



COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

May 1, 2015

MEDICAID ELIGIBILITY MANUAL – VOLUME XIII

TRANSMITTAL #100

The following acronyms are used in this transmittal:

- SPARK – Services Programs Answers Resources Knowledge
- VDSS – Virginia Department of Social Services
- MA – Medical Assistance

This Transmittal includes policy clarifications, updates and revisions to the Medical Assistance Program's Medicaid Eligibility Manual. Unless otherwise noted, all provisions included in this Transmittal are effective May 1, 2015. A number of the revisions to policy made in this Transmittal have previously been announced through Broadcasts posted on SPARK.

This Transmittal includes new policy regarding local agency processing of eligibility for Medical Assistance of individuals incarcerated in local and regional jails as well as youth being held in Virginia Department of Juvenile Justice (DJJ) facilities. Incarcerated individuals (adults and juveniles) who are hospitalized, can be eligible for Medicaid payment, limited to services received during an inpatient hospitalization, provided that they meet all Medicaid eligibility requirements applicable. Intake and ongoing case maintenance for these individuals will be provided by the LDSS where the individual lived prior to incarceration. See section M0130.050 for this new policy.

Transmittal #100 is available electronically on SPARK and the VDSS public web site. The electronic version is the Transmittal of record. Significant revisions to the manual are as follows:

Section	Action
Master Table of Contents	Revised title change in M1370. Changed to "Limited Benefit Enrollees" since policy on spenddowns for people in Plan First, who also meet an MN covered group, was added.
M0110.100	Added Call Center to the list of DMAS responsibilities.
M0110.120	Addresses Confidentiality Program—added that TPL can be omitted/removed for individuals with court order. DMAS must be notified to coordinate with TPL data match service.

Section	Action
M0120.100	Clarified that if the wrong name is entered for an electronic signature, the agency must obtain a valid signature for the case record (i.e. the signature page of a paper form).
M0120.200	Reorganized the section and added policy on DOC/DJJ applications.
M0120.500	Added information on GAP.
M0130.001	Updated 'No Wrong Door' policy.
M0130.050 (new)	Added policy/procedures on incarcerated individuals regarding pre-release planning and coverage limited to inpatient hospitalization.
M0130.200	Incorporated Broadcast 8701--SVES inquiry not required when the Hub verifies SSA data. SVES or SOLQ-I may be used for other cases.
M0130.300	Clarified policy on an application from an individual who moves from another state and still has open coverage in the other state. The worker just needs to inform the person to have his coverage cancelled and can enroll the person in VA MA.
M0220	Iraqi/Afghan Special immigrants--corrected references to QQI—should be SQI; also, corrected repeated text on pages 17 and Appendix 5. Corrected spacing on page 18.
M0230	Clarified residency for non-IV-E foster care child
M0240.001	Clarified that SVES inquiry not required when the Hub verifies SSA data. SVES or SOLQ-I may be used for other cases.
M0280	This subchapter was significantly revised to incorporate the policy on incarcerated individuals and the DOC inpatient process.
M0310	Removed obsolete definitions for EWB and VIEW.
M0310.110	Clarified who a child is for MAGI purposes under the definition of a child.
M0310.112	Clarified that disabled individuals who become incarcerated and lose Social Security/SSI benefits do not need a referral for a disability determination; renumbered pages 28 and 28a.
M0310.114	Clarified the definition of F&C.
M0310 Appendix	Updated DDS Regional Contacts list.
M0320.201	Included point of contact for income limits.

Section	Action
M0320.203	Revised COLA-based figures for protected groups and MSPs.
M0320.300	Added new AC 109 for incarcerated individuals.
M0320.400	Revised MEDICAID WORKS policy.
M0330.107	Reflected name change from ICF-MR to ICF-ID.
M0330.109	Revised policy on former FC children—can have been in another state’s custody while in FC.
M0330.400	Updated policy to reflect new AC 109 for incarcerated individuals.
M0330.501. - 503	Revised the policy on resources for children’s eligibility in the 300% SSI covered groups.
M0330.600	Updated income limits.
M0330.804	Reflected name change from ICF-MR to ICF-ID.
M04	Made clarifications to policy on countable income; revised the income limits.
M0520.010	Removed policy regarding Children’s Mental Health Program services received after discharge from a PRTF.
M0530.201	Reference to MI removed; clarified policy; revised income limits.
M0610.001	Remove references to MI
M0710	Removed the obsolete LIFC policies and the income limits for Extended Medicaid (they were added to M1520); revised F&C medically needy (MN) income limits effective 7/1/14. The subchapter is now policy for F&C MN.
M0810	Revised all ABD income limits that have changed since TN #99.
M0820.555	Updated income and mileage rates.
S1110	Revised MSP resource limits.
M1130.140 B.1.a and D	Revised language to state “at or below” or “no more than” current market value (CMV); also in B. 4 changed “recipient” to “individual; in D, eliminated the “permission to sell” language.
M1130.300	Revised policy on verification for life insurance--use of chart included in the policy, if there is one, is acceptable to verify the cash value.

Section	Action
M1130.410	Updated website references.
M1340.500	Clarified that verification of a covered service as medically necessary can be by whatever authorization is required for Medicaid to cover the service (i.e. a licensed mental health professional for behavioral health services). Also, appliances that can be used for other purposes (refrigerators, whole house generators) are not allowable spenddown expenses.
M1370	Title page updated.
M1410	Changed manual citation.
M1450.520 and .530	Consolidated the policies for the purchase of an annuity into M1450.520 as the look-back period for the old policy has passed. Deleted M1450.530.
M1450.630	Clarified the policy on imposing a penalty period for CBC enrollees; Added Loudoun County to the list of northern VA localities. Revised Average Monthly Private NF rate for northern VA effective 1/1/15 (the other rate for all other localities did not change).
M1460	Revised the policy throughout to incorporate the resource policy for children in the 300% SSI covered group and the new individual Medicaid rate (RUG) for MN facility patients; revised some very outdated examples.
M1470.100	Clarified that the reference to a spouse is to the community spouse.
M1470.600	Revised the policy on medically needy facility patients to incorporate the new individual Medicaid rate (RUG).
M1470.900	<p>Clarified that when there is a delay in entering patient pay (PP) for new enrollees--if underpayment for prior months (including retroactive period) is more than \$1500, referral must be made to RAU for collection. Enter PP for current month going forward.</p> <p>If the individual was already active in Medicaid, make the adjustment to PP per M1470.900 going forward; if the underpayment exceeds \$1,500, refer to RAU.</p>
M1480	Slightly modified procedures for claiming undue hardship for resource assessments; updated information regarding institutionalized individuals who meet a spenddown; revised spousal maintenance standard and allowances.
M1510.100	Clarified policy on applications from an individual who moves from another state and still has open coverage in the other state.
M1510.101	Clarified retroactive entitlement verification procedures for individuals subject to Modified Adjusted Gross Income Methodology (MAGI)

Section	Action
M1510.102	Clarified that changes in income do not impact pregnant women regardless of her covered group.
M1520.001- M1520.200	Clarified Adequate Notice policy. Significantly revised the policy to incorporate ACA-specified renewal policies such as the three-month reconsideration period and policies on the changes related to renewals now that we are past the transitional period for renewals. Added policy on when an individual with GAP is eligible for Medicaid or individual with Plan First becomes eligible for GAP; revised the policy to allow renewals for newborns turning one.
M1520.300 - 500	Revised the policies on Extended Medicaid to incorporate changes, such as income from child support is no longer a reason for an extension; streamlined the policies on notices and case transfers; added the Extended Medicaid income limits that were removed from M0710.
M1550 Appendix	Updated contact list for DBHDS Hospital facilities.
M16	Changed FAX address for Appeals Division.
M1830.100	Revised and streamlined the chapter to incorporate current managed care and covered service information. Removed the detailed information about covered services, which is not needed.
M21	Streamlined the chapter to remove the policies on the four-month waiting period and state employee bar, and the now-obsolete FAMIS protected coverage for children who lost Medicaid due to the elimination of earned income disregards.
M22	Revised the policy to incorporate the revival of FAMIS MOMS.

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



Margeret R. Schultze
Commissioner

Attachment

TABLE OF CONTENTS Changes

Changed With	Effective Date	Pages Changed
TN #100	5/1/15	Page ii
TN #99	1/1/14	Pages i, iii
TN #98	10/1/13	Page i
TN #93	1/1/10	Page iii
Update (UP) #2	8/24/09	Page iii

M07 FAMILIES AND CHILDREN INCOME

GENERAL--F&C INCOME RULESM0710
F&C WHAT IS NOT INCOME.....M0715
F&C EARNED INCOMEM0720
F&C UNEARNED INCOMEM0730

S08 ABD INCOME

GENERAL--ABD INCOME RULESS0810
WHAT IS NOT INCOME.....S0815
EARNED INCOME.....S0820
UNEARNED INCOMES0830

S11 ABD RESOURCES

RESOURCES, GENERALS1110
IDENTIFYING RESOURCESS1120
RESOURCES EXCLUSIONSS1130
TYPES OF COUNTABLE RESOURCESS1140

M13 SPENDDOWN

SPENDDOWN GENERAL PRINCIPLES
AND DEFINITIONSM1310
SPENDDOWN INFORMATION.....M1320
SPENDDOWN BUDGET PERIODS.....M1330
SPENDDOWN DEDUCTIONS.....M1340
CHANGES PRIOR TO MEETING SPENDDOWN.....M1350
CHANGES AFTER SPENDDOWN IS METM1360
SPENDDOWN – LIMITED BENEFIT
ENROLLEESM1370

M14 LONG-TERM CARE

GENERAL RULESM1410
PRE-ADMISSION SCREENINGM1420
FACILITY CARE.....M1430
COMMUNITY-BASED CAREM1440
TRANSFER OF ASSETS.....M1450
LTC FINANCIAL ELIGIBILITYM1460
PATIENT PAY - POST-ELIGIBILITY TREATMENT
OF INCOMEM1470
MARRIED INSTITUTIONALIZED INDIVIDUALS
ELIGIBILITY & PATIENT PAY.....M1480

M0110 Changes

Changed With	Effective Date	Pages Changed
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 General Information

M0110.100 Legal Base and Agency Responsibilities

A. Introduction

Virginia's two medical assistance programs are Medicaid and the Family Access to Medical Insurance Security Plan (FAMIS). Collectively, these programs are referred to as medical assistance (MA). The MA programs pay medical service providers for medical services rendered to eligible individuals. When an individual submits an application for MA, his eligibility is determined for Medicaid first. If he is not eligible for Medicaid due to excess income, his eligibility is determined for FAMIS.

The policies and procedures for determining Medicaid eligibility are contained in Chapters 1 through 18 of this manual; the policies and procedures for determining FAMIS eligibility for children and pregnant women (FAMIS MOMS) are contained in Chapters 21 and 22, respectively.

The MA eligibility determination consists of an evaluation of an individual's situation that compares each of the individual's circumstances to an established standard. Requests for Virginia MA must be made on an approved electronic or paper application form or telephonically through the Cover Virginia Call Center.

All activity of the agency in receiving and acting upon an application must be consistent with the objectives of the MA programs and be conducted in a manner which respects the personal dignity and privacy of the individual.

B. Legal Base

The Medicaid Program is established under Title XIX of the Federal Social Security Act and is financed by state and federal funds. The State Plan for Medical Assistance (State Plan) is the official body of regulations covering the operation of the Medicaid program in Virginia. The FAMIS program is established under Title XXI of the Social Security Act.

Virginia law provides that the MA programs be administered by the Department of Medical Assistance Services (DMAS). Determination of eligibility for medical assistance is the responsibility of local departments of social services under the supervision of the Virginia Department of Social Services (DSS).

Exception: DSS carries direct responsibility for the determination of eligibility of certain patients in Virginia Department of Behavioral Health and Developmental Services (DBHDS) facilities and for their enrollment in the Medicaid program.

C. Agency Responsibilities

1. DMAS

The administrative responsibilities of DMAS are:

- the development of the State Plan to cover eligibility criteria and scope of services, in conformity with federal law and regulation,
- the determination of medical care covered under the State Plan,

- *oversight of the Cover Virginia Call Center and Central Processing Unit (CPU), which handles telephonic applications for MA, adding people to existing MA cases, processing referrals from the Health Insurance Marketplace (HIM) and eligibility determinations/ongoing case maintenance for the Governor's Access Plan (GAP).*
- the handling of appeals related to the MA programs,
- the approval of providers authorized to provide medical care and receive payments under the MA programs,
- the processing of claims and making payments to medical providers, and
- the recovery of MA expenditures in appropriate cases. Suspected applicant fraud is a combined responsibility of both DMAS and DSS.

2. DSS

The responsibilities of DSS are:

- the determination of initial and continuing eligibility for Medicaid and FAMIS,
- the enrollment of eligible persons in the Medicaid or FAMIS programs,
- the maintenance of case records pertaining to the eligibility of MA enrollees,
- the referral of individuals with inappropriate MA payments to the DMAS Recipient Audit Unit, and
- the referral of certain individuals to the Health Insurance Marketplace.

M0110.110 Confidentiality

A. Confidentiality

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

B. Release of Client Information

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

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

When the agency does not concur, the client shall be allowed to enter a statement in the record refuting such information. Corrections and statements shall be made a permanent part of the record and shall be disclosed to any entity that receives the disputed information.

M0110.120 Address Confidentiality Program (ACP)

- A. Purpose** The Virginia Attorney General's Office's ACP was created to help a victim of domestic violence who has recently moved to a new location that is unknown to the abuser. The victim wants to keep the new address confidential. Effective July 1, 2011, this program was made available statewide.
- B. All Mail Goes to Richmond P.O. Box Address** The ACP offers a substitute mailing address for the individual in a high risk situation. An individual participating in the ACP will have an ACP authorization card that can be used to verify participation in the program; a participant will use a post office box address in Richmond as his address. This address is to be accepted as a mailing address. No locality, FIPS code, or other geographic identification is included on the ACP authorization card.
- The actual physical address of the participant **MUST NOT** be entered into any of the VDSS automated systems. Only the mailing address (which is P.O. Box 1133, Richmond, Virginia, 23218) is entered into the computer systems as the participant's residence address; no separate mailing address is entered.
- C. Accept Participant's Verbal Statement of Residency** Virginia state residency and locality residency is established by the participant's verbal statement that he is residing in the locality where he is applying for assistance.
- D. Third Party Liability (TPL)** *When an individual in the ACP is covered on the abuser's private health insurance plan (TPL), do not add the TPL coverage in the enrollment system. For an individual with TPL who is already receiving MA at the time of entry into the ACP, delete the TPL. Notify the DMAS TPL Unit by e-mail at tplunit@dmas.virginia.gov to ensure that the insurance is not billed or added back to the individual's case record upon a subsequent data match with the insurance company.*
- E. Refer to Local Domestic Violence Program** Please refer any victims of domestic violence to the local Domestic Violence Program for consideration of the ACP, for safety planning, and other services. Local domestic violence advocates are currently receiving training about the ACP. In most localities, the applications for the ACP program will be completed with the DV advocates as a part of in depth safety planning.

M0110.200 Definitions

- A. Adult Relative** means an individual who is age 18 or older, who is not a parent, but who is related to a child by blood or marriage and who lives with and assumes responsibility for day-to-day care of the child in a place of residence maintained as his or their own home.
- B. Applicant** means an individual who has directly or through his authorized representative made written application for MA at the local social services department serving the locality in which he is a resident, or if institutionalized, the locality in which he last resided outside an institution.

Virginia DSS, Volume XIII

M0120 Changes

Changed With	Effective Date	Pages Changed
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

TABLE OF CONTENTS

M01 APPLICATION FOR MEDICAL ASSISTANCE

M0120.000 MEDICAL ASSISTANCE APPLICATION

	Section	Page
Applying for Medical Assistance	M0120.100.....	1
When an Application Is Required	<i>M0120.150</i>	<i>1</i>
Who Can Sign the Application.....	M0120.200.....	2
Application Forms.....	M0120.300.....	9
Place of Application	M0120.400.....	12
Receipt of Application.....	M0120.500.....	16

Appendices

Sample Letter Requesting Signature.....	Appendix 1.....	1
The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application, form #032-03-384.....	Appendix 2.....	1
Interstate Compact on Adoption and Medical Assistance (ICAMA) Member States and Reciprocity.....	Appendix 3.....	1

M0120.000 Medical Assistance Application

M0120.100 Applying for Medical Assistance

- A. Right to Apply** An individual cannot be refused the right to complete an application for medical assistance (MA) for himself (the applicant) or any other individual for whom he is authorized to apply. Under no circumstances can an individual be discouraged from asking for assistance for himself or any person for whom he is a legally responsible or authorized to represent. An applicant may be assisted with the application by an individual of his choice. A face-to-face interview is not required.
- B. Signed Application Required** An application for MA must be signed to be valid. Paper forms must bear the signature of the applicant or an individual authorized to apply on his behalf. Applications submitted electronically or through the approved telephonic process meet the signature requirement.
- 1. Unsigned Application** A paper application that bears no signature is invalid. Return the application to the applicant with a letter requesting a signature.
- 2. Invalid Signature** An application that is signed by an individual who is not authorized to sign on behalf of the applicant is invalid. *For paper applications*, return the application with a letter indicating who must sign the application to the individual who filed the application on behalf of the applicant. See M0120, Appendix 1 for a sample letter.

If an electronic application does not bear a valid signature, the agency must obtain a valid signature from the applicant or his authorized representative for the case record. The signature page of a paper application form can be used.

M0120.150 When An Application Is Required

- A. New Application Required** A new application is required when there is:
- an initial request for medical assistance, or
 - a request to add a person to an existing case.

When an application is received because there is a new person in the family for whom medical assistance is requested, the annual renewal for the existing enrollees is done using the same application form. See subchapter M1520 for renewal policy and procedures.

- B. Application NOT Required** A new application is not required when an individual is already an active Medicaid enrollee or is enrolled in another medical assistance program. *An application is not needed for a child turning age one when the child was deemed to be eligible based on the mother's enrollment at the time of birth. A renewal following the procedures in M1520 must be completed when the child turns one.*

Changes in the enrollee's circumstances do not require a new application. Changes that do not require a new application include, but are not limited to, the following:

- a change in the case name,
- a change in living arrangements, and
- a change in income.

A change in living arrangements may require a partial review of the individual's eligibility when the change results in a change to the assistance unit. Whenever the change requires verifications that can be used to complete a renewal, the annual renewal should be completed at the time the change is reported.

M0120.200 Who Can Sign the Application

A. Individuals in State Facilities

Staff with certain Virginia state agencies may assist individuals who are in state residential facilities in applying medical assistance.

1. Patients in DBHDS Facilities

Patients of any age in the Department of Behavioral Health and Developmental Services (DBHDS) facilities may have applications *signed and submitted* by DBHDS staff. The DBHDS facilities are listed in subchapter M1550.

2. Incarcerated Individuals

Inmates of any age who are being held in Department of Corrections (DOC) or Department of Juvenile Justice (DJJ) facilities may have applications submitted by DOC or DJJ staff.

B. Applicants Age 18 or Older

The applicant must sign the application, even if the form is filled out by another person, unless the application is filed and signed by the applicant's legal guardian, conservator (known as the "committee" for persons declared incompetent prior to the 1997 changes in the guardianship section of the Code of Virginia), attorney in fact, or authorized representative. A spouse, aged 18 or older, may sign the application for his spouse when they are living together.

EXCEPTION: A parent can submit and sign an application for a child under age 21, when the child is living with the parent. The child does not need to authorize the parent to apply or conduct Medicaid business on his behalf.

If the applicant cannot sign his or her name on a paper application but can make a mark, the mark must be correctly designated (the individual's first and last name and the words "his mark" or "her mark" must be printed adjacent to the mark) and witnessed by one person as in the example below:

E.g.: (X) John Doe, his mark

Witness's signature: _____

1. Authorized Representative

An authorized representative is a person age 18 years or older who is authorized to conduct business for an individual. A competent individual age 18 years or older must designate the authorized representative in a written statement (which defines the representative's responsibilities). The authorized representative statement is valid until:

- the application is denied;
- medical assistance coverage is canceled; or
- the individual changes his authorized representative.

The authorized representative of an incompetent or incapacitated individual is the individual's spouse, parent, attorney-in-fact (person who has the individual's power-of-attorney), legally appointed guardian, legally appointed conservator (committee), or family substitute representative.

EXCEPTION: Patients in the DBHDS facilities may have applications submitted by DBHDS staff.

**2. Family
Substitute
Representative**

When it is reported that an applicant cannot sign the application and the applicant does not have a guardian, conservator, attorney in fact or designated authorized representative, one of the individuals listed below who is age 18 years or older and is willing to take responsibility for the applicant's MA business will be the applicant's "family substitute" representative. The family substitute representative will be, in this preferred order, the applicant's:

- spouse,
- child,
- parent,
- sibling,
- grandchild,
- niece or nephew, or
- aunt or uncle.

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 in the MMIS 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 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.

M0120.500 Receipt of Application

A. General Principle

An applicant or authorized representative may submit an application for medical assistance only or may apply for MA in addition to other programs.

An applicant may be assisted with completing the various aspects of the application by an individual(s) of his choice and may designate in writing that such individual(s) may represent him in subsequent contacts with the agency.

B. Application Date

The application date is the earliest date the signed application for medical assistance is received by the local agency, an outstationed site, or an entity contracted with DMAS to accept applications. The application must be on a form prescribed by DMAS and signed by the applicant or person acting on his behalf.

The application may be received by mail, fax, hand delivery, electronically or telephonically. The date of receipt by the agency must be recorded. If an application is received after the agency's business hours, the date of the application is the next business day. The date of application for foster care children in the custody of a local department of social services is the date the application is received by the eligibility worker.

Send a Notice of Action indicating that the individual's MA application was denied and that his HPE coverage was cancelled with the effective date. Because the individual receives notice of the HPE coverage period from the hospital at the time of the HPE enrollment, advance notice of the HPE cancellation is not required. There are no appeal rights for HPE.

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

2) MA Application Not Submitted

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

E. Governor's Access Plan (GAP)

GAP covers uninsured, low-income adults ages 21-64 years with serious mental illness (SMI) who are not eligible for any existing full-benefit MA entitlement program. Eligibility determinations and ongoing case maintenance for eligible individuals are handled by dedicated staff in the Cover Virginia GAP unit. GAP is not a medical assistance program for which LDSS staff have responsibility. However, LDSS staff is involved in the transfer process when individuals transition between GAP and Medicaid or FAMIS MOMS.

Eligibility for GAP is a two-step process. The individual must: 1) receive a GAP SMI screening and 2) meet non-financial and income eligibility requirements. SMI evaluations will be completed by community services boards, Federally Qualified Healthcare Centers, inpatient psychiatric hospitals, or general hospitals with inpatient psychiatric units. GAP uses Medicaid non-financial requirements and Modified Adjusted Gross Income for household composition and income eligibility.

The GAP income limit is 95% of the Federal Poverty Level (FPL) plus the 5% FPL disregard as appropriate. GAP eligibility can begin no earlier than January 12, 2015. For applications received on or after February 2015, eligibility will begin the first day of the month of application, provided all eligibility requirements are met that month. There is no retroactive coverage in GAP. The Aid Category for GAP coverage is 087.

*Additional information about GAP is available at:
<http://www.coverva.org/gap.cfm>.*

M0130 Changes

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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

M0130.001 Medical Assistance Application Processing Principles

A. Introduction

Under the Affordable Care Act (ACA), the Medicaid and FAMIS medical assistance (MA) programs are part of a continuum of health insurance options available to Virginia residents. MA application processing is based on several principles that are prescribed by the ACA.

B. Principles

1. Single Application

Applications for affordable health insurance, including qualified health plans with Advance Premium Tax Credit (APTC) assistance and MA, are made on a single, streamlined application. The application gathers information needed to determine eligibility for both APTC and MA.

2. No Wrong Door

Individuals may apply for MA through their local department of social services (LDSS), through the Health Insurance Marketplace (HIM), *through CommonHelp*, or through the Cover Virginia Call Center. *HIM applications and telephonic applications received by the Cover Virginia Central Processing Unit (CPU) are sent to the LDSS for either case management or LDSS processing.*

3. Use of Electronic Data Source Verification

The eligibility determination process for MA is based on electronic data source verification (EDSV) to the fullest extent possible. LDSS are to rely on EDSV as the first course of action and are to request information from the applicant only when it is not available through an approved data source or the information is inconsistent with agency records.

The Federally-managed Data Services Hub (the Hub) provides verification of a number of elements related to eligibility for MA applications processed in the Virginia Case Management System (VaCMS).

Searches of online information systems, including but not limited to the Hub, State Online Query-Internet (SOLQ-I) and the State Verification Exchange System (SVES) are permitted **only** for applicants and family members whose income and/or resource information is required to determine eligibility for the applicant or patient pay for an enrollee. This includes spouses of applicants and parents of child applicants.

4. Processing Time

Agencies are required by the State Plan to adhere to prescribed standards for the processing of MA applications, including applications processed using the self-directed functionality in VaCMS. The amount of time allowed to process an application is based on the availability of required information and verifications, as well as the covered group under which the application must be evaluated.

When all necessary information is available through EDSV, it is expected that the application be processed without delay.

When it is necessary to request information from the applicant and/or a disability determination is required, the processing standards in M0130.100 are applicable.

M0130.050 Incarcerated Individuals

A. Introduction

Virginia has two MA initiatives for incarcerated individuals: 1) pre-release planning (application processing) for individuals transitioning from or leaving a correctional facility and 2) coverage limited to medical services received during an inpatient hospitalization. For the purpose of these initiatives, incarcerated individuals include those individuals being held in Virginia Department of Corrections (DOC) facilities, regional and local jails, and youth being held in Virginia Department of Juvenile Justice (DJJ) facilities. Incarcerated individuals must meet all MA eligibility requirements and can only be eligible for MA payment for medical services when they are not physically residing in the correctional facility.

Staff employed by DOC or DJJ are responsible for coordinating the application process and communicating information for individuals held in their facilities and the LDSS. DOC/DJJ staff assigned to assist in the application process will be identified on the application or in a separate document on agency letterhead. Communication between the staff assisting the individual and the LDSS handling the application is permitted. Direct communication between the incarcerated individuals and the LDSS may be prohibited, depending on the facility placement.

Once an individual is released from a DOC facility, the individual will be responsible for all matters pertaining to his MA eligibility and involvement of the correctional facility staff will end. DJJ staff may continue to assist juveniles returning to the community as long as the juvenile continues to receive DJJ services.

Individuals in regional or local jails may file their own applications or may name an authorized representative, including facility staff, to assist with the application process and ongoing eligibility. The authorized representative statement must indicate if the authority to act on the applicant's behalf will continue after the applicant is no longer incarcerated.

Applications are to be processed in the same manner and within the same processing time standard as any other MA applications.

Individuals who are actively enrolled in MA programs at the time of incarceration are not required to file a new application, but are subject to partial reviews based on the change in their living situation (see M1520.100) and annual renewals (see M1520.200). Ongoing case maintenance for individuals enrolled for inpatient services will be provided by the LDSS where the individual lived prior to incarceration.

B. Pre-release Planning

Pre-release planning permits individuals who are completing their term of confinement to apply for MA and have their eligibility determined prior to release. Eligibility is to be determined based on the living arrangement anticipated upon release. Applications are not to be refused or denied because an applicant is an inmate of a public institution. Individuals who are determined to meet all Medicaid eligibility requirements are to be

enrolled in the appropriate MA coverage after release and beginning with the date of release. The DOC/DJJ staff or the individual can contact the LDSS to report the actual date of release. Enroll the individual in the appropriate MA coverage and provide the individual's enrollee identification number so services can be accessed without delay. Send notice of the eligibility determination to the individual at the address where he will be living. A copy of the notice must also be sent to DOC/DJJ staff if the individual was in one of their facilities.

Pre-release planning for individuals being held by the DOC is coordinated by assigned staff and the Offender Release Services-Community Release Unit, 6900 Atmore Drive, Richmond, Virginia 23225.

Pre-release planning for juveniles being held by the DJJ is coordinated by assigned staff and the DJJ Re-entry Services Unit, 600 E. Main Street, Richmond, Virginia 23219.

Pre-release planning for individuals in regional and local jails is handled by the individual and/or his authorized representative.

1. Release to a Community Living Arrangement

Individuals returning to a community living arrangement (outside of an institution) will have their eligibility determined based on their anticipated living situation upon release. If it is anticipated that the individual will enter a community living arrangement in a different locality from the one he lived in prior to incarceration, the application will be processed by the locality of prior residence and if eligible, transferred to the new locality of residence. Application processing is not to be delayed based on the individual's change in locality. Denied applications are not transferred.

2. Release to an Institutional Placement or Long-term Care (LTC) Services

Applications for incarcerated individuals in need of placement in an institution or community-based care (CBC) services are processed by the locality where the individual lived prior to incarceration. If the individual lived outside of Virginia prior to incarceration and he plans to remain in Virginia, the application is processed in the locality where the correctional facility is located.

Correctional facility staff will notify the agency where the individual is housed if a pre-admission screening is needed for nursing facility or CBC services. The pre-admission screening is to be done by the LDSS in the locality where the correctional facility is located even if the application is being processed by another locality. Correctional facility staff will coordinate with the screening team, service provider and eligibility worker to ensure the eligible individual can receive necessary medical support/services when released.

C. Inpatient Hospitalization (Medicaid Only)

*Incarcerated individuals (adults and juveniles) who meet **all** Medicaid eligibility requirements, including a categorically needy (CN) covered group (see M0310.108), are eligible for Medicaid coverage limited to inpatient hospitalization services. These individuals are not considered to be inmates of ineligible institutions while they are hospitalized.*

Information about the individual's incarceration and initial dates of inpatient hospitalization must be provided, along with the verifications needed for the Medicaid application. Medicaid coverage for inpatient hospitalization for incarcerated individuals is based on the month of application and can include up to three months prior to the month of application, provided all eligibility requirements were met. Enroll eligible individuals in aid category (AC) 109 regardless of the covered group. AC 109 identifies the individual as eligible for coverage limited to inpatient hospitalization and ensures claims will be paid correctly.

Eligibility in AC 109 may continue as long as the individual continues to meet all Medicaid eligibility requirements and remains incarcerated. Set the first annual renewal date for 11 months from the date of application for incarcerated individuals other than pregnant women. If the individual is a pregnant woman, set the renewal date based on the expected delivery date and the post-partum period to determine if she will meet a full benefit CN covered group after the pregnancy ends. Incarcerated individuals are not referred to the Health Insurance Marketplace.

Non-citizen incarcerated individuals who meet all Medicaid eligibility requirements other than alien status may be eligible for Medicaid payment limited to emergency services received during an inpatient hospitalization. Determine eligibility for emergency services using the policy in M0220.500 B and enroll eligible individuals using the procedures in M0220.600.

All communication regarding individuals incarcerated in DOC facilities who have inpatient hospitalizations must be sent to the DOC Health Services Reimbursement Unit, 6900 Atmore Drive, Richmond, Virginia 23225.

Applications for juveniles in DJJ facilities will be coordinated through the DJJ Re-entry Services Unit, 600 E. Main Street, Richmond VA 23219.

Applications for individuals in regional or local jails may be submitted by the individual or his authorized representative.

M0130.100 Processing Time Standards

A. Processing Time Standards

1. 10 Day Requirement (Expedited Application)

a. Pregnant Women

Applications for pregnant women must be processed within 10 working days of the agency's receipt of the signed application.

If the pregnant woman also applies for other children or other persons in her family and the agency cannot determine the other persons' eligibility within

10 working days, the agency must determine just the MA eligibility of the pregnant woman within the working 10 days.

The agency must have all necessary verifications within the 10 working days in order to determine eligibility. If the agency does not receive the verifications within the 10 working days, the worker must send the applicant written notice on the 10th day. The notice must state why action on the application was not taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 days by which to submit the documentation.

Once all necessary verifications for the pregnant woman are received, an eligibility decision must be made immediately and the applicant must be immediately notified of the decision. If the pregnant woman applied for other persons in the family, and the eligibility determination for those persons has not been completed, the written notice must state that the application is still pending.

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

b. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Applications

BCCPTA Medicaid applications filed by individuals who do not meet the description of an individual in the Low-income Families with Children (LIFC), Medicaid pregnant women, or SSI recipients covered groups must be processed within 10 working days of the agency's receipt of the signed application.

BCCPTA Medicaid applications filed by individuals who meet the description of an individual in the LIFC, pregnant women, or the SSI recipients covered groups must be processed as soon as possible, but no later than 45 days of the agency's receipt of the signed application.

If the BCCPTA Medicaid application is the only application required and no additional information is required, the eligibility decision must be made immediately and the applicant must be notified of the decision within 10 working days of the agency's receipt of the application.

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

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

2. 45/90 Day Requirement

Applications for which information in addition to that provided on the application is required, including requests for retroactive coverage, must be processed within 45 calendar days for all applicants other than pregnant women, women in the BCCPTA covered group, or individuals needing a disability determination.

For individuals who require a disability determination to meet the covered group requirement, the time standard for processing an application is 90 calendar days. Other non-financial requirements, however, must be met and verified by the 45th calendar day, or the application must be denied and DDS must be notified to stop action on the disability determination (see M0310.112 G.3).

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

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

3. Early Denial Before Deadline Date

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

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

4. Processing Priority

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

5. Time Standard Exceptions

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

- the applicant's inability to furnish necessary information for a reason beyond his/her control,
- a delay in receipt of information from an examining physician,
- a delay in the disability determination process,
- a delay in receiving DMAS decision on property transfer undue hardship claim, or
- an administrative or other emergency beyond the agency's control.

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, 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 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.

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 eligibility worker must allow at least 10 calendar days for receipt of the necessary verifications, but additional time may be allowed depending on the type of information requested. The specific information requested and the deadline for receipt of the verifications must be documented in the case record. If the applicant reports to the EW that he needs help to obtain certain verifications, the EW must attempt to assist the applicant. If the verification cannot be obtained, the application must be denied.

**3. Copy
Verification
Documents**

Legal documents and documents that may be needed for future eligibility determinations must be copied and preserved for the record. These include citizenship and identity documents, alien status documentation, verification of legal presence, trusts, annuities, contracts, wills, and life insurance policies. It is not necessary to retain a copy of verifications of income or the current value of resources in the case record. However, if a copy is not retained, the worker must document electronically or in the case record the date and method used to obtain the information (viewed, telephone call, etc.), the type of verification, the source, and a description of the information.

**4. Information
Not Provided**

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

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

**C. Verification of
Nonfinancial
Eligibility
Requirements**

**1. Verification
Not Required**

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

- Virginia state residency;
- pregnancy.

**2. Verification
Required**

The following information must be verified:

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

1. General Principle

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

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

2. Entitlement and Enrollment

a. Entitlement

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

If an applicant indicates that he has been receiving MA (Medicaid or Children's Health Insurance Program) coverage in another state prior to moving to Virginia, instruct him to contact his eligibility worker there and request that his coverage be cancelled, if he has not already done so. He is no longer considered a resident of the other state once he has moved to and intends to reside in Virginia and is not entitled to receive services paid for by the other state's MA program. 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. Enrollment

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

Applications for individuals who are not subject to MAGI methodology are processed outside the eligibility system, and eligible individuals must be enrolled directly into the MMIS.

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

M0220 Changes

Changed With	Effective Date	Pages Changed
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 Pages 19, 23, 24 Appendix 4 was removed.
TN #98	10/1/13	Pages 2-3b Appendix 1 Pages 1-5 Pages 6-18 were removed.
UP #9	4/1/13	Page 3 Appendix 1, pages 3, 17 Appendix 3, pages 3, 4
UP #8	10/1/12	Table of Contents Pages 4, 7-8, 12, 14d-20 Page 17a was deleted. Appendix 5, page 3 Appendix 7 pages 1-5
UP #7	7/1/12	Table of Contents Pages 14d, 16-19 Appendix 5, page 3
TN #96	10/1/11	Table of Contents Pages 2, 3, 7, 8, 14d, 18-22a, 23 Appendix 5, page 3
TN #95	3/1/11	Table of Contents Pages 3, 3a, 4-6a, 14a-14c, 17, 19, 20 Pages 22a, 23, 24 Appendices 1-2a removed. Appendix 3 and Appendices 5-8 reordered and renumbered.
TN #94	9/1/10	Pages 3-3b, 7-9, 14a-14d, 18, 21, 22a, 23 Appendix 1 Appendix 3, page 3
Update (UP) #3	3/1/10	Pages 1-3a
TN #93	1/1/10	Table of Contents Pages 7-8, 14a, 14c-14d, 15-20, 22a Appendix 1 Appendix 3, page 3 Appendix 4, pages 1 and 2 Appendix 6, page 2

M0220 Changes

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 and Documentation Charts	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

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

For eligibility determinations processed through VaCMS, the Social Security data match takes place when the individual's information is sent through the Hub. For cases not processed in VaCMS, the SSA data match will take place after the individual has been enrolled in MMIS.

1. MMIS Data Matches SSA

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

2. MMIS Data Does Not Match SSA

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

a. SSA Cannot Verify C&I

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

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

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

Acceptable forms of documentation for C &I are also included in Appendix 1 to this subchapter.

b. Individual Does Not Provide Verification in 90 Days

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

c. Discrepancy Resolved With SSA Within 90 Days

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

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

d. Verification of C&I Provided Within 90 Days

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

3. Subsequent Applications

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

M0220.200 ALIEN IMMIGRATION STATUS**A. Introduction**

An alien's immigration status is used to determine whether the alien meets the definition of a "full benefit" alien. All aliens who meet the state residency, covered group and all other nonfinancial eligibility requirements (except SSN for illegal aliens), and who meet all financial eligibility requirements are eligible for Medicaid coverage of emergency services. "Full benefit" aliens may be eligible for all Medicaid covered services. "Emergency services" aliens may be eligible for emergency services only.

B. Procedure

An alien's immigration status must be verified. Use the procedures in sections M0220.201 and 202 below to verify immigration status. After the alien's immigration status is verified, use the policy and procedures in section M0220.300 to determine if the alien is a full benefit alien. If the alien is a full benefit alien and is eligible for Medicaid, use the policy and procedures in section M0220.600 to enroll the alien in Medicaid.

If the alien is an emergency services alien who is eligible for Medicaid, use the policy and procedures in section M0220.700 to enroll an eligible emergency services alien in Medicaid for emergency services only.

C. Changes in Immigration Status

If a "full benefit" alien who was admitted to the U.S with immigration status in one of the "seven-year" alien groups listed in M0220.313.A becomes a Lawful Permanent Resident, he is considered to have full benefit status for the purposes of Medicaid eligibility for the first seven years of residency in the U.S.

M0220.201 IMMIGRATION STATUS VERIFICATION**A. Verification Procedures**

An alien's immigration status is verified by the official document issued by the United States Citizenship and Immigration Services (USCIS) and a comparison with the Systematic Alien Verification for Entitlements (SAVE) system. The EW must see the original document or a photocopy. Submission of just an alien number is NOT sufficient verification.

If the alien has an alien number but no USCIS document, or has no alien number and no USCIS document, use the **secondary verification** SAVE procedure in M0220.202 below if the alien provides verification of his or her identity.

NOTE: If the alien claims to be an illegal alien, do not use the verification procedures in this section or the SAVE procedures. Go to section M0220.400 below to determine the illegal alien's eligibility.

B. Documents That Verify Status

Appendix 7 to this subchapter contains a list of typical immigration documents used by lawfully present aliens.

Verify lawful permanent resident status by a Resident Alien Card or Permanent Resident Card (Form I-551), or for recent arrivals a temporary I-551 stamp in a foreign passport or on Form I-94.

Verify lawful admission by a Resident Alien Card (issued from August 1989 until December 1997) or Permanent Resident Card (Form I-551); a Re-entry Permit; or a Form I-688B with a provision of law section 274A.12(A)(1). Afghan and Iraqi immigrants admitted to the U.S. under a Special Immigrant Visa will have either (1) a Form I-551 or (2) a passport or I-94 form indicating categories SI1, SI2, SI3, SQ1, SQ2, or SQ3 and bearing the Department of Homeland Security stamp or notation.

- the alien child resides in the same household as a parent who has been battered or subjected to extreme cruelty while in the U.S. by that parent's spouse, or by a member of the spouse's family residing in the same household as the parent and the spouse consented or acquiesced to such battery or cruelty.
- b. the agency providing benefits determines (according to the guidelines to be issued by the U.S. Attorney General) that there is a substantial connection between the battery or cruelty and the need for benefits; and
- c. the alien has a petition approved by or pending with USCIS for one of the following:
- status as an immediate relative (spouse or child) of a U.S. citizen;
 - classification changed to immigrant;
 - status as the spouse or child of a lawful permanent resident alien (LPR); or
 - suspension of deportation and adjustment to LPR status based on battery or extreme cruelty by a spouse or parent who is a U.S. citizen or LPR alien.

9. Afghan or Iraqi Special Immigrant

an alien who is lawfully admitted into the U.S. on a Special Immigrant Visa (SIV) for permanent residency. Aliens in this group include the principal SIV holder, his spouse, and his children under age 21 living in the home. Afghan and Iraqi Special Immigrants will have either (1) a Form I-551 or (2) a passport or I-94 form indicating categories SI1, SI2, SI3, SQ1, SQ2, or SQ3 and bearing the Department of Homeland Security stamp or notation.

10. Victims of Trafficking

an alien who has been granted nonimmigrant status under section 101(a)(15)(T) or who has a pending application that sets forth a prima facie (has sufficient evidence) case for eligibility for such status.

M0220.311 VETERAN & ACTIVE DUTY MILITARY ALIENS

A. Veterans or Active Duty Military Aliens

An alien lawfully residing in the state (not here illegally) is always eligible for full Medicaid benefits (if he/she meets all other Medicaid eligibility requirements) **regardless of the date of entry into the U. S.**, if he or she meets one of the following conditions:

1. he/she is a qualified alien and is a veteran discharged honorably not on account of alienage, and who fulfills the minimum active-duty service requirements of section 5303A(d) of title 38, United States Code;
2. he/she is a qualified alien and is on active duty (other than active duty for training) in the Armed Forces of the United States (not in the Armed Forces Reserves),
3. he/she is the
 - a) spouse or the unmarried dependent child of a living (not deceased) qualified alien who meets the conditions of 1. or 2. above, or

C. AFTER 7 Years of Residence in U.S.

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

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

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

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

- 5. Afghan and Iraqi Special Immigrants** Medicaid coverage for Afghan and Iraqi Special Immigrants who are eligible in a Medicaid covered group cannot begin earlier than December 26, 2007. After 7 years of residence in the U.S., Afghan and Iraqi Special Immigrants are no longer eligible for full Medicaid benefits and become “emergency services” aliens.

