COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

CYNTHIA B. JONES
DIRECTOR

SUITE 1300
600 EAST BROAD
STREET RICHMOND,
VA 23219
804/786/7933
800/343-0634 (TDD)
www.dmas.virginia.gov

January 1, 2017

Virginia Medical Assistance Eligibility Manual

Transmittal #DMAS-3

The following acronyms are used in this cover letter:

- ABLE – Achieving a Better Life Experience
- ACR – Adult Care Residence
- ALF – Assisted Living Facility
- COLA – Cost of Living Adjustment
- DMAS – Department of Medical Assistance Services
- FAMIS – Family Access to Medical Insurance Security
- HIPP – Health Insurance Premium Payment
- ICF-ID – Intermediate Care Facility for the Intellectually Disabled
- ICF-MR – Intermediate Care Facility for the Mentally Retarded
- LIFC – Low Income Families with Children
- LTC – Long-term Care
- MAGI – Modified Adjusted Gross Income
- MMIS – Medicaid Management Information System
- MSP – Medicare Savings Program
- SSI – Supplemental Security Income
- SSN – Social Security number
- TN – Transmittal
- TPL – Third Party Liability
- VaCMS – Virginia Case Management System
- WaMS – Waiver Management System

TN #DMAS-3 includes policy clarification, updates and revisions to the MA Eligibility Manual. Unless otherwise noted, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after January 1, 2017.

The following changes are contained in TN #DMAS-3:

Changed Pages	Changes
Subchapter M0110 Page 15	On page 15, clarified how to scan a document into the case record.
Subchapter M0120 Page 15	On page 15, removed a reference to MMIS.
Subchapter M0130 Pages 5, 7, 11	On pages 5 and 7, clarified that any non-citizen who is only eligible to receive an SSN for a valid non-work reason is not required to provide or apply for an SSN. On page 11, clarified that changes and questionable information must be documented in VaCMS or the hard case record.
Subchapter M0220 Table of Contents Page 22a Appendix 1, page 1	The Table of Contents was revised. On page 22a, removed references to MMIS. Revised the title of Appendix 1.
Subchapter M0310 Pages 8, 13, 28b	On page 8, clarified that both a parent and a stepparent can be eligible in the LIFC covered group. On page 13, clarified that verification of the child living in the home is by declaration unless the information on the application is questionable. On page 28b, clarified the procedures used when an applicant moves to another locality while his disability decision is under appeal and then has a reversal of his disability denial.
Subchapter M0320 Pages 11, 27, 29, 40, 41, 44, 45, 52	On page 11, updated the COLA calculation for 2017. On page 27, updated the Medicaid Works earned income limit for 2017. On the remaining pages, removed references to MMIS and replaced them with VaCMS, as appropriate.
Subchapter M0330 Pages 9, 10 Page 9a was removed.	On pages 9 and 10, removed obsolete policy regarding the LIFC covered group.
Chapter M04 Table of Contents Pages 3 -5, 13a, 20 Appendix 6, page 1 Page 20a was added.	The Table of Contents was revised. On page 3, clarified the definition of a caretaker relative. On page 4, clarified the definition of a parent. On page 5, clarified that married couples who are separated and not living together are not in each other's MAGI household. On page 13a, clarified when verification of income is required. On pages 20 and 20a, added an example. In Appendix 6, corrected an income limit.

Changed Pages	Changes
Subchapter M0520 Table of Contents Pages 3, 5-35 Pages 36-38 were removed.	The Table of Contents was revised. On all other pages, removed obsolete policy and/or updated the examples.
Subchapter M0530 Appendix 1, page 1	An Appendix 1, updated the ABD deeming standards for 2017.
Subchapter M0810 Pages 1, 2	On pages 1 and 2, updated the income limits that are based on the SSI amounts for 2017.
Subchapter M0820 Pages 30, 31	On pages 30 and 31, updated the ABD student earned income exclusion for 2017.
Subchapter M1110 Pages 2, 7, 10, 11 Page 10a was added as a runover page.	On page 2, revised the MSP resource limits for 2017. On page 7, revised the list of resource exclusions. On pages 10 and 10a, added policy on accepting certified appraisals for determining the countable value of real property. This policy was effective with Broadcast DMAS-7 on October 4, 2016. On page 11, clarified that the procedures for determining the countable value of real property are contained in M1130, Appendices 1 and 4.
Subchapter M1130 Table of Contents, page ii Page 76 Page 77 is a runover page. Pages 78 and 79 were added.	The Table of Contents was revised. On page 76, revised the section category. On pages 78 and 79, added policy on ABLE accounts.
Subchapter M1370 Pages 3-5	On pages 3-5, removed the references to MMIS and replaced them with VaCMS, as appropriate.
M14 Table of Contents, page i	The Table of Contents was revised.
Subchapter M1410 Pages 6, 7, 12-14	On pages, 6, 7 and 12, added information about the My Life, My Community Waiver Redesign and revised the names of the waivers impacted by the redesign. On pages 13 and 14, removed references to MMIS and replaced them with VaCMS, as appropriate.

Changed Pages	Changes
Subchapter M1420 Table of Contents Pages 3-6 Appendix 3 Appendices 4 and 5 were removed.	The Table of Contents was revised. On pages 3, 5 and 6, revised the names of the waivers impacted by the My Life, My Community Waiver Redesign. On page 4, clarified that individuals in a Veteran's Administration Medical Center when Medicaid payment for LTC is requested do not need a preadmission screening. In Appendix 3, revised the obsolete waiver authorization screen with the new WaMS screen.
Subchapter M1440 Table of Contents Pages 3-12 Appendix 1 was added. Page 2 is a runover page. Pages 13-23 were deleted.	The Table of Contents was revised. On page 3, revised ACR to ALF. On pages 4 and 5, revised ICF-MR to ICF-ID. Removed pages 6-10 regarding the institutional status requirements, which are contained in subchapter M0280. The remaining pages were renumbered and information about the My Life, My Community Waiver Redesign was added. The names of the waivers impacted by the redesign were added, obsolete policy was deleted, the pages were reformatted as necessary. Appendix 1, My Life My Community Services and Support Options, was added.
Subchapter M1450 Pages 30, 40-42, 44	On page 30, revised the policy to include certified real property appraisals as an alternative to the tax assessed value. This policy was effective with Broadcast DMAS-7 on October 4, 2016. On the remaining pages, revised the policy on claiming an asset transfer undue hardship to allow for more time to submit the claim and for a subsequent claim to be allowed after a denial of undue hardship when the individual's circumstances change.
Subchapter M1460 Pages 3, 4, 4b, 24, 25, 29	On page 3, revised the home equity limit for 2017. On pages 4, 24, 25, and 29, removed the references to MMIS and added VaCMS, as appropriate. On page 4b, updated the names of the waivers impacted by the My Life, My Community Waiver Redesign.
Subchapter M1470 Table of Contents, page ii Pages 1, 14, 17, 19, 20, 28a, 45-47, 50 Appendix 1, pages 1 and 2	The Table of Contents was revised. On page 19, updated the personal maintenance allowance for 2017. On page 20, updated the special earnings allowances for 2017. In Appendix 1, revised the sample notice of obligation to the notice that is generated by VaCMS. On the remainder of the pages, removed references to MMIS and replaced them with VaCMS, as appropriate.
Subchapter M1480 Pages 7, 9, 18, 18b, 18c, 20, 47, 51, 66, 67, 77	On page 7, updated the home equity limit for 2017. On pages 9 and 18b, deleted obsolete policy references. On pages 18 and 20, clarified the procedures when a resource assessment is not completed because the necessary information was not provided by the applicant. On page 18c, updated the spousal resource standards for 2017. On the remaining pages, removed the references to MMIS and replaced them with VaCMS, as appropriate.

Changed Pages	Changes
Subchapter M1510 Table of Contents Pages 1, 8, 8a, 12-15 Page 11a was deleted.	The Table of Contents was revised. On page 1, clarified when Medicaid entitlement begins. On page 12, clarified the procedures for entering TPL information in VaCMS for HIPP enrollees. On page 15, added the exceptions to the SSN requirement. On the remaining pages, removed the references to MMIS and added VaCMS, as appropriate.
Subchapter M1520 Pages 1, 2, 4, 6, 8, 14, 26	On page 1, clarified the timeframe for acting on reported changes. On page 2, clarified that an increase in income must be verified when it causes a child to move from Medicaid to FAMIS coverage. On pages 6 and 7, clarified that VEC data may be used if it is dated within the past 12 months. On the remaining pages, removed the references to MMIS and replaced them with VaCMS, as appropriate.
Chapter M1550 Pages 4-6, 8, 9	On all pages, removed the references to MEDPEND and/or MMIS and replaced them with VaCMS, as appropriate.
Chapter M21 Appendix 1, page 1	In Appendix 1, corrected an income limit.

Please retain this TN letter for future reference. Should you have questions about information contained in this transmittal, please contact Cindy Olson, Eligibility Policy Manager with DMAS, at cindy.olson@dmas.virignia.gov or (804) 225-4282.

Sincerely,

Linda Nablo

Linda Nablo
Chief Deputy Director

Attachment

M0110 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-3	1/1/17	Page 15
TN #DMAS-2	10/1/16	Pages 3, 13
TN #100	5/1/15	Pages 2, 7 Page 1 is a runover page.
TN #98	10/1/13	Table of Contents Pages 1-15 Page 6a was removed. Page 16 was added.
TN #97	9/1/12	Table of Contents Page 13 Page 14 was added. Appendix 1 was added.
Update #7	7/1/12	Pages 3, 6a, 7, 8
TN #96	10/1/11	Table of Contents Pages 2-6a
TN #95	3/1/11	Pages 2-4a
TN #94	9/1/10	Pages 2, 3
TN #93	1/1/10	Pages 1, 6

M0110.400 Retention of Case Information

A. Introduction

The agency must maintain case records that contain information necessary to support the facts essential to the determination of initial and continuing eligibility as well as any basis for discontinuing or denying assistance. The case record shall consist of a hard (i.e. paper) record, an electronic record, or a combination of the two. *To be stored electronically in the individual's case record in the Virginia Case Management System (VaCMS), a document is scanned into VaCMS using the Document Management Imaging System (DMIS).*

Records of active cases must be maintained for as long as the client receives benefits. Closed records must be maintained for a minimum of three years from the date of closure.

B. Policy

Case records must contain the following elements:

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

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

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

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

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

M0120 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-3	1/1/17	Page 15
TN #DMAS-2	9/1/16	Pages 2, 15 Page 2a is a runover page.
TN #DMAS-1	6/1/16	Pages 7, 10, 11, 16-20
TN #100	5/1/15	Table of Contents Pages 1, 2, 15, 20 Page 2a and 16 are runover pages.
UP #10	5/1/14	Table of Contents Pages 11, 16-18 Pages 11a and 11b were deleted. Pages 19 and 20 were added.
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

c. Pending Discharge to the Community

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

d. Eligibility Determination and Enrollment

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

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

e. Coverage Begin Date

The eligible individual's coverage Begin Date cannot be earlier than the date of discharge from the DBHDS institution.

E. Individuals In Virginia Veteran's Care Center

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

F. Incarcerated Individuals and DJJ Supervisees

Inmates of state, regional, and local correctional facilities and individuals under the age of 21 under the supervision of DJJ (placed in a facility or receiving services from any court services unit or DJJ contractor) may apply for Medicaid, limited to inpatient hospitalization and as part of pre-release planning. Responsibility for processing the application and determining eligibility rests with the local department of social services in the locality where the individual was living prior to incarceration or DJJ/court custody. Applications are not to be refused because an applicant is an inmate of a public institution at the time of application.

If the individual did not reside in Virginia prior to becoming incarcerated or committed to DJJ, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in which correctional facility is located.

M0130 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-3	1/1/17	Pages 5, 7, 11
TN #DMAS-2	10/1/16	Table of Contents Pages 2. 4, 5, 7-10, 12, 13 Page 2a is a runover page. Page 14 was added as a runover page.
TN #DMAS-1	6/1/16	Table of Contents Pages 4, 6, 10, 12 Page 11 is a runover page. Page 13 was added as a runover page.
TN #100	5/1/15	Pages 1, 2-2b, 5, 11 Pages 3, 6 and 2c are runover Pages.
UP #10	5/1/14	Table of Contents Pages 8-12 Page 13 was added.
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
TN #95	3/1/11	Page 8
TN #94	9/1/10	Pages 2-6, 8
TN #93	1/1/10	Pages 4-6, 8
Update (UP) #2	8/24/09	Pages 8, 9

M0130.200 Required Information and Verifications

A. Identifying Information

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

1. Name

The name entered in the official case record and computer enrollment systems for an applicant must match the applicant's name on his Social Security card or Social Security Administration (SSA) records verification. This is important because of the Medicare Buy-in and other computer matches the Medicaid Management Information System (MMIS) performs with SSA. At the time of the initial MA application, verify the SSA record of the individual's name.

The Federally managed Data Services Hub verifies the individual's name and SSN with the SSA for cases processed in VaCMS (see M0130.200 B.1 below). For an individual whose name and SSN cannot be verified in VaCMS and for all individuals whose cases are not processed in VaCMS, either SVES or the State Online Query-Internet system (SOLQ-I) SSA Title II and Title XVI results may be used.

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

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

2. SSN

The SSN of an individual for whom medical assistance is requested *and for whom having an SSN or proof of application for one is an eligibility requirement*, must be provided by the applicant and verified by the worker through SSA. The Hub or SOLQ-I may be used to verify the individual's SSN. *See M0240.001*.

B. Required Verifications

1. The Federally-managed Data Services Hub

The Hub is a data center that links the following federal systems:

- Social Security Administration
- Internal Revenue Service (IRS)
- Systematic Alien Verification for Entitlements (SAVE).

Income verification by the Hub is acceptable for retroactive eligibility determinations provided that reasonable compatibility is met (see M0420.100 B.9).

Information from other sources, such as the Work Number, may become available via the Hub in the future.

2. Other Verification Sources

An individual must provide verifications of certain MA eligibility requirements when they cannot be verified through EDSV. Before taking action on the application, the applicant must be notified in writing of the required information. The verification request (checklist) must be sent to the authorized representative, if one has been designated.

See M0130.200 E below for instructions on the verification of legal presence. See subchapter M0220 for instructions on the verification of identity and citizenship. See subchapter M0310 for instructions on the verification of age and disability.

D. Social Security Numbers

Applicants must provide the SSN of any person for whom they request Medicaid, *if an SSN is required for that individual's eligibility*. An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

1. SSN Verification

The Federal Hub, SVES or SOLQ-I may be used to verify the individual's SSN.

2. Exceptions to SSN Requirements

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

Any non-citizen who is only eligible to receive an SSN for a valid non-work reason is not required to provide or apply for an SSN. These individuals include, but are not limited to, undocumented aliens, non-citizens admitted to the U.S. on non-immigrant visas and individuals who do not intend to work in the U.S. and would only have needed an SSN for the purposes of receiving public assistance (see M0220).

3. SSN Not Yet Issued

If an SSN has not been issued, the applicant must cooperate by applying for a number with the local Social Security Administration (SSA) office. Instruct the applicant to submit form SS-5, the Application for Social Security Number, to the SSA and to obtain a receipt from the SSA verifying that the application was submitted. The SS-5 is available online at: https://www.ssa.gov/forms/ss-5.pdf. The applicant must provide the SSN to the local social services department as soon as it is received and the number must be entered in *the eligibility and enrollment system*. Applicants who refuse to furnish an SSN or to show proof of application for a number will be ineligible for medical assistance.

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

When entering the individual in the eligibility/enrollment system, use the date the individual applied for an SSN, or the individual's date of birth, preceded by "999" as the individual's SSN. For example, an individual applied for an SSN on October 13, 2006, enter "999101306" as the individual's SSN.

E. Legal Presence (Effective January 1, 2006)

Effective January 1, 2006, Section 63.2-503.1 of the Code of Virginia requires most applicants for or recipients of public assistance who are age 19 or older to provide proof of citizenship or legal presence in the U.S. Applicants or recipients age 19 or older for whom medical assistance is requested must prove their citizenship or legal presence.

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.

It is crucial that individuals reviewing a case, including auditors, be able to follow the eligibility determination process in VaCMS. Changes and any questionable information must be appropriately documented as comments in the VaCMS case record.

The evaluation of eligibility requirements must be documented in writing for cases not processed in *VaCMS*. 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.

Changed With	Effective Date	Pages Changed
TN #DMAS-3	1/1/17	Table of Contents Page 22a Appendix 1, page 1
TN #DMAS-2	10/1/16	Pages 13, 19-22, 23, 24
TN #DMAS-1	6/1/16	Pages 4, 4b, 5, 23
TN #100	5/1/15	Table of Contents Pages 4b, 12, 17, 18 Appendix 5, page 3 Page 4 was renumbered for clarity. Page 4a is a runover page.
TN #99	1/1/14	Table of Contents Pages19, 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 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

Changed With	Effective Date	Pages Changed
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

TABLE OF CONTENTS

M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS

	Section	Page
General Principles	**M0220.001**	**1**
Citizenship and Naturalization	**M0220.100**	**2**
Alien Immigration Status	**M0220.200**	**4a**
Immigration Status Verification	**M0220.201**	**4b**
Systematic Alien Verification for Entitlements (SAVE)	**M0220.202**	**5**
Full Benefit Aliens	**M0220.300**	**7**
Aliens Receiving SSI	**M0220.305**	**8**
Certain American Indians	**M0220.306**	**9**
Qualified Aliens Defined	**M0220.310**	**9**
Veteran & Active Military Aliens	**M0220.311**	**12**
Qualified Aliens Who Entered U.S. Before 8-22-96	**M0220.312**	**14**
Qualified Aliens Who Entered U.S. On/After 8-22-96	**M0220.313**	**14a**
Lawfully Residing Non-citizen Children under age 19 and Pregnant Women	**M0220.314**	**14d**
Emergency Services Aliens	**M0220.400**	**15**
Emergency-Services-Only Qualified Aliens Who Entered U.S. On/After 8-22-96	**M0220.410**	**16**
Unqualified Aliens	**M0220.411**	**18**
Aliens Eligibility Requirements	**M0220.500**	**19**
Full Benefit Aliens Entitlement & Enrollment	**M0220.600**	**22a**
Emergency Services Aliens Entitlement & Enrollment	**M0220.700**	**23**

Appendices

Citizenship & Identity *Procedures*	**Appendix 1**	**1**
Sample Letters of Certification/Eligibility for Victims of a Severe Form of Trafficking	**Appendix 2**	**1**
SSA Quarters of Coverage Verification Procedures for Lawful Permanent Residents	**Appendix 3**	**1**
Reserved	**Appendix 4**	**1**
Alien Codes Chart	**Appendix 5**	**1**
Proof of U.S. Citizenship and Identity for Medicaid	**Appendix 6**	**1**
Typical Documents Used by Lawfully Present Immigrants	**Appendix 7**	**1**

If more than one period of service is requested, the records must be separated, and a separate certification form must be attached for each period of service.

If a request is received with one certification form and the records contain multiple dates of service, and/or DMAS is unable to make a determination with the medical records received, the entire request will be returned to the eligibility worker with a note specifying the information needed.

Do not include application forms for disability, FAMIS, etc. These forms contain protected health information that is not needed for the determination of medical necessity.

Do **not** take action to approve or enroll an emergency services alien until you receive the completed Emergency Medical Certification form back from DMAS. If approved, DMAS will provide the certification for Medicaid payment for emergency services and coverage begin and end dates.

M0220.600 FULL BENEFIT ALIENS ENTITLEMENT & ENROLLMENT

A. Policy

An alien who is determined eligible for full Medicaid benefits and who meets all Medicaid eligibility requirements (including covered group requirements) is eligible for all Medicaid-covered services available to the recipient's covered group.

B. Application & Entitlement

1. Application Processing

The eligibility worker must take the application and develop it in the same manner as any other individual's application. All eligibility requirements, including covered group requirements must be met.

2. Entitlement

If the applicant is found eligible for Medicaid, ongoing eligibility may exist unless the recipient is on a spenddown.

3. Spenddown

Spenddown provisions apply to medically needy individuals who have excess income.

4. Notice

Appropriate notice must be sent to the applicant of the status of his application and of his Medicaid eligibility.

C. Enrollment Procedures

Once a full benefit alien is found eligible for Medicaid, he must be enrolled in *VaCMS* using the following data:

1. Country

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

2. Cit Status

In this field, Citizenship Status, enter the Citizenship code that applies to the alien. Below, next to the Citizenship code, is the corresponding Alien Code from the Alien Code Chart in Appendix 5 to this subchapter. Eligible alien codes are:

R = refugee (Alien Chart codes F1, F2, G1, G2); also used for Afghan and Iraqi Special Immigrants (Alien Chart Code Z1).
E = entrant (Alien Chart code D1).
P = full benefit qualified aliens (Alien Chart codes A1, A2, A3, B1, B3, C1, E1, H1, H2, I1, J1, J2).
I = legal immigrant children under age 19 only (Alien Chart codes Y1, Y2, Y3)

Citizenship & Identity *Procedures*

Workers are to use the following procedures when citizenship and identity verification is required to determine the individual's continued eligibility.

A. Documents Establishing U.S. Citizenship and Identity

4. Documents that Verify Citizenship and Identity

Both U.S. Citizenship and identity are verified by a:

- U.S. Passport,
- Certificate of Naturalization, or
- Certificate of U. S. Citizenship

Documentary evidence issued by a federally recognized Indian tribe which identifies the tribe that issued the document, indentifies the individual by name and confirms membership, enrollment or affiliation with the tribe (tribal enrollment card, certificate of degree of Indian blood, Tribal census. document, documents on Tribal letterhead)If the individual presents one of these documents, he has verified his citizenship and identity. **Photocopies of original documents are acceptable.**

5. Documents that Verify Identity

a. Documents

The agency must accept any of the documents listed below as proof of identity, provided such document has a photograph or other identifying information including, but not limited to, name, age, sex, race, height, weight, eye color or address. **Photocopies of original documents are acceptable.**

- Identity documents listed at 8 CFR 274a.2(b)(1)(v)(B)(l), except a driver's license issued by a Canadian government authority
- Driver's license issued by a State or Territory
- School identification card
- U.S. military card or draft record
- Identification card issued by the Federal, State or local government
- Military dependent's identification card
- U.S. Coast Guard Merchant Mariner's card
- For children under age 19, a clinic, doctor, hospital or school record, including preschool or daycare records

M0310 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-3	1/1/17	Pages 8, 13, 28b
TN #DMAS-2	10/1/16	Pages 4, 7, 29 Page 30 is a runover page. Appendix 2, page 1
TN #DMAS-1	6/1/16	Table of Contents, page ii Pages 13, 26, 28 Appendix 2, page 1
TN #100	5/1/15	Table of Contents, pages i, ii pages 11, 23, 28b, Pages 27a-27c were renumbered to 28-28a for clarity. Page 10 is a runover page. Appendix 2
UP #10	5/1/14	Pages 29, 30
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

M0310.107 CARETAKER-RELATIVE

A. Definitions

1. Caretaker-relative

A "caretaker-relative" is an individual who is not a parent, but who

- is a relative, of a specified degree, of a dependent child (as defined in M0310.111) and
- is living with and assuming continuous responsibility for day to day care of the dependent child (as defined in M0310.111) in a place of residence maintained as his or their own home.

A caretaker-relative is also referred to as a “non-parent caretaker” to distinguish the caretaker-relative from the parent.

2. Specified Degree

A relative of specified degree of the dependent child is

- any blood relative, including those of half-blood and including first cousins, nephews or nieces and persons of preceding generations as denoted by prefixes of grand, great, or great-great;
- a stepfather, stepmother, stepbrother, and stepsister;
- a relative by adoption following entry of the interlocutory or final order, whichever is first; the same relatives by adoption as listed above: including first cousins, nephews or nieces and persons of preceding generations as denoted by prefixes of grand, great, or great-great, and stepfather, stepmother, stepbrother, and stepsister.
- spouses of any persons named in the above groups even after the marriage is terminated by death or divorce.

Neither severance of parental rights nor adoption terminates the relationship to biological relatives.

B. Procedures

1. Relationship

The relationship as declared on the application/redetermination form is used to determine the caretaker-relative’s relationship to the child. No verification is required.

2. Living in the Home

A child’s presence in the home as declared on the application/ redetermination form is used to determine if the child is living in the home with a parent or a caretaker-relative. No verification is required.

3. Parent and Stepparent in Home

The presence of a parent in the home does not impact a stepparent’s eligibility in the Low Income Families with Children (LIFC) covered group. Both the parent and stepparent may be eligible in the LIFC covered group. See M0330.300.

2. Living in the Home

A child's presence in the home as declared on the application/ redetermination is used to determine if the child is living in the home with a parent or caretaker-relative. No verification is required *unless the information contained in the application does not clearly establish whether or not the child is living with the parent or care-taker relative.*

A child who is living away from the home is considered living with his parents in the household if:

- the child is not emancipated, and
- the absence is temporary and the child intends to return to the parent's home when the purpose of the absence (such as vacation, visit, education, rehabilitation, placement in a facility for less than 30 days) is complete.

  NOTE: If the stay in the medical facility has been or is expected to be 30 days or more, go to M1410.010 to determine if the child is institutionalized in long-term care.

Children living in foster homes or medical institutions are NOT temporarily absent from the home. They are indefinitely absent from home and are NOT living with their parents or siblings for Medicaid purpose.

Children placed in Level C psychiatric residential treatment facilities (PRTF) are considered absent from their home if their stay in the facility has been 30 days or more. A child who is placed in a Level C PRTF is considered NOT living with his parents for Medicaid eligibility purposes as of the first day of the month in which the 30th day of residential placement occurs. Modified Adjusted Gross Income (MAGI) methodology contained in Chapter M04 is applicable to children in PRTFs; long-term care rules do not apply to these children.

The levels of administrative review are in the following order:

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

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

3. RRB Denial, Termination and RRB Appeal

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

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

4. Subsequent SSA/SSI Disability Decisions

If the individual appeals a disability denial and the decision is 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. If the individual has moved to another locality in Virginia, it is the responsibility of the agency that processed the application to reopen the application and determine eligibility prior to transferring the case. See M1510.104.

M0310.113 RESERVED

M0310.114 FAMILIES & CHILDREN (F&C)

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

- children under 19,
- pregnant women,
- specified subgroups of children under age 21,
- former Virginia foster care children under age 26 (effective January 1, 2014), and
- parent/caretakers of dependent children under age 18.

Also included in the F&C groups are individuals eligible only for family planning services (Plan First) and participants in BCCPTA.

M0320 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-3	1/1/17	Pages 11, 27, 29, 40, 41, 44, 45, 52
TN #DMAS-2	10/1/16	Pages 4, 15, 16, 18, 20, 22, 30, 33, Pages 39- 41, 43-45, 48, 51, 52, 55
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 1, 11, 25-27, 46-49 Page 50 is a runover page.
TN #100	5/1/15	Pages 6, 11, 24, 25-27, 29-30
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, 2011 or 2016.

Cost-of-living calculation formula:

a. *Current Title II Benefit* = *Benefit Before*
1.003 (1/17 Increase) *1/17 COLA*

b. Benefit Before 1/17 COLA = Benefit Before
1.017 (1/15 Increase) 1/15 COLA

c. Benefit Before 1/15 COLA = Benefit Before
1.015 (1/14 Increase) 1/14 COLA

d. Benefit Before 1/14 COLA = Benefit Before
1.017 (1/13 Increase) 1/13 COLA

5. Medicare Premiums

a. Medicare Part B premium amounts:

1-1-17 $109.00
1-1-16 $121.80
1-1-15 $104.90
1-1-14 $104.90
1-1-13 $104.90

Note: 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:

1-1-17 $413.00
1-1-16 $411.00
1-1-15 $407.00
1-1-14 $426.00
1-1-13 $441.00

Contact a Medical Assistance Program Consultant for amounts for years prior to *2013*.

6. Evaluation

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

in all future Medicaid determinations for former MEDICAID WORKS enrollees. The account must be exclusively used to hold resources accumulated while in MEDICAID WORKS (including interest) in order for the exclusion to continue.

3) For **all** other resources, the resource requirements in chapter S11 and Appendix 2 to chapter S11 apply. All of the individual's countable, nonexempt resources must be verified and evaluated.

All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements. The resource limit for resources not excluded in 1) or 2) above is $2,000 for an individual.

3. Income

a. Initial eligibility determination

For the initial eligibility determination, the income limit is ≤ 80% of the FPL (see M0810.002). The income requirements in chapter S08 must be met. Individuals who receive SSI are considered to meet the income requirements and no evaluation of income is necessary for the initial eligibility determination (see M0320.101).

b. Ongoing eligibility

Once the individual is enrolled in MEDICAID WORKS, the following income policies apply:

1) The income limit for earned income in *2017* is $6,250 per month ($75,000 per year) as long as the funds are deposited in a WIN Account. The policy for determining countable earned income is contained in subchapter S0820.

   If the individual is self-employed, net earnings from self-employment (NESE) must be demonstrated through documentation of Internal Revenue Service (IRS) filings, quarterly estimated taxes, business records, and/or business plans. The individual's signed allegation of self-employment is acceptable if no other evidence of NESE can be obtained. Follow the policy in S0820.220 for determining NESE.

2) The income limit for unearned income remains less than or equal to 80% of the FPL. The policy for determining countable unearned income is contained in subchapter S0830.

3) Any increase in an enrollee's Social Security Disability benefits resulting from employment as a MEDICAID WORKS participant OR as a result of a COLA adjustment to the Social Security Disability benefits will not be counted as long as it is regularly deposited upon receipt into the individual's WIN account.

