



COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

January 1, 2014

MEDICAID ELIGIBILITY MANUAL – VOLUME XIII

TRANSMITTAL #99

The following acronyms are used in this transmittal:

- ABD – Aged, Blind and Disabled
- ACA – Affordable Care Act
- COLA – Cost of Living Adjustment
- DDS – Disability Determination Services
- DMAS – Department of Medical Assistance Services
- F&C – Families & Children
- FAMIS – Family Access to Medical Insurance Security Plan
- LDSS – Local Departments of Social Services
- LIFC – Low-income Families with Children
- LTC – Long-term Care
- MA – Medical Assistance
- MAGI – Modified Adjusted Gross Income
- MSP – Medicare Savings Program
- PDP – Prescription Drug Plan
- PE – Presumptive Eligibility
- QI – Qualified Individual
- SPARK – Services Programs Answers Resources Knowledge
- SSI – Supplemental Security Income
- TN – Transmittal
- UP - Update
- VaCMS – Virginia Case Management System
- VDSS – Virginia Department of Social Services
- VIEW – Virginia Initiative for Employment not Welfare

Medicaid TN #99 includes new, revised and clarified Medicaid eligibility policy and procedures effective January 1, 2014, unless otherwise indicated. Some of the policies effective January 1, 2014 were added with TN #98 to give advance notice to LDSS. These policies will also be highlighted below.

New Policy

TN #99 contains policy on the implementation of PE. The Affordable Care Act requires states to allow inpatient hospitals to enroll patients who meet certain Families & Children covered groups in Medicaid for a limited time on the basis of their PE. DMAS is responsible for coordinating the PE enrollment process with hospitals and monitoring the appropriate use of the PE enrollments. Hospital staff will submit the PE application via the provider portal in MMIS. The individual will be enrolled at a central site. **The local DSS will not process PE applications or enrollments.** Individuals enrolled on the basis of PE will be covered by Medicaid for the month in which the PE application was made and the following month. For their coverage to continue beyond the following month, they must submit a full MA application to the LDSS. If the person does not submit an MA application before the end of his PE coverage, his PE coverage will be automatically terminated; in that case, no involvement from the LDSS is required.

Medicaid TN #99 also contains the policy and procedures for completing Medicaid and FAMIS renewals effective April 1, 2014. The new renewal policy applies effective April 1, 2014 to both F&C and ABD/LTC renewals, other than renewals for SSI Medicaid enrollees who have not reported countable real property. LDSS will complete the first renewal due on or after April 1, 2014 for each enrollee using paper renewal forms generated by VaCMS. The forms are necessary to gather tax filing status and other information not currently in the case record but needed for entry into VaCMS. The renewal policy will be revised in a future transmittal to incorporate additional methods for completing renewals as they become applicable. The ex parte renewal policies have not changed for SSI Medicaid enrollees.

The ACA requires states to ensure that F&C enrollees whose renewals are completed between January 1, 2014 and March 31, 2014 are not found ineligible solely because of the application of MAGI and new household composition rules. For renewals completed during this period, the enrollee's continued eligibility should first be evaluated using the non-MAGI F&C policies contained in Chapter M07 (i.e. that were in place prior to October 1, 2013). If the individual is no longer eligible under non-MAGI rules, do not cancel coverage. Obtain a Cover Virginia Application and manually enter the case into VaCMS after April 1, 2014, for an evaluation using the MAGI methodology.

Effective January 1, 2014, Medicaid coverage will be provided to former Virginia foster care children between the ages of 18 and 26. The new policy was added in TN #98 to acclimate LDSS to the new covered group prior to its implementation. In TN #99, it was clarified that this covered group applies to former foster care children who were in the custody of an LDSS, not a private foster care agency.

Revised and Clarified Policy

Effective January 1, 2014, no new pregnant women will be enrolled in FAMIS MOMS. Women enrolled in FAMIS MOMS as of December 31, 2013, or who file an application on or before December 31, 2013 and are found eligible, will remain covered through the end of their post-partum period. This revision was also included in TN #98.

TN #99 includes a significant revision to the Plan First policy. While an individual's application is pending during the non-expedited disability determination process, he is to be enrolled in Plan First if he is determined to be eligible. When the disability decision is made, his eligibility for full coverage is to be redetermined. Additionally, the income limit for Plan First is being lowered to 100% of FPL effective January 1, 2014. The new income limit table is included in M04.

Clarifications included in TN #99 include: the procedures for enrolling an applicant who has open MA coverage in another state; the use of an addendum to the adoption assistance agreement for Special Medical Needs Adoption Assistance children; that preadmission screening is not required for a full-benefit MA enrollee who was admitted to a nursing facility for less than 30 days; and the treatment of asset transfers made for reasons exclusively for a purpose other than to qualify for Medicaid.

Updated Policy

The policies on when a disability referral must be made to DDS have been revised. DDS **will** accept a disability referral on an individual whose previous disability denial is still in an appeal status after 12 months. This is a reversal from a change made in UP #9.

TN #99 also contains the SSI-based income limits and standards, as well as the LTC home equity limit, spousal resource standards and maintenance standards for 2014. TN #99 also contains the Medicare premium amounts and MSP resource limits for 2013. These figures were posted in Broadcast 8263 and became effective January 1, 2014.

Electronic Version

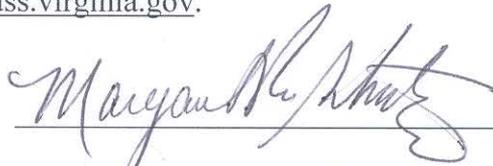
Transmittal #99 is available electronically on SPARK and the VDSS public web site. It has not been printed for distribution. The electronic version is the Transmittal of record. Significant changes to the manual are as follows:

Pages With Significant Changes	Changes
subchapter M0120 pages 11-11b	On pages 11-11b, added information about and policy on PE.
subchapter M0130 pages 10, 11	On page 10, added policy on determining whether or not an applicant is already receiving MA when the application is submitted. On page 11, clarified the enrollment process when an applicant is still receiving coverage in another state.
subchapter M0220 pages 19, 23	On page 19, revised the policy on the residency statement to align with the current residency policy. On page 23, clarified that emergency services aliens receiving dialysis are given up to a 12 month emergency services certification period.
subchapter M0310 pages 6, 7, 24, 25, 27a, 39	On page 6, clarified that the “special medical need” documentation can be on an addendum to the adoption assistance agreement. On page 7, revised the definition of blindness. On pages 24 and 25 revised the policy on making a disability referral when the applicant’s previous disability denial is still in an appeal status after 12 months. On page 27a, added policy for enrolling individuals who are in the process of having a disability determination in Plan First if they meet the Plan First income limit. On page 39, clarified that MAGI methodology does not differentiate between VIEW participants and other individuals.
subchapter M0320 page 11	On page 11, updated the COLA figures for 2013.

Pages With Significant Changes	Changes
subchapter M0330 pages 1, 8, 9, 24	On page 1, added the 300 % SSI covered groups to the hierarchy for evaluating eligibility. On pages 8 and 9, clarified that the Former Foster Care Child Under 26 covered group applies to individuals who were in the custody of an LDSS. On page 24, added policy for enrolling individuals who are in the process of having a disability determination in Plan First if they meet the Plan First income limit.
chapter M04 page 8 Appendix 6, page 1	On page 8, corrected the example in M0430.300 C. In Appendix 6, revised the income limits for Plan First.
subchapter M0530 Appendix 1, page 1	In Appendix 1, updated the deeming allocations.
subchapter M0810 pages 1, 2	On pages 1 and 2, updated the ABD SSI-based figures.
subchapter M0820 pages 30, 31	On pages 30 and 31 updated the student child earned income exclusion.
subchapter M1110 page 2	On page 2, updated the MSP resource limits.
subchapter M1370 page 2	On page 2, clarified that QI individuals are placed on two consecutive spenddowns.
subchapter M1410 page 10	On page 10, clarified that a pre-admission screening is not required for a full-benefit enrollee if the nursing facility stay was or is expected to be less than 30 days.
subchapter M1420 page 4	On page 4, clarified that a pre-admission screening is not required for a full-benefit enrollee if the nursing facility stay was or is expected to be less than 30 days.
subchapter M1450 page 10	On page 10, revised the policy on asset transfers made for reasons exclusive of becoming or remaining eligible for Medicaid payment of LTC services
subchapter M1460 pages 3, 35	On page 3, updated the home equity limit. On page 35, updated the student child earned income exclusion.

Pages With Significant Changes	Changes
subchapter M1470 9, 19, 20, 23, 40	On pages 9 and 23, clarified that when a full-benefit Medicaid enrollee is enrolled in a Medicare Part D PDP, any premium that is the individual's responsibility is an allowable deduction from patient pay. On page 19, updated the personal maintenance allowance. On page 20, updated the special earnings allowance amounts. On page 40, removed a sentence with erroneous text from M1470.0630 A.3
subchapter M1480 pages 7, 18c, 66, 69, 70	On page 7, updated the home equity limit. On page 18c, updated the spousal resource standards. On page 66, updated the maximum monthly maintenance needs allowance amount. On page 69, also updated the personal maintenance allowance amount. On page 70, updated the special earnings allowance amounts.
subchapter M1510 pages 1, 8	On page 1, clarified the entitlement process when an applicant is still receiving coverage in another state. On page 8, added information and policy on PE.
subchapter M1520 pages 7-15	On pages 7-15, revised the renewal policy to include the procedures for completing renewals effective April 1, 2014 and also for completing F&C renewals between January 1, 2014 and March 31, 2014.
Chapter M21 Page 2	On page 2, revised the policy on FAMIS coverage for children who lose Medicaid coverage; they are eligible to receive FAMIS for 12 months if their loss of Medicaid is due to excess income.

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.



Margeret Ross Schultze
Commissioner

Electronic Attachment

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TN #99	1/1/14	Pages i, iii
TN #98	10/1/13	page i
TN #93	1/1/10	page iii
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Changed With	Effective Date	Pages Changed
TN #99	1/1/14	page 11 Pages 11a and b were added.
TN #98	10/1/13	Table of Contents pages 1-17
UP #9	4/1/13	page 13, 15, 16
UP #7	7/1/12	pages 1, 10-12
TN #96	10/1/11	Table of Contents pages 6-18
TN #95	3/1/11	pages 1, 8, 8a, 14
TN #94	9/1/10	pages 8, 8a
TN #93	1/1/10	pages 1, 7, 9-16
Update (UP) #1	7/1/09	page 8
TN #91	5/15/09	page 10

b. Model Application for Medicare Premium Assistance Form

The Model Application for Medicare Premium Assistance Form was 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 valid Virginia MA application* 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>.

5. Presumptive Eligibility

The Affordable Care Act requires states to allow inpatient hospitals to enroll patients who meet certain Families & Children covered groups in Medicaid for a limited time on the basis of their presumptive eligibility (PE). The Department of Medical Assistance Services (DMAS) is responsible for coordinating the PE enrollment process with hospitals and monitoring the appropriate use of the PE enrollments.

a. PE Enrollment by Hospital

To enroll an individual in PE coverage, the hospital obtains basic demographic information about the individual, as well as attestations from the individual that he meets the nonfinancial and financial requirements of his covered group and that his gross household monthly income is within the income limit for his covered group. No verifications are required.

Prior to initiating enrollment in PE coverage, the hospital must determine whether or not the individual is already enrolled in MA using the verification systems available to providers. DMAS is available to provide technical assistance to hospitals. LDSS are not responsible for verifying current enrollment for patients.

The local DSS DOES NOT process PE applications or enrollments. Hospital staff initiates enrollment as PE via the provider portal in MMIS. The enrollment is not entered in the Virginia Case Management System (VaCMS), and the individual is enrolled at DMAS in the appropriate Aid Category (AC) for his covered group. Once the hospital receives confirmation of the PE enrollment, the hospital is responsible for notifying the individual of his PE coverage and that he must file a full MA application by the end of the following month for continued eligibility to be determined.

The covered groups to which PE applies and the ACs used for PE are:

- *Pregnant Women (AC 035)*
- *Child Under Age 19 (AC 064)*
- *Low Income Families with Children (065)*
- *Former Foster Care Children Under Age 26 (077)*
- *Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) (067)*

While enrolled as PE, individuals in all covered groups except pregnant women receive full Medicaid benefits. Coverage for pregnant women is limited to ambulatory (non-emergency) care.

Enrollment as PE is limited to one PE period per calendar year for all individuals other than pregnant women. For pregnant women, enrollment is limited to one PE eligibility period per pregnancy.

b. LDSS Procedures

Individuals enrolled on the basis of PE receive a closed period of coverage for the month of PE application and the following month. For their coverage to continue beyond the following month, they must submit a full MA application to the LDSS. When an application is received and pended in VaCMS, the individual's PE coverage is to be extended, if necessary, while the application is processed.

If the person is determined eligible for continued MA coverage, the eligibility worker is to continue ongoing coverage in the appropriate AC beginning the first day of the month after the effective date of the PE coverage cancellation.

*An individual's eligibility for retroactive coverage for the three months prior to the month of the MA application is determined when the individual had a medical service within the three months prior to the month of the full MA application. If the individual had **full** coverage while enrolled as PE, only determine his eligibility for months in the retroactive period that he was not enrolled as PE.*

Because pregnant women are eligible only for limited benefits, if the woman is determined eligible for full coverage in the retroactive period, cancel PE coverage retroactively and reinstate in full coverage for the retroactive months.

If the applicant is determined to not be eligible for ongoing MA coverage, send written notice that the individual is not eligible for continued MA coverage. The individual receives notice of the PE coverage period from the hospital at the time of the PE enrollment; advance notice of the PE cancellation is not required.

*The individual's PE coverage is valid regardless of whether or not the individual is eligible for ongoing coverage; do **not** refer the case to the DMAS Recipient Audit Unit.*

If the person does not submit an MA application prior to the end of the PE coverage period, his PE coverage will be automatically terminated. No involvement from the LDSS is required.

B. Application Forms

Medical assistance must be requested using an application method or form approved by the Departments of Medical Assistance Services (DMAS) and Social Services (VDSS). Applications may be made electronically through CommonHelp or the Health Insurance Marketplace. When an individual applies for assistance through the Marketplace and is assessed as being Medicaid-eligible, his application data is electronically transmitted to the local DSS for a final determination of eligibility.

Applications may also be made telephonically through the Cover Virginia Call Center or with a paper application form.

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

1. Streamlined Applications

The following forms are used to apply for affordable health insurance, including qualified health plans with the Advance Premium Tax Credit (APTC), through the Health Insurance Marketplace or the local DSS:

- the Cover Virginia Application for Health Coverage & Help Paying Costs and all applicable appendices, including Appendix D for applications submitted for aged, blind or disabled and/or long-term care applicants.
- the federal Application for Health Coverage & Help Paying Costs for multiple individuals and all applicable appendices and
- the federal Application for Health Coverage & Help Paying Costs (Short Form) for individuals and all applicable appendices.

M0130 Changes

Changed With	Effective Date	Pages Changed
TN #99	1/1/14	pages 10-12 Page 13 was added.
TN #98	10/1/13	Table of Contents pages 1-12
UP #9	4/1/13	page 3, 5
UP #7	7/1/12	pages 4, 5
TN #96	10/1/11	pages 6-8
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TN #93	1/1/10	pages 4-6, 8
Update (UP) #2	8/24/09	pages 8, 9

M0130.300 Eligibility Determination Process

A. Evaluation of Eligibility Requirements

When an MA application is received by the LDSS agency, the agency must determine through a “file clearance” search of the eligibility and enrollment systems whether or not the individual already has Medicaid or FAMIS coverage.

With the exception of individuals enrolled on the basis of presumptive eligibility (PE), applications for MA submitted by individuals who already have an application recorded or who are currently active are denied as duplicate applications.

Applications submitted by individuals currently enrolled as PE or as Newborn Children are not duplicate applications because they were initially enrolled without filing a full MA application. See M0120.300 A.5 for more information.

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 eligibility determination computer system. The Evaluation of Eligibility (form #032-03-823) may be used. The form is available online at <http://www.localagency.dss.state.va.us/divisions/bp/me/forms/general.cgi>. Agency-created evaluation forms are also acceptable as long as all information needed to determine eligibility is documented on the evaluation form.

Eligibility decisions are made following a prescribed sequence:

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

Subchapter M0210 contains the Medicaid non-financial requirements.

B. Hierarchy of Covered Group

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

C. Applicant’s Choice of Covered Group

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

D. Application Disposition

1. General Principle

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

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

2. Entitlement and Enrollment

a. Entitlement

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

If an applicant indicates that he has been receiving MA (Medicaid or Children's Health Insurance Program) coverage in another state prior to moving to Virginia, instruct him to contact his eligibility worker there and request that his coverage be cancelled, if he has not already done so. He is no longer considered a resident of the other state once he has moved to and intends to reside in Virginia and is not entitled to receive services paid for by the other state's MA program. As long as the individual meets the residency requirement per M230 and his cancellation in the other state is verified, he may be enrolled in Virginia Medicaid beginning the same month that his coverage ends in the other state.

b. Enrollment

MA enrollees must be enrolled in the Medicaid Management Information System (MMIS), either through the system interface with the eligibility determination system or directly by the eligibility worker.

When enrolling an individual in the MMIS, the appropriate aid category (AC) for the applicant's covered group must be used. Enrollment procedures and a list of ACs are found in the MMIS Users' Guide for DSS, available at: http://localagency.dss.virginia.gov/divisions/bp/me/vammis_documents.cgi.

When an individual who does not have Medicare is eligible for only limited MA benefits, such as Plan First, a referral to the HIM must be made so that the individual's eligibility for the APTC in conjunction with a Qualified Health Plan (QHP) can be determined. Medicare beneficiaries are not referred to the HIM.

c. Denials

Applications for MA which are denied, including when an individual is placed on a spenddown) must be referred to the HIM so that the applicant's eligibility for the APTC can be determined.

3. Notification to Applicant

Either a Notice of Action generated by the eligibility determination system or the Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs (NOA), form #032-03-008 (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) must be used to notify the applicant of the specific action taken on the application. A copy of the notice must also be mailed to an individual who has applied on behalf of the applicant.

a. Approvals

As applicable, the notice must state that:

- the application has been approved, including the effective date(s) of Medicaid or FAMIS coverage;
- retroactive Medicaid coverage was approved, including the effective dates.
- For approvals of limited coverage, that the application has been referred to the HIM for determination of eligibility for the APTC.

b. Denials

As applicable, the notice must state that:

- the application has been denied, including the specific reason(s) for denial cited from policy;
- retroactive Medicaid coverage was denied, including the specific reason(s) for denial cited from policy.
- the application has been referred to the HIM for determination of eligibility for the APTC.

c. Delays

The notice must state that there is a delay in processing the application, including the reason.

d. Other Actions

Other actions for which a notice must be sent include when a request for re-evaluation of an application in spenddown status has been completed.

E. Notification for Retroactive Entitlement Only

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

M0130.400 Applications Denied Under Special Circumstances

A. General Principle

When an application is withdrawn or the applicant cannot be located, the application is denied. The reason for the denial must be recorded in the case record, and a notice must be sent to the applicant's last known address.

B. Withdrawal

An applicant may withdraw his application at any time. The request can be verbal or written. An applicant may voluntarily withdraw only his application for retroactive coverage by signing a statement or by a verbal statement specifically indicating the wish to withdraw the retroactive coverage part of the application.

A written withdrawal request must be placed in the case record. A verbal request for withdrawal can be accepted only from the applicant or case head, or his authorized representative. A verbal request must be documented in the case record with the date and time the withdrawal request was received, the name of the person who made the withdrawal request, and the signature and title of the agency staff person who took the call.

When the applicant withdraws an application, the eligibility worker must send a notice of action on MA to the applicant.

C. Inability to Locate

The agency must send a letter to the last known address informing the applicant of the agency's attempt to locate him and asking that he contact the office. For applicants who are documented as homeless, maintain all correspondence at the local agency. If the applicant does not respond within 45 days of the date of application, deny the application.

D. Duplicate Applications

Applications received requesting MA for individuals who already have an application recorded or who are currently active will be denied due to duplication of request. A notice will be sent to the applicant when a duplicate application is denied.