After the applicable limited time period expires, individuals become “emergency services” aliens unless the requirements in M0220.313 B or M0220.314 are met.

D. Services Available To Eligibles

An emergency services alien who meets all Medicaid eligibility requirements is eligible for Medicaid coverage of emergency services only.

E. Entitlement & Enrollment of Eligibles

The Medicaid entitlement policy and enrollment procedures for emergency services aliens are found in section M0220.700 below.

M0220.411 UNQUALIFIED ALIENS

A. Unqualified Aliens Aliens who do not meet the qualified alien definition M0220.310 above and who are **NOT** lawfully residing non-citizen children under age 19 or pregnant women per M0220.314 above are “unqualified” aliens and are eligible for emergency services only if they meet all other Medicaid eligibility requirements. Unqualified aliens include illegal and non-immigrant aliens.

B. Illegal aliens Illegal aliens were never legally admitted to the U.S. or were legally admitted for a limited period of time and did not leave when that period expired. If an alien remains in the U.S. after his visa expires, he becomes an illegal alien.

C. Non-immigrant Aliens Aliens who are lawfully admitted to the U.S. for a temporary or limited period of time, and the limited period has **not** expired, are non-immigrant aliens. Non-immigrants, such as visitors, tourists, some workers, and diplomats, are not eligible for Medicaid because of the temporary nature of their admission status (they do not meet the state residency requirement). Non-immigrants have the following types of USCIS documentation:

- Form I-94 Arrival-Departure Record,
- Form I-185 Canadian Border Crossing Card,
- Form I-186 Mexican Border Crossing Card,
- Form SW-434 Mexican Border Visitor's Permit,
- Form I-95A Crewman's Landing Permit.

Note: If the alien remains in the U.S. after the limited time period (visa) is over, he becomes an illegal alien.

Non-immigrants include:

- 1. Visitors** visitors for business or pleasure, including exchange visitors;
- 2. Foreign Government Representative** foreign government representatives on official business and their families and servants;
- 3. Travel Status** aliens in travel status while traveling directly through the U.S.;
- 4. Crewmen** Crewmen on shore leave;
- 5. Treaty Traders** treaty traders and investors and their families;
- 6. Travel Status** aliens in travel status while traveling directly through the U.S.;
- 7. Foreign Students** foreign students;
- 8. International Organization** international organization representatives and personnel, and their families and servants;

	UNQUALIFIED ALIEN GROUPS (cont.)	Arrived Before 8-22-96	Arrived On or After 8-22-96	
T	Aliens granted suspension of deportation pursuant to Section 244 of the INA and whose deportation the USCIS does not contemplate enforcing [Immigration Judge Court Order]	Emergency Only T1	Emergency Only T2	Emergency Only T3
U	Any other aliens living in the US with the knowledge and permission of the USCIS whose departure the agency does not contemplate enforcing [USCIS Contact]	Emergency Only U1	Emergency Only U2	Emergency Only U3
V	Illegal aliens – aliens not lawfully admitted or whose lawful admission status has expired	Emergency Only V1	Emergency Only V2	Emergency Only V3
W	Visitors (non-immigrants): tourists, diplomats, foreign students, temp. workers, etc. [I-688B – 274a.12(b)(1)-(20); I-94; I-185; I-I186; SW-434; I-95A]	Emergency Only W1	Emergency Only W2	Emergency Only W3

	LAWFULLY RESIDING NON-CITIZENS	Effective 1/1/10	Effective 7/1/12
Y	Non-citizen (alien) children under the age of 19 and pregnant women lawfully residing in the U.S. who meet the requirements in M0220.314.	Full Benefits for Medicaid children under age 19 (FAMIS Plus)	Full Benefits for Medicaid (FAMIS Plus), Medicaid pregnant women, FAMIS and FAMIS MOMS

	AFGHAN AND IRAQI SPECIAL IMMIGRANTS	First 7 Years after Entry into U.S.	After 7 Years
Z	Afghan and Iraqi Special Immigrants admitted on a Special Immigrant Visa (SIV), including the spouse and children under age 21 living in the home with the principal visa holder. [I-551 or passport/ I-94 indicating categories SI1, SI2, SI3, SQ1, SQ2, or SQ3 and bearing Department of Homeland Security stamp or notation]	Full Benefits Z1	Emergency Only Z2

M0230 Changes

Changed With	Effective Date	Pages Changed
TN #100	5/1/15	Pages 3, 4
TN #98	10/1/13	Table of Contents pages 3-6 Page 7 was deleted.
TN #97	9/1/12	Page 4
TN #95	3/3/11	Pages 1, 2
TN #93	1/1/10	Page 2

M0230.200 RESIDENCY REQUIREMENTS**M0230.201 INDIVIDUALS UNDER AGE 21****A. Under Age 21
NOT In An
Institution**

An individual under age 21 is considered a resident of Virginia if he:

- a. is married or emancipated from his parents, is capable of indicating intent and is residing in Virginia with the intent to reside Virginia.
- b. is not emancipated but is not living with a parent or caretaker and is presently residing in Virginia with the intent to reside in Virginia;
- c. lives with a parent or caretaker who is presently residing in Virginia with the intent to reside in Virginia;
- d. is a non-IV-E (state/local) foster care child whose custody is held by Virginia (see M230.204 C. and D.);
- e. *is a non-IV-E foster care child whose custody is held by another state but who has been placed with and is residing in Virginia with a parent caretaker relative;*
- f. is a non-IV-E child adopted under an adoption assistance agreement with Virginia (see M230.204 C. and D.);
- g. is a non-IV-E foster care child whose custody is held by a licensed, private foster care agency in Virginia, regardless of the state in which the child physically resides;
- h. is under age 21 and is residing in another state for temporary period (for reasons such as medical care, education or training, vacation, (or visit) but is still in the custody of his/her parent(s) who reside in Virginia.
- i. is living with a parent(s) who is a non-immigrant alien (admitted to the U.S. for a temporary or limited time) when the parent has declared his intent to reside in Virginia permanently or for an indefinite period of time, and no other information is contrary to the stated intent.

**B. Under Age 21 In
An Institution**

If the individual was placed in the institution by a state government agent, go to section M0230.203 below.

An institutionalized individual (who was not placed in the institution by a state government) who is under age 21 and is not married or emancipated, is a resident of Virginia if:

1. the individual's parent or legal guardian was a Virginia resident at the time of the individual's institutional placement;
2. the individual's parent or legal guardian who applies for Medicaid is a Virginia resident and the individual is institutionalized in Virginia; or
3. the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, and the individual is institutionalized in Virginia.

- C. Under Age 21, Custody or Adoption Agreement with Another State**
- When another state's child-placing agency has custody of a child who lives in Virginia with a foster family, the child is NOT a Virginia resident unless the child is eligible as a IV-E Foster Care child and receives a IV-E Foster Care maintenance payment.
- 1. IV-E Eligible Children**
- A Title IV-E Foster Care child who lives in Virginia and who receives a Title IV-E maintenance payment from another state meets the Virginia residency requirements for Medicaid.
- A Title IV-E Adoption Assistance child who lives in Virginia and has a Title IV-E Adoption Assistance agreement in effect with another state's child-placing agency meets the Virginia residency requirements for Medicaid.
- 2. Non-IV-E Foster Care Children**
- A non-IV-E Foster Care child placed in Virginia from another state does NOT meet the Virginia residency requirements for Medicaid *unless placed with and residing in Virginia with a parent or caretaker-relative.*
- 3. Foster Care Children with SSI**
- A foster care child who receives Supplemental Security Income (SSI) benefits meets the Virginia residency requirement regardless of which state's child-placing agency maintains custody.
- 4. Non-IV-E Adoption Assistance and Adoptive Placement Children**
- A child who lives in Virginia with an adoptive family is considered to be living with a parent, regardless of whether a final order of adoption has been entered in court. When his adoptive parent is a Virginia resident, the child is a Virginia resident for Medicaid eligibility purposes. A Non-IV-E Adoption Assistance child whose adoption assistance agreement is signed by another state's child-placing agency is a Virginia resident when the child lives in Virginia with the adoptive parent(s).

M0230.202 INDIVIDUALS AGE 21 OR OLDER

- A. Introduction**
- For an individual age 21 or older, the determination of state residency depends on
- whether or not the individual is in an institution, and
 - whether or not the individual is capable of indicating his or her intent to reside in the state.
- B. Age 21 Or Older NOT In An Institution**
- For any individual age 21 or older NOT residing in an institution, the state of residence is Virginia when:
- the individual is living in Virginia with or without a fixed address with the intention to reside in Virginia;
 - the individual is living in Virginia and entered the state with a job commitment or seeking employment (whether or not currently employed).
 - the individual is incapable of indicating intent and the individual is living in Virginia.

Virginia DSS, Volume XIII

M0240 Changes

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TN #100	5/1/15	Page 2
TN #98	10/1/13	Table of Contents Pages 1-5 Page 6 was deleted.
TN #96	10/1/11	Pages 2-4
TN #94	9/1/10	Pages 1-6
TN #93	1/1/10	Pages 1-4
Update (UP) #1	7/1/09	Pages 1, 2
TN #91	5/15/09	Pages 1, 2

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

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

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

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

E. Procedure Section M0240.100 below explains in detail how to determine if an individual meets the SSN requirements when the individual or child does not have an SSN.

M0240.100 APPLICATION FOR SSN

A. Policy If an SSN has not been issued for the individual or the individual's child(ren), the applicant must cooperate in applying for a number with the local Social Security Administration Office (SSA). Instruct the applicant to submit form SS-5, the Application for Social Security Number, to the SSA and to obtain a receipt from SSA verifying that the application was submitted. The SS-5 is available online at:
<http://www.socialsecurity.gov/ssnumber/ss5.htm>.

The applicant must provide the SSN to the local social services department as soon as it is received and the number must be verified and entered in the eligibility/enrollment system.

1. Newborns In the case of a newborn child, the applicant/recipient may satisfy this requirement by requesting that an SSN be applied for by hospital staff in conjunction with the filing of the birth record at the time of the child's birth. Form SSA-2853 will be given to the mother by hospital staff as verification of application for the child's SSN.

Virginia DSS, Volume XIII

M0280 Changes

Changed With	Effective Date	Pages Changed
TN #100	5/1/15	Table of Contents Pages 1-11 Appendix 1 was added Pages 12 and 13 were deleted.
UP #9	4/1/13	Page 5
Update (UP) #7	7/1/12	Table of Contents Page 8 Appendix 1 was deleted.
TN #94	9/1/10	Page 1
TN #93	1/1/10	Page 13

TABLE OF CONTENTS

M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

M0280.000 INSTITUTIONAL STATUS REQUIREMENTS

	Section	Page
General Principles	M0280.001	1
Definition of Terms	M0280.100	1
Institutional Status Rule	M0280.200	3
Individuals In Medical Facilities.....	M0280.201	4
Individuals In Residential Facilities	M0280.202	5
Inmate of A Public Institution.....	M0280.300	6
Who Is NOT An Inmate of A Public Institution	M0280.301	8
Individuals Moving To or From Public Institutions	M0280.500	10
Departmental Responsibility	M0280.600	10

Appendix

<i>Institutional Status Quick Reference Guide</i>	<i>Appendix 1</i>	<i>1</i>
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M0280.000 INSTITUTIONAL STATUS REQUIREMENTS**M0280.001 GENERAL PRINCIPLES**

- A. Introduction** To be eligible for Medicaid, an institutionalized individual must meet the institutional status requirement. An individual does not necessarily have to live in an institution (*facility*) to be considered an "inmate of a public institution." *While inmates of public institutions are generally NOT eligible for Medicaid, incarcerated individuals may be eligible for Medicaid payment limited to inpatient hospitalization, provided they meet all other eligibility requirements.*
- B. Procedure** This subchapter, M0280, contains the Medicaid institutional status policy, inmate of a public institution policy and procedures for determining whether an individual meets the Medicaid institutional status eligibility requirement.

M0280.100 DEFINITION OF TERMS

- A. Child Care Institution** A child care institution is a
- non-profit private child-care institution, or
 - a public child care institution that accommodates no more than 25 children which has been licensed by the state in which it is located or has been approved by the agency of the state responsible for licensing or approval of institutions of this type, as meeting the standards established for licensing.
- The term "child care institution" does NOT include detention facilities, forestry camps, training schools or any other facility operated primarily for the detention of children who are determined to be delinquent.
- B. Inpatient** *Inpatient means a patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist and who is admitted and receives room, board and professional services in the institution for a 24 hour period or longer, or is expected by the institution to receive room, board and professional services in the institution for a 24 hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another medical facility and does not actually stay in the institution for 24 hours.*
- C. Institution** An institution is an establishment that furnishes (in single or multiple facilities) food, shelter and some treatment or services to four or more persons unrelated to the proprietor.
- D. Institution for Mental Diseases (IMD)** An IMD is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, to persons with mental diseases. A psychiatric residential treatment facility for children and adolescents is an IMD. An institution for individuals with intellectual disabilities is NOT an IMD.

**E. Institution for
Individuals with
Intellectual
Disabilities**

An “institution for individuals with intellectual disabilities” means an institution that is primarily for the diagnosis, treatment, or rehabilitation of individuals with Intellectual Disabilities or persons with related conditions that provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability. An intermediate care facility for individuals with intellectual disabilities (ICF-ID) is not an IMD. Therefore, an individual under age 65 who is in an ICF-ID meets the institutional status eligibility requirement.

F. Medical Facility

A medical facility is an institution that:

- is organized to provide medical care, including nursing and convalescent care,
- has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,
- is authorized under state law to provide medical care, and
- is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

**G. Public Institution
(Facility)**

A public institution is an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control, and which is NOT a medical facility.

The following are NOT public facilities for this section's purposes:

- a medical facility, including a nursing facility;
- a publicly operated community residence (serves no more than 16 residents);
- a child care institution, for children who receive foster care payments under Title IV-E, that accommodates no more than 25 children;
- an institution certified as an ICF-ID for individuals with mental retardation or related conditions.

**H. Publicly Operated
Community
Residence**

A publicly operated community residence is a public residential facility (institution) with 16 beds or less, that provides some services beyond food and shelter such as social services, help with personal living activities or training in socialization and life skills. Occasional medical or remedial care may also be provided.

Publicly operated community residences do NOT include the following facilities even though these facilities have 16 or fewer beds:

- residential facilities located on the grounds of, or adjacent to, any large (more than 16 beds) institution;
- correctional or holding facilities for individuals who are prisoners, who have been arrested or detained pending disposition of charges, or who are held under court order as material witnesses or juveniles
- educational or vocational training institutions that primarily provide an approved, accredited or recognized program to individuals residing there
- hospitals, nursing facilities, and intermediate care facilities for individuals with intellectual disabilities.

NOTE: An individual residing in a public educational or vocational training institution for purposes of securing education or vocational training is NOT an inmate of a public institution, and therefore may be eligible for Medicaid, even though the educational or training facility is not a publicly operated community residence.

I. Residential Institution

An institution that does not meet the definition of a “medical facility.”

M0280.200 INSTITUTIONAL STATUS RULE

A. Introduction

Federal regulations in 42 CFR 435.1008 prohibit federal financial participation in Medicaid services provided to two groups of individuals in institutions; these individuals are NOT eligible for Medicaid:

- individuals who are **inmates of a public institution**
- individuals under age 65 years who are patients in an institution for the treatment of mental diseases (IMD), unless they are under age 22 and are receiving inpatient psychiatric services. NOTE: an ICF-ID is not an IMD.

B. Procedures

The policy and procedures for determining whether an individual is in an IMD are contained in subchapter M1430.

The policy and procedures for determining whether an individual is an inmate of a public institution are contained in the following sections:

- M0280.201 Individuals in Medical Facilities
- M0280.202 Individuals in Residential Facilities
- M0280.300 Inmate of A Public Institution
- M0280.301 Who Is NOT An Inmate of A Public Institution
- M0280.400 Procedures For Determining Institutional Status
- M0280.500 Individuals Moving To or From Public Institutions
- M0280.600 Departmental Responsibility.

See Appendix 1 to this subchapter for an Institutional Status Quick Reference Guide.

M0280.201 INDIVIDUALS IN MEDICAL FACILITIES**A. Public or Private**

The public or private ownership or administration of a **medical** facility is irrelevant because a medical facility is not a public institution as defined in this subchapter.

B. Individuals in IMDs

The following individuals in public or private IMDs are NOT eligible for Medicaid because they do not meet the institutional status requirement:

- an individual who is age 22 or over, but under age 65;
- an individual who is under age 22 who is NOT receiving inpatient psychiatric services in the IMD.

An individual is in an IMD from the date of admission to the IMD until discharge from the IMD.

1. Eligible Patient In An IMD

An individual is in an IMD when he/she is admitted to live there and receive treatment or services provided there that are appropriate to his/her requirements. A patient in an IMD is an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or lessening of illness, disability, or pain.

An individual who is age 65 or older and who is a patient in a public or private IMD meets the institutional status requirement for Medicaid. An individual who is under age 22, who is a patient in a public or private IMD and who is receiving inpatient psychiatric services in the IMD meets the institutional status requirement for Medicaid.

2. Conditional Release From IMD

A patient in an IMD who is transferred or discharged to a medical facility that is not an IMD, including a patient under conditional release or convalescent leave from the IMD, meets the institutional status requirement and may be eligible for Medicaid.

C. ICF-ID

An *ICF-ID* is not an IMD. Therefore, an individual under age 65 who is in an *ICF-ID* meets the institutional status eligibility requirement.

D. Residential Facilities With Certified Medical Beds

Some institutions have both medical and residential sections. Individuals in the residential section (or beds) are residents of a residential facility. If the resident receives Medicaid Community-based Care (CBC) waiver services, use chapter M14 to determine the individual's eligibility. If the resident does not receive Medicaid CBC, he is not in long-term care; use the Medicaid eligibility requirements for non institutionalized individuals.

Individuals in the medical certified portion (or beds) of an institution are patients in a medical facility. Use chapter M14 in determining their Medicaid eligibility.

- E. Cross Reference** If the individual has been, or is expected to be, in the medical facility or medical section of the facility for 30 or more consecutive days, the individual is receiving long-term care. Chapter 14 contains additional eligibility policy for individual in long term care.

M0280.202 INDIVIDUALS IN RESIDENTIAL FACILITIES

- A. Institutions With Medical and Residential Sections** Some institutions have both medical and residential sections. An individual in the medical certified section (or beds) of the institution is a patient in a medical facility. If the individual has been, or is expected to be, in the medical facility for 30 or more consecutive days, the individual is receiving long-term care. Go to chapter M14 to determine the individual's eligibility.
- An individual in the residential portion (or beds) of the institution is a resident of a residential facility. Use this subchapter to determine the resident's institutional status.
- B. Private Residence or Group Home** An individual who lives in a private residence in the community that is not an institution (it is an establishment that provides food, shelter and some services to three or less persons unrelated to the proprietor) is not living in an institution. **A group home that has a capacity of no more than three residents is not an institution.**
- C. Private Residential Facility** A resident of any age in a private residential facility meets the institutional status requirement for Medicaid UNLESS the individual is incarcerated, as defined below.
- D. Public Residential Facility** A resident of any age in a PUBLIC residential facility meets the institutional status requirement for Medicaid UNLESS:
- the public residential facility has more than 16 beds, or
 - the individual is an inmate - an incarcerated adult or a juvenile in detention - as described in section M0280.300 below, and is not an individual listed in M0280.301 below.

M0280.300 INMATE OF A PUBLIC INSTITUTION**A. Policy**

Inmates of public institutions fall into three groups:

- individuals living in ineligible public institutions;
- incarcerated adults; and
- juveniles in detention.

An individual is an inmate of a public institution from the date of admission to the public institution until discharge, or from the date of actual incarceration in a prison, county or city jail or juvenile detention facility until permanent release, bail, probation or parole. An individual is considered incarcerated until permanent release, bail, probation or parole.

Incarcerated individuals (adults and juveniles) who are hospitalized can be eligible for Medicaid payment limited to services received during an inpatient hospitalization, provided they meet all other Medicaid eligibility requirements.

An individual released from jail under a court probation order due to a medical emergency is NOT an inmate of a public institution because he is no longer incarcerated.

B. Public Residential Facility Residents

An individual who lives in a public residential facility that serves more than 16 residents is NOT eligible for Medicaid.

A public residential facility that does not meet the definition of a “publicly operated community residence” in section M0280.100 above, is an “ineligible public institution.”

The following are ineligible public institutions:

- public residential institutions with more than 16 beds
- residential facilities located on the grounds of, or adjacent to, a public institution with more than 16 beds:

C. Incarcerated Adults

Incarcerated individuals can be eligible for Medicaid payment limited to services received during an inpatient hospitalization of 24 hours or longer.

Incarcerated individuals include:

- *individuals under the authority of the Department of Corrections (DOC)*
- *individuals held in regional and local jails, including those on work release*

Individuals are not eligible for full benefit Medicaid coverage while they are living in a correctional facility, regional or local jail or juvenile facility.

An individual in prison or jail who transfers temporarily to a halfway house or residential treatment facility prior to a formal probation release order is still an inmate of a public institution and can only be eligible for *Medicaid payment limited to services received during an inpatient hospitalization*.

Once an individual is released from the correctional facility, he can be enrolled in full benefit Medicaid, provided he meets all Medicaid eligibility requirements.

D. Juveniles in Detention

In determining whether a juvenile (individual under age 21 years) is incarcerated, the federal Medicaid regulations distinguish between the nature of the detention, pre- and post- disposition situations, and types of facilities.

1. Held for Care, Protection or Best Interest

A juvenile who is in a detention center due to care, protection or in the best interest of the child can be eligible for full benefit Medicaid or Family Access to Medical Insurance Security (FAMIS) coverage.

2. Held for Criminal Activity

a. Prior to Court Disposition

The following juveniles can be eligible for *Medicaid payment limited to services received during an inpatient hospitalization*.

- juvenile who is in a detention center due to criminal activity
- juvenile who has criminal charges pending (no court disposition has been made) who is ordered by the judge to go to a treatment facility, then come back to court for disposition when the treatment is completed

b. After Court Disposition

Juveniles who are on probation with a plan of release which includes residence in a detention center are inmates of a public institution. If they go to any of the secure juvenile correctional facilities, they are inmates of a public institution *and can only be eligible for Medicaid payment limited to inpatient hospitalization*. A list of secure detention facilities in Virginia is available on the Department of Juvenile Justice's web site at http://www.djj.virginia.gov/Residential_Programs/Secure_Detention/pdf/Detention_Home_Contacts_02242011rev.pdf. Because this list is subject to change, consult the list whenever eligibility must be evaluated for a juvenile who is reportedly in a detention center.

If they go to a non-secure group home, they *can be eligible for Medicaid or FAMIS because a non-secure group home is not a detention center*.

3. Type of Facility

The type of facility, whether it is residential or medical and whether it is public or private must be determined. A juvenile is not eligible *for full-benefit Medicaid* if he/she is a resident of an ineligible public residential facility. *He can be eligible for Medicaid coverage limited to inpatient hospitalization if he is admitted to a medical facility for inpatient services.*

EXAMPLE #1: A juvenile is detained for criminal activity. He is placed on probation with specific conditions of release, including a stay of 30 days or longer at a detention facility. The facility is identified as a juvenile detention center, not a treatment center. Upon release from the detention center, he will be placed on probation and will live with his mother. Because of the nature of his custody (criminal activity) and the nature of the facility (a detention center is a public institution) he is not eligible for *full-benefit Medicaid/FAMIS* during the period of incarceration, *but can be eligible for Medicaid coverage for inpatient hospitalization.* After he is released from the detention center and while he is on probation, he is NOT an inmate of a public institution and may be eligible for *full benefit Medicaid/FAMIS.*

M0280.301 WHO IS NOT AN INMATE OF A PUBLIC INSTITUTION

A. Who Is NOT An Inmate of a Public Institution

An individual is NOT an inmate of a public institution if:

- he is in a public educational or vocational training institution for purposes of securing education or vocational training OR
- he is in a public institution for a temporary period pending other arrangements appropriate to his needs.

B. Educational or Vocational Institution

An individual residing in a public educational or vocational training institution for purposes of securing education or vocational training is NOT an inmate of a public institution, and therefore may be eligible for Medicaid.

C. Temporary Stay

An individual residing in a public institution for a temporary period pending other arrangements appropriate to his needs is NOT an inmate of a public institution, and therefore may be eligible for Medicaid.

D. Admitted Under TDO

An individual over age 18 who was arrested or detained, but did not reside overnight in a prison or jail before being admitted to a public institution under a temporary detention order (TDO) is NOT an inmate of a public institution because he did not reside in the jail or prison immediately before admission to the treatment facility.

E. Arrested Then Admitted to Medical Facility

An individual who, after arrest but before booking, is escorted by police to a hospital for medical treatment and held under guard is NOT an inmate of a public institution and may be eligible for Medicaid. He is not an inmate of a public institution because he did not reside in a jail, prison or secure detention facility immediately prior to admission to the medical facility.

F. Inmate Out On Bail

An inmate in a prison or jail prior to arraignment, conviction, or sentencing is not eligible for Medicaid unless he/she is out on bail or released on his/her own recognizance.

G. Probation, Parole, or Conditional Release

An individual released from prison or jail on probation, parole, or release order with a condition of:

- home arrest
- community services
- outpatient treatment
- inpatient treatment

is not an inmate of a public institution and may be eligible for Medicaid.

An individual released from prison or jail under a court probation order due to a medical emergency is NOT an inmate of a public institution and may be eligible for Medicaid.

H. Juvenile in Detention Center Due to Care, Protection, Best Interest

A minor in a juvenile detention center prior to disposition (judgment) due to care, protection or the best interest of the child (e.g., Child Protective Services [CPS]), if there is a specific plan for that child that makes the detention center stay temporary, is NOT an inmate of a public institution and may be eligible for Medicaid.

This could include a juvenile awaiting placement but who is still physically present in the juvenile detention center.

I. Juvenile on Probation in Secure Treatment Center

A minor placed on probation by a juvenile court and placed in a secure treatment facility is NOT an inmate of a public institution and may be eligible for Medicaid.

J. Juvenile On Conditional Probation

A minor placed on probation by a juvenile court with, as a condition of probation, treatment in a psychiatric hospital or a residential treatment center, or treatment as an outpatient is NOT an inmate of a public institution and may be eligible for Medicaid

However, if the minor is NOT on probation but is ordered to the treatment facility, he remains an inmate of a public institution and not eligible for full benefit Medicaid. *He may be eligible for Medicaid coverage limited to inpatient hospitalization.*

K. Juvenile On Probation in Secure Treatment Center

A minor placed on probation by a juvenile court and placed in a secure treatment facility may be eligible for Medicaid.

L. Juvenile On Conditional Probation

A minor placed on probation by a juvenile court with, as a condition of probation, treatment in a psychiatric hospital or a residential treatment center, or treatment as an outpatient may be eligible for Medicaid. However, if the juvenile is NOT on probation but is ordered to the treatment facility, he remains an inmate of a public institution and *may be eligible for Medicaid coverage limited to inpatient hospitalization.*

M0280.500 INDIVIDUALS MOVING TO OR FROM PUBLIC INSTITUTIONS

- A. Moves To Public Institution** If a currently eligible *individual* enters a public institution, a partial review *must be completed to determine if he continues to meet institutional status requirements for continued coverage, as well as all other Medicaid eligibility requirements.*
- Outstanding bills for covered medical services incurred prior to his admission and during his Medicaid coverage period will be paid.
- B. Moving From Public Institution** Although a person may not be eligible for Medicaid while living in a specified public institution or part thereof, he may apply for such assistance as a part of prerelease planning. If he is found eligible (except for institutional status), do not enroll until he leaves the institution to live elsewhere.
- C. Resident Admitted to Medical Facility** A resident of an ineligible public institution *may be eligible for Medicaid coverage limited to inpatient hospitalization when admitted to a medical institution (general hospital or nursing facility) for inpatient care.*

M0280.600 DEPARTMENTAL RESPONSIBILITY

A. Department of Behavioral Health & Developmental Disabilities (DBHDS) Patients

1. ABD Covered Groups

Medicaid eligibility of patients who are:

- in State-owned *Department Behavioral Health and Developmental Services (DBHDS)* institutions for the treatment of mental disease and *intellectual disabilities,*
- not currently enrolled in Medicaid, and
- eligible in an Aged, Blind, or Disabled (ABD) covered group

is determined by the Medicaid Technician staff of the Division of Benefit Programs, Department of Social Services, who also carries responsibility for enrollment. (See subchapter M1550).

2. F&C DBHDS Patients

Local social services departments continue to carry responsibility for the determination of eligibility for Medicaid of a child eligible in a Families and Children's covered group who have been admitted to a *DBHDS* institution for treatment of the *intellectually disabled,* and for the child's enrollment in Medicaid.

**B. All Other
Institutions**

Local social services departments carry responsibility for the Medicaid eligibility determination and enrollment of individuals in institutions that are not operated by DBHDS. The local DSS agency in the Virginia locality where the individual last resided outside of an institution is the responsible DSS agency. If the individual resided outside of Virginia immediately before admission to the institution, the responsible local DSS is the DSS agency serving the locality where the institution is located.

When a local department carries responsibility for eligibility determination and enrollment of an individual living in an institution, the department is also responsible for:

- advising the institution of the individual's eligibility for Medicaid and enrollment in the program;
- submitting a DMAS-225 form to the institution to indicate the patient's eligibility and availability of current patient pay information in the Medicaid Management Information System (MMIS), if applicable; and
- seeing that the Medicaid card is forwarded to the institution for the enrollee's use.

Institutional Status Quick Reference Guide

<i>Placement or living arrangement</i>	<i>Full Benefit</i>	<i>Inpatient Only</i>	<i>Ineligible</i>
IMDs			
<i>age 22-65</i>			X
<i>under age 22 and receiving inpatient psychiatric treatment</i>	X		
<i>age 65 and older</i>	X		
<i>conditional release</i>	X		
ICF-ID – all ages	X		
Residential			
<i>medical section</i>	X		
<i>private group home with no more than 3 beds</i>	X		
<i>private residential</i>	X		
<i>public residential</i>			
<i>less than 16 beds</i>	X		
<i>16 or more beds</i>			X
<i>educational or vocational Institution</i>	X		
Correctional Facilities			
adults			
<i>DOC</i>		X	
<i>regional jails</i>		X	
<i>local jails</i>		X	
juveniles (DJJ) in secure facilities			
<i>held for care, protection, best, interest</i>	X		
<i>on probation</i>	X		
<i>held for criminal activity</i>		X	
<i>juvenile on probation placed in psychiatric hospital or residential treatment center</i>	X		
<i>juvenile not on probation ordered to treatment in a psychiatric hospital/residential treatment facility</i>		X	
Adult arrested, but not held in corrections			
<i>in medical facility prior to correctional facility placement</i>	X		
<i>in regional or local jail prior to medical facility</i>		X	
TDO			
<i>not in jail prior to hospitalization</i>	X		
<i>in jail prior to hospitalization</i>		X	
Individual out on bail/released on own recognizance	X		
Adult on probation, parole or conditional release	X		

M0310 Changes

Changed With	Effective Date	Pages Changed
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

TABLE OF CONTENTS

M03 MEDICAID COVERED GROUPS

M0310.000 GENERAL RULES & PROCEDURES	Section	Page
General Principles of Medicaid Covered Groups	M0310.001	1
List of Medicaid Covered Groups.....	M0310.002	2a
Definitions of Terms	M0310.100	5
ABD	M0310.101	5
Adoption Assistance	M0310.102	5
AFDC.....	M0310.103	6
AG	M0310.104	6a
Age & Aged	M0310.105	7
*BCCPTA	M0310.133	39
Blind.....	M0310.106	7
Caretaker-Relative	M0310.107	8
Categorically Needy (CN).....	M0310.108	10
Covered Group	M0310.109	10
Child	M0310.110	11
Dependent Child	M0310.111	11
Disabled	M0310.112	21
<i>Reserved</i>	M0310.113	28b
Families & Children (F&C)	M0310.114	28b
Foster Care.....	M0310.115	29
*HIPP Program	M0310.134	39

* out of numerical order

Hospice M0310.116 30a

Institution M0310.117 31

LIFC M0310.118 31

Medically Indigent (MI)..... M0310.119 31

Medically Needy (MN) M0310.120 32

Medicare Beneficiary M0310.121 32

OASDI M0310.122 34

Parent M0310.123 35

Pregnant Woman..... M0310.124 35

QDWI M0310.125 36

QI M0310.126 37

QMB M0310.127 37

RSDI M0310.128 37

SLMB..... M0310.129 38

SSI..... M0310.130 38

State Plan M0310.131 38

TANF M0310.132 39

Appendices

Cover Sheet for Expedited Referral to DDS Appendix 1 1

DDS Regional Offices..... Appendix 2 1

M0310.108 CATEGORICALLY NEEDY (CN)

A. CN Definition "CN" is the short name for "categorically needy." CN is a federal classification of a Medicaid covered group. The CN covered groups include both the mandatory categorically needy groups listed in the federal Medicaid regulations as well as the optional groups Virginia has chosen to cover in the Medicaid State Plan.

B. Procedures See subchapter M0320 for the policy and procedures to use to determine if an individual meets an ABD CN covered group.

See subchapter M0330 for the policy and procedures to use to determine if an individual meets a F&C CN covered group.

M0310.109 COVERED GROUP

A. Definition The federal Medicaid law and the State Plan for Medicaid describe the groups of individuals who may be eligible for Medicaid benefits. These groups of individuals are the Medicaid covered groups. The individuals in the covered groups must meet specified definitions, such as age or disability, and other specified requirements such as living in a medical facility.

The covered groups are classified in Virginia as CN and MN. The covered groups are divided into the ABD and F&C covered groups for financial eligibility purposes.

B. Procedure The covered groups are listed in section M0310.002.

The detailed requirements of the covered groups are in subchapters M0320 and M0330.

M0310.110 CHILD

A. Definition

The definition of "child" that is applicable depends on the individual's covered group.

1. Covered Groups to Which Modified Adjusted Gross Income (MAGI) Is Applicable

a. Tax-filer Household

A child is an individual of any age who is claimed as a tax dependent by a biological or adopted parent or step-parent.

b. Non-filer Household

A child is an individual under age 19.

2. F&C Non-MAGI, ABD and MN covered groups

A child is an individual under age 21 years who has not been legally emancipated from his/her parent(s).

A married individual under age 21 is a child unless he/she has been legally emancipated from his/her parents by a court. Marriage of a child does not emancipate a child from his/her parents and does not relieve the parents of their legal responsibility to support the child.

M0310.111 DEPENDENT CHILD

A. Definition

The definition of "dependent child" is the definition in section 406(a) of the Social Security Act: the term "dependent child" means a child who is:

- under the **age of 18**, OR
- under the **age of 19** and is a **full-time student** in a secondary school or in the equivalent level of vocational or technical training, or in a General Educational Development (GED) program IF he may be reasonably expected to complete the secondary school, training or program before *or in the month* he attains age 19; **AND**

NOTE: The above definition of a full-time student does NOT apply when determining student status for the student earned income exclusion. See sections M0720.500 B.2 and M0720.510 for the student income exclusion requirements.

- **living in the home of a parent or a caretaker-relative** of the first, second, third, fourth or fifth degree of relationship in a place of residence maintained by one or more of such relatives as his or their own home. See section M0310.107 for the definition of a caretaker-relative.

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

C. Procedures for Verifying Disability Status

- 1. Receives SSDI/SSI Disability Benefits** Verify SSDI/SSI disability status through a SVES (State Verification Exchange System) or SOLQ (State Online Verification Query) request or through documentation provided to the applicant by the SSA.
- 2. Receives RRB Disability Benefits** Verify RRB disability by contacting the RRB National Telephone Service at 1-877-772-5772 or through documentation provided to the applicant by the RRB.
- 3. Determined Disabled by DDS** If disability status cannot be ascertained **after** reviewing SVES or SOLQ, contact your regional DDS office to verify disability status. Contact information for the regional DDS offices is contained in Appendix 2 of this subchapter.
- 4. Incarcerated Disabled Individual** *Although benefits administered by the Social Security Administration are suspended while an individual is incarcerated, a disabled individual continues to meet the definition of a disabled individual while incarcerated.*

D. When a DDS Disability Determination is Required

- The DDS makes a disability determination for Medicaid when the individual alleges a disabling condition and has never applied for disability benefits from SSA or has not been denied disability within the past 12 months; **or**
 - the individual alleges a disabling condition and SSA has not yet made a determination on a pending SSDI/SSI claim; **or**
 - the individual alleges a disabling condition which is different from that considered by SSA or is in addition to that considered by SSA.
- 1. Individual Age 19 Years or Older** An individual age 19 years or older must have his disability determined by DDS if he:
 - is claiming to have a disabling condition but does not receive SS/SSI disability benefits or RR total disability benefits, **and**
 - has not been denied SSDI or SSI disability benefits in the past 12 months.
 - 2. Individual Under Age 19** A child under age 19 who is claiming to have a disabling condition must have his disability determined by DDS:
 - if he is not eligible for FAMIS Plus or FAMIS, **or**

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

4. LDSS Responsibilities for Communication with DDS

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

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

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

H. Notification of DDS Decision to LDSS

1. Hospitalized Individuals

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

2. Individuals Not Hospitalized

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

3. Disability Cannot Be Determined Timely

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

4. DDS Rescinds Disability Denial

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

I. LDSS Action & Notice to the Applicant

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

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

K. Subsequent SSA or RRB Disability Decisions When SSA or the RRB make a disability decision subsequent to the Medicaid decision which differs from the Medicaid decision, the SSA or RRB decision must be followed in determining Medicaid eligibility unless one of the conditions in M0310.112 E.2 above applies.

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

Disability Approved More Than 12 Months Past

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

Spenddown

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

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

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

The levels of administrative review are in the following order:

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

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

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

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

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

M0310.113 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.

DDS Regional Offices

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

DDS Regional Office	Local DSS Agency Assignments
<p>Central Regional Office Disability Determination Services 9960 Mayland Drive, Suite 200 Richmond, Virginia 23233</p> <p>Phone: 800-523-5007 804-367-4700 <i>Expedited FAX: 804-527-4518</i></p> <p><i>Professional Relations: Alvin Gritz</i> <i>Office Manager: Karry Rouse</i> <i>Regional Director: Miguel Johnson</i></p>	<p>Amelia, Brunswick, Buckingham, Charles City, Charlotte, Chesterfield, Colonial Heights, Cumberland, Danville, Dinwiddie, Emporia, Essex, Goochland, Greenville, Halifax, Hanover, Henrico, Hopewell, King and Queen, King William, Lancaster, Lunenburg, Mecklenburg, Middlesex, New Kent, Northumberland, Nottoway, Petersburg, Pittsylvania, Powhatan, Prince Edward, Prince George, Richmond County, Richmond City, South Boston, Surry, and Sussex</p>
<p>Tidewater Regional Office Disability Determination Services 5850 Lake Herbert Drive, Suite 200 Norfolk, Virginia 23502</p> <p>Phone: 800-379-4403 757-466-4300 <i>Expedited FAX: 757-455-3829</i></p> <p><i>Professional Relations: Sandy Bouldinz</i> <i>Office Manager: Heidi Dukelow</i> <i>Regional Director: Cheryl McCall</i></p>	<p>Accomack, Chesapeake, Franklin, Gloucester, Hampton, Isle of Wight, James City, Mathews, Newport News, Norfolk, Northampton, Portsmouth, Poquoson, Southampton, Suffolk, Courtland, Virginia Beach, Williamsburg, York</p>
<p>Northern Regional Office Disability Determination Services 11150 Fairfax Boulevard, Suite 200 Fairfax, Virginia 22030</p> <p>Phone: 800-379-9548 703-934-7400 <i>Expedited FAX: 703-934-7410</i></p> <p><i>Professional Relations: Tamera Hargrove</i> <i>Office Manager: Nicholas Marshal</i> <i>Regional Director: Sharon Gottovi</i></p>	<p>Albemarle, Alexandria, Arlington, Augusta, Caroline, Charlottesville, Clarke, Culpepper, Fairfax City, Fairfax County, Falls Church, Fauquier, Fluvanna, Frederick, Fredericksburg, Greene, Harrisonburg, Highland, King George, Loudoun, Louisa, Madison, Manassas City, Orange, Page, Prince William, Rappahannock, Rockingham, Shenandoah, Spotsylvania, Stafford, Staunton, Warren, Waynesboro, Westmoreland, and Winchester</p>
<p>Southwest Regional Office Disability Determination Services 612 S. Jefferson Street, Suite 300 Roanoke, Virginia 24011-2437</p> <p>Phone: 800-627-1288 540-857-7748 FAX: 866-802-5842 <i>Expedited FAX: 540-983-4799</i></p> <p><i>Professional Relations: Teresa Sizemore-Hernandez</i> <i>Office Manager: Marcia Hubbard</i> <i>Regional Director: Betsy Stone</i></p>	<p>Alleghany, Amherst, Appomattox, Bath, Bedford City, Bedford County, Bland, Botetourt, Bristol, Buchanan, Buena Vista, Campbell, Carroll, Covington, Craig, Dickenson, Floyd, Franklin, Galax, Giles, Grayson, Henry, Lee, Lexington, Lynchburg, Martinsville, Montgomery, Nelson, Patrick, Pulaski, Radford, Roanoke County, Roanoke City, Rockbridge, Russell, Salem, Scott, Smyth, Tazewell, Washington, Wise, and Wythe</p>

M0320 Changes

Changed With	Effective Date	Pages Changed
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

- he would have been eligible for one of those programs if he was not in a medical institution or intermediate care facility and the Medicaid plan covered this optional group. The Virginia plan covered this group.

2. Would Currently Be Eligible If Increase Were Excluded

The individual would meet the F&C income limits for LIFC or currently eligible for SSI or AG except that the increase in OASDI under P.L. 92-336 raised his income over the F&C income limits or SSI. This includes an individual who

- meets all LIFC requirements or current SSI requirements except for the requirement to file an application; or
- would meet all current LIFC or SSI requirements if he were not in a medical institution or intermediate care facility and the Medicaid plan covers this optional group. The Virginia plan covers this group

B. Nonfinancial Requirements

The protected individual must meet all of the following criteria:

- he was a recipient of OAA, AB, APTD, or AFDC cash assistance as of August, 1972;
- his money payment was subsequently discontinued as a result of the 20% increase in Social Security benefits received in October, 1972;
- his current countable resources are less than or equal to the current resource limit for Medicaid; and
- his current countable income is less than or equal to the F&C income limit or the current SSI income limit, as appropriate, after excluding the 20% increase amount received in 1972. The current SSI standards are in subchapter S0810; *the F&C income limit is available from a Regional Medical Assistance Program consultant.*

Contact a Medicaid Assistance Consultant if you have an applicant you believe meets this covered group.

