



# COMMONWEALTH of VIRGINIA

## DEPARTMENT OF SOCIAL SERVICES

January 1, 2008

### MEDICAID MANUAL – VOLUME XIII

#### TRANSMITTAL #88

The following acronyms are used in this transmittal:

- ABD – Aged, Blind, Disabled
- AC – Aid Category
- ADAPT – Application Benefit Delivery Automation Project
- COLA – Cost of Living Adjustment
- CNNMP – Categorically Needy Non-money Payment
- CBC – Community-based Care
- CMS – Centers for Medicare and Medicaid Services
- DDS – Disability Determination Services
- DMHMRSAS – Department of Mental Health, Mental Retardation and Substance Abuse Services
- DRA – Deficit Reduction Act of 2005
- DSS – Department of Social Services
- F&C – Families and Children
- FAMIS – Family Access to Medical Insurance Security Plan
- FPL – Federal Poverty Level
- FPS – Family Planning Services
- HIPP – Health Insurance Premium Payment
- LDSS – Local Department of Social Services
- LTC – Long-term Care
- QDWI – Qualified Disabled Working Individuals
- QI – Qualified Individuals
- QMB – Qualified Medicare Beneficiaries
- SLH – State and Local Hospitalization
- SLMB – Special Low Income Medicare Beneficiaries
- SSI – Supplemental Security Income
- SSN – Social Security Number
- TANF – Temporary Assistance for Needy Families
- VDSS – Virginia Department of Social Services
- VIEW – Virginia Initiative for Employment not Welfare

Medicaid Transmittal #88 contains new, revised, clarified, and updated Medicaid eligibility policy as outlined within this letter.

### **New Policy**

The transmittal contains new policy on the retention of case records. The policy was added to recognize the use of electronic record keeping and the importance for program integrity purposes of maintaining thorough documentation of eligibility determination activities.

This transmittal contains the policy on LTC Partnership Policies, effective September 1, 2007, that was published in Broadcast 4453. The DRA gives states the ability to offer Partnership Policies, which are a type of long-term care insurance, as a means of encouraging individuals to plan for their long-term care needs. A major incentive for purchasing a Partnership Policy is that an individual is able to preserve resources at the point that he needs Medicaid to begin covering his long-term care. The amount expended on long-term care services by the Partnership Policy is disregarded dollar-for-dollar in the resource evaluation for an individual applying for Medicaid as an LTC recipient.

This transmittal also contains information about new covered services. Children's Mental Health Program services are available to children who have been discharged from a psychiatric residential treatment facility. The services provide intensive support and treatment to children in home and community settings. These services are **not** considered Medicaid CBC services, and the child's eligibility is not determined as an institutionalized individual (i.e. he is not treated as an assistance unit of one).

Substance abuse services are now covered for adults. Information about the substance abuse services and how to access them was disseminated in Broadcast 4379.

### **Revised Policy**

This transmittal contains revisions to Medicaid policies on citizenship and identity documentation based on the CMS Final Regulations and Guidelines published on July 2, 2007. The major revisions include an expansion of the lists of acceptable citizenship and identity documentation, as well as the use of an affidavit of identity for a disabled individual over age 16 in a residential facility, including a patient in an acute care hospital. The policy for completing a renewal for an enrollee who is unable to provide documentation of citizenship or identity but who is otherwise eligible has been revised to allow the renewal to be completed. Similarly, a Medicaid application may continue to pend beyond the reasonable opportunity period for applicants born outside of Virginia when the LDSS is utilizing the VDSS process for obtaining an out-of-state birth verification.

This transmittal also contains policy on the expanded FPS program, Plan First. Plan First includes FPS-only coverage for men and women of any age who have income less than or equal to 133% of the FPL. The eligible individual cannot have creditable health insurance and cannot have undergone a sterilization procedure. Enrollment in Plan First is not time-limited as long as the person remains eligible. The individual must apply for Plan First on the new Plan First application form. Individuals who are eligible for Medicaid services under Plan First are **not** currently eligible for SLH.

### **Clarifications**

Clarifications to policy contained in this transmittal include the following:

- With the exception of citizenship and identity requirements, applicants must meet all non-financial eligibility requirements by the 45<sup>th</sup> calendar day from the date of application even if a referral was made for a disability determination;

- Individuals receiving CBC services may also be enrolled in MEDICAID WORKS;
- The policy regarding the father of a child conforms to TANF policy;
- The process for the electronic transfer of FAMIS cases, which is also contained in Broadcast 4376;
- The exemption of the SSN requirement for a foster care child voluntarily entrusted to a public or private child-placing agency who meets all other Medicaid eligibility requirements, which is also contained in Broadcast 4352;
- The information that must be submitted with an asset transfer hardship request;
- The procedures to be followed by the LDSS for medical assistance appeals.

### **Updates**

The SSI amounts, ABD deeming standard amount, ABD student child earned income exclusion, CBC personal maintenance allowance, spousal resource standard, spousal resource maximum, maximum monthly maintenance needs allowance, Medicare premiums, and COLA amounts for 2008 are included in this transmittal and are effective January 1, 2008. The updated LTC utility standard deduction, effective October 1, 2007, is also included in this transmittal. The updated amount was announced in Broadcast 4477. The utility standard deduction is used to determine if the community spouse's shelter expenses exceed the excess shelter standard. The revised average monthly nursing facility costs are included in this transmittal. The costs, which were announced in Broadcast 4540 and were effective October 1, 2007, are used to calculate an LTC penalty period when an uncompensated asset transfer has occurred.

### **Effective Date**

Unless otherwise specified in this transmittal letter, the new policy, policy revisions, clarifications, and updates contained in this transmittal are effective for all eligibility determinations completed on or after January 1, 2008.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Chapter M01 Table of Contents pages i, ii	Chapter M01 Table of Contents page i	Revised the Chapter M01 Table of Contents.
Subchapter M0110 Table of Contents pages 1, 2 page 9, 10	Subchapter M0110 Table of Contents pages 1, 2 pages 9-11	Revised the Table of Contents. On page 1, corrected the format. Pages 2 and 9 are reprinted. On pages 10 and 11, added new policy on the retention of case records.
Subchapter M0120 pages 9, 10	Subchapter M0120 pages 9, 10	On page 9, clarified that the ADAPT Statement of Facts may be used as an application for any covered group. On page 10, added the new Plan First application and a link to the form.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0130 pages 1-4 pages 7, 8	Subchapter M0130 pages 1-4 pages 7, 8	Pages 1 and 7 are runover pages. On page 2, clarified that an applicant must meet all non-financial eligibility requirements by the 45 <sup>th</sup> calendar day from the application date regardless of whether a disability referral was made. Page 3 is reprinted. On page 4, clarified the documentation requirements when a verification is not retained in the case record. On page 8, clarified that written evaluations are not used for cases processed in ADAPT.
Subchapter M0210 pages 3, 4	Subchapter M0210 pages 3, 4	Page 3 is reprinted. On page 4, added the link to the “Affidavit Of United States Citizenship Or Legal Presence In The United States” form.
Subchapter M0220 Table of Contents pages 1-4p pages 21, 22	Subchapter M0220 Table of Contents pages 1-4t pages 21, 22	Revised the Table of Contents. Page 1 is reprinted. Pages 4b, 4n-4o and 4r-4t are runover pages. On page 2, clarified the newborns of emergency services aliens policy and the exemption for SSI recipients; the individual must be a current SSI recipient - former SSI recipients are not exempt from the citizenship & identity verification requirements. On page 3, clarified the acceptable documents policy. On page 4, corrected the Appendix number for the list of acceptable documents. On page 4a, clarified the citizenship documentation levels for naturalized citizens and added links to the forms that contain identity affidavit language for children under age 16 and the affidavit for individuals age 16 or older residing in institutions. On pages 4c-4e, clarified the U.S. public birth record documentation and identified the sections pertaining to collective naturalization. On page 4f, added the Level 2 documentation of citizenship via the Child Citizenship Act of 2000. On page 4g, added religious records and early school records to the Level 3 chart. On pages 4h and 4i, clarified the Level 4 documentation requirements. On page

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## Significant Changes

		4j, clarified identity documentation. On page 4k-4m, added three or more corroborating documents, death certificate and special rules for individuals in institutions to the identity documentation chart, and clarified the special rules for children under age 16. On pages 4p and 4q, clarified the reasonable opportunity to provide verification for applicants and recipients. Page 21 is reprinted. On page 22, clarified that a child born to a woman eligible on the child's birth date for Medicaid payment of emergency services only is eligible as a certain newborn.
Subchapter M0240 Table of Contents pages 1, 2	Subchapter M0240 Table of Contents pages 1, 2	Revised the Table of Contents. On pages 1 and 2, clarified that a foster care child who is voluntarily entrusted to a public or private child-placing agency who is unable to obtain an SSN does not have to meet the SSN requirements until the child's adoption is final or the child-placing agency obtains legal custody.
Subchapter M0290 pages 1, 2	Subchapter M0290 pages 1, 2	Page 1 is reprinted. On page 2, removed individuals with CHAMPUS/TRICARE (military) insurance from the list of individuals who are not considered for the HIPPP Program.
Chapter M03 Table of Contents	Chapter M03 Table of Contents	Updated the Table of Contents.
Subchapter M0310 Table of Contents, pages i, ii pages 11-14 pages 23-28 pages 35, 36 Appendix 4 Appendix 5	Subchapter M0310 Table of Contents, pages i, ii pages 11-14 pages 23-28 pages 35, 36 Appendix 4	Page i of the Table of Contents is reprinted. Page ii was revised. Page 11 is a runover page. On page 12, clarified who is a child's father when the mother was married on the child's birth date. On page 13, renumbered the section. Page 14 is reprinted. On page 23, updated the DDS Medicaid Unit fax number. Page 24 is a runover page. On page 25, updated the DDS Medicaid Unit address and clarified that all non-financial eligibility requirements must be met by the 45 <sup>th</sup> calendar day from the date of application. On page 26,

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## Significant Changes

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pages 1, 2  
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pages 35-38  
pages 41-42  
pages 45-46f  
pages 47-50c

Subchapter M0320  
Table of Contents  
pages 1, 2  
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pages 47-50c

clarified the procedures to be followed when DDS rescinds a disability denial. Pages 27 and 28 are runover pages. On page 35, clarified the definition of a parent. Page 36 is reprinted. Appendix 4, the “DDS Referral Form,” was removed, and the “Cover Sheet for Expedited Referral to DDS and DSS” was renumbered and is now Appendix 4.

Revised the Table of Contents. On page 1, added the new name “Plan First” to the Family Planning Services covered group title. Page 2 is a reprint. On page 9, corrected the COLA date used in Example #1. Pages 10 and 11 are reprinted. On page 12, updated the COLA and Medicare premium amounts for 2008. Page 35 is reprinted. On page 36, corrected the AC numbers. On pages 37 and 41, clarified the basis for spenddown periods. Pages 38, 42 and 45 are reprinted. On page 46, removed the prohibition against LTC services for MEDICAID WORKS participants. On page 46a, clarified that premiums are currently not being charged and revised the 1619(b) threshold amount for 2008. Pages 46b and 46c are runover pages. Pages 46d and 46e are reprinted. On pages 46f, 47 and 48, clarified that a newborn child remains eligible for Medicaid as long as the child lives with the mother and they remain in Virginia. On pages 49-50a, revised the Family Planning Services covered group policy and procedures for the new Plan First program. On page 50b, clarified when a child under 19 may be evaluated for FAMIS. Page 50c is a runover page.

Subchapter M0520  
pages 1-6

Subchapter M0520  
pages 1-6

Page 1 is a runover page. On page 2, clarified when a man is an acknowledged father. On pages 2 and 5, clarified that only children who are in psychiatric residential treatment facilities are assistance units of one if

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0530 Appendix 1	Subchapter M0530 Appendix 1	they have been in the facility for 30 or more consecutive days. Page 3 is a runover page. Pages 4 and 6 are reprinted.  Revised the ABD deeming allocations for 2008.
Subchapter M0730 pages 3-6 pages 7, 8	Subchapter M0730 pages 3-6 pages 7, 8	Pages 4, 6 and 8 are runover pages. On pages 3 and 5, clarified that VIEW transitional payments are counted as income. On page 7, added VIEW transitional payments to the list of benefits that are counted.
Subchapter S0810 pages 1, 2	Subchapter S0810 pages 1, 2	On page 1, revised the income limits for the CNNMP Protected covered groups for 2008. On page 2, revised the 300% SSI income limits for 2008.
Subchapter S0815 pages 11, 12	Subchapter S0815 pages 11, 12	On page 11, clarified that capital gains are not income. Page 12 is reprinted.
Subchapter S0820 pages 29-32	Subchapter S0820 pages 29-32	Pages 29 and 32 are reprinted. On pages 30 and 31, revised the Blind or Disabled Student Child Earned Income Exclusion for 2008.
Subchapter S0830 pages 7, 8	Subchapter M0830 pages 7, 8	On page 7, added a reference for capital gains. Page 8 is reprinted.
Subchapter S1110 page 19	Subchapter S1110 page 19	Clarified that capital gains are not income.
Subchapter M1370 pages 1-4	Subchapter M1370 pages 1-4	On page 1, clarified that subsequent spenddown budget periods for QMB, SLMB and QDWI enrollees are based on the date the LDSS receives the renewal form. Page 2 is a runover page. On pages 3 and 4, deleted reference to MMIS automatically canceling coverage of an enrollee who meets a spenddown; the worker must enter the end date of coverage when enrolling the individual who meets a spenddown.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M1410 pages 7, 8	Subchapter M1410 pages 7, 8	Page 7 is a runover page. On page 8, clarified that Children's Mental Health services are not considered LTC.
Subchapter M1450 Table of Contents pages 15, 16 pages 19, 20 pages 23, 24 pages 29-32 pages 39-42 Appendix 1 Appendix 3 Appendix 4, pages 1-3	Subchapter M1450 Table of Contents pages 15, 16 pages 19, 20 pages 23, 24 pages 29-32 pages 39-42 Appendix 1 Appendix 3, pages 1-3	Revised the Table of Contents. On page 15, removed personal effects and household items from the list of transfers that affect eligibility and added information about LTC Partnership Policies. Pages 16 and 19 are reprinted. On page 20, clarified that the purchase of a life estate is considered to have occurred when the life estate is acquired as the result of a single transaction or multiple transactions. Page 23 is reprinted. On page 24, clarified that once a person begins receiving Medicaid LTC services, his personal and medical needs are considered met. On page 29, revised the appendix number in item H. Pages 30 and 31 are reprinted. On page 32, updated the average monthly nursing facility costs. On page 39, clarified that nursing facilities may submit an undue hardship request on behalf of a patient. On pages 40, 41 and Appendix 1 (Asset Transfer Hardship Claim Form), clarified the information that must be submitted with an undue hardship request. Page 42 is reprinted. Appendix 3 (Localities in the Northern Region) was removed, and Appendix 4 (Settlement Statement) was renumbered and is now Appendix 3.
Subchapter M1460 Table of Contents pages 3, 4 pages 35, 36	Subchapter M1460 Table of Contents, pages i and ii pages 3-4a pages 35, 36 Appendix 1 Appendix 2	Revised the Table of Contents. Page 3 is reprinted. On pages 4 and 4a, added section on LTC Partnership Policies. On page 35, revised the Blind or Disabled Student Child Earned Income Exclusion for 2008. Page 36 is reprinted. Appendix 1 (Partnership Disclosure Notice) and Appendix 2 (Long-term Care Partnership Certification Form) are added.

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Subchapter M1470 pages 21, 22	Subchapter M1470 pages 21, 22	On page 21, revised the personal maintenance allowance for 2008. On page 22, added the dollar amounts for the special earnings allowance.
Subchapter M1480 page 8c pages 9, 10 pages 13, 14 pages 17-20 pages 25-28 pages 35-38 pages 65-66 pages 69, 70	Subchapter M1480 page 8c, 8d pages 9, 10 pages 13, 14 pages 17-20 pages 25-28 pages 35-38 pages 65-66 pages 69, 70	Page 8c is a runover page. On page 8d, clarified when a resource assessment is completed. On pages 9 and 14, clarified that resources excluded as an LTC Partnership Policy disregard do not affect the resource assessment. Page 10 is a runover page. Page 13 is reprinted. On pages 17, 19, 20, 26, 27, and 28, clarified that the institutionalized spouse's partnership policy disregard amount is subtracted from the couple's total countable resources. On page 18, updated the spousal resource standards for 2008. Page 25 is a runover page. Page 35 is reprinted. On pages 36 and 37, clarified that the intent to transfer resources must be made in writing prior to the date action is taken on the application. Page 38 is reprinted. Page 65 is reprinted. On page 66, revised the utility standard deduction, effective October 1, 2007, and the maximum monthly maintenance needs allowance for 2008. On page 69, revised the personal maintenance allowance for 2008. On page 70, added the dollar amounts for the special earnings allowance.
Subchapter M1510 Table of Contents Pages 7, 8 Pages 13-15	Subchapter M1510 Table of Contents Pages 7-8a Pages 13-16	Revised the Table of Contents. On pages 7 and 8, clarified the end date of coverage when an individual is admitted to an ineligible institution. Page 8a is a runover page. Page 13 is a reprint. On pages 14-16, added follow-up policy and procedures for foster care children in voluntary entrustments who do not have an SSN.
Subchapter M1520 Table of Contents Pages 1-10	Subchapter M1520 Table of Contents Pages 1-10 Appendix 1	Revised the Table of Contents. On page 1, added instructions to send Plan First information with cancellation notices. Page 2 is a runover page. On page 3,

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M1550 Appendix 1	Subchapter M1550 Appendix 1	clarified the changes that affect eligibility of a certain newborn under age 1. On page 4, added the policy and procedures for pre-release planning for a child in a psychiatric residential treatment facility. On page 4a, added references to the new ABD and F&C renewal forms and to the LTC renewal form. Page 4b is a runover page. On pages 5 and 6, revised the pregnant woman and family planning services review requirements. Page 7 is a runover page. On pages 8 and 9, clarified when to reinstate coverage pending a hearing decision. On page 10, clarified the action taken at the end of a spenddown coverage period. Appendix 1 is added; it contains the “Sample Children’s Mental Health Program Pre-release Referral Form.”
Chapter M16 Table of Contents Pages 1-17	Chapter M16 Table of Contents Pages 1-10	Revised the contact information for the DMHMRSAS Facilities Medicaid Technicians.
Chapter M16 Table of Contents Pages 1-17	Chapter M16 Table of Contents Pages 1-10	Revised the Table of Contents. On pages 1-4, clarified <i>ex parte</i> communication, the local agency conference and continued coverage during the appeal process. On pages 4-10, added section about pre-hearing actions, clarified scheduling the hearing, added a link to the Agency Appeal Summary form, added the agency’s right to legal representation at the hearing, clarified the Hearing Officer’s decision and local agency actions after the decision. Deleted Appendix 1 (Agency Appeal Summary form).
Chapter M17 pages 3, 4	Chapter M17 pages 3, 4	Page 3 is reprinted. On page 4, added information about LTC Partnership Policies.
Chapter M18 Table of Contents pages 3-6 pages 9-17	Chapter M18 Table of Contents pages 3-6 pages 9-17	Revised the Table of Contents. On page 3, clarified that certain individuals receiving CBC services are exempt from managed care. On page 4, updated the

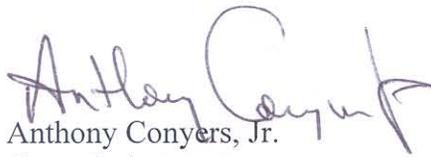
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Significant Changes

		name of FPS. On page 5, added the intranet link for the "Foster Care Child-Exemption from Managed Care" form. On page 6, removed the reference to foster care children. Page 9 is reprinted. On pages 10 and 12, added Children's Mental Health Program services. On page 11, added substance abuse services and changed "optometrist" services to "vision" services. Pages 13-15 are runover pages. On page 16, added substance abuse services. On page 17, changed optometrist services to vision services.
Chapter M20 Appendix 3	Chapter M20 Appendix 3	Updated the Extra Help contributed food and shelter amounts for 2008.
Chapter M21 Pages 1, 2 Pages 9-15	Chapter M21 Pages 1, 2 Pages 9-15	On page 1, clarified that a child can be eligible for FAMIS if his countable income exceeds the FAMIS Plus income limits. Pages 2 and 9 are reprints. On pages 10-13, added FAMIS case transfer procedures for cases in ADAPT. Pages 14 and 15 are runover pages.

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

  
Anthony Conyers, Jr.  
Commissioner

Attachment

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## M01 MEDICAID APPLICATION

### M0110.000 General Information

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## M0110 General Information

### M0110.100 Legal Base and Agency Responsibilities

#### A. Introduction

Medicaid is an assistance program that pays medical service providers for medical services rendered to eligible individuals. The Medicaid eligibility determination consists of an evaluation of an individual's situation that compares each of the individual's circumstances to an established standard. Requests for Virginia Medicaid must be made in written form on an official Medicaid application or in the Application/Benefit Delivery Automation Project (ADAPT) system.

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

#### B. Legal Base

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

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

Exception: DSS carries direct responsibility for the determination of eligibility of certain patients in Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) facilities and for their enrollment in the Medicaid program.

#### C. Agency Responsibilities

##### 1. DMAS

The administrative responsibilities of DMAS are:

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

- the approval of providers authorized to provide medical care and receive payments under Medicaid,
- the processing of claims and making payments to medical providers, and
- the recovery of Medicaid expenditures in appropriate cases. Suspected applicant fraud is a combined responsibility of both DMAS and DSS.

**2. DSS**

The responsibilities of DSS are:

- the determination of initial and continuing eligibility for Medicaid and
- the enrollment of eligible persons in the Medicaid program.

**3. Confidentiality**

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

**a. Release of Client Information**

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

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

**b. Release of Information to Medical Providers**

*Although certain individuals are authorized to receive information about an applicant's/recipient's case, only the minimum data necessary to respond to the request is to be released. Federal regulations stipulate that the disclosure of information about an applicant or recipient can only be for purposes related to administration of the Medicaid State Plan.*

*Information in the case record related to an individual's medical treatment, or method of reimbursement for services may be released to Medicaid providers by DMAS or DSS without the applicant's/enrollee's consent. Enrollee consent is not needed for the agency to provide an updated DMAS-122 to a Medicaid provider or to provide confirmation*

**B. Information Made Available to the Public in General****1. Availability of Manual**

Federal regulations require copies of the State Plan and eligibility rules and policies to be available in agency offices and other designated locations. Policy manuals must be made available in agency offices and other designated locations to individuals who ask to see them.

Upon request, copies of program policy materials must be made available without charge or at a charge related to the cost of reproduction. Copies of manual pages may be made at the local departments of social services, or Medicaid manuals may be ordered from:

Virginia Department of Social Services  
Division of General Services  
730 East Broad Street,  
Richmond, Virginia 23219

**2. Medicaid Handbook and Fact Sheets**

Federal regulation 42 CFR 435.905 requires the state agency to publish bulletins or pamphlets describing eligibility in easy to understand language. The "Virginia Medicaid Handbook" includes basic information about the program and provides a listing of rights and responsibilities. To supplement the "Virginia Medicaid Handbook," fact sheets that explain specific policy areas are available to local social services agencies from the state department of social services. The "Virginia Medicaid Handbook" will be given to all recipients at initial approval and to other individuals upon request. The handbook is also available on the internet at [www.dmas.state.va.us](http://www.dmas.state.va.us).

**C. Inquiries****1. General Inquiries**

The following information has been developed to give guidance to employees of the State and local departments of social services about how to respond to inquiries:

- Limit verbal and written information to explaining the written materials provided. Those written materials may include copies of manual pages, the "Virginia Medicaid Handbook," or fact sheets. The individual may also be referred to the Virginia Department of Social Services website at [www.dss.state.va.us](http://www.dss.state.va.us) and the Virginia Department of Medical Assistance Services website at [www.dmas.state.va.us](http://www.dmas.state.va.us) for additional information.
- Do not go beyond the scope of the written materials. Questions about hypothetical situations, such as (but not limited to) "what would happen if a certain value of resources were transferred?" or "what would be the effect on Medicaid if a trust were written in a certain way?" cannot be answered.

Medicaid rules and policies are applied to the facts of a specific application after an application is received. Prior to receipt, do not give hypothetical advice or answers to hypothetical questions to applicants, their attorneys or anyone applying on behalf of the applicant. Answering hypothetical questions is inappropriate for two reasons:

- Until a complete application is received, the local agency cannot be sure it has all the relevant facts. An attempt to be helpful could be futile or lead to incorrect advice. In the event of a dispute, the applicant may then assert that the agency is bound by the incorrect advice. The applicant or other persons affected by the applicant's actions (such as those affected by a property transfer or those otherwise responsible for the care of the applicant) may attempt to hold the agency employee or employees involved individually liable for damages suffered as a result of alleged negligent advice.
- Providing responses to hypothetical questions may under some circumstances constitute the practice of law. The practice of law includes advising another for compensation, direct or indirect, in any matter involving the application of legal principles to facts or purposes or desires. Local agency workers, regional Medicaid consultants, and central office Medicaid employees, even if they are attorneys, are not functioning as legal counsel and must not give legal advice which may affect the rights of applicants, recipients, or others who may not be applying or eligible for Medicaid.

All Medicaid staff are bound by these guidelines for the dissemination of information. Do not refer inquiries from attorneys, applicants or others acting on behalf of the applicant to regional or state Medicaid staff.

## 2. Case Specific Inquiries

Send questions that occur as a direct result of the receipt of an application to the regional Medicaid consultant. Do not refer questions from attorneys (or legal questions in general) to the Regional Assistant Attorney General. These attorneys are responsible for providing legal advice to the regional Medicaid consultant and are not authorized to give legal advice to the public.

## ***M0110.400 Retention of Case Information***

### ***A. Introduction***

*The agency must maintain case records that contain information necessary to support the facts essential to the determination of initial and continuing eligibility as well as any basis for discontinuing or denying assistance. The case record shall consist of a hard (i.e. paper) record, an electronic record, or a combination of the two. Records of active cases must be maintained for as long as the client receives benefits, while closed records must be maintained for a minimum of three years from the date of closure.*

**B. Policy**

*Case records must contain the following elements:*

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

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

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

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

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

2. **Application/Redetermination For SSI Recipients**

The Application/Redetermination for Medicaid for SSI Recipients, form #032-03-091 (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) is used for SSI recipients. If the applicant is not eligible for Medicaid in the SSI recipients covered group, his eligibility in other Medicaid covered groups, for FAMIS and for SLH can be determined using this application form.
3. **Medicaid Application/Redetermination For Medically Indigent Pregnant Women**

The Medicaid Application/Redetermination for Medically Indigent Pregnant Women, form #032-03-040 (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) is acceptable if submitted for pregnant women. If any additional information is necessary (individual requires a resource evaluation for medically needy spenddown or for SLH), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant.
4. **Health Insurance For Children and Pregnant Women**

The Health Insurance for Children and Pregnant Women, form FAMIS-1 (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) is an application form for children and/or pregnant women. If any additional information is necessary (individual requires a resource evaluation for medically needy spenddown or for SLH), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant.
5. **BCCPTA Medicaid Application**

The 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 2 is provided for reference purposes only).
6. **ADAPT Statement of Facts**

A signed ADAPT Statement of Facts (SOF) *may be used as* an application. 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.
7. **Title IV-E Foster Care & Medicaid Application/Redetermination**

The Title IV-E Foster Care & Medicaid Application/Redetermination, form #032-03-636 (available at: <http://www.localagency.dss.state.va.us/divisions/bp/me/forms/general.cgi>) is used for foster care or adoption assistance children who are eligible under Title IV-E of the Social Security Act. If any additional information is necessary (individual requires a resource evaluation for medically needy spenddown or for SLH), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant's guardian.

Other forms that serve as Medicaid and FAMIS application forms are listed in section M0120.300.C., below.

### C. Other Medicaid Applications

1. **Auxiliary Grant (AG)** An application for AG is also an application for Medicaid. A separate Medicaid application is not required.
2. **Title IV-E Foster Care (FC) and Medicaid Application/Redetermination (Form #032-03-636)** For a FC child whose custody is held by a local department of social services or a private FC agency, or for an adoption assistance (AA) child, the Title IV-E Foster Care & Medicaid Application/Redetermination, form #032-03-636, is used to determine if the child meets *Medicaid* IV-E eligibility requirements. This form is also used to determine Medicaid eligibility for IV-E FC and AA children and non-IV-E FC children in the custody of a local agency in Virginia. This form is **not** used for children in non-custodial agreement cases or non-IV-E AA. When a child enters care through a non-custodial agreement or is a non-IV-E AA child, a separate Medicaid application must be completed and signed by the parent or guardian.

For IV-E FC children in the custody of another state's social services agency and IV-E AA children, a separate Medicaid application is not required. The worker must verify the IV-E maintenance payment (for FC) or the IV-E status (for AA). Virginia residency (by declaration) and current third party liability (TPL) information must be obtained. This information may be supplied by the foster/adoptive parent or obtained from the agency that entered into the FC or AA agreement. For Non IV-E AA children, the parent must file a separate application.

### D. SLH Application Form

The following form has been prescribed as the application form for SLH:

- Application for Benefits, form #032-03-824, also referred to as the Combined Application.

### E. Plan First Application Form

*The Plan First Application is for men and women who wish to apply for Medicaid coverage of family planning services only. Individuals who wish to apply for family planning services must complete and sign the Plan First Application. The Plan First Application form is available on the VDSS intranet at: <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.*

## M0120.400 Place of Application

### A. Principle

The place of application is ordinarily the office of the local social service department serving the locality in which the applicant resides. Verification of residence is not required. Medicaid applications are also taken at designated hospitals and health clinics (Medicaid outstationed sites). If an applicant is homebound and needs assistance with completing the application, the agency, upon request, must arrange to have the application taken where he resides or is a patient.

A child whose residence is divided between two custodial parents living in different localities is considered to reside in the locality in which he attends school. If the child is not enrolled in school, the parents must decide which locality is the child's residence for Medicaid application/enrollment purposes.

## M0130.100 Processing Time Standards

### A. General Principle

Agencies are required by the State Plan to adhere to prescribed standards for the processing of medical assistance (Medicaid and FAMIS/FAMIS MOMS) applications. The amount of time allowed to process an application is based on the covered group under which the application must be evaluated.

### B. Processing Time Standards

#### 1. 10 Day Requirement (Expedited Application)

##### a. Pregnant Women

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

If the pregnant woman also applies for other children or other persons in her family and the agency cannot determine the other persons' eligibility within 10 working days, the agency must determine just the Medicaid eligibility of the pregnant woman within the working 10 days.

The agency must have all necessary verifications within the 10 working days in order to determine eligibility. If the agency does not receive the verifications within the 10 working days, the worker must send the applicant a Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs (NOA), form #032-03-008 (<http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) on the 10th day. The NOA must state why action on the application was not taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 days by which to submit the documentation.

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

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

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

BCCPTA Medicaid applications filed by women who do not meet the description of an individual in the LIFC, MI pregnant women, or the SSI recipients covered groups must be processed within 10 working days of the agency's receipt of the signed application.

BCCPTA Medicaid applications filed by 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 days of the agency's receipt of the signed application.

If the BCCPTA Medicaid application is the only application required and no additional information is required, the eligibility decision must be made

immediately and the applicant must be notified of the decision within 10 working days of the agency's receipt of the application.

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

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

**2. 45/90 Day Requirement**

Applications, including requests for retroactive coverage, must be processed within 45 *calendar* days for all applicants other than pregnant women, women in the BCCPTA covered group, or individuals needing a disability determination.

*For individuals who require a disability determination to meet the covered group requirement, the time standard for processing an application is 90 calendar days. Other non-financial requirements, however, must be met and verified by the 45<sup>th</sup> calendar day, or the application must be denied and DDS must be notified to stop action on the disability determination (see M0310.112 E.2). Exception: allow up to the full 90 calendar days when the individual or agency is unable to obtain documentation of citizenship and/or identity within 45 calendar days of the application date (see M0220.100 D.9).*

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

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

**3. Processing Priority**

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

**4. Time Standard Exceptions**

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

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

If action is not taken within the time standard, the case record must show the cause for the delay and the applicant must be notified in writing of the status of his application, the reason for the delay, and his right of appeal.

When an application is delayed after 90 days because of a disability decision and the agency has determined that excess resources exist at the time the delay notice is sent, the NOA must inform the applicant that he/she has excess resources and the amount. The notice must also state that:

- a final action cannot be taken until the disability decision is made;
- if the applicant is determined to be disabled, he/she will not be eligible unless the excess resources are reduced; and
- he will be notified when the disability decision is made.

### C. Application for Retroactive Coverage

Retroactive Medicaid eligibility must be determined when an applicant for Medicaid or other medical assistance reports that he, or anyone for whom he requests assistance, received a medical service within the three months prior to application. Eligibility for SLH must be determined when the individual is not eligible for Medicaid if the applicant reports receiving a **hospital** service within the 30 days prior to the application date.

The retroactive period is based on the month in which the application is filed with the agency. The retroactive period is the three months prior to the application month.

Retroactive coverage can be requested at any time subsequent to an application even if the application was denied or the applicant signed a statement saying he did not want retroactive coverage. The retroactive period is based on the application month regardless of whether the application was denied or approved.

If the application was denied, the application is reopened for determination of eligibility in the three months prior to the application month. The applicant must provide all verifications necessary to determine eligibility during that period.

If the applicant is found eligible for retroactive coverage and a Medicaid-covered medical service was received over one year prior to the date the retroactive eligibility is determined, the applicant must be given an "Eligibility Delay" letter to give to the medical provider so that Medicaid will pay the claim (use the sample letter on the intranet at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>). Once retroactive eligibility is established, Medicaid coverage begins the first day of the earliest retroactive month in which eligibility exists.

## M0130.200 Required Information and Verifications

### A. Identifying Information

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

#### 1. Name

The name entered in the official case record and computer enrollment systems for *an* applicant must match the *applicant's* name on his Social

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

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

**2. SSN**

The SSN of an individual for whom Medicaid or other medical assistance is requested must be provided by the applicant and verified by the worker through SSA.

**B. Required Verifications**

An individual must provide verifications of most Medicaid eligibility requirements. Before taking action on the application, the applicant must be notified in writing of the required information.

The eligibility worker must allow at least 10 days for receipt of the necessary verifications, but additional time may be allowed depending on the type of information requested. The specific information requested and the deadline for receipt of the verifications must be documented in the case record.

**1. Copy Verification Documents**

Legal documents and documents that may be needed for future eligibility determinations must be copied and preserved for the record. These include citizenship and identity documents, alien status documentation, verification of legal presence, trusts, annuities, contracts, wills, and life insurance policies.

It is not necessary to retain a copy of verifications of income or the current value of resources in the case record. However, if a copy is not retained, the worker must document *electronically or in the case record* the date and method used to obtain the information (viewed, telephone call, etc.), the type of verification, the source, and a description of the information.

**2. Information Not Provided**

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

**C. Verification of Nonfinancial Eligibility Requirements**

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

**1. Verification Not Required**

Verification is not required for:

- Virginia state residency,
- application for other benefits,
- institutional status,
- age for children under age 19,

waivers) are **exempt** from this requirement. **Non-citizens applying for Medicaid payment for emergency services are not subject to the legal presence requirement.** An individual who is applying on behalf of another and is not requesting assistance for himself is not subject to the legal presence requirement.

**2. Documents That Demonstrate Legal Presence**

An applicant may demonstrate legal presence by presenting one of the following documents:

- valid evidence of U.S. citizenship;
- valid evidence of legal permanent resident status;
- valid evidence of conditional resident alien status;
- a valid SSN verified by SSA;
- a U.S. non-immigrant visa;
- a pending or approved application for legal asylum;
- a refugee or temporary protected status document; or
- a pending application for an adjustment of residence status.

**3. Failure to Provide Proof of Legal Presence**

An applicant who cannot provide documentation that he is a citizen or legally present at the time of application must sign an affidavit under oath attesting that he is a U.S. citizen or legally present in the U.S. in order to meet the requirement for proof of legal presence for either:

- a period of 90 days or until it is determined that he is not legally present in the U.S., whichever is earlier; or
- indefinitely if the applicant provides a copy of a completed application for a birth certificate that has been filed and is pending and being actively pursued in accordance with federal or state law. Such extension shall terminate upon the applicant's receipt of a birth certificate or determination that a birth certificate does not exist because the applicant is not a U.S. citizen.

The affidavit form is on the intranet at:

<http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.

NOTE: The individual's address on the affidavit form must be the individual's **residence** address, not the mailing address.

**4. Relationship to Other Medicaid Requirements**

Providing proof of legal presence or submitting a signed affidavit meets the legal presence eligibility requirement. To be eligible for Medicaid, however, the individual must meet all other state and federal Medicaid eligibility requirements. Submission of the affidavit without proof of application for an SSN as required by M0130.200 D. does **NOT** meet the SSN requirement.

**F. Third Party Liability (TPL)**

Applicants must be asked to provide information about any health insurance they may have. The eligibility worker must enter that information into the Medicaid Management Information System (MMIS) TPL file. Verification of health insurance information is not required.

In the event the client is eligible for benefits to be used exclusively for the payment of medical expenses (i.e. an insurance settlement), but there is no

TPL code for that benefit, the worker must email the information to the DMAS TPL Unit at [TPLUnit@dmas.virginia.gov](mailto:TPLUnit@dmas.virginia.gov), or send the information to:

DMAS Third Party Liability Section  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219

**G. Health Insurance  
Payment Program  
(HIPP)**

If a member of the assistance unit is employed more than 30 hours per week and is eligible for coverage under an employer's group health plan the HIPP Application and Medical History Questionnaire must be completed by the applicant. The Insurance Verification Form must be given to the applicant/recipient for completion by the employer (see M0290).

**H. Verification of  
Financial  
Eligibility  
Requirements**

The eligibility worker must verify the following financial eligibility requirements:

- the value of all countable, non-excluded resources;
- all earned and unearned income; and
- asset transfer information for individuals in need of long-term care services, including the date of transfer, asset value, and compensation received.