4) Unemployment insurance benefits received due to loss of employment through no fault of the individual's own are not counted during the six-month safety net period (see M0320.400 G) as income as long as the payments are regularly deposited upon receipt into the individual's WIN account.

Resources accumulated while in MEDICAID WORKS and retained in an IRS-approved account described in M0320.400 D. 2. b. 2) that has been designated as a WIN Account are excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees.

H. Benefit Package

Individuals enrolled in MEDICAID WORKS are entitled to the standard benefits available to full-benefit Medicaid enrollees (see Chapter M18), as well as Personal Assistance Services; MEDICAID WORKS enrollees do **not** have a patient pay. Intensive Behavioral Dietary Counseling is also covered for MEDICAID WORKS enrollees when a physician determines that the service is medically necessary.

I. Entitlement and Enrollment

Entitlement for MEDICAID WORKS is dependent upon meeting the requirements listed above.

There is no retroactive coverage under MEDICAID WORKS. The application date in *the Virginia Case Management System (VaCMS)* is the date the individual signed the MEDICAID WORKS Agreement. Coverage shall begin on the first day of the month following the month in which all requirements are met. If the applicant has a future start date for employment, the effective date of eligibility shall be no earlier than the first day of employment. However, unless employment begins on the first day of the month, MEDICAID WORKS enrollment will begin on the first of the following month.

Complete the MEDICAID WORKS fax cover sheet and fax it together with the following information to DMAS at 804-612-0020:

- a signed MEDICAID WORKS Agreement,
- the Work Incentive Account (WIN) information (a bank account statement or verification from the bank that the account was opened), and
- one of the following verifications of employment:
  - a pay stub showing current employment or
  - an employment letter with start date or
  - self-employment document(s).

The AC for MEDICAID WORKS is 059. Use the following procedures to enroll the individual in *VaCMS*:

<u>New Application – Applicant Eligible as 80% FPL</u>

1. For the month of application and any retroactive months in which the person is eligible in the 80% FPL covered group, enroll the individual in a closed period of coverage using AC 039 (blind) or 049 (disabled), beginning the first day of the month in which eligibility exists. The cancel date is the last day of the month in which the MEDICAID WORKS Agreement was signed. Use Cancel Code 042.
2. Reinstate the individual's coverage in MEDICAID WORKS using AC 059 beginning the first day of the following month (the first day of the month following the month in which the MEDICAID WORKS Agreement is signed). Use the same application date (the actual date of the initial application) that was used for the month of application.

3. Income

The income requirements in chapter S08 must be met by QMBs. The income limits are in M0810.002. By law, for QMBs who have SSA benefits, the new QMB income limits are effective the first day of the second month following the month in which the federal poverty limit is updated. For QMBs who do NOT have SSA benefits, the new QMB income limits are effective the date the updated FPL is published. Local DSS are notified each year of the new FPL via the broadcast system. Check that system to ascertain when the SSA COLA must be counted in determining QMB income eligibility.

4. Income Exceeds QMB Limit

Spenddown does not apply to the MSP income limits. If the individual's income exceeds the QMB limit, he is not eligible as QMB and cannot spenddown to the QMB limit. Determine the individual's eligibility in the SLMB covered group below in M0320.602.

At application and renewal, if the eligible QMB individual's resources are within the medically needy limit and the individual meets a MN covered group, place the individual on two 6-month spenddown based on the MN income limit.

D. QMB Entitlement

Entitlement to Medicaid coverage for QMB only begins the first day of the month **following** the month in which Medicaid eligibility as a QMB is approved.

Because QMB coverage does not begin until the month following the month of approval, an applicant who is eligible for QMB coverage must apply for Extra Help in order to receive the subsidy for the month of QMB approval. See chapter M20 for more information on Extra Help.

Retroactive eligibility does **not** apply to the QMB covered group. To be eligible for Medicaid in the retroactive period, and in the application month, a QMB must meet the requirements of another Medicaid covered group.

E. Enrollment

1. Aid Categories

The following ACs are used to enroll individuals who are only eligible as QMBs; they do not meet the requirements of another covered group:

- 023 for an aged QMB only;
- 043 for a blind QMB only;
- 063 for a disabled or end-stage renal disease QMB only.

2. Enrollee's *Covered Group* Changes To QMB

If a Medicaid enrollee becomes **ineligible** for full-coverage Medicaid because of an increase in income or resources, but is eligible as a QMB, the agency must send an advance notice of proposed action to the enrollee because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare premiums, deductibles and coinsurance amounts as a QMB.

Cancel the enrollee's full coverage effective the last day of the month, using cancel reason "007". Reinstate the enrollee's coverage with the begin date as the first day of the month following the cancellation effective date. The AC is QMB-only.

3. QMB *Becomes Eligible For* Full Coverage

When an enrolled QMB-only becomes eligible in another covered group and covered group which has full Medicaid coverage, except when he/she meets a spenddown, e.g., a QMB-only individual's resources change to below the MN limits:

- cancel the QMB-only coverage effective the last day of the month immediately **prior** to the month in which he/she became eligible in the full coverage covered group, using cancel reason "024";
- reinstate the enrollee's coverage with the begin date as the first day of the month in which he/she became eligible in the full coverage covered group, with the appropriate full coverage AC.

4. Spenddown Status

At application and redetermination, eligible QMBs who meet an MN covered group and who have resources that are within the lower MN resource limits are placed on two 6-month medically needy spenddowns. All spenddown periods are based on the application or renewal date, as appropriate. See M1370.

In order to be placed on spenddown, QMBs with end-stage renal disease must meet a medically needy covered group.

5. QMB Meets Spenddown

When an eligible QMB meets the spenddown, cancel the QMB-only coverage effective the day before the spenddown was met, using cancel reason "024". Reinstate the enrollee's coverage with the first date the spenddown was met as the begin date of coverage, and enter the end date of the spenddown period as the end date of coverage. The aid category is medically needy dual-eligible:

- 028 for an aged MN individual also eligible as QMB;
- 048 for a blind MN individual also eligible as QMB;
- 068 for a disabled MN individual also eligible as QMB.

6. Spenddown Period Ends

After the spenddown period ends, reinstate the QMB-only coverage using the appropriate QMB-only AC. The begin date of the reinstated coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial QMB eligibility.

3. Income

The income requirements in chapter S08 must be met by SLMBs. The income limits for SLMBs are in M0810.002. An SLMB's income must exceed the QMB limit and must be less than the SLMB limit.

By law, for SLMBs who have Title II benefits, the new SLMB income limits are effective the first day of the second month following the month in which the federal poverty limit is updated. For SLMBs who do NOT have Title II benefits, the new SLMB income limits are effective the date the updated federal poverty level is published.

Local DSS are notified each year of the new poverty limits via the broadcast system. Check that system to ascertain when the Title II COLA must be counted in determining SLMB income eligibility.

4. Income Equals or Exceeds SLMB Limit

Spenddown does not apply to the MSP income limits. If the individual's income is equal to or exceeds the SLMB limit, he/she is not eligible as SLMB and cannot spenddown to the SLMB limit. At application and redetermination, if the individual's resources are within the medically needy limit and the individual meets a medically needy covered group, place the individual on two 6-month spenddowns based on the MN income limit.

D. SLMB Entitlement

If all eligibility factors are met in the application month, entitlement to Medicaid as an SLMB begins the first day of the application month.

SLMBs are entitled to retroactive coverage if they meet all the SLMB requirements in the retroactive period. However, coverage under this group cannot begin earlier than January 1, 1993.

The eligible SLMB will only receive Medicaid payment of his/her Medicare Part B premium through the Medicaid Buy-In Agreement with SSA. **The SLMB will not receive a Medicaid card.**

E. Enrollment

1. Aid Category

The AC for all SLMBs is "053".

2. Enrollee's *Covered Group Changes To SLMB*

If a Medicaid recipient becomes ineligible for full-coverage Medicaid or QMB-only coverage because of an increase in income, but is eligible as an SLMB, the agency must send an advance notice of proposed action to the enrollee because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare Part B premiums as an SLMB.

Cancel the enrollee's full coverage effective the last day of the month, using cancel reason "007." Reinstate the enrollee's coverage with the begin date as the first day of the month following the cancellation effective date. The aid category (AC) is "053."

3. SLMB *Becomes Eligible for* Full Coverage

When an enrolled SLMB becomes eligible in another covered group which has full Medicaid coverage, except when he/she meets a spenddown, e.g., an SLMB's resources change to below the MN limits:

- cancel the SLMB coverage effective the last day of the month immediately prior to the month in which he/she became eligible in the full coverage covered group, using cancel reason "024";
- reinstate the enrollee's coverage with the begin date as the first day of the month in which he/she became eligible in the full coverage covered group, with the appropriate full coverage AC.

4. Spenddown Status

At application and redetermination, eligible SLMBs who meet an MN covered group and who have resources that are within the lower MN resource limits are also placed on two 6-month MN spenddowns.

All spenddown periods are based on the application or renewal date, as appropriate. See M1370.

SLMBs who are not determined disabled must be determined disabled or blind, or must be pregnant, under age 18 or under age 21 if in foster care or adoption assistance in order to meet a medically needy covered group for spenddown.

5. SLMB Meets Spenddown

When an SLMB meets a spenddown, cancel his AC "053" coverage effective the date before the spenddown was met, using cancel reason "024". Reinstate the enrollee's coverage with the first date the spenddown was met as the begin date of coverage, and enter the end date of the spenddown period as the end date of coverage. The AC is medically needy dual-eligible as SLMB Plus:

- 024 for an aged MN individual also eligible as SLMB;
- 044 for a blind or disabled MN individual also eligible as SLMB.

6. Spenddown Period Ends

After the spenddown period ends, reinstate the SLMB-only coverage using the AC 053.

The begin date of the reinstated AC 053 coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial SLMB eligibility.

2. Enrollee's AC Changes To QDWI

An enrolled enrollee's AC cannot be changed to AC "055" using a "change" transaction in *VaCMS*. If a Medicaid enrollee becomes ineligible for full-coverage Medicaid, but is eligible as a QDWI, the agency must send an advance notice of proposed action to the enrollee because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare Part A premiums as a QDWI.

Cancel the enrollee's full coverage effective the last day of the month, using cancel reason "007." Reinstate the enrollee's coverage as QDWI with the begin date as the first day of the month following the cancellation effective date. AC is "055."

3. QDWI's AC Changes To Full Coverage AC

When an enrolled QDWI becomes eligible in another covered group which has full Medicaid coverage (except when he/she meets a spenddown); e.g., he/she is no longer able to work and starts to receive SSA and SSI disability benefits:

- cancel the QDWI coverage effective the last day of the month immediately prior to the month in which he/she became eligible in the full coverage covered group, using cancel reason "024;"
- reinstate the enrollee's coverage with the begin date as the first day of the month in which he/she became eligible in the full coverage covered group, with the appropriate full coverage AC.

4. Spenddown Status

Eligible QDWIs who meet an MN covered group and who have resources that are within the lower MN resource limits are also placed on two 6-month medically needy spenddowns.

5. QDWI Meets Spenddown

When a QDWI meets a spenddown, cancel his AC "055" coverage effective the date before spenddown was met using cancel reason "024." Reinstate coverage as medically needy beginning the day the spenddown was met and ending the last day of the spenddown budget period.

The AC is NOT dual-eligible:

- 018 for an aged MN individual NOT eligible as QMB;
- 038 for a blind MN individual NOT eligible as QMB;
- 058 for a disabled MN individual NOT eligible as QMB.

6. Spenddown Period Ends

After the spenddown period ends, reinstate the QDWI-only coverage using the AC "055."

The begin date of the reinstated AC "055" coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial QDWI eligibility.

M0330 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-3	1/1/17	Pages 9, 10 Page 9a was removed.
TN #DMAS-2	10/1/16	Pages 8 Page 9b was renumbered to 9a.
TN #DMAS-1	6/1/16	Pages 2, 8, 9, 15, 31, 32-35 Page 9b was added as a runover page.
TN #100	5/1/15	Table of Contents Pages 4-8, 15-22, 24,25 36-38
UP #10	5/1/14	Pages 5, 8, 9
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

B. Nonfinancial Eligibility Requirements

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

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 or the URM Program if the child was enrolled in Medicaid during the month foster care ended.

Accept the individual's declaration of enrollment in foster care or the URM Program and enrollment in Medicaid at the time turned at least 18.

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.

Individuals in this covered group receive full Medicaid coverage, including long-term care (LTC) services. Do not move enrollees in this covered group who need LTC to the 300% of SSI covered group.

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. 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. *Children are not enrolled as LIFC except when the child* is under age 18 *and* his parents are receiving LIFC Extended Medicaid coverage (see M1520.500). In these situations, if the *child's household* 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.

For an adult to be eligible in the LIFC covered group, the adult must be living in the home with his or her dependent child under the age of 18 or must meet the definition of a caretaker-relative of a dependent child in M0310.107. *The presence of a parent in the home does not impact a stepparent's eligibility in the Low Income Families with Children (LIFC) covered group. Both the parent and stepparent may be eligible in the LIFC covered group.*

An LIFC child 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 caretaker-relative, as defined in M0310.107

C. Financial Eligibility

Modified Adjusted Gross Income (MAGI) methodology is applicable to the LIFC covered group. The policies and procedures contained in Chapter M04 are used to determine eligibility for LIFC individuals.

***1. Basis For Eligibility* ("Assistance Unit")**

The basis for financial eligibility is the LIFC individual's MAGI household. See M0430.100.

2. Resources

There is no resource test for the LIFC covered group.

3. Income

The income limits, policies and procedures used to determine eligibility in the LIFC covered group are contained in Chapter M04.

4. Income Exceeds Limit

If the *individual's* income exceeds the LIFC income limit, the *individual* is not eligible as LIFC. Ineligible individuals must be referred to the Health Insurance Marketplace for evaluation for the APTC. Spenddown does not apply to the LIFC income limits.

Note: LIFC families who have been enrolled in Medicaid for at least three of the past six months and who are no longer eligible due to excess earned income must be evaluated for continued eligibility in LIFE Extended Medicaid. See M1520.400.

D. Entitlement

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

E. Enrollment

The ACs for individuals in the LIFC covered group are:

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

M04 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-3	1/1/17	Table of Contents Pages 3 -5, 13a, 20 Appendix 6, page 1 Page 20a was added.
TN #DMAS-2	10/1/16	Appendix 2, pages 1, 2 Appendices 3, 5
TN #DMAS-1	6/1/16	Pages 3, 5, 6, 12, 13, 14a Appendices 1, 2, 6 and 7 Appendix 2, page 2 was added. Page 13a is a runover page.
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

TABLE OF CONTENTS

M04 MODIFIED ADJUSTED GROSS INCOME (MAGI)

	Section	Page
MAGI General Information	**M0410.100**	**1**
Definitions	**M0420.100**	**3**
MAGI Household Composition	**M0430.100**	**4**
Tax Filer Household Examples	**M0430.200**	**6**
Non Tax Filer Household Examples	**M0430.300**	**7**
Tax Filer and Non Tax Filer Household Examples	**M0430.400**	**8**
Household Income	**M0440.100**	**11**
Steps for Determining MAGI Eligibility	**M0450.100**	**14a**
Examples – Tax Filer Households	**M0450.200**	**16**
Examples – Non Tax Filer Households	**M0450.300**	***20a***

Appendices

5% FPL Disregard	**Appendix 1**	**1**
Child Under Age 19 and Pregnant Women Income Limits	**Appendix 2**	**1**
LIFC Income Limits	**Appendix 3**	**1**
Grouping of Localities	**Appendix 4**	**1**
Individuals Under Age 21 Income Limits	**Appendix 5**	**1**
Plan First Income Limits	**Appendix 6**	**1**
Treatment of Income For Families & Children Covered Groups	**Appendix 7**	**1**

4. Children in Level C Psychiatric Residential Treatment Facilities (PRTFs)

Children placed in Level C PRTFs are considered absent from their home if their stay in the facility has been 30 consecutive days or more. A child who is placed in a Level C PRTF is considered NOT living with his parents for MAGI purposes as of the first day of the month in which the 30th day of psychiatric residential placement occurs. Long-term care rules do not apply. See M0520.100 B.3.

M0420.100 Definitions

A. Introduction

The definitions below are used in this chapter. Some of the definitions are also in subchapter M0310. Some of the definitions are from the IRC.

B. Definitions

1. Caretaker Relative

means a *non-parent* relative of a "dependent" child by blood, adoption, or marriage with whom the child lives, who assumes primary responsibility for the child's care.

2. Child

means a natural, biological, adopted, or stepchild.

3. Dependent Child

means a child under age 18, or age 18 and a full-time student in a secondary school, who lives with his parent or caretaker-relative.

4. Family

means the tax filer (including married tax filers filing jointly) and all claimed tax dependents.

5. Family Size

means the number of persons counted as an individual's household. The family size of a pregnant woman's household includes the pregnant woman plus the number of children she is expected to deliver. When determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted as just one person.

6. Household

A household is determined by tax dependency. Parents, children and siblings are included in the same household. A child claimed by non-custodial parent is evaluated for eligibility in the household in which he is living and is also counted in the family size of the parent claiming him as a dependent. There can be multiple households living in the home.

This definition is different from the use of the word household in other programs such as the Supplemental Nutrition Assistance Program (SNAP).

7. Non-filer Household

means individuals who do not expect to file a Federal tax return and/or do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made. A non-filer household can also be a child who lives in the household with his custodial parent who is claimed on his non-custodial parent's taxes.

8. Parent *for the purposes of MAGI methodology,* means a natural, biological, adoptive, or stepparent. *When both the child's parent and stepparent are living in the home with the dependent child, both may be eligible as LIFC.*

9. Reasonable Compatibility means the income attested to (declared) by the applicant is within 10% of income information obtained from electronic sources. If the income from both sources meets the 10% requirement, then the attestation is considered verified.

The applicant's income reported on the application is verified through a match with income data in the federal Hub, if is available. The eligibility/enrollment system will compare the reported income with the income from the data match and determine if reasonable compatibility exists. If reasonable compatibility exists, the income will be labeled verified, and no further verification of the income is necessary.

If reasonable compatibility does not exist or income data was not available through the Hub, the income will be labeled unverified. If the system indicates that the income is not verified and the attestation is below the medical assistance income level, documentation of income is required.

10. Sibling means a natural, biological, stepsibling or half-sibling.

11. Tax-Dependent means an individual for whom another individual claims a deduction for a personal exemption under section 151 of the Internal Revenue Code of 1986 for a taxable year.

12. Tax-filer Household means individuals who expect to file a Federal tax return and/or who expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made.

M0430.100 MAGI HOUSEHOLD COMPOSITION

A. Introduction The household composition is the basis for the financial eligibility determination for each person in the home who applies for MA. Eligibility is based on the countable income of the household members.

The MAGI rules for household composition represent a major change for Medicaid. Included in the MAGI household composition are:

- stepparents and stepchildren,
- children/siblings with income,
- children ages 21 and older who are claimed as tax dependents, and
- other adult tax dependents.

B. Household Composition Rules Tax filers and tax dependents use the tax household rules with limited exceptions. In most cases, the household is determined by principles of tax dependency.

- Parents, children and siblings are included in the same household.
- 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.
- *Married couples that are separated and not living together but file jointly are not included in each other's household.*
- 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 Special Medical Needs AA children and children who have been in a Level C PRTF for at least 30 consecutive days, 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. **A Special Medical Needs AA child or a child who has been in a Level C PRTF for at least 30 consecutive days 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 a Special Medical Needs AA child or a child who has been in a Level C PRTF for at least consecutive 30 days.

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: A Special Medical Needs AA child or a child who has been in a Level C PRTF for at least 30 consecutive days is in his own household with no parents or siblings.

A. Monthly Income Determinations

Medicaid and FAMIS income eligibility is determined using current monthly income.

Sources and amounts of income that are verified electronically and are reasonably compatible do not require additional verification. When income cannot be verified electronically **or** the information reported is not reasonably compatible (see M0420.100 for the definition), the individual must be asked to provide current verification of the household income so a point-in-time income eligibility determination can be made.

$300 is less than the Medicaid Child < Age 19 limit for 2 ($1,849) so Joy is eligible for Medicaid in the Child < Age 19 covered group. The 5% disregard is not applied because it is not necessary since her gross household income is within the Medicaid Child < Age 19 income limit.

A. *Example # 3 Tax Filer with Dependent Outside of the Home (Using January 1, 2017 figures)*

John applies for Medicaid for himself and his child Richard. John files taxes and claims Richard as well as his 17 year old daughter, Bridget, who does not live with him. John works part time making $800 a month and Bridget works part time making $625 a month.

Person	*# - Household Composition*	*Reason*
John	*3 - John, Richard, Bridget*	*Tax filer and dependents*
Richard	*3 - Richard, John, Bridget*	*Tax dependent, tax filer, and other dependent*

Even though Bridget has income over the tax filing threshold ($6,300 in 2016) and is required to file taxes on her own, she is part of John's tax filing household as a dependent, so her income counts toward any HH in which she is included.

John's eligibility determination:

Potential covered groups:
LIFC
Plan First
The full-coverage Medicaid covered group John meets that has the highest income limit is LIFC.

Monthly income limits:
LIFC, Group II for HH of 3 = $575
Plan First 200% FPL for HH of 3 = $3,360
5% FPL for HH of 3 = $84

John's gross HH income of $1,425.00 exceeds the LIFC income limit for 3 of $575. He is entitled to the 5% FPL disregard.

$1,425.00 gross household income
- 84.00 5% FPL for 3
$1,341.00 countable income (after 5% FPL disregard)

His countable income of $1,343.00 is compared to the LIFC income limit for 3 of $556; it exceeds the LIFC limit so John is not eligible for full-coverage MA.

His gross HH income of $1,425.00 is compared to the Plan First 200% FPL income limit for 3, $3,360. John is eligible for Plan First.

John is also referred to the HIM.

Richards's eligibility determination:

Potential covered groups:
Child < Age 19
FAMIS

Monthly Income limits:
Child < 19 143% FPL for a HH of 3 = $2,403
FAMIS 200% FPL for HH of 3 = $3,360
5% FPL for 3 = $84

Richard's gross HH income of $1,425 (his father's and sibling's earnings) does not exceed the Medicaid Child < Age 19 143% FPL income limit for 3 ($2,329) so Richard does not need the 5% disregard applied to his income. He is eligible for full-coverage MA.

M0450.300 INCOME EXAMPLES – NON TAX FILER HOUSEHOLDS

A. Example #1

Non Tax Filer Single Parent, Two Children

(Using Oct. 1, 2013

:k receives of $2,000 per month disability, with projected annual income of $24,000. Mike and Ike each receive $600 monthly or $14,400 annually, from interest from the trusts their grandparents set up for them.

The MAGI households are:

Person	# - Household Composition	Reason
Mark	3 – Mark, Mike & Ike	Non tax filer & his 2 children < 19
Mike	3 – Mike, Mark & Ike	Non-filer child < 19, his parent & his sibling < 19
Ike	3 – Ike, Mark & Mike	Non-filer child < 19, his parent & his sibling < 19

Mark's eligibility determination:

Potential covered groups:

LIFC
Plan First

PLAN FIRST
200% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE 1/25/16

Household Size	200% FPL Monthly Amount	205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)
1	$ 1,980	$2,030
2	2,670	2,737
3	3,360	*3,444*
4	4,050	4,152
5	4,740	4,869
6	5,430	5,566
7	6,122*	6,276
8	6,815*	6,986
Each additional, add	694*	712

*No change for 2016.

M0520 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-3	1/1/17	Table of Contents Pages 3, 5-35 Pages 36-38 were removed.
TN #100	5/1/15	Page 2
TN #98	10/1/13	Title Page Table of Contents Pages 1,2,9
UP #7	7/1/12	Table of Contents Pages 2-5
Update (UP) #4	7/1/10	Pages 2, 2a

TABLE OF CONTENTS

M05 MEDICAID ASSISTANCE UNIT

M0520.000 FAMILIES & CHILDREN (F&C) MEDICALLY NEEDY (MN) FAMILY/BUDGET UNIT

	Section	Page
Overview	M0520.001	1
Definitions	M0520.010	2a
Family Unit Rules	M0520.100	3
Multiple Family Units	M0520.101	6
Budget Unit Rules	M0520.200	7
Child(ren) With Resources and/or Income	M0520.201	9
Married Medicaid Minor or Medicaid Minor Caretaker Living With Parent	M0520.202	10
Stepparent In Household	M0520.203	12
Acknowledged Father in Household	M0520.204	13
Deeming From Spouse	M0520.300	13
Deeming From Parent	M0520.400	17
Changes In Status	M0520.500	25
Family/Budget Unit Changes	M0520.501	25
Deeming Changes	M0520.502	26
Pregnant Woman Budget Unit	M0520.600	27
Unmarried PG Woman Over Age 21 Unit	M0520.601	28
Married PG Woman Unit	M0520.602	29
Unmarried Minor PG Woman Under Age 21 Unit	M0520.603	30
Individual Under Age 21 Family Unit	M0520.700	32
Foster Care Child Family Unit	M0520.701	32
Adoption Assistance Child Family Unit	M0520.702	33
Special Medical Needs Adoption Assistance Child Family Unit	M0520.703	35
Child in ICF or ICF-MR Family Unit	M0520.704	35

Appendix

Medicaid F&C Resource and Income Deeming Worksheet	Appendix 1	1

F. Medicaid Minor A child under age 21 years is a Medicaid minor.

M0520.100 FAMILY UNIT RULES

A. Introduction

This section contains the rules that apply to the family unit within a household applying for Medicaid. The family unit consists of the individuals in the household among whom legal responsibility for support exists. A parent or non-parent caretaker can choose to exclude any child from the family unit by excluding the child from the Medicaid application (see M0520.001 B).

B. Family Unit Composition

When determining composition of the F&C family unit, start with the individual who applies for Medicaid and who meets a *MN* F&C covered group's requirements. These covered groups are:

- MN Pregnant Women ;
- MN Newborn Children;
- MN Children Under Age 18;
- MN Individuals < 21 in foster care, adoption assistance, and ICF or an ICF-MR.

Begin forming the family unit(s) by identifying a pregnant woman in the household, if any. If the household does not contain a pregnant woman, begin forming the family unit(s) by identifying the child(ren) who meets an F&C *MN* covered group.

1. Member In One Unit At A Time

An applicant/recipient's Medicaid eligibility can only be determined in one F&C family unit at a time.

2. Include Responsible Relative(s)

The unit must include the legally responsible relative(s) with whom the individual lives (parent for child under age 21 and spouse for spouse), EXCEPT when:

- the child is in foster care and is placed in his/her home for a trial visit; or

- the spouse or the parent receives an SSI or IV-E foster care/adoption subsidy payment. Do not include SSI and IV-E Foster Care/Adoption Assistance recipients in the unit.

4. Pregnant Woman

An individual who meets the pregnant woman definition is counted as at least **two persons** when her eligibility is being determined in the MI Pregnant Woman or MN Pregnant Woman covered group. The unborn child (or children, if medical documentation verifies more than one fetus) must be included in the unit with the pregnant woman when determining her eligibility. A separate calculation is required for the other family unit members who do not meet a pregnant woman covered group. This calculation does NOT include the unborn child(ren) as part of the family unit and/or budget unit (BU).

5. Cohabitant

A cohabitant is not the child(ren)'s parent and is not legally responsible for anyone in the family unit. Therefore, the cohabitant is not included in the family unit. Do not count a cohabitant's income or resources.

C. *Family Unit* Examples *for MN Eligibility Determinations*

1. Household With Excluded Child

EXAMPLE #1: Household listed on application consists of applicant, her disabled spouse, her 15-year old son, and husband's 20-year old daughter. The 20-year old daughter is employed full-time. Medicaid is requested for applicant, her spouse, and her son. She specifies in writing that she wishes to exclude her husband's 20-year old daughter. *It is determined that the applicants are not eligible for Medicaid in any categorically needy covered groups due to excess income; however, the 15-year old son meets a MN Children Under 18 covered group and his mother requests that he be evaluated for a spenddown.*

The family unit consists of:

- the applicant
- her husband, and
- her 15-year old son.

The family unit's income is determined using the F&C income policy and procedures.

2. Household With Acknowledged Father

EXAMPLE #2: Household listed on the Medicaid application consists of pregnant woman applicant, her 5-year old son and her boyfriend, who is the acknowledged father of the 5-year old. They all request Medicaid. *It is determined that the applicants are not eligible for Medicaid in any categorically needy covered groups due to excess income; however, the pregnant woman and her son both meet MN covered groups, and the pregnant woman requests that they be evaluated for a spenddown.*

The family unit for the Medicaid eligibility determination for the 5-year old child consists of:

- the woman,
- the 5-year old child and
- the child's acknowledged father.

The family unit for the Medicaid eligibility determination for the pregnant woman consists of:

- the pregnant woman,
- her unborn child,
- the 5-year old child, and
- the child's acknowledged father.

The family unit's income is determined using the F&C income policy and procedures.

M0520.101 MULTIPLE FAMILY UNITS

A. Policy

Multiple family units exist in a household in the following situations:

1. Non-parent Caretaker

When the individual is applying for Medicaid as a non-parent caretaker of a dependent child, multiple family units exist.

2. Child--No Responsible Relative In Home

When the individual applying is a child under age 21 but has no responsible relative living in the household and is not a sibling of another child(ren) in the household, multiple family units exist.

***3.* Adult--No Responsible Relative In Home**

When the individual applying is age 21 or older and is not legally responsible for the other applicant(s) in the household, multiple family units exist.

***4.* Foster Care Child**

When the individual applying is a foster care child whose parent(s) live in the household and who is placed in his/her home for a trial visit (see M0520.701 below), multiple family units exist.

***5.* Siblings**

Siblings under age 21 are included in the same family unit.

