



COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

April 20, 2006

MEDICAID MANUAL – VOLUME XIII

TRANSMITTAL #83

The following acronyms are used in this transmittal:

- AAL – Alzheimer’s Assisted Living Waiver
- ABD – Aged, Blind, and Disabled
- BCCPTA – Breast and Cervical Cancer Prevention and Treatment Act
- DDS – Disability Determination Services
- F&C – Families and Children
- FAMIS – Family Access to Medical Insurance Security Plan
- FICA – Federal Insurance Contributions Act
- FPL – Federal Poverty Level
- ICAMA – Interstate Compact on Adoption and Medical Assistance.
- LDSS – Local Departments of Social Services
- LTC – Long-term Care
- MI – Medically Indigent
- SS – Social Security
- SSI – Supplemental Security Income
- USCIS – United States Citizenship and Immigration Services

The attached Medicaid Transmittal #83 contains new, updated, revised, and clarified policies as outlined below.

New Policy

Policy has been added in this transmittal to address several types of income encountered by LDSS staff. The new policy addresses military income and the Trade Adjustment Assistance Act income for F&C eligibility determinations. Policy and procedures for deducting Medicare Part D prescription drug expenses from spenddown and patient pay are added; these were originally published in Broadcast #3558.

Updates to Income Limits & Utility Standard

This transmittal contains the new MI, FAMIS, FAMIS MOMS and Extra Help income limits, based upon the revised FPL effective January 24, 2006, which were included in Broadcast #3589. The new income limits were effective January 24, 2006 for all F&C MI, ABD MI without SS,

FAMIS, FAMIS MOMS, and Extra Help eligibility determinations. The new income limits were effective March 1, 2006, for all ABD MI with SS eligibility determinations.

The Maximum Value of Contributed Food and Shelter amounts used in determining eligibility for Extra Help were increased based upon the January 2006 SSI amounts and are updated in this transmittal. Effective February 1, 2006, the LTC Utility Standard deduction increased and is also updated in this transmittal.

Policy Clarifications

Policy clarifications in this transmittal address the following areas: the number of days a request for assistance is valid; the treatment of certain expired alien status documents; the definition of a Special Medical Needs Child; when cooperation with the pursuit of medical support is required; the requirements for reporting changes in an applicant's circumstances to DDS; entitlement for the SSI Medicaid covered group; military income and in-kind income; the treatment of assets under income and resource counting rules; the reasonable efforts to sell real property exclusion; instructions for counting the value of a bank account; when a pre-admission screening is not required for LTC; the treatment of long-term care insurance premiums and payments for LTC eligibility and patient pay determinations; the format for the eligibility delay letter; and for FAMIS eligibility determinations, the treatment of health insurance coverage when canceled by an absent parent.

Effective Dates

The new policy and policy clarifications contained in this transmittal are effective for all eligibility determinations completed on or after April 1, 2006. The various effective dates of the income and other updates are listed above.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Chapter M01 Table of Contents	Chapter M01 Table of Contents	Corrected page number for M0120.300 and corrected formatting.
Subchapter M0120 Table of Contents pages 5, 6 pages 7-8a	Subchapter M0120 Table of Contents pages 5, 6 pages 7-8a	Corrected page number for M0120.300 in the Table of Contents. On page 5, clarified that calendar days are used for the time periods. On page 6, added proper name for ICAMA. On page 7, modified text style. On page 8, clarified that a request for assistance preserves the application date for 30 calendar days. On page 8a, corrected the form number for the FAMIS-1 form.
Chapter M02 Table of Contents	Chapter M02 Table of Contents	Added section M0210.150 to the Table of Contents and corrected formatting and the section name for M0210.200.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0210 pages 1-2	Subchapter M0210 pages 1-2	On page 1, corrected the reference for the legal presence requirement. Page 2 is a reprint.
Subchapter M0220 pages 3-6a	Subchapter M0220 pages 3-6a	Pages 3 and 5 are reprints. On page 4, clarified that an expired I-151 form is acceptable as documentation of alien status and updated phone number for USCIS. On page 6, clarified that online request for a secondary alien status verification is acceptable. On page 6a, clarified the agency action required when expired I-151 and I-551 alien status documents are presented.
Subchapter M0230 pages 5-7	Subchapter M0230 pages 5-6	Page 5 is a reprint. On page 6, clarified residency for non-IV-E foster care children.
Subchapter M0250 pages 5-11	Subchapter M0250 pages 5-11	On pages 5-10, clarified that any parent or caretaker-relative who applies for or receives Medicaid in any covered group must cooperate with the pursuit of medical support for any child for whom the parent or caretaker-relative is also requesting medical assistance. Page 11 is a runover page.
Subchapter M0310 pages 5, 6 pages 25-28	Subchapter M0310 pages 5, 6 pages 25-28	On page 5, clarified that a medical assistance-only adoption assistance agreement meets the IV-E adoption assistance definition. On page 6, clarified that a special medical needs adoption assistance agreement must specify that the child has a special medical need. On page 25, clarified that hard copies of on-line Disability Report forms are acceptable. On page 26, clarified that the applicant's excess resources do not cause the cessation of the disability determination. Pages 27 and 28 are runover pages.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
<p>Subchapter M0320 pages 23-26 pages 41, 42 pages 45, 46 page 71</p>	<p>Subchapter M0320 pages 23-26 pages 41, 42 pages 45, 46 page 71</p>	<p>On pages 23 and 25, clarified Medicaid entitlement for SSI recipients who are not receiving a cash payment due to the recovery of an overpayment. Page 24 is a runover page. Pages 26, 41 and 46 are reprints. On page 42, corrected typographical error. On page 45, deleted reference to the date the ABD 80% FPL covered group was implemented. On page 71, removed the reference to the implementation date for the BCCPTA covered group.</p>
<p>Subchapter M0710 Table of Contents pages 5, 6 Appendix 6, pages 1, 2 Appendix 7</p>	<p>Subchapter M0710 Table of Contents pages 5, 6 Appendix 6, pages 1, 2 Appendix 7</p>	<p>Corrected a typographical error in the Table of Contents. On page 5, clarified rental income. On page 6, added reference for estimating fluctuating income. In Appendix 6, updated the income limits for the MI Child Under Age 19 and MI Pregnant Woman covered groups. In Appendix 7, updated the income limits for Extended Medicaid.</p>
<p>Subchapter M0715 page 3</p>	<p>Subchapter M0715 page 3</p>	<p>On page 3, deleted the reference to contributions in-kind.</p>
<p>Subchapter M0720 Table of Contents pages 1-4</p>	<p>Subchapter M0720 Table of Contents pages 1-4 page 8a</p>	<p>Section M0720.290, Income from Uniformed Services (Military), was added to the Table of Contents and to page 1. On page 2, added proper name for FICA. On page 3, defined fluctuating income and clarified how to count earned income. Page 4 is a reprint. Page 8a added to address military income.</p>
<p>Subchapter M0730 Table of Contents page 7, 8</p>	<p>Subchapter M0730 Table of Contents pages 7-8a</p>	<p>Section M0730.210, Trade Adjustment Assistance Act Income, was added to the Table of Contents and to page 7. Pages 8 and 8a are runover pages.</p>

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter S0810 pages 1, 2	Subchapter S0810 pages 1, 2	Page 1 is a reprint. On page 2, updated the ABD MI income limits.
Subchapter S0815 pages 1, 2	Subchapter S0815 pages 1, 2	On page 1, clarified that in-kind contributions are not income. Page 2 is a reprint.
Subchapter S0830 Table of Contents (i, ii) pages 57, 58	Subchapter S0830 Table of Contents (i, ii) pages 57, 58	Corrected the Table of Contents by deleting S0830.425 (the section was previously deleted). On Page 57, removed obsolete text. On page 58, corrected reference to Plan for Achieving Self-Support.
Subchapter S1110 pages 17, 18	Subchapter S1110 pages 17, 18	On page 17, clarified reference to subchapter M1480. On page 18, clarified the treatment of assets under income and resource counting rules.
Subchapter S1120 pages 17, 18	Subchapter S1120 pages 17, 18	On page 17, clarified that disbursements from a trust in the form of in-kind support and maintenance are not counted as income. Page 18 is a reprint.
Subchapter S1130 pages 1-8 pages 13-16	Subchapter S1130 pages 1-8 pages 13-16	On page 1, clarified to which covered groups the subsection applies. On page 2, added articles to the bulleted text. On pages 3 through 7, clarified the limitations on the home property exclusion. Page 8 is a runover page. Pages 13 and 16 are reprints. On page 14, clarified that the retroactive exclusion for reasonable efforts to sell real property applies to property listed at or below 150% of the current market value. On page 15, clarified that reasonable efforts to sell real property must continue until the property is sold or Medicaid coverage is canceled.
Subchapter S1140 pages 15-18	Subchapter S1140 pages 15-18	Page 15 is a reprint. On pages 16 and 17, changed the section number

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Significant Changes

		from S1140.200 to M1140.200 to reflect the inclusion of State policy. On page 18, added instructions for determining the value of a bank account and accepting electronic bank verifications.
Subchapter M1320 pages 1, 2	Subchapter M1320 pages 1, 2	Page 1 is a reprint. On page 2, clarified the use of the Medicaid Renewal form for establishing additional spenddowns.
Subchapter M1340 Table of Contents pages 1-6	Subchapter M1340 Table of Contents pages 1-6a	The Table of Contents is updated. Pages 1 and 4 are reprints. On page 2, added Medicare Part D premiums. On page 3, added the statement from a Medicare prescription drug plan as a type of verification. On pages 5 and 6, added the rules for deducting prescription drug costs when the individual is enrolled in a Medicare prescription drug plan. Page 6a is a runover page.
Subchapter M1370 Table of Contents pages 1-5	Subchapter M1370 Table of Contents pages 1-4	Updated the Table of Contents. On pages 1 and 3, clarified the use of the Medicaid Renewal form for establishing additional spenddowns and deleted outdated references to Qualified Individuals – Group 2. On pages 2-4, corrected the cancel reason code and aid category references, updated the reinstatement instructions and the examples.
Subchapter M1420 pages 1-5	Subchapter M1420 pages 1-6	On pages 1 and 4, clarified that a preadmission screening is not required when an individual received Medicaid LTC in one of the preceding 12 months and the LTC coverage was terminated for a reason other than no longer meeting the level of care. Page 2 is a reprint. On page 3, clarified screening teams for the AAL waiver. Pages 5 and 6 are runover pages.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M1460 pages 3, 4 pages 29-30	Subchapter M1460 pages 3, 4 pages 29, 30a	Page 3 is a reprint. On page 4, deleted reference to chapter “M06.” On page 29, clarified the treatment of third-party payments. Pages 30 and 30a are runover pages.
Subchapter M1470 pages 7-10 pages 13, 14 pages 25, 26 pages 29, 30 pages 53-54	Subchapter M1470 pages 7-10 pages 13-14a pages 25-26a pages 29-30a pages 53-54a	Page 7 is a reprint. On page 8, added “Part A and/or B” to the headings to distinguish this Medicare premium deduction policy from the Medicare Part D premium deduction policy. On page 8a, added policy for deducting Medicare Part D premiums. On pages 8a, 26 and 26a, clarified the treatment of LTC insurance premiums for patient pay. On pages 9, 10 and 54, updated the word “recipient” to “enrollee.” On pages 13 and 14, added policy for deducting Medicare Part D co-pays in certain circumstances. Page 14a is a runover page. On page 25, changed the heading to specify Medicare Part A and/or Part B premiums. On page 26, added the policy for deducting Medicare Part D premiums. Page 29 is a reprint. On page 30 and 30a, added procedures for deducting Medicare Part D prescription drug copays for waiver services patients. On page 53, clarified the treatment of LTC insurance as third-party liability. Page 54a is a runover page.
Subchapter M1480 Table of Contents page 13, 14 page 51, 52 page 65, 66	Subchapter M1480 Table of Contents page 13, 14 page 51-52a page 65, 66	Section M1480.315 was added to the Table of Contents and to pages 51 and 52 to address third party and LTC insurance payments. On page 13, clarified the resources that are excluded per policy in M1480.220 and are different from the exclusions in Chapter S11. Page 14 is a reprint. Page 52a is a runover page. Page 65 is a reprint. On page 66, updated the Utility Standard Deduction.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M1510 pages 9, 10 Appendix 1	Subchapter M1510 pages 9, 10 Appendix 1	On page 9, clarified that the eligibility delay letter must be dated. Page 10 is a reprint. The sample Eligibility Delay Letter in Appendix 1 was revised to include the preparation date.
Subchapter M1520 pages 3, 4	Subchapter M1520 pages 3, 4	On page 3, changed references for Program Designation to Aid Category. On page 4, clarified that the Eligibility Review A and B forms are acceptable as renewal forms when required by another program.
Chapter M17 pages 3, 4	Chapter M17 pages 3, 4	On page 3, added the requirement to refer the case within 5 business days from disposition. On page 4, corrected a typographical error and changed “recipient” to “enrollee.”
Chapter M20 Appendix 3	Chapter M20 Appendix 3	Updated the income limits for Extra Help, the Medicare Part D low-income subsidy, and the Maximum Value of Contributed Food and Shelter figures.
Chapter M21 pages 1-6 pages 9-11 Appendix 1	Chapter M21 page 1-6 pages 9-11 Appendix 1	Pages 1 and 3 are reprints. On page 2, clarified the alienage requirements for FAMIS. On page 4, clarified that for the purposes of evaluating health insurance coverage requirements, “family member” includes parents with whom the child is living, and does not include an absent parent. On page 5, clarified that discontinuance of health insurance by an absent parent, or other person who does not live with the child, does not affect eligibility. On page 6, clarified the example of how to treat dropped insurance. On page 9, clarified who can sign the application. On page 10, clarified that the response period for applicants to return an application for a medically needy evaluation is 10

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Significant Changes

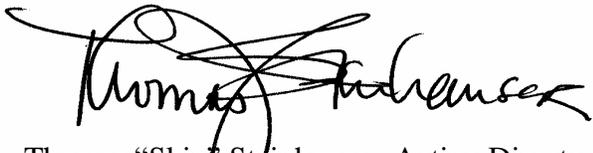
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calendar days, and updated the case material sent to the FAMIS CPU. On page 11, clarified that participation in FAMIS Select is voluntary. In Appendix 1, updated the income limits for FAMIS.

On page 7, corrected the last word on the page from “application” to “verification.” On page 8, revised the procedures for handling approved cases due to recent systems enhancements. In Appendix 1, updated the income limits for FAMIS MOMS.

Please retain this transmittal letter in the back of Volume XIII.



Thomas “Skip” Steinhauser, Acting Director
Division of Benefit Programs

Attachment

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**C. Applicants Under
Age 18**

1. Child Applicant

A child under age 18 years is not legally able to sign *his own* Medicaid application unless he is legally emancipated from his parents. If the child is not legally emancipated, one of the following *individuals* must sign the application:

- his parent,
- legal guardian,
- authorized representative, or
- an adult related by blood or marriage with whom the child lives (documentation of the relationship is not required).

If the child *under 18 years of age* is married and living with his spouse who is age 18 or older, the child's spouse may sign the application.

a. No Guardian or Legal Custody

If the child does not live with a parent or an adult relative and no adult is the child's guardian or has legal custody of the child, *whomever* the child *is living with* is responsible for seeking custody or guardianship of the child in the Juvenile and Domestic Relations court. Determine if the person submitting the application, or another person, has begun the process to obtain legal guardianship or custody of the child applicant.

b. Action Is Initiated To Appoint Guardian/Award Custody

If action has been initiated to appoint a guardian for or seek legal custody of the child, meaning a court guardianship or custody hearing is scheduled on the court docket, request verification that the action is on the court docket. Give 10 *calendar* days for this verification to be provided.

If the verification is provided within the 10-*calendar*-day period, continue to pend the application until a guardian is appointed or custody is awarded. If the application pends for 45 *calendar* days, send a notice to the applicant *explaining that the application pending period will be* extended.

Once the guardian has been appointed or custody awarded, request verification of the appointment or award and that the application be signed by the guardian or adult who was awarded custody. Allow 10 *calendar* days for the signed application and guardianship or custody papers to be returned.

If the court refuses to appoint a guardian or custodian *and there is no adult who is legally able to sign an application for the child*, deny the application as invalid.

c. Action Not Initiated – Refer to Child Welfare Services

If guardianship or custody procedures have not begun or have not been verified as being on the court docket, refer the child to the appropriate *Family Services* worker.

Continue to pend the application until the service investigation is completed and any court proceedings are completed. Once the guardian has been appointed or custody awarded, request verification of the appointment or award and that the application be signed by the guardian or adult who was awarded custody. Retain a copy of the application and mail the original application to the guardian or custodian. Allow 10 *calendar* days for the signed application and guardian or custody papers to be returned.

If the child was emancipated by the court, request the child's signature on the application. If the application is mailed to the child, allow 10 *calendar* days for the signed application form to be returned.

If the application form is not signed by the applicant, the guardian, *the* custodial adult, *or the emancipated child* and returned to the agency by the specified date, deny the application because it is invalid.

2. Minor Parent Applying for His Child

A parent under age 18 years may apply for Medicaid for his own child because he is the parent of the child.

3. Foster Care Child

a. Non-IV-E

The Medicaid application for a non-IV-E child who is in foster care must be signed by an authorized employee of the public or private agency that has custody of the child. If there is a non-custodial agreement, the parent or legal guardian must sign the Medicaid application.

b. IV-E

A separate Medicaid application is not required for a child in the custody of a Virginia public or private child-placing agency whose IV-E eligibility has been evaluated using the Title IV-E Foster Care and Medicaid Application/Redetermination. If there is a non-custodial agreement for the IV-E eligible child, the parent or legal guardian must sign a Medicaid application for the child.

4. Adoption Assistance & Special Medical Needs Children

a. Placed by a Virginia Agency

A separate Medicaid application is not required for a IV-E adoption assistance child. **A Medicaid application is required for all other adoption assistance children placed by a Virginia agency.**

b. Placed by Another State

IV-E and non-IV-E special medical needs children who have been placed for adoption by another state through *the Interstate Compact for Adoption and Medical Assistance* (ICAMA) should have a form 6.01

which verifies eligibility for Medicaid. A separate application is not required. All states and territories EXCEPT New York, Vermont, Wyoming, Puerto Rico and Virgin Islands are members of ICAMA.

A Medicaid application is required for all other adoption assistance children placed by another state.

D. Deceased Applicant

1. An application may be made on the behalf of a deceased person within a three-month period subsequent to the month of his death if both of the following conditions *were* met:
 - the deceased received a Medicaid-covered service on or before the date of death, and
 - the date of service was within a month covered by the Medicaid application.
2. If the above conditions *were* met, an application may be made by any of the following:
 - his guardian or conservator,
 - attorney-in-fact,
 - executor or administrator of his estate,
 - his surviving spouse, or
 - his surviving family member, in this order of preference: adult child, parent, adult brother or sister, adult niece or nephew, or aunt or uncle.

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

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

E. Unsigned Application

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

F. Invalid Signature

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

M0120.300 Medicaid Application Forms

A. General Principle

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

- IV-E Foster Care/*Adoption Assistance* children
- Non-IV-E Special Medical Needs children
- *Auxiliary Grant (AG) applicants*
- *Newborn children under age 1*

The Request for Assistance--ADAPT--, form #032-03-875 (see M0120, Appendix 2) may be used to establish and preserve the application date *for 30 calendar days*, but a signed application must be submitted *within 30 calendar days* in order for eligibility to be determined.

A child born to a mother who was Medicaid eligible at the time of the child's birth, including a child born to an emergency services alien certified for Medicaid payment for labor and delivery, is deemed to have applied and been found eligible for Medicaid on the date of the child's birth. An application for the child is not required. The child remains eligible for Medicaid to age 1 year *as long as the mother remains eligible for Medicaid, or would be eligible if she were still pregnant, and they live together.*

B. Medicaid Application Forms

An applicant may obtain a prescribed application form from a number of sources, including a variety of human service agencies, hospitals, and the internet.

There are specialized forms intended for use with certain covered groups, including medically indigent pregnant women, children, SSI recipients, and women who have been screened under the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). These forms should be used whenever possible because they do not ask the applicant to provide information that is not used in the eligibility determination.

Appendices 3 through 8 of this chapter contain sample prescribed Medicaid application forms. Other forms that serve as Medicaid application forms are listed in section M0120.300.C.

The following forms have been prescribed as application forms for Medicaid:

- Application for Benefits, form #032-03-824, also referred to as the Combined application, may be used by any applicant (see M0120, Appendix 3).
- Application/Redetermination for Medicaid for SSI Recipients, form #032-03-091 (see M0120, Appendix 4);

- Medicaid Application/Redetermination for Medically Indigent Pregnant Women, form #032-03-040 (see M0120, Appendix 5);
- Health Insurance for Children and Pregnant Women, form FAMIS-1 (see M0120, Appendix 6);
- Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application, form #032-03-384, is used only by women screened under the Breast and Cervical Cancer Early Detection Program. This form is not to be given to applicants by the local departments of social services (M0120, Appendix 7 is provided for reference purposes);
- Signed ADAPT Statement of Facts (SOF). If any additional information is necessary (individual requires a resource evaluation), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant and attached to the SOF.
- Title IV-E Foster Care & Medicaid Application/Redetermination, form #032-03-636 (see M0120, Appendix 8).

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M0260 RESERVED

NOTE: Policy references to M0260 that are still in effect have been moved to subchapter M0250.

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M0210.000 GENERAL RULES & PROCEDURES**M0210.001 PRINCIPLES OF MEDICAID ELIGIBILITY DETERMINATION****A. Introduction**

Medicaid is an assistance program which pays medical service providers for services rendered to eligible needy individuals. An individual's need for medical care, the state of his health, or his coverage by private health insurance, have no effect on his Medicaid eligibility.

The eligibility determination consists of an evaluation of an individual's situation which compares each of the individual's circumstances to an established standard or definition. The evaluation provides a structured decision-making process. An individual must be evaluated for eligibility in all covered groups for which he meets the definition, and the applicant/enrollee shall be informed of all known factors that affect eligibility.

B. Eligibility Requirements

Although all the requirements that follow may not be applicable in a particular individual's situation, they must be looked at and evaluated.

1. Nonfinancial Eligibility Requirements

The Medicaid nonfinancial eligibility requirements are:

- a. Legal presence in the U.S., effective January 1, 2006 (*M0210.150*).
- b. Citizenship/alien status (*M0220*).
- c. Virginia residency (*M0230*).
- d. Social Security number (SSN) provision/application requirements (*M0240*).
- e. Assignment of rights to medical benefits and pursuit of support from the absent parent requirements (*M0250*).
- f. Application for other benefits (*M0270*).
- g. Institutional status requirements (*M0280*).
- h. Application to the Health Insurance Premium Payment Program (HIPP) (*M0290*).
- i. Covered group requirements (*M03*).

2. Financial Eligibility Requirements

The Medicaid financial eligibility requirements are:

- a. Asset transfer for individuals who need long-term care (subchapter M1450).
- b. Resources within resource limit appropriate to the individual's covered group. (Chapter M06 for F&C covered groups; Chapter S11 for ABD covered groups).
- c. Income within income limit appropriate to the individual's covered group. (Chapter M07 for F&C covered groups; Chapter S08 for ABD covered groups).

3. Example

EXAMPLE: On *January 5, 2006*, Mr. H applies for Medicaid. He is in a nursing facility in Virginia, *and has been there since July 5, 2005*. When evaluating his application, the worker finds that he:

- is a U.S. citizen,
- is currently a Virginia resident residing in a medical institution in Virginia,
- *provided* his SSN,
- refused to provide third party liability and medical support information,
- has applied for all benefits to which he is entitled,
- meets the institutional status requirements,
- is not required to apply to the HIPP Program,
- is age 67 years and meets a covered group requirement.

He currently has \$5,000 in the bank. His income is \$600 per month Social Security (SS). *Since he refused to provide third party liability and medical support information, he does not meet the assignment of right requirements and his application must be denied.* He is also informed of the resource limit and that he is ineligible for Medicaid because his resources exceed the limit.

M0210.100 INELIGIBLE PERSONS**A. Introduction**

The individuals listed in this section are not eligible for Medicaid. However, their income and resources may be considered in determining the eligibility of others in the household who have applied for Medicaid.

B. Certain Recipients of General Relief (GR)

A recipient of General Relief (*GR*) maintenance who does not meet a Medicaid covered group is not eligible for Medicaid.

An applicant for Medicaid and *Supplemental Security Income (SSI)* who receives GR from the interim assistance component may become eligible for Medicaid following the establishment of SSI eligibility. Eligibility for an SSI payment is effective the month **following** the SSI application month. When the Medicaid application is dated in the same month as the SSI application, Medicaid eligibility can be effective the month of application if the applicant meets all Medicaid eligibility requirements and another covered group requirement in the application month.

C. Essential Spouse of an ABD Individual

An essential spouse of an aged, blind, or disabled person who does not himself/herself meet a covered group is not eligible for Medicaid.

D. Individual Who Refuses to Assign Rights

An individual, who refuses to assign rights to third-party payments or support for himself or anyone for whom he can legally assign rights, is not eligible for Medicaid. Failure to assign rights for another person will not affect the eligibility of that other person.

3. Verification

For an individual born outside the U.S. other than an adopted child, citizenship is verified by a certificate of derivative citizenship, passport, naturalization papers, or document issued by a U.S. Embassy or Consulate attesting that the person is a U.S. citizen born abroad, such as Form FS-240, "Report of Birth Abroad of a Citizen of the U.S." or Form I-97 "Consulate Report of Birth or Certification of Birth." If such documents are not available, citizenship must be verified through the nearest U.S. Citizenship and Immigration Services (USCIS), formerly known as Immigration and Naturalization Service (INS). Locations and telephone numbers are:

Norfolk Commerce Park
5280 Henneman Drive
Norfolk, Virginia 23513
Telephone – 1-800-375-5283

*2675 Prosperity Avenue
Fairfax, Virginia 22031
Telephone – 1-800-375-5283*

For a legally adopted child born outside the U.S., citizenship is verified by the adoption papers and verification of lawful permanent resident status at the time of adoption.