Social Security and/or Supplemental Security Income must be verified through SSA. The State Data Exchange (SDX) system should only be used as an alternate method when the State Verification Exchange System (SVES) or State Online Query-Internet system (SOLQ-I) cannot be used. If the SDX system is used to verify benefits, the case record must be documented to show why SVES or SOLQ-I was not used.

Chapters M05 through M11 include specific instructions for the verification of resources and income. Subchapter M1450 includes instructions for verifying the transfer of assets.

## **M0130.300 Eligibility Determination Process**

**A. Evaluation of  
Eligibility  
Requirements**

The eligibility determination process consists of an evaluation of an individual's situation that compares each of the individual's circumstances to an established standard or definition. The applicant must be informed of all known factors that affect eligibility.

The evaluation of eligibility requirements must be documented in writing *for cases not processed in the ADAPT system*. The Evaluation of Eligibility (form #032-03-823) may be used. The form is available online at <http://www.localagency.dss.state.va.us/divisions/bp/me/forms/general.cgi>. Agency-created evaluation forms are also acceptable as long as all information needed to determine eligibility is documented on the evaluation form.

*Because ADAPT has a built-in verification log and evaluation record, a written evaluation is not used for cases processed in ADAPT.*

- E. Individual Who Refuses to Pursue Support From an Absent Parent** An individual, other than a medically indigent pregnant woman, applying for Medicaid for herself and on behalf of a child who refuses to cooperate in the pursuit of support from an absent parent, is not eligible for Medicaid. Eligibility could exist if the individual meets a covered group and the individual chooses not to apply for the child.
- F. Individual Found Guilty of Medicaid Fraud** An individual found guilty by a court of Medicaid fraud is not eligible for Medicaid. Ineligibility will last for a period of 12 months beginning with the month of conviction.
- G. Individual Who Has Transferred Assets** An individual who transferred *assets*:
- to become or remain eligible for Medicaid,
  - who did not receive adequate compensation, and
  - who did not meet one of the asset transfer exceptions
- is ineligible for Medicaid payment for long-term care services for a specified period of time unless adequate compensation is received before the time period is over. See Chapter M1450 for asset transfer policy.
- H. Individual Who Refuses to Supply or Apply For an SSN** Any individual, except a child under age 1 born to a Medicaid-eligible mother or an illegal alien, who does not apply for an SSN account number or who fails or refuses to furnish all SSNs to the Department of Social Services is not eligible for Medicaid.

## M0210.150 LEGAL PRESENCE

- A. Legal Presence (Effective January 1, 2006)** Effective January 1, 2006, Section 63.2-503.1 of the Code of Virginia requires most applicants for or recipients of public assistance who are age 19 or older to provide proof of citizenship or legal presence in the U.S. Applicants or recipients age 19 or older for whom medical assistance is requested must prove their citizenship or legal presence. Individuals who, on June 30, 1997, were Medicaid eligible and were residing in long-term care facilities or participating in home and community-based waivers, and who continue to maintain that status (eligible for Medicaid and reside in long-term care facilities or participate in home and community-based waivers) are **exempt** from this requirement. **Non-citizens applying for Medicaid payment for emergency services are not subject to the legal presence requirement.**
- An individual who is applying on behalf of another and is not requesting assistance for himself is not subject to the legal presence requirement.
- B. Documents That Demonstrate Legal Presence** An applicant may demonstrate legal presence by presenting one of the following documents:
- valid evidence of U.S. citizenship;
  - valid evidence of legal permanent resident status;
  - valid evidence of conditional resident alien status;
  - a valid SSN verified by the Social Security Administration (SSA);
  - a U.S. non-immigrant visa;
  - a Resident Alien Card, form I-551, showing lawful permanent residence (green card);
  - a pending or approved application for legal asylum;

- a refugee or temporary protected status document; or
- a pending application for an adjustment of residence status.

**C. Failure to Provide Proof of Legal Presence**

At the time of application, an applicant who cannot provide documentation that he is a citizen or legally present must sign an affidavit under oath attesting that he is a U.S. citizen or legally present in the United States in order to meet the requirement for proof of legal presence for either:

- a period of 90 days or until it is determined that he is not legally present in the U.S., whichever is earlier; or
- indefinitely if the applicant provides a copy of a completed application for a birth certificate within the United States or its territories that has been filed and is pending. The affidavit's validity shall terminate upon the applicant's receipt of a birth certificate or determination that a birth certificate does not exist because the applicant is not a citizen of the United States.

*The Affidavit Of United States Citizenship Or Legal Presence In The United States is available at:*

<http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>

NOTE: The individual's address on the affidavit form must be the individual's **residence** address, not the mailing address.

**D. Relationship to Other Medicaid Requirements**

Providing proof of legal presence or submitting a signed affidavit meets the legal presence eligibility requirement. To be eligible for Medicaid, however, the individual must meet all other state and federal Medicaid eligibility requirements. Submission of the affidavit without proof of application for an SSN as required by M0130.200.D does **NOT** meet the SSN requirement.

## M0210.200 COVERED GROUPS

**A. Introduction**

An individual who meets the nonfinancial eligibility requirements must also meet the definition for a Medicaid covered group. Covered groups include individuals who are age 65 or older, blind, disabled, under age 19, pregnant women, and the parent(s) or caretaker-relative of a dependent child. Medicaid financial eligibility requirements vary depending upon the covered group for which eligibility is being determined.

See chapter M03 for the covered groups' definitions, policy and procedures.

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## M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS

### M0220.001 GENERAL PRINCIPLES

#### A. Introduction

The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) made major changes to the Medicaid eligibility of non citizens of the UNITED STATES. These changes eliminated the permanently residing under color of law (PRUCOL) category of aliens. The level of Medicaid benefits for aliens is based on whether the alien is a “qualified” alien and the alien’s date of entry into the *United States*.

As a result of these federal changes in Medicaid eligibility for aliens, the 1997 Virginia General Assembly enacted legislation to protect Medicaid eligibility for certain aliens who would otherwise lose their Medicaid benefits.

This subchapter (M0220), effective on July 1, 1997, explains in detail how to determine if an individual is a citizen or alien eligible for full Medicaid benefits (referred to as “full benefit aliens”) or emergency services only (referred to as “emergency services aliens”). It contains the entitlement and enrollment procedures for full benefit aliens and emergency services aliens who meet all other Medicaid eligibility requirements.

#### B. Declaration of Citizenship/Alien Status

The Immigration Reform and Control Act (IRCA) requires as a condition of eligibility that the adult applicant who is head of the household (with exceptions below) declare in writing under penalty of perjury whether or not the individual(s) for whom he is applying is a citizen or national of the United States, and if not, that the individual is a lawfully admitted alien. For children under 18 years of age, the declaration is made by an adult family member. *The declaration statement is on the application form.*

EXCEPTION: An individual who is an “unqualified” alien (as defined in section M0220.410) does NOT complete the declaration.

**Individuals who are required to sign the declaration and who fail or refuse to sign are NOT eligible for any Medicaid services.**

#### C. Procedures

The policy and procedures for determining whether an individual is a citizen or a “full benefit” or an “emergency services” alien are contained in the following sections:

M0220.100 Citizenship & Naturalization;  
M0220.200 Alien Immigration Status;  
M0220.300 Full Benefit Aliens;  
M0220.400 Emergency Services Aliens;  
M0220.500 Aliens Eligibility Requirements;  
M0220.600 Full Benefit Aliens Entitlement & Enrollment;  
M0220.700 Emergency Services Aliens Entitlement & Enrollment.

## M0220.100 CITIZENSHIP AND NATURALIZATION

#### A. Introduction

A citizen or naturalized citizen of the *United States* meets the citizenship requirement for Medicaid eligibility, and is eligible for all Medicaid services if he meets all other Medicaid eligibility requirements.

**1. Citizenship and Identity Verification Required**

The Deficit Reduction Act (DRA) of 2005 requires that effective July 1, 2006, all Medicaid applicants and enrollees who declared citizenship at the time of application, or for whom citizenship was declared at the time of application, present satisfactory evidence of citizenship and identity.

Non-Title-IV-E Special Medical Needs (Adoption Assistance) children who apply for or receive Medicaid must have in their case record a declaration of citizenship or qualified immigration status AND documentary evidence of the children's citizenship or declared qualified immigration status. Non-Title-IV-E Special Medical Needs children must also verify identity.

**2. Exceptions to Verification Requirements**

The citizenship and identity of the following groups of individuals do NOT need verification:

- a. all foster care children and IV-E Adoption Assistance children (*non-Title-IV-E adoption assistance and Non-Title-IV-E Special Medical Needs children must verify their citizenship and identity*);
- b. newborns who meet the Medically Indigent (MI) Newborn Children in section M0320.301 or Medically Needy (MN) Newborn Children in section M0330.302, covered groups because a Medicaid application is not required for these newborns;
- c. Medicare beneficiaries, Social Security Disability Insurance (SSDI) beneficiaries and SSI recipients *currently entitled to SSI payments (this does NOT include former SSI recipients)* if the local department of social services (LDSS) has verification from the Social Security Administration (such as a SVES response) of the individual's Medicare enrollment, SSDI entitlement or current SSI recipient status.

**NOTE:** A parent or caretaker who is applying for a child, but who is NOT applying for Medicaid for himself is NOT required to verify his or her citizenship and identity; the parent or caretaker must verify only the child's citizenship and identity, unless the parent signs an Affidavit of Citizenship on Behalf of Medicaid Applicants and Recipients attesting to a Medicaid applicant/recipient's citizenship.

**B. Procedures**

**1. Individual Born in the United States**

An individual born in the United States, any of its territories (Guam, Puerto Rico, United States Virgin Islands, or Northern Mariana Islands), American Samoa, or Swain's Island is a United States citizen.

A child born to an emergency services alien mother, who is eligible only for Medicaid payment of her labor and delivery services, *is deemed eligible for Medicaid as a "certain newborn" through age one as long as the child continues to reside with his mother and the mother and child continue to reside in Virginia. See M0320.301.*

**NOTE:** A child born in the United States to non-citizen parents who are in the United States as employees of a foreign country's government may not meet the United States citizen requirement. When a child born in the United States to non-citizen parents is a United States citizen by birth, the child may not meet the Virginia residency requirements in M0230.201 because of the parents' temporary stay in the United States.

**2. Individual Born Outside the U.S.**

**a. Individual Born to or Adopted by U.S. Citizen Parents**

A child or individual born outside the United States to U.S. citizen parents (the mother, if the child was born out-of-wedlock) automatically becomes a citizen by birth. A child under age 18 years who is a lawful permanent resident, who is currently residing permanently in the U.S. in the legal and physical custody of a U.S. citizen parent, and who meets the requirements applicable to adopted children under immigration law automatically becomes a citizen when there is a final adoption of the child, and does not have to apply for citizenship.

**b. Individual Born to Naturalized Parents**

A child born outside the United States to alien parents automatically becomes a citizen after birth, if his parents (the mother, if the child was born out-of-wedlock) are naturalized before he becomes 16 years of age.

**c. Naturalized Individual**

A child or individual born outside the U.S. and not automatically a citizen as in a) or b) above, must have been naturalized to be considered a citizen.

**3. Verification Required One Time**

At the time of application, the applicant must be given a reasonable opportunity to present documents establishing U.S. citizenship and identity. An individual who is active in Medicaid and who was enrolled in Medicaid prior to July 1, 2006, must present documentation of his citizenship and identity at the time of the first redetermination of eligibility occurring on or after July 1, 2006. Once documentation has been provided and recorded in the case record, it is not necessary to obtain documentation again. Documentary evidence may be accepted without requiring the applicant or recipient to appear in person.

**C. Documents Establishing U.S. Citizenship and Identity**

**1. Citizenship Document**

To establish U.S. citizenship, the document must show:

- a U.S. place of birth, or
- that the person is a U.S. citizen.

NOTE: Children born in the U.S. to foreign sovereigns or diplomatic officers are **not** U.S. citizens.

NOTE: A state driver's license issued by any state or territory, including Virginia, does NOT prove citizenship. It will satisfy requirements for proof of identity if the license has either a photograph of the individual or other identifying information about the individual such as name, age, sex, race, height, weight or eye color.

**2. Identity Document**

To establish identity, a document must show evidence that provides identifying information that relates to the person named on the document.

**3. Acceptable Documents**

All documents must be either originals or copies certified by the issuing agency. Photocopies of original documents, including notarized copies, **are not** acceptable. *The original must be viewed by the agency or other authorized staff and a copy made of the original; the copy must have written on it the date the original was seen and the name and title of the individual who saw the original.*

**Exception:** A copy of a **Virginia birth certificate** that is in the existing LDSS agency record, or is presented by an individual as verification, is acceptable temporarily while the LDSS agency is waiting for certification of the copy as a true copy by the Virginia Department of Health (VDH). The agency may approve or renew coverage if the individual meets **all** other eligibility requirements.

The agency must obtain certification of the copy by VDH, and the certified copy must be placed in the record when received. The procedures for obtaining VDH certification are contained in the Citizenship and Identity Verification Procedures document posted on the LDSS Intranet.

Acceptance of a photocopied birth certificate does not apply to individuals born outside of Virginia or for documentation of an individual's identity.

**4. Levels of Acceptable Documents**

The tables in section D, below, list acceptable evidence of U.S. citizenship and identity in the order of their reliability level. Level tables 1-4 address citizenship; Level table 1 and Chart 5 address identity.

If an individual presents documents from Level 1, no other information is required. If an individual presents documents from Levels 2-4, then an identity document from Chart 5 must also be presented. Level tables 1-4 establish the hierarchy of reliability of citizenship documents.

The following instructions specify when a document of lesser reliability may be accepted by the agency. An asterisk by the document in the charts means that the document is listed in the law, section 6036 of DRA 2005 (public law No. 109-171).

See the Level 2 section for documents that prove citizenship by collective naturalization.

See M0220, Appendix 7 for information about the documents, the document issuer, and contact information for each document.

**5. How to Verify Citizenship and Identity**

First, ask the individual if he has a Level 1 document listed – U.S. Passport, Certificate of Naturalization or a Certificate of Citizenship. If the individual presents the original of one of these documents, he has verified his citizenship and identity.

**6. How to Verify Citizenship**

If the individual does not have one of the Level 1 documents, ask if he has one of the Level 2 documents to prove citizenship. If the individual presents the original of one of the documents in Level 2, he has verified his citizenship, but not his identity. He must present a document from Chart 5 to verify his identity.

If the individual does not have one of the Level 2 documents, ask if he has one of the Level 3 documents to prove citizenship. If the individual presents the original of one of the documents in Level 3, he has verified his citizenship, but not his identity. He must present a document from Chart 5 to verify his identity.

If the individual does not have one of the Level 3 documents, ask if he has one of the Level 4 documents to prove citizenship, which includes a written affidavit. If the individual presents the original of one of the

documents in Level 4, he has verified his citizenship, but not his identity. He must present a document from Chart 5 to verify his identity.

If the individual does not present one of the Level 4 documents to verify citizenship, he is not eligible for Medicaid because he has failed to provide documentary evidence of citizenship. **However, see section E that follows before denying or cancelling Medicaid because of failure to verify citizenship.**

*NOTE: Naturalized citizens are limited to the documents in Level 1, Level 2 and the citizenship affidavit in Level 5 because they were not born in the United States. They should not have the documents listed in Levels 3 and 4, and they should not have any of the Level 5 documents except for the affidavit.*

#### 7. How to Verify Identity

If the individual presents the original of one of the documents in Levels 2, 3, or 4, he has verified his citizenship, but not his identity. He must present a document from Chart 5 to verify his identity.

##### a. Children Under Age 16

A written affidavit for a child under age 16 *may be used to verify the child's identity if an affidavit was not used to prove the child's citizenship and the identity affidavit language is not on the application or renewal form submitted by the individual.* The Affidavit of Identity for Medicaid Applicants and Recipients Under Age 16 is on the intranet at: <http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/032-03-0282-02-eng.pdf>.

*The Health Insurance for Children and Pregnant Women application form, form number 032-03-0401, has been updated to include the identity affidavit language. The application form is available on the intranet at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/famis.cgi>. The Families & Children Medicaid and FAMIS Plus Renewal form contains the identity affidavit language. The form is available on the intranet at: <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.*

##### b. Individuals Age 16 or Older

**An affidavit of identity cannot be used for an individual age 16 or older, except when the individual resides in an institution. This form is available on SPARK at:**

<http://spark.dss.virginia.gov/divisions/bp/me/citizenship/forms.cgi>. If the applicant is age 16 or older, the agency must assist the applicant in obtaining an identity document. If the individual does not present one of the documents in Chart 5 to verify identity, he is not eligible for Medicaid because he has failed to provide documentary evidence of identity. **See section E below before denying or cancelling Medicaid because of failure to verify identity.**

#### D. Hierarchy of Documentation

The agency's contact with the client about citizenship documents must follow the hierarchy of documentation. If the client does not have a Level 1, Level 2 or Level 3 citizenship document, the client must tell the agency why he or she cannot obtain these documents. The agency must write in the case record why the client cannot get Level 1, 2 or 3 document in order to explain why a Level 4 document was used (Level 4 includes the affidavits of citizenship).

**NOTE:** Applicants or recipients born outside the United States must submit a document listed under Level 1 - **primary evidence** of United States citizenship.

There is no hierarchy for the documentation of identity. For children under age 16, an affidavit of identity signed by the parent is acceptable whether or not other forms of identification may exist (see M0220.100 D.5 below).

**1. LEVEL 1 –  
Primary  
Documents to  
Establish Both  
United States  
Citizenship  
and Identity**

Level 1 primary evidence of citizenship and identity is documentary evidence of the highest reliability that conclusively establishes that the person is a United States citizen. Obtain primary evidence of citizenship and identity before using secondary evidence. Accept any of the documents listed in the Level 1 table as primary evidence of both United States citizenship and identity if the document meets the listed criteria and there is nothing indicating the person is not a United States citizen (e.g., lost United States citizenship).

NOTE: Persons born in American Samoa (including Swain's Island) are generally United States non-citizen nationals. References in this guidance to "citizens" should be read as references to non-citizen nationals.

NOTE: References to documents issued by the Department of Homeland Security (DHS) include documents issued by its predecessor, the Immigration and Naturalization Services (INS). On March 1, 2003, the former INS became part of DHS, and its naturalization function was assumed by United States Citizenship and Immigration Services (USCIS) within DHS. However, even documents issued after this date may bear INS legends.

**Applicants or recipients born outside the United States who were not citizens at birth must submit a document listed under primary evidence of United States citizenship.**

<b>LEVEL 1 – Primary Documents</b>	<b>Explanation – Level 1</b>
* United States Passport	<p>The Department of State issues this. A United States passport does not have to be currently valid to be accepted as evidence of United States citizenship, as long as it was originally issued without limitation.</p> <p>Note: Spouses and children were sometimes included on one passport through 1980. United States passports issued after 1980 show only one person. Consequently, the citizenship and identity of the included person can be established when one of these passports is presented.</p> <p>Exception: Do not accept any passport as evidence of United States citizenship when it was issued with a limitation. However, such a passport may be used as proof of identity.</p>
* Certificate of Naturalization (N-550 or N-570)	<p>Department of Homeland Security issues this document for naturalization. NOTE: A Certificate of Naturalization may not have a number on it. Form numbers N-550 and N-570 are no longer used. DHS now uses form number N-565. The application form for naturalization is now N-400.</p>

* Certificate of Citizenship (N-560 or N-561)	Department of Homeland Security issues certificates of citizenship to individuals who derive citizenship through a parent.
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**2. LEVEL 2 - Secondary Documents to Establish United States Citizenship**

Level 2 secondary evidence of citizenship is documentary evidence of satisfactory reliability that is used when primary evidence of citizenship is not available. Available evidence is evidence that exists and can be obtained within the application processing time frame (see section M0130.100). **A second document establishing identity MUST also be presented (see Chart 5, Evidence of Identity).**

Accept any of the documents listed in the Level 2 table as secondary evidence of United States citizenship if the document meets the listed criteria and there is nothing indicating the person is not a United States citizen (e.g., lost United States citizenship).

NOTE: Applicants or recipients born outside the United States must submit a document listed under **primary evidence** of United States citizenship.

<b>LEVEL 2 – Secondary Documents</b>	<b>Explanation – Level 2</b>
A United States public birth record	<p>A United States public birth record showing birth in:</p> <ul style="list-style-type: none"> <li>• one of the 50 United States;</li> <li>• District of Columbia;</li> <li>• Puerto Rico (if born on or after January 13, 1941);</li> <li>• Guam (on or after April 10, 1899).</li> <li>• Virgin Islands of the United States (on or after January 17, 1917);</li> <li>• American Samoa;</li> <li>• Swain's Island; or</li> <li>• Northern Mariana Islands (after November 4, 1986 (NMI local time)).</li> </ul> <p>The birth record document may be <i>recorded</i> by the State, Commonwealth, Territory or local jurisdiction. It must have been <i>recorded</i> before the person was 5 years of age. A <i>delayed</i> birth record document that is <i>recorded</i> after 5 years of age is considered fourth level evidence of citizenship.</p> <p>Plastic birth certificate cards issued by the Virginia Department of Health are valid birth certificates. A copy of the card is to be placed in the case record, with a note that the original card was viewed. Other states may have issued similar plastic birth certificate cards. If an individual presents a plastic birth certificate card from another state, verify with that state’s office of vital records that such cards are issued by the state.</p>
	<b>NOTE: Individuals born to foreign diplomats residing in one of the states, the District of Columbia, Puerto Rico, Guam or the Virgin Islands are not citizens of the United States.</b>
<i>Collective Naturalization</i>	If the document shows the individual was born in Puerto Rico, the Virgin Islands of the United States, or the Northern Mariana Islands before these areas became part of the United States, the individual may be a collectively naturalized citizen. Collective naturalization

LEVEL 2 – Secondary Documents	Explanation – Level 2
<i>Collective Naturalization</i>	occurred on the dates listed for each of the Territories. The following will establish United States citizenship for collectively naturalized citizens:
	<p><b>a. Puerto Rico:</b></p> <ol style="list-style-type: none"> <li>1) Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's statement that he or she was residing in the United States, a United States possession or Puerto Rico on January 13, 1941; or</li> <li>2) Evidence that the applicant was a Puerto Rican citizen and the applicant's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain.</li> </ol> <p><b>b. United States Virgin Islands:</b></p> <ol style="list-style-type: none"> <li>1) Evidence of birth in the United States Virgin Islands, and the applicant's statement of residence in the United States, a United States possession or the United States Virgin Islands on February 25, 1927; or</li> </ol>
	<ol style="list-style-type: none"> <li>2) The applicant's statement indicating residence in the United States Virgin Islands as a Danish citizen on January 17, 1917 and residence in the United States, a United States possession or the United States Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; or</li> <li>3) Evidence of birth in the United States Virgin Islands and the applicant's statement indicating residence in the United States, a United States possession or Territory or the Canal Zone on June 28, 1932.</li> </ol> <p><b>c. Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)):</b></p> <ol style="list-style-type: none"> <li>1) Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the United States, or a United States Territory or possession on November 3, 1986 (NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or</li> <li>2) Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or</li> </ol>

LEVEL 2 – Secondary Documents	Explanation – Level 2
<i>Collective Naturalization</i>	<p>3) Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time).</p> <p>4) NOTE: If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a United States citizen.</p>
*Certification of Report of Birth (DS-1350)	The Department of State issues a DS-1350 to United States citizens in the United States who were born outside the United States and acquired United States citizenship at birth, based on the information shown on the FS-240. When the birth was recorded as a Consular Report of Birth (FS-240), certified copies of the Certification of Report of Birth Abroad (DS-1350) can be issued by the Department of State in Washington, D.C. The DS-1350 contains the same information as that on the current version of Consular Report of Birth FS-240. The DS-1350 is not issued outside the United States.
*Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240)	The Department of State consular office prepares and issues this. A Consular Report of Birth can be prepared only at an American consular office overseas while the child is under the age of 18. Children born outside the U.S. to U.S. military personnel usually have one of these.
*Certification of Birth Issued by the Department of State (Form FS-545 or DS-1350)	Before November 1, 1990, Department of State consulates also issued Form FS-545 along with the prior version of the FS-240. In 1990, U.S. consulates ceased to issue Form FS-545. Treat an FS-545 the same as the DS-1350.
U.S. Citizen Identification Card	(This form was issued as Form I-197 until the 1980s by INS. Although no longer issued, holders of this document may still use it consistent with the provisions of section 1903(x) of the Act. Note that section 1903(x) of the Act incorrectly refers to the same document as an I-97). INS issued the I-179 from 1960 until 1973. It revised the form and renumbered it as Form I-197. INS issued the I-197 from 1973 until April 7, 1983. INS issued Form I-179 and I-197 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.
Northern Mariana Card (I-873)	Issued by the DHS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 4, 1986). The former Immigration and Naturalization Service (INS) issued the I-873 to a collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986. The card is no longer issued, but those previously issued are still valid.
American Indian Card (I-872)	(Issued by DNS to identify a member of the Texas Band of Kickapoos living near the U.S./Mexican border). DHS issues this card to identify a member of the Texas Band of Kickapoos living near the

LEVEL 2 – Secondary Documents	Explanation – Level 2
	U.S./Mexican border. A classification code "KIC" and a statement on the back denote U.S. citizenship.
Final adoption decree showing the child’s name and a U.S. place of birth	The adoption decree must show the child's name and U.S. place of birth. In situations where an adoption is not finalized <b>and</b> the State in which the child was born will <b>not</b> release a birth certificate prior to final adoption, a statement from a State-approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.
Evidence of civil service employment by the U.S. government	The document must show employment by the U.S. government <b>before June 1, 1976.</b>
Official Military record of service	The document must show a U.S. place of birth (for example a DD-214 or similar official document showing a U.S. place of birth).
<i>Child Citizenship Act of 2000</i>	<p><i>Adopted or biological children born outside the U.S. may establish citizenship obtained automatically under section 320 of the Immigration and Nationality Act (8 U.S.C. § 1431), as amended by the Child Citizenship Act of 2000 (Pub. L. 106-395, enacted October 30, 2000). The agency must obtain documentary evidence that verifies that at any time on or after February 27, 2001, the following conditions have been met:</i></p> <ul style="list-style-type: none"> <li>• <i>At least one parent of the child is a United States citizen by either birth or naturalization (as verified under the Medicaid eligibility requirements);</i></li> <li>• <i>The child is under the age of 18;</i></li> <li>• <i>The child is residing in the United States in the legal and physical custody of the U.S. citizen parent;</i></li> <li>• <i>The child was admitted to the United States for lawful permanent residence (as verified under the requirements of 8 U.S.C. 1641 pertaining to verification of qualified alien status); and</i></li> <li>• <i>If adopted, the child satisfies the requirements of section 101(b)(1) of the Immigration and Nationality Act (8 U.S.C. § 1101(b)(1) pertaining to international adoptions (admission for lawful permanent residence as IR-3 (child adopted outside the United States)), or as IR-4 (child coming to the United States to be adopted) with final adoption having subsequently occurred).</i></li> </ul>

**3. LEVEL 3 – Third Level Documents to Establish U.S. Citizenship**

Level 3 third level evidence of U.S. citizenship is documentary evidence of satisfactory reliability that is used when neither primary nor secondary evidence of citizenship is available. Third level evidence may be used **ONLY** when the following conditions exist:

- primary evidence cannot be obtained within the State's reasonable opportunity period (see reasonable opportunity discussion below),

- secondary evidence does not exist or cannot be obtained, **and**
- the applicant or recipient alleges being born in the U.S.

**In addition, a second document establishing identity MUST be presented as described in Chart 5, “Evidence of Identity.”**

Third level evidence is generally a non-government document established for a reason other than to establish U.S. citizenship and showing a U.S. place of birth. The place of birth on the non-government document and the application must agree. Accept any of the documents listed in the Level 3 table as third level evidence of U.S. citizenship if the document meets the listed criteria, the applicant alleges birth in the U.S., and there is nothing indicating the person is not a U.S. citizen (e.g., lost U.S. citizenship).

LEVEL 3 - Third Level Documents	Explanation – Level 3
Extract of hospital record on hospital letterhead established at the time of the person’s birth that was created 5 years before application and indicates a U.S. place of birth	<p>An extract of a hospital record on hospital letterhead that was established at the time of the person's birth, that was created at least 5 years before the initial Medicaid application date and that indicates a U.S. place of birth is acceptable.</p> <p>Do not accept a birth certificate “souvenir” issued by the hospital.</p> <p>NOTE: For children under 16, the document must have been created near the time of birth or 5 years before the date of application.</p>
Life, health or other insurance record created at least 5 years before initial Medicaid application date and indicates a U.S. place of birth	<p>Life, health <i>or other</i> insurance records may show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth and it was created at least 5 years before the initial Medicaid application date.</p> <p>NOTE: For children under 16, the document must have been created near the time of birth or 5 years before the date of application.</p>
<i>Religious record recorded in the U.S. showing a U.S. place of birth</i>	<p><i>Religious record recorded in the U.S. within 3 months of birth showing the birth occurred in the U.S. and showing either the date of the birth or the individual’s age at the time the record was made. The record must be an official record recorded with the religious organization.</i></p>
	<p><i>CAUTION: In questionable cases (for example, where the child’s religious record was recorded near a U.S. international border and the child may have been born outside the U.S.), the agency must verify the religious record and/or document that the individual’s mother was in the U.S. at the time of the individual’s birth.</i></p>
<i>Early school record showing a U.S. place of birth</i>	<p><i>The early school record showing a U.S. place of birth must be from a Head Start program, a pre-school, kindergarten or elementary school (early school records do NOT include report cards). The school record must show the name of the child, the date of admission to the school, the date of birth, a U.S. place of birth, <b>and the name(s) and place(s) of birth of the applicant’s parents.</b></i></p>

**4. LEVEL 4 -  
Fourth Level  
Documents**

Level 4 fourth level evidence of citizenship is documentary evidence of the lowest reliability. Fourth level evidence should ONLY be used in the rarest of circumstances. This level of evidence is used ONLY when primary evidence is not available, both secondary and third level evidence do not exist or cannot be obtained within the State's reasonable opportunity period, and the applicant alleges a U.S. place of birth. In addition, a second document establishing identity MUST be presented as described in Chart 5, Evidence of Identity. Available evidence is evidence that can be obtained within the State's reasonable opportunity period as discussed below.

Fourth level evidence, as described in the Level 4 table below, consists of documents established for a reason other than to establish U.S. citizenship and showing a U.S. place of birth. The U.S. place of birth on the document and the application must agree. Accept any of the documents listed in the Level 4 table as fourth level evidence of U.S. citizenship if the document meets the listed criteria, the applicant alleges U.S. citizenship, and there is nothing indicating the person is not a U.S. citizen (e.g., lost U.S. citizenship). A second document establishing identity must be presented.

**The written affidavit described in the Level 4 table may be used only when the State is unable to secure evidence of citizenship listed in any other Level.**

<b>LEVEL 4 - Fourth Level Documents</b>	<b>Explanation – Level 4</b>
Federal or State census record showing U.S. citizenship or a U.S. place of birth (Generally for persons born 1900 through 1950).	The census record must also show the applicant's age.  NOTE: Census records from 1900 through 1950 contain certain citizenship information. To secure this information the applicant, recipient or agency should complete a Form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks portion "U.S. citizenship data requested." Add that the purpose is for Medicaid eligibility. This form requires a fee.
One of the documents listed that was created at least 5 years before the application for Medicaid	<i>The other document must be one of the following documents that shows a U.S. place of birth and was created at least 5 years before the application for Medicaid. (For children under 16 the document must have been created near the time of birth or 5 years before the date of application.) This document must be one of the following and must show a U.S. place of birth:</i> <ul style="list-style-type: none"> <li>• Seneca Indian tribal census record,</li> <li>• Bureau of Indian Affairs tribal census records of the Navaho Indians,</li> <li>• U.S. State Vital Statistics official notification of birth registration,</li> <li>• A <i>delayed</i> U.S. public birth record that is <i>recorded</i> more than 5 years after the person's birth,</li> </ul>

LEVEL 4 - Fourth Level Documents	Explanation – Level 4
	<ul style="list-style-type: none"> <li>• Statement signed by the physician or midwife who was in attendance at the time of birth, <i>or</i></li> <li>• <i>The Roll of Alaska Natives maintained by the Bureau of Indian Affairs.</i></li> </ul>
Institutional admission papers <i>created at least 5 years before the initial application date</i>	Institutional admission papers from a nursing <i>facility</i> , skilled nursing care facility, a local, state or federal prison or other institution <i>created at least 5 years before the initial application date</i> that indicate a U.S. place of birth <i>are acceptable</i> . Admission papers generally show biographical information for the person including place of birth. The record can be used to establish U.S. citizenship when it shows a U.S. place of birth.
Medical (clinic, doctor, or hospital) record created at least 5 years before the initial application date and indicates a U.S. place of birth.	Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth <i>and was created at least 5 years before the initial application date</i> .  NOTE: An immunization record is not considered a medical record for purposes of establishing U.S. citizenship.  NOTE: For children under 16 the document must have been created near the time of birth or 5 years before the date of Medicaid application.
Written affidavit of citizenship	Affidavits should ONLY be used in rare circumstances. <i>When the LDSS is unable to secure any other form of documentation of citizenship listed above within the allowed processing time frame, a written affidavit described below may be accepted for citizens born in the U.S. and for naturalized citizens. The individual must also provide documentation of identity.</i>  <b>NOTE: The Affidavit of Identity for Medicaid Applicants/Recipients Under Age 16 cannot be used when an affidavit of citizenship is used.</b>  If the citizenship documentation requirement needs to be met through affidavits, the following rules apply: <ul style="list-style-type: none"> <li>• There must be at least two affidavits by two individuals who <i>are United States citizens, including naturalized citizens, who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship.</i></li> <li>• At least one of the individuals making the affidavit cannot be related to the applicant/recipient. Neither of the two individuals can be the applicant/recipient.</li> <li>• <b>In order for the affidavits to be acceptable, the persons making the affidavits must be able to provide proof of their own citizenship and identity.</b></li> <li>• If the individuals making the affidavits have information which explains why documentary evidence establishing the</li> </ul>

LEVEL 4 - Fourth Level Documents	Explanation – Level 4
Written affidavit of citizenship	<p>applicant's claim of citizenship does not exist or cannot be readily obtained, the affidavit <b>must</b> contain this information as well.</p> <ul style="list-style-type: none"> <li>• The agency must obtain a separate affidavit from the applicant/recipient or other knowledgeable individual (or guardian or representative) explaining why the evidence does not exist or cannot be readily obtained.</li> <li>• The affidavits must be signed under penalty of perjury by the persons making the affidavits.</li> </ul> <p>The Affidavit of Citizenship On Behalf Of Medicaid Applicants and Recipients, to be used by the two persons attesting to the applicant/recipient's citizenship, is available on the intranet at: <a href="http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/032-03-0280-00-eng.doc">http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/032-03-0280-00-eng.doc</a>.</p> <p>The Affidavit of Citizenship By Medicaid Applicants and Recipients, to be used by the applicant/recipient or his guardian or authorized representative, is available on the intranet at: <a href="http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/032-03-0281-00-eng.doc">http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/032-03-0281-00-eng.doc</a></p>

**5. CHART 5 - Evidence of Identity**

Section 1903 (x) of the Act provides that identity must be established. When Level 1 primary evidence of citizenship is not available, a document from the Level 2, Level 3 or Level 4 tables above may be presented if accompanied by an identity document from the following Chart 5 Identity Documents table.

The identity documents do not have a hierarchy of reliability. For applications or renewals that include children under age 16, the LDSS workers can send an Affidavit of Identity for Medicaid Applicants and Recipients Under Age 16 with the application or renewal forms, *if an affidavit was not used to verify citizenship*.

**Exception to Identity Documentation:** *Do not accept a voter's registration card or Canadian driver's license [as listed in 8 CFR 274a.2 (b) (1) (v) (B) (1)].*

CHART 5 – Identity Documents	Explanation – Chart 5
Driver's license	A driver's license issued by State or Territory either with a photograph of the individual, or other identifying information such as name, age, sex, race, height, weight or eye color, is acceptable.
School identification card	A school identification card with the name and photograph of the individual is acceptable. The school ID card must be an official ID card issued by the school; unofficial ID cards such as those provided as a courtesy with school photographs, are not acceptable.