M0320.202 CONVERSION CASES

A. Policy

42 CFR 435.131, 435.133--Conversion cases are classified as categorically needy and consist of the following individuals:

- blind or disabled individuals eligible in December 1973;
- individuals eligible as essential spouses of aged, blind or disabled individuals in December 1973.

B. Eligibility Determination

The agency must continue the individual's Medicaid if

- the ABD individual continues to meet the December 1973 eligibility requirements of the applicable cash assistance program; and

Note: There was no COLA in 2010 or 2011.

Cost-of-living calculation formula:

- a. $\frac{\text{Current Title II Benefit}}{1.017 \text{ (1/15 Increase)}} = \frac{\text{Benefit Before}}{1/15 \text{ COLA}}$
- b. $\frac{\text{Benefit Before 1/15 COLA}}{1.015 \text{ (1/14 Increase)}} = \frac{\text{Benefit Before}}{1/14 \text{ COLA}}$
- c. $\frac{\text{Benefit Before 1/14 COLA}}{1.017 \text{ (1/13 Increase)}} = \frac{\text{Benefit Before}}{1/13 \text{ COLA}}$
- d. $\frac{\text{Benefit Before 1/13 COLA}}{1.036 \text{ (1/12 Increase)}} = \frac{\text{Benefit Before}}{1/12 \text{ COLA}}$
- e. $\frac{\text{Benefit Before 1/12 COLA}}{1.058 \text{ (1/09 Increase)}} = \frac{\text{Benefit Before}}{1/09 \text{ COLA}}$

5. Medicare Premiums

a. Medicare Part B premium amounts:

1-1-15	\$104.90 (no change)
1-1-14	\$104.90
1-1-13	\$104.90
1-1-12	\$ 99.90
1-1-11	\$115.40
1-1-10	\$110.50
1-1-09	\$ 96.40

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:

1-1-15	\$407.00
1-1-14	\$426.00
1-1-13	\$441.00
1-1-12	\$451.00
1-1-10	\$461.00
1-1-09	\$443.00

Contact a Medical Assistance Program Consultant for amounts for years prior to 2009.

6. Evaluation

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

B. Financial Eligibility

- 1. Assistance Unit** The assistance unit policy and procedures in chapter M05 apply to ABD individuals with income less than or equal to 80% FPL. If not institutionalized, deem or count any resources and income from the individual's spouse with whom he lives. If institutionalized with a community spouse, go to subchapter M1480.

- 2. Resources** The resource limit is \$2,000 for an individual and \$3,000 for a couple.

The resource requirements in chapter S11 and Appendix 2 to chapter S11 apply to this covered group.

All of the individual's resources must be verified and evaluated. All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements.

- 3. Income** The income limits are \leq 80% of the FPL and are in section M0810.002. The income requirements in chapter S08 must be met.

- 4. Income Exceeds 80% FPL** **Spendedown does not apply** to this covered group. If the individual's income exceeds the 80% FPL limit, he is not eligible in this covered group. Determine the individual's eligibility in all other Medicaid covered groups.

D. Entitlement

If all eligibility factors are met in the application month, entitlement to full Medicaid coverage in this covered group begins the first day of the application month.

ABD individuals in this covered group are entitled to retroactive coverage if they meet all the requirements in the retroactive period.

E. Enrollment

The ABD 80% group AC is:

- 029 for an aged individual;
- 039 for a blind individual;
- 049 for a disabled individual; or
- *109 for all incarcerated individuals.*

M0320.400 MEDICAID WORKS

A. Policy

The Appropriations Act of 2006 authorized an amendment to the Virginia State Plan for Medical Assistance that allows disabled (including blind) individuals *to work and earn higher income while retaining Medicaid coverage. This program is called MEDICAID WORKS.*

- who are working or have a documented date for employment to begin in the future

to retain Medicaid coverage by cost-sharing through the payment of a premium as long as they remain employed and their earned income is less than or equal to 200% of the FPL. This type of cost-sharing arrangement is known as a **Medicaid** buy-in (MBI) program. MEDICAID WORKS is Virginia's MBI program.

**B. Relationship Between
MEDICAID
WORKS and 1619(b)
Status**

An individual with SSI or eligible for Medicaid as a Qualified Severely Impaired Individual (QSII) (1619(b)) must not be discouraged from enrolling in MEDICAID WORKS. An individual who meets the criteria for 1619(b) *status* may choose to participate in MEDICAID WORKS because of the higher resource limit.

**C. Nonfinancial
Eligibility**

The individual must also meet the following additional nonfinancial criteria:

- The individual must be competitively employed in an integrated setting. Work must occur in a work setting in the community or in a personal business alongside people who do not have disabilities. Work performed in a sheltered workshop or similar setting is **not** considered competitive employment in an integrated setting. Contact a Regional Medical Assistance Program Consultant if there is a question about whether the employment meets the criteria for MEDICAID WORKS.
- The individual must receive pay at the minimum wage or at the prevailing wage or “going rate” in the community, and the individual must provide documentation that payroll taxes are withheld. Self-employment must be documented according to the policy contained in S0820.210.
- The individual must establish a Work Incentive (WIN) Account at a bank or other financial institution, such as a checking or savings account. The individual must provide documentation for the case record designating the account(s) as a WIN Account. The account must either be a new account or an existing account with no other income but the wages earned while in MEDICAID WORKS. It cannot contain the individual's Social Security benefits.
- All individuals requesting enrollment in MEDICAID WORKS must also sign a MEDICAID WORKS Agreement, available on *SPARK* at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>. The agreement outlines the individual's responsibilities as an enrollee in the program.
- The individual must participate in cost sharing through the payment of a monthly premium to the Department of Medical Assistance Services. Note: Monthly premiums are not being charged at this time.

D. Financial Eligibility

1. Assistance Unit

a. Initial eligibility determination

In order to qualify for MEDICAID WORKS, the individual must meet, the assistance unit policy and procedures in chapter M05 that apply to ABD individuals with income less than or equal to 80% FPL.

Resources from the individual's spouse with whom he lives or, if under age 21, the individual's parents with whom he lives, must be deemed available.

*Spousal and parental income are **not** considered deemable income and are not counted for the initial eligibility determination for individuals requesting to participate in MEDICAID WORKS.*

b. Ongoing eligibility

Once the individual is enrolled in MEDICAID WORKS, **the individual is treated as an assistance unit of one.** Spousal and parental resources and income are disregarded for ongoing enrollee eligibility.

2. Resources

a. Initial eligibility determination

For the initial eligibility determination, the resource limit is \$2,000 for an individual and \$3,000 for a couple. Resources must be evaluated for all individuals, including SSI recipients, who wish to qualify for MEDICAID WORKS. The resource requirements in chapter S11 and Appendix 2 to chapter S11 apply for the initial eligibility determination. The individual's countable, nonexempt resources must be verified. All countable resources, must be added together to determine if the individual's countable resources are within the limit.

b. Ongoing eligibility

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

- 1) For **earnings** accumulated **after** enrollment in MEDICAID WORKS, up to the current 1619(b) income threshold amount will be disregarded if deposited and retained in the WIN Account. The 1619(b) threshold amount for 2015 is \$34,543.
- 2) Resources accumulated while in MEDICAID WORKS and held in Internal Revenue Service (IRS)-approved retirement accounts, medical savings accounts, medical reimbursement accounts, education accounts, independence accounts, and other similar State-approved accounts are excluded. Examples of these accounts include Archer Medical Savings Accounts, 401(k) accounts, traditional Individual Retirement Accounts (IRAs), Roth IRAs, SEP-IRAs, SIMPLE IRAs, Thrift Savings Plans, and 503(b) plans. The account must be designated as a WIN Account in order to be excluded. **Resources accumulated while in MEDICAID WORKS and held in IRS-approved accounts that have been designated as WIN Accounts are also excluded**

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 \leq 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 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 MMIS 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 MMIS:

New Application – Applicant Eligible as 80% FPL

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.

Current Enrollee

1. Cancel current coverage using Cancel Code 042.
2. Reinstate in AC 059 beginning the first day of the following month. **Use the date the MEDICAID WORKS Agreement was signed for the application date.**

Send a Notice of Action to the applicant/recipient advising him of his eligibility and acceptance into MEDICAID WORKS. Do not send the Advance Notice of Proposed Action when a recipient moves to MEDICAID WORKS, because his Medicaid coverage has not been reduced or terminated.

Eligibility for MEDICAID WORKS continues as long as the enrollee continues to:

- be employed,
- meet the definition of disability or blindness,
- meet the age limitation, and
- does not exceed the income and resource limits for MEDICAID WORKS.

The MEDICAID WORKS enrollee continues to meet the disability criteria as long as SSA has not completed a Continuing Disability Review and has not determined that the individual no longer has a disabling condition. The fact that the MEDICAID WORKS enrollee is earning over the SSA substantial gainful activity amount has no bearing on whether he meets the disability criteria. If the enrollee's disability status is unclear, contact a Regional Medical Assistance Program Consultant for assistance.

The individual's continuing eligibility must be determined at least every 12 months.

If the individual is no longer eligible for MEDICAID WORKS, the eligibility worker must determine whether the individual remains eligible in any other covered group. **The policy in M0320.400 G above must be reviewed to determine whether the *resource exclusion safety net rules* apply.** If the individual is not eligible for Medicaid in any other covered group, coverage shall be cancelled effective the first of the month following the expiration of the 10-day advance notice.

M0320.500 300% of SSI INCOME LIMIT GROUPS

A. Introductions

The 300% of SSI income limit groups are for individuals who meet the definition of an institutionalized individual or have been screened and approved for long-term care (LTC) services (see M1410. B. 2) and are not eligible in any other full-benefit Medicaid covered group.

B. Covered Groups

- M0320.501 ABD in a Medical Institution, Income \leq 300% of SSI
- M0320.502 ABD Receiving Medicaid Waiver Services (CBC)
- M0320.503 ABD Hospice

Virginia DSS, Volume XIII

M0330 Changes

Changed With	Effective Date	Pages Changed
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

TABLE OF CONTENTS

M03 MEDICAID COVERED GROUPS

M0330.000 FAMILIES & CHILDREN GROUPS

	Section	Page
General Policy Principles	M0330.001	1
Families & Children Categorically Needy Groups	M0330.100.....	2
IV-E Foster Care & IV-E Adoption Assistance.....	M0330.105.....	2
Individuals Under Age 21	M0330.107.....	4
Special Medical Needs Adoption Assistance	M0330.108.....	7
Former Foster Care Children Under Age 26 Years.....	M0330.109	8
Low Income Families With Children (LIFC)	M0330.200.....	9
Child Under Age 19 (FAMIS Plus)	M0330.300.....	10
Pregnant Women & Newborn Children	M0330.400.....	13
300% of SSI Income Limit Groups	M0330.500.....	16
<i>F&C in Medical institution, Income ≤ 300% SSI</i>	M0330.501.....	16
<i>F&C Receiving Waiver Services (BCB)</i>	M0330.502.....	18
<i>F&C Hospice</i>	M0330.503.....	21
Plan First - Family Planning Services	M0330.600.....	24
Breast and Cervical Cancer Prevention Treatment Act (BCCPTA).....	M0330.700.....	26
Families & Children Medically Needy Groups	M0330.800	29
Pregnant Women.....	M0330.801	30
Newborn Children Under Age 1	M0330.802	33
Children Under Age 18	M0330.803	34
Individuals Under Age 21	M0330.804	36
Special Medical Needs Adoption Assistance.....	M0330.805	39

B. Entitlement

1. IV-E Foster Care Child

Entitlement to Medicaid as a IV-E Foster Care child begins the first day of the month of commitment or entrustment if a Medicaid application is filed within 4 months of commitment or entrustment. Retroactive entitlement prior to the month of commitment or entrustment is not allowed.

If the Medicaid application is filed more than 4 months after entrustment or commitment, entitlement may be retroactive up to 3 months prior to application if the child met all Medicaid eligibility requirements in the retroactive months. However, Medicaid entitlement cannot go back to the month of entrustment or commitment when the application is filed more than 4 months after entrustment or commitment.

2. IV-E Adoption Assistance Child

Entitlement to Medicaid as a IV-E Adoption Assistance child begins the first day of the application month 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.

C. Enrollment

The aid category (AC) for IV-E foster care children is “076.” The AC for IV-E Adoption Assistance children is “072”.

M0330.107 INDIVIDUALS UNDER AGE 21

A. Policy

42 CFR 435.222 – The federal Medicaid law allows the State Plan to cover reasonable classifications of individuals under age 21 years who do not receive cash assistance but who meet the income requirements of the state’s July 16, 1996 AFDC State Plan. Children under age 19 should be evaluated in the FAMIS Plus covered group if not eligible as individuals under age 21.

Individuals ages 19 and 20 should be evaluated in the Individuals Under Age 21 covered group when they are not eligible for Medicaid in any other full-benefit covered group.

The reasonable classifications of individuals under age 21 are:

- IV-E eligible foster care children who do NOT receive a IV-E maintenance payment,
- Non-IV-E foster care children,
- Department of Juvenile Justice (DJJ) children,
- Non-IV-E Adoption Assistance children,
- Children in intermediate care nursing facilities (ICF), and
- Children in intermediate care facilities for the *intellectually disabled* (ICF-ID).

• Nonfinancial Eligibility Requirements

The individual must be under age 21 and meet the nonfinancial requirements in chapter M02.

C. Reasonable Classifications

The individual under age 21 must meet one of the following classifications:

1. **Non IV-E Foster Care**

Children who meet the foster care definition in M0310.115 but do not receive a IV-E maintenance payment are “individuals in foster homes, private institutions or independent living arrangements for whom a public or private nonprofit child-placing agency is assuming full or partial financial responsibility.” This group also includes DJJ children.

a. Children Living In Public Institutions

Non-IV-E foster care recipients meet the Medicaid institutional status requirements when they live in a public child care institution if the facility has less than 25 beds, or if they live in a publicly operated community residence that has no more than 16 beds. See section M0280.100 for definitions of public institutions.

When these children are placed in public residential institutions, the facility must not have capacity for more than 16 children (see M0280).

b. Child in Independent Living Arrangement

A child under age 18 in an independent living arrangement is eligible for Medicaid in this covered group if the child is receiving services from the local social services agency.

A child age 18 and over who is in an Independent Living arrangement with a local department of social services no longer meets the definition of a foster care child and may be eligible for Medicaid in the covered group of Former Foster Care Children Under Age 26 Years group. See M0330.109

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

Children under age 21 who meet the adoption assistance definition in M0310.102 for whom a Non-IV-E adoption assistance agreement between the local department of social services (LDSS) and the adoptive parent(s) is in effect are “individuals in adoptions subsidized in full or in part by a public agency.” If the child receives a Non-IV-E adoption assistance payment, or if the child was adopted under an adoption assistance agreement and is not eligible as a IV-E Adoption Assistance child, then the child meets the “Non-IV-E adoption assistance” definition.

Non IV-E adoption assistance children who have “special medical needs” have additional requirements. See section M0330.805 for the Special Medical Needs Adoption Assistance requirements.

3. **In ICF or ICF-ID**

Children under age 21 who are patients in either an ICF or ICF-ID meet the classification of “individuals in an ICF or ICF-ID” in the Individual Under Age 21 covered group.

D. Assistance Unit

1. **Non-IV-E Foster Care Children (Includes DJJ)**

The child is an assistance unit of one effective the date the child is removed from the home and placed in foster care. Each child in foster care is evaluated as a separate assistance unit, even if the child is living with his/her siblings in a foster care home.

A foster care or DJJ child continues to be a single person unit during a trial visit in his own home. A “trial visit” is no longer than six months for this section’s purposes.

- 2. Adoptive Placement** While in adoptive placement, the child may continue to be treated as a foster care child. However, once the interlocutory or the final order of adoption is entered, the child must be treated as a Non-IV-E adoption assistance child; see 3. below.
 - 3. Non-IV-E Adoption Assistance-Interlocutory or Final Order Entered** For applications received prior to October 1, 2013 and renewals completed prior to April 1, 2013, financial eligibility is determined using the assistance unit procedures in subchapter M0520, which require the inclusion of the child's adoptive parent(s) and sibling(s). An adoption assistance child must have his/her eligibility determined by counting or deeming (as appropriate) his/her parent's and sibling's income.

For applications received on or after October 1, 2013, use the policies and procedures contained in chapter M04.
 - 4. Child in ICF or ICF- ID** A child in an ICF or an ICF- *ID* is an institutionalized individual in a medical facility when he meets the definition of "institutionalized individual" in section M1410.010 B.2. When he meets the institutionalized individual definition, he is an assistance unit of one person.
- E. Resources** There is no resource test for the Individuals Under Age 21 covered group.
- F. Income**
- 1. Income Limits** For the Individuals Under Age 21 covered group, the income limit is the income limit found in M04, Appendix 4.

The foster care or adoption subsidy payment is excluded when determining the unit's income eligibility.

Foster care and Adoption Assistance children in residential facilities do not have a different income limit. For a foster care/adoption assistance child living outside the State of Virginia, the income limit for the assistance unit is the income limit for the Virginia locality which holds custody, pays the adoption subsidy, or signed the adoption assistance agreement.
 - 2. Income Exceeds F&C 100% Income Limit** For foster care (including DJJ) and adoption assistance children whose income exceeds the Individuals Under Age 21 income limit, determine the child's Medicaid eligibility in the Child Under 19 covered group and for FAMIS if the child under 19 or as an MN Individual Under Age 21 if the child is over 19 but under 21 (see M0330.804). Ineligible individuals must be referred to the Health Insurance Marketplace for evaluation for the Advance Premium Tax Credit (APTC).
- G. Entitlement & Enrollment**
- 1. Entitlement** Entitlement to Medicaid begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

2. **Enrollment** The aid category (AC) for individuals in the covered group of Individuals Under Age 21 is:
- 076 for a non-IV-E Foster Care child;
 - 075 for a Department of Juvenile Justice child;
 - 072 for a Non-IV-E Adoption Assistance child;
 - 082 for a child under age 21 in an ICF or ICF-ID.

M0330.108 SPECIAL MEDICAL NEEDS ADOPTION ASSISTANCE CHILDREN

A. Policy

42 CFR 435.227 - The federal Medicaid law allows the State Plan to cover an individual under age 21 years:

- for whom a non-IV-E adoption assistance agreement between the state and the adoptive parent(s) is in effect;
- who cannot be placed with adoptive parents without Medicaid because the child has special needs for medical or rehabilitative care; and
- who was enrolled in Medicaid under any covered group before the adoption assistance agreement was entered into OR who would have been eligible for Medicaid before the adoption assistance agreement was entered into if the eligibility requirements and standards of the IV-E foster care program were used, without employing the threshold title IV-A eligibility determination.

If the child was not enrolled in Medicaid or would not have been eligible for Medicaid prior to the adoption assistance agreement being entered into, the child is **not** eligible for Medicaid “Special Medical Needs” covered group.

The child’s eligibility in another covered group must be evaluated. If the child is under age 19, evaluate his eligibility in the FAMIS Plus covered group of Child Under Age 19 (see M0330.300). If the child is over age 19 but under age 21, the child may be eligible as a Non-IV-E Adoption Assistance child in the MN Individuals Under Age 21 covered group. See section M0330.804.

B. Nonfinancial Eligibility Requirements

The child must:

- be under age 21,
- meet the “special medical needs” adoption assistance definition in M0310.102, and
- meet the nonfinancial requirements in chapter M02.

C. Financial Eligibility Requirements

1. Assistance Unit

The assistance unit consists of only the child if the child was eligible for Medicaid prior to the adoption assistance agreement being entered into. The adoptive parent(s)’ income and resources are **not** counted or deemed; only the Special Medical Needs child’s own income and resources are counted.

- 2. Resources** There is no resource test for the Special Medical Needs Adoption Assistance Children covered group.
- 3. Income** Adoption assistance children in residential facilities do not have a different income limit. The income limit for Individuals Under Age 21 for one person in the child's locality is used to determine eligibility in the Special Medical Needs covered group. See M04, Appendix 4.
- For a Virginia Special Medical Needs adoption assistance child living outside the State of Virginia, the income limit for the unit is the income limit for the Virginia locality that signed the adoption assistance agreement.
- The adoption subsidy payment is excluded when determining the child's financial eligibility.
- If the child's countable income exceeds the income limit for Individuals Under Age 21, evaluate the child in the Special Medical Needs Adoption Assistance MN covered group (see M0330.805). Ineligible individuals must be referred to the Health Insurance Marketplace for evaluation for the APTC.
- D. Entitlement & Enrollment** Entitlement to Medicaid begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.
- The AC for individuals in the covered group of Special Medical Needs Adoption Assistance children is "072."

M0330.109 FORMER FOSTER CARE CHILDREN UNDER AGE 26 YEARS

- A. Policy** P.L. 111-148 (The Affordable Care Act) - The federal Medicaid law requires the State Plan to cover individuals who were formerly in Title IV-E or non-IV-E foster care when the individual:
- was in the custody of a local department of social services in Virginia *or another* state and receiving Medicaid until his discharge from foster care upon turning 18 years or older,
 - is not eligible for Medicaid in another mandatory Medicaid covered group (LIFC parent, Pregnant Woman, Child Under age 19 or SSI), and
 - is under age 26 years.
- A child age 18 and over who is in an Independent Living arrangement with a local department of social services may be eligible in this covered group.
- B. Nonfinancial Eligibility Requirements** The individual must meet all the nonfinancial eligibility requirements in chapter M02.
- C. Financial Eligibility** A separate Medicaid financial eligibility determination is not made for former foster care children under age 26. Verify the child's former foster care status

For example, a married pregnant woman applies for Medicaid on October 10. She received a medical service in the retroactive period. Her expected delivery date is January 15. She and her husband have been unemployed since June 23. Her husband began earning \$3,000 a month on October 9; she remains unemployed. Since they had no income during the retroactive period, she is found eligible for retroactive coverage effective July 1.

Because her available income (from her husband) changed after she established eligibility on July 1, the change in income does not affect her eligibility and she remains eligible for Medicaid in October and subsequent months until she no longer meets the pregnant woman definition or other nonfinancial requirements.

b. Newborn

Income changes do NOT affect the certain newborn's eligibility for the first year of the child's enrollment as a certain newborn.

The mother's failure to complete a renewal of her own eligibility and/or the eligibility of other children in the household does NOT affect the eligibility of the certain newborn.

6. Income Exceeds Limit

If the pregnant woman's income exceeds the 143% FPL limit, she is not eligible in this covered group. Determine her eligibility for FAMIS MOMS. *FAMIS MOMS was closed to new applications from January 1, 2014 until November 30, 2014. Enrollment in the program resumed on December 1, 2014.* If the pregnant woman is not eligible for FAMIS MOMS, evaluate her eligibility as MN (see M0330.801). Ineligible individuals must be referred to the Health Insurance Marketplace for evaluation for the APTC.

D. Entitlement

Eligible pregnant women are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group if the woman was pregnant during the retroactive month(s).

The newborn's Medicaid coverage begins the date of the child's birth. A Medicaid application for the newborn child is not required until the month in which the child turns age 1.

Eligible pregnant women and newborns are entitled to all Medicaid covered services as described in chapter M18.

After her eligibility is established as a pregnant woman, the woman's Medicaid entitlement continues through her pregnancy and the 60-day period following the end of her pregnancy regardless of income changes. Medicaid coverage ends the last day of the month in which the 60th day occurs.

E. Enrollment

The AC for CN pregnant women *who are not incarcerated* is "091." *The AC for CN pregnant women who are incarcerated* is "109."

The AC for newborns born to women who were enrolled in Medicaid as CN or to teens enrolled in FAMIS is "093."

M0330.500 300% of SSI INCOME LIMIT GROUPS

M0330.501 F&C IN MEDICAL INSTITUTION, INCOME ≤ 300% SSI

A. Policy

42 CFR 435.236 - The State Plan includes the covered group of individuals who meet a families & children definition who are in medical institutions and who

- meet the Medicaid resource requirements; and
- have income that does not exceed 300% of the SSI individual payment limit (see M0810.002 A. 3).

B. Nonfinancial Eligibility

An individual is eligible in this covered group if he/she meets the nonfinancial requirements in M02.

The individual must be a child under age 18, under age 21 who meets the adoption assistance or foster care definition or under age 21 in an ICF or ICF-ID, or must be a parent or caretaker-relative of a dependent child, or a pregnant woman as defined in M0310.

C. Financial Eligibility

When determining income to compare to the 300% of SSI income limit, use the ABD income policy and procedures, regardless of the individual's definition or covered group. MAGI methodology is not used to determine eligibility for this covered group.

When determining resources, use F&C resource policy in chapter M06 for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

The individual must also meet the asset transfer policy in M1450.

1. Resources

a. Resource Eligibility – Married Individual Age 18 and Older

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

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

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

b. Resource Eligibility – Unmarried Individual Age 18 and Older

When determining resources for an unmarried F&C institutionalized individual, use the Medicaid F&C resource requirements in chapter M06. All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the F&C resource limit of \$1,000. Pay close attention to ownership of his/her former residence when the individual is in an institution. Determine if the former home is excluded in **M06**.

If current resources are within the limit, go on to determine income eligibility. If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible in a different covered group.

c. Resource Eligibility – Child Under Age 18

Children under age 18 are not subject to a resource test.

2. Income

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

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

Compare the **total gross income** to the 300% of SSI income limit (see M810.002 A. 3.). If gross income is less than or equal to this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds the 300% of SSI income limit, the individual is not eligible for Medicaid in the covered group of F&C individuals in medical institutions.

D. Entitlement & Enrollment

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

Eligible individuals in this group are classified as **300% SSI**. If the individual has Medicare Part A, re-calculate the individual's income - subtract appropriate ABD income exclusions. Compare the countable income to the QMB limit.

1. Dual-eligible As QMB

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

2. Not QMB

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

E. Ineligible In This Covered Group

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

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

M0330.502 F&C RECEIVING WAIVER SERVICES (CBC)

A. Policy

42 CFR 435.217 - The State Plan includes the covered group of individuals who meet a families & children definition who live in the community, who

- would be eligible for Medicaid if institutionalized;
- are screened and approved to receive Medicaid waiver services and have selected the option to receive Medicaid waiver services in lieu of nursing facility care;
- in the absence of the waiver services would require the level of care furnished in a hospital, nursing facility or ICF- *ID*; and
- have income that does not exceed 300% of the SSI individual payment limit (see M0810.002 A. 3).

B. Nonfinancial Eligibility

An individual who receives Medicaid waiver services is eligible in this covered group if he/she:

1. meets the nonfinancial requirements in M02.
2. is not in a medical institution, may be in a residential institution that meets the institutional status requirements; and
3. *is a child under age 18, under age 21 and meets the adoption assistance or foster care definition, a parent or caretaker-relative of a dependent child, or a pregnant woman as defined in M0310.*

Verify receipt of Medicaid waiver services; use the procedures in chapter M14.

Do not wait until the individual starts to receive the waiver services to determine his/her eligibility in this covered group. Determine his/her eligibility in this covered group if he/she is screened and approved to receive Medicaid waiver services, has not been placed on a waiting list for services, and has selected the option to receive Medicaid waiver services in lieu of nursing facility services. Presume that he/she will receive the services and go on to determine financial eligibility using the policy and procedures in C. below. If determined eligible, the individual is not entitled to Medicaid in this covered group unless the policy in item D. below is met. See item D. below for the entitlement and enrollment procedures.

C. Financial Eligibility

When determining **income** to compare to the 300% of SSI income limit, use the ABD income policy and procedures, regardless of the individual's definition or covered group. MAGI methodology is not used to determine eligibility for this covered group.

When determining **resources**, use F&C resource policy in chapter **M06** for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

The individual must also meet the asset transfer policy in M1450.

1. Resources

a. Resource Eligibility - Married Individual Age 18 and Older

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

b. Resource Eligibility - Unmarried Individual Age 18 and Older

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

- ownership of his/her former residence when the individual is in an institution. Determine if the former home is excluded in **M06**.

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

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

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

c. Resource Eligibility – Child Under Age 18

Children under age 18 are not subject to a resource test.

2. Income

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

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

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

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

D. Entitlement & Enrollment

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

Eligible individuals in this group are classified as 300% of SSI. If the individual has Medicare Part A, re-calculate the individual's income - subtract the appropriate ABD income exclusions. Compare the countable income to the QMB limit.

1. Dual-eligible As QMB

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

2. Not QMB

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

E. Ineligible In This Covered Group

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

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

M0330.503 F&C HOSPICE

A. Policy

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

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

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

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

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

B. Nonfinancial Eligibility

A terminally ill individual who elects hospice services is eligible in this covered group if he/she meets the *non-financial requirements in M02, and:*

1. is not in a medical institution, may be in a residential institution that meets the institutional status requirements; and
2. *is a child under age 18, under age 21 and meets the adoption assistance or foster care definition, a parent or caretaker-relative of a dependent child, or a pregnant woman as defined in M0310.*

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

C. Financial Eligibility

When determining **income** to compare to the 300% of SSI income limit, use the ABD income policy and procedures, regardless of the individual's definition or covered group. *MAGI methodology is not used to determine eligibility for this covered group.*

When determining **resources**, use F&C resource policy in *chapter M06* for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

The individual must also meet the asset transfer policy in M1450. When determining **resources**, use F&C resource policy for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

1. Resources

a. Resource Eligibility - Married Individual Age 18 and Older

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

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

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

b. Resource Eligibility - Unmarried Individual Age 18 and Older

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

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

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

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

c. Resource Eligibility - Child Under Age 18

Children under age 18 are not subject to a resource test.

2. Income

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

M0330.600 PLAN FIRST - FAMILY PLANNING SERVICES

A. Policy

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

The income limit for this group was 211% FPL through December 31, 2013. *The income limit between January 1, 2014, and December 31, 2014, was 100% FPL. Effective January 1, 2015, the income limit is 200% FPL.* While there are no specific age requirements for Plan First, eligibility for Plan First is not determined for children under 19 years or for individuals age 65 years and older unless the child's parent or the individual requests an evaluation for Plan First.

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

If the information contained in the application indicates **potential** eligibility in a full-benefit Medicaid covered group (e.g., the applicant has a child under 18 in the home or alleges disability), in another limited benefit covered group (e.g., the individual has Medicare) or in FAMIS, the worker must determine whether eligibility exists in another covered group before the individual(s) can be determined eligible for Plan First.

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

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

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

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

- B. Nonfinancial Requirements** Individuals in this covered group must meet the following Medicaid nonfinancial requirements in chapter M02.
- DCSE services are available to all Medicaid recipients, but cooperation with DCSE is not a condition of eligibility for this covered group.
- C. Financial Eligibility** Refer to chapters M05 and M07 for applications submitted before October 1, 2013 and for renewals completed before April 1, 2014. Refer to Chapter M04 for eligibility determinations completed on applications submitted on or after October 1, 2013.
- 1. Assistance Unit** Use the assistance unit policy in chapter M05 to determine the individual's financial eligibility for applications submitted before October 1, 2013 and for renewals completed before April 1, 2014. Refer to chapter M04 for eligibility determinations completed on applications submitted on or after October 1, 2013.
 - 2. Resources** There is no resource test.
 - 3. Income** The income limit for this group was 211% FPL through December 31, 2013. *The income limit between January 1, 2014, and December 31, 2014, was 100% FPL. Effective January 1, 2015, the income limit is 200% FPL.* The income limits are contained in M04, Appendix 5.
 - 4. Spenddown** Spenddown does not apply to Plan First. However, because an individual enrolled in the Plan First covered group does not receive full Medicaid coverage, if he meets a MN covered group listed in M0320 or M0330, he must be evaluated to determine if he could become eligible for full Medicaid coverage as medically needy (MN) by meeting a spenddown. At application and redetermination, Plan First enrollees who meet the MN covered group and resource requirements are placed on two six-month spenddown budget periods within the 12 month renewal period. They may also be eligible for a retroactive MN spenddown determination. See chapter M13 for spenddown instructions.
- D. Entitlement and Enrollment**
- 1. Begin Date** Eligibility in the Plan First covered group begins the first day of the month in which the application is filed, if all eligibility factors are met in the month.
 - 2. Retroactive Coverage** Individuals in this covered group are entitled to retroactive coverage if they meet all the requirements in the retroactive period.
 - 3. Enrollment** The AC for Plan First enrollees is "080."

M0330.804 INDIVIDUALS UNDER AGE 21

A. Policy

42 CFR 435.308(b) - A state may choose to provide medically needy coverage to reasonable classifications of individuals under 21 years of age who are not eligible for coverage as categorically needy but who meet the medically needy resource and income requirements.

Virginia has chosen to cover the following reasonable classifications of individuals under age 21:

- Non-IV-E Foster Care children
- Department of Juvenile Justice (DJJ) children,
- Non-IV-E Adoption Assistance children,
- Children in intermediate care nursing facilities (ICF), and
- Children in an ICF-*ID*.

NOTE: the ICF- *ID* services are **not** covered for medically needy individuals, but other Medicaid covered services such as prescription drugs, physicians, inpatient and outpatient hospital services are covered for medically needy patients in ICF- *IDs*.

B. Nonfinancial Eligibility

The individual must be under age 21 and meet the nonfinancial requirements in chapter M02. The child meets the age requirement until the end of the month in which the child turns age 21.

C. Reasonable Classifications

The individual under age 21 must meet one of the following classifications:

1. Non IV-E Foster Care

Children who meet the foster care definition in M0310.115 but do not receive a IV-E maintenance payment are “individuals in foster homes, private institutions or independent living arrangements for whom a public or private nonprofit child-placing agency is assuming full or partial financial responsibility.” This group also includes DJJ children.

c. Children Living In Public Institutions

Non-IV-E foster care children meet the Medicaid institutional status requirements when they live in a public child care institution if the facility has less than 25 beds, or if they live in a publicly operated community residence that has no more than 16 beds. See section M0280.100 for definitions of public institutions.

When these children are placed in public residential institutions, the facility must not have capacity for more than 16 children (see M0280).

d. Child in Independent Living Arrangement

A child in an independent living arrangement is eligible for Medicaid in this covered group if the child is receiving services from the local social services agency.

2. Non-IV-E Adoption Assistance

Children under age 21 who meet the adoption assistance definition in M0310.102 for whom a Non-IV-E adoption assistance agreement between the LDSS and the adoptive parent(s) is in effect are “individuals in adoptions subsidized in full or in part by a public agency.” If the child receives a Non-IV-E adoption assistance payment, or if the child was adopted under an adoption assistance agreement and is not eligible as a IV-E Adoption Assistance child, then the child meets the “Non-IV-E adoption assistance” definition.

Non IV-E adoption assistance children who have “special medical needs” have additional requirements. See section M0330.805 for the medically needy Special Medical Needs Adoption Assistance requirements.

3. In ICF or ICF-ID

Children under age 21 who are patients in either an ICF or ICF- *ID* meet the classification of “individuals in an ICF or ICF- *ID*” in the Individual Under Age 21 covered group.

D. Assistance Unit

a. Non-IV-E Foster Care Children (Includes DJJ)

The child is an assistance unit of one effective the date the child is removed from the home and placed in foster care. Each child in foster care is evaluated as a separate assistance unit, even if the child is living with his/her siblings in a foster care home.

A foster care or DJJ child continues to be a single person unit during a trial visit in his own home. A “trial visit” is no longer than six months for this section’s purposes.

b. Adoptive Placement

While in adoptive placement, the child may continue to be treated as a foster care child. However, once the interlocutory or the final order of adoption is entered, the child must be treated as a Non-IV-E adoption assistance child; see 3. below.

c. Non-IV-E Adoption Assistance-Interlocutory or Final Order Entered

Financial eligibility is determined using the assistance unit procedures in subchapter M0520, which require the inclusion of the child’s adoptive parent(s) and sibling(s). An adoption assistance child must have his/her eligibility determined by counting or deeming (as appropriate) his/her parent’s and sibling’s income.

- d. Child in ICF or ICF- ID** A child in an ICF or an ICF- ID is an institutionalized individual in a medical facility when he meets the definition of “institutionalized individual” in section M1410.010 B.2. When he meets the institutionalized individual definition, he is an assistance unit of one person.
- E. Resources** The resource limit and requirements are found in chapter M06.
- If the resources exceed the limit, the child is not eligible for Medicaid. If the child is under age 19, determine the child’s eligibility as FAMIS Plus because that classification has no resource limits.
- F. Income** The MN income requirements are found in subchapter M0710.
- 1. Income Limits** For the MN Individuals Under Age 21 covered group, the income limit is the medically needy income limit found in chapter M0710, Appendix 5.
- The foster care or adoption subsidy payment is excluded when determining the unit’s income eligibility.
- Foster care or adoption assistance children in residential facilities do not have a different income limit. For a foster care/adoption assistance child living outside the State of Virginia, the MN income limit for the unit is the income limit for the Virginia locality which holds custody, pays the adoption subsidy, or signed the adoption assistance agreement.
- 2. Income Exceeds MN Income Limit** If the unit’s resources are within the medically needy limit, but the income exceeds the medically needy income limit, the unit is placed on a spenddown. All medical expenses of the unit members are used to meet the spenddown. Once the spenddown is met, only the child and family members who meet an MN covered group and who applied for Medicaid are enrolled in Medicaid.
- G. Entitlement & Enrollment**
- 1. Entitlement** Entitlement to Medicaid begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. If the individual is eligible after meeting a spenddown, entitlement begins the date the spenddown was met and ends after the last day of the spenddown period.
- Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.
- 2. Enrollment** The aid category for medically needy individuals in the MN covered group of Individuals Under Age 21 are:
- 086 for an MN Non-IV-E foster care, MN Non-IV-E adoption assistance,
 - 085 for an MN Juvenile Justice Department child;
 - 098 for an MN child under age 21 in an ICF or ICF- ID.

Virginia DSS, Volume XIII

M04 Changes

Changed With	Effective Date	Pages Changed
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.
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

M0410.000 MODIFIED ADJUSTED GROSS INCOME (MAGI)

M0410.100 MAGI GENERAL INFORMATION

A. Introduction

Beginning October 1, 2013, determinations of eligibility for most families and children (F&C) Medicaid covered groups and the Family Access to Medical Insurance Security Plan (FAMIS) will be done using the Modified Adjusted Gross Income (MAGI) methodology. MAGI methodology will also be used to determine eligibility for participation in the Federal Health Insurance Marketplace. Medicaid, FAMIS and the Federal Health Insurance Marketplace (HIM) are called insurance affordability programs. Medicaid and FAMIS are collectively referred to as medical assistance (MA) programs.

The goal of using MAGI methodology for all insurance affordability programs is to align financial eligibility rules, provide a seamless and coordinated system of eligibility and enrollment, and maintain the eligibility of low-income populations, especially children.

B. Legal Base

The Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152) (collectively referred to as the Affordable Care Act [ACA]) is the legal base for the changes required to be made in the Medicaid and CHIP (FAMIS) eligibility determinations.

MAGI and household income are defined in section 36B(d)(2)(A) and (B) of the Internal Revenue Service Code (IRC). The MAGI-based methodology under the Medicaid statute includes certain unique income counting and household (HH) composition rules reflected in the Centers for Medicare and Medicaid Services (CMS) regulations at 42 CFR 435.603 and discussed in section III.B. of the preamble to the eligibility final rule published in the Federal Register on March 23, 2012.

C. Policy Principles

1. What is MAGI?

MAGI:

- is a methodology for how income is counted and how household composition and family size are determined,
- is based on federal tax rules for determining adjusted gross income (with some modification), and
- has no asset test.

2. MAGI Rules

- MAGI has an income disregard equal to 5% of the federal poverty level (FPL) for the individual's household size. The disregard is only given if the individual is not eligible for coverage due to excess income. It is applicable to individuals in both full-benefit and limited-benefit covered groups.

If the individual meets multiple Medicaid covered groups (and/or FAMIS) his gross income is compared first to the income limit of the group with the highest income limit under which the individual could

be eligible. If the income exceeds the limit, the 5% FPL disregard can be allowed, and the income again is compared to the income limit.

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

**3. Eligibility
Based on
MAGI**

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

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

**4. Eligibility
NOT Based on
MAGI**

MAGI methodology is NOT used for eligibility determinations for:

- a. individuals for whom the agency is not required to make an income determination:
 - Supplemental Security Income (SSI) recipients
 - Auxiliary Grant recipients
 - IV-E foster care or adoption assistance recipients
 - Deemed newborns
 - BCCPTA (Breast and Cervical Cancer Prevention and Treatment Act) enrollees.
- b. individuals who are eligible on the basis of being aged (age 65 or older), blind or disabled;
- c. *individuals who are eligible only in the 300% of SSI covered group;*
- d. individuals evaluated as Medically Needy;

**5. Special Medical
Needs Adoption
Assistance
Children**

A Special Medical Needs Adoption Assistance (AA) child *is* subject to modified MAGI methodology for the *child's initial* Medicaid eligibility determination. *These* children are in their own household apart from parents and siblings. Parents' and siblings' income is not counted for these children.

Person	# - Household Composition	Reason
Gerry	4 – Gerry, Bree, Tad and Tansy	Tax filers and dependent children
Bree	4 – Gerry, Bree, Tad and Tansy	Tax filers and dependent children
Tad	4 – Gerry, Bree, Tad, Tansy	Tax filer and dependents

G. Tax Filer, Her Son and Her Nephew

Daria lives with her son, Jack age 11, and her nephew Billy age 8. All applied for MA.

Daria is a tax filer who claims her son and nephew as dependents. Her MAGI household is the same as her tax household. Jack is a tax dependent and no exceptions exist; his MAGI household is the same as the tax household. Billy is a tax dependent claimed by a tax filer who is not his parent so an exception exists and non-filer rules are used. Billy’s MAGI household consists of Billy only because he has no parents or siblings in the home. The following table shows each person’s MAGI household:

Person	# - Household Composition	Reason
Daria	3 – Daria, Jack and Billy	Tax filer and dependent children
Jack	2 – Jack and Daria	Non filer and parent living in home
Billy	1 – Billy	Non filer rules; Daria is not his parent, Jack is not his sibling

H. Tax Filer, Spouse, Their Child, His Parent Not Living In the Home

Dave lives with his wife Jean and their child, Cathy age 8. Dave files taxes separately from his wife who files her own taxes each year. Dave claims their child Cathy and his mother, Becky, as his tax dependents. Dave, Jean and Cathy applied for MA.