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.

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

An alien's immigration status is verified by the official document issued by the 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

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).

Form I-151 (*Alien Registration Receipt Card – the old “green card”*), Form AR-3 and AR-3a are earlier versions of the *Resident Alien Card (Form I-551)*. An alien with one of the older cards who does not have an I-551 should be referred to USCIS to obtain the application forms for the I-551. The forms may be ordered by calling 1-800-375-5283. *When an I-151 is presented, refer the alien to USCIS, but accept the document for further verification (see M0220.201.E below).*

C. Letters that Verify Status

The USCIS and the Office of Refugee Resettlement (ORR) issue letters that are used in lieu of or in conjunction with USCIS forms to identify alien status. If the letter is the only document provided, it is necessary to verify the status of the alien. For USCIS letters, contact the local USCIS office for assistance in identifying the alien's status (see Appendix 1 of this subchapter). For ORR letters, contact the toll-free ORR Trafficking Verification Line at 866-401-5510 (see Appendix 5 of this subchapter). Do not verify ORR letters via the SAVE system.

D. Local USCIS Office Documents

Some USCIS offices have developed their own stamps. Therefore, it is possible that a locally produced stamp or legend will be on an USCIS form. If there is any question as to the veracity or status of the document, contact USCIS.

E. Expired or Absent Documentation

If an applicant presents an expired USCIS document or is unable to present any document showing his/her immigration status, refer the individual to the USCIS district office to obtain evidence of status **unless** he/she provides an alien registration number.

If the applicant provides an alien registration number with supporting verification of his or her identity, use the SAVE procedures in M0220.202 below to verify immigration status. If an applicant presents an expired I-551 or I-151, follow procedures for initiating a primary verification. If the alien presents any expired document other than an expired I-551 or I-151, follow procedures for initiating a secondary verification.

If the alien does not provide verification of his identity, his immigration status cannot be determined, and he must be considered an unqualified alien.

M0220.202 SYSTEMATIC ALIEN VERIFICATION FOR ENTITLEMENTS (SAVE)

A. SAVE

Aliens must submit documentation of immigration status before eligibility for the full package of Medicaid benefits can be determined. If the documentation provided appears valid and meets requirements, eligibility is determined based on the documentation provided AND a comparison of the documentation provided with immigration records maintained by the United States Citizenship and Immigration Services (USCIS).

The comparison is made by using the SAVE system established by Section 121 of the Immigration Reform and Control Act of 1986 (IRCA).

1. Primary Verification

Primary verification is the automated method of accessing the USCIS data bank. SAVE regulations require that automated access be attempted prior to initiating secondary verification. There are some specific instances, however, when the agency will forego the primary verification method and initiate secondary verification (see **Secondary Verification**).

SAVE is accessed by the Alien Registration Number. SAVE is accessed directly by the local agency. The alien registration number begins with an "A" and should be displayed on the alien's USCIS document(s).

Information obtained through SAVE should be compared with the original USCIS document. If discrepancies are noted, the secondary verification process must be initiated. No negative action may be taken on the basis of the automated verification only.

A primary verification document must be **initiated prior to case approval**. The primary verification document must be filed in the case record.

2. Secondary Verification

Secondary verification is required in the following situations:

- a. The alien has an alien number but no USCIS document, or the alien has no alien number and no USCIS document.
- b. Primary verification generates the message "Institute Secondary Verification" or "No File Found."
- c. Discrepancies are revealed when comparing primary verification to the original immigration document.
- d. Immigration documents have no Alien Registration Number (A-Number).

- e. Documents contain an A-Number in the A60 000 000 or A80 000 000 series.
- f. The document presented is an USCIS Fee Receipt.
- g. The document presented is Form I-181 or I-94 in a foreign passport that is endorsed "Processed for I-551, Temporary Evidence of Lawful Permanent Residence," and the I-181 or I-94 is more than one year old.

When secondary verification is required, the agency *must* complete the top portion of a Document Verification Request (Form G-845) *or initiate an on-line request for a secondary verification through SAVE*. Appendix 2 of this subchapter contains a copy of the *G-845*.

**B. Document
Verification
Request (Form
G-845)**

If the alien has filed an USCIS application for or received a change in status, the application for or change in status in itself is not sufficient basis for determining immigration status. Likewise, any document which raises a question of whether USCIS contemplates enforcing departure is not sufficient basis for determining the alien's status. In such situations, verify the alien's status with USCIS using the Document Verification Request (Form G-845). For an alien who entered the U.S. before 8-22-96 and whose status is adjusted to a qualified status after he entered the U.S. use the Form G-845 Supplement to request the period of continuous presence in the U.S. A copy of the G-845 Supplement (S) is in Appendix 2a of this subchapter.

Form G-845 should be completed as fully as possible by the submitting agency. It is essential that the form contain enough information to identify the alien.

A separate form must be completed for each alien. Completely legible copies (front and back) of the alien immigration documents must be stapled to the upper left corner of Form G-845. Copies of other documents used to make the initial alien status determination such as marriage records or court documents must also be attached.

Once the requirement to obtain secondary verification is determined, the agency must initiate the request within ten work days. A photocopy of the completed G-845 form must be filed in the record as evidence that the form has been forwarded to USCIS. Refer to Appendix 1 for the USCIS mailing address appropriate to your local DSS agency.

The USCIS maintains a record of arrivals and departures from the United States for most legal entrants, and LDSS can obtain the required information from their USCIS office. The USCIS does not maintain an arrival and departure record for Canadian and Mexican border crossers. For these immigrants, as well as immigrants whose status was adjusted and whose original date of entry cannot be verified by USCIS, LDSS will need to verify continuance presence by requiring the immigrant to provide documentation showing proof of continuous presence.

Acceptable documentation includes:

- letter from employer
- school or medical records
- series of pay stubs
- shelter expense receipts, such as utility bills

in the immigrant's name that verify continuous presence for the period of time in question.

C. Agency Action

When the primary verification response requires the eligibility worker to initiate a secondary verification from USCIS, do not delay, deny, reduce or terminate the individual's eligibility for Medicaid **on the basis of alien status**. If the applicant meets all other Medicaid eligibility requirements, approve the application and enroll the applicant in Medicaid. Upon receipt of the G-845 *or response to the on-line query*, compare the information with the case record. Timely notice must be given to the individual when Medicaid benefits are denied or reduced.

Note: When a secondary verification is requested for an alien with an expired I-551, the G-845 or response to the on-line SAVE query should indicate that the person continues to have lawful permanent resident status. When a secondary verification is requested for an alien with an expired I-151, the G-845 or response to the on-line SAVE query will indicate that the documentation is expired; however, do not delay, deny, reduce or terminate an individual's eligibility for Medicaid on the basis of an expired I-151.

Once information has been obtained through SAVE, aliens with a permanent status are no longer subject to the SAVE process. Aliens with a temporary or conditional status are subject to SAVE at the time of application and when the temporary or conditional status expires.

state arranging or actually making the placement is considered the individual's state of residence. When an individual is placed by state or local government in an institution in another state, the individual remains the responsibility of the placing state unless the state or local government agency in the other state assumes responsibility for the individual's care or Medicaid eligibility.

When an individual is placed by a Virginia government agency in an institution in another state, the individual remains the responsibility of Virginia unless

- a state or local government agency in the other state assumes responsibility for the individual's care or Medicaid eligibility,
- *the individual is a child who receives a IV-E foster care or adoption assistance payment, or*
- *the individual is a child who receives **non-IV-E adoption assistance** and the state in which he is placed is a reciprocal state under the interstate compact, verified by the central office Deputy Compact Administrator, Adoption Unit, Division of Family Services, Virginia Department of Social Services (DSS).*

B. State Placement

Placement by a state government agency is any action taken by the agency, beyond providing general information to the individual and *his* family, to arrange admission to an institution for the individual. The following actions do not constitute state placement:

- providing basic information to individuals about other states' Medicaid programs or about the availability of health care services and facilities in other states;
- assisting an individual, who is capable of declaring intent and who independently decides to move out-of-state, in locating an institution in another state.

1. Lack Of Facilities

When a placement is initiated by a state because the state lacks a sufficient number of appropriate facilities to provide services to its residents, the state making the placement is the individual's state of residence for Medicaid purposes.

2. Individual Leaves Facility

When a competent individual leaves the facility in which *he* was placed by a state, that individual's state of residence for Medicaid purposes is the state where the individual is physically located.

C. Individual Placed Out-of-State by Virginia Government

An individual can leave Virginia and retain Virginia residency if he is placed in an institution outside Virginia by a Virginia government agency. Out-of-state placement into a long-term care facility must be preauthorized by the Director of the Virginia Department of Medical Assistance Services for Virginia Medicaid to pay for the institutional care.

When a competent individual voluntarily leaves the facility in which Virginia placed him, he becomes a resident of the state where he is physically located.

M0230.204 CASH ASSISTANCE PROGRAM RECIPIENTS

- A. Introduction** Certain individuals are considered residents of Virginia for Medicaid purposes if they live in Virginia and receive a cash assistance payment specified below in this section. Some recipients of cash assistance from a Virginia social services agency who do NOT reside in Virginia are considered residents of Virginia for Medicaid purposes, as specified below.
- B. Auxiliary Grants Recipients** An individual receiving an Auxiliary Grants (AG) payment from a locality in Virginia is considered a Virginia resident.
- An individual who receives a State Supplement of SSI payment from another state is considered a resident of the state making the State Supplement payment.
- C. IV-E Payment Recipients** For an individual of any age who receives federal foster care or adoption assistance payments under Title IV-E of the Social Security Act, the state of residence for Medicaid eligibility is the state where the child lives.
- D. Non-IV-E Foster Care Recipients** The non IV-E (state/local) foster care payment recipient is a resident of the state that is making the non IV-E payment.

M0230.300 SPECIFIC PROHIBITIONS

- A. No Fixed Address** The agency cannot deny Medicaid to an eligible Virginia resident just because the resident has no fixed address. A Virginia resident is not required to have a fixed address in order to receive Medicaid.
- For an eligible Virginia resident who does not have a fixed address, use the local social services department's address for the Medicaid card and inform the resident that he must come to the social services department to receive his card until he obtains a fixed address.
- B. Length of Residency** The agency may not deny Medicaid eligibility because an individual has not resided in Virginia for a specified period of time.
- C. Residency in Virginia Prior to Admission to Institution** The agency may not deny Medicaid eligibility to an individual in an institution who meets the Virginia residency requirements previously identified in this subchapter, because the individual did not establish residence in Virginia before entering the institution.
- D. Temporary Absence** The agency may not deny or terminate Medicaid eligibility because of that individual's temporary absence from Virginia if the individual intends to return to Virginia when the purpose of the absence has been accomplished, UNLESS another state has determined that the individual is a resident there for Medicaid purposes.

M0230.400 DISPUTED RESIDENCY

- A. Disputed or Unclear Residency** If state residency is unclear or is in dispute, contact the regional specialist for help in resolution. When two or more states cannot resolve the residency, the state where the individual is physically located becomes the state of residence.

C. F&C Covered Groups

A child who is **temporarily** living away from his parent's home is considered living with the parent and the family unit policy in subchapter M0520 applies.

If the child is living apart from the parent or is receiving LTC services, only the income and resources which the parent actually makes available to the child are counted.

M0250.500 SUPPORT FROM ABSENT PARENT

A. Policy

A parent or caretaker-relative who is applying for Medicaid for himself *in any covered group*, and on behalf of a child under age 18 (DCSE will not pursue medical support for children age 18 and over unless a court order has extended support beyond age 18) who has an absent parent, must cooperate with the agency and DCSE in establishing the paternity and in obtaining medical support for the Medicaid-eligible child, unless the:

- *parent or caretaker-relative* is an MI pregnant woman and is requesting assistance for herself and her child born out of wedlock, or
- *the parent or caretaker-relative* has good cause for not cooperating, or
- *the parent or caretaker-relative* is only eligible under the Family Planning Services (FPS) covered group.

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

If the *parent or caretaker-relative* is required to cooperate with the agency in the pursuit of support from an absent parent as a condition of eligibility and refuses or fails to cooperate, he is ineligible for Medicaid, *regardless of the parent or caretaker-relative's covered group (unless the parent or caretaker-relative meets one of the exceptions bulleted above)*. The parent's or *caretaker-relative's* refusal or failure to cooperate does not affect the child's eligibility for Medicaid.

B. DCSE

DCSE District Offices have the responsibility of pursuing support from absent legally responsible parent(s) and establishing paternity when the alleged father is absent from the home. This responsibility entails locating the parent(s), determining ability to support, collecting support from legally responsible parent(s), establishing medical support and/or health insurance covering the applicant child (ren), and court action to secure support from the absent legally responsible parent.

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

- C. Cooperation with DCSE** Medicaid applicants and enrollees (except an MI pregnant woman under certain conditions in D. below, child-only cases in G. below, and *an* FPS woman in H. below) are required to cooperate with paternity establishment and securing medical support as a condition of eligibility for Medicaid. Cooperation in the establishment or enforcement of a child support obligation is optional and Medicaid enrollees may refuse these services not related to medical support or paternity establishment.
- D. Exception For MI Pregnant Women** An MI pregnant woman is not required to cooperate with DCSE when requesting assistance for herself and her child(ren) born out of wedlock. If she is or was married, she is required to cooperate in pursuing medical support for her legitimate child(ren) from the legitimate child(ren)'s absent father.
- E. No Exception For MN Pregnant Women** If a pregnant woman has countable income over the MI limit, she may be eligible for medically needy (MN) Medicaid if her resources are within the MN limit, she meets a spenddown and she meets all nonfinancial requirements including cooperation in pursuing support. An MN pregnant woman must cooperate with the agency in obtaining medical support for herself and any child for whom she applies from a legally responsible relative, unless she has good cause for not cooperating.
- F. Child Born to Medicaid Eligible Woman** When a child is born to a Medicaid-eligible woman and is enrolled in Medicaid, contact the parent *or caretaker* with whom the child lives as soon as administratively possible, but no later than 60 *calendar* days after the child's birth to explain and offer DCSE services.
- G. Child-Only Cases** In child-only cases (*the parent or caretaker-relative who applies for the child has not applied for Medicaid for himself or herself*), cooperation with DCSE in the establishment of paternity and the pursuit of support is not a condition of the child's eligibility.
- DCSE services are available to all Medicaid *enrollees*, but the refusal or failure to cooperate with DCSE *of the parent or caretaker-relative who applied for Medicaid for the child* will not affect the child's Medicaid eligibility.
- H. Family Planning Services (FPS) Covered Group** For the FPS covered group, cooperation with DCSE in the establishment of paternity and pursuit of support is not a condition of eligibility. The woman's refusal or failure to cooperate with DCSE does not affect her eligibility in this covered group (see M320.302).
- I. Procedures For Pursuing Support** The procedures for pursuing support from absent parents are different depending on whether or not the *parent or caretaker-relative* is also a Medicaid applicant/*enrollee*.

1. Parent or Caretaker-relative is a Medicaid Applicant/Recipient

When the *parent or caretaker-relative has applied*, or is also applying, for Medicaid and cooperation with DCSE is a condition of eligibility, the cooperation requirements must be met or good cause for not cooperating must be established prior to approval. A *parent or caretaker-relative* who does not meet the cooperation requirements and does not establish good cause for not meeting the cooperation requirements is not eligible for Medicaid.

The following forms are used to determine if the cooperation requirements are met.

a. "The Notice of Cooperation and Good Cause", form #032-03-036 (see M0250, Appendix 1)

The "Notice of Cooperation and Good Cause" form is used to inform all *parent or caretaker-relatives* who apply for Medicaid for children who have an absent parent of the benefits of cooperation, claiming good cause for not cooperating, the good cause determination, and penalty for refusing or failing to meet cooperation requirements. The "Notice of Cooperation and Good Cause" must be given to all *parent or caretaker-relatives* who apply for children who have an absent parent (AP). On the "Notice of Cooperation and Good Cause", the applicant/*enrollee* can choose to:

- agree to cooperate with DCSE;
- claim good cause for not cooperating with DCSE; or
- in child only cases, refuse to cooperate with DCSE.

The *parent or caretaker-relative's* choice determines whether additional forms must be completed.

b. Parent or Caretaker-relative Agrees to Cooperate with DCSE

Complete the "Absent Parent/Paternity Information" form #032-03-501 (see M0250, Appendix 3) when the *parent or caretaker-relative* agrees to cooperate with DCSE. The "Absent Parent/Paternity Information" form is used to provide information that will be beneficial to DCSE in locating the absent responsible person. This form is completed at initial application, when a *parent or caretaker-relative* is added to the family or budget unit, and/or at redetermination. The 501 form must be returned before enrolling an eligible in Medicaid.

For DCSE to have a "workable case," certain key information must be obtained when completing the form. Key information includes the AP's name, Social Security number, date of birth, current and past addresses, employers, and parent's name and address. When there is no legal parent or acknowledged father and more than one individual is named as a child's parent, refer all named individuals.

When support is received from the absent responsible parent who is married to someone other than the parent filing the Medicaid application and he has requested that his family not be involved, the address where the responsible parent wishes to be contacted should be noted. All future contacts with such absent responsible parent regarding support will be made by DCSE.

If voluntary or court-ordered third party payments such as rent are being made by the absent responsible parent, a notation of such payment must be made on the form.

The agency must complete page 4 of the form and send the completed document to the District DCSE office when the Medicaid application is approved. The full range of DCSE services will be provided to all referred cases unless DCSE is notified that the *parent or caretaker-relative* elects partial services for the child.

c. *Parent or Caretaker-relative Claims Good Cause*

The cooperation requirements can be waived when the agency finds that cooperation is against the best interests of the *parent or caretaker-relative* or other person for whom he can legally assign rights. Good cause exists when the agency anticipates that cooperation will result in reprisal against or cause physical or emotional harm to the *parent or caretaker-relative* or other person.

Complete the "Good Cause Determination", #032-03-035 (see M0250, Appendix 2) when the *parent or caretaker-relative* claims good cause for not cooperating with DCSE. The *child's* parent or legal custodian must provide evidence to support the claim to be excused from cooperating.

The local agency may determine that cooperation would be harmful to the child only if one or more of the following circumstances exist:

- anticipation that cooperation will result in physical or emotional harm to the child;
- anticipation that cooperation will result in physical or emotional harm to the *child's* parent or *caretaker-relative* which would impair the ability to care for the child;
- the child was conceived as a result of rape or incest;
- legal proceedings for the adoption of the child are pending;
or
- the parent, assisted by a public or private social services agency, is considering adoptive placement for the child for whom assistance is requested.

Each *parent or caretaker-relative* who claims to have good cause for not cooperating with DCSE must provide, within 20 days of making the claim, acceptable evidence or sufficient information such as:

- court, medical, criminal, child protective services, psychological, law enforcement records, or written statement from domestic violence or sexual assault crisis center professional indicating the putative father or absent parent might inflict physical or emotional harm on the child or parent;
- birth certificates, medical or law enforcement records in the case of incest or rape; or
- court documents or legal records which indicate legal proceeding for adoption are pending.

In addition to the above evidence, sworn statements from individuals including neighbors, clergymen, social workers, and medical professionals who might have knowledge of the circumstances supporting claims of physical harm can be used to substantiate good cause. This information cannot be the only evidence to support the claim.

On every claim of good cause, the worker will make the final determination that:

- good cause exists and DCSE may not pursue support; or
- good cause does not exist.

When the worker determines good cause exists, the "Absent Parent/Paternity Information" form is not completed, and the *parent or caretaker-relative* is not penalized for not cooperating in pursuing support. When the worker determines good cause does not exist, the *parent or caretaker-relative* is penalized for not cooperating and is not eligible for Medicaid. The "Good Cause Determination" form is used to document the agency finding.

d. *Parent or Caretaker-relative Refuses To Cooperate*

When the *parent or caretaker-relative* who is required to cooperate refuses or fails to return the completed "Notice of Cooperation and Good Cause", cooperation requirements are not met and the *parent or caretaker-relative* is not eligible for Medicaid. The *parent or caretaker-relative* who is required to cooperate and refuses or fails may choose not to apply for the child, or may choose to have the child's Medicaid coverage cancelled so that the *parent or caretaker-relative* may be eligible for Medicaid for himself.

The *parent or caretaker-relative's* refusal or failure to cooperate does not affect the child's Medicaid eligibility.

2. Child-Only Applicant/Recipient

When the application is filed on behalf of a child only, and cooperation with DCSE is not a condition of eligibility, the pursuit of support from absent parent(s) is initiated after the child has been determined eligible and has been enrolled in Medicaid.

The "Notice of Cooperation and Good Cause" and the "Absent Parent/Paternity Information" forms must be sent with the approval notice for all Medicaid-eligible children who have an absent parent. Document in record that the forms were sent. See I.1.a. above for a description of "Notice of Cooperation and Good Cause". See I.1.b. above for instructions for completing the "Absent Parent/Paternity Information" form.

If the *parent or caretaker-relative who applied for the child* wishes to claim good cause for not cooperating, refuses to cooperate, or fails to complete and return the "Notice of Cooperation and Good Cause", no additional forms must be completed. The child remains Medicaid-eligible.

J. Communication Between Agency and DCSE

1. Eligibility Worker Responsibilities

The eligibility worker must make every effort to provide DCSE with complete and accurate information. Changes including address, absent parent information, range of service, subsequent good cause determination, and Medicaid eligibility must be reported to DCSE. The "Medicaid Information Transmittal" form #032-11-520 (see M0250, Appendix 4) is used to communicate with DCSE.

2. DCSE Responsibilities

DCSE uses the "Cooperation/Non-cooperation Notification" form #803-11-96 to inform the eligibility worker of the following:

- the client is not cooperating with DCSE and asks if good cause exists;
- no further action on the case is possible without the client's cooperation;
- a recipient has accepted direct payment of child support; or
- DCSE closes the case.

K. Parent or Caretaker-relative Withdraws From DCSE Services

The *parent or caretaker-relative who applied for the child* can withdraw from the full range of services at any time without penalty. However, in order to meet the cooperation in pursuing paternity and medical support eligibility requirement, he or she cannot withdraw from cooperating with DCSE in pursuit of paternity and medical support without good cause (see I. 1. c. above). If good cause exists, DCSE will close its case upon receipt of such notification from the local DSS. If good cause does not exist, the eligibility worker will determine if the *parent or caretaker-relative who applied for the child* remains eligible for Medicaid.

**L. Medicaid
Cancellation &
Continued DCSE
Services**

When a child's Medicaid coverage is cancelled, send a "Medicaid Information Transmittal" form #032-11-520 (see M0250, Appendix 4) to DCSE informing them of the cancellation.

DCSE will send the recipient a package of information called the "transition package" which explains DCSE services and explains that support services will continue to be provided unless DCSE is notified to the contrary. DCSE must send a notice to the former *enrollee* within 5 working days of receipt of a notice of ineligibility for Medicaid.

parents who adopt "hard to place" foster care children who were in the custody of a local department of social services or a child placing agency licensed by the state of Virginia.

Adoption assistance children are children who reside in Virginia who are adopted under a Title IV-E adoption assistance agreement with a department of social services or in conjunction with a child placing agency.

A child placing agency is an agency that is licensed by the State Department of Social Services for child placing services. Not all child placing agencies provide adoption services; some may provide foster home placement. The services offered must be identified in the description given for the license. The foster care service unit of the local department of social services should be familiar with the function of the child placing agency, and whether or not it is licensed.

B. Procedures

A child under 21 is an adoption assistance child when the adoption assistance agreement is signed, even if the interlocutory or judicial decree of adoption has not been issued or subsidy payments are not being made.

A child's status as an adoption assistance child is verified by the local agency foster care/adoption assistance worker. Documentation of the child's adoption assistance eligibility must be part of the Medicaid case record.

1. IV-E Adoption Assistance

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

- 1) Children adopted under a IV-E adoption assistance agreement with a Virginia local department of social services or in conjunction with a private child placing agency, who reside in Virginia. Eligibility begins when the IV-E adoption assistance agreement is signed even if an interlocutory or judicial decree of adoption has not been issued, or subsidy payments are not being made.
- 2) children adopted under a IV-E adoption assistance agreement with another state's department of social services, who now reside in Virginia.

The IV-E adoption assistance definition is met when the adoption assistance agreement specifies that the only assistance required is medical assistance. Cash assistance is not required.

b. Verification of a child's status as a Virginia IV-E adoption assistance recipient is obtained through the local agency's Service Programs Division.

When the IV-E adoption assistance agreement is with another state and the IV-E child resides in Virginia, verification of the child's status as a Title IV-E adoption assistance recipient is verified through the Deputy Compact Administrator, Adoption Unit, Division of Family Services, Virginia Department of Social Services.

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

- a. The following children meet the non-IV-E adoption assistance definition:
- 1) “special medical needs” children legally adopted under a non IV-E adoption assistance agreement with a Virginia local department of social services, in accordance with policies established by the State Board of Social Services.
 - 2) special medical needs children legally adopted under a non-IV-E adoption assistance agreement with a private, non-profit child placement agency in conjunction with a local department of social services, and in accordance with policies established by the Virginia Board of Social Services.
- b. A child with “special medical needs” is a child who was determined unlikely to be adopted because of:
- a physical, mental or emotional condition that existed prior to adoption; or
 - a hereditary tendency, genetic defect, congenital problem or birth injury leading to a substantial risk of future disability.