CHART 5 – Identity Documents	Explanation – Chart 5
United States military card or draft record	United States military card or draft record is acceptable.
Identification card issued by the Federal, State, or local government	An identification card issued by the Federal, State, or local government with the same information included on driver's licenses is acceptable. At a minimum, the ID must have the individual's name, address and photo. For photo ID cards, the photo must have been affixed to the ID card by the government agency that issued it. ID cards issued by a government agency that just have a space for the individual to attach a photo are NOT acceptable.
Military dependent's ID card	A military dependent's identification card is acceptable.
Native American Tribal document	A Native American Tribal document is acceptable.
United States Coast Guard Merchant Mariner card	A United States Coast Guard Merchant Mariner card is acceptable.
Certificate of Degree of Indian Blood, or other United States American Indian/Alaska Native tribal document	A Certificate of Degree of Indian Blood, or other United States American Indian/Alaska Native tribal document with a photograph or other personal identifying information relating to the individual is acceptable. <i>The other personal identifying information relating to the individual on the document must be information such as age, weight, height, race, sex, and eye color.</i>
State Agency Computer Data	Identifying information from a Virginia state governmental data system can be used to provide identity verification for applicants and recipients. A copy of the screen(s) from a state data system that shows the individual's name, DOB, gender and SSN is acceptable documentation of the individual's identity if the agency establishes the true identity of the individual.  <b><i>NOTE: The state computer data base can only be used for identity verification; it cannot be used for verifying citizenship.</i></b>
<i>Three or more corroborating documents</i>	<i>The agency may accept three or more documents that together reasonably corroborate the identity of an individual provided such documents have <b>not</b> been used to establish the individual's citizenship and the individual submitted second or third tier evidence of citizenship. The agency must first ensure that no other evidence of identity is available to the individual prior to accepting such documents.  The documents must at a minimum contain the individual's name, plus any additional information establishing the individual's identity. All three documents used must contain consistent identifying information.</i>

CHART 5 – Identity Documents	Explanation – Chart 5
<i>Three or more corroborating documents</i>	<i>Examples of these documents include employer identification cards, high school and college diplomas from accredited institutions (including general education and high school equivalency diplomas), marriage certificates, divorce decrees and property deeds/titles.</i>
<i>Death Certificate</i>	<i>An official death certificate can be used to verify the identity of a deceased Medicaid applicant. NOTE: a death certificate CANNOT be used to verify citizenship.</i>
Special identity rules for children under age 16	<p>For children under 16, when the application form does not contain the parent or caretaker’s statement of identity for children under age 16, a clinic, doctor, hospital or school record may be accepted for purposes of establishing identity. School records may include nursery or child care records and report cards that contain the required information.</p> <p>The school, nursery or daycare record must contain the child’s name, date of birth, place of birth and the parents’ names. The form agencies should use to request the school, nursery or daycare record is posted on the intranet. The school record request form workers can give to a child’s parent or caretaker to give to the school is posted to the intranet at:  <a href="http://localagency.dss.virginia.gov/divisions/bp/me/citizenship/forms.cgi">http://localagency.dss.virginia.gov/divisions/bp/me/citizenship/forms.cgi</a>.</p>
	<p><b>a. Foster Care and Title IV-E Adoption Assistance Children</b></p> <p>All foster care children and Title IV-E Adoption Assistance children are excluded from the citizenship and identity verification requirements. Non-Title-IV-E Special Medical Needs children and non-Title-IV-E adoption assistance children must verify their citizenship and identity.</p> <p><b>b. Written affidavit of identity</b></p> <p><b>For children under 16 only</b>, an affidavit of identity may be used when the application or renewal form does not contain the identity affidavit language. An affidavit is only acceptable if it is signed under penalty of perjury by a parent or caretaker stating the date and place of the birth of the child and <b>cannot be used if an affidavit for citizenship was provided for the child</b>. The Affidavit of Identity for Medicaid Applicants and Recipients Under Age 16 is available on the LDSS Intranet at:  <a href="http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/032-03-0282-02-eng.pdf">http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/032-03-0282-02-eng.pdf</a> and may be sent to the parent or caretaker with the application or renewal form that does not contain the identity affidavit language when the agency is aware that a child under age 16 is in the home.</p> <p>The Application for Health Insurance for Children and Pregnant Women (FAMIS 1) and the Families &amp; Children Medicaid and FAMIS Plus Renewal form contain an area for the parent or caretaker to attest</p>

CHART 5 – Identity Documents	Explanation – Chart 5
<i>Special identity rules for children under age 16</i>	<p>to the identity of a child under age 16. <i>The forms are available on the intranet.</i> A separate affidavit of identity is not necessary when the parent or caretaker has attested to identity on the application or renewal form.</p> <p>The affidavit of identity, or the attestation of identity on the original application form, remains valid when the child reaches age 16 or older, as long as the child remains continuously enrolled in Medicaid. If the child’s enrollment is canceled and he reapplies after turning age 16, his identity must be verified.</p>
<i>Special rules for individuals in institutions</i>	<p><i>The agency may accept an identity affidavit signed under penalty of perjury by a director or administrator of a residential care facility (such as an assisted living facility or group home), nursing home or hospital on behalf of an institutionalized individual who is residing or is an inpatient in the facility. The affidavit is not required to be notarized. <b>The agency should first pursue other means of verifying identity prior to accepting an affidavit.</b></i></p> <p><i>The Affidavit of Identity for Medicaid Applicants/Recipients Residing in an Institution form is available on the intranet at:</i>  <a href="http://localagency.dss.virginia.gov/divisions/bp/me/citizenship/forms.cgi">http://localagency.dss.virginia.gov/divisions/bp/me/citizenship/forms.cgi</a>.</p>

**E. Agency Action**

**1. Documentation From Case Record and Individual**

Documentation of citizenship and/or identity may be obtained from a number of different sources including the following:

- Existing LDSS agency records as long as the documentation conforms to Medicaid policy for citizenship and identity verification in M0220 of the Medicaid Eligibility Manual.
- Applicants and Recipients. All applicants and recipients, **except** SSI recipients, Medicare beneficiaries, SSDI beneficiaries, *certain newborns*, all foster care children and IV-E Adoption Assistance children, must provide documents that show proof of United States citizenship and proof of the person’s identity. Contact information for obtaining the various acceptable documents is available on the VDSS local agency intranet and the DSS public website and may be given to individuals to facilitate their obtaining documentation.

Original documents may be viewed by all eligibility, administrative, and services staff of the LDSS as long as the person viewing the document makes a copy of the document, notes that the original was viewed, and signs and dates the copy.

**2. Authorized Representative**

For individuals who have authorized representatives, such as the disabled or individuals who are institutionalized, initiate efforts to assist in securing documentation with the appropriate representative.

In those instances in which an authorized representative lives in another locality than the Medicaid enrollee and the authorized representative's LDSS is more convenient to them than the locality where the case is maintained, a LDSS may copy and verify an original document for an authorized representative. The LDSS is not to give the copy to the client's representative; the agency staff must send it to the LDSS that holds the Medicaid enrollee's case. In this way, the "chain of evidence" is not broken—it has always stayed within DSS.

A local DSS agency may accept the copy as verification providing another LDSS:

- saw the original document,
- made the copy of the original,
- wrote on the copy that the staff member saw the original document on (date), and
- signed and dated the copy.

### 3. Documents From Other Approved Organizations

Original citizenship and identity documents can be accepted from other organizations approved by DMAS when the original document is viewed, the authorized person makes a copy and affixes a statement to the copy that has the following information:

- the original document was viewed and copied by (name and title of the individual who viewed the documentation), signature of staff member who saw the original,
- the name of the entity with which the individual is affiliated, and
- the date the documentation was viewed and copied.

DMAS has approved documentation copies from the following:

- an established outreach organization,
- local health department,
- Department of Corrections personnel for prisoners leaving the correctional system,
- Federally Qualified Health Centers (FQHC),
- hospital discharge planners or social workers.

**Two lists of approved organizations are posted on the local agency intranet site:** "Project Connect and Independent Outreach Projects List" and "FQHC-Virginia Primary Care Association Membership Roster".

Hospital contractors, such as Chamberlin-Edmonds, are **not** considered authorized to view original documents.

### 4. DMAS FAMIS Plus Unit

Original documents can be viewed by local department of social services (LDSS) for applications handled by the Department of Medical Assistance Services (DMAS) FAMIS Plus Unit. As a service to clients, staff from any LDSS is to view an original document, make a copy, and note on the copy that the original was viewed, including the date and signature of the staff person. The LDSS are to send or fax the annotated copy to the DMAS FAMIS Plus Unit. The DMAS FAMIS Plus Unit will accept the copy and place it in the record. This process will significantly reduce the likelihood

of important and possibly irreplaceable documents being misplaced or destroyed.

**5. Birth Certificate Viewed By Out-of-State Agency**

Local agencies are to accept copies of out-of-state birth certificates if the copies have statements on or attached to them that say the original birth certificates were viewed by staff of the issuing state's Department of Social Services or Medicaid state agency, and the statements are signed and dated by the issuing state's staff who viewed the originals.

**6. SSI Recipients and Medicare Beneficiaries**

Verify the SSI recipient's or Medicare beneficiary's entitlement to benefits through SVES or SOLQ-I. A copy of the SVES or SOLQ-I printout must be placed in the case file.

**7. Individual NOT Required to Submit Documents in Person**

Individuals do not have to submit their citizenship and identity to the agency worker in person. They may mail-in the **original document** for the agency to copy and mail back to the individual, with the exception of a copy of a Virginia birth certificate, which may be furnished rather than the original. The worker must write on the copy made for the case record that "the original document was viewed on (date) and the original was mailed back to the individual on (date)."

For individuals who need assistance securing a birth certificate, LDSS may request birth certificate verification from the Virginia Department of Health (VDH) without receiving additional approval from the recipient beyond the recipient's original signature on the individual's application for Medicaid. If VDH is unable to produce birth certificate verification, however, the individual is to be notified that documentation of citizenship is needed and allowed the reasonable opportunity period to secure the documentation (see M0220.100 D.8 below).

**8. Special Populations Needing Assistance**

The agency shall assist special populations who need additional assistance, such as the homeless, mentally impaired, or physically incapacitated individual who lacks someone who can act on his behalf, to provide necessary documentation.

For individuals who are mentally impaired or physically incapacitated and lack someone who can act on their behalf, the agency should initiate action to secure the documentation for these individuals using the Virginia Department of Health (VDH) procedure for requesting birth certificate documentation described in the Citizenship and Identity Verification Procedures document posted on the LDSS Intranet.

**9. Reasonable Opportunity to Verify Citizenship and Identity**

Many individuals will be able to produce the required citizenship and identity verification requirements given the maximum amount of time allowed by processing time frames. Inquiries should be made to determine if they can produce the required documentation. LDSS agencies shall assist these individuals in helping to secure the required documentation by providing information on what documentation is necessary and alerting them to agencies that may be contacted for the needed documentation.

The "reasonable opportunity period" permits exceptions from the standard time limits for processing applications when an applicant or recipient in good faith tries to present documentation, but is unable to do so because the documents are not available. In such cases, the agency should extend the application processing time limit and assist the individual in securing evidence of citizenship and/or identity.

If the individual cannot readily or easily produce citizenship documentation or it is a hardship to secure that documentation, secure the documentation for the individual using the process contained in the "Citizenship and Identity Verification Procedures" document posted on the VDSS Intranet for contact with the Virginia Department of Health for birth certificate documentation.

If the individual, legal guardian or other responsible party indicates that additional time is required, allow a reasonable amount of additional time based on the time frames below.

**10. Applicants -  
Extending the  
Processing Time  
Frames**

Applicants, with the exception of those needing a disability determination, who have attempted to obtain citizenship and identity documentation will be given additional time beyond the normal time frame for processing *applications* (45 days for applications, 30 days for renewals) as follows:

**a. Applicants Born in a State Other Than Virginia**

*An indefinite extension may be granted when out-of-state birth verification has been requested through the Virginia Department of Social Services or the FAMIS-Plus Unit at the FAMIS CPU. The status of the birth verification request must be documented in the case record until the required documentation is received.*

**b. Applicants Born in Virginia**

*For an applicant born in Virginia, the agency will, at the applicant's request, initiate a birth record verification request from the Virginia Department of Health (VDH). The turn-around time for the VDH birth verification process is generally well within the standard application processing time; therefore, the reasonable opportunity period for applicants who were born in Virginia has not changed.*

*Applicants who were born in Virginia, with the exception of those needing a disability determination, who have attempted to obtain citizenship and identity documentation will be given an extension of 30 calendar days when the applicant has requested, but not received the required documents, or requested assistance in obtaining documents, as follows.*

- An extension of 30 calendar days may be granted when the applicant/recipient has requested, but not received the required documents, or requested assistance in obtaining documents.
- An additional extension of up to 10 working days may be granted at the end of the 30-day extension when there is documentation that the information has been requested, but has not been received.

Because the processing time for applicants who require a disability determination remains 90 calendar days, which actually exceeds the extension periods listed above, **these applicants do not receive the extensions.**

**Information regarding the need for the extension and agency's efforts to assist in helping obtain documentation must be included in the case file.**

*The worker should periodically review the status of the good faith effort and document the status in the case record until the required documentation is received. If the required information has not been received by the end of the extensions, appropriate action to deny coverage must be taken.*

**11. Recipients -  
Extending the  
Processing Time  
Frames**

For recipients of Medicaid, the processing time frame extension is indefinite, as long as

- a "good faith" effort continues to be made by the recipient, his authorized representative or other person(s) acting on the recipient's behalf to obtain appropriate documentation of citizenship and identity, *and*
- *the recipient meets all other Medicaid eligibility requirements.*

The case record must be documented by the worker noting the attempts being made to secure the required verification. Providing all other Medicaid eligibility requirements are met, an existing Medicaid recipient's case is allowed to remain open as long as a good faith effort is being made to obtain the verification.

**12. Failure to  
Provide  
Requested  
Verifications**

Failure to provide satisfactory evidence of citizenship and identity, after being provided a reasonable time to present such documentation, is to result in the denial or termination of Medicaid.

An applicant or recipient who fails to cooperate with the agency in presenting documentary evidence of citizenship may be denied or terminated. Failure to cooperate consists of failure by an applicant, recipient or that individual's representative, after being notified, to take a required action within the reasonable opportunity time period.

**13. Denial or  
Cancellation  
Action**

Local agencies must give the maximum allowable time for securing citizenship and identity verification permitted by the processing time frames and to pend cases of those individuals who are acting in good faith to secure the documentation not available through the agencies' efforts.

Eligibility should only be denied or cancelled for lack of citizenship and/or identity verification reasons if there is clear and convincing evidence that the recipient has failed to present a good faith effort to produce the required documentation. Agencies are to recognize that, particularly for individuals who are aged, disabled and/or institutionalized, the intervention and assistance of authorized representatives may be needed to secure this information, and the maximum time and necessary assistance from the agency should be provided to the authorized representatives acting in good faith on behalf of the recipient.

A local agency is neither to deny nor terminate Medicaid eligibility based solely upon lack of citizenship or identity documentation without supervisory review and approval. An agency that has questions about a denial or a termination of eligibility should first consult the Medical Assistance Program Consultant assigned to the agency's service area.

**14. Notification Requirements**

Prior to the termination of benefits, the enrollee must be sent the Advance Notice of Proposed Action (Form 032-03-018) at least 10 calendar days (plus one day for mailing) prior to the effective date of the closure.

A Notice of Action and appeal rights must be sent to an individual whose application is denied because of failure to provide citizenship and/or identity verification.

**15. Maintain Documents in Case Record**

The agency must maintain copies of the documents used to verify citizenship and identity in the individual's case record or data base and must make the documents available for state and federal audits.

**16. Reporting Requirements**

Each month, agencies will report information regarding **denials** of eligibility **on cases that are not in ADAPT** when one of the reasons, or the only reason, for the denial was failure to verify citizenship or identity. (Cancellations are reported from MMIS data, and denials on ADAPT cases are reported in ADAPT).

The Medical Assistance Program Consultants will also be conducting reviews of cases where Medicaid eligibility was denied or terminated because of lack of citizenship and/or identity verification.

**17. Refer Cases of Suspected Fraud to DMAS**

If documents are determined to be inconsistent with pre-existing information, are counterfeit, or are altered, refer the individual to DMAS for investigation into potential fraud and abuse. See section M1700.200 for fraud referral procedures.

## **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 immigration status, refer the individual to the USCIS district office to obtain evidence of status **unless** he provides an alien registration number.

If the applicant provides an alien registration number with supporting verification of his 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.

- |   |   |
|---|---|
| 3. <b>Assignment of Rights and Pursuit of Support from Absent Parents</b>         | the assignment of rights to medical benefits requirements (M0250);  |
| 4. <b>Application for Other Benefits</b>  | the requirements regarding application for other benefits (M0270);  |
| 5. <b>Institutional Status</b>  | the institutional status requirements (M0280);  |
| 6. <b>HIPP</b>  | the application to the Health Insurance Premium Payment (HIPP) Program (M0290);   |
| 7. <b>Covered Group</b>   | the covered group requirements (chapter M03);   |
| 8. <b>Financial Eligibility</b>   | <p>the asset transfer requirements (see subchapter M1450) apply.</p> <p>Resources must be within the resource limit appropriate to the individual's covered group. (Chapter M06 for F&amp;C covered groups; Chapter S11 for ABD covered groups).</p> <p>Income must be within the income limit appropriate to the individual's covered group. (Chapter M07 for F&amp;C covered groups; Chapter S08 for ABD covered groups). Spenddown provisions apply to these individuals. All medical expenses count toward meeting the spenddown, but once an entitlement date is determined after the individual meets the spenddown, only emergency services rendered on or after the entitlement date and which are within the period of coverage on the Emergency Medical Certification form are covered for emergency services aliens.</p> |
| <b>B. Emergency Services Certification--Not Applicable to Full Benefit Aliens</b> | <p>Certification that the service provided was an emergency service is an additional eligibility requirement for emergency services aliens (not applicable to full benefit aliens). LDSS can certify emergency services coverage for pregnancy-related labor and delivery services for limited, specified periods of time. DMAS must certify emergency services coverage for all other requests and determine the period of coverage.</p>   |
| 1. <b>LDSS Certification for Pregnancy-Related Labor and Delivery Services</b>    | <p>LDSS can certify emergency services payment for pregnancy-related labor and delivery services, including inpatient hospitalizations that did not exceed:</p> <ul style="list-style-type: none"> <li>• 3 days for a vaginal delivery, or</li> <li>• 5 days for a cesarean delivery.</li> </ul>  |

To determine the length of stay, count the day of admission, but not the day of discharge. If the length of stay exceeded 3 days for a vaginal delivery or 5 days for a cesarean delivery, DMAS must approve the coverage following the procedures in *M0220.500 B.2* below. Note that the enrollment period for the emergency service(s) includes the day of discharge even though it is not counted to determine the length of stay (see *M0220.700*).

For LDSS certifications, verification of the labor and delivery services must be obtained from the physician or hospital and include the following information:

- patient name, address and date of birth,
- facility name and address where the delivery took place
- type of delivery (vaginal or cesarean), and
- inpatient hospital admission and discharge dates

The verification must be documented in the record.

NOTE: A child born to an emergency-services-only alien mother *who was eligible for Medicaid on the date of the child's birth* is entitled to Medicaid as a newborn child (see *M320.301*).

**2. DMAS  
Certification for  
Emergency  
Services  
Required**

When DMAS certification for emergency services is required, the worker must obtain a signed release of information from the applicant and request evidence of emergency treatment from the hospital and/or treating physician. If the hospital or treating physician wants to know what information is needed, refer the hospital's staff or physician (or physician's staff) to the Virginia Medicaid Hospital Provider Manual, Chapter VI "Documentation Guidelines."

The worker must send the medical evidence to:

Division of Program Operations  
Department of Medical Assistance Services (DMAS)  
600 E. Broad Street, Suite 1300  
Richmond, VA 23219

for a determination of medical emergency and the duration of the emergency services certification period. Use the Emergency Medical Certification, form #032-03-628 (see Appendix 4 of this subchapter) as a cover letter.

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

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## M0240.000 SOCIAL SECURITY NUMBER REQUIREMENTS

### M0240.001 GENERAL PRINCIPLE

- A. Policy** To be eligible for Medicaid, an individual must provide his/her Social Security number (SSN) as well as the SSNs of any children for whom Medicaid is requested, or must provide proof of application for an SSN, UNLESS the applicant
- is an illegal alien as defined in subchapter M0220,
  - is a child under age 1 as defined in M0320.301 B. 2., or
  - *is a foster care child voluntarily entrusted to a public or private child-placing agency who is unable to obtain an SSN.*
- B. Failure to Meet This Requirement** Any Medicaid family unit member for whom an application for an SSN has not been filed or for whom the SSN is not furnished **is not eligible** for Medicaid EXCEPT for:
- 1. Child Under Age 1** a child under age one born to a Medicaid-eligible mother; a newborn is deemed to have applied and been found eligible for Medicaid as long as the mother remains Medicaid-eligible (or would be eligible if she were pregnant) and they continue to live together, whether or not the eligibility requirements, including SSN, have actually been met.
  - 2. Illegal Alien** an illegal alien as defined in Section M0220; an illegal alien does not have to provide or apply for an SSN.
  - 3. Foster Care Child - Voluntary Entrustment** *a foster care child voluntarily entrusted to a public or private child-placing agency who is unable to obtain an SSN. See M0240.100, below.*
- C. Relationship to Other Medicaid Requirements** An applicant who cannot provide documentation that he is a citizen or legally present at the time of application must sign an affidavit under oath attesting that he is a U.S. citizen or legally present in the U.S. in order to temporarily meet the requirement for proof of legal presence (see M0210.150). **Submission of the affidavit without proof of application for an SSN does NOT meet the SSN requirement.**
- D. Verification** The individual's SSN must be verified by the Social Security Administration (SSA).
- E. Procedure** Section M0240.100 below explains in detail how to determine if an individual meets the SSN requirements when the individual or child does not have an SSN.

**M0240.100 APPLICATION FOR SSN****A. Policy**

If an SSN has not been issued for the individual or the individual's child(ren), the applicant must cooperate in applying for a number with the local Social Security Administration Office. An Enumeration Referral Form, form #032-03-400, must be completed by the applicant. The applicant must provide the SSN to the local social services department as soon as it is received and the number must be *verified and* entered in the Medicaid Management Information System (MMIS).

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

Applicants who refuse to furnish an SSN or to show proof of application for a number are ineligible for Medicaid.

**B. Exceptions**

Any Medicaid family unit member for whom an SSN has not been applied **is not eligible** for Medicaid EXCEPT for:

**1. Child Under Age 1**

a child under age one born to a Medicaid-eligible mother. A newborn is deemed to have applied and been found eligible for Medicaid as long as the mother remains Medicaid-eligible (or would be eligible if she were pregnant) and they continue to live together, whether or not the eligibility requirements, including SSN, have actually been met. *See M0320.301 for a newborn's eligibility as a child under age 1.*

**2. Illegal Alien**

an illegal alien as defined in Section M0220. An illegal alien does not have to provide or apply for an SSN.

**3. Foster Care Child - Voluntary Entrustment**

*a foster care child voluntarily entrusted to a public or private child-placing agency who is unable to obtain an SSN.*

*When a foster care child is eligible for Medicaid without an SSN or application for an SSN, the agency worker must review the child's SSN or SSN application by the time the annual renewal is due. The agency worker should ask if the child-placing agency has gone to court to obtain legal custody. The child remains exempt from the SSN requirement until:*

- *legal custody is granted to the child-placing agency, or*
- *the child is adopted and the adoption is final.*

*If the child is still exempt from the SSN requirement after the first annual renewal and continues to meet all Medicaid eligibility requirements, the agency worker is to follow-up again at the next renewal unless the child's adoption is finalized or the child placing agency obtains legal custody before the next renewal.*

## M0290.000 HIPP REQUIREMENTS

### M0290.001 GENERAL PRINCIPLES

- A. Introduction** To be eligible for Medicaid, certain individuals must *make application to* the Health Insurance Premium Payment (*HIPP*) Program.
- B. Procedure** The definitions of terms used in this subchapter are in section M0290.100 below.
- The HIPP requirements are in section M0290.200 below.

### M0290.100 DEFINITIONS

- A. Assistance Unit** means the individual or family who applies for Medicaid and whose financial eligibility is determined. The assistance unit for Families & Children (F&C) covered groups is called the "family unit" or the "budget unit".
- The assistance unit for an ABD individual is just the individual, unless the individual is married, living with his/her spouse and the spouse is also ABD. In this situation, the assistance unit is the married ABD couple.
- B. HIPP** means the Health Insurance Premium Payment Program. HIPP is a cost-saving program administered by the Department of Medical Assistance Services (DMAS) for Medicaid *enrollees*, which *reimburses some or all of* the employee portion of the group health insurance premium for *enrollees* who have *employer sponsored group* health insurance available to them through their own or their family member's employment.

## M0290.200 HEALTH INSURANCE PREMIUM PAYMENT PROGRAM (HIPP) REQUIREMENTS

- A. Policy** As a condition of Medicaid eligibility, any individual who:
- is eligible for Medicaid,
  - is a member of an assistance unit which contains an individual employed more than 30 hours per week, and
  - is eligible for coverage under an employer's group health plan
- must complete the HIPP Application Form and the Medical History Questionnaire, and submit the *Employer* Insurance Verification Form to the employer.
- If DMAS determines that enrollment of the individual in the group health plan is cost-effective; the individual must enroll in the group health plan in order to remain eligible for Medicaid.

To determine if the employer-sponsored group health plan is cost-effective, the cost of the applicant's or enrollee's insurance premium is compared to the cost of Medicaid managed-care for an individual of similar age, gender, and locality of residence. These comparison figures are known as HIPP Capitation Rates. The rates periodically change based on enrollee changes in age, aid category, or locality of residence.

Under this program, DMAS provides reimbursement of some or all of the employee's portion of the group health insurance premium. The HIPP Program may reimburse some or all of the premiums for non-Medicaid eligible family members if they must be enrolled in order for Medicaid eligible family members to obtain the health plan coverage.

**B. Individuals Who Will Not Be Considered for HIPP**

The following individuals will not be considered for HIPP unless extraordinary circumstances indicate the group health plan might be cost-effective:

- individuals eligible for Medicaid after meeting a spenddown;
- individuals eligible for retroactive Medicaid only;
- individuals in a nursing facility or who have a deduction from patient pay responsibility to cover the insurance premium;
- individuals eligible for or enrolled in Medicare Part B; or
- individuals who are absent parents.

**C. Individuals with Special Medical Conditions**

An individual described in B. above may be considered for HIPP if he has a medical condition that requires ongoing treatment and the group health insurance plan might be cost-effective. Contact the HIPP Unit for guidance on situations requiring special consideration.

An individual who has a medical condition requiring ongoing treatment and who has any employer-sponsored group health insurance coverage available may submit a HIPP Application to the HIPP Unit at DMAS. The HIPP Unit will verify insurance coverage with the company and determine if Medicaid reimbursement of the premiums would be cost-effective.

**D. Failure to Cooperate**

If an individual, without good cause, fails to complete either the HIPP Application or Medical History Questionnaire, or fails to enroll in a cost-effective group health plan when required to by DMAS, the individual loses eligibility for Medicaid. An "Advance Notice of Proposed Action" must be sent prior to canceling coverage. Non-cooperation of a parent or spouse does not affect eligibility for Medicaid benefits for the individual's spouse or child.

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## M0310.109 COVERED GROUP

### A. Definition

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

The covered groups are classified in Virginia as categorically needy (CN), categorically needy non money payment (CNNMP), medically indigent (MI) and medically needy (MN). The covered groups are divided into the ABD and F&C covered groups for financial eligibility purposes.

### B. Procedure

The covered groups are listed in section M0310.002.

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

## M0310.110 CHILD

### A. Definition

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

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

## M0310.111 DEPENDENT CHILD

### A. Definition

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

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

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

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

**B. Age & School Enrollment****1. Age**

The child's date of birth declared on the application/redetermination form is used to determine if the child meets the age requirement. No verification is required.

A child who becomes 18 after the first day of his birth month meets the age requirement in the month of his 18th birthday; he is still considered under age 18 during his birth month. If he becomes age 18 on the first day of his birth month, he is age 18 for the whole birth month.

An 18 year old child does **not** meet the age requirement in the month following the month in which his 18th birthday occurs unless the child is enrolled full-time in a secondary school or vocational/technical school of secondary equivalency AND is reasonably expected to complete the program of secondary school or vocational/technical training before or in the month he attains age 19.

**2. School Enrollment**

Accept the declaration of school enrollment.

**C. Living With a Parent or Caretaker-Relative****1. Relationship**

The child's relationship to the parent or caretaker-relative with whom he lives as declared on the application or redetermination document is used to determine if the child is living with a relative. No verification is required.

For the purpose of determining a relationship, neither death, divorce, nor adoption terminates relationship to the biological relatives.

**2. Child's Father**

*Virginia law considers a man who is legally married to the mother of a child on the date of the child's birth to be the legal father of the child UNLESS DCSE or a court has determined that another man is the child's father. NOTE: The mother's marriage at the time of the child's birth does not require verification; the mother's declaration is sufficient.*

*The man listed on the application form as the child's father is considered the father when:*

- the mother was not married to another man on the child's birth date, or*
- the mother was married to another man on the child's birth date but DCSE or a court determined that the man listed on the application is the child's father,*

*unless documentation, such as the child's birth certificate, shows that another man is the child's father.*

*See M0310.123 for the definition of a parent.*

**3. Living in the Home**

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

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

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

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

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

Children placed in residential treatment facilities are considered absent from their home if their stay in the residential facility has been 30 days or more. A child who is placed in a residential facility is considered NOT living with his parents for Medicaid eligibility purposes as of the first day of the month in which the 30<sup>th</sup> day of residential placement occurs. Long-term care rules do not apply to children in residential treatment facilities.

PAGES 15 – 20 WERE INTENTIONALLY REMOVED FROM THIS SUBCHAPTER

The DDS makes a determination of disability when the:

- applicant alleges a disabling condition and has never applied for a disability from SSA or has not been denied disability within the past 12 months;
- SSA has not made a decision on a pending SS/SSI claim; or
- applicant alleges a disabling condition which is different from that considered by SSA or is in addition to that considered by SSA.

**1. Hospital Referrals to DDS for Expedited Disability Determination**

The 2004 Budget Bill mandated DDS make a disability determination within seven (7) working days of receipt of a referral from DSS when the Medicaid applicant is hospitalized and needs to be transitioned to a rehabilitation facility. To identify those hospitalized individuals who require an expedited disability determination, the following procedures have been established:

**a. Hospital staff will:**

- send DSS the Medicaid application and a cover sheet (see Appendix 4 for an example of the cover sheet); and simultaneously
- send DDS the medical documentation (disability report, authorizations to release information and medical records) needed to make the disability determination and a copy of the cover sheet.

**b. DDS must:**

- make a disability determination within seven (7) working days; and
- fax the result of the disability decision to the DSS.

**c. DSS must:**

- fax a completed DDS Referral Form #032-03-0095, available on the intranet at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>, to DDS at (804) 527-4525, verifying receipt of the Medicaid application;
- give priority to processing the applications and immediately request any verifications needed;
- process the application as soon as the DDS disability determination and all necessary verifications are received; and
- notify the hospital contact identified on the cover sheet of the action on the application and provide the Medicaid enrollee number, if eligible.

Should DDS be unable to render a decision within 7 working days, DDS will send a communication to the DSS advising that the disability determination has been delayed.

**2. DSS Referral to DDS Required When Disability Determination Has Not Been Made**

The DDS must make a determination of disability when the applicant alleges a disability and a disability determination has not been made by SSA or the RRB. The DDS must make a disability determination within a time frame that will allow the DSS to process the application within 90 days, provided all medical information has been submitted. Follow the procedure in E. 1. below for making a referral to DDS except when a hospital has initiated an expedited disability determination (see D.1. above).

**3. DSS Referral to DDS Required When SSA Denied Disability Within Past 12 Months**

SSA decisions made within the past 12 months are final decisions for Medicaid purposes unless:

- a. The applicant alleges a condition that is new or in addition to the condition(s) already considered by SSA,

OR

- b. The applicant alleges his condition has changed or deteriorated causing a new period of disability, AND
- he no longer meets the SSI financial requirements but might meet Medicaid financial requirements, or
  - he applied to SSA for a reconsideration or a reopening and SSA has refused to reconsider or reopen his case.

If the conditions in a. or b. exist, DDS must make a disability determination. The eligibility worker must follow the procedure in E. 1. below to make a referral to DDS. Information regarding the new, changed and/or deteriorated condition(s) must be identified and sent to DDS using the procedure in E. 1. below.

If the conditions in a. or b. do not exist, the SSA denial of disability is final for Medicaid purposes. Do not make a referral to DDS for a disability determination.

**4. Referral to DDS When SSA Denied Disability More Than 12 Months Ago**

If the applicant alleges a disability and SSA denied the disability more than 12 months ago, the eligibility worker must follow the procedure in E. 1. below to make a referral to DDS.

**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 #032-03-0095, available on the intranet at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.

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 *Medicaid* Unit  
9960 Mayland Drive, Suite 203  
Richmond, Virginia 23233-1463

#### **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 *calendar* days from the date of application, the applicant is considered not to meet the covered group, and the Medicaid application must be denied.

### 2. *Nonfinancial Requirements*

*For individuals who require a disability determination to meet the covered group requirement, the time standard for processing an application is 90 calendar days. Other non-financial requirements, however, must be met and verified by the 45<sup>th</sup> calendar day, or the application must be denied and DDS must be notified to stop action on the disability determination. Exception: allow up to the full 90 calendar days when the individual or agency is unable to obtain documentation of citizenship and/or identity within 45 calendar days of the application date. See M0220.100 D.9 for additional information.*

## **F. Communication Between Agency and DDS**

### **1. Agency**

The *agency* 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 *agency* 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 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 *agency*. For all other disability determinations, DDS will send the *agency* 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 agency so the *agency* can send a Notice of Action to extend the pending application.

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

## **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 *agency* 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.

## **M0310.123 PARENT**

### **A. Definition**

Under federal regulations, a parent means either the mother or the father, married or unmarried, natural or adoptive following entry of the interlocutory or final adoption order, whichever comes first.

#### **1. *Mother Married on Child's Birth Date***

*A mother who was married at the time of her child's birth may name on the application someone other than her husband as the child's father. The man to whom she was married at the time of the child's birth, however, is considered the child's father unless DCSE or a court determines otherwise. DCSE or the court must exclude the mother's husband, considered the legal father, as the child's father before the paternity status of the man named on the application is determined.*

#### **2. *Mother NOT Married on Child's Birth Date***

*If the mother was NOT married when the child was born, the man who is living in the home and who is listed on the application as the child's father is the child's acknowledged father, unless the agency receives evidence that contradicts the application, such as the child's birth certificate that has another man named as the child's father.*

#### **3. *Paternity Evidence***

If evidence of paternity is required to establish eligibility or ineligibility, such evidence must be entered in the eligibility case record.

### **B. Procedures**

*NOTE: The mother's marital status at the time of the child's birth does not require verification; her declaration of her marital status is sufficient.*

Section M0320.306 contains the detailed requirements for the LIFC covered group in which a parent of a dependent child can be eligible for Medicaid.

## **M0310.124 PREGNANT WOMAN**

### **A. Definition**

A woman of any age who is medically determined to be pregnant meets the definition of a pregnant woman.

#### **1. *Effective Date***

The pregnant woman definition is met the first day of the estimated month of conception as medically verified, or the first day of the earliest month which the medical practitioner certifies as being a month in which the woman was pregnant.

The definition of "pregnant woman" is met for sixty days following the last day the woman was pregnant regardless of the reason the pregnancy ended, and continues to be met until the last day of the month in which the 60th day occurs.

**Example #3:** a pregnant woman applies for Medicaid in May 1997; she received medical treatment in March and April 1997. The physician gives her a written statement dated May 20, 1997 saying that he "treated her in March 1997. She was approximately 3 months pregnant at that time. She is still pregnant this date." Therefore, her pregnancy is

medically verified for February - April 1997, since the doctor's statement verifies that she was pregnant in February, March, April, and May.

## B. Procedures

### 1. Verification

Verification of pregnancy, including the expected delivery date, must be provided. Acceptable verification is a written or verbal statement from a physician, nurse or similar *health* practitioner. Documentation of how the pregnancy was verified must be included in the case record.

If retroactive converge is requested the statement must also include an estimated month of conception since the pregnant woman definition is not met in any month prior to the conception month. If the medical practitioner cannot or will not give an estimated month of conception, the practitioner's certification that the woman was and is pregnant in the specific months for which Medicaid coverage is requested will suffice as pregnant woman definition verification.

Proof of the birth of a child to the mother is sufficient verification of the mother's pregnancy in the three months prior to the child's birth month.

### 2. Covered Groups Eligibility

A pregnant woman may be eligible for Medicaid if she meets all of the Medicaid eligibility requirements including any one or more of the covered groups. Two of the Medicaid covered groups are specifically for pregnant women: MI Pregnant Women and MN Pregnant Women.

See section M0320.301 for the MI pregnant woman covered group requirements, and section M0330.301 for the MN pregnant woman covered group requirements.

## M0310.125 QDWI

### A. Qualified Disabled & Working Individuals (QDWI)

QDWI is the short name used to designate the Medicaid covered group of Medicare beneficiaries who are "Qualified Disabled and Working Individuals." A qualified disabled and working individual means an individual

- who is entitled to enroll for Medicare Part A,
- whose resources do not exceed twice the maximum amount of resources that an individual or couple may have and be eligible for SSI,
- whose income does not exceed 200% of the federal poverty limit,
- who is NOT otherwise eligible for Medicaid.

### B. Procedure

QDWI is a mandatory covered group that the state plan must cover for the purpose of paying the beneficiary's Medicare Part A premium. See section M0320.209 for the procedures to use to determine if an individual meets the QDWI covered group.

**SAMPLE**

**Cover Sheet for Expedited Referral to DDS and DSS**

This cover sheet is used when a Medicaid Disability Determination is required to transition a hospitalized patient to a rehabilitation facility.

**Patient:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**This individual appears to satisfy the severity and duration requirements contained in Section 223(d) and Section 1614(a) of the Social Security Act.**

**DISABILITY is defined as:**

**The inability to do any substantial gainful work, because of a severe, medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or is expected to last for a continuous period of not less than 12 months.**

**The Medicaid Application has been sent to this Dept. of Social Services:**

**Agency Name:** \_\_\_\_\_

**Agency Address:** \_\_\_\_\_

**Date Mailed:** \_\_\_\_\_

**The information checked below is being faxed/overnighted to:**

**Disability Determination Services, Medicaid Unit  
9960 Mayland Drive, Suite 203  
Richmond, VA 23233-1463  
Telephone – 1-800-578-3672, Fax – (804) 527-4525**

\_\_\_\_\_ **Form SSA-3368 Disability Report Form**

\_\_\_\_\_ **SSA-827 Authorization to Disclose Information**

\_\_\_\_\_ **Medical Reports**

\_\_\_\_\_ **Medical History & Physical, including consultations**

\_\_\_\_\_ **Clinical findings (such as physical/mental status examination findings)**

\_\_\_\_\_ **Laboratory findings (such as latest x-rays, scans, pathology reports.)**

\_\_\_\_\_ **Diagnosis.**

\_\_\_\_\_ **A physician’s statement providing an opinion about the individual’s expected response to treatment and prognosis of residual capacity one year from onset.**

**Specific Clinical and Laboratory Findings Generally Required to Support Diagnosis and Assess Impairment Severity:**

- medically acceptable imaging - X-rays/scans/MRIs
- spirometry, DLCO (diffusing capacity of lungs for carbon monoxide), AGBS (arterial blood gas studies)
- EKGs, cardiac catheterization, echocardiogram, Doppler studies
- pathology reports
- psychological test reports

**Name of Hospital:** \_\_\_\_\_

**Date Completed:** \_\_\_\_\_

**Hospital Contact Person:** \_\_\_\_\_

**Telephone:** (\_\_\_\_) \_\_\_\_\_

**Please Print**

**Fax:** (\_\_\_\_) \_\_\_\_\_

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## M0320.000 CATEGORICALLY NEEDY GROUPS

### M0320.001 GENERAL POLICY PRINCIPLES

#### A. Overview

A State Plan for Medicaid must include the mandatory federal categorically needy (CN) groups of individuals. Most of the CN groups are mandatory; some are optional which Virginia has chosen to cover in its Medicaid state plan.