6. SSI Child

A child receiving SSI is always a separate family unit of one person.

B. Procedures

When an applicant applies for a child in the household, begin forming the family unit by identifying the child(ren) who applies and meets an F&C covered group. Divide the household into multiple family units when:

- the household contains an individual(s) who applies for Medicaid but who is not a legally responsible relative of the other individual(s) who has applied; or

- the household contains a foster care child under age 21 who is placed in the home for a trial visit.

Each family unit must contain only those individuals among whom legal responsibility for financial support exists.

M0520.200 BUDGET UNIT RULES

A. Policy

BUs are formed to assure that only the individual's resources and income and the resources and income of those persons legally responsible for the individual are used to determine the individual's Medicaid financial eligibility. If the individual's family unit has resources or income which cannot be verified or which exceed the limit for the individual's covered group, determine if the family unit can be broken into BU. Forming BUs based on resources is only applicable to the F&C MN covered groups. A family unit must be broken into BUs when:

1. a child in the family unit has his/her own income;
2. a child in the family unit has his/her own resources (applicable only for F&C MN covered groups);
3. the child's stepparent is in the family unit;
4. the child's parent with whom he/she lives is a Medicaid minor (under age 21) and they live with the minor parent's parent(s);
5. the child is married and living with his/her spouse and his/her parent(s);
6. the child(ren)'s acknowledged father lives in the household and is not married to the child(ren)'s mother.

All members of a family unit must be placed in a BU when the family unit can be divided into BUs. Although they will be included in a BU, persons found eligible at the family unit level do NOT have their eligibility redetermined at the BU level.

B. Budget Unit Rules

The rules that apply to BU composition are:

1. Member In One Unit

An applicant/recipient can be a member of only one F&C BU.

2. Children With Own Resources (F&C MN Only) or Income

The child(ren) with his or her own resources or income is in a separate BU. Deem resources and income from parents. Resources are deemed and/or counted only when determining eligibility for F&C MN covered groups.

The parent(s) is/are included in the unit with child(ren) who has no resources or income.

If all of the children have resources or income, the parent(s) is/are in a separate BU. If there is more than one child with resources or income, the resources or income deemed from the parents are divided evenly among the children.

3. Medicaid Minor Caretaker Applicant

When the Medicaid minor parent is not married and lives with his/her parent(s), he or she is included in a BU with his/her parent(s), NOT with his or her child(ren).

When the Medicaid minor parent is married and lives with his/her parent(s) and spouse, he or she is in a BU by himself/herself, NOT with his/her parent(s) and NOT with his or her child(ren) and spouse.

A married Medicaid minor parent is in a separate BU when living with his/her spouse and the minor's parent(s).

4. Married Medicaid Minor

When the Medicaid minor is married and lives with his/her parent(s) and spouse, he or she is in a BU by himself/herself, NOT with his/her parent(s) and NOT with his or her child(ren) and spouse. A married Medicaid minor is in a separate BU when living with his/her spouse and the minor's parent(s).

5. Stepparent In Household

A stepparent is not included in a BU with his/her stepchild(ren). A married parent **(except a Medicaid minor parent who lives with his/her parents)** is included in a BU with his/her spouse and their child(ren)-in-common. The parent's other child(ren) who are not the child(ren) of his/her spouse are in a separate BU.

6. Deeming From Parents

When determining how much of the child's parent's income or resources are deemed available to the child's BU, any income or resources deemed to the parent from the parent's spouse who is not the child's parent, is NOT counted in the deeming calculation.

No income or resources deemed from the parent(s) of a minor child are deemed to the minor child's spouse or the minor's child.

7. Acknowledged Father

An acknowledged father who lives in the household and is not married to the child(ren)'s mother is in a BU separate from the mother. Their child(ren)-in-common is NOT included in the BU with the father; the child(ren)-in-common is in a separate BU.

8. Spenddown Expenses

If a BU is ineligible because of excess income, only the unit's member's medical expenses will count toward the unit's spenddown, unless a BU member is legally liable to pay the medical expenses of another person in the household, whether or not that other person is in another Medicaid BU. If a BU member is legally liable for another person in the household, the other person's medical bills can count toward the BU member's spenddown.

A medical expense can only be used once to meet only one unit's spenddown. A child's medical expenses are first deducted from the child's unit. If the child's unit spenddown is not met, the child's medical expenses can be deducted from the parent's spenddown. If the child's unit's spenddown is met, then the child's medical expenses that were not used to meet the child's spenddown can be deducted from the parent's spenddown, if the medical expenses are not covered by Medicaid or other health insurance.

M0520.201 CHILD(REN) WITH RESOURCES AND/OR INCOME

A. Policy

The child(ren) with his or her own resources (F&C MN covered groups only) or income is in a separate BU. Forming BUs based on resources is only applicable to F&C MN covered groups. Deem income and resources from the parents if the child is living with the parents; and from the child's spouse if the child is married and living with the spouse.

B. Forming Budget Units *for the MN Eligibility Determination*

Place the child who has his/her own resources or income in a BU by himself.

EXAMPLE #6: Household listed on application consists of a woman, her disabled spouse, their 15-year old son, and their 20-year old daughter. *The son's MN eligibility is being determined.*

The family unit consists of:

- the mother,
- her husband, and
- their two children under age 21.

Because the son receives unearned income from a trust fund, the family unit is broken into BUs:

- BU #1 = son
- BU #2 = mother, her husband, and their daughter

The parent's BU's countable income is calculated to determine how much income is deemed to the son's BU. The parent's deemed income is added to the son's income to determine the son's BU's countable income for *MN* eligibility.

M0520.202 MARRIED MEDICAID MINOR OR MEDICAID MINOR CARETAKER LIVING WITH PARENT

A. Policy

The Medicaid minor parent (caretaker) is included in a BU with his/her parent(s), NOT with his or her child(ren), unless the Medicaid minor caretaker has resources (F&C MN covered groups only) or income of his/her own, or is married and living with his/her spouse.

If the Medicaid minor parent (caretaker) has resources or income, or is married and living with a parent(s)and his/her spouse, place the Medicaid minor caretaker in a BU by himself/herself and deem the parents' resources and income (and the spouse's resources and income, when the Medicaid minor caretaker is married and living with his/her spouse) to the Medicaid minor caretaker.

B. Forming Budget Units

1. Medicaid Minor Caretaker

Place the Medicaid minor parent caretaker in a BU with his/her parents when the Medicaid minor parent:

- is not married, or is married but not living with his/her spouse, and
- has no resources or income of his/her own.

EXAMPLE #7: Household listed on application consists of woman applicant, her disabled spouse, their 17-year old daughter and her 2-year old son (woman's grandson). *The daughter's MN eligibility is being determined.*

The family unit consists of :

- the mother,
- her husband,
- their daughter, and
- the daughter's son.

The family unit's income is determined using the F&C income policy and procedures. Because the daughter is a Medicaid minor parent, the family unit is broken into BUs:

- BU #1 = 2-year old grandson
- BU #2 = the mother, her husband and the 17-year old Medicaid minor parent

The mother and her husband's countable income is calculated to determine the Medicaid minor parent's eligibility as *MN*.

2. Married Medicaid Minor

Place the married Medicaid minor in a BU by himself/herself when the Medicaid minor:

- is married and living with his/her spouse, or
- has resources or income of his/her own, AND
- lives with his/her parent(s).

Deem a portion of the married Medicaid minor's parent's resources and income to the married minor, and deem a portion of the married minor's spouse's resources and income to the married minor.

EXAMPLE #8: Household listed on application consists of the married Medicaid minor applicant age 17, her spouse age 25 and her parents. *The minor's MN eligibility is being determined.*

The family unit consists of:

- the married Medicaid minor,
- her husband, and
- her parents.

Because the daughter is a married Medicaid minor who lives wth her parents and her spouse, the family unit is broken into BUs:

- BU #1 = the married Medicaid minor
- BU #2 = her husband
- BU #3 = her parents

The parent's BU's countable income is calculated to determine the amount deemed to the married Medicaid minor. Her husband's countable income is calculated to determine the amount deemed to the married Medicaid minor. The income deemed from the married Medicaid minor's parents and the income deemed from her husband are added to the married Medicaid minor's income to determine her total countable income.

1. Medicaid Minor Parent Caretaker Has Resources or Income

Place the Medicaid minor parent caretaker in a BU by himself/herself when the Medicaid minor caretaker has resources or income of his/her own.

EXAMPLE #9: Household listed on application consists of woman applicant, her spouse, their 17-year old daughter and the 17-year old's 2-year old son. *The daughter's MN eligibility is being determined.*

The family unit consists of:

- the mother,
- her husband,
- their daughter, and
- their daughter's 2-year old son.

The family unit's income is determined using the F&C income policy and procedures. Because the Medicaid minor parent caretaker has unearned income from a trust fund, the family unit is broken into BUs:

- BU #1 = the 2-year old
- BU #2 = the Medicaid minor parent
- BU #3 = the mother and father of the minor parent

The mother and father's BU's countable income is calculated to determine the amount of income to deem to their daughter.

The Medicaid minor parent's BU's countable income is first calculated to determine her income. Her income then is added to the amount of income deemed from her parents to determine her eligibility. A separate calculation must be done to determine the amount of the Medicaid minor parent's own income (not including income deemed from her parents) that must be deemed to her 2-year old.

The 2-year old's BU's countable income is the amount of income deemed from his mother since he has no other source of income.

M0520.203 STEPPARENT IN HOUSEHOLD

A. Policy

A stepparent is in a BU separate from his/her stepchild(ren). A married parent (except a minor married parent) is included in a BU with his/her spouse and their child(ren)-in-common. The parent's(s') other child(ren) who are not the child(ren) of his/her spouse are in a separate BU.

Deem resources and income from the parent to his/her child's BU. Do not deem any of the stepparent's resources or income to the parent's child.

B. Forming Budget Units

Place a married parent in a BU that is separate from the parent's child(ren); include the married parent's spouse (the child's stepparent) in the BU with the parent. Include the parent's and stepparent's child(ren)-in-common in the BU with the parent and stepparent.

EXAMPLE #10: Household listed on application consists of mother, her spouse, their 6-year old son, and her 8-year old son from another relationship. *The children's MN eligibility is being determined.*

The family unit consists of:

- the mother,
- her 8-year old son,
- her spouse (stepparent to her son), and
- their 6-year old son.

The family unit's income is determined using the F&C income policy and procedures. BUs are *applicable* because there is a stepparent in the home:

- BU #1 = 8-year old child
- BU #2 = mother, stepparent, their 6-year old child

M0520.204 ACKNOWLEDGED FATHER IN HOUSEHOLD

A. Policy

An acknowledged father who lives in the household and is not married to the child(ren)'s mother is in a BU separate from the mother. Their child(ren)-in-common is NOT included in the BU with the father; the child(ren)-in-common is in a separate BU.

The mother's own children (who are not the acknowledged father's children) are included in a BU with the mother (unless the child(ren) has resources or income of his/her own).

B. Forming Budget Units

When an acknowledged father lives in the household and is not married to the child(ren)'s mother, place the child(ren) and the acknowledged father in separate BUs.

EXAMPLE #11: Household listed on application consists of mother, her boyfriend who is the acknowledged father of their 4-year old son, their 4-year old son and her 8-year old daughter. *The children's MN eligibility is being determined.*

The family unit consists of:

- the mother,
- her 8-year old daughter,
- the acknowledged father, and
- their 4-year old son.

Because there is an acknowledged father, BUs are formed:

BU #1 = mother, her 8-year old child
BU #2 = their 4-year old child
BU #3 = acknowledged father

M0520.300 DEEMING FROM SPOUSE

A. Policy

The spouse is included in the F&C spouse's budget unit UNLESS:

- the spouse is an SSI or IV-E recipient (do NOT deem any resources or income from an SSI or IV-E recipient spouse to the F&C spouse);

- the F&C spouse is a Medicaid minor parent and they are living with his/her parent(s);

the F&C spouse's spouse is under age 21 and they are living with the spouse's parent(s).

B. SSI or IV-E Recipient Spouse

If eligibility is being determined in an F&C covered group that has a resource test, the income and resources owned **solely** by an SSI or IV-E recipient are not considered available to his/her spouse. The pro-rata share of resources owned **jointly** by the F&C spouse and his/her SSI or IV-E recipient spouse is counted available to the F&C spouse when they are living together.

When **not** living together, resources owned jointly with the SSI or IV-E recipient are available only if the SSI or IV-E recipient agrees to sell or liquidate the resource. If the SSI or IV-E recipient agrees, then only 1/2 of the resource's value is counted as available to the F&C spouse.

C. Married Medicaid Minor Living With Parents

Determine how much of the deemor spouse's resources and income to deem to the F&C spouse (Medicaid minor) using the following procedures:

1. Deem Resources

a. Determine Countable Resources

Determine the value of the deemor spouse's countable resources owned solely and jointly, according to policy in chapter M06.

b. Subtract Resource Deeming Standard

From the total of the deemor spouse's share of jointly held resources and resources held in his/her name only, subtract the $1,000 resource deeming standard.

c. Deem Remaining Resources

The remaining value, if any, is deemed available to the F&C spouse.

d. Deeming Does Not Reduce Resources

If any of the deemor spouse's resources that are over the resource limit are deemed, this does not make the spouse resource-eligible. Deeming resources does not reduce the deemor's countable resources.

2. Deem Income

To determine how much of the deemor spouse's income to deem to the F&C spouse, use the following procedures:

a. Determine Countable Income

Determine the deemor spouse's gross monthly countable unearned and earned income according to chapter M07.

b. Subtract Earned Income Exclusions

Subtract the applicable earned income exclusions listed in section M0720.500:

- Standard work exclusion of $90 (M0720.520), and
- Child/incapacitated adult care exclusion (M0720.540).

c. Subtract Deeming Standard

Subtract the deeming standard. The deeming standard is the F&C 100% income limit for the locality for

- the number of persons in the deemor spouse's BU, **plus**
- the number of deemor's child(ren) under age 21 in the household who are excluded from the Medicaid application (are not included in **any** Medicaid BU) and who are or can be claimed as dependents on the deemor's federal income tax return. If the deemor has not previously filed a return or states that he/she will claim a different number of dependents for the current year, use the number of dependents he/she intends to claim for the current year.

See M0710, Appendix 3, for the F&C 100% income limit.

NOTE: For the deeming calculation, a pregnant woman is only 1 person.

d. Subtract Support Payments Made

Subtract actual support paid to individuals NOT in the home, who are or could be claimed as dependents on the **deemor's** federal tax return.

Subtract actual alimony and/or child support payments made to individuals NOT in the home and not claimed as dependents on the **deemor**'s federal income tax return.

e. Deem Remainder

Deem the remaining balance to the eligible F&C spouse (plus the spouse's F&C child(ren), if any, who is not in the spouse's BU) as unearned income.

NOTE: Deeming income does not reduce the deemor's countable income for his Medicaid eligibility determination.

D. Example--Married Minor Living With Parents

EXAMPLE #12: (Using 1999 figures)
A Medicaid minor pregnant woman lives with her husband, their 1-year old child, his 14-year old child from a previous marriage, and her parents. They live in Group I. Her husband earns $3,200 monthly. She has no income. She and her husband own a joint savings account with a balance of $1,600. Her father earns $2,000 monthly; her mother has no income. *MN eligibility is being determined for the minor pregnant woman.*

1. Family Unit

The Medicaid minor pregnant woman's family unit consists of herself, her unborn child, her husband, their 1-year old child, his 14-year old child, and her parents (a family unit of 7).

2. Budget Units

Because there is a Medicaid minor parent and a stepparent in the household, the family unit is divided into BUs:

- BU #1 = the minor PG woman and unborn child (2);
- BU #2 = her spouse, their 1-year old child (2);
- BU #3 = her spouse's 14-year old child (1);
- BU #4 = her parents (2).

Due to excess income at the BU level, a MN eligibility determination is required. Portions of her spouse's resources (for F&C MN only) and income are deemed to her BU according to the spouse deeming procedures.

BU #1 spouse deeming calculations:

a. Resource Deeming

$ 800	husband's ½ of joint savings
-1,000	resource deeming standard
0	excess (no resources deemed to F&C spouse)

b. Income Deeming

$3,200	husband's earnings
- 90	standard work exclusion
3,110	countable income
- 229	deeming standard for deemor's BU (2 persons in Group I)
2,881	excess
÷ 2	PG woman (spouse) and 14-year-old child
$1,440.50	deemed to each

The parents' deemed resources and income to the pregnant woman's BU are calculated according to M0520.400 below. The parents' deemed income is added to the spouse's deemed income to determine the minor PG woman's income eligibility.

M0520.400 DEEMING FROM PARENT

A. Policy

A parent's resources and income are considered available (either counted in the unit or deemed) to a child under age 21 living with a parent. The parent's resources and income are deemed to the child when the child is in a separate BU from the parent, unless

- the parent is an SSI recipient or has a 1619b status,
- the parent receives IV-E foster care or adoption assistance,
- the child is living away from home per M0520.001 B.3, or
- the child is a foster care child placed in the home for a trial visit of 6 months or less.

1. Deeming Standard

The deeming standard is the portion of the parent's countable resources or income that is not considered available to the child who is in a separate BU from the parent. The resource deeming standard is $1,000. The income deeming standard is the locality F&C 100% income limit for the deemor parent's BU plus any excluded children.

2. Single Parent or Parent and Stepparent with No Child in Common

When each child in the home has only one parent in the home and the parent is in a separate BU, subtract the whole deeming standard from the parent's countable resources and income.

Note: A stepparent is not a "parent" for deeming purposes.

3. Both Parents In Same BU-Married With Child in Common

a. No Stepchildren

When both parents (at least one child in common) are in the same BU and there are no stepchildren, subtract the whole deeming standard from the parents' resources and income.

b. Stepchildren

When both parents (at least one child in common) are in the same BU and they have at least one child in common in the home who is included in the family unit, subtract one-half of the deeming standard for the parents' BU from deemor parent's resources and income.

When both parents are in the same BU and all their children-in-common are excluded from the family unit, subtract the whole deeming standard for the parents' BU from the deemor parent's resources and income.

4. Both Parents In Different BUs

When both parents (at least one child in common) are in separate BUs, subtract the whole deeming standard from the deemor parent's countable resources and income.

B. Deeming Resources

To determine how much of the deemor parent’s resources to deem to the child, use the following procedures:

1. Determine Countable Resources

Determine the value of countable resources owned solely by the parent and the value of countable resources owned jointly with the parent’s spouse or another person, according to policy in chapter M06. All resources that are in the deemor parent’s name only plus the deemor's share of jointly held resources are counted.

2. Subtract Resource Deeming Standard

a. Single Parent or Parent and Stepparent with No Child in Common

Subtract the whole resource deeming standard of $1,000 from the deemor's total countable resources (those in the deemor’s name only plus the deemor's share of jointly held resources).

Separate deeming calculations for each deemor parent must be done to ensure stepparent resources are not deemed.

b. Both Parents In Same BU With Child in Common

1) Subtract the whole deeming standard of $1,000 from the parents' countable resources when there are children in common and no stepchildren in the home.

   When both parents are deeming only to children in common, their resources are combined and only one deeming calculation is done.

2) Subtract one-half of the resource deeming standard ($500) from each deemor parent's countable resources, when there are children in common **and** stepchildren in the home, and at least one child-in-common in the home is included in the family unit.

   Separate deeming calculations for each deemor parent must be done to ensure stepparent resources are not deemed.

c. Both Parents In Different BUs

When both parents are in the home but in different budget units, subtract the whole resource deeming standard of $1,000 from the deemor's total countable resources (those in the deemor's name only plus the deemor's share of jointly held resources).

Separate deeming calculations must be completed for each deemor parent.

3. Deem Resources Remainder

The remaining value, if any, is deemed available to the non-excluded F&C child(ren) who are not in the parent's BU. If the parent has more than one non-excluded child in the household who is not in the parent's BU, divide the remaining resource value by the number of non-excluded children who are not in the parent's BU.

NOTE: Deeming resources does not reduce countable resources for the deemor's eligibility determination.

4. Example--Resource Deeming From Parent

EXAMPLE #13: A woman lives with her husband, their 5-year old child, her 11- year old and 12-year old children from a previous marriage, and his 14-year old child from a previous marriage. They live in Group I. *The children's MN eligibility is being determined.*

The family's resources consist of a savings account of $1,050 owned jointly by the woman and her spouse, one car owned by the husband with an equity value of $1,000 and a second car (owned jointly by the woman and her spouse) with an equity value of $50. Each child owns a U.S. savings bond valued at $100.

The Medicaid family unit is broken into budget units to determine resource eligibility.

- budget unit #1 = her husband's 14-year old child;
- budget unit #2 = their 5 year old child;
- budget unit #3 = her 11 year old child;
- budget unit #4 = her 12 year old child;
- budget unit #5 = the woman, her husband.

Each parent has a child who is not the child of his/her spouse; therefore, separate deeming calculations are used.

a. Mom's Resource Deeming Calculation

The mother's resources are deemed available to each of her children who are not in her BU (including her child-in-common with her husband):

$ 525	½ savings account
+ 25	her ½ equity in the second car (not excluded)
550	countable resources
- 500	½ resource deeming standard (parents in same BU, child in common)
50	deemable resources
÷ 3	number of her children not in her BU
$16.67	deemed to each of her children not in her BU

b. Dad's Resource Deeming Calculation

The Dad's resources are deemed available to each of his children who are not in his BU (including his child-in-common with his wife):

$ 525	½ savings account
+ 25	his ½ equity in the second car (not excluded)
550	countable resources
- 500	½ resource deeming standard (parents in same BU, child in common)
50	deemable resources
÷ 2	number of his children not in his BU
$ 25	deemed to each of his children not in his BU

c. Budget Units #3 and #4

$ 100.00	child's savings bond
+ 16.67	deemed from Mom
$ 116.67	child's countable resources

Each child has total resources of $116.67. Each child's resources are less than the MN resource limit; each is resource-eligible and is placed on an MN spenddown.

d. Budget Unit #1

$ 100.00	child's savings bond
+ 25.00	deemed from Dad
$ 125.00	child's countable resources

The child has total resources of $125. Dad's child's resources are less than the MN resource limit, so the child is resource-eligible and is placed on an MN spenddown.

e. Budget Unit #2

$100.00	child's savings bond
+ 16.67	deemed from Mom
+ 25.00	deemed from Dad
$141.67	child's countable resources

Their child's countable resources are less than the MN resource limit, so their child is resource-eligible and is placed on an MN spenddown.

C. Deeming Income

To determine how much of the deemor parent's income to deem to the F&C child(ren), use the following procedures:

1. Determine Countable Income

Determine the deemor parent's gross monthly countable unearned and earned income according to chapter M07.

2. Subtract Earned Income Exclusions

Subtract the applicable earned income exclusions listed in section M0720.500:

- standard work exclusion of $90 (M0720.520), and
- child/incapacitated adult care exclusion(M0720.540).

3. Subtract Income Deeming Standard

a. Single Parent or Parent and Stepparent with No Child in Common

Subtract the whole income deeming standard. The income deeming standard is the F&C 100% income limit for the locality (see M710, Appendix 3) for

- the number of persons in the deemor's BU, **plus**
- the number of children under age 21 in the household who are excluded from the Medicaid application (not included in **any** Medicaid assistance unit) and who are or can be claimed as dependents on the deemor's federal income tax return. If the deemor has not previously filed a tax return or states that he/she will claim a different number of dependents for the current year, use the number of dependents he/she intends to claim for the current year. Do not count children who receive SSI when determining the income deeming standard.

A deeming calculation must be done for each deemor parent.

NOTE: For the deeming calculation, a pregnant woman is only 1 person.

b. Both Parents In Same BU and Child-in-Common

1) Subtract the whole income deeming standard from the parents' income when there is a child(ren)-in-common and no stepchildren in the home.

When both parents are deeming only to child(ren)-in-common, only one deeming calculation is done.

2) Subtract one-half of the income deeming standard from the parent's countable income when there are children in common **and** stepchildren in the home, and at least one child-in-common in the home was included in the family unit.

   Separate deeming calculations for each deemor parent must be done to ensure stepparent income is not deemed.

3) When both parents are in the same BU and ALL their children-in-common are **excluded** from the family unit, subtract the whole income deeming standard for the parents' BU from the deemor parent's income.

   Separate deeming calculations for each deemor parent must be done to ensure stepparent income is not deemed.

c. Both Parents In Different BUs

Subtract the whole income deeming standard from the deemor parent's countable income.

Separate deeming calculations must be done for each deemor parent.

4. Subtract Support Payments Made

Subtract actual alimony and/or child support payments made to individuals not in the home, regardless of whether or not the individuals are claimed as dependents on the deemor's federal income tax return.

5. Deem Remainder

Deem the remaining income as unearned income to the non-excluded F&C child(ren) in the household who are not in the parent's BU. If the parent has more than one non-excluded F&C child in the household who is not in the parent's BU, divide the remaining income by the number of non-excluded children who are not in the parent's BU (plus the parent's minor spouse, if any, who is not in the parent's BU).

NOTE: Deeming income does not reduce the deemor's countable income for the deemor's eligibility determination.

6. Example—Income Deeming From Parent; Stepchildren In Home

EXAMPLE #14: (Using July 2002 figures)
An application is filed for a woman who lives with her husband, their 5-year-old child, her 11-year-old and 12-year-old children from a previous marriage, and his 14-year-old child from a previous marriage. They live in Group I. Her husband earns $2,200 monthly. She earns $800 monthly. Her children each receive $150 monthly child support. They have no resources. *The children's MN eligibility is being determined.*

The Medicaid family unit is broken into budget units because there are stepparents in the home and some of the children have their own income.

- budget unit #1 = Dad's 14-year old child
- budget unit #2 = Mom's 11-year old child
- budget unit #3 = Mom's 12-year old child
- budget unit #4 = Mom, Dad, and their child

Each parent has a child who is not the child of his/her spouse; therefore, separate deeming calculations are used.

a. Mom's Income Deeming Calculation

Mom's countable income is deemed to each of her children who are not in her BU.

$ 800.00	Mom's earnings
- 90.00	standard work exclusion
710.00	countable income
- 156.63	½ deeming standard for 3 in Group I ($313.25)
553.37	deemable income
÷ 2	number of her children not in her BU
$ 276.69	deemed to each child

b. Dad's Income Deeming Calculation

Dad's countable income is deemed to his child.

$2,200.00	Dad's earnings
- 90.00	standard work exclusion
2,110.00	countable income
- 156.63	½ deeming standard for 3 in Group I ($313.25)
$1,953.37	= deemable income

c. BU #1

$1,953.37 = countable income (deemed from Dad).

d. BUs #2 and #3

$ 276.69	deemed unearned income from Mom
+ 150.00	child's own income
- 50.00	child support disregard
376.69	= countable income for both BUs

e. BU #4

$2,200	husband's earnings
+ 800	woman's earnings
- 180	standard work exclusions ($90 x 2 = 180)
2,820	= countable earned income *for the child in common*.

7. Example—Income Deeming From Parent; All Children-in-Common Excluded

EXAMPLE #14a: (Using July 2005 figures)
A woman lives with her husband, their 5-year old child, her 11-year old and 12 year-old children from a previous marriage, and his 14-year old child from a previous marriage. They exclude their child, and apply for the other three children. They live in Group III. Her husband earns $2,200 monthly. She earns $800 monthly. Her children each receive $150 monthly child support. They have no resources. *The three children's MN eligibility is being determined.*

The Medicaid family unit is broken into budget units because there are stepparents in the home and Mom's two children have their own income.

- budget unit #1 = Dad's 14-year old child
- budget unit #2 = Mom's 11-year old child
- budget unit #3 = Mom's 12-year old child
- budget unit #4 = Mom and Dad

Their excluded child is not included in the parents' BU, but is counted when determining the deeming standard. Each parent has a child who is not the child of his/her spouse; therefore, separate deeming calculations are used.

a. Mom's Income Deeming Calculation

Mom's countable income is deemed to each of her children who are not in her BU.

$ 800.00	Mom's earnings
- 90.00	standard work exclusion
710.00	countable income
- 437.58	whole deeming standard for 3 in Group III
272.42	deemable income
÷ 2	number of her children not in her BU
$136.21	deemed to each child

b. Dad's Income Deeming Calculation

Dad's countable income is deemed to his child.

$2,200.00	Dad's earnings
- 90.00	standard work exclusion
2,110.00	countable income
- 437.58	whole deeming standard for 3 in Group III
$1,672.42	= deemable income

***c.* BU #1**

$1,672.42 = countable income (deemed from Dad)

d. BUs #2 and #3

$ 136.21 deemed income from Mom
+ 150.00 child's own income
- 50.00 child support disregard
236.21 = countable income

e. BU #4

$2,200 Dad's earnings
+ 800 Mom's earnings
- 180 standard work exclusions ($90 x 2 = 180)
2,820 = countable income

Mom and Dad *do not meet a MN covered group.*

M0520.500 CHANGES IN STATUS

A. Policy

When the household composition changes, or the circumstances of the household members change, the F&C family and budget unit may change, and the requirements to deem a spouse's or parent's resources and income may change.

B. Procedure

See M0520.501 for Family/Budget Unit Changes.
See M0520.502 for Deeming Changes.

M0520.501 FAMILY/BUDGET UNIT CHANGES

A. Introduction

Some changes in the household composition which require changes in the family unit or budget units are listed and described in this section.

B. Spouses Separate or Divorce

If a married F&C individual and his/her spouse separate or divorce and no longer live together, the spouse is not included in the F&C individual's family or budget unit beginning the month after the month in which the separation or the divorce occurred. If a married F&C individual and his/her spouse divorce but they remain living in the same household, the divorced father is considered an acknowledged father beginning the month after the month in which the divorce occurred.