M0220 Changes

Changed With	Effective Date	Pages Changed
TN #99	1/1/14	Table of Contents pages 19, 23, 24 Appendix 4 was removed
TN #98	10/1/13	pages 2-3b Appendix 1 pages 1-5 pages 6-18 were removed.
UP #9	4/1/13	page 3 Appendix 1, pages 3, 17 Appendix 3, pages 3, 4
UP #8	10/1/12	Table of Contents pages 4, 7-8, 12, 14d-20 page 17a was deleted Appendix 5, page 3 added new Appendix 7, pages 1-5
UP #7	7/1/12	Table of Contents pages 14d, 16-19 Appendix 5, page 3
TN #96	10/1/11	Table of Contents pages 2, 3, 7, 8, 14d, 18-22a, 23 Appendix 5, page 3
TN #95	3/1/11	Table of Contents pages 3, 3a, 4-6a, 14a-14c, 17, 19, 20 pages 22a, 23, 24 Appendices 1-2a removed. Appendix 3 and Appendices 5-8 reordered and renumbered.
TN #94	9/1/10	pages 3-3b, 7-9, 14a-14d, 18, 21, 22a, 23 Appendix 1 Appendix 3, page 3
Update (UP) #3	3/1/10	pages 1-3a
TN #93	1/1/10	Table of Contents pages 7-8, 14a, 14c-14d, 15-20, 22a Appendix 1 Appendix 3, page 3 Appendix 4, pages 1 and 2 Appendix 6, page 2
TN #92	5/22/09	Table of Contents pages 1-6a Appendix 8 (18 pages) pages 4a-4t were removed and not replaced.
TN #91	5/15/09	page 7 pages 14a, 14b page 18 page 20 Appendix 3, page 3

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

M0220.500 ALIENS ELIGIBILITY REQUIREMENTS

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

1. **Residency** the Virginia residency requirements (M0230);

Aliens who are visitors (non-immigrants) usually do not meet the Virginia state residency requirements because *they have been admitted to the U.S. on a time-limited basis and have a visa with an expiration date*. Ask the non-immigrant alien "Where do you intend to go after your visa expires?" If the individual *is presently living in Virginia and* states in writing that he "intends to reside in Virginia after his visa expires," he has stated his intent to reside in and meets the Virginia state residence eligibility requirement for Medicaid.

If an individual who signed a statement indicating that he does not intend to remain subsequently changes his mind, eligibility cannot begin prior to the date of the original statement.

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

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

- 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 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, *available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi>*.

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.

With the exception of dialysis patients, 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.

DMAS will certify dialysis patients for up to a one year period of services without the need for a new Medicaid application. However, due to edits in MMIS, only one six-month certification period at a time can be entered. The worker must manually enter the second certification period of up to six months (as certified by DMAS) after the first period expires.

The dialysis patient must reapply for Medicaid after their full certification period expires.

- 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 5 to this subchapter.

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

3. **Entry date** **THIS FIELD MUST BE ENTERED.** Enter the date on which the alien entered the U.S., except for asylees and deportees. For asylees, enter the date asylum was granted. For deportees, enter the date deportation withholding was granted.

4. **App Dt** In this field, application date, enter the date of the alien's Medicaid application upon which the eligibility coverage period is based.

5. **Covered Dates Begin** In this field, coverage begin date, enter the begin date of the emergency service(s).

6. **Covered Dates End** In this field, coverage end date, enter the date when the alien's emergency service(s) ends. When the emergency service(s) received was related to labor and delivery, the end date includes the day of discharge even though it is not counted to determine the length of stay for certification purposes.

7. **AC** Enter the code applicable to the alien's covered group.

D. Notices Appropriate notice must be sent to the applicant of the status of his application and the duration of his eligibility.

The USCIS requires that all benefit applicants who are denied benefits based **solely or in part** on the SAVE response be provided with adequate written notice of the denial as well as the information necessary to contact USCIS, so that the individual may correct his records in a timely manner, if necessary. The fact sheet, "Information for Applicants: Verification of Immigration Status and How to Correct Your Record with USCIS" (Form # 032-03-0427-00) must be included with the Notice of Action when benefits are denied, **including the approval of emergency-services-only Medicaid coverage**, and with the Advance Notice of Proposed Action when benefits are subsequently cancelled based on the results of a SAVE inquiry. The fact sheet is available on SPARK at <http://www.localagency.dss.state.va.us/divisions/dgs/warehouse.cgi>.

A Medicaid card will not be generated for an individual enrolled as an emergency services alien.

The agency must contact the provider(s) and supply the eligibility dates and Medicaid number for billing purposes by sending a copy of the completed referral form #032-03-628, Emergency Medical Certification, to the provider(s).

M0310 Changes

Changed With	Effective Date	Pages Changed
TN #99	1/1/14	pages 6, 7, 21, 24, 25, 27a, 39
TN #98	10/1/13	pages 2, 4, 27a, 27b, 28, 35, 36, 39
UP #9	4/1/13	pages 24-27 Appendix 2
TN #97	9/1/12	Table of Contents, page i pages 1-5a, 10-13 pages 23, 28, 29, 30a, 31 pages 33, 36, 38, 39
UP #7	7/1/12	Table of Contents, page ii pages 23, 26, 27 Appendices 1-3 were removed. Appendices 3 and 4 were renumbered and are now Appendices 1 and 2, respectively.
TN #96	10/1/11	Appendix 4
TN #95	3/1/11	Pages 30, 30a
TN #94	9/1/10	pages 21-27c, 28
TN #93	1/1/10	page 35 Appendix 5, page 1
Update (UP) #2	8/24/09	Table of Contents page 39
TN #91	5/15/09	pages 23-25 Appendix 4, page 1 Appendix 5, page 1

b. IV-E Adoption Assistance payment not required

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

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

a. Non-IV-E definition

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

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

b. Special Medical Needs definition

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

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

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

The adoption assistance agreement *or amendment to the agreement* must specify that the child has a special medical need; the agreement does NOT need to specify a particular diagnosis or condition. *If an amendment was used to specify that the child has special medical needs, it must document that the special medical needs began prior to the effective date of the adoption assistance agreement.*

d. Virginia Medicaid coverage for Special Medical Needs children

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

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

M0310.105 AGE and AGED

A. Age “Age” is the individual's age reached on the anniversary of birth. If the year but not the month and day of the individual's birth is known, July 1 is assigned for both eligibility determination and enrollment.

Eligibility in a Medicaid covered group often depends on an individual's age.

B. Aged “Aged,” means age 65 years or older.

C. Procedures For individuals under age 21, accept the date of birth provided on the application/redetermination form. No verification is required.

For aged individuals, verify the individual's age by Social Security records or documents in the individual's possession. Acceptable documents include:

- birth certificate or notification of birth;
- hospital or physician's record;
- court record of adoption;
- baptismal record;
- midwife's record of birth;
- form VS95 from state Bureau of Vital Statistics; or
- marriage records.

M0310.106 BLIND

A. Definition The Medicaid blindness definition is the same as that of the Supplemental Security Income (SSI) blindness definition.

Blindness is defined by using one of two criteria. The first criteria indicates that blindness is defined as having best corrected central visual acuity of 20/200 or less in the better eye. The second criteria indicates that blindness is defined as the contraction of the visual field in the better eye with the widest diameter subtending an angle around the point of fixation no greater than 20 degrees.

B. Procedures An SSI recipient who receives SSI as blind meets the blindness definition for Medicaid. Verify the SSI recipient's SSI eligibility via SVES (State Verification Exchange System).

Individuals who meet the visual eligibility are certified by the Department for the Blind and Vision Impaired (DBVI) and are listed in the Virginia Registry of the Blind. Call DBVI at 1-800-622-2155 to verify that an individual has been certified as blind.

An individual who requires a determination of blindness must be referred to the Disability Determination Services (DDS) using the procedure in M0310.112 E. 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 *for Aging and Rehabilitative Services (DARS)*. 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 *DARS* 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.

- 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** SSA has refused to do so or denied it for non-medical reasons. Proof of decision made by SSA is required.

If the applicant indicates that one of the above exceptions applies, the Medicaid referral should be documented appropriately and sent to the DDS. After reviewing the Medicaid referral and Social Security decision, the DDS may determine that the SSA decision addressed all the conditions reported to Medicaid. In this situation, the DDS will determine that no exception applies and that the SSA decision is still binding. In this situation, the DDS will not make an independent disability determination for Medicaid. Instead, the DDS will document that an exception does not apply and that the SSA determination is still binding until the end of the 12-month period.

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.

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, *follow the procedure in M0310.112 G below to make a referral to DDS. DDS will accept and fully develop the Medicaid referral if more than 12 months have passed since the most recent SSA medical determination, regardless of appeal status with SSA, and for any reason.*

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 *regardless of whether or not the decision is in an appeal with SSA.*

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.

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.

5. Evaluation for Plan First and Referral to Health Insurance Marketplace

While an individual's application is pending during the non-expedited disability determination process, evaluate his eligibility for Plan First and enroll him if eligible (see M0330.600) and refer the individual to the Health Insurance Marketplace (HIM) for evaluation for the Advance Premium Tax Credit (APTC).

H. Notification of DDS Decision to LDSS

1. Hospitalized Individuals

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.

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.

B. State Plan Governs Medicaid Eligibility Rules

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

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

M0310.132 TANF

A. Temporary Assistance for Needy Families (TANF)

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

M0310.133 BCCPTA

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

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

B. Procedures

Section M0330.700 contains the detailed requirements for the BCCPTA covered group.

M0310.134 VIEW PARTICIPANT

A. Virginia Initiative for Employment not Welfare (VIEW) Participants

A VIEW participant is an individual who has signed the TANF Agreement of Personal Responsibility. *For renewals completed and changes reported prior to April 1, 2014*, VIEW participants have a higher earned income limit than non-VIEW participants. An individual under a TANF VIEW sanction is a VIEW participant for Medicaid purposes. An individual only receiving TANF transitional support services is not a VIEW participant for Medicaid purposes.

Modified Adjusted Gross Income (MAGI) methodology does not differ between VIEW participants and other individuals.

M0310.135 HIPP PROGRAM

A. Health Insurance Premium Payment (HIPP) Program

HIPP is a cost savings program administered by the DMAS for Medicaid enrollees which reimburses some or all of the employee portion of group health insurance premiums. HIPP is available to Medicaid enrollees when a family member is employed at least 30 hours per week and is enrolled in an employer's group health plan. Eligibility for HIPP is determined by the HIPP Unit at DMAS. Participation in HIPP is voluntary.

B. Procedures

M0130.200 G contains additional information about HIPP.

M0320 Changes

Changed With	Effective Date	Pages Changed
TN #99	1/1/14	page 11
TN #98	10/1/13	pages 1, 54, 55.
UP #9	4/1/12	pages 11, 26, 32, 34-37, 45, 46, 55
TN #97	9/1/12	Table of Contents pages 1-56 (all pages)
UP #6	4/1/12	pages 11, 12, 46a
TN #96	10/1/11	Table of Contents pages 46f-50b page 50c deleted
TN #95	3/1/10	pages 11, 12, 42c, 42d, 50, 53, 69 pages 70, 71 page 72 added.
TN #94	9/1/10	pages 49-50b
UP #3	3/1/10	pages 34, 35, 38, 40, 42a, pages 42b, 42f
TN #93	1/1/10	pages 11-12, 18, 34-35, 38 pages 40, 42a-42d, 42f-44, 49 pages 50c, 69-71
UP #2	8/24/09	pages 26, 28, 32, 61, 63, 66
Update (UP) #1	7/1/09	pages 46f-48
TN #91	5/15/09	pages 31-34 pages 65-68

Note: There was no COLA in 2010 or 2011.

Cost-of-living calculation formula:

- a. $\frac{\text{Current Title II Benefit}}{1.015 \text{ (1/14 Increase)}} = \frac{\text{Benefit Before}}{1/14 \text{ COLA}}$
- b. $\frac{\text{Benefit Before 1/14 COLA}}{1.017 \text{ (1/13 Increase)}} = \frac{\text{Benefit Before}}{1/13 \text{ COLA}}$
- c. $\frac{\text{Benefit Before 1/13 COLA}}{1.036 \text{ (1/12 Increase)}} = \frac{\text{Benefit Before}}{1/12 \text{ COLA}}$
- d. $\frac{\text{Benefit Before 1/12 COLA}}{1.058 \text{ (1/09 Increase)}} = \frac{\text{Benefit Before}}{1/09 \text{ COLA}}$
- e. $\frac{\text{Benefit Before 1/09 COLA}}{1.023 \text{ (1/08 Increase)}} = \frac{\text{Benefit Before}}{1/08 \text{ COLA}}$

5. Medicare Premiums

a. Medicare Part B premium amounts:

1-1-14 \$104.90 (no change)
1-1-13 \$104.90
1-1-12 \$99.90
1-1-11 \$115.40
1-1-10 \$110.50
1-1-09 \$96.40
1-1-08 \$96.40

These figures are based on the individual becoming entitled to Medicare during the year listed. The individual's actual Medicare Part B premium may differ depending on when he became entitled to Medicare. Verify the individual's Medicare Part B premium in SVES or SOLQ-I if it is necessary to know the premium amount for Medicaid eligibility or post-eligibility purposes.

b. Medicare Part A premium amounts:

1-1-14 \$426
1-1-13 \$441.00
1-1-12 \$451.00
1-1-10 \$461.00
1-1-09 \$443.00
1-1-08 \$423.00

Contact a Medical Assistance Program Consultant for amounts for years prior to 2008.

6. Evaluation

Individuals who are eligible when a cost-of-living increase is excluded are eligible.

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M0330 Changes

Changed With	Effective Date	Pages Changed
TN #99	1/1/14	Pages 1, 8, 9, 13, 24
TN #98	10/1/13	Table of Contents pages 1-3, 6-16, 19, 22, 24-29
UP #8	10/1/12	pages 4, 6
TN #97	9/1/12	Table of Contents pages 1-40 (all pages)
UP #2	8/24/09	pages 3, 6, 8, 16, 22
Update (UP) #1	7/1/09	pages 20, 21

M0330.000 FAMILIES & CHILDREN GROUPS

M0330.001 GENERAL POLICY PRINCIPLES

A. Overview A State Plan for Medicaid must include the mandatory federal categorically needy (CN) groups of individuals as well as the optional groups a state has elected to cover. This subchapter divides the Families & Children (F&C) covered groups into categorically needy and medically needy (MN) groups.

B. Procedure Determine an individual's eligibility first in a CN covered group. If the individual is not eligible as CN or for the Family Access to Medical Insurance Security Plan (FAMIS), go to the MN groups.

A determination of eligibility for a F&C child should follow this hierarchy:

1. If the child meets the definition of a foster care child, adoption assistance child, special medical needs adoption assistance child or an individual under age 21, evaluate in these groups first.
2. If the child meets the definition of a newborn child, evaluate in the pregnant woman/newborn child group.
3. *If the child is in medical institution, has been screened and approved for Community-based Care waiver services or has elected hospice, evaluate in the appropriate F&C 300 % of SSI covered group.*
4. If a child is under the age of 19, evaluate in this group.
5. Effective January 1, 2014, if a child is a former Virginia foster care child under age 26 years, evaluate for coverage in this group.
6. If a child has income in excess of limits individual, evaluate for the Family Access to Medical Insurance Security Plan (FAMIS) eligibility (chapter M21).
7. If the child is a child under age 1, child under age 18, an individual under age 21 or a special medical needs adoption assistance child, but has income in excess of the appropriate F&C income limit, evaluate as MN.

A determination of eligibility for a F&C adult should follow this hierarchy:

1. If the individual meets the definition of a parent/caretaker relative, evaluate in the LIFC covered group.
2. If the individual is not LIFC, but meets the definition of a pregnant woman, evaluate in the pregnant woman/newborn child group.
3. *If the individual is not LIFC or pregnant, is in medical institution, has been screened and approved for Community-based Care waiver services or has elected hospice, evaluate in the appropriate F&C 300 % of SSI covered group.*
4. Effective January 1, 2014, if the individual is a former Virginia foster care child under 26 years, evaluate in this covered group.
5. If the individual has been screened and diagnosed with breast or cervical cancer or precancerous conditions by the Every Woman's Life program and does not meet the definition of for coverage as SSI, LIFC, Pregnant Woman or Child Under 19 individual, evaluate in the BCCPTA covered group.
6. If the individual has excess income for full coverage in a Medicaid covered group and is between the ages of 19 and 64, evaluate for Plan First coverage.
7. If the individual is a pregnant woman but has excess income for coverage in a CN group or FAMIS MOMS (for applications submitted before 12/31/13 only), evaluate as MN.

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

3. Income Adoption assistance children in residential facilities do not have a different income limit. The income limit for Individuals Under Age 21 for one person in the child's locality is used to determine eligibility in the Special Medical Needs covered group. See M04, appendix 4.

For a Virginia Special Medical Needs adoption assistance child living outside the State of Virginia, the income limit for the unit is the income limit for the Virginia locality that signed the adoption assistance agreement.

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

If the child's countable income exceeds the income limit for Individuals Under Age 21, evaluate the child in the Special Medical Needs Adoption Assistance MN covered group (see M0330.805). Ineligible individuals must be referred to the Health Insurance Marketplace for evaluation for the APTC.

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

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

M0330.109 FORMER FOSTER CARE CHILDREN UNDER AGE 26 YEARS (EFFECTIVE JANUARY 1, 2014)

A. Policy P.L. 111-148 (The Affordable Care Act) - The federal Medicaid law requires the State Plan to cover individuals who were formerly in Title IV-E or non-IV-E foster care when the individual:

- was *in the custody* of a *local department of social services* in Virginia and receiving Medicaid until his discharge from foster care upon turning 18 years or older,
- is not eligible for Medicaid in another mandatory Medicaid covered group (LIFC parent, Pregnant Woman, Child Under age 19 or SSI), and
- is under age 26 years.

B. Nonfinancial Eligibility Requirements The individual must meet all the nonfinancial eligibility requirements in chapter M02.

C. Financial Eligibility A separate Medicaid financial eligibility determination is not made for former foster care children under age 26. Verify the child's former foster care status documentation provided by the applicant, agency records or contact with the local agency that held custody.

D. Entitlement

Entitlement as a former foster care child begins the first day of the month following the month the child was no longer in the custody of a *local department of social services* in Virginia if the child was enrolled in Medicaid during the month foster care ended. However, coverage in this covered group cannot begin prior to January 1, 2014.

If Medicaid coverage of a former foster care child was previously discontinued when the child turned 18, he may reapply for coverage and be eligible in this covered group if he meets the requirements in this section. The policies regarding entitlement in M1510 apply.

E. Enrollment

The AC for former foster care children is “070.”

M0330.200 LOW INCOME FAMILIES WITH CHILDREN (LIFC)**A. Policy**

Section 1931 of the Act - The federal Medicaid law requires the State Plan to cover dependent children under age 18 and parents or caretaker-relatives of dependent children who meet the financial eligibility requirements of the July 16, 1996 AFDC state plan. In addition, Medicaid covers dependent children and parents or caretaker-relatives of dependent children who participate in the Virginia Initiative for Employment not Welfare (VIEW) component of the Virginia Independence Program (VIP) and meet the requirements of the 1115 waiver. This covered group is called “Low Income Families With Children” (LIFC).

Public Law 111-148 (The Affordable Care Act) requires that coverage for all children under the age of 19 be consolidated in the Child Under Age 19 (FAMIS Plus) covered group. Virginia has chosen to implement this coverage effective October 1, 2013.

An exception is made for children under age 18 whose parents are receiving LIFC Extended Medicaid coverage (see M1520.500) In these situations, if family income exceeds the limit for coverage in the Child Under Age 19 group, the child must be evaluated for LIFC Extended Medicaid coverage with his family.

B. Nonfinancial Eligibility

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

The child(ren) must meet the definition of a dependent child in M0310.111. The adult with whom the child lives must be the child’s parent or must meet the definition of a caretaker-relative of a dependent child in M0310.107. For applications submitted prior to October 1, 2013, a child or adult who lives in the household but who is not the dependent child’s parent or caretaker-relative may be eligible as LIFC if he/she meets the definition of an EWB in M0310.113. Effective October 1, 2013, EWB is not included in the definition of LIFC.

C. Financial Eligibility

The financial eligibility policy used for this covered group depends on when the application is submitted or renewal is processed. Refer to Chapters M05 and M07 for applications submitted before October 1, 2013 and renewals completed before April 1, 2014. Refer to Chapter M04 for eligibility determinations completed on applications submitted on or after October 1, 2013, and renewals completed on or after April 1, 2014.