Two of the Virginia Medicaid “subclassifications,” the “categorically needy non-money payment (CNNMP)” and the “medically indigent (MI),” are actually categorically needy covered groups according to the federal Medicaid law and regulations. This subchapter divides the covered groups which are classified as CN into “protected,” “ABD” and “F&C” groups.

#### B. Procedure

Determine an individual’s eligibility first in a categorically needy covered group. If the individual is not eligible as categorically needy, go to the medically needy groups in subchapter M0330.

The following sections in this chapter contain the policy and procedures for determining whether an individual meets a Medicaid categorically needy covered group:

- M0320.100 Protected Covered Groups
- M0320.101 Former Money Payment Recipients August 1972
- M0320.102 Conversion Cases
- M0320.103 Former SSI/AG Recipients
- M0320.104 Protected Widows or Widowers
- M0320.105 Qualified Severely Impaired Individuals (QSII-1619(b))
- M0320.106 Protected Adult Disabled Children
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- M0320.302 *Plan First - Family Planning Services*
- 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 Dependent Children (LIFC)

- M0320.307 Individuals Under Age 21
- M0320.308 Special Medical Needs Adoption Assistance Children
- M0320.309 F&C In Medical Institution, Income ≤ 300% SSI
- M0320.310 F&C Receiving Waiver Services
- M0320.311 F&C Hospice
  
- M0320.312 Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)

## **M0320.100 PROTECTED COVERED GROUPS**

**A. Legal base** Federal law and regulations require that the Medicaid eligibility status of certain groups of persons be protected even though they may not meet current eligibility requirements. These groups, and the applicable eligibility requirements, are described in this section.

- B. Procedure**
- M0320.101 Former Money Payment Recipients August 1972
  - M0320.102 Conversion Cases
  - M0320.103 Former SSI/AG Recipients
  - M0320.104 Protected Widows or Widowers
  - M0320.105 Qualified Severely Impaired Individuals (QSII)-1619(b)
  - M0320.106 Protected Adult Disabled Children
  - M0320.107 Protected SSI Disabled Children.

## **M0320.101 FORMER MONEY PAYMENT RECIPIENTS AUGUST 1972**

**A. Policy** 42 CFR 435.114 and 42 CFR 435.134--The agency must provide Medicaid to individuals who meet the following conditions:

- 1. Entitled to OASDI In August 1972 & Received Cash Assistance**
- In August 1972, the individual was entitled to OASDI and
- he was receiving AFDC, Old Age Assistance (OAA), Aid to the Blind (AB), or Aid to the Permanently and Totally Disabled (APTD); or
  - he would have been eligible for one of those programs if he had applied and the Medicaid plan covered this optional group. The Virginia plan covered this group; or
  - he would have been eligible for one of those programs if he was not in a medical institution or intermediate care facility and the Medicaid plan covered this optional group. The Virginia plan covered this group.
- 2. Would Currently Be Eligible If Increase Were Excluded**
- The individual *would meet the F&C income limits for LIFC* or currently eligible for SSI or AG except that the increase in OASDI under P.L. 92-336 raised his income over the *F&C income limits or SSI*. This includes an individual who
- meets all *LIFC* requirements or current SSI requirements except for the requirement to file an application; or

Her current SSA is \$537. Her countable resources are less than the current Medicaid resource limit.

Ms. C meets the former SSI recipient protected individual criteria because she was eligible for and received SSA and SSI concurrently. Her countable income is her SSA amount prior to the January 1, 1995 COLA - \$410 - less the \$20 disregard. The result, \$390, is compared to the current SSI individual limit.

Because her resources are within the Medicaid limit, and her countable income of \$390 is within the current SSI limit, she is eligible for Medicaid as a CNNMP protected former SSI recipient.

## B. Eligibility Procedures

### 1. Assistance Unit

If the protected individual lives with his/her spouse (or parent in the case of a blind/disabled child) whose resources and income would be counted or deemed in determining the individual's SSI or AG eligibility, the SSA cost-of-living increase(s) (COLAs) received by the spouse (or parent) since the individual lost SSI or AG eligibility is also excluded in determining the protected individual's income eligibility under this section.

Use the assistance unit composition and resource deeming procedures policy in chapter M05 to determine when a spouse's resources or income are counted or deemed in determining the individual's eligibility.

The resources and income of a parent living in the home are always deemed available in determining the blind/ disabled child's eligibility. Therefore, a parent's SSA COLAs are always excluded when determining a protected blind or disabled child's income eligibility.

### 2. Resource Eligibility

Resource eligibility is determined by comparing the former SSI recipient's resources to the current Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). 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 protected covered group; he/she may be eligible as ABD medically indigent (which has more liberal resource methods and standards).

### 3. Income Eligibility

#### a. Allocation For NBD Child(ren)

When determining the amount of a spouse's or parent's deemable income, the allocation for a non blind or disabled (NBD) child(ren) in the home is the same regardless of locality (see M0530, Appendix 1). On the income worksheet, insert the SSI individual payment limit whenever the worksheet calls for the Medicaid income limit.

**b. Countable Income**

In figuring income to compare to the current SSI or AG income limit, the income exclusions in chapter S08 are applicable including the \$20 exclusion.

When the individual meets the above criteria for a protected case and the individual's assistance unit's resources are within the Medicaid resource limit:

- 1) Identify the individual's, and the individual's spouse's (or parent's when applicable), amount of Social Security Title II benefits at the time of SSI termination.

If this amount is unknown and cannot be obtained, see item 4. below.

- 2) When the amount of Social Security Title II benefits at the time of SSI termination is determined:
  - add the Medicare premium amount to the Title II check amount if only the check amount is known (see item 5. below for Medicare premium amounts);
  - determine if any change in benefit had occurred between loss of SSI and the point of application. If questionable, multiply the prior Title II amount by the COLA percentages and compare to current entitlement. If the figures are significantly different, use the procedures in 4. below to obtain the amount of Title II at the time SSI was terminated;
  - if there were no changes, count the Title II amount at the time of SSI loss. Subtract the \$20 general exclusion;
  - count all other current sources of income, apply appropriate exclusions, total countable income.

**c. Income Limit**

Countable income is compared to the AG or SSI income limit for an individual or couple, as appropriate.

The SSI limit for a couple is used whenever evaluating a couple when both meet an ABD definition and both request Medicaid. The SSI limit for an individual is used when only one member of a couple applies or meets an ABD definition.

The SSI income limit reduced by one-third is used whenever an applicant/recipient lives in the home of another person throughout a month and does not pay his/her pro rata share of food and shelter expenses.

Compare total countable income to current appropriate SSI or AG income limit/payment amount as follows:

- 1) for a protected individual living with a protected or aged, blind, disabled (ABD) spouse who applies for Medicaid, compare the countable income to the current SSI payment limit for a couple. The SSI couple limit is reduced by one-third only if both members of the couple have their shelter and food provided by another person.

If income is within the appropriate limit, the individual spouse who meets the protected group criteria is eligible. If both spouses meet the protected group criteria, each is eligible as a CNNMP former SSI recipient.

The non-protected spouse's eligibility is evaluated in another covered group.

- 2) for an individual living with a spouse and/or minor dependent children who meet a families and children category or do not apply for Medicaid, count only the individual's income and the spouse's deemed income (as determined by deeming procedures in chapter M05) and compare it to the SSI limit for an individual or couple as appropriate. If all food and shelter needs are provided by the spouse or someone else, compare the countable income to the SSI limit for an individual, reduced by one-third.
- 3) for a blind or disabled child living with a parent, calculate the parent's income (as determined by deeming procedures in chapter M05) and compare the child's countable income to the SSI payment limit for an individual. If all food and shelter needs are provided by the child's parent(s) or someone else, compare the total countable income to the SSI limit for an individual, reduced by one-third.

#### 4. COLA Formula

If only the current Title II benefit amount is known OR the benefit was changed or recalculated after loss of SSI, use the formula below to figure the base Title II amount to use in determining financial eligibility. Divide the current Title II entitlement amount by the percentages given. Then follow the steps in item B.3.b. above to determine income eligibility.

Cost-of-living calculation formula:

- a.  $\frac{\text{Current Title II Benefit}}{1.023 \text{ (1/08 Increase)}} = \frac{\text{Benefit Before}}{1/08 \text{ COLA}}$
- b.  $\frac{\text{Benefit Before 1/08 COLA}}{1.033 \text{ (1/07 Increase)}} = \frac{\text{Benefit Before}}{1/07 \text{ COLA}}$
- c.  $\frac{\text{Benefit Before 1/07 COLA}}{1.041 \text{ (1/06 Increase)}} = \frac{\text{Benefit Before}}{1/06 \text{ COLA}}$
- d.  $\frac{\text{Benefit Before 1/06 COLA}}{1.027 \text{ (1/05 Increase)}} = \frac{\text{Benefit Before}}{1/05 \text{ COLA}}$
- e.  $\frac{\text{Benefit Before 1/05 COLA}}{1.021 \text{ (1/04 Increase)}} = \frac{\text{Benefit Before}}{1/04 \text{ COLA}}$
- f.  $\frac{\text{Benefit Before 1/04 COLA}}{1.014 \text{ (1/03 Increase)}} = \frac{\text{Benefit Before}}{1/03 \text{ COLA}}$

Contact a Medical Assistance Program Consultant for amounts for years prior to 2003.

**5. Medicare Premiums**

**a. Medicare Part B premium amounts:**

1-1-08 \$96.40  
1-1-07 \$93.50  
1-1-06 \$88.50  
1-1-05 \$78.20  
1-1-04 \$66.60  
1-1-03 \$58.70

**b. Medicare Part A premium amounts:**

1-1-08 \$423.00  
1-1-07 \$410.00  
1-1-06 \$393.00  
1-1-05 \$375.00  
1-1-04 \$343.00  
1-1-03 \$316.00

Contact a Medical Assistance Program Consultant for amounts for years prior to 2003.

**6. Classification**

Individuals who are eligible when a cost-of-living increase is excluded are eligible as categorically needy non-money payment (CNNMP).

Individuals who are ineligible because of excess income after the cost-of-living increase(s) is excluded can only become Medicaid-eligible in another covered group. If they do not meet an F&C MI covered group, are not institutionalized, are not receiving CBC or do not have Medicare Part A, they must be determined eligible in a medically needy covered group.

If an individual appears to be eligible for Medicare but is not enrolled in Medicare, refer him to the SSA district office to apply for Medicare enrollment.

If an individual must pay a monthly premium for Medicare Part A, and cannot afford the premium, the SSA office will give the individual a bill for the premium when the individual is enrolled. The individual must present this bill and the Medicare Part A enrollment verification to the local DSS worker in order to be eligible for Medicaid as a QMB.

NOTE: A disabled working individual who is enrolled or is eligible to enroll in Medicare Part A under Section 1818A of the Social Security Act **cannot** be enrolled as a QMB; he may be eligible as a Qualified Disabled and Working Individual (QDWI). See M0320.209 below for information on the QDWI covered group.0

**3. Verification Not Provided**

If the applicant does not provide information documenting enrollment in Medicare Part A within the application processing time standard, he is not eligible for Medicaid as QMB, but may be eligible for Medicaid in another covered group.

**C. Financial Eligibility**

**1. Assistance Unit**

The assistance unit policy in chapter M05 applies to QMBs.

If the QMB individual is living with his spouse who is aged, blind, or disabled, but does not have Medicare Part A, and both apply for Medicaid, two different financial calculations must be completed for the unit because of the different income limits used in the eligibility determinations. One is the medically indigent QMB determination; the other is for the ABD spouse's CN or MN covered group.

**2. Resources**

The asset transfer rules in subchapter M1450 must be met by the medically indigent Medicare beneficiary.

The resource requirements in chapter S11 and Appendix 2 to chapter S11 must be met by the medically indigent Medicare beneficiary. Some of the real and personal property requirements are different for QMBs. The different requirements are identified in Appendix 2.

The resource limit for an individual is twice the medically needy resource limit for an individual; the resource limit for a couple is twice the medically needy resource limit for a couple (See Appendix 2 to chapter S11).

### 3. Income

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

### 4. Income Exceeds QMB Limit

Spendedown does not apply to the medically indigent income limits. If the individual's income exceeds the QMB limit, he is not eligible as QMB and cannot spenddown to the QMB limit. Determine the individual's eligibility in the SLMB covered group below in M0320.207.

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

## D. QMB Entitlement

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

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

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

## E. Enrollment

### 1. Aid Categories

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

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

### 2. Recipient's AC Changes To QMB

An enrolled recipient's AC cannot be changed to the QMB-only AC using a "change" transaction in the MMIS. If a Medicaid recipient becomes **ineligible** for full-coverage Medicaid because of an increase in income or resources, but is eligible as a QMB, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare premiums, deductibles and coinsurance amounts as a QMB.

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

**3. QMB's AC Changes To Full Coverage AC**

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

- cancel the QMB-only coverage effective the last day of the month immediately **prior** to the month in which he/she became eligible in the full coverage 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 classification and covered group, with the appropriate full coverage AC.

**4. Spenddown Status**

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

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

**5. QMB Meets Spenddown**

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

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

**6. Spenddown Period Ends**

After the spenddown period ends, reinstate the QMB-only coverage using the appropriate QMB-only AC.

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

**7. QMB Enters  
Long-term Care**

The enrollment of a QMB who is admitted to long-term care and who becomes eligible for Medicaid in another classification and covered group is handled like a QMB who meets a spenddown. Cancel the QMB-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.

**M0320.207 SLMB (SPECIAL LOW INCOME MEDICARE  
BENEFICIARY)**

**A. Policy**

1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act - Coverage of Special Low-income Medicare Beneficiaries is mandated by the federal Medicaid law. Medicaid will only pay the Medicare Part B premium for individuals eligible as SLMB.

An SLMB is an individual who meets all of the eligibility requirements for QMB (M0320.206 above) EXCEPT for income that exceeds the QMB limit but is less than the higher limit for SLMB. Like QMBs, eligible SLMBs who meet an MN covered group are also placed on a medically needy spenddown if resources are within the medically needy limit.

An SLMB individual

- is entitled to Medicare Part A hospital insurance benefits, but not entitled solely because he/she is eligible to enroll in Part A under section 1818A of the Act (1818A is applicable to QDWI);
- has resources (as determined for SSI purposes) that do not exceed twice the SSI resource limit; and
- has income that exceeds the QMB limit (100% of the federal poverty limits) but is less than 120% of the poverty limits.

**B. Nonfinancial  
Eligibility**

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

**1. Entitled to  
Medicare Part A**

The individual must be entitled to or must be enrolled in Medicare Part A. The individual does not have to be aged, blind or disabled.

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." Reinstatement the recipient's coverage with the begin date as the first day of the month following the cancellation effective date. The aid category (AC) is "053."

**3. SLMB'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.

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

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

**5. SLMB Meets Spenddown**

When an SLMB meets a spenddown, cancel his AC "053" coverage effective the date before the spenddown was met, using cancel reason "024". Reinstatement the recipient's coverage with the first date the spenddown was met as the begin date *of coverage*, and enter the end date of the spenddown period *as the end date of coverage*. The AC is medically needy 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". Reinstatement of 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." *QI funds are maintained in the MMIS for the current and previous year only.*

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 enrollee;
- 039 for a blind enrollee; or
- 049 for a disabled enrollee.

**M0320.211 MEDICAID WORKS****A. Policy**

The Appropriations Act of 2006 authorized an amendment to the Virginia State Plan for Medical Assistance that allows disabled (including blind) individuals who are:

- at least age 16 and are under age 65, **and**
- who have countable income less than or equal to 80% of the FPL, *(including SSI recipients)* **and**

- who have countable resources less than or equal to \$2,000 for an individual and 3,000 for a couple; **and**
- who are working or have a documented date for employment to begin in the future

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

#### **B. Nonfinancial Eligibility**

An individual in this covered group must meet the nonfinancial requirements in chapter M02:

- aged, blind, or disabled definition in subchapter M0310;
- citizenship/alien status;
- Virginia residency;
- Social Security number provision/application requirements;
- assignment of rights to medical benefits requirements;
- application for other benefits; and
- institutional status.

The individual must also meet the following additional nonfinancial criteria:

- The individual must be competitively employed in an integrated setting. Work must occur in a work setting in the community or in a personal business alongside people who do not have disabilities. Work performed in a sheltered workshop or similar setting is **not** considered competitive employment in an integrated setting. Contact a Regional Medical Assistance Program Consultant if there is a question about whether the employment meets the criteria for MEDICAID WORKS.
- The individual must receive pay at the minimum wage or at the prevailing wage or "going rate" in the community, and the individual must provide documentation that payroll taxes are withheld. Self-employment must be documented according to the policy contained in S0820.210.
- The individual must establish a Work Incentive (WIN) Account at a bank or other financial institution, such as a checking or savings accounts. The individual must provide documentation for the case record designating the account(s) as a WIN Account. The account must either be a new account or an existing account with no other income but the wages earned while in MEDICAID WORKS. It cannot contain the individual's Social Security benefits.

- All individuals requesting enrollment in MEDICAID WORKS must also sign a MEDICAID WORKS Agreement, available on the LDSS Intranet at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>. The agreement outlines the individual's responsibilities as an enrollee in the program.
- The individual must participate in cost sharing through the payment of a monthly premium to the Department of Medical Assistance Services. *Note: Monthly premiums are not being charged at this time.*

## C. Financial Eligibility

### 1. Assistance Unit

#### a. Initial eligibility determination

In order to qualify for MEDICAID WORKS, the individual must meet the assistance unit policy and procedures in chapter M05 that apply to ABD individuals with income less than or equal to 80% FPL. Resources and income from the individual's spouse with whom he lives or, if under age 21, the individual's parents with whom he lives, must be deemed available.

#### b. Ongoing eligibility

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

### 2. Resources

#### a. Initial eligibility determination

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

#### b. Ongoing eligibility

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

- i. For **earnings** accumulated **after** enrollment in MEDICAID WORKS, up to the current 1619(b) income threshold amount will be disregarded if deposited and retained in the WIN Account. The 1619(b) threshold amount for 2008 is \$29,348.
- ii. Resources accumulated while in MEDICAID WORKS and held in Internal Revenue Service (IRS)-approved retirement accounts, medical savings accounts, medical reimbursement accounts,

education accounts, independence accounts, and other similar State-approved accounts are excluded. Examples of these accounts include Archer Medical Savings Accounts, 401(k) accounts, traditional Individual Retirement Accounts (IRAs), Roth IRAs, SEP-IRAs, SIMPLE IRAs, Thrift Savings Plans, and 503(b) plans. The account must be designated as a WIN Account in order to be excluded. **Resources accumulated while in MEDICAID WORKS and held in IRS-approved accounts that have been designated as WIN Accounts are also excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees.** The account must be exclusively used to hold resources accumulated while in MEDICAID WORKS (including interest) in order for the exclusion to continue.

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

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

### 3. Income

#### a. Initial eligibility determination

For the initial eligibility determination, the income limit is  $\leq 80\%$  of the FPL (see M0810.002). The income requirements in chapter S08 must be met. Individuals who receive SSI are considered to meet the income requirements and no evaluation of income is necessary for the initial eligibility determination (see M0320.201).

#### b. Ongoing eligibility

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

- i. The income limit for earned income is 200% of the FPL for one person (see M0810.002) as long as the funds are deposited in a WIN Account. The policy for determining countable earned income is contained in subchapter S0820.

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

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

**4. Income Exceeds  
80% FPL at  
Eligibility  
Determination**

**Spenddown does not apply** to the Medicaid Works covered group. Therefore, admission into MEDICAID WORKS is not available to individuals whose income exceeds 80% of the FPL. Evaluate the individual's eligibility in all other Medicaid covered groups.

**D. Cost Sharing and  
Premium Payment**

Cost sharing is required of all individuals enrolled in MEDICAID WORKS. Enrollees are responsible for copayments for services received (see M1850.100 B).

Premiums are assessed on a sliding scale based on the individual's income and are subject to change. Based on the sliding scale, some individuals may not owe a premium.

**Note: premiums are not being charged at this time.**

**E. Good Cause**

An individual may remain eligible for MEDICAID WORKS if one of the following good cause exceptions is met:

- If the individual is unable to maintain employment due to illness or unavoidable job loss, the individual may remain in MEDICAID WORKS for up to six months as long as any **required** premium payments continue to be made. The six-month period begins the first day of the month following the month in which the job loss occurred. The individual must provide documentation that he is unable to work from a medical or mental health practitioner or employer.
- DMAS may establish other good cause reasons. Requests for good cause other than the temporary loss of employment due to illness or unavoidable job loss must be submitted to DMAS on the enrollee's behalf by the local department of social services.

**F. Safety Net**

Enrollees who are unable to sustain employment for longer than six months must be evaluated for continued coverage in all other Medicaid covered groups for which the individual meets the definition. Resources held in the WIN Account that are accumulated from the enrollee's earnings while in MEDICAID WORKS will be disregarded up to the 1619(b) threshold amount for this eligibility determination.

If found eligible and enrolled in another Medicaid covered group, the individual shall have a "safety-net" period of up to one year from MEDICAID WORKS termination and enrollment in another group to dispose of these excess resources before they are counted toward ongoing eligibility.

If the individual resumes working within the safety-net period, he may be re-enrolled in MEDICAID WORKS provided that all eligibility requirements are met, except that the resources in the WIN Account are disregarded up to the 1619(b) threshold amount. If the individual wishes to be re-enrolled in MEDICAID WORKS after the one-year safety net period, any resources retained in the WIN Account are countable.

**Resources accumulated while in MEDICAID WORKS and retained in an IRS-approved account described in M0320.211 C.2.b.ii that has been designated as a WIN Account are excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees.**

**G. Benefit Package**

Individuals enrolled in MEDICAID WORKS are entitled to the standard benefits available to full-benefit Medicaid enrollees (see Chapter M18).

**H. Entitlement and Enrollment**

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

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

*Complete the Medicaid Works fax cover sheet and fax it together with the following information to DMAS at 804-786-0973:*

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

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

*New Application – Applicant Eligible as 80% FPL*

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

*Current Enrollee*

1. *Cancel current coverage using Cancel Code 042.*

2. *Reinstate in AC 059 beginning the first day of the following month. Use the date the MEDICAID WORKS Agreement was signed for the application date.*

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

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

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

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

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

If the individual is no longer eligible for MEDICAID WORKS, the eligibility worker must determine whether the individual remains eligible in any other covered group. **The policy in M0320.211 F. above must be reviewed to determine whether the safety net rules apply.** If the individual is not eligible for Medicaid in any other covered group, coverage shall be cancelled effective the first of the month following the expiration of the 10-day advance notice

## **M0320.300 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 *Plan First--*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 *level (FPL)*. 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 at the time the child was born (including a newborn child born to an alien eligible for Medicaid payment of emergency services only) is eligible as a newborn child under age 1 year. The child remains eligible for Medicaid so long as the *child resides with the mother, they reside in Virginia, and the mother remains eligible for Medicaid or would be eligible if she were still pregnant (with the newborn)*.

##### a. Eligible To Age 1

*A child no longer meets this covered group effective the end of the month in which the child reaches age 1, provided he was under age 1 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 1. Any child born a Medicaid-eligible woman will continue to be eligible up to age 1 as long as the following conditions are met:*

- 1) the child remains in the home with the mother,
- 2) the child *and* mother *reside in Virginia, and*

- 3) *the mother remains eligible for Medicaid or would be eligible if she were still pregnant (with the newborn)*

**b. Living With Mother**

A newborn child is considered living with its mother from the moment of birth until the child is

- entrusted or committed into foster care,
- institutionalized, or
- goes to live with someone other than the child's mother.

**c. No Other Nonfinancial Eligibility Requirements**

No other nonfinancial or financial eligibility requirements need to be met by the newborn child.

**C. Financial Eligibility**

**1. Assistance Unit**

Use the assistance unit policy in chapter M05 to determine the pregnant woman's financial eligibility.

If a pregnant woman also applies for other family unit members living with her who do not meet the pregnant woman, newborn child or child under age 19 years covered group requirements, separate financial eligibility calculations must be completed for the unit. One is the MI pregnant woman determination; the other is based on the other members' covered group(s).

**2. Asset Transfer**

The asset transfer rules in subchapter M1450 apply to institutionalized MI individuals.

**3. Resources**

There is no resource limit.

**4. Income**

The income requirements in chapter M07 must be met by a pregnant woman. The income limits are 133% of the federal poverty limit and are found in subchapter M710, Appendix 6.

**5. Income Changes After Eligibility Established**

**a. Pregnant Woman**

Once eligibility is established as a pregnant woman, changes in income do not affect her eligibility as long as she meets the pregnant definition and the other nonfinancial Medicaid eligibility requirements. This also includes situations where eligibility is established in the retroactive period.

For example, a married pregnant woman applies for Medicaid on October 10. She received a medical service in the retroactive period. Her expected delivery date is January 15. She and her husband have been unemployed since June 23. Her husband began earning \$3,000 a month on October 9; she remains unemployed. Since they had no income during the retroactive period, she is found eligible for retroactive coverage effective July 1. Because her available income (from her husband) changed after she established eligibility on July 1, the change in income does not affect her eligibility and she remains eligible for Medicaid in October and subsequent

months until she no longer meets the pregnant woman definition or other nonfinancial requirements.

**b. Newborn**

*Income changes do NOT affect the certain newborn's eligibility for the first year of the child's enrollment as a certain newborn. The newborn remains eligible so long as*

- 1) *the child resides in the home with the mother, and*
- 2) *the child and mother reside in Virginia.*
- 3) *the mother remains eligible for Medicaid or would be eligible if she were still pregnant (with the newborn)*

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

**6. Income Exceeds  
MI Limit**

A pregnant woman whose income exceeds the MI income limit may be eligible for Virginia's Title XXI program, FAMIS MOMS. The income limit for FAMIS MOMS is 150% FPL. See chapter M22 to determine FAMIS MOMS eligibility.

Spenddown does not apply to the medically indigent. If the pregnant woman's income exceeds the medically indigent limit, she is not eligible as medically indigent regardless of medical expenses. Eligibility as medically needy (MN) must then be determined in order for spenddown to apply, and all medically needy eligibility requirements must be met, including resource limits.

**D. Entitlement**

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

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

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

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

**E. Enrollment**

The AC (*aid category*) for MI pregnant women is "091." The AC for newborns *born to women who were enrolled in Medicaid as categorically needy or MI* is "093."

**M0320.302 PLAN FIRST - FAMILY PLANNING SERVICES (FPS)****A. Policy**

Since October 2000, family planning services (FPS) have been available to eligible women up to 24 months after the receipt of a Medicaid-covered pregnancy related service. **Effective January 1, 2008**, a new family planning services health program known as Plan First is available to **uninsured** men and women who have countable income within 133% FPL and have not had a sterilization procedure. The previous requirements for receipt of a Medicaid-paid pregnancy-related service by women and the time limitations have been eliminated from the Plan First requirements.

The Plan First Application Form must be submitted for eligibility to be determined in this covered group. *Exception:* the application requirement for this covered group is different for women whose coverage in the MI Pregnant Woman covered group ended on or before December 31, 2007 or who were enrolled in FPS prior to January 1, 2008.

**1. MI Pregnant Woman Coverage Ended On or Before December 31, 2007 or Already Enrolled in FPS as of January 1, 2008**

Women who were eligible in the MI Pregnant Woman covered group and received a pregnancy-related service paid for by Medicaid became automatically eligible for FPS following the end of the 60-day postpartum period **when the postpartum period ended on or before December 31, 2007**. A separate eligibility determination was not required.

**Changes in income do not affect eligibility for FPS for 12 months following the end of the pregnancy when:**

- the woman was eligible in the MI Pregnant Woman covered group and received a pregnancy-related service paid for by Medicaid, and the postpartum period ended on or before December 31, 2007, or
- the woman was already enrolled in FPS as of January 1, 2008.

For FPS coverage to continue after the twelfth month, a redetermination of eligibility for Plan First, using the Plan First Application Form, must be completed.

**2. Plan First Applications Taken On or After January 1, 2008**

Uninsured men and women who have countable income within 133% FPL and have not had a sterilization procedure may be eligible for Plan First. **A Plan First application form is required** for initial eligibility and for each annual renewal. There is no automatic eligibility for Plan First other than the exception noted in A.1 above.

Plan First coverage cannot begin earlier than January 1, 2008.

Retroactive coverage is **NOT** available in the Plan First covered group.

**B. Nonfinancial Requirements**

**1. General Nonfinancial Requirements**

Men and women in this covered group must meet the following Medicaid nonfinancial requirements in chapter M02:

- citizenship/alien status (emergency services aliens described in M0220.700 are not eligible);
- Virginia residency;
- Social Security number;
- assignment of rights to medical benefits;
- application for other benefits; and
- institutional status.

*Men and women who have been determined eligible for a full benefit Medicaid covered group are not eligible for this covered group.*

DCSE services are available to all Medicaid recipients, but cooperation with DCSE is not a condition of eligibility for *this* covered group.

## **2. Creditable Health Insurance Coverage**

*Plan First men and women must **not** have creditable health insurance coverage. Creditable health insurance coverage includes:*

- *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.*

*Creditable health insurance coverage does not include:*

- *accident only;*
- *credit or disability insurance;*
- *long-term care insurance;*
- *dental only or vision only insurance;*
- *specified disease insurance;*
- *hospital confinement indemnity coverage;*
- *limited benefit health coverage;*
- *coverage issued as a supplement to liability insurance;*
- *insurance arising out of workers' compensation or similar law;*
- *automobile medical payment insurance; or*
- *insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.*

## **3. Sterilization Procedure**

*Individuals who have had a sterilization procedure (such as tubal ligation, hysterectomy, vasectomy) are **not** eligible for Plan First. Information regarding receipt of a sterilization procedure is collected on the Plan First application/renewal form.*

*If an individual enrolled in this covered group receives a sterilization procedure paid for by Medicaid, DMAS will take action to cancel the coverage and send the appropriate notice.*

**C. Financial Eligibility**

1. **Assistance Unit** Use the assistance unit policy in chapter M05 to determine the FPS financial eligibility.
2. **Asset Transfer** The asset transfer rules do not apply to the FPS covered group.
3. **Resources** There is no resource limit.
4. **Income** The income requirements in chapter M07 must be met for *this* covered group. The income limits are 133% FPL and are found in subchapter M710, Appendix 6.
5. **Spenddown** Spenddown does not apply to this covered group.

**D. Entitlement and Enrollment**

1. **Entitlement**

*Eligibility in the Plan First covered group begins the first day of the month in which the Plan First application is filed, if all eligibility factors are met in the month. Retroactive coverage is NOT available in the Plan First covered group.*

*Coverage for Plan First can begin no earlier than January 1, 2008.*

*Completion of a Plan First application is required at each renewal.*
2. **Enrollment** The AC for Plan First *enrollees* is “080.”

**M0320.303 MI CHILD UNDER AGE 19 (FAMIS PLUS)**

- A. Policy**
- Section 1902(a)(10)(A)(i)(VI) and 1902 (l)(1)(C) of the Act - The federal Medicaid law requires the Medicaid State Plan to cover children from birth to age 6 years whose countable income is less than or equal to 133% of the federal poverty limit (FPL). Section 1902(a)(10)(A)(i)(VII) and 1902 (l)(1)(D) of the Act - The federal Medicaid law requires the Medicaid State Plan to cover children who have attained age 6 years but are under age 19 years whose countable income is less than or equal to 100% of the FPL and allows states to cover children at higher income limits.
- Virginia has elected to cover children *from age 6 to age 19* with countable income less than or equal to 133% of the FPL. The federal law allows the State Plan to cover these children regardless of their families’ resources; Virginia has chosen to waive the resource eligibility requirements for these children. Coverage under the MI Child Under Age 19 covered group is also referred to as FAMIS Plus.

**B. Nonfinancial Eligibility**

The child must meet the nonfinancial eligibility requirements in chapter M02.

The child must be under age 19 years. The child's date of birth must be provided, but birth verification is not required. Any child under age 19 years can be eligible in this covered group regardless of the child's living arrangements or the child's mother's Medicaid eligibility.

A child no longer meets this covered group 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.

*NOTE: a child who does not meet a Medicaid non-financial eligibility criterion AND who has excess income for Medicaid may be evaluated for FAMIS eligibility.*

**C. Financial Eligibility**

**1. Assistance Unit**

Use the assistance unit policy in chapter M05 to determine the child's financial eligibility.

**2. Asset Transfer**

The asset transfer rules in subchapter M1450 apply to institutionalized MI individuals.

**3. Resources**

There is no resource limit.

**4. Income**

The income requirements in chapter M07 must be met by the child. The income limits are 133% of the FPL and are found in subchapter M0710, Appendix 6.

**5. Income Changes**

Any changes in an MI child's income that occur after his eligibility has been established affect eligibility. Recalculate income and compare to the MI 133% FPL income limits.

**6. Income Exceeds MI Limit**

A child under age 19 whose income exceeds the MI income limit may be eligible for Virginia's Title XXI program, Family Access to Medical Insurance Security (FAMIS). The income limit for FAMIS is 200% FPL. See chapter M21 to determine FAMIS eligibility.

Spenddown does not apply to the medically indigent. If the child's income exceeds the medically indigent limit, he/she is not eligible as medically indigent regardless of medical expenses. Eligibility as medically needy (MN) must then be determined in order for spenddown to apply, and all medically needy eligibility requirements must be met, including resource limits.

**D. Entitlement**

Eligible MI children are entitled to full Medicaid coverage beginning the first day of the child's application month if all eligibility requirements are met in that month, but no earlier than the date of the child's birth. Retroactive coverage is applicable to this covered group; however, the

income limit for children age 6 – 19 cannot exceed 100% FPL for any period prior to September 1, 2002.

Eligible MI children are entitled to all Medicaid covered services as described in chapter M18.

**E. Enrollment**

The ACs for the MI child are:

AC	Meaning
090	MI child under age 6; income greater than 100% FPL, but less than or equal to 133% FPL
091	MI child under age 6; income less than or equal to 100% FPL
092	<ul style="list-style-type: none"> <li>• MI child age 6-19; insured or uninsured with income less than or equal to 100% FPL;</li> <li>• MI child age 6-19; <b>insured</b> with income greater than 100% FPL and less than or equal to 133% FPL</li> </ul>
94	MI child age 6-19; <b>uninsured</b> with income greater than 100% FPL and less than or equal to 133% FPL

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

**M0520.000 FAMILIES & CHILDREN (F&C) FAMILY/BUDGET UNIT****M0520.001 OVERVIEW****A. Introduction**

This subchapter contains the policy and procedures for determining the assistance unit for an individual or family who meets a Families & Children (F&C) covered group. For F&C financial eligibility determination purposes, the assistance unit is called the “family/budget” unit. A household is divided into one or more family units.

The family unit’s financial eligibility is determined first. If the family unit has resources or income that cannot be verified or that exceeds the limit for the individual’s covered group, the family unit is divided into “budget” units if certain requirements are met.

**B. Policy**

Medicaid law prohibits the consideration of resources and income of any person other than a spouse or parent in the final Medicaid eligibility determination. Resources and income CANNOT be counted

- from a stepparent to a stepchild;
- from a sibling to a sibling;
- from a child to a parent;
- from a spouse or parent living apart from the individual, unless it is a voluntary or court-ordered or DCSE-ordered contribution (exception for individuals in long-term care);
- from an alien sponsor to the alien.

The family unit will include any child(ren) under age 21 living in the home for whom a unit member is legally responsible regardless of whether or not the child(ren) meet(s) a covered group, unless the child is specifically excluded.

**1. Member In One Unit**

An applicant/recipient can be a member of only one family unit or one budget unit at a time.

**2. May Exclude A Child**

The applicant can choose to exclude any child(ren) from the family unit for any reason. If the parent wants to exclude a child who has been listed on the application, the request for exclusion must be in writing. None of the excluded child’s needs are considered, and none of his income or resources are counted or deemed available to the unit. The advantages and disadvantages of the choice must be explained to the applicant or recipient.

**3. Living Away From Home**

A parent, or a child under age 21 who has not been emancipated, is considered living in the household for family unit composition purposes if the absence is temporary and the parent or child intends to return to the home when the purpose of the absence (such as employment, military service, education, rehabilitation, medical care, vacation, visit) is completed.

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

Children placed in *psychiatric* residential treatment facilities are considered absent from their home if their stay in the facility has been 30 days or more. A child who is placed in a *psychiatric* residential *treatment* facility is considered NOT living with his parents for Medicaid eligibility purposes as of the first day of the month in which the 30<sup>th</sup> day of *psychiatric* residential placement occurs. Long-term care rules do not apply to these children.

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

### C. Procedure

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

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

## M0520.010 DEFINITIONS

### A. Introduction

This section contains definitions of the terms used in the F&C family/budget unit policy and procedures.