C. Individual Begins Living With A Spouse

For applicants, if an F&C individual or deemor begins living with a spouse, the spouse is included in the family or budget unit beginning with the month in which they begin living together.

For recipients, if an F&C individual or deemor begins living with a spouse, the spouse is included in the family or budget unit beginning with the month after the month they begin living together.

D. Parent and Child Begin Living in Same Household

For applicants, if an F&C child begins living with a parent in the same household (e.g., a child comes from aunt's home to live in mother's home), the child and parent are included in the family unit for purposes of determining eligibility beginning the month in which they begin living together.

For recipients, if an F&C child begins living with a parent in the same household (e.g., a child comes from aunt's home to live in mother's home), the child and parent are included in the family unit for purposes of determining eligibility beginning the month **after** the month they begin living together.

NOTE: A newborn child is considered living with the parent(s) as of the date the child is born, unless the child is entrusted into foster care on that date.

E. Spouse or Parent Dies

If a spouse or parent dies, the spouse or parent is deleted from the family or budget unit effective with the month following the month of death.

F. Individual Becomes Institutionalized

If an F&C individual becomes institutionalized, either in a medical facility or in Medicaid CBC waiver services, the individual is a separate family unit effective with the first month in which the individual is institutionalized.

G. Individual Leaves Home

If an F&C individual leaves the household, the individual is deleted from the family or budget unit beginning with the month following the month in which he left the household.

NOTE: If a spouse, parent or child was temporarily absent from the household, this rule applies effective with the month after the month the spouse's, parent's or child's absence is no longer considered temporary.

H. Child Attains Age 21

Effective the month following the month in which a child attains age 21, the child is removed from the family or budget unit. An individual attains age 21 on the day preceding the anniversary of his/her birth.

M0520.502 DEEMING CHANGES

A. Introduction

Some changes in the circumstances of the household members which require changes in the deeming procedures are listed and described in this section.

B. Spouses Separate or Divorce

If a married F&C individual and his/her spouse separate or divorce and no longer live together, or their marriage ends in divorce but they remain living in the same household, the spouse's resources (F&C MN only) and income are not deemed to the F&C spouse's family or budget unit beginning the month after the month in which the separation or the divorce occurred. The divorced father who lives in the household with his child(ren) and ex-wife is treated like an acknowledged father.

NOTE: If an application is filed in the month of separation or divorce, deeming applies that month even if the application is filed on or after the date of separation or divorce.

C. Individual Begins Living With A Spouse

If an F&C individual begins living with a spouse, deeming of the spouse's resources (F&C MN only) and income to the F&C spouse's BU begins effective with the month after the month they begin living together.

D. Spouse Or Parent Dies

If a spouse or parent dies, deeming stops for purposes of determining eligibility effective with the month following the month of death. If the child lives with two parents and one dies, deeming continues from the surviving parent to determine eligibility.

E. Individual Becomes Institutionalized

If an F&C individual becomes institutionalized, either in a medical facility or in Medicaid CBC waiver services, deeming stops for purposes of determining eligibility effective with the first month in which the individual is institutionalized.

F. Individual Leaves Home

If a spouse, parent or child no longer live in the same household, deeming of that spouse's or parent's resources (F&C MN only) and income stops effective the month after the month the spouse, parent or child leaves the household for purposes of determining eligibility, except for a foster care child. When a child is removed from the home and placed in foster care, the child becomes an FU of 1 person effective the date of commitment or entrustment or non-custodial foster care agreement. The child is deleted from the family's FU effective the end of the month during which the child was placed in foster care.

NOTE: If a spouse, parent or child was temporarily absent from the household, this rule applies effective with the month after the month the spouse's, parent's or child's absence is no longer considered temporary.

G. Parent and Child Begin Living in Same Household

If an F&C child begins living with a parent in the same household (e.g., a newborn child comes home from a hospital), the parent's income is deemed to the child's BU for purposes of determining eligibility beginning the month after the month they begin living together.

H. Child Attains Age 21

Deeming stops effective the month following the month in which a child attains age 21. An individual attains age 21 on the day preceding the anniversary of his/her birth. Eligibility is determined using only the individual's own income after the child attains age 21. The individual's income for the current month and subsequent months must include any income in the form of cash provided by the parents.

M0520.600 PREGNANT WOMAN BUDGET UNIT

A. Policy

A pregnant woman's family or budget unit always consists of at least 2 persons--herself and the unborn child, or children when it is medically verified that there is more than one fetus.

The other members of the household who are included in the pregnant woman's family or budget unit depend on whether the pregnant woman is under age 21 years, is married and is living with her parent(s) or spouse.

B. Budget Unit

The BU includes her spouse who lives with her unless the spouse receives SSI, or she and/or her spouse are Medicaid minors living with her or his parent(s).

The BU also includes her child(ren) under age 21 living in the home unless:

- the child(ren) has his or her (their) own income (child is separate BU);
- she specifically excludes the child(ren);
- the child(ren)'s acknowledged father is living in the home and is not married to the pregnant woman;
- she is a Medicaid minor and lives with her parent(s);
- she is a married Medicaid minor and lives with her spouse and parent(s); or
- she is married and living with her spouse who is not the father of the child(ren). If she is married, living with her spouse who is not the father of her child(ren), and she does not exclude her child(ren) under age 21 living in the home, the child(ren) is a separate BU and the pregnant woman's own income and resources deemed available to the child.

M0520.601 UNMARRIED PG WOMAN OVER AGE 21 BUDGET UNIT

A. Policy

An unmarried pregnant woman's family or budget unit always consists of at least 2 persons--herself and the unborn child, or children when it is medically verified that there is more than one fetus. It includes her minor child(ren) under age 21 who live with her unless

- the child has his/her own resources or income,
- the child's acknowledged father lives in the home, or
- she excludes the child.

B. Example--Unmarried PG Woman Over Age 21

EXAMPLE #15: (Using February 2000 figures) Group II locality. An unmarried pregnant woman age 25 applies for Medicaid for herself and her 10-year old child. She lives with her parents, her 20 year old brother and her 10-year old child. They have no resources. She earns $1,200 per month and her 10-year old child receives $200 monthly child support from his father. Her family unit consists of herself (pregnant woman counts as two persons for her eligibility) and her 10-year old, 3 persons. The 10-year child's family unit consists of the 10-year old and his mother, 2 persons.

$1,200 PG woman's earnings -
90 standard work exclusion
1,110 countable earning

$ 200	monthly child support
- 50	support disregard
150	countable unearned
+1,110	countable earned
1,260	= countable monthly income

M0520.602 MARRIED PG WOMAN BUDGET UNIT

A. Policy

A married pregnant woman's BU includes her spouse with whom she lives, unless

- she is under age 21 and they live with her parent(s),
- her spouse is under age 21 and they live with his parent(s),
- she has a minor child(ren) living in the household who is not her spouse's child, or
- her spouse has a minor child(ren) living in the household who is not the PG woman's child.

1. PG Woman Is Medicaid Minor Living With Her Parents

When the married PG woman is a Medicaid minor (under age 21 years old) and they live with her parent(s), the BU consists of the Medicaid minor pregnant woman and her unborn child (or children if medically verified). Her spouse and their child(ren) are in a separate BU.

2. PG Woman's Spouse Is Medicaid Minor Living With Spouse's Parents

When the married PG woman's spouse is a Medicaid minor and they live with her spouse's parent(s), the BU consists of the pregnant woman, the unborn child(ren) and their child(ren)-in-common, if any. Her Medicaid minor spouse is in a separate BU and her spouse's parents are in a separate BU.

3. PG Woman And/Or Spouse Have Other Children

When the married PG woman and/or her spouse are age 21 or older, or are under age 21 but do not live with either's parent(s), and have other children in the household who are not their children-in-common, the BU consists of the pregnant woman, her unborn child(ren) and her spouse. Her child(ren) is in a separate BU and his child(ren) is in a separate BU.

B. Example—Married PG Woman Over Age 21, Other Children In Household

EXAMPLE #16: A Medicaid application is filed for a pregnant woman and everyone in her family. She lives with her husband who is not aged, blind, or disabled, her 10-year old child by a former marriage, and his 15-year old child from a former marriage. They have no resources. The family unit's income exceeds the MI pregnant woman income limit for 5 persons, the MI child income limit for 4 persons, and the LIFC 185% standard of need for 4 persons, so BUs are formed because there is a stepparent in the household. Three BUs exist:

- BU #1 = the pregnant woman, her unborn child, and her
- husband (3);
- BU #2 = her husband's 15-year old child (1);
  BU #3 = her 10-year old child (1)

C. Example—Married PG Woman Under Age 21, Living With Spouse's Parents

EXAMPLE #17: A minor pregnant woman age 19 lives with her husband who is age 19, her 2-year old child by a former relationship, and his parents (6 persons). Budget units are formed because there are a stepparent and a minor spouse in the household. Four budget units exist:

- #1 = the pregnant woman and her unborn child (2);
- #2 = her 2-year old child (1);
- #3 = her husband (1);
- #4 = his parents (2).

M0520.603 UNMARRIED MINOR PG WOMAN BUDGET UNIT

A. Policy

When the Medicaid minor (under age 21 years old) pregnant woman is not married, the budget unit consists of the Medicaid minor pregnant woman and her unborn child (or children if medically verified) and the minor pregnant woman's child(ren) who live with her, unless

- she lives with her parent(s), or
- her child(ren) has resources or income of his/her own.

If the unmarried Medicaid minor pregnant woman lives with her parent(s), the budget unit consists of the Medicaid minor pregnant woman and her unborn child (or children if medically verified) and the Medicaid minor pregnant woman's parent(s). Her child(ren) are in a separate budget unit.

1. Her Stepparent In Household

If the Medicaid minor pregnant woman's parent is married and the spouse lives in the household, the Medicaid minor pregnant woman's parent is NOT included in the budget unit with her. A portion of her parent's own resources and income is deemed to the Medicaid minor pregnant woman.

2. Siblings In Household

If the Medicaid minor pregnant woman has a minor (under age 21) sibling(s) in the household who is listed on the application form, that sibling is included in the unit with her parent(s) unless

- the sibling(s) has his/her own resources or income, or
- a stepparent or acknowledged father lives in the home.

If the sibling(s) has resources or income, the parent(s) must be advised of the opportunity to exclude that sibling from the family unit.

3. Medicaid Minor PG Woman Is Also Medicaid Minor Caretaker

If the Medicaid minor pregnant woman lives with her parents and also has a child(ren) of her own living with her for whom Medicaid is requested, she is also a Medicaid minor caretaker. Her child(ren) is in a separate budget unit. The pregnant woman is in a separate budget unit with her parent(s) and minor siblings who live at home, if the Medicaid minor PG woman and her siblings have no income or resources of their own. If the

Medicaid minor PG woman has resources or income of her own, she is in a separate BU and a portion of the pregnant woman's own income and resources is deemed available to her child(ren).

B. Example—Unmarried Medicaid Minor PG Woman

EXAMPLE #18: A Medicaid minor pregnant woman lives with her 2-year old child, her parents, and her 16 year old brother. The pregnant woman's family unit consists of the Medicaid minor pregnant woman, her unborn child, her 2 year old child, her parents and her brother. She has income from part-time work. The family unit is broken into budget units because the Medicaid minor PG woman has her own income and she is a minor parent living with her parents. Three budget units exist:

- budget unit #1 = the Medicaid minor PG woman (2);
- budget unit #2 = her 2 year old child (1);
- budget unit #3 = the parents, her 16 year-old brother (3).

M0520.700 INDIVIDUAL UNDER AGE 21 FAMILY UNIT

A. Policy

The family unit of an individual who meets the covered group of MN Individuals Under Age 21 (who are in foster care, adoption assistance or in ICF/ICF-MR care) is determined using the family unit rules in M0520.100 above when the individual lives with a parent or spouse. If the individual does not live with a parent or spouse, the individual is in a family unit by himself.

If the individual under age 21 is living away from home, see M0520.001 B.3. to determine if the individual is considered living with his parents.

B. Procedure

The following sections contain the policy and procedures to use when determining the family/budget unit of an individual under age 21:

- M0520.701 Foster Care Child Family Unit;
- M0520.702 Non IV-E Adoption Assistance Family Unit;
- M0520.703 Special Medical Needs Adoption Assistance Child
- M0520.704 Child In ICF or ICF-MR.

M0520.701 FOSTER CARE CHILD FAMILY UNIT

A. Policy

A foster care child who is not living with his/her parents is a family unit of one person. A child in foster care who is not living with his or her parent(s) is evaluated as a separate family unit, even if the child is living with his or her own siblings in foster care. When a child is removed from his home and placed in foster care, the child becomes a family unit of 1 person effective the date of the commitment or entrustment to, or non-custodial agreement with the agency.

1. Child Living With Parents

If the foster child is living with his or her parents and/or siblings NOT on a trial visit basis, the foster care child is included in the family unit with his/her parents and siblings.

If the child's family unit has resources or income which exceeds the limit for the child's covered group, determine if the family unit can be broken into BUs. The foster care child is included in a BU with his/her parents UNLESS:

- the child has his/her own resources;
- the child has his/her own income;
- the child's stepparent is in the family unit;
- the child's parent with whom he/she lives is a minor (under age 21) and they live with the minor parent's parent(s);

- the child(ren)'s acknowledged father lives in the household and is not married to the child(ren)'s mother.

2. Child Placed In Own Home For Trial Visit

A foster care child who is placed in the home with his/her parents and siblings **for a trial visit** is a family unit of 1 person. The parent(s)' resources and income are NOT deemed available to the foster care child. Verify the trial visit with the agency's *Family* Services staff.

The trial visit is no longer than 6 months for this section's purposes. A child will continue to be a single person BU during a trial visit and only the child's income and resources will be counted in determining the child's Medicaid eligibility.

3. Foster Care Payment Is Excluded

The foster care payment is excluded when determining the family unit's financial eligibility.

B. Examples

1. Trial Visit

EXAMPLE #19: The agency services staff places the foster care child, age 10, with his family for a trial visit. The child does not receive a foster care payment from the agency. The household consists of the foster care child, his mother and father, his 13-year old sister, and his 22-year old brother. The household consists of 2 family units:

- family unit #1 = foster care child (1);
- family unit #2 = foster care child's parents, 13-year old sister (3).

2. Home Placement, Not Trial Visit

EXAMPLE #20: The agency services staff places the foster care child, age 10, with his family. This is NOT a trial visit, but the agency retains custody of the child. The child does not receive a foster care payment from the agency. The household consists of the foster care child, his mother and father, his 13-year old sister, and his 22-year old brother. The household consists of one family unit: the foster care child, his parents and his 13-year old sister (4).

M0520.702 NON IV-E ADOPTION ASSISTANCE CHILD FAMILY UNIT

A. Policy

A non IV-E adoption assistance child who is not living with his/her parents is a family unit of one person.

1. Child Living With Parent(s)

A non IV-E adoption assistance child who is living with his or her parent(s) is evaluated as a separate family unit from placement until the interlocutory or final order of adoption, whichever comes first. The adoptive parents' resources and income are NOT deemed available to the adoption

assistance child until the interlocutory or final order of adoption, whichever comes first, is entered.

After the interlocutory or final order of adoption, whichever comes first, a non IV-E adoption assistance child who is living with his or her parent(s) is included in a the family unit with his/her parent(s). If the family unit has resources (F&C MN only) or income which exceeds the limit for the child's covered group, determine if the family unit can be broken into BUs. The non IV-E adoption assistance child is included in a BU with his/her parents UNLESS:

- the child has his/her own resources;
- the child has his/her own income;
- the child's stepparent is in the family unit.

2. Exclude Adoption Subsidy Payment

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

B. Example –Child Placed With Adoptive Parents

EXAMPLE #21: Mary B. is a 19-year old non IV-E foster care child who is in the custody of the local social services agency. On August 5, 1997, she is placed with Mr. and Mrs. G who plan to adopt her. The adoption assistance agreement was signed on August 5, 1997. There is no interlocutory order and the final order will not be signed until February 1998. Mr. and Mrs. G have two children, Tom who is age 17 and Jane who is age 15. Mary receives $575 per month SSA benefits from her deceased father's work record. Mr. G earns $3,000 per month gross earnings. Mrs. G has no income of her own. Mary's continued Medicaid eligibility is determined:

Mary's family unit consists of Mary by herself because she does not live with any responsible relative. The final order of adoption will not be signed until February 1998. Beginning with the month following the month in which the final adoption order is signed. Mary will be in a family unit with her adoptive parents and siblings.

C. Example—Child Living With Adoptive Parents

EXAMPLE #22: John is a 20-year old non IV-E adoption assistance child who is in the custody of the local social services agency until August 5, 1997, when the final order of adoption was signed by the judge. His adoptive parents are Mr. and Mrs. T. The adoption assistance agreement was signed on September 15, 1996. Mr. and Mrs. T have two other children, George who is age 17 and Julie who is age 15. John receives $250 per month adoption subsidy. Mr. T earns $3,000 per month gross earnings. Mrs. T has no income of her own. John's continued Medicaid eligibility for September 1997 and subsequent months is determined:

John's family unit consists of himself, his adoptive parents and his two siblings, a family unit of 5 persons.

M0520.703 SPECIAL MEDICAL NEEDS ADOPTION ASSISTANCE CHILD FAMILY UNIT

A. Policy

A non IV-E special medical needs adoption assistance child who is living with his or her parent(s) is evaluated as a separate family unit. **The adoptive parents' income is NOT deemed available to the special medical needs adoption assistance child at any time.**

B. Exclude Adoption Subsidy Payment

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

M0520.704 CHILD IN ICF OR ICF-MR FAMILY UNIT

A. Policy

When an individual under age 21 is in an intermediate care facility (ICF) (nursing facility) or ICF-MR (intermediate care facility for the mentally retarded) for 30 consecutive days or more, the child is institutionalized and is considered separated from his/her parents.

Child in medical institutions (facilities) are temporarily absent from home if their stay in the medical facility is less than 30 consecutive days. If the stay has been, or is expected to be, 30 or more consecutive days, go to section M1410.010 to determine if the child is institutionalized in long- term care. A child who is institutionalized in a medical facility or Medicaid waiver services is NOT considered living with his or her parents for Medicaid eligibility purposes.

The child is a family unit of one person, regardless of the child's covered group. The parents' resources and income are **not** deemed available to the child. If the parents give the child any money, that money is counted as income according to the F&C income rules in chapter M07.

M0530 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-3	1/1/17	Appendix 1, page 1
TN #DMAS-2	10/1/16	Pages 23, 24
TN #DMAS-1	6/1/16	Appendix 1, page 1
TN #100	5/1/15	Pages 14, 16, 29, 30 Appendix 1, page 1
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

2017: $1,103 - $735 = $368
2016: $1,100 - $733 = $367

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 = *$735 for 2017*; $733 for 2016
The living allowance for both parents living with the child is the SSI payment for a couple.

SSI payment for both parents = *$1,103 for 2017*; $1,100 for 2016.

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

2017: $1,103 - $735 = $368
2016: $1,100 - $733 = $367

M0810 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-3	1/1/17	Pages 1, 2
TN #DMAS-2	10/1/16	Page 2
TN #DMAS-1	6/1/16	Pages 1, 2
UP #11	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

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	*2017 Monthly Amount*	2016 Monthly Amount
1	*$735*	$733
2	*1,103*	1,100
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size	*2017 Monthly Amount*	2016 Monthly Amount
1	*$490.00*	$488.67
2	*735.34*	733.34

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	*2017 Monthly Amount*	2016 Monthly Amount
1	*$2,205*	$2,199

4. ABD Medically Needy

a. Group I	7/1/2016 (no change)		7/1/2015 – 6/30/16	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$1,861.63	$310.27	$1,861.63	$310.27
2	2,370.20	395.03	2,370.20	395.03
b. Group II	7/1/2016 (no change)		7/1/2015 – 6/30/16	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,148.04	$358.00	$2,148.04	$358.00
2	2,645.09	440.84	2,645.09	440.84
c. Group III	7/1/2016 (no change)		7/1/2015 – 6/30/16	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,792.45	$465.40	$2,792.45	$465.40
2	3,366.75	561.12	3,366.75	561.12

5. ABD Categorically Needy

For:

ABD 80% FPL, QMB, SLMB, & QI <u>without</u> Social Security income; all QDWI; effective 1/25/16

ABD 80% FPL, QMB, SLMB, & QI <u>with</u> Social Security income; effective 3/1/16

All Localities	2016		2015	
ABD 80% FPL	Annual	Monthly	Annual	Monthly
1	$9,504	$792	$9,416	$785
2	12,816	1,068	12,744	1,062
QMB 100% FPL	Annual	Monthly	Annual	Monthly
1	$11,880	$990	$11,770	$981
2	16,020	1,335	15,930	1,328
SLMB 120% of FPL	Annual	Monthly	Annual	Monthly
1	$14,256	$1,188	$14,124	$1,177
2	19,224	1,602	19,116	1,593
QI 135% FPL	Annual	Monthly	Annual	Monthly
1	$16,038	$1,337	$15,890	$1,325
2	21,627	1,803	21,506	1,793
QDWI	Annual	Monthly	Annual	Monthly
200% of FPL	$23,760	$1,980.00	$23,540	$1962.00
1	32,040	2,670.00	31,860	2,655.00
2				

S0820 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-3	1/1/17	Pages 30, 31
TN #DMAS-1	6/1/16	Pages 30, 31, 47
TN #100	5/1/15	Pages 30, 31, 47 Page 48 is a runover page.
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 2017*, up to *$1,790* per month, but not more than *$7,200* in a calendar year, of the earned income of a blind or disabled student child.

.

For 2016, up to $1,780 per month, but not more than $7,180 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.

5. 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.

Months	Up to per month	But not more than in a calendar year
In calendar year 2017	*$1,790*	*$7,200*
In calendar year 2016	$1,780	$7,180

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.

M1110 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-3	1/1/17	Pages 2, 7, 10, 11 Page 10a was added as a runover page.
TN #100	5/1/15	Page 2
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 ≤ 80% FPL	$2,000	$3,000
QDWI	$4,000	$6,000
QMB SLMB QI	**Calendar Year** ***2017*** *$7,390* **2016** $7,280	**Calendar Year** ***2017*** *$11,090* **2016** $10,930

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.

B. Description--List of Resource Exclusions

Exclusion	**Reference**	**No Limit on Value and/or Length of Time**	**Limit on Value and/or Length of Time**
Life insurance, depending on its face value	S1130.300		X
Burial space or plot held for an eligible individual, his/her spouse, or member of his/her immediate family	M1130.400	X	
Burial funds for an individual and/or his/her spouse	M1130.410		X
Certain prepaid burial contracts	M1130.420		X
Household Goods and Personal Effects	M1130.430	X	
Property essential to self-support	S1130.500-.504		X
Resources of a blind or disabled person which are necessary to fulfill an approved plan for achieving self-support	*M0810.430* S1130.510		X
Retained retroactive SSI or RSDI benefits	S1130.600		X
Radiation Exposure Compensation Trust Fund payments	S1130.680	X	
German reparations payments made to World War II Holocaust survivors	S0830.710 S1130.610	X	
Austrian social insurance payments	S0830.715 S1130.615	X	
Japanese-American and Aleutian restitution payments	S0830.720	X	
Federal disaster assistance received because of a Presidentially declared major disaster, including accumulated interest	S0830.620 S1130.620	X	
Cash (including accrued interest) and in-kind replacement received from any source at any time to replace or repair lost, damaged, or stolen excluded resources	S0815.200 S1130.630		X
Certain items excluded from both income and resources by other Federal statutes	S0830.055 S1130.640	Varies	
Agent Orange settlement payments to qualifying veterans and survivors	S0830.730 S1130.660	X	
Victim's compensation payments	S0830.660 S1130.665		X
Tax refunds related to Earned Income Tax Credits	S0820.570 S1130.675		X
Achieving a Better Life Experience (ABLE) accounts	*M1130.740*		*X*

C. References

- Identifying excluded funds that have been commingled with non-excluded funds, S1130.700

S1110.310 RESOURCES ASSUMED TO BE NONLIQUID

A. Introduction

Certain non-cash resources, though they may occasionally be liquid, are nearly always non-liquid.

B. Operating Policy

1. Assumption of Nonliquidity

Absent evidence to the contrary, we assume that the following type of resources are non-liquid.

- automobile, trucks, tractors, and other vehicles;
- machinery and livestock;
- buildings, land and other real property rights; and
- non-cash business property.

2. Evidence to The Contrary

a. If there is no apparent evidence to the contrary of the assumptions in 1. above, we do not seek out any evidence to the contrary. There is no need to document a lack of evidence to the contrary.

b. In very rare situations an individual may volunteer firm evidence that one of the above types of resources is liquid (i.e., its sale has been accomplished or arranged within 20 workdays). Document the file *in the VaCMS case record* and proceed accordingly only if the distinction is material.

C. Operating Policy-- Life Insurance

This subchapter provides no categorical assumption regarding the liquidity or non-liquidity of life insurance policies.

VALUATION OF RESOURCES

M1110.400 WHAT VALUES APPLY TO RESOURCES

A. Policy Principles

1. Definitions

a. The current market value (CMV) or fair market value (FMV) of a resource is:

- Real property – 100% of the local tax assessed value ***or*** *effective 10/4/16, the certified value as determined by an appraiser licensed in Virginia. The use of an appraisal is applicable only to non-commercial real property.*

The cost of the appraisal must be paid by either the applicant/recipient or the individual acting on the applicant or recipient's behalf. Certified appraisals documenting the value of the property must contain the name and license number of the individual conducting the appraisal, and the VaCMS case comments must contain information about the appraisal, the name of the individual conducting the appraisal, as well as that individual's license number. License validity, if necessary, can be verified through the "License Lookup" tool on the Department of Professional and Occupational Regulation's website at www.dpor.virginia.gov or by calling the Real Estate Appraiser staff at 804-367-2039.

- Countable vehicles – the **average trade-in value** listed in the National Automobile Dealers Official Used Car Guide (NADA) Guide, **or** the value assessed by the locality for tax purposes may be used, if vehicle is not listed in N.A.D.A. Guide.

b. Equity value (EV) is the CMV of a resource minus any encumbrance on it.

c. An encumbrance is a legally binding debt against a specific property. Such a debt reduces the value of the encumbered property but does not have to prevent the property owner from transferring ownership (selling) to a third party. However, if the owner of encumbered property does sell it, the creditor will nearly always require a debt satisfaction from the proceeds of sale.

2. Valuation

General Rule
The value of a resource is the amount of an individual's/couple's equity in it.

3. Determining the Countable Value of Real Property

The procedures for determining the countable value of real property are found in Appendices 1 *and 4* to subchapter S1130. An "ABD Home Property Evaluation Worksheet" is found in Appendix 2 to subchapter S1130.

B. Related Policy

See M1110.600 concerning the points in time for establishing resource values.

OWNERSHIP INTERESTS

S1110.500 SIGNIFICANCE OF OWNERSHIP

A. Introduction

Ownership interests in property, whether real or personal, can occur in various types and forms. Since the type and form of ownership may affect the value of property and even its status as a resource, they are significant in determining resource eligibility.

B. Description-Types of Ownership

1. Sole vs. Shared Ownership

An individual may have sole ownership of a property or may share its ownership with others. See S1110.510.

2. Fee Simple Ownership

Fee simple ownership, which relates only to real property, is completely free of conditions imposed by others. See S1110.515 A.1.

3. Less than Fee Simple Ownership

a. A life estate interest conveys ownership of limited duration. See S1110.515 A.2. and B.

b. Equitable ownership can occur when an individual does not have legal title to property. See S1110.515 A.2b. and C.

4. Property Rights Without Ownership

a. A leasehold conveys a time-limited control of property but not ownership of it. See S1110.520 B.1.

b. An incorporeal interest in property is a right to use the property but without any right to possess it or sell it. See S1110.520. B.2.

C. Operating Policy--Variance in State Laws with Respect to Ownership

The explanations of ownership in the following sections represent general legal principles. However, specific points may vary with State law and issues may have to be reviewed by the Regional Office and/or Assistant Attorney General's Office.

M1130 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-3	1/1/17	Table of Contents, page ii Page 76 Page 77 is a runover page. Pages 78 and 79 were added.
TN #DMAS-1	6/1/16	Pages 4, 14, 15
TN #100	5/1/15	Pages 13, 15, 21, 31, 33, 34 Pages 16 and 32 are runover pages.
UP #9	4/1/13	Table of Contents, page ii Pages 5, 62 Pages 62a was added.
TN#97	9/1/12	Page 14
Update #7	7/1/12	Page 24
TN #96	10/1/11	Table of Contents, page ii Pages 4, 73, 74 Appendix 1, pages 1-14 Appendix 2, page 1 Appendix 4, pages 1-8 added
TN #95	3/1/11	Pages 28, 29, 33
TN #94	9/1/10	Pages 20, 20a, 28-29a
TN #93	1/1/10	Pages 63-65 Pages 70, 74, 75
TN #91	5/15/09	Page 13

M1130.000 ABD RESOURCES EXCLUSIONS Section Page

RETAINED CASH AND IN-KIND PAYMENTS

Retroactive SSI and RSDI Payments M1130.600 62
Dedicated Accounts For Past Due Benefits Due to Individuals Under 18 Who Have a Representative Payee S1130.601 62
Netherlands WUV Payments to Victims of Persecution S1130.605 63
German Reparations Payments S1130.610 64
Austrian Social Insurance Payments S1130.615 65
Disaster Assistance S1130.620 66
Cash and In-Kind Items Received for the Repair or Replacement of Lost, Damaged, or Stolen Excluded Resources S1130.630 67
Benefits Excluded from Both Income and Resources by a Federal Statute Other Than Title XVI S1130.640 70
Agent Orange Settlement Payments S1130.660 70
Victim's Compensation Payments S1130.665 71
State or Local Relocation Assistance Payments S1130.670 72
Tax Advances and Refunds Related to Earned Income Tax Credits And The Tax Relief, Unemployment Insurance Reauthorization And Job Creation Act Of 2010 ..... M1130.675 73
Radiation Exposure Compensation Trust Fund Payments S1130.680 74
Walker v. Bayer Settlement Payments M1130.685 75

OTHER EXCLUDED RESOURCES

Identifying Excluded Funds That Have Been Commingled With Non-excluded Funds S1130.700 76
Achieving a Better Life Experience (ABLE) Accounts S1130.740 78

Appendix

Determining the Countable Value of Home & Contiguous Property ..... Appendix 1 1
ABD Home Property Evaluation Worksheet ..... Appendix 2 1
Burial Fund Designation ..... Appendix 3 1
Determining the Countable Value of Non-Home Real Property ..... Appendix 4 1

B. Procedure

Information received by claimants in this lawsuit shows that claimants can choose to receive the payment in one of three ways - in a lump sum, a structured settlement, or a special needs trust. Regardless of which form the individual chooses, the payment(s) are excluded if the above requirements are met.