Medicaid coverage is to be provided to any child who has been determined to be a non-IV-E child with “special medical needs” and for whom there is in effect an adoption assistance agreement between the State and an adoptive parent(s). Verification of the child’s status as a “special medical needs” child is obtained from the local agency’s service programs division. *The* adoption assistance agreement *must specify* that the child has a special medical need; the agreement does NOT need to specify a particular diagnosis or condition.

- c. Verification of a child’s status as a Virginia non-IV-E adoption assistance recipient is obtained through the local agency’s Service Programs Division. Verification of the child’s non-IV-E adoption assistance status with another state, and the state’s reciprocal agreement under the interstate compact, is obtained through the Deputy Compact Administrator, Adoption Unit, Division of Family Services, Virginia Department of Social Services.

M0310.103 AFDC

**A. Aid To
Families With
Dependent
Children (AFDC)**

AFDC is the short name of the Aid to Families With Dependent Children cash assistance program that was operated in Virginia prior to the February 1, 1997 implementation of TANF (Temporary Assistance to Needy Families). It was a federally funded assistance program under Title IV-A of the Social Security Act. In Virginia, AFDC was replaced by TANF on February 1, 1997.

B. Procedure

AFDC is defined here because of the occasional references in Medicaid policy to the AFDC program that was in effect on July 16, 1996. There are no current recipients of AFDC because the AFDC program no longer exists.

**E. DSS Procedures
When a Disability
Determination is
Required**

**1. DSS Referrals
to DDS**

The following forms must be completed and sent to DDS when *DSS is* requesting a disability determination:

- [Disability Report Adult SSA-3368-BK](#) (see Appendix 1 to this subchapter) or the [Disability Report Child SSA-3820-BK](#), (see Appendix 2 to this subchapter); and
- a minimum of 5 signed, original forms: [Authorization to Disclose Information to the Social Security Administration form SSA-827-02-2003](#) (see Appendix 3 to this subchapter) **or** 1 for each medical provider if more than 5; and
- a DDS Referral Form - 032-03-095/05 (see Appendix 4 to this subchapter).

NOTE: the applicant may have a hard (printed) copy of an on-line Disability Report used to apply for Social Security benefits. A hard copy of the SSA on-line Disability Report for adults (3368PRO or 3369) or children (3820) may be accepted in lieu of the SSA-3368-BK or SSA-3820-BK; however, an individual cannot submit an actual on-line Disability Report to DDS for Medicaid disability determination purposes.

When the SSA disability report and the Authorization to Disclose Information to the Social Security Administration forms must be sent to the applicant for completion, send the request immediately, giving the applicant 10 *calendar* days to return the completed forms. When the completed forms are returned, mail them along with the DDS Referral form to:

Disability Determination Services Unit
5211 West Broad Street, Suite 201
Richmond, Virginia 23230-3032

Do not send referrals to DDS via the courier.

The eligibility worker must request the necessary verifications needed to determine eligibility so that the application can be processed as soon as the decision on the disability determination is received.

If the completed forms are not returned by the applicant within 45 days from the date of application, the applicant *is considered* not to meet the covered group, and the Medicaid application must be denied.

**2. Application for
Other Benefits**

Individuals with a work history, or individuals whose disability began prior to reaching age 22 years and whose parent(s) is retired (because of age or disability) or deceased must apply for Social Security or RR benefits as a disabled individual as a nonfinancial requirement of Medicaid eligibility. Refer individuals with a work history to the appropriate SSA Office to apply for benefits. Refer individuals who report a railroad work history to the Railroad Retirement Board (RRB) to apply for benefits. Applicants are not required to apply for SSI benefits.

Do not delay processing the Medicaid application while waiting for the applicant to apply for SSA/RR benefits. However, if the applicant does not apply for SSA/RR benefits within 45 days from the date of the Medicaid application, deny the Medicaid application due to “failure to apply for benefits (SSA/RR) for which the individual might be entitled” (see M0270). Notify the DDS to stop action on the disability determination.

F. Communication

Between Agency and DDS

1. Eligibility Worker Responsibilities

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

If the eligibility worker is aware of changes in the applicant’s situation that would make him ineligible for Medicaid even with a favorable disability determination, the information must immediately be provided to the DDS so that office will not complete a disability determination. *The fact that an individual has excess resources is not a reason for DDS to stop the development of a disability claim (see M0130.100.B.4).* When an application is denied for a nonfinancial reason not related to the disability determination, DDS must be notified immediately.

2. DDS Responsibilities

The DDS will advise the local 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 (within 7 working days) disability determination, DDS will fax the outcome of the disability determination decision to the eligibility worker. For all other disability determinations, DDS will send the eligibility worker a notice to be sent to the applicant advising him of the outcome of his disability determination.

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 directly of the delay and/or the need for additional information. A copy of the DDS’s notice to the applicant will be sent to the local agency so the eligibility worker can send a Notice of Action to extend the pending application.

G. Notice to the Applicant

The eligibility worker must complete the Medicaid eligibility determination immediately after receiving notification of the applicant’s disability status and send the client both the DDS’s notification of the disability determination and a Notice of Action of the agency’s decision on the Medicaid application.

H. Applicant is Deceased

When an individual who applies for a disability determination and Medicaid dies or when the applicant is deceased at the time of the Medicaid application, the DDS will determine if the disability requirement for Medicaid eligibility was met. The eligibility worker must immediately notify DDS of the individual’s death and provide a copy of the death certificate, if available.

I. Subsequent SSA or RRB Disability Decisions

When SSA or the RRB make a disability decision subsequent to the DDS decision which differs from the DDS decision, the SSA or RRB decision must be followed in determining Medicaid eligibility unless one of the conditions in D. 3. above applies.

a. 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, reevaluate the denied Medicaid application. The individual's Medicaid entitlement is based on the Medicaid application date, but eligibility as a disabled individual cannot begin prior to the disability onset date.

b. SSA Denial, Termination and SSA 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 timely (within 60 *calendar* days from the SSA notification) the SSA disability decision 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 administrative review.

The levels of administrative review are in the following order:

- 1) reconsideration,
- 2) the hearing before an administrative law judge (ALJ), and
- 3) the Appeals Council.

For example, an 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 nor another covered group, his Medicaid coverage must be canceled.

c. RRB Denial, Termination and RRB Appeal

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

Persons who believe that their claims have not been adjudicated correctly may ask for reconsideration by the Board's Office of Programs. If not satisfied with that review, the applicant may appeal to the Board's Bureau of Hearings and Appeals. Further, if the individual timely appeals the RRB disability decision, Medicaid coverage must be reinstated until the final decision on the RRB appeal is made. The

individual must provide verification that he filed a timely appeal with RRB and must provide verification of the decisions made at all levels of appeal in order for Medicaid to continue during the process.

M0310.113 EWB

A. Essential to The Well-Being (EWB)

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

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

B. Services Essential to Well-Being

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

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

C. Procedure

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

M0310.114 FAMILIES & CHILDREN (F&C)

A. Families & Children (F&C)

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

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

- M0320.201 SSI Recipients
- M0320.202 AG Recipients
- M0320.203 ABD In Medical Institution, Income \leq 300% SSI
- M0320.204 ABD Receiving Waiver Services
- M0320.205 ABD Hospice
- M0320.206 QMB (Qualified Medicare Beneficiary)
- M0320.207 SLMB (Special Low-income Medicare Beneficiary)
- M0320.208 QI (Qualified Individuals)
- M0320.209 QDWI (Qualified Disabled & Working Individual)
- M0320.210 ABD with Income \leq 80% FPL.

M0320.201 SSI RECIPIENTS

A. Introduction

42 CFR 435.121 - SSI recipient are a mandatory CN covered group. However, in Virginia, not all SSI recipients are eligible for Medicaid. Virginia has chosen to impose real property eligibility requirements that are more restrictive than SSI real property eligibility requirements. Thus, Virginia SSI recipients must apply separately for Medicaid at their local department of social services.

B. Nonfinancial Eligibility

An individual who is receiving an SSI payment is eligible for Medicaid if he meets the following nonfinancial requirements:

1. Citizenship or Alien Status

The SSI recipient is a citizen of the United States or full benefit alien (see M0220).

2. Virginia Residency

The SSI recipient is a resident of Virginia (see M0230).

3. Assignment Of Rights

The SSI recipient meets the assignment of rights to medical support and third party payments requirements (see M0250).

4. Institutional Status

The SSI recipient meets the institutional status requirements in M0280.

5. Not Conditionally Or Presumptively Eligible

The SSI recipient is NOT conditionally or presumptively eligible for SSI, or is not presumptively disabled or blind. Conditionally eligible SSI recipients are being allowed time to dispose of excess resources. Presumptively blind or disabled SSI recipients are presumed to be blind or disabled; no final blindness or disability determination has been made.

6. SSI Entitlement

SSI payments for eligible individuals are effective the first day of the month following the month in which the SSI application was 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 for which he receives his first SSI payment. *When the SSA record indicates a payment code of "C01" but shows no payment amount due to a recovery of an overpayment, the individual is considered to be an SSI recipient.*

Eligibility for months prior to SSI entitlement must be evaluated in other covered groups.

C. Financial Eligibility**a. Asset Transfer****1. Resources**

The SSI recipient must meet the asset transfer policy in subchapter M1450. See subchapter M1450 to determine if the asset transfer precludes Medicaid eligibility for *the* Medicaid payment of long-term services.

b. Resource Eligibility

Determine if the SSI recipient has the following real property resource(s):

- 1) equity in non-exempt property contiguous to his home which exceeds \$5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;
- 2) an interest in undivided heir property and the equity value of his share when added to all other countable resources exceeds the appropriate Medicaid resource limit. (The interest in the estate must be legally available. If a partition suit is necessary to sell the interest, costs of partition and attorneys' fees may be deducted as described in M1120.215;
- 3) ownership (equity value) of his former residence and the SSI recipient is in an institution for longer than 6 months. Determine if the former home is excluded under policy in section M1130.100 D;
- 4) equity value in property owned jointly with another person, to whom the SSI recipient is not married, as tenants in common or joint tenants with the right of survivorship at common law. Determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;
- 5) other real property; determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property.

When an SSI recipient has any of the real property listed in 1) through 5) above, ALL of the recipient's resources must be verified, evaluated, and counted together to determine if the SSI recipient meets the Medicaid resource requirements.

Calculate resources according to the assistance unit policy in chapter M05. 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 may be eligible as medically indigent (which has more liberal resource methods and standards).

2. Income

Verify the SSI recipient's eligibility for SSI payments by an SSI awards notice and inquiring the SDX (State Data Exchange) or SVES (State Verification Exchange System). If the recipient is eligible for SSI, he meets the Medicaid income eligibility requirement.

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, including the receipt of, or entitlement to, an SSI payment in that month. *An individual is considered to be an SSI recipient when the SSA record indicates a payment code of "C01" but shows no payment amount due to a recovery of an overpayment.*

Retroactive coverage is applicable to this covered group. However, if the individual did not receive, or was not entitled to, an SSI payment in the retroactive period, the individual is not eligible for retroactive Medicaid in the SSI recipients covered group. His retroactive eligibility must be evaluated in another Medicaid covered group.

Eligible SSI recipients are categorically needy (CN). *The AC is*

- 011 for an aged SSI recipient;
- 031 for a blind SSI recipient;
- 051 for a disabled SSI recipient.

E. Ineligible as SSI Recipient

If a non-institutionalized SSI recipient is not eligible for Medicaid because of resources, evaluate the individual's eligibility in all other Medicaid covered groups including, but not limited to, the ABD with Income \leq 80% FPL and QMB covered groups.

M0320.202 AG RECIPIENTS**A. Policy**

42 CFR 435.234 - An Auxiliary Grants (AG) recipient is eligible for Medicaid if he meets the assignment of rights to medical support and third party payments requirements (see M0250). AG eligibility is determined using the AG eligibility policy in Volume II.

B. Procedure

Verify the AG recipient's eligibility for AG by agency records.

C. 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.

AG recipients are categorically needy (CN). *The AC is:*

- 012 for an aged AG recipient;
- 032 for a blind AG recipient;
- 052 for a disabled AG recipient.

M0320.203 ABD IN MEDICAL INSTITUTION, INCOME \leq 300% SSI LIMIT

- A. Policy** 42 CFR 435.236 - The state plan includes the covered group of aged, blind or disabled individuals in medical institutions 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 meets the nonfinancial requirements in M1410.020:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Is institutionalized in a medical institution that is not an IMD;
8. Application to the Health Insurance Premium Payment Program (HIPP);
9. Meets either the Aged, Blind, or Disabled definition in M0310.

C. Financial Eligibility

- 1. Asset Transfer** The individual must meet the asset transfer policy in *subchapter* M1450.

2. Resources **a. Resource Eligibility – Married Individual**

If the individual is married, use the resource policy in subchapter M1480. 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 may be eligible in a medically indigent covered group (which has more liberal resource methods and standards).

b. Resource Eligibility - Unmarried Individual

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. Pay close attention to:

of an increase in income, but is eligible as an SLMB, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare Part B premiums as an SLMB.

Cancel the recipient's full coverage effective the last day of the month, using cancel reason "007". Reinststate the recipient's coverage with the begin date as the first day of the month following the cancellation effective date. *Aid category (AC)* is "053".

3. SLMB's AC Changes To Full Coverage AC

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

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

4. Spenddown Status

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

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

5. SLMB Meets Spenddown

When an SLMB meets a spenddown, cancel his *AC* "053" coverage effective the date before the spenddown was met, using cancel reason "024". Reinststate the recipient's coverage with the begin date as the first date the spenddown was met, *and enter the end date of the spenddown period*. *AC* is medically needy NOT dual-eligible:

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

- 6. Spenddown Period Ends** After the spenddown period ends, reinstate the SLMB-only coverage using the AC 053.
- The begin date of the reinstated AC 053 coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial SLMB eligibility.
- 7. SLMB Enters Long-term Care** The enrollment of an SLMB who is admitted to long-term care and who becomes eligible for Medicaid in another classification and covered group is handled like an SLMB who meets a spenddown. Cancel the SLMB-only coverage effective the last day of the month before the month of admission to long-term care, reason "024". Reinstated the coverage with the begin date as the first day of the month of admission to long-term care.

M0320.208 QUALIFIED INDIVIDUALS-(QI)

- A. Policy** P.L. 105-33 (Balanced Budget Act of 1997) – mandated Medicaid coverage of Qualified Individuals who would be Qualified Medicare Beneficiaries (QMBs) except that their income exceeds the QMB income limit. When implemented on January 1, 1998, the QI covered group consisted of two components, Group 1 and Group 2. Group 1 individuals receive Medicaid coverage for the payment of their *Medicare* Part B premium. Group 2 individuals receive Medicaid coverage for the portion of the Medicare Part B premium that is attributable to the cost of transferring coverage of home health services to Medicare Part B from Part A. The federal authority for Group 2 expired and Medicaid coverage for this component ended December 31, 2002. Effective January 1, 2003, the QI covered group consists only of the component formerly referred to as "Group 1".
- Like QMBs and SLMBs, eligible QIs are also placed on a medically needy spenddown if resources are within the medically needy limit.
- 1. Not An Entitlement** Medicaid coverage for this covered group is not an individual entitlement, which means that when the Department of Medical Assistance Services (DMAS) runs out of money for this covered group, no additional eligible individuals in this covered group will receive Medicaid benefits. DMAS will notify the DSS Central Office when the money for this covered group will run out.
- Local departments of social services must continue to take and process applications for this covered group even after the funds run out. The MMIS will generate and send a notice to the recipient if the recipient will not receive the benefit because the funds have run out.
- Applications for QI coverage for an upcoming year may not be taken until January 1 of that year.

C. Financial Eligibility

1. **Asset Transfer** The individual must meet the asset transfer policy in subchapter M1450.
2. **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.
3. **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.
4. **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.
5. **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

1. **Begin Date** 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.
2. **Retroactive Entitlement** 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 recipient;
- 039 for a blind recipient; or
- 049 for a disabled recipient.

M0320.300 FAMILIES & CHILDREN CATEGORICALLY NEEDY**A. Introduction**

An F&C individual must be a child under age 19 or must meet the adoption assistance, dependent child, foster care, parent or caretaker-relative of a dependent child living in the home, pregnant woman definition in M0310, or BCCPTA definition in M0310.

The F&C CN covered groups are divided into the medically indigent (MI), CN and CNNMP classifications. First determine if the F&C individual meets an MI covered group. If the individual does not meet an MI covered group, then determine if the individual meets the requirements of an F&C CN or CNNMP covered group.

B. Procedure

The policy and procedures for determining whether an individual meets an F&C MI, CN or CNNMP covered group are contained in the following sections:

- M0320.301 MI Pregnant Women & Newborn Children;
- M0320.302 Family Planning Services (*FPS*);
- M0320.303 MI Child Under Age 19 (*FAMIS Plus*);
- M0320.305 IV-E Foster Care or IV-E Adoption Assistance Recipients;
- M0320.306 Low Income Families With Children (LIFC);
- M0320.307 Individuals Under Age 21;
- M0320.308 Special Medical Needs Adoption Assistance;
- M0320.309 F&C In Medical Institution, Income \leq 300% SSI;
- M0320.310 F&C Receiving Waiver Services (CBC);
- M0320.311 F&C Hospice;
- M0320.312 Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA).

M0320.301 MI PREGNANT WOMEN & NEWBORN CHILDREN**A. Policy**

The federal Medicaid law requires the Medicaid State Plan to cover pregnant women and newborn children whose family income is within 133% of the federal poverty limit. The law allows the State Plan to cover these pregnant women and newborns regardless of their resources; Virginia has chosen to waive the resource eligibility requirements for this covered group.

B. Nonfinancial Eligibility**1. Pregnant Woman**

42 CFR 435.170 - The woman must meet the pregnant woman definition in M0310.124.

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

2. Newborn Child

42 CFR 435.117 - A child born to a *woman* who was eligible for Medicaid (*including Medicaid payment for labor and delivery as an emergency services alien*) at the time the child was born is eligible as a newborn child under age 1 year. The child remains eligible for Medicaid as long as the mother remains eligible for Medicaid or would be eligible if she were still pregnant, and they live together.

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

3. Notices

If the BCCPTA Medicaid application is the only application required and no additional information is required, the eligibility decision must be made immediately and 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 "Notice of Action on Medicaid", form #032-03-008, on the 10th day stating why action has not been taken, specifying what information is needed and a deadline for submitting the information.

E. Entitlement

1. Entitlement Begin Date

Eligibility under this covered group is met the beginning of the month the screening is completed if the woman later has a positive diagnosis as a result of the screening and is determined to be in need of treatment for her breast and/or cervical cancer.

Eligible BCCPTA 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.

2. Retroactive Entitlement

Retroactive coverage is applicable to this covered group if the individual was screened by a medical provider operating under the BCCEDP and diagnosed as needing treatment for breast or cervical cancer in the retroactive month(s).

F. Enrollment

The aid category for BCCPTA women is "066".

G. Renewal

Annual renewal requirements are applicable to the BCCPTA covered group. At the time of the annual renewal, the recipient must provide a statement from her medical provider verifying continued treatment for breast or cervical cancer. The BCCPTA Redetermination (form #032-03-653) is used for the renewal. See M1520.200 for renewal requirements.

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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 number of months' actual receipts that will provide an accurate indication of the individual's future income situation.

See section M0720.155 C.2 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.

MEDICALLY INDIGENT CHILD UNDER AGE 19 (FAMIS PLUS) INCOME LIMITS FEDERAL POVERTY LEVEL (FPL) EFFECTIVE 1-24-06 ALL LOCALITIES		
<u># of Persons in Family/Budget Unit</u>	<u>100% FPL Monthly Limit</u>	<u>133% FPL Monthly Limit</u>
1	\$ 817	\$1,087
2	1,100	1,463
3	1,384	1,840
4	1,667	2,217
5	1,950	2,594
6	2,234	2,971
7	2,517	3,348
8	2,800	3,724
each add'l person add	284	377

MI Child under age 6 with income less than or equal to 100% FPL –AC 091

MI Child age 6 to 19 with income less than or equal to 100% FPL – AC 092

MI Child under age 6 with income greater than 100% FPL and less than or equal to 133% FPL – AC 090

Insured MI Child age 6 to 19 with income greater than 100% FPL and less than or equal to 133% FPL –AC 092

Uninsured MI Child age 6 to 19 with income greater than 100% FPL and less than or equal to 133% FPL – AC 094

MEDICALLY INDIGENT PREGNANT WOMAN INCOME LIMITS 133% FPL EFFECTIVE 1-24-06 ALL LOCALITIES	
<u># of Persons in Family/Budget Unit</u>	<u>Monthly Limit</u>
1	\$1,087
2	1,463
3	1,840
4	2,217
5	2,594
6	2,971
7	3,348
8	3,724
each add'l person add	377

Pregnant Woman with income less than or equal to 133% FPL – AC 091

**TWELVE MONTH EXTENDED MEDICAID
INCOME LIMITS
185% of FEDERAL POVERTY LIMITS
EFFECTIVE 1-24-06
ALL LOCALITIES**

<u># of Persons in Family/Budget Unit</u>	<u>Monthly Limit</u>
1	\$1,511
2	2,035
3	2,560
4	3,084
5	3,608
6	4,132
7	4,656
8	5,180
each add'l person add	525

M0715.370 SHELTER CONTRIBUTED

A. Policy Shelter that is contributed is not income.

B. Exception Pending establishment of a child support obligation by the District Child Support Enforcement Office, payments for shelter made to a third party such as a rental agency in lieu of or in addition to child support, whether based on a court order or a mutual voluntary agreement between the Medicaid applicant/*enrollee* and the responsible person, must be counted as unearned income to the family/budget unit. The \$50 disregard is not applicable to third party shelter payments.

Once the support order is established and payments are made to a third party for shelter in lieu of child support these payments are third party payments for shelter and are not income.

C. Reference Child/Spousal Support, M0730.400

M0715.400 BILLS PAID BY A THIRD PARTY

A. Policy Bills paid by a third party directly to a supplier are not income.

EXAMPLE: A church pays the electric company for Mrs. Brown's electric bill. This is a bill paid by a third party and is not income to Mrs. Brown.

B. Exceptions Pending establishment of a child support obligation by the District Child Support Enforcement Office, payments made to a third party such as a day care provider or telephone company in lieu of or in addition to child support, whether based on a court order or a mutual voluntary agreement between the Medicaid applicant/recipient and the responsible person, must be counted as unearned income to the family/budget unit.

Once the support order is established and payments are made in lieu of child support, these are third party payments and are not income unless they meet the definition of contributions in kind (food or clothing totally supplied on a regular basis). The \$50 disregard is not applicable to third party payments.

Third party payments made by an absent spouse in lieu of spousal support are treated as contributions in kind.

C. Reference Child/Spousal Support, M0730.400

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M0720.000 F & C EARNED INCOME**M0720.001 OVERVIEW**

- A. Introduction** This subchapter provides policy and procedures for identifying and counting earned income.
- B. Policy**
- 1. What Constitutes Earned Income** Earned income may be received in cash and consists of:
- wages
 - profit from self-employment
- The source and amount of all earned income other than Workforce Investment Act and student income must be verified.
- 2. Earned Income Exclusions** Earned income exclusions are subtracted from the gross monthly income in determining eligibility.
- C. References**
- Income From Self-Employment, M0720.200
 - Income From Real Property, M0720.250
 - Income From Room and Board, M0720.260
 - Income From Day Care, M0720.270
 - Income From Small Businesses/Cash Crops, M0720.280
 - *Income From Uniformed (Military) Services*, M0720.290
 - Contract Income, M0720.400
 - Earned Income Exclusions, M0720.500

M0720.100 WAGES -- GENERAL

- A. Definition** Wages are what an individual receives (before deductions; not "take home" pay) for working as someone else's employee.
- NOTE: Under certain circumstances, services performed as an employee are deemed to be self-employment rather than wages.
- B. Policy**
- 1. Kinds of Wages** Wages may take the form of:
- contract earnings
 - commissions

- pay for jury duty
- severance pay
- tips
- vacation pay
- sick pay from employer or employer-obtained insurance

2. When to Count

Wages are calculated on a monthly basis and counted at the earliest of the following points:

- when they are received, or
- when they are credited to the individual's account, or
- when they are set aside for the individual's use.

Absent evidence to the contrary, if FICA (*Federal Insurance Contributions Act*) taxes have been deducted from an item, assume it meets the definition of wages. Failure to deduct FICA taxes does not mean the income is not wages.

EXAMPLE #1:

Mrs. Green is employed by Mr. Brown who owns a small business. Mr. Brown does not deduct FICA taxes from Mrs. Green's income. Mrs. Green's income from Mr. Brown is wages.

C. Verification

Verify wages, salaries, and commissions by pay stubs, pay envelopes, a written statement from the employer, or by the eligibility worker's verbal contact with the employer.

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/*enrollee* and the eligibility worker, a third party statement, a collateral contact, or as a last resort, the applicant's/*enrollee's* written statement can be used as verification and to determine the amount of income to be counted.

Verify tips by a weekly record of the tips prepared by the employed individual.

M0720.105 INCOME FROM A CORPORATION

If a person has incorporated a self-employment enterprise either alone or with other persons and draws a salary from the business, the wages drawn are regular earned income, not self-employment income.

M0720.110 HOW TO COUNT INCOME IN THE RETROACTIVE PERIOD

When evaluating eligibility for a retroactive period, income eligibility is based on income actually received each month in the retroactive period.

M0720.155 HOW TO ESTIMATE EARNED INCOME

A. General

Ongoing income eligibility is determined based on the income that is anticipated (expected) to be received within the ongoing evaluation

period. Income received in prior periods is normally used to determine the amount of income to be received in future periods. Income from the prior period is averaged and converted to a monthly amount. That monthly amount is the amount anticipated to be received in each of the future months. New sources of income may be anticipated based on statements from the provider of the income.