### B. Acknowledged Father

*In Virginia, a man who is legally married to the mother of a child on the child date of birth is considered to be the legal father of the child UNLESS another man has been determined by DCSE or a court to be the child's father. The man listed on the application form as the child's father is considered to be the child's acknowledged father when:*

- *the mother was not married to another man on the child's birth date, or*
- *the mother was married to another man on the child's birth date but DCSE or a court determined that the man listed on the application is the child's father,*

*unless documentation, such as the child's birth certificate, shows that another man is the child's father.*

*NOTE: Her declaration on the application of the child's father's name is sufficient unless there is evidence that contradicts the application. The mother's marital status at the time of the child's birth does not require verification; her declaration of her marital status is sufficient. See M0310.123 for the definition of a parent.*

- C. Household** For this subchapter's purposes, the "household" is everyone living in the residence and who is listed on the Application for Benefits as living in the residence.
- D. Legal Emancipation** "Legal emancipation" from parents means that the parents and child have gone through court and a judge has declared that the parents have surrendered the right to the care, custody and earnings of the child and have renounced parental duties.
- A married Medicaid minor is NOT emancipated unless a court has declared the married minor emancipated from his or her parent(s).
- E. Legally Responsible Relative** A legally responsible relative is a person who is related to the individual applicant or recipient and who has a legal obligation under federal and state law to support the individual applicant/recipient.
- Under federal Medicaid law and regulations, the only relatives who are legally responsible relatives are the following relative(s) with whom the individual applicant or recipient lives:
- the individual's spouse, and
  - the individual's parent if the individual is a child under age 21 years.
- F. Medicaid Minor** A child under age 21 years is a Medicaid minor.

## M0520.100 FAMILY UNIT RULES

- A. Introduction** This section contains the rules that apply to the family unit within a household applying for Medicaid. The family unit consists of the individuals in the household among whom legal responsibility for support exists. A parent or non-parent caretaker can choose to exclude any child from the family unit by excluding the child from the Medicaid application (see M0520.001 B).
- B. Family Unit Composition** When determining composition of the F&C family unit, start with the individual who applies for Medicaid and who meets an F&C covered group's requirements. These covered groups are:
- Pregnant women (MI and MN);
  - Low income families with children (LIFC) (CNNMP);
  - Newborn children (MI and MN);
  - Children under age 19 (MI);

- Children under age 18 (MN);
- Individuals < 21 in foster care, adoption assistance, and ICF or an ICF-MR (CNNMP and MN).

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

**1. Member In One Unit At A Time**

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

**2. Include Responsible Relative(s)**

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

- the child is in foster care and is placed in his/her home for a trial visit; or
- the spouse or the parent receives an SSI or IV-E foster care/adoption subsidy payment. Do not include SSI and IV-E Foster Care/Adoption Assistance recipients in the unit.

Include a TANF recipient who is a responsible relative in the unit but **do not count the TANF grant as income**. Non-TANF income is counted as income to the unit.

The unit must also include all individuals in the household for whom each individual in the unit is legally responsible except

- excluded individuals;
- SSI recipients, and
- IV-E recipients.

For example, a child age 10 lives with his mother and his 5 year-old sister who receives SSI; all are included on the application. The family unit consists of the 10 year old child and his mother who is legally responsible for him, but not his SSI recipient sister even though the mother is also legally responsible for her.

**3. Child Under 21 Living Away From Home**

A child under age 21 who is living away from home is considered living with his/her parent(s) in the household for family unit composition purposes if:

- the child is not emancipated, and
- the absence is temporary and the child intends to return to the parent's home when the purpose of the absence (such as education, rehabilitation, medical care, vacation, visit) is completed.

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

Children placed in *psychiatric* residential treatment facilities are considered absent from their home if their stay in the *psychiatric residential treatment* facility has been 30 days or more. A child who is placed in a *psychiatric* residential facility is considered NOT living with his parents for Medicaid eligibility purposes as of the first day of the month in which the 30<sup>th</sup> day of *psychiatric* residential placement occurs. Long-term care rules do not apply to these children.

#### 4. Pregnant Woman

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

When an individual is pregnant but her eligibility is determined in a covered group other than MI or MN Pregnant Woman, such as blind, disabled or Low Income Families with Children (LIFC), the pregnant woman is counted as just one person.

#### 5. Cohabitant

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

### C. Examples

#### 1. Household With Excluded Child

**EXAMPLE #1:** Household listed on application consists of applicant, her disabled spouse, her 15-year old son, and husband's 20-year old daughter. The 20-year old daughter is employed full-time. Medicaid is requested for applicant, her spouse, and her son. She specifies in writing that she wishes to exclude her husband's 20-year old daughter. The family unit consists of:

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

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

**2. Household With Acknowledged Father**

**EXAMPLE #2:** Household listed on the Medicaid application consists of pregnant woman applicant, her 5-year old son and her boyfriend, who is the acknowledged father of the 5-year old. They all request Medicaid.

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

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

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

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

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

## M0520.101 MULTIPLE FAMILY UNITS

### A. Policy

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

1. **Non-parent Caretaker**  
When the individual is applying for Medicaid as a non-parent caretaker of a dependent child, multiple family units exist.
2. **EWB (Essential to the Well-Being)**  
When the individual is applying for Medicaid as an individual who is EWB to family with a dependent child, multiple family units exist.
3. **Child--No Responsible Relative In Home**  
When the individual applying is a child under age 21 but has no responsible relative living in the household and is not a sibling of another child(ren) in the household, multiple family units exist.
4. **Adult--No Responsible Relative In Home**  
When the individual applying is age 21 or older and is not legally responsible for the other applicant(s) in the household, multiple family units exist.
5. **Foster Care Child**  
When the individual applying is a foster care child whose parent(s) live in the household and who is placed in his/her home for a trial visit (see M0520.701 below), multiple family units exist.
6. **Siblings**  
Siblings under age 21 are included in the same family unit.
7. **SSI Child**  
*A child receiving SSI is always a separate family unit of one person.*

## Deeming Allocations

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

### NBD (Non-blind/disabled) Child Allocation

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

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

$$2008: \$956 - \$637 = \$319$$

$$2007: \$934 - \$623 = \$311$$

### Parental Living Allowance

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

SSI payment for one person = \$637 for 2008  
\$623 for 2007

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

SSI payment for both parents = \$956 for 2008  
\$934 for 2007

### Deeming Standard

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

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

$$2008: \$956 - \$637 = \$319$$

$$2007: \$934 - \$623 = \$311$$

- 9. Vocational Rehabilitation Training Allowances** Training allowances (transportation, books, required training expenses and motivational allowances) provided by Vocational Rehabilitation for persons participating in Vocational Rehabilitation Programs are excluded.
- The exclusion is not applicable to the allowances provided by VR to the family of the participating individual.
- 10. SSI, TANF or Auxiliary Grant** Any portion of an SSI, TANF and/or Auxiliary Grant payment is excluded. *NOTE: A VIEW Transitional Payment (VTP) is NOT TANF and is counted as unearned income.*
- 11. VISTA Payments** Payments to VISTA Volunteers under Title I, when the monetary value of such payments is less than minimum wage as determined by the Director of the action office, and payments for services of reimbursement for out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and other programs pursuant to Titles II and III, of Public Law 93-113, the Domestic Volunteer Service Act of 1973 are excluded. The worker must contact the Action Office at the following address or telephone number when VISTA payments are reported; Action Office, 400 N. 8th Street, Richmond, Virginia 23219, (804) 771-2197.
- 12. VA Educational Allowances** The Veterans Administration educational amount for the caretaker 18 or older is excluded when it is used specifically for educational purposes. Any additional money included in the benefit amount for dependents is counted as income to the individual for whom intended.
- 13. Foster Care/Adoption Assistance Payments** Foster care or adoption assistance payments received by anyone in the assistance unit are excluded.
- 14. Job Corps Payments to Eligible Children** Any unearned income received from Title IV, Part B (Job Corps) of the Job Training Partnership Act (JTPA) by an eligible child (less than 18 or 18 and expected to graduate by the end of the month in which he turns 19) is excluded as an incentive payment. However, any payment received by any other Job Corps participant or any payment made on behalf of the participant's eligible child(ren) is counted as income to the individual.
- 15. Fuel Assistance Program** Any payment made under the Fuel Assistance Program is excluded.
- 16. Child Nutrition Act** The value of supplemental food assistance received under the Child Nutrition Act of 1966 is excluded. This includes all school meal programs, the Women, Infants and Children (WIC) Program, the child care food program, and U.S.D.A. reimbursement payments to day care providers which are authorized by the National School Lunch Act.

- 17. HUD Payments** HUD Section 8 and Section 23 payments are excluded.
- 18. JTPA Income to Eligible Children** Any unearned income received by an eligible child (less than 18 or 18 and expected to graduate by the end of the month in which he turns 19) under Title II, Parts A and B, and Title IV, Part A of the Job Training Partnership Act (JTPA) is excluded.
- 19. Certain Funds for Indian Tribes** Any funds distributed to, or held in trust for, members of any Indian tribe under Public Law 92-254, 93-134, 94-540, 98-64, 98-123, 98-124 or 97-458 are excluded. Additionally, interest and investment income accrued on such funds while held in trust, and purchases made with such interest and investment income are excluded.
- 20. Alaska Native Claims Settlement Act** The following of distributions received from a Native Corporation under the Alaska Native Claims Settlement Act (Public Law 100-241) are excluded:
- a. Cash (including cash dividends on stock received from a Native Corporation) to the extent that the total received does not exceed \$2,000 per individual per calendar year;
  - b. Stock (including stock issued or distributed by a Native Corporation as a dividend or distribution on stock);
  - c. A partnership interest;
  - d. Land or an interest in land (including land or an interest in land received from a Native Corporation as a dividend or distribution on stock); and
  - e. An interest in a settlement trust.
- 21. Income from Submarginal Land** Income derived from certain submarginal land of the United States which is held in trust for certain Indian tribes (Public Law 94-114) is excluded.
- 22. Child/Spousal Support Payments** The first \$50 of total child or child and spousal support payments received by the family/budget unit is excluded. The \$50 exclusion is only applicable to current child/spousal support payments received each month. (See M0730.400)
- 23. DCSE Payments of Excluded Support** Payments sent to the recipient by the State which are identified as excluded support are excluded. See M0730.400.
- 24. Disaster Relief** Federal major disaster and emergency assistance provided under the Disaster Relief and Emergency Assistance Amendments of 1988 and disaster assistance provided by state and local governments and disaster assistance organizations (Public Law 100-707) is excluded.

- 25. Certain Payments to Japanese and Aleut** Payments received by individuals of Japanese ancestry under the Civil Liberties Act of 1988, and by Aleut under the Aleutian and Pribilof Islands Restitution Act (Public Law 100-383) are excluded.
- 26. ESP or VIEW Support Payments** Payments by Employment Services Program or VIEW for support services such as transportation, uniforms, child care, etc. are excluded. *VIEW Transitional Payments (VTP) are NOT excluded; VTP must be counted as unearned income.*
- 27. Agent Orange Payments** Any payment received from the Agent Orange Settlement Fund or any other fund established in response to the Agent Orange product liability litigation is excluded. To verify whether a payment is an Agent Orange payment, use documents in the individual's possession. If the individual cannot provide verification or the situation is unclear, write to the Agent Orange Veteran Payment Program, P.O. Box 110, Hartford, CT 06104, Attention: Agent Orange Verification. Include in the request the veteran's name and social security number. If a survivor of a qualifying veteran was paid, also provide the survivor's name and social security number.
- 28. Radiation Exposure Compensation Act Payments** Payment received by individuals under the Radiation Exposure Compensation Act (Public Law 101-426) is excluded.
- 29. Maine Indians Claims Settlement Act** Funds received pursuant to the Maine Indians Claims Settlement Act of 1980 (Public Law 96-420); and the Aroostook Band of Micmacs Settlement Act (Public Law 102-171) are excluded.
- 30. Higher Education Act Student Financial Assistance** Student financial assistance received under Title IV of the Higher Education Act. Assistance to be excluded under this provision, whether awarded to an undergraduate or graduate student, includes but is not limited to:
- Pell Grants,
  - Supplemental Educational Opportunity Grants,
  - State Student Incentive Grants,
  - Federal College Work-Study Programs,
  - Perkins Loans (formerly National Direct Student Loans), and
  - Guaranteed Student Loans (including PLUS loans and Supplemental Loans for Students).
- 31. Carl D. Perkins Student Financial Assistance** Student financial assistance received under the Carl D. Perkins Vocational and Applied Technology Education Act made available for attendance costs (Public Law 101-392) is excluded. Attendance costs are defined below:
- tuition and fees normally assessed a student carrying the same academic workload as determined by the institution, and including

costs for rental or purchase of any equipment, materials, or supplies required of all students in the same course of study; and

- an allowance for books, supplies, transportation, dependent care, and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution.

- 32. HUD Self-Sufficiency Program** Funds paid to an escrow account established under the Family Self-Sufficiency Program of the Department of Housing and Urban Development are excluded.
- 33. BIA Student Assistance** Student financial assistance received under Bureau of Indian Affairs (BIA) student assistance programs is excluded.
- 34. Interest on Certain Savings Accounts** Interest earned on a savings account for the purpose of paying for tuition, books, and incidental expenses at any elementary, secondary, or vocational school or any college or university for a family member, for making a down payment on a primary residence, or establishing a business is excluded.
- 35. Up To \$2000/yr. Received by Individual Indians** Up to \$2,000 per year of income received by individual Indians, which is derived from leases or other uses of individually-owned trust or restricted lands is excluded.
- 36. Nazi Persecution Payments** Payments received by victims of Nazi persecution under Public Law 103-286 are excluded.
- 37. First \$30 for Special Occasions** The first \$30 received by each individual in the family/budget unit per calendar quarter for special occasions, such as birthdays, Christmas, etc. is excluded. See M0730.520.
- 38. Lump Sum** A lump sum plus all other earned and unearned income that is less than 100% of need in the locality for the number of members in the FU/BU is excluded from countable unearned income when evaluating lump sum income. See M0730.800.
- 39. Walker v. Bayer Settlement Payments** Section 4735 of the Balanced Budget Act of 1997 (P.L. 105-33) states that payments described in this subsection from the settlement of the Susan Walker v. Bayer Corp., et.al., class action lawsuit are NOT counted as income in determining eligibility for Medicaid. Payments described in this subsection are:
- a. payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corp., et.al., 96-C-5024 (N.D.III.); and

**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  
*VIEW Transitional Payments*

**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.

**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	2008 Monthly Amount	2007 Monthly Amount
1	\$637	\$623
2	956	934
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size	2008 Monthly Amount	2007 Monthly Amount
1	\$424.67	\$415.33
2	637.33	622.67

**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	2008 Monthly Amount	2007 Monthly Amount
1	\$1911	\$1,869

**4. Medically Needy**

a. Group I		
Family Unit Size	Semi-annual	Monthly
1	\$ 1,556.59	\$ 259.43
2	1,982.06	330.34
b. Group II		
Family Unit Size	Semi-annual	Monthly
1	\$ 1,796.07	\$ 299.34
2	2,211.97	368.66
c. Group III		
Family Unit Size	Semi-annual	Monthly
1	\$ 2,334.89	\$ 389.14
2	2,815.29	469.21

**5. ABD Medically Indigent**

**For:  
 ABD 80% FPL,  
 QMB, SLMB, &  
 QI without Social  
 Security (SS) and  
 QDWI, effective  
 1/24/07;  
 ABD 80% FPL,  
 QMB, SLMB, &  
 QI with SS,  
 effective 3/01/07;  
 and MEDICAID  
 WORKS,  
 effective 1/24/07**

ABD 80% FPL	Annual	Monthly
1	\$ 8,168	\$ 681
2	10,952	913
QMB 100% FPL	Annual	Monthly
1	\$10,210	\$ 851
2	13,690	1,141
SLMB 120% of FPL	Annual	Monthly
1	\$12,252	\$1,021
2	16,428	1,369
QI 135% FPL	Annual	Monthly
1	\$13,784	\$1,149
2	18,482	1,541
QDWI and MEDICAID WORKS 200% of FPL	Annual	Monthly
1	\$20,420	\$1,702
2	27,380	2,282

## M0815.200 CONVERSION OR SALE OF A RESOURCE

- A. Policy** Receipts from the sale, exchange, or replacement of a resource are **not income** but are resources that have changed their form.
- This includes any cash or in-kind items that is provided to replace or repair a resource that has been lost, damaged, or stolen
- Capital gains, which are profits made from the sale of capital assets (long-term assets such as land or buildings), are also not income. Any proceeds that remain the month after this type of sale must be evaluated as a resource.*
- B. Reference** See S1110.600 B.4. for a complete discussion of the policy.
- C. Example** Jerry Wallace sells his 1974 Plymouth Satellite for \$300. The money he receives is not income but a resource which has been converted from one form (a car) to another form (cash).

## M0815.250 REBATES AND REFUNDS

- A. Policy** When an individual receives a rebate, refund, or other return of money he or she has already paid, the money returned is **not income**.
- CAUTION:** The key idea is applying this policy is a return of an individual's own money. Some "rebates" do not fit that category. For example, if a cooperative operating as a jointly-owned business pays a "rebate" as a return on a member's investment, this money is unearned income similar to a dividend. Developmental guidelines for interest and dividends are in S0830.500.
- B. Procedure**
- 1. General** Unless you have reason to question the situation, accept an individual's signed allegation that a rebate or refund of money is a return of money already paid and do not count it as income.
  - 2. Questionable Situation** In questionable situations, make copies for the file of any documents in the individual's possession, and contact the source of the payment, etc. to verify that the payment is a return of money already paid.
- C. Example** Rose Woods, an elderly recipient, pays property taxes on the home she lives in. Because of her low income, the city government returns part of Mrs. Woods' property taxes in the form of a check. This return of money already paid by Mrs. Woods is not income.
- D. References** See S0830.705 for rules on the exclusion of certain taxes.

## M0815.270 INCOME TAX REFUNDS

### A. Policy

1. **General** Any amount refunded on income taxes already paid is **not income**.
2. **Tax Withheld Prior to Application Date** Income tax refunds are not income even if the income from which the tax was withheld or paid was received in a period prior to application for Medicaid.
3. **Tax Refunds and Blind Work Expenses** Income tax refunds are **not income** even if the income taxes were included as work expenses of the blind.  
(See S0820.535 B.3.)

## M0815.300 CREDIT LIFE OR CREDIT DISABILITY INSURANCE PAYMENTS

- A. Definition of Credit Life/Disability Insurance** Credit life and credit disability insurance policies are issued to or on behalf of borrowers, to cover payments on loans, mortgages, etc. in the event of death or disability. These insurance payments are made directly to loan or mortgage companies, etc. and are not available to the individual.
- B. Policy**
- Payments made under a credit life or credit disability insurance policy on behalf of an individual are **not income**.
  - Food, clothing, or shelter received as the result of a credit life or credit disability payment is **not income**.
- C. Example** Frank Fritz, a Medicaid recipient, purchased credit disability insurance when he bought his home. Subsequently Mr. Fritz was in a car accident and became totally disabled. Because of his disability, the insurance company pays off the home mortgage. Neither the payment nor the increased equity in the home is income to Mr. Fritz.

C. Procedure

1. **Verification**
  - a. Verify these payments by examining documents in the individual's possession which reflect:
    - the amount of the payment,
    - the date(s) received, and
    - the frequency of payment, if appropriate.
  - b. If the individual has no such evidence in his possession, contact the source of the payment.
  - c. If verification cannot be obtained by the above means, accept any evidence permitted by either S0820.130 A. or S0820.220.
2. **Assumption**

Assume that any honoraria received is **in consideration of services rendered**, absent evidence to the contrary. Evidence to the contrary would include a statement or document indicating that part or all of the honoraria is for something other than services rendered (e.g., travel expenses or lodging).
3. **Expenses of Obtaining Income**

DO NOT DEDUCT any expenses of obtaining income from royalties or honoraria that are earned income. (Such expenses are deductible from royalties/honoraria that are unearned income.)
4. **Documentation**

Document the file by including copies of documents or indicating in the file information provided by the payment source concerning the amount and, if appropriate, frequency of payment.

- D. References
- Royalties as unearned income, S0830.510.
  - To determine deductible IRWE/BWE, see S0820.535 - .565.

## EARNED INCOME EXCLUSIONS

### S0820.500 GENERAL

A. Policy

1. **General**

The source and amount of all earned income must be determined, but not all earned income counts when determining Medicaid eligibility.
2. **Other Federal Laws**

First, income is excluded as authorized by other Federal laws.

**3. Other Earned Income**

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

- a. Federal earned income tax credit payments
- b. Up to \$10 of earned income in a month if it is infrequent or irregular
- c. For 2007, up to \$1,510 per month, but not more than \$6,100 in a calendar year, of the earned income of a blind or disabled student child.

For 2008, up to \$1,550 per month, but not more than \$6,240 in a calendar year, of the earned income of a blind or disabled student child.

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

**4. Unused Exclusion**

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

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

**5. Couples**

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

**B. References**

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

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

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

**S0820.510 STUDENT CHILD EARNED INCOME EXCLUSION**

**A. Policy**

**1. General** For a blind or disabled child who is a student regularly attending school, earned income is excluded under this provision, limited to the maximum amounts shown below.

<b>For Months</b>	<b>Up to per month</b>	<b>But not more than in a calendar year</b>
In calendar year 2007	\$1,510	\$6,100
In calendar year 2008	\$1,550	\$6,240

**2. Qualifying for the Exclusion** The individual must be:

- a child under age 22; and
- a student regularly attending school.

**3. Earnings Received Prior to Month of Eligibility** Earnings received prior to the month of eligibility do not count toward the yearly limit.

**4. Future Increases** The monthly and yearly limits will be adjusted annually based on increases in the cost of living index. Under this calculation, these amounts will never be lower than the previous year's amounts. However, there may be years when no increases result from the calculation.

**B. Procedure**

**1. Application of the Exclusion** Apply the exclusion:

- consecutively to months in which there is earned income until the exclusion is exhausted or the individual is no longer a child; and
- only to a student child's own income.

**2. School Attendance and Earnings** Develop the following factors and record them:

- whether the child was regularly attending school in at least 1 month of the current calendar quarter, or expects to attend school for at least 1 month in the next calendar quarter, and
- the amount of the child's earned income (including payments from Neighborhood Youth corps, Work-Study, and similar programs).

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

**C. References**

- Grants, scholarships and fellowships, S0830.455.
- Educational assistance with Federal funds involved, S0830.460.

**D. Example**

*(Using April  
2002 Figures)*

Jim Thayer, a student child, starts working in June at a local hardware store. He had no prior earnings during the year, and he has no unearned income. Jim earns \$1,600 a month in June, July and August. In September, when he returns to school, Jim continues working part-time. He earns \$800 a month in September and October. Jim's countable income computation for June through October is as follows:

June, July and August

\$1600.00	gross earnings
<u>- 1320.00</u>	student child exclusion
\$ 280.00	
<u>- 20.00</u>	general income exclusion
\$ 260.00	
<u>- 65.00</u>	earned income exclusion
\$ 195.00	
<u>- 97.50</u>	one-half remainder
\$ 97.50	countable income

Jim has used up \$3,960 of his \$5,340 yearly student child earned income exclusion (\$1,320 in each of the three months).

September

\$800.00	gross earnings
<u>- 800.00</u>	student child exclusion
0	countable income

Jim has now used up \$4,760 of his \$5,340 yearly student child earned income exclusion.

October

\$800.00	gross earnings
<u>- 580.00</u>	student child exclusion <i>remaining (\$5,340-\$4,760=\$580)</i>
\$220.00	
<u>- 20.00</u>	general income exclusion
\$200.00	
<u>- 65.00</u>	earned income exclusion
\$135.00	
<u>- 67.50</u>	one-half remainder
\$ 67.50	countable income

Jim has exhausted his entire \$5,340 yearly student child earned income exclusion. The exclusion cannot be applied to any additional earnings during the calendar year.

**S0830.099 GUIDE TO EXCLUSIONS**

**A. Introduction**

The following provides a list of those instructions which address a partial or total exclusion of unearned income. Those in **bold print** involve an exclusion under another Federal statute.

**B. List of Instructions About Unearned Income Exclusions**

<b>Action Programs S0830.610</b>	
<b>Agent Orange Settlement Payments</b> .....	S0830.730
Austrian Social Insurance Payments .....	S0830.715
<b>BIA Student Assistance</b> .....	S0830.460
<i>Capital Gains</i> .....	<i>M0815.200</i>
Child Support .....	S0830.420
.....	S0830.425
Disaster Assistance .....	S0830.620
<b>Educational Assistance</b> .....	S0830.450
<b>Energy Assistance</b> .....	S0830.600
.....	S0830.605
<b>Farmers Home Administration Housing</b>	
<b>Assistance (FMHA)</b> .....	S0830.630
<b>Food/Meal Programs</b> .....	S0830.635
<b>Food Stamps</b> .....	S0830.635
<b>Foster Grandparents Program</b> .....	S0830.610
General Assistance (General Relief) .....	S0830.175
German Reparation Payments .....	S0830.710
Gifts Occasioned by a Death .....	S0830.545
Gifts of Domestic Travel Tickets .....	S0830.521
Grants, Scholarships, and Fellowships .....	S0830.455
<b>HUD Subsidies</b> .....	S0830.630
<b>Home Energy Assistance</b> .....	S0830.600
.....	S0830.605
Home Produce .....	S0830.700
Hostile Fire Pay from the Uniformed	
Services .....	S0830.540
Housing Assistance .....	S0830.630
Interest on Excluded Burial Funds .....	S0830.501
<b>Japanese-American and Aleutian</b>	
<b>Restitution Payments</b> .....	S0830.720
<b>Low Income Energy Assistance</b> .....	S0830.600
<b>Meals for Older Americans</b> .....	S0830.635
<b>Milk Programs</b> .....	S0830.635

<b>National Defense Student Loans (NDSL)</b> .....	S0830.460
<b>Pell Grants</b> .....	S0830.460
Private Non-profit Assistance .....	S0830.605
<b>Radiation Exposure Compensation Trust</b>	
<b>Fund (RECTF) Payments</b> .....	S0830.740
Refunds of Taxes Paid on Real Property or Food .....	S0830.705
Relocation Assistance .....	S0830.655
<b>Retired Senior Volunteer Program (RSVP)</b> .....	S0830.610
<b>School Breakfasts</b> .....	S0830.635
<b>School Lunches</b> .....	S0830.635
<b>Senior Companion Program</b> .....	S0830.610
<b>Supplemental Education Opportunity Grant (SEOG)</b> .....	S0830.460
<b>Special and Demonstration Volunteer Program</b> .....	S0830.610
<b>State Student Incentive Grants (SSIG)</b> .....	S0830.460
State Assistance Based on Need. ....	S0830.175
<b>University Year for Action (UYA)</b> .....	S0830.610
Victim's Compensation Payments .....	S0830.660
<b>Volunteers in Service to America (VISTA)</b> .....	S0830.610
<b><u>Walker v. Bayer Settlement Payments</u></b> .....	M0830.760
<b>Women, Infants, and Children Program (WIC)</b> .....	S0830.635

**4. Receipts from the Sale, Exchange, or Replacement of a Resource**

If an individual sells, exchanges, or replaces a resource, what he/she receives in return is not income. It is a different form of resource. This includes assets which have never been subject to resources counting because the owner sold, exchanged, or replaced them in the same month in which he/she received them.

*Capital gains, which are profits made from the sale of capital assets (long-term assets such as land or buildings), are also not income. Any proceeds that remain the month after this type of sale must be evaluated as a resource.*

The concept of such transactions not producing income does not apply to receipts from the sale of timber, minerals, or other like items which are part of the land.

**C. Example--Receipt of a Resource Considered as Income and Exchanged in Same Month**

Miss Laramie, a disabled individual, received a \$350 unemployment insurance benefit on January 10 at which time it was unearned income. On January 18, she used the \$350 to purchase several shares of stock; i.e., she exchanged one resource (cash) for another resource (stock). We never counted the \$350 cash payment as a resource because Miss Laramie exchanged it for stock in the month of receipt. The stock is not income; it is a different form of resource. Since a resource is not countable until the first moment of the month following its receipt, we first count the stock in the resources determination made as of February 1.

**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 *to be* eligible as ABD MI. If he remains eligible as ABD MI, the ABD Medicaid Renewal form (#032-03-0186) 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.

*The spenddown budget period is based on the application date. At renewal, the new spenddown budget period begins the month following the end of the previous spenddown budget period if the renewal is filed in the last month of the spenddown budget period or the following month. If the renewal is filed two or more months after the end of the last spenddown budget period, the new spenddown budget periods (retroactive or prospective) are based on the date the renewal form was received in the LDSS. Do not complete an early renewal on a spenddown case because the spenddown period must not be shortened by the completion of an early renewal.*

**3. QI**

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

## M1370.300 Qualified Individuals (QI)

**A. Introduction**

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

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

**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 *MN coverage will end* the last date of the spenddown budget period.

**D. Continuing Eligibility and Enrollment After Spenddown Ends**

When the spenddown budget period ends, reinstate the 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 *ends* 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.

**6. Individual and Family Developmental Disabilities Support Waiver (DD Waiver)**

The Individual and Family Developmental Disabilities (DD) waiver provides home and community-based services to individuals with developmental disabilities who do not have a diagnosis of mental retardation. The developmental disability must have manifested itself before the individual reached age 21 and must be likely to continue indefinitely.

The services provided under this waiver include:

- support coordination (case management)
- adult companion services
- assistive technology
- crisis intervention/stabilization
- environmental modifications
- residential support
- skilled nursing
- supported employment
- therapeutic consultation
- respite care
- personal attendant services
- consumer-directed personal and respite care.

**7. Day Support Waiver for Individuals with Mental Retardation**

The Day Support Waiver for Individuals with Mental Retardation (DS Waiver) is targeted to provide home and community-based services to individuals with mental retardation who have been determined to require the level of care provided in an ICF/MR. These individuals may currently reside in an ICF/MR or may be in the community at the time of assessment for DS Waiver services. Only those individuals on the urgent and non-urgent waiting lists for the MR Waiver are considered for DS Waiver services. Individuals may remain on the MR Waiver waiting list while receiving DS Waiver Services.

The services provided under this waiver include:

- day support
- prevocational services

**8. Alzheimer's Assisted Living Waiver**

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

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

The services provided under the AAL waiver include:

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

- nursing services for assessments and evaluations
- therapeutic social and recreational programming which provides daily activities for individuals with dementia.

**D. Children's Mental Health Program—  
Not Medicaid CBC**

*Children's Mental Health Program services are home and community-based services to children who have been discharged from psychiatric residential treatment facilities. **Children's Mental Health Program services are NOT Medicaid CBC services.** See M1520.100 E. for additional information.*

## **M1410.050 FINANCIAL ELIGIBILITY REQUIREMENTS**

**A. Introduction** An individual in LTC must meet the financial eligibility requirements that are specific to institutionalized individuals; these requirements are contained in this chapter:

**B. Asset Transfer** The asset transfer policy is found in subchapter M1450.

**C. Resources** The resource eligibility policy for individuals in LTC who do not have community spouses is found in subchapter M1460 of this chapter.

The resource eligibility requirements for married individuals in LTC who have community spouses are found in subchapter M1480 of this chapter.

**D. Income** The income eligibility policy for individuals in LTC who do not have community spouses is found in subchapter M1460 of this chapter.

The income eligibility policy for individuals in LTC who have community spouses is found in subchapter M1480.

## **M1410.060 POST-ELIGIBILITY TREATMENT OF INCOME (PATIENT PAY)**

**A. Introduction** Medicaid-eligible individuals must pay a portion of their income to the LTC provider; Medicaid pays the remainder of the cost of care. The portion of their income that must be paid to the provider is called "patient pay."

**B. Patient Pay** The policies and procedures for patient pay determination are found in subchapter M1470 of this chapter for individuals who do not have community spouses and in subchapter M1480 for individuals who have community spouses.

## **M1410.100 LONG-TERM CARE APPLICATIONS**

**A. Introduction** The general application requirements applicable to all Medicaid applicants/recipients found in chapter M01 also apply to applicants/recipients who need LTC services. This section provides those additional or special application rules that apply only to persons who meet the institutionalization definition.

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a transfer for less than fair market value and no penalty period will be calculated.

Assets transferred on or after February 8, 2006, that have a total cumulative value of more than \$1,000 but less than or equal to \$4,000 per calendar year may not be considered a transfer for less than fair market value if documentation is provided that such transfers follow a pattern that existed for at least three years prior to applying for Medicaid payment of LTC services. Christmas gifts, birthday gifts, graduation gifts, wedding gifts, etc. meet the criteria for following a pattern that existed prior to applying for Medicaid payment of LTC services.

**I. LTC Partnership Policy**

*The value of assets transferred that were disregarded as a result of an LTC Partnership Policy does not affect an individual's eligibility for Medicaid payment of LTC services. See M1460.160 for more information about LTC Partnership Policies.*

**J. Return of Asset**

The transfer of an asset for less than fair market value does not affect eligibility for Medicaid LTC services' payment if the asset has been returned to the individual.

**K. Undue Hardship Policy**

Policy for claiming undue hardship was moved to M1450.700.

## **M1450.500 TRANSFERS THAT AFFECT ELIGIBILITY**

**A. Policy**

If an asset transfer does not meet the criteria in sections M1450.300 or M1450.400, the transfer will be considered to have been completed for reasons of becoming or remaining eligible for Medicaid payment of LTC services, unless evidence has been provided to the contrary.

Asset transfers that affect eligibility for Medicaid LTC services payment include, but are not limited to, transfers of the following assets:

- cash, bank accounts, savings certificates,
- stocks or bonds,
- resources **over \$1,500** that are excluded under the burial fund exclusion policy,
- cash value of life insurance when the total face values of all policies owned on an individual exceed \$1,500,
- interests in real property, including mineral rights,
- rights to inherited real or personal property or income.

**B. Procedures**

Use the following sections to evaluate an asset transfer:

- M1450.510 for a purchase of term life insurance.
- M1450.520 for a purchase of an annuity before February 8, 2006.
- M1450.530 for a purchase of an annuity on or after February 8, 2006.
- M1450.540 for promissory notes, loans, or mortgages.
- M1450.550 for a transfer of assets into or from a trust.
- M1450.560 for a transfer of income.

**M1450.510 PURCHASE OF TERM LIFE INSURANCE**

**A. Policy** The purchase of any term life insurance after April 7, 1993, except term life insurance that funds a pre-need funeral under section 54.1-2820 of the Code of Virginia, is an uncompensated transfer for less than fair market value if the term insurance's benefit payable at death does not **equal or exceed twice the sum of all premiums paid for the policy.**

**B. Procedures**

**1. Policy Funds Pre-need Funeral** Determine the purpose of the term insurance policy by reviewing the policy. If the policy language specifies that the death benefits shall be used to purchase burial space items or funeral services, then the purchase of the policy is a compensated transfer of funds and does not affect eligibility.

However, any benefits **paid** under such policy in excess of the actual funeral expenses are subject to recovery by the Department of Medical Assistance Services for Medicaid payments made on behalf of the deceased insured Medicaid recipient.

**2. Policy Funds Irrevocable Trust** Since **an irrevocable trust for burial is not a pre-need funeral**, the purchase of a term life insurance policy(ies) used to fund an irrevocable trust is an uncompensated transfer of assets for less than fair market value.

**3. Determine If Transfer Is Uncompensated** When the term life insurance policy does not fund a pre-need funeral, determine if the purchase of the term insurance policy is an uncompensated transfer:

- a. Determine the benefit payable at death. The face value of the policy is the "benefit payable at death."
- b. From the insurance company, obtain the sum of all premium(s) paid on the policy; multiply this sum by 2. The result is "twice the premium."
- c. Compare the result to the term insurance policy's face value.
  - 1) If the term insurance's face value equals or exceeds the result (twice the premium), the purchase of the policy is a transfer for fair market value and does not affect eligibility.
  - 2) If the term insurance's face value is less than the result (twice the premium), the purchase of the policy is an uncompensated transfer for less than fair market value. Determine a penalty period per M1450.620 or M1450.630 below.

**EXAMPLE #1:** Mr. C. uses \$5,000 from his checking account to purchase a \$5,000 face value term life insurance policy on August 13, 1995. Since the policy was purchased after April 7, 1993, and \$5,000 (benefit payable on death) is not twice the \$5,000 premium, the purchase is an uncompensated transfer. The uncompensated value and the penalty period for Medicaid payment of long-term care services must be determined.

- simple retirement accounts; or
- a. the annuity is a simplified employee pension (within the meaning of section 408(k) of the IRS Code; or a Roth Individual Retirement Account (IRA); or
- b. *the annuity is:*
  - irrevocable and non-assignable;
  - actuarially sound (see M1450.520 C.); and
  - provides for equal payments with no deferral and no balloon payments.

**1. Send Copy to DMAS**

A copy of the annuity agreement must be sent to:

DMAS, Division of Policy and Research  
Eligibility Section  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219

**2. Maintain Copy of Annuity**

*The copy must be maintained by DMAS until the terms of the annuity have expired. A copy of the annuity must also be maintained in agency's case record.*

## **M1450.540 PURCHASE OF A PROMISSORY NOTE, LOAN, OR MORTGAGE ON OR AFTER FEBRUARY 8, 2006**

**A. Introduction**

This policy applies to the purchase of a promissory note, loan, or mortgage on or after February 8, 2006. Subchapter S1140.300 contains explanations of promissory notes, loans, and mortgages.

**B. Policy**

Funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, must be evaluated as an uncompensated transfer unless the note, loan, or mortgage:

- has a repayment term that is actuarially sound (see M1450.520),
- provides for payments to be made in equal amounts during the term of the loan with no deferral and no balloon payments, and
- prohibits the cancellation of the balance upon the death of the lender.

**C. Uncompensated Amount**

If the promissory note, loan, or mortgage does not meet the above criteria, the uncompensated amount is the outstanding balance as of the date of the individual's application for Medicaid.

Note: The countable value as a resource is the outstanding principal balance for the month in which a determination is being made.