E. Enrollment

The Medicaid ACs for children are:

AC	Meaning
090	child under age 6; income greater than 109% FPL, but less than or equal to 143% FPL
091	child under age 6; income less than or equal to 109% FPL
092	<ul style="list-style-type: none">child age 6-19; insured or uninsured with income less than or equal to 109% FPL;child age 6-19; insured with income greater than 109% FPL and less than or equal to 143% FPL
094	child age 6-19; uninsured with income greater than 109% FPL and less than or equal to 143% FPL

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

M0330.400 PREGNANT WOMEN & NEWBORN CHILDREN

A. Policy

The federal Medicaid law requires the Medicaid State Plan to cover categorically needy (CN) pregnant women and newborn children whose family income is within 143% of the federal poverty level (FPL). The law allows the State Plan to cover these pregnant women and newborns regardless of their resources.

B. Nonfinancial Eligibility

1. Pregnant Woman

42CFR 435.116- The woman must meet the pregnant woman definition in M0310.124.

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

Non-citizen pregnant women who meet the lawfully residing policy in M0220.314 meet the citizenship requirements for full coverage in the pregnant woman group.

M0330.600 PLAN FIRST - FAMILY PLANNING SERVICES**A. Policy**

Plan First, Virginia's family planning services health program covers individuals who are not eligible for another full or limited-benefit Medicaid covered group or FAMIS. This optional covered group is available to individuals regardless of their age, gender, disability status, insured status or if they previously had a sterilization procedure. Plan First covers only family planning services, including transportation to receive family planning services.

The income limit for this group is 211% FPL through December 31, 2013. Effective January 1, 2014, the income limit for this group is 100% FPL. While there are no specific age requirements for Plan First, eligibility for Plan First is not determined for children under 19 years or for individuals age 65 years and older unless the child's parent or the individual requests an evaluation for Plan First.

Individuals who are eligible for Plan First must be referred to the Federal Health Insurance Marketplace for an evaluation for the APTC, because they are not eligible for full Medicaid coverage.

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 or alleges disability), in another limited benefit covered group (e.g., the individual has Medicare) or in FAMIS, the worker must determine whether eligibility exists in another covered group before the individual(s) can be determined eligible for Plan First.

***Exception:** While an individual's application is pending during the non-expedited disability determination process, evaluate his eligibility for Plan First and enroll him if eligible. When the disability decision is made, redetermine his eligibility for full coverage.*

If additional information is needed to complete the eligibility determination in another 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, determine the applicant's eligibility for Plan First only.

When an individual age 19 through 64 years is not eligible for Medicaid in any other covered group, evaluate his eligibility for Plan First unless the individual has indicated otherwise on the application or communicated the desire to opt out to the LDSS by other means.

When a Medicaid enrollee no longer meets the requirements for his current covered group, prior to cancelling his coverage he must be evaluated in all covered groups for which he may meet the definition. If the individual is age 19 through 64 years and is not eligible for full-benefit Medicaid coverage or as a Medicare beneficiary, he must be evaluated for Plan First unless he has declined that coverage. If a child is under age 19 or an individual is age 65 or older, evaluate for Plan First only if the child's parent or the individual requests the coverage.

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M04 Changes

Changed With	Effective Date	Pages Changed
TN #99	1/1/14	page 2, 5, 6, 8, 14, 15 Appendix 6

If the individual meets multiple Medicaid covered groups (and/or FAMIS) his gross income is compared first to the income limit of the group with the highest income limit under which the individual could be eligible. If the income exceeds the limit, the 5% FPL disregard can be allowed, and the income again is compared to the income limit.

- When considering tax dependents in the tax filer's household, the tax dependent may not necessarily live in the tax filer's home.
- Under MAGI counting rules, an individual may be counted in more than one household but is only evaluated for eligibility in his household.
- Use non-filer rules when the household does not file taxes.
- Use non-filer rules when the applicant is claimed as a tax dependent by someone outside the applicant's household.
- Non-filer rules may be used in multi-generational households.

1. Eligibility Based on MAGI

MAGI methodology is used for eligibility determinations for insurance affordability programs including Medicaid, FAMIS, the Advance Premium Tax Credit (APTC) and cost sharing reductions through the Health Insurance Marketplace for the following individuals:

- a. Children under 19
- b. Parent/caretaker relatives of children under the age of 18 (LIFC)
- c. Pregnant women
- d. Individuals Under Age 21
- e. Plan First.

2. Eligibility NOT Based on MAGI

MAGI methodology is NOT used for eligibility determinations for:

- a. individuals for whom the agency is not required to make an income determination:
 - Supplemental Security Income (SSI) recipients
 - Auxiliary Grant recipients
 - IV-E foster care or adoption assistance recipients
 - Deemed newborns
 - BCCPTA (Breast and Cervical Cancer Prevention and Treatment Act) enrollees.
- b. individuals who are eligible on the basis of being aged (age 65 or older), blind or disabled;
- c. individuals eligible for Medicaid payment for long-term care services;
- d. individuals evaluated as Medically Needy;

5. Special Medical Needs Adoption Assistance Children

Special Medical Needs (SMN) Adoption Assistance (AA) children are subject to modified MAGI methodology for their Medicaid eligibility determinations. SMN AA children are in their own household apart from parents and siblings. Parents' and siblings' income is not counted for these children.

- Stepparents and parents are treated the same.
- Children and siblings with or without income are included in the same household as the rest of the family.
- Older children are included in the family if claimed as tax dependent by the parents.
- Married couples living together are **always** included in each other's household even if filing separately.
- Dependent parents may be included in the household if they are claimed for income tax purposes.

1. Tax Filer Household Composition

The tax filer household is determined based on the rules of tax dependency. Parents, children and siblings are included in the same household. The tax filer's household consists of the tax filer and all tax dependents who **are expected to be claimed for the current year**. This could include non-custodial children claimed by the tax filer, but living outside the tax filer's home and dependent parents claimed by the tax filer, but living outside the tax filer's home.

The tax filer household is composed of the individual who expects to file a tax return this year and does not expect to be claimed as dependent by another tax filer. The household consists of the tax filer and all individuals the individual expects to claim as a tax dependent.

2. Tax Dependent Household Composition

means all dependents expected to be claimed by another tax filer for the taxable year.

Except for SMN AA children, the tax dependent's household consists of the tax dependent, his parents and his siblings living in the home. If the tax dependent is living with a tax filer other than a parent or spouse, the tax dependent is included in the tax filer household, but the tax filer is NOT included in the tax dependent's household.

An SMN AA child is in his own household with no parents or siblings.

Exceptions to the tax household composition rules apply when:

- individuals other than biological, adopted or stepchildren are claimed as tax dependents,
- children are claimed by non-custodial parents,
- married couples and children of parents are not filing jointly.
-
- the tax dependent is an SMN AA child.

3. Non Filer Household Composition

The Non Tax Filer household rules mirror the tax filer rules to the maximum extent possible.

- The household consists of parents and children under age 19.
Exception: an SMN AA child is in his own household with no parents or siblings.

- Non-filer rules are used when a child is claimed as a tax dependent of someone not living in the home.
- Non-filer rules are used in the case of a multi-generational household where the tax dependent is also the parent of a child.
- Children under age 19 living with a relative other than a parent are included only in their own household.
- Spouses, parents, stepparents and children living together are included in the same household. *Exception: an SMN AA child is in his own household with no parents or siblings.*
- For non-filers, a “child” is defined as under age 19.

4. Married Couple

In the case of a married couple living together, the spouse is always included in the household of the other spouse, regardless of their tax filing status.

M0430.200 TAX FILER HOUSEHOLD EXAMPLES

A. Married Parents and Their Tax Dependent Children

Sam and Sally are a married couple. They file taxes jointly and claim their two children Susie and Sarah as tax dependents. All of them applied for MA.

The MAGI household is the same as their tax household because the tax filers are a married couple filing jointly and claiming their dependent children. No additional individuals live in the home.

Ask the following questions for each tax dependent to determine if exceptions exist:

- Is Susie the tax dependent of someone other than a spouse or a biological, adopted, or stepparent? No, also applies to Sarah
- Is Susie a child living with both parents, but the parents do not expect to file a joint tax return? No, also applies to Sarah
- Is Susie a child who expects to be claimed by a non-custodial parent? No, also applies to Sarah

The following table shows each person’s MAGI household:

Person	# - Household Composition	Reason
Sam	4 - Sam, Sally, Susie, Sarah	Tax-filer & dependents
Sally	4 - Sally, Sam, Susie, Sarah	Tax filer & dependents
Susie	4 - Susie, Sam, Sally, Sarah	Tax dependent, tax-filer parents and other tax dependent
Sarah	4 - Sarah, Sam, Sally, Susie	Tax dependent, tax-filer parents and other tax dependent

B. Married Parents and Their Dependent Children

Josh and Penny are a married couple. They live with their children Daisy and Kate, both under age 18. They do not expect to file federal taxes this year so non-filer rules are used. All applied for MA. The following table shows each person’s MAGI household:

Person	# - Household Composition	Reason
Josh	Josh, Penny, Daisy, Kate	Non -filer household-married parents living with 2 children in common
Penny (Spouse)	Josh, Penny, Daisy, Kate	Non- filer household-married parents living with 2 children in common
Daisy	Josh, Penny, Daisy, Kate	Non- filer household-married parents living with 2 children in common
Kate	Josh, Penny, Daisy, Kate	Non- filer household-married parents living with 2 children in common

C. Parent, Stepparent, and Parent’s Child (not child of stepparent)

Paul and Pattie are a married couple. They live with Pattie’s son by a first marriage, Edgar age 17. They do not plan to file taxes this year. The household for the MAGI determination is the non-filer household which includes Paul (stepparent/spouse) , Pattie (parent/spouse) and Edgar (child/stepchild). All of them applied for MA. The following table shows each person’s tax filer household:

Person	# - Household Composition	Reason
Paul	3-Paul, Pattie, Edgar	Non filers – spouses, parent, stepparent and child/stepchild under age 19
Pattie	3-Pattie, Paul, Edgar	Non filers - spouses, parent, stepparent and child/stepchild under age 19
Edgar	3-Edgar, Paul, Pattie	Non filer lives with parents

M0430.400 TAX FILER AND NON TAX FILER HOUSEHOLD EXAMPLES

A. Parent and Child Claimed by Non-custodial Parent

Linda and her daughter, Liza, live in the home. Linda works and claims only herself as a tax dependent. Liza is claimed by her father who does not live in the home. Both applied for MA.

Linda’s is a tax filer claiming only herself. Her tax household and MAGI household are the same. Liza is a tax dependent claimed by a non-custodial parent so a tax dependent exception exists and non-filer rules must be used. The following table shows each person’s MAGI household:

Person	# - Household Composition	Reason
Linda	1– Linda	Tax-filer with no additional tax dependent
Liza	2 – Liza, Linda	Non-filer child and parent living in the home

M0450.100 STEPS FOR DETERMINING MAGI-BASED ELIGIBILITY

A. Determine Household Composition

1. **Does the individual expect to file taxes?**
 - a. If No - Continue to Step 2
 - b. If Yes - Does the individual expect to be claimed as a tax dependent by anyone else?
 - 1) If No - the household consists of the tax filer, a spouse living with the tax filer, and all persons whom the tax filer expects to claim as a tax dependent
 - 2) If Yes - Continue to Step 2

2. **Does the Individual Expect to be Claimed As a Tax Dependent?**
 - a. If No - Continue to Step 3
 - b. If Yes - Does the individual meet any of the following exceptions?
 - 1) the individual expects to be claimed as a tax dependent of someone other than a spouse or a biological, adopted, or stepparent;
 - 2) the individual is a child (under age 19) living with both parents, but the parents do not expect to file a joint tax return; or
 - 3) the individual is a child under age 19 who expects to be claimed by a non-custodial parent?
 - i. If no - the household is the household of the tax filer claiming her/him as a tax dependent.
 - ii. Is the individual married? If yes – does the household also include the individual’s spouse?
 - iii. If yes - Continue to Step 3.
 - 4) *the child is an SMN AA child? If yes, continue to Step 3.*

3. **Individual Is Neither Tax Filer Nor Tax Dependent Or Meets An Exception In 2. b Above**

For individuals, *other than SMN AA children*, who neither expect to file a tax return nor expect to be claimed as a tax dependent, as well as tax dependents who meet one of the exceptions in 2.b above, the household consists of the individual and, if living with the individual:

 - the individual’s spouse;
 - the individual’s natural, adopted and step children under the age 19; and
 - In the case of individuals under age 19, the individual’s natural, adopted and stepparents and natural, adoptive and stepsiblings under age 19.

The household of an SMN AA child consists only of the child.

B. Determine the MA Income for Each Member of the Household

1. Is Any Household Member The Child Or Expected Tax Dependent Of Another Member Of The Household?

- a. If yes - is the individual expected to be required to file a tax return?
- 1) If yes, continue to Step 2 and include child's income in total household income.
 - 2) If no, continue to Step 2, but do not include child's income in total household income.
- b. If no, continue to Step 2.

2. Determine MAGI Income For Each Member

Determine MAGI-based income of each member of the individual's household, unless income of such member is flagged as not being counted in step 1. Recall that, for purposes of MA eligibility, the following rules apply:

- an amount received as a lump sum is counted as income only in the month received
- scholarships, awards or fellowship grants used for education purposes and not for living expenses are excluded from income
- certain distributions, payments and student financial assistance for American Indians/Alaska Natives are excluded from income
- child support is not countable income.

3. Using the 5% of FPL Disregard

If the individual's household income is over the income limit for his covered group, subtract an amount equal to 5% of FPL for his household size (see M04, Appendix 1). Compare the countable income against the income limit for the individual's covered group to determine his income eligibility.

If the individual meets multiple Medicaid covered groups (and/or FAMIS) his gross income is compared first to the income limit of the full-benefit covered group with the highest income limit for which the individual could be eligible. If the income exceeds the limit, subtract 5% FPL based on his household size and compare the income again to the income limit. If he is still not eligible, the same process is followed for Plan First, if the individual is age 19 through 64 years.

C. Household Income

Household income is the sum of the MAGI-based income for every member of the individual's household as determined in step 2 above.

**PLAN FIRST
100% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE 1/1/14**

Household Size	Monthly Income Limit
1	\$958
2	1,293
3	1,628
4	1,963
5	2,298
6	2,633
7	2,968
8	3,303
For each additional person, add	335

M0530 Changes

Changed With	Effective Date	Pages Changed
TN #99	1/1/14	Appendix 1, page 1
UP #9	4/1/13	Appendix 1, page 1
UP #6	4/1/12	Appendix 1, page 1
Update (UP) #5	7/1/11	page 14
TN #95	3/1/11	page 1 Appendix 1, page 1
TN #93	1/1/10	pages 11, 19 Appendix 1, page 1

Deeming Allocations

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

NBD (Non-blind/disabled) Child Allocation

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

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

2014: \$1,082 - \$721 = \$361

2013: \$1,066 - \$710 = \$356

Parental Living Allowance

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

SSI payment for one person = \$721 for 2014; \$710 for 2013.

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

SSI payment for both parents = \$1,082 for 2014; \$1,066 for 2013.

Deeming Standard

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

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

2014: \$1,082 - \$721 = \$361

2013: \$1,066 - \$710 = \$356

M0810 Changes

Changed With	Effective Date	Pages Changed
TN #99	1/1/14	pages 1, 2
TN #98	10/1/13	page 2
UP #9	4/1/13	pages 1, 2
UP #7	7/1/12	page 2
UP #6	4/1/12	pages 1, 2
TN #95	3/1/11	Pages 1, 2
TN #93	1/1/10	pages 1, 2
Update (UP) #1	7/1/09	page 2

GENERAL

M0810.001 INCOME AND ELIGIBILITY

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

B. Policy Principles

- 1. Who is Eligible** An individual is eligible for Medicaid if the person:
 - meets a covered group; and
 - meets the nonfinancial requirements; and
 - meets the covered group's resource limits; and
 - meets the covered group's income limits.

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

M0810.002 INCOME LIMITS

A. Income Limits The Medicaid covered group determines which income limit to use to determine eligibility.

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

2. Categorically Needy Protected Cases Only

Categorically-Needy Protected Covered Groups Which Use SSI Income Limits		
Family Unit Size	2014 Monthly Amount	2013 Monthly Amount
1	\$721	\$710
2	1,082	1,066
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size	2014 Monthly Amount	2013 Monthly Amount
1	\$480.67	\$473.34
2	721.34	710.67

3. **Categorically
Needy 300% of
SSI**

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

Categorically Needy 300% of SSI		
Family Size Unit	2014 Monthly Amount	2013 Monthly Amount
1	\$2163	\$2,130

4. **Medically
Needy (Effective
July 1, 2013)**

a. Group I		
Family Unit Size	Semi-annual	Monthly
1	\$1,803.47	\$300.58
2	2,296.23	382.70
b. Group II		
Family Unit Size	Semi-annual	Monthly
1	\$2,080.93	\$346.82
2	2,562.56	427.09
c. Group III		
Family Unit Size	Semi-annual	Monthly
1	\$2,705.21	\$450.87
2	3,261.66	543.61

5. **ABD
Categorically
Needy**

For:

ABD 80% FPL,
QMB, SLMB, &
QI without Social
Security income;
all QDWI; all
MEDICAID
WORKS,
effective 1/24/13

ABD 80% FPL,
QMB, SLMB, &
QI with Social
Security income,
effective 3/1/13

ABD 80% FPL	Annual	Monthly
1	\$9,172	\$766
2	12,408	1,034
QMB 100% FPL	Annual	Monthly
1	\$11,490	\$958
2	15,510	1,293
SLMB 120% of FPL	Annual	Monthly
1	\$13,788	\$1,149
2	18,612	1,551
QI 135% FPL	Annual	Monthly
1	\$15,512	\$1,293
2	20,939	1,745
QDWI and MEDICAID WORKS 200% of FPL	Annual	Monthly
1	\$22,980	\$1,915
2	31,020	2,585

S0820 Changes

Changed With	Effective Date	Pages Changed
TN #99	1/1/14	pages 30, 31
UP #9	4/1/13	pages 30, 31
Update (UP) #6	4/1/12	pages 30, 31
TN #95	3/1/11	pages 3, 30, 31
TN #93	1/1/10	pages 30, 31
TN #91	5/15/09	Table of Contents pages 29, 30

3. Other Earned Income

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

- a. Federal earned income tax credit payments.
- b. Up to \$10 of earned income in a month if it is infrequent or irregular.
- c. For 2014, up to \$1,750 per month, but not more than \$7,060 in a calendar year, of the earned income of a blind or disabled student child.

For 2013, up to \$1,730 per month, but not more than \$6,960 in a calendar year, of the earned income of a blind or disabled student child.

- d. Any portion of the \$20 monthly general income exclusion which has not been excluded from unearned income in that same month.
- e. \$65 of earned income in a month.
- f. Earned income of disabled individuals used to pay impairment-related work expenses.
- g. One-half of remaining earned income in a month.
- h. Earned income of blind individuals used to meet work expenses.
- i. Any earned income used to fulfill an approved plan to achieve self-support.

4. Unused Exclusion

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

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

6. Couples

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

B. References

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

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

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

S0820.510 STUDENT CHILD EARNED INCOME EXCLUSION

A. Policy

- 1. General** For a blind or disabled child who is a student regularly attending school, earned income is excluded under this provision, limited to the maximum amounts shown below.
- | For Months | Up to per month | But not more than in a calendar year |
|------------------------------|------------------------|---|
| <i>In calendar year 2014</i> | <i>\$1,750</i> | <i>\$7,060</i> |
| In calendar year 2013 | \$1,730 | \$6,960 |
- 2. Qualifying for the Exclusion** The individual must be:
- a child under age 22; and
 - a student regularly attending school.
- 3. Earnings Received Prior to Month of Eligibility** Earnings received prior to the month of eligibility do not count toward the yearly limit.
- 4. Future Increases** The monthly and yearly limits will be adjusted annually based on increases in the cost of living index. Under this calculation, these amounts will never be lower than the previous year's amounts. However, there may be years when no increases result from the calculation.

B. Procedure

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

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

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S1110 Changes

Changed With	Effective Date	Pages Changed
TN #99	1/1/14	page 2
UP #9	4/1/13	page 2
UP #6	4/1/12	page 2
TN #96	10/1/11	page 2
TN #95	3/1/11	page 2
Update (UP) #3	3/2/10	Table of Contents page 2
TN #93	1/1/10	page 2
TN #91	5/15/09	pages 14-16

M1110.003 RESOURCE LIMITS

A. Introduction

The resource limit is the maximum dollar amount of countable assets an individual, couple, or family may own and still meet the established criteria for Medical Assistance in an ABD category. These amounts are established by law.