Dave’s MAGI household includes the individuals in his tax household and his wife, Jean because married spouses are always included in each other’s MAGI household. Jean is also a tax filer with no additional dependents. Jean’s MAGI household includes Dave because married spouses are always included in each other’s MAGI household. Cathy is a tax dependent whose parents are not filing jointly so non-filer rules are used; her MAGI household includes herself and her parents. The following table shows each person’s MAGI household:

Person	# - Household Composition	Reason
Dave	4 – Dave, Jean, Cathy and Becky	Tax filer, spouse, dependent child and dependent parent
Jean	2 – Dave, Jean,	Tax filer and spouse
Cathy	3 – Cathy, Dave, Jean	Non filer rules; child and parents in home

M0440.100 HOUSEHOLD INCOME

A. General Rule

The income counted under MAGI rules is the income counted for federal tax purposes with few exceptions. All taxable income sources and some non-taxable income sources are counted for the MA eligibility determinations.

Whenever possible, income reported on the application will be verified through a data match with the federal Hub. If no data sources exists to verify the attestation,

and the attestation is below the medical assistance income level, documentation of income is required.

If an income calculation must be made, use the information in subchapter M0710 for estimating income, subchapter M0720 for sources of earned income, and subchapter M0730 for sources of unearned income with the exceptions in B. below.

B. MAGI Income Rules

1. Income That is Counted

- a. *Gross earned income is counted. There are no earned income disregards.*
- b. *Earnings and unearned income, including Social Security benefits, of everyone in the household are counted, except the income of a tax dependent who is claimed by his parent(s) and who is not required to file income taxes.*
- c. Depreciation and capital losses are deducted in calculating countable income from self-employment and farming.
- d. *Losses are subtracted from self-employment income. If the losses exceed income, the resulting negative dollar amount offsets other countable income.*
- e. Foreign income and interest, including tax-exempt interest, are counted.
- f. Stepparent income is counted.

2. Income That is Not Counted

- a. Child support received is not counted as income (it is not taxable income).
- b. Workers Compensation is not counted.
- c. *When a child is included in a parent or stepparent's household, the child's Social Security benefits of any type are **not** countable in the household income unless the child is required to file taxes because the tax-filing threshold is met. The child's Social Security benefits do not count in determining whether or not the tax filing threshold is met.*
- d. Veterans benefits which are **not** taxable in IRS pub 907 are not counted:
 - Education, training, and subsistence allowances,
 - Disability compensation and pension payments for disabilities paid either to veterans or their families,
 - Veterans' insurance proceeds and dividends paid either to veterans or their beneficiaries, including the proceeds of a veteran's endowment policy paid before death,
 - Interest on insurance dividends left on deposit with the VA,
 - Benefits under a dependent-care assistance program,
 - The death gratuity paid to a survivor of a member of the Armed Forces who died after September 10, 2001, or

- Payments made under the VA's compensated work therapy program.
- e. Alimony **paid** to a separated or former spouse outside the home is deducted from countable income.
- f. Interest paid on student loans is deducted from countable income.
- g. *Proceeds from life insurance.*

**3. American
Indian-Alaska
Native
Payments**

In addition, the following payments to American Indian/Alaska Natives are not counted as income:

- a. distributions received from the Alaska Native Corporations and Settlement Trusts (Public Law 100-241),
- b. distributions from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the Supervision of the Interior,
- c. distribution and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extractions and harvest from:
 - rights of any lands held in trust located within the most recent boundaries of a prior Federal reservation or under the supervision of the Secretary of the Interior,
 - federally protected rights regarding off-reservation hunting, fishing, gathering or usage of natural resources,
 - distributions resulting from real property ownership interests related to natural resources and improvements,
 - located on or near a reservation of within the most recent boundaries of a prior Federal reservation, or
 - resulting from the exercise of federally-protected rights relating to such property ownership interests.
- d. payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or right or rights that support subsistence or a traditional lifestyles according to applicable Tribal Law or custom.
- e. Student financial assistance provided under the Bureau of Indian Affairs Education Program.

**C. 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, the information reported is not reasonably compatible (see M0420.100 for the definition) and/or the source of income is new or has changed, the individual must be asked to provide current verification of the household income so a point-in-time income eligibility determination can be made.

D. Steps for Calculating MAGI

For non-filers or any other individuals whose income cannot be verified by the Hub, use the following steps for calculating an individual’s MAGI. Subtract any deductions listed below if they are reported by the individual.

For tax filers whose income is verified in the Hub, the steps below are not followed: no MAGI calculation is required.

<p>Adjusted Gross Income (AGI)</p> <p>Line 4 on Internal Revenue Service (IRS) Form 1040 EZ</p> <p>Line 21 on IRS Form 1040A</p> <p>Line 37 on IRS Form 1040</p>	<p>Include:</p> <ul style="list-style-type: none"> • Wages, salaries, tips, etc • Taxable interest • Taxable amount of pension, annuity or Individual Retirement Account (IRA) distributions and Social Security benefits • Business Income, farm income, capital gain, other gains (or loss) • Unemployment Compensation • Ordinary dividends • Alimony received • Rental real estate, royalties, partnerships • S corporations, trusts, etc. • Taxable refunds, credits, or offset of state and local income taxes • Other income 	<p>Deduct:</p> <ul style="list-style-type: none"> • Certain self-employment expenses • Student loan interest deduction • Educator expenses • IRA deduction • Moving expenses • Penalty on early withdrawal of savings • Health savings account deduction • Alimony paid • Domestic production activities deduction • Certain business expenses of reservists, performing artists, and fee-basis government officials
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Note: Check the IRS website for detailed requirements for the income and deduction categories above. Do not include Veteran’s disability payments, Worker’s Compensation or child support received. Pre-tax contributions, such as those for child care, commuting, employer-sponsored health insurance, flexible spending accounts and retirement plans such as 401(k) and 403(b), are not included in AGI but are not listed above because they are already subtracted out of W-2 wages and salaries.

<p>Add (+) back certain income</p>	<ul style="list-style-type: none"> • Non-taxable Social Security benefits (line 20a minus 20b on Form 1040) • Tax –exempt interest (Line 8b on Form 1040) • Foreign earned income and housing expenses for Americans living abroad (calculated in IRS Form 2555)
-------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

<p>Exclude (-)from income</p>	<ul style="list-style-type: none"> • Social Security benefits received by a child are not countable for his eligibility when a parent is in the household, unless the child is required to file taxes. • Scholarships, awards, or fellowship grants used for education purposes and not for living expenses • Certain American Indian and Alaska Native income derived from distributions, payments, ownership interests, real property usage rights and student financial assistance • <i>Proceeds from life insurance</i> • An amount received as a lump sum is counted only in the month received.
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5% FPL DISREGARD	
EFFECTIVE 1/22/15	
# of Persons in Household or Family Size	Monthly Amount
1	\$ 50
2	67
3	84
4	102
5	119
6	136
7	154
8	171
Each additional, add	18

CHILD UNDER AGE 19 and PREGNANT WOMEN 143% FPL INCOME LIMITS ALL LOCALITIES EFFECTIVE 1/22/15	
# of Persons in Household or Family Size	Monthly Amount
1	<i>\$1,403</i>
2	<i>1,899</i>
3	<i>2,395</i>
4	<i>2,890</i>
5	<i>3,386</i>
6	<i>3,882</i>
7	<i>4,377</i>
8	<i>4,873</i>
Each additional, add	<i>496</i>

LIFC INCOME LIMITS

EFFECTIVE 7/1/14

Group I

Household Size	Income Limit
1	\$239
2	364
3	464
4	563
5	663
6	748
7	844
8	945
Each additional person add	98

Group II

Household Size	Income Limit
1	\$313
2	449
3	565
4	675
5	794
6	895
7	1,002
8	1,119
Each additional person add	111

Group III

Household Size	Income Limit
1	\$472
2	633
3	774
4	909
5	1,074
6	1,195
7	1,330
8	1,471
Each additional person add	135

INDIVIDUALS UNDER AGE 21 INCOME LIMITS

EFFECTIVE 7/1/14

Group I

Household Size	Income Limit
1	\$229
2	354
3	455
4	552
5	650
6	729
7	825
8	927
Each additional person add	94

Group II

Household Size	Income Limit
1	\$310
2	450
3	564
4	676
5	798
6	985
7	1002
8	1118
Each additional person add	109

Group III

Household Size	Income Limit
1	\$412
2	554
3	671
4	785
5	929
6	1025
7	1136
8	1251
Each additional person add	110

**PLAN FIRST
200% FPL
INCOME LIMITS
ALL LOCALITIES**

EFFECTIVE 1/22/15

Household Size	Monthly Income Limit
1	\$ 1,962
2	2,655
3	3,349
4	4,042
5	4,735
6	5,429
7	6,122
8	6,815
For each additional person, add	694

**TREATMENT OF INCOME FOR
FAMILIES & CHILDREN COVERED GROUPS**

INCOME	MAGI COVERED GROUPS	MEDICALLY NEEDY AND 300% SSI F&C COVERED GROUPS
Earnings	Counted with no disregards	Counted with appropriate earned income disregards
Social Security Benefits Adult's MAGI household	Benefits received by a parent or stepparent are counted for his eligibility determination, as well as the eligibility determinations of his spouse and children in the home.	Counted if anyone in the Family Unit/Budget Unit receives
Social Security Benefits Child's MAGI household	Benefits received by a child with at least one parent/stepparent in household are not countable unless the child is required to file taxes. When the child is in his own household, benefits are always countable.	Counted if anyone in the Family Unit/Budget Unit receives
Child Support Received	Not counted	Counted – subject to \$50 exclusion
Child Support Paid	<i>Not deducted from income</i>	<i>Not deducted from income</i>
Alimony Received	Counted	Counted – subject to \$50 exclusion if comingled with child support
Alimony Paid	Deducted from income	Not deducted from income
Worker's Compensation	Not counted	Counted
Veteran's Benefits	Not counted	Counted
Scholarships, fellowships, grants and awards used for educational purposes	Not counted	Not counted
Foreign Income (whether or not excluded from taxes)	Counted	Counted
Interest (whether or not excluded from taxes)	Counted	Counted
Lump Sums	Income in month of receipt	Income in month of receipt
Gifts, inheritances, life insurance proceeds	Not counted	Counted as lump sum in month of receipt

Virginia DSS, Volume XIII

M0520 Changes

Changed With	Effective Date	Pages Changed
TN #100	5/1/15	Page 2 removed 4.b
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

**4. Psychiatric
Residential
Treatment
Facilities
(PRTFs)**

Children Living in a PRTF

Children residing in Level C PRTFs are not temporarily absent from home. They are indefinitely absent from home and are not living with their parents or siblings for Medicaid purposes, if their stay in the facility has been 30 calendar days or longer. Long-term care rules do not apply to these children.

If the child is placed in a PRTF, verify that it is a Level C facility on the Department of Medical Assistance Services' web site at http://dmasva.dmas.virginia.gov/Content_pgs/obh-home.aspx. If the facility is not a Level C facility, the child is considered not to be living away from his parents.

**5. Medical
Facilities**

Children 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.

C. Procedure

This section contains an overview of the F&C family unit and budget unit rules. The detailed policy and procedures are contained in the following sections:

- M0520.010 Definitions;
- M0520.100 Family Unit Rules;
- M0520.200 Budget Unit Rules;
- M0520.300 Deeming From Spouse;
- M0520.400 Deeming From Parent;
- M0520.500 Changes In Status;
- M0520.600 Pregnant Woman Budget Unit;
- M0520.700 Individual Under Age 21 Family Unit.

M0530 Changes

Changed With	Effective Date	Pages Changed
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

individual applies for Medicaid, their financial eligibility is determined as an ABD couple--an assistance unit of two persons (see M0530.201 below). If one spouse receives SSI, this spouse must be included in the unit with the spouse who does not receive SSI. The resources and income (other than the SSI payment) of the SSI recipient spouse must be considered available along with those of the spouse who does not receive SSI.

EXCEPTION: When

- a member of the ABD couple is a Medicaid minor spouse (under age 21),
- the ABD couple lives with the minor spouse's parent(s), and
- the parent's(s') deemed resources or income makes the ABD couple ineligible,

recalculate each spouse's resource and income eligibility as a separate assistance unit (1 person in each). Deem the parent's(s') resources and income to the Medicaid minor spouse. Do NOT deem the spouses' resources and income to each other.

B. Resource Determination

Determine the couple's countable resources according to chapter S11. NOTE: Some resources' values are calculated differently *depending on the* ABD covered *group*. If a spouse also has Medicare Part A, determine a resource's value using both the MN and *Categorically Needy (CN)* methods.

1. Compare To Couple's Resource Limit

Total the couple's countable resources and compare to the resource limit appropriate to each individual's covered group. The ABD resource limits are contained in M1110.003.

2. Resources Meet Limit

If the couple's resources are less than or equal to the resource limit, the couple meets the resource requirements for the covered group whose resource limit was met.

3. Resources Exceed Limit

If the couple's resources exceed the resource limit, the couple is not eligible for Medicaid in that covered group. If the couple's resources exceed both resource limits, the couple is not eligible for Medicaid in any ABD covered group. Deny Medicaid because of excess resources. If the wife is pregnant, determine her eligibility as a pregnant woman.

EXCEPTION: When

- a member of the ABD couple is a Medicaid minor spouse (under age 21),
- the ABD couple lives with the minor spouse's parent(s), and

$$\begin{array}{r}
 \$ 920 \text{ couple's countable income} \\
 - 922 \text{ QMB income limit for 2} \\
 \hline
 0 \text{ excess}
 \end{array}$$

$$\begin{array}{r}
 \$ 920 \text{ couple's countable income} \\
 \times 6 \text{ months} \\
 \hline
 \$5,520 \text{ 6 month's income} \\
 - 1,850 \text{ Group II income limit for 2} \\
 \hline
 \$3,670 \text{ excess}
 \end{array}$$

The couple's income is compared to the *CN limits* for two persons, since the husband has Medicare Part A, and to the MN income limit for two persons in Group II. Because the couple's income does not exceed the QMB limit for 2 persons, the husband is eligible for QMB Medicaid. The couple's countable income exceeds the MN limit for two; only the husband is placed on spenddown. The wife is eligible as a CN SSI recipient.

2. ABD Couple With NBD Child

EXAMPLE #3: (Using 1999 figures)

Mr. and Mrs D live in a Group I locality with their 18 year-old daughter. Mr. D is 67 years old. Mrs. D is 58 years old and disabled, but she works part-time. Her impairment-related work expenses (IRWE) are \$50 per month. Mr. D receives SSA of \$475 per month and \$100 gross earnings per month. Mrs. D receives \$150 SSA and \$300 gross earnings per month. Their daughter has no income. Mr. and Mrs. D both have Medicare Part A and both apply for Medicaid. They are an assistance unit of two for Medicaid resource eligibility purposes. Their countable resources are within the Medicaid resource limit for 2 persons. Their income eligibility is calculated (NOTE: no allocation is subtracted for their NBD child because they are an ABD couple):

$$\begin{array}{r}
 \$475 \text{ Mr. D's SSA} \\
 +150 \text{ Mrs. D's SSA} \\
 \hline
 625 \text{ couple's unearned income} \\
 - 20 \text{ general income exclusion} \\
 \hline
 \$605 \text{ couple's countable unearned income} \\
 \\
 \$300 \text{ Mrs. D's gross earned income} \\
 - 50 \text{ Mrs. D's IRWE exclusion} \\
 \hline
 250 \text{ Mrs. D's net earnings} \\
 +100 \text{ Mr. D's gross earned income} \\
 \hline
 350 \text{ couple's gross earnings} \\
 - 65 \text{ exclusion} \\
 \hline
 285 \\
 \hline
 2 \text{ 2 remainder earnings exclusion} \\
 \hline
 142.50 \text{ couple's countable earned income} \\
 +605.00 \text{ couple's countable unearned income} \\
 \hline
 \$747.50 \text{ couple's countable monthly income} \\
 - 922.00 \text{ QMB income limit for 2} \\
 \hline
 0 \text{ excess}
 \end{array}$$

\$ 935.00	countable income November - March
<u>+442.00</u>	countable income for October
1377.00	total countable income for 6 months
<u>- 2025.00</u>	income limit for October - March ($\$325 \times 5 = \$1625 + \$400 = \2025)
0	no excess for 6 months

Mrs. B's countable income for the 6-month period October 1997 through March 1998 is within the MN income limit for the period and she is eligible as a disabled medically needy individual beginning 10-1-97.

M0530.300 BLIND/DISABLED CHILD UNDER AGE 21

A. Introduction

When determining the Medicaid eligibility of a blind/disabled (BD) child who is under age 19 years, first determine the child's *CN* eligibility because the *CN* covered group has no resource limit and a higher income limit. If the child's income exceeds the *CN limits*, then determine the child's MN eligibility using the resource and income deeming policy and procedures in this section.

B. Policy

An unmarried blind or disabled child is always an assistance unit of one person, even when he/she lives with siblings who are blind or disabled and also apply for Medicaid. The parent's(s) resources and income are deemed available to a blind or disabled child under age 21 years when the child lives with the parent(s) and when the parent(s) is not eligible for Medicaid. Do NOT deem a stepparent's resources or income to a BD child.

A married blind or disabled (BD) child under age 21 who does not live with his/her spouse is an assistance unit of one person. If the married BD child lives with his/her spouse, resources and income are deemed from the spouse according to section M0530.200 above. If the married BD child lives with his/her spouse **and** his/her parent(s), the parent(s) resources and income are deemed to the BD child **before** calculating the spouse's resources and income.

C. Child Under 21 Living Away From Home

A blind or disabled child under age 21 who is living away from home is considered living with his/her parent(s) for deeming purposes 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 education, rehabilitation, medical care, vacation, visit) is completed.

Children living in foster homes or non medical (residential) institutions are NOT temporarily absent from home. They are indefinitely absent from home and are NOT living with their parents or siblings for Medicaid purposes.

Children 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 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.

D. Deeming

A parent's income and resources are deemed to an BD child beginning:

- the month following the month the child comes home;
- the month following the month a child born in a hospital comes home from the hospital;
- the month of birth when a child is born in the parent's home;
- the month after the month of adoption; the month of adoption in Virginia is the month the interlocutory order or final adoption order, whichever comes first, is entered.

E. BD Child Assistance Unit Examples

EXAMPLE #17: A blind 16-year-old child lives with his 65-year-old father and 52-year-old mother. His mother is neither blind, disabled, nor pregnant. His father does not apply for Medicaid for himself. The child is an assistance unit of one for both resource and income determinations. A portion of his parents' resources and income is deemed available to him.

EXAMPLE #18: A 19-year-old disabled child lives with his mother and his two brothers who are under age 18. The children's father died. The mother applies for Medicaid for herself and all children. She is not eligible in the LIFC group and she meets no other covered group. When determining the disabled child's eligibility, the disabled child is not included in an assistance unit with his mother and brothers; the disabled child is an assistance unit of one, with deemed income and resources from the mother.

M0530.301 DEEMING RESOURCES FROM PARENTS

A. Policy

In determining eligibility of a BD child under 21 who lives with his parent(s), the resources of the child include the value of the countable resources of the parent(s), to the extent that the resources of the parent(s) exceed the resource limit of:

- an individual, if one parent lives in the household; or
- a couple, if two parents live in the household.

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

$$2015: \$1,100 - \$733 = \$367$$

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

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 = *\$733 for 2015; \$721 for 2014.*

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

SSI payment for both parents = *\$1,100 for 2015; \$1,082 for 2014.*

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

$$2015: \$1,100 - \$733 = \$367$$

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

Virginia DSS, Volume XIII

M0610 Changes

Changed With	Effective Date	Pages Changed
TN #100	5/1/15	pages 1, 2

M0610.000 GENERAL RULES FOR FAMILIES AND CHILDREN RESOURCES

M0610.001 OVERVIEW

A. Introduction

Medicaid is a needs based program. Two financial criteria, income and resources, are used to determine if a person is in need and is financially eligible for Medicaid. Most F&C categorically needy (*CN*) covered groups (see subchapter M0320) do not have a resource requirement. Resource policy does not apply to the following categorically needy covered groups:

- *CN* Pregnant Women & Newborn Children;
- Family Planning Services;
- *CN* Child Under Age 19 (FAMIS Plus);
- IV-E Foster Care or IV-E Adoption Assistance Recipients;
- Low Income Families With Children (LIFC);
- Individuals Under Age 21;
- Special Medical Needs Adoption Assistance; and
- BCCPTA.

This section addresses how to determine resource eligibility for the following:

- F&C in Medical Institution, Income \leq 300% SSI;
- F&C Receiving Waiver(CBC) Services;
- F&C Hospice; and
- all F&C medically needy covered groups.

All real and personal property legally owned by each member of the family unit/budget unit (FU/BU) is evaluated and the countable value is considered in determining Medicaid eligibility for the FU/BU.

Resources of each member of a FU/BU are evaluated using the rules in this chapter. Resource eligibility is determined by comparing the countable resources to the appropriate limit based on the composition of FU/BU. The policy governing the formation of the FU/BU is contained in M05.

B. Policy Principles

1. Monthly Determinations

Eligibility with respect to resources is a determination made for each calendar month, beginning with the third month prior to the month in which the application is received.

2. Countable Resources

Any assets that are resources but are not specifically excluded by policy are countable resources. Only countable resources are used to determine resource eligibility. See:

- M0610.002 for the resource limits;
- M0610.100 for the distinction between assets and resources;
- M0630.100 for a listing of exclusions.

- 3. Whose Resources Must Count**

Medicaid law requires that resources are only considered available between spouses and from parents to their children under age 21 who live at home.
- 4. Whose Resources Must Count**

Medicaid law does not allow certain resources to be considered in determining eligibility. Do not count resources:

 - from a step-parent to a step-child;
 - from siblings to siblings;
 - from child to parent;
 - from spouse or parent, living apart unless it is a voluntary financial contribution (exception for long-term care, see M1480);
 - from an alien sponsor.
- 5. Total Countable Resources**

The total value of the countable resources owned or deemed available to all FU members are counted in determining the resource eligibility of each FU member.

The total value of the countable resources owned or deemed available to all BU members is counted in determining the resource eligibility of each BU member.
- 6. Resource Eligibility**

If the total countable value of the FU/BU's countable resources are at or below the resource limit at any point during the application month, retroactive month, or a month in which the case is pending, resource eligibility exists for that month.
- 7. Excess Resources**

After determining countable resources in accordance with B.2 through B.5 above, if the family unit has resources other than the excluded items listed in M0630 totaling more than the allowable resource limit, determine if budget units can be formed. See Budget Unit rules in M0520. If BUs cannot be formed, or the BU's countable resources exceed the resource limit, resource eligibility does not exist.

If the FU/BU has a real property resource, see M0630.105 and M0630.110 for reasonable effort to sell real property.
- 8. Income Not Resources**

When determining the value of resources available to the family/budget unit, do not consider any income as a resource in the month in which it is received.

M0610.002 RESOURCE LIMITS

- A. Introduction**

A separate resource limit is set for each Medicaid classification. A resource limit is the maximum dollar amount of countable resources a FU or BU may own and the individuals within that unit be eligible for Medicaid.

M0710 Changes

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

TABLE OF CONTENTS

M07 FAMILIES AND CHILDREN INCOME

M0710.000 GENERAL--F & C INCOME RULES

	Section	Page
Overview	M0710.001	1
Net Countable Income	M0710.002	3
Income Exclusions.....	M0710.003	4
Relationship of Income to Resources	M0710.010	4
Types of Income	M0710.015	4
When Income is Counted	M0710.030	5
How to Estimate Income	M0710.610	6
Determining Based on Income.....	M0710.700	8

Appendices

Grouping of Localities	Appendix 1	1
Medically Needy Income Limits	Appendix 2	1
F&C 100% Standard of Assistance Amounts	Appendix 3	1

M0710.000 GENERAL-- F&C INCOME RULES

M0710.001 OVERVIEW

A. Introduction

Medicaid is a needs based program. Two financial criteria, income and resources, are used to determine if a person is in need and is financially eligible for Medicaid. The income eligibility policies that are used for the eligibility determination depend on the individual's covered group, as well as the date of the determination.

1. Use Policies in Chapter M07

The policies in **chapter M07** apply for **all initial applications, reapplications and renewals** for the Families & Children (F&C) Medically Needy (MN) covered groups.

2. Use Policies in Chapter M04 and Chapter M07 as Directed

The income policies, procedures and income limits for Modified Adjusted Gross Income (MAGI) contained in **chapter M04** apply to the covered groups listed below.

- CN Pregnant Women & Newborn Children;
- Plan First;
- CN Child Under Age 19 (FAMIS Plus);
- Low Income Families With Children (LIFC);
- Individuals Under Age 21;
- Special Medical Needs Adoption Assistance.

The income types and verification procedures in chapter M07 are used with MAGI methodology as directed in chapter M04.

3. Use Other Policies

Income eligibility for Medicaid is not determined by the local DSS for the following F&C covered groups:

- IV-E Foster Care or IV-E Adoption Assistance Recipients;
- BCCPTA.

See subchapter M0330 for additional information about these covered groups.

B. Use of Family Units/Budget Units

Family Units (FUs) are formed to establish whose income and resources are counted in determining financial eligibility. If financial eligibility does not exist at the family unit level for one or more persons for whom Medicaid was requested and if budget unit (BU) rules permit, form BUs.

Financial eligibility is determined at the BU level for each person for whom Medicaid was requested and who was financially ineligible in the FU determination. Eligibility is not determined for an individual who was found eligible in the FU determination.

See M0520 for F&C Family Unit/Budget Unit (FU/BU) policy and procedures.

**C. Individual
Income Eligibility**

An individual's income eligibility is based on the total countable income available to his/her FU/BU.

Each source of income received by a member of the FU/BU is evaluated and the countable amount determined based on the policy in this chapter. The countable amount of each FU/BU member's income is added to the countable amount of the income of all other FU/BU members. That total is used to determine the income eligibility of each individual within that FU/BU. The FU/BU's total countable income is compared to the income limit that is applicable to the individual's classification and to the number of members in the FU/BU.

D. Policy Principles

1. Income

Everything an individual owns and all monies received are assets. Monies received are income in the month received when the monies are cash or its equivalent.

Income may be either earned or unearned. See M0720 for earned income and M0730 for unearned income.

2. Verification

All income other than Workforce Investment Act and the earned income of a student under age 19 must be verified. When attempts to verify income are unsuccessful because the person or organization who is to provide the information cannot be located or refuses to provide the information to both the applicant/recipient and the eligibility worker, a third party statement, a collateral contact, or as a last resort, the applicant's/recipient's written statement can be used as verification and to determine the amount of income to be counted.

Failure of the applicant/enrollee to verify his income results in the agency's inability to determine Medicaid eligibility and the applicant/enrollee's Medicaid coverage must be denied or canceled.

**3. Converted
Income**

For the ongoing evaluation period, all income received more frequently than monthly must be converted to a monthly amount.

- Weekly income is multiplied by 4.3
- Bi-weekly income is multiplied by 2.15
- Semi-monthly income is multiplied by 2.

**4. Available
Income**

Retroactive period –available income is the gross income actually received in each month in the retroactive period.

Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months. The applicant's actual gross income received in the application month may be used to determine eligibility for that month if the application is processed after the month has passed and the person is eligible only when using the actual gross income for the month.

- 5. MN - Ongoing 6 Month Income Determination Period** MN income eligibility for the ongoing period is based on income that is anticipated to be received within the six month period beginning with the month of application.
- 6. MN - Retro 3 Month Income Determination Period** MN income eligibility for the retroactive period is based on income that was actually received in the three-month period immediately prior to the month of application.
- 7. Countable Income** Assets that meet the definition of income minus the exclusions allowed by policy are countable income. Only countable income is used to determine income eligibility. See M0720 Earned Income, M0730 Unearned Income.
- 8. Whose Income is Counted** The total countable income of all FU members is used in determining the income eligibility of each FU member. The total countable income of all BU members is used in determining the income eligibility of each BU member.
- 9. Income Eligibility** If the total amount of the FU/BU's countable income is equal to or less than the income limit for the evaluation period, income eligibility exists.
- 10. Excluded Income** State and federal policy require that certain types of income or portions of income be excluded (not counted) when determining income eligibility. See:
- Earned Income Exclusions, M0720.500
 - Unearned Exclusions, M0730.099
- 11. F&C MN Income Limits** *Refer to M0710, Appendix 2 for the grouping of localities and M0710, Appendix 2 for the MN income limits.*

M0710.002 NET COUNTABLE INCOME

- A. Policy Principle** Income is
- cash, or
 - its equivalent unless specifically listed in M0715 as not being income.
- B. Available Income** Retroactive period –available income is the gross income actually received in each month in the retroactive period.
- Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months. The applicant's actual gross income received in the application month may be used to determine eligibility for that month if the application is processed after the month has passed and the person is eligible only when using the actual gross income for the month.
- C. Net Countable Income** Net countable income is all money, both earned and unearned, which is available to the members of the FU/BU, after portions specifically excluded and all amounts that are not income are subtracted.

M0710.003 INCOME EXCLUSIONS

- A. Introduction** Medicaid eligibility is based on countable income. See M0710.003 for the definition of countable income. In determining countable income, apply any income exclusions. Some exclusions totally negate the amount of income received. Other exclusions reduce the amount counted.
- B. Definition** Excluded income is an amount which is income but does not count in determining eligibility.
- C. Policy Principles** Some Federal laws other than the Social Security Act prohibit counting some income for Medicaid purposes. Section 402(a) of the Social Security Act provides for several income exclusions in determining countable income for Medicaid purposes.
- D. References**
- Earned income exclusions, M0720.500
 - Unearned income exclusions, M0730.099

M0710.010 RELATIONSHIP OF INCOME TO RESOURCES

- A. Policy** In general, anything received in a month from any source is income to an individual, subject to the definition of income in M0710.003.
- Anything the individual owns in the month under consideration is subject to the resource counting rules.
- An item received in the current month is income for the current month only. If held by the individual until the following month, that item is subject to resource counting rules.
- B. References**
- Definition of Resources, M0610.100
 - Conversion or sale of a resource, M0715.200
 - Casualty property loss payments, M0630.650
 - Lump sums, M0730.800

M0710.015 TYPES OF INCOME

- A. Policy Principle** Income is either earned or unearned, and different rules apply to each.
- B. Types of Income**
- 1. Earned Income** Earned income consists of the following types of payments:
- wages;
 - salaries, and/or commissions;
 - profits from self employment; or
 - severance pay.

2. Unearned Income

Unearned income is all income that is not earned income. Some types of unearned income are:

- annuities, pensions, and other periodic payments;
- alimony and support payments;
- dividends, interest, and royalties; or
- rental income.

C. References

- Definition of net countable income, M0710.003
- Earned income, M0720
- Unearned income, M0730

M0710.030 WHEN INCOME IS COUNTED

A. Policy Principles

For applications and reapplications, the income generally to be counted is the income verified for the calendar month prior to the month of application or the most current equivalent (last 4 weekly pays, last 2 bi-weekly pays, or last 2 semi-monthly pays). When evaluating eligibility for a retroactive period, income eligibility is based on income actually received each month in the retroactive period.

For redeterminations, the income generally to be counted is the income verified for the month prior to the month of review or the most current equivalent.

B. Exceptions to Policy Principles

1. Payment Not Received In Normal Month of Receipt

FU/BUs receiving monthly or semi-monthly income, such as state or federal payments or semi-monthly pay checks, must have the income assigned to the normal month of receipt even if mailing cycles, weekends or holidays cause the income to be received in a different month.

EXAMPLE #1: The applicant/enrollee is employed and is paid semi-monthly on the first and sixteenth. Because June 1 falls on a Saturday, the client receives her June 1 paycheck on May 31. The Eligibility Worker will count the paycheck received May 31 as income for June.

2. Self-Employment or Sale of Livestock or Cash Crops

Profit from the sale of livestock or cash crops, such as tobacco or peanuts, or from small businesses, such as but not limited to, vending stands, home beauty shops, or small grocery stores, is prorated on an annual basis or over the number of months in which the income is earned, whichever is appropriate. Federal farm subsidies are prorated over a 12-month period.

3. Contract Income

Guaranteed salaries paid under contract are prorated over the period of the contract even though the employee elects to receive such payments in fewer months than are covered by the contract. When the contract earnings will be received monthly over a period longer than that of the contract, the earnings must be prorated over the number of months the income is anticipated to be received.

- C. **References** Contract Income, M0720.400
Income From Self-Employment, M0720.200

M0710.610 HOW TO ESTIMATE INCOME

- A. **Monthly Estimates** Generally, estimate future income on a monthly basis.
- 1. Anticipated Income** Anticipated income means any income the applicant/*enrollee* and local agency are reasonably certain will be received during the month. If the amount of income or when it will be received is uncertain, that portion of the FU/BU's income that is uncertain is not counted by the local agency. Reasonably certain means that the following information is known:
- who the income will come from,
 - in what month it will be received, and
 - how much it will be (i.e. rate, frequency and payment cycle).
- 2. Fluctuating Income** When income fluctuates, use the previous months' actual receipts that will provide an accurate indication of the individual's future income situation. Average the income received in no more than 3 previous months.
See section M0720.155 C. for detailed information about how to estimate fluctuating income.
- 3. Income Expected Less Than Once a Month** Determine the specific month(s) of receipt and use the amount(s) estimated for the appropriate month(s).
- 4. Converting to Monthly Totals** To estimate income for an income evaluation, convert to a monthly amount:
- multiply average weekly amounts by 4.3
 - multiply average bi-weekly amounts by 2.15
 - multiply semi-monthly amounts by 2
- 5. Partial Month Income** If the FU/BU will receive less than a full month's pay, use the exact monthly figure or an average per pay period times the actual number of pays. If actual income is used in any given calculation, adjust the figure for subsequent months if the actual income varies.
- 6. Examples** **a. Example #2**
The client's weekly pay for the prior month was:
\$220.40
\$175.80
\$210.00
\$195.70
To obtain a monthly amount, multiply the weekly average by 4.3.
\$801.90 (total of the pay stubs) divided by 4 (number of paystubs) equals \$200.48 (average weekly amount).
\$200.48 x 4.3 = \$862.06 monthly income.

b. Example #3

The client's bi-weekly pay for the prior month was:

\$185.40
\$209.50
\$394.90

To obtain a monthly amount, multiply the bi-weekly average by 2.15.
\$394.90 (total of the pay stubs) divided by 2 (number of pay stubs) equals
\$197.45 (average bi-weekly amount).

$\$197.45 \times 2.15 = \424.52 monthly income.

c. Example #4

The client's salary is \$100 weekly. The pay does not vary. The client is paid every Friday.

The client reports she quit her job and will receive a final weekly paycheck on September 3. Since the client was paid for a partial month, the exact amount of \$100 will be used.

d. Example #5

The client reports she quit her job on June 21. She will receive a final bi-weekly paycheck on July 5.

For the month of May, she received \$190 and \$220 for a total of \$410. This amount is divided by two (the number of pays) to determine the average bi-weekly pay of \$205. \$205 is used to calculate her July Medicaid eligibility.

B. Procedure

1. When a Change Occurs

An anticipated change in income occurs when you expect an individual's income to start, to stop, or to come in at a different rate in the future.

2. How to Develop a Change

When you anticipate an increase in income, use only that income which the individual is reasonably certain he will receive.

3. Handling Changes in Income

When a change in income occurs, redetermine Medicaid eligibility.

C. Documentation

1. What the File Must Contain

Verify and document the case record regarding the rate and frequency of payment (i.e., weekly, biweekly, semi-monthly, monthly, etc.) and the payment cycle (i.e., on what day the client is paid).

The case record must be documented to reflect the method used to arrive at the anticipated income.

2. Who May Provide an Estimate

Estimates of income may come from the applicant/recipient, employer, or representative.

M0710.700 DETERMINING ELIGIBILITY BASED ON INCOME

A. Locality Grouping and Income Limits

The countable income, allowing income exclusions when appropriate, is compared to the MN income limits for the locality and the number of members in the FU/BU.

Refer to M0710, Appendix 2 for the grouping of localities and M0710, Appendix 5 for the MN income limits.

B. Gross Income

Total gross income includes all gross earned income, other than Workforce Investment Act income and/or other earned income of a child under age 19 who is a student. It also includes the unearned income of all FU/BU members and any income deemed available to the family/budget unit.

C. Excluded Income

The following income is excluded when income is compared to MN limits:

1. Unearned Income

All unearned income specifically excluded per M0730.099;

2. Earned Income

Earned income is excluded in the following order:

- standard work exclusion of the first \$90 of gross earned income for each employed member of the assistance unit whose income;
- is not otherwise exempt per M0720.520;
- child care/incapacitated adult care exclusion per M0720.540.

D. Income Eligibility

If the countable income (gross income minus above exclusions) is equal to or less than the appropriate MN limit for the locality and the number of members in the FU/BU, the FU/BU is income eligible as MN. If the countable income is in excess of the MN limit, the FU/BU must be placed on an MN spenddown following policy in chapter M13.

GROUPING OF LOCALITIES EFFECTIVE 7/01/01

<u>GROUP I</u>		<u>GROUP II</u>	<u>GROUP III</u>
<u>Counties</u>	Madison	<u>Counties</u>	<u>Counties</u>
Accomack	Mathews	Albemarle	Arlington
Alleghany	Mecklenburg	Augusta	Fairfax
Amelia	Middlesex	Chesterfield	Montgomery
Amherst	Nelson	Henrico	Prince William
Appomattox	New Kent	Loudoun	
Bath	Northampton	Roanoke	
Bedford	Northumberland	Rockingham	<u>Cities</u>
Bland	Nottoway	Warren	Alexandria
Botetourt	Orange		Charlottesville
Brunswick	Page		Colonial Heights
Buchanan	Patrick	<u>Cities</u>	Falls Church
Buckingham	Pittsylvania	Chesapeake	Fredericksburg
Campbell	Powhatan	Covington	Hampton
Caroline	Prince Edward	Harrisonburg	Manassas
Carroll	Prince George	Hopewell	Manassas Park
Charles City	Pulaski	Lexington	Waynesboro
Charlotte	Rappahannock	Lynchburg	
Clarke	Richmond County	Martinsville	
Craig	Rockbridge	Newport News	
Culpeper	Russell	Norfolk	
Cumberland	Scott	Petersburg	
Dickenson	Shenandoah	Portsmouth	
Dinwiddie	Smyth	Radford	
Essex	Southampton	Richmond	
Fauquier	Spotsylvania	Roanoke	
Floyd	Stafford	Staunton	
Fluvanna	Surry	Virginia Beach	
Franklin	Sussex	Williamsburg	
Frederick	Tazewell	Winchester	
Giles	Washington		
Gloucester	Westmoreland		
Goochland	Wise		
Grayson	Wythe		
Greene	York		
Greensville			
Halifax	<u>Cities</u>		
Hanover	Bristol		
Henry	Buena Vista		
Highland	Danville		
Isle of Wight	Emporia		
James City	Franklin		
King George	Galax		
King & Queen	Norton		
King William	Suffolk		
Lancaster			
Lee			
Louisa			
Lunenburg			

MEDICALLY NEEDY INCOME LIMITS EFFECTIVE 7/1/14

# of Persons in Family/Budget Unit	GROUP I		GROUP II		GROUP III	
	Semi-Annual Income	Monthly Income	Semi-Annual Income	Monthly Income	Semi-Annual Income	Monthly Income
1	\$1,830.52	\$305.09	\$2,112.14	\$352.02	\$2,745.78	\$457.63
2	2,330.62	388.44	2,600.95	433.49	3,310.53	551.76
3	2,745.78	457.63	3,027.42	504.57	3,731.47	621.91
4	3,097.82	516.30	3,379.44	563.24	4,083.49	680.58
5	3,449.84	574.97	3,731.47	621.91	4,435.52	739.25
6	3,801.87	633.94	4,083.49	680.58	4,787.55	797.92
7	4,153.89	692.32	4,435.52	739.25	5,139.57	856.60
8	4,576.33	762.72	4,857.95	809.66	5,491.61	915.27
9	4,998.76	833.13	4,990.92	831.82	6,001.68	1,000.28
10	5,491.61	915.27	5,773.23	962.21	6,406.88	1,067.82
Each add'l person add	473.10	78.85	473.10	78.85	473.10	78.85

**F&C 100% STANDARD OF ASSISTANCE
AMOUNTS EFFECTIVE 7/1/14**

(Used as the F&C Deeming Standard)

Group I

Household Size	Monthly Amount
1	\$239
2	364
3	464
4	563
5	663
6	748
7	844
8	945
Each additional person add	98

Group II

Household Size	Monthly Amount
1	\$313
2	449
3	565
4	675
5	794
6	895
7	1,002
8	1,119
Each additional person add	111

Group III

Household Size	Monthly Amount
1	\$472
2	633
3	774
4	909
5	1,074
6	1,195
7	1,330
8	1,471
Each additional person add	135

M0810 Changes

Changed With	Effective Date	Pages Changed
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	2015 Monthly Amount	2014 Monthly Amount
1	\$733	\$721
2	1,100	1,082
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size	2015 Monthly Amount	2014 Monthly Amount
1	\$488.67	\$480.67
2	733.34	721.34

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.

Categorically Needy 300% of SSI		
Family Size Unit	2015 Monthly Amount	2014 Monthly Amount
1	\$2199	\$2163

4. **Medically
Needy (Effective
July 1, 2014)**

a. Group I		
Family Unit Size	Semi-annual	Semi-annual
1	\$1,830.52	\$1,803.47
2	2,330.62	2,296.23
b. Group II		
Family Unit Size	Semi-annual	Semi-annual
1	\$2,112.14	\$2,080.93
2	2,600.95	2,562.56
c. Group III		
Family Unit Size	Semi-annual	Semi-annual
1	\$2,745.78	\$2,705.21
2	3,310.53	3,261.66

5. **ABD
Categorically
Needy**

For:

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

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

ABD 80% FPL		
1	Annual	Annual
2	\$9,416	\$9,336
	12,744	12,584
QMB 100% FPL		
1	Annual	Annual
2	\$11,770	\$11,670
	15,930	15,730
SLMB 120% of FPL		
1	Annual	Annual
2	\$14,124	\$14,004
	19,116	18,876
QI 135% FPL		
1	Annual	Annual
2	\$15,890	\$15,755
	21,506	21,236
QDWI and MEDICAID WORKS 200% of FPL		
1	Annual	Annual
2	\$23,540	\$23,340
	31,860	31,460

S0820 Changes

Changed With	Effective Date	Pages Changed
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 2015, 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.

For 2014, up to \$1,750 per month, but not more than \$7,060 in a calendar year, of the earned income of a blind or disabled student child.
- 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.

For Months	Up to per month	But not more than in a calendar year
<i>In calendar year 2015</i>	\$1,780	\$7,180
In calendar year 2014	\$1,750	\$7,060

- 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.