## M1450.545 TRANSFERS INVOLVING LIFE ESTATES

- A. Introduction** This policy applies to the purchase of a life estate on or after February 8, 2006.
- B. Policy** Funds used to purchase a life estate in another individual's home on or after February 8, 2006, must be evaluated as an uncompensated transfer unless the purchaser resides in the home for at least 12 consecutive months. If the purchaser resides in the home for less than 12 consecutive months, the entire purchase amount will be considered a transfer for less than fair market value.
- For Medicaid purposes, the purchase of a life estate is said to have occurred when an individual acquires or retains a life estate as a result of a single purchase transaction or a series of financial and real estate transactions.*

## M1450.550 TRANSFERS INVOLVING TRUSTS

- A. Introduction** A transfer of assets into or from a trust may be a transfer of assets for less than market value. See M1120.200 for trust resource policy, definitions pertaining to trusts, and for instructions for determining if the trust is a resource.
- B. Revocable Trust**
- 1. Transfer Into Revocable Trust** A transfer of assets **into** a revocable trust does not affect eligibility because the entire principal of a revocable trust is an available resource to the individual.
  - 2. Payments From a Revocable Trust** Any payments from the revocable trust which are made to or for the benefit of the individual are counted as income to the individual and are not transfers for less than market value.  
  
Any payments from the revocable trust's principal or income which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value.
  - 3. Look-back Date** The look-back date is 60 months for assets transferred (payments made) **from** a revocable trust.  
  
**EXAMPLE #4:** Mr. B established a revocable trust with a principal of \$100,000 on March 1, 1994. He enters a nursing facility on November 15, 1997, and applies for Medicaid on February 15, 1998. The trustee has complete discretion in disbursing funds from the trust. Each month, the trustee disburses \$100 to Mr. B and \$500 to a property management firm for the upkeep of Mr. B's home. On June 14, 1994, the trustee gave \$50,000 of the trust principal to Mr. B's brother.  
  
The \$100 and \$500 payments are counted as income to Mr. B. Because the trust is revocable, the entire principal is a resource to Mr. B. Because the trustee gave \$50,000 away, the countable value of the trust is the remaining \$50,000. The transfer of the \$50,000 to Mr. B's brother is a transfer for less than fair market value. The look-back date is February 15, 1993, which is 60 months prior to February 15, 1998, the date Mr. B was both in an institution and applied for Medicaid. The transfer occurred on June 14, 1994 which is after the look-back date. The uncompensated value is \$50,000. The penalty

The \$100 and \$500 payments are counted as income to Mr. D. Because none of the principal can be disbursed to Mr. D, the entire value of the trust at the time the trust was established (\$100,000 in 3-1-94) is a transfer of assets for less than fair market value. The look-back date is February 15, 1993, which is 60 months prior to the baseline date of February 15, 1998, the date Mr. D was both in an institution and applied for Medicaid. The transfer occurred on 3-1-94 which is after the look-back date. The uncompensated value is \$100,000.

The 7-2-96 transfer of \$10,000 into the trust is another asset transfer for less than fair market value that occurred on 7-2-96. The transfer occurred on 7-2-96 which is after the look-back date. The uncompensated value is \$10,000.

## M1450.560 INCOME TRANSFERS

**A. Policy** Income is an asset. When an individual's income is given or assigned in some manner to another person, such gift or assignment may be a transfer of an asset for less than market value.

**B. Procedures** Determine whether the individual has transferred lump sum payments actually received in a month. Such payments are counted as income in the month received for eligibility purposes, and are counted as resources in the following month if retained. Disposal of a lump sum payment before it can be counted as a resource could be an uncompensated asset transfer.

Attempt to determine whether amounts of regularly scheduled income or lump sum payments, which the individual would otherwise have received, have been transferred. Normally, such a transfer takes the form of transferring the right to receive income. For example, a private pension may be diverted to a trust and no longer be paid to the individual. Question the individual concerning sources of income, income levels in the past versus the present, direct questions about giving away income or assigning the right to receive income, to someone else, etc.

In determining whether income has been transferred, do not attempt to ascertain in detail the individual's spending habits during the look-back period. Absent a reason to believe otherwise, assume that the individual's income was legitimately spent on the normal costs of daily living.

When income or the right to income has been transferred, and none of the criteria in M1450.300 or M1450.400 are met, determine the uncompensated value of the transferred income (M1450.610) and determine a penalty period (M1450.620 or 630).

## M1450.570 SERVICES CONTRACTS

**A. Policy** *Services contracts (i.e. personal care contract, care contracts, etc.) are typically entered into for the completion of tasks such as, but not limited to, grocery shopping, house keeping, financial management and cooking, that individuals no longer can perform for themselves. For purposes of Medicaid payment of LTC services, payments made under these types of contracts may be considered an uncompensated transfer of assets.*

- B. Procedures** When a services contract, sometimes referred to as a personal care contract, is presented as the basis for a transfer of assets, the eligibility worker must do the following:
1. **Determine Institutionalization** Determine when the individual met the requirement for institutionalization.
  2. **Verify Contract Terms and Value of Services** Obtain a copy of the written contract, or written statements verifying the terms of the agreement by all parties. Determine when the agreement was entered into/signed, who entered into/signed the contract and if the contract is legally binding as defined by policy at M1450.003 H. The terms of the contract must include the types of services, rate of payment and the number of hours for each service. The terms must be specific and verifiable. Verification of payments made and services provided must be obtained. Any payment for a service which does not have a fair market value is an uncompensated transfer.
  3. **Contract Services Must Be Received Before Admission to LTC** *A contract for services may have been created prior to or after the individual's entrance into LTC. Once an individual begins receipt of Medicaid LTC services, the individual's personal and medical needs are considered to be met by the LTC provider. Payments to other individuals for services received after the individual enters LTC are considered an uncompensated transfer for Medicaid purposes.*
  4. **Physician Statement Required** A statement must be provided by the individual's physician that indicates the types of services that were to be provided under the contract, and that these services were necessary to prevent the individual's entrance into LTC.
  5. **Contract Made By Individual or Authorized Representative** The contract must have been made by the applicant/recipient or his authorized representative.
  6. **Payments Prior To Contract Date** Any payment(s) made prior to the date the contract was signed (if contract is written) or date the contract was agreed upon (if contract is a legally binding oral contract) by all parties is considered an uncompensated transfer.
  7. **Advance Lump Sum Payments Made To Contractor** Certain contracts for services provide an advance lump sum payment to the person who is to perform the duties outlined in the contract. Any payment of funds for services that have not been performed is considered an uncompensated transfer of assets. The Medicaid applicant/recipient has not received adequate compensation, as he has yet to receive valuable consideration.
  8. **Determine Penalty Period** If it is determined that an uncompensated transfer of assets occurred, follow policy in this subchapter to determine the penalty period.

The uncompensated value is \$100,000. The fact that \$50,000 was paid out of the trust to Mr. D's brother after payment to Mr. D was foreclosed does not alter the uncompensated amount upon which the penalty is based because the value of the transferred asset can be no less than its value on the date payment from the trust was foreclosed.

Mr. D placed an additional \$25,000 in the same trust on June 20, 1996. Under the terms of the trust, none of this \$25,000 can be disbursed to him. This is a new transfer of assets for less than fair market value. The uncompensated value is \$25,000; the transfer date is 6-20-96.

## G. Income Transfers

### 1. Lump Sum Transfer

When a single lump sum, or single amounts of regularly paid income, is transferred for less than fair market value, the uncompensated value is the amount of the lump sum, less any compensation received. For example, an individual gives a \$2,000 stock dividend check that is paid once a year to the individual, to another person in the month in which the individual received the check. No compensation was received. The uncompensated value is \$2,000.

### 2. Stream of Income Transfer

When a stream of income (income received regularly) or the right to a stream of income is transferred, determine the total amount of income expected to be transferred during the individual's life, based on an actuarial projection of the individual's life expectancy. The uncompensated value is the amount of the projected income, less any compensation received. Use the life expectancy tables in M1450, Appendix 2.

### 3. Income Transfer Example

**EXAMPLE #12:** A man aged 65 years, assigns his right to a \$500 monthly annuity payment to his brother. He receives no compensation in return. Based on the life expectancy tables for males, the uncompensated value of the transferred income is \$89,760.

\$ 500
<u>    </u> x12 months
\$6,000 yearly income
<u>    </u> x14.96 life expectancy from table
\$89,760 value
- <u>    </u> 0 compensation
\$89,760 uncompensated value

## H. Real Property Transfers

The uncompensated value of transferred real property is determined by evaluating the settlement document which outlines the monetary transactions between the individual who sells the property and the individual who buys the property. A copy of the Settlement Document is in **M1450, Appendix 3**.

The eligibility worker must obtain:

- documentation of the tax assessed value of the property at the time of the transfer; and
- a copy of the closing or settlement documents from the client or the financial institution.

1. *Summary of Seller's Transactions*

Review the summary of the seller's transactions:

- Determine the Gross Amount Due to Seller.
- Is the Gross Amount Due to Seller less than the **tax assessed value**?
  - If **no**, the seller received adequate compensation for the property and there is **no** uncompensated transfer.
  - If **yes**, determine the uncompensated value of the asset transfer.

2. *Real Property Uncompensated Value Calculations*

- a. When the lien is satisfied from the proceeds received by the seller, deduct the Gross Amount Due to Seller from the tax assessed value to determine the uncompensated amount of the asset transfer.
- b. When the lien is assumed by the buyer, deduct the lien amount from the tax assessed value of the property, to determine the equity value. From the equity value deduct the Gross Amount Due to Seller for the property to determine the uncompensated amount of the asset transfer.
- c. Determine the penalty period. The beginning of the penalty period depends upon whether the transfer took place prior to or on/after 2/08/2006.

**Note:** Any funds deducted from the Gross Amount Due to Seller that are paid to another individual, such as funds for repair of the property, are not considered usual and customary fees and must be evaluated as a separate asset transfer. If the transfer was uncompensated then the amount of this transfer may be added to any uncompensated value from the sale of property, as the transfer occurred at the same point in time.

**Example #13a:** Mrs. K. is receiving CBC services. The worker discovers that Mrs. K. has moved in with her daughter and has sold her home to her son. The tax assessed value of her home at the time of transfer was \$200,000. The closing documents indicate that she sold her home for \$125,000 (the gross amount due to seller). The closing costs were paid by Mrs. K. There was no lien against the property.

The uncompensated value of the transferred real property is calculated as follows:

\$200,000	tax assessed value
<u>-125,000</u>	Gross Amount Due to Seller
\$ 75,000	uncompensated value

The penalty period is based on the uncompensated value of \$75,000. The begin date of the penalty period depends on whether the transfer took place prior to or after February 8, 2006.

**Example #13b:** On October 20, Mr. B. was admitted to a nursing facility. He transferred his home in July of the same year, which was within the look-back period. His home was assessed at \$100,000 in July. The mortgage against his home had a balance due of \$16,000 in July.

In reviewing the settlement statement for the sale of the property, it is noted that the sale price of the home was \$70,000 (gross amount due to seller), which was less than the tax assessed value of the home. The lien of \$16,000 was satisfied at closing from the \$70,000 sale price. The other fees deducted were usual and customary and were determined to have been paid by the buyer. Mr. B. received a \$54,000 net settlement for the sale of his home.

The uncompensated value of the transferred real property is calculated as follows:

$$\begin{array}{r} \$100,000 \text{ tax assessed value} \\ - \underline{70,000} \text{ Gross Amount Due to Seller (includes the lien amount)} \\ \$ 30,000 \text{ uncompensated value} \end{array}$$

The penalty period is based on the uncompensated transfer value of \$30,000. When the penalty period begins depends on whether the transfer took place prior to or after February 8, 2006.

**Example #13c:** The scenario is the same as in example 13b. However, the lien will be assumed by the purchaser rather than satisfied from the seller's gross settlement amount (Gross Amount Due to Seller). The equity value of the home is used to determine the uncompensated value in this case, because the seller was not responsible for satisfaction of the lien.

$$\begin{array}{r} \$100,000 \text{ tax assessed value} \\ - \underline{16,000} \text{ lien amount} \\ \$ 84,000 \text{ equity value (EV)} \\ \\ \$ 84,000 \text{ EV} \\ - \underline{70,000} \text{ Gross Amount Due to Seller} \\ \$ 14,000 \text{ uncompensated value} \end{array}$$

## M1450.620 PENALTY PERIOD FOR TRANSFERS BEFORE FEBRUARY 8, 2006

### A. Policy

When a transfer of an asset before February 8, 2006 affects eligibility, the penalty period during which Medicaid will not pay for long-term care services, begins with the penalty date, which is:

- for applicants, the first day of the month in which the asset was transferred;
- for recipients, the first day of the month **following** the month in which the asset was transferred.

### B. Penalty Date

For applicants who are applying for Medicaid, the penalty date is **the first day of the month in which the asset transfer occurred** provided that date does not occur during an existing penalty period.

For recipients of Medicaid who transfer an asset while receiving Medicaid, the penalty date is **the first day of the month FOLLOWING the month** in which the asset transfer occurred, provided that date does not occur during an existing penalty period.

**C. Penalty Period Calculation**

The penalty period is the number of months calculated by *dividing* the uncompensated value of the assets transferred on or after the look-back date, by the average monthly cost of nursing facility services to a private patient **at the time of application for Medicaid**. Beginning 10-1-97, the average cost differs for individuals in *the following* Northern Virginia localities: *Arlington, Fairfax, Loudoun and Prince William counties and the cities of Alexandria, Fairfax, Falls Church, Manassas and Manassas Park*. The average cost is determined based on the locality in which the **individual is physically located at the time of application for Medicaid**.

See the chart below for the average private nursing facility cost for the Northern Virginia localities and all other Virginia localities.

**D. Average Monthly Private Nursing Facility Cost**

<b>Average Monthly Private Nursing Facility Cost*</b>		
<u>Application Date</u>	<u>Northern Virginia</u>	<u>All Other Localities</u>
10-1-96 to 9-30-97	\$2,564	\$2,564
10-1-97 to 12-31-99	\$3,315	\$2,585
01-01-00 to 12-31-00	\$3,275	\$2,596
01-01-01 to 12-31-01	\$4,502	\$3,376
01-01-02 to 12-31-03	\$4,684	\$3,517
01-01-04 to 9-30-07	\$5,403	\$4,060
10-1-07 and after	\$6,654	\$4,954

\*Figures provided by Virginia Health Information.

Contact a Medicaid Consultant for amounts prior to October 1, 1996.

**E. One Transfer**

1. Determine the penalty period:
  - divide the uncompensated value by the average monthly private pay nursing facility cost at the time the individual applied for Medicaid;
  - round the result down;
  - the result is the number of months in the penalty period.
2. Determine the penalty date.
3. Beginning with the penalty date, count the number of months in the penalty period to the end of the period.
4. The last day of the last month in the penalty period is the end date of the penalty period.

**EXAMPLE #14:** Mr. D. a 67 year old widower who lives in his own home applies for Medicaid on October 1, 1996. He is found eligible for retroactive and ongoing Medicaid.

**C. Example #21  
Partial  
Compensation  
Received**

**Example #21:** Ms. H. applied for Medicaid on November 2, 2004, after entering a nursing facility on March 15, 2004. On October 10, 2004, she transferred her non-home real property worth \$40,000 to her son and received no compensation in return for the property. Ms. H.'s Medicaid application was approved, but she was ineligible for Medicaid payment of long-term care services for 9 months beginning October 1, 2004 and continuing through June 30, 2005.

On December 12, 2004, the agency verified that Ms. H.'s son paid her \$20,000 for the property on December 8, 2004. The agency re-evaluated the transfer and determined a remaining uncompensated value of \$20,000 and a penalty period of 4 months, beginning October 1, 2004 and continuing through January 31, 2005.

The \$20,000 payment must be evaluated as a resource in determining Ms. H.'s Medicaid eligibility for January 2005.

## **M1450.700 CLAIM OF UNDUE HARDSHIP**

### **A. Policy**

The opportunity to claim an undue hardship must be given when the imposition of a penalty period affects Medicaid payment for LTC services. The individual has the burden of proof and must provide written evidence to clearly substantiate the circumstances surrounding the transfer, attempts to recover the uncompensated value and the impact of the denial of Medicaid payment of LTC services.

*Applicants, recipients, or authorized representatives, may request an undue hardship evaluation. Additionally, the Deficit Reduction Act of 2005 authorized nursing facilities to act on behalf of their patients, when necessary, to submit a request for undue hardship. The nursing facility must have written authorization from the recipient or his authorized representative in order to submit the claim of undue hardship.*

### **B. Procedures**

#### **1. Eligibility Worker**

The worker must complete documentation of the uncompensated asset transfer as outlined below and inform the applicant/recipient of the evidence which he must provide, as indicated in section C.2, below.

**a.** The worker must send a letter to the individual that includes the following:

- The uncompensated value of each asset transfer,
- the penalty period, **and**
- the right to claim undue hardship.

A copy of the Asset Transfer Hardship Claim Form must be included with the letter (see M1450 Appendix 1). The individual must be given 10 calendar days to return the completed form to the local agency.

**b.** If undue hardship is claimed, the eligibility worker must provide to DMAS, the client's name, Medicaid case number, if appropriate, and the date on which LTC services began.

**c.** Retain a copy of all documentation for the case the record and send the

undue hardship claim and supporting documents to DMAS at the following address:

DMAS, Division of Policy and Research  
Eligibility Section  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219

- d. DMAS will notify the worker of the decision on the hardship claim. If undue hardship is not claimed or if a penalty period must be imposed per DMAS, follow the procedures in M1450.800 through M1450.830 for notifying the individual and DMAS of the action. The individual must be informed that a denial of a claim for undue hardship may be appealed in accordance with the provisions of 12 VAC 30-110. If the individual meets all other eligibility requirements, he is eligible for Medicaid payment of all covered services other than LTC.

## 2. Applicant or Recipient

The evidence as required below must show that the assets transferred can not be recovered and that the immediate adverse impact of the denial of Medicaid coverage for payment of LTC services due to the uncompensated transfer would result in the individual being removed from the institution or becoming unable to receive life-sustaining medical care, food, clothing, shelter or other necessities of life.

*The applicant/recipient or his authorized representative must provide all of the following information for a claim of undue hardship:*

- What was transferred, to whom it was transferred and the relationship between the parties;
- The reason(s) for the transfer;
- A list of all assets owned and verification of their value at the time of the transfer;
- Include documents such as deeds, wills and bank statements;
- A statement from an independent third party substantiating the reason(s) for the transfer;
- *Evidence of the efforts made to recover the asset(s) and/or documentation from all parties of why no recovery is possible;*
- If the asset was alleged to have been stolen or transferred without permission, attach documentation of the legal action taken to recover the asset and the results of that action;

**Note:** If the applicant/recipient was a victim of an individual who is not the individual's attorney in fact, guardian, conservator or trustee and undue hardship is claimed, the **agency** must provide a statement documenting the facts and what actions were taken by the agency with regard to their findings. If the transfer was by a court-appointed guardian or conservator, documentation

of any bond insurance that would cover the loss if the property cannot be directly recovered or if compensation by the guardian/conservator or transferee was not received must be provided.

- Documentation of the impact of a denial of payment of long-term care services. If there is an allegation that the individual's medical condition is life-threatening or requires immediate attention, a doctor's statement must be included.
- *Documentation that the denial/termination of Medicaid payment of LTC services would result in the discharge of the individual from the nursing home must be provided.*

This information must be provided to the agency along with the Asset Transfer Hardship Claim form for submission to DMAS.

## M1450.800 AGENCY ACTION

**A. Policy** If an institutionalized individual's asset transfer is not allowable by policy, the individual is eligible for Medicaid but is not eligible for Medicaid payment of long-term care services. The individual, the service provider, and the Department of Medical Assistance Services (DMAS) must be notified of his/her ineligibility for Medicaid payment of long-term care services.

**B. Procedures** The procedures used for notifying the recipient, the provider and DMAS are in sections M1450.810, 820, and 830 below.

## M1450.810 APPLICANT/RECIPIENT NOTICE

**A. Policy** Whenever an institutionalized individual is not eligible for Medicaid payment of long-term care services because of an asset transfer, the form which notifies him/her of Medicaid eligibility must include the penalty period during which Medicaid will not cover LTC services for the individual.

**B. Notice Contents** The Notification of Action on Medicaid sent to the individual must specify:

- the individual is eligible for Medicaid beginning (the appropriate date) and
- Medicaid will not pay for nursing facility or CBC waiver services for the months (state the begin and end dates of the penalty period) because of the uncompensated asset transfer(s) that occurred (date/dates).
- the penalty period may be shortened if compensation is received.

**C. Advance Notice** When an institutionalized Medicaid recipient is found no longer eligible for Medicaid payment of long-term care services because of an asset transfer, the Advance Notice of Proposed Action must be sent to the individual at least 10 days before cancelling coverage of LTC services, and must specify:

- the individual is eligible for Medicaid.
- Medicaid will not pay for long-term care services for the months (state the penalty period begin and end dates) because of the asset transfer(s) that occurred (date/dates).
- The penalty period may be shortened if compensation is received.

## M1450.820 PROVIDER NOTICE

### A. Introduction

Use the DMAS-122 to notify the provider of the individual's Medicaid eligibility and ineligibility for Medicaid payment of long-term care services.

### B. DMAS-122

The DMAS-122 form includes:

- the individual's full name, Medicaid and Social Security numbers;
- the individual's birth date;
- the patient's Medicaid coverage begin date;
- the patient's income;
- no deductions or patient pay amounts; and
- that the patient is not eligible for Medicaid payment of nursing facility/CBC waiver services for the months (state the penalty period begin and end dates) because of an asset transfer(s).

## M1450.830 DMAS NOTICE

### A. Introduction

The worker must notify DMAS that the recipient is not eligible for LTC services payment because of an asset transfer. DMAS must input the code in the MMIS that will deny payment of LTC services claims.

The worker notifies DMAS via a copy of the DMAS-122 sent to the provider.

### B. Copy of DMAS-122

The copy of the DMAS-122 that is sent to DMAS must contain the following information, in addition to the information on the provider's copy of the DMAS-122:

- date(s) the asset transfer(s) occurred;
- the uncompensated value(s); and
- penalty period(s) (begin and end dates) and computation of that period(s).

ASSET TRANSFER HARDSHIP CLAIM FORM

TO:
DMAS, Division of Policy and Research
Eligibility Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Agency Name:
Case Name:
Case #:
Worker Name:
Worker Telephone #:

If you wish to claim that an Undue Hardship would result if you were ineligible for Medicaid payment of nursing facility services or community-based care (CBC) waiver services, check the first box below, attach copies of any necessary documentation and sign and date where indicated.

If you do not wish to claim an Undue Hardship, check the second box, sign your name and the date where indicated below the second box.

\*\*\*\*\*

\_\_\_ I want to claim Undue Hardship.

Please provide all of the following information:

- What was transferred, to whom it was transferred and the relationship between the parties;
• The reason(s) for the transfer(s);
• A list of all assets owned and verification of their value at the time of the transfer;
• Documents such as deeds, wills and bank statements;
• A statement from an independent third party substantiating the reason(s) for the transfer(s);
• Evidence of the efforts made to recover the asset(s) and/or documentation from all parties of why recovery is not possible;
• If the asset was alleged to have been stolen or transferred without permission, documentation of any legal action taken;
• The impact of a denial of payment of long-term care services must be documented. Documentation should include a doctor's statement verifying any allegation that the individual's medical condition is life-threatening or requires immediate attention;
• Documentation that the denial/termination of Medicaid payment of long-term care services will result in the individual's discharge from the nursing facility.

Your explanation will be evaluated by the Department of Medical Assistance Services. You will be notified in writing of the decision that is made.

I affirm that the information provided about my claim for an Undue Hardship is true and correct to the best of my knowledge and belief.

Signature of Claimant or Authorized Representative

Date

\*\*\*\*\*

\_\_\_ I do not want to claim hardship. My right to claim hardship has been explained to me, and I choose not to claim a hardship.

Signature of Claimant or Authorized Representative

Date

**Settlement Statement-**

Form HUD-1 follows on pages 2 and 3 of this appendix. This form is frequently used as the settlement statement when closing a real estate transaction or transfer. Note that there is a specific section for the borrower and the seller. The Borrower is the individual(s) who is purchasing the property. The Seller is the owner of the property.

The Gross Amount Due to Seller for the property noted on line 420 of the first page of the statement represents the amount of funds being paid for purchase the property. This amount includes the funds which satisfy any outstanding liens against the property at the time of transfer, which are noted on lines 504 and 505 of the first page.

Usual and customary fees associated with real estate transactions are already indicated on the form, such as the lien amounts, any additional deductions must be added to the form. These types of deductions should be carefully examined by the eligibility worker, as they may represent a separate uncompensated transfer from the seller's portion of the proceeds from the sale of the property.

Any questions regarding this form and any deductions listed should be referred to the appropriate Medical Assistance Program Consultant.

A. Settlement Statement

U.S. Department of Housing and Urban Development

OMB Approval No. 2502-02 (expires 11/30/200)

B. Type of Loan

1.  FHA 2.  FmHA 3.  Conv. Unins. 4.  VA 5.  Conv. Ins. 6. File Number: 7. Loan Number: 8. Mortgage Insurance Case Number:

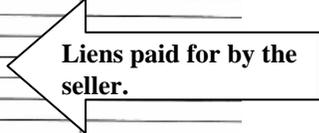
C. Note: This form is furnished to give you a statement of actual settlement costs. Amounts paid to and by the settlement agent are shown. Items marked "(p.o.c.\*)" were paid outside the closing; they are shown here for informational purposes and are not included in the totals.

D. Name & Address of Borrower: E. Name & Address of Seller: F. Name & Address of Lender:



G. Property Location: H. Settlement Agent: I. Settlement Date:

Table with columns for Borrower's Transaction (100-220) and Seller's Transaction (400-603). Rows include Gross Amount Due, Adjustments for items paid/unpaid by seller, Total Paid, and Cash at Settlement.



Section 5 of the Real Estate Settlement Procedures Act (RESPA) requires the following: • HUD must develop a Special Information Booklet to help persons borrowing money to finance the purchase of residential real estate to better understand the nature and costs of real estate settlement services; • Each lender must provide the booklet to all applicants from whom it receives or for whom it prepares a written application to borrow money to finance the purchase of residential real estate; • Lenders must prepare and distribute with the Booklet a Good Faith Estimate of the settlement costs that the borrower is likely to incur in connection with the settlement. These disclosures are mandatory.

Section 4(a) of RESPA mandates that HUD develop and prescribe this standard form to be used at the time of loan settlement to provide full disclosure of all charges imposed upon the borrower and seller. These are third party disclosures that are designed to provide the borrower with pertinent information during the settlement process in order to be a better shopper.

The Public Reporting Burden for this collection of information is estimated to average one hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

This agency may not collect this information, and you are not required to complete this form, unless it displays a currently valid OMB control number. The information requested does not lend itself to confidentiality.

<b>L. Settlement Charges</b>				Paid From Borrowers Funds at Settlement	Paid From Seller's Funds at Settlement
<b>700. Total Sales/Broker's Commission based on price \$</b>	@	% =			
Division of Commission (line 700) as follows:					
701. \$	to				
702. \$	to				
703. Commission paid at Settlement					
704.					
<b>800. Items Payable in Connection With Loan</b>					
801. Loan Origination Fee	%				
802. Loan Discount	%				
803. Appraisal Fee	to				
804. Credit Report	to				
805. Lender's Inspection Fee					
806. Mortgage Insurance Application Fee to					
807. Assumption Fee					
808.					
809.					
810.					
811.					
<b>900. Items Required By Lender To Be Paid In Advance</b>					
901. Interest from	to	@ \$	/day		
902. Mortgage Insurance Premium for			months to		
903. Hazard Insurance Premium for			years to		
904.			years to		
905.					
<b>1000. Reserves Deposited With Lender</b>					
1001. Hazard insurance	months @ \$		per month		
1002. Mortgage insurance	months @ \$		per month		
1003. City property taxes	months @ \$		per month		
1004. County property taxes	months @ \$		per month		
1005. Annual assessments	months @ \$		per month		
1006.	months @ \$		per month		
1007.	months @ \$		per month		
1008.	months @ \$		per month		
<b>1100. Title Charges</b>					
1101. Settlement or closing fee	to				
1102. Abstract or title search	to				
1103. Title examination	to				
1104. Title insurance binder	to				
1105. Document preparation	to				
1106. Notary fees	to				
1107. Attorney's fees	to				
(includes above items numbers:			)		
1108. Title insurance	to				
(includes above items numbers:			)		
1109. Lender's coverage	\$				
1110. Owner's coverage	\$				
1111.					
1112.					
1113.					
<b>1200. Government Recording and Transfer Charges</b>					
1201. Recording fees: Deed \$		; Mortgage \$		; Releases \$	
1202. City/county tax/stamps: Deed \$		; Mortgage \$			
1203. State tax/stamps: Deed \$		; Mortgage \$			
1204.					
1205.					
<b>1300. Additional Settlement Charges</b>					
1301. Survey	to				
1302. Pest inspection	to				
1303.					
1304.					
1305.					
<b>1400. Total Settlement Charges (enter on lines 103, Section J and 502, Section K)</b>					

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**10. Old Bills**

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

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

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

**11. Projected Expenses**

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

**12. Spenddown Liability**

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

## ***M1460.150 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LTC***

**A. Applicability**

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

**1. Approved for LTC Before 01-01-2006**

*If a Medicaid enrollee was approved for LTC **before** January 1, 2006, do not evaluate substantial home equity at the next renewal. As long as he remains continuously eligible for Medicaid, do not evaluate substantial home equity.*

*If the enrollee is found ineligible for Medicaid, and he subsequently re-applies for Medicaid LTC, substantial home equity must be evaluated when he re-applies.*

**2. Approved for LTC On/After 01-01-2006**

*If a Medicaid enrollee was approved for LTC on or after January 1, 2006 but before July 1, 2006, evaluate substantial home equity at the next renewal.*

*If a Medicaid applicant or enrollee was approved for LTC on or after July 1, 2006, the substantial home equity must be evaluated immediately and appropriate action taken if the individual has substantial home equity.*

**B. Policy**

*Individuals with equity value (tax assessed value minus encumbrances) in home property that exceeds \$500,000 are **NOT** eligible for Medicaid payment of long-term care services unless the home is occupied by*

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

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

**1. Reverse Mortgages**

Reverse mortgages **do not** reduce equity value until payments are being received from the reverse mortgage.

**2. Home Equity Credit Lines**

A home equity line of credit **does not** reduce the equity value until credit line has been used or payments from the credit line have been received.

**C. Verification Required**

Verification of the equity value of the home is required.

**D. Notice Requirement**

If an individual is ineligible for Medicaid payment of LTC services because of substantial home equity exceeding \$500,000, the Notice of Action must state why he is ineligible for Medicaid payment of LTC. The notice must also indicate whether the applicant is eligible for other Medicaid covered services.

**E. References**

See section M1120.225 for more information about reverse mortgages.

## **M1460.160 LONG-TERM CARE PARTNERSHIP POLICIES**

**A. Introduction**

*A Long-term Care Partnership Policy (Partnership Policy) is a type of LTC insurance. Under section 6021(a)(1)(A) of the Deficit Reduction Act (DRA) of 2005 states were permitted to develop LTC partnerships. In addition to paying for assisted living or long-term care services, a Partnership Policy allows for additional assets to be disregarded in the Medicaid eligibility determination.*

*The value of assets disregarded in the Medicaid eligibility determination is equal to the dollar amount of benefits paid to or on behalf of the individual as of the month of application, even if additional benefits remain available under the terms of the policy.*

*The Partnership Policy disregard is not applicable to the resource assessment for married individuals with a community spouse. See M1480 for more information regarding resource assessments and Partnership Policies.*

**B. LTC Insurance Policy Issued Prior to 9/01/2007**

*LTC policies issued prior to 9/01/2007 are **not** Partnership Policies. See M1470.230 B.6, M1470.430 B.5 and M1470.820 D for more information regarding these types of insurance policies.*

**C. LTC Insurance Policy Issued on or After 9/01/2007**

*LTC policies issued on or after 9/01/2007 may or may not be Partnership Policies. For a policy to be considered a Partnership Policy, it must meet the following conditions:*

- *issued on or after 09/01/2007,*
- *contain a disclosure statement indicating that it meets the requirements under § 7702B(b) of the Internal Revenue Service Code of 1986, and*

- *provide inflation protection:*
  - *under 61 years of age, compound annual inflation protection,*
  - *61 to 76 years of age, some level of inflation protection, or*
  - *76 years or older, inflation protection may be offered, but is not required.*

*Obtain a copy of the Partnership Disclosure Notice and the LTC Partnership Certification Form (See M1460, Appendices 1 and 2) for verification of the requirements noted above. Also, verification of the amount of benefit paid to or on behalf of an individual as of the month of application must be obtained. This can be found on the Explanation of Benefits statement or by calling the insurance carrier.*

*Partnership Policies that are issued in other states may or may not meet Virginia's requirements. Please contact your Medicaid Consultant to verify reciprocity with Virginia.*

*Verifications and documentation regarding a Partnership Policy must be kept with other permanent verifications in the case record.*

*See M1470.820 for data entry procedures for MMIS.*

## **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.

6. **Domestic Travel Tickets** Gifts of domestic travel tickets [1612(b)(15)].
7. **Victim's Compensation** Victim's compensation provided by a state.
8. **Tech-related Assistance** Tech-Related Assistance for Individuals with Disabilities [ref. P.L. 100-407].
9. **\$20 General Exclusion** \$20 a month general income exclusion for the unit.  
**EXCEPTION:** Certain veterans (VA) benefits are not subject to the \$20 income exclusion. Refer to subchapter S0830 for complete explanation of which VA payments are entitled to the \$20 general exclusion.
10. **PASS Income** Any unearned income used to fulfill an SSI approved plan to achieve self-support (PASS). See item 12 below for earned income used to fulfill a PASS [1612(b) (4)(A) & (B)].
11. **Earned Income Exclusions** The following earned income exclusions are not deducted for the 300% SSI group:
- a. In 2007, up to \$1,510 per month, but not more than \$6,100 in a calendar year, of the earned income of a blind or disabled student child [1612(b) (1)].  
  
In 2008, up to \$1,550 per month, but not more than \$6,240 in a calendar year, of the earned income of a blind or disabled student child
  - b. Any portion of the \$20 monthly general income exclusion which has not been excluded from unearned income in that same month [1612(b) (2)(A)].
  - c. \$65 of earned income in a month [1612(b) (4)(C)].
  - d. IRWE - earned income of disabled individuals used to pay impairment-related work expenses [1612(b) (4)(B)].
  - e. One-half of remaining earned income in a month [1612(b) (4)(C)].
  - f. BWE - Earned income of blind individuals used to meet work expenses [1612(b) (4)(A)].
  - g. Earned income used to fulfill an SSI approved plan to achieve self-support (PASS) [1612(b) (4)(A) & (B)].
12. **Child Support** Child support payments received from an absent parent for a blind or Disabled child [1612(b) (9)].

**13. Native American Funds**

The following Native American funds (only exclude for ABD MN groups):

- a. Puyallup Tribe [ref. P.L. 101-41]
- b. White Earth Reservational Land Settlement [ref. P.L. 99-264]
- c. Chippewas of Mississippi [ref. P.L. 99-377]
- d. Saginaw Chippewas of Michigan [ref. P.L. 99-346]
- e. Shoalwater Bay Indian Tribe [ref. P.L. 98-432]
- f. Wyandotte Tribe [ref. P.L. 98-602]
- g. Chippewas of Lake Superior [ref. P.L. 99-146]
- h. Cow Creek Band of Umpqua [ref. P.L. 100-139]
- i. Coushatta Tribe of Louisiana [ref. P.L. 100-411]
- j. Wisconsin Band of Potawatomi [ref. P.L. 100-581]
- k. Seminole Indians [ref. P.L. 101-277]
- l. receipts from land distributed to:
  - Pueblo of Santa Ana [ref. P.L. 95-498]
  - Pueblo of Zia [ref. P.L. 95-499].

**14. State/Local Relocation**

State or local relocation assistance [1612(b) (18)].

**15. USC Title 37 Section 310**

Special pay received pursuant to section 310 of title 37, United States Code [1612(b)(20)].

NOTE: For additional F&C medically needy (MN) income exclusions, go to Chapter M07. For additional ABD medically needy (MN) income exclusions, go to Chapter S08.

**M1460.620 RESERVED****M1460.640 INCOME DETERMINATION PROCESS FOR STAYS LESS THAN 30 DAYS****A. Policy - Individual in An Institution for Less Than 30 Days**

This subsection is applicable ONLY if it is known that the time spent in the institution has been, or will be, less than 30 days. If the individual is institutionalized for less than 30 days, Medicaid eligibility is determined as a non-institutionalized individual because the definition of “institutionalization” is not met. If there is no break between a hospital stay and admission to a nursing facility or Medicaid CBC waiver services, the hospital days count toward the 30 days in the “institutionalization” definition.

**B. Recipient**

If a Medicaid recipient is admitted to a medical institution for less than 30 days, go to subchapter M1470 for patient pay policy and procedures.

**C. Applicant**

If the individual is NOT a Medicaid recipient and applies for Medicaid determine the individual’s income eligibility as a non-institutionalized individual. Go to Chapter M07 for F&C or S08 for ABD to determine the individual’s income eligibility.

Form 200-B  
(eff. 9/07)

**Partnership Disclosure Notice**

[Company Name]  
[Company Address]

[Policyholder/Certificateholder] Name:  
[Policy/Certificate] Number/Identifier:  
Effective Date:

**Important Information Regarding Your Policy's [Certificate's]  
Long-Term Care Insurance Partnership Status**

**NOTE: Please keep this Notice with Your Long-Term Care Insurance Policy**

**Partnership Policy [Certificate] Status. Your long-term care insurance policy [certificate] is intended to qualify as a Partnership Policy [Certificate] under the Virginia Long-Term Care Partnership Program as of your Policy's [Certificate's] effective date.**

The long-term care insurance policy [certificate] recently purchased and enclosed qualifies for the Virginia Long-Term Care Insurance Partnership Program. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance policies [certificates] that qualify as Partnership Policies [Certificates] may protect your assets through a feature known as "Asset Disregard" under Virginia's Medicaid program.