B. Policy Principles

1. Resource Ineligibility

An individual (or couple) with countable resources in excess of the applicable limit is not eligible for Medicaid.

2. Resource Limits

ABD Eligible Group	One Person	Two People
Categorically Needy Medically Needy	\$2,000	\$3,000
ABD With Income \leq 80% FPL	\$2,000	\$3,000
QDWI	\$4,000	\$6,000
QMB SLMB QI	Calendar Year <i>2014</i> \$7,160 2013 \$7,080	Calendar Year <i>2014</i> \$10,750 2013 \$10,620

3. Change in Marital Status

A change in marital status can result in a change to the applicable resource limit. The resource limit change is effective with the month that we begin treating both members of a couple as individuals. For example, separation from an ineligible spouse can change the limit from \$3,000 to \$2,000. See M1110.530 B.

4. Reduction of Excess Resources

Month of Application

Excess resources throughout the month of application causes ineligibility for the application month. Reduction of excess resources within the application month can cause resource eligibility for that month.

M1370 Changes

Changed With	Effective Date	Pages Changed
TN #99	1/1/14	page 2
UP #9	4/1/13	Table of Contents pages 1-5 Page 6 was added.
TN #94	9/1/2010	Table of Contents pages 1-5

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 enrollees who meet the MN covered group and resource requirements are placed on *two consecutive* MN spenddowns. If an enrolled QI medically indigent enrollee does not meet the spenddowns, 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 Spend-down 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.

5. Plan First

If an individual enrolled in the Plan First covered group meets a MN covered group listed in M0320 or M0330, he must be evaluated to determine if he could become eligible for full Medicaid coverage as medically needy (MN) by meeting a spenddown. At application and redetermination, Plan First enrollees who meet the MN covered group and resource requirements are placed on two six-month spenddown budget periods within the 12 month renewal period. They may also be eligible for a retroactive MN spenddown determination.

M1410 Changes

Changed With	Effective Date	Pages Changed
TN #99	1/1/14	page 11
Update #7	7/1/12	pages 6, 7
TN #96	10/1/11	page 11, 12
TN #95	3/1/11	pages 13, 14 Page 15 was removed.
TN #94	9/1/10	pages 6, 7, 13
TN #93	1/1/10	pages 1, 7, 9, 12
TN #91	5/15/09	pages 11-14

3. Processing

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

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

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

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

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

4. Notices

See section M1410.300 for the required notices.

M1410.200 INITIATING LONG-TERM CARE FOR CURRENT RECIPIENTS**A. Introduction**

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

For example, an enrollee may be ineligible for Medicaid payment of LTC services because he/she transferred assets without receiving adequate compensation. The asset transfer policy found in M1450 applies to individuals who receive any type of long-term care. Individuals who are ineligible for Medicaid payment of LTC may remain eligible for other Medicaid-covered services.

B. Pre-admission Screening

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

A pre-admission screening is not required for a full-benefit enrollee if the nursing facility stay was or is expected to be less than 30 days.

C. Recipient Enters LTC

A re-evaluation of eligibility must be done when the EW learns that a Medicaid recipient has started receiving LTC services. If the recipient has been in a nursing facility for at least 30 consecutive days, a pre-admission

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M1420 Changes

Changed With	Effective Date	Pages Changed
TN #99	1/1/14	page 4
UP#7	7/1/12	pages 3, 4
TN #94	09/01/2010	Table of Contents pages 3-5 Appendix 3
TN #93	01/01/2010	pages 2, 3, 5 Appendix 3, page 1 Appendix 4, page 1

- 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 waiver or PACE;
 - the individual leaves a nursing facility and begins receiving EDCD waiver services or enters PACE and a pre-admission screening was completed prior to the nursing facility admission;
 - the individual enters a nursing facility from out-of-state; *or*.
 - *an individual with full Medicaid coverage was or is expected to be admitted to a nursing facility for less than 30 days.*
- C. Documentation**
- If the individual has not been institutionalized for at least 30 consecutive days and a screening is required, 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 and Tech 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);

M1450 Changes

Changed With	Effective Date	Pages Changed
TN #99	1/1/14	page 7, 10, 21
UP #7	6/1/12	Table of Contents pages 37-43 Page 43a was added.
TN #96	10/1/11	Table of Contents pages 4-8 pages 15, 16, 25, 26 pages 31-38 page 31a removed.
TN #95	3/1/11	pages 4, 24,32, 36, 37, 37a, pages 39, 42, 43
TN #94	9/1/10	Table of Contents pages 36-37a, 39-44
TN #93	1/1/10	Table of Contents pages 3, 17-18, 29 Appendix 2, page 1
TN #91	5/15/09	pages 41, 42

M1450.100 RESERVED**M1450.200 POLICY PRINCIPLES****A. Policy**

An institutionalized individual who transfers (or has transferred), or whose spouse transfers or has transferred, an asset in ways not allowed by policy is not eligible for Medicaid payment of long-term care services. The DRA established new policy for evaluating transfers made on or after February 8, 2006. The look-back period for all transfers is 60 months; there is no distinction between transfers involving trusts and other transfers.

B. Procedures

When a Medicaid enrollee is institutionalized, review the individual's eligibility to determine if an asset transfer occurred within the 60 months prior to institutionalization. When a Medicaid applicant reports an asset transfer, or the worker discovers a transfer, determine if the transfer occurred within 60 months prior to the month in which the individual is both institutionalized and a Medicaid applicant/enrollee.

1. All Transfers

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

2. Determine Effect

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

If the transfer affects eligibility and was for less than market value, determine the uncompensated value (*M1450.610*) and establish a penalty period (period of ineligibility for Medicaid payment of LTC services, *M1450.630*).

- Payments from sections 25-239, 25-240, and 25-241 of the Code of Virginia for relocation assistance.
- Payments from sections 404(g) and 418 of the Domestic Volunteer Service Act of 1973.
- Retroactive Supplemental Security Income and/or retroactive Social Security payments for nine (9) months after the month of receipt of the payment(s).
- Retained disaster assistance.

M1450.400 TRANSFERS THAT DO NOT AFFECT ELIGIBILITY

A. Policy

An asset transfer does NOT affect eligibility for Medicaid payment of LTC services if the transfer meets the following criteria:

- the transfer(s) of assets was made for reasons exclusive of becoming or remaining eligible for Medicaid payment of LTC services (M1450.400 B),
- the individual received adequate compensation for the asset(s), or
- the asset transfer meets the criteria in either section B, C or D below.

If the transfer **does not** meet the criteria in this section, see section 1450.500 below to evaluate the asset transfer.

B. Reason Exclusive of Becoming or Remaining Medicaid Eligible

Assume that when an institutionalized individual or his community spouse has transferred assets for less than the CMV during the look back period, the transfer is subject to a penalty period. During this penalty period, Medicaid will not pay for LTC services. The institutionalized individual must be given the opportunity to rebut this assumption by showing satisfactorily that he intended to receive CMV or that the reason for the transfer of assets was exclusively for a purpose other than to qualify for Medicaid.

The individual must provide convincing and objective evidence showing that there *was* no reason to believe that Medicaid payment of LTC services might be needed. *The fact the individual had not yet applied for Medicaid, had not been admitted to an institution or was not aware of the asset transfer provisions does not meet the evidence requirement.* The sudden loss of income or assets, the sudden onset of a disabling condition or personal injury may provide convincing evidence.

The individual must provide evidence that other assets were available at the time of transfer to meet current and expected needs of that individual, including the cost of nursing home or other medical institutional care.

date is June 1, 1994, the first day of the month in which the transfer occurred. The penalty period is 19 months beginning June 1, 1994.

C. Irrevocable Trust

A transfer of funds **into** an irrevocable trust and a transfer of funds **from** an irrevocable trust **MAY** be asset transfers for less than fair market value, depending on whether the terms of the trust

- allow for payments to or for the benefit of the individual, OR
- do not allow for payments to or for the benefit of the individual.

1. When Payment to Individual Is Allowed

When the trust allows for circumstances under which payment can be made to or for the benefit of the individual from all or a portion of the trust,

- 1) the portion of the trust principal that could be paid to or for the benefit of the individual is a resource available to the individual;
- 2) income (produced by the trust principal), which could be paid to or for the benefit of the individual, is a resource available to the individual;
- 3) payments from the trust income or principal, which are made to or for the benefit of the individual, are counted as income to the individual;
- 4) payments from income or from the trust principal which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value.

a. Transfer Into Trust

A transfer of assets **into** an irrevocable trust that allows for payment to or for the benefit of the individual does NOT affect eligibility because the irrevocable trust is a resource to the individual.

b. Payments From Trust

Payments from income or from the trust principal which are made to or for the benefit of the individual are counted as income.

Payments from income or from the trust principal which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value.

The date the transfer occurs is the date that the payment to the individual was foreclosed (the date the payment was paid to another person not for the benefit of the individual).

c. Look-back Date When Payment to Individual Is Allowed

The look-back date is **60 months** for assets transferred from an irrevocable trust under which some payment can be made to or for the benefit of the individual.

EXAMPLE #5: Mr. C established an irrevocable trust with a principal of \$100,000 on March 1, 1994. He enters a nursing facility on November 15, 1997, and applies for Medicaid on February 15, 1998. The trustee has discretion to disburse the entire principal of the trust and all income from the trust to anyone, including Mr. C, the grantor. Each month, the trustee

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M1460 Changes

Changed With	Effective Date	Pages Changed
TN #99	1/1/14	pages 3, 35
UP #9	4/1/13	Table of Contents pages 3, 35, 38, 41, 42, 50, 51
TN #97	9/1/12	Table of Contents pages 1, 4-7, 9-17 Page 8a was deleted. pages 18a-20, 23-27, 29-31 pages 37-40, 43-51 Pages 52 and 53 were deleted
UP #6	4/1/12	pages 3, 35
TN #96	10/1/11	pages 3, 20, 21
TN #95	3/1/11	pages 3, 4, 35
TN #94	9/1/10	page 4a
TN #93	1/1/10	pages 28, 35
TN #91	5/15/09	pages 23, 24

10. Old Bills

Old bills are unpaid medical, dental, or remedial care expenses which:

- were incurred prior to the Medicaid application month and the application's retroactive period,
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and
- remain a liability to the individual.

EXCEPTION: Bills paid by a state or local program and which meet the definition of "old bills" are treated as old bills even though they are not the individual's liability.

11. Projected Expenses

Expenses for services that have not yet been incurred but are reasonably expected to be incurred are projected expenses.

12. Spenddown Liability

The spenddown liability is the amount by which the individual's countable income exceeds the MNIL for the budget period.

M1460.150 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LTC

A. Applicability

The policy in this section applies to nursing facility and CBC/PACE patients, who meet the requirements for LTC on or after January 1, 2006. This includes individuals who filed reapplications after a break in Medicaid eligibility. It does **not apply** to Medicaid recipients who were approved for LTC prior to January 1, 2006, and who maintain continuous Medicaid eligibility.

For Medicaid applicants or enrollees approved for LTC on or after July 1, 2006, the amount of equity in the home at the time of the initial LTC determination and at each renewal must be evaluated.

B. Policy

Individuals with equity value (tax assessed value minus encumbrances) in home property that exceeds the limit are NOT eligible for Medicaid payment of long-term care services unless the home is occupied by

- a spouse,
- a dependent child under age 21 years, or
- a blind or disabled child of any age.

Individuals with substantial home equity may be eligible for Medicaid payment of other covered services if they meet all the other Medicaid eligibility requirements.

1. Home Equity Limit

The home equity limit applied is based on the date of the application or request for LTC coverage. Effective January 1, 2011, the home equity limit is subject to change annually. The home equity limit is:

- Effective January 1, 2006 through December 31, 2010: \$500,000
- Effective January 1, 2011: \$506,000
- Effective January 1, 2012: \$525,000.
- Effective January 1, 2013: \$536,000
- *Effective January 1, 2014: \$543,000*

6. **Domestic Travel Tickets** Gifts of domestic travel tickets [1612(b)(15)].
7. **Victim's Compensation** Victim's compensation provided by a state.
8. **Tech-related Assistance** Tech-Related Assistance for Individuals with Disabilities [ref. P.L. 100-407].
9. **\$20 General Exclusion** \$20 a month general income exclusion for the unit.
EXCEPTION: Certain veterans (VA) benefits are not subject to the \$20 income exclusion. Refer to subchapter S0830 for complete explanation of which VA payments are entitled to the \$20 general exclusion.
10. **PASS Income** Any unearned income used to fulfill an SSI approved plan to achieve self-support (PASS). See item 12 below for earned income used to fulfill a PASS [1612(b) (4)(A) & (B)].
11. **Earned Income Exclusions** The following earned income exclusions are not deducted for the 300% SSI group:
- a. For 2014, up to \$1,750 per month, but not more than \$7,060 in a calendar year, of the earned income of a blind or disabled student child.

For 2013, up to \$1,730 per month, but not more than \$6,960 in a calendar year, of the earned income of a blind or disabled student child.
 - b. Any portion of the \$20 monthly general income exclusion which has not been excluded from unearned income in that same month [1612(b) (2)(A)].
 - c. \$65 of earned income in a month [1612(b) (4)(C)].
 - d. IRWE - earned income of disabled individuals used to pay impairment-related work expenses [1612(b) (4)(B)].
 - e. One-half of remaining earned income in a month [1612(b) (4)(C)].
 - f. BWE - Earned income of blind individuals used to meet work expenses [1612(b) (4)(A)].
 - g. Earned income used to fulfill an SSI approved plan to achieve self-support (PASS) [1612(b) (4)(A) & (B)].
12. **Child Support** Child support payments received from an absent parent for a blind or Disabled child [1612(b) (9)].

M1470 Changes

Changed With	Effective Date	Pages Changed
TN #99	1/1/14	pages 9, 19, 20, 23, 24, 40
TN #98	10/1/13	pages 9, 24
UP #9	4/1/13	pages 9, 16, 19, 20, 24, 43
UP #7	7/1/12	pages 19, 46-48
UP #6	4/1/12	pages 4, 9, 19, 20, 24, 26
TN #96	10/1/11	pages 3, 4, 7-9, 19, 22-24, 43
TN #95	3/1/11	pages 9, 19, 20, 23
TN #94	9/1/10	Table of Contents pages 1, 1a, 3, 3a, 11, 12, pages 19, 20, 24, 28, 31
TN #93	1/1/10	pages 9, 13, 19-20, 23, 43, 44
TN #91	5/15/09	Table of Contents pages 1-56 Appendix 1

- 6. Medicare Part D Premiums** An individual who is eligible for Medicare and Medicaid is entitled to enrollment in a basic Medicare Part D prescription drug plan (PDP) *at no cost*. However, the individual may elect enrollment in a plan with a premium.

When a full-benefit Medicaid enrollee is enrolled in a *Medicare Part D* PDP, any premium that is the individual's responsibility is an allowable deduction from patient pay.

- 7. LTC Insurance** **a. Deduct LTC premium in admission month only**

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

b. LTC insurance benefits

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

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

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

- C. Non-covered Medical/Dental Services** Deductions for the cost of a patient's medically necessary medical or dental services not covered by Medicaid, other insurance (such as Medicare), or another person are subtracted from income to determine patient pay. Some deductions for noncovered services must be approved by DMAS before they can be subtracted from the patient's income.

Services that are covered by Medicaid in the facility's per diem rate cannot be deducted from patient pay as a noncovered service. See M1470.230 C.3 for examples of services that are included in the facility per diem rate.

- 1. Zero Patient Pay Procedures** If deductions from patient pay cannot be allowed because the recipient has no income remaining after deducting the personal needs allowance, dependent child allowance(s) and health insurance premiums, or the recipient has no income available for patient pay, deny the request.

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

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

- 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.

The PMA is:

- January 1, 2014 through December 31, 2014: \$1,189
- January 1, 2013 through December 31, 2013: \$1,171

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

2. Guardianship Fee

Deduct an amount up to 5% of the patient's gross monthly income (including amounts not counted as income and excluded income) for guardianship fees, if the patient has a legally appointed guardian or conservator AND the guardian or conservator charges a fee. The guardianship **filing** fees CANNOT be deducted from the individual's income. Document how it was determined that the guardian/conservator charges a fee and the amount of the fee.

No deduction is allowed if the patient's guardian receives a payment for providing guardianship services from a public agency or organization that receives funding for guardianship services.

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 (\$2,163 in 2014) per month.
- b. for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI (\$1442 in 2014) 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.

deduct Medicare premiums in the patient pay determination for months in the retroactive and ongoing coverage periods.

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

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

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

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

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

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

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

**3. Medicare
Advantage
(Part C)
Premiums**

Medicare Advantage plans, also referred to as Medicare Part C, are voluntary managed-care Medicare plans. In addition to Medicare Part B premiums, some individuals may pay an extra Medicare Advantage premium. The Medicaid Medicare buy-in is initiated for individuals with Medicare Advantage; however, the buy-in covers only the allowable Medicare Part A and/or B premiums. The individual is responsible for any additional Medicare Advantage monthly premium. The Medicare Advantage monthly premium remains the individual's responsibility and is an allowable deduction from patient pay.

**4. Medicare Part
D Premiums**

An individual who is eligible for Medicare and Medicaid is entitled to enrollment in a basic Medicare Part D prescription drug plan (PDP) *at no cost*. However, the individual may elect enrollment in a plan with a premium.

When a full-benefit Medicaid enrollee is enrolled in a *Medicare Part D* PDP, any premium that is the individual's responsibility is an allowable deduction from patient pay.

5. 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.

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

2. Full Month's Coverage If Spenddown Met

When incurred medical expenses equal or exceed the monthly spenddown liability, the individual is eligible for the full month of Medicaid coverage beginning the first day of the month, and ending the last day of the month.

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

3. Patient Pay

Because the spenddown is completed after the month and expenses are not projected, the spenddown liability is NOT added to the available income for patient pay. Use the following procedures to calculate the patient pay for the month in which the spenddown was met.

B. Patient Pay Procedures

1. Patient Pay Gross Monthly Income

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

2. Calculate Remaining Income for Patient Pay

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

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

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

3. Patient Pay

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

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

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

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

M1480 Changes

Changed With	Effective Date	Pages Changed
TN #99	1/1/14	pages 7, 18c, 66, 69, 70
TN #98	10/1/13	page 66
UP #9	4/1/13	pages 7, 18c, 66, 69, 70
UP #8	10/1/12	page 66
TN #97	9/1/12	pages 3, 6, 8b, 16 pages 20-25 Page 20a was deleted.
UP #7	7/1/12	pages 11, 14, 18c, 21 pages 32, 66, 67, 69
UP #6	4/1/12	pages 7, 18c, 66, 68, 69, 70
TN #96	10/1/11	pages 7, 14, 66, 71
UP #5	7/1/11	page 66
TN #95	3/1/11	pages 7-9, 13, 18a, 18c, 66, pages 69, 70
TN #94	9/1/10	pages 64, 66, 69, 70
TN #93	1/1/10	Table of Contents, page ii pages 3, 8b, 18, 18c, 20a pages 21, 50, 51, 66, pages 69, 70, 93 Appendix 4 was removed.
Update (UP) #1	7/1/09	page 66
TN # 91	5/15/09	pages 67, 68 pages 76-93

- 27. Spousal Share** means ½ of the couple's combined countable resources at the beginning of the **first** continuous period of institutionalization, as determined by a resource assessment.
- 28. Spouse** means a person who is legally married to another person under Virginia law.
- 29. Waiver Services** means Medicaid-reimbursed home or community-based services covered under a 1915(c) waiver approved by the Secretary of the United States Department of Health and Human Services.

M1480.015 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LONG-TERM CARE

- A. Applicability** The policy in this section applies to nursing facility and CBC/PACE patients, who meet the requirements for LTC on or after January 1, 2006. This includes individuals who filed reapplications after a break in Medicaid eligibility. It does **not apply** to Medicaid recipients who were approved for LTC prior to January 1, 2006, and who maintain continuous Medicaid eligibility.

For Medicaid applicants or enrollees approved for LTC on or after July 1, 2006, the amount of equity in the home at the time of the initial LTC determination and at each renewal must be evaluated.

- B. Policy** Individuals with equity value (tax assessed value minus encumbrances) in home property that exceeds the limit are NOT eligible for Medicaid payment of long-term care services unless the home is occupied by

- a spouse,
- a dependent child under age 21 years, or
- a blind or disabled child of any age.