B. Definitions

1. Anticipated Income

Income the individual and local agency are reasonably certain will be received during the ongoing evaluation period.

To be reasonably certain that income will be received determine:

- from whom the income will come (the provider);
- in what month and on what dates it will be received (frequency and payment cycle); and
- how much will be received (rate).

2. Fluctuating Income

Fluctuating income is earned income where neither the pay rate nor hours per pay period can reasonably be predicted.

3. Income Base Period

A period of time immediately prior to the month of application/redetermination that includes one or more pay periods, or the most current equivalent {last *four* (4) weekly pays, last *two* (2) bi-weekly pays, or last *two* (2) semi-monthly pays} that is used to provide an accurate reflection of the individual's future income.

4. Monthly Income

Monthly income is the income received in an average month. An average month contains 4.3 weeks. Income received more frequently than monthly is converted to a monthly figure.

5. Pay Period

The time period covered by each pay check. A pay period may be weekly, bi-weekly, semi-monthly, monthly or longer periods of time.

C. Income Base Period Used

Use the income received in the month prior to the month of application/redetermination unless the prior month's *income* cannot by itself provide an accurate indication of anticipated income.

When the prior month's *income* cannot by itself provide an accurate indication of anticipated income, *the applicant/recipient must be given the opportunity to provide the additional information necessary to accurately project monthly income.*

- 3. Seasonal Income** When the individual's income fluctuates seasonally, use the most recent season, past seasons, or the current calendar month prior to the month of application/redetermination, as an indicator of future income.
- Use the information obtained from the income provider and worker judgement to determine the anticipated income. Document the file to support how the income was anticipated.
- 4. Migrant Or Seasonal Farm Worker** For migrant and seasonal farm workers, the income that is reasonably certain to be received is based on formal or informal commitments for work for an individual, rather than on the general availability of work in an area.
- Base income on the information obtained from the income provider and worker judgement to determine the anticipated income. Document the file to support how the income was anticipated.
- Do not base income on an assumption of optimum weather or field conditions.
- 5. New or Increased Income** Use the income provider's statement of the beginning date, the amount of income to be received, the frequency of receipt, and the day/dates of receipt to establish the amount to be received per pay period.
- 6. Terminated Income** *Income from a terminated source must only be verified when it was received in a month in which eligibility is being determined.*
- 7. Decreased Income** Use the income provider's statement of the beginning date of the decrease, the new amount of income to be received, the frequency of receipt, and the day/date of receipt to establish the amount to be received per income period. Document the file to support how the income was anticipated.
- If an employed person anticipates a decrease in wages that is not supported by evidence in the file, the individual must be advised to report the decrease as soon as it can be verified. Adjustments are made when the decrease is verified.

D. Calculating Estimated Monthly Income

- 1. Full Month's Income** Total the income received in the Income Base Period. Divide that total by the number of pay periods in the Income Base Period. The result is the average amount to be received per pay period. If the income is received more frequently than monthly, convert the income to a monthly amount.

M0720.290 INCOME FROM UNIFORMED SERVICES (MILITARY)**A. Introduction**

Compensation to most members of the Uniformed Services takes the form of earned income and other payments.

If the military employee receives a payment that is not listed below, contact a Medical Assistance Program Consultant for guidance.

B. Earned Income

The following forms of compensation are countable earned income:

- *basic pay,*
- *subsistence allowance (food)*
- *housing allowance (when not also listed as a deduction on the pay stub),*
- *special and incentive pay, such as bonuses, flight pay, overseas pay.*

C. Payments That Are Not Income

The following payments are not countable income for Medicaid eligibility:

- *clothing*
- *hostile fire pay (combat pay).*

*Any amount of income received by or made available to household members for deployment or service in a combat zone will not count as income for Medicaid purposes **unless the payment was received before the deployment.** This exclusion includes items such as, but not limited to, incentive pay for hazardous duty, special pay for imminent duty or hostile fire duty.*

D. Verification

The Leave and Earnings statement (LES) is the pay slip issued to military service members. The LES shows all types of compensation and deductions.

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B. Definitions

- 1. Annuity** An annuity is a sum paid yearly or at other specific times in return for the payment of a fixed sum. Annuities may be purchased by an individual or by an employer.
- 2. Pensions and Retirement Benefits** Pensions and retirement benefits are payments to a worker following his retirement from employment. These payments may be paid directly by a former employer, by a trust fund, an insurance company, or other entity.
- 3. Disability Benefits** Disability benefits are payments made because of injury or other disability.

C. List of Benefits

The following are examples of benefits:

Social Security Benefits
 VA Payments
 Worker's Compensation
 Railroad Retirement
 Black Lung Benefits
 Civil Service Payments
 Military Pensions

D. Procedure

Verify entitlement amount and amount being received by documents in the applicant/enrollee's possession, such as an award letter or benefit payment check, or by contact with the entitlement source.

M0730.200 UNEMPLOYMENT COMPENSATION**A. Policy**

Unemployment Compensation received by an individual is counted as unearned income. The amount counted is the gross benefit before any taxes or deductions.

B. Procedures

Count Unemployment Compensation as unearned income for all covered groups, but do not count it in the 185% income screening for LIFC.

Exclude Unemployment Compensation in the 185% income screening for LIFC. Count Unemployment Compensation in the 90% income screening.

M0730.210 TRADE ADJUSTMENT ASSISTANCE ACT INCOME**A. Policy**

The Trade Adjustment Assistance Act is administered by the Virginia Employment Commission. The Act allows qualified unemployed individuals to receive additional weeks of Unemployment Compensation (UC). UC benefits are counted as unearned income. The amount counted is the gross benefit before any taxes or deductions.

B. Procedure

See M0730.200, above, for procedures to use in counting UC benefits.

M0730.400 CHILD/SPOUSAL SUPPORT

- A. Policy** Support received by an individual, whether it comes directly from the provider or is redirected to the individual by DCSE, is unearned income. The support received by the individual is subject to the \$50 Support Exclusion.
- B. TANF Recipients**
- 1. Distribution of Support** As a condition of eligibility for Temporary Assistance to Needy Families (TANF), an individual is required to assign to the State any rights to support from an absent parent of a child receiving TANF.
- The State, through the Division of Child Support Enforcement (DCSE), sends the first \$50 of support collected in a month on behalf of the TANF assistance unit to that unit. (If the total support collected is less than \$50, the entire amount is sent to the unit.) Any remaining amount of support is kept by the State as reimbursement of TANF payments made to the family. If DCSE collects more support than the State is entitled to keep as reimbursement for TANF paid, it will forward the excess to the TANF assistance unit. That excess amount is counted as unearned income.
- 2. After TANF Stops** If the Medicaid recipient has been removed from the TANF unit and is no longer included in the money payment, the assignment of rights to support for that individual is no longer valid (except with respect to any unpaid support obligation that has accrued under the assignment). From that point forward, the Medicaid recipient is entitled to receive from the State his or her share of any support collected on his behalf. Any support received is unearned income in the month received.
- C. Procedures**
- 1. Retained by State** Child support collected by a State and retained as reimbursement for TANF payments is not income to a Medicaid recipient.
- 2. \$50 Pass Through** Child support collected by DCSE and paid to a TANF assistance unit as a \$50 (or less) pass-through of child support is not income to the Medicaid family/budget unit.
- 3. Amount in Excess of the \$50 Pass-Through** Child support collected by DCSE and forwarded to a TANF family because the support exceeds the amount which the State is entitled to keep as reimbursement for TANF is a payment of child support and is unearned income.
- 4. Direct Child/Spousal Support** Support collected by DCSE and paid to the Medicaid family/budget unit is unearned income in the form of child support to the family/budget unit. Support paid directly to the Medicaid family/budget unit by an absent parent or spouse is unearned income in the form of child/spousal support to the family/budget unit.

NOTE: The first \$50 of total child or child and spousal support paid to the family/budget unit is excluded. The \$50 exclusion is only applicable current child/spousal support payments received each month. The \$50 exclusion does not apply to alimony that is not commingled with child support.

5. Payments Made to Third Party (Other Than DCSE)

Pending establishment of a child support obligation by the District Child Support Enforcement Office, payments made to a third party such as a rental agency in lieu of or in addition to child support, whether based on a court order or a mutual voluntary agreement between the Medicaid

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 Non-Money Payment-Protected Cases Only

Categorically-Needy Non-Money Payment Protected Covered Groups Which Use SSI Income Limits		
Family Unit Size	2006 Monthly Amount	2005 Monthly Amount
1	\$603	\$579
2	904	869
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size	2006 Monthly Amount	2005 Monthly Amount
1	\$402	\$386
2	602.67	579.34

**3. Categorically
Needy-Non
Money Payment
(CNNMP) -
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-Non Money Payment 300% of SSI		
Family Size Unit	2006 Monthly Amount	2005 Monthly Amount
1	\$1,809	\$1,737

**4. Medically
Needy**

a. Group I		
Family Unit Size	Semi-annual	Monthly
1	\$ 1,447.52	\$ 241.25
2	1,843.37	307.22
b. Group II		
Family Unit Size	Semi-annual	Monthly
1	\$ 1,670.22	\$ 278.37
2	2,056.98	342.83
c. Group III		
Family Unit Size	Semi-annual	Monthly
1	\$ 2,171.28	\$ 361.88
2	2,618.02	436.33

**5. ABD Medically
Indigent**

**For:
ABD 80% FPL,
QMB, SLMB, &
QI without Social
Security (SS) and
QDWI, effective
1/24/06; and
ABD 80% FPL,
QMB, SLMB, &
QI with SS,
effective 3/01/06**

ABD 80% FPL	Annual	Monthly
1	\$ 7,840	\$ 654
2	10,560	880
QMB 100% FPL	Annual	Monthly
1	\$ 9,800	\$ 817
2	13,200	1,100
SLMB 120% of FPL	Annual	Monthly
1	\$11,760	\$ 980
2	15,840	1,320
QI 135% FPL	Annual	Monthly
1	\$13,230	\$1,103
2	17,820	1,485
QDWI 200% of FPL	Annual	Monthly
1	\$19,600	\$1,634
2	26,400	2,200

WHAT IS NOT INCOME

M0815.001 WHAT IS NOT INCOME-GENERAL

A. Introduction

Some items that an individual receives are not income because they do not meet the definition of income in S0810.005 A. Other items are income but are excluded by statute (see S0830.099). In making income determinations, the eligibility worker (EW) must distinguish between an income exclusion and an item which is not income by definition. Only those items specifically listed in the law and regulations can be excluded from income.

B. Policy

An item received is not **income** if it is not cash, or its equivalent, or listed in this chapter. *Contributions of in-kind items are not income.*

An item which is not income when received by an individual, if retained until the following month, is subject to evaluation as a resource as of the first of the month after the month of receipt. (See S1110.600.)

C. Procedure

1. Is the Item Income?

In evaluating whether an item meets the definition of income, determine if it is:

- cash,
- **not** listed in this subchapter

If the item is **neither** of the above, consider it as not income.

2. Need to Document

Do not document the receipt of those items listed in this subchapter which are not income unless:

- Documentation is required by specific operating instructions elsewhere (e.g., rebates and refunds in S0815.250); or
- It is material to an eligibility computation.

D. References

- Treatment of income which is subject to garnishment, S0810.025.
- Treatment of contributions made to and benefits received from a cafeteria plan, S0820.102.

M0815.050 MEDICAL AND SOCIAL SERVICES, RELATED CASH AND IN-KIND ITEMS

A. General

Policy Principle: Medical and social services are **not income** for purposes of the Medicaid program. Under the circumstance specified in this section, cash and in-kind items received in conjunction with medical and social services are not income for Medicaid purposes.

1. Governmental Services

Assume that government medical and social service programs which provide cash or in-kind items are authorized to provide such items only in order to provide a medical or social service. Therefore, when an individual alleges receiving cash or in-kind items from a governmental medical or social service program, develop only the source of the item, not its purpose.

2. Non-governmental Services

Do not assume, however, that cash or in-kind items provided by a nongovernmental medical or social service organization can only be for medical or social service purposes. When a nongovernmental medical or social service organization is involved, develop both the source and the purpose of the cash or in-kind item. Subsection B. through E. explain the guidelines for determining whether or not the cash or item is income.

3. Do Count-Sheltered Workshop Income And Incentive Payments

Do not apply the rules in this section to two kinds of payments which, although commonly associated with medical or social services, are income, regardless of the source of payment.

1. Remuneration for work or for activities performed as a participant in a program conducted by a sheltered workshop or work activities center is earned income. See S0820.300.
2. Incentive payments to encourage individuals to utilize specified facilities or to participate in specified medical or social service programs are unearned income, to the extent that these payments are unrestricted as to use and are not reimbursement for medical or social services already received. Accept the individual's allegation as to the purpose and the amount of the payment; however, if the person does not know this information or if there is reason to question his statement, verify the information by obtaining documentary evidence or by contacting the source of the payment.

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EDUCATIONAL ASSISTANCE

S0830.450 GENERAL

A. Introduction

Educational assistance is provided in many forms. For Medicaid purposes, treatment will vary depending on the nature and sometimes the use of the assistance. Educational assistance may be earned or unearned income and may be counted or excluded, B. below provides a guide to specific educational assistance instructions and related sections.

B. References

1. Specific Instructions

The following sections address specific types of educational assistance:

- Department of Education or Bureau of Indian Affairs Involved S0830.460
- Tuition, Fees, and Other Expense Amount of Grants, Scholarships & Fellowships S0830.455
- VA Educational Benefits S0830.306

2. Related Instructions

The following sections contain related instructions:

- Student Child Earned Income Exclusion S0820.510
- Plan for Achieving Self-Support S0810.430
- Proceeds of a Loan S0815.350
- Earned Income S0820.001

M1110.530 WHOSE RESOURCES TO CONSIDER**A. Introduction**

In addition to resources that actually belong to an eligible (or would-be eligible) individual, Medicaid Law provides that the resources of certain other persons are considered to be available to the individual. Therefore, all appropriate resources determinations include those other persons' resources.

B. Policy**1. Spouse of Adult Individual**

The resources of an individual include those of a spouse, and the applicable resource limit is that for a couple, provided that the spouse:

- if **eligible**, lives in the same household as the individual as of the first of the month for which resources are being determined.
- if **ineligible**, lives in the same household as the individual as of the first of the month for which resources are being determined.

For institutionalized individuals with a community spouse, *see subchapter M1480*.

2. Parent(s) of Child under 18

If a blind or disabled child is under age 18 and is living in the same household with a parent, the agency must consider the parent's resources available to the child, whether or not they are actually contributed.

The applicable resource limit for a blind and/or disabled child is always that for an individual.

3. Parent(s) of Child Age 18 to 21

If a blind or disabled child age 18 to 21 is living in the same household with his parent, the agency must consider the parent(s)' resources available to the child, whether or not they are actually contributed:

The applicable resource limit for a disabled or blind child is always that for an individual.

DETERMINING ELIGIBILITY BASED ON RESOURCES

M1110.600 RULE FOR MAKING DETERMINATIONS

A. Policy Principle-- Rule Make all resource determinations per calendar month. Resource eligibility exists for the full month if countable resources were at or below the resource standard for any part of the month.

B. Policy Principle-- Significance of the Rule

1. Increase in Value of Resources

Consider any increase in the value of an individual's resources in the resources determination the month following the month in which:

- the value of an existing resource increase (e.g., the value of a share of stock goes up or installment payments increase a property's equity value);
- an individual acquires an additional resource (e.g., inherits property); or
- an individual replaces an excluded resource with one that is not excluded (e.g., sells an excluded automobile for nonexcludable cash).

2. Decrease in Value of Resources

Consider any decrease in the value of an individual's resources in the resource determination the month in which:

- the value of an existing resource decreases (e.g., the value of a share of stock goes down);
- an individual spends a resource (e.g., withdraws \$150 from a savings account to pay bills); or
- an individual replaces a countable resource with one that is not countable (e.g., trades a countable piece of real property for an excluded automobile).

3. Treatment of Assets Under Income and Resource Counting Rules

When an individual receives an asset (real or personal property) during a month, *it is* evaluated under the appropriate income-counting rules in that month. If the individual retains the item into the month following the month of receipt, *it is* evaluated under the resource-counting rules. Do not evaluate the same asset under two sets of counting rules for the same month.

Funds cannot be both income and a resource in the same month. Income that has been added to a bank account during the month must be subtracted from the ending balance to ensure that the income is not also counted as a resource. See M1140.200.

EXCEPTION: Trusts established on or after August 11, 1993, have different counting rules. See M1120.201.

E. Policy – Disbursements from Trusts

1. When Trust Principal Is Not a Resource

If the trust principal is not a resource, disbursements from the trust may be income to the Medicaid *enrollee*/beneficiary, depending on the nature of the disbursements. Regular rules to determine when income is available apply.

a. Disbursements Which are Income

Cash paid directly from the trust to the individual is unearned income.

b. Disbursements Which Result in Receipt of In-kind Support and Maintenance

Food, clothing or shelter received as a result of disbursements from the trust by the trustee to a third party are income in the form of in-kind support and maintenance *and are not counted for Medicaid purposes*.

c. Disbursements Which Are Not Income

Disbursements from the trust by the trustee to a third party that result in the individual receiving items that are not food, clothing or shelter are not income. For example, if trust funds are paid to a provider of medical services for care rendered to the individual, the disbursements are not income for Medicaid purposes.

2. When Trust Principal Is a Resource – Trusts Created By Will or Prior to Aug. 11, 1993

If the trust principal is a resource to the individual, disbursements from the trust principal received by the individual are not income, but conversion of a resource. See S1110.100 for instructions pertaining to conversion of resources from one form to another and F.2. below for treatment of income when the trust principal is a resource.

3. When Trust Principle is a Resource – For Trust Created on or After August 11, 1993

Effective August 11, 1993:

- payments for the benefit of the individual are counted as unearned income;
- corpus is a resource, and
- payments to other individual(s) are evaluated as asset-transfer;
- trust earnings, e.g., interest, are income.

F. Policy
Earnings/Additions
to Trusts

1. Trust Principal
Is Not a
Resource

a. Trust Earnings

Trust earnings are not income to the trustee or grantor unless designated as belonging to the trustee or grantor under the terms of the trust; e.g., as fees payable to the trustee or interest payable to the grantor.

Trust earnings are not income to the Medicaid claimant or recipient who is a trust beneficiary unless the trust directs, or the trustee makes, payment to the beneficiary.

b. Additions to Principal

Additions to trust principal made directly to the trust are not income to the grantor, trustee or beneficiary. Exceptions to this rule are listed in c. and d. below.

c. Exceptions

Certain payments are non-assignable by law and, therefore, are income to the individual entitled to receive the payment under regular income rules. They may not be paid directly into a trust, but individuals may attempt to structure trusts so that it appears that they are so paid. Non-assignable payments included:

- Aid to Families with Dependent Children (AFDC);
- Railroad Retirement Board-administered pensions;
- Veterans pensions and assistance;
- Federal employee retirement payments (CSRS, FERS) administered by the Office of Personnel Management;
- Social Security title II and SSI payments; and
- Private pensions under the Employee Retirement Income Security Act (ERISA) (29 U.S.C.A. section 1056(d)).

d. Assignment of Income

A legally assignable payment (see c. above for what is not assignable), that is assigned to a trust, is income for Medicaid purposes unless the assignment is irrevocable. If the assignment is revocable, the payment is income to the individual legally entitled to receive it.

S1130.000 RESOURCES EXCLUSIONS**REAL PROPERTY****M1130.100 THE HOME**

A. Policy Principles -- General Rules *This policy only applies to SSI Recipients, ABD Individuals with Income ≤ 300% SSI, and ABD Medically Needy (MN) covered groups. It does NOT apply to the following ABD covered groups:*

- *Qualified Disabled and Working Individuals (QDWI),*
- *Qualified Medicare Beneficiaries (QMB),*
- *Special Low-income Medicare Beneficiaries (SLMB),*
- *Qualified Individuals (QI), and*
- *ABD 80% FPL.*

The home property resource exclusion for the QDWI covered group is in Appendix 1 to Chapter S11. The home property resource exclusion for the QMB, SLMB, QI and ABD 80% FPL covered groups is in Appendix 2 to Chapter S11.

- 1. Home Exclusion** Ownership of a dwelling occupied by the applicant as his home does not affect eligibility.
- 2. Definition of the Home** An individual's home is property that serves as his or her principal place of residence.

A home means the house and lot used as the principal residence and all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed \$5,000.

In any case in which the definition of home as provided here is more restrictive than that provided in the State Plan for Medical Assistance in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value.

- 3. Principal Place of Residence** An individual's principal place of residence is the dwelling the individual considers his established or principal home and to which, if absent, he intends to return. It can be real or personal property, fixed or mobile, and located on land or water. Only one resource can be exempted as home property.
- 4. Individual Owns the Land but Not the Shelter** For purposes of excluding "the land on which the shelter is located" (see A.2. above), it is not necessary that the individual own the shelter itself.

EXAMPLE: If an individual lives on his own land in someone else's trailer, the land meets the definition of home and is excluded.

**B. Operating Policy --
Home Lot**

1. Land

The home exclusion applies to the plot of land on which the home is located. The excluded home lot size may vary according to the locality's building requirements.

For localities with set minimum building lot size use the lesser of:

- *the* plat;
- *the* survey; or
- *the* locality's minimum size for a building lot.

For localities with no minimum building lot requirements, use the lesser of:

- *the* plat;
- *the* survey; or
- one acre.

2. Buildings

The home exclusion applies to all buildings on land excluded in B.1. above.

**C. Operating Policy --
Contiguous Property
Allowed Under
Home Exclusion**

The home exclusion may be applied to property contiguous to the home. Property adjoining the home lot may come under the home exclusion by using one of two different calculations. Apply the calculation which is most advantageous.

**1. \$5,000 Assessed
Value of
Contiguous
Land**

The home exclusion applies to land adjoining the home plot if not completely separated from it by land in which neither the individual nor his or her spouse has an ownership interest. **\$5,000 of assessed value of land contiguous to the home lot can be included in the home exclusion.**

Easements and public rights of way (utility lines, roads, etc.) do not separate other land from the home plot.

**2. Contiguous
Property
Essential to the
Operation of the
Home**

The equity value of countable contiguous property may cause resources to exceed the maximum limit. In these cases, reevaluate the home property applying the definition of the home used in the State Plan for Medical Assistance in Virginia in effect on January 1, 1972. At that time a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value.

Property essential to the operation of the home means:

- a. land used for regular production of any food/goods for the household's consumption only, including:
 - vegetable gardens;
 - pastureland for livestock raised for milk or meat;
 - land to raise chickens, pigs, etc;
 - outbuildings used to process and/or store any of the above.

The amount of land necessary to support animals named above is established by the local extension service. However, only actual land being used to support the animals will be allowed.

- b. driveways connecting the homesite to public roadways.
- c. land necessary to **the** homesite to meet local zoning requirements (e.g. building site, mobile home sites, road frontage, distance **from** road, etc.).
- d. land necessary for compliance with state local health requirements (e.g., distance between home and septic tank(s));
- e. water supply for the household.
- f. existing burial plots.
- g. outbuildings used in connection with dwelling, such as garages or tool sheds.

3. ABD Home Property Evaluation Worksheet

See Appendix 2 to this subchapter for the "ABD Home Property Evaluation Worksheet."

D. Limitations On Home Property Exclusion

1. Property That No Longer Serves as the Principal Place of Residence

Property ceases to be the principal place of residence, *and is no longer* excludable as the home, as of the date that *an individual who has left the home determines that he* does not intend to return to it.

Such property, if not excluded under another provision, will be included in determining countable resources.

2. 6-Month Exemption

An institutionalized individual's former residence is an excluded resource for six months beginning with the month following the month of the *individual's* admission to a medical institution. *The following are types of medical institutions:*

- *chronic disease hospitals,*
- *hospitals and/or training centers for the mentally retarded,*
- *institutions for mental diseases (IMDs),*
- *intermediate care facilities(ICFs),*
- *nursing facilities, and*
- *rehabilitation hospitals.*

After six months the former residence is counted as an available resource.

**3. Extended
Exclusion for
Institutionalized
Individual**

An institutionalized individual's home property continues to be excluded if it is occupied by his:

- spouse;
- minor dependent child under age 18;
- dependent child, **under** age 19, **who attends** school or vocational training; or
- parent or adult child who is disabled (per Medicaid disability definition) and was living in the home with the person for at least one year prior to person's institutionalization, and who is dependent upon the person for his shelter needs.

**E. Development and
Documentation--
Initial Applications**

1. Ownership

a. Verify Ownership

Verify an individual's allegation of home ownership. Have the individual submit one of the items of evidence listed in b.- d. below.

b. Evidence of real property ownership;

- tax assessment notice;
- recent tax bill;
- current mortgage statement;
- deed;
- report of title search;
- evidence of heirship in an unprobated estate (e.g., receipt of income from the property, a will, or evidence of relationship recognizable under State intestate distribution laws in cases where the home is unprobated property).

c. Evidence of personal property ownership (e.g., a mobile home):

- title,
- current registration.

d. Evidence of life estate or similar property rights:

- a deed,
- a will,
- other legal document.

e. Equitable Ownership

If an individual alleges equitable ownership (e.g., an unwritten ownership interest or right of use for life) obtain any pertinent documents and a signed statement from each of the parties involved regarding any arrangement that has been agreed to. Forward the document to a *medical assistance program consultant* for an opinion from legal counsel.

2. Principal Place of Residence-- Operating Assumption

If the individual does not own more than one residence and there is no evidence that raises a question about his principal place of residence, assume that the alleged home is the individual's principal place of residence.

3. Indication of More than One Residence

If an individual alleges or other evidence indicates ownership of more than one residence, obtain his signed statement concerning such points as:

- how much time is spent at each residence;
- where he is registered to vote;
- which address he uses as a mailing address or for tax purposes.