**Asset Disregard** means that an amount of the policyholder's [certificateholder's] assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy [Certificate] will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership Policy [Certificate] without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply and special rules may apply to persons whose home equity exceeds \$500,000. **In addition, the purchase of this Partnership Policy does not automatically qualify you for Medicaid.**

**What Could Disqualify Your Policy [Certificate] as a Partnership Policy.** If you make any changes to your policy [certificate], such changes could affect whether your policy [certificate] continues to be a Partnership Policy. *Before you make any changes, you should consult with [carrier name] to determine the effect of a proposed change.* In addition, if you move to a state that does not maintain a Partnership Program or does not recognize your policy [certificate] as a Partnership Policy [Certificate], you would not receive beneficial treatment of your policy [certificate] under the Medicaid program of that state. The information contained in this Notice is based on current Virginia and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your policy [certificate] under Virginia's Medicaid program.

**Additional Information.** If you have questions regarding your insurance policy [certificate], please contact [carrier name]. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Virginia Department of Medical Assistance Services.

Form 200-C  
(eff. 9/07)

**LONG-TERM CARE PARTNERSHIP  
CERTIFICATION FORM**

Note: This Form must be completed and submitted with each long-term care policy or certificate form for which the insurer is seeking Partnership qualification. A separate form must be completed for each policy form and a specimen copy of the form, including all riders and endorsements, must be attached. A long-term care policy or certificate form may not be issued in Virginia as a partnership policy or certificate unless and until this form has been submitted to and approved by the Bureau of Insurance.

---

Under § 1917(b)(5)(B)(iii) of the Social Security Act (42 U.S.C. 1396p(b)(5)(B)(iii)) and in accordance with the 14 VAC 5-200-205 D, the insurer hereby submits information relating to policy or certificate form \_\_\_\_\_ (form number) to substantiate that the form includes all required consumer protection requirements set forth in § 1917(b)(5)(A) of the Social Security Act (42 U.S.C. 1396p(b)(5)(A)) and that it includes certain specified provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act promulgated by the National Association of Insurance Commissioners (adopted as of October 2000) (referred to herein as the "2000 Model Regulation" and "2000 Model Act," respectively).

**Part I:**

Name of Insurer \_\_\_\_\_

Company NAIC # \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Company Contact  
Name \_\_\_\_\_

Title \_\_\_\_\_

Telephone \_\_\_\_\_

E-Mail \_\_\_\_\_

**B. Procedure**

Subtract the deduction(s) from gross monthly income in the order presented below:

1. Medicaid CBC Personal Maintenance Allowance (M1470.410)
2. Dependent Child Allowance (M1470.420)
3. Medicaid CBC - Incurred Medical Expenses (M1470.430)

**C. Appeal Rights**

The patient or his representative has the right to appeal the patient pay determination, the amounts used in the calculation and denial of any request for adjustment. If a recipient or his representative appeals the patient pay, the EW who made the decision prepares the appeal summary and attends the hearing.

**M1470.410 MEDICAID CBC - PERSONAL MAINTENANCE ALLOWANCE****A. Individuals**

For the month of entry and subsequent months, deduct from the patient's gross monthly countable income a personal maintenance allowance. The amount of the allowance depends upon under which Medicaid CBC waiver the patient receives LTC services.

**1. Basic  
Maintenance  
Allowance**

**a. Elderly or Disabled with Consumer-Direction (EDCD) Waiver, Mental Retardation (MR) Waiver, Technology-Assisted Individuals Waiver, Individual and Family Developmental Disabilities Support (DD) Waiver and Day Support (DS) Waiver**

Patients receiving Medicaid CBC under the following waivers are allowed a monthly basic personal maintenance allowance.

- EDCD Waiver,
- MR Waiver,
- Technology-Assisted Individuals Waiver
- DD Waiver, and
- DS Waiver

Prior to September 1, 2006, the personal maintenance deduction *was* equal to the monthly SSI payment limit for one person. Effective September 1, 2006, the personal maintenance deduction is equal to 165% of the monthly SSI payment limit for one person. The personal maintenance deduction is:

- January 1, 2007 through December 31, 2007: \$1,028
- *January 1, 2008 through December 31, 2008: \$1,051.*

*Contact a Medical Assistance Program Consultant for the SSI amount in effect for years up to 2006.*

**b. AIDS Waiver**

Patients under the AIDS waiver are allowed a monthly basic personal maintenance allowance that equals 300% of the SSI payment limit for one person (see M0810.002 A. 3.).

**2. Guardianship Fee**

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

NOTE: The guardianship filing fees CANNOT be deducted from the individual's income.

NOTE: No deduction is allowed for representative payee or "power of attorney" fees or expenses.

**3. Special Earnings Allowance for Recipients in EDCD, DD, MR or DS Waivers**

Deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

- 1) for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (\$1,911) per month.
- 2) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI (\$1,274) per month.

The total amount of the personal maintenance allowance and the special earnings allowance cannot exceed 300% SSI.

**EXAMPLE #9: (Using January 2005 figures)**

A working patient receiving EDCD waiver services is employed 18 hours per week. His income is gross earnings of \$928.80 per month and SSA of \$300 monthly. His special earnings allowance is calculated by comparing his gross earned income (\$ 928.80) to the 200% of SSI maximum (\$ 1,158.00). His gross earned income is less than 200% of SSI; therefore, he is entitled to a special earnings allowance. His personal maintenance allowance is computed as follows:

\$ 579.00	CBC personal maintenance allowance
+ 928.80	special earnings allowance
\$ 1,507.80	total personal maintenance allowance

**B. Couples**

The Medicaid CBC waivers do not specify personal maintenance allowances for a married couple living together when both spouses receive Medicaid CBC because each spouse is considered an individual for patient pay purposes. The individual maintenance allowance in section M1470.410 applies to each spouse in a couple when each receives Medicaid CBC.

## **M1480.200 RESOURCE ASSESSMENT RULES**

### **A. Introduction**

A resource assessment must be completed when an institutionalized spouse with a community spouse applies for Medicaid coverage of long term care services and may be requested without a Medicaid application.

A resource assessment is strictly a:

- compilation of a couple's reported resources that exist(ed) at the first moment of the first day of the month in which the first continuous period of institutionalization began on or after September 30, 1989.
- calculation of the couple's total countable resources at that point, and
- calculation of the spousal share of those total countable resources.

A resource assessment does not determine resource eligibility but is the first step in a multi-step process. A resource assessment determines the spousal share of the couple's combined countable resources.

### **B. Policy Principles**

#### **1. Applicability**

The resource assessment and resource eligibility rules apply to individuals who began a continuous period of institutionalization on or after September 30, 1989 and who are likely to remain in the medical institution for a continuous period of at least 30 consecutive days, or have been screened and approved for Medicaid CBC waiver services, or have elected hospice services.

The resource assessment and resource eligibility rules do **NOT** apply to individuals who were institutionalized before September 30, 1989, **unless** they leave the institution (or Medicaid CBC waiver services) for at least 30 consecutive days and are then re-institutionalized for a new continuous period that began on or after September 30, 1989.

#### **2. Who Can Request**

A resource assessment without a Medicaid application can be requested by the institutionalized individual in a medical institution, his community spouse, or an authorized representative. See section M1410.100.

#### **3. When to Do A Resource Assessment**

##### **a. Without A Medicaid Application**

A resource assessment without a Medicaid application may be requested when a spouse is admitted to a **medical institution**. Do not do a resource assessment **without** a Medicaid application unless the individual is in a medical institution.

##### **b. With A Medicaid Application**

The spousal share is used in determining the institutionalized individual's resource eligibility. A resource assessment must be completed when a married institutionalized individual with a community spouse *who*

- is in a nursing facility, *or*
- is screened and approved to receive nursing facility or Medicaid CBC waiver services, *or*
- has elected hospice services

applies for Medicaid. *The resource assessment is completed when the applicant is screened and approved to receive nursing facility or Medicaid CBC services or the month of application, whichever is later.*

*The following table contains examples that indicate when an individual is treated as an institutionalized individual for the purposes of the resource assessment:*

<i>Screened and Approved in:</i>	<i>In a Facility?</i>	<i>Application Month</i>	<i>Resource Assessment Month</i>	<i>Processing Month</i>	<i>Month of Application/ongoing as Institutionalized</i>	<i>Retroactive Determination as Institutionalized (in a medical facility)</i>
<i>January</i>	<i>no</i>	<i>January</i>	<i>January</i>	<i>January</i>	<i>yes</i>	<i>no</i>
<i>January</i>	<i>no</i>	<i>February</i>	<i>February</i>	<i>February</i>	<i>yes</i>	<i>no</i>
<i>N/A</i>	<i>yes</i>	<i>January</i>	<i>first continuous period of institutionalization</i>	<i>February</i>	<i>yes</i>	<i>yes</i>
<i>January</i>	<i>no</i>	<i>March</i>	<i>March</i>	<i>April</i>	<i>yes</i>	<i>no</i>
<i>April</i>	<i>no</i>	<i>March</i>	<i>April</i>	<i>Whenever</i>	<i>no, but yes for April</i>	<i>no</i>

**c. Both Spouses Request Medicaid CBC**

**When both spouses request Medicaid CBC, one resource assessment is completed. The \$2,000 Medicaid resource limit applies to each spouse.**

**C. Responsible Local Agency**

The local department of social services (DSS) in the Virginia locality where the individual last resided outside of an institution (including an ACR) is responsible for processing a request for a resource assessment without a Medicaid application, and for processing the individual's Medicaid application. If the individual never resided in Virginia outside of an institution, the local DSS responsible for processing the request or application is the local DSS serving the Virginia locality in which the institution is located.

The Medicaid Technicians in the Department of Mental Health, Mental Retardation & Substance Abuse Services (DMHMRSAS) facilities are responsible for processing a married patient's request for a resource assessment without a Medicaid application, and for processing the patient's Medicaid application.

## M1480.210 RESOURCE ASSESSMENT WITHOUT A MEDICAID APPLICATION

**A. Introduction**                    **This section applies only to married individuals with community spouses who are inpatients in medical institutions or nursing facilities and who have NOT applied for Medicaid.**

### **B. Policy**

#### **1. Resource Evaluation**

For the purposes of the resource assessment and spousal share calculation, countable and excluded resources are determined for all covered groups using the ABD resource policy found in Virginia DSS, Volume XIII, Chapter S11 **regardless of the individual's covered group and regardless of community property laws or division of marital property laws**, except for the following resources which are excluded as indicated below when completing the resource assessment and spousal share [1924(c)(5)]:

- the home and all contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SS & SSI payments received on or after 11/01/05 for nine (9) calendar months following the month in which the individual receives the benefits. 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.

*The resource assessment is not affected by the amount disregarded in the eligibility determination as a result of an LTC Partnership Policy (Partnership Policy).*

#### **2. No Appeal Rights**

When a resource assessment is requested and completed **without** a concurrent Medicaid application, it cannot be appealed pursuant to the existing Virginia Client Appeals regulations (VR 460-04-8.7). The spousal share determination may be appealed when a Medicaid application is filed.

**C. Procedures**

The Medicaid Resource Assessment Request form (#032-03-815) is completed by the person requesting the resource assessment when the assessment is not part of a Medicaid application.

Nursing facilities are required to advise new admissions and their families that Medicaid resource assessments are available for married individuals from their local department of social services.

**1. Case Record Number**

If the institutionalized individual does not already have a case record, assign a case number and establish a case record in the institutionalized individual's name. If there is an existing case record for the institutionalized individual, use the established case number and record for the resource assessment.

**2. Determining the First Continuous Period of Institutionalization**

The resource assessment is based on the couple's resources owned **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. This may be different from the current period of institutionalization. Use the information below to determine exactly when the individual's first continuous period of institutionalization began.

Inquire if the individual was ever institutionalized prior to the current institutionalization but not earlier than September 30, 1989. If yes, ascertain the first date on or after September 30, 1989, on which the individual was admitted to a medical institution.

Ask the following:

- From where was he admitted?

If admitted from a home in the community that is not an institution as defined in section M1410.010, determine if Medicaid CBC waiver services were received and covered by Medicaid while the individual was in the home. If so, the days of Medicaid CBC receipt are "institutionalization" days.

If admitted from another institution, ascertain the admission and discharge dates, institution's name and type of institution. The days he was in a medical institution are institutionalization days if there was less than a 30-day break between institutionalizations.

- What was the last date the individual resided outside a medical institution (in the community, at home, or in a non-medical institution)?

**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**, except for the following resources which are excluded as indicated below when completing the resource assessment and spousal share:

- 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.

*The resource assessment is not affected by the amount disregarded in the eligibility determination as a result of a Partnership Policy.*

### 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,
- all reported countable resources owned by the couple on the first moment of the first day of the month of application, and
- all reported countable resources owned by the couple as of the first moment of the first day of each retroactive month for which eligibility is being determined.

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.

Either the Medicaid Resource Assessment form (#032-03-816) or the electronic Resource Assessment and Eligibility Workbook may be used to complete the assessment of resources and spousal share calculation at the time of the first continuous period of institutionalization. The workbook is located on the VISSTA web site at:

[http://www.vcu.edu/vissta/bps/bps\\_resources/ltc\\_medicaid.htm](http://www.vcu.edu/vissta/bps/bps_resources/ltc_medicaid.htm).

On the Medicaid Resource Assessment form or electronic workbook, the worker lists the couple's resources as of December 1, 1995 as follows:

<u>Resource</u>	<u>Owner</u>	<u>Countable</u>	<u>Countable Value</u>
Home	Mr & Mrs	No	0
Savings	Mr & Mrs	Yes	\$100,000
CD	Mr	Yes	\$31,000

\$131,000 Total Value of Couple's Countable Resources

\$ 65,500 Spousal Share

In the eligibility evaluation, the worker uses the spousal share amount (\$65,500) as one factor to determine the spousal protected resource amount (PRA) that is subtracted from the couple's current resources to determine the institutionalized spouse's resource eligibility.

#### F. Notice Requirements

Do not send the Notice of Medicaid Resource Assessment when a resource assessment is completed as a part of a Medicaid application.

Include a copy of the Medicaid Resource Assessment form with the Notice of Action on Medicaid that is sent when the eligibility determination is completed.

## M1480.230 RESOURCE ELIGIBILITY OF INSTITUTIONALIZED SPOUSE

### A. Introduction

This section contains the resource rules that apply to the institutionalized spouse's eligibility.

If the community spouse applies for Medicaid, do not use the rules in this subchapter to determine the community spouse's eligibility. Use the financial eligibility rules for a non institutionalized person in the community spouse's covered group.

### B. Policy

An institutionalized spouse meets the resource eligibility requirements for Medicaid if the difference between the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined, the community spouse's protected resource amount (PRA) and the institutionalized spouse's partnership policy disregard amount (see M1460.160) is equal to or less than \$2,000.

In initial eligibility determinations for the institutionalized spouse, the spousal share of resources owned by the couple **at the first moment of the first day of the first month of the first continuous period of institutionalization** that began on or after September 30, 1989, remains a constant factor in determining the spousal PRA.

#### 1. Use ABD Resource Policy

For the purposes of eligibility determination, countable and excluded resources are determined for all covered groups using the ABD resource policy in Chapter S11, **regardless of the individual's covered group and regardless of community property laws or division of marital property laws**, except for the following resources which are excluded as indicated below when determining eligibility of the institutionalized spouse:

- the home and **all** contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SS & SSI payments received on or after 11/01/05 for nine (9) calendar months following the month in which the individual receives the benefits; and
- up to **\$3,500** of burial funds for each spouse.

Resources owned in the name of one or both spouses are considered available in the initial month for which eligibility is being determined regardless of whether either spouse agrees to sell or liquidate the resource, and regardless of whether either spouse refuses to make the resource available.

**2. After Eligibility is Established**

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

**C. “Institutionalized Spouse Resource Eligibility Worksheet”**

Use the “Institutionalized Spouse Resource Eligibility Worksheet” (M1480, Appendix 4) or the electronic Resource Assessment and Eligibility Workbook located at [http://www.vcu.edu/vissta/bps/bps\\_resources/ltc\\_medicaid.htm](http://www.vcu.edu/vissta/bps/bps_resources/ltc_medicaid.htm) to determine the institutionalized spouse’s resource eligibility.

**M1480.231 SPOUSAL RESOURCE STANDARDS**

**A. Introduction**

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

<b>B. Spousal Resource Standard</b>	\$20,880	1-1-08
	\$20,328	1-1-07
<b>C. Maximum Spousal Resource Standard</b>	\$104,400	1-1-08
	\$101,640	1-1-07

**M1480.232 INITIAL ELIGIBILITY DETERMINATION PERIOD**

**A. Policy**

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

If the applicant is not eligible in the month of application, the initial eligibility determination period continues until the first month in which the institutionalized spouse is eligible. NOTE: Established application processing procedures and timeframes apply.

An institutionalized spouse meets the resource eligibility requirements for Medicaid if the difference between the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined, the *community spouse's* protected resource amount (PRA) and the *institutionalized spouse's partnership policy disregard amount* (see M1460.160) is equal to or less than \$2,000.

**1. First Application**

Use the procedures in item B below for the initial resource eligibility determination for an institutionalized spouse's first application for Medicaid in a continuous period of institutionalization that began on or after 9-30-89.

**2. Subsequent Applications**

**a. Medicaid Eligibility For LTC Services Achieved Previously**

If an individual achieved Medicaid eligibility as an institutionalized spouse during a period of institutionalization that began on/after 9-30-89, regardless of whether the period of institutionalization is the same continuous period covered by the previous application(s), **do not consider the couple's resources. Use only the institutionalized spouse's resources.** Use the policy and procedures in section M1480.255 to determine the institutionalized individual's financial eligibility.

**b. Medicaid Eligibility For LTC Services Not Previously Achieved**

If an individual has never achieved Medicaid eligibility as an institutionalized spouse, **treat the application** as an "initial eligibility" determination.

- Determine countable resources for the application month (see item B below);
- Deduct the spousal PRA from the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined.
- *Deduct a dollar amount equal to the Partnership Policy disregard, if any.*

**B. Procedures**

Use the following criteria to determine Medicaid eligibility for any month in the initial eligibility determination period.

NOTE: The initial eligibility determination period begins with the month of application. If the institutionalized spouse is not eligible in that month, the initial eligibility determination period continues until the first month in which the institutionalized spouse is eligible.

**1. Couple's Total Resources**

Verify the amount of the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined.

NOTE: When a loan or a judgment against resources is identified, send the documents pertaining to the loan and/or judgment to DMAS for review before taking action on the application. Send the documents, along

with case identifying information (institutionalized spouse's and community spouse's names, address, SSN, case number) to:

Division of Policy and Research, Eligibility Section  
DMAS  
600 E. Broad Street, Suite 1300  
Richmond, Virginia 23219

**2. Deduct Spousal Protected Resource Amount (PRA)**

Deduct the spousal protected resource amount (PRA) from the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined. The PRA is the greatest of the following:

- the **spousal share** of resources as determined by the resource assessment, provided it does not exceed the maximum spousal resource standard in effect at the time of application. **If the spousal share exceeds the maximum spousal resource standard, use the maximum spousal resource standard.** If no spousal share was determined because the couple failed to verify resources held at the beginning of the first continuous period of institutionalization, the spousal share is \$0. The spousal share does not change; if a spousal share was previously established and verified as correct, use it;
- the **spousal resource standard** in effect at the time of application;
- an amount **actually transferred** to the community spouse from the institutionalized spouse under a **court spousal support order**;
- an amount designated by a DMAS Hearing Officer.

If the individual does not agree with the PRA, see subsection F. below.

**Once the PRA is determined, it remains a constant amount for the current Medicaid application (including retroactive months) and all subsequent Medicaid applications.**

**3. Deduct Partnership Policy Disregard Amount**

*When the institutionalized spouse is entitled to a Partnership Policy disregard, deduct a dollar amount equal to the benefits paid as of the month of application.*

**4. Compare Remainder**

Compare the remaining amount of the couple's resources to the appropriate Medicaid resource limit for one person.

**a. Remainder Exceeds Limit**

**When the remaining resources exceed the limit, the individual is not eligible for Medicaid because of excess resources. Go to section M1480.250 below.**

**b. Remainder Less Than or Equal to Limit**

When the remaining resources are equal to or less than the Medicaid limit, the institutionalized spouse is resource eligible in the month for which eligibility is being determined:

**Step 3:** The couple's total countable resources on November 1, 1996 (first moment of the first day of the month for which eligibility is being determined) are \$80,000.

**Step 4:** Determine the spousal protected resource amount (PRA). The spousal PRA is the greatest of:

\$75,000 (the spousal share, which is less than the maximum spousal resource standard of \$76,740 in November 1996);

**Step 5:** Deduct the PRA from the couple's combined countable resources as of November 1, 1996 (the first moment of the first day of the month for which eligibility is being determined).

\$80,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
- 75,000	Step 4 PRA
\$ 5,000	countable resources in month for which eligibility is being determined.

\$5,000 is the countable resources available to the institutionalized spouse in the month for which eligibility is being determined.

**Steps 6 & 7:** Compare the \$5,000 countable resources to the resource limit of \$2,000. The countable resources of the institutionalized spouse exceed the limit, so he is not eligible for Medicaid in November 1996 (the month for which eligibility is being determined). He is not a QMB, so his application was denied in January 1997 because of excess resources.

Mrs. C appealed the denial because she believes that she needs more resources protected so that her income will be sufficient to meet her needs. After a hearing in March 1997, and evidence gathered of Mrs. C's extraordinary shelter and medical expenses, the DMAS Hearing Officer decided that more of the couple's resources should be protected in order to raise Mrs. C's income to the minimum monthly maintenance needs allowance (MMMNA). The Hearing Officer decided that the spousal resource maximum of \$76,740 should be the PRA. Mr. C's eligibility was recalculated using the \$76,740 PRA.

**Step 5 again:** The revised PRA was deducted from the couple's total combined countable resources in November 1996 (the initial month for which eligibility is being determined):

\$80,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
- 76,740	Step 4 PRA
\$3,260	countable resources in month for which eligibility is being determined.

\$3,260 is the countable resources available to Mr. C in November 1996 (the month for which eligibility is being determined). Because he has excess resources, and because he is not a QMB (has no Medicare Part A), he is not eligible for Medicaid and the denial was sustained.

## **M1480.233 INITIAL ELIGIBILITY - RETROACTIVE MONTHS**

### **A. First Application**

Use the procedures for the initial resource eligibility determination (section M1480.232 above) for each of the three (3) months preceding an institutionalized spouse's first application for Medicaid in a continuous period of institutionalization that began on or after 9-30-89.

To determine the institutionalized spouse's countable resources in each retroactive month, subtract the spousal PRA from the couple's total countable resources held **on the first moment of the first day of each retroactive month**. Use the procedures in C below.

### **B. Subsequent Applications**

#### **1. Medicaid Eligibility Established Previously**

If an individual established Medicaid eligibility as an institutionalized spouse during a period of institutionalization that began on/after 9-30-89, regardless of whether the period of institutionalization is the same continuous period covered by the previous application(s), **do not consider the couple's resources**. Use **only the institutionalized spouse's resources**. Use the policy and procedures in section M1480.255 to determine the institutionalized individual's financial eligibility.

For the application's retroactive month(s), determine resources using only the institutionalized spouse's resources in each retroactive month. If the institutionalized spouse's countable resources exceed the Medicaid resource limit in a retroactive month, the institutionalized spouse is NOT eligible for that month.

#### **2. Medicaid Eligibility Not Previously Established**

If an individual has never established Medicaid eligibility as an institutionalized spouse, **treat the application** as an "initial eligibility" determination (section M1480.232 above).

- Determine countable resources for the application month (see section M1480.232 above).
- Deduct the spousal PRA from the couple's total countable resources held **on the first moment of the first day of each retroactive month**.
- *Deduct a dollar amount equal to the Partnership Policy disregard as of **the month of application** (Note: this amount is also used when determining eligibility for a retroactive month).*

For the application's retroactive month(s), determine resources using the procedures in subsection C below.

### **C. Procedures**

The procedures in this subsection are used for the retroactive determination based on a

- first application; or
- subsequent application when Medicaid eligibility as an institutionalized spouse was NOT previously established.

1. **Couple's Resources** Determine the couple's total countable resources as of the **first moment of the first day of each retroactive month.**
2. **Subtract PRA** Subtract the spousal PRA (M1480.232 above) from the couple's total resources in each retroactive month. Each result is the countable resources available to the institutionalized spouse in each retroactive month.
3. **Subtract Partnership Policy Disregard** *When the institutionalized spouse is entitled to a Partnership Policy disregard, deduct the dollar amount equal to the benefits paid as of the month of application.*
4. **Countable Resources Within Limit** If the countable resources in a *retroactive* month are less than or equal to the resource limit, the institutionalized spouse is eligible in that month.
5. **Countable Resources Exceed Limit** If the countable resources exceed the Medicaid resource limit in a retroactive month, the institutionalized spouse is NOT eligible for that month.

**D. Retroactive Example**

**EXAMPLE #8:** Mr B's first continuous period of institutionalization began on 9-20-92. He **first applied for Medicaid on February 3, 1998** and requested retroactive coverage for December 1997 and January 1998. Mrs. B is his community spouse.

**Retroactive Month**

December 1997

**Step 1:**

The couple's total resources as of September 1, 1992 (the first moment of the first day of the first continuous period of institutionalization) were \$200,000.

**Step 2:**

$\$200,000 \div 2 = \$100,000$ . The spousal share is \$100,000.

**Step 3:**

The couple's total countable resources as of December 1, 1997 (the retroactive month for which eligibility is being determined) are \$96,000.

**Step 4:**

Determine the spousal protected resource amount (PRA). The spousal PRA is the greatest of:

- \$80,760 (the maximum spousal resource standard in effect at the time of application (February 20, 1998) is less than the spousal share of \$100,000);
- \$16,152 (the spousal resource standard in effect at the time of application (February 20, 1998),
- \$0 (no amount designated by DMAS Hearing Officer),
- \$0 (no amount transferred pursuant to court support order).

The PRA is \$80,760 (the lesser of the maximum resource standard and the spousal resource standard, because there was no amount designated by DMAS Hearing Officer or transferred per court order).

NOTE: Once the PRA is determined, it remains the same for all retroactive months and for months in the initial eligibility determination period.

**Step 5:** *Deduct the PRA from the couple's combined countable resources on as of December 1, 1997 (the first moment of the first day of the month for which eligibility is being determined)*

\$96,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
<u>- 80,760</u>	Step 4 PRA
\$15,240	countable resources in month for which eligibility is being determined.
\$15,240	countable to Mr. B.

**Step 6:** Since \$15,240 exceeds the \$2,000 limit, Mr. B is not eligible for Medicaid for December 1997 (the retroactive month for which eligibility is being determined).

Complete a retroactive determination for January 1998.

***Retroactive Month*** *January 1998*

**Step 1:** *The couple's total resources as of September 1, 1992 (the first moment of the first day of the first continuous period of institutionalization) were \$200,000.*

**Step 2:** *\$200,000 ÷ 2 = \$100,000. The spousal share is \$100,000.*

**Step 3:** *The couple's total countable resources as of January 1, 1998 (the retroactive month for which eligibility is being determined) are \$93,000.*

**Step 4:** *Determine the PRA: Once the PRA is determined, it remains the same for all retroactive months and for months in the initial eligibility determination period.*

*The PRA is \$80,760 (See Step 4 in the retroactive determination for December 1997 above).*

**Step 5:** *Deduct the PRA from the couple's combined countable resources as of January 1, 1998 (the first moment of the first day of the month for which eligibility is being determined):*

\$93,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
<u>- 80,760</u>	Step 4 PRA
\$ 12,240	countable resources in month for which eligibility is being determined.

*\$12,240 countable resources for Mr. B.*

**Step 6:** *Since \$12,240 exceeds the \$2,000 limit, Mr. B is not eligible for Medicaid in for January 1998 (the retroactive month for which eligibility is being determined. Proceed to determine eligibility for the initial eligibility determination period that begins with February 1998 (month of application).*

- \$0 (amount actually transferred as court-ordered spousal support);  
or
- \$0 (DMAS hearing decision amount).

Since \$15,804 is the greatest, \$15,804 (the spousal resource standard) is the PRA.

**Step 5:**

*Deduct the PRA from the couple's combined countable resources on December 1, 1997 (the first moment of the first day of the month for which eligibility is being determined)*

\$12,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
<u>- 15,804</u>	Step 4 PRA
\$ 0	countable resources in month for which eligibility is being determined (-\$3,804 difference)

\$0 is the countable resources available to Mrs. T, the institutionalized spouse, in the month for which eligibility is being determined.

**Steps 6 & 7:**

Compare the \$0 countable resources to the resource limit of \$2,000. The countable resources of the institutionalized spouse are less than the limit, so she is resource-eligible for Medicaid in the month for which eligibility is being determined.

**Step 8a:**

The community spouse owns, in his name only, \$6,000 of the couple's total countable resources as of the first moment of the first day of the month for which eligibility was established, and 1/2 of the couple's \$2,000 joint savings account; his share = \$1,000. The community spouse's available resources total \$7,000.

**Step 8b:**

The institutionalized spouse owns, in her name only, \$4,000 of the couple's total countable resources as of the first moment of the first day of the month for which eligibility was established, and owns 1/2 of the couple's \$2,000 joint savings account; her share = \$1,000. The institutionalized spouse's available resources total \$5,000.

**Step 9:**

The CSRA is calculated:

\$15,804	Step 4 PRA
<u>- 7,000</u>	Step 8a community spouse's available resources
\$8,804	CSRA

**Step 10:**

\$5,000	Step 8b institutionalized spouse's resources
<u>- 8,804</u>	Step 9 CSRA
\$ 0	institutionalized spouse's countable resources

**Steps 11 & 12:**

Because \$0 is less than the \$2,000 limit, Mrs. T's resource eligibility in the months following the month in which eligibility was established can be "protected" for up to 90 days if she states, in writing, her intent to transfer the

amount of her resources (\$3,000) which exceeds the \$2,000 resource limit to Mr. T. The institutionalized spouse can transfer to the community spouse an amount of resources up to the amount of the CSRA. If Mrs. T receives additional resources of \$3,804 or less within the 90 days, she can remain eligible if she transfers the additional resources to her spouse before the 90-day protected period expires.

## M1480.242 PROTECTED PERIOD OF ELIGIBILITY

### A. Policy

After the initial eligibility determination, an institutionalized spouse who has resources in his name which exceed the Medicaid resource limit may have his Medicaid resource eligibility "protected" for a period of time IF he has expressly indicated in writing his intent to transfer resources to his community spouse *prior to the date action is taken on the application*. The protected period, not to exceed 90 days, is designed to allow the institutionalized spouse time to legally transfer some or all of his resources to the community spouse.

During the protected period, resource eligibility is determined by subtracting the community spouse resource allowance (CSRA) from the institutionalized spouse's own resources. The CSRA is subtracted only during the protected period of eligibility.

**Resources in the institutionalized spouse's name are excluded only in the amount of the CSRA and only for one 90-day period.** If the institutionalized spouse does not transfer resources to the community spouse within the 90-day period, all of the institutionalized spouse's resources will be counted available to the institutionalized spouse when the protected period ends. If the institutionalized spouse loses eligibility after the 90-day protected period is over, and then reapplies for Medicaid, he CANNOT have resource eligibility protected again and a CSRA is NOT subtracted from his resources.

### B. When A Protected Period Is Not Applicable

A protected period of eligibility is not applicable to an institutionalized spouse when

- the institutionalized spouse is not eligible for Medicaid;
- the institutionalized spouse previously established Medicaid eligibility as an institutionalized spouse, had a protected period of eligibility, became ineligible, and reapplies for Medicaid;
- at the time of application, a community spouse has title to resources equal to or exceeding the PRA (the calculated CSRA is \$0); or
- the eligible institutionalized spouse does NOT express his intent to transfer assets to the community spouse.

In these circumstances, an institutionalized spouse may transfer resources in any amount to the community spouse according to the Medicaid asset transfer policy, **but there will be no protected period of eligibility for doing so.**

- C. Intent to Transfer Resources To Community Spouse**
- To be entitled to the protected period of eligibility, the institutionalized spouse (or the institutionalized spouse's guardian or conservator, or the institutionalized spouse's attorney-in-fact who has the power to dispose of the institutionalized spouse's resources) must expressly indicate **in writing** his intention to transfer resources to the community spouse. Use the form "Intent to Transfer Assets to A Community Spouse" (Appendix 5 to this subchapter) to record the institutionalized spouse's intent to transfer resources to the community spouse. *The form must be signed and returned prior to the date action is taken on the application for the protected period of eligibility to apply.*
- When the community spouse is a Medicaid recipient, the eligibility worker must inform the couple that the transfer of resources to the community spouse could impact the community spouse's Medicaid eligibility.
- There is no protected period of eligibility when the institutionalized spouse does NOT expressly indicate his intention to transfer resources to the community spouse. Deny (cancel) Medicaid eligibility for the months following the initial eligibility determination period. Since the institutionalized spouse is eligible for Medicaid in the initial eligibility determination period only, his Medicaid must be canceled effective the last day of the last month in the initial eligibility determination period. Use eligibility Type 4 to enroll the institutionalized spouse for the initial eligibility determination period only.
- D. How to Determine the Protected Period**
- The 90-day protected period begins with the date the local agency takes action to approve the institutionalized spouse's initial eligibility for Medicaid LTC services, if the institutionalized spouse or his guardian, conservator or attorney-in-fact expressly indicates his intent to transfer resources to the community spouse.
- 1. Applicant**
- An individual who was not receiving Medicaid prior to the initial eligibility determination is allowed a protected period of 90 days from the date eligibility is approved, if he has expressed intent to transfer resources to the community spouse.
- 2. Recipient**
- An individual who is receiving Medicaid at the time he became an institutionalized spouse must have his eligibility reviewed. He is allowed a protected period of 90 days from the date his eligibility is redetermined, if he has expressed the intent to transfer resources to the community spouse.
- E. Protected Period Ends**
- Set a special review for the month in which the 90-day period ends. When the protected period of eligibility is over, all resources owned in the institutionalized spouse's name are counted available to the institutionalized spouse. Extension of the protected period is NOT allowed.
- F. Institutionalized Spouse Acquires Resources During the Protected Period of Eligibility**
- If the **institutionalized spouse** obtains additional resources during the protected period of eligibility, the additional resources shall be excluded during the protected period if:
- the new resources combined with other resources that the institutionalized spouse intends to retain do not exceed the appropriate Medicaid resource limit for one person, OR

- the institutionalized spouse intends to transfer the new resources to the community spouse during the protected period of eligibility and the total resources to be transferred do not exceed the balance remaining (if any) of the CSRA.

NOTE: Some assets, such as inheritances, are income in the month of receipt. Be careful to count only those assets that are resources in the month of receipt, and to count assets that are income as a resource if retained in the month following receipt.

**1. Determine  
CSRA Balance**

The CSRA balance is the CSRA less the amount of resources actually transferred to the community spouse after initial eligibility was established. If the institutionalized spouse acquires additional resources during the protected period, the CSRA balance is the amount which can be excluded from the institutionalized spouse's countable resources for the remainder of the protected period.

**2. Determine  
Countable  
Resources**

- Total the institutionalized spouse's countable resources in the month in which the new resource was received.
- Subtract the CSRA balance.
- The remainder is the value of his countable resources in the month.

**3. Countable  
Resources  
Exceed the  
Resource  
Limit**

If the institutionalized spouse has excess resources after acquiring new resources during the protected period, he is ineligible for the month of receipt and subsequent month(s). Take appropriate action to cancel Medicaid, and refer the case to the Department of Medical Assistance Services (DMAS) for recovery of Medicaid payments made in the months in which the institutionalized spouse had excess resources.

NOTE: If the institutionalized spouse transfers or reduces his resources to the resource limit within the month of receipt of the new resources, reinstate his Medicaid coverage. Be sure to determine if the resource transfer or reduction meets the asset transfer policy in subchapter M1450.

**4. Example--  
Additional  
Resources  
Acquired**

**EXAMPLE #11:** Mr. Frost applied for Medicaid on January 2, 1998. He was admitted to the nursing facility on December 20, 1995. He is married to Mrs. Frost who lives in an Adult Care Residence (ACR). This is his first application for Medicaid as an institutionalized spouse. The first day of the first month of the first continuous period of institutionalization is December 1, 1995. The court ordered him to transfer \$68,000 of his resources to Mrs. Frost as spousal support; he transferred \$68,000 to her on December 5, 1997. *Eligibility is being determined for January 1998.*

**Step 1:**

The couple's total countable resources as of December 1, 1995 (*the first moment of the first day of the first continuous period of institutionalization*) were \$130,000.

**Step 2:**

$\$130,000 \div 2 = \$65,000$ . The spousal share is \$65,000.

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**

\$1,711.25	7-1-07	
\$1,650.00	7-1-06	
- C. Maximum Monthly Maintenance Needs Allowance**

\$2,610.00	1-1-08	
\$2,541.00	1-1-07	
- D. Excess Shelter Standard**

\$513.38	7-1-07	
\$495.00	7-1-06	
- E. Utility Standard Deduction (Food Stamps)**

\$252	1 - 3 household members	10-1-07
\$317	4 or more household members	10-1-07
\$281	1 - 3 household members	10-1-06
\$352	4 or more household members	10-1-06

**M1480.420 PATIENT PAY FOR ABD 80% FPL AND 300% SSI INSTITUTIONALIZED SPOUSE**

- A. Policy** After a 300% SSI or ABD 80% FPL institutionalized spouse has been found eligible for Medicaid, determine his patient pay (post-eligibility treatment of income).

\$875 gross earned income  
 - 75 first \$75 per month  
 800 remainder  
 ÷ 2  
 400 ½ remainder  
 + 75 first \$75 per month  
 \$475 which is > \$190

His personal needs allowance is calculated as follows:

\$ 40.00 basic personal needs allowance  
 +190.00 special earnings allowance  
 + 17.50 guardianship fee (2% of \$875)  
 \$247.50 personal needs allowance

**2. Medicaid  
 CBC Waiver  
 Services**

**a. Maintenance Allowance**

Deduct the appropriate maintenance allowance for one person, based on the specific Medicaid CBC waiver under which the individual receives LTC services:

- 1) For the Elderly or Disabled with Consumer Direction Waiver (EDCD Waiver), Mental Retardation (MR) Waiver, Technology-Assisted Individuals Waiver, Individual and Family Developmental Disabilities Support (DD) Waiver, and Day Support (DS) Waiver:

Prior to September 1, 2006, the personal maintenance allowance was equal to the monthly SSI payment limit for one person. Effective September 1, 2006, the personal maintenance deduction is equal to 165% of the monthly SSI payment limit for one person. *The personal maintenance deduction is:*

- January 1, 2007 through December 31, 2007: \$1,028
- January 1, 2008 through December 31, 2008: \$1,051.