Individuals with substantial home equity may be eligible for Medicaid payment of other covered services if they meet all the other Medicaid eligibility requirements.

- 1. Home Equity Limit** The home equity limit applied is based on the date of the application or request for LTC coverage. Effective January 1, 2011, the home equity limit is subject to change annually. The home equity limit is:

- Effective January 1, 2006 through December 31, 2010: \$500,000
- Effective January 1, 2011: \$506,000
- Effective January 1, 2012: \$525,000.
- Effective January 1, 2013: \$536,000
- *Effective January 1, 2014: \$543,000*

- 2. Reverse Mortgages** Reverse mortgages **do not** reduce equity value until the individual begins receiving the reverse mortgage payments from the lender.

2. After Eligibility is Established Once an institutionalized spouse has established Medicaid eligibility as an institutionalized spouse, count only the institutionalized spouse’s resources when determining the institutionalized spouse’s Medicaid eligibility. Do not count or deem the community spouse’s resources available to the institutionalized spouse.

If an institutionalized spouse’s Medicaid coverage was cancelled and he reapplies as an institutionalized individual, use only the resources of the institutionalized spouse for his eligibility determination.

C. Institutionalized Spouse Resource Eligibility Worksheet Use the “Institutionalized Spouse Resource Eligibility Worksheet,” available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi, or the electronic Resource Assessment and Eligibility Workbook located at <http://spark.dss.virginia.gov/divisions/bp/me/training/index.cgi>. to determine the institutionalized spouse’s resource eligibility.

M1480.231 SPOUSAL RESOURCE STANDARDS

A. Introduction This section provides the amounts and the effective dates of the standards used to determine an institutionalized spouse’s initial and ongoing resource eligibility. Use the standard in effect on the date of the institutionalized spouse's Medicaid application. Definitions of the terms are found in section M1480.010.

B. Spousal Resource Standard \$23,448 1-1-14
 \$23, 184 1-1-13

C. Maximum Spousal Resource Standard \$117,240 1-1-14
 \$115, 920 1-1-13

M1480.232 INITIAL ELIGIBILITY DETERMINATION PERIOD

A. Policy The initial eligibility determination period begins with the month of application. If the institutionalized spouse is eligible for the month of application, the initial eligibility determination period will both begin and end with that month.

After eligibility is established, the usual reporting and notification processes apply. Send *written notice* 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**

\$1,938.75	7-1-13
\$1,891.25	7-1-12
- C. Maximum Monthly Maintenance Needs Allowance**

\$2,931	1-1-14
\$2,898.00	1-1-13
- D. Excess Shelter Standard**

\$581.63	7-1-13
\$567.38	7-1-12
- E. Utility Standard Deduction (SNAP)**

\$275	1 - 3 household members	10-1-13
\$345	4 or more household members	10-1-13
\$277	1 - 3 household members	10-1-12
\$348	4 or more household members	10-1-12

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

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, deduct the appropriate maintenance allowance for one person as follows:

- January 1, 2014 through December 31, 2014: \$1,189
- January 1, 2013 through December 31, 2013: \$1,171.

Contact a Medical Assistance Program Consultant for the amount in effect for years prior to 2013.

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.

NOTES: No deduction is allowed for representative payee or "power of attorney" fees or expenses. No deduction is allowed if the patient's guardian receives a payment for providing guardianship services from a public agency or organization that receives funding for guardianship services. The guardianship filing fees CANNOT be deducted from the individual's income.

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

[EXAMPLE #19 was deleted]

For ED CD, 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 (\$2,163 for 2014) per month.

- 1) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI (\$1,442 for 2014) 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
- <u>1,024.00</u>	200% SSI maximum
\$ 0	remainder

\$928.80 = special earnings allowance

His personal maintenance allowance is calculated as follows:

\$ 512.00	maintenance allowance
+ <u>928.80</u>	special earnings allowance
\$1,440.80	personal maintenance allowance

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M15 Table of Contents Changes

Changed With	Effective Date	Pages Changed
TN #99	1/1/14	Table of Contents

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M1510 Changes

Changed With	Effective Date	Pages Changed
TN #99	1/1/14	Table of Contents pages 1, 2, 8, 8a, 9-11 Page 11a was added.
UP #9	4/1/13	pages 2-7, 10-12, 14
UP #7	7/1/12	pages 8, 9
TN #96	10/01/11	pages 8a, 10
TN #95	3/1/11	Table of Contents Pages 8, 11-15
TN #94	9/1/10	pages 2a, 8-8a
TN #93	1/1/10	page 6
Update (UP) #2	8/24/09	page 11
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M1510.000 ENTITLEMENT POLICY & PROCEDURES

M1510.100 MEDICAID ENTITLEMENT

A. Policy

If an individual meets all eligibility factors within a month covered by the application, eligibility exists for the entire month unless the individual became eligible by meeting a spenddown.

1. Spenddown Met

If the applicant had excess income and met the spenddown within the month, he remains responsible for his spenddown liability and his coverage begin date cannot be any earlier than the date he met the spenddown.

2. Applicant Dies

If an applicant dies during the application process, his eligibility is determined only for the days he was alive. He must have been eligible for Medicaid while he was alive in order to be entitled to enrollment in Medicaid. Any changes in the individual's resources or income after his death do not affect the eligibility determination.

Example: An individual applies on July 23 for retroactive and ongoing Medicaid. The worker determines that the individual had excess resources (cash value of life insurance) throughout the retroactive period and the application month. The individual dies on August 5. The family asserts that he no longer owned the life insurance policies on August 5 and meets the resource requirements for the month of August. The worker determines that the individual owned the policies on the date of his death, the countable value exceeded the resource limit and he was not eligible for medical assistance on or before the date of his death.

3. Applicant Has Open MA Coverage in Another State

If an applicant indicates that he has been receiving Medical Assistance (MA--Medicaid or Children's Health Insurance Program) coverage in another state prior to moving to Virginia, instruct him to contact his eligibility worker there and request that his coverage be cancelled, if he has not already done so. He is no longer considered a resident of the other state once he has moved to and intends to reside in Virginia and is not entitled to receive services paid for by the other state's MA program. As long as the individual meets the residency requirement per M230 and his cancellation in the other state is verified, he may be enrolled in Virginia Medicaid beginning the same month that his coverage ends in the other state.

B. SSI Entitlement Date Effect on Medicaid

SSI payments for eligible individuals are effective the first day of the month following the month in which the SSI application was filed. Medicaid coverage for eligible individuals is effective the first day of the month in which the Medicaid application is filed. When the Medicaid application is filed in the same month as the SSI application, the applicant is not eligible for Medicaid as an SSI recipient until the month in which his SSI entitlement began - the month following the application month. His eligibility for Medicaid in the application month must be determined in another covered group.

C. Procedures

The procedures for determining an eligible individual's Medicaid coverage entitlement are contained in the following sections:

- M1510.101 Retroactive Eligibility & Entitlement

C. Procedures

- M1510.102 Ongoing Entitlement
- M1510.103 Disability Denials
- M1510.104 Foster Care Children
- M1510.105 Delayed Claims

M1510.101 RETROACTIVE ELIGIBILITY & ENTITLEMENT**A. Definitions****1. Retroactive Period**

The retroactive period is the three months immediately prior to the application month. Within this retroactive period, the individual may be Categorically Needy (CN) in one or two months and Medically Needy (MN) in the third month, or any other combination of classifications.

2. Retroactive Budget Period

The "budget period" is the period of time during which an individual's income is calculated to determine income eligibility. The retroactive budget period depends on the individual's covered group.

B. Policy

An application for Medicaid or Auxiliary Grants (AG) is also an application for retroactive Medicaid coverage whenever the applicant reports that he/she received a Medicaid-covered service in retroactive period. Eligibility for retroactive coverage is determined at the same time as the ongoing eligibility is determined, using the same application.

When an applicant reports that he/she, or anyone for whom he/she is applying, received a Medicaid covered service in any one of the three retroactive months, determine the applicant's eligibility for all three retroactive months, regardless of the service date. Determine nonfinancial, resource and income eligibility for each month in the retroactive period.

C. Budget Periods By Classification**1. CN**

The retroactive budget period for CN covered groups (categories) is one month.

CN eligibility is determined for each month in the retroactive period, including a month(s) that is in a prior spenddown that was not met. Do not determine eligibility for a retroactive month that was included in a previous Medicaid coverage period; the applicant has already received Medicaid for that month.

NOTE: There is never any retroactive eligibility or entitlement as a Qualified Medicare Beneficiary (QMB) only. An individual who is eligible as Special Low-income Medicare Beneficiary (SLMB) or Qualified Disabled & Working (QDWI) can have retroactive coverage as an SLMB or QDWI.

2. MN

For the retroactive period, the **MN budget period is always all three months**. Unlike the retroactive CN period, the retroactive MN budget period may include a portion of a prior Medicaid coverage or

- 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 PRESUMPTIVE ELIGIBILITY

- A. Policy** *Individuals enrolled on the basis of PE are covered by Medicaid for the month in which the PE application was made and the following month. For their coverage to continue beyond the following month, they must submit a full MA application to the LDSS. See M0120.300 A.5 for additional information.*
- B. Procedures** *Individuals are enrolled in PE for a closed period of coverage for the month of the PE application and the following month. When a full MA application is received and pended in VaCMS, the individual's PE coverage is to be extended, if necessary, while the full application is being processed by the local agency. If the person is determined eligible for continued MA coverage, the eligibility worker is to continue ongoing coverage in the appropriate aid category beginning the first day of the month after the effective date of the PE coverage cancellation.*
- 1. Retroactive Entitlement** *An individual's eligibility for retroactive coverage for the three months prior to the month of the full MA application is determined when the individual had a medical service within the three months prior to the month of application. If the individual had **full** coverage while enrolled as PE, only determine his eligibility for months in the retroactive period that he was not enrolled as PE.*
- Because pregnant women are eligible only for limited benefits, if the woman is determined eligible for full coverage in the retroactive period, cancel PE coverage retroactively and reinstate in full coverage for the retroactive months.*
- 2. Not Eligible for Ongoing Coverage** *If the applicant is determined to not be eligible for ongoing MA coverage, send written notice that the individual is not eligible for continued MA coverage. The individual receives notice of the PE coverage period from the hospital at the time of the PE enrollment; advance notice of the PE cancellation is not required.*
- The individual's PE coverage is valid regardless of whether or not the individual is eligible for ongoing coverage; do **not** refer the case to the DMAS Recipient Audit Unit.*

- 3. Individual Does Not Submit MA Application** *If the person does not submit an MA application prior to the end of the PE coverage period, his PE coverage will be automatically terminated. No involvement from the LDSS is required..*

M1510.104 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 as long as the disability onset month is prior to the month of application or is no later than 90 days after the month of 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 month is no later than 90 days from the month of 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 in Chapter M13 for placement on a spenddown, a first prospective and additional 6 month spenddown budget period are 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.

M1510.105 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 retroactive period. If the Medicaid application is filed more than 4 months after entrustment or commitment, retroactive entitlement as a foster care child exists in the 3 months prior to Medicaid application. Entitlement cannot go back more than 3 months prior to the Medicaid application month.

M1510.106 DELAYED CLAIMS**A. When Applicable**

Medicaid will not pay claims from providers that are filed more than 12 months after the date the service was provided, unless the reason for the delayed filing was a delay in the enrollee's eligibility determination and enrollment. If the applicant is eligible for Medicaid and the coverage begin date is 12 months or more prior to the month during which the enrollee is enrolled on the Medicaid computer, the agency must write a letter for the applicant to give to all medical providers who will bill Medicaid for services provided over 1 year ago.

B. Eligibility Delay Letter Requirements

The letter must:

- be on the agency's letterhead stationery and include the date completed.
- be addressed to the "Department of Medical Assistance Services, Claims Processing Unit."
- state the enrollee's name and Medicaid recipient I.D. number.
- state that "the claim for the service was delayed for more than one year because eligibility determination and enrollment was delayed."

C. Procedures

The "eligibility delay" letter and a sufficient number of copies must be given to the enrollee to give to each provider who provided a covered medical service to the recipient over one year ago. The provider must attach the letter to the claim invoice in order to receive Medicaid payment for the service. If the date the letter was prepared by the agency is not included on the letter, the claim will be denied. If the individual was enrolled in a closed period of coverage, include the dates of coverage in the letter.

A sample eligibility delay letter is available on the local agency intranet at: <http://spark.dss.virginia.gov/divisions/bp/me/forms/>.

M1510.200 NOTICE REQUIREMENTS

A. Policy

Federal regulations in 42 CFR 431.206 through 431.214 require the agency to inform every applicant or enrollee in writing

- of his right to a hearing;
- of the method by which he may obtain a hearing; and
- that he may represent himself or use legal counsel, a relative, a friend or other spokesperson.

The agency must provide the information required above at the time of any action affecting his claim for Medicaid benefits.

B. Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs

A system-generated Notice of Action or the "Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs" (Form 032-03-008) must be used to notify the applicant:

- that his application has been approved and the effective date(s) of his Medicaid coverage.
- that retroactive Medicaid coverage was approved and the effective dates.
- that his application has been denied including the specific reason(s) for denial.
- that retroactive Medicaid coverage was denied, including the specific reason(s) for denial.
- of the reason for delay in processing his application.
- of the status of his request for reevaluation of his application in spenddown status.

When the application was filed by the applicant's authorized representative, a copy of the notification must be mailed to the applicant's authorized representative.

1. CN Children or Pregnant Women

When the application of a medically indigent child or pregnant woman is denied because of excess income, the denial notice must state the reason for denial. The notice must also include the resource question pages from *an MA application form* and must advise the applicant of the following:

- a. that he/she may complete and return the enclosed form for a Medicaid spenddown to be evaluated, and
- b. if the information is returned within 10 days of this notice, the medically indigent application date will be used as the Medicaid spenddown application date.

2. Qualified Medicare Beneficiaries

a. Excess resources

When a Qualified Medicare Beneficiary's (QMB's) application for full benefit Medicaid coverage is denied because of excess resources, the denial notice must state that the applicant is not eligible for full Medicaid coverage because of excess resources.

b. Excess income

- 1) If the QMB's resources are within the Medicare Savings Program (MSP) limit but are over the MN limit, and the income exceeds the limit for full Medicaid coverage, the notice must state that the applicant is not eligible for QMB Medicaid because of excess income, and is not eligible for MN spenddown because of excess resources. The notice must specify the dollar amount of the appropriate MN resource limit.
- 2) If the QMB's resources are within the MN income limit, and income exceeds the limit for full Medicaid coverage, the notice must state that the applicant is not eligible for full-benefit Medicaid because of excess income, but that the applicant can become eligible by incurring medical or dental expenses that equal or exceed his excess income. The notice must specify the spenddown amount, the spenddown period begin and end dates, and include a copy of the Spenddown Fact Sheet.

3. Retroactive Entitlement Only or Limited Period of Entitlement

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

4. Example #7 Limited Period of Entitlement

A Medicaid application was filed on December 30. The client inherited real property on January 30. The agency processed the application on February 5 and determined the client was eligible for Medicaid for the months of December and January, but was ineligible for additional coverage beginning February because the countable value of the inheritance caused excess resources. One notice is sent to the applicant stating that his Medicaid application was approved beginning December 1 and ending January 31, and that he was denied coverage after January 31 because of excess resources (real property).

M1510.300 FOLLOW-UP RESPONSIBILITIES

M1510.301 THIRD PARTY LIABILITY (TPL)

- A. Introduction** Medicaid is a “last pay” program and cannot pay any claim for service until the service provider has filed a claim with the recipient’s liable third parties such as health insurance companies or legally liable person. The procedures depend on the type of third party liability (TPL) the recipient has.
- B. Private Health Insurance** Information on an eligible individual’s private health insurance coverage must be obtained and recorded in the case record and in the MMIS. This must include the company name (code number for the TPL file), the policy number, and the begin date of coverage. This information does NOT require verification.
- Health insurance policy or coverage changes must be updated in the eligibility record and the MMIS TPL file.
- 1. Verification Required - Policy or Coverage Termination** Verification of the date the health insurance policy and/or a coverage type terminated is required. The verification of the termination date can be a written letter from, or verbal statement by, the insurance company that states the termination date. If verification is obtained, the worker is to **end-date** the TPL coverage in MMIS (note: do not delete the TPL from MMIS).

CHAPTER M15
ENTITLEMENT POLICY & PROCEDURES
SUBCHAPTER 20

MEDICAL ASSISTANCE ELIGIBILITY REVIEW

M1520 Changes

Changed With	Effective Date	Pages Changed
TN #99	1/1/14	Table of Contents Pages 1-34 (entire subchapter)
UP #9	4/1/13	pages 7b and 10a
TN #97	9/1/12	page 1
UP #7	7/1/12	pages 1, 7, 7c, 7g
TN #96	10/1/11	Table of Contents pages 1-7g pages 11-13 pages 21-24
TN #95	3/1/11	pages 6a, 7, 21, 22
TN #94	9/1/10	Table of Contents pages 3, 4b, 5, 6-6a, 10 Appendix 1 was removed.
UP #4	7/1/10	page 4
TN #93	1/1/10	pages 3, 4b, 5-6, 10, 15 pages 21, 22
Update (UP) #2	8/24/09	pages 1, 2, 13, 14, 17, 18
Update (UP) #1	7/01/09	page 3

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M1520.000 MEDICAL ASSISTANCE ELIGIBILITY REVIEW

M1520.001 GENERAL PRINCIPLE

A. Policy

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

An annual review of all of the enrollee's eligibility requirements is called a "renewal." A renewal of the enrollee's eligibility must be completed at least once every 12 months. The renewal should be initiated in the 11th month to ensure timely completion of the renewal. The timeframe for acting on a change or renewal is 30 calendar days from the report of the change or upon receipt of the completed renewal form. When a telephone interview is conducted for a renewal, the 30 day period begins upon completion of the telephone interview.

Exception: Children meeting the definition of a newborn in M0330.802 are to be enrolled as soon as possible upon report of the birth.

When an enrollee no longer meets the requirements for his current covered group, prior to cancelling his coverage, he must be evaluated in all covered groups for which he may meet the definition. If the individual is not eligible for full benefit Medicaid coverage and is not eligible as a Medicare beneficiary, he must be evaluated for Plan First, unless he has declined that coverage.

1. Negative Action Requires Advance Notice

When a change is reported that impacts eligibility or a renewal is completed and the enrollee is no longer eligible, the Advanced Notice of Proposed Action must be sent to the enrollee before the enrollee's benefits can be reduced or his eligibility can be terminated (see M1520.301).

2. Renewal Approval Requires Notice

When a change is reported and eligibility continues, no notice is necessary. When a renewal is completed and eligibility continues, the Notice of Action is used to inform the enrollee of continued eligibility and the next scheduled renewal.

3. Voter Registration

If the individual reports a change of address in person, voter registration application services must be provided (see M0110.300 A.3).

B. Procedures For Partial Review and Renewals

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

- the requirements for **partial reviews** are in section M1520.100;
- the requirements for **renewals** are in section M1520.200;
- the policy and procedures for **canceled** an enrollee's coverage or reducing the enrollee's Medicaid *level of* benefits are in section M1520.300;
- the policy and procedures for **extended Medicaid coverage** are in section M1520.400;
- the policy and procedures for **transferring cases** within Virginia are in section M1520.500.