Determine the principal place of residence accordingly and document the determination in the case file.

4. Evidence Indicates Non-adjointing Property

a. Individual Agrees With Evidence

If evidence indicates that land the individual owns does not adjoin the home plot, and the individual agrees that it does not:

- **obtain** his statement to that effect; and
- **develop** the non-adjointing portion per S1140.100 (Non-home Real Property) or S1130.500 (Property Essential to Self-Support), as applicable.

b. Individual Disagrees With Evidence

If the individual maintains that all the land adjoins the home plot, document the file with:

- a sketch of the land showing the boundaries of the various plots and the location of the shelter used as the home; and
- evidence of how the land is treated for tax assessment purposes.

The sketch may be by the individual, from public records, or by EW (from direct observation).

The tax assessment information may be in the form of a tax assessment notice or obtained from the appropriate tax jurisdiction.

c. Combined or Single Holding for Tax Assessment

Assume that the land is a single piece of property in which all the land adjoins the home plot if:

- it is recorded and treated as a single holding for tax assessment purposes; or
- the original holding has been subdivided, but still is treated as a single holding for tax assessment purposes.

d. More Than Single Holding for Tax Assessment

If the land is recorded and treated as two or more holdings for tax assessment purposes, use the sketch to determine whether other holdings adjoin the home plot.

**5. Absences From
The Home**

a. Summary of Development

If the individual is in an institution, determine whether a spouse or dependent relative is living in the home (see b. below).

If no spouse or dependent relative is living in the home, or if the absence is for a reason other than institutionalization, determine *if the individual intends to return when the purpose of the absence (such as medical care, rehabilitation, vacation/visit, education, employment, military service) is completed.*

NOTE: If a previously undeveloped absence from the home has ended, assume that the individual always intended to return. The absence, regardless of duration, will not affect the home exclusion.

b. Spouse or Dependent Relative Development

Obtain a signed statement from the individual as to:

- whether anyone is living in the home while the individual is in the institution;
- if so, how that person is related to the individual, if at all; and
- if related (except for the individual's spouse), how that person is dependent on the individual for shelter needs, if at all.

Absent evidence to the contrary, accept the allegation.

6. Value of Home Lot

Verify the current assessed value of the home lot from the locality's Real Estate Assessment Office.

NOTE: The home lot assessed value is usually more than the value assessed to the contiguous property. Therefore, prorating the total assessed land value on the real estate tax assessment bill may not give the true assessed value of the home lot.

7. Total Home Exclusion Value

a. Add Together:

- the assessed value of the home lot as verified in 6. above, and
- \$5,000 of contiguous assessed property value.

This total equals the amount of assessed land value allowed under the Home Exclusion.

If excess resources exist and any countable contiguous property was included in the evaluation, the Home Exclusion must be re-evaluated.

b. Add Together:

- the assessed value of the home lot as verified in 6. above, and
- the assessed value of contiguous property essential to the operation of the home.

This equals the amount of assessed property value allowed under the Home Exclusion used under the State Plan for Medical Assistance in Virginia in effect on January 1, 1972.

F. Procedure – Post-eligibility

If, after Medicaid eligibility is established, an individual receives real property—for example, as an inheritance or gift—which may be excludable as his home, apply the policy and procedures in A. and B. above to determine whether the home exclusion applies.

Redevelop the exclusion from resources of an individual's home only if something raises a question about the correctness of the original determination or indicates that the exclusion may no longer apply (e.g., a change of address).

G. References

- Home replacement funds, S1130.110
- Real property whose sale would cause undue hardship due to loss of housing, to a co-owner, Appendix 2 to chapter S11.
- Real property following reasonable but unsuccessful efforts to sell it, **M1130.140.**

S1130.110 HOME REPLACEMENT FUNDS

A. Policy Principles

1. General

When an individual sells an excluded home, the proceeds of the sale are excluded resources if the individual:

- plans to use them to buy another excluded home, and
- does so within 3 full calendar months of receiving them.

2. Installment Sales Contracts

If an individual receives the proceeds under an installment contract, the contract is an excluded resource for as long as the individual:

- plans to use the entire down payment and the entire principal portion of a given installment payment to buy another excluded home; and
- does so within 3 full calendar months of receiving such down payment or installment payment.

B. Operating Policy

1. Proceeds Defined

a. If Paid in a Lump Sum

The proceeds are the net amount the seller receives at settlement.

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

A. Policy Principles

1. Exclusion

Real property 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.

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 if, it is listed at 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 refuse to list the property. The reason for refusal must be that the property is unsalable at CMV (other reasons are not sufficient); or

- c. *When the applicant has personally advertised his property at or below CMV for 90 days by use of a "Sale by Owner" sign located on the property and by other reasonable efforts, such as newspaper advertisements, reasonable inquiries with all adjoining land-owners, or other potential interested purchasers.*
- d. For property owned by an individual who is incompetent if no general power of attorney exists:

When court action is initiated for appointment of a guardian or *conservator* to secure the court's approval to dispose of the property, an initial effort to sell shall be deemed to have been made beginning the date the hearing for appointment of a guardian is placed on the court docket and continuing until the court authorizes sale of the property or six months, whichever is less.

Any period of time in excess of six months to secure appointment of a guardian and authorization to sell by the court is not deemed reasonable and the property loses this exemption. Upon authorization, and only upon authorization, the guardian must make a continuing reasonable effort to sell the property as described in paragraph B.3.

- e. For property which is an interest in an undivided estate and for jointly owned property when a co-owner refuses to sell:

An initial reasonable effort to sell shall have been made when all other co-owners have refused to purchase the applicant's or recipient's share, and at least one of the other co-owners has refused to agree to sell the property. After an initial effort to sell has been made, the individual must immediately make a continuing effort to sell in accordance with 3.d. below.

2. Retroactive Exclusion

There will be applications received with property already listed for sale. Inform the applicant of Reasonable Efforts to Sell policy.

Reasonable efforts to sell may have been made if the property was listed at more than 100% CMV. The following criteria will be applicable to property already listed for sale when the application is received. To receive the Reasonable Efforts to Sell exclusion for the month of application and the retroactive period when property has already been listed, the following criteria must be met:

- If the property was listed **at or below** 150% of CMV, the Reasonable Efforts to Sell exclusion will be granted for the month of application and the retroactive time period when the requirements in B.1., except for the listing price, are met.
- If property was listed **higher** than 150% of CMV, reasonable effort to sell *cannot be established in the retroactive period.*

The above is a screening trigger to determine if property may be excluded.

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

If the recipient has made a continuing effort to sell the property for 12 months, then the recipient may sell the property between 75% and 100% of its tax assessed value and such sale shall not result in disqualification under the transfer of assets rule. If the recipient requests to sell his property at less than 75% of assessed value, he must submit documentation from the listing realtor, or knowledgeable source if the property is not listed with a realtor, that the requested sale price is the best price the recipient can expect to receive for the property at this time. Sale at such a documented price shall not result in disqualification under the transfer of property rules.

5. Date Property is Disregarded

After the applicant has demonstrated that his property is unsaleable 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.

EXHIBIT--TABLE UNISEX LIFE ESTATE OR REMAINGER TABLE (Cont.)	AGE	LIFE ESTATE	REMAINDER
	75	.52149	.47851
	76	.50441	.49559
	77	.48742	.51258
	78	.47049	.52951
	79	.45357	.54643
	80	.43659	.56341
	81	.41967	.58033
	82	.40295	.59705
	83	.38642	.61358
	84	.36998	.63002
	85	.35359	.64641
	86	.33764	.66236
	87	.32262	.67738
	88	.30859	.69141
	89	.29526	.70474
	90	.28221	.71779
	91	.26955	.73045
	92	.25771	.74229
	93	.24692	.75308
	94	.23728	.76272
	95	.22887	.77113
	96	.22181	.77819
	97	.21550	.78450
	98	.21000	.79000
	99	.20486	.79514
	100	.19975	.80025
	101	.19532	.80468
	102	.19054	.80946
	103	.18437	.81563
	104	.17856	.82144
	105	.16962	.83038
	106	.15488	.84512
	107	.13409	.86591
	108	.10068	.89932
	109	.04545	.95455

FINANCIAL INSTITUTION ACCOUNTS

M1140.200 CHECKING AND SAVINGS ACCOUNTS

A. Operating Policies

1. **Ownership** Assume that the person designated as owner in the account title owns all the funds in the account (see S1140.205 regarding joint accounts).
2. **Right to Withdraw Funds** Absent evidence to the contrary, assume that the person shown as owner in the account title has the legal right to withdraw funds from the account.
3. **Fiduciaries** A fiduciary's right to withdraw funds is the same as the owner's right to withdraw them.
4. **Examples of Evidence to the Contrary**
 - a. **Right to Withdraw Funds Restricted to a Specified Account Holder**

An account is titled, "In trust for John Jones and Mary Smith, subject to sole order of John Jones, balance at death of either to belong to survivor." Since John alone has unrestricted access, none of the funds in the account could be considered Mary's resources unless John were her fiduciary or his resources were deemed available to her.
 - b. **Withdrawals Require Authorization of Third Party**

An account is title, "George Dahey, restricted Individual Indian Money Account." Mr. Dahey cannot withdraw funds from the account without Bureau of Indian Affairs (BIA) authorization. Therefore, the account is not his resource.
 - c. **"Blocked" Accounts**

If State law specifically requires the funds be made available for the care and maintenance of an individual, assume, absent evidence to the contrary, that they are that individual's resource. This is true despite the fact that the individual or his/her agent is required to petition the court to withdraw funds for the individual's care. Refer to regional coordinator any questions regarding State law on "blocked accounts."
5. **Right to Use for Support and Maintenance** Absent evidence to the contrary, assume that an individual who owns and has the legal right to withdraw funds from a bank account also has the legal right to use them for his or her own support and maintenance.

6. Examples of Evidence to the Contrary

a. Use Restricted by Court Order

Even with ownership interest and the legal ability to access property, a legal restriction against the property's use for the owner's own support and maintenance means the property is not the owner's resources (§1110.100).

EXAMPLE: An account is titled, "Aristotle Iris by Hester Pry, Representative Payee," where Ms. Pry is an officer of the institution in which Mr. Iris lives. A statewide court order prohibits such officers from using the funds of an institutionalized person for support and maintenance provided by the State. Therefore, the funds in the account are not a resource while Mr. Iris is in the institution.

b. Special Purpose Accounts

An account is titled, "Thomas Green, Kiwanis Club Fund for Heart Surgery." While Mr. Green has unrestricted access to funds, development shows that their use is restricted to the expenses of his surgery. Therefore, they are not a resource.

B. Development and Documentation Initial Applications and Post-eligibility

1. Informing the Individual of Reporting Responsibilities

Be sure the individual understands that:

- he must report any bank account on which his or her name appears, regardless of any special purpose for which the account may have been established or whose money is in it;
- DSS may use other statements or forms to obtain information from any bank account or financial institution to verify the allegations.

2. Curtailing Development

Do not verify account balances under any of the following circumstances:

- a. the individual alleges that his name does not appear on any accounts, and there is no evidence to the contrary;
- b. the individual is ineligible for a non-financial reason.

3. Minimum Documentation -Account Balances Must Be Verified

Document, in addition to the balances themselves;

- the name and address of the financial institution;
- the account number(s); and
- the exact account designation.

4. Electronic Verifications

Electronic verifications, such as on-line bank statements and automated teller machine (ATM) receipts, are acceptable verifications provided that they include:

- *the name of the financial institution,*
- *the individual's name,*
- *the individual's account number, and*
- *date of the receipt or online statement.*

5. Determining the Value of a Bank Account

There is no single method for determining the countable value of a bank account. The countable value is the lower of:

- *the balance before income is added, or*
- *the ending balance minus any income added during the month.*

Funds cannot be both income and a resource in the same month. Income that has been added to a bank account during the month must be subtracted from the ending balance to ensure that the income is not also counted as a resource.

6. Requesting Information from Financial Institutions

- a. When it is necessary to request account information from a financial institution, have the individual sign an authorization for release of the information.

b. Balance Information

The financial institution may show the opening balance for the first day of a given month or the closing balance for the last business day of the previous month. Accept either, the amount will be the same. See M1110.001 for Monthly Determinations of Resource Eligibility.

c. Financial Institution Does Not Cooperate

If a financial institution refuses to provide the information needed for a determination, try to obtain its cooperation by explaining why assistance is required.

M1320.000 SPENDDOWN INFORMATION**M1320.100 INFORMING THE APPLICANT****A. Introduction**

An individual applicant who meets all the medically needy Medicaid eligibility requirements except income, because his countable income exceeds the Medicaid income limits, must be told about spenddown and what he can do to become eligible for Medicaid coverage for a limited time period.

This section lists the items of which the EW must inform the applicant.

B. Allowable Expenses

The worker must inform the applicant about the incurred medical, dental, or remedial care expenses, either paid or unpaid, that can be deducted from the spenddown liability.

1. Covered By State or Local Public Program

Expenses for incurred medical services received on or after December 22, 1987, which were provided, covered, or paid for by a state or local government program can be deducted even though the applicant does not owe anything for the service.

Expenses covered by Medicare and Medicaid (which are federal programs) CANNOT be deducted.

2. Old Bills

Expenses incurred for medical services received prior to the initial application's retroactive period may be deducted if:

- the applicant is legally liable to pay the expense;
- the applicant still owes a balance to the medical service provider for the service;
- the expense was not deducted from (counted in) any previous spenddown budget period in which the spenddown was met, and
- a claim for the expense was submitted to the liable third party(ies), if any.

3. Third Party Payment

An allowable medical expense cannot be deducted until the individual's insurance or other third party, if applicable, has taken action on the claim and the applicant provides evidence documenting:

- the claim was denied, or
- the amount of the claim paid by the third party.

Only the amount not covered by the third party(ies) and which remains the liability of the individual may be deducted from the spenddown liability.

- C. Incur Noncovered Expenses First** The worker must inform the applicant that it is to his advantage to use the spenddown liability (excess income) for medical and dental services not covered by the Medicaid program before he uses the spenddown liability for covered services. Medicaid will not pay for noncovered medical services even after the spenddown is met.
- D. Estimate When Spenddown Liability Will Be Met** The worker can help the applicant estimate the approximate time when the spenddown liability will be met if:
- the individual has already spent or owes for medical services received prior to, on, or after the first day of the month of application, and
 - the individual anticipates medical expenditures in the near future.
- E. Reapplying At The End Of The Spenddown Period** The worker must inform the individual of the spenddown period and the need to file a re-application if additional coverage is needed. If eligible as QMB, SLMB, or QDWI, the *Medicaid Renewal form (#032-03-669)* may be used to establish new spenddown budget periods.
- The Eligibility Review Part A (#032-03-729A) and Eligibility Review Part B (#032-03-729B) forms should only be used for QMB, SLMB, or QDWI enrollees when the forms are required by another program under which the individual is receiving benefits. For all others, the Application For Benefits (#032-03-824) is required to establish additional spenddown budget periods.

M1320.200 PROCESSING TIME STANDARDS

A. Applications

- 1. Processing Standards** The time standards for Medicaid eligibility determination must be met when determining spenddown. The processing time standards are:
- 90 days for applicants whose disability must be determined and
 - 45 days for all other applicants
- from the date the signed Medicaid application is received by the local agency.
- 2. Third Party Payment Verifications** The standards shall also apply to receipt of third party payment or verification of third party intent to pay in order to determine allowable expenses deductible from the spenddown liability. Efforts to determine the third party liability shall continue through the last day of the processing standard period of time. If information regarding third party liability for an incurred expense is not received by this date, eligibility must be determined without deducting the expense.

B. Changes

The time standard for evaluating a reported change is 30 days from the date the worker receives notice of a change in circumstances or a medical or dental expense submitted by the individual.

Efforts to determine the third party liability shall continue through the last day of the processing time standard. If information regarding third party

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M1340.000 SPENDDOWN DEDUCTIONS**M1340.100 SPENDDOWN DEDUCTIONS****A. Introduction**

Medical expenses incurred by the individual, family or a financially responsible relative that are not subject to payment by a third party are deducted from the individual's spenddown liability. An expense is incurred on the date liability for the expense arises. The agency must determine which incurred expenses can be deducted and must deduct those expenses in accordance with section M1340.200 below.

The policy and procedures for deducting old bills and incurred expenses are based on federal regulations which were developed to remove the incentive for individuals to not pay their old bills.

B. Policy

Only those medical, dental, or remedial care expenses incurred by the applicant, budget unit member(s) and the applicant's spouse and/or child in the household who is not included in the applicant's assistance unit, are considered as potential deductions from spenddown.

1. Legal Liability For Expense

Medical expenses, or portions of medical expenses, that are covered by Medicare or other health insurance are not legal obligations of the individual and cannot be deducted from spenddown. If the expense was covered by a state or local public program as defined in section M1340.1100, see that section.

If a legally responsible relative's income is deemed to the assistance unit, the legally responsible relative's incurred expenses are deducted from the unit's spenddown. When the legally responsible relative also has a spenddown liability that has not been met, the legally responsible relative must choose the spenddown from which the incurred expense is deducted. An incurred expense can be deducted from only one spenddown. If not totally used to meet the spenddown, the balance can be applied to another spenddown.

2. Projected Expenses

"Projected" expenses are for services that have not yet been rendered. Projected expenses for medical services cannot be deducted, except for nursing facility care. Expenses included in a prepaid package of services cannot be deducted prior to the date the service(s) is actually rendered. See subchapter M1460 or M1480 for nursing facility patients.

3. Chronological Deduction

Expenses are deducted in chronological order based on the date they are incurred. The date incurred is the date the service was received or, in the case of health insurance premiums *that are withheld from monthly benefit payments, the first day of the month the premium payment is due.*

4. Multiple Spenddown Periods

When an individual has established more than one spenddown period, medical expenses are first deducted from the spenddown period during which they were incurred. If not used to achieve eligibility, the bill can be evaluated for use in succeeding budget periods. Specific instructions for treatment of prior

incurred expenses can be found in sections M1340.600, M1340.700 and M1340.800.

M1340.200 KINDS OF ALLOWABLE DEDUCTIONS

- | | |
|--|--|
| A. Policy | To determine the allowable incurred expenses that will be deducted from income, the agency must identify the kind of service. |
| B. Kinds of Service | In determining allowable incurred expenses, the medical or remedial care expenses listed below may be deducted from the spenddown liability. |
| 1. Health Insurance Expenses | Medicare and other health insurance premiums are allowable health insurance expenses. |
| 2. Noncovered Services Expenses | Noncovered services expenses are expenses incurred by the individual or family or financially responsible relative for necessary medical or remedial care services which are not covered by the Virginia Medicaid State Plan. Noncovered services include expenses for Medicaid-covered services that exceed the State Plan limits on the amount, duration and scope of services. Medicaid co-payments and deductibles on covered services are “noncovered services.” Section M1340.400 lists noncovered services. |
| 3. Covered Services Expenses | Covered services expenses are expenses incurred by the individual or family or financially responsible relative for necessary medical or remedial care services which are covered by the Virginia Medicaid State Plan. |

M1340.300 HEALTH INSURANCE PREMIUMS, DEDUCTIBLES, COINSURANCE

- | | |
|-------------------------------------|---|
| A. Policy | Incurred expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, including deductibles and copayments imposed by Medicaid, are deducted from the spenddown liability. |
| B. Health Insurance Premiums | Health insurance premium payments include: |
| 1. Private Health Insurance | Payments made from the applicant’s own income for private medical insurance are allowed deductions. Income protection insurance (indemnity) policy premiums are not medical expenses and are not deducted from the spenddown liability. |
| 2. Medicare Premiums | Medicare Part A, Part B and/or <i>Part D</i> premium payments are allowed deductions when the premiums are paid from the applicant’s own income. |
| 3. Amount Deducted | The amount deducted is the amount of the premium paid. |

- 4. When Deducted** A health insurance premium is deducted from the spenddown liability when the monthly premium is due. The worker cannot deduct a pre-paid premium that is paid before the month the premium is due.
- When a health insurance premium is withheld from the individual's monthly benefit check, the premium is deducted on the first day of the month. For example, the individual receives a Social Security benefit from which is deducted the Medicare Part B premium. The Social Security check is dated December 13. The Medicare Part B premium is deducted from the individual's spenddown liability on December 1.
- C. Deductibles, Coinsurance, and Copayments**
- Deductibles, coinsurance and co-payment amounts are those portions of a medical services expense which the health insurance policy designates as the individual's responsibility to pay. The health insurance policy will not pay these amounts.
- 1. Amount Deducted** The amount deducted is the amount of the deductible, coinsurance or co-payment owed for the service.
- 2. When Deducted** A deductible, coinsurance or co-payment amount is deducted from the spenddown liability on the date the service was received.
- D. Verification** Verification of health insurance premiums, deductibles, coinsurance and copayment amounts include:
- a copy of the insurance premium notice,
 - the explanation of benefits paid by health insurance,
 - *the statement, or a copy of the statement, from the Medicare Part D prescription drug plan (PDP),*
 - Medicaid co-pays and deductibles as listed in chapter M18, or the Virginia Medicaid Handbook.

M1340.400 NONCOVERED SERVICES

- A. Policy** Noncovered services expenses are incurred expenses for necessary medical or remedial care services which are not covered by the Virginia Medicaid State Plan, including the amounts for covered services that exceed the State Plan limits on amount, duration and scope of services. Noncovered services must be ordered by a physician or dentist in order to be deducted.
- Noncovered 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. 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,
- Adult Care Residence (ACR) 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. a prescription, physician's referral, or statement from the patient's physician or dentist that the service was medically necessary.

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:

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

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

M1340.600 OLD BILLS

A. Policy

Old bills are any unpaid medical, dental and/or remedial care expenses incurred prior to the retroactive period based on an initial application. Unpaid medical, remedial, and dental care expenses incurred prior to a re-application and its retroactive period may also be deducted as old bills provided that:

- they were not incurred during a prior spenddown budget period, in which spenddown eligibility was established,
- they were not fully deducted from any previous spenddown that was met, and
- they remain the liability of the individual.

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

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

B. Procedures

Decide whether an old bill is deducted using the following procedures:

1. Verification

Request the following verification from the individual or his representative:

- proof that the bill is still owed,
- if applicable, the amount owed that was not covered by the patient's insurance or liable third party,
- the service provider's name, address, and profession
- proof that the service was medically necessary (prescription, physician's referral, statement from the patient's physician or dentist).

2. Determine Amount of Deduction

Upon receipt of the requested documentation, determine the unpaid balance still owed on the old bill minus the amount used to meet a prior spenddown, if any.

3. Subtract The Old Bill

Subtract the old bill amount from the spenddown liability on the first day of the spenddown budget period according to policy in subsection A above.

C. Example--Deduct Balance of Old Bill

EXAMPLE #1: The application month is October 1999. The individual never applied for Medicaid before October 1999. He did not receive a Medicaid-covered service in the retroactive period. The spenddown liability for the first prospective budget period October 1999 through March 2000 is \$560. The individual provides verification that he still owes \$100 for a medically necessary service received in May 1999 (prior to the retroactive period). The \$100 old bill is deducted from the first prospective budget period spenddown liability, leaving him a spenddown balance of \$460 on October 1, 1999.

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

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

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

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

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

**1. Placed on
Spenddown**

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

**2. QMB, SLMB,
and QDWI**

If an enrolled QMB, SLMB, or QDWI does not meet the spenddown, he continues eligible as ABD MI. If he remains eligible as ABD MI, *the Medicaid Renewal form (#032-03-669) may be used as an application for establishing additional spenddown budget periods. The Eligibility Review Part A (#032-03-729A) and the Eligibility Review Part B (#032-03-729B) forms should only be used when they are required by another program under which the individual is receiving benefits.*

3. QI

The QI medically indigent recipients who meet the MN covered group and resource requirements are placed on a MN spenddown. If an enrolled QI medically indigent recipient does not meet the spenddown, he continues to be eligible as QI for the calendar year, or as long as the program is funded. He must file an Application for Benefits (#032-03-824) to reapply as a medically indigent Qualified Individual and to establish a new spenddown budget period.

B. References

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

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

M1370.200 QMBs, SLMBs & QDWIs

- A. Policy** QMBs are eligible only for Medicaid coverage of their Medicare premiums, the Medicare deductible and coinsurance charges for Medicare covered services. Medicare does not cover all of the services that Medicaid covers. For example, Medicare does not cover prescription drugs.
- SLMBs and QDWIs are eligible only for Medicaid coverage of their Medicare premiums.
- B. Entitlement After Meeting Spenddown** When an enrolled QMB, SLMB or QDWI meets a medically needy spenddown, he is eligible for Medicaid as medically needy beginning the date the spenddown was met and ending the last day of the spenddown budget period.
- C. Enrollment Procedures** The MMIS enrollment must be canceled and then reinstated in order for the individual to receive the full scope of Medicaid services for the portion of the spenddown budget period in which he is eligible as medically needy. Take the following actions:
- 1. Cancel ABD MI Coverage** **Cancel** the recipient's current coverage line that has the medically indigent program designation.
 - a. Cancel date is the date **before** the date the spenddown was met.
 - b. Cancel reason is "024".
 - 2. Reinstate MN Coverage** Reinstate the recipient in the appropriate medically needy *aid category* (AC).
 - enter the eligibility begin date as the date the spenddown was met.
 - *enter the eligibility end date - the date the spenddown budget period ends.*

Be sure that the application date is the first month in the spenddown budget period. The MMIS will cancel eligibility effective the *end date entered*.
- D. Continuing Eligibility and Enrollment After Spenddown Ends** When the spenddown budget period ends, reinstate the recipient's Medicaid eligibility as medically indigent beginning the day after the MN spenddown budget period eligibility cancel date. Use the original Medicaid application date. ABD MI eligibility resumes the first day of the month following the end of the spenddown budget period. The month in which the spenddown budget period ends is considered the month in which the agency determines the recipient's ABD MI eligibility.
- To establish a new spenddown budget period, *use the Medicaid Renewal form (#032-03-669)*. The "Eligibility Review Part A" (#032-03-729A) and "Eligibility Review Part B" (#032-03-729B) *forms should only be used when they are required by another program under which the individual is receiving benefits*. When the annual redetermination is filed, new spenddown budget periods are established. Eligibility for each spenddown budget period is evaluated.