Verify the source of the funds from a letter from the individual's attorney or a copy of the check which identifies the payor as a Walker v. Bayer settlement account.

OTHER EXCLUDED RESOURCES

S1130.700 IDENTIFYING EXCLUDED FUNDS THAT HAVE BEEN COMMINGLED WITH NONEXCLUDED FUNDS

A. Policy Principle

Otherwise excludable funds must be identifiable in order to be excluded.

B. Operating Policy

1. Identified vs. Segregated

Identifiability does not require that excluded funds be kept physically apart from other funds (e.g., in a separate bank account).

2. Operating Assumption

Always assume, when withdrawals are made from an account with commingled funds in it, that **nonexcludable funds are withdrawn first,** leaving as much of the excluded funds in the account as possible.

3. Effect of Account Transactions

If excluded funds are withdrawn, the excluded funds left in the account can be added to only by:

- deposits of subsequently received funds that are excluded under the same provision; and
- excluded interest (see 4. below).

4. Interest

If interest on the excluded funds is excluded (as with disaster assistance), the percent of an interest payment to be excluded is the same as the percent of funds in the account that is excluded **at the time the interest is posted**. The excluded interest is then added to the excluded funds in the account.

C. Development and Documentation - Initial Application and Posteligibility

1. Evidence

Obtain a **complete** history of account transactions back to the initial deposit of excluded funds. Use the individual's own records if possible.

2. Determination

a. Accept the individual's allegation as to the date and amount of a deposit of excluded funds if it agrees with the evidence in file on the receipt of the funds.

b. Record in case record:

- each deposit of excluded funds;
- each withdrawal that reduces the amount of excluded funds;
- each computation of excluded interest and its addition to the excluded funds.

D. Examples

1. One Time Receipt and Deposit of Excluded Funds

An individual deposits a $1,000 SSA check ($800 for the preceding 4 months and $200 for the current month) in a checking account. The account already contains $300 in nonexcluded funds.

- Of the new $1,300 balance, $800 is excluded as retroactive SSI benefits.
- The individual withdraws $300. The remaining $1,000 balance still contains the excluded $800.
- The individual withdraws another $300, leaving a balance of $700. All $700 is excluded.
- The individual deposits $500, creating a new balance of $1,200. Only $700 of the new balance is excluded.

2. Periodic Receipt and Deposit of Excluded Funds

An individual deposits $200 in excluded funds in a non-interest bearing checking account that already contains $300 in nonexcluded funds.

- The individual withdraws $400. The remaining $100 is excluded.
- The individual then deposits $100 in nonexcluded funds. Of the
- resulting $200 balance, $100 is excluded.
- The individual next deposits $100 in excludable funds. Of the new $300 balance, $200 is excluded.

3. Interest

A $1,000 savings account includes $800 in excluded disaster assistance when a $10 interest payment is posted. Since 80 percent of the account balance is excluded at the time the interest is posted, 80 percent of the interest ($8) is excluded. The amount of excluded funds now in the account is $808.

M1130.740 ACHIEVING A BETTER LIFE EXPERIENCE (ABLE) ACCOUNTS

A. Policy

The federal Stephen Beck, Jr. Achieving a Better Life Experience Act (ABLE Act), was enacted by Congress on December 19, 2014 and approved by the Virginia General Assembly and Governor in 2015. An ABLE account is a type of tax-advantaged account that an eligible individual can use to save funds for the disability related expenses of the account's designated beneficiary, who must be blind or disabled by a condition that began before the individual's 26th birthday. Funds retained in these accounts are not considered to be resources for Medicaid.

An ABLE program can be established and maintained by a State or a State agency directly or by contracting with a private company working with the State. In Virginia, the ABLE program is operated by the Virginia529 program.

An eligible individual can be the designated beneficiary of only one ABLE account, which must be administered by a qualified ABLE program.

The designated beneficiary is the eligible individual who established and owns the ABLE account. To be an eligible individual, he or she must be:

- *Eligible for Supplemental Security Income (SSI) based on disability or blindness that began before age 26;*
- *Entitled to disability insurance benefits, childhood disability benefits, or disabled widow's or widower's benefits based on disability or blindness that began before age 26; or*
- *Someone who has certified, or whose parent or guardian has certified, that he or she:*
    - *Has a medically determinable impairment meeting certain statutorily specified criteria; or is blind; and,*
    - *The disability or blindness occurred before age 26.*

NOTE: A certification that someone meets disability requirements for the ABLE program does not replace a disability determination from either SSA or DDS in determining whether someone meets the Medicaid definition of a disabled individual.

Upon the death of the designated beneficiary, funds remaining in the ABLE account, after payment of any outstanding qualified disability expenses, reimburse the State for Medicaid benefits that the designated beneficiary received.

B. Procedures

The individual, or person acting on the individual's behalf, must provide a copy of the ABLE account documentation for the case record. A copy also must be sent to DMAS at the following address:

Department of Medical Assistance Services
Eligibility Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

M1370 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-3	1/1/17	Pages 3-5
TN #100	5/1/15	Title page
TN #99	1/1/14	Page 2
UP #9	4/1/13	Table of Contents Pages 1-5 Page 6 was added.
TN #94	9/1/10	Table of Contents Pages 1-5

M1370.200 QMBs, SLMBs, QDWIs & PLAN FIRST ENROLLEES

A. Policy

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

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

Plan First enrollees are eligible only for limited Medicaid coverage related to family planning services and transportation to access those services.

B. Entitlement After Meeting Spenddown

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

C. Enrollment Procedures

The *enrollee's limited coverage* must be canceled and then reinstated *in VaCMS* in order for the individual to receive the full scope of Medicaid services for the portion of the spenddown budget period in which he is eligible as medically needy. Take the following actions:

1. Cancel Limited Benefit Coverage

Cancel the enrollee's current coverage line that has the limited-benefit aid category (AC).

a. Cancel date is the date **before** the date the spenddown was met.

b. Cancel reason is "024".

2. Reinstate MN Coverage

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

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

Be sure that the application date is the first month in the spenddown budget period. Eligibility will be cancelled effective the end date entered.

D. Continuing Eligibility and Enrollment After Spenddown Ends

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

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

For Plan First enrollees who meet a MN covered group, use the procedures in section M1520.200 for completing a contact-based renewal for Plan First enrollees. Because Plan First enrollees do not have a resource test, it is necessary to obtain resource information for Plan First enrollees who meet an MN covered group. The resource pages from the ABD Medicaid Renewal form or Eligibility Review Part B may be used.

E. Example--QMB Meets Spenddown

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

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

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

M1370.300 QUALIFIED INDIVIDUALS (QI)

A. Introduction

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

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

B. Entitlement After Meeting Spenddown

When an enrolled QI meets a spenddown, he is eligible for Medicaid as medically needy. MN eligibility begins the date the spenddown was met and ends the last day of the spenddown budget period.

C. Enrollment Procedures

The ABD MI enrollment must be canceled and the MN coverage reinstated in order for him to receive the full scope of Medicaid services for the portion of the spenddown budget period in which he is MN-eligible. Take the following actions:

1. Cancel QI Coverage

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

a. Cancel date is the date before the date the spenddown was met.

b. Cancel reason is "024".

2. Reinstate MN Coverage

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

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

Be sure that the application date is the first month in the spenddown budget period. The MN coverage will end the last date of the spenddown budget period.

D. Continuing Eligibility and Enrollment After Spenddown Ends

When the spenddown budget period ends, reinstate the enrollee's Medicaid eligibility as medically indigent QI beginning the day after the MN spenddown eligibility cancel date. Use the initial Medicaid application date. The QI medically indigent coverage begin date is the first day of the month following the end of the spenddown budget coverage period.

E. Example- QI Meets Spenddown

EXAMPLE #2: Mr. P. is 69 years old. He has Medicare Parts A & B, and applied for Medicaid on May 14. Resources are within the medically needy limit. His income exceeds the medically needy limit, but is less than the QI limit. His eligibility is determined on June 1. He is enrolled in Medicaid QI coverage beginning May 1. He is placed on a spenddown for the budget period May 1 through October 31. The agency enrolls him with an eligibility begin date of May 1, AC 056.

M14 Table of Contents Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-3	1/1/17	page i
TN #97	9/1/12	page ii
TN #96	10/1/11	pages i, ii

TABLE OF CONTENTS

M14 LONG-TERM CARE SUBCHAPTER Page

GENERAL RULES.....M1410

General--Long-term Care.....M1410.010..... 1
Nonfinancial Eligibility Requirements .....M1410.020..... 3
Facility Care.....M1410.030..... 3
Community-based Care Waiver Services .....M1410.040..... 5
Financial Eligibility Requirements .....M1410.050..... 8
Post-eligibility Treatment of Income .....M1410.060..... 9
Long-term Care Applications .....M1410.100..... 9
Initiating Long-term Care for Current Medicaid Recipients .....M1410.200..... 10
Notice Requirements .....M1410.300..... 11

PRE-ADMISSION SCREENING M1420

What Is Pre-admission Screening.....M1420.100..... 1
Pre-admission Screening.....M1420.200.....*2*
Communication Procedures .....M1420.300..... 3
Screening Certification .....M1420.400..... 4

FACILITY CARE.....M1430

Facility Care.....M1430.000..... 1
Types of Facilities & Care .....M1430.010..... 1
Basic Eligibility Requirements .....M1430.100..... 3

COMMUNITY-BASED CARE M1440

Governing Laws.....M1440.001..... 1
Basic Eligibility Requirements .....M1440.010..... 2
CBC Waiver Descriptions .....M1440.100.....*3*
Covered Services .....M1440.200.....*10*

TRANSFER OF ASSETS.....M1450

Overview .....M1450.001..... 1
***Reserved*.....M1450.100..... 7**
Policy Principles .....M1450.200..... 7
Assets That Are Not Resources For Transfer Rule.....M1450.300..... 8
Transfers That Do Not Affect Eligibility.....M1450.400..... 10

M1410 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-3	1/1/17	Pages 6, 7, 12-14
TN #DMAS-1	6/1/16	Pages 12-14
TN #100	5/1/15	Page 2
TN #99	1/1/14	Page 10
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

2. *Community Living Waiver (Formerly the* Intellectual Disabilities Waiver)

As part of the My Life, My Community Developmental Disabilities Waiver Redesign, the Intellectual Disabilities (ID) Waiver *was renamed the Community Living Waiver in 2016*. The *waiver* is targeted to provide home and community-based services to individuals with *developmental disabilities* and individuals under the age of six years at developmental risk who have been determined to require the level of care provided in an ICF/*ID*, and to individuals with related conditions currently residing in nursing facilities who require specialized services. *See M1440, Appendix 1 for a list of services available through this waiver.*

***3.* Technology-Assisted Individuals Waiver**

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

The services provided under this waiver include:

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

4. *Family and Individual Supports Waiver (Formerly the* Individual and Family Developmental Disabilities Support Waiver)

As part of the My Life, My Community Waiver Developmental Disabilities Redesign, the Individual and Family Developmental Disabilities Support (DD) Waiver *was renamed the Family and Individual Supports Waiver in 2016. The waiver* provides home and community-based services to individuals with developmental disabilities. *See M1440, Appendix 1 for a list of services available through this waiver.*

5. *Building Independence Waiver (Formerly the* Day Support Waiver for Individuals with Intellectual Disabilities)

As part of the My Life, My Community Waiver Developmental Disabilities Redesign, the Day Support Waiver for Individuals with Intellectual Disabilities (DS Waiver) *was renamed the Building Independence Waiver in 2016. The waiver* is targeted to provide home and community-based services to individuals with mental retardation who have been determined to require the level of care provided in an ICF/*ID. See M1440, Appendix 1 for a list of services available through this waiver.*

6. Alzheimer's Assisted Living Waiver

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

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

The services provided under the AAL waiver include:

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

B. Forms to Use

1. Notice of Action on Medicaid & FAMIS (#032-03-0008)

The EW must send the Notice of Action on Medicaid *generated by VaCMS or the equivalent hard form*, available on SPARK at: http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi to the applicant/ recipient and the person who is authorized to conduct business for the applicant to notify him of the agency's decision on the initial Medicaid application, and on a redetermination of eligibility when a recipient starts LTC services.

2. Notice of Obligation for Long-Term Care Costs (#032-03-0062)

The Notice of Obligation for Long-term Care Costs is sent to the applicant/enrollee or the authorized representative to notify them of the amount of patient pay responsibility. The form is generated and sent by the *Virginia Case Management System (VaCMS) on the day the case is authorized*.

3. Medicaid LTC Communication Form (DMAS-225)

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

- a change in the LTC provider, including when an individual moves from CBC to a nursing facility or the reverse;
- the enrollee's physical residence, if different than the LDSS locality;
- changes in the patient's deductions (e.g. a medical expense allowance);
- admission, death or discharge to an institution or community-based care service;
- changes in eligibility status; and
- changes in third-party liability.

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

a. When to Complete the DMAS-225

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

b. Where to Send the DMAS-225

1) For hospice services patients, including hospice patients in a nursing facility or those who are also receiving CBC services, send the original form to the hospice provider.

2) For facility patients, send the original form to the nursing facility.

3) For PACE or adult day health care recipients, send the original form to the PACE or adult day health care provider.

4) For Medicaid CBC, send the original form to the following individuals

- the case manager at the Community Services Board, for the *Developmental Disabilities Waivers*;
- the case manager (support coordinator), for the DD Waiver,
- the personal care provider, for agency-directed EDCD personal care services and other services. If the patient receives both personal care and adult day health care, send the DMAS-225 to the personal care provider.
- the service facilitator, for consumer-directed EDCD services,
- the case manager, for any enrollee with case management services, and
- the case manager at DMAS, for the Tech Waiver, at the following address:

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

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

4. Advance Notices of Proposed Action

The recipient must be notified in advance of any adverse action that will be taken on his/her Medicaid eligibility or patient pay.

a. Advance Notice of Proposed Action

The system-generated Advance Notice of Proposed Action *or hard equivalent* **(#032-03-0018)**, available on SPARK at *http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi* must be used when:

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

b. Notice of Obligation for Long-Term Care Costs

When a change in the patient pay amount is entered in *VaCMS*, a "Notice of Obligation for Long-term Care Costs" will be generated and sent as the advanced notice to the recipient or the authorized representative.

Patient pay must be entered into *VaCMS* no later than close-of-business *on the system cut-off date*, to meet the advance notice requirement.

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

5. Administrative Renewal Form

A system-generated paper Administrative Renewal Form is used to redetermine Medicaid eligibility of an individual who is in long-term care. The individual or his authorized representative completes and signs the form where indicated. The EW completes and signs the eligibility evaluation sections on the form.

A renewal can also be completed online using CommonHelp or by telephone by calling the Cover Virginia Call Center. See M1520.200 for information regarding Medicaid renewals.

M1420 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-1	1/1/17	Table of Contents Pages 3-6 Appendix 3 Appendices 4 and 5 were removed.
TN #DMAS-1	6/1/16	Pages 3-5 Page 6 is a runover page. Appendix 3, page 1
TN #99	1/1/14	Page 4
UP#7	7/1/12	Pages 3, 4
TN #94	09/01/10	Table of Contents Pages 3-5 Appendix 3
TN #93	01/01/10	Pages 2, 3, 5 Appendix 3, page 1 Appendix 4, page 1

TABLE OF CONTENTS

LONG-TERM CARE

M1420.000 PRE-ADMISSION SCREENING

Section Page

Pre-admission Screening Process .....M1420.100.....1

Responsibility for Pre-admission Screening .....M1420.200.....2

Communication Procedures .....M1420.300.....3

Screening Certification .....M1420.400.....4

Forms

DMAS-96 Medicaid Funded Long-Term Care
Service Authorization Form (DMAS-96) ..... Appendix 1 1

Technology Assisted Waiver
Level of Care Eligibility Form ..... Appendix 2 1

***Waiver Management System (WaMS) Screen Print*..... Appendix 3 .....1**

3. *Community Living Waiver (Formerly the* Intellectual Disabilities Waiver)

Local Community Mental Health Services Boards (CSBs) and the Department for *Aging and* Rehabilitative Services (*DARS*) are authorized to screen individuals for the *Community Living* Waiver. Final authorizations for waiver services are made by DBHDS staff.

4. *Family and Individual Supports Waiver (Formerly the* Individual and Family Developmental Disabilities Support Waiver)

DMAS and the Virginia Health Department child development clinics are authorized to screen individuals for the *Family and Individual Supports* Waiver.

5. Alzheimer's Assisted Living (AAL)Waiver

Local screening committees/teams and hospital screening committees/teams are authorized to screen individuals for the AAL waiver; however, a copy of the pre-admission screening is not required for the Medicaid eligibility record. Documentation of the verbal assurance by the screeners must be included in the case record.

6. *Building Independence Waiver (Formerly the* Day Support Waiver for Individuals with Intellectual Disabilities)

Local CSB and DBHDS case managers are authorized to screen individuals for the *Building Independence* Waiver. Final authorizations for the waiver services are made by DBHDS staff.

D. PACE

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

M1420.300 COMMUNICATION PROCEDURES

A. Introduction

To ensure that nursing facility/PACE placement or receipt of Medicaid CBC services are be arranged as quickly as possible, there must be prompt communication between screeners and eligibility staff.

B. Procedures

1. LDSS Contact

The LDSS should designate an appropriate staff member for screeners to contact. Local social services staff, hospital staff and *DARS* staff should be given the name and contact information for that person to facilitate timely communication between screeners and eligibility staff.

2. Screeners

Screeners must inform the individual's eligibility worker when the screening process has been initiated and completed.

3. Eligibility Worker (EW) Action

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

M1420.400 SCREENING CERTIFICATION

A. Purpose

The screening certification authorizes the local DSS to determine financial eligibility using the more liberal rules for institutionalized individuals, including the 300% SSI covered group and the special rules for married institutionalized individuals with a community spouse. The screening certification is valid for one year.

B. Exceptions to Screening

Pre-admission screening is NOT required when:

- the individual is a patient in a nursing facility at the time of application;
- the individual received Medicaid LTC in one or more of the preceding 12 months and LTC was terminated for a reason other than no longer meeting the level of care;
- the individual 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;
- *the individual is in a Veteran's Administration Medical Center (VAMC) at the time of the request for nursing facility or EDCD/PACE services (these individuals receive an equivalent VAMC screening);*
- an individual with full Medicaid coverage was or is expected to be admitted to a nursing facility for less than 30 days; or.
- the individual is no longer in need of long-term care but is requesting assistance for a prior period of long term care.

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) *or the equivalent information printed from the Pre-admission Screening (PAS) system*;

- Technology Assisted Waiver Level of Care Eligibility Form (see Appendix 2);

- *Copy of the authorization screen from the Waiver Authorization System (WaMS)* (see Appendix 3). *A Copy of the authorization screen from the Intellectual Disability On-line System (IDOLS) is also acceptable.*

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

1. Nursing Facility/PACE

Individuals who require care in a nursing facility or elect PACE will have a DMAS-96 signed and dated by the screener and the supervising physician *or the equivalent information printed from the PAS system*.

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

2. EDCD Waiver

Individuals screened and approved for the EDCD waiver must have a DMAS-96 signed and dated by the screener and the physician *or the equivalent information printed from the PAS system*.

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

3. Tech Waiver

Individuals screened and approved for the Tech Waiver will have either a DMAS-96 signed and dated by the screener and physician *or the equivalent information printed from the PAS system*; or a Technology Assisted Waiver Level of Care Eligibility Form signed and dated by a DMAS representative.

4. *Community Living* Waiver Authorization Screen Print

Individuals screened and approved for the *Community Living Waiver* will have a printout of the *WaMS* authorization screen completed by the DBHDS representative. The screen print will be accompanied by a completed DMAS-225 form identifying the client, the Community Services Board providing the service, and begin date of service.

5. *Building Independence* Waiver Level of *Authorization Screen Print*

Individuals screened and approved for the *Building Independence Waiver* will have a printout of the *WaMS* authorization screen completed by the DBHDS representative. The screen print will be accompanied by a completed DMAS-225 form identifying the client, the Community Services Board providing the service, and begin date of service.

6. *Family and Individual Supports* Waiver *Authorization Screen Print*

Individuals screened and approved for the *Family and Individual Supports Waiver* will have a printout of the *WaMS* authorization screen completed by the DBHDS representative. The screen print will be accompanied by a completed DMAS-225 form identifying the client, the Community Services Board providing the service, and begin date of service.

D. Authorization for LTC Services

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

The appropriate authorization document (form or screen print) must be maintained in the individual's case record.

1. Authorization Not Received

If a pre-admission screening is required and the appropriate documentation is not received, Medicaid eligibility for an individual who is living in the community must be determined as a non-institutionalized individual.

2. Authorization Rescinded

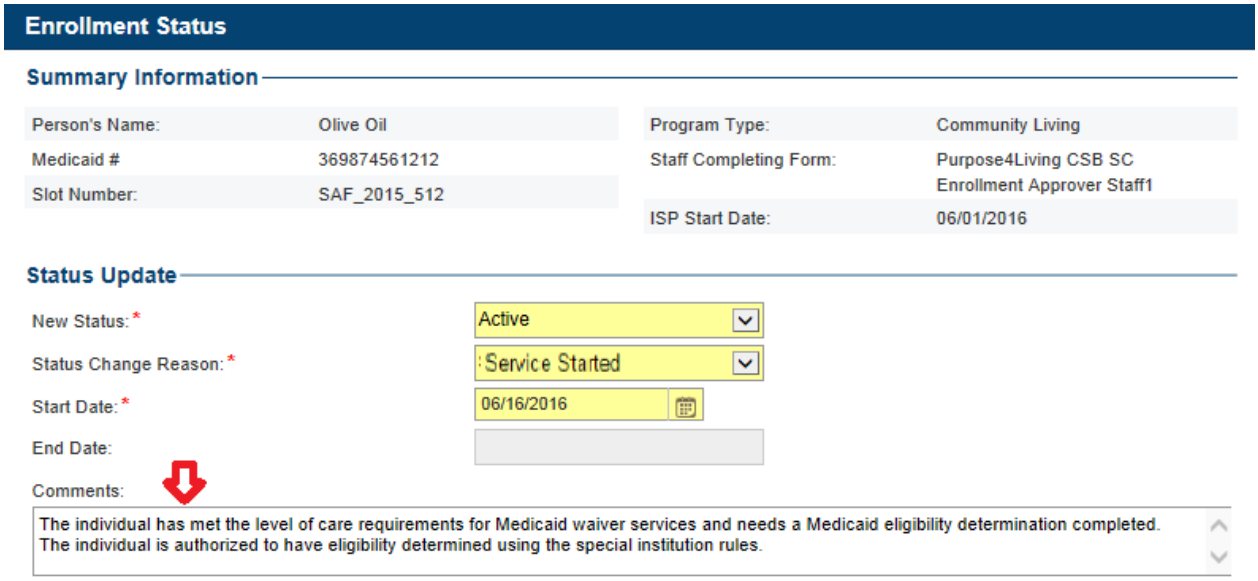
The authorization for Medicaid payment of LTC services may be rescinded by the physician or by DMAS at any point that the individual is determined to no longer meet the required Medicaid level of care criteria.

When an individual is no longer eligible for a CBC Waiver service, the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

When an individual leaves the PACE program and no longer receives LTC services, the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

For an individual in a nursing facility who no longer meets the level of care but continues to reside in the facility, continue to use the eligibility rules for institutional individuals even though the individual no longer meets the level of care criteria. If the individual is eligible for Medicaid, Medicaid will not make a payment to the facility for LTC.

Waiver Management System (WaMS) Screen Print
for Community Living Waiver, Building Independence Waiver,
and Family and Individual Supports Waiver Authorizations



Enrollment Status

Summary Information

Person's Name:	Olive Oil	Program Type:	Community Living
Medicaid #	369874561212	Staff Completing Form:	Purpose4Living CSB SC Enrollment Approver Staff1
Slot Number:	SAF_2015_512	ISP Start Date:	06/01/2016

Status Update

New Status: *	Active
Status Change Reason: *	Service Started
Start Date: *	06/16/2016
End Date:	

Comments:

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

Note: *Continue to accept the existing IDOLS screen print until DBHDS/CSB staff transitions to using WaMS.*

M1440 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-3	1/1/17	Table of Contents Pages 3-12 Appendix 1 was added. Page 2 is a runover page. Pages 13-23 were deleted.
UP #9	4/1/13	Page 5
Update (UP) #7	7/1/12	Table of Contents Pages 2, 14, 15, 18a-18c Pages 19, 20
TN #94	9/1/2010	Table of Contents Pages 13, 16, 18b, 19-22
TN #93	1/1/2010	Pages 14, 16
TN #91	5/15/2009	Table of Contents Page 12 Pages 17-18c

TABLE OF CONTENTS

M14 LONG-TERM CARE

M1440.000 COMMUNITY-BASED CARE WAIVER SERVICES

	SECTION	Page
Governing Laws	**M1440.001**	**1**
Basic Eligibility Requirements	**M1440.010**	**2**
CBC Waiver Descriptions	**M1440.100**	***3***
Elderly or Disabled with Consumer-Direction Waiver	**M1440.101**	***4***
Community Living Waiver	**M1440.102**	***5***
Technology-Assisted Individuals Waiver	***M1440.103***	**6**
Building Independence Waiver	***M1440.104***	**7**
Alzheimer's Assisted Living Waiver	***M1440.105***	**7**
Family and Individual Supports Waiver	***M1440.106***	**8**
Program of All-inclusive Care for the Elderly (PACE)	***M1440.107***	**9**
Covered Services	**M1440.200**	***10***
Personal Care/Respite Care Services	**M1440.201**	***10***
Adult Day Health Services	**M1440.202**	***11***
Private Duty Nursing Services	**M1440.*203***	***11***
Nutritional Supplements	**M1440.*204***	***12***
Personal Emergency Response System (PERS)	**M1440.*205***	***12***

Appendices

Developmental Disabilities Waivers - Services and Support Options	***Appendix 1***	***1***

M1440.010 BASIC ELIGIBILITY REQUIREMENTS

A. Introduction

Services provided through the Waivers can be covered by Medicaid when the applicant or recipient meets the Medicaid eligibility requirements in this section.

B. Waiver Requirements

The individual must meet the pre-admission screening criteria for CBC waiver services and the targeted population group requirement. Some of the targeted population groups are:

- individuals age 65 or older, blind or disabled
- individuals with mental retardation
- individuals who need a medical device to compensate for loss of a vital bodily function
- individuals with developmental disabilities who do not have a diagnosis of mental retardation

The eligibility worker does NOT make the determination of whether the individual meets the waiver requirements; this is determined by the pre-admission screener or by DMAS.

NOTE: The individual cannot be authorized to receive services under more than one waiver at a time.

C. Non-financial Eligibility

The individual must meet the Medicaid non-financial and financial eligibility requirements listed below:

1. Citizenship/ Alienage

The citizenship and alien status policy is found in subchapter M0220.

2. Virginia Residency

The Virginia state resident policy specific to CBC waiver services patients is found in subchapter M0230.

3. Social Security Number

The social security number policy is found in subchapter M0240.

4. Assignment of Rights/ Cooperation

The assignment of rights and support cooperation policy is found in subchapters M0250 and M0260.

5. Application for Other Benefits

The application for other benefits policy is found in subchapter M0270.

6. Institutional Status

To be eligible for Medicaid, an individual approved for CBC waiver services must meet the institutional status requirement. A CBC waiver services recipient usually is not in a medical institution; most CBC recipients live in a private residence in the community. However, an individual who resides in a residential facility such as an *assisted living facility (ALF)* may be eligible for some CBC waiver services. The institutional status requirements *applicable* to CBC waiver services recipients are in *subchapter M0280.*

7. Covered Group

The requirements for the covered groups are found in subchapters M0320 and M0330.

D. Financial Eligibility

An individual who has been screened and approved for CBC services is treated as an institutionalized individual for the Medicaid eligibility determination. Financial eligibility is determined as a one-person assistance unit separated from his legally responsible relative(s) with whom he lives.

If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has 30 days from the date on the Notice of Action to begin receiving CBC services.

For unmarried individuals and for married individuals without community spouses, the resource and income eligibility criteria in subchapter M1460 is applicable.

For married individuals with community spouses, the resource and income eligibility criteria in subchapter M1480 is applicable.

The asset transfer policy in M1450 applies to all CBC waiver services recipients.

M1440.100 CBC WAIVER DESCRIPTIONS

A. Introduction

This section provides a brief overview of the Medicaid CBC waivers. The overview is a synopsis of the target populations, basic eligibility rules, available services, and the assessment and service authorization procedure for each waiver.