M1520.100 PARTIAL REVIEW

- A. Enrollee's Responsibility** Enrollees must report changes in circumstances which may affect eligibility and/or patient pay within 10 days from the day the change is known. For enrollees participating in the Health Insurance Premium Payment (HIPP) Program, changes that may affect participation in HIPP must also be reported to the DMAS HIPP Unit within the 10 day timeframe.
- B. Eligibility Worker's Responsibility** The eligibility worker has a responsibility for keeping a record of changes that may be anticipated or scheduled, and for taking appropriate action on those changes. The worker can set a follow-up review in the MMIS for anticipated changes. Examples of anticipated changes include, but are not limited to, the receipt of an SSN, receipt of SSA benefits and the delivery date for a pregnant woman.
- Appropriate agency action on a reported change must be taken within 30 days of the report. If the enrollee reports any changes requiring verifications, such as changes in income or resources, or an asset transfer for enrollees receiving LTC services, send the enrollee a checklist requesting the necessary verifications, and allow at least 10 calendar days for the information to be returned. Document the information and evaluation in the case record.
- 1. Changes That Require Partial Review of Eligibility** When changes in an enrollee's situation are reported by the enrollee or when the agency receives information indicating a change in an enrollee's circumstances (i.e. SSI purge list, reported transfer of assets), the worker must take action to partially review the enrollee's continued eligibility.
- A reported increase in income and/or resources can be acted on without requiring verification, unless a reported change causes the individual to move from a limited-benefit covered group to a full-benefit covered group. The reported change must be verified when it causes the individual to move from a limited-benefit covered group to a full-benefit covered group.
- 2. Changes That Do Not Require Partial Review** When changes in an enrollee's situation are reported or discovered, such as the enrollee's SSN and card have been received, the worker must document the change in the case record and take action appropriate to the reported change in the appropriate computer system(s).
- Example: The MA enrollee who did not have an SSN, but applied for one when he applied for MA, reports by calling the worker that he received his SSN. The worker records the telephone call and the enrollee's newly assigned SSN in the case record, verifies the SSN via SPIDeR and enters the enrollee's verified SSN in the eligibility determination/enrollment systems.
- 3. HIPP** The eligibility worker must provide the enrollee with a copy of the HIPP FACT Sheet when it is reported that he or a family member is employed more than 30 hours per week and is eligible for coverage under an employer's group health plan. The HIPP Fact Sheet is available on-line at: <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>. The eligibility worker must report to the HIPP Unit at DMAS any changes in an enrollee's situation that may affect the premium payment. The worker may report changes by e-mail to hipp@dmass.virginia.gov. This e-mail address is for use by the local agency staff only. See M0130.200 G for additional information about HIPP requirements.

- 4. Program Integrity** The MA eligibility of enrollees is subject to periodic review through the program integrity process (such as Medicaid Quality Control and the DMAS Recipient Audit Unit). It may be necessary for program integrity staff to request information, such as income verification, from the enrollee. The enrollee will be notified in writing and given a reasonable amount of time, as determined by the program integrity staff, to provide the information.

Should the enrollee not provide the requested information to the program integrity staff within the specified time, program integrity staff will notify the eligibility worker, and the worker must take action to follow up by requesting the appropriate verifications and/or sending advance notice, if necessary, to cancel coverage due to the inability to determine continued eligibility. An individual's failure to provide information to program integrity staff does not affect any future Medicaid applications.

C. 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) *or a teen enrolled in the Family Access to Medical Insurance Security Plan (FAMIS)*, 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) *or teen covered by FAMIS* 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 a Child *Under Age 19* 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. F&C Enrollee Becomes Entitled to SSI** When an individual who is enrolled in a Families and Children (F&C) covered group becomes entitled to SSI, the enrollee must be given the opportunity to provide information regarding ownership interest in countable real property for eligibility in the SSI Medicaid covered group. Contact the individual by telephone, inquire about any ownership interest in real property, and document the case record regarding the individual's statement. If the enrollee cannot be reached by telephone, request the information *in writing*.

If the individual reports no ownership interest in countable real property, take action to change the individual's AC to the appropriate SSI Medicaid AC. Because full coverage continues, no notice is required.

If the SSI individual reports ownership of countable real property, request verification of all countable resources. If verification is provided, determine eligibility in the SSI Medicaid covered group. If eligible, change the AC to the appropriate SSI Medicaid AC. Otherwise, the individual remains enrolled as an F&C enrollee as long as F&C eligibility continues.

See M0320.201 for information regarding eligibility requirements for the SSI Medicaid covered group.

4. 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) must be completed.

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

D. Child Discharged From A Psychiatric Residential Treatment Facility

Children who receive Medicaid-covered treatment in a psychiatric residential treatment facility may receive a special benefit package through the Children's Mental Health Program following discharge from the facility. Effective July 1, 2010, children receiving Children's Mental Health Program services after discharge from a psychiatric residential treatment facility continue to be eligible for Medicaid without the need for an eligibility review. When determining the Medicaid eligibility of these children, each child is considered an assistance unit of one (1) as long as the child continues to receive Children's Mental Health Program services.

1. Notification to LDSS

The discharge planner with the psychiatric residential treatment facility will send a Children's Mental Health Program Pre-Release Referral (form DMAS-800) to the agency. The referral will identify the child, the proposed date of discharge, and the proposed placement in the community. Transitional services care coordinators may download the official form from the DMAS web site, <http://www.dmas.virginia.gov>.

2. Agency Responsibility

Upon receipt of the Children's Mental Health Program Pre-Release Referral, the agency will document in the case record that the child has been approved for Children's Mental Health Program services. The child continues to be an assistance unit of one (1) for Medicaid eligibility purposes as long as the child continues to receive Children's Mental Health Program services.

Unless a change is subsequently reported that may impact eligibility, the child's Medicaid eligibility is not reviewed until the next annual renewal is due. A copy of the completed referral form must be kept in the case record.

E. Child Moves From Parental Home

When an enrolled child moves out of the parental home but is still living in Virginia, do not cancel *MA* coverage solely on the basis of the move, and do not require a new application. Complete a partial review to determine the child's continuing eligibility if any changes in income, such as the child becoming employed, are reported.

1. Case Management

The necessary case management actions depend on the child's age and whether or not the child has moved to an arrangement in which an authorized representative is necessary.

a. Child Age 18 years or Under 18 and Living with a Relative

If the child is age 18, he may be placed in his own *MA* case if he was previously on a case with other enrollees. If the child is under age 18 and moved in with an adult relative, the child may be placed on a case with the relative and the relative authorized to conduct *MA* business on behalf of the child.

b. Child Under Age 18 years Living with Non-relative

When a child under age 18 moves to the home of a non-relative adult without legal custody, the non-relative adult does not have to be an authorized representative to report changes in the child's situation. However, the worker cannot discuss the case or send the non-relative adult a copy of the child's *MA* card unless the person is authorized to handle the *MA* business for the child. Follow the procedures in M1520.100 E.2 through E.4 below.

2. MMIS Enrollment

a. MMIS Case Number

The child's MMIS member ID number does not change, but the child's Member ID number must be moved to an MMIS base case number in the child's name as case head, if the person with whom the child is living does NOT have authority to act on the child's behalf.

b. MMIS Demographics Comment Screen

On the child's MMIS Demographics screen, enter a Comment that will inform staff that the person with whom the child lives cannot be given information from the child's MMIS records. Type a message in the Comment screen that says "information from the case cannot be shared with (the name of the person with whom the child lives) because he/she is NOT authorized to receive the information."

c. Renewal Date

If establishing a new MMIS case for the child, enter the child's existing renewal date from his former MMIS case. If moving the child to the adult relative's already established MMIS case, the child's renewal date will be the adult relative's case renewal date only if this action does not extend the child's renewal date past one year.

d. Medicaid Card

A new *MA* insurance ID card is only generated when the enrollee's name, SSN or gender changes, or when a worker requests a replacement ID card.

Changing the child's address or MMIS case number does not generate a new card. The worker must request a replacement card in MMIS if one is needed. The existing card will be voided when the replacement is issued.

3. Obtain Authorization from Parent Prior to Renewal

Prior to the next scheduled renewal, the agency should try to obtain an authorization from the parent to allow the agency to communicate with the adult. However, as long as the parent has not formally lost custody of the child, the parent is still the responsible party and can transact the Medicaid business if he is capable and willing, or until there is a guardian/custodian established. If the parent cannot or will not designate an authorized representative, refer the case to the agency's Family Services Unit so that guardianship can be established per M0120.200 C.

4. Renewal

Follow the rules in M0120.200, which apply to both applications and renewals. If the adult is a relative, the adult can complete the renewal for the child. If the adult is a non-relative and not an authorized representative, then the adult cannot complete the child's renewal. If the child's parent cannot or will not complete the renewal, a referral to the agency's Family Services Unit is needed to pursue guardianship.

F. Recipient Enters LTC

An evaluation of continued eligibility must be done when a Medicaid enrollee begins receiving Medicaid-covered long-term care (LTC) services. When the re-evaluation is done, complete and send all required notices to the enrollee/authorized representative, and send a DMAS-225 to the provider (see M1410.300).

Note: To determine the enrollee's Medicaid eligibility as an institutionalized individual, a pre-admission screening may be required (see M1420.100).

1. Partial Review Required

If an annual renewal has been done within the past 6 months, a partial review to address factors pertinent to receipt of LTC, such as asset transfer, spousal resource assessment, etc., must be completed. If the enrollee reports any changes requiring verifications, such as changes in income or resources, or an asset transfer, send the enrollee a written request for the necessary verifications, and allow at least 10 calendar days for the information to be returned. Document the renewal information and evaluation in the case record. Send all required notices (see M1410.300).

If the individual is already enrolled in a full benefit Medicaid covered group other than the ABD with Income \leq 80% FPL covered group, do not change the AC. If the individual is enrolled as \leq 80% FPL, the individual must be evaluated for eligibility in one of the covered groups for institutionalized individuals (i.e. income \leq 300% of SSI). Follow the procedures in M1460 to determine the appropriate covered group/AC for the individual.

2. Renewal Required

If an annual renewal has not been done within the past 6 months, a complete renewal must be completed (see M1520.200 and M1520.300).

3. SSI Recipients

For an SSI recipient who has no community spouse and owns no countable real property, verify continued receipt of SSI through SOLQ-I or SVES, obtain information regarding asset transfer from the enrollee or authorized representative, and document the case record. As long as the individual continues to receive SSI, do not change the AC. If the individual loses SSI, evaluate his Medicaid eligibility in other covered groups. See M1430.103 for additional information regarding an SSI recipient who enters a nursing facility.

- 4. Individual on a Spenddown** When an individual on a spenddown enters LTC, his Medicaid eligibility must be determined using the procedures in subchapter M1460.
- An individual on a spenddown in an assistance unit with a spouse and/or children becomes a separate assistance unit when he enters LTC. The spouse's and/or children's spenddown liability is recalculated to reflect a decrease in assistance unit size. See M1350.220 for additional information.
- 5. Married Institutionalized Individuals with a Community Spouse** Rules for determining Medicaid eligibility for married institutionalized recipients who have a community spouse are found in subchapter M1480.

M1520.200 RENEWAL REQUIREMENTS

- A. Policy** The agency must evaluate the eligibility of all MA enrollees, with respect to circumstances that may change, at least every 12 months. Each renewal must be authorized by an eligibility worker or supervisor, although administrative staff may assist in the gathering of information.
- 1. Required Verifications** An individual's continued eligibility for MA requires verification of income for all covered groups and resources for covered groups with resource requirements. Blindness and disability are considered continuing unless it is reported that the individual is no longer blind or disabled.
- 2. SSN Follow Up** If the enrollee's Social Security Number (SSN) has not been assigned by the renewal date, the worker must obtain the enrollee's assigned SSN at renewal in order for coverage to continue. See subchapter M0240 for detailed procedures for obtaining the SSN.
- 3. Evaluation and Documentation** An evaluation of the information used to determine continued eligibility must be completed and included in the case record. For *SSI Medicaid ex parte renewals (and F&C ex parte renewals completed prior to April 1, 2014)*, the Record of Ex Parte Medicaid Renewal (#032-03-0740) is recommended. For contact-based renewals, either a paper renewal form or the Record of Telephone Interview for Medicaid Renewal (#032-03-0741), available on SPARK at <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi> must be used to document the case record.

For the period of April 2014 until March 2015, all individuals (other than SSI Medicaid enrollees who have not reported countable real property) who were in MMIS as existing enrollees prior to October 1, 2013, are to have their renewals conducted using the approved paper Administrative Renewal form. This renewal form allows for the gathering of applicant information necessary to determine an individual's eligibility for affordable healthcare, including MA.

For F&C enrollees, certain demographic information regarding the enrollee will be pre-filled on the Administrative Renewal form that is sent to the enrollee. New or revised information provided by the enrollee (or any applicant new to the case) must be entered into the Virginia Case Management System (VaCMS).

For the ABD enrollee, no information will be pre-filled. Except for individuals in the SSI Medicaid covered group, ex parte renewals are not to be conducted during the time period above to ensure that LDSS have all necessary information for a determination of eligibility for affordable healthcare.

Note: for individuals who were new enrollees as of October 1, 2013 going forward, a new renewal process will be utilized. Policy guidance regarding that renewal process will be explained in a future transmittal.

The enrollee must be informed in writing of the findings of the renewal and the action taken using the Notice of Action or *system generated notice* when continued eligibility exists. *Advance written notice* must be used when there is a reduction of benefits or termination of eligibility.

**4. Voter
Registration
Requirement**

The National Voter Registration Act of 1993 (NVRA) requires local social services agencies to offer Medicaid enrollees an opportunity to apply to register to vote at each renewal (redetermination) of eligibility (see M0110.300.A.3).

5. Renewal Period

Renewals must be completed prior to cut-off in the 12th month of eligibility. The first 12-month period begins with the month of application for Medicaid.

EXCEPTION: *For F&C MA renewals using Modified Adjusted Gross Income (MAGI) methodology, a 90-day reconsideration period must be allowed. A renewal application may be submitted within 90 days of case closure and re-evaluated without penalty. After 90 days, a new application will be required.*

Subsequent renewals must be completed by the MMIS cut-off date no later than 12 months following the month in which the last renewal was filed/initiated. Monthly annual renewal lists are generated by the VDSS Data Warehouse using MMIS data. These reports notify eligibility workers of enrollees due and overdue for renewal.

**6. Scope of
Renewals**

The scope of renewals is limited to information that is necessary to determine ongoing eligibility and that relates to circumstances that are subject to change, such as income and resources. Verification of information that is not subject to change, such as date of birth and Social Security Number (SSN), is not required at renewal, unless it has not been verified previously.

**7. Types of
Renewals**

Whenever the necessary renewal information is available to the worker through data verification sources and policy permits, the client is not to be contacted and the renewal is to be completed. When it is necessary to obtain information and/or verifications from the enrollee, *a contact-based renewal must be completed.*

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

Note: *For the period of April 2014 until March 2015, all individuals (other than SSI Medicaid enrollees who have not reported countable real property) who were in MMIS as existing enrollees prior to October 1, 2013, are to have their renewals conducted using the approved paper Administrative Renewal form.*

Ex Parte Renewal

An ex parte renewal is an internal review of eligibility based on information available to the agency. By relying on information available, the agency avoids unnecessary and repetitive requests for information from individuals and families that can add to administrative burdens, make it difficult for individuals and families to retain coverage, and cause eligible individuals and families to lose coverage. The procedures for completing an ex parte renewal are in M1520.200 B, below. ***Beginning April 1, 2014, ex parte renewals will not be used for individuals enrolled prior to October 1, 2013, except for SSI Medicaid enrollees who have not reported countable real property.***

b. Telephone Interview Renewal Process (*Prior to April 1, 2014*)

If an ex parte renewal cannot be done, the eligibility worker may conduct a telephone interview renewal, either in conjunction with the renewal for other benefits or for Medicaid only. The procedures for completing a telephone renewal interview are in M1520.200 C below. ***Beginning April 1, 2014, telephone interview-based renewals will not be used for individuals enrolled prior to October 1, 2013 for reasons specified in M1520.200 A.3.***

c. Renewal Using a Paper Renewal Form

(1) *Renewals Prior to April 1, 2014*

If ongoing eligibility cannot be established *solely using information available from electronic data sources (or telephone for renewals completed prior to April 1, 2014)*, the agency must provide the individual the opportunity to present additional or new information on a paper renewal form and to present verifications necessary to determine ongoing eligibility. The procedures for completing a renewal when a paper form is used are in section M1520.200 D, below.

For renewals completed prior to April 1, 2014, the following Medicaid renewal forms are available on SPARK at <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>:

- The Families & Children Medicaid and FAMIS Plus Renewal Form (#032-03-0187);
- The ABD Medicaid Renewal Form (#032-03-0186) ;
- The BCCPTA Redetermination Form (#032-03-0653), for woman enrolled in the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) covered group.
- The Medicaid Application/Redetermination for Long-Term Care (#032-03-0369), available at: http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi, for individuals receiving LTC services;
- The Eligibility Review Part A (#032-03-729A) and Eligibility Review Part B (#032-03-729B) for individuals required to complete them for another benefit program.

(2) Renewals On or After April 1, 2014

For renewals completed on or after April 1, 2014 for enrollees in MMIS prior to October 1, 2013, LDSS are to send Administrative Renewal forms to all enrollees (other than SSI Medicaid enrollee who have not reported countable real property). All paper renewal forms must be signed. Information from the forms must be entered into VaCMS upon receipt from the enrollee.

B. Ex Parte Renewal Process

Conduct renewals of ongoing Medicaid eligibility through the ex parte renewal process when:

- the local agency has access to on-line systems information for verifications necessary to determine ongoing eligibility and/or income verifications obtained for other benefit programs, and
- the enrollee's covered group is not subject to a resource test.

Ex parte renewals will not be used beginning April 1, 2014 except for SSI Medicaid enrollees who have not reported countable real property.

1. F&C Ex Parte Renewal Procedures (for Renewals Completed Prior to April 1, 2014)

a. Use Available Information

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

The eligibility worker is to take every opportunity to renew Medicaid eligibility when information is reported/verified that will allow a renewal of eligibility to be completed. For example, when an ongoing Medicaid enrollee applies for SNAP or TANF or reports a change in income, use the income information obtained to complete an early ex parte Medicaid renewal and extend the Medicaid renewal for another 12 months.

b. Income Verification

The eligibility worker must document the date and method used to obtain the verification information (viewed pay stub dated xx/xx/xxxx, telephone call on xx/xx/xxxx date, etc.), the type of verification, the source and a description of the information. Income verification that is 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 income verifications in the case record. If the renewal is not processed and documented in ADAPT, the documentation must be in the case record.

An enrollee who has previously reported \$0 income must provide confirmation of income at each renewal, either on a renewal form or by a written statement. If the agency has not obtained written confirmation for another program (e.g. SNAP), do not complete an ex parte renewal when an

enrollee has reported \$0 income. \$0 income statements must be no more than 30 days old to be used. If written confirmation was provided for another program, it cannot be used if it is more than 30 days old.

2. Renewal Procedures For SSI Recipients and 1619(b) Individuals

a. Review Case Record

An ex parte renewal for an SSI recipient (including an LTC recipient with no community spouse) who has reported no ownership interest in countable real property can be completed by verifying the individual's 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-excluded real property. He is subject to a resource evaluation and the agency has no internal means to verify all his resources.

For a 1619(b) individual, check the Medicaid Test Indicator field in SVES or SOLQ-I to verify there is a code of A, B or F.

The case record must also contain documentation that the individual reported no ownership interest in countable real property, either on the application form or on a subsequent renewal form. If the case record does not contain documentation that the individual reported no ownership interest in real property, a contact-based (telephonic or paper form) renewal is to be completed at the next annual renewal.

b. Individual Loses SSI or 1619(b) Status

If the individual is no longer an SSI recipient or no longer has 1619(b) status and the information needed to determine continued eligibility is not known to the agency, a contact-based (telephone interview or paper form) renewal must be completed and necessary verifications obtained to evaluate the individual's eligibility in all other covered groups prior to canceling his Medicaid coverage.

C. Telephone Interview Renewal Procedures (for Renewals Completed Prior to April 1, 2014)

When an ex parte renewal cannot be completed for an enrollee in any covered group, the eligibility worker may contact the enrollee by telephone. When a renewal interview is conducted by telephone, no renewal form is sent to the enrollee, and the enrollee's signature is **not** required. Send the enrollee a written request for the necessary verifications, and allow at least 10 calendar days for the information to be returned. **If an enrollee whose renewal is conducted by telephone interview reports \$0 income, obtain a written statement indicating that he has no income. A signed renewal form can be used in lieu of a written statement.**

Beginning April 1, 2014, telephone interview-based renewals will not be used for individuals enrolled prior to October 1, 2013.

The renewal information and evaluation must be documented in the case record. The enrollee must be informed of the findings of the renewal.

D. Paper Renewal Procedures

The enrollee must be allowed 30 days to return the Administrative Renewal form and the necessary verifications. The form needs to be sent to the enrollee no later than the beginning of the 11th month of the eligibility cycle to allow for the 30 day return period and processing prior to the MMIS cutoff on the 16th of the month. The specific information requested and the deadline for receipt of the verification must be documented in the case record.

All enrollees who were in MMIS as existing enrollees prior to October 1, 2013, will have their renewals conducted using the approved paper Administrative Renewal form from April 2014 until March 2015, with the exception of SSI Medicaid individuals.

For F&C cases housed in VaCMS, certain demographic enrollee information will be pre-filled and printed on the form from VaCMS.

