Virginia DSS, Volume XIII

M04 Changes

Changed With	Effective Date	Pages Changed
UP #11	7/1/15	Appendices 3 and 5
TN #100	5/1/15	pages 2, 11, 12, 13, 14 Appendices 1, 2, 3, 5, 6 and 7 Page 1 is a runover page.
Update (UP) #10	5/1/14	Table Contents pages 2, 3, 5, 6, 10-15 Appendices 1, 2 and 6 Appendix 7 was added.
TN #99	1/1/14	pages 2, 5, 6, 8, 14, 15 Appendix 6

LIFC INCOME LIMITS

EFFECTIVE 7/1/15

Group I

Household Size	Income Limit
1	
2	$244
3	371
4	472
5	573
6	675
7	761
8	859
	962
Each additional person add	100

Group II

Household Size	
1	$319
2	457
3	575
4	687
5	808
6	911
7	1,020
8	1,139
Each additional person add	113

Group III

Household Size	
1	481
2	644
3	788
4	925
5	1,093
6	1,216
7	1,353
8	1,496
Each additional person add	138

INDIVIDUALS UNDER AGE 21 INCOME LIMITS

EFFECTIVE 7/01/15

Group I

Household Size	Income Limit
1	$233
2	361
3	463
4	562
5	662
6	742
7	840
8	943
Each additional person add	96

Group II

Household Size	Income Limit
1	$316
2	458
3	574
4	688
5	812
6	1,002
7	1,020
8	1,138
Each additional person add	111

Group III

Household Size	Income Limit
1	$420
2	564
3	683
4	799
5	945
6	1,043
7	1,156
8	1,273
Each additional person add	112

M0710 Changes

Changed With	Effective Date	Pages Changed
UP #11	7/1/15	Appendix 5
TN #100	5/1/15	Table of Contents pages 1-8 Pages 9-13 were deleted. Appendices 1, 2 and 3 Appendices 4-7 were removed.
TN #98	10/1/13	pages 1-4, 8, 9 Page 1a was added. Appendices 1, 3, 5
UP #9	4/1/13	Appendix 6, pages 1, 2 Appendix 7
UP #7	7/1/12	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1
UP #6	4/1/12	Appendix 6, pages 1, 2 Appendix 7
TN #96	10/01/11	Appendix 6, page 1
UP #5	7/1/11	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1
TN #95	3/1/11	Appendix 6, pages 1, 2 Appendix 7
Update (UP) #1	7/1/09	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1

F&C MEDICALLY NEEDY INCOME LIMITS EFFECTIVE 7-01-15

GROUP 1			GROUP II		GROUP III	
# of Persons in Family/Budget Unit	Semi-Annual Income	Monthly Income	Semi-Annual Income	Monthly Income	Semi-Annual Income	Monthly Income
1	1,861.63	310.27	2,148.04	358.00	2,792.45	465.40
2	2,370.20	395.03	2,645.09	440.84	3,366.75	561.12
3	2,792.45	465.40	3,078.88	513.14	3,794.89	632.48
4	3,150.47	525.07	3,436.89	572.81	4,152.90	692.15
5	3,508.48	584.74	3,794.89	632.48	4,510.92	751.82
6	3,866.49	644.41	4,152.90	692.15	4,868.93	811.48
7	4,224.50	704.08	4,510.92	751.82	5,226.94	871.15
8	4,654.12	775.68	4,940.53	823.42	5,584.96	930.82
9	5,083.73	847.28	5,075.76	845.96	6,103.70	1,017.28
10	5,584.96	930.82	5,871.37	978.56	6,515.79	1,085.96
Each add'l person add	481.13	80.18	481.13	80.18	481.13	80.18

M0810 Changes

Changed With	Effective Date	Pages Changed
UP #10	7/1/15	page 2
TN #100	5/1/15	pages 1, 2
UP #10	5/1/14	page 2
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

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.

Family Size Unit	2015 Monthly Amount	2014 Monthly Amount
1	$2,199	$2,163

4. *ABD* Medically Needy

a. Group I	*7/1/2015*		7/1/2014 – 6/30/15	
Family Unit Size	*Semi-annual*	*Monthly*	Semi-annual	*Monthly*
1	*$1,861.63*	*$310.27*	$1830.52	*$305.09*
2	*2,370.20*	*395.03*	2,330.62	*388.44*
b. Group II	*7/1/2015*		7/1/2014 – 6/30/15	
Family Unit Size	*Semi-annual*	*Monthly*	Semi-annual	*Monthly*
1	*$2,148.04*	*$358.00*	$2,112.14	*$352.02*
2	*2,645.09*	*440.84*	2,600.95	*433.49*
c. Group III	*7/1/2015*		7/1/2014 – 6/30/15	
Family Unit Size	*Semi-annual*	*Monthly*	*Semi-annual*	*Monthly*
1	*$2,792.45*	*$465.40*	$2,745.78	*$457.63*
2	*3,366.75*	*561.12*	3,310.53	*551.76*

5. ABD Categorically Needy

For:

ABD 80% FPL, QMB, SLMB, & QI <u>without</u> Social Security income; all QDWI; all MEDICAID WORKS, effective 1/22/15

ABD 80% FPL, QMB, SLMB, & QI <u>with</u> Social Security income, effective 3/1/15