*Contact a Medical Assistance Program Consultant for the SSI amount in effect for years prior to 2007.*

- 2) For the AIDS Waiver: the personal maintenance allowance is equal to 300% of the SSI limit for one person (\$1,911).

**b. Guardian Fee**

Deduct the actual fee a guardian or conservator charges, up to a maximum of 5% of the patient's actual gross income (including amounts not counted as income and excluded amounts) for guardianship fees, IF:

- the patient has a legally appointed guardian or conservator AND
- the guardian or conservator charges a fee.

Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

NOTE: The guardianship filing fees CANNOT be deducted from the individual's income.

**c. Special Earnings Allowance For DD, DS and MR Waivers**

**[EXAMPLE #19 was deleted]**

For DD, DS and MR Waivers, deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

- a) for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (\$1,911) per month.
- b) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI (\$1,274) per month.

**EXAMPLE #20: (Using January 2000 figures)**

A working patient in the MR Waiver is employed 18 hours per week. He has gross earnings of \$928.80 per month and SS of \$300 monthly. His special earnings allowance is calculated first:

\$ 928.80	gross earned income
- <u>1,024.00</u>	200% SSI maximum
\$ 0	remainder

\$928.80 = special earnings allowance

His personal maintenance allowance is calculated as follows:

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

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his local agency a Medicaid application which is received on August 18. The facility's statement notes that he will be discharged on September 17 to ABC Nursing Home, a nursing facility. The agency completes the determination on August 27 and finds that he will be eligible once he is discharged to the nursing facility.

The agency does not enroll Mr. A until the discharge is confirmed. The CSB case manager calls the agency on September 21 and informs the agency that the patient was discharged to the ABC Nursing Home on September 18. The patient is enrolled in Medicaid with a begin date of September 18.

**B. Coverage End Date**

Medicaid entitlement ends the last day of the month in which the recipient fails to meet all of the Medicaid eligibility requirements, unless the recipient is an MI pregnant woman *or is age 21-64 and admitted to an IMD or other ineligible institution* (see below).

Medicaid coverage is canceled on the last day of the month in which the agency determines that the recipient no longer meets the eligibility requirements IF the agency can send an advance notice to the recipient at least 11 days before the last day of the month. If the agency cannot send the notice at least 11 days before the end of the month, coverage is canceled effective the last day of the next month.

**1. MI Pregnant Woman**

For an eligible MI pregnant woman, entitlement to Medicaid continues after eligibility is established regardless of any changes in family income, as long as she meets the pregnant category (during pregnancy and the 60-day period following the end of pregnancy) and all other non-financial criteria.

Following the end of the postpartum period, the MI pregnant woman continues to be eligible for Medicaid in the Family Planning Services (see M0320.302) covered group for 10 months (12 months following the end of the pregnancy) regardless of any change in income.

**2. Individual Age 21-64 Admitted to Ineligible Institution**

**a. Entitlement - applicants**

For a Medicaid enrollee age 21-64 years, entitlement to Medicaid *begins on the first day of the application month and ends on the date following the date he is admitted to an IMD or other ineligible institution. When enrolling the individual in the MMIS, enter the begin date and the end date of coverage.*

**b. Cancel procedures for ongoing enrollees**

Cancel coverage as soon as possible after learning of the enrollee's admission to an ineligible institution. **DO NOT cancel coverage retroactively.** Cancel coverage in the MMIS effective the date the cancel transaction is done in the MMIS, using cancel reason code "008."

*c. Notice*

*An Advance Notice of Proposed Action is not required.* Send a Notice of Action to the enrollee or his authorized representative informing him of the cancel date and the reason.

**3. Spenddown Enrollees**

Medicaid entitlement ends on the last day of the last month in the spenddown budget period, unless the individual's or family's circumstances change before that date.

**C. Ongoing Entitlement After Resources Are Reduced**

When an applicant has excess resources throughout the application month, he is not eligible for Medicaid for the month of application. An applicant who reduces excess resources during the month of application or a subsequent month before action is taken on the application may become eligible in the month in which the value of his resources is reduced to, or below, the Medicaid resource limit. In order to reduce resources, the resources must actually be expended and the expenditure documented. (For example: a receipt, a canceled check, or a bank statement).

Reduction of resources is an asset transfer and must be evaluated under asset transfer policy (subchapter M1450).

When excess resources are reduced, entitlement to ongoing Medicaid may begin no earlier than the first day of the month in which the resources were reduced to the Medicaid limit. When retroactive coverage is requested, policy in M1510.101 above must be followed.

**M1510.103 DISABILITY DENIALS**

**A. Policy**

When an individual concurrently applies for SSI or SS and Medicaid as disabled, and either the DDS or the Social Security Administration (SSA) denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.

When an individual applies for Medicaid as disabled or concurrently applies for SS/SSI and Medicaid as disabled, and DDS denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.

**B. Procedures**

**1. Subsequent SSA/SSI Disability Decisions**

The SSA disability decision takes precedence over a DDS decision (DDS will make a decision before SSA if SSA does not take action within the 90-day Medicaid application processing time). If SSA denies disability and the decision is appealed and subsequently reversed, reopen and re-evaluate the denied Medicaid application. The original application is used as long as the application was denied because the individual was not disabled and the subsequent disability onset date is within 90 days of the application. If the re-evaluation determines that the individual is eligible, entitlement is based on the date of the Medicaid application and the disability onset date. If the denied application is more than 12 months old, a redetermination using current information must also be completed.

**M1510.104 FOSTER CARE CHILDREN**

- A. Policy** Entitlement begins the first day of the month of commitment or entrustment IF a Medicaid application is filed within 4 months of the commitment or entrustment date.
- If the Medicaid application is filed more than 4 months after entrustment or commitment, entitlement begins the first day of the application month if retroactive coverage is NOT requested.
- B. Retroactive Entitlement** If the Medicaid application is filed within 4 months of entrustment or commitment, retroactive eligibility exists only if the child met another covered group and all other Medicaid eligibility requirements in the

be included in the TPL section of the *MMIS* eligibility file maintained by the Department of Medical Assistance Services.

**b. Applicants Who Cannot Produce a Claim Number**

In the event the applicant either does not have a Medicare card or does not know his claim number, inquire SSA via the SVES (State Verification Exchange System) using the applicant's own SSN.

If the applicant has never applied for Medicare, complete the Referral to Social Security Administration Form DSS/SSA-1 (form #032-03-099) and write in, "Buy-In" on the upper margin. Mail the form to the Social Security Office serving the locality in which the applicant resides. The SSA office will provide the correct claim number if the individual is on their records. Should the (local/area) SSA office have no record of an application for Medicare, a representative will contact the applicant to secure an application.

Should the applicant be uncooperative (not wish to apply) or be deceased, the Social Security Office will contact the local social services department and ask that agency to file the Medicare application in his behalf. A local department of social services must also submit an application for Medicare on behalf of an individual who is unable or unwilling to apply. When the local department must file a Medicare application, the local Social Security office will advise the local department of the procedure to follow.

**4. Buy-in Begin Date**

Some individuals have a delay in Buy-in coverage:

Classifications	Buy-in Begin Date
Category Needy Cash Assistance	1st month of eligibility
ABD MI (includes dually-eligible)	1st month of eligibility
Categorically Needy Non-money Payment and Medically Needy who are dually-eligible (countable income ≤ 100% FPL and Medicare Part A)	1st month of eligibility
Categorically Needy Non-money Payment and Medically Needy who are not dually-eligible (countable income > 100% FPL or no Medicare Part A)	3 <sup>rd</sup> month of eligibility

If the medically needy coverage begin date is other than the first day of a month, Buy-in is effective the first day of the month in which the 60th day after the begin date occurs.

- D. Other Third Party Liability** When the agency identifies another third party which has responsibility to pay for a recipient's medical bill, the agency must report the third party to:

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

Examples of other third parties include liability insurance settlements, trust funds established for the recipient's medical care, awards resulting from liability lawsuits, and persons ordered by the court to pay for the recipient's medical care.

- E. Pursuing Third Party Liability and Medical Support** In order to continue to be eligible for Medicaid, an individual who is required to assign rights to, and cooperate in, pursuing medical support and third party liability must continue to cooperate with the local agency and DMAS. See subchapter M0250 for details.

## M1510.302 SOCIAL SECURITY NUMBERS

- A. Policy** Applicants must provide the Social Security number (SSN) of any person for whom they request Medicaid, or must apply for a Social Security number if he/she does not have one. An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

- 1. Exceptions** An SSN or application for an SSN are not required for the following individuals:

- Children under age one born to Medicaid-eligible mothers, as long as the mother would still be eligible for Medicaid had the pregnancy not ended and the mother and child continue to live together;
- Illegal aliens who are eligible only for Medicaid payment of emergency services (see M0220); *and*
- *Foster care children voluntarily entrusted to a public or private child-placing agency who meet all other Medicaid eligibility requirements; these children must be enrolled without an SSN or application for SSN. The child-placing agency cannot apply for the child's SSN unless the agency has gone to court and has been awarded custody of the child by a court; a voluntarily entrustment does not require court action and most child-placing agencies do not go to court when the birth parent signs a voluntary entrustment.*

- 2. Application for SSN Required** If the applicant does not have an SSN, he must cooperate in applying for such a number with the local Social Security Administration Office (SSA). An Enumeration Referral Form, form #032-03-400, available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi> must be completed by the applicant.

The applicant must provide the SSN to the local social services department as soon as it is received and the number must be entered in the MMIS. Applicants who refuse to furnish an SSN or to show proof of application for a number will be ineligible for Medicaid.

## B. Procedures

### 1. Documentation

If the applicant does not have a Social Security number, the agency must document in the record when he/she has applied for an SSN.

When entering the individual in ADAPT or MedPend, use the date the individual applied for an SSN, or the individual's date of birth, preceded by "APP." For example, an individual applied for an SSN on October 13, 2006. Enter "APP101306" as the individual's SSN.

### 2. Follow-up

#### *a. Follow-up in 90 Days*

The agency must follow-up this action within 90 days of the Social Security number application date or 120 days if application was made through hospital enumeration:

- document the recipient's assigned Social Security number in the case record,
- enter the recipient's Social Security number on the MMIS computer recipient eligibility file, and in ADAPT if the enrollee is in ADAPT.

#### *b. Foster Care Child With Voluntary Entrustment*

*When a foster care child is eligible for Medicaid without an SSN or application for an SSN, the agency must review the child's SSN or SSN application by the time the annual renewal is due. The agency should ask if the child-placing agency has gone to court to obtain legal custody. The child remains exempt from the SSN requirement until:*

- *legal custody is granted to the child-placing agency, or*
- *the child is adopted and the adoption is final.*

*If the child is still exempt from the SSN requirement after the first annual renewal and continues to meet all Medicaid eligibility requirements, the agency must follow-up again at the next renewal unless the child's adoption is finalized or the child placing agency obtains legal custody before the next renewal.*

*If the child is adopted and the adoption is final before the annual renewal, the adoptive parent(s) must apply for the child's SSN.*

**3. Renewal Action**      **a. *Check for Receipt of SSN***

At renewal, check the MMIS and ADAPT records for the enrollee's SSN. If the SSN has "888" or "APP" as the first 3 digits, contact the enrollee to obtain the enrollee's SSN verbally, by mail or email, or on the renewal form if a renewal form is required.

**b. *Verify SSN***

Verify the SSN by a computer system inquiry of the SSA records.

**c. *Enter Verified SSN on Systems***

Enter the enrollee's SSN in MMIS, and in ADAPT if the enrollee is in ADAPT. If the enrollee is in an active Medicaid case in ADAPT, and his pseudo SSN is not changed to a valid SSN at renewal, ADAPT will determine him ineligible for Medicaid.

**d. *Foster Care Child With Voluntary Entrustment***

*If the child is still in foster care, the agency has not gone to court for custody and the child's adoption is not final, the child does not require an SSN or application for an SSN.*

## **M1510.303 PATIENT PAY NOTIFICATION**

**A. Policy**

After an individual in long-term care is found eligible for Medicaid, the recipient's patient pay must be determined. When the patient pay amount is initially established or when it is changed, a written notice must be sent to the recipient or the recipient's authorized representative.

**B. Procedure**

When patient pay is determined, the "Notice of Obligation for Long-Term Care Costs" form must be sent. For any subsequent decrease in patient pay, the form will serve as adequate notice.

When patient pay increases, the "Notice of Obligation for Long-Term Care Costs" form must be sent in advance of the date the new amount is effective. Following the advance notice period, the new DMAS-122 is released to the provider, if an appeal was not filed.

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## M1520.000 MEDICAID ELIGIBILITY REVIEW

### M1520.001 GENERAL PRINCIPLE

#### A. Policy

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

An annual review of all of the enrollee's Medicaid eligibility requirements is called a "renewal." A renewal of the enrollee's eligibility must be completed at least once every 12 months.

When a Medicaid enrollee no longer meets the requirements for the covered group under which he is enrolled, the eligibility worker must evaluate the individual's eligibility in all other covered groups prior to canceling his Medicaid coverage.

When a change is reported that impacts eligibility or a renewal is completed and the enrollee is no longer eligible, the Advanced Notice of Proposed Action must be sent to the enrollee before the enrollee's benefits can be reduced or his eligibility can be terminated (see M1520.401). *The individual may be eligible for the limited benefit family planning services covered group, Plan First. A Plan First Brochure or a Plan First Fact Sheet, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>, must be included with the Advance Notice of Proposed Action. Eligibility for Plan First is not determined unless the individual submits a Plan First application.*

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

#### B. Procedures For Partial Review and Renewals

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

- the requirements for **partial reviews** are in section M1520.100;
- the requirements for **renewals** are in section M1520.200;
- the policy and procedures for **canceling** a enrollee's Medicaid coverage or reducing the enrollee's Medicaid services (benefit package) are in section M1520.400;
- the policy and procedures for **extended Medicaid coverage** are in section M1520.500;
- the policy and procedures for **transferring cases** within Virginia are in section M1520.600.

## M1520.100 PARTIAL REVIEW

#### A. Enrollee's Responsibility

The enrollee has a responsibility to report changes in his circumstances which may affect his eligibility, patient pay or HIPP premium payments within 10 days from the day the change is known.

**B. Eligibility Worker's Responsibility**

The eligibility worker has a responsibility for keeping a record of changes that may be anticipated or scheduled, and for taking appropriate action on those changes. The worker can set a follow-up review in the MMIS for anticipated changes. Examples of anticipated changes include, but are not limited to, the receipt of an SSN, receipt of SSA benefits and the delivery date for a pregnant woman.

**1. Changes That Require Partial Review of Eligibility**

When changes in an enrollee's situation are reported by the enrollee or when the agency receives information indicating a change in an enrollee's circumstances (i.e. SSI purge list, reported transfer of assets), the worker must take action to partially review the enrollee's continued eligibility.

A reported increase in income and/or resources can be acted on without requiring verification, unless a reported change causes the individual to move from a limited-benefit covered group to a full-benefit covered group. The reported change must be verified when it causes the individual to move from a limited-benefit covered group to a full-benefit covered group.

**2. Changes That Do Not Require Partial Review**

When changes in an enrollee's situation are reported or discovered, such as the enrollee's SSN and card have been received, the worker must document the change in the case record and take action appropriate to the reported change in the appropriate computer system(s).

Example: The Medicaid enrollee who did not have an SSN, but applied for one when he applied for Medicaid, reports by calling the worker that he received his SSN. The worker records the telephone call and the enrollee's newly assigned SSN in the case record, verifies the SSN via SPIDeR and enters the enrollee's verified SSN in MMIS and ADAPT.

**3. HIPP Requirements**

A HIPP Application and Medical History Questionnaire must be completed when it is reported that a member of the assistance unit is employed more than 30 hours per week and is eligible for coverage under an employer's group health plan. The eligibility worker must report to the HIPP Unit at DMAS any changes in an enrollee's situation that may affect the premium payment.

**4. Program Integrity**

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

Should the enrollee not provide the requested information to the program integrity staff within the specified time, program integrity staff will notify the eligibility worker, and the worker must take action (including sending advance notice) to cancel coverage due to the inability to determine continued eligibility. An individual's failure to provide information to program integrity staff does not affect any future Medicaid applications.

**C. Time Standard**

Appropriate agency action on a reported change must be taken within 30 days of the report.

## D. Covered Group Changes

### 1. Newborn Child

When a child is born to a Medicaid-eligible woman (**including an emergency services alien certified for Medicaid payment for labor and delivery**), the only information needed to enroll the child in Medicaid (Child Under One covered group) is the child's name, gender and date of birth and that the child is living with the mother.

This information may be reported through any reliable means, such as the hospital where the child was born, the medical practitioner, or the mother's managed care organization. The agency may **not** require that only the mother make the report.

An eligibility determination for a child born to a Medicaid eligible pregnant woman (including an emergency services alien certified for Medicaid payment for labor and delivery) is not required until the month in which the child turns one year old, unless there is an indication that the child *no longer resides* with the mother *or that the mother and child no longer reside in Virginia*. If the child continues to *reside* with the mother *in Virginia*, an application and an eligibility determination must be completed prior to MMIS cut-off in the month the child turns one year old.

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 Enrollee Becomes a Qualified Severely Impaired Individual (QSII) – 1619(b)

When an SSI Medicaid enrollee loses eligibility for an SSI money payment due to receipt of earned income, continued Medicaid eligibility under the Qualified Severely Impaired Individual (QSII) -1619(b) covered group may exist. A partial review to determine the individual's 1619(b) status via the State Online Query Internet (SOLQ-I) or the State Verification Exchange System (SVES) must be completed.

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

**E. Pre-release Planning for a Child in a Psychiatric Residential Treatment Facility**

*A partial review of circumstances is required for children who may be discharged from a psychiatric residential treatment facility. Continued eligibility for Medicaid is a critical factor in determining the discharge plan, and an eligibility review must be completed to determine if the child will continue to be eligible for Medicaid following discharge. If eligible for ongoing Medicaid, the child will be able to receive a special benefit package through the Children's Mental Health Program following discharge.*

**1. Transitional Services Care Coordinator Responsibility**

*The transitional services care coordinator will send a Children's Mental Health Program Pre-Release Referral to the agency. The referral will identify the child, the proposed date of discharge, and the proposed placement in the community. M1520, Appendix 1 contains a sample form; transitional services care coordinators may download the official form from the DMAS web site, <http://www.dmas.virginia.gov>.*

**2. Agency Responsibility**

*Upon receipt of the Children's Mental Health Program Pre-Release Referral, the agency must determine if the child will continue to be eligible for Medicaid if discharged to the proposed placement using the assistance unit policy in subchapter M0520. **The partial review must be completed no later than 30 days following receipt of the referral.***

*Current income information must be obtained if the pre-release plan is to place the child with a parent or spouse because the child is no longer considered an assistance unit of one. The income limit for continued coverage is 133% FPL for the family/budget unit. **Medically needy or FAMIS children are not eligible to receive services under the Children's Mental Health Program.***

*The result of the partial review must be entered on the Children's Mental Health Program Pre-Release Referral and returned to the transitional services care coordinator.*

***If, based upon the result of the pre-release partial review, the child will not be eligible upon discharge to the proposed placement, action to cancel the child's Medicaid coverage must be taken only if the child is actually discharged to the proposed placement.** The transitional services care coordinator will notify the agency if and when the child is discharged.*

*A copy of the completed referral form must be kept in the case record.*

## **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.

- 1. 12-Month Renewal Period**

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.
  
- 2. Scope of Renewals**

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

Individuals who claim citizenship but cannot obtain documentation of citizenship and identity must be given reasonable opportunity to provide verification. See M0220.100.
  
- 3. Ex Parte Renewal**

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.
  
- 4. Medicaid Renewal Forms**

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 *ABD Medicaid Renewal form #03-032-0186* or the *Families & Children Medicaid and FAMIS Plus Renewal form #03-032-0187* (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) and verifications necessary to determine ongoing eligibility before the coverage is canceled.

*For individuals who are in long-term care, use the Medicaid redetermination for Long-Term Care form #032-03-0369 available at: [http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm\\_care.cgi](http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi).*

*For enrollees in Plan First, use the Plan First Application form available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.*

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. These forms are available on the intranet at:  
<http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.

**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 12<sup>th</sup> 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 programs. The agency has ready access to Food Stamp and TANF records, some wage and payment information, information from SSA through the SVES, SDX and Bendex, and child support and child care files.

**The enrollee is not required to complete and sign a renewal form when all information necessary to redetermine Medicaid eligibility can be obtained through an ex parte renewal process.**

**2. Income Verification Required**

Income verification no older than 6 months old may be used unless the agency has reason to believe it is no longer accurate. It is not necessary to retain a copy of verifications of income in the case record. If a copy is not retained, the worker must document the date and method used to obtain the information (viewed, telephone call, etc.), the type of verification, the source and a description of the information.

When the enrollee has reported that he has no income (\$0 income), the enrollee must be given the opportunity to report income on a renewal form. Do not complete an ex parte renewal when the enrollee has reported \$0 income.

3. **Renewal For SSI Recipient**  
The renewal for an SSI recipient who has no countable real property can be completed by verifying continued receipt of SSI through SVES and documenting the case record. The ex parte process cannot be used for an SSI recipient who owns non-exempt real property. He is subject to a resource evaluation and the agency has no internal means to verify all his resources.
4. **Coordination With Other Benefit Programs**  
When an ongoing F&C Medicaid enrollee applies for Food Stamps or TANF, the income information obtained for the application can be used to complete an early Medicaid renewal and extend the Medicaid renewal to coincide with the Food Stamp certification period. However, failure to complete an early renewal must not cause ineligibility for Medicaid.
5. **Medicaid Renewal Form Required**  
When a Medicaid Renewal form is required, the form must be sent to the enrollee no later than the 11<sup>th</sup> month of eligibility. The Medicaid Renewal form can be completed by the worker and sent to the enrollee to sign and return or can be mailed to the enrollee for completion. The eligibility worker must allow at least 10 days for receipt of the necessary verifications, but additional time may be allowed depending on the type of information requested. The specific information requested and the deadline for receipt of the verification must be documented.

If information necessary to redetermine eligibility is not available through on-line information systems available to the agency and the enrollee has been asked, but failed to provide the information, the renewal must be denied and the coverage cancelled due to the inability to determine continued eligibility.

### C. Special Requirements for Certain Covered Groups

1. **Pregnant Woman**  
A renewal of eligibility of an MI pregnant woman is not required during her pregnancy. *Eligibility* as a pregnant woman *ends* effective the last day of the month in which the 60<sup>th</sup> day following the end of her pregnancy occurs.

*When eligibility as a pregnant woman ends, determine if the woman meets the definition for another Medicaid covered group (see M0310.002). If the woman meets the definition of a full-benefit covered group, determine if an ex parte renewal can be completed or if a renewal form is required and take appropriate action.*

*If the woman does not meet the definition and/or the income requirements for another full-benefit covered group, she may be eligible for the limited benefit family planning services covered group, Plan First. A Plan First Brochure or a Plan First Fact Sheet, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>, must be included with the Advance Notice of Proposed Action. Eligibility for Plan First is not determined unless the woman submits a Plan First application.*

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

**2. Plan First (FPS) Review Requirements**

*Effective January 1, 2008, a Plan First application/renewal form must be filed for individuals (men and women) who request Medicaid coverage for family planning services only (see M0320.302). The application/renewal form is available on SPARK at*

*<http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.*

*The ex parte renewal process cannot be used for this covered group.*

**3. Newborn Child Turns Age 1**

An application for a child enrolled as a Newborn Child Under Age 1 must be filed before MMIS cut-off in the last month in which the child meets the Newborn Child Under Age 1 covered group and must include:

- an application (see M0120.300)
- verification of citizenship and identity
- SSN or proof of application
- verification of income
- verification of resources for the MN child.

**4. Child Under Age 19 (FAMIS Plus)**

Eligibility of children in the MI Child Under Age 19 (FAMIS Plus) covered group must be renewed at least once every 12 months.

When an enrolled FAMIS Plus child no longer meets the MI income limits, evaluate the child for the Family Access to Medical Insurance Security Plan (FAMIS) using the eligibility requirements in chapter M21. If the child is eligible for FAMIS, send the family an Advance Notice of Proposed Action that Medicaid will be cancelled effective the last day of the month in which the 10-day advance notice expires and the FAMIS coverage will begin the first day of the month following the Medicaid cancellation. Use cancel reason "042" when the child loses eligibility in Medicaid and is reinstated in FAMIS and there is no break in coverage.

**Do not use change transactions to move a child between Medicaid and FAMIS.**

If the child is not eligible for FAMIS, the worker must provide an opportunity for the child to be evaluated as medically needy prior to sending an advance notice and canceling the child's Medicaid coverage.

**5. FAMIS Plus Child Turns Age 19**

When a FAMIS Plus child turns age 19, redetermine the child's continuing Medicaid eligibility in other covered groups.

If the child does not meet a definition for another covered group, send an advance notice and cancel the child's Medicaid coverage because the child does not meet a Medicaid covered group.

**6. Child Turns Age 21**

When an enrollee who is enrolled as a child under age 21 attains age 21, determine from the case information if the enrollee meets a definition for another covered group, such as blind, disabled, or pregnant woman.

- 7. IV-E FC and AA and Special Medical Needs AA Children From Another State**
- For FC or AA children placed by another state's social services agency, verification of continued IV-E *eligibility status* or non-IV-E special medical needs status, current address, and TPL can be obtained from agency records, the parent or the other state.
- 8. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)**
- The BCCPTA Redetermination, form #032-03-653, is used to redetermine eligibility for the BCCPTA covered group. The renewal form is available online at: <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.html>. The enrollee must provide a statement from her medical provider verifying continued treatment for breast or cervical cancer. There are no Medicaid financial requirements for the BCCPTA covered group.
- 9. SSI and QSII (1619(b)) Covered Group Recipients**
- For recipients enrolled in the SSI and QSII Medicaid covered groups, the ex parte renewal consists of verification of continued SSI or 1619(b) status by inquiring SOLQ-I or SVES.
- If the individual is no longer an SSI recipient or no longer has 1619(b) status and the information needed to determine continued eligibility is not known to the agency, a Medicaid Renewal, form #032-03-699, must be completed and necessary verifications obtained to allow the eligibility worker to evaluate the individual's eligibility in all other covered groups prior to canceling his Medicaid coverage.
- D. Recipient Becomes Institutionalized**
- When a recipient is admitted to long-term care in a medical facility or is screened and approved for Medicaid waiver services, eligibility as an institutionalized individual must be determined using the policies and procedures in chapter M14.
- E. LTC**
- LTC recipients, other than those enrolled in the Medicaid SSI covered group, must complete the Medicaid Redetermination for LTC, form #032-03-369 available at <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi> for the annual renewal. The DMAS-122 must be updated at least every 12 months even when there is no change in the patient pay.
- Ongoing eligibility for LTC recipients enrolled in the Medicaid SSI covered group can be established through an ex parte renewal, i.e., SVES inquiry.

## M1520.400 MEDICAID CANCELLATION OR SERVICES REDUCTION

### M1520.401 NOTICE REQUIREMENTS

#### A. Policy

Following a determination that eligibility no longer exists or that the *enrollee*'s Medicaid services must be reduced, the "Advance Notice of Proposed Action" must be sent to the *enrollee* at least 10 days plus one day for mail, before action is taken to cancel or reduce Medicaid coverage. If the action to cancel or reduce benefits cannot be taken in the current month due to MMIS cut-off, then the action must be taken by MMIS cut-off in the following month. The "Advance Notice of Proposed Action" must inform the *enrollee* of the last day of Medicaid coverage.

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

#### B. Change Results in Adverse Action

##### 1. Services Reduction

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

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

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

##### 2. Adverse Action Resulting from Computer Matches

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

**3. Matches That Require Advance Notice**

The following list indicates some of the computer match sources which require a ten (10) day advance notice.

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

**C. Procedures**

**1. Action Appealed**

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

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

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

**2. Death of Recipient**

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

- If the enrollee has an SSN, the worker must verify the date of death. If the individual receives Social Security (Title II) payments or Supplemental Security Income, SOLQ-I can be used to verify the date of death. If the recipient does not receive these benefits but has an SSN, the worker must run a SVES request to verify the date of death. SVES will display an “X” and the date of death in the “SSN VERIFICATION CODE” field on Screen 1.
- If the recipient does not have an SSN, or if SOLQ-I or SVES does not return information showing that the recipient is deceased, contact the parent/caretaker relative or authorized representative to obtain the date of death. Information from a medical professional/facility is also acceptable.
- The worker must document the case file. Send adequate notice of cancellation to the estate of the enrollee at the enrollee’s last known address and to any authorized representative(s) using the “Notice of Action on Medicaid.”
- Cancel coverage in MMIS using cancel code “001.” The effective date of cancellation is the date of death. Enter the date of death on the enrollee’s demographics screen under data field “DOD.”

**3. End of Spenddown Period**

When eligibility terminates at the end of a six-month spenddown period, advance notice is not required. The individual is notified of the limited period of spenddown eligibility on the Notice of Action sent at the time the *spenddown* application is approved. Explanation of this limitation and information relative to re-application is provided at the time of the *spenddown* eligibility determination and enrollment.

## M1520.402 CANCELLATION ACTION OR SERVICES REDUCTION

### A. Introduction

**1. MMIS Computer Transaction**

*An enrollee’s coverage* must be canceled in MMIS prior to the date of the proposed action. The change to the MMIS enrollee file must be made after system cut-off in the month the proposed action is to become effective. For example, if the Notice of Action specifies the intent to cancel coverage on October 31, a change to the Medicaid computer is made prior to cut-off in October.

In the event the proposed action is not taken, the *enrollee’s coverage* must be immediately *reinstated*. *If the enrollee files an appeal prior to the proposed date of action, the DMAS Appeals Division will notify the agency if the enrollee’s coverage should be reinstated.*

SAMPLE CHILDREN'S MENTAL HEALTH PROGRAM  
PRE-RELEASE REFERRAL

From: \_\_\_\_\_ To: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

This form is used for pre-release planning and placement purposes for children in psychiatric residential treatment facilities.

- The transitional services care coordinator sends the form local department of social services (LDSS).
- The LDSS eligibility worker must review the child's Medicaid eligibility based on the proposed placement as soon as possible, but no later than **30 days** after receipt of this referral.
- The eligibility worker returns the form to the transitional services care coordinator and **retains a copy in the LDSS case record.**

**A. CHILD'S INFORMATION** (COMPLETED BY THE TRANSITIONAL SERVICES CARE COORDINATOR)

NAME: \_\_\_\_\_ MEDICAID #: \_\_\_\_\_

SSN: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

PROPOSED DISCHARGE DATE: \_\_\_\_\_  ACTUAL DISCHARGE DATE: \_\_\_\_\_

COMMUNITY PLACEMENT WITH:

PARENT(S)  OTHER RELATIVE  GUARDIAN  FOSTER CARE

NAME: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

**B. REFERRAL SOURCE** (COMPLETED BY THE TRANSITIONAL SERVICES CARE COORDINATOR)

NAME: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_\_

TRANSITIONAL SERVICES COORDINATOR

AGENCY NAME: \_\_\_\_\_ FAX #: (\_\_\_\_) \_\_\_\_\_

AGENCY ADDRESS: \_\_\_\_\_

DATE MAILED/FAXED TO LDSS: \_\_\_\_\_

**C. MEDICAID DETERMINATION** (COMPLETED BY THE LDSS ELIGIBILITY WORKER)

CHILD WILL REMAIN ELIGIBLE FOR MEDICAID IF DISCHARGED TO PROPOSED PLACEMENT.

CHILD WILL NO LONGER BE ELIGIBLE FOR MEDICAID IF DISCHARGED TO PROPOSED PLACEMENT.

ELIGIBILITY DETERMINATION COULD NOT BE COMPLETED DUE TO: \_\_\_\_\_

\_\_\_\_\_

ELIGIBILITY WORKER: \_\_\_\_\_ PHONE #: (\_\_\_\_) \_\_\_\_\_

DATE RETURNED TO TRANSITIONAL SERVICES COODINATOR BY MAIL/FAX: \_\_\_\_\_

## DMHMRSAS Facilities Medicaid Technicians

NAME	LOCATION	WORK TELEPHONE	CASELOAD
Brenda Wolhfert, Supervisor	Central Virginia Training Center Medicaid Office Madison Heights, VA  Mail to: P. O. Box 1098 Lynchburg, VA 24505	434-947-2754 cell 434-906-0024	CVTC-caseload-A-H
Mary Lou Spiggle	Central Virginia Training Center Medicaid Office Madison Heights, VA  Mail to: P. O. Box 1098 Lynchburg, VA 24505	434-947-6256	CVTC-caseload-I-Z PGH-caseload-H-Z WSH-caseload-all NVMHI-caseload-all SVMHI-caseload-all
Janet Benton	Central State Hospital Medicaid Office P. O. Box 4030 Petersburg, VA 23803	804-524-7582	SSVTC-caseload-all Hiram-Davis-caseload-all PGH-caseload-A-G
Debra J. Quesenberry	Catawba Hospital Medicaid Office P. O. Box 200 Catawba, VA 24070	540-375-4350	Catawba-caseload-all NVTC-caseload-all
Frances Jones	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0841	SWVTC-caseload-all ESH-caseload-A-J
Terri Neel-Kinder	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0842	SEVTC-caseload-all ESH-caseload-K-Z SWVMHI-caseload-all

**NOTE: Because the Medicaid Technicians handle various hospitals in their caseloads, LDSS staff should send transferred case records directly to the Medicaid Technician who requested the case record. In the case record transfer request, the Medicaid Technician will give specific instructions about where to send the case record.**

**DMHMRSAS Facilities:**

CVTC – Central Virginia Training Center

ESH – Eastern State Hospital

NVTC – Northern Virginia Training Center

PGH – Piedmont Geriatric Hospital

SEVTC – Southeastern Virginia Training Center

SSVTC – Southside Virginia Training Center

SWVMHI – Southwestern Virginia Mental Health Institute

SWVTC – Southwestern Virginia Training Center

WSH – Western State Hospital

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## M1600.00 APPEALS PROCESS

### M1610.100 PURPOSE AND SCOPE

#### A. Legal Base

The Social Security Act requires that the State Plan for Medical Assistance provide individuals affected by the administration of the Medical Assistance Program an opportunity for a fair hearing. The act establishes the right of any individual to appeal and receive a fair hearing before the administering agency, the Department of Medical Assistance Services (DMAS), when DMAS or any of its designated agents:

- takes an action to terminate, deny, suspend, or reduce benefits,
- fails to take an application for medical assistance,
- fails to act on an application for medical assistance with reasonable promptness, or
- takes any other action that adversely affects receipt of medical assistance.

The State law governing the State/Local Hospitalization (SLH) program requires that DMAS use the Medicaid applicant/*enrollee* appeals and hearings procedures for SLH applicants and *enrollees*. The procedures in this Chapter also apply to SLH appeals.

#### B. Participants

*The DMAS Appeals Division provides the Hearing Officer who makes arrangements for the fair hearing. The Appeals Division is separate and apart from operational divisions and units within and outside of DMAS. The Division provides a neutral forum for appeals. The Hearing Officer is an impartial decision-maker who will conduct hearings, decide on questions of evidence, procedure and law, and render a written final decision. The Hearing Officer is one who has not been directly involved in the initial adverse action which is the issue of the appeal.*

**The local agency taking the action being appealed, including Disability Determination Services (DDS) disability decisions,** and the appellant (the individual appealing some aspect of his entitlement to medical assistance or its scope of services) or his representative must participate in the hearing. *Most hearings will be conducted by telephone.*

#### C. *Ex Parte* Communication

***Ex parte communication with the Hearing Officer is strictly prohibited.*** *Ex parte communication is any off-the-record communication (oral or written) between the Hearing Officer and an interested party outside the presence of the other parties to the proceeding during the life of the appeal proceeding.*

*The Hearing Officer cannot discuss the substantive issues of an appeal with anyone outside of the hearing. Therefore, it is not appropriate to contact the Hearing Officer to discuss the agency's action prior to or after the hearing.*

*Any information provided to the Hearing Officer must be provided to all parties of the proceeding. However, as noted in M1620.100, it is appropriate to notify all parties to the appeal when an action is taken by an agency to resolve the issue of the appeal. Communication is also allowed for procedural issues such as scheduling hearings, canceling hearings, and indicating a desire to withdraw an appeal.*

**D. Notification and Rights**

At the time of application or redetermination, and at the time of any action or proposed action affecting eligibility for medical assistance, medical services or patient pay, every applicant for and *enrollee* of medical assistance shall be informed in writing of his right to a hearing. He shall also be notified of the method by which he may obtain a hearing, and of his right to represent himself at the hearing or to be represented by an authorized representative such as an attorney, relative, friend, or other *spokesperson*.

**M1620.100 LOCAL AGENCY CONFERENCE**

**A. Time Limits**

A dissatisfied applicant or *enrollee* must be given the opportunity to request a local agency conference. *If a conference is requested, it must be scheduled within 10 working days of receiving the request.*

**B. Conference Procedures**

At the conference, the applicant/*enrollee* must be:

- given an explanation of the action.
- allowed to present any information to support his disagreement with the action.
- allowed to represent himself or be represented by an authorized representative such as a legal counsel, friend, or relative.

**C. Failure to Request a Conference**

*The applicant's or enrollee's failure to request a conference does not affect his right to appeal within 30 days and does not affect his right to continued eligibility if he appeals prior to the effective date of the action.*

**D. The Conference & Right to Appeal**

*The local agency conference must not be used as a barrier to the individual's right to a fair hearing.*

**E. Decision Notification**

*The local agency conference may or may not result