TYPE OF EXPENSES	DEDUCTIBLE AS		AMOUNT OF DEDUCTIBLE
	BWE	IRWE	
Transportation to and from work	X		<ul style="list-style-type: none"> In own vehicle the rate is <i>the Internal Revenue Service (IRS) standard mileage rate</i>: 2014 – 56 cents per mile 2015 – 57.5 cents per mile For other than in own vehicle the actual cost of the bus, car, pool, or cab fare.
Vehicle modification	X	X	Whatever seems reasonable.

M0820.560 ALLOCATING WORK EXPENSES

A. Policy- Deduct (or begin allocating) the amount paid in the first month income is received.

B. Procedure

1. Expenses Paid Prior to Receipt of Income

a. No downpayment involved

Deduct the amount of a monthly recurring work expense in the month in which the expense is paid.

2. Monthly Recurring Expenses

b. Downpayment involved

- Have the individual decide whether the downpayment is to be deducted in the month paid; **or** prorated over a consecutive 12-month period.
- If the downpayment is to be deducted in the month paid, deduct the regular recurring monthly expense when paid.
- If the downpayment is being prorated, divide by number of months.

3. Other Recurring Expenses

a. Less frequently than monthly

Have the individual decide whether the work expense is to be deducted in the month paid or prorated for the months in the billing period.

b. Daily/Weekly/Biweekly

- Use the submitted receipts, bills, etc., in conjunction with any allegation obtained per S0820.550 C to determine the number of days the expense is paid each month; **and** whether the expense fluctuates or remains the same.
- Multiply the amount of the expense by the number of days the expense is paid each month if the expense remains the same.
- Add the individual amounts paid in each month if the expense fluctuates.

NOTE: If the computation is being based on the individual's allegation, assume that the expense remains the same.

4. Expense Is One-Time Payment

Have the individual decide whether the work expense is to be:

- deducted entirely in the month of payment; or
- prorated over a consecutive 12-month period beginning with the month of payment.

5. Self-Employment

Deduct the work expenses related to a self-employed activity for an individual who is blind and self-employment, provided the expenses were not used to complete the net earnings from self-employment (NESE). If it is to the person's advantage, prorate the work expenses over all the months of the tax year; otherwise, follow 1-4 above, as appropriate.

Virginia DSS, Volume XIII**S1110 Changes**

Changed With	Effective Date	Pages Changed
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 \leq 80% FPL	\$2,000	\$3,000
QDWI	\$4,000	\$6,000
QMB SLMB QI	Calendar Year <i>2015</i> \$7,280 2014 \$7,160	Calendar Year <i>2015</i> \$10,930 2014 \$10,750

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.

Virginia DSS, Volume XIII

S1130 Changes

Changed With	Effective Date	Pages Changed
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

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

A. Policy Principles

1. Exclusion

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

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

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

B. Operating Procedure

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

1. Initial Effort Established

The following criteria define reasonable efforts to sell. The listing price must not exceed 100% of CMV *in order for the initial effort to sell to be met.*

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

- a. As of the date the property becomes subject to a realtor's listing agreement (must be actively marketed) if it is listed at *no more than* current market value **AND** the listing realtor verifies that it is unlikely to sell within 90 days of listing given particular circumstances involved; for example
 - owner's fractional interest;
 - zoning restrictions;
 - poor topography;
 - absence of road frontage or access;
 - absence of improvements;
 - clouds on title;
 - right of way or easement;
 - local market conditions; or
- b. When at least two realtors employed by different realty companies refuse to list the property. The reason for refusal must be that the property is unsalable at CMV (other reasons are not sufficient – *documentation of the property's deficiencies must be provided*); or

3. Continuing Effort to Sell

Notwithstanding the fact that the recipient made a reasonable effort to sell the property and failed to sell it, and although the recipient has become eligible, the recipient must make a continuing reasonable effort to sell until the property is sold or Medicaid coverage is canceled. Continuing effort to sell is established by one of the following means:

- a. Continually renewing a listing agreement at no more than 100% of the taxed assessed value, until the property is sold. If the list price was initially higher than the tax-assessed value, the listed sales price must be reduced to no more than 100% of the tax-assessed value.
- b. In the case where at least two realtors have refused to list the property, the recipient must personally try to sell the property by efforts described in B.1.c. above, for 12 months.
- c. In the case of recipient who has personally advertised his property for a year without success (the newspaper advertisements, "for sale" sign, do not have to be continuous; these efforts must be done for at least 90 days within a 12 month period), the recipient must then:
 - subject his property to a realtor's listing agreement priced at or below current market value; or
 - meet the requirements of B.1.b. above, which are that the recipient must try to list the property and at least two realtors must refuse to list it because it is unsaleable at current market value; other reasons for refusal to list are not sufficient.

- d. For jointly owned property or interest in an undivided estate:

When a partition suit is necessary in order to liquidate the property, a continuing reasonable effort to sell property shall be demonstrated by filing suit with the court to partition the property within 60 days of proving the property is otherwise unsaleable (in accordance with section B.1.e.) and shall continue until the property is sold or 9 months, whichever is less. Any period of time in excess of 9 months to sell shall not be deemed reasonable and the property loses this exemption.

4. After Continuing Effort Has Been Established

Even when real property is excluded while reasonable efforts to sell it are met, the sale of real property for less than fair market value is subject to an asset transfer penalty for the Medicaid payment of long-term care services (see M1450). However, if the individual made a continuing effort to sell the property for 12 months, then the individual may sell the property between 75% and 100% of its tax assessed value without a penalty.

If the individual sells his property at less than 75% of assessed value, he must submit documentation from the listing realtor, or knowledgeable source if the property was not listed with a realtor, that the sale price was the best price the recipient can expect to receive for the property at this time. In this situation a sale can take place for less than 75% of assessed value without penalty.

- 5. Date Property is Disregarded** After the applicant has demonstrated that his property is unsalable by following the procedures in Section B., the property is disregarded in determining eligibility starting the first day of the month in which the most recent application was filed, or up to three months prior to the month of application if the applicant met all other eligibility requirements in the period. A recipient must continue his reasonable efforts to sell the property as required in B.3.

S1130.150 INTERESTS OF INDIVIDUAL INDIANS IN TRUST RESTRICTED LANDS

- A. Policy** In determining the resources of an individual (and spouse, if any) who is of Indian descent from a federally recognized Indian tribe, **any** interests of the individual (or spouse) in trust or restricted lands are excluded from resources.
- B. Procedure** If an individual Indian alleges an interest in trust or restricted land:
- obtain for the file a copy of any document or documents that might identify it as such; and/or
 - verify the allegation with the appropriate Indian agency.
- If verification is by phone, document the case record. Prepare a determination on the basis of the evidence.
- C. References**
- Income derived from individuals interests in trust or restricted lands, S0830.850
 - Other resource exclusions from members of Indian tribes, S0830.830

M1130.160 OTHER REAL PROPERTY

A. Policy Principles

- 1. Countable** Ownership of other real property generally precludes eligibility. The property's equity value is counted with all other countable resources.
- 2. Exceptions**
- a. When equity value of the property, plus all other resources, does not exceed the appropriate resource limit;
 - b. The property is smaller than the county or city zoning ordinances allow:
 - for home sites or building purposes, or
 - property has less than the amount of road frontage required by the county or city for building purposes, and
 - adjoining land owners will not buy the property;
 - c. The property has no access, or the only access is through the exempted home site;
 - d. The property is contiguous to the recipient's home site and the survey expenses required for its sale reduce the value of such property, plus all other resources, below applicable resource limitations; or
 - e. The property cannot be sold after a reasonable effort to sell it has been made.

6. Accelerated Life Insurance Payments

a. Income and Resources Treatment

Since accelerated payments can be used to meet food, clothing, or shelter needs, the payments are income in the month received and a resource if retained into the following month and not otherwise excludable.

b. Payments Not "Conversion of a Resource"

The receipt of an accelerated payment is not treated as a conversion of a resource for Medicaid purposes. This is because, under an accelerated arrangement, an individual receives proceeds from the policy, not the policy's resource value--which is its CSV.

C. Procedure Initial Application

1. Using the Individual's Records for Verification

a. Ask the individual to submit:

- all the life insurance policies he or she owns; and
- the most recent annual dividend statement issued for each policy.

b. For countable and excludable policies, use these records to verify:

- the owner;
- the insured;
- the FV;
- whether the policy pays dividends and, if it does, what option the individual selected for their disposition (i.e. accumulations, additions, applied to premiums, paid by check); and
- if dividend accumulations, their current amount.

c. Additionally, for countable policies, use these records to verify:

- whether the policy generates a CSV and, if it does,
- the current CSV (including the CSV of any dividend additions and any loans on the policy which reduce the CSV). *Some insurance policies include a CSV table. For policies that do not pay dividends, if the table lists a CSV value for the specific number of years the individual has owned the policy, no additional verification is needed.*

2. Contacting an Insurance Company or Agent for Verification

If examination of a policy does not reveal an item of information listed in 1. above, obtain that information from the individual's agent or the insurance company, subject to the operating assumptions in 4. below. Do so by phone, if possible, and document the information in the case record.

3. Exception to Verification

Do **not** verify employer-provided term insurance.

5. When to Develop Use for Another Purpose

Determine if excluded burial funds have been used for some purpose other than as burial funds only if:

- there is some indication that excluded funds may have been used for another purpose, and
- the sum of the excluded funds (including any that may have been spent) and countable resources exceeded the applicable (individual or couple) resources limit as of the month in which the excluded funds may have been used for another purpose, and
- the individual was eligible for the month in which the excluded burial funds may have been used for another purpose.

6. How to Develop Use for Another Purpose

If the criteria in 1. above indicate a need to pursue the issue of use for another purpose:

- obtain the individual's signed statement as to whether any of the funds were so used and, if so, the amount;
- obtain any pertinent evidence, including signed statements from other individuals who may know about the funds in question.
- follow resource policy if funds have been retained as a resource.
- follow asset transfer policy if funds were transferred.

7. Deeming Considerations

If the individual is a blind or disabled child under age 21 who lives with his parent, resources (and income) of the parent are deemed to the child. The burial funds exclusion applies to resources that belong to the parent and are designated as set aside for the burial expenses of the parent and/or his or her spouse.

D. Designation of Burial Funds

1. How Designation May Be Made

Burial funds may be designated by the applicant at the time of application or during the initial application processing period or by an enrollee at any time after eligibility has been determined. Burial funds may be designated by:

- an indication on the burial fund document (e.g., the title on a bank account); or
- a signed statement.

See Appendix 3 for a sample burial funds designation form. A printable version of the form is located at

<http://spark.dss.virginia.gov/divisions/bp/me/training/index.cgi>.

2. Signed Statement Designating Burial Funds

A signed statement must include:

- the value and owner of the resources;
- for whose burial the resources are set aside;
- the form(s) in which the resources are held (burial contract, bank account, etc.); and
- the date the individual first considered the funds set aside for the burial of the person specified.

3. Date of Intent

We accept the individual's allegation as to the date he or she first considered the funds set aside for burial unless there is evidence that the funds were used and replaced after that date.

4. Effective Date of Exclusion

Once the date that burial funds were considered set aside for burial has been established, the first month for which the exclusion affects resource determination is the latest of:

- the month in which the funds were considered to have been set aside, or
- the month of application, if the funds were considered set aside before the month (or first month of retroactive period, if retroactive coverage is requested).

5. Designating Life Insurance as a Burial Fund

When designating a countable life insurance policy as a burial fund, the policy itself is designated. However, because the countable value of the policy is its cash surrender value, it is the cash surrender value at the time of designation that is applied toward the burial funds exclusion when determining countable resources.

If life insurance is designated as a burial fund, the individual can also designate any dividend accumulations on the life insurance policy (M1130.300 A.5.b.) as a burial fund. Dividend accumulations are a separate resource (i.e. **not** considered as an increase in the value of the CSV) and must be designated as burial funds separate from the life insurance policy itself.

6. Designation Remains

Once a burial fund is designated, it remains a burial fund until:

- eligibility terminates or
- the individual states in writing that the funds are no longer set aside for burial.

E. Procedure-Initial Applications Development and Documentation

1. Ask About Burial Funds

Unless the individual is ineligible for a reason other than resources, inquire to determine the presence of excluded burial funds.

NOTE: Make sure the individual understands what we mean by a burial fund and the effect a burial fund could have on countable resources and income.

2. Verify Form and Separation of Funds

Verify that the funds meet the definition of burial funds in B.1. above and that the funds are separated from all other non-burial-related assets (C.3. above). Burial funds must meet both of these requirements before we can exclude them. If funds cannot be excluded, tell the individual why (e.g., if the funds are not separate from non-burial assets).

3. Determine Date Funds Set Aside for Burial

If an individual alleges having set aside funds for burial, determine the date they were first considered as set aside and document the file with supporting evidence.

- If the funds are already clearly designated (e.g., by the title of a savings account), accept any official record which shows the title of the account and which establishes that the designation was in effect prior to the month of application.
- If the funds are **not** already clearly designated, obtain the statement described in D. above.
- See D.4. above regarding effective date of the exclusion for funds considered set aside for burial prior to filing.

4. Verify Value of Funds

Verify the value of any burial funds to be excluded, using the instructions that apply to the specific resources in question.

5. Determine Amount of Exclusion Available

Document the file with evidence of:

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

Should the \$3,500 maximum exclusion be reduced by life insurance, any irrevocable arrangement including an irrevocable burial trust established before 8/11/93, burial insurance, or a burial contract, document the amount by which the exclusion will be reduced, including the computation of the amount. To make this computation, you may use the electronic Burial Funds Exclusion Worksheet located at:

<http://spark.dss.virginia.gov/divisions/bp/me/training/index.cgi>.

**F. Procedures-
Renewal or a
Reported Change**

**1. Verify Funds
Already
Excluded**

If the case record shows excluded burial funds, verify the current amount. When \$3,500 or less was initially designated as a burial fund, increases in the burial fund due to appreciation or accumulated interest are excluded even if they result in the total burial fund exclusion exceeding the \$3,500 maximum.

If more than \$3,500 was initially designated for burial funds exclusion, interest and appreciation that have subsequently accrued on the excluded portion of the burial fund are excluded. Interest and appreciation that have subsequently accrued on the countable portion are countable. To calculate the countable value of a burial fund at renewal or when a change is reported you may use the electronic "BFE Increased Value Determination Worksheet". The worksheet is located on the Virginia Department of Social Services Local Agency web site (SPARK) at:

<http://spark.dss.virginia.gov/divisions/bp/me/training/index.cgi>.

Also, inquire whether designated burial funds continue to be maintained separately from non-burial-related assets (C3. above).

If the funds have decreased, see G. below.

**2. Enrollee Wishes
to Designate
Funds**

If an enrollee wishes to designate funds for burial, proceed as you would for an initial application. This applies whether no funds are currently excluded or less than \$3,500 (excluding appreciation or accumulated interest) is currently excluded.

**3. Apply Burial
Funds-Related
Income/
Resources
Exclusions**

See H. below.

**G. Procedure-Burial
Funds Are Used for
Another Purpose**

**1. When to
Evaluate Use
for Another
Purpose**

Determine if excluded burial funds have been used for some other purpose only if:

- there is some indication that excluded funds may have been used for another purpose, and
- the sum of the excluded funds (including any that may have been spent) and countable resources exceeded the applicable (individual or couple) resources limit as of the month in which the excluded funds may have been used for another purpose, and
- the individual was eligible for the month in which the excluded burial funds may have been used for another purpose.

CHAPTER M13 TABLE OF CONTENTS Changes

Changed With	Effective Date	Pages Changed
TN #100	5/1/15	Page ii

CHANGES PRIOR TO MEETING SPENDDOWN ...M1350

Changes Prior to Meeting Spenddown M1350.1001
 Increase In Assistance Unit Size M1350.2002
 Decrease In Unit Size Not Due To Institutionalization. M1350.2103
 Decrease In Unit Size Due to Institutionalization M1350.2205
 Income Changes M1350.3005
 Income Limit Changes..... M1350.4007
 Resource Changes M1350.5008
 Nonfinancial Eligibility Requirement Not Met M1350.6009
 Change of Covered Group Classification M1350.70011
 Individual Becomes Institutionalized M1350.80013
 Changes Due to Death M1350.90014

CHANGES AFTER SPENDDOWN IS METM1360

Changes After Spenddown Is Met..... M1360.1001

SPENDDOWN – LIMITED BENEFIT

ENROLLEESM1370

Spenddown – Limited Benefit Enrollees..... M1370.1001
QMBs, SLMBs, QDWIs & Plan First Enrollees M1370.2003
Qualified Individuals M1370.3005

M1340 Changes

Changed With	Effective Date	Pages Changed
TN #100	5/1/15	Pages 4, 5
TN #95	3/1/11	Page 6
TN #94	9/1/10	Page 6
TN #93	1/1/10	Page 18

B. Noncovered Services

Noncovered services (not covered by Medicaid) include:

1. routine dental care for individuals age 21 or older.
2. services of other licensed practitioners of the healing arts such as chiropractors, naturopaths or acupuncturists, unless the services are covered by Medicare and the individual has Medicare.
3. professional nursing services in an individual's home when prescribed by the individual's physician and the cost is not part of a home health program or a Medicaid CBC waiver.
4. medical services provided by non-participating providers (providers who do not participate in Virginia Medicaid) unless the services are covered by Medicare and the individual has Medicare.
5. over-the-counter medications and medical supplies when ordered by a physician and the cost is not covered by Medicaid or Medicare, if the individual has Medicare.

C. Not Medical/ Remedial Care Services

The following are examples of services that are NOT medical/remedial care services and CANNOT be deducted from a spenddown liability, even if ordered by a physician:

- air conditioners or humidifiers,
- *refrigerators, whole house generators and other non-medical equipment,*
- *assisted living facility (ALF) room & board and services,*
- personal comfort items, such as reclining chairs or special pillows,
- health club memberships and costs,
- animal expenses such as for seeing eye dogs,
- cosmetic procedures.

D. Verification

Verification of noncovered services expenses includes:

1. a copy of the provider's bill or the insurance company's explanation of benefits paid, that shows:
 - the amount still owed that is the patient's responsibility, and
 - the service provider's name, address, and profession.
2. a prescription, physician's referral, or statement from the patient's physician or dentist that the service was medically necessary.

M1340.500 COVERED SERVICES**A. Policy**

Covered services expenses are incurred expenses for necessary medical or remedial care services which are covered by the Virginia Medicaid State Plan. Covered services expenses are deducted on the date the service was rendered. For medical supplies and equipment that are ordered, the date of service is the

date the supply or equipment was delivered to the individual. Expenses included in a prepaid package of services cannot be deducted prior to the date the service(s) is actually rendered.

B. Covered Services

Some of the medical services covered by Medicaid, and the limits on these services, are described in chapter M18. Medicaid covered services include:

- inpatient and outpatient hospital care
- physicians' services
- prescription drugs
- lab and x-ray services
- nursing facility care
- home health care
- rehabilitative services
- psychiatrists' and psychologists services
- licensed clinical social worker and licensed professional counselor services
- physical therapy services
- medical supplies and equipment
- transportation to secure medical care which is purchased, not provided in the individual's own vehicle.

C. Verification

Medical supplies and drugs must be prescribed or ordered by a physician or dentist.

Covered services expenses verification includes:

1. A copy of the provider's bill or the insurance company's explanation of benefits paid, that shows:
 - the amount still owed that is the patient's responsibility, and
 - the service provider's name, address, and profession.
2. *Documentation that the service is or was medically necessary. Documentation can include a prescription, physician's referral, statement from the patient's physician or dentist, or authorization from a licensed mental health provider or other individual as specified by DMAS to authorize a Medicaid covered service.*

D. Medicare Part D Prescription Drug Expenses

Because enrollment in Medicare Part D is voluntary, not all Medicare beneficiaries will be enrolled in a Medicare PDP. For those enrolled in a PDP, not all drugs will be covered. Each PDP may have a different combination of deductibles, co-pays and coverage gaps.

The PDP must issue a periodic (at least monthly) statement to the beneficiary explaining all benefits paid and denied, and any deductible and/or co-pays incurred by the beneficiary. Use the PDP statement to verify prescription drug costs that remain the beneficiary's responsibility.

To determine if drug costs incurred by Medicare beneficiaries are allowable under spenddown, apply the following rules:

M1370 Changes

Changed With	Effective Date	Pages Changed
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	9/1/2010	Table of Contents Pages 1-5

CHAPTER M13

SPENDDOWN

SUBCHAPTER 70

SPENDDOWN – *LIMITED BENEFIT ENROLLEES*

M1410 Changes

Changed With	Effective Date	Pages Changed
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

individual has been screened and approved to receive LTC services and it is anticipated that he is likely to receive the services for 30 or more consecutive days. If it is known at the time the application is processed that the individual did not or will not meet the 30 consecutive day requirement, the individual is not to be treated as an institutionalized individual.

The 30-consecutive-days requirement is expected to be met if the pre-admission screening committee provides verbal or written confirmation of its approval for the individual's receipt of long-term care (LTC). This allows the agency to begin the evaluation of the applicant in the 300% SSI covered group for institutionalized individuals and to use the special rules for married institutionalized individuals who have a community spouse, if appropriate. However, prior to approval of the individual for Medicaid payment of LTC services, the worker must have received the DMAS-96 that was signed by the supervising physician or the signed Waiver Level of Care form. Applicants must be evaluated as non-institutionalized individuals for the months prior to the month in which the completed form is dated.

The worker must verify that LTC services started within 30 days of the date on the Notice of Action on Medicaid. If services do not start within 30 days of the Notice of Action on Medicaid, the individual can no longer be considered an institutionalized individual and continued eligibility must be re-evaluated as a non-institutionalized individual.

CBC Waiver applicants cannot receive Medicaid payment of CBC services prior to the date the DMAS-96 was signed by the supervising physician. For applicants for whom a Waiver Level of Care form is the appropriate authorization document, Medicaid payment of CBC services cannot begin prior to the date the form has been signed.

For purposes of this definition, continuity is broken by 30 or more consecutive day's absence from a medical institution or by non-receipt of waiver services. For applicants in a nursing facility, if it is known at the time of application processing that the individual left the nursing facility and did not stay for 30 consecutive days, the individual is evaluated as a non-institutionalized individual. Medicaid recipients without a community spouse who request Medicaid payment of LTC services, except MN individuals, and are in the nursing facility for less than 30 consecutive days will have a patient pay determination (see *M1470.320*).

3. **Institution** An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor is an **institution**.
4. **In An Institution** "**In an institution**" refers to an individual who is admitted to live in an institution and receives treatment or services provided there that are appropriate to his requirements.
5. **Long-term Care** **Long-term care** is medical treatment and services directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or lessening of illness, disability or pain which have been received, or are expected to be received, for longer than 30 consecutive days.

M1450 Changes

Changed With	Effective Date	Pages Changed
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

TABLE OF CONTENTS

M14 LONG-TERM CARE

M1450.000 TRANSFER OF ASSETS

	Section	Page
Overview.....	M1450.001.....	1
Legal Base.....	M1450.002.....	1
Definition of Terms.....	M1450.003.....	2
Transfer of Assets Flow Chart	M1450.004.....	6
 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
 Transfers That Affect Eligibility	 M1450.500.....	 15
Purchase of Term Life Insurance.....	M1450.510.....	16
Purchase of Annuity	M1450.520.....	17
Reserved	M1450.300.....	19
Purchase of a Promissory Note, Loan, of Mortgage		
On or After February 8, 2006.....	M1450.540.....	19
Transfers Involving Life Estates	M1450.545.....	20
Transfers Involving Trusts	M1450.550.....	20
Income Transfers.....	M1450.560.....	23
Services Contracts	M1450.570.....	24
 Applying a Penalty Period	 M1450.600.....	 25
Uncompensated Value.....	M1450.610.....	25
Reserved	M1450.620.....	31
Penalty Period Calculation	M1450.630.....	35
Subsequent Receipt of Compensation.....	M1450.640.....	39
 Claim of Undue Hardship.....	 M1450.700.....	 40
 Agency Action	 M1450.800.....	 43
Applicant/Enrollee Notice.....	M1450.810.....	43
Provider Notice	M1450.820.....	43a
DMAS Notice	M1450.830.....	44

Appendices

Average Monthly Private Nursing Facility Cost		
Prior to October 1, 1996.....	Appendix 1.....	1
Life Expectancy Table.....	Appendix 2.....	1
Settlement Statement, HUD-1	Appendix 3.....	1

M1450.520 PURCHASE OF ANNUITY

A. Introduction

An annuity is a sum paid yearly or at other specific times in return for the payment of a fixed sum. Annuities may be purchased by an individual or by an employer. For Medicaid purposes, an annuity is a contract reflecting payment to an insurance company, bank or other registered or licensed entity by which one receives fixed, non variable payments on an investment for a lifetime or a specified number of years.

Although usually purchased to provide a source of income for retirement, annuities are sometimes used to shelter assets so that the individuals purchasing them can become eligible for Medicaid. To avoid penalizing individuals who validly purchased annuities as part of a retirement plan, determine the ultimate purpose of the annuity, i.e., whether the annuity purchase is a transfer of assets for less than fair market value.

B. Policy

All annuities purchased by an applicant/recipient or his spouse must be declared on the Medicaid application or renewal form. Annuities purchased by either the institutionalized individual or the community spouse must be evaluated even after initial eligibility as an LTC recipient has been established. In addition to determining if the annuity is a countable resource, the eligibility worker must evaluate the purchase of the annuity to determine if it is a compensated transfer.

The following rules apply to the purchase of an annuity:

1. *Purchased by Institutionalized Individual or Community Spouse*

An annuity purchased by the institutionalized individual or the community spouse will be treated as an uncompensated transfer unless:

- *the state is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual; or*
- *the state is named the remainder beneficiary in the second position after the community spouse or minor or disabled child. If the spouse or the representative of a minor or disabled child disposes of any remainder for less than fair market value, the state must be named in the first position.*

2. *Purchased by Institutionalized Individual*

An annuity purchased by the institutionalized individual will be considered an uncompensated transfer unless:

- a. *the annuity is described in one of the following subsections of section 408 of the Internal Revenue Service (IRS) Code:*
 - *individual retirement account,*
 - *accounts established by employers and certain associations of employees,*
 - *simple retirement accounts; or*

- b. *the annuity is a simplified employee pension (within the meaning of section 408(k) of the IRS Code; or a Roth Individual Retirement Account (IRA); or*
- c. *the annuity is:*
 - *irrevocable and non-assignable;*
 - *actuarially sound (see M1450.520 C); and*
 - *provides for equal payments with no deferral and no balloon payments.*

C. Procedures

1. Determine If Actuarially Sound

Determine if the annuity is actuarially sound. Use the Life Expectancy Table in M1450, Appendix 2:

- a. Find the individual's age at the time the annuity was purchased in the "Age" column for the individual's gender ("Male" or "Female").
- b. The corresponding number in the "Life Expectancy" column is the average number of years of expected life remaining for the individual.
- c. Compare the life expectancy number to the life of the annuity (the period of time over which the annuity benefits will be paid).
- d. When the average number of years of expected life remaining for the individual (the "life expectancy" number in the table) equals or exceeds the life of the annuity, the annuity is actuarially sound. When the annuity is actuarially sound, the purchase of the annuity is a compensated transfer for fair market value and does not affect eligibility.
- e. When the average number of years of expected life remaining for the individual (the "life expectancy" number in the table) is less than the life of the annuity, the annuity is NOT actuarially sound. The annuity purchase is a transfer for less than fair market value. The transfer occurred at the time the annuity was purchased.
- f. When the annuity is not actuarially sound, determine the uncompensated value and the penalty period (sections M1450.610 and M1450.620 below).

EXAMPLE #2:

A man at age 65 purchases a \$10,000 annuity to be paid over the course of 10 years. His life expectancy according to the table is 15.52 years. Thus, the annuity is actuarially sound; the purchase of the annuity is a compensated transfer for fair market value and does not affect eligibility for LTC services payment.

EXAMPLE #3:

A man at age 80 purchases the same \$10,000 annuity to be paid over the course of 10 years. His life expectancy according to the table is only 7.16 years. The annuity is not actuarially sound. The purchase of the annuity is a transfer for less than fair market value.

3. Send Copy to DMAS

A copy of the annuity agreement must be sent to:

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

4. Maintain Copy of Annuity

The copy must be maintained by DMAS until the terms of the annuity have expired. A copy of the annuity must also be maintained in agency's case record.

M1450.530 RESERVED

M1450.540 PURCHASE OF A PROMISSORY NOTE, LOAN, OR MORTGAGE ON OR AFTER FEBRUARY 8, 2006

A. Introduction

This policy applies to the purchase of a promissory note, loan, or mortgage on or after February 8, 2006. Subchapter S1140.300 contains explanations of promissory notes, loans, and mortgages.

B. Policy

Funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, must be evaluated as an uncompensated transfer unless the note, loan, or mortgage:

- has a repayment term that is actuarially sound (see M1450.520),
- provides for payments to be made in equal amounts during the term of the loan with no deferral and no balloon payments, and
- prohibits the cancellation of the balance upon the death of the lender.

C. Uncompensated Amount

If the promissory note, loan, or mortgage does not meet the above criteria, the uncompensated amount is the outstanding balance as of the date of the individual's application for Medicaid.

Note: The countable value as a resource is the outstanding principal balance for the month in which a determination is being made.

M1450.630 PENALTY PERIOD CALCULATION

A. Policy

When a transfer of assets on or after February 8, 2006, affects eligibility, the penalty period begins when the individual would otherwise be eligible for Medicaid payment for LTC services if not for the penalty period. The penalty period includes the fractional portion of the month, rounded down to a day. Penalty periods for multiple transfers cannot overlap.

Individuals in a penalty period who meet all other Medicaid eligibility requirements may be eligible for Medicaid payment for all other Medicaid covered services.

B. Penalty Begin Date

For individuals not receiving LTC services at the time of transfer, the penalty period begins the first day of the month in which the individual would otherwise be eligible for Medicaid payment for LTC services, except for the imposition of a penalty period. This includes the application retroactive period for nursing facility patients who have been in the facility during the retroactive period.

For individuals who are receiving Medicaid payment for LTC services at the time of transfer, the penalty period begins the month following the month of transfer.

1. Medicaid LTC Not Received at Time of Transfer

If the individual is not receiving Medicaid-covered LTC services at the time of the asset transfer, the penalty period begins the first day of the month in which the individual would otherwise be eligible for Medicaid payment for LTC services but for the application of the penalty period, as long as the date does not fall into another period of ineligibility imposed for any reason.

2. Receiving Medicaid LTC Services at Time of Transfer

If the individual is receiving Medicaid LTC services at the time of the asset transfer, the penalty period begins the first day of the month following the month in which the asset transfer occurred. A referral to the DMAS Enrollee Audit Unit (RAU) must be made for the months in the penalty period during which the individual received Medicaid LTC services. See Chapter M17 for instructions on RAU referrals.

3. Penalty Periods Cannot Overlap When multiple asset transfers result in multiple penalty periods, the penalty periods cannot overlap. One penalty period must be completed prior to the beginning of the next penalty period.

4. Nursing Facility If the individual in a nursing facility meets all Medicaid eligibility requirements, he is eligible for Medicaid payment of all other covered services.

5. CBC, PACE, Hospice

a. Transfer Reported At Application

If the individual has been screened and approved for or is receiving Medicaid CBC, PACE, or hospice services, he cannot be eligible for Medicaid in the 300% of SSI covered group or for the Medicaid payment of LTC services in any other covered group. The individual's Medicaid eligibility in other covered groups must be determined. His penalty period cannot be imposed unless and until he is (1) eligible for Medicaid in a *full-benefit* covered group other than the 300% of SSI covered group, (2) he meets a spenddown and would otherwise be eligible for the Medicaid payment of LTC services, or (3) he is admitted to a nursing facility.

b. Transfer Reported After Eligibility is Established

If it is reported or discovered that an individual receiving CBC services in the 300% of SSI covered group made an uncompensated asset transfer prior to beginning CBC, determine a penalty period. Evaluate for another covered group prior to cancelling. His penalty period cannot be imposed unless and until he is (1) eligible for Medicaid in a full-benefit covered group other than the 300% of SSI covered group, (2) he meets a spenddown and would otherwise be eligible for the Medicaid payment of LTC services, or (3) he is admitted to a nursing facility.

A referral to the DMAS Enrollee Audit Unit (RAU) must be made for the months in the penalty period during which the individual received Medicaid LTC services. See Chapter M17 for instructions on RAU referrals.

C. Penalty Period Calculation

The penalty period is the number of months, including any fractional portion of a month that an individual will be ineligible for the Medicaid payment of LTC services.

The period is calculated by taking the uncompensated value of the assets transferred on or after the look-back date, divided by the average monthly cost of nursing facility services to a private-pay patient in his locality at the time of the application for Medicaid. The remainder is divided by the daily rate (the monthly rate divided by 31).

When the uncompensated value of an asset transfer is less than the monthly nursing facility rate, go to step #4 in E below to calculate the partial month penalty period.

D. Average Monthly Nursing Facility Cost (Figures Provided by Virginia Health Information)

Average Monthly Private Nursing Facility Cost

<u>Application Date</u>	<u>Northern Virginia*</u>	<u>All Other Localities</u>
10-1-96 to 9-30-97	\$2,564	\$2,564
10-1-97 to 12-31-99	\$3,315	\$2,585
1-1-00 to 12-31-00	\$3,275	\$2,596
1-1-01 to 12-31-01	\$4,502	\$3,376
1-1-02 to 12-31-03	\$4,684	\$3,517
1-1-04 to 9-30-07	\$5,403	\$4,060
10-1-07 to 12-31-10	\$6,654	\$4,954
1-1-11 to 12-31-14	\$7,734	\$5,933
1-1-15 and after	\$8,367	\$5,933(no change)

*The northern Virginia localities are: Alexandria, Arlington, Fairfax, Fairfax County, Falls Church, Loudoun County, Manassas, Manassas Park and Prince William County.

See M1450, Appendix 1 for amounts prior to October 1, 1996.

E. Partial Month Transfer

The following example shows how to compute a penalty period for an uncompensated transfer that occurred on or after February 8, 2006 and involving a partial month.

Example #19: An individual makes an uncompensated asset transfer of \$30,534 in April 2006, the same month he applies for Medicaid. The uncompensated value of \$30,534 is divided by the average monthly rate of \$4,060 and equals 7.52 months. The full 7-month penalty period runs from April 2006, the month of the transfer, through October 2006, with a partial penalty calculated for November 2006. The partial month penalty is calculated by dividing the partial month penalty amount (\$2,114) by the daily rate. The calculations are as follows:

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

$$\begin{aligned}
 \text{Step \#2 } & \$ 4,060.00 \quad \text{avg. monthly nursing facility rate at time of} \\
 & \quad \quad \quad \text{application} \\
 & \quad \quad \quad \times \quad \quad \quad 7 \quad \text{seven-month penalty period} \\
 & \quad \quad \quad \hline
 & \$28,420.00 \quad \text{penalty amount for seven full months}
 \end{aligned}$$

M1460 Changes

Changed With	Effective Date	Pages Changed
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

TABLE OF CONTENTS

M14 LONG-TERM CARE

M1460.000 LTC FINANCIAL ELIGIBILITY

	Section	Page
Overview.....	M1460.001.....	1
Definitions	M1460.100.....	1
Substantial Home Equity Precludes Eligibility for LTC	M1460.150.....	3
Third Party & Long-Term Care Insurance Payments.....	M1460.155.....	4
Long-Term Care Partnership Policies.....	M1460.160.....	4a
Determination of Covered Group	M1460.200.....	4b
SSI Recipients	M1460.201.....	7
ABD 80% FPL Covered Group	M1460.210.....	9
300% SSI	M1460.220.....	10
Medically Needy Covered Groups	M1460.230.....	11
Assistance Unit	M1460.300.....	12
Steps for Determining Financial Eligibility	M1460.400.....	12
Steps for Determining MN Eligibility	M1460.410.....	16

RESOURCES

Resource Determination.....	M1460.500.....	17a
Determining Countable Resources.....	M1460.510.....	17a
Retroactive Resource Determination.....	M1460.520.....	18a
Home Ownership	M1460.530.....	18a
Suspension Procedures.....	M1460.540.....	24

INCOME

Income Determination.....	M1460.600.....	26
What is Not Income	M1460.610.....	27
Countable Income for 300% SSI Group	M1460.611.....	33
Reserved	M1460.620.....	36
Income Determination Process For Stays Less Than 30 Days.....	M1460.640.....	36
Retroactive Income Determination.....	M1460.650.....	37
Notices & Enrollment Procedures for CN and Medicare Savings Programs (MSPs).....	M1460.660.....	38
Medically Needy Income & Spenddown	M1460.700.....	40
Spenddown for Facility Patients	M1460.710.....	41
Spenddown For Patients Receiving CBC	M1460.740.....	47
Medically Needy Enrollment and Post-eligibility Procedures.....	M1460.750.....	50

M1460.000 LTC FINANCIAL ELIGIBILITY

M1460.001 OVERVIEW

A. Introduction

This subchapter contains the Medicaid financial eligibility requirements for individuals receiving facility or Medicaid waiver long-term care (LTC) services, who are not married or who are married but do not have community spouses. **For married individuals with community spouses (when both are not in a medical facility), go to subchapter M1480 to determine financial eligibility and patient pay.**

All individuals whose Medicaid eligibility has been determined PRIOR to entering LTC must have their financial eligibility redetermined, including asset transfer evaluation, home ownership and other resource evaluation. First, determine if the individual meets the Medicaid non-financial requirements including covered group in M1410.020. Then determine financial eligibility. Financial eligibility requirements for an individual differ depending on the individual's covered group, marital status and type of long-term care.

This subchapter contains policy and procedures for resources and income eligibility determination for institutionalized individuals. Patient pay (post-eligibility treatment of income) policy and procedures for unmarried individuals or married individuals without community spouses are in subchapter M1470.

B. Related Policies

- ABD resource rules in Chapter S11.
- ABD income rules in Chapter S08.
- Family and Children resource rules in Chapter M06.
- Family and Children *Medically Needy (MN)* income rules in Chapter M07.
- Married Institutionalized Individuals' Eligibility & Patient Pay rules in subchapter M1480.

M1460.100 DEFINITIONS

A. Purpose

This section provides definitions for terms used in this subchapter.

B. Definitions

1. 300% SSI Group

The 300 SSI group is the short name for the categorically needy covered groups of Aged, Blind & Disabled (ABD) and Families & Children (F&C) individuals who are institutionalized in medical facilities or Medicaid-covered waiver services, who have resources within the Medicaid resource limits and whose gross income is less than or equal to 300% of the *Supplemental Security Income (SSI)* income limit for one person.

2. Budget Period

The budget period is the period of time during which an individual's income is calculated to determine eligibility.

- 3. Carry-over Expenses** Carry-over expenses are the balance due on medical, dental, and remedial care expenses incurred in the retroactive or prospective budget period prior to the current budget period which were not used in establishing eligibility and which may be deducted in a consecutive budget period(s) when there has been no break in spenddown eligibility.
- 4. Certification Period** The certification period is the period of time over which an application or redetermination is valid.
- 5. Current Payments** Current payments are payments made in the current spenddown budget period on expenses incurred before the current spenddown budget period which were not used in establishing eligibility in a previous spenddown budget period and when there has been a break in spenddown eligibility. The payment amount allowed is the actual payment amount paid to the provider and is deducted from the spenddown liability on the date the payment is actually made.
- 6. Income Determination Period** The income determination period is the budget period; for all LTC cases, the budget period is one month.
- 7. LTC Case** A case in which the Medicaid applicant or recipient is an institutionalized individual receiving long-term care services is an LTC case.
- 8. Lump Sum Payment** Income received on a "non-recurring basis" and/or income that is received once a year is a lump sum payment. All lump sum payments are income in the month of receipt and a resource in the following month(s), if retained.

Different types of lump sum payments must be treated differently. Refer to the ABD Income chapter S08 (for both ABD and F&C individuals) for policy specific to the type of lump sum payment that is being evaluated.
- 9. Medicaid Rate** The Medicaid rate is a monthly rate which is calculated:

 - for a facility, by multiplying the individual's daily *Resource Utilization Group (RUG) code amount* by the number of days in the month. *A patient's RUG code amount is based on his room and board and ancillary services. The RUG code amount may differ from facility to facility and from patient to patient within the same facility. Confirmation of the individual's RUG code amount must be obtained by contacting the facility;*

NOTE: When projecting the facility's monthly Medicaid rate, the *daily RUG code amount* is multiplied by 31 days.

 - for Medicaid CBC waiver services, by multiplying the provider's Medicaid hourly rate by the number of hours of service received by the patient in the month. Confirm the provider's hourly Medicaid rate and number of service hours by contacting the provider.

2. Applicants Who Do Not Receive Cash Assistance

a. Child Under Age 18

Modified Adjusted Gross Income (MAGI) methodology is not applicable to F&C individuals needing LTC services. If the applicant is a child under age 18, determine the child's eligibility in the F&C 300% SSI group, using the covered group policy in subchapter M0330 and the financial eligibility policy and procedures in this subchapter. The resource requirement for the F&C 300% SSI covered group does NOT apply to children under age 18.

If the child's income exceeds the limit for the F&C 300% SSI group, determine the child's eligibility in an MN covered group.

NOTE: A child who is age 18, 19 or 20 meets an MN covered group if he is blind, disabled, pregnant, in foster care, adoption assistance, or institutionalized in a nursing facility. An individual age 21 or older, must meet the pregnant, aged, blind or disabled definition in order to meet an MN covered group.

c. Individual Age 18 or Older

If the applicant is an individual age 18 or older, determine the individual's eligibility in an ABD or F&C covered group, depending on which definition the individual meets, using the financial eligibility policy and procedures in this subchapter.

For ABD individuals, determine the individual's eligibility in the ABD 80% FPL covered group. If not eligible in the ABD 80% FPL covered group, determine the individual's eligibility in the ABD 300% SSI covered group. If not eligible in the either of these covered groups, determine the individual's eligibility in all other groups for which he meets a definition.

For F&C individuals, first determine the individual's eligibility in the LIFC or Pregnant Woman groups. If the individual's income exceeds the limits for the LIFC or Pregnant Woman covered groups, determine the individual's eligibility in the F&C 300% SSI covered group. If the income exceeds the 300% SSI group limit, determine the individual's eligibility in an MN covered group (see M0330).

NOTE: Because a child over 18 does not meet the definition of a dependent child, the child must have a disability determination unless another F&C covered group is met (i.e. pregnant woman).

If the income exceeds the 300% SSI group limit *and the individual meets a MN covered group*, determine the individual's eligibility in an MN covered group.