All Localities	*2015*		*2014*	
ABD 80% FPL	Annual	*Monthly*	Annual	*Monthly*
1	$9,416	*$785*	$9,336	*$778*
2	12,744	*1,062*	12,584	*1,049*
QMB 100% FPL	Annual	*Monthly*	Annual	*Monthly*
1	$11,770	*$981*	$11,670	*$973*
2	15,930	*1,328*	15,730	*1,311*
SLMB 120% of FPL	Annual	*Monthly*	Annual	*Monthly*
1	$14,124	*$1,177*	$14,004	*$1,167*
2	19,116	*1,593*	18,876	*1,573*
QI 135% FPL	Annual	*Monthly*	Annual	*Monthly*
1	$15,890	*$1,325*	$15,755	*$1,313*
2	21,506	*1,793*	21,236	*1,770*
QDWI and MEDICAID WORKS 200% of FPL	Annual	*Monthly*	Annual	*Monthly*
1	$23,540	*$1962.00*	$23,340	*$1,945*
2	31,860	*2,655.00*	31,460	*2,622*

M1470 Changes

Changed With	Effective Date	Pages Changed
UP #11	7/1/15	pages 43-46 Page 46a was deleted.
TN #100	5/1/15	pages 2a, 4, 29, 31, 32, 34, 43, 44, 45, 53, 54 Pages 1a, 2, 3a and 4 were renumbered for clarity. Pages 3, 4a, 46 and 46a are runover pages. Pages 1 and 3 are reprinted.
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

Retrospective spenddown eligibility determinations are made monthly after the month has passed and the expenses have actually been incurred. The PACE rate (minus the Medicare Part D premium) along with other allowable medical and dental expenses are deducted daily and chronologically as the expenses are incurred. The individual's income and resources must be verified each month before determining if the spenddown has been met. See M1470.520 for allowable medical deductions.

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

4. Patient Pay

a. Projected Spenddown Eligibility Determinations

Medicaid must assure that enough of the individual's income is allowed so that he can have a personal maintenance allowance. Therefore, the spenddown liability is NOT subtracted from his gross income nor added to the available income for patient pay.

Subtract the allowances listed in M1470.400 from gross monthly income, as applicable. Compare the remaining income for patient pay to the monthly PACE rate (minus the Medicare Part D premium) for the month. The patient pay is the lesser of the two amounts.

b. Retrospective Spenddown Eligibility Determinations

Because the spenddown eligibility determination is completed after the month in which the PACE services were received and expenses are not projected, the spenddown liability is NOT added to the available income for patient pay. Follow the instructions in M1470.630 for calculating the spenddown and patient pay when the spenddown liability exceeds the monthly PACE rate (minus the Medicare Part D premium).

M1470.800 COMMUNICATION BETWEEN LOCAL DSS AND LTC PROVIDER

A. Introduction

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

B. Purpose

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

- notify the LTC provider of a patient's Medicaid eligibility status;
- notify a new provider that the patient pay is available through the verification systems;
- reflect changes in the patient's deductions, such as a medical expense allowance;
- document admission, death or discharge of a patient to an institution or community-based care services;

- provide information on health insurance, LTC insurance or VA contract coverage, and

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

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

C. When to Complete the DMAS-225

Complete the DMAS-225 at the time of eligibility determination and/or the recipient's entry into LTC. Complete a new DMAS-225 when the recipient's eligibility status changes, such as when the recipient's Medicaid coverage is canceled or changed to limited QMB or SLMB coverage, or when the LTC provider changes.

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

D. Where to Send the DMAS-225

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

M1470.900 ADJUSTMENTS AND CHANGES

A. Policy

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

There are situations when the EW **cannot increase** the patient pay, such as when the current patient pay amount equals the Medicaid rate for the month. In this situation, an adjustment that results in an increase in patient pay cannot be made and a referral to the DMAS Recipient Audit Unit (RAU) must be completed following the procedures in M1470.900 D.3.c.1) below.

B. Action When A Change Is Reported

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

1. Recalculate the patient pay.

2. If the patient pay remains the same, send written notification to the person handling the patient's income that the patient pay is unchanged.

3. If the patient pay decreases, follow the instructions found in Item C. below. If the patient pay increases, follow the instructions found in Item D. below.

C. Patient Pay Decreases

1. When to Adjust

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

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

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

2. Procedures

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

a. Verify the decrease.

b. Calculate the new patient pay based on the change(s).

c. Subtract the "new" patient pay from the "old" patient pay amount; the result is the reduced amount.

d. Multiply the reduced amount by the number of months in which the reduced amount should have been effective; the result is the total reduction.

e. Subtract the total reduction from the next month's (the month following the month in which the worker is taking this action) patient pay. If the total reduction exceeds the patient pay, the patient pay amount will be zero until the total reduction has been subtracted from the patient pay.

3. Example-Patient Pay Decrease

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

D. Patient Pay Increases

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

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

1. Prospective Month(s)

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

2. Current and Past Month(s)

Determine the amount of the recipient underpayment when:

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

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

3. Procedures

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

1) Calculate the new monthly patient pay based on the change(s), beginning with the month in which the change occurred.

2) Subtract the "old" monthly patient pay from the "new" monthly patient pay amount. The result is the amount of the recipient's underpayment for that month.

3) Add the monthly underpayment(s) together to determine the total amount of the recipient's underpayment. If the underpayment is less than $1,500, follow the procedures in "b" below. If the underpayment is $1,500 or more, follow the procedures in "c" below.

b. Total underpayment of less than $1,500

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

1) Add the total underpayment to the new ongoing patient pay. This is the total patient pay obligation.

2) Compare the total patient pay obligation to the provider's Medicaid rate.

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

M1480 Changes

Changed With	Effective Date	Pages Changed
UP #11	7/1/15	page 18c
TN #100	5/1/15	pages 7, 16, 18, 18a, 18c, 65, 66 Pages 8, 15, 17 and 18b are reprinted.
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

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	*$*23,844	1-1-15
	$23,448	1-1-14
C. Maximum Spousal Resource Standard	*$119,220*	1-1-15
	$117,240	1-1-14

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.