The eligibility worker does not make the determination of whether the individual is eligible for the waiver services; this is determined by the pre- admission screener or by DMAS. The policy in the following sections is only for the eligibility worker's information to better understand the CBC waiver services.

B. Definitions

Term definitions used in this section are:

1. Developmental Disability

"Developmental disability," as defined in Virginia Code § 37.2-100, means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated; and (vi) an individual from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v), if the individual, without services and supports, has a high probability of meeting those criteria later in life.

***2.* Financial Eligibility Criteria**

means the rules regarding asset transfers; what is a resource; when and how that resource counts; what is income; when and how that income is considered.

***3.* Non-financial Eligibility Criteria**

means the Medicaid rules for non-financial eligibility. These are the rules for citizenship and alienage; state residence; social security number; assignment of rights and cooperation; application for other benefits; institutional status; cooperation DCSE; and covered group and category requirements.

***4.* Patient**

an individual who has been approved by a pre-admission screener to receive Medicaid waiver services.

C. Developmental Disabilities Waivers

In 2016, as part of the My Life, My Community Waiver Redesign, the Intellectual Disabilities Waiver, Day Support Waiver and Individual and Family Developmental Disabilities Support Waiver (DD waiver) were renamed. They were renamed to the Community Living Waiver, Building Independence Waiver, and Family and Individual Supports Waivers, respectively. These waivers are referred to collectively as the Developmental Disabilities Waivers. The services offered under these waivers are contained in M1440, Appendix 1.

M1440.101 ELDERLY OR DISABLED WITH CONSUMER-DIRECTION WAIVER

A. General Description

The Elderly or Disabled with Consumer-Direction (EDCD) Waiver is targeted to provide home and community-based services to individuals age 65 or older, or who are disabled, who have been determined to require the level of care provided in a medical institution and are at risk of facility placement.

Recipients may select agency-directed services, consumer-directed services, or a combination of the two. Under consumer-directed services, supervision of the personal care aide is furnished directly by the recipient. Individuals who are incapable of directing their own care may have a spouse, parent, adult child, or guardian direct the care on behalf of the recipient. Consumer-directed services are monitored by a Service Facilitator.

M1440.102 *COMMUNITY LIVING WAIVER*

A. General Description

The Community Living Waiver program, formerly the Intellectual Disabilities (ID) Waiver, is targeted to provide home and community-based services to individuals with *developmental disabilities* and individuals under the age of six years at developmental risk who have been determined to require the level of care provided in an ICF-*ID*.

***B.* Eligibility Rules**

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

The income limit used for this waiver is 300% of the current SSI payment standard for one person. Medically needy individuals are not eligible for this waiver. If the individual's income exceeds 300% SSI, the individual is not eligible for services under this waiver.

***C.* Services Available**

The services available under the Community Living Waiver are included in M1440, Appendix 1.

***D.* Assessment and Service Authorization**

The individual's need for CBC is determined by the Community Services Board (CSB), *Behavioral Health Authority (BHA)* or Department *for Aging* and Rehabilitative Services (*DARS*) case manager after completion of a comprehensive assessment.

All recommendations are submitted to Department of Behavioral Health and Developmental Services (DBHDS) or DMAS staff for final authorization.

1. CSB

The CSB/BHA *support coordinator*/case manager may only recommend waiver services if:

- the individual is found Medicaid eligible; and
- the individual is intellectually disabled, or is under age 6 and at developmental risk; and
- the individual is not an inpatient of a nursing facility or hospital.

2. *DARS* The *DARS* case manager may only recommend waiver services if:

- the individual is found Medicaid eligible, and
- the individual is in a nursing facility and has a related condition such as defined in the federal Medicaid regulations.

M1440.103 TECHNOLOGY-ASSISTED INDIVIDUALS WAIVER

A. General Description

"Technology-Assisted" means any individual defined as chronically ill or severely impaired who needs both a medical device to compensate for the loss of a vital body function and substantial and ongoing skilled nursing care to avert death or further disability. The objective of the waiver is to provide medically appropriate and cost-effective coverage of services necessary to maintain these individuals in the community.

B. Targeted Population

Individuals who need both 1) a medical device to compensate for the loss of a vital body function and 2) substantial and ongoing skilled nursing care.

C. Eligibility Rules

The individual must meet the following basic requirements:

1. has a live-in primary care giver who accepts responsibility for the individual's health and welfare.

2. is not receiving services in a general acute care hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded.

3. is not residing in a board and care facility or adult care residence.

4. All patients under the waiver must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid-eligible in a medical facility.

5. Financial eligibility rules that apply to institutionalized individuals apply to patients under this waiver. Resource and income rules apply to waiver eligible individuals as if the individual were residing in a medical institution.

   The income limit used for this waiver is 300% of the current SSI payment standard for one person, or the medically needy (MN) income limit and spenddown.

D. Services Available

The services provided under this waiver include:

- private duty nursing
- respite care

M1440.104 BUILDING INDEPENDENCE WAIVER

A. General Description

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

***B.* Eligibility Rules**

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

The income limit used for this waiver is 300% of the current SSI payment standard for one person. Medically needy individuals are not eligible for this waiver. If the individual's income exceeds 300% SSI, the individual is not eligible for services under this waiver.

***C.* Services Available**

The services available under the Building Independence Waiver are included in M1440, Appendix 1.

***D.* Assessment and Service Authorization**

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

M1440.105 ALZHEIMER'S ASSISTED LIVING WAIVER

A. General Description

The Alzheimer's Assisted Living (AAL) Waiver is available only to individuals who are Auxiliary Grants (AG) recipients. The AAL Waiver allows for the provision of services to individuals in approved assisted living facilities who, without the waiver, might require nursing home placement. **Individuals on this waiver do not have Medicaid eligibility determined as institutionalized individuals, and there are no post-eligibility requirements**.

The AAL waiver serves persons who are:

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

B. Eligibility Rules

Individuals in the AAL Waiver have Medicaid eligibility determined in the AG covered group (see M0320.202) and do not have Medicaid eligibility determined as institutionalized individuals. There are no post-eligibility requirements.

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

C. Services Available

Services available under the AAL waiver are**:**

- assistance with activities of daily living
- medication administration by licensed professionals
- nursing services for assessments and evaluations
- therapeutic social and recreational programming which provides daily activities for individuals with dementia.

D. Assessment and Service Authorization

Local and hospital screening committees or teams are authorized to screen individuals for the AAL waiver; however, a copy of the pre-admission screening is not required for the Medicaid eligibility record.

M1440.106 FAMILY AND INDIVIDUAL SUPPORTS WAIVER

A. General Description

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

B. Eligibility Rules

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

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

C. Services Available

The services available under the Family and Individual Supports Waiver are included in M1440, Appendix 1.

D. Assessment and Service Authorization

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

M1440.107 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

A. General Description

PACE is NOT a CBC Waiver, but rather is the State's community model for the integration of acute and long-term care. PACE combines Medicaid and Medicare funding. PACE provides the entire spectrum of acute and long-term care services to enrollees without limitations on the duration of services or the dollars spent and is centered on an adult day health care model.

B. Targeted Population

PACE serves individuals aged 55 and older who (1) meet the nursing facility level of care criteria and (2) reside in their own communities. PACE provides all of their health care and long-term care medical needs. Individuals who meet the criteria for the EDCD Waiver may be enrolled in PACE in lieu of the EDCD Waiver.

C. Eligibility Rules

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

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

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

D. Services Available

The following services are provided through PACE:

- adult day care that offers nursing, physical, occupational, speech and recreational therapies;
- meals and nutritional counseling; social services;
- medical care provided by a PACE physician; personal care and home health care;
- all necessary prescription drugs;
- access to medical specialists such as dentists, optometrists and podiatrists; respite care;
- hospital and nursing facility care when necessary; and
- transportation.

E. Assessment and Service Authorization

Participation in PACE is **voluntary**. The nursing home pre-admission screening team will advise the individual of the availability of PACE and will facilitate enrollment if the Medicaid enrollee chooses PACE. The PACE team is responsible for authorizing as well as providing the services.

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

M1440.200 COVERED SERVICES

A. Introduction

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

Note: Services covered under the Building Independence, Community Living and Family and Individual Supports Waivers are described separately in M1440, Appendix 3.

B. Waiver Services Information

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

- M1440.201 Personal Care/Respite Care Services
- M1440.202 Adult Day Health Services
- M1440.*203* Private Duty Nursing Services
- M1440.*204* Nutritional Supplements
- M1440.*205* Personal Emergency Response System (PERS)

M1440.201 PERSONAL CARE/RESPITE CARE SERVICES

A. What Are Personal Care Services

Personal Care services are defined as long term maintenance or support services which are necessary in order to enable the individual to remain at home rather than enter an institution. Personal Care services provide eligible individuals with aides who perform basic health-related services, such as helping with ambulation/exercises, assisting with normally self-administered medications, reporting changes in the recipient's conditions and needs, and providing household services essential to health in the home.

B. What are Respite Care Services

Respite Care services are defined as services specifically designed to provide temporary but periodic or routine relief to the primary caregiver of an individual who is incapacitated or dependent due to frailty or physical disability. To receive this service the individual must meet the same criteria as the individual who is authorized for Personal Care, but the focus in Respite Care is on the needs of the caregiver for temporary relief. This focus on the caregiver differentiates Respite Care from programs which focus on the dependent or disabled care receiver.

C. Relationship to Other Services

An individual may receive Personal Care or Respite Care in conjunction with Adult Day Health Care services as needed.

When an individual receives Hospice services, the hospice is required to provide the first 21 hours per week of personal care needed and a maximum of an additional 38.5 hours per week.

D. Who May Receive the Service

An individual must meet the criteria of the EDCD Waiver or the Technology-Assisted Waiver in order to qualify for Personal/Respite Care services.

M1440.202 ADULT DAY HEALTH CARE SERVICES

A. What Is Adult Day Health Care

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

B. Relationship to Other Services

ADHC centers may provide transportation and individuals may receive this service, if needed, to enable their attendance at the center. An individual may receive ADHC services in conjunction with Personal Care or Respite Care services as needed.

C. Who May Receive the Service

An individual must meet the EDCD Waiver criteria to qualify for ADHC services.

M1440.*203* PRIVATE DUTY NURSING SERVICES

A. What is Private Duty Nursing

Private Duty Nursing services are called "nursing services" in the ID/MR waiver. These services are offered to medically fragile patients who require substantial skilled nursing care. Patients receive nursing services from Registered Nurses or Licensed Practical Nurses. Services are offered as needed by the patient, but always exceed what is available through the Home Health program.

For example, in the Technology-Assisted waiver, most patients receive 8 hours or more of continuous nursing services at least four times per week. ID/MR Waiver patients may need the service for either routine nursing or in lieu of Home Health nursing.

B. Relationship to Other Services

There are no requirements that other waiver services be or not be received.

C. Who May Receive the Service

An individual must meet the Technology-Assisted waiver criteria for nursing services. A Medicaid recipient who qualifies under EPSDT (Early & Periodic Screening, Diagnosis & Treatment) to receive private duty nursing services may also receive private duty nursing.

M1440.*204* NUTRITIONAL SUPPLEMENTS

Nutritional Supplements (enteral nutrition products) are provided through DME (durable medical equipment) providers for patients who have an identified nutritional risk. Nutritional supplements are ordered by the individual's physician to cover a six-month period and Medicaid payment is authorized by the pre-admission screener or DMAS.

M1440.*205* PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

A. What is PERS

PERS is an electronic device that enables certain recipients who are at high risk of institutionalization to secure help in an emergency through the use of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the recipient's home telephone line. PERS may include medication monitoring to remind certain recipients at high risk of institutionalization to take their medications at the correct dosages and times.

B. Relationship to Other Services

An individual may receive PERS services in conjunction with agency-directed or consumer-directed Personal Care or Respite Care services.

C. Who May Receive the Service

PERS is available only to EDCD recipients who live alone or are alone for significant parts of the day, who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Developmental Disabilities Waivers – Services and Support Options - Effective June 30, 2016

(BI = Building Independence Waiver; FI = Family & Individual Waiver; CL = Community Living Waiver)

	BI	FI	CL	Description
Employment and Day Options				
Individual Supported Employment	✓	✓	✓	Individual Supported Employment services are provided one-on-one by a job coach to an individual in an integrated employment or self-employment situation at or above minimum wage in a job that meets personal and career goals.
Group Supported Employment	✓	✓	✓	Group Supported Employment services are continuous support provided in regular business, industry and community settings to groups of two to eight individuals with disabilities and involves interactions with the public and with co-workers without disabilities.
Workplace Assistance Services		✓	✓	Workplace Assistance services are provided to someone who has completed job development and completed or nearly completed job placement training but requires more than typical job coach services to maintain stabilization in their employment. Workplace Assistance services are supplementary to job coach services; the job coach still provides professional oversight and coaching.
Community Engagement	✓	✓	✓	Community Engagement Services are provided in groups of no more than one staff to three individuals. Community Engagement fosters the ability of the individual to acquire, retain, or improve skills necessary to build positive social behavior, interpersonal competence, greater independence, employability and personal choice necessary to access typical activities in community life such as those chosen by the general population. These may include community education or training, retirement, and volunteer activities.
Community Coaching	✓	✓	✓	Community Coaching is a service designed for individuals who need one to one support in order build a specific skill or set of skills to address a particular barrier(s) preventing a person from participating in activities of Community Engagement.
Group Day Services	✓	✓	✓	Group Day Services are provided in groups of no more than one staff to seven individuals. They provide opportunities for peer interactions, community integration, career planning and enhancement of social networks. Supports may also be provided to ensure an individual's health and safety.
Self-Directed Options (*can also be agency-directed)				
Consumer-Directed Services Facilitation		✓	✓	Services Facilitation assists the individual or the individual's family/caregiver, or Employer of Record (EOR), as appropriate, in arranging for, directing, and managing services provided through the consumer-directed model of service delivery.
CD Personal Assistance Services*		✓	✓	Personal assistance services include support with activities of daily living, instrumental activities of daily living, access to the community, monitoring of self-administered medications or other medical needs, monitoring of health status and physical condition, and work-related personal assistance.
CD Respite*		✓	✓	Respite services are specifically designed to provide temporary, substitute care for that which is normally provided by the family or other unpaid, primary caregiver of an individual. Services are provided on a short-term basis because of the emergency absence or need for routine or periodic relief of the primary caregiver.

	BI	FI	CL	Description
CD Companion*		✓	✓	Companion services provide nonmedical care, socialization, or support to adults, ages 18 and older. This service is provided in an individual's home or at various locations in the community.
Residential Options				
Independent Living Supports	✓			Independent Living Supports are provided to adults (18 and older) that offers skill building and support to secure a self-sustaining, independent living situation in the community and/or may provide the support necessary to maintain those skills.
Shared Living	✓	✓	✓	Shared Living is Medicaid payment for a portion of the total cost of rent, food, and utilities that can be reasonably attributed to a person who has no legal responsibility to support the individual and resides in the same household as the individual. Parents and spouses are excluded.
Supported Living		✓	✓	Supported Living services take place in an apartment/house setting operated by a DBHDS licensed provider and provides 'round the clock availability of staff services performed by paid staff who have the ability to respond in a timely manner. These supports enable an individual to acquire, retain, or improve skills necessary to reside successfully in their home and community.
In-home Support Services		✓	✓	In-Home Support services are residential services that take place in the individual's home, family home, or community settings and typically supplement the primary care provided by the individual, family or other unpaid caregiver. Services are designed to ensure the health, safety and welfare of the individual.
Sponsored Residential			✓	Sponsored Residential Services take place in a licensed or DBHDS authorized sponsored residential home with no more than two individuals are supported. They consist of supports that enable an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in their home and
Group Home Residential			✓	Group Home Residential services are provided across 24 hours primarily in a licensed or approved residence that enables an individual to acquire, retain, or improve the self-help, socialization, and adaptive skills necessary to reside successfully in their home and community.
Crisis Support Options				
Community-Based Crisis Supports	✓	✓	✓	Community-based crisis supports are supports to individuals who may have a history of multiple psychiatric hospitalizations; frequent medication changes; enhanced staffing required due to mental health or behavioral concerns; and/or frequent setting changes. Supports are provided in the individual's home and community setting. Crisis staff work directly with and assist the individual and their current support provider or family. These services provide temporary intensive supports that avert emergency psychiatric hospitalization or institutional placement or prevent other out-of-home placement.
Center-based Crisis Supports	✓	✓	✓	Center-based crisis supports provide long term crisis prevention and stabilization in a residential setting (Crisis Therapeutic Home) through utilization of assessments, close monitoring, and a therapeutic milieu. Services are provided through planned and emergency admissions. Planned admissions will be provided to individuals who are receiving ongoing crisis services and need temporary, therapeutic interventions outside of their home setting in order to maintain stability. Crisis stabilization admissions will be provided to individuals who are experiencing an identified behavioral health need and/or a behavioral challenge that is preventing them from experiencing stability within their home setting.

	BI	FI	CL	Description
Crisis Support Services	✓	✓	✓	Crisis support services provide intensive supports by appropriately trained staff in the area of crisis prevention, crisis intervention, and crisis stabilization to an individual who may experience an episodic behavioral or psychiatric crisis in the community which has the potential to jeopardize their current community living situation. This service shall be designed to stabilize the individual and strengthen the current living situation so the individual can be supported in the community during and beyond the crisis period.
Medical and Behavioral Support Options				
Skilled Nursing		✓	✓	Skilled Nursing is part-time or intermittent care that may be provided concurrently with other services due to the medical nature of the supports provided. These medical services that are ordered by a physician, nurse practitioner or physician assistant and that are not otherwise available under the State Plan for Medical Assistance.
Private Duty Nursing		✓	✓	Private Duty Nursing is individual and continuous care (in contrast to part-time or intermittent care) for individuals with a medical condition and/or complex health care need, certified by a physician, nurse practitioner, or physician assistant as medically necessary to enable the individual to remain at home, rather than in a hospital, nursing facility or Intermediate Care Facility for Individuals with Intellectual Disability (ICF-ID).
Therapeutic Consultation		✓	✓	Therapeutic consultation services are designed to assist the individual and the individual's family/caregiver, as appropriate, with assessments, plan design, and teaching for the purpose of assisting the individual enrolled in the waiver. This service provides expertise, training, and technical assistance in any of the following specialty areas to assist family members, caregivers, and other service providers in supporting the individual. The specialty areas are: (i) psychology, (ii) behavioral consultation, (iii) therapeutic recreation, (iv) speech and language pathology, (v) occupational therapy, (vi) physical therapy, and (vii) rehabilitation engineering.
Personal Emergency Response System (PERS)	✓	✓	✓	PERS is a service that monitors individual's safety in their homes, and provides access to emergency assistance for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the individuals' home telephone system. While medication- monitoring services are also available, medication-monitoring units must be physician ordered and are not a stand-alone service.

	BI	FI	CL	Description
Additional Options				
Assistive Technology	✓	✓	✓	Assistive technology is specialized medical equipment, supplies, devices, controls, and appliances, not available under the State Plan for Medical Assistance, which enable individuals to increase their abilities to perform activities of daily living (ADLs), or to perceive, control, or communicate with the environment in which they live, or which are necessary for life support, including the ancillary supplies and equipment necessary to the proper functioning of such technology.
Electronic Home-Based Services	✓	✓	✓	Electronic Home-Based Services are goods and services based on Smart Home© technology. This includes purchases of electronic devices, software, services, and supplies not otherwise provided through this waiver or through the State Plan, that would allow individuals to access technology that can be used in the individual's residence to support greater independence and self-determination.).
Environmental Modifications	✓	✓	✓	Environmental modifications physical adaptations to the individual's primary home, primary vehicle, or work site that are necessary to ensure the health and welfare of the individual, or that enable the individual to function with greater independence.
Individual and Family/Caregiver Training		✓		Training and counseling to individuals, families and caregivers to improve supports or educate the individual to gain a better understanding of his/her disability or increase his/her self-determination/self-advocacy abilities.
Transition Services	✓	✓	✓	Transition services are nonrecurring set-up expenses for individuals who are transitioning from an institution or licensed or certified provider- operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

M1450 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-3	1/1/17	Pages 30, 40-42, 44
TN #DMAS-1	6/1/16	Pages 13, 15, 35 Pages 14 and 16 are runover pages.
TN #100	5/1/15	Table of Contents Pages 17-19, 36, 37 Page 35 is a runover page.
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

1. Summary of Seller's Transactions

Review the summary of the seller's transactions:

- Determine the Gross Amount Due to Seller.
- Is the Gross Amount Due to Seller less than the **tax assessed *or effective 10/4/16, the certified appraised* value**?
  - If **no**, the seller received adequate compensation for the property and there is **no** uncompensated transfer.
  - If **yes**, determine the uncompensated value of the asset transfer.

2. Real Property Uncompensated Value Calculations

a. When the lien is satisfied from the proceeds received by the seller, deduct the Gross Amount Due to Seller from the tax assessed *or certified appraised* value to determine the uncompensated amount of the asset transfer.

b. When the lien is assumed by the buyer, deduct the lien amount from the tax assessed *or certified appraised* value of the property, to determine the equity value. From the equity value deduct the Gross Amount Due to Seller for the property to determine the uncompensated amount of the asset transfer.

c. Determine the penalty period. The beginning of the penalty period depends upon whether the transfer took place prior to or on/after 2/08/2006.

Note: Any funds deducted from the Gross Amount Due to Seller that are paid to another individual, such as funds for repair of the property, are not considered usual and customary fees and must be evaluated as a separate asset transfer. If the transfer was uncompensated then the amount of this transfer may be added to any uncompensated value from the sale of property, as the transfer occurred at the same point in time.

Example #13a: Mrs. K. is receiving CBC services. The worker discovers that Mrs. K. has moved in with her daughter and has sold her home to her son. The tax assessed value of her home at the time of transfer was $200,000. The closing documents indicate that she sold her home for $125,000 (the gross amount due to seller). The closing costs were paid by Mrs. K. There was no lien against the property.

The uncompensated value of the transferred real property is calculated as follows:

$200,000 tax assessed value
-125,000 Gross Amount Due to Seller
$ 75,000 uncompensated value

The penalty period is based on the uncompensated value of $75,000.

M1450.700 CLAIM OF UNDUE HARDSHIP

A. Policy

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

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

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

A claim of undue hardship:

- can be made for an individual who meets all Medicaid eligibility requirements and is subject to a penalty period,
- cannot be made on a denied or closed Medicaid case *or when the individual is deceased*,
- cannot be made when the penalty period has already expired, and
- cannot be used to dispute the value of a resource.

B. Procedures

If the individual chooses to make a claim of an undue hardship, documentation regarding the transfer and the individual's circumstances must be sent to the Department of Medical Assistance Services (DMAS) for an undue hardship determination **prior** to the eligibility worker taking action to impose a penalty period.

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

1. Eligibility Worker

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

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

a. Undue Hardship Claimed - Required Documentation

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

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

b. 10 Days to Return Undue Hardship Claim

The individual must be given *at least* 10 calendar days to return the completed form and documentation to the local agency. *If the individual requests additional time to provide the form and documentation, the worker shall allow up to 30 calendar days from the date the checklist was sent.* If the form and documentation are not returned within *30* calendar days, the penalty period must be imposed.

c. Documentation for DMAS

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

- a copy of the undue hardship claim form
- a description of each transfer:
  - what was transferred
  - parties involved and relationship
  - uncompensated amount
  - date of transfer

- the penalty period(s)
- a brief summary of the applicant/recipient's current eligibility status and living arrangements (nursing facility or community), and
- other documentation provided by the applicant/recipient

Send the documentation to DMAS at the following address:

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

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

d. When Applicant/Recipient Was Victim

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

e. Undue Hardship Not Claimed or Not Granted by DMAS

If undue hardship is not claimed or if a penalty period must be imposed per DMAS, follow the procedures in M1450.800 through M1450.830 for notifying the individual and DMAS of the action. The individual must be informed that a denial of a claim for undue hardship may be appealed in accordance with the provisions of 12 VAC 30-110. If the individual meets all other eligibility requirements, he is eligible for Medicaid payment of all covered services other than LTC.

2. DMAS

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

3. Subsequent Claims

If DMAS is unable to approve an undue hardship request because sufficient supporting documentation was not submitted, the claim must be denied *and the penalty period must begin.* Once a claim is denied, no further decision related to the same asset transfer will be made by DMAS *unless the individual experiences a change in circumstances, such as receiving a discharge notice, that would result in the individual being removed from the institution or becoming unable to receive life-sustaining medical care, food, clothing, shelter or other necessities of life while still in the penalty period.*

If the individual reports a change in circumstances to the local DSS, he or his authorized representative must be offered the chance to submit an additional claim of undue hardship. Follow the procedures in M1450.700 B above.

If DMAS grants the claim of undue hardship, the portion of the asset transfer penalty remaining ***as of the date of the undue hardship request*** *is nullified.* ***Medicaid cannot pay for long-term care services received during the penalty period prior to the undue hardship request.*** *Nursing facility charges incurred during a penalty period may be evaluated as a patient pay deduction using the policy and procedures in M1470.230.*

Once the penalty period has expired, no additional claims of undue hardship may be made.

M1450.830 DMAS NOTICE

A. Introduction

The worker must notify DMAS that the recipient is not eligible for LTC services payment because of an asset transfer. DMAS must input the code in the *Virginia Case Management System* (*VaCMS)* that will deny payment of LTC services claims.

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

B. Copy of DMAS-225

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

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

C. Send DMAS Notice

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

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

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

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

M1460 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-3	1/1/17	Pages 3, 4, 4b, 24, 25, 29
TN #DMAS-2	10/1/16	Page 35
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 3, 8a, 17, 32
TN #100	5/1/15	Table of Contents, page i Pages 1, 2, 5, 6, 10, 15, 16-17a, 25,41-51
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, 2012: $525,000.
- Effective January 1, 2013: $536,000
- Effective January 1, 2014: $543,000
- Effective January 1, 2016: $552,000
- *Effective January 1, 2017: $560,000*

2. Reverse Mortgages

Reverse mortgages **do not** reduce equity value until payments are being received from the reverse mortgage.

3. Home Equity Credit Lines

A home equity line of credit **does not** reduce the equity value until credit line has been used or payments from the credit line have been received.

C. Verification Required

Verification of the equity value of the home is required.

D. Notice Requirement

If an individual is ineligible for Medicaid payment of LTC services because of substantial home equity exceeding the limit, the Notice of Action must state why he is ineligible for Medicaid payment of LTC. The notice must also indicate whether the applicant is eligible for other Medicaid covered services.

E. References

See section M1120.225 for more information about reverse mortgages.

M1460.155 THIRD PARTY & LONG-TERM CARE INSURANCE PAYMENTS

A. Payments Made by Another Individual

Payment of an individual's bills (including Medicare supplementary medical insurance or other medical insurance premiums) by a third party directly to the supplier is not income.

Payments made directly to the service provider by another person for the individual's private room or "sitter" in a medical facility are NOT income to the individual. Refer all cases of Medicaid eligible enrollees in nursing facilities who have a "sitter" to DMAS, Division of Long-term Care, for DMAS review to assure that DMAS is not paying the facility for services provided by the sitter.

B. LTC Insurance Policy Payments

The LTC insurance policy must be entered into the recipient's TPL file on MMIS. The insurance policy type is "H" and the coverage type is "N." When entered in the *Virginia Case Management System (VaCMS)* on the TPL system, *Medicaid* will not pay the nursing facility's claim unless the claim shows how much the policy paid.

If the patient receives the payment from the insurance company, it is **not** counted as income. The patient should assign it to the nursing facility. If the patient cannot do this, or the policy prohibits assignment, the payment should be given directly to the nursing facility. The facility should report the payment as a third party payment on its claim form.

If the patient received the payment and cannot give it to the facility for some reason, then the patient should send the insurance payment to:

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

M1460.200 DETERMINATION OF COVERED GROUP

A. Overview

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

1. Covered Groups Eligible for LTC Services

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

All categorically needy (CN) full benefit covered groups for ABD and F&C:

- SSI Recipients; see M0320.101 and M1460.201
- "Protected" covered Groups; see M0320.200
- ABD 80% FPL; see M0320 and M1460.210
- MEDICAID WORKS; see M0320.400
- 300% SSI; see M0320.500 , M0330.500, and M1460.220
- IV-E Foster Care and Adoption Assistance; see M0330.105
- Individuals Under Age 21; see M0330.107
- Special Medical Needs Adoption Assistance; see M0330.108
- Low Income Families With Children (LIFC); see M0330.200
- Child Under Age 19 (FAMIS Plus); see M0330.300
- Pregnant Women and Newborn Children; see M0330.400
- Breast and Cervical Cancer Prevention Treatment Act (BCCPTA); see M0330.700

All medically needy (MN) covered groups

- ABD Individuals; see M0320.701
- December 1973 Eligibles; see M0320.702
- Pregnant Women; see M0330.801
- Newborn Children Under Age 1; see M0330.802
- Children Under Age 18; see M0330.803
- Individuals Under Age 21; see M0330.804
- Special Medical Needs Adoption Assistance; see M0330.805

Medicaid will not pay for the following for MN individuals:

- services in an intermediate care facility for the *intellectually disabled* (ICF-*ID)*
- services in an institution for the treatment of mental disease (IMD)
- *Community Living Waiver (formerly* Intellectual Disabilities Waiver) services, and
- *Family and Individual Supports Waiver (formerly* Individual and Family Development Disability Support (DD) Waiver) services.

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

2. Individual Does Not Have Medicare Part A

When the individual DOES NOT have Medicare Part A:

a. cancel the recipient's Medicaid coverage because of excess resources;

b. prepare and send an Advance Notice of Proposed Action to the recipient;

c. send a DMAS-225 to the provider, stating that the recipient's Medicaid will be canceled because of excess resources, and the effective date of cancellation.