B. Relation to Income Limits

Determination of the appropriate covered group must be made prior to determination of income because the income limits are determined by the covered group:

1. ABD 80% FPL

The ABD income policy in chapter S08 is used to determine countable income for the ABD 80% FPL covered group. The income items listed in Sections M1460.610 and M1460.611 are NOT counted as income in determining income eligibility for the ABD 80% FPL covered group.

2. **300% SSI** The ABD income policy in chapter S08 is used to determine income for all individuals (ABD and F&C) in the 300% SSI group. The items found in section M1460.611 ARE counted in determining income eligibility for long-term care. The income items listed in M1460.610 are not counted for the 300% SSI groups (ABD and F&C).

3. **ABD MN Groups** The ABD income policy in chapter S08 is used to determine countable income for the ABD MN covered groups. However, the income items listed in "What Is Not Income", Section M1460.610 and in "Countable Income for the 300% SSI Group", Section M1460.611 are NOT counted as income in determining income eligibility for ABD MN groups.

4. **F&C MN Groups** The F&C income policy in chapter M07 is used to determine countable income for individuals *in F&C MN covered groups*. However, the income items listed in "What Is Not Income", section M1460.610 and "Countable Income for the 300% SSI Group", Section M1460.611 are NOT counted when determining income eligibility for F&C MN groups.

C. Ongoing Recipient Enters LTC

1. **SSI Recipients** SSI recipients who are already enrolled in Medicaid when they enter Medicaid long-term care *must have their eligibility reviewed*. They already meet a covered group but they must also meet the asset transfer, resource and financial eligibility requirements in order for Medicaid to cover the cost of long-term care services.

2. **Other Recipients** Recipients who do not receive cash assistance but who are already enrolled in Medicaid when they enter long-term care in a medical facility **must have their eligibility redetermined**. They must meet a covered group and they must meet the asset transfer, resource, and financial eligibility requirements in order for Medicaid to cover the LTC services cost.

Review the asset transfer policy in subchapter M1450 with the recipient if he has transferred assets. If the recipient is admitted to a nursing facility, or moves from his home to receive Medicaid CBC in another person's home, review asset transfer, home property and other resource requirements to determine if the individual remains eligible for Medicaid.

A married recipient who enters LTC must have resource and income eligibility redetermined using the rules in subchapter M1480, if his spouse is a community spouse.

M1460.220 300% of SSI PAYMENT LIMIT GROUP

A. Description

These are ABD or F&C individuals in medical facilities or who receive Medicaid CBC waiver services, who meet the appropriate CN resource requirements and resource limit and whose income is less than or equal to 300% of the SSI payment limit for an individual.

Individuals who have been screened and approved for Medicaid LTC services may be evaluated in this covered group. 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 services.

B. ABD Groups

Aged, blind or disabled individuals institutionalized in medical facilities, or who require institutionalization and are approved to receive Medicaid CBC waiver services are those who:

- meet the Medicaid ABD resource requirements; and
- have gross income, determined according to the ABD income requirements, that does not exceed 300% of the SSI individual payment limit.

See sections M0320.501 and M0320.502 for details about these covered groups.

C. F&C Groups

Individuals who meet an F&C definition (foster care or adoption assistance children under age 21, parents or caretaker-relatives of dependent children, and pregnant women) in medical facilities, or who require institutionalization and who are approved to receive Medicaid home and community-based care (CBC) waiver services, are those who:

- meet the F&C CN resource requirements if unmarried, (married individuals *over age 18* must meet the ABD resource requirement); and
- have gross income, determined according to the ABD income requirements, that does not exceed 300% of the SSI individual payment limit.

Children under age 18 in the 300% of SSI covered group have no resource requirement.

See sections M0330.501 and M0330.502 for details about these covered groups.

2) Married Individual with Community Spouse

Determine ABD countable resources using chapter S11 and subchapter M1480.

Compare to ABD CN resource limit = \$2000 for 1 person

b. F&C groups

1) Unmarried Individual *age 18 or over* or Married Individual *age 18 or over* with no Community Spouse

- Determine F&C CN countable resources using chapter M06 for the unmarried institutionalized individual.
- Compare to F&C CN resource limit = \$1,000.

2) Married Individual *age 18 or over* with Community Spouse

- Determine ABD countable resources, Chapter S11, M1480.
- Compare to ABD CN resource limit = \$2000 for 1 person.

2. Are resources within CN limit?

Yes: eligible in the covered group whose income limit is met; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

No: go to item 3 below.

3. Does person meet an MN covered group?

Yes: go to section M1460.410 "Steps for Determining MN Eligibility," below.

No: person is not eligible for Medicaid because of excess resources; STOP. Go to section M1460.660 for notice procedures.

C. Determine MN
Income

1. ABD groups

Determine ABD MN countable income, Chapter S08.

Compare to MN income limit for 1 person in individual's home locality - where the individual last resided in Virginia outside of an institution (use Group III MN limit if individual was admitted to Virginia facility from out-of-state).

2. F&C groups

Determine F&C MN income, Chapter M07.

Compare to MN income limit for 1 person in individual's home locality - where the individual last resided in Virginia outside of an institution (use Group III MN limit if individual was admitted to Virginia facility from out-of-state).

3. Is Income Less
Than or Equal
to MN Income
Limit?

NOTE: A person who has gross income exceeding the 300% SSI limit will **always** have countable income that exceeds the MN limit.

Yes: eligible as MN; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

No: Spenddown; excess amount is "spenddown liability." Go to 4. below for facility patients, 5. below for CBC recipients.

1. Spenddown--
Facility
Patients

The RUG code amount may differ from facility to facility and from patient to patient within the same facility. For MN patients, the nursing facility must be contacted to obtain the RUG code amount.

a. Spenddown Liability Less Than or Equal to the Individual's Medicaid Rate

If the spenddown liability is less than or equal to the *individual's* Medicaid rate, determine spenddown eligibility by projecting the facility's costs at the *individual's* Medicaid rate for the month. Spenddown balance after deducting projected costs at the *individual's* Medicaid rate should be zero or less.

The patient is eligible as MN for the whole month. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

b. Spenddown Liability More Than the Individual's Medicaid Rate

When the spenddown liability is **more than** the *individual's* Medicaid rate, determine spenddown eligibility AFTER the month has passed, on a daily basis (do not project expenses) by chronologically deducting old bills and carry-over expenses, then deducting the facility daily cost at the **private** daily rate and other medical expenses as they were incurred.

If the spenddown is met on any date within the month, the patient is eligible effective the first day of the month in which the spenddown was met. Eligibility ends the last day of the month.

Each month must be evaluated separately. These patients will always be enrolled after the month being evaluated has passed.

**5. Spenddown--
CBC Patients**

Do not project CBC waiver services costs. Eligibility is evaluated on a monthly basis. Determine spenddown eligibility AFTER the month has passed, by deducting old bills and carry-over expenses first, then (on a daily basis) chronologically deducting the daily CBC cost at the **private** daily rate and other medical expenses **as they are incurred**. If the spenddown balance is met on a date within the month, the patient is eligible effective the first day of the month in which the spenddown was met. Eligibility ends the last day of the month.

Each month must be evaluated separately. These patients will always be enrolled after the month being evaluated has passed.

M1460.500 RESOURCE DETERMINATION

A. Introduction

The following sections describe the resource eligibility rules that are applicable to individuals in long-term care.

B. Resource Limits

1. ABD Groups

ALL aged, blind and disabled (ABD) covered groups = \$2,000 per individual.

2. F&C Groups

F&C 300% SSI and Hospice groups = \$1,000 *for individuals age 18 and over*, regardless of the number of individuals in the assistance unit. *Children under age 18 do not have a resource requirement.*

There are no resource requirements for any other F&C covered group.

3. MN Groups

MN groups = \$2,000 for an individual and \$3,000 for 2 persons (pregnant woman with 1 unborn child; add \$100 for each additional unborn child).

C. Budget Period

The budget period for determining long-term care resource eligibility is always one month.

M1460.510 DETERMINING COUNTABLE RESOURCES

**A. Married
Individual**

**1. With A
Community
Spouse**

See **subchapter M1480** for the rules to determine the **institutionalized individual's resource eligibility** when he is married and his spouse is a community spouse (the spouse is not in a medical institution or nursing facility).

b) **cancel** the recipient's full coverage line in the MMIS effective the last day of the month in which the 10-day advance notice period expires, using cancel reason "07". Reinstatement of 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 in the MMIS 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 the MMIS. 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 case record. Reinstatement of his Medicaid eligibility in the MMIS 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 MMIS, because his eligibility has already been canceled. The individual will have to file a new Medicaid application.

Income for all LTC recipients is determined on a monthly basis. Upon receipt of long term care services, the spenddown budget period is one month. A separate monthly spenddown budget period is established for each month of receipt of LTC services.

A spenddown case is considered denied; however, the application is valid for a certification period of 12 months from the last application or redetermination.

B. Spenddown Procedures

The spenddown procedures for facility patients differ from the spenddown procedures for CBC patients. The expected monthly cost of the facility care is projected at the beginning of the month. The cost of CBC is NOT projected and must be deducted daily as incurred. Specific instructions for determining MN income eligibility for facility and CBC patients are provided in the following sections:

- M1460.710 Spenddown For Facility Patients
- M1460.740 Spenddown For Patients Receiving CBC
- M1460.750 Medically Needy Spenddown Enrollment and Post-eligibility Procedures.

M1460.710 SPENDDOWN FOR FACILITY PATIENTS

A. Policy

Facility patients in the MN classification fall into two distinct subgroups for the purpose of spenddown eligibility determination. These subgroups are:

1. individuals with a spenddown liability less than or equal to the *individual's* Medicaid rate.
2. individuals with a spenddown liability greater than the *individual's* Medicaid rate.

The RUG code amount may differ from facility to facility and from patient to patient within the same facility. The nursing facility must be contacted to obtain the RUG code amount whenever a daily facility cost of care is needed to determine eligibility and patient pay for medically needy individuals.

Entitlement and enrollment procedures depend on whether the individual's spenddown liability is less than, equal to or greater than the Medicaid rate.

Applications for individuals who are placed on spenddown are valid for a 12 month period and the cases are subject to annual redetermination.

B. Determine the Spenddown Liability

Calculate the individual's monthly MN income:

1. **ABD MN Groups**
 - a. Start with the gross monthly income for the ABD MN income determination found in section M1460.640 B. 4.
 - b. Subtract the applicable ABD MN income exclusions. The result is the MN countable income.
 - c. Subtract the monthly MN income limit for 1 person in the individual's home locality from the MN monthly countable income. The remainder is the ABD individual's spenddown liability.

2. **F&C MN Groups**
 - a. Start with the gross monthly income for the F&C MN income determination found in section M1460.640 B. 4.
 - b. If the *individual* has earned income, subtract the F&C earned income exclusions in M0720.500 except for the 30 + 1/3 exclusion which is not applicable to this group.

If the *individual* has child support income, subtract the \$50 child support exclusion. See section M0730.400.
 - a. The remainder is the MN monthly countable income.
 - d. Subtract the monthly MN income limit appropriate to the individual's home locality from the MN monthly countable income. The remainder is the F&C individual's spenddown liability.

- C. **Determine the Individual's Projected Medicaid Rate**

The *individual's* projected monthly Medicaid rate is the daily RUG code amount at the time of the spenddown calculation multiplied by 31 days. **For the month of entry, use the actual number of days that care was received or is projected to be received in the facility.**

- D. **Compare**

Compare the individual's spenddown liability to the *individual's* Medicaid rate.

- E. **SD Liability Is Less Than or Equal To Medicaid Rate**

If the spenddown liability is less than or equal to the *individual's* Medicaid rate, the individual is income eligible as medically needy for the full month. Individuals with a spenddown liability less than or equal to the *individual's* Medicaid rate will meet their spenddown based on the Medicaid rate alone. The Medicaid rate is projected and compared to the spenddown liability. Because the spenddown liability is less than the *individual's* Medicaid rate, eligibility begins the first day of the month.

Go to section M1460.750 below for enrollment procedures.

- F. **SD Liability Is Greater Than Medicaid Rate**

If the spenddown liability is greater than the Medicaid rate, the individual is NOT income eligible as MN. The individual must incur medical expenses, including old bills, carry-over expenses and the facility's cost of care at the private rate, which equal or exceed the spenddown liability for the month. These determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred.

To determine spenddown eligibility for a medically needy individual whose spenddown liability is greater than the *individual's* Medicaid rate, go to G. below.

G. Facility Spenddown Determination Procedures

To determine spenddown eligibility for a medically needy institutionalized individual whose spenddown liability is greater than the *individual's* Medicaid rate, take the following actions:

1. Calculate Private Cost of Care

Multiply the facility's **private** per diem rate by the number of days the individual was actually in the facility in the month. Do not count any days the individual was in a hospital during the month.

The result is the private cost of care for the month.

2. Compare to Spenddown Liability

Compare the private cost of care to the individual's spenddown liability for the month.

a. Private Cost of Care Greater Than or Equal To Spenddown Liability

If the private cost of care is **greater than or equal to** the individual's spenddown liability, the individual meets the spenddown in the month because of the private cost of care. He is entitled to **full-month coverage** for the month in which the spenddown was met.

Enroll the individual in Medicaid with the begin date of the first of the month, the end date the last day of the month. Go to section M1460.750 below for enrollment procedures. Determine patient pay according to subchapter M1470.

b. Private Cost of Care Less Than Spenddown Liability

If the private cost of care is less than the individual's spenddown liability, **determine spenddown on a day-by-day basis** in the month by deducting allowable incurred expenses from the spenddown liability.

From the spenddown liability, deduct old bills, carry-over expenses and incurred medical/remedial care expenses per subchapter M1340. When the monthly spenddown liability is reduced to \$0, eligibility is established. Eligibility can be established only **AFTER** the expenses are actually incurred.

If the spenddown is met any time during the month, the individual is eligible for full month coverage. Enroll the individual in Medicaid with the begin date of the first of the month, the end date the last day of the month. Go to section M1460.750 below for enrollment procedures.

Determine patient pay according to subchapter M1470.

**3. Example -
Spendedown
Liability
Greater than
Cost of Care,
(using July
2014 figures)**

EXAMPLE #4: Mr. Not lives in Group III and applied for Medicaid on April 21 *and was determined disabled by Disability Determination Services (DDS)*. He is in a nursing facility and was admitted on April 1. His income is \$2,800 per month disability benefit from a private company. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His resources are within the Medicaid limit in April (application month).

He is not eligible as CN because his \$2,800 gross income exceeds the 300% SSI income limit. The *individual's* Medicaid rate is \$100 per day. His MN income eligibility is calculated:

\$2,800.00	disability benefit
<u>- 20.00</u>	general income exclusion
\$2,780.00	MN countable income
<u>- 457.63</u>	MNIL for 1 month for 1 person in Group III
\$2,322.37	spendedown liability

The *individual's* Medicaid rate for the admission month is calculated as follows:

\$100.00	<i>daily RUG code amount</i>
<u>x 30</u>	days
\$3,000.00	<i>individual's projected Medicaid rate</i>

The \$2,322.37 spendedown liability is *less* than the *individual's* Medicaid rate of \$3,000.00. Because his spendedown liability is *less* than the Medicaid rate, his application is *approved for ongoing coverage*.

4. Example - On Prior Spenddown, Spenddown Liability Greater Than Cost of Care (Using July 2014 Figures)

EXAMPLE #5: Ms. Was, age 62, lives in Group I and applied for Medicaid on May 6, 2015. She is in a nursing facility and was admitted on May 1. She had applied for Medicaid previously and was on a spenddown from December 1, 2013 through May 31, 2014, which she met on May 2, 2014. She did not re-apply until May 2015. She verifies that she has an unpaid \$2,300 hospital bill and a \$1,500 physician's bill for September 10 to September 12, 2014 (total = \$3,800) on which she pays \$50 a month. She also has a retroactive incurred expense - a \$678 outpatient hospital bill for services dated February 13, 2015. She has no health insurance and is not eligible for Medicare.

She was not institutionalized in the retroactive period. Her income in the retroactive spenddown budget period was \$1,600 per month Civil Service Annuity (CSA) disability. The retroactive spenddown budget period is February, March and April; the income limit is \$915.27.

Her retroactive spenddown liability is \$3,824.73.

\$1,600.00	CSA disability
<u>- 20.00</u>	general income exclusion
1,580.00	countable income
<u>x 3</u>	months
4,740.00	countable income for retroactive spenddown budget period
<u>- 915.27</u>	MNIL for retroactive spenddown budget period
\$3,824.73	retroactive spenddown liability

Her May 2015 application is a re-application. The September 2014 medical expenses are old bills based on her May 2015 re-application because they were incurred prior to the re-application's retroactive period, were not incurred during a prior spenddown budget period in which eligibility was established. These old bills, totaling \$3,800, are deducted from the retroactive spenddown liability. Her retroactive spenddown eligibility is calculated:

\$3,824.73	retroactive spenddown liability
<u>- 3,800.00</u>	September 2014 old bills (hospital & physician bills)
24.73	spenddown balance on February 1, 2015
<u>- 678.00</u>	February 13, 2015 outpatient expense
0	spenddown balance on February 13, 2015

The retroactive spenddown was met on February 13, 2015. Ms. Was is enrolled in retroactive Medicaid for the period February 13, 2015 through April 30, 2015.

Her income starting May 1, 2015 increased. Her Civil Service Annuity is \$1,620 per month and she began to receive Social Security of \$600 per month; total income is \$2,220 per month. Because this exceeds the 300% SSI income limit, her medically needy income eligibility is calculated as follows:

\$2,220.00	total monthly income
- 20.00	general income exclusion
<u>2,200.00</u>	countable income
- 305.09	MNIL for 1 month for 1 person in Group I
<u>\$1,894.91</u>	spenddown liability

Ms. Was' daily RUG code amount is \$45. The projected Medicaid rate for the month is calculated as follows:

\$ 45	daily RUG code amount
x 31	days
<u>\$1,395</u>	individual's projected Medicaid rate

The \$1,894.91 spenddown liability is greater than her Medicaid rate of \$1,395. Because her spenddown liability is greater than the Medicaid rate, her May application is denied and she is placed on a monthly spenddown for the certification period of May 1, 2015 through April 30, 2016.

On June 3, her authorized representative requests re-evaluation of her spenddown for May. She was in the facility for 31 days in May. The private cost of care for May is calculated:

\$ 53	private per diem cost
x 31	days in May
<u>\$1,643</u>	private cost of care

The private cost of care, \$1,643, is less than her spenddown liability of \$1,894.91. Therefore, her spenddown eligibility in May must be determined on a daily basis. The prospective budget period is May 1 through May 31, 2015. Since all of her old bills were used to meet her retroactive spenddown, they cannot be deducted from her current spenddown. The only incurred medical expenses which can be deducted are the medical expenses she incurred in May. In addition to the facility care, she incurred a doctor's expense on May 30 of \$400. Her spenddown eligibility for May is determined:

\$1,894.91	spenddown liability
- 1,590.00	30 days @ \$53 per day (5-1 through 5-30)
- 400.00	noncovered doctor's expense 5-30-2015
<u>0</u>	spenddown balance on 5-30-2015

Because the spenddown was met on May 30, Ms. Was is entitled to Medicaid coverage beginning May 1, 2015 and ending May 31, 2015.

M1460.740 SPENDDOWN FOR PATIENTS RECEIVING CBC

A. Policy

An individual meets the definition of "institutionalized" when he is screened and approved for Medicaid waiver services and the services are being provided. An individual who has been screened and approved for Medicaid waiver services and whose income exceeds the 300% SSI income limit is not eligible for Medicaid until he meets the monthly spenddown liability. These determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred. The private cost of his home-based medical care is deducted as a noncovered medical expense.

For an individual on spenddown **before** starting Medicaid CBC waiver services, the spenddown budget period and the spenddown liability are prorated and recalculated to include the months prior to the receipt of Medicaid CBC services. A separate monthly spenddown budget period is calculated for each month of receipt of Medicaid CBC services.

A *MN CBC* patient must incur medical expenses, including old bills, carry-over expenses and the cost of CBC at the private rate, *which* equal or exceed the spenddown liability for the month. From the spenddown liability, deduct old bills, carry-over expenses and incurred medical/remedial care expenses per section M1340.210. When the monthly spenddown liability is reduced to \$0, eligibility is established. Eligibility can be established only **AFTER** the expenses are actually incurred. Do not project CBC expenses. The eligibility begin date is the first day of the month in which the spenddown was met and the end date is the last day of the month.

B. CBC Spenddown Eligibility Procedures

To determine spenddown eligibility for a CBC institutionalized individual, take the following actions:

1. Calculate Private Cost of Care

Multiply the CBC provider's (or providers' if the individual has multiple CBC providers) **private** hourly rate by the number of hours of service the individual actually received from the provider in the month.

The result is the private cost of care for the month.

2. Compare to Spenddown Liability

Compare the private cost of care to the individual's spenddown liability for the month.

3. Spenddown Liability Less Than Private Cost of Care

If the individual's spenddown liability is less than or equal to the private cost of care, the individual meets the spenddown in the month because of the private cost of care. He is entitled to **full-month coverage** for the month in which the spenddown was met.

Enroll the individual in Medicaid with the begin date of the first of the month, the end date the last day of the month. Go to section M1460.750 below for enrollment procedures. Determine patient pay according to subchapter M1470.

4. Spenddown Liability Greater Than Private Cost of Care

If the individual's spenddown liability is greater than the private cost of care, **determine spenddown on a day-by-day basis** in the month by deducting allowable incurred expenses from the spenddown liability. Refer to section M1340.210 to determine allowable deductions from the individual's spenddown liability.

If the spenddown is met any time in the month, the individual is eligible for full-month Medicaid coverage beginning the first day of the month in which the spenddown was met and ending the last day of the month.

5. Example - No Prior Spenddown, Spenddown Liability Greater than Private Cost of Care (Using July 2014 Figures)

EXAMPLE #6: Mr. May lives in Group III and applied for Medicaid on April 21, 2015. He was screened and approved for the EDCD waiver on April 10, 2015. The DDS determined that he is disabled. He has no health insurance. His income is \$2,800 per month disability benefit from a private company. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His resources are within the Medicaid limit in April 2015 (application month).

He is not eligible as CN because his \$2,800 gross income exceeds the 300% SSI income limit. His MN income is calculated:

\$2,800.00	disability benefit
- 20.00	general income exclusion
\$2,780.00	MN countable income
- 457.63	MNIL for 1 month for 1 person in Group III
\$2,322.37	spenddown liability

His CBC costs cannot be projected. Eligibility can be established only after the expenses are actually incurred. He received 20 days of CBC services in April.

His April application is denied and he is placed on a monthly spenddown for the certification period of 4-1-2015 through 3-31-2016.

\$ 8	per hour private rate
x 6	hours per day
\$ 48	private per diem cost
x 20	days in April
\$ 960	private cost of care

Mr. May's spenddown liability of \$2,322.37 is greater than the private cost of care, \$960. His Medicaid eligibility was not established in April.

6. Example - On Prior Spenddown, Spenddown Liability Less Than Private Cost of Care (Using July 2014 Figures)

EXAMPLE #7: Ms. Gray lives in Group I and applied for Medicaid on May 6, 2015. She was screened and approved for Medicaid EDCD waiver services on May 2, 2015; the services started on May 4, 2015. She had applied for Medicaid previously and was on a spenddown from December 1, 2013 through May 31, 2014, which she met on May 2, 2014. She did not re-apply until May 2015. She verifies that she has an unpaid \$2,300 hospital bill and a \$1,500 physician's bill for September 10 to September 12, 2014 (total = \$3,800) on which she pays \$50 a month. She also has an incurred expense in the retroactive period - a \$678 outpatient hospital bill for services dated February 13, 2015. She has no health insurance and is not eligible for Medicare.

She was not institutionalized in the retroactive period. Her income in the retroactive spenddown budget period was \$1,600 per month CSA disability. The retroactive spenddown budget period is February, March and April, 2015; the income limit is \$915.27.

Mrs. Gray's retroactive spenddown liability is \$4,090:

\$1,600.00	CSA disability
<u>- 20.00</u>	general income exclusion
1,580.00	countable income
<u>x 3</u>	months
4,740.00	countable income for retroactive spenddown budget period
<u>- 915.27</u>	MNIL for retroactive spenddown budget period
\$3,824.73	retroactive spenddown liability

There was a break between spenddown budget periods (June, July, August, September, October, November and December 2014 and January 2015). The September 2014 medical expenses are old bills based on her May 2015 re-application because they were incurred prior to the re-application's retroactive period and were not incurred during a prior spenddown budget period in which eligibility was established. These old bills, totaling \$3,800, are deducted from the retroactive spenddown liability. Her retroactive spenddown eligibility is calculated:

\$3,824.73	retroactive spenddown liability
<u>- 3,800.00</u>	September 2014 old bills (hospital & physician bills)
24.73	spenddown balance on February 1, 2015
<u>- 678.00</u>	February 13, 2015 outpatient expense
0	spenddown balance on February 13, 2015
	(\$653.27 carry over balance)

A balance of \$653.27 (\$678-24.73) on the 2-13-2015 outpatient expense remains and can be used as a carry-over expense for the first prospective budget period.

The retroactive spenddown was met on 2-13-2015. Ms. Gray is enrolled in retroactive Medicaid for the period 2-13-2015 through 4-30-2015.

Her income starting May 1, 2015 increased. Her CSA is \$1,620 per month and she began to receive Social Security of \$630 per month; total income is \$2,250 per month. Because this exceeds the 300% SSI income limit, her medically needy income eligibility is calculated as follows:

\$2,250.00	total monthly income
<u>- 20.00</u>	general income exclusion
2,230.00	countable income
<u>- 305.09</u>	MNIL for 1 month for 1 person in Group I
\$1,924.91	spenddown liability
<u>- 653.27</u>	carry-over expense from retroactive period
\$1,271.64	spenddown liability balance

Her May application is denied and she is placed on a monthly spenddown for the certification period of May 1, 2015 through April 30, 2016.

On June 3, she submits verification of expenses for May. In May, she received CBC services from one provider for 28 days, 6 hours per day, at the private hourly rate of \$10. The private cost of care for May is calculated:

\$ 10	per hour private rate
<u>x 6</u>	hours per day
\$ 60	private per diem cost
<u>x 28</u>	days received services in May
\$1,680	private cost of care

The spenddown liability of \$1,271.64 is less than the private cost of care, \$1,680. Therefore, she is eligible for the period 5-1-2015 through 5-31-2015.

M1460.750 MEDICALLY NEEDY ENROLLMENT AND POST-ELIGIBILITY PROCEDURES

A. AC

1. Use Appropriate MN AC

- Aged = **018**
- Blind = **038**
- Disabled = **058**
- Child Under 21 in ICF/ICF-MR = **098**
- Child Under 18 = **088**
- Juvenile Justice Child = **085**
- Foster Care/ Adoption Assistance Child = **086**
- Pregnant Woman = **097**

B. Patient Pay

Determine patient pay according to subchapter M1470.

C. MN Post-eligibility Requirements

1. Facility Patient with Spenddown Liability Less Than or Equal to Medicaid Rate

When the spenddown liability for an individual who is in a facility is less than or equal to the individual's Medicaid rate, the individual has ongoing eligibility for the 12-month certification period. The individual must file a redetermination after the 12-month certification period ends.

**2. All CBC
Patients and
Facility Patients
with
Spendedown
Liability
Greater Than
Medicaid Rate**

When an individual (1) receives CBC or (2) an individual in a facility has a spenddown liability that exceeds individual's Medicaid rate and meets a spenddown, the individual does NOT have ongoing eligibility. Therefore, the individual will need to submit monthly reports of actual expenses and changes in income and resources so that spenddown eligibility can be determined each month. This report, "Medical Expense Record - Medicaid" (form # 032-03-023) is found in subchapter M1330, Appendix 1. Instructions for use and completion are also in subchapter M1330, Appendix 1.

The notification to the applicant (and his representative) approving the application with spenddown must include a copy of the "Medical Expense Record - Medicaid" for the individual to use to provide verification of the expenses used to meet the spenddown.

a. When Spendedown Liability is Met

When expenses have been incurred, the individual must submit the "Medical Expense Record - Medicaid" with bills or receipts for medical services either paid or incurred, and evidence of third party payment or denial of payment if applicable. Entitlement begins the first day of the month in which the spenddown is met, and ends on the last day of the month.

Appropriate notice of action must be sent to the applicant every time spenddown eligibility is evaluated. After eligibility is established, the usual reporting and notification processes apply. The individual must provide verification of income and resources for any month for which bills are presented.

b. Certification Period

The certification period is 12 months; therefore, a new application is not required each month. However, the applicant must file a redetermination for Medicaid when the 12-month certification period ends. If the redetermination is not filed, the individual's Medicaid must be canceled, the case must be closed and the individual will have to file a new application.

M1470 Changes

Changed With	Effective Date	Pages Changed
TN #100	5/1/15	Table of Contents Pages 2a, 31, 32, 43, 44, 45, and 53 Pages 2 and 4 were renumbered for clarity. Pages 4a, 33, 34, 46 and 46a are runover pages.
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

TABLE OF CONTENTS

M14 LONG-TERM CARE

M1470 PATIENT PAY--POST-ELIGIBILITY TREATMENT OF INCOME

	Section	Page
Overview.....	M1470.001	1
Available Income for Patient Pay	M1470.100	2
Facility Patients - Allowable Deductions from Income	M1470.200	3
Facility Personal Needs Allowance	M1470.210	4
Dependent Child Allowance	M1470.220	5
Facility - Noncovered Medical Expenses	M1470.230	6
Facility - Home Maintenance Deduction	M1470.240	14
Facility Patients	M1470.300	15
Facility Admission from a Community Living Arrangement	M1470.310	15
Patient Pay for Facility Stay of Less Than 30 Days.....	M1470.320	16
Medicaid CBC Patients - Allowable Deductions from Income.....	M1470.400	18
Medicaid CBC Personal Maintenance Allowance	M1470.410	19
Dependent Child Allowance	M1470.420	20
Medicaid CBC - Noncovered Medical Expenses	M1470.430	21
Medicaid CBC Patients	M1470.500	29
Community Living Arrangement Admission To Medicaid CBC		
Waiver Services	M1470.510	30
PACE.....	M1470.520	31
MN Patients - Spenddown Liability.....	M1470.600	32
Facility Patients--Spenddown Liability Less Than Or Equal		
To Medicaid Rate	M1470.610	33
Facility Patients--Spenddown Liability Greater Than		
Medicaid Rate	M1470.620	37
CBC Patients With Spenddown Liability.....	M1470.630	39
PACE Recipients with Spenddown Liability	M1470.640	42
Communication Between Local DSS and LTC Providers	M1470.800	43
Adjustments and Changes	M1470.900	44
Retroactive Adjustments for Prior Months	M1470.910	48
LTC Provider Change Within A Month	M1470.920	48
Death or Discharge From LTC	M1470.930	50

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

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

1. Facility Option #1

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

The LDSS will take the following steps:

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

2. Facility Option #2

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

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

M1470.100 AVAILABLE INCOME FOR PATIENT PAY

A. Gross Income

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

1. **300% SSI Group** If the individual is eligible in the 300% SSI group, to determine patient pay start with the gross monthly income calculated for eligibility. Then add and deduct any amounts that are listed in subsection C. below.
 2. **Groups Other Than 300% SSI Group** If the individual is eligible in a covered group other than the 300% SSI group, determine the individual's patient pay income using subsections B. and C. below.
- B. Income Counted For Patient Pay** All countable sources of income for the 300% SSI group listed in section M1460.611 are considered income in determining patient pay. Any other income NOT specified in C. below is counted as income for patient pay.
1. **Aid & Attendance and VA Pension Payments** Count the total VA Aid & Attendance payments and/or VA pension payments in excess of \$90.00 per month as income for patient pay when the patient is:
 - a veteran who does not have a *community* spouse or dependent child, or
 - a deceased veteran's surviving spouse who does not have a dependent child.

Do not count any VA Aid & Attendance payments and/or VA pension payments when the patient is:

 - a veteran who has a *community* spouse or dependent child, or
 - a deceased veteran's surviving spouse who has a dependent child.

NOTE: This applies to all LTC recipients, including patients who reside in a Veterans Care Center.
 2. **Non-Refundable Advance Payments To LTC Providers** Advance payments and pre-payments paid by a recipient to the LTC provider that will not be refunded are counted as income for patient pay. M1470.1100 contains instructions for calculating the patient pay when an advance payment has been made to reduce resources within a month.
- C. Income Excluded For Patient Pay** Income from sources listed in subchapter M1460.610 "What is Not Income" is not counted when determining patient pay, **EXCEPT** for the VA Aid & Attendance and VA pension payments to veterans which are counted in the patient pay calculation (see B. above). Additional types of income excluded from patient pay are listed below.
1. **SSI & AG Payments** All SSI and Auxiliary Grants (AG) payments are excluded from income when determining patient pay.
 2. **Certain Interest Income**
 - a. Interest or dividends accrued on excluded funds which are set aside for burial are not income for patient pay.
 - b. Interest income when the total interest accrued on all interest-bearing accounts is less than or equal to \$10 monthly is not income for patient pay. Interest income that is not accrued monthly must be converted to a monthly amount to make the determination of whether it is excluded.
 - Verify interest income at application and each scheduled redetermination.

- B. Order of Patient Pay Deductions** Deductions from gross monthly income are subtracted in the order presented below. Deductions are made only to the extent that income remains after a prior deduction has been subtracted. Therefore, if the patient has no income remaining after a deduction, no additional deductions can be made.
1. **Personal Needs** See section M1470.210 “Facility Personal Needs Allowance.”
 2. **Dependent Child Allowance** See section M1470.220 “Dependent Child Allowance.”
 3. **Noncovered Medical Expenses** See section M1470.230 “Facility - Noncovered Medical Expenses.”
 4. **Home Maintenance Deduction** See section M1470.240 “Facility - Home Maintenance Deduction.”
- C. Appeal Rights** The patient or his representative has the right to appeal the patient pay determination, the amounts used in the calculation and denial of any request for adjustment. If a recipient or his representative appeals the patient pay, the EW or Medicaid Technician who made the decision prepares the appeal summary and attends the hearing.

M1470.210 FACILITY PERSONAL NEEDS ALLOWANCE

A. Policy

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

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

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

1. Basic Personal Allowance

Deduct \$40 per individual.

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

Working patients are allowed a higher personal needs allowance if they meet the following criteria. These patients will be identified by the facility. The patient must regularly participate in vocational activity which is a planned habilitation program and is carried out as a therapeutic work program, such as:

- sheltered workshops
- vocational training
- pre-vocational training.

M1470.520 PACE

A. Policy

The Program of All-inclusive Care for the Elderly (PACE) serves individuals aged 55 and older who (1) meet the nursing facility level of care criteria and (2) reside in their own communities. PACE provides all of an individual's health care and long-term care medical needs. PACE is not a CBC Waiver; individuals who meet the criteria for the EDCD Waiver may be enrolled in PACE in lieu of the EDCD Waiver. Individuals who are enrolled in Medicaid as AG recipients (Aid Categories 012, 032, and 052) are not eligible for PACE. See M1440.108 for additional information about PACE.

Individuals enrolled in PACE have a patient pay obligation.

B. Procedures

The patient pay for an individual enrolled in PACE who is not Medically Needy is calculated using the procedures in M1470.400 through M1470.520 for an individual in CBC, with the exceptions listed below.

1. Medicare Part D Premiums

PACE recipients are not responsible for Medicare Part D premiums because their prescriptions are provided through PACE and they are eligible for the full Medicare Part D subsidy. Therefore, the cost of the Medicare Part D premium is not allowable as a deduction from patient pay.

2. Covered Medical Expenses

Because PACE includes most medically-necessary services the individual needs, the allowable medical expense deductions differ from the allowable medical expense deductions for CBC.

The following services are provided through PACE:

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

Any medical expenses incurred by the individual for the services listed above are not allowable patient pay deductions. With the exception of the services listed above, the noncovered expenses listed in M1470.430 C.2 are allowable for PACE recipients. DMAS approval **is not required** for deductions of noncovered services from patient pay for PACE recipients, regardless of the amount of the deduction.

3. PACE Recipient Enters a Nursing Facility

Because PACE is a program of all-inclusive care, nursing facility services are part of the benefit package for PACE recipients who can no longer reside in the community. When a PACE recipient enters a nursing facility, the PACE provider or the individual has 60 days from the date of admission to notify the eligibility worker of the individual's placement in the nursing facility and the need for a recalculation of the patient pay.

After notification of the individual's entrance into a nursing facility, the eligibility worker will take action to recalculate the individual's patient pay prospectively for the month following the month the 10 day advance notice period ends. There is NO retroactive calculation of patient pay back to the date the individual entered the facility. When the change is made, the individual is entitled to a personal needs allowance of \$40 per month.

M1470.600 MN PATIENTS - SPENDDOWN LIABILITY

A. Policy

This section is for unmarried individuals or married individuals who have no community spouse. **DO NOT USE this section** for a married individual with a community spouse, go to subchapter M1480.

MN individuals have a spenddown liability that must be met before they are eligible for Medicaid because their monthly income exceeds 300% of SSI, which exceeds the MN income limits. When an MN individual meets the spenddown, he is eligible for Medicaid (see section M1460.700 for spenddown determination policy and procedures). Patient pay for **each** month in which the individual meets the spenddown must be determined.

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

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

B. Definitions

The following definitions are used in this section and subsequent sections of this subchapter:

1. Medicaid Rate

The Medicaid rate for facility patients is the *patient's daily Resource Utilization Group (RUG) code amount multiplied by the number of days in the month. A patient's RUG code amount is based on his room and board and ancillary services. The RUG code amount may differ from facility to facility and from patient to patient within the same facility.* Confirmation of the *individual's RUG code amount must be obtained by contacting the facility.* For the month of entry, use the actual number of days that care was received or is projected to be received. For ongoing months, multiply the *daily RUG code amount by 31 days.*

The Medicaid rate for CBC patients is the number of hours per month actually provided by the CBC provider multiplied by the Medicaid hourly rate.

PACE has a capitated monthly rate that is due and payable on the first day of the month. The monthly PACE rate is available from the PACE provider.

2. Remaining Income

Remaining income is the amount of the patient's total monthly countable income for patient pay minus all allowable patient pay deductions.

3. **Spenddown Liability** The spenddown liability is the amount by which the individual's countable income exceeds the medically needy income limit.

C. **Procedures** The subsections identified below contain the procedures for determining patient pay when an LTC patient meets a spenddown liability and is determined eligible for Medicaid.

1. **Facility Patients** Patient pay determination procedures are different for medically needy facility patients, depending on whether the spenddown liability is less than or equal to or greater than the Medicaid rate. To determine patient pay for MN facility patients:

- a. Determine the individual's spenddown liability using the policy and procedures in subchapter M1460.
- b. Compare the spenddown liability to the Medicaid rate.
- c. If the spenddown liability is less than or equal to the Medicaid rate, go to section M1470.610 below to determine patient pay.
- d. If the spenddown liability is greater than the Medicaid rate, go to section M1470.620 to determine patient pay.

2. **Medicaid CBC Patients** Medicaid CBC patient pay determination procedures are different from facility procedures. For CBC patients with a spenddown liability, go to section M1470.630.

3. **PACE Recipients** For PACE recipients with a spenddown liability, go to section M1470.640.

M1470.610 FACILITY PATIENTS--SPENDDOWN LIABILITY LESS THAN OR EQUAL TO MEDICAID RATE

- A. **Policy** This section is applicable ONLY to an unmarried individual, or a married individual without a community spouse. **DO NOT USE this section** for a married individual with a community spouse; go to subchapter M1480.

An MN facility patient whose spenddown liability is less than or equal to the Medicaid rate is eligible for Medicaid effective the first day of the month, based on the projected Medicaid rate for the month.

Medicaid must NOT pay any of the recipient's spenddown liability to the provider. In order to prevent any Medicaid payment of the spenddown liability, the spenddown liability is added to available income for patient pay.

- B. **Procedures** Determine patient pay for the month using the procedures below.

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

2. **Subtract Spenddown Liability** From the individual's gross monthly income for the month, subtract the spenddown liability. The result is the remaining income.

3. **Subtract Allowable Deductions** Deduct the following from the remaining income:
 - a. a personal needs allowance (M1470.210),
 - b. a dependent child allowance, if appropriate (M1470.220),
 - c. any allowable noncovered medical expenses (M1470.230), not including the facility cost of care,
 - d. a home maintenance deduction, if appropriate (M1470.240).The result is the **remaining income**.

4. **Add Spenddown Liability** Add the spenddown liability to the remaining income (**because the individual is responsible to pay his spenddown liability to the facility**). The result is the **contributable income** for patient pay.

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

C. Examples

1. **Facility--MN And Patient Pay Income Are The Same (Using April 2000 Figures)** Mr. Cay first applied for Medicaid in April. He was admitted to the facility a year earlier. He has a monthly Civil Service Annuity (CSA) benefit of \$1,600. He last lived outside the facility in a Group III locality. His income exceeds the CNNMP 300% SSI income limit. He has no old bills, but he has a health insurance premium of \$50 monthly plus a \$25 noncovered medical expense he incurred on April 2, and a guardian who charges a guardian fee of 5% of Mr. Cay's income. His MN eligibility is being determined for April. The MN determination results in a spenddown liability of \$1,255:

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

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

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

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

4. Patient Pay

a. Projected Spenddown Eligibility Determinations

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

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

b. Retrospective Spenddown Eligibility Determinations

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

M1470.800 COMMUNICATION BETWEEN LOCAL DSS AND LTC PROVIDER

A. Introduction

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

B. Purpose

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

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

- provide information on health insurance, LTC insurance or VA contract coverage, and
- provide other information unknown to the provider that might cause a change in eligibility status or patient pay amount.

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

C. When to Complete the DMAS-225

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

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

D. Where to Send the DMAS-225

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

M1470.900 ADJUSTMENTS AND CHANGES

A. Policy

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

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

B. Action When A Change Is Reported or When There is a Delay in Entering Patient Pay

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

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

If an underpayment occurs due to a delay in entering patient pay, take the following actions:

1. *For new enrollees, if the underpayment for prior months (including the retroactive period) is more than \$1,500, a referral to the RAU must be completed following the procedures in M1470.900 D.3.c.1). Enter the current patient pay going forward in MMIS.*
2. *If the individual was already active in Medicaid, make the adjustment to patient pay following the procedures in M1470.900 D.3. If the underpayment exceeds \$1,500, complete a referral to the RAU.*

C. Patient Pay Decreases

1. When to Adjust

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

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

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

2. Procedures

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

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

**3. Example-Patient
Pay Decrease**

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

**D. Patient Pay
Increases**

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

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

**1. Prospective
Month(s)**

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

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

Determine the amount of the recipient underpayment when:

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

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

3. Procedures

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

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

b. Total underpayment of less than \$1,500

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

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

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

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

b. Spenddown Eligibility & Patient Pay NOT Previously Determined

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

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

M1470.1100 REDUCTION OF EXCESS RESOURCES

A. Policy

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

**B. Resource
Reduction Defined**

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

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

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

C. Procedures

**1. Required
Contact**

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

M1480 Changes

Changed With	Effective Date	Pages Changed
TN #100	5/1/15	Pages 18, 18a, 18c, 65, 66
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

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 file. Refer to Section 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 file. Refer to Section 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 record and deny the application due to 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 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.