The paper Administrative Renewal form will also be used for ABD enrollees, but the forms will not be pre-filled. LDSS are to send Administrative Renewal forms to all enrollees. All paper renewal forms must be signed. Information from the forms must be entered into VaCMS upon receipt from the enrollee.

E. Dual Renewal Procedures for Some F&C Enrollees for the Period Between January 1, 2014 and March 31, 2014.

The ACA requires states to ensure that F&C enrollees whose renewals are completed between January 1, 2014 and March 31, 2014 under the eligibility rules in place prior to October 1, 2013 and who are found to be ineligible are provided an opportunity to be evaluated under MAGI and new household composition rules.

*For renewals completed during this period, the enrollee's continued eligibility should first be evaluated using the non-MAGI F&C policies contained in Chapter M07, which were in place prior to October 1, 2013. If the individual is no longer eligible under non-MAGI rules, **do not** cancel his MA coverage until his eligibility using MAGI methodology can be determined.*

*Send the enrollee a Cover Virginia Application for Health Coverage & Help Paying Costs. **On or after April 1, 2014**, enter the application into VaCMS for his continued eligibility to be evaluated using MAGI methodology. If he is not eligible using MAGI rules, send advance notice and cancel his coverage.*

F. Disposition of Renewal

1. Renewal Completed

Notify the enrollee in writing of the findings of the renewal and the action taken. When eligibility continues, use the Notice of Action, and include the month and year of the next scheduled renewal. When the individual is no longer eligible, use the Advance Notice of Proposed Action and include spenddown information, if applicable. When there is a reduction of benefits, use the Advance Notice of Proposed Action and include the month and year of the next scheduled renewal.

2. 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. Action cannot be taken to cancel coverage until after the deadline for the receipt of verifications has passed, except for situations when the deadline falls on a weekend or holiday.

- 3. Action Taken After Cutoff but Prior to Cancellation Date** 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-evaluate the renewal if the individual provides the necessary information by the last day of the month in which the renewal is due.

EXCEPTION: For F&C Medical Assistance renewals using MAGI methodology, a 90-day reconsideration period must be allowed. A renewal application may be submitted within 90 days of case closure and re-evaluated without penalty. After 90 days, a new application will be required.

If the individual is determined eligible, the LDSS must reinstate the individual's coverage and send a notice to the individual notifying him of the reinstatement, his continued coverage and the next renewal month and year. If the re-evaluation determines that the enrollee is not eligible, send a Notice of Action indicating the correct reason for the cancellation (e.g. countable income exceeds the limit). *Unless the individual has Medicare, a referral to the Health Insurance Marketplace (HIM) must be made so that the individual's eligibility for the Advance Premium Tax Credit (APTC) in conjunction with a Qualified Health Plan (QHP) can be determined.*

G. 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 the pregnancy occurs.

When eligibility in a pregnant woman covered group ends, prior to the cancellation of her coverage, 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, or for limited coverage under Plan First, 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, determine her eligibility in the limited benefit Plan First covered group using the eligibility requirements in M0320.302.

If the woman is eligible for Plan First, reinstate her coverage in Plan First and send the Advance Notice of Proposed Action indicating that she has been enrolled in Plan First. On the notice, state that if she does not wish to remain covered by Plan First, to contact the eligibility worker and request that the coverage be cancelled. Include a Plan First Fact Sheet, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>, with the Advance Notice of Proposed Action.

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

- 2. 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)
 - SSN or proof of application
 - verification of income
 - verification of resources for the MN child.
- 3. Child Under Age 19—Income Exceeds FAMIS Plus Limit** Eligibility of children in the 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 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.
- 4. 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 must be made at least 90 calendar days prior to the child’s 19th birthday to allow the disability determination to be made prior to the child’s 19th birthday.
- If the child does not meet the definition for another covered group, determine the child’s eligibility in Plan First using the eligibility requirements in M0320.302. If the child is eligible for Plan First, reinstate coverage in Plan

First and send the Advance Notice of Proposed Action indicating that he has been enrolled in Plan First. On the notice, state that if he does not wish to remain covered by Plan First, to contact the eligibility worker and request that the coverage be cancelled. Include a Plan First Fact Sheet, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>, with the Advance Notice of Proposed Action.

5. Child Under 21 Turns Age 21

When an individual who is enrolled in the Child Under Age 21 covered group turns 21, redetermine his continuing Medicaid eligibility in other covered groups, including Plan First.

6. IV-E FC & AA Children and Special Medical Needs Children From Another State

The renewal of Medicaid coverage for Title IV-E foster care or adoption assistance children and non-IV-E special medical needs adoption assistance children requires only the following information:

- verification of continued IV-E eligibility status or non-IV-E special medical needs status,
- the current address, and
- any changes regarding third-party liability (TPL).

This information can be obtained from agency records, the parent or the Interstate Compact office from another state, when the child's foster care or adoption assistance agreement is held by another state. A renewal form is not required. The information must be documented in the case record.

7. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)

The BCCPTA Redetermination Form (#032-03-653), is used to redetermine eligibility for the BCCPTA covered group. The form is available on SPARK at: <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.html>. The enrollee must provide a statement from her medical provider verifying continued treatment for breast or cervical cancer. There are no Medicaid financial requirements for the BCCPTA covered group.

8. Hospice Covered Group

At the annual renewal for an individual enrolled in the Hospice covered group (AC 054), the worker must verify the enrollee's continued election and receipt of hospice services, in addition to determining continued Medicaid eligibility.

9. Qualified Individuals

Coverage for individuals enrolled in the Qualified Individuals (QI) covered group (AC 056) is automatically cancelled effective December 31 of the current year. However, coverage for QIs can be renewed annually provided that there is no break in Medicaid eligibility. Renewals are to be completed by sending a renewal form. ***Telephone interview-based renewals will not be used for QI renewals completed in 2014.***

Renewals for all QIs are due by December 31 of each year. On or after November 1 of each year, follow the *Aged, Blind or Disabled (ABD)* Medicaid renewal procedure to request verifications and complete the evaluation.

a. The renewal form is returned BEFORE December 31st

If the individual remains eligible for QI coverage, do not change the renewal date in MMIS prior to December 31. On or after January 1 of the following year, reinstate the QI coverage in MMIS, effective January 1. Change the renewal date in MMIS to December 31 of the current year. Send a [Notice of Action on Medicaid and FAMIS \(form #032-03-0008\)](#) indicating that the individual's coverage continues and the date of the next renewal.

b. The renewal form is returned AFTER December 31st

If the renewal form is not returned by December 31st the individual must submit a new application for Medicaid. The MMIS-generated cancellation notice will serve as the 10-day advance notice for cancellation of the individual's QI coverage.

H. LTC

The ex parte renewal process is used for institutionalized individuals who receive SSI and have no countable real property. It can also be used for other enrollees when the local agency has access to on-line information for verifications necessary to determine ongoing eligibility and/or income verifications obtained for other benefit programs and the covered group has no resource test. *Ex parte renewals will not be used beginning April 1, 2014.*

*For renewals completed prior to April 1, 2014, for all other individuals in LTC who were enrolled in MMIS as of October 1, 2013, the eligibility worker may complete a telephone interview renewal or a paper-based renewal. Use the Medicaid Redetermination for Long-Term Care form for all renewals for individuals age 19 and over. For children under age 19, the paper Families & Children Medicaid and FAMIS Plus Renewal Form or the Record of Ex Parte Medicaid Renewal (#032-03-0740) are appropriate. **Beginning April 1, 2014, telephone interview-based renewals will not be used for individuals enrolled prior to October 1, 2013.***

Send the enrollee a written request for the necessary verifications, and allow at least 10 calendar days for the information to be returned. Document the renewal information and evaluation in the case record. Send all required notices (see section 1410.300).

The patient pay must be updated in MMIS at least every 12 months, even if there is no change in patient pay. Send the provider a DMAS-225 when there has been a change in circumstances resulting in a change in eligibility. If there has been no change in circumstances, do not send a DMAS-225 to the provider.

M1520.300 MA CANCELLATION OR SERVICES REDUCTION

M1520.301 NOTICE REQUIREMENTS

A. Policy

Following a determination that eligibility no longer exists or that the enrollee's Medicaid services must be reduced, the Advance Notice of Proposed Action *or system-generated advance* notice must be sent to the enrollee at least 10 days plus one day for mail, before action is taken to cancel or reduce Medicaid coverage.

If the action to cancel or reduce benefits cannot be taken in the current month due to MMIS cut-off, then the action must be taken by MMIS cut-off in the following month. The Advance Notice of Proposed *Action or system-generated notice* must inform the enrollee of the last day of Medicaid coverage.

The Advance Notice of Proposed Action is available on SPARK at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.

Unless the individual has Medicare, a referral to the HIM must be made when coverage is cancelled. The notice must state that the individual has been referred to the HIM for determination of eligibility for the APTC.

B. Change Results in Adverse Action

1. Services Reduction

When information is secured that results in a reduction of Medicaid services to the enrollee or a reduction in the Medicaid payment for the enrollee 's services (when the patient pay increases), advance *written* notice must be sent to the enrollee at least 10 days plus one day for mail, before the adverse action is taken.

If the enrollee requests an appeal hearing before the effective date, the enrollee may choose to have eligibility continued at the current level of services until a decision is reached after a hearing. In the event the decision is adverse to the enrollee, the amount Medicaid paid on the services being appealed that were received by the recipient during the continuation is subject to recovery by the Department of Medical Assistance Services (DMAS). If the enrollee requests an appeal hearing before the effective date of the action and the DMAS Appeals Division notifies the local agency that the enrollee's coverage must be reinstated during the appeal process, reinstate the enrollee's coverage in the MMIS. **Do not reinstate coverage until directed to do so by the DMAS Appeals Division.**

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

2. Adverse Action Resulting from Computer Matches

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

3. Matches That Require Advance Notice

The following list indicates some of the computer match sources which require a ten (10) day advance notice when, after the worker reviews the individual's eligibility in light of the match information, the enrollee is determined ineligible:

<u>Match Source</u>	<u>Notification Period</u>
Internal Revenue Service (IRS) unearned income files	10 days
Beneficiary and Earnings Data Exchange (Bendex)	10 days
State Data Exchange (SDX)	10 days
Enumeration Verification System (SSN)	10 days
Systematic Alien Verification For Entitlements (SAVE)	10 days
Department of Motor Vehicles (DMV)	10 days
Virginia Employment Commission (VEC)	10 days
Benefit Exchange Earnings Record (BEERS)	10 days
Public Assistance Reporting Information System (PARIS)	10 days

C. Procedures

1. Action Appealed

Adverse action must not be taken if the recipient requests an appeal hearing before the effective date of the action. The DMAS Appeals Division will notify the local agency whether to continue coverage during the appeal. **Do not reinstate coverage until directed to do so by the DMAS Appeals Division.**

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

When notification is received from DMAS that the agency's proposed adverse action was sustained, the recipient's eligibility must be terminated effective the date of the receipt of that letter. No further advance notice to the recipient is necessary since he/she is also informed of DMAS' decision.

2. Death of Recipient

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

If the enrollee has an SSN, the worker must verify the date of death. 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.

M1520.302 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.

**2. Reason "012"
Cancellations**

Cancel actions done by DMAS staff or MMIS are reported in the monthly System Cancellation Report (RS-O-112) available on SPARK at: <https://securelocal.dss.virginia.gov/reports/benefits/vammis/index.cgi>. The report is issued between the 21st and 25th day of each month and is to be monitored so that appropriate follow up may be made.

When information is received from DMAS that a case is canceled for cancel reason "012", the local social services department must determine if the cancellation is valid. When cancellation is not valid, the case must be re-enrolled immediately.

When the cancellation is valid, the local department must mail the individual an adequate notice of cancellation using the NOA. Adequate notice consists of specifying the date the cancel action took place, which is the date the notice is mailed, in the section marked "Other" on the notification form.

M1520.303 ENROLLEE REQUESTS CANCELLATION

A. Introduction

An enrollee may request cancellation of his and/or his children's medical assistance coverage at any time. The request can be verbal or written.

B. Written Request

A written withdrawal request must be placed in the case record.

C. Verbal Request

A verbal request for withdrawal can be accepted only from the enrollee or case head, or his authorized representative. A verbal request must be documented in the case record with the date and time the withdrawal request was received, the name of the person who made the withdrawal request, and the signature and title of the agency staff person who took the call.

D. Worker Action

When the enrollee requests cancellation of Medicaid, the local department must send a **Notice of Action** to the enrollee no later than the effective date of cancellation. Advance notice is not required when the enrollee requests cancellation.

**E. Notice
Requirements**

On the notice:

- check the "other" block and list the reason as "Medicaid coverage cancelled at the enrollee's request,"
- include the effective date of cancellation and instruct the enrollee to discontinue using the card after that date, and
- instruct the enrollee to retain the Medicaid card for future use in case coverage is reinstated within the next 12 months (the system will generate a new card after 12 months).

Cancel Medicaid coverage in MMIS using the cancel reason code "004."

M1520.400 EXTENSIONS OF MEDICAID COVERAGE

A. Policy

Medicaid recipients may be eligible for an extended period of Medicaid coverage when the family meets all the requirements for the Low Income Families with Children (LIFC) covered group except income.

LIFC families who received Medicaid in 3 of the last 6 months and who became ineligible for Medicaid due to increased income from child and/or spousal support may be eligible for a 4-month extension.

LIFC families who received Medicaid in 3 of the last 6 months and who became ineligible for Medicaid due to an increase in earnings may be eligible for a 12 months extension. Earnings could increase because of a new job, a raise in the rate of pay or more hours are being worked.

NOTE: Children must first be evaluated for Medicaid eligibility in the Categorically Needy (CN) Child Under Age 19 (FAMIS Plus) covered group and if eligible, enrolled using the appropriate Child Under Age 19 AC. If ineligible as CN, the child must be evaluated for the Medicaid extensions. If ineligible for the Medicaid extensions, the child must be evaluated for FAMIS. If ineligible for FAMIS, the family must be given an opportunity for a medically needy determination prior to the worker taking action to cancel the Medicaid coverage. *Unless the individual has Medicare, a referral to the HIM must be made so that the individual's eligibility for the APTC in conjunction with a QHP can be determined.* .

B. Procedure

The policy and procedures for the four-month extension are in section M1520.501 below.

The policy and procedures for the twelve-month extension are in section M1520.502 below.

M1520.401 FOUR-MONTH EXTENSION

A. Policy

An LIFC Medicaid family is entitled to four additional months of Medicaid coverage after they lose Medicaid LIFC eligibility when the following conditions are met:

- The family received Medicaid as LIFC in at least three of the six months immediately preceding the month in which they became ineligible for LIFC;
- The family lost eligibility solely or partly due to receipt of or increased child or spousal support income; and
- All other Medicaid eligibility factors except income are met.

B. Procedures

1. Received in Error

For purposes of this subsection, "received Medicaid as LIFC" does not include received Medicaid erroneously. Therefore, a family unit who received Medicaid erroneously during 3 or more of the 6 months before the month of ineligibility does **not** qualify for the Medicaid extension.

- 2. New Family Member** A new member of the family unit is eligible for Medicaid under this provision if he/she was a member of the unit in the month the unit became ineligible for LIFC Medicaid. However, even if a baby was not born as of that month, a baby born to an eligible member of the unit during the 4-month extension is eligible under this provision because the baby meets the categorically needy non-money payment newborn child under age 1 covered group.
- 3. Moves Out of State** Eligibility does not continue for any member of the family unit who moves to another state.
- 4. Coverage Period** Medicaid coverage will continue for a period of four months beginning with the month in which the family became ineligible for LIFC Medicaid because of support income.
- 5. Aid Category** Cases eligible for this four-month extension are categorically needy non-money payment. A Medicaid-Only application and case are recorded statistically. The aid category (AC) for the recipients in the unit remains "081" for an LIFC family unit with one parent or caretaker-relative or "083" for a two-parent family unit.
- 6. Case Handling** Those cases closed in a timely manner must be held in a suspense file until the fourth month after the LIFC Medicaid cancellation month. At that time, action must be taken to evaluate continuing Medicaid eligibility.

If all eligibility factors are met, the children in the case may continue eligible as MI or medically needy. Make the appropriate AC changes to the enrollee's MMIS record.

The caretaker's Medicaid coverage must be canceled if he/she does not meet a Medicaid covered group. An appropriate "Advance Notice of Proposed Action", form 032-03-018 must be sent to the recipient if the caretaker or the case is no longer eligible for Medicaid.

M1520.402 TWELVE-MONTHS EXTENSION

- A. Policy** An LIFC Medicaid family is entitled to six additional months, with possible extension to twelve months, of Medicaid coverage after they lose Medicaid LIFC eligibility when the following conditions are met:
- The family received Medicaid as LIFC in at least three of the six months immediately preceding the month in which they became ineligible for LIFC;
 - The family lost eligibility solely or partly due to receipt of or increased income from earnings or expiration of \$30 + one-third or \$30 earned income exclusion; and
 - All other Medicaid eligibility factors except income are met.

The family consists of those individuals living in the household whose needs and income were included in determining the LIFC Medicaid

eligibility of the assistance unit at the time that the LIFC Medicaid eligibility terminated. It also includes family members born, adopted into, or returning to the family after extended benefits begin who would have been considered a member of the unit at the time the LIFC Medicaid eligibility terminated.

The earned income of family members added after the family loses LIFC Medicaid eligibility must be counted to determine gross family income.

B. Eligibility Conditions

The following conditions must be met:

1. Received LIFC Medicaid in 3 of 6 Months

The family received LIFC Medicaid in at least 3 of the 6 months immediately before the month in which the family became ineligible for LIFC. Months during which the family received Extended Medicaid are not considered months in which the family received LIFC Medicaid.

2. Cancel Reason

LIFC Medicaid was canceled solely because of:

- the caretaker/relative's new employment,
- the caretaker/relative's increased hours of employment,
- the caretaker/relative's increased wages of employment, or
- expiration of any assistance unit member's \$30 plus 1/3, or \$30, earned income disregard.

3. Has A Child Living in Home

The family continues to have at least one child under age 18, or under age 19 if in school, living in the home.

4. No Fraud

The family has not been determined to be ineligible for LIFC Medicaid because of fraud any time during the last six months in which the family received LIFC Medicaid.

C. Entitlement & Enrollment

Entitlement does not continue for any member of the unit who moves to another state.

Enrollees receiving this extension are categorically needy non-money payment aid category (AC) "081" for an LIFC family unit with one parent or caretaker-relative or "083" for a two-parent family unit.

1. Determining Extension Period

Medicaid coverage will continue for six months beginning with the first month the family is not eligible for LIFC Medicaid because of excess income due to any unit member's expiration of the \$30 plus 1/3 or \$30 earned income disregard, or due to the increased earnings of the caretaker/relative. Extension for an additional 6-month period is possible if the reporting and financial requirements are met (below).

a. New/increased Earnings Not Reported Timely

When the new/increased earnings were not reported so that action to cancel LIFC Medicaid could be taken in a timely manner, the extension period begins the month following the month the assistance unit would have last received LIFC Medicaid if reported timely.

For example, if the increased earnings were received in April, but were not reported or discovered until a review of eligibility in June, the 12-month period begins with May, the first month the family's LIFC Medicaid should not have been received. The screening period to determine if the family unit received LIFC Medicaid in at least 3 of the six months immediately preceding the month in which the unit became ineligible for LIFC Medicaid will be November to April.

b. Simultaneous Income Changes

In situations where an earned income case has simultaneous income changes which cause LIFC Medicaid ineligibility, such as new or increased earned income plus an increase in support, the eligibility worker must determine if the case would have been ineligible due to new or increased earnings or loss of the disregards. This requires that the eligibility worker recalculate the LIFC income eligibility only considering the increased earned income or loss (expiration) of the disregards.

- 1) If the family would have been ineligible for one of these reasons, it will be considered the reason for LIFC Medicaid ineligibility and the family is eligible for the 12-month Medicaid extension.
- 2) If, however, the family would have continued to be eligible for LIFC Medicaid if the only change had been increased earnings or expiration of the disregards, the other changes which occurred simultaneously will be the reason for LIFC Medicaid ineligibility. The family is **not** eligible for the Medicaid extension.

2. Extension Ends

Entitlement to Medicaid under this extension period terminates at the end of the first month in which the family unit ceases to include a child under age 18 or under age 19 if in school, the family unit fails to comply with the reporting requirements in D below, or at the end of the extension period.

The child(ren)'s eligibility for Medicaid in another covered group or for FAMIS must be determined prior to canceling the child(ren)'s Medicaid coverage. An "Advance Notice of Proposed Action" must be sent prior to canceling extended Medicaid coverage.