M1460.540 SUSPENSION PROCEDURES

A. Policy

This section applies ONLY to Medicaid recipients:

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

B. Procedures

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

1. For Recipients Who Have Medicare Part A

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

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

1) When the recipient's income is less than or equal to the QMB, SLMB, or QI income limit:

a) prepare and send an advance notice to reduce the recipient's Medicaid coverage from full benefits to limited benefits (specify the appropriate QMB, SLMB, or QI coverage). Write a note on the notice telling the recipient that:

- the limited (QMB, SLMB, or QI) benefits will NOT pay for long-term care services, and
- if he verifies that his resources are less than or equal to the $2,000 resource limit, he should request reinstatement of full Medicaid benefits.

b) **cancel** the recipient's full coverage effective the last day of the month in which the 10-day advance notice period expires. Reinstate the recipient's coverage with the begin date as the first day of the month following the cancellation effective date, using the appropriate QMB, SLMB or QI AC.

2) When the recipient's income exceeds the QMB, SLMB and QI income limits, follow the procedures in 2 below (the procedures for recipients who do not have Medicare Part A).

b. Resources Exceed ABD MSP Resource Limit

If resources are greater than the ABD MSP resource limit, follow the procedures in item 2 below (the procedures for recipients who do not have Medicare Part A).

2. For Recipients Who Do NOT Have Medicare Part A

a. Prepare and Send Advance Notice

Prepare and send an advance notice to cancel the recipient's Medicaid eligibility. Specify the effective date, which is the last day of the month in which the 10-day advance notice period expires. Write a note on the notice telling the recipient that if he verifies that his resources are less than or equal to the $2,000 resource limit before the specified date (specify the date which is 3 months from the cancel effective date), he should request reinstatement of Medicaid eligibility.

b. Cancel Medicaid Eligibility

Cancel the recipient's eligibility effective the last day of the month in which the 10-day advance notice period expires.

c. Suspend Case Administratively

Suspend the case administratively for a maximum of 3 months; do not close the case statistically. The suspension effective date is the effective date of the Medicaid cancellation in *VaCMS*. While suspended, the case remains open for a maximum of 3 months.

If, by the end of 3 months from the suspension effective date, the individual provides verification that his resources have been reduced to or below the resource limit, document the reduction in resources in the individual's *VaCMS* case record. Reinstate his Medicaid eligibility effective the first day of the month in which his resources are less than or equal to the resource limit.

If the individual does NOT provide verification within 3 months of the suspension effective date that his resources have been reduced to or below the resource limit, close the case administratively and statistically. Do not take any action on his enrollment in *VaCMS*, because his eligibility has already been canceled. The individual will have to file a new Medicaid application.

7. Credit Life/Disability Payments

(S0815.300) Payments made under a credit life or credit disability insurance policy on behalf of an individual are not income.

8. Loan Proceeds

(S0815.350) Proceeds of a bona fide loan are not income to the borrower because of the borrower's obligation to repay.

9. Third Party Payments

a. Payments made by another individual

(S0815.400) Payment of an individual's bills (including Medicare supplementary medical insurance or other medical insurance premiums) by a third party directly to the supplier is not income.

Payments made directly to the service provider by another person for the individual's private room or "sitter" in a medical facility are **not** income to the individual. Refer all cases of Medicaid eligible recipients who have a "sitter" to DMAS, Division of Long-term Care, for DMAS review to assure that DMAS is not paying the facility for services provided by the sitter.

EXCEPTION: For F&C covered groups **except** the 300% SSI group: If the person paying the bill(s) is the child's absent father and the Division of Child Support Enforcement (DCSE) has not established an obligation for the absent parent, the amount(s) paid by the absent parent for the child is counted as income.

b. Long-term care (LTC) insurance payments

Institutionalized individuals who have LTC insurance coverage must have the LTC insurance coverage information entered into the recipient's TPL file *in VaCMS*. The insurance policy type is "H" and the coverage type is "N."

If the patient receives the payment from the insurance company, it is not counted as income. The patient should assign it to the provider. If the patient cannot do this, or the policy prohibits assignment, the payment should be given directly to the provider facility. The provider should report the payment as a third party payment on its claim form. If the patient received the payment and cannot give it to the provider for some reason, then the patient should send the insurance payment to the DMAS Fiscal Division, Accounts Receivable, 600 E. Broad Street, Suite 1300, Richmond, Virginia 23219.

10. Replacement Income

(S0815.450) If an individual's income is lost, stolen, or destroyed and the individual receives a replacement, the replacement is not income if the original payment was counted in determining the individual's Medicaid eligibility.

11. Erroneous Payments

(S0815.460) A payment is not income when the individual is aware that he is not due the money and returns the check uncashed or otherwise refunds all of the erroneously received money.

M1470 Changes

Changed With	Effective Date	Pages Changed
DMAS-3	1/1/17	Table of Contents, page ii Pages 1, 14, 17, 19, 20, 28a, 45-47, 50 Appendix 1, pages 1 and 2
DMAS-2	10/1/16	Pages 12, 27, 28 Pages 12a and 28a were added as runover pages.
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

Lump Sum Payments M1470.1000 50
Lump Sum Reported in Receipt Month M1470.1010 50
Lump Sum Not Reported Timely M1470.1020 51
Patient Pay Determination for Lump Sums M1470.1030 51

Reduction of Excess Resources M1470.1100 53

Incorrect Payments to Provider M1470.1200 55
Adjustments Not Allowed M1470.1210 55
Adjustments Allowed M1470.1220 56

APPENDIX

Sample Notice of Obligation for LTC Costs *from VaCMS* ..... Appendix 1 1

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

M1470.001 OVERVIEW

A. Introduction

"Patient pay" is the amount of the long-term care (LTC) patient's income which must be paid as his share of the LTC services cost. This subchapter provides basic rules regarding the post-eligibility determination of the amount of the LTC patient's income which must be paid toward the cost of his care.

B. Policy

The state's Medicaid program must reduce its payment to the LTC provider by the amount of the eligible patient's monthly income, after allowable deductions. Patient pay is calculated after an individual has been determined eligible for Medicaid and for Medicaid LTC services. A Medicaid recipient who is admitted to a nursing facility, *facility for individuals with intellectual disability* (ICF-*ID*) or Medicaid waiver services for less than 30 days must have a patient pay determined for the month(s) in which the recipient is in the facility or waiver services**.** The provider collects the patient pay from the patient or his authorized representative. Patient pay information *is fed* to the Automated Response System (ARS) and the MediCall Systems for provider verification of patient pay. These systems report the amount of patient pay and the date of service to the provider responsible for collecting patient pay.

C. *VaCMS* Patient Pay Process

The patient pay calculation is completed in *VaCMS*. Refer to the *VaCMS Help feature* for information regarding data entry. *VaCMS* allows the patient pay to be calculated for up to three months to capture changes in allowances due to the Medicare buy-in, etc. The patient pay must be updated *in the system* whenever the patient pay changes, but at least once every 12 months.

D. Patient Notification

The patient or the authorized representative is notified of the patient pay amount on the Notice of Obligation for Long-term Care Costs. *VaCMS* will generate and send the Notice of Obligation for LTC Costs. M1470, Appendix 1 contains a sample Notice of Obligation for LTC Costs generated by *VaCMS*.

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

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

Do not send requests for adjustments to DMAS when the patient has no available income for patient pay. Refer to M1470.230 C.5.c for notification procedures to be followed by the local worker.

When a request for an adjustment is approved or denied by DMAS, the local DSS worker will receive a copy of the letter sent to the recipient by DMAS:

1) If approved, adjust the patient pay using the *VaCMS* Patient Pay process.

2) If the adjustment request is denied, DMAS prepares the notification.

b. DMAS Approval Not Required

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

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

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

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

c. Notice Procedures

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

M1470.240 FACILITY - HOME MAINTENANCE DEDUCTION

A. Policy

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

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

B. Non-Institutionalized Individuals on MN Spenddown

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

1. Individual Who Meets the Spenddown

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

a. Add together the number of days in the facility stay that are NOT covered by Medicaid. Multiply the result by the facility's private pay daily rate.

b. Determine the remaining balance of the spenddown prior to applying the bill that caused the spenddown to be met.

c. Add the amount in a. above to the figure obtained in b. above. The total is the individual's patient pay for the part of the facility stay that occurs in the spenddown coverage period.

d. Enter patient pay into *VaCMS*.

2. Example – Spenddown Met

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

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

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

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

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

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,
- *Community Living Waiver (formerly* Intellectual Disabilities (ID) Waiver),
- Technology-Assisted Individuals Waiver,
- *Family and Individual Supports Waiver (formerly* Individual and Family Developmental Disabilities Support (DD) Waiver , and
- *Building Independence Waiver (formerly* Day Support (DS) Waiver).

The PMA is:

- January 1, *2017* through December 31, *2017*: *$1,213*
- January 1, 2016 through December 31, 2015: $1,210

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, *Community Living, Family and Individual Supports and Building Independence* 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 *($2,205* in *2017*) per month.

b. for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI *($1,470* in *2017*) 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.

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

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

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

b. Notice Procedures

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

C. Patient Pay Decreases

1. When to Adjust

Reflect a patient pay decrease using the *VaCMS* 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 *VaCMS* Patient Pay process, take the following steps to reflect a decrease in patient pay:

a. Verify the decrease.

b. Once the decrease is verified, *enter the correct information into VaCMS along with the correct effective begin dates. VaCMS will* 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. *VaCMS* 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 *VaCMS* 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 or an allowable deduction stops or decreases. *When the underpayment is more than $1,500, VaCMS will not make an adjustment to the patient pay. Follow the instructions in M1700.300 for making a referral to the DMAS Recipient Audit Unit.*

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.

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

c. Total underpayment of $1,500 or more

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

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

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

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

2) Prospective months' patient pay

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

***4.* Example--Patient Pay Increase -Total Underpayment Less than $1,500**

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

His "old" patient pay is subtracted from his "new" patient pay for February, March and April to determine his underpayment for those months. The $50 underpayment for three months ($150) is added to his "new" ongoing patient pay ($350) and the total patient pay obligation ($500) is compared to the Medicaid rate of $1,700. Since the total patient pay obligation of $500 is less than the Medicaid rate of $1,700, the patient pay for May is $500. The ongoing patient pay starting in June is $350.

M1470.930 DEATH OR DISCHARGE FROM LTC

A. Policy

The LTC provider may not collect an amount of patient pay that is more than the Medicaid rate for the month. When a patient dies or is discharged from LTC to another living arrangement that does not include LTC services, do not recalculate patient pay for the month in which the patient died or was discharged. The provider is responsible for collecting an amount of patient pay for the month of death or discharge that does not exceed the Medicaid rate for the month.

B. Procedure

Refer to the *VaCMS Help* feature for procedures regarding death or discharge from LTC. Send a DMAS-225 to the provider regarding the eligibility status of the patient. Send a notice to the patient or the patient's representative that reflects the reduction or termination of services.

M1470.1000 LUMP SUM PAYMENTS

A. Policy

Lump sum payments of income or accumulated benefits are counted as income in the month they are received. Patient pay must be adjusted to reflect this income change for the month following the month in which the 10-day advance notice period expires. Any amount retained becomes a resource in the following month.

B. Lump Sum Defined

Income such as interest, trust payments, royalties, etc., which is received regularly but is received less often than quarterly (i.e., once every four months or three times a year, once every five months, once every six months or twice a year, or once a year) is treated as a lump sum for patient pay purposes.

EXCEPTION: Income that has previously been identified as available for patient pay, but which was not actually received because the payment source was holding the payment(s) for some reason or had terminated the payment(s) by mistake, is **NOT** counted again when the corrective payment is received.

See section M1470.1030 below for instructions for determining patient pay when a lump sum is received.

M1470.1010 LUMP SUM REPORTED IN RECEIPT MONTH

A. Lump Sum Available

Lump sum payments reported in the month the payment was received are counted available for patient pay effective the first of the month following the month in which the 10-day advance notice period expires.

If the individual is no longer in the facility and is not receiving Medicaid CBC, adjust the patient pay for the lump sum receipt month if the money is still available.

B. Lump Sum Not Available

If the money is not available, complete and send a "Notice of Recipient Fraud/Non-Fraud Overissuance" to the DMAS, Recipient Audit Unit.

Sample Notice of Obligation for Long-term Care Costs *from VaCMS*

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

NOTICE OF OBLIGATION FOR LONG-TERM CARE COSTS

TO:

Recipient Name:

Recipient ID:

This form serves as your notice of patient pay, which is the amount of your income that must be paid to the provider every month for the cost of long-term care services you receive. The long-term care provider who is responsible for collection of any portion of your patient pay will directly bill you or your representative. A portion of patient pay may be paid to more than one provider when services are received from multiple providers. If you currently receive Medicaid long-term care services, this will serve as the 10-day advance notice when your patient pay amount is increased. Please contact your local worker if you have questions.

PATIENT PAY CALCULATIONS

Effective Date of Patient
Pay (Month and Year):

Reason

Income

Social Security
Other Unearned Income
Total Earned Income
Total Gross Income
Minus Spenddown Liability (SDL)
Remaining Income

Allowances Deducted from Income
Personal/Maintenance Needs
Spousal
Child/Family Member
Non-covered Medical Expenses
Home Maintenance
Income Remaining after Allowances

Spenddown Liability
Contribution Income
Medicaid Rate for Month

Patient Pay

DATE OF ACTION/NOTICE	AGENCY REPRESENTATNE	TELEPHONE NUMBER

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Patient pay may be the lesser of the SDL amount, contributable income amount (income remaining after deductions plus the SDL), remaining income or the Medicaid Rate, whichever is applicable to the individual's circumstances.

Patient pay will not exceed the Medicaid Rate.

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

If you have Medicare Part A coverage, and were admitted to a nursing facility under "Skilled Care", the patient pay amount you owe for the first 100 days may be less than the amount shown on this notice. The nursing facility will determine how many days are covered by Medicare and will send you a bill. Once Medicare stops paying, you will be responsible for the full patient pay amount shown on this notice.

Appeal Information

If you disagree with this action, you have the right to file an appeal. You or your authorized representative must send a written appeal request within 30 days of receipt of this notification. If you file an appeal before the effective date of this action, the patient pay will remain unchanged during the appeal process. However, if the Appeals Division upholds this action, you may be required to reimburse the Medicaid Program for the excess cost of services paid on your behalf during the appeal period.

You may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, at your local department of social services, or by calling (804) 371-8488.

Please include a copy of this notification. Sign the appeal request and mail it to:

Appeals Division
Department of Medical
Assistance Services 600 E
Broad Street, 6th Floor
Richmond, Virginia
23219

Appeal requests may also be faxed
to: (804) 371-8491

M1480 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-3	1/1/17	Pages 7, 9, 18, 18b, 18c, 20 Pages 47, 51, 66, 67, 77
TN #DMAS-2	10/1/16	Pages 66, 72
TN #DMAS-1	6/1/16	Pages 7, 11, 14, 18, 18c, 30, 66, 69, 70, 92, 93
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

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. For the purposes of the home equity evaluation, the definition of the home in M1130.100 A.2 is used; the home means the house and lot used as the principal residence and all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000.

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.

4. 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, 2013: $536,000
- Effective January 1, 2014: $543,000
- Effective January 1, 2015: $552,000
- Effective January 1, 2016: $552,000
- *Effective January 1, 2017: $560,000*

2. Reverse Mortgages

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

M1480.210 RESOURCE ASSESSMENT WITHOUT A MEDICAID APPLICATION

A. Introduction

This section applies only to married individuals with community spouses who are inpatients in medical institutions or nursing facilities and who have NOT applied for Medicaid.

B. Policy

1. Resource Evaluation

For the purposes of the resource assessment and spousal share calculation, countable and excluded resources are determined for all covered groups using the ABD resource policy found in Chapter S11 **regardless of the individual's covered group and regardless of community property laws or division of marital property laws**, except for the following resources which are excluded as indicated below when completing the resource assessment and spousal share [1924(c)(5)]:

- the home and all contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SS & SSI payments received on or after 11/01/05 for nine (9) calendar months following the month in which the individual receives the benefits; and
- up to **$1,500** of burial funds for each spouse (NOT $3,500), if there are designated burial funds.

Resources owned in the name of one or both spouses are considered available regardless of whether either spouse agrees to sell or liquidate the resource and regardless of whether either spouse refuses to make the resource available.

The resource assessment is not affected by the amount disregarded in the eligibility determination as a result of an LTC Partnership Policy (Partnership Policy).

2. No Appeal Rights

When a resource assessment is requested and completed **without** a concurrent Medicaid application, it cannot be appealed pursuant to the existing Virginia Client Appeals regulations (VR 460-04-8.7). The spousal share determination may be appealed when a Medicaid application is filed.

3. The applicant has assigned to DMAS, to the full extent allowed by law, all claims he or she may have to financial support from the spouse; and
4. The applicant cooperates with DMAS in any effort undertaken or requested by DMAS to locate the spouse, to obtain information about the spouse's resources and/or to obtain financial support from the spouse.

B. Procedures

1. Assisting the Applicant

The EW must advise the applicant of the information needed to complete the resource assessment and assist the applicant in contacting the separated spouse to obtain resource and income information.

If the applicant cannot locate the separated spouse, document the *VaCMS* case record. Refer to *M1480.225 B.2.b* below.

If the applicant locates the separated spouse, the EW must contact the separated spouse to explain the resource assessment requirements for the determination of spousal eligibility for long-term care services.

If the separated spouse refuses to cooperate in providing information necessary to complete the resource assessment, document the *VaCMS case record*. Refer to *M1480.225 B.2.b* below.

EXCEPTION: If the separated spouse is institutionalized and is a Medicaid applicant/recipient, the definition of "community spouse" is not met, and a resource assessment is not needed.

2. Undue Hardship

If the applicant is unable to provide the necessary information to complete the resource assessment, he/she must be advised of the hardship policy and the right to claim undue hardship

a. Undue hardship not claimed

If the applicant does not wish to claim undue hardship, the EW must document the *VaCMS* case record, *and the application must be processed using rules for non-institutionalized individuals. Payment for LTC services must be denied for failure to verify resources held at the beginning of institutionalization.*

b. Undue hardship claimed

If the applicant claims an undue hardship, he must provide a written statement requesting an undue hardship evaluation. A Resource Assessment Undue Hardship Request Form, including affidavit and assignment forms, may be given to the applicant to be used instead of an original statement but is **not required**. The forms are available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi.

The applicant or his representative must make an effort to locate and contact the estranged spouse or provide documentation as to why this is not possible. Contact or action to locate the estranged spouse by the EW alone is not sufficient to complete the undue hardship evaluation. When it is reported that the applicant has a medical condition that prevents participation in the process, then a physician's statement must be provided documenting the medical condition.

M1480.230 RESOURCE ELIGIBILITY OF INSTITUTIONALIZED SPOUSE

A. Introduction

This section contains the resource rules that apply to the institutionalized spouse's eligibility.

If the community spouse applies for Medicaid, do not use the rules in this subchapter to determine the community spouse's eligibility. Use the financial eligibility rules for a non institutionalized person in the community spouse's covered group.

B. Policy

An institutionalized spouse meets the resource eligibility requirements for Medicaid if the difference between the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined and the spousal protected resource amount (PRA) is equal to or less than $2,000.

In initial eligibility determinations for the institutionalized spouse, the spousal share of resources owned by the couple **at the first moment of the first day of the first month of the first continuous period of institutionalization** that began on or after September 30, 1989, remains a constant factor in determining the spousal PRA.

For the purposes of determining eligibility of an institutionalized spouse with excess resources, an institutionalized spouse **cannot** establish resource eligibility by reducing resources within the month. The institutionalized spouse may become eligible for Medicaid payment of LTC services when the institutionalized spouse's resources are equal to or below the $2,000 resource limit as of the first moment of the first day of a calendar month.

1. Use ABD Resource Policy

For the purposes of eligibility determination, countable and excluded resources are determined for all covered groups using the ABD resource policy in Chapter S11, **regardless of the individual's covered group and regardless of community property laws or division of marital property laws,** except for the following resources which are excluded as indicated below when determining eligibility of the institutionalized spouse:

- the home and all contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SS & SSI payments received on or after 11/01/05 for nine (9) calendar months following the month in which the individual receives the benefits; and
- up to $3,500 of burial funds for each spouse.

Resources owned in the name of one or both spouses are considered available in the initial month for which eligibility is being determined regardless of whether either spouse agrees to sell or liquidate the resource, and regardless of whether either spouse refuses to make the resource available.

2. After Eligibility is Established

Once an institutionalized spouse has established Medicaid eligibility as an institutionalized spouse, count only the institutionalized spouse's resources when determining the institutionalized spouse's Medicaid eligibility. Do not count or deem the community spouse's resources available to the institutionalized spouse.

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

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	*$24,180*	*1-1-17*
	$23,844	1-1-16
C. Maximum Spousal Resource Standard	*$120,900*	*1-1-17*
	$119,220	1-1-16

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.

NOTE: When a loan or a judgment against resources is identified, send the documents pertaining to the loan and/or judgment to DMAS for review before taking action on the application. Send the documents, along with case identifying information (institutionalized spouse's and community spouse's names, address, SSN, case number) to:

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

2. Deduct Spousal Protected Resource Amount (PRA)

Deduct the spousal protected resource amount (PRA) from the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined.

If no spousal share was determined because the couple failed to verify resources held at the beginning of the first continuous period of institutionalization, *the application must be processed using rules for non-institutionalized individuals and payment for LTC services must be denied for failure to verify resources held at the beginning of institutionalization.*

The PRA is the greatest of the following:

- the **spousal share** of resources as determined by the resource assessment, provided it does not exceed the maximum spousal resource standard in effect at the time of application. **If the spousal share exceeds the maximum spousal resource standard, use the maximum spousal resource standard.** The spousal share does not change; if a spousal share was previously established and verified as correct, use it;
- the **spousal resource standard** in effect at the time of application;
- an amount designated by a DMAS Hearing Officer;
- an amount **actually transferred** to the community spouse from the institutionalized spouse under a **court spousal support order** issued as the result of an appeal of the DMAS Hearing Officer's decision**.**

The EW cannot accept a court order for a greater PRA unless the individual has exhausted the Medicaid administrative appeals process, the individual appealed the DMAS Hearing Officer's decision to the circuit court and the circuit court ordered a higher amount.

If the individual does not agree with the PRA, see subsection F. below.

Once the PRA is determined, it remains a constant amount for the current Medicaid application (including retroactive months). If the application is denied and the individual reapplies, the spousal share remains the same but a new PRA must be determined.

3. Deduct Partnership Policy Disregard Amount

When the institutionalized spouse is entitled to a Partnership Policy disregard, deduct a dollar amount equal to the benefits paid as of the month of application.

M1480.260 SUSPENSION PROCEDURES

A. Policy

This section applies to institutionalized individuals who:

are enrolled in ongoing Medicaid coverage,
have Medicare Part A,
have a patient pay that exceeds the Medicaid rate, and
have resources between $2,000 and $4,000.

B. Procedures

If the conditions above are met, take the following actions:

1. Prepare and Send Advance Notice

Prepare and send an advance notice to reduce the recipient's full Medicaid coverage to the appropriate ABD covered group. Specify the effective date, which is the last day of the month in which the 10-day advance notice period expires. Write a note on the notice telling the recipient that if he verifies that his resources are less than or equal to the $2,000 resource limit before the specified date (specify the date which is 3 months from the cancel effective date), he should request reinstatement of Medicaid coverage.

2. Suspend Case Administratively

Suspend the case administratively for a maximum of 3 months; do not close the case statistically. The suspension effective date is the effective date of the Medicaid cancellation in the *Virginia Case Management System* (*VaCMS)*. The case is counted as a "case under care" while suspended. While suspended, the case remains open for a maximum of 3 months.

If, by the end of 3 months from the suspension effective date, the individual provides verification that his resources have been reduced to or below the resource limit, update the latest application or redetermination form in the individual's case record. Reinstate his Medicaid coverage effective the first day of the month in which his resources are less than or equal to the resource limit.

If the individual does NOT provide verification within 3 months of the suspension effective date that his resources have been reduced to or below the resource limit, close the case administratively and statistically. Do not take any action on his enrollment in the *VaCMS* because his coverage has already been canceled. The individual will have to file a new Medicaid application.

M1480.315 THIRD PARTY & LONG-TERM CARE INSURANCE PAYMENTS

A. Payments Made by Another Individual

Payment of an individual's bills (including Medicare supplementary medical insurance or other medical insurance premiums) by a third party directly to the supplier is not income.

Payments made directly to the service provider by another person for the individual's private room or "sitter" in a medical facility are NOT income to the individual. Refer all cases of Medicaid eligible enrollees in nursing facilities who have a "sitter" to DMAS, Division of Long-term Care, for DMAS review to assure that DMAS is not paying the facility for services provided by the sitter.

B. LTC Insurance Policy Payments

The LTC insurance policy must be entered into the recipient's TPL file *in VaCMS*. The insurance policy type is "H" and the coverage type is "N." When entered in *VaCMS* on the TPL system, the nursing facility's claim *will not be paid* unless the claim shows how much the policy paid.

If the patient receives the payment from the insurance company, it is **not** counted as income. The patient should assign it to the nursing facility. If the patient cannot do this, or the policy prohibits assignment, the payment should be given directly to the nursing facility. The facility should report the payment as a third party payment on its claim form.

If the patient received the payment and cannot give it to the facility for some reason, then the patient should send the insurance payment to:

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

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. *VaCMS* 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 Allowance	$2002.50	7-1-16	
	$1,991.25	7-1-15	
C. Maximum Monthly Maintenance Needs Allowance	*$3,022.50*	*1-1-17*	
	$2,980.50	1-1-16	
D. Excess Shelter Standard	$600.75	7-1-16	
	$597.38	7-1-15	
E. Utility Standard Deduction (SNAP)	$287.00	1 - 3 household members	10-1-16
	$357.00	4 or more household members	10-1-16
	$294.00	1 - 3 household members	10-1-15
	$369.00	4 or more household members	10-1-15

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

A. Policy

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

B. What Is Patient Pay

The institutionalized spouse's gross monthly income, less all appropriate deductions according to this section, constitutes the patient pay - the amount of income the institutionalized spouse will be responsible to pay to the LTC facility or waiver services provider. The community spouse's and family member's monthly income allowances rules for patient pay apply to all institutionalized spouses with community spouses, regardless of when institutionalization began.

C. Dependent Allowances

A major difference in the institutionalized spouse patient pay policy is the allowance for a dependent child and for a dependent family member. If the institutionalized spouse has a dependent child, but the dependent child does NOT live with the community spouse, then **NO** allowance is deducted for the child. Additionally, an allowance may be deducted for other dependent family members living with the community spouse.

D. Home Maintenance Deduction

A major difference in the institutionalized spouse patient pay policy is the home maintenance deduction policy. A married institutionalized individual with a community spouse living in the home is **NOT allowed** the home maintenance deduction because the community spouse allowance provides for the home maintenance, **UNLESS**:

- the community spouse is not living in the home (e.g., the community spouse is in an ACR), and
- the institutionalized spouse still needs to maintain their former home.

E. *VaCMS* Patient Pay Process

The patient pay is calculated in *VaCMS*. The patient pay must be updated in *in the system* whenever the patient pay changes, but at least once every 12 months. Refer to the *VaCMS Help feature* for information regarding data entry.

The Automated Response System (ARS) and the MediCall System convey the necessary patient pay information to the provider.

M1480.430 ABD 80% FPL and 300% SSI PATIENT PAY CALCULATION

A. Patient Pay Gross Monthly Income

Determine the institutionalized spouse's patient pay gross monthly income for patient pay. Use the gross income policy in section M1480.310 B.1 for both covered groups.

B. Subtract Allowable Deductions

If the patient has no patient pay income, he has no patient pay deductions.

When the patient has patient pay income, **deduct the following amounts in the following order** from the institutionalized spouse's gross monthly patient pay income. Subtract each subsequent deduction as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.

Her patient pay for August is calculated as follows:

$1,000.00	SS
+ 400.00	private pension
1,400.00	total gross income
- 30.00	PNA (personal needs allowance)
- 106.25	community spouse monthly income allowance
- 468.75	family member's monthly income allowance
795.00	
- 120.50	Medicare premium & health insurance premium
$ 674.50	remaining income for patient pay (August)

Mrs. Bay's patient pay for September is calculated as follows:

$1,000.00	SS
+ 400.00	private pension
1,400.00	total gross income
- 30.00	PNA (personal needs allowance)
- 106.25	community spouse monthly income allowance
- 468.75	family member's monthly income allowance
795.00	
- 75.00	health insurance premium
$ 720.00	remaining income for patient pay (September)

The worker completes the *VaCMS* Patient Pay process for July, August and September. *VaCMS* generates and sends a "Notice of Obligation" to Mr. Bay showing Mrs. Bay's patient pay for July, August and September and each month's patient pay calculation.

M1480.440 MEDICALLY NEEDY PATIENT PAY

A. Policy

When an institutionalized spouse has income exceeding 300% of the SSI payment level for one person, he is classified as medically needy (MN) for income eligibility determination. Because the 300% SSI income limit is higher than the MN income limits, an institutionalized spouse whose income exceeds the 300% SSI limit will be on a spenddown. He must meet the spenddown liability to be eligible for Medicaid as MN. See sections M1480.330, 340 and 350 above to determine countable income, the spenddown liability, and to determine when an institutionalized spouse's spenddown is met.

