.

Mental retardation case management is available to recipients who are not enrolled in the *ID/MR* Waiver. Other community mental retardation services are available to recipients enrolled in the *ID/MR* Waiver and include mental retardation case management, day support, residential support, and supported employment services.

M21 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/10	page3 Appendix 3, pages 1 and 2
UP #3	03/01/10	pages 2-5
TN #93	01/01/10	page 2-4, 8
Update (UP) #2	08/24/09	page 4

opportunity period must be given to the applicant. The *C&I* verification requirements in M0220.100 apply to FAMIS, including use of the Social Security Administration (SSA) data match when a Social Security number (SSN) has been provided. If an SSN has not been provided for the child, a reasonable opportunity to provide acceptable documentation of C&I must be given. The reasonable opportunity period will last until the time of the first annual renewal.

If the child is not a U.S. citizen, the child must meet the FAMIS alienage requirements.

1. Alienage Requirements

Alien status must be verified. Refer to sections M0220.200, M0220.201 and M0220.202 for information about verifying alien status.

FAMIS alienage requirements are different from the Medicaid alienage requirements. Qualified aliens who entered the U.S. before August 22, 1996 meet the alienage requirements and are not subject to time limitations.

a. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **without regard to time limitations**:

- refugees or Cuban-Haitian Entrants (see M0220.310 A. 2 and 7),
- asylees (see M0220.310 A. 4),
- veteran or active military (see M0220.311),
- deportation withheld (see M0220.310 A. 6),
- victims of a severe form of trafficking (see M0220.313 B.5), and
- *Iraqi and Afghan Special Immigrants* (see M0220.313 A.6).

b. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **after five years of residence in the United States**:

- lawful permanent residents (LPR),
- conditional entrants-aliens admitted pursuant to 8 U.S.C.1153(a)(7),
- aliens, other than Cuban-Haitian Entrants, paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA, and
- battered aliens, alien parents of battered children, alien children of battered parents.

3. Legal Immigrant Children < 19 Not Applicable

The legal immigrant children policy in M0220.314 does NOT apply to the FAMIS program.

4. No Emergency Services Only For Unqualified Aliens

Unqualified aliens, including illegal and non-immigrant aliens, do not meet the alienage requirements and are not eligible for FAMIS.

FAMIS ALIEN ELIGIBILITY CHART

QUALIFIED ALIEN GROUPS	ARRIVED BEFORE AUGUST 22, 1996	ARRIVED ON OR AFTER AUGUST 22, 1996	
		1 ST 5 YEARS	AFTER 5 YEARS
Qualified aliens who are Veterans or Active Military (includes spouses/dependent children); certain American Indians Form DD 214-veteran	Eligible	Eligible	Eligible
Permanent Resident Aliens (Aliens lawfully admitted for permanent residence), except Amerasians I-151; AR-3a; I-551; I-327; I-688B-274a.12(a)(1)	Eligible	NOT Eligible	Eligible
Conditional entrants-aliens admitted Pursuant to 8 U.S.C. 1153(a)(7), section 203(a)(7) of the INA I-94	Eligible	NOT Eligible	Eligible
Aliens, other than Cuban or Haitian Entrants, paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA I-94; I-688B – 274a(12)(c)(11)	Eligible	NOT Eligible	Eligible
Battered aliens, alien parents of battered children, alien children of battered parents U.S. Attorney General	Eligible	NOT Eligible	Eligible
QUALIFIED ALIEN GROUPS		ELIGIBLE REGARDLESS OF ENTRY DATE OR LENGTH OF RESIDENCE	
Aliens granted asylum pursuant to section 208 of the INA I-94; I-688B – 274a.12(a)(5)		Eligible	
Aliens admitted as refugees pursuant to section 207 of the INA, or as Cuban or Haitian Entrants as defined in section 501(e) of the Refugee Education Assistance Act of 1980 {including those under section 212(d)(5)} I-551; I-94; I-688B		Eligible	
Aliens whose deportation has been withheld pursuant to Section 243(h) or 241(b)(3) of the INA I-688-B – 274a.12(a)(10) Immigration Judge's Order		Eligible	
Victims of a severe form of trafficking pursuant to the Trafficking Victims Protection Act of 2000 (P.L. 106-386) [ORR certification/eligibility letter]		Eligible	
Iraqi Special Immigrants admitted on a Special Immigrant Visa (SIV), including the spouse and children under age 21 living in the home with the principal visa holder. [I-551 or passport/ I-94 indicating categories SI1, SI2, SI3, QQ1, SQ2, or SQ3 and bearing Department of Homeland Security stamp or notation]		<i>Eligible</i>	

UNQUALIFIED ALIEN GROUPS
<u>NOT ELIGIBLE REGARDLESS OF ENTRY DATE OR LENGTH OF RESIDENCE</u>
Aliens residing in the US pursuant to an indefinite stay of deportation (I-94; Immigration Letter)
Aliens residing in the US pursuant to an indefinite voluntary departure (I-94; Immigration Letter)
Aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition who are entitled to voluntary departure under 8 CFR 242.5(a)(2)(vi) and whose departure the INS does not contemplate enforcing (I-94; I-210)
Aliens who have filed an application for adjustment of status pursuant to §245 INA that the INS has accepted as properly filed and whose departure the INS does not contemplate enforcing (I-181; Endorsed Passport)
Aliens granted stay of deportation by court order, statute or regulation, or by individual determination of the INS whose departure the agency does not contemplate enforcing (I-94; Court Order; INS Letter)
Aliens granted voluntary departure pursuant to section 242(b) of the INA whose departure the INS does not contemplate enforcing (I-94; I-210; I-688B – 247a.12(a)(11) or (13))
Aliens granted deferred action status pursuant to INS Operations Instruction 103.1(a)(ii) prior to 6/15/84 or 242.1a22 issued 6/15/84 and later (I-210; INS Letter)
Aliens residing in the U.S. under orders of supervision (I-220B)
Aliens who entered before January 1972 and have continuously resided in the U.S. since January 1972 (Case Record)

M22 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/2010	page 3
UP #3	03/01/2010	page 2
TN #93	01/01/2010	pages 2-10
UP #2	08/24/2009	page 3
Update (UP) #1	07/01/2009	pages 1, 2, 7 Appendix 1, page 1

- refugees (see M0220.310 A. 2),
- asylees (see M0220.310 A. 4),
- veteran or active military (see M0220.311),
- deportation withheld (see M0220.310 A. 6),
- victims of a severe form of trafficking (see M0220.313 A. 5), and
- *Iraqi and Afghan Special Immigrants (see M0220.313 A.6)..*

c. The following qualified aliens who entered the U.S. on or after August 22, 1996 meet the alienage requirements **after 5 years of residence in the United States:**

- lawful permanent residents (LPRs),
- conditional entrants-aliens admitted pursuant to 8 U.S.C.1153(a)(7),
- aliens paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA, and
- battered aliens, alien parents of battered children, alien children of battered parents.

d. Appendix 3 to Chapter M21 contains a FAMIS Alien Eligibility Chart that lists the alien groups that meet or do not meet the FAMIS MOMS alienage requirements.

3. Legal Immigrant Children < 19 Not Applicable

The legal immigrant children policy in M0220.314 does NOT apply to the FAMIS program.

3. No Emergency Services for Unqualified Aliens

Unqualified aliens, including illegal and non-immigrant aliens do not meet the alienage requirements. FAMIS MOMS does not provide any emergency services eligibility for unqualified aliens.

4. SSN not Required

The applicant is not required to provide an SSN or proof of an application for an SSN.