D. Notice and Reporting Requirements

1. LIFC Medicaid Cancellation Month

When LIFC Medicaid is canceled, the unit must be notified of its entitlement to extended Medicaid coverage for six months, and that

Medicaid coverage will terminate if the child(ren) in the family turns age 18, or turns age 19 if the child is in school. Use the Notice of Extended Medicaid Coverage form that is posted on SPARK at:

<http://spark.dss.virginia.gov/divisions/bp/files/me/forms/general/032-03-0728-04-eng.doc>.

a. Instructions to Family

The family unit must be instructed to retain verifications of all earnings received during each month of the extension and attach verifications of the first three-month period's earnings to the agency by the 21st day of the fourth month in the extension period. The names of the three months in the three-month period must be written out on the notice form and the earnings report form.

b. Notices

The instructions to the family are on the Notice of Extended Medicaid Coverage and on the second page of the notice which is the Medicaid Extension Earnings Report. The 2-page form is posted on SPARK at: <http://spark.dss.virginia.gov/divisions/bp/files/me/forms/general/032-03-0728-04-eng.doc>.

c. MMIS Data Entry

After the worker sends the initial Extended Medicaid notice, the worker enters a Follow-up Code and Follow-up Date (the begin date of the extension) on the Case Data screen in MMIS. MMIS will automatically generate subsequent notices and earnings reports to the family. The MMIS Extended Medicaid procedures are contained in Chapter I of the MMIS Users' Guide for DSS.

2. Third Month of Extension

In the third month of extension, the unit must be notified that it must return the Medicaid Extension Earnings Report, with the earnings verifications attached, to the agency by the 21st of the following month (the fourth month).

This notice will be sent automatically by MMIS if the correct Follow-up Code and effective date of the 12-month extension are entered on the Case Data screen in MMIS. If the Follow-up Code and Follow-up Date are **not** entered correctly or in a timely manner, the agency must manually send the notice.

The notice will state that if the earnings report and verifications are not received by the 21st day of the fourth month, Medicaid coverage will be canceled effective the last day of the sixth month, and that the family will not be eligible for any additional Medicaid extension.

3. Fourth Month of Extension

If the first three-month period's report is not received by the 21st day of the fourth month, the family is not eligible for the additional six-month extension. Medicaid must be canceled effective the last day of the sixth month in the extension period.

a. Notice Requirements

MMIS will send the advance notice and automatically cancel coverage at the end of the sixth month if the initial Follow-up Code and Date were entered correctly, and the code is **not** updated because the report was not received on time. If the code was not entered correctly, the agency must manually send the Advance Notice of Proposed Action and must cancel the family's coverage in MMIS after the Medicaid cut-off date in the fifth month. The effective date of cancellation will be the last day of the sixth month in the extension period.

b. Determine Child(ren)'s Eligibility

The child(ren)'s eligibility for Medicaid in another covered group or for FAMIS must be determined before canceling coverage. Contact the recipient and request current verification of the family's total income, including earned and unearned income. If the child is eligible, change the child's enrollment to the appropriate aid category **before the cut-off date** of the sixth extension month. If not eligible, leave the child's enrollment (the case Follow-up Code and Follow-up Date fields) as it is and MMIS will cancel the child's coverage.

If the child(ren)'s eligibility is not reviewed by the **cut-off date** of the sixth extension month, MMIS will cancel coverage. The agency must reopen the child(ren)'s Medicaid if the child(ren) is determined eligible and must notify the recipient of the reopened coverage.

c. Report Received Timely

If the first three-month period's report is received by the 21st day of the fourth month, and the family continues to include a child, entitlement to extended Medicaid continues. The Follow-up Code must be changed on the MMIS Case Data screen when the report is received in order for Extended Medicaid to continue. No action is taken on the first three-month period's earnings.

4. Sixth Month of Extension

In the sixth month of extension, the unit must be notified that it must return the "Medicaid Extension Earnings Report" for the previous three-month period (the fourth through the sixth month), with the earnings verifications for those three months attached, to the agency by the 21st day of the seventh month of extension.

The notice must state that if this three-month period's report and verifications are not returned by the 21st day of the seventh month, Medicaid coverage will be canceled effective the last day of the eighth month of extension.

MMIS will automatically send this notice if the Follow-up Code in the base case information is correct. If it is not correct, the agency must manually send this notice.

5. Seventh Month of Extension

If the second three-month period's report and verifications are not received by the 21st of the seventh month, the family's Medicaid coverage must be canceled after an Advance Notice of Proposed Action is sent. MMIS will send the advance notice and automatically cancel coverage if the report is not received on time and the code is not changed.

Medicaid coverage must be canceled unless the family establishes good cause for failure to report on a timely basis. Examples of good cause for failure to report timely are:

- illness or injury of family member(s) who is capable of obtaining and sending the material;
- agency failure to send the report notice to the family in the proper month of the extension.

a. Determine Child(ren)'s Eligibility

The child(ren)'s eligibility for Medicaid in another covered group or for FAMIS must be determined before canceling coverage. Contact the recipient and request current verification of the family's total income, including earned and unearned income. If the child is eligible, change the child's enrollment to the appropriate aid category before the **cut-off date** of the eighth extension month. If not eligible, leave the child's enrollment (the base case Follow-up Code and Follow-up Date fields) as it is and MMIS will cancel the child's coverage.

If the child(ren)'s eligibility is not reviewed by the **cut-off date** of the eighth extension month, MMIS will cancel coverage. The agency must then reopen coverage and notify the recipient if the child is subsequently found eligible.

b. Cancellation Effective Date

Cancellation is effective the last of the eighth month of extension.

c. Report Received Timely

If the second three-month period's report is received by the 21st of the seventh month, change the case Follow-up Code in MMIS immediately upon receipt of the report and verifications. The family will continue to be eligible for extended Medicaid coverage unless:

- 1) no child under age 18, or under age 19 if in school, lives with the family;
- 2) the caretaker/relative had no earnings in one or more of the previous three months, unless the lack of earnings was due to:
 - the caretaker/relative's involuntary lay-off,
 - the business closed,
 - the caretaker/relative's illness or injury,
 - other good cause (such as serious illness of child in the home which required the caretaker/relative's absence from work);

- 3) the family unit's average gross monthly **earned** income (earned income only; unearned income is not counted) less costs for child care that was necessary for the employment of the caretaker/relative, during the preceding three-month period exceeds the 185% Federal Poverty Level (FPL) appropriate to the family unit size.

See subchapter M0710, Appendix 7, for the 185% FPL income limits.

d. Calculate Family's Gross Earned Income

- 1) The "family's" gross earned income means the earned income of all family unit members who worked in the preceding three-month period. "Gross" earned income is total earned income before any deductions or disregards. All earned income must be counted, including students' earned income, JTPA earned income, children's earned income, etc. No exclusions or disregards are allowed.
- 1) Child care costs that are "necessary for the caretaker/relative's employment" are expenses that are the responsibility of the caretaker/relative for child care that if not provided would prevent the caretaker/relative from being employed.
- 2) To calculate average gross monthly income:
 - add each month's cost of child care necessary for the caretaker/relative's employment; the result is the three-month period's cost of child care necessary for the caretaker/relative's employment.
 - add the family unit's total gross earned income received in each of the 3 months; the result is the family's total gross earned income.
 - subtract the three-month period's cost of child care necessary for the caretaker/relative's employment from the family's total gross earned income.
 - divide the remainder by 3; the result is the average monthly earned income.
 - compare the average monthly earned income to the monthly 185% FPL for the appropriate number of family unit members.

e. Family No Longer Entitled To Extended Medicaid

- 1) If the family is not entitled to further Medicaid coverage because of one of the reasons in item 5.c. above, each family member's eligibility for Medicaid in another covered group must be determined before canceling coverage.

Contact the recipient and request current verification of the family's total income, including earned and unearned income. If eligible, change the enrollment to the appropriate aid category before cut-off in the eighth extension month.

- 2) If the family is ineligible because of excess income, cancel Medicaid coverage. If any of the ineligible family members meet a medically needy covered group definition, send an Application for Benefits to the family giving them the opportunity to apply for spenddown.
- 3) If any of the family members are eligible for FAMIS, enroll them in FAMIS.

f. Family Remains Entitled To Extended Medicaid

If the family remains eligible for Extended Medicaid, no action is required until the ninth month of extension, except to be sure that the Follow-up Code was updated in the computer when the income report was received.

6. Ninth Month of Extension

In the ninth month of extension, the unit must be notified that it must return the "Medicaid Extension Earnings Report" with earnings verifications attached, for the previous three-month period (seventh through ninth month) to the agency by the 21st day of the tenth month of the extension.

The notice must state that if the report and verifications are not returned by 21st day of the tenth month, Medicaid coverage will be canceled effective the last day of the eleventh month of extension.

MMIS will automatically send this notice if the correct Follow-up Code is in the base case information on the computer. If it is not correct, the local agency must manually send this notice.

7. Tenth Month of Extension

If the third three-month period's report and verifications are not received by the 21st of the tenth month, the family's Medicaid coverage must be canceled after an advance notice is sent. MMIS will automatically cancel coverage and send the advance notice if the report is not received on time and the Follow-up Code is not changed.

Medicaid coverage must be canceled unless the family establishes good cause for failure to report timely (see 5. above for good cause).

a. Determine Child(ren)'s Eligibility

If the report is not received on time, the child(ren)'s eligibility for Medicaid in another covered group or for FAMIS must be determined before canceling coverage. Contact the recipient and request current verification of the family's total income. If eligible, change the child(ren)'s enrollment to the appropriate aid category before the **cut-off date** of the eleventh extension month. If not eligible, leave the child's enrollment (the base case Follow-up Code and Follow-up Date fields) as it is and MMIS will cancel the child(ren)'s coverage.

If the child(ren)'s eligibility is not reviewed by the **cut-off date** of the eleventh extension month, MMIS will cancel coverage. The agency must then reopen coverage and notify the recipient if the child(ren) is subsequently found eligible.

b. Cancellation Effective Date

Cancellation is effective the last day of the eleventh month of extension.

c. Report Received Timely

If the third three-month period's report is received by the 21st of the tenth month, change the case Follow-up Code in MMIS immediately upon receipt of the report and verifications. The family continues to be eligible for Medicaid unless one of the items in 5.c. above applies. Calculate the family's income using the procedures in 5.d. above.

d. Family No Longer Entitled To Extended Medicaid

- 1) If the family is not entitled to **extended** Medicaid coverage, review their eligibility for Medicaid in another category or for FAMIS. If not eligible, cancel Medicaid after sending the **Advance Notice of Proposed Action**. Cancellation is effective the last day of the eleventh month of extension.
- 2) If the family is ineligible because of excess income, cancel Medicaid coverage. **Send the Advance Notice of Proposed Action**. If any of the ineligible family members meet a medically needy covered group definition, send an Application for Benefits to the family giving them the opportunity to apply for spenddown.
- 3) If any of the family members are eligible for FAMIS, enroll them in FAMIS.

e. Family Remains Entitled To Extended Medicaid

If the family remains entitled to Extended Medicaid coverage, a redetermination of the family's Medicaid eligibility must be completed by the Medicaid cut-off in the twelfth month.

8. Twelfth Month of Extension

Before Medicaid cut-off in the twelfth month, complete the family's redetermination. MMIS will automatically cancel coverage and send the advance notice after cut-off of the twelfth month, if the Follow-up Code was updated correctly. Therefore, for any of the family members that remain eligible for Medicaid or FAMIS, the AC and the Follow-up Code must be changed before cut-off of the twelfth month.

If any of the family members are eligible for FAMIS, enroll them in FAMIS.

For family members who are not eligible for Medicaid or FAMIS, **send the Advance Notice of Proposed Action** and cancel Medicaid effective the last day of the twelfth month.

If any of the ineligible family members meet a medically needy covered group definition, send an Application for Benefits to the family giving them the opportunity to apply for spenddown.

M1520.500 CASE TRANSFERS

- A. Introduction** Applications and ongoing cases are transferred only when the individual retains residence in Virginia.
- B. Nursing Facility and Assisted Living Facility (ALF)** When an applicant/recipient is admitted to a nursing facility or an ALF from a community living arrangement, the case is not transferred, but remains with the Virginia locality in which the individual last lived outside of an institution. Community living arrangements do not include medical facilities, ALFs or group homes with four or more beds.
- When an applicant/recipient is discharged from a nursing facility or ALF to a community living arrangement not in the Virginia locality that had responsibility for the individual's case while he was in the nursing facility or ALF, the case is transferred to the new locality.
- C. DBHDS Facilities** The procedures for transfer of Medicaid cases of ABD patients admitted to or discharged from Department of Behavioral Health and Developmental Services (DBHDS) facilities are in subchapter M1550. F&C cases are not transferred to the DBHDS facilities.
- D. Cases From Outstationed Workers** Medicaid applications taken and Medicaid cases approved by outstationed workers, such as the workers stationed at the University of Virginia (UVA) or the workers at Medical College of Virginia (MCV) hospitals, must be transferred to the LDSS where the applicant/enrollee lives. Medicaid cases and applications are **not** transferred from LDSS **to** outstationed workers.
- 1. Confirm Receipt** The receiving LDSS must confirm receipt of the case by completing the Case Record Transfer Form and returning the copy to the outstationed worker.
 - 2. Review Eligibility** LDSS workers must review (partial review) the Medicaid eligibility determination in approved cases transferred from an outstationed worker, and must take any necessary corrective action.
 - 3. Corrective Action** If an eligibility error(s) is found, do not send the case back. Correct the error(s), send the notice to the case head if required, and refer the case to the LDSS supervisor for possible contact with the outstationed worker's supervisor.
- E. Local Agency to Local Agency** When a Medicaid applicant/enrollee (including a Medicaid CBC waiver services enrollee) moves from one locality to live in a community living arrangement (not a medical facility, an ALF, or group home with 4 or more beds) in another locality within the state of Virginia, the following procedures apply:

1. Sending Locality Responsibilities

a. Case Renewal Cannot Be Overdue

The sending locality must make certain the case is current and complete before transferring the case. If the annual renewal has been completed within the past 10 months, a partial review based on known information, as to whether or not the recipient will meet a covered group and the income and resource limits in the new locality, must be completed before transferring the case.

If the annual renewal is due in the month the LDSS plans to transfer the case or the following month, the renewal must be completed before transferring the case.

Exception: When the individual *has an active* SNAP case, the SNAP case transfer rules override the Medicaid policy that the Medicaid renewal cannot be overdue. The case must be transferred immediately to the new locality, even if the Medicaid renewal is overdue, due in the transfer month or due in the following month to comply with the SNAP case transfer rule.

b. When Renewal Must Be Completed Before Transferring

If the sending LDSS must complete the renewal before transferring the case, the Sending LDSS must keep the case record to complete the renewal.

The sending locality must update the enrollees' VaCMS/MMIS records as follows to assure managed care continuity:

- 1) Case Data screen - change the case address to the case's new address. Do not change the Case FIPS or Caseworker number because the sending LDSS worker retains responsibility for the case until the renewal is completed.
- 2) Enrollee Demographics screen, Enrollee FIPS – change each enrollee's Enrollee FIPS to the new address's FIPS code.

When the renewal is completed and the enrollee remains eligible, transfer the electronic case, if applicable, or update the enrollee's MMIS Case FIPS to the enrollee's locality of residence and update the Caseworker number to M0000. Send the paper case record to the enrollee's locality of residence with a completed Case Record Transfer Form.

c. Do Not Transfer Ineligible Cases

If the annual renewal or the partial review finds that eligibility no longer exists for one or all enrollees in the case, the agency must take the necessary action, including advance notice to the individuals, to cancel the ineligible individuals' coverage. Only eligible enrollees' cases are transferred.

d. Transfer Eligible Enrollees/Cases

If the renewal or the partial review indicates that the enrollee(s) will continue to be eligible for Medicaid in the new locality, the sending locality must update the enrollment system. The sending locality must prepare the "Case Record Transfer Form" and forward it with the case record to the LDSS in the new locality of residence.

e. Transfer Pending Medicaid Applications

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

f. Foster Care & Adoption Assistance

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

g. Sending Transferred Cases

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

**2. Receiving
Locality
Responsibilities**

a. Confirm Receipt

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

b. Process Pending Applications

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

c. Review Eligibility

LDSS workers must review (partial review) the Medicaid eligibility determination for cases transferred from other LDSS and must take any necessary corrective action.

d. Corrective Action

If an eligibility error(s) is found or the case is overdue for renewal, do not send the case back. Correct the error(s), and/or complete the renewal, send the notice to the case head if required, and refer the case to the LDSS supervisor for possible contact with the sending agency's supervisor.

E. Spenddown Cases

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

- 1. Sending Locality Responsibilities**

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

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

- 2. Receiving Locality Responsibilities**

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

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

- F. Receiving LDSS Case Management Procedure**

To identify and manage transferred Medicaid cases, use the report titled "Caseworker Alpha Case/Enrollee Listing." This report is posted in the Data Warehouse, MMIS Reporting, Medicaid Management Reports. It is updated on or about the 22nd of each month.

Most LDSS agencies and the FAMIS *Central Processing Unit* *electronically* transfer cases to Worker Number "M000" or "M0000." To identify transferred Medicaid cases, check the locality's report for Worker Number "M000" and "M0000." If the receiving LDSS uses another worker or caseload number for transferred-in cases, and the sending locality or DMAS FAMIS Plus Unit knows about the worker/caseload number for transfer cases, also check for cases in that worker number.

M21 Changes

Changed With	Effective Date	Pages Changed
TN #99	1/1/14	Page 2
TN # 98	10/1/13	Table of Contents pages 1-10 Pages 10a and 11-16 were deleted.
UP #9	4/1/13	pages 3, 4
UP #8	10/1/12	Table of Contents Pages 2-4 Appendix 3 deleted
TN #97	9/1/12	pages 3, 4
UP #7	7/1/12	pages 3, 4 Appendix 2, pages 1 Appendix 3, pages 1 and 2
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	pages 3, 8
TN #95	3/1/11	Table of Contents pages 5, 6, 14, 15, page 16 added Appendix 1
TN #94	9/1/10	page3 Appendix 3, pages 1 and 2
UP #3	3/1/10	pages 2-5
TN #93	1/1/10	page 2-4, 8
Update (UP) #2	8/24/09	page 4
Changed With	Effective Date	Pages Changed
TN # 98	10/1/13	Table of Contents pages 1-10 Pages 10a and 11-16 were deleted.
UP #8	10/1/12	Table of Contents Pages 2-4 Appendix 3 deleted
TN #97	9/1/12	pages 3, 4
UP #7	7/1/12	pages 3, 4 Appendix 2, pages 1 Appendix 3, pages 1 and 2
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	pages 3, 8
TN #95	3/1/11	Table of Contents pages 5, 6, 14, 15, page 16 added Appendix 1
TN #94	9/1/10	page3 Appendix 3, pages 1 and 2
UP #3	3/1/10	pages 2-5
TN #93	1/1/10	page 2-4, 8
Update (UP) #2	8/24/09	page 4

D. Children enrolled in Medicaid on December 31, 2013 who lose Medicaid eligibility

Children who were:

- enrolled in Medicaid on December 31, 2013, and
- who lose Medicaid eligibility **due to excess income** at their first Medicaid renewal in which Modified Adjusted Gross Income (MAGI)-based methodology is applied

are protected by Section 2101(f) of the Affordable Care Act. They must be enrolled in FAMIS for one year, regardless of whether or not their income is within the FAMIS limit.

M2120.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

The child must meet, with certain exceptions, the Medicaid Nonfinancial Eligibility Requirements in chapter M02 and the nonfinancial eligibility requirements imposed by FAMIS.

B. M02 Requirements

The nonfinancial eligibility requirements in chapter M02 that must be met for FAMIS eligibility are:

- citizenship and alienage requirements, including Afghan and Iraqi special immigrants in M0220.313 A, with the exceptions noted in M2120.100 C below.
- Virginia residency requirements;
- Provision of a Social Security Number (SSN) or proof of application for an SSN.
- Assignment of rights to payment for medical care from any liable third party is a condition of eligibility for the child;
- institutional status requirements regarding inmates of a public institution.

C. M02 Exception: No Emergency Services Only Coverage

FAMIS does not provide emergency services only coverage for non-citizens who are not lawfully residing in the U.S., such as illegal aliens or those whose lawful admission status has expired. These aliens are not eligible for FAMIS.