Section 1924 (d) of the Social Security Act contains rules which protect portions of an institutionalized spouse's income from being used to pay for the cost of institutional care. Protection of this income is intended to avoid the impoverishment of a community spouse. In order to insure that an institutionalized spouse will have enough income for his personal needs or maintenance allowance, the community spouse income allowance and the family members' income allowance, an institutionalized spouse who meets a spenddown is granted a full month's eligibility. The spenddown

M1510 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-2	1/1/17	Table of Contents Pages 1, 8, 8a, 12-15 Page 11a was deleted.
TN #DMAS-2	10/1/16	On pages 3-15, corrected the subchapter number in the headers. Neither the dates nor the policies were changed.
TN #DMAS-1	6/1/16	Pages 2 Pages 1 and 2a are runover pages.
TN #100	5/1/15	Table of Contents Pages 1-2a, 5-8b
UP #10	5/1/14	Table of Contents Pages 7-8a Page 8b was added.
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
TN #91	5/15/09	Page 14

TABLE OF CONTENTS

M15 ENTITLEMENT POLICY & PROCEDURES

M1510.000 MEDICAID ENTITLEMENT

	Section	Page
Medicaid Entitlement	**M1510.100**	**1**
Retroactive Eligibility & Entitlement	**M1510.101**	**2**
Ongoing Entitlement	**M1510.102**	**5**
Hospital Presumptive Eligibility	**M1510.103**	**8a**
Disability Denials	**M1510.104**	**8b**
Foster Care Children	**M1510.105**	**9**
Delayed Claims	**M1510.106**	**9**
Notice Requirements	**M1510.200**	**10**
Follow-Up Responsibilities	**M1510.300**	***12***
Third Party Liability (TPL)	**M1510.301**	***12***
Social Security Numbers	**M1510.302**	***15***
Patient Pay Notification	**M1510.303**	**15**

M1510.000 ENTITLEMENT POLICY & PROCEDURES

M1510.100 MEDICAID ENTITLEMENT

A. Policy

An individual's entitlement to Medicaid coverage is based on the individual meeting all nonfinancial and financial eligibility requirements for the individual's covered group during a month covered by the application, as well as any additional entitlement policies that are applicable to the covered group.

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. Individual is Deceased

If an application is filed on behalf of a deceased individual or the 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. His enrollment may begin with the month of application or the earliest month in the application's retroactive period that he met the residency requirement per M0230.

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.

agency can send an advance notice to the recipient at least 11 days before the last day of the month. If the agency cannot send the notice at least 11 days before the end of the month, coverage is canceled effective the last day of the next month.

1. CN Pregnant Woman

After eligibility is established, a pregnant woman in any CN covered group continues to be eligible for Medicaid during the remainder of her pregnancy and the 60-day post-partum period regardless of any changes in family income, as long she continues to meet all non-financial criteria.

2. Individual Age 21-64 Admitted to Ineligible Institution

a. Entitlement - applicants

For a Medicaid enrollee age 21-64 years, entitlement to Medicaid begins on the first day of the application month and ends on the date following the date he is admitted to an IMD or other ineligible institution. When enrolling the individual, enter the begin date and the end date of coverage.

b. Cancel procedures for ongoing enrollees

Cancel coverage as soon as possible after learning of the enrollee's admission to an ineligible institution. **DO NOT cancel coverage retroactively.** Cancel coverage effective the current date (date the worker enters the cancel transaction *in the system).*"

c. Notice

An Advance Notice of Proposed Action is not required. Send a Notice of Action to the enrollee or his authorized representative informing him of the cancel date and the reason.

3. Spenddown Enrollees

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

C. Ongoing 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 HOSPITAL PRESUMPTIVE ELIGIBILITY

A. Policy

Individuals enrolled on the basis of Hospital Presumptive Eligibility (HPE) are covered by Medicaid beginning with the date of the HPE determination through the last day of the following month or the date MA eligibility is determined by an LDSS, whichever comes first. For their coverage to continue beyond the HPE enrollment period, they must submit a full MA application to the LDSS. If the individual does not submit an MA application, no further action is necessary on the part of the LDSS. See M0120.500 C. for additional information.

B. Procedures

When an HPE enrollee submits a full MA application and it is pended in VaCMS, the individual's coverage in the HPE AC is extended by the eligibility worker, as necessary, while the application is processed.

The 10-working day processing standard applies to applications submitted by pregnant women and BCCPTA individuals enrolled in HPE.

1. Enrollment

When an individual is determined eligible for MA coverage, his MA coverage under the appropriate MA AC includes any days to which he is entitled that are not already covered by HPE. If the individual submitted the MA application in the same month HPE coverage began and HPE began on any day other than the first day of the month, his MA coverage begins the first day of that month and the eligibility worker enrolls him in a closed period of coverage in the appropriate MA AC beginning with the first day of the month and ending the day before the HPE begin date. The worker is to enroll the eligible individual in ongoing coverage in the appropriate MA AC beginning the first day of the month after the effective date of the HPE coverage cancellation.

2. Individuals Enrolled in HPE as Pregnant Women or in Plan First

If an individual who was enrolled in HPE with partial coverage as a pregnant woman or in Plan First is determined eligible for full MA coverage in the period covered by HPE, cancel HPE coverage retroactively and reinstate in full coverage for the retroactive months and ongoing, if eligible.

3. Retroactive Entitlement

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 HPE, only enroll him for the portion of the retroactive period that he was not enrolled as HPE.

4. HPE Enrollee Not Eligible for Ongoing Coverage

If the applicant is determined to not be eligible for ongoing MA coverage, his entitlement to HPE coverage ends. Cancel the HPE coverage effective the current date (i.e. day of the eligibility determination).

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 *VaCMS*. 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 *VaCMS*.

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 *VaCMS* (note: do not delete the TPL from *VaCMS*).

Absent receipt of documentation showing that the TPL coverage has ended, it must be left open in *VaCMS and* MMIS and cannot be ended by the worker. If the worker is unable to obtain verification of the coverage termination date from the insurance company or the enrollee/authorized representative, the worker is to notify DMAS that the enrollee's TPL coverage was terminated, but verification cannot be obtained. The notification should be sent via e-mail to: tplunit@dmas.virginia.gov. If it is determined that TPL coverage no longer exists, the coverage will be closed in MMIS by DMAS staff. *The worker must then close the coverage in VaCMS.*

2. *Health Insurance Premium Payment* (HIPP)*Program*

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

*If the enrollee opts to enroll in HIPP, update **VaCMS** with the TPL information when it is provided by the enrollee.* Call the HIPP Unit at 1-800-432-5924 *when an enrollee reports changes to the TPL information so that MMIS can be updated.*

C. Medicare

For persons age 65 or over, for persons under age 65 who have received SSA or Railroad Retirement benefits because of disability for 24 consecutive months, and for persons with chronic end-stage renal disease, the Department of Medical Assistance Services has a buy-in agreement with Medicare to provide to those eligible individuals who are also eligible for Medicare the medical services available under Medicare, Part B (Title XVIII of the Social Security Act) through payment of the Part B premium.

When the recipient has to pay a Medicare Part A premium, Medicaid will pay the Part A premium for

- all QMBs; the "dually-eligible" (those who are eligible in a CN or MN covered group and also are QMB), and the QMB-only (those QMBs who are not eligible for Medicaid in another covered group);
- Qualified Disabled and Working Individuals (QDWI).

1. Buy-In Procedure

The Centers for Medicare and Medicaid Services(CMS) maintains a current list of individuals for whom the State is paying the Part B premiums. The list is updated on a monthly basis by adding newly enrolled individuals and deleting those no longer eligible. Before CMS will admit an individual to the buy-in list for Part B coverage, the individual must have established his eligibility for Medicare. His name and claim number, if one has been assigned, must be identical to the information in the SSA files. A difference between the name and number on the MMIS and in the SSA files results in a mismatch and rejection of Part B premium coverage.

2. Medicare Claim Numbers

Only two types of claim numbers correctly identify an individual's entitlement to Medicare coverage: a Social Security claim number or a Railroad Retirement claim number.

a. SSA claim numbers consist of a nine-digit number followed by a letter, or a letter and numerical symbol. The most common symbols are T, M, A, B, J1, K1, D, W, and E.

b. RR annuity-claim numbers have a letter (alpha) prefix followed by a six or nine digit number. The most common prefixes are A, M, H, WCD, NCA, CA, WD, WCH, and PD.

c. Certain letters following nine digit numbers identify an individual as an SSI recipient and are not acceptable as a Medicare claim number. These claim symbols are AI, AS, BC, BI, BS, DC, DI, and DS.

3. Procedures for Obtaining Claim Numbers

a. Requesting Medicare Card

Each Medicaid applicant who appears to qualify for Medicare must be asked if he has applied for Medicare. Those that have applied and are eligible have received a white card with a red and a blue stripe at the top, with his name as it appears in the SSA files and the assigned claim number on the card. The name as it appears and the claim number must be included in the TPL section of the MMIS eligibility file maintained by the Department of Medical Assistance Services.

b. Applicants Who Cannot Produce a Claim Number

In the event the applicant either does not have a Medicare card or does not know his claim number, inquire SSA via the SVES (State Verification Exchange System) using the applicant's own SSN.

If the applicant has never applied for Medicare, complete the Referral to Social Security Administration Form DSS/SSA-1 (form #032-03-099) and write in, "Buy-In" on the upper margin. Mail the form to the Social Security Office serving the locality in which the applicant resides. The SSA office will provide the correct claim number if the individual is on their records. Should the (local/area) SSA office have no record of an application for Medicare, a representative will contact the applicant to secure an application.

Should the applicant be uncooperative (not wish to apply) or be deceased, the Social Security Office will contact the local social services department and ask that agency to file the Medicare application in his behalf. A local department of social services must also submit an application for Medicare on behalf of an individual who is unable or unwilling to apply. When the local department must file a Medicare application, the local Social Security office will advise the local department of the procedure to follow.

4. Buy-in Begin Date

Some individuals have a delay in Buy-in coverage:

Classifications	Buy-in Begin Date
SSI and AG recipients (includes dually-eligible)	1st month of eligibility
CN and MN who are dually-eligible (countable income < 100% FPL and Medicare Part A)	1st month of eligibility
CN and MN who are not dually-eligible (countable income > 100% FPL or no Medicare Part A)	3rd month of eligibility

If the medically needy coverage begin date is other than the first day of a month, Buy-in is effective the first day of the month in which the 60th day after the begin date occurs.

D. Other Third Party Liability

When the agency identifies another third party which has responsibility to pay for a recipient's medical bill, the agency must report the third party to:

Department of Medical Assistance Services
Third Party Liability Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Examples of other third parties include liability insurance settlements, trust funds established for the recipient's medical care, awards resulting from liability lawsuits, and persons ordered by the court to pay for the recipient's medical care.

E. Pursuing Third Party Liability and Medical Support

In order to continue to be eligible for Medicaid, an individual who is required to assign rights to, and cooperate in, pursuing medical support and third party liability must continue to cooperate with the local agency and DMAS. See subchapter M0250 for details.

M1510.302 SOCIAL SECURITY NUMBERS

A. Policy

Applicants must provide the Social Security number (SSN) of any person for whom they request Medicaid, or must apply for a Social Security number if he/she does not have one.

Exceptions *– the SSN requirement does not apply to:*

- *an alien who is eligible only for Medicaid payment of emergency services, as defined in subchapter M0220, or*
- *a non-citizen who is only eligible to receive an SSN for a valid non-work reason, or*
- *a child under age one born to a Medicaid-eligible or FAMIS-covered mother (see M0330.301 B. 2 and M2220.100).*

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

When an individual has applied for an SSN and is determined eligible for medical assistance, the worker must take follow-up action to obtain the individual's SSN.

B. Procedures

See subchapter M0240 for the SSN application follow-up procedures required after enrolling an eligible individual who has applied for an SSN.

M1510.303 PATIENT PAY INFORMATION

A. Policy

After an individual in long-term care is found eligible for Medicaid, the recipient's patient pay must be determined. When the patient pay amount is initially established or when it is changed, the worker enters the information in *VaCMS*. *VaCMS* sends the "Notice of Obligation for Long-Term Care Costs" to the enrollee or the enrollee's authorized representative.

B. Procedure

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

M1520 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-3	1/1/17	Pages 1, 2, 4, 6, 8, 14, 26
TN #DMAS-2	10/1/16	Pages 1, 3, 6, 8, 12, 14, 15 Pages 19-24
TN #DMAS-1	6/1/16	Pages 3, 6, 7, 9, 11-14, 17 Appendix 2, page 1 Pages 3a and 7a were added. Page 8 is a runover page.
TN #100	5/1/15	Table of Contents Pages 1-27 (entire subchapter –pages 28-34 were deleted) Appendices 1 and 2 were added.
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

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, *online renewal or telephonic renewal.*

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 Notice

When a change is reported that impacts eligibility or a renewal is completed and the enrollee is no longer eligible, the Advance 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). Send the notice to the authorized representative if one has been designated.

Adequate notice using the Notice of Action must be provided when an enrollee dies, enters an ineligible institution, is incarcerated and no longer meets a covered group, moves out of Virginia, requests termination of his coverage, or is unable to be located by the local agency.

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, a Notice of Action must be sent to enrollee or authorized representative, if one has been designated, informing him 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:

- **Partial reviews –** M1520.100;
- **Renewals –** M1520.200;
- **Canceling coverage or Reducing the level of benefits** – M1520.300;
- **Extended Medicaid coverage** – M1520.400;
- **Transferring cases within Virginia** – 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.

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 long-term-care (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 *VaCMS* 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. Supplemental Security Income [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 *or from Medicaid to FAMIS*. 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 Social Security number (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@dmas.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.

2. Enrollment

a. Case Number

The child's member ID number does not change, but the child's Member ID number must be moved to a 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. Demographics Comment Screen

In VaCMS, enter a comment that will inform staff that 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 case for the child, enter the child's existing renewal date from his former case. If moving the child to the adult relative's already established 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 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 case number does not generate a new card. The worker must request a replacement card 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 is 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.

E. Recipient Enters LTC

An evaluation of continued eligibility must be completed using the rules in chapter M14 when a Medicaid enrollee begins receiving Medicaid-covered LTC services or has been screened and approved for LTC services. Rules for determining Medicaid eligibility for married institutionalized recipients who have a community spouse are found in subchapter M1480.

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.

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 ex parte (see M1520.200 B.1). Verification of income obtained through available verification sources, *including the Virginia Employment Commission (VEC),* may be used if it is dated within the previous 12 months.

When it is necessary to obtain information and/or verifications from the enrollee, a contact-based renewal must be completed. If an enrollee's attested resources are over the resource limit, the applicant or authorized representative must be given the opportunity to provide verification of the resources. T**he renewal must be signed by the enrollee or authorized representative.**

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 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. *It is crucial that individuals reviewing a case, including auditors, be able to follow the eligibility determination process in VaCMS. Changes and any questionable information must be appropriately documented as comments in the VaCMS case record.*

For renewals of cases outside of VACMS, the Evaluation of Eligibility (#032-03-0823), available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi, is recommended to document the case record.

4. 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.

B. Renewal Procedures

Renewals may be completed in the following ways:

- ex parte,
- using a paper form,
- online,
- by telephone through the Cover Virginia Call Center.

1. Ex Parte Renewals

An ex parte renewal is an internal review of eligibility based on information available to the agency. 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.

a. MAGI-based Cases

For cases subject to Modified Adjusted Gross Income (MAGI) methodology, an ex parte renewal should be completed when income verification is available through the federal hub. An individual may authorize the use of Internal Revenue Services (IRS) data for up to five years on the application form and at each renewal. In order for the federal Hub to be used for income, there must be a valid authorization in the electronic or paper case record.

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. Verification of income from available sources, *including the VEC*, may be used if it is dated within the previous 12 months.

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.

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. It is not necessary to retain a copy of income verifications in the case record. If the renewal is not processed and documented electronically, the documentation must be in the case record.

b. $0 Income Reported

When the household members all reported $0 income at application, search the VEC online quarterly wage data and unemployment records and other agency records to verify the absence of income. If an individual receives benefits through other benefit programs and/ or childcare, income information in those records must also be reviewed.

If the VEC inquiry and review of other agency records confirms that the household has not received wages, unemployment compensation, or other unearned income within the most recent reporting period, document the absence of verifiable income and determine or redetermine income eligibility. No statement regarding income is necessary from the individual.

If the inquiry indicates recent or current income that is countable for the MAGI determination, follow the steps in M1520.200 B.2 below for completing a paper-based renewal.

2. Paper Renewals

When an ex parte renewal cannot be completed, send the enrollee a pre-filled paper Administrative Renewal form to sign and return. Send the form to the authorized representative if one has been designated.

If the enrollee submits a completed application form, accept it as a renewal form and obtain any additional information needed to complete the renewal.

The enrollee must be allowed 30 days to return the 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 *system* 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.

New or revised information provided by the enrollee must be entered into the system. Local agencies are to accept the Application for Health Coverage & Help Paying Costs if it is submitted in lieu of a renewal form.

When an individual does not return the renewal form and action is taken to cancel coverage, a three-month reconsideration period applies (see M1520.200 C.4).

Note: Follow Auxiliary Grants *(AG)* policy regarding the appropriate renewal form to use for AG/Medicaid enrollees.

3. Online and Telephonic Renewals

Enrollees may opt to complete a renewal online using CommonHelp or by telephone through the Cover Virginia Call Center.

Renewals completed through CommonHelp are electronically signed by the enrollee or authorized representative. For cases in VaCMS, renewals completed through CommonHelp will automatically be entered into VaCMS for the worker to complete processing. For non-VaCMS cases, the renewal must be completed manually. It is not necessary to print a renewal completed through CommonHelp for the case record because it will be maintained electronically; however, the evaluation of eligibility and verifications must documented in the *VaCMS* case record.

Telephonic renewals may be taken only by the Cover Virginia Call Center. Telephonic renewals cannot be taken directly by the local agency because a telephonic signature is required.

C. Disposition of Renewal

The enrollee must be informed in writing of the findings of the renewal and the action taken using the Notice of Action when continued eligibility exists. Advance written notice must be used when there is a reduction of benefits or termination of eligibility (see M1520.300).

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.

The worker must document the *VaCMS* case record. 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 the enrollee's coverage, using the date of death as the effective date of cancellation.

4. Enrollee Enters Ineligible Institution

When an enrollee who is not incarcerated enters an institution and is no longer eligible (e.g. an individual between the ages of 22 and 65 enters an institution for the treatment of mental diseases), cancel coverage as soon as possible after learning of the enrollee's admission to an ineligible institution. **DO NOT cancel coverage retroactively.** Cancel coverage effective the current date (date the worker enters the cancel transaction in *the system*).

If an enrollee becomes incarcerated, a partial review must be completed to determine if he continues to meet the requirements for coverage in a full-benefit CN covered group. If he continues to be eligible, cancel the existing coverage the date of the report and reinstate in AC 109 for ongoing coverage the following day. If the individual no longer meets the requirements for a full benefit CN covered group, cancel the coverage, effective the date the determination is made.

5. 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.

6. Reason "012" Cancellations

Cancellations by DMAS staff due to returned mail are reported in the monthly System Cancellation Report (RS-O-112) available in the Data Warehouse Medicaid Management Reports. 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 adequate notice of cancellation using the Notice of Action. 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.

sending LDSS must complete the renewal process if the case is currently due for a renewal or overdue for a renewal. The sending LDSS must process the renewal if a renewal or application is submitted during the reconsideration period.

The sending locality must update the enrollee's VaCMS records as follows to assure managed care continuity:

1) 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) 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 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.

M1550 Transmittal Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-3	7/1/15	Pages 4-6, 8, 9
TN #100	5/1/15	Appendix 1,page 1
UP #9	4/1/13	Appendix 1, page 1
Update (UP) #7	7/1/12	Appendix 1, page 1
TN #96	10/1/11	Appendix 1, page 1
TN #93	1/1/10	Title page Table of Contents Pages 1-9 Appendix 1, page 1
TN #91	5/15/09	Appendix 1

If the recipient is not in the DBHDS facility for 30 days, the local EW must complete the DMAS-225 for the patient's stay in the facility, and must send it to the facility's Reimbursement office.

After the ABD recipient has been in the facility for 30 days, transfer the Case to the appropriate Medicaid Technician in the appropriate DBHDS facility. **Do not close the case.**

1. F&C Recipient

IF the patient being admitted is an individual eligible in a Families and Children (F&C) category, the case will NOT be transferred to the DBHDS facility, but will be retained by the LDSS. The individual will be considered temporarily absent from the home and will continue to be eligible in the F&C category as long as all non-financial and financial requirements are met.

B. DBHDS Reimbursement Office

Send a DMAS-225 to the Medicaid Technician to advise of name of the patient, date of admission, facility, etc. The technician will take the following steps.

1. Inquire *the Eligibility and Enrollment Systems*

The Technician will inquire through *the Virginia Case Management System (VaCMS)* and Medicaid Management and Information System (MMIS) to see if the patient has a pending Medicaid application or is enrolled in Medicaid. If a pending case is found in *VaCMS* and the Medicaid Technician has not received the case, the Medicaid Technician will contact the eligibility worker (EW) in the LDSS which holds the patient's case and advise the EW that the recipient has been admitted to the facility. Pending applications must have eligibility determined with 45-90 days as per policy. The Medicaid Technician will request that the case be transferred immediately.

2. Active Case Found

If the inquiry indicates an active Medicaid case and the Medicaid Technician has not received the case, the Medicaid Technician will contact Medical Records at the end of 30 days to determine if the patient is still in the facility.

- If the patient is still in the facility, the Medicaid Technician will request that the case be transferred.
- If the patient has left the facility before the end of the 30 day period, the Medicaid Technician will advise the EW in the local agency that the individual has left the facility. Reimbursement will send the DMAS-225 to the local EW for completion.

3. No Active Case Found

If the patient has neither a pending application nor an active Medicaid case and Medicaid eligibility needs to be pursued, Reimbursement must submit a completed Application For Benefits on behalf of the patient, providing as much information as possible. Attach any verifications available and send to the Medicaid Technician.

C. Medicaid Technician

When a DMAS-225 is received from Reimbursement, search *VaCMS* and MMIS. NOTE: If the patient is between the ages of 21 and 65 and in an IMD, he or she cannot be Medicaid eligible while in the IMD. For other patients admitted, including those admitted as respite or emergency admissions, use the following procedures:

1. Pending Case in *VaCMS*

If a pending case is found in *VaCMS*, contact the local agency shown holding the case. Advise them that the recipient is now a patient in the facility and request that the pending case be transferred immediately, since an eligibility determination must be made within 45/90 days. When a determination is completed, notify the agency according to policy. Send the Notice of Action on Medicaid to the Reimbursement office and a copy of the notice to the patient's authorized representative.

2. Active Case

If an active case is found, follow-up 30 days from the date the patient entered the facility. Contact Medical Records to determine if the patient is still in the facility.

a. If so, ask the EW in the LDSS holding the case to transfer the case.

b. If the patient has left the facility at the time of the 30 day follow-up, advise the EW of that information; return the DMAS-225 to Reimbursement indicating that patient's eligibility must be determined by the local agency because the patient was not in the facility for 30 days.

3. Transfer Case Received

When an active case is received in transfer, a full redetermination must be done in order to determine if the patient continues to be eligible for Medicaid based on his or her current status using policy for institutionalized ABD individuals. After the redetermination is completed, update *the system* and send appropriate notification according to policy. Send appropriate notice to Reimbursement office and a copy to the patient's authorized representative.

4. No Pending or Active Case

If neither a pending application nor an active Medicaid case is found, open a case using a completed Application for Benefits submitted by the Reimbursement Office on behalf of the patient.

a. If a case number is found in *VaCMS* or MMIS, use that case number to establish the hospital case.

b. If no case number is found in *VaCMS* or MMIS, *open a new case in VaCMS.*

c. Send all notification required by policy to Reimbursement with a copy to the authorized representative for the patient.

5. Patient Discharged

If the patient is discharged before spending 30 days in the facility and the application is received after discharge, immediately forward the case to the appropriate local DSS agency for processing.

M1550.402 PATIENTS DISCHARGED FROM DBHDS FACILITIES

A. Introduction

When a Medicaid recipient in a DBHDS facility will be discharged from the facility, follow the procedures in the following sections:

- for patients discharged to a community living arrangement, see this section M1550.402;
- for patients discharged to an assisted living facility (ALF), see section M1550.403;
- for patients discharged to a nursing facility, see section M1550.404.

B. DBHDS Discharge Planner/Social Worker/ Reimbursement

For Medicaid patients who do not receive SSI, contact the Social Security Administration (SSA) within 15 days of discharge to apply for SSI. If a patient's SSI has been decreased while in the institution, advise SSI of the patient's discharge so that, if appropriate, his or her SSI may be increased.

Medicaid cases of patients discharged to a living arrangement which is not an assisted living facility (ALF) or nursing facility will be transferred to the LDSS in which he or she will be living.

C. Reimbursement Office

Send the DMAS-225 to the Medicaid Technician and DMAS to advise of the date the patient will leave the facility.

D. Medicaid Technician

The Medicaid case of a Medicaid enrollee discharged to a living arrangement which is not an ALF or nursing facility will be transferred to the LDSS in the locality where he or she will be living.

Complete a partial review of all cases to be transferred to an LDSS, **but do NOT determine if the recipient will be eligible in the locality.**

Update *VaCMS*. Enter the new city/county code on the case, new address, and change worker number to M0000.

Forward the case containing all original Medicaid information, any verification provided by discharge planner and/or Reimbursement office, and the DMAS-225, via certified mail to the appropriate LDSS.

E. Eligibility Worker in LDSS

When the case is received, do a full redetermination to determine the recipient's continued eligibility for Medicaid in his or her new circumstances.

Send the Case Record Transfer Form to the Medicaid Technician to notify the Technician of disposition of the transfer.

A. Medicaid Technician

Complete a partial review of all cases to be transferred to a LDSS, **but do NOT determine if case will be eligible in the locality.** Update *VaCMS*. Enter new city/county code and new address.

Forward the case containing all original Medicaid information, any verifications provided by discharge planner/Reimbursement office, and DMAS-225, via certified mail to the appropriate LDSS.

B. Eligibility Worker in LDSS

When the case is received, do a full redetermination to determine the recipient's continued eligibility for Medicaid and, if appropriate, eligibility for Auxiliary Grants, in his or her new circumstances. Send the Case Record Transfer Form to the Medicaid Technician to notify the Technician notify the Technician that the case was received by the agency

M1550.404 PATIENTS DISCHARGED TO NURSING FACILITY/CBC

A. Introduction

When a patient in a DBHDS facility will be discharged to a nursing facility or to a community living arrangement with Medicaid CBC waiver services, follow the procedures in this section.

B. DBHDS Discharge Planner/ Social Worker/ Reimbursement

1. Patient Not On Medicaid

If the patient was not Medicaid-eligible in the DBHDS facility but Medicaid eligibility in the patient's new circumstances needs to be determined, the Discharge Planner, Social Worker, Reimbursement, patient or the patient's authorized representative may complete an Application For Benefits and send it to the appropriate LDSS.

Applications for patients being discharged to a nursing facility must be sent to the LDSS in the locality in which the patient last resided prior to entering the DBHDS facility. If admission to the DBHDS facility was from out of state but the patient intends to remain in Virginia, the application form must be sent to the Virginia locality in which the nursing facility is located.

Applications for patients being discharged to a community living arrangement with Medicaid CBC waiver services must be sent to the locality in which the patient will reside.

2. Medicaid Patient

If the patient was Medicaid eligible in the facility, provide the Medicaid Technician a copy of the Community Placement Plan, the DMAS-225 and any other information necessary to transfer the Medicaid case record.

C. Reimbursement Office

Send the DMAS-225 to the Medicaid Technician and DMAS to advise them of the date the patient will leave the facility.

D. Medicaid Technician

The Medicaid case of an eligible individual discharged to a nursing facility or CBC will be transferred to the LDSS in the locality in which he or she last resided outside of an institution.

Complete a *partial* review of the case to be transferred to the LDSS. Update *VaCMS* with the new city/county code and new address.

Forward the case containing all original Medicaid information, any verification provided by the discharge planner and/or Reimbursement office, and the DMAS-225, via certified mail to the appropriate LDSS. Note on the Case Transfer Form that this case is a nursing facility or CBC waiver case so that the receiving agency will be alerted to take immediate action.

E. Eligibility Worker in LDSS

When the case is received, do a full redetermination to determine the recipient's continued eligibility for Medicaid in his or her new circumstances.

Send the Case Record Transfer Form copy to the Medicaid Technician to notify the Technician that the case was received by the agency.

M21 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-2	1/1/17	Appendix 1, page 1
TN #DMAS-2	10/1/16	Page 3
TN #DMAS-1	6/1/16	Appendix 1, page 1
TN #100	5/1/15	Table of Contents Pages 1-7 Appendices 1 Pages 8-10 and Appendices 2 and 3 were deleted.
UP #10	5/1/14	Pages 1-3 Appendix 1
TN #99	1/1/14	Pages 1-3 Appendix 1
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

FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS)
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE 1/25/16

# of Persons in FAMIS House-hold	**FAMIS 150% FPL**		**FAMIS 200% FPL**		
	Annual Limit	Monthly Limit	Annual Limit	Monthly Limit	205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)
1	$17,820	$1,485	$23,760	$ 1,980	$2,030
2	24,030	2,003	32,040	2,670	2,737
3	30,240	2,520	40,320	3,360	*3,444*
4	36,450	3,038	48,600	4,050	4,152
5	42,660	3,555	56,880	4,740	4,869
6	48,870	4,073	65,160	5,430	5,566
7	55,095*	4,592*	73,460*	6,122*	6,276
8	61,335*	5,112*	81,780*	6,815*	6,986
Each add'l, add	6,240*	520*	8,320*	694*	712

*No change for 2016.