**E. Example--QMB
Meets Spenddown**

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

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

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

M1370.300 *Qualified Individuals (QI)*

A. Introduction

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

If all eligibility factors are met in the application month, eligibility for Medicaid as QI begins the first day of the application month and ends December 31 of the calendar year, if funds are still available.

B. Entitlement After Meeting Spenddown

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

C. Enrollment Procedures

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

1. Cancel QI Coverage

Cancel the recipient's current eligibility in the *QI aid category*.

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

2. Reinstate MN Coverage

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

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

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

D. Continuing Eligibility and Enrollment After Spenddown Ends

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

The *QI* must file a new application in order to be placed on a new MN spenddown budget period.

E. Example- *QI* Meets Spenddown

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

On July 15 he brings in prescription drug bills. He meets the spenddown on July 13. On July 25 the agency cancels his *QI (AC 056) coverage* effective July 12. His Medicaid eligibility as MN is reinstated using *AC 018* (medically needy aged) with an application date May 14, eligibility begin date of July 13, and *eligibility end date of October 31*.

His spenddown eligibility is automatically canceled by the MMIS effective October 31. On November 1, the agency worker reinstates his *QI Medicaid coverage* with a begin date of November 1, *AC 056*, application date May 14. He must file an "Application for Benefits" to establish a new spenddown for the spenddown budget period November 1 through April 30.

M1420.000 PRE-ADMISSION SCREENING**M1420.100 WHAT IS PRE-ADMISSION SCREENING****A. Introduction**

The Nursing Home Pre-admission Screening Program was implemented in 1977 to ensure that Medicaid eligible individuals placed in nursing facilities actually require nursing facility care. In 1982 the program was expanded to require pre-admission screening for individuals who will be eligible for Medicaid-covered Home and Community-based Care Waiver Services or institutional long-term care. A pre-admission screening is used to determine if an individual living outside a nursing facility meets the level of care for LTC services. Once an individual is admitted to a nursing home or Medicaid CBC, the provider is responsible for certifying the individual continues to meet the level of care for LTC services.

This subchapter describes the pre-admission screening process; the eligibility implications; the communication requirements; the inter-agency cooperation requirements; and the role of the eligibility worker within the pre-admission screening process.

B. Operating Policies**1. Payment****Authorization**

A pre-admission screening provides authorization for Medicaid payment of facility (medical institution) and community-based care (CBC) long-term care services for Medicaid recipients.

2. When the Pre-admission Screening Form is Needed

Pre-admission screening is used to determine if an individual entering LTC meets the nursing facility level of care criteria or if living outside of a nursing facility is CBC waiver eligible. The EW does not need the certification form for an individual who is already in a nursing facility, *who received Medicaid LTC in one or more of the preceding 12 months and whose LTC terminated for a reason other than no longer meeting the level of care*, or who already meets the definition of institutionalization PRIOR to Medicaid application.

3. Determines Applicable Eligibility Rules

The pre-admission screening form is used to determine the appropriate rules used for the eligibility determination (which LTC rules to use, or whether to use non-institutional Medicaid eligibility rules). An individual who is screened and approved for LTC services is treated as an institutionalized individual in the Medicaid eligibility determination. The pre-admission screening document also identifies the type of LTC service and provides information for the personal needs/maintenance allowance.

M1420.200 PRE-ADMISSION SCREENING**A. Introduction**

In order to qualify for Medicaid payment for long-term care, an individual must meet both functional and medical components of the level of care criteria.

B. Nursing Facility Screening

This evaluation is completed by local teams composed of agencies contracting with the Department of Medical Assistance Services (DMAS) or by staff of acute care hospitals.

The local committees usually consist of the local health department director, a local health department nurse, and a local social services department service worker, plus any other professionals designated by the health department director.

Patients placed directly from acute care hospitals are usually screened by hospital screening teams. Generally, hospitals contract with DMAS to establish pre-admission screening committees to perform the screening process internally.

A state level committee is used for patients being discharged from State Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) institutions for the treatment of mental illness, and mental retardation.

Patients in a Veterans Administration Medical Center (VAMC) who are applying to enter a nursing facility are assessed by VAMC staff. VAMC discharge planning staff use their own Veterans' Administration assessment form, which serves as the pre-admission screening certification.

C. CBC Screening

Entities other than hospital or local health committees are authorized to screen individuals for CBC.

The following entities are authorized to screen patients for Medicaid CBC:

1. Elderly or Disabled with Consumer-Direction (EDCD) Waiver

Local and hospital screening committees or teams are authorized to screen individuals for the *EDCD* waiver.

2. Technology-Assisted Individuals Waiver

The DMAS Health Care Coordinator is authorized to screen individuals for the Technology-Assisted waiver.

3. Mental Retardation (MR) Waiver

Local Community Mental Health Services Boards (CSBs) and the Department of Rehabilitative Services (DRS) are authorized to screen individuals for the MR waiver. Final authorizations for MR waiver services are made by DMHMRSAS staff.

4. AIDS Waiver

Local and hospital screening committees or teams are authorized to screen individuals for the AIDS waiver. AIDS Services Organizations (ASOs) that have contracts with DMAS are also authorized to screen individuals for the AIDS waiver:

- Peninsula AIDS Foundation
 - Northern Virginia AIDS Project
 - INOVA System/Office of HIV
 - Council of Community Services
 - AIDS Support Group, Inc.
 - Whitman Walker Clinic of Northern Virginia
5. **Individual and Family Developmental Disabilities Support (DD) Waiver** DMAS and the Virginia Health Department child development clinics are authorized to screen individuals for the DD waiver.
6. **Alzheimer's Assisted Living (AAL) Waiver** Local *screening committees or teams* and hospital screening committees or teams are authorized to screen individuals for the AAL waiver; however, a copy of the pre-admission screening is not required for the Medicaid eligibility record.
7. **Day Support Waiver for Individuals with Mental Retardation (DS) Waiver** Local CSB and DMHMRSAS case managers are authorized to screen individuals for the DS waiver. Final authorizations for DS waiver services are made by DMHMRSAS staff.

M1420.300 COMMUNICATION PROCEDURES

- A. **Introduction** To ensure the eligibility determination process takes place simultaneously with screening decisions so that nursing facility placement or receipt of CBC services may be arranged as quickly as possible, prompt communication between screeners and eligibility staff must occur.
- Each agency shall designate an appropriate eligibility staff member for screeners to contact. Local social services staff, hospital social services staff, and DRS staff shall be given instructions on how to contact that person.
- B. **Procedures**
1. **Screeners** Screeners must inform the agency eligibility worker that the screening process has been initiated.
2. **EW Action** The eligibility worker must begin to process the individual's Medicaid application when informed that the screening process has begun.
3. **Provider Involvement** If the individual is found eligible and verbal assurance of approval by the screening committee has been received, the EW must provide, without delay, the facility or CBC provider with the recipient's Medicaid ID number.
4. **Designated DSS Contact** The local DSS agency should designate an appropriate eligibility staff member for screeners to contact. Local social services staff,

hospital social services staff and DRS staff should be given the name of, and instructions on how to contact, that person. This will facilitate timely communication between screeners and the eligibility determination staff.

M1420.400 SCREENING CERTIFICATION

A. Purpose

The screening certification authorizes a local DSS to determine financial eligibility using the more liberal rules for institutionalized individuals and verifies qualification for special personal maintenance allowances for temporary stays in long-term care facilities. The screening certification is valid for one year.

B. Procedures

1. Exceptions to Screening

Pre-admission screening is NOT required when:

- the individual is a patient in a nursing facility at the time of application or has been a patient in a nursing facility for at least 30 consecutive days;
- *the individual received Medicaid LTC in one or more of the preceding 12 months and whose LTC was terminated for a reason other than no longer meeting the level of care;*
- the individual is no longer in need of long-term care but is requesting assistance for a prior period of long term care;
- the individual enters a nursing facility directly from the EDCD or AIDS waiver;
- the individual leaves a nursing facility and begins receiving EDCD or AIDS waiver services; or
- the individual enters a nursing facility from out-of-state.

2. Documentation

- a. If the individual has not been institutionalized for at least 30 consecutive days, the screener's certification of approval for Medicaid long-term care must be substantiated in the case record.
- b. Substantiation is by:
 - a DMAS-96 (see Appendix 1);
 - a MR Waiver Level of Care Eligibility Form (see Appendix 2);
 - a DD Waiver Level of Care Eligibility Form (see Appendix 3); or
 - a DS Waiver Level of Care Eligibility Form (see Appendix 4).
- c. The screening certification is valid for one year.

3. DMAS-96

For an individual who has been screened and approved for the EDCD, Technology-Assisted, or AIDS wavier, the DMAS-96 "Medicaid Funded Long-term Care Pre-admission Screening Authorization" form will be

signed and dated by the screener. The "Medicaid Authorization" section will have a number in the box that matches one of the numbers listed under "Nursing Home Pre-admission Screening." These numbers denote approval of Medicaid payment for a waiver service. See Appendix 1 for a copy of the DMAS-96.

- 4. EDCD Waiver Authorization for Consumer-Directed Services**

When an individual has been screened and approved for the EDCD waiver, the local DSS must determine his eligibility as an institutionalized individual and if eligible, enroll him in Medicaid. DMAS or its contractor must give final authorization for consumer-directed services. If the services are not authorized, the Service Facilitator will notify the LDSS, and the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.
- 5. MR Waiver Level of Care Eligibility Form**

For an individual who has been screened and approved for the MR waiver, the "MR Waiver Level of Care Eligibility Form" will be signed and dated by the DMHMRSAS representative. The "MR Waiver Level of Care Eligibility Form" will include the individual's name, address and the date of DMHMRSAS approval. See Appendix 2 for a copy of the "MR Waiver Level of Care Eligibility Form."
- 6. DS Waiver Level of Care Eligibility Form**

For an individual who has been screened and approved for the DS waiver, the "DS Waiver Level of Care Eligibility Form" authorizing Medicaid waiver services will be signed and dated by the DMHMRSAS representative. The "DS Waiver Level of Care Eligibility Form" will include the individual's name, address and the date of DMHMRSAS approval. See Appendix 4 for a copy of the "DS Waiver Level of Care Eligibility Form."
- 7. DD Waiver Level of Care Eligibility Form**

For an individual who has been screened and approved for the DD waiver, a "DD Waiver Level of Care Eligibility Form" authorizing Medicaid waiver services will be signed and dated by a DMAS Health Care Coordinator. The form letter will include the individual's name, address and the date of approval for waiver services. See Appendix 3 for a copy of the "DD Waiver Level of Care Eligibility Form."
- 8. LTC Authorization Not Received**

If the form is not available when placement needs to be made, verbal assurance from a screener or DMAS that the form approving long-term care will be mailed or delivered is sufficient to establish the Medicaid pre-authorization. The date of receipt of such assurance and the name of the person providing the information must be entered in the case record.

If a pre-admission screening is required and the documented or verbal assurance of screening and approval is not received, Medicaid eligibility for an individual who is living in the community must be determined as a community resident using the rules applicable to a non-institutionalized Medicaid applicant.
- 9. LTC Authorization Rescinded**

The authorization for Medicaid-funded long-term care may be rescinded by the physician or by DMAS at any point that the individual is determined to no longer meet the level of care criteria for Medicaid-funded long-term care.

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

Continue to use the institutional eligibility criteria for persons who are in a medical institution even though they no longer meet the level of care criteria. If eligible, Medicaid will not make a payment to the facility for the care.

10. Old Bills

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

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

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

11. Projected Expenses

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

12. Spenddown Liability

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

M1460.200 DETERMINATION OF COVERED GROUP**A. Overview**

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

1. Covered Groups Eligible for Long Term Care Services

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

- a. All categorically needy (CN) covered groups.
- b. All categorically needy non-money payment (CNNMP) covered groups.
- c. ABD with income \leq 80% FPL (ABD 80% FPL).
- d. All medically indigent (MI) Families & Children (F&C) covered groups:
 - pregnant women and newborns under age 1 year,
 - children under age 19.
- e. All medically needy (MN) covered groups; however, Medicaid will not pay for the following services for MN individuals:
 - ICF-MR services,
 - IMD services,
 - MR Waiver services, and
 - DD Waiver services.

**2. Applicants
Who Do Not
Receive Cash
Assistance**

a. Child Under Age 19

If the applicant is a child under age 19, first determine the child's eligibility as an MI child, using the covered group policy in M0320 and the financial eligibility policy in chapters M05 and M07. If not eligible as MI, determine the child's eligibility in the CNNMP 300% SSI group, using the covered group policy in subchapter M0320 and the financial eligibility policy and procedures in this subchapter.

If the child's resources or income exceed the limits for the 300% SSI group, determine the child's eligibility in an MN covered group (subchapter M0330).

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.

b. Individual Age 19 or Older

If the applicant is an individual age 19 or older, determine the individual's eligibility in the 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 300% SSI covered group. If not eligible in the 300% SSI covered group, 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 MN (see M0330) and the limited benefit ABD MI (see M0320) covered groups.

For F&C individuals, first determine the individual's eligibility in the CNNMP 300% SSI group. If the individual's income exceeds the limits for 300% SSI covered group, determine the individual's eligibility in an MN covered group (see M0330).

**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. 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 "Countable Income for the 300% SSI Group," section M1460.611 ARE counted in determining income eligibility for long-term care. The income items listed in "What Is Not Income," section M1460.610 are not counted for the 300% SSI groups (ABD and F&C).

2. 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 "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

7. **Credit Life/Disability Payments** (S0815.300) Payments made under a credit life or credit disability insurance policy on behalf of an individual are not income.
8. **Loan Proceeds** (S0815.350) Proceeds of a bona fide loan are not income to the borrower because of the borrower's obligation to repay.
9. **Third Party Payments**
- a. Payments made by another individual*
- (S0815.400) Payment of an individual's bills (including Medicare supplementary medical insurance or other medical insurance premiums) by a third party directly to the supplier is not income.
- Payments made directly to the service provider by another person for the individual's private room or "sitter" in a medical facility are **not** income to the individual. Refer all cases of Medicaid eligible recipients who have a "sitter" to DMAS, Division of Long-term Care, for DMAS review to assure that DMAS is not paying the facility for services provided by the sitter.
- EXCEPTION:** For F&C covered groups **except** the 300% SSI group: If the person paying the bill(s) is the child's absent father and the Division of Child Support Enforcement (DCSE) has not established an obligation for the absent parent, the amount(s) paid by the absent parent for the child is counted as income.
- b. Long-term care (LTC) insurance payments*
- Institutionalized individuals who have LTC insurance coverage must have the LTC insurance coverage information entered into the recipient's TPL file on MMIS. The insurance policy type is "H" and the coverage type is "N."*
- If the patient receives the payment from the insurance company, it is not counted as income. The patient should assign it to the provider. If the patient cannot do this, or the policy prohibits assignment, the payment should be given directly to the provider facility. The provider should report the payment as a third party payment on its claim form. If the patient received the payment and cannot give it to the provider for some reason, then the patient should send the insurance payment to the DMAS Fiscal Division, Accounts Receivable, 600 E. Broad Street, Suite 1300, Richmond, Virginia 23219.*
10. **Replacement Income** (S0815.450) If an individual's income is lost, stolen, or destroyed and the individual receives a replacement, the replacement is not income if the original payment was counted in determining the individual's Medicaid eligibility.
11. **Erroneous Payments** (S0815.460) A payment is not income when the individual is aware that he is not due the money and returns the check uncashed or otherwise refunds all of the erroneously received money.

- 12. Weatherization Assistance** (S0815.500) Weatherization assistance (e.g., insulation, storm doors, and windows, etc.) is not income.
- 13. Certain Employer Payments** (S0815.600) The following payments by an employer are not income UNLESS the funds for them are deducted from the employee's salary:
- funds the employer uses to purchase qualified benefits under a "cafeteria" plan;
 - employer contribution to a health insurance or retirement plan;
 - the employer's share of FICA taxes or unemployment compensation taxes in all cases;
 - the employer's share of FICA taxes or unemployment compensation taxes paid by the employer on wages for domestic service in the private home of the employer or for agricultural labor only, to the extent that the employee does not reimburse the employer.
- 14. Payments to Victims of Nazi Persecution** Any payments made to individuals because of their status as victims of Nazi persecution are not income [P.L.103-286 and 1902(r)(1)].
- 15. Advance Payments That will Be Reimbursed** Advance payments made by a person other than the patient which are expected to be reimbursed once Medicaid is approved, and payments made by outside sources to hold the facility bed while the patient is hospitalized, are **not counted as income** in determining eligibility or patient pay.
- There are instances when the family of a prospective Medicaid patient, or other interested party(ies), makes an advance payment on the cost of facility care prior to or during the Medicaid application process to assure the Patient's admission and continued care. The individual may have been promised that the advance payment will be refunded if Medicaid eligibility is established. Any monies contributed toward the cost of patient care pending a Medicaid eligibility determination must be reimbursed to the patient or the contributing party by the facility once Medicaid eligibility is established.
- 16. Medical Expense Reimbursement** Medical expense reimbursement from either VA or an insurance policy is not income. Medical expense reimbursements are resources.

The income in items 17 through 23 below are not income by other federal statutes or law:

- 17. Energy Assistance** Energy Assistance through Block Grants (Virginia's Fuel Assistance payments) is excluded [P.L. 93-644].
- 18. Radiation Exposure Trust Fund** Radiation Exposure Compensation Trust Fund payments are excluded [P.L. 101-426].

19. Agent Orange

Agent Orange Payments are excluded [P. L. 101-239].

**20. Native
American
Funds**

The following funds for Native Americans are excluded:

- a. Alaska Native Claims Settlement Act (cash payments not to exceed \$2,000) [P.L. 100-241]
- b. Maine Claims Settlement Act [P.L. 96-420]
- c. Blackfeet and Gros Ventre [P.L. 92-254]
- d. Grand River Band of Ottawa [P.L. 94-540]
- e. Red Lake Band of Chippewa [P.L. 98-123]

NOTE: If Mrs. K's institutionalized spouse is eligible for Medicaid, an allowance for their child may also be deducted from his income in determining his patient pay. However, the income the child receives from Mrs. K will be counted in the child's gross income when determining any allowance from Mr. K.

**B. Married With
Community
Spouse**

For a married patient with a community spouse, go to subchapter M1480.

A community spouse is a person who is not an inpatient in a medical facility and who is married to an institutionalized person.

M1470.230 FACILITY - NONCOVERED MEDICAL EXPENSES

A. Policy

Amounts for incurred medical and dental expenses not covered by Medicaid or another third party are deducted from the patient's gross monthly income when determining patient pay.

**B. Health Insurance
Premiums**

Payments for medical/health insurance which meet the definition of a health benefit plan are deducted from patient pay when:

- the premium amount is deducted from the patient's benefit check;
- the premium is paid from the patient's own funds; OR
- the premium is paid by a relative (other than a spouse or parent for minor child) when that relative receives a benefit payment (income) which includes a benefit amount for the patient.

The amount deducted is the amount of the **monthly** premium. If the patient pays the premium less often than monthly, such as quarterly, prorate the amount paid by the number of months covered by the payment to obtain the monthly amount to deduct in the patient pay calculation.

“Health benefit plan” means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA (Multiple Employer Welfare Arrangement) or plan provided by another benefit arrangement.

Health benefit plan does not mean 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 a 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 (14VAC5-234-30).

Income protection insurance (indemnity) policy premiums are not medical expenses and are not deducted from the patient pay.

**1. Deduct
Medicare Part
A and/or B
Premiums**

Medicare Part B premiums and/or Medicare Part A premiums are paid by Medicaid for eligible recipients. The premiums are paid by Medicaid via the “Buy-in” and are not usually deducted from patient pay. However, Medicaid does not start paying the premiums immediately for all eligible patients, so the Medicare premium(s) must be deducted from patient pay in those months for which Medicaid does not pay the premium.

Deduct the Medicare premium(s) **for the first two months** of ongoing eligibility for the following eligible recipients:

- CNNMP individuals who are **not** dually eligible QMB,
- MN recipients who are **not** dually eligible QMB.

Buy-in is usually effective the second month following the month in which ongoing Medicaid coverage begins for the above recipients. Therefore, the patient will be responsible for premium payment until the Buy-in is effective.

**2. Do Not Deduct
Medicare Part
A and/or B
Premiums**

Do not deduct Medicare premiums for the following eligible recipients:

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

Buy-in is usually effective starting with the first month of Medicaid coverage for the above recipients.

**3. Example--Dual
Eligible QMB**

EXAMPLE #5: Mrs. Q has Medicare coverage and SSA income of \$580 per month. Her Medicare premiums are deducted from her SSA check. She was admitted to the nursing facility on September 9. Her daughter filed a Medicaid application for her on September 10.

Mrs. Q is eligible in the CNNMP 300% SSI group in September and is eligible as QMB. Her Medicare premiums are not deducted for September because they will be paid by Medicaid.

**4. Example--Not
Dual Eligible
QMB**

EXAMPLE #6: Mr. A is 80 years old. He applied for Medicaid on February 20. His Medicare Part B premium is deducted from his SSA check. His gross SSA entitlement is \$1,195. Therefore, he is not eligible as a QMB. He requested, and was found eligible for, retroactive Medicaid because he met the retroactive spenddown on January 3; retroactive coverage ended January 31. He is approved and placed on a 6-month spenddown for the period February 1 through July 31.

His authorized representative reports that he was admitted to a nursing facility on March 5. He met the CNNMP 300% SSI group effective March 1. The worker prorates his spenddown budget period to 1 month - February 1999, and recalculates his spenddown liability. The worker determines that he met the prorated spenddown on February 10.

Enrollment in Medicaid is completed by the agency on March 15, before March cut-off. He is enrolled in Medicaid in *Aid Category (AC) 018*, for the period beginning February 1 and ending February 28. He is reinstated in AC 020.

His patient pay for March (month of entry into the nursing facility) includes a deduction for the Medicare premium. Because he is not QMB eligible, the buy-in is not effective until the second month following the month in which his ongoing Medicaid coverage began. His ongoing coverage began on March 1; the second month following March is May, so the Buy-in will begin in May. His Medicare premium is not deducted from his patient pay for May and subsequent months.

5. Medicare Part D Premiums

Individuals who are eligible for Medicare and Medicaid are entitled to premium-free enrollment in a Medicare Part D basic prescription drug plan (PDP). However, they may elect enrollment in an enhanced plan. Individuals who enroll in an enhanced plan are responsible for that portion of the premium attributable to the enhancement. When a full benefit Medicaid enrollee is enrolled in a Medicare enhanced PDP, the portion of the premium that remains the individual's responsibility is an allowable deduction from patient pay.

6. LTC Insurance Premiums

a. Deduct premium in admission month only

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

b. Individual receives the insurance payment

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

If the individual received the payment and cannot give it to the facility for some reason, then the individual should send the insurance payment to:

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

**C. Non-covered
Medical/Dental
Services**

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

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

**1. Zero Patient
Pay
Procedures**

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

Notify the patient (and the patient's representative, if appropriate) using the "Notice of Obligation for LTC Costs". This form provides notice of the right to appeal the agency's decision.

If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service has been approved, notify the patient or his authorized representative that the deduction for the new noncovered service will be made after the first noncovered service deductions are completed.

**2. Allowable
Non-covered
Expenses**

When a patient has income available for patient pay, the following can be deducted as noncovered expenses:

a. Old Bills

"Old bills" are deducted from patient pay as noncovered expenses. "Old bills" are unpaid medical, dental, or remedial care expenses which:

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

"Old bills" do not require approval from DMAS in order to be deducted in the patient pay calculation even when the amount of the "old bill" exceeds \$500.

b. Medically Necessary Covered Services Provided By A Non-participating Provider

Medically necessary medical and dental services that are covered by Medicaid, but that the *enrollee* received from a provider who does not participate in Virginia Medicaid, are deducted from patient pay as non-covered services.

c. Covered Services Outside of Medicaid's Scope

Medically necessary medical and dental services exceeding Medicaid's amount, duration, or scope can be deducted from patient pay.

d. Other Allowable Noncovered Services

- 1) The following medically necessary medical and dental services that are NOT covered by Medicaid can be deducted from patient pay by the local department of social services without DMAS approval when the cost does NOT exceed \$500. **If the service is not identified in the list below and/or the cost of the service exceeds \$500, send the request and the documentation to DMAS for approval.** DMAS will advise the eligibility worker if the adjustment is allowable and the amount that is to be allowed.
 - routine dental care, necessary dentures and denture repair for recipients 21 years of age and older. **Pre-approval for dental services that exceed \$500 must be obtained from DMAS prior to receipt of the service;**
 - routine eye exams, eyeglasses and eyeglass repair;
 - hearing aids (when medically necessary), hearing aid batteries and hearing aid repair;
 - batteries for power wheelchairs or other power mobility items owned by the recipient, not to exceed four batteries in a 12-month period;
 - chiropractor services, except for Medicare recipients (Medicare covers chiropractor services and Medicaid covers the Medicare deductible and coinsurance amounts);
 - dipyridamole (Persantine) and other prescription medications not covered by Medicaid but ordered by the recipient's physician;
 - **transportation to medical, dental or remedial services not covered by Medicaid.**
- 2) Services received by a Medicaid *enrollee* during a period of limited Medicaid eligibility (e.g., LTC services not covered because of a property transfer) can be deducted in the patient pay calculation by the local agency without DMAS approval even when the amount of the service exceeds \$500.

b. DMAS Approval Not Required

Determine if the expense is deducted from patient pay using the following sequential steps:

- 1) Upon receipt of the requested documentation, determine the amount of the bill that is a valid deduction. Do not deduct more than the available income that remains after the personal needs, dependent child allowance(s), and health insurance premiums are deducted.