1) Applicant or Authorized Representative

The applicant or his authorized representative must provide a letter (*or the Resource Assessment Undue Hardship Request Form including affidavit and assignment*) indicating the following:

- The applicant is requesting an undue hardship evaluation;
- The name of the applicant's attorney-in-fact (i.e. who has the power of attorney) or authorized representative;
- The length of time the couple has been separated;
- The name of the estranged spouse and his
 - Last known address,
 - Last known employer,
 - The types (i.e. telephone, in-person visit) and number of attempts made to contact the spouse:
 - Who made the attempt
 - Date(s) the attempt(s) were made,
 - The name of the individual contacted and relationship to estranged spouse; and
- Any legal proceeding initiated, protective orders in effect, etc.

2) Eligibility Worker

A cover sheet is to be prepared that includes the following information:

- The applicant's name, case number, and
- Documentation of any actions the EW took to locate or contact the estranged spouse.

The cover sheet and all information supporting the undue hardship claim must be sent to :

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

*The completed Resource Assessment Undue Hardship Request Form (number) including affidavit and assignment forms may be used instead of a letter from the worker but is **not required**.*

If DMAS determines that undue hardship does not exist, and the resource assessment cannot be completed, the EW must deny the application due to failure to verify resources held at the beginning of institutionalization.

If DMAS determines that undue hardship does exist, the EW will be sent instructions for continued processing of the case as well as the DMAS Affidavit and Assignment forms (*if not already submitted*), which the applicant or his representative must sign, have notarized and return to the agency.

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

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

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

M1480.231 SPOUSAL RESOURCE STANDARDS

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

B. Spousal Resource Standard	<i>\$23,844</i>	<i>1-1-15</i>
	<i>\$23,448</i>	<i>1-1-14</i>
C. Maximum Spousal Resource Standard	<i>\$119,200</i>	<i>1-1-15</i>
	<i>\$117,240</i>	<i>1-1-14</i>

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.

M1480.350 SPENDDOWN ENTITLEMENT

- A. Entitlement After Spenddown Met** When an institutionalized spouse meets a spenddown within a month, the begin date of eligibility will be the first day of the month in which the spenddown was met. Eligibility will end on the last day of the month in which the spenddown was met.
- B. Procedures**
- 1. Coverage Dates** Coverage begin date is the first day of the month; the coverage end date is the last day of the month.
- 2. AC** *Enroll the institutionalized spouse in one of the following ACs:*
- Aged = 018
 - Blind = 038
 - Disabled = 058
 - Child Under 21 in ICF/ICF-MR = 098
 - Child Under Age 18 = 088
 - Juvenile Justice Child = 085
 - Foster Care/Adoption Assistance Child = 086
 - Pregnant Woman = 097
- 3. Patient Pay** Determine patient pay according to section M1480.400 below.
- 4. Notices & Re-applications** The institutionalized spouse on a spenddown must have his eligibility re-evaluated monthly, unless he is in a facility and the spenddown liability is less than or equal to the Medicaid rate. The institutionalized spouse must complete an annual redetermination.

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

M1480.400 PATIENT PAY

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

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

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

\$1,966.25	7-1-14	
\$1,938.75	7-1-13	
- C. Maximum Monthly Maintenance Needs Allowance**

\$2,980.50	1-1-15	
\$2,931.00	1-1-14	
- D. Excess Shelter Standard**

\$589.88	7-1-14	
\$581.63	7-1-13	
- E. Utility Standard Deduction (SNAP)**

\$298.00	<i>1 - 3 household members</i>	<i>10-1-14</i>
\$375.00	<i>4 or more household members</i>	<i>10-1-14</i>
\$275.00	1 - 3 household members	10-1-13
\$345.00	4 or more household members	10-1-13

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).

M1510 Changes

Changed With	Effective Date	Pages Changed
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
<i>Hospital Presumptive Eligibility</i>	M1510.103	<i>8a</i>
Disability Denials.....	M1510.104	<i>8b</i>
Foster Care Children	M1510.105	9
Delayed Claims	M1510.106	9
Notice Requirements	M1510.200	10
Follow-Up Responsibilities	M1510.300	11a
Third Party Liability (TPL)	M1510.301	11a
Social Security Numbers.....	M1510.302	14
Patient Pay Notification	M1510.303	15

M1510.000 ENTITLEMENT POLICY & PROCEDURES

M1510.100 MEDICAID ENTITLEMENT

A. Policy

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

1. Spenddown Met

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

2. 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.

C. Procedures

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

- M1510.101 Retroactive Eligibility & Entitlement

C. Procedures

- M1510.102 Ongoing Entitlement
- *M1510.103 Hospital Presumptive Eligibility*
- *M1510.104 Disability Denials*
- *M1451.105 Foster Care Children*
- *M1510.106 Delayed Claims*

M1510.101 RETROACTIVE ELIGIBILITY & ENTITLEMENT**A. Definitions**

- 1. Retroactive Period** The retroactive period is the three months immediately prior to the application month. Within this retroactive period, the individual may be Categorically Needy (CN) in one or two months and Medically Needy (MN) in the third month, or any other combination of classifications.
- 2. Retroactive Budget Period** The "budget period" is the period of time during which an individual's income is calculated to determine income eligibility. The retroactive budget period depends on the individual's covered group.

B. Policy

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

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

C. Budget Periods By Classification

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

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

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

- 2. MN** For the retroactive period, the **MN budget period is always all three months**. Unlike the retroactive CN period, the retroactive MN budget period may include a portion of a prior Medicaid coverage or spenddown period, and may also include months in which he is eligible as CN.

D. Verification

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

For eligibility determinations completed for individuals subject to Modified Adjusted Gross Income (MAGI) methodology, income verification by the Federal Hub is acceptable for retroactive eligibility determinations provided that reasonable compatibility is met (see M0420.100 B.9). The applicant must provide verification of income received in the retroactive period, as well as for ongoing eligibility if his income is not verified by the Hub.

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

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

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

Medicaid medically needy eligibility factors are met in that month(s), determine if the unit meets the MN income limit for the **3-month** retroactive budget period.

When the unit's countable income exceeds the MN limit for 3 months, place the unit on a spenddown for the month(s) in which excess income existed. See subchapter M1330 for retroactive spenddown eligibility determination policy and procedures.

H. Retroactive Entitlement

Retroactive coverage can begin the first day of the third month prior to application month if all eligibility requirements are met.

NOTE: A QMB is never eligible for retroactive coverage as a QMB-only.

The applicant is entitled to Medicaid coverage for only the month(s) in which all eligibility factors were met. If all factors except income were met in all the retroactive months, then the applicant is placed on spenddown for the retroactive period. **See subchapter M1330 to determine retroactive spenddown eligibility.**

1. Retroactive Coverage Begin Date

If the applicant is eligible for retroactive coverage, he is enrolled effective the first day of the month in which he met all eligibility factors. When excess income existed in a retroactive month(s), entitlement begins the date the retroactive spenddown was met.

2. Retroactive Coverage End Date

The Medicaid recipient's retroactive Medicaid coverage expires after the last day of the retroactive month(s) in which he was entitled to Medicaid.

3. Example

EXAMPLE #5: Mr. B applied for Medicaid for himself on July 8. He reported receiving a Medicaid covered service in each retroactive month. The retroactive period is April 1 through June 30. He met all eligibility requirements in the retroactive period. He is entitled to retroactive Medicaid coverage beginning April 1 and ending June 30.

M1510.102 ONGOING ENTITLEMENT

A. Coverage Begin Date

Ongoing Medicaid entitlement for all covered groups except the QMB group **begins the first day of the application month** when all eligibility factors are met at any time in the month of application. Exceptions:

- when an applicant has excess income;
- when the applicant is eligible only as a QMB;
- when the applicant is age 21-64 years and is admitted to an institution for mental diseases (IMD), or
- *when the individual is incarcerated.*

1. **Applicant Has Excess Income** When all eligibility requirements are met except for income, entitlement begins the date the spenddown is met. Only medically needy applicants can be eligible after meeting a spenddown. See subchapter M1330 to determine retroactive spenddown eligibility.
2. **QMB Applicant** Entitlement to Medicaid for QMB begins the first day of the month **following** the month in which the individual's QMB eligibility is determined.
3. **SLMB and QDWI** Ongoing entitlement for the Special Low Income Medicare Beneficiary (SLMB) and the Qualified Disabled and Working Individuals (QDWI) covered groups is the first day of the application month when all eligibility factors are met at any time in the month of application.
4. **Applicant Age 21-64 Is Admitted To An IMD** An applicant who is age 21-64 years and who is admitted to an IMD is NOT eligible for Medicaid. If otherwise eligible for Medicaid in the application month, his entitlement to Medicaid begins the date he is discharged from the ineligible institution in the month.

EXAMPLE #6: Mr. A is a 50 year old man who applies for Medicaid at his local agency on October 1, 2006. He receives Social Security disability benefits. He was admitted to Central State Hospital (an IMD) on October 20, 2006, and was discharged on November 2, 2006, back to his home locality. The agency completes the Medicaid determination on November 5 and finds that he is eligible for Medicaid in October 2006 and ongoing, except for the period of time he was in Central State Hospital.

The worker enrolls him in Medicaid for a closed period of coverage beginning October 1, 2006, and ending October 20, 2006. The worker also enrolls him in an ongoing period of Medicaid coverage beginning November 2, 2006.

5. **Applications From CSBs For IMD Patients Ages 21-64 Years** A patient who is age 21 years or older but is less than 65 years and who is *in an IMD* is not eligible for Medicaid while in the IMD. Local agencies will take the **applications received from the CSBs** for Department of Behavioral Health and Developmental Services (DBHDS) IMD patients who will be discharged within 30 days and process the applications within the established time frames. Eligibility will be determined based on the type of living arrangement to which the patient will be discharged. If eligible, do not enroll the patient until the date the patient is discharged from the IMD.

If the patient is discharged from the facility and the patient meets all eligibility factors, the agency will enroll the patient effective the date of discharge.

EXAMPLE #6a: Mr. A is a 50 year old patient at Central State Hospital (an IMD). He receives Social Security disability benefits. The CSB sends

his local agency a Medicaid application which is received on August 18. The facility's statement notes that he will be discharged on September 17 to ABC Nursing Home, a nursing facility. The agency completes the determination on August 27 and finds that he will be eligible once he is discharged to the nursing facility.

The agency does not enroll Mr. A until the discharge is confirmed. The CSB case manager calls the agency on September 21 and informs the agency that the patient was discharged to the ABC Nursing Home on September 18. The patient is enrolled in Medicaid with a begin date of September 18.

**6. Incarcerated
Individuals**

a. Pre-release Planning

Incarcerated individuals, who are approved for Medicaid in advance of their release, are enrolled in the appropriate AC for the covered group beginning with the date of release. If the individual is already enrolled in AC 109 at the time of release, cancel the AC 109 coverage effective the day prior to the date of release and reinstate the ongoing coverage effective the following day.

b. Inpatient Hospitalization – Aid Category (AC) 109

Incarcerated individuals (see M0130.050) who meet all Medicaid eligibility requirements, including eligibility in a full benefit CN covered group are eligible for Medicaid coverage limited to inpatient hospitalization. Incarcerated individuals are enrolled in AC 109 regardless of the covered group to ensure Medicaid claims payment is limited to inpatient hospitalization.

Entitlement for newly eligible individuals begins the first day of the month of application/reapplication, provided all eligibility factors are met and the individual had an inpatient hospitalization. Entitlement can also begin the first day of any month in the application's retroactive period, provided all eligibility requirements were met and he had an inpatient hospitalization in the retroactive period.

If the individual has active coverage when the agency becomes aware of his incarceration, 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.

**B. Coverage End
Date**

Medicaid entitlement ends the last day of the month in which the recipient fails to meet all of the Medicaid eligibility requirements, unless the recipient is a CN pregnant woman or is age 21-64 and admitted to an IMD or other ineligible institution.

Medicaid coverage is canceled on the last day of the month in which the agency determines that the recipient no longer meets the eligibility requirements IF the

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 in the MMIS, 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 in the MMIS effective the current date (date the worker enters the cancel transaction in MMIS), using cancel reason code "008."

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 in MMIS, as necessary, while the application is processed. The MMIS User's Guide for DSS, available at http://dmasva.dmas.virginia.gov/Content/pgs/dss-elgb_enrl.aspx, contains procedures for completing the MA enrollment of an individual who was enrolled in HPE at the time of application.

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), using Cancel Reason 008.

Send a Notice of Action indicating that the individual's MA application was denied and that his HPE coverage was cancelled with the effective date. The individual receives notice of the HPE coverage period from the hospital at the time of the HPE enrollment; advance notice of the HPE cancellation is not required. There are no appeal rights for HPE.

M1510.104 DISABILITY DENIALS

A. Policy

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

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

B. Procedures

1. Subsequent SSA/SSI Disability Decisions

The SSA disability decision takes precedence over a DDS decision (DDS will make a decision before SSA if SSA does not take action within the 90-day Medicaid application processing time). If SSA denies disability and the decision is appealed and subsequently reversed, reopen and re-evaluate the denied Medicaid application as long as the disability onset month is prior to the month of application or is no later than 90 days after the month of application.

2. Use Original Application

The original application is used as long as the application was denied because the individual was not disabled and the subsequent disability onset month is no later than 90 days from the month of application.

3. Entitlement

If the re-evaluation determines that the individual is eligible, the individual's Medicaid entitlement is based on the Medicaid application date including the retroactive period if all eligibility requirements were met during the retroactive period. However, eligibility as a disabled individual cannot begin prior to the disability onset date when the disability onset date falls after the application date.

4. Renewal Required When More Than 12 Months Have Passed

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

5. Spenddown

If, based upon the re-evaluation, the individual is determined not eligible but met the requirements in Chapter M13 for placement on a spenddown, a first prospective and additional 6 month spenddown budget period(s) are established to cover the period of time between the date of application and the date action is taken on his case.

A new application is not required for each 6 month spenddown budget period leading up to the date of processing; however, verification of all income and resources for those time periods must be obtained.

M1520 Changes

Changed With	Effective Date	Pages Changed
TN #100	4/1/15	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

TABLE OF CONTENTS

M15 ENTITLEMENT POLICY & PROCEDURES

M1520.000 MEDICAL ASSISTANCE (MA) ELIGIBILITY REVIEW

	Section	Page
General Principle	M1520.001	1
Partial Review	M1520.100	2
Renewal Requirements	M1520.200	5
MA Cancellation or Services Reduction	M1520.300	12
Extended Medicaid Coverage	M1520.400	15
Four Month Extension	M1520.401	16
Twelve Months Extension	M1520.402	17
Case Transfers	M1520.500	24

APPENDICES

<i>Renewal Process Reference Guide</i>	<i>Appendix 1</i>	<i>1</i>
<i>Twelve Month Extended Medicaid Income Limits</i>	<i>Appendix 2</i>	<i>1</i>

M1520.000 MEDICAL ASSISTANCE ELIGIBILITY REVIEW**M1520.001 GENERAL PRINCIPLE****A. Policy**

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

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

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

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

1. Negative Action Requires 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).

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, the Notice of Action is used to inform the enrollee of continued eligibility and the next scheduled renewal.

3. Voter Registration

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

B. Procedures For Partial Review and Renewals

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

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

M1520.100 PARTIAL REVIEW

- A. Enrollee's Responsibility** Enrollees must report changes in circumstances which may affect eligibility and/or patient pay within 10 days from the day the change is known. For enrollees participating in the Health Insurance Premium Payment (HIPP) Program, changes that may affect participation in HIPP must also be reported to the DMAS HIPP Unit within the 10 day timeframe.
- B. Eligibility Worker's Responsibility** The eligibility worker has a responsibility for keeping a record of changes that may be anticipated or scheduled, and for taking appropriate action on those changes.
- 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 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. 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@dmass.virginia.gov. This e-mail address is for use by the local agency staff only. See M0130.200 G for additional information about HIPP requirements.

4. Program Integrity

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

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

C. Covered Group Changes

When a change in an enrollee's situation results in a potential change in covered group, his eligibility in all other covered groups must be evaluated. Examples of such changes include when:

- *a newborn child reaches age one year,*
- *a child turns age six years,*
- *a families & children's (F&C) enrollee becomes entitled to SSI,*
- *an SSI Medicaid enrollee becomes a Qualified Severely Impaired Individual (QSI) (1619(b)).*

D. Child Moves From Parental Home

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

1. Case Management

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

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

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

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

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

**2. MMIS
Enrollment**

a. MMIS Case Number

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

b. MMIS Demographics Comment Screen

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

c. Renewal Date

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

d. Medicaid Card

A new MA insurance ID card is only generated when the enrollee's name, SSN or gender changes, or when a worker requests a replacement ID card. Changing the child's address or MMIS case number does not generate a new card. The worker must request a replacement card in MMIS if one is needed. The existing card will be voided when the replacement is issued.

**3. Obtain
Authorization
from Parent
Prior to Renewal**

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

4. Renewal

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

**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.

If an annual renewal has been done within the past 6 months, a partial review to address factors pertinent to receipt of LTC, such as asset transfer, spousal resource assessment, etc., must be completed. If an annual renewal has not been done within the past 6 months, a complete renewal must be completed (see M1520.200). When the re-evaluation is completed, send all required notices to the enrollee/authorized representative, and send a DMAS-225 to the provider (see M1410.300).

If the individual is already enrolled in a full benefit Medicaid covered group, do not change the AC. If the individual is enrolled in a limited-benefit covered group, the individual must be evaluated for eligibility in one of the covered groups for institutionalized individuals (i.e. income \leq 300% of SSI) (see M1460).

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

When an individual on a spenddown enters LTC, his Medicaid eligibility must be determined using the procedures in subchapter M1460. An individual on a spenddown in an assistance unit with a spouse and/or children becomes a separate assistance unit when he enters LTC. The spouse's and/or children's spenddown liability is recalculated to reflect a decrease in assistance unit size. See M1350.220 for additional information.

F. Changes Between Coverage Under MA and the Governor's Access Plan (GAP)

If an individual enrolled in Plan First subsequently applies and is eligible for GAP, staff at the GAP Unit with the Cover Virginia Call Center will cancel the Plan First coverage and reinstate GAP coverage. The GAP Unit will send a Communication Form to the local agency to report the GAP enrollment. The worker will close Plan First coverage in VaCMS using the override function and notify the individual of the Plan First cancellation.

When an individual enrolled in GAP coverage becomes eligible for MA, prior to enrollment in Medicaid, the local eligibility worker will send a Communication form to the GAP Unit to report eligibility for Medicaid/FAMIS and the effective date of coverage. GAP Unit staff will cancel GAP coverage within two work days. Once GAP coverage is cancelled, the local eligibility worker will complete the MA enrollment and send notice of eligibility to the enrollee. The GAP Unit will send separate notice of the GAP cancellation.

M1520.200 RENEWAL REQUIREMENTS

A. Policy

The agency must evaluate the eligibility of all MA enrollees, with respect to circumstances that may change, at least every 12 months. Each renewal must be authorized by an eligibility worker or supervisor, although administrative staff may assist in the gathering of information.

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

1. Required Verifications An individual's continued eligibility for MA requires verification of income for all covered groups and resources for covered groups with resource requirements. Blindness and disability are considered continuing unless it is reported that the individual is no longer blind or disabled.

2. SSN Follow Up If the enrollee's 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 *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. When it is necessary to obtain information and/or verifications, such as verification of resources, from the enrollee, a contact-based renewal must be completed and **the renewal must be signed by the enrollee.***

An evaluation of the information used to determine continued eligibility must be completed and included in the case record. For SSI Medicaid ex parte renewals, the Record of Ex Parte Medicaid Renewal (#032-03-0740) is recommended.

For other 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.*

For Virginia Case Management System (VaCMS) cases, 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.

For SSI Medicaid enrollees (including an LTC enrollee with no community spouse) who has reported no ownership interest in countable real property, an ex parte renewal can be completed by verifying the individual's continued receipt of SSI through the State Verification Exchange System (SVES) or the State Online Query-Internet system (SOLQ-I) and documenting the case record. The ex parte renewal process cannot be used for an SSI Medicaid enrollee who owns non-excluded real property because the individual is subject to a resource evaluation.

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

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

The eligibility worker must document the date and method used to obtain the verification information (viewed pay stub dated xx/xx/xxxx, telephone call on xx/xx/xxxx date, etc.), the type of verification, the source and a description of the information. Income verification *from sources other than the federal Hub* that is no older than 6 months old may be used unless the agency has reason to believe it is no longer accurate. It is not necessary to retain a copy of income verifications in the case record. If the renewal is not processed and documented *electronically*, the documentation must be in the case record.

An enrollee who has previously reported \$0 income must provide confirmation of income at each renewal, either on a renewal form or by a written statement. If the agency has not obtained written confirmation for another program (e.g. SNAP), do not complete an ex parte renewal when an enrollee has reported \$0 income. \$0 income statements must be no more than 30 days old to be used. If written confirmation was provided for another program, it cannot be used if it is more than 30 days old.

An ex parte renewal for an SSI recipient (including an LTC recipient with no community spouse) who has reported no ownership interest in countable real property can be completed by verifying the individual's continued receipt of SSI through SVES or SOLQ-I and documenting the case record. For a 1619(b) individual, check the Medicaid Test Indicator field in SVES or SOLQ-I to verify there is a code of A, B or F.

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

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

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. 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 MMIS cutoff on the 16th of the month. The specific information requested and the deadline for receipt of the verification must be documented in the case record.

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).

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 be documented in the 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.
- 2. Renewal Not Completed**

If information necessary to redetermine eligibility is not available through online information systems that are available to the agency and the enrollee has been asked but has failed to provide the information, the renewal must be denied and the coverage cancelled using cancel reason “005” due to the inability to determine continued eligibility. Action cannot be taken to cancel coverage until after the deadline for the receipt of verifications has passed, except for situations when the deadline falls on a weekend or holiday.
- 3. Referral to Health Insurance Marketplace (HIM)**

Unless the individual has Medicare, a referral to the HIM—*also known as the Federally Facilitated Marketplace (FFM)*--must be made when an individual’s coverage is cancelled so that the individual’s eligibility for the Advance Premium Tax Credit (APTC) in conjunction with a Qualified Health Plan (QHP) can be determined. If the individual’s renewal was not processed in VaCMS, his case must be entered in VaCMS in order for the HIM referral to be made.
- 4. Renewal Filed During the Three-month Reconsideration Period**

If the individual’s coverage is cancelled because the individual did not return the renewal form (or complete an online or telephonic renewal) or requested verifications per M1520.200 D.2, the Affordable Care Act (ACA) requires a reconsideration period of 90 days be allowed for an individual to file a renewal or submit verifications. For MA purposes, the 90 days is counted as three calendar months. The reconsideration period applies to all renewals, including renewals for the Qualified Medicare Beneficiary (QMB) and Qualified Individuals (QI) covered groups.

If the individual files a renewal or returns verifications during the reconsideration period and is determined to be eligible, reinstate the individual’s coverage back to the date of cancellation. Send a Notice of Action informing him of the reinstatement, his continued coverage and the next renewal month and year. See M1520, Appendix 1 for the Renewal Process Reference Guide.

If the individual is not eligible, send a Notice of Action indicating the correct reason for the cancellation (e.g. countable income exceeds the limit). Renewal forms filed after the end of the reconsideration period are treated as reapplications. Accept the form and request any additional information needed to determine the individual’s eligibility.

D. Special Requirements for Certain Covered Groups

- 1. Pregnant Woman**

Do not initiate a renewal of eligibility of an MI pregnant woman, or a pregnant woman in any other covered group, during her pregnancy. Eligibility in a

pregnant woman covered group ends effective the last day of the month in which the 60th day following the end of the pregnancy occurs.

When eligibility in a pregnant woman covered group ends, prior to the cancellation of her coverage, determine if the woman meets the definition for another Medicaid covered group (see M0310.002). If the woman meets the definition of a full-benefit covered group, or for limited coverage under Plan First, determine if an ex parte renewal can be completed or if a renewal form is required and take appropriate action.

If the woman does not meet the definition and/or the income requirements for another full-benefit covered group, determine her eligibility in the limited benefit Plan First covered group using the eligibility requirements in M0320.302.

2. Newborn Child Turns Age 1

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

- SSN or proof of application
- verification of income
- verification of resources for the MN child.

The ex parte process may be used if appropriate.

3. Child Under Age 19—Income Exceeds FAMIS Plus Limit

When an enrolled FAMIS Plus child no longer meets the *FAMIS Plus* income limits *and there is not an LIFC parent on the case*, evaluate the child for the FAMIS, using the eligibility requirements in chapter M21. If the child is eligible for FAMIS, send the family an Advance Notice of Proposed Action that Medicaid will be cancelled effective the last day of the month in which the 10-day advance notice expires and the FAMIS coverage will begin the first day of the month following the Medicaid cancellation. Use cancel reason “042” when the child loses eligibility in Medicaid and is reinstated in FAMIS and there is no break in coverage.

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

4. Child Receiving LTC Services Turns 18

A child enrolled in the F&C 300% of SSI covered group no longer meets the covered group upon turning 18, unless he meets another F&C definition (e.g. pregnant woman or parent of a dependent child). A referral to Disability Determination Services (DDS) must be made at least 90 calendar days prior to the child’s 18th birthday to allow the disability determination to be made prior to the child’s 18th birthday.

5. FAMIS Plus Child Turns Age 19

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

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

If the child does not meet the definition for another covered group, determine the child's eligibility in Plan First using the eligibility requirements in M0320.302. If the child is eligible for Plan First, reinstate coverage in Plan First and send the Advance Notice of Proposed Action indicating that he has been enrolled in Plan First. On the notice, state that if he does not wish to remain covered by Plan First, to contact the eligibility worker and request that the coverage be cancelled. Include a Plan First Fact Sheet, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>, with the Advance Notice of Proposed Action.

**6. IV-E FC & AA
Children and
Special Medical
Needs Children**

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

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

**7. Child Under 21
Turns Age 21**

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

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

**8. Foster Care
Child in an
Independent
Living
Arrangement
Turns Age 18**

A foster care child who is in an Independent Living arrangement with a local department of social services (*LDSS*) no longer meets the definition of a foster care child when he turns 18. Determine the child's eligibility in the Former Foster Care Children Under Age 26 Years covered group.

**9. Breast and
Cervical Cancer
Prevention and
Treatment Act
(BCCPTA)**

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

**10. Hospice Covered
Group**

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

**11. Qualified
Individuals**

Coverage for individuals enrolled in the Qualified Individuals (QI) covered group (AC 056) is automatically cancelled effective December 31 of the current year. However, coverage for QIs can be renewed annually provided that there is no break in Medicaid eligibility (*the three-month reconsideration period applies*).

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

E. LTC

The ex parte renewal process is used for institutionalized individuals who receive SSI and have no countable real property. It can also be used for F&C enrollees subject to *Modified Adjusted Gross Income* (MAGI) methodology when the local agency has access to on-line information for verifications necessary to determine ongoing eligibility and/or income verifications obtained for other benefit programs.

ABD, as well as F&C individuals over age 18, in the 300% of SSI covered group LTC must complete a contact-based renewal due to the resource requirement.

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

**F. Incarcerated
Individuals**

Incarcerated individuals who have active Medicaid are subject to annual renewals. Renewals for individuals in Department of Corrections and Department of Juvenile Justice facilities will be handled through the designated liaison.

- *For individuals incarcerated in DOC facilities, send the renewal form and related correspondence to the DOC Health Services Reimbursement Unit, 6900 Atmore Driver, Richmond, Virginia 23225.*
- *For individuals in DJJ facilities, send the renewal form and related correspondence to the DJJ Re-entry Services Unit, 600 E. Main Street, Richmond VA 23219.*
- *For individuals in regional or local jails, send the renewal form and related correspondence to the individual or his authorized representative.*

Although benefits administered by the Social Security Administration are suspended while an individual is incarcerated, a disabled individual continues to meet the definition of a disabled individual while incarcerated.

M1520.300 MA CANCELLATION OR SERVICES REDUCTION

A. Policy

At the time of any action affecting an individual's MA coverage, federal regulations in 42 CFR 431.206 through 431.214 require the agency to inform every applicant or enrollee in writing

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

B. Procedures

**1. Change Results
in Adverse
Action**

Following a determination that eligibility no longer exists or that the enrollee's Medicaid services must be reduced, the Advance Notice of Proposed Action, available on SPARK at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi> or system-generated advance notice must be sent to the enrollee at least 10 days plus one day for mail, before action is taken to cancel or reduce Medicaid coverage.

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

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

**2. Enrollee Appeals
Action**

If the enrollee requests an appeal hearing before the effective date of the action, subject to approval by the DMAS Appeals Division, the enrollee may choose to have eligibility continued at the current level of services until a decision is reached after a hearing. The DMAS Appeals Division will notify the local agency that the enrollee's coverage must be reinstated during the appeal process. **Do not reinstate coverage until directed to do so by the Department of Medical Assistance Services (DMAS) Appeals Division.**

If the decision is adverse to the recipient, the amount Medicaid paid on the services being appealed that were received by the recipient during the continuation is subject to recovery by DMAS.

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

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

**3. Death of
Enrollee**

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

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

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

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

Cancel 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 in the MMIS effective the current date (date the worker enters the cancel transaction in MMIS), using cancel reason code "008."*

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 on SPARK. 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.

7. **Enrollee
Requests
Cancellation**

An enrollee may request cancellation of his and/or his children's medical assistance coverage at any time. The request can be verbal or written. A written withdrawal request must be placed in the case record. A verbal request for withdrawal can be accepted only from the enrollee or case head, or his authorized representative. A verbal request must be documented in the case record with the date and time the withdrawal request was received, the name of the person who made the withdrawal request, and the signature and title of the agency staff person who took the call.

When the enrollee requests cancellation of Medicaid, the local department must send *adequate notice using* the Notice of Action to the enrollee no later than the effective date of cancellation.

On the notice:

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

M1520.400 EXTENSIONS OF MEDICAID COVERAGE

A. Policy

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

LIFC families who received Medicaid in three of the last six months and who became ineligible for Medicaid due to increased income from spousal support may be eligible for a four-month extension.

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

NOTE: Children must first be evaluated for Medicaid eligibility in the CN Child Under Age 19 (FAMIS Plus) covered group and if eligible, enrolled using the appropriate Child Under Age 19 AC. If ineligible as Child Under Age 19, the child must be evaluated for the Medicaid extensions.

MAGI methodology for the formation of households does not apply to individuals in Extended Medicaid. The family unit policies in M0520 apply to Extended Medicaid.

If ineligible for the Medicaid extensions, the child must be evaluated for FAMIS. If ineligible for FAMIS, the *child* must be given an opportunity for a medically needy determination prior to the worker taking action to cancel the Medicaid coverage *and* unless *the child* has Medicare, a referral to the HIM must be made.

B. Procedure

The policy and procedures for the four-month extension are in section M1520.401 below.

The policy and procedures for the twelve-month extension are in section M1520.402 below.

M1520.401 FOUR-MONTH EXTENSION

A. Policy

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

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

B. Procedures

1. Received in Error

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

2. New Family Member

A new member of the family, other than a newborn, is eligible for Medicaid under this provision if he/she was a member of the family in the month the unit became ineligible for LIFC Medicaid. A newborn born to an eligible member of the family at any time during the 4-month extension is eligible under this provision because the baby meets the CN newborn child under age 1 covered group.

3. Moves Out of State

Eligibility does not continue for any member of the family who moves to another state.

4. Coverage Period and AC

Medicaid coverage will continue for a period of four months beginning with the month in which the family became ineligible for LIFC Medicaid because *of the receipt of or increase in spousal support*. The AC for the enrollees in the family *receiving the four-month extension is "081" for an LIFC family with one parent or caretaker-relative or "083" for a two-parent family.*

5. **Case Handling** *Prior to the end of the fourth month of the extension, evaluate the individuals in the family for continuing Medicaid eligibility. Cancel coverage for any individuals in the family who are no longer eligible and send advance notice of the cancellation. Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made so that the individual's eligibility for the APTC in conjunction with a QHP can be determined.*

M1520.402 TWELVE-MONTHS EXTENSION

A. Policy

An LIFC Medicaid family is entitled to six additional months, with possible extension to twelve months, of Medicaid coverage after they lose Medicaid LIFC eligibility when the following conditions are met:

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

The family consists of those individuals included in the *family unit as defined in M0520.100* at the time that the LIFC Medicaid eligibility terminated. It also includes individuals born, adopted into, or returning to the family after extended benefits begin who would have been considered a member of the family at the time the LIFC Medicaid eligibility terminated. *The earned income received by a member of the family unit added after the loss of LIFC eligibility must be counted in determining the family's gross income.*

B. Eligibility Conditions

The following conditions must be met:

1. Received LIFC Medicaid in Three of Six Months

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

2. Cancel Reason

LIFC Medicaid was canceled solely because of:

- the *parent's or caretaker/relative's* new employment,
- the *parent's or caretaker/relative's* increased hours of employment, or
- the *parent's or caretaker/relative's* increased wages of employment.

3. Has A Child Living in Home

There continues to be at least one child under age 18 or if in school, a child who is expected to graduate before or in the month he turns 19, living in the home with the parent or caretaker/relative.

4. No Fraud

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

C. Entitlement & Enrollment

The AC for enrollees in the family receiving the twelve-month extension is "081" for an LIFC family with one parent or caretaker-relative or "083" for a two-parent family.

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

1. Determining Extension Period

Medicaid coverage will continue for six months beginning with the first month the family is not eligible for LIFC Medicaid because of excess income due to the increased earnings of the parent or caretaker/relative. Extension for an additional six-month period is possible if the reporting and financial requirements below are met.

a. New/increased Earnings Not Reported Timely

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

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

b. Simultaneous Income Changes

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

- 1) If the family would have been ineligible solely *due to the increase in earned income*, it will be considered the reason for LIFC Medicaid ineligibility and the family is eligible for the twelve-month Medicaid extension.
- 2) If, however, the family would have continued to be eligible for LIFC Medicaid if the only change had been increased earnings, the other changes which occurred simultaneously will be the reason for LIFC Medicaid ineligibility. The *family* is **not** eligible for the twelve-month Medicaid extension. *If the reason for LIFC Medicaid ineligibility was due to the receipt of or increase in spousal support, evaluate the family's eligibility for the four-month extension in M1520.401.*

- 2. Extension Ends** Entitlement to Medicaid under this extension terminates at the end of the first month in which there is no longer a child under 18 (*or if in school, a child who is expected to graduate before or in the month he turns 19*), living in the home, the *family* fails to comply with the reporting requirements in D below, or at the end of the extension period.

The individuals must be evaluated for continuing Medicaid eligibility prior to cancellation. Cancel coverage for any individuals in the family who are no longer eligible and send advance notice of the cancellation. Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.

D. Notice and Reporting Requirements

- 1. LIFC Medicaid Cancellation Month** When LIFC Medicaid is canceled, the family must be notified of its entitlement to extended Medicaid coverage for six months, and that Medicaid coverage will terminate if the child(ren) in the *home* turns age 18, or turns age 19 if the child is in school and *is expected to graduate before or in the month he turns 19*. Use the Notice of Extended Medicaid Coverage form that is posted on SPARK at:

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

a. Instructions to Family

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

b. Notices

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

c. MMIS Data Entry

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

2. Third Month of Extension

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

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

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

3. Fourth Month of Extension

a. Report Received Timely

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

If eligibility is not reviewed by the **cut-off date** of the sixth extension month, MMIS will cancel coverage. The agency must reopen *coverage for any individuals who remain eligible in another Medicaid covered group or in FAMIS* and must notify the *individual* of the reopened coverage.

b. Notice Requirements

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

c. Report Not Received Timely

If the first three-month period's report is not received by the 21st day of the fourth month, the family is not eligible for the additional six-month extension. Medicaid must be canceled effective the last day of the sixth month in the extension period *for any individuals who are not eligible for coverage in another Medicaid covered group or for FAMIS. Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.*

4. Sixth Month of Extension

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

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

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

5. Seventh Month of Extension

a. Report Received Timely

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

- 1) no child under age 18, *or if in school, a child who is expected to graduate before or in the month he turns 19*, lives with the family;
- 2) the *parent or caretaker/relative* had no earnings in one or more of the previous three months, unless the lack of earnings was due to:
 - the *parent's or caretaker/relative's* involuntary lay-off,
 - the business closed,
 - the *parent's or caretaker/relative's* illness or injury,
 - other good cause (such as serious illness of child in the home which required *the parent's or caretaker/relative's* absence from work);
- 3) the family's average gross monthly **earned** income (earned income only; unearned income is not counted) less costs for child care that was necessary for the employment of the caretaker/relative, during the preceding three-month period exceeds the 185% Federal Poverty Level (FPL) appropriate to the family unit size. See *M1520, Appendix 2*, for the 185% FPL income limits.

b. Calculate Family's Gross Earned Income

- 1) The family's gross earned income means the earned income of all family members who worked in the preceding three-month period. "Gross" earned income is total earned income before any deductions or disregards *and profit from self-employment*. All earned income must be counted, including students' earned income, *Workforce Investment Act (WIA)* earned income, children's earned income, etc. No exclusions or disregards are allowed. *Use policy in M0720.200 for determining profit from self-employment.*
- 2) Child care costs that are "necessary for the caretaker/relative's employment" are expenses that are the responsibility of the

caretaker/relative for child care that if not provided would prevent the caretaker/relative from being employed.

3) To calculate average gross monthly income:

- add each month's cost of child care necessary for the caretaker/relative's employment; the result is the three-month period's cost of child care necessary for the caretaker/relative's employment.
- add the family unit's total gross earned income received in each of the 3 months; the result is the family's total gross earned income.
- subtract the three-month period's cost of child care necessary for the caretaker/relative's employment from the family's total gross earned income.
- divide the remainder by 3; the result is the average monthly earned income.
- compare the average monthly earned income to the monthly 185% FPL for the appropriate number of family unit members (*see M1520, Appendix 2*).

c. Family No Longer Entitled To Extended Medicaid

If the family is not entitled to further Medicaid coverage because of one of the reasons in item *M1520.402 D.5.a* above, each *individual's* eligibility for Medicaid in another covered group or for *FAMIS* must be determined before canceling coverage. *Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.*

d. Family Remains Entitled To Extended Medicaid

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

e. Report Not Received Timely

If the second three-month period's report and verifications are not received by the 21st day of the seventh month, the family's Medicaid coverage must be canceled for individuals who are not eligible for Medicaid in another covered group or for *FAMIS* unless the family establishes good cause for failure to report on a timely basis. Examples of good cause for failure to report timely are:

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

Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.

MMIS will send the advance notice and automatically cancel coverage if the report is not received on time and the code is not changed. Cancellation is effective the last of the eighth month of extension.

If an individual's continuing eligibility is not reviewed by the **cut-off date** of the eighth extension month and MMIS cancels coverage, the agency must then reopen coverage and notify the recipient if the child is subsequently found eligible. If an individual remains eligible, change the individual's enrollment to the appropriate aid category before the **cut-off date** of the eighth extension month.

6. Ninth Month of Extension

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

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

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

7. Tenth Month of Extension

a. Report Received Timely

If the third three-month period's report is received by the 21st of the tenth month, change the case Follow-up Code in MMIS immediately upon receipt of the report and verifications. The family continues to be eligible for Medicaid unless one of the items in *M1520.402 D.5* above applies. Calculate the family's income using the procedures in *M1520.402 D.5* above.

b. Family No Longer Entitled To Extended Medicaid

If the *family* is not entitled to **extended** Medicaid coverage, review *each individual's* eligibility for Medicaid in another category or for FAMIS. *If the individual is not eligible, cancel Medicaid after sending the **Advance Notice of Proposed Action**. Cancellation is effective the last day of the eleventh month of extension. Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.*

c. Family Remains Entitled To Extended Medicaid

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

d. Report Not Received Timely

If the third three-month period's report and verifications are not received by the 21st of the tenth month, *Medicaid coverage must be canceled for individuals who are not eligible for Medicaid in another covered group or for FAMIS unless the family establishes good cause for failure to report timely (see M1520.402 D.5 above for good cause). Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.*

MMIS will automatically cancel coverage and send the advance notice if the report is not received on time and the Follow-up Code is not changed. Cancellation is effective the last day of the eleventh month of extension.

8. Twelfth Month of Extension

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

Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.

M1520.500 CASE TRANSFERS

A. Introduction

Applications and ongoing cases are transferred only when the individual retains residence in Virginia.

B. Nursing Facility and Assisted Living Facility (ALF)

When an *individual* is admitted to a nursing facility or an ALF from a community living arrangement, the case is not transferred, but remains with the Virginia locality in which the individual last lived outside of an institution. Community living arrangements do not include medical facilities, ALFs or group homes with four or more beds.

When an applicant/recipient is discharged from a nursing facility or ALF to a community living arrangement not in the Virginia locality that had responsibility for the individual's case while he was in the nursing facility or ALF, the case is transferred to the new locality.

C. DBHDS Facilities

The procedures for transfer of Medicaid cases of ABD patients admitted to or discharged from Department of Behavioral Health and Developmental Services (DBHDS) facilities are in subchapter M1550. F&C cases are not transferred to the DBHDS facilities.

D. Cases From Outstationed Workers

Medicaid applications taken and Medicaid cases approved by outstationed workers, such as the workers stationed at the University of Virginia (UVA) and Virginia Commonwealth University-Medical College of Virginia (VCU-MCV) hospitals, must be transferred to the LDSS where the applicant/enrollee lives. Medicaid cases and applications are **not** transferred from LDSS to outstationed workers.

1. Confirm Receipt

The receiving LDSS must confirm receipt of the case by completing the Case Record Transfer Form and returning the copy to the outstationed worker.

2. Review Eligibility

LDSS workers must review (partial review) the Medicaid eligibility determination in approved cases transferred from an outstationed worker, and must take any necessary corrective action.

3. Corrective Action

If an eligibility error(s) is found, do not send the case back. Correct the error(s), send the notice to the case head if required, and refer the case to the LDSS supervisor for possible contact with the outstationed worker's supervisor.