If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service is requested, deduct the new noncovered services after the first noncovered service deductions have been completed.

- 2) Subtract the deduction for the month following the month the change is reported. If the deduction exceeds the available income, the remaining balance can be carried over to the following month(s).

c. Notice Procedures

Upon the final decision to allow the deduction, take the following actions:

- 1) Prepare a DMAS-122 for the adjusted patient pay obligation. In the comments section, note that a deduction for the noncovered service has been made.
- 2) Copies of the DMAS-122 are:
 - filed in the case record,
 - sent to the LTC provider,
- 3) Prepare and send the "Notice of Obligation for LTC Costs" form to the patient (and the patient's representative, if appropriate). This form notifies the patient of the adjustment in the patient pay and the right to appeal the adjustment decision.

**6. Allowed
Deduction for
Prescription
Drugs Purchased
Before Medicare
Part D
Enrollment**

Individuals who:

- *qualify for Medicare Part D,*
- *are NOT enrolled in a Medicare Part D PDP, and*
- *are NOT Medicaid eligible at the time of admission to a nursing facility*

will be fully responsible for their drug costs until Medicaid eligibility is determined and the Medicare Part D PDP enrollment process is completed. The individual remains responsible for any drugs purchased prior to the effective date of the PDP enrollment; Medicaid cannot pay for these drugs. The cost of drugs purchased before the PDP begin date can be deducted from patient pay.

7. Medicare Part D Deductions Not Allowed

*Medicaid-enrolled nursing facility patients who are enrolled in a Medicare Part D PDP are **not** responsible for the payment of deductibles or co-pays, nor will they be subject to a coverage gap in their Part D benefits. Do **NOT** deduct from patient pay any Medicare PDP deductibles, co-pays or coverage gap costs.*

If a full-benefit Medicaid/Medicare recipient was subject to PDP co-pays prior to his admission to a nursing facility, he may continue to be assessed co-pays until the PDP is notified of his admission to the nursing facility. Once DMAS has identified him as a nursing facility patient, the PDP will reimburse him for co-pays incurred during the month(s) in which he was in a nursing facility.

If an individual is enrolled in Part D and is in a nursing facility but was not eligible for Medicaid at the time of admission to the nursing facility, he may continue to be charged co-pays or deductibles until the PDP is notified of his eligibility as a full-benefit Medicaid enrollee. The PDP will reimburse him for co-pays or deductibles incurred during the months in which he was determined to be a full-benefit Medicaid enrollee.

M1470.240 FACILITY - HOME MAINTENANCE DEDUCTION

A. Policy

A single institutionalized individual can be allowed a deduction for the cost of maintaining a home for not more than six months, if a physician has certified he or she is likely to return home within that period.

Home maintenance means that the individual has the responsibility to pay shelter costs on his former place of residence in Virginia, such as rent, mortgage, utilities, taxes, room and board, or Adult Care Residence payments, and that the home, apartment, room or bed is being held for the individual's return to his former residence in Virginia. For Adult Care Residence residents in the month of entry to a nursing facility, deduct a home maintenance (MNIL) allowance even if the Adult Care Residence room or bed is not being held.

Only one spouse of an institutionalized married couple (both spouses are in a medical facility) is allowed the deduction to maintain a home for up to six months, if a physician certifies that he is likely to return home within that period.

NOTE: If the individual is receiving the full SSI benefit for the first three months of institutionalization, do not allow a home maintenance deduction in those months.

B. Temporary Care

Temporary care is defined as not exceeding 6 months of institutionalization, beginning the **month** of admission to the medical facility. A physician's written statement that the individual is expected to return to his home within 6 months of admission is required to certify temporary care. When the temporary care period ends, the home maintenance deduction must be discontinued and if necessary resource eligibility reevaluated.

C. Amount Deducted

The home maintenance deduction is the MN income limit for one person in the individual's locality of residence. See Appendix 5 to subchapter M0710 or section M0810.002 A. 4 for the MN income limits.

M1470.300 FACILITY PATIENTS**A. Overview**

This section provides policy and procedures for calculating patient pay for the facility patient.

B. Policy and Procedures

Policy and procedures for determining patient pay in the most common admission situations are contained in the following sections:

- Facility Admission From A Community Living Arrangement (M1470.310)

B. Health Insurance Premiums

Payments for medical/health insurance which meet the definition of a health benefit plan are deducted from patient pay when:

- the premium amount is deducted from the patient's benefit check;
- the premium is paid from the patient's own funds; OR
- the premium is paid by a relative (other than a spouse or parent for minor child) when that relative receives a benefit payment (income) which includes a benefit amount for the patient.

The amount deducted is the amount of the **monthly** premium. If the patient pays the premium less often than monthly, such as quarterly, prorate the amount paid by the number of months covered by the payment to obtain the monthly amount to deduct in the patient pay calculation.

“Health benefit plan” means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA (Multiple Employer Welfare Arrangement) or plan provided by another benefit arrangement.

Health benefit plan does not mean 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 a 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 (14VAC5-234-30).

Income protection insurance (indemnity) policy premiums are not medical expenses and are not deducted from the patient pay.

1. Deduct Medicare Part A and/or Part B Premiums

a. For Ongoing Coverage Periods

For CNNMP and MN recipients, the Medicare Buy-in is effective **2 months after the begin date** of Medicaid coverage. If the begin date of coverage is other than the first day of a month, the Buy-in is effective the first of the month in which the 60th day occurs. Part B premiums (and Part A premiums if the recipient must pay the Part A premium) must be deducted from patient pay in the month(s) in which the Buy-in is not effective.

Deduct the Medicare premium(s) for the first two months of ongoing eligibility for the following recipients:

- CNNMP individuals who are not dually eligible QMB,
- MN recipients who are not dually eligible QMB.

b. MN Spenddowns - Closed Periods of Coverage

The Medicaid Medicare Buy-in does NOT pay for Medicare premiums in closed periods of coverage for LTC patients who are on spenddown and

whose eligibility is *for a closed period*. Deduct the Medicare Part B premiums

(and Part A premiums if the recipient must pay the Part A premium) from patient pay in the month(s) in which the Buy-in is NOT effective.

2. Do Not Deduct Medicare Premiums

a. Cash Assistance and QMB Recipients

For cash assistance and QMB (either just QMB or dually-eligible) recipients, the Buy-in is effective with the begin date of Medicaid coverage. Therefore, do NOT deduct Medicare premiums in the patient pay determination for months in the retroactive and ongoing coverage periods.

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

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

b. Recipients in Retroactive and Closed Periods of Coverage

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

3. Medicare Buy-in Example

EXAMPLE #12: (Using January 2000 figures)

Mr. A is 80 years old and started receiving CBC on February 15. He applied for Medicaid on February 2. His only income is \$644 per month. He has no Medicare Part A premium. His Part B premium is withheld from his SSA benefit. Therefore, his gross SSA entitlement is actually \$688. He is CNNMP eligible, but he is not dually-eligible as QMB.

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

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

4. Medicare Part D Premiums

Individuals who are eligible for Medicare and Medicaid are entitled to premium-free enrollment in a Medicare Part D basic prescription drug plan (PDP). However, they may elect enrollment in an enhanced plan. Individuals who enroll in an enhanced plan are responsible for that portion of the premium attributable to the enhancement. When a full-benefit Medicaid enrollee is enrolled in a Medicare enhanced PDP, the portion of the premium that remains the individual's responsibility is an allowable deduction from patient pay.

**5. LTC Insurance
Premiums**

a. Deduct premium in admission month only

*When an individual has an LTC insurance policy that covers long-term care services received in the home, the individual stops paying premiums beginning the month after he is admitted to the home-based LTC. The premium paid for the policy in the LTC admission month can be deducted from the **admission month's patient pay only**. The LTC insurance premium is not deducted from patient pay for the months following the admission month.*

b. Individual receives the insurance payment

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

If the individual received the payment and cannot give it to the provider for some reason, then the individual should send the insurance payment to:

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

**C. Noncovered
Medical/Dental
Services**

Deductions for the cost of a patient's medically necessary medical or dental services not covered by Medicaid, other insurance (such as Medicare), or another person are subtracted from income to determine patient pay.

See item 6 below for the procedures used to deduct Medicare Part D prescription drug co-pays for patients who have Medicare.

- b. TED stockings (billed separately as durable medical supplies),
- c. acupuncture treatment,
- d. massage therapy,
- e. personal care items, such as special soaps and shampoos,
- f. physical therapy,
- g. speech therapy,
- h. occupational therapy.

4. Documentation Required

a. Requests For Adjustments From A Patient or An Authorized Representative

Request the following documentation from the patient or his representative:

- a copy of the bill;
- the amount still owed by the patient;
- if applicable, the amount owed that was not covered by the patient's insurance;
- proof that the service was medically necessary. Proof may be the prescription, doctor's referral or a statement from the patient's doctor or dentist.

b. Requests For Adjustments From CBC Providers

If the request for an adjustment to patient pay to deduct a noncovered expense is made by a Medicaid CBC waiver service provider or case manager, the request must be accompanied by:

- 1) the recipient's correct Medicaid ID number;
- 2) the current physician's order for the non-covered service (not required for replacement of hearing aid batteries or eyeglass frames or for repair of hearing aids or eyeglasses);
- 3) actual cost information;
- 4) documentation that the recipient continues to need the equipment for which repair, replacement, or battery is requested; and
- 5) a statement of denial or non-coverage by other insurance. The denial may be from the insurance carrier or may be a written statement from the facility that the insurance company was contacted and the item/service is not covered.

If the request from a provider or case manager does not include all the above documentation, return the request to the provider or case manager asking for the required documentation.

5. Procedures

a. Determine Deduction

Determine if the expense is deducted from patient pay using the following sequential steps:

- 1) Upon receipt of the requested documentation, determine the amount of the bill that is a valid deduction. Do not deduct more than the available income that remains after the personal needs, dependent child allowance(s), and health insurance premiums are deducted.

If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service is requested, deduct the new noncovered services after the first noncovered service deductions have been completed.

- 2) Subtract the deduction for the current month. If the deduction exceeds the available income, the remaining balance can be carried over to the following month(s).

b. Notice Procedures

Upon the final decision to allow the deduction, take the following actions:

- 1) Prepare a DMAS-122 for the adjusted patient pay obligation.
- 2) Copies of the DMAS-122 are:
 - filed in the case record,
 - sent to the LTC provider.
- 3) Prepare and send the "Notice of Obligation for LTC Costs" form to the patient (and the patient's representative, if appropriate). This form notifies the patient of the adjustment in the patient pay and the right to appeal the adjustment decision.

6. Medicare Part D Co-pay Deductions

Full benefit Medicaid enrollees who have Medicare, are receiving Medicaid CBC services and are enrolled in a Medicare Part D PDP are responsible for the payment of co-pays, but are not subject to payment of deductibles or a coverage gap in their Part D benefits.

a. Individuals receiving Medicaid CBC as of January 1, 2006

*Individuals who have Medicare, were enrolled in full benefit Medicaid and were receiving Medicaid CBC services as of January 1, 2006, were auto-enrolled into a PDP. The PDP will require copays but will not require payment of deductibles and will apply no coverage gap. When patient pay is calculated, subtract deductions for Medicare Part D **co-pays** only. Do NOT subtract*

Medicare Part D deductibles or coverage gap costs because the patient will not be subject to those charges.

b. Individuals not enrolled in a PDP when Medicaid is approved

Individuals who qualify for Part D but are not enrolled in a PDP at the time of Medicaid approval for CBC services will be fully responsible for their drug costs until Medicaid eligibility is determined and Part D auto-enrollment is processed. The PDP will charge co-pays, but will not charge a deductible or apply a coverage gap. When patient pay is calculated, subtract deductions for Medicare Part D co-pays only. Do NOT subtract Medicare Part D deductibles or coverage gap costs because the patient will not be subject to those charges.

The individual will remain responsible for Medicare Part D-covered drugs purchased prior to the effective date of the Part D PDP enrollment. The cost of these drugs is an allowable deduction from patient pay.

Once enrolled in a Medicare Part D PDP, the individual will be responsible for payment of co-pays. Patient pay deductions can be made for Medicare Part D co-pay amounts in most situations.

c. Monthly Statements

PDPs must issue a periodic (at least monthly) statement to the beneficiary explaining all benefits paid and denied. Part D drugs that are not covered by the PDP may not be covered by Medicaid and, absent other drug coverage, remain the responsibility of the individual. When a PDP denies coverage of a prescription, the beneficiary has the right to request an exception for coverage of the drug. The beneficiary is notified in writing of the decision on any exception requested.

d. Verifying Allowable Co-pays

To determine whether or not prescription expenses can be deducted from patient pay, apply the following rules:

- If the drug expense appears on the statement as a denial, and no exception was requested, **do not** allow the expense.*
- If the drug expense appears on the statement as a denial, and an exception was requested and denied, allow the expense.*

Enrollees should be advised to maintain these monthly statements if they wish to request patient pay adjustments for Medicare Part D co-pays and for drugs for which the PDP denied coverage.

M1470.820 OTHER HEALTH INSURANCE COVERAGE**A. Introduction**

When a Medicaid *enrollee* has a health insurance policy which covers nursing facility care or medical supplies or services included in the facility cost of care, the DMAS-122 to the provider must note this information. The DMAS auditors will use the DMAS-122s when auditing the providers to ensure that DMAS has not duplicated the third party payments.

B. Procedures

When the Medicaid *enrollee* has other health insurance through a private insurer, determine patient pay according to the policy and procedures in this subchapter.

On the DMAS-122, check the box “has other health insurance”.

C. Patient Receives Payment

If the *enrollee* or his authorized representative receives payment directly from the insurer, *and he cannot assign it to the nursing facility*, he must send the payment directly to:

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

The payment is not income for patient pay or eligibility determinations.

D. LTC Insurance Policy

The LTC insurance policy must be entered into the individual’s TPL file on MMIS. The insurance policy type is “H” and the coverage type is “N.” Do not code any other coverage type under this insurance policy in MMIS.

When entered in MMIS on the TPL system, this coverage type works like hospital and physician insurance coverage work. MMIS will not pay the nursing facility’s claim unless the claim form shows how much the policy paid.

See M1470.230 B.5 or M1470.430 B.4 for instructions on when to deduct the LTC insurance premium from patient pay.

M1470.830 VA CONTRACT COVERAGE**A. Introduction**

The Veterans Administration (VA) often pays a nursing facility for a specified number of months to care for a veteran. The VA signs a contract with the nursing facility. The veteran usually applies for Medicaid before the VA contract expires.

When the veteran is eligible for Medicaid, the DMAS-122 to the provider must note this information. The DMAS auditors will use the DMAS-122s when auditing the providers to ensure that DMAS has not duplicated the VA payment.

B. Procedures

The *enrollee's* Medicaid eligibility and patient pay are determined using the policy and procedures in this subchapter. The VA payment to the facility is NOT income.

Medicaid must not duplicate the VA payment to the facility. When the VA contract is in effect in a month during which the patient is Medicaid eligible, write on the DMAS-122: "Note: Veterans Administration contract covers NF care from [specify the dates in the month covered by the VA contract]."

EXAMPLE #22: An unmarried patient in a nursing facility under a VA contract applies for Medicaid in July because the VA contract expires on July 17. He does not have Medicare or any other health insurance. His income is \$950 Civil Service Annuity (CSA) and \$250 VA Aid & Attendance. He is eligible for Medicaid beginning July 1.

The DMAS-122 for July and subsequent months is completed:

\$950	gross income (VA Aid & Attendance is not patient pay income)
- 30	personal needs allowance
\$920	patient pay for July and subsequent months

NOTE: Veterans Administration contract covers NF care from July 1 through July 17.

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 must be completed following the procedures in D.3.c.1) below.

B. Action When A Change Is Reported

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

1. Recalculate the patient pay.
2. If the patient pay remains the same, send written notification to the person handling the patient's income that the patient pay is unchanged.
3. If the patient pay decreases, follow the instructions found in Item C. below. If the patient pay increases, follow the instructions found in Item D. below.

**C. Patient Pay
Decreases**

Reflect a patient pay decrease on the DMAS-122 effective the month following the month in which the change was reported when:

1. When to Adjust

- 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.

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8. Notification Requirements**a. When the Assessment Is Not Completed**

Both spouses and the guardian, conservator or authorized representative must be notified in writing that the assessment was not completed; note the specific reason on the form. Use the form Notice of Medicaid Resource Assessment (#032-03-817).

b. When the Assessment Is Completed

Both spouses and the guardian, conservator, or authorized representative must be notified in writing of the assessment results and the spousal share calculated. Use the form Notice of Medicaid Resource Assessment (#032-03-817). Attach a copy of the Medicaid Resource Assessment form (#032-03-816) to each Notice. A copy of all forms and documents used must be kept in the agency's case record.

M1480.220 RESOURCE ASSESSMENT WITH MEDICAID APPLICATION**A. Introduction**

This section applies to married individuals with community spouses who are inpatients in medical institutions or nursing facilities, who have been screened and approved to receive Medicaid CBC waiver services, or who have elected hospice services. If a married individual with a community spouse is receiving private-pay home-based services, he **cannot** have a resource assessment done without also filing a concurrent Medicaid application.

B. Policy**1. Resource Assessment**

If a resource assessment was **not completed** before the Medicaid application was filed, the spousal share of the couple's total countable resources that existed **on the first moment of the first day of** the first month of the first continuous period of institutionalization that began on or after September 30, 1989, is calculated when processing a Medicaid application for a married institutionalized individual with a community spouse.

If a resource assessment was completed before the Medicaid application was filed, use the spousal share calculated at that time in determining the institutionalized spouse's eligibility.

2. Use ABD Resource Policy

For the purposes of the resource assessment and spousal share calculation, countable and excluded resources are determined for all covered groups using the ABD resource policy in Chapter S11, **regardless of the individual's covered group and regardless of community property laws or division of marital property laws.**

In addition, for married institutionalized individuals with a community spouse, the following resources are excluded for both the resource assessment and the eligibility determination:

- the home and **all** contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SS & SSI payments *received on or after 11/01/05 for nine (9) calendar months following the month in which the individual receives the benefits. For retroactive SSI and SS benefits received **before** 11/01/05, exclude from resources for six (6) calendar months;* and
- up to **\$1,500** of burial funds for each spouse (NOT \$3,500).

Resources owned in the name of one or both spouses are considered available regardless of whether either spouse agrees to sell or liquidate the resource, and regardless of whether either spouse refuses to make the resource available.

C. Appeal Rights

When the resource assessment is completed as part of a Medicaid application and eligibility determination, the spousal share calculation can be appealed pursuant to the existing Client Appeals regulations (VR 460-04-8.7).

D. Eligibility Worker Responsibility

Each application for Medicaid for a person receiving LTC services who has a community spouse requires the completion of a resource assessment to determine the spousal share used in determining eligibility.

The EW must provide the applicant with a written request for verification of:

- all reported countable resources owned by the couple **on the first moment of the first day of the first month** of the first continuous period of institutionalization, and
- all resources owned as of the application month.

The same verification requirements as for all Medicaid applications apply to the resource assessment.

If the applicant reports to the EW that he cannot obtain certain verifications, the EW must determine why he cannot obtain them and what the EW can do to assist the applicant.

E. Procedures

The resource assessment is only a part of the eligibility determination process. The spousal share is calculated as a result of the resource assessment. The spousal share is used in the calculation of the spousal protected resource amount (PRA) and the institutionalized spouse's countable resources.

1. Forms

The applicant or his representative does not complete a Medicaid Resource Assessment Request form. The Medicaid application is the resource assessment request.

Use the Medicaid Resource Assessment form (#032-03-816) to complete the assessment of resources and spousal share calculation at the time of the first continuous period of institutionalization.

D. Expected Contributions From Legally Responsible Relative An expected contribution from a legally responsible relative is not counted unless it is actually contributed to the institutionalized child or spouse. If a separated spouse has income over the spousal maximum maintenance standard (see M1480.410) or a higher amount set by hearing officer or judge, an expected contribution of income is determined using the scale in Appendix 6 to this subchapter. However, the contribution is not counted as income available to the institutionalized spouse for patient pay or the eligibility determination unless it is actually made available to the institutionalized spouse from the separated spouse.

The separated spouse has no expected contribution if his income is less than or equal to the spousal maximum maintenance standard in subchapter M1480 (or a higher amount determined by a DMAS hearing officer or court judge as necessary for the separated spouse's maintenance needs) or if the separated spouse receives an allowance from the institutionalized spouse's income.

M1480.315 THIRD PARTY & LONG-TERM CARE INSURANCE PAYMENTS

A. Payments Made by Another Individual *Payment of an individual's bills (including Medicare supplementary medical insurance or other medical insurance premiums) by a third party directly to the supplier is not income.*

Payments made directly to the service provider by another person for the individual's private room or "sitter" in a medical facility are NOT income to the individual. Refer all cases of Medicaid eligible enrollees in nursing facilities who have a "sitter" to DMAS, Division of Long-term Care, for DMAS review to assure that DMAS is not paying the facility for services provided by the sitter.

B. LTC Insurance Policy Payments *The LTC insurance policy must be entered into the recipient's TPL file on MMIS. The insurance policy type is "H" and the coverage type is "N." When entered in MMIS on the TPL system, MMIS will not pay the nursing facility's claim unless the claim shows how much the policy paid.*

*If the patient receives the payment from the insurance company, it is **not** counted as income. The patient should assign it to the nursing facility. If the patient cannot do this, or the policy prohibits assignment, the payment should be given directly to the nursing facility. The facility should report the payment as a third party payment on its claim form.*

If the patient received the payment and cannot give it to the facility for some reason, then the patient should send the insurance payment to:

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

M1480.320 RETROACTIVE MN INCOME DETERMINATION

- A. Policy**
- The retroactive spenddown budget period is the three months immediately prior to the application month, when none of the months overlap (was included in) a previous MN spenddown budget period in which spenddown eligibility was established. When some of the months overlap a previous MN spenddown budget period in which spenddown eligibility was established, the retroactive spenddown budget period is shortened (prorated) to include only the month (s) which were not included in the previous MN spenddown budget period.
- 1. Institutionalized**

For the retroactive months in which the individual was institutionalized, determine income eligibility on a **monthly basis** using the policy and procedures in this subchapter. A spenddown must be established for a month during which excess income existed.
 - 2. Individual Not Institutionalized**

For the retroactive months in which the individual was NOT institutionalized, determine income eligibility for ABD groups using the ABD policy and procedures in chapter S08. Determine income eligibility for F&C groups using policy and procedures in chapter M07. A spenddown must be established for a month(s) during which excess income existed.
 - 3. Retroactive Entitlement**

If the applicant meets all eligibility requirements, he is entitled to Medicaid coverage for the month(s) in which all eligibility factors were met.
- B. Countable Income**
- Countable income is that which was actually received in the retroactive month(s). Count the income received in the months in which the individual meets all other Medicaid eligibility requirements.
- The countable income is compared to the appropriate income limit for the retroactive month, if the individual was CNNMP in the month. **For the institutionalized MN individual, Medicaid income eligibility is determined monthly.**
- C. Entitlement**
- Retroactive coverage cannot begin earlier than the first day of the third month prior to the application month. When an applicant reports that he received a medical service within the retroactive period, entitlement for Medicaid will begin with the first day of the third month prior to the application month, provided all eligibility factors were met in all three months. If the applicant had excess income in the retroactive period and met his spenddown, he is enrolled beginning the first day of the month in which his retroactive spenddown was met. For additional information refer to section M1510.101.
- D. Retroactive Example**
- EXAMPLE #15:** A disabled institutionalized spouse applies for Medicaid on June 5 and requests retroactive coverage for unpaid medical bills that he incurred in March, April, and May. His disability onset date was April 10. He was institutionalized on April 10. The retroactive period is March, April and May. He is not eligible for March because he did not meet a covered group in March. His countable resources are less than \$2,000 in April, May and June. The income he received in April and May is counted monthly because he was institutionalized in each month.

His April income is calculated and compared to the monthly 300% SSI income limit. It exceeds that limit. His May income is calculated and compared to the monthly 300% SSI income limit; it is within the limit. Therefore, he is placed on a one-month retroactive spenddown for April, and is enrolled in retroactive Medicaid in the CNNMP 300% SSI covered group for May.

M1480.330 MEDICALLY NEEDY INCOME & SPENDDOWN

A. Policy

An institutionalized spouse whose income exceeds the 300% SSI income limit must be placed on a monthly medically needy (MN) spenddown if he meets a medically needy (MN) covered group and has countable resources that are less than or equal to the MN resource limit. His income is over the MN income limit because 300% of SSI is higher than the highest MN income limit for one person for one month.

MN countable income must be calculated to exclude income and portions of income that were counted in the 300% SSI income limit group calculation. Income is determined on a monthly basis and an institutionalized individual's spenddown budget period is one month. The certification period for all long term care cases is 12 months from the last application or redetermination month. This includes MN cases placed on spenddown.

B. Recalculate Income

Evaluate income eligibility for an institutionalized spouse who has income over the 300% SSI income limit using a one-month budget period and the following procedures:

1. ABD MN Covered Groups

The income sources listed in both sections M1460.610 "What is Not Income" and M1460.611 "Countable Income for 300% SSI Group" are NOT counted when determining income eligibility for the ABD MN covered groups. Countable income is determined by the income policy in chapter S08; applicable exclusions are deducted from gross income to calculate the individual's countable income.

The income actually received in the retroactive period is considered for retroactive eligibility. The income expected to be received within the application month is considered when determining eligibility in that month.

February spenddown eligibility evaluated.

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. Aid Category**
- a. If the institutionalized spouse does NOT have Medicare Part A:**
- 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
- b. If the institutionalized spouse has Medicare Part A:**
- Compare the individual's monthly MN countable income to the QMB monthly income limit for 1 person (see M0810.002 for the current QMB limit):
- 1) When income is less than or equal to the QMB limit, enroll using the following ACs:
- Aged = 028
 - Blind = 048
 - Disabled = 068
- 2) When income is greater than the QMB limit, enroll using the following ACs:
- Aged = 018
 - Blind = 038
 - Disabled = 058
- 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 the “Notice of Action on Medicaid” and the “Notice of Obligation for LTC Costs” for the month(s) during which the individual establishes Medicaid eligibility.

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**

\$1,603.75	7-1-05		
\$1,561.25	7-1-04		
- C. Maximum Monthly Maintenance Needs Allowance**

\$2,488.50	1-1-06		
\$2,377.50	1-1-05		
- D. Excess Shelter Standard**

\$481.13	7-1-05		
\$468.37	7-1-04		
- E. Utility Standard Deduction (Food Stamps Program)**

\$253	<i>1 - 3 household members</i>		<i>2-1-06</i>
\$317	<i>4 or more household members</i>		<i>2-1-06</i>
\$227	<i>1 - 3 household members</i>		<i>10-1-05</i>
\$282	<i>4 or more household members</i>		<i>10-1-05</i>

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).

delayed filing was a delay in the *enrollee's* eligibility determination and enrollment. If the applicant is eligible for Medicaid and the coverage begin date is 12 months or more prior to the month during which the *enrollee* is enrolled on the Medicaid computer, the agency must write a letter for the applicant to give to all medical providers who will bill Medicaid for services provided over 1 year ago.

B. Eligibility Delay Letter Requirements

The letter must:

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

C. Procedures

The "eligibility delay" letter and a sufficient number of copies must be given to the *enrollee* to give to each provider who provided a covered medical service to the recipient over one year ago. The provider must attach the letter to the claim invoice in order to receive Medicaid payment for the service. *If the date the letter was prepared by the agency is not included on the letter, the claim will be denied. M1510, Appendix 1 contains a sample eligibility delay letter.*

M1510.200 NOTICE REQUIREMENTS

A. Policy

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

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

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

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

The "Notification of Action on Medicaid *and Family Access to Medical Insurance Security Plan (FAMIS) Programs*" (Form 032-03-008) must be used to notify the applicant:

- that his application has been approved and the effective date(s) of his Medicaid coverage.
- that retroactive Medicaid coverage was approved and the effective dates.
- that his application has been denied including the specific reason(s) for denial.

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

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

**1. MI Children
or Pregnant
Women**

When the application of a medically indigent child or pregnant woman is denied because of excess income, the denial notice ("Notification of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs ") must state the reason for denial. The notice must also include the "Application For Benefits" form and must advise the applicant of the following:

- a. that he/she may complete and file the enclosed application for Medicaid spenddown, and
- b. if he/she files the application (Application For Benefits) within 10 days of this notice, the medically indigent application date will be used as the Medicaid spenddown application date.

**2. Qualified
Medicare
Beneficiaries**

a. Excess resources

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

b. Excess income

- 1) If the QMB's resources are within the medically indigent limit but are over the medically needy limit, and the income exceeds the medically indigent limit, the notice must state that the applicant is not eligible for QMB Medicaid because of excess income, and is not eligible for medically needy spenddown because of excess resources. The notice must specify the dollar amount of the appropriate medically needy resource limit.
- 2) If the QMB's resources are within the medically needy limit, and income exceeds the medically indigent limit, the notice must state that the applicant is not eligible for Medicaid because of excess income, but that the applicant can spenddown his/her income to become eligible. The notice must specify the spenddown amount, the spenddown period begin and end dates, and should include information about how spenddown works (such as the "Virginia Medicaid Handbook" or the spenddown Fact Sheet.

SAMPLE "ELIGIBILITY DELAY" LETTER TO MEDICAL PROVIDERS

- AGENCY LETTERHEAD -

DATE PREPARED: _____

ENROLLEE'S NAME: _____

ADDRESS: _____

SSN: _____

MEDICAID #: _____

MEDICAID COVERAGE DATES: _____

Dear Medicaid Service Provider:

The above named individual was recently enrolled in Medicaid, effective _____. The
(Date)

delay in enrollment was because of a delay in eligibility determination that was beyond the *enrollee's* control.

To obtain Medicaid payment for covered services provided over 12 months ago, *please* attach this letter to your invoice and submit the invoice and letter to:

Attention: Claims Processing Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Thank you for your cooperation.

Sincerely,

Agency Representative

Telephone Number

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

If the child is no longer living with the mother, the child's caretaker must be given the opportunity to file an application and receive an eligibility determination prior to the agency taking action to cancel the child's coverage.

**2. Child Turns
Age 6**

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

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

When an SSI Medicaid *enrollee* loses eligibility for an SSI money payment due to receipt of earned income, continued Medicaid eligibility under the Qualified Severely Impaired Individual (QSII) -1619(b) covered group may exist. A partial review to determine the individual's 1619(b) status in SVES must be completed. To identify a 1619(b) individual, check the "Medicaid Test Indicator" field on the State Verification Exchange System (SVES) WMVE9068 screen. If there is a code of A, B, or F, the individual has 1619(b) status. The eligibility worker must change the AC to the appropriate AC.

M1520.200 RENEWAL REQUIREMENTS

A. Policy

The agency must evaluate the eligibility of all Medicaid *enrollees*, with respect to circumstances that may change, at least every 12 months. An individual's continued eligibility for Medicaid 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.

The first 12-month period begins with the month of application for Medicaid. Subsequent renewals must be completed by the MMIS cut-off date no later than 12 months following the month of the last renewal. Monthly annual renewal lists are generated by the MMIS. These lists notify eligibility workers of *enrollees* due for renewal.

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. Individuals cannot be required to provide information that is not relevant to their ongoing eligibility, or that has already been provided with respect to an eligibility factor that is not subject to change, such as date of birth, Social Security number or United States citizenship.

An *ex parte* renewal is an internal review of eligibility based on available information. By relying on information available, the agency can avoid unnecessary and repetitive requests for information from individuals and families that can add to administrative burdens, make it difficult for individuals and families to retain coverage, and cause eligible individuals and families to lose coverage. Local departments of social services are required to conduct renewals of ongoing eligibility through an **ex parte renewal** process when the local agency has access to on-line systems information for verifications necessary to determine ongoing eligibility, there is no resource test, and *the enrollee* is not receiving long-term care (LTC) services. Individuals in the SSI Medicaid covered group may have an *ex parte* renewal unless they reported ownership of non-exempt real property.

If ongoing eligibility cannot be established through an *ex parte* renewal because the individual's covered group has a resource test or he receives LTC services or the *ex parte* renewal suggests that the individual may no longer be eligible for Medicaid, the agency must provide the individual the opportunity to present additional or new information using the Medicaid Renewal, form #032-03-669, (see M1520, Appendix 2) and verifications necessary to determine ongoing eligibility before the coverage is cancelled. *The Eligibility Review Part A (#032-03-729A) and Eligibility Review Part B (#032-03-729B) forms are acceptable when the individual is required to complete them for another program under which he is receiving benefits.*

B. Renewal Requirements and Time Standard

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

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

1. Ex Parte Renewal Process

The agency must utilize on-line systems information verifications that are available to the agency without requiring verifications from the individual or family and make efforts to align renewal dates for all

3. Suspected Fraud Involving Recipients of Public Assistance **a. Temporary Assistance for Needy Families (TANF) and Auxiliary Grant (AG) Cases**

Cases of suspected fraud involving ineligibility for a TANF or AG payment are the responsibility of the local department of social services. The local agency determines the period of ineligibility for Medicaid, and the DMAS Recipient Audit Unit provides the amount of Medicaid payments made. The amount of misspent Medicaid funds must be included in the TANF or AG fraud cases, whether the action results in prosecution or in voluntary restitution. The final disposition on all money payment fraud cases must be communicated to the Recipient Audit Unit, DMAS, *no later than 5 business days after disposition* for inclusion in federal reporting.

b. Food Stamps, General Relief (GR), Fuel, etc.

For suspected fraud involving Food Stamps, GR, Fuel, or other such assistance which does not directly relate to the provision of Medicaid, the local agency must notify the Recipient Audit Unit of the agency's action on the other assistance case so that Medicaid can take concurrent action if necessary.

C. Medicaid Ineligibility Following Fraud Conviction

1. Period of Eligibility

When an individual has been convicted of Medicaid fraud by a court, that individual will be ineligible for Medicaid for a period of 12 months beginning with the month of fraud conviction. Action to cancel the individual's Medicaid coverage must be taken in the month of conviction or in the month the agency learns of the conviction using cancel reason 14.

2. Who is Ineligible

a. TANF or Families and Children (F&C) Cases

In a TANF or F&C Medicaid case, only the parent/caretaker will be ineligible for Medicaid when the parent/caretaker has been convicted of Medicaid fraud. The TANF payment for the caretaker may not be affected.

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

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

3. Family Unit

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

M1700.300 NON-FRAUD RECOVERY

- A. Definition** The Virginia State Plan for Medicaid defines Non-Fraud Recovery as: "Investigation by the local department of social services of situations involving eligibility in which there is no reason to suspect that there has been deliberate misrepresentation by an applicant/recipient with intent to defraud." These cases are referred to DMAS when there is reason to suspect that an overpayment has occurred. **(42 CFR§431).**
- B. Recovery of Misspent Funds** DMAS has the authority to investigate cases and recover expenditures made for services received by ineligible *enrollees* without fraudulent intent. Among the situations where recovery of expenditures is possible are:
- when eligibility errors are due to recipient misunderstanding,
 - when agency errors are made, or
 - when medical services are received during the appeal process and the agency's cancellation action is upheld.
- C. Recovery of Funds Correctly Paid** Within specific restrictions, DMAS may recover funds correctly paid for medical services received by eligible recipients
- 1. Deceased Recipient's Estate** Under federal regulations and state law, DMAS may make a claim against a deceased *enrollee's* estate when the recipient was age 55 or over. The recovery can include any Medicaid payments made on his/her behalf. This claim can be waived if there are surviving dependents. **(42 CFR 433.36; Va. Code §32.1-326.1 and 32.1-327).**
- 2. Uncompensated Property Transfers** DMAS may seek recovery when a Medicaid *enrollee* transferred property with an uncompensated value of more than \$25,000. The transferees (recipients of the transfer) are liable to reimburse Medicaid for expenditures up to the uncompensated value of the property or resource. The property transfer must have occurred within 30 months of the recipient (transferor) becoming eligible for or receiving Medicaid. **(Va. Code §20-88.02).**
- 3. Local DSS Referral** When an agency discovers a Medicaid case involving property transfers, a Medicaid Fraud Referral form must be completed and sent to:
- Supervisor
Recipient Audit Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

EXTRA HELP INCOME LIMITS ALL LOCALITIES EFFECTIVE 1/24/06 MONTHLY GUIDELINES					
FAMILY SIZE	PERCENT OF FEDERAL POVERTY LEVEL (FPL)				
	100%	135%	140%	145%	150%
1	<i>\$ 816.67</i>	<i>\$1,102.50</i>	<i>\$1,143.33</i>	<i>\$1,184.17</i>	<i>\$1,225.00</i>
2	<i>1,100.00</i>	<i>1,485.00</i>	<i>1,540.00</i>	<i>1,595.00</i>	<i>1,650.00</i>
3	<i>1,383.33</i>	<i>1,867.50</i>	<i>1,936.67</i>	<i>2,005.83</i>	<i>2,075.00</i>
4	<i>1,666.67</i>	<i>2,250.00</i>	<i>2,333.33</i>	<i>2,416.67</i>	<i>2,500.00</i>
5	<i>1,950.00</i>	<i>2,632.50</i>	<i>2,730.00</i>	<i>2,827.50</i>	<i>2,925.00</i>
6	<i>2,233.33</i>	<i>3,015.00</i>	<i>3,126.67</i>	<i>3,238.33</i>	<i>3,350.00</i>
7	<i>2,516.67</i>	<i>3,397.50</i>	<i>3,523.33</i>	<i>3,649.17</i>	<i>3,775.00</i>
8	<i>2,800.00</i>	<i>3,780.00</i>	<i>3,920.00</i>	<i>4,060.00</i>	<i>4,200.00</i>

For family units of more than 8 members, *contact a Medical Assistance Program Specialist.*

MAXIMUM VALUE OF CONTRIBUTED FOOD AND SHELTER

SINGLE/COUPLE	MONTHLY AMOUNT
SINGLE	<i>\$201.00</i>
COUPLE	<i>301.33</i>

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.

Initial eligibility for FAMIS is determined by local DSS, including DSS outstationed sites, or by the FAMIS Central Processing Unit (CPU). 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. There is no retroactive coverage in FAMIS. Case management and ongoing case maintenance, and selection for managed care are handled by the FAMIS CPU.

B. Legal Base

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 Principles

FAMIS covers uninsured low-income children under age 19 who are not eligible for Medicaid and whose gross family income is less than or equal to 200% of the federal poverty level (FPL) for the family size (see M2130.100 for the definition of the FAMIS assistance unit and Appendix 1 for the income limits).

A child is eligible for FAMIS if all of the following are met:

- he is **not** eligible for Medicaid due to excess income;
- he is under age 19 and a resident of Virginia;
- he is uninsured;
- he is **not** a member of a family eligible for health benefits coverage under the State Employee Health Insurance Plan on the basis of a family member's employment with a State agency (see Appendix 2 to this chapter);

- he is **not** a member of a family who has dropped health insurance coverage on him within 4 months of the application without good cause;
- he is **not** an inmate of a public institution;
- he is **not** an inpatient in an institution for mental diseases;
- he meets the Medicaid Nonfinancial Eligibility Requirements in Chapter M02 with certain exceptions; and
- he has gross family income less than or equal to 200% FPL.

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 Medicaid Nonfinancial Eligibility Requirements in Chapter M02 that must be met are:

- citizenship and alienage requirements, *with the exceptions noted in M2120.100 C.1. below*;
- Virginia residency requirements;
- institutional status requirements regarding inmates of a public institution.

C. M02 Exceptions

The exceptions to the Medicaid Nonfinancial Eligibility Requirements in Chapter M02 are:

1. Alienage Requirements

Refer to sections M0220.200, M0220.201 and M0220.202 for information about verifying alien status.

FAMIS alienage requirements are different from the Medicaid alienage requirements. Qualified aliens who entered *the U.S.* before August 22, 1996 meet the alienage requirements and are not subject to time limitations.

- a. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **without regard to time limitations**:
 - refugees (see M0220.310 A. 2),
 - asylees (see M0220.310 A. 4),
 - veteran or active military (see M0220.311),
 - deportation withheld (see M0220.310 A. 6), and
 - victims of a severe form of trafficking (see M0220.313 A.52)
- b. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **after five years of residence in the United States**:

- lawful permanent residents (LPR),
- conditional entrants-aliens admitted pursuant to 8 U.S.C.1153(a)(7),
- aliens paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA, and
- battered aliens, alien parents of battered children, alien children of battered parents.

Unqualified aliens, including illegal and non-immigrant aliens, do not meet the alienage requirements.

Appendix 4, FAMIS Alien Eligibility Chart, lists alien groups that meet or do not meet the alienage requirements.

2. SSN A Social Security number (SSN) or proof of application for an SSN (M0240) is **not** a requirement for FAMIS.

3. Assignment of Rights Assignment of rights to payment for medical care from any liable third party is a condition of eligibility for the child.

4. HIPP Application requirements for the Health Insurance Premium Payment (HIPP) program (M0290) do not apply to 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. State Employee Prohibition A child is ineligible for FAMIS if he is a member of a family eligible for health insurance coverage under any Virginia State Employee Health Insurance Plan on the basis of the family member's employment with a State agency.

4. IMD Prohibition The child cannot be an inpatient in an institution for mental diseases (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 creditable health insurance coverage is dropped within 4 months of the application for FAMIS unless good cause for discontinuing the insurance is demonstrated, *or the child is pregnant*.

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;
- 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. Family Member

When determining whether the child is eligible for coverage under a State Employee Health Insurance Plan, *or whether the discontinuance of health insurance affects the child's eligibility*, family member means:

- parent(s) *with whom the child is living*, and
- a stepparent with whom the child is living if the stepparent claims the child as a dependent on his federal tax return.

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:

- Medicare, Medicaid, 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.

4. Insured means having creditable health insurance coverage or coverage under a health benefit plan.

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 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.);
- be a member of a family eligible for health benefits coverage under a State Employee Health Insurance Plan (a full-time, salaried, classified State employee or a permanent, full-time, salaried State education institution faculty member) [see Appendix 3 to this chapter], or
- without good cause (see item E. below), have had creditable health insurance coverage terminated within 4 months prior to the month of application.

D. Health Insurance Coverage Discontinued

If the child's insurance coverage was discontinued by a parent or other individual who does NOT live with the child, the discontinuance of the insurance does NOT affect the child's eligibility for FAMIS.

A child is ineligible for FAMIS coverage if creditable health insurance coverage was terminated by a family member, as defined in M2120.200 B.3, above, without good cause within four months prior to the month for which eligibility is being established, unless the child was pregnant at the time of application.

Example: A child's health insurance was terminated without good cause in November. A FAMIS application was filed the following February. The child is ineligible for February because his health insurance was terminated within four months of November. He may be eligible in *April* because his insurance was terminated more than four months prior to *April*.

NOTE: For purposes related to FAMIS eligibility, a child is NOT considered to have been insured if health insurance coverage was provided under Medicaid, HIPP, FAMIS, FAMIS Select, or if the insurance plan covering the child does not have a network of providers in the area where the child resides.

E. Good Cause for Dropping Health Insurance

The ineligibility period can be waived if there is good cause for the discontinuation of the health insurance. A parent, guardian, legal custodian, authorized representative, or adult relative **with whom the child lives** may claim to have good cause for the discontinuation of the child(ren)'s health insurance coverage. The local agency *or the CPU* will determine that good cause exists and waive the period of ineligibility if the health insurance was discontinued for one of the following reasons:

- The family member who carried insurance changed jobs or stopped employment, and no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
- The employer stopped contributing to the cost of family coverage and no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
- The child's coverage was discontinued by an insurance company for reasons of uninsurability, e.g., the child has used up lifetime benefits or the child's coverage was discontinued for reasons unrelated to payment of premiums. Verification is required from the insurance company.
- Insurance was discontinued by a family member who was paying the full cost of the insurance premium under a COBRA policy AND no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
- Insurance on the child is discontinued by someone other than the child (if 18 years of age), or, if under age 18, the child's parent or stepparent, e.g. the insurance was discontinued by the child's grandparent, aunt, uncle, godmother, etc. Verification is not required.
- Insurance on the child is discontinued because the cost of the health insurance premiums for all family members exceeds 10% of the family's GROSS monthly income or exceeded 10% of the family's GROSS monthly income at the time the insurance was discontinued.

The parent, legal guardian, authorized representative, an adult relative with whom the child lives, *or the child if age 18*, must sign the application. The adult relative must be related by blood or marriage. *Accept declaration of relationship*; documentation of the relationship is not required. The child's parent or legal guardian may designate in writing an authorized representative to complete and sign the application. The date of the application is the date the application is received at the local DSS, including DSS outstationed sites, or at the FAMIS CPU.

Applications can be mailed to the local DSS or the CPU. A face-to-face interview is not required.

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. 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 or the FAMIS CPU. Cases approved for FAMIS must be transferred to the FAMIS CPU for case management and ongoing case maintenance.

C. Entitlement and Enrollment

Children determined eligible for FAMIS are enrolled for benefits in the Medicaid Management Information System (MMIS) 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. There is no retroactive coverage in the FAMIS program.**

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 > 133% FPL and ≤ 150% FPL
009	child 6 – 19 with income > 133% FPL and ≤ 150% FPL

Because Medicaid and FAMIS are separate programs, Medicaid eligible individuals and FAMIS eligible children cannot share the same case number in the MMIS. When a child is determined eligible for FAMIS and the child has family members enrolled in Medicaid in the MMIS, the FAMIS child must be given a new case number when enrolled in the MMIS. Only children eligible for the same program can share the same base case number in the MMIS.

After the child is enrolled in the MMIS, the local DSS worker must change the MMIS worker number to V000 to transfer the case to the FAMIS CPU. The local DSS worker must not change the FIPS code or make any other change to the case after the case has been transferred to FAMIS in the MMIS

**D. Notification
Requirements**

1. Notice of Action

The local DSS 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 eligible for FAMIS, the notice must inform the family that the case has been transferred to FAMIS and that further information on the program will come from 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 and must be given the opportunity to have a Medicaid medically needy evaluation. Along with the notice, send the Application for Benefits to the family and advise them that if the signed application is returned within 10 *calendar* days, the original application date will be honored.

**2. Transfer to
FAMIS CPU**

Once the enrolled case is transferred in MMIS and the notice is sent to the family, the eligibility worker must send to the FAMIS CPU:

- a. the original application *or ADAPT Statement of Facts*,
- b. *copies of the ADAPT income detail screens from the Application Entry Income Eligibility submenu for each family member who has income*,
- c. *copies of the ADAPT Medicaid Wrap-up screen “MC F&C FAMIS Family Unit Income Test” (AEXXIU)*,
- d. *eligibility evaluation form when the case is not in ADAPT*,
- e. verifications used to determine FAMIS eligibility,
- f. *a copy of the ADAPT NOA, or a copy of the written Notice of Action, that was sent to the applicant about the FAMIS eligibility, and*
- g. the case record transfer form.

Cases must be sent to the FAMIS CPU, FIPS 976, via the courier the day of enrollment or the next working day.

The FAMIS CPU will send the local DSS the signed copy of the case transfer form confirming receipt of the case.

**3. Communica-
tion Between
Local DSS and
FAMIS CPU**

The Children’s Health Insurance Communication form (see Appendix 3 to this chapter) is used to request cancellation of FAMIS coverage of children found eligible for Medicaid, report changes and communicate information between local DSS and the FAMIS CPU.

E. FAMIS Select

Under the FAMIS program, *a family 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 FAMIS CPU 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.

**F. 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.

<p align="center">FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS) INCOME LIMITS ALL LOCALITIES EFFECTIVE 1/24/06</p>				
<p align="center"># of Persons in FAMIS Assistance Unit</p>	<p align="center">FAMIS 150% FPL</p>		<p align="center">FAMIS 200% FPL</p>	
	<p align="center">Annual Limit</p>	<p align="center">Monthly Limit</p>	<p align="center">Annual Limit</p>	<p align="center">Monthly Limit</p>
1	\$14,700	\$1,225	\$19,600	\$1,634
2	19,800	1,650	26,400	2,200
3	24,900	2,075	33,200	2,767
4	30,000	2,500	40,000	3,334
5	35,100	2,925	46,800	3,900
6	40,200	3,350	53,600	4,467
7	45,300	3,775	60,400	5,034
8	50,400	4,200	67,200	5,600
each add'l person add	5,100	425	6,800	567

For applicants under the age of 18, the parent, legal guardian, authorized representative, or an adult relative with whom the child lives must sign the application. The adult relative must be related by blood or marriage.

Documentation of the relationship is not required. The child's parent or legal guardian may designate in writing an authorized representative to complete and sign the application.

For applicants age 18 or older, the applicant, family substitute relative, authorized representative or the guardian can sign the application.

**B. Eligibility
Determination**

**1. Pregnant
Teenager Under
Age 19**

When an application is received for a pregnant teenager who is under age 19, is not eligible for Medicaid and has income in excess of the Medicaid limits, process her eligibility in the following order:

- a. first, process eligibility as a Medicaid MI child under age 19; if not eligible because of excess income, go to item b.
- b. second, process eligibility as a Medicaid MI pregnant woman; if not eligible because of excess income, go to item c.
- c. third, process eligibility as a FAMIS child under age 19; if not eligible because of excess income, go to item d.
- d. fourth, process eligibility as a FAMIS MOMS pregnant woman. In order 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 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, a Notice of Action on Medicaid and FAMIS Programs (NOA), form #032-03-008 (see subchapter M0130, Appendix 1) must be sent to the applicant. The NOA 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**

Because Medicaid and FAMIS MOMS are separate programs, Medicaid eligible individuals and FAMIS MOMS eligible individuals cannot share the same base case number in the Virginia Medicaid Management Information System (MMIS). Only individuals eligible for the same program (Medicaid or FAMIS/FAMIS MOMS) can share the same base case number in the MMIS.

When an individual is determined eligible for FAMIS MOMS and the individual has family members enrolled in Medicaid, the FAMIS MOMS individual must be given a new MMIS base case number when enrolled.

The local DSS worker cannot change the FIPS code or make any other change to the case after the case has been transferred to the FAMIS CPU in MMIS.

**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**

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.

If the pregnant woman is eligible for FAMIS MOMS, the notice must inform the pregnant woman that the case has been transferred to the FAMIS CPU and that further information on the program will come from the FAMIS CPU.

If the pregnant woman is ineligible for both Medicaid and FAMIS MOMS due to excess income, she must be sent a notice that she is not eligible for

FAMIS MOMS INCOME LIMITS ALL LOCALITIES EFFECTIVE 1/24/06		
# of Persons in FAMIS MOMS Assistance Unit	FAMIS MOMS 150% FPL	
	Annual Limit	Monthly Limit
2	\$19,800	\$1,650
3	24,900	2,075
4	30,000	2,500
5	35,100	2,925
6	40,200	3,350
7	45,300	3,775
8	50,400	4,200
each add'l person add	5,100	425