E. Local Agency to Local Agency

When a Medicaid applicant/enrollee (including a Medicaid CBC waiver services enrollee) moves from one locality to live in a community living arrangement (not a medical facility, an ALF, or group home with 4 or more beds) in another locality within the state of Virginia, the following procedures apply:

1. Sending Locality Responsibilities

a. Case Renewal Cannot Be Overdue

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

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

b. When Renewal Must Be Completed Before Transferring

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

sending 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/MMIS records as follows to assure managed care continuity:

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

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

c. Do Not Transfer Ineligible Cases

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

d. Transfer Eligible Enrollees/Cases

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

e. Transfer Pending Medicaid Applications

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

f. Foster Care & Adoption Assistance

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

g. Sending Transferred Cases

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

**2. Receiving
Locality
Responsibilities**

a. Confirm Receipt

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

b. Process Pending Applications

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

c. Review Eligibility

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

d. Corrective Action

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

F. Spenddown Cases

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

**1. Sending Locality
Responsibilities**

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

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

**2. Receiving
Locality
Responsibilities**

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

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

**G. Receiving LDSS Case
Management
Procedure**

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

Renewal Process Reference Guide

Renewal Due	Renewal Grace Period	Renewal Completed & Individual Remains Eligible	Next Renewal Period	Next Renewal Due
May 2014	N/A	May 9 th (before cutoff)	June 2014-May 2015	May 2015
May 2014	N/A	May 19 th (after cutoff)	June 2014-May 2015	May 2015
June 2014	N/A	In May (any day)	July 2014-June 2015	June 2015
July 2014	N/A	In May (any day)	August 2014-July 2015	July 2015
April 2014 Client does not return renewal form and coverage is cancelled effective April 30, 2014.	May, June, July Renewal form returned in May 2014	In May (any day) Coverage is reinstated back to May 1	May 2014-April 2015	April 2015
April 2014 Client does not return renewal form and coverage is cancelled effective April 30, 2014.	May, June, July Renewal form returned in June 2014	In June (any day) Coverage is reinstated back to May 1.	July 2014-June 2015 (May is treated as retro month)	June 2015
April 2014 Client does not return renewal form and coverage is cancelled effective April 30, 2014.	May, June, July Renewal form returned in July 2014	July (any day) Coverage is reinstated back to May 1.	August 2014-July 2015 (May and June treated as retro months)	July 2015
April 2014 Client does not return renewal form and coverage is cancelled effective April 30, 2014.	May, June, July Renewal form returned in August 2014	Treat as new application since grace period expired (a new application form is not required). Application date is date of receipt, retroactive period is May-July.	August 2014-July 2015	July 2015
November 2013 (overdue renewal)	N/A	May 2014	June 2014-May 2015	May 2015

TWELVE MONTH EXTENDED MEDICAID INCOME LIMITS 185% of FEDERAL POVERTY LIMITS EFFECTIVE 1-22-15 ALL LOCALITIES	
# of Persons in Family Unit/Budget Unit	185% FPL Monthly Limit
1	\$1,815
2	2,456
3	3,098
4	3,739
5	4,380
6	5,022
7	5,663
8	6,304
Each additional person add	642

M1550 Transmittal Changes

Changed With	Effective Date	Pages Changed
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

**DBHDS Facilities
Medicaid Technicians**

NAME	LOCATION	WORK TELEPHONE	CASELOAD
Mary Lou Spiggle Medicaid Field Supervisor (T003)	Central Virginia Training Center Medicaid Office Madison Heights, VA <u>Mail To:</u> PO Box 1098 Lynchburg, VA 24505	434-947-6256 Cell 434-660-8259 FAX 434-947-2114	PGH-caseload-all NVMHI-caseload-all SVMHI-caseload-all WSH-caseload-all
Carrie Richardson (T002)	Central Virginia Training Center Medicaid Office Madison Heights, VA <u>Mail To:</u> PO Box 1098 Lynchburg, VA 24505	434-947-6255 FAX 434-947-2114	CVTC-caseload-all VCBR-caseload-all
Frances Jones (T004)	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0841 FAX 276-782-9732	ESH-caseload-all NVTC-caseload-all SWVTC-caseload-all
Vickie C. Simmons (T005)	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0842 FAX 276-782-9732	Catawba-caseload-all Hiram-Davis-caseload-all SEVTC-caseload-all SWVMHI-caseload-all

NOTE: Because the Medicaid Technicians handle various hospitals in their caseloads, LDSS staff should send transferred case records directly to the Medicaid Technician who requested the case record. In the case record transfer request, the Medicaid Technician will give specific instructions about where to send the case record.

DBHDS State Hospital facilities:

FIPS	FACILITY INITIALS and FULL NAME
997	Catawba – Catawba Hospital
990	CVTC – Central Virginia Training Center
994	ESH – Eastern State Hospital
996	HDMC – Hiram Davis Medical Center
988	NVMHI – Northern Virginia Mental Health Institute
986	NVTC – Northern Virginia Training Center
993	PGH – Piedmont Geriatric Hospital
985	SEVTC – Southeastern Virginia Training Center
983	SVMHI – Southern Virginia Mental Health Institute
992	SWVMHI – Southwestern Virginia Mental Health Institute
984	SWVTC – Southwestern Virginia Training Center
993	VCBR – Virginia Center for Behavioral Rehabilitation
991	WSH – Western State Hospital

Virginia DSS, Volume XIII

M16 Changes

Changed With	Effective Date	Pages Changed
TN #100	5/1/15	page 3
Update #9	4/1/13	page 8

- F. Conference Decision** If the applicant/enrollee is not satisfied with the agency action following the conference and wants to request a fair hearing, he must be given that opportunity. See M1630.100 C. below. The applicant/enrollee may request an appeal before or after the conference. Participation in a conference does not extend the 30 day time limit for requesting an appeal.

M1630.100 APPEAL REQUEST PROCEDURES

- A. Appeal Definition** An appeal is a request for a fair hearing. The request must be a clear, written expression by an applicant or enrollee, his legal representative (such as a guardian, conservator, or person having power of attorney), or his authorized representative acting at his request, of a desire to present his case to a higher authority. It may be a letter or a completed "Medicaid/SLH/FAMIS Appeal Request Form."
- B. Where to File an Appeal** Appeals must be sent to the:
- Department of Medical Assistance Services
Appeals Division
600 East Broad Street
Richmond, Virginia 23219
- Appeals may also be faxed to (804) 612-0036.
- C. Assuring the Right to Appeal** The right to appeal must not be limited or interfered with in any way. When requested to do so, the agency must assist the applicant/enrollee in preparing and submitting his request for a fair hearing.
- D. Appeal Time Standards** A request for an appeal must be made within 30 days of receipt of notification that Medicaid coverage or medical services has been denied, terminated, reduced, adversely affected, or that it has not been acted upon with reasonable promptness.
- Notification is presumed received by the applicant/enrollee within three days of the date the notice was mailed, unless the applicant/enrollee substantiates that the notice was not received in the three-day period through no fault of his/her own.
- An appeal request shall be deemed to be filed timely if it is mailed, faxed, or otherwise delivered to the DMAS Appeals Division before the end of last day of filing (30 days plus 3 mail days after the date the agency mailed the notice of adverse action). The date of filing will be determined by:
- the postmark date,
 - the date of an internal DMAS receipt date-stamp, or
 - the date the request was faxed or hand-delivered.

M18 Changes

Changed With	Effective Date	Pages Changed
TN #100	5/1/15	Table of Contents Pages 1-9 Pages 10-17 were deleted. Appendix 1 was removed.
UP #9	4/1/13	Page 3
UP #7	7/1/12	Page 12
TN #96	10/01/11	Pages 3, 4, 16
TN #95	3/1/11	Page 9
TN #94	9/1/10	Page 12
TN #93	1/1/10	Pages 4, 5
TN #91	5/15/09	Page 2 Pages 5, 6 Page 8

TABLE OF CONTENTS

M18 MEDICAL SERVICES

MEDICAL SERVICES

	Section	Page
Medicaid Eligibility Card	M1810.100	1
Service Providers	M1820.100	2
Managed Care	M1830.100	3
Utilization Review and Client Medical Management.....	M1840.100	5
Covered Services	M1850.100	6
Services Received Outside Virginia	M1860.100	9

M1800 MEDICAL SERVICES

M1810.100 MEDICAID ELIGIBILITY CARD

A. Medicaid Card Issuance

A Medicaid card is issued to an individual who has been found eligible for Medicaid and is enrolled with the Department of Medical Assistance Services (DMAS). The card is plastic with the enrollee's name, gender and birth date on the front, and a strip on the back that providers can "swipe" to ascertain the type of coverage and the begin date of coverage. The card is intended to be permanent. Presentation of the card to the Medicaid-enrolled (certified) provider of medical services authorizes the provider to bill Medicaid for the needed services, if such services are covered by the Medical Assistance Program and DMAS has pre-authorized the service, when pre-authorization is required.

Exception: The following recipients do not receive a Medicaid card:

- individuals eligible for Medicare premium payment only,
- individuals enrolled in a closed period of coverage in the past with no ongoing coverage, and
- *incarcerated individuals eligible for Medicaid payment of inpatient hospitalization services only.*

B. Use of the Medicaid Card

1. General

Local social services departments must provide recipients with information concerning use of the Medicaid card. This includes information that misuse of the card is fraud and can result in prosecution. Examples of misuse include:

- using the card following cancellation of eligibility,
- alteration of names, dates, or other information to secure medical care to which the individual is not entitled, and
- knowingly permitting another person to use an individual's card to secure medical care.

2. Foster Care Children in Institutional Facilities

The local department of social services (LDSS) should use the local department's address when enrolling a foster care child whose custody is held by the local department of social services and who is placed in an institution. Upon receipt of the Medicaid card, it should be sent to the appropriate institution for use on the child's behalf. The local department has the responsibility of advising the child caring institution of the medical and dental services covered by Medicaid.

3. Nursing Facility Patients

Patients in nursing facilities receive Medicaid cards. The nursing facility also receives a computer-generated list at the first of the month which lists all eligible Medicaid patients in that facility.

This *report* reflects only those Medicaid-eligible patients for whom the nursing facility has submitted an "admission packet."

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

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

M1820.100 SERVICE PROVIDERS**A. Enrollment Requirement**

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

B. Out-of-State Providers**1. Covered Services**

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

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

2. Provider Enrollment

In instances where an out-of-state provider is not currently enrolled as a DMAS provider, DMAS will accept the provider's initial billing and will contact the provider to determine the provider's wish to become enrolled so that subsequent services can be paid through the computerized Medicaid claims processing system.

M1830.100 MANAGED CARE**A. General Information**

DMAS provides Medicaid coverage to enrollees primarily through two delivery systems: fee-for-service (FFS) and managed care. FFS benefits are administered by DMAS through participating providers within the traditional Medicaid program rules.

DMAS operates one Medicaid mandatory managed care program, Medallion 3.0. The Medallion 3.0 program is administered through DMAS' contracted managed care organizations (MCO). Most Virginia Medicaid enrollees are required to receive medical care through a managed care organization.

B. Enrollees Exempt from Managed Care

*Individuals eligible for Medallion 3.0 include non-institutionalized enrollees in both Families & Children (F&C) and Aged, Blind or Disabled (ABD) covered groups. Some enrollees in the above groups are not Medallion 3.0 eligible because they meet exclusionary criteria. The following is a **partial** list of enrollees excluded from managed care enrollment:*

- *Enrollees who are inpatients in state mental hospitals,*
- *Enrollees who are in long-stay hospitals, nursing facilities, or intermediate care facilities for the intellectually disabled,*
- *Enrollees who meet a spenddown and are enrolled for a closed period of coverage,*
- *Enrollees who are participating in Plan First,*
- *Enrollees under age 21 in Level C residential facilities,*
- *Enrollees with other comprehensive group or member health insurance coverage, and*
- *Enrollees who have an eligibility period that is less than three months or who have an eligibility period that is only retroactive.*

The criteria for exclusion from Medallion 3.0 are contained in the Managed Care Resource Guide, available at http://www.dmas.virginia.gov/Content_attachments/mc/MC%20Resource%20Guide%2002192015_MCH_update_SG.pdf.

Enrollees excluded from mandatory managed care enrollment shall receive Medicaid services under the current fee-for-service system. When enrollees no longer meet the criteria for exclusion, they shall be required to enroll in the appropriate managed care program.

C. Managed Care HelpLine

Eligible individuals can enroll in an MCO or obtain additional information, as well as assistance with coverage issues, by calling the Managed Care HelpLine at 1-800-643-2273 (TTY/TDD 1-800-817-6608). The Helpline is available Monday through Friday from 8:30 a.m. until 6:00 p.m. Information is available online at www.virginiamanagedcare.com.

**D. Family Access to
Medical Insurance
Security Plan
(FAMIS) Managed
Care**

FAMIS benefits are administered through DMAS contracted MCOs or through FAMIS fee-for-service. The DMAS contracted MCOs for FAMIS are the same as those contracted with DMAS for Medallion 3.0.

In all areas of the Commonwealth, FAMIS enrollees have the choice between 2 or more MCOs. When a child is first enrolled in FAMIS, he or she is able to access health care through the FAMIS fee-for-service program. Within 1 or 2 months after FAMIS enrollment, the child will be enrolled with a FAMIS MCO.

*FAMIS benefits are slightly different than the benefits that children enrolled in Medicaid receive. There are benefit limitations and small co-payments similar to those associated with commercial group health insurance. The following is a partial list of services (while covered under Medicaid) are **NOT** covered under FAMIS:*

- *Early and Period Screening Diagnosis and Treatment (EPSDT) for FAMIS MCO members; Many of the services that are covered as EPSDT services by Medicaid are covered under FAMIS MCO's well child and immunization benefits. EPSDT services **are** covered for FAMIS FFS members because they receive the Medicaid benefit package.*
- *psychiatric treatment in free standing facilities (psychiatric treatment is covered when provided in a psychiatric unit of an acute hospital)*
- *routine transportation to and from medical appointments for FAMIS MCO enrollees. Children enrolled in FAMIS FFS may receive non-emergency transportation services. Emergency transportation is covered for both FAMIS MCO and FAMIS FFS enrollees.*
- *community mental health rehabilitation services other than: Intensive in-home, therapeutic day treatment, mental health crisis intervention, and case management for children at risk of or experiencing a serious emotional disturbance.*

**E. Commonwealth
Coordinated
Care (CCC)**

The Commonwealth Coordinated Care (CCC) program is person-centered care for individuals who are dually eligible for both Medicare and full benefit Medicaid. It covers all the same benefits under Medicare and Medicaid in a single program that coordinates primary, preventative, acute, behavioral, and long term care services. Individuals who meet the criteria for participation in CCC are automatically enrolled in the program but may opt out at any time.

Questions about CCC should be referred to MAXIMUS at 1-855-889-5243 or online at: www.virginiacc.com.

**E. Enrollment
Corrections/
Changes**

DMAS pays a capitation rate for every month an *individual* is enrolled in managed care regardless of whether the *individual* receives medical services during the month. If an *individual* is incorrectly enrolled in a Medicaid managed care program, the eligibility worker must refer the case to DMAS at the following address for possible recovery of expenditures (see chapter M1700):

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

M1840.100 UTILIZATION REVIEW AND CLIENT MEDICAL MANAGEMENT**A. Utilization Review**

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

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

**B. Client Medical
Management
(CMM) Program**

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

Individuals identified as high utilizers will receive a letter of notification with instructions about selecting primary providers and identifying those providers to DMAS. Individuals who do not respond to the letter within the specified time will have their primary physician and pharmacy designated by DMAS.

For recipients who have been placed in the CMM Program, Medicaid payment for physicians' services will be limited to those services rendered by the primary physician (including a physician providing services to the patients of the primary physician when the primary physician is not available), physicians seen on referral from the primary physician, and emergency medical services.

Prescriptions may be filled by a non-designated pharmacy only in emergency situations when the designated pharmacy is closed or cannot readily obtain the drug.

M1850.100 COVERED SERVICES

A. General Information

Information on Medicaid covered services is provided to assist the eligibility worker in responding to general inquiries from applicants/recipients.

Individuals who have problems with bills or services from providers of care should be referred as follows:

- Refer FFS Medicaid *enrollees* to the DMAS Recipient Helpline at 804-786-6145. Refer individuals who need assistance with transportation to the DMAS transportation broker at 1-866-386-8331.
- *Refer individuals* enrolled in managed care to the Managed Care HelpLine at 1-800-643-2273 or directly to their MCO. Individuals in managed care who need assistance with transportation must contact their MCO directly.

B. Copayments

a. Medicaid Enrollees without Medicare

Most Medicaid covered services have a “copayment,” which is the portion of the cost of the service for which the recipient is responsible. Copayment amounts range from \$1.00 to \$3.00 for most services. There is a \$100.00 copayment per admission for inpatient hospital stays. The provider collects the copayment directly from the *enrollee* at the time the service is provided.

b. Medicare Beneficiaries

Individuals with Medicare and full-benefit Medicaid (dual eligibles) and Qualified Medicare Beneficiaries (QMB) are responsible for Medicaid copayments only. Medicaid covers the remainder of the Medicare copayment for these individuals. However, a provider is allowed to collect the Medicare copayment at the time of service. If the provider requires the individual to pay the Medicare copayment, the individual must be reimbursed or credited the difference between the Medicare and Medicaid copayments once the provider receives payment of the Medicaid claim.

B. Individuals Exempt from Copayments

The following individuals are exempt from the Medicaid copayments:

- children under 21 years old,
- individuals who receive long-term care services in a nursing facility, rehabilitation hospital, or long-stay hospital, and
- individuals receiving Medicaid community-based care (CBC) waiver services and hospice care.

C. Services with No Copayments

The following services do not have copayments:

- emergency-room services,
- pregnancy-related services,
- family planning services, and
- dialysis services.

D. Covered Services

The services listed below are covered:

- case management services;
- certified pediatric nurse and family nurse practitioner services;
- clinical psychologist services;
- *community-based services for individuals with intellectual disabilities, including day health rehabilitation services and case management;*
- dental services for individuals under age 21 years *and pregnant women;*
- emergency hospital services;
- Early Periodic Screening, Diagnostic and Treatment (EPSDT) services;
- family planning services;
- Federally Qualified Health Center clinic services;
- home and community-based care waiver services (see subchapter M1440);
- home health services: nurse, aide, supplies, treatment, physical therapy, occupational therapy, and speech therapy services;
- hospice services;
- inpatient hospital services;
- *Intensive Behavioral Dietary Counseling, for individuals in MEDICAID WORKS;*
- intermediate care facility services *for the intellectually disabled (ICF-ID);*
- laboratory and x-ray services;
- Medicare premiums: Hospital Insurance (Part A); Supplemental Medical Insurance (Part B) for the Categorically Needy (CN) and Medically Needy (MN);

- mental health services, including clinic services, case management, psychosocial rehabilitation, day treatment/partial hospitalization, therapeutic day treatment for children and adolescents, intensive in-home services for children and adolescents, and crisis intervention services;
- nurse-midwife services;
- nursing facility care;
- other clinic services: services provided by rehabilitation agencies, ambulatory surgical centers, renal dialysis clinics, and local health departments;
- outpatient hospital services;
- *personal assistance services, for individuals in MEDICAID WORKS;*
- physical therapy and related services;
- physician services;
- podiatrist services;
- prescribed drugs;
- prosthetic devices;
- Rural Health Clinic services;
- skilled nursing facility services for individuals under age 21 years;
- substance abuse services;
- transplant services;
- transportation to receive medical services; and
- vision services.

M1860.100 SERVICES RECEIVED OUTSIDE VIRGINIA**A. General**

Medicaid must pay for covered medical services received by any eligible person who is temporarily absent from Virginia if the medical service provider agrees to accept Medicaid payment.

B. Out-of-State Institutional Placements

Virginia Medicaid will cover an *enrollee* who is placed in an *LTC* facility in another state only if the placement is preauthorized by the DMAS Long Term Care Section.

A child in IV-E Foster Care who is placed in an institution outside Virginia is eligible for Medicaid through the state in which he resides. A child in non-IV-E Foster Care is eligible for Virginia Medicaid when the child is in an institution outside Virginia, since the child is considered to be a resident of the locality which holds custody.

M21 Changes

Changed With	Effective Date	Pages Changed
TN #100	5/1/15	Table of Contents Pages 1-7 Appendix 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

TABLE OF CONTENTS

M21 – FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS)

	Section	Page
FAMIS General Information	M2110.100.....	1
Nonfinancial Eligibility Requirements	M2120.100.....	2
Health Insurance Coverage	M2120.200.....	3
Financial Eligibility	M2130.100.....	4
Application and Case Procedures	M2140.100.....	5
Review of Adverse Actions	M2150.100.....	7
 <i>APPENDIX</i> 		
FAMIS Income Limits	Appendix 1.....	1

M2100.000 FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS)

M2110.100 FAMIS GENERAL INFORMATION

A. Introduction

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program, enacted as Title XXI of the Social Security Act, to provide funds to States to enable them to initiate the provision of child health insurance to **uninsured low-income children**.

FAMIS is not an entitlement program, which means that if funds for this program are exhausted, no additional individuals will receive benefits under the program. The Department of Medical Assistance Services (DMAS) will notify the Department of Social Services (DSS) Central Office if funds for this program run out.

Children found eligible for FAMIS receive benefits described in the State's Title XXI Child Health Insurance Program. Eligible children are enrolled for benefits effective the first day of the child's application month if all eligibility requirements are met in that month, but no earlier than the date of the child's birth.

Retroactive coverage is only available to an eligible child who was born within the 3 months prior to the FAMIS application month. Eligibility for FAMIS coverage will be effective retroactive to the child's date of birth if the child would have met all eligibility criteria during that time.

Eligibility for FAMIS is determined by either the local DSS, including a DSS outstationed site, or the Cover Virginia Central Processing Unit (CPU). Applications processed by the Cover Virginia CPU will be transferred to the appropriate local DSS for case maintenance.

B. Legal Basis

The 1998 Acts of Assembly, Chapter 464, authorized Virginia's Children's Health Insurance Program by creating the Children's Medical Security Insurance Plan for uninsured children under 19 years of age. In August 2001, the program was revised and renamed the Family Access to Medical Insurance Security Plan (FAMIS).

C. Policy

FAMIS covers uninsured low-income children under age 19 who are not eligible for Medicaid (children's Medicaid) and whose gross family income is less than or equal to 200% of the federal poverty level (FPL) for the individual's household size (see M2130.100 for the definition of the FAMIS household and Appendix 1 for the income limits).

M2120.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

- A. Introduction** The child must meet, with certain exceptions, the Medicaid Nonfinancial Eligibility Requirements in chapter M02 and the nonfinancial eligibility requirements imposed by FAMIS.
- B. M02 Requirements** The nonfinancial eligibility requirements in chapter M02 that must be met for FAMIS eligibility are:
- the citizenship and alienage requirements, with the exception noted in M2120.100 C below;
 - Virginia residency requirements;
 - Provision of a Social Security Number (SSN) or proof of application for an SSN.
 - Assignment of rights to payment for medical care from any liable third party is a condition of eligibility for the child;
 - institutional status requirements regarding inmates of a public institution.
- C. FAMIS Alien Status Requirements** *Lawfully residing children under age 19 meet the FAMIS alien requirements without regard to their date of arrival or length of time in the U.S. The lawfully residing alien groups are contained in section M0220.314.*
- Exception to M02:**
- FAMIS does **not** provide emergency services only coverage for non-citizens who are not lawfully residing in the U.S., such as illegal aliens or those whose lawful admission status has expired. These aliens are not eligible for FAMIS
- D. FAMIS Nonfinancial Requirements** The child must meet the following FAMIS nonfinancial requirements:
- 1. Age Requirement** The child must be under age 19 for at least one day during the month. No verification is required.

A child no longer meets the age requirements for FAMIS effective the end of the month in which the child reaches age 19 years, provided he was under age 19 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 19.
 - 2. Uninsured Child** The child must be uninsured, that is, he must not be covered under any health insurance plan offering hospital and medical benefits. See M2120.200.
 - 3. IMD Prohibition** The child cannot be an inpatient in an IMD.

M2120.200 HEALTH INSURANCE COVERAGE

A. Introduction

The intent of FAMIS is to provide health coverage to low-income uninsured children. *Eligibility for this program is prohibited when a child has creditable health insurance coverage.*

B. Definitions

1. Creditable Coverage

For the purposes of FAMIS, creditable coverage means coverage of the individual under any of the following:

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

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

2. Health Benefit Plan

“Health benefit plan” is defined in the Virginia Bureau of Insurance Regulations (14VAC5-234-30) and means:

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

Health benefit plan does not mean:

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

3. Insured means having creditable health insurance coverage or coverage under a health benefit plan.

4. Uninsured means having no insurance; having insurance that is not creditable; having coverage which is not defined as a health benefit plan, or having a health insurance plan that does not have a network of providers in the area where the child resides.

C. Policy A nonfinancial requirement of FAMIS is that the child be uninsured. A child **cannot:**

- have creditable health insurance coverage;
- have coverage under a group health plan (TRICARE, federal employee benefit plan, private group insurance such as Anthem, etc.) or Medicare;

M2130.100 FINANCIAL ELIGIBILITY

A. Financial Eligibility

1. Asset Transfer Asset transfer rules do not apply to FAMIS.

2. Resources Resources are not evaluated for FAMIS.

3. Income **a. Countable Income**

FAMIS uses the MAGI methodology for counting income contained in chapter M04. The source and amount of all income that is not excluded in chapter M04 must be verified.

To the maximum extent possible, income must be verified by information obtained from electronic data sources, such as the federal hub or another reliable data source, prior to requesting paystubs or employer statements.

FAMIS uses MAGI methodology for estimating income (see chapter M04).

b. Available Gross Income

Retroactive period (for newborns only) – available income is the gross income actually received in each month in the retroactive period.

Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months.

c. Income Limits

The FAMIS income limit is 200% of the FPL (see Appendix 1 to this subchapter) for the number of individuals in the FAMIS assistance unit. *Per MAGI policy in chapter M04, a 5% FPL income disregard is applicable.*

5. Spenddown

Spenddown does not apply to FAMIS. If the household's gross income exceeds the FAMIS income limits, the child is not eligible for the FAMIS program regardless of medical expenses.

M2140.100 APPLICATION and CASE PROCEDURES

A. Application Requirements

The policies in subchapters M0120 and M0130 apply.

B. Eligibility Determination

When an application is received and the child is not eligible for Medicaid due to excess income, determine eligibility for FAMIS. In order to complete an eligibility determination, both the FAMIS nonfinancial requirements in M2120.100 and the financial requirements in M2130.100 must be met. Income must be verified.

The applicant/enrollee must be notified in writing of the required information and the deadline by which the information must be received. Applications must be acted on as soon as possible, but no later than 45 days from the date the signed application was received at the local DSS.

C. Entitlement and Enrollment

1. Begin Date

Children determined eligible for FAMIS are enrolled for benefits effective the first day of the child's application month if all eligibility requirements are met in that month, **but no earlier than the date of the child's birth.**

2. Retroactive Coverage For Newborns Only

Retroactive coverage is available ONLY to an eligible child who was born within the 3 months prior to the FAMIS application month. Eligibility for FAMIS coverage will be effective retroactive to the child’s date of birth if the child was born within the retroactive period and would have met all eligibility criteria during the retroactive period.

The following eligibility requirements must be met in order for a newborn child to be enrolled in FAMIS for retroactive FAMIS coverage:

- a. Retroactive coverage must be requested on the application form or in a later contact.
- b. The child’s date of birth must be within the three months immediately preceding the application month (month in which the agency receives the signed application form for the child).
- c. The child must meet all the FAMIS eligibility requirements during the retroactive period.

3. FAMIS Aid Categories

The aid categories (ACs) for FAMIS are:

AC	Meaning
006	child under age 6 with income > 150% FPL and ≤ 200% FPL
007	child 6 – 19 with income > 150% FPL and ≤ 200% FPL
008	child under age 6 with income > 143% FPL and ≤ 150% FPL
009	child 6 – 19 with income > 143% FPL and ≤ 150% FPL

D. Notification Requirements

The *eligibility worker* must send a Notice of Action on Medicaid and FAMIS to the family informing them of the action taken the application. The notice must include the eligibility determination for both Medicaid and FAMIS.

If the child is ineligible for both Medicaid and FAMIS, the family must be sent a notice that the child is not eligible for either program. A referral to the Health Insurance Marketplace must be made, and the child must be given the opportunity to have a Medicaid medically needy evaluation if he is under 18 years. Along with the notice, *request verification of resources using Appendix D to the Application for Health Insurance and Help Paying Costs*. Advise *the family* that if the signed application is returned within 10 calendar days, the original application date will be honored.

E. Transitions Between Medicaid And FAMIS (Changes and Renewals)

When excess income for Medicaid causes the child’s eligibility to change from Medicaid to FAMIS, the new income must be verified using an electronic data source such as the federal Hub or another reliable data source prior to requesting paystubs or employer statements.

F. FAMIS Select

Under the FAMIS program, a family, whose child(ren) are determined eligible for FAMIS and who has access to health insurance through an employer or wishes to purchase a private policy, has the option of enrolling the family in that health plan. “FAMIS Select” allows the choice of the private or employer’s insurance instead of FAMIS. Children enrolled in FAMIS whose families have access to private or employer sponsored health insurance coverage may qualify to have the State pay part of the family’s share of the health insurance premium.

Once a child is enrolled in FAMIS, *the worker* will identify if the family is interested in more information about FAMIS Select. Families who have access to health insurance will receive information from DMAS about the benefits of enrolling in the FAMIS Select component of FAMIS and information about how to participate in the program. Participation in the FAMIS Select component is voluntary.

**G. 12-Month
Continuous
Coverage**

Children under age 19 who are enrolled in FAMIS are entitled to 12 months of continuous coverage provided the family continues to reside in Virginia and the family income is less than or equal to 200% of the FPL.

Children enrolled in FAMIS who subsequently apply for Medicaid and are found eligible must have their FAMIS coverage cancelled so they can be reinstated in Medicaid.

M2150.100 REVIEW OF ADVERSE ACTIONS

A. Case Reviews

An applicant for FAMIS may request a review of an adverse determination regarding eligibility for FAMIS. FAMIS reviews follow the procedures established by Medicaid for client appeals (see chapter M16).

The payment of medical services on the part of any child or any right to participate in the program is not subject to review if funds for FAMIS are exhausted.

**FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN
(FAMIS)
INCOME LIMITS
ALL LOCALITIES**

EFFECTIVE 1/22/15

# of Persons in FAMIS Assistance Unit	FAMIS 150% FPL		FAMIS 200% FPL	
	Annual Limit	Monthly Limit	Annual Limit	Monthly Limit
1	\$17,655	\$1,472	\$23,540	\$1,962
2	23,895	1,992	31,860	2,655
3	30,135	2,512	40,180	3,349
4	36,375	3,032	48,500	4,042
5	42,615	3,552	56,820	4,735
6	48,855	4,072	65,140	5,429
7	55,095	4,592	73,460	6,122
8	61,335	5,112	81,780	6,8152
Each additional, add	6,240	520	8,320	694

M22 Changes

Changed With	Effective Date	Pages Changed
TN #100	5/1/15	Table of Contents Pages 1, 2, 5, 6, 7 Appendix 1 Pages 3 and 4 are runover Pages.
TN #98	10/1/13	Table of Contents Pages 1-7 Appendix 1 Pages 8-10 were deleted.
UP #9	4/1/13	Appendix 1
UP #8	10/1/12	Pages 2, 3 Page 3a deleted
UP #7	7/1/12	Pages 2, 3
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	Pages 3, 3a
TN #95	3/1/11	Pages 4-6 Appendix 1
UP #4	7/1/10	Page 10
TN #94	9/1/10	Page 3
UP #3	3/01/10	Page 2
TN #93	1/1/10	Pages 2-10
UP #2	8/24/09	Page 3
Update (UP) #1	7/1/09	Pages 1, 2, 7 Appendix 1, page 1

TABLE OF CONTENTS

M22 – FAMIS MOMS

	Section	Page
FAMIS MOMS General Information	M2210.100.....	1
Nonfinancial Eligibility Requirements	M2220.100.....	2
Health Insurance Coverage	M2220.200.....	3
No Child Support Cooperation Requirements	M2220.300.....	4
Financial Eligibility	M2230.100.....	5
Application and Case Handling Procedures	M2240.100.....	5
Review of Adverse Actions	M2250.100.....	7

APPENDIX

FAMIS MOMS Income Limits	Appendix 1.....	1
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M2200.000 FAMIS MOMS

M2210.100 FAMIS MOMS GENERAL INFORMATION

A. Introduction

The 2005 Appropriations Act directed the Department of Medical Assistance Services (DMAS) to amend the Family Access to Medical Insurance Security Plan (FAMIS) and expand medical coverage to uninsured pregnant women who are ineligible for Medicaid and have income in excess of the Medicaid limits, but whose family income is less than or equal to 200% of the federal poverty level (FPL). *FAMIS MOMS was closed to new applications from January 1, 2014 until November 30, 2014. Enrollment in the program resumed on December 1, 2014.*

Eligibility for FAMIS MOMS is determined by either the local DSS, including a DSS outstationed site, or the Cover Virginia Central Processing Unit (CPU). Applications processed by the Cover Virginia CPU will be transferred to the appropriate local DSS for case maintenance.

Eligible women are enrolled for benefits effective the first day of the application month if all eligibility requirements are met in that month. There is no retroactive coverage in FAMIS MOMS. Pregnant women found eligible for FAMIS MOMS receive the same benefits as Medicaid pregnant women, *including comprehensive dental services*. An eligible woman will receive coverage through her pregnancy and 60 days following the end of the pregnancy.

B. Policy Principles

FAMIS MOMS covers uninsured low-income pregnant women who are not eligible for Medicaid due to excess income, and whose countable income is less than or equal to 200% of the FPL.

A pregnant woman is eligible for FAMIS MOMS if all of the following are met:

- she is not eligible for Medicaid and has income in excess of the Medicaid limits;
- she is a resident of Virginia;
- she is uninsured;
- she is not an inmate of a public institution;
- she is **not** an inpatient in an institution for mental diseases; and
- she has countable family income less than or equal to 200% FPL.

M2220.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

- A. Policy** The pregnant woman must meet, with certain exceptions, the Medicaid nonfinancial eligibility requirements in Chapter M02 and the nonfinancial eligibility requirements imposed by FAMIS.
- B. M02 Applicable Requirements** The Medicaid nonfinancial eligibility requirements in Chapter M02 that must be met are:
- citizenship or alien status, *with the exception noted in M2220.100 C below*;
 - Virginia residency requirements;
 - Provision of a Social Security Number (SSN) or proof of application for an SSN;
 - assignment of rights;
 - application for other benefits;
 - institutional status requirements regarding inmates of a public institution.
- C. FAMIS MOMS Alien Status Requirements** *Lawfully residing pregnant women meet the FAMIS alien requirements without regard to their date of arrival or length of time in the U.S. The lawfully residing alien groups are contained in section M0220.314.*
- Exception to M02:**
- FAMIS MOMS does **not** provide emergency services only coverage for non-citizens who are not lawfully residing in the U.S., such as illegal aliens or those whose lawful admission status has expired. These aliens are not eligible for FAMIS MOMS.
- D. FAMIS MOMS Covered Group Requirements**
- 1. Declaration of Pregnancy** The woman's pregnancy is declared on the application and requires no further verification unless the agency has received conflicting information. See M0310.124 for the definition of a pregnant woman.
 - 2. Must be Uninsured** The pregnant woman must be uninsured; that is, she must not be covered under any creditable health insurance plan offering hospital and medical benefits. If a pregnant woman has creditable health insurance that does not cover pregnancy, labor and/or delivery services, the pregnant woman is ineligible for FAMIS MOMS because she is insured.
 - 3. IMD Prohibition** The pregnant woman cannot be an inpatient in an institution for mental diseases (IMD).

M2220.200 HEALTH INSURANCE COVERAGE

A. Introduction

The intent of FAMIS MOMS is to provide health coverage to low-income uninsured pregnant women. A pregnant woman who has creditable health insurance coverage is not eligible for FAMIS MOMS.

B. Definitions

1. Creditable Coverage

For the purposes of FAMIS MOMS, creditable coverage means coverage of the individual under any of the following:

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

2. Employer-Sponsored Dependent Health Insurance

Employer-sponsored dependent health insurance means the employer pays a portion of the premium payment. COBRA coverage in which the employer makes no contribution to the payment of the premium is not employer-sponsored insurance.

3. Health Benefit Plan

“Health benefit plan” is defined in the Virginia Bureau of Insurance Regulations (14VAC5-234-30) and means:

- any accident and health insurance policy or certificate,
- health services plan contract,
- health maintenance organization subscriber contract,
- plan provided by a Multiple Employer Welfare Arrangement (MEWA)”.

Health benefit plan does NOT mean:

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

4. Insured means having creditable health insurance coverage or coverage under a health benefit plan. A woman is considered to be insured if she is covered by a creditable health insurance plan, even if the policy or plan does not cover pregnancy-related services.

5. Uninsured means having no insurance; having insurance that is not creditable; having coverage which is not defined as a health benefit plan, or having a health insurance plan that does not have a network of providers in the area where the pregnant woman resides.

C. Policy

1. Must be Uninsured A nonfinancial requirement of FAMIS MOMS is that the pregnant woman be uninsured. A pregnant woman **cannot**:

- have creditable health insurance coverage; or
- have coverage under a group health plan (TRICARE, federal employee benefit plan, private group insurance such as Anthem, etc.) or Medicare.

2. Prior Insurance Prior insurance coverage is not a factor as long as the pregnant woman is uninsured during the month for which FAMIS MOMS eligibility is being determined.

M2220.300 NO CHILD SUPPORT COOPERATION REQUIREMENTS

A. Policy There are no requirements for FAMIS MOMS applicants or recipients to cooperate in pursuing support from an absent parent.

M2230.100 FINANCIAL ELIGIBILITY

A. Financial Eligibility

1. **Income** Modified Adjusted Gross Income (MAGI) methodology is used for the FAMIS MOMS income evaluation. Use the policies and procedures contained in Chapter M04.

The FAMIS MOMS income limit is 200% of the FPL (see Appendix 1 to this chapter) for the number of individuals in the pregnant woman's MAGI household composition as defined in M04. The pregnant woman is counted as herself plus the number of children she is expected to deliver. *Per MAGI policy in chapter M04, a 5% FPL income disregard is applicable.*
2. **Resources** Resources are not evaluated for FAMIS MOMS.
3. **No Spenddown** Spenddown does not apply to FAMIS MOMS. If countable income exceeds the FAMIS MOMS income limit, the pregnant woman is not eligible for the FAMIS MOMS program. She must be referred to the Health Insurance Marketplace and be given the opportunity to have a MN Medicaid evaluation.

M2240.100 APPLICATION and CASE PROCEDURES

A. Application Requirements

The policies in subchapters M0120 and M0130 apply.

B. Eligibility Determination

1. **Pregnant Teenager Under Age 19** Process an application by a pregnant teenager under age 19 in the following order:
 - a. Determine eligibility for Medicaid as a child under age 19; if not eligible because of excess income, go to item b.
 - b. Determine eligibility for Medicaid as a pregnant woman; if not eligible because of excess income, go to item c.
 - c. Determine eligibility for FAMIS; if not eligible because of excess income, go to item d.
 - d. Determine eligibility for FAMIS MOMS. To complete the eligibility determination, the FAMIS MOMS nonfinancial requirements in M2220.100 and the financial requirements in M2230.100 must be met. If she is not eligible for FAMIS MOMS because of excess income, she must be referred to the Health Insurance Marketplace and given the opportunity to have a Medically Needy evaluation completed.

- 2. 10-day Processing**

Applications for pregnant women must be processed as soon as possible, but no later than 10 working days from the date the signed application was filed. If all necessary verifications are not received, the application continues to pend until the 45 day processing time limit is met.
- 3. Notice Requirements**

The applicant/recipient must be notified in writing of the required information and the deadline by which the information must be received.

The agency must have all necessary verifications within 10 working days in order to determine eligibility. If all verifications are not received within 10 working days, written notice must be sent to the applicant. The notice must state why action on the application could not be taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 calendar days to submit the verification.

Once all necessary verifications for the pregnant woman are received, an eligibility determination must be made immediately and the applicant must be notified of the decision.
- C. Case Setup Procedures for Approved Cases**

A woman enrolled as FAMIS MOMS may have the same base case number in the Virginia Medicaid Management Information System (MMIS) as Medicaid enrollees.
- D. Entitlement and Enrollment**

 - 1. Begin Date of Coverage**

Pregnant women determined eligible for FAMIS MOMS are enrolled for benefits in the Virginia Medicaid Management Information System (MMIS) effective the first day of the application month, if all eligibility requirements are met in that month.
 - 2. No Retroactive Coverage**

There is no retroactive coverage in the FAMIS MOMS program.
 - 3. Aid Category**

The FAMIS MOMS aid category (AC) is “005.”
- E. Notification Requirements**

Written notice must be sent to the pregnant woman informing her of the action taken on the application. The notice must include the eligibility determination results for both Medicaid and FAMIS MOMS, as well as a referral to the Health Insurance Marketplace, if applicable.

If the pregnant woman is ineligible for both Medicaid and FAMIS MOMS due to excess income, she must be sent a written notice that she is not eligible for either program and that her case has been referred to the Health Insurance Marketplace. She must also be given the opportunity to have a Medicaid medically needy evaluation completed. Send the notice and a request for information about her resources to the pregnant woman and advise her that if the resource information is returned within 10 days the original application date will be honored.

**F. Application Not
Required for
Newborn**

The newborn child born to a FAMIS MOMS enrollee is deemed eligible for FAMIS coverage until his first birthday. Follow the procedures for enrolling a newborn in M0330.802, *using the appropriate AC as follows:*

AC 010 = mother's income > 143% FPL but ≤ 150% FPL

AC 014 = mother's income > 150% FPL but ≤ 200% FPL.

M2250.100 REVIEW OF ADVERSE ACTIONS

An applicant for FAMIS MOMS may request a review of an adverse determination regarding eligibility for FAMIS MOMS. FAMIS MOMS follows the procedures established by Medicaid for client appeals (see Chapter M16).

The payment of medical services on the part of any pregnant woman or any right to participate in the program is not subject to review if the reason for denial or cancellation is that funds for the FAMIS MOMS program are exhausted.

FAMIS MOMS 200% FPL INCOME LIMITS ALL LOCALITIES EFFECTIVE 1/22/15	
# of Persons in FAMIS MOMS Household	Monthly Limit
2	\$2,655
3	3,349
4	4,042
5	4,735
6	5,429
7	6,122
8	6,8152
Each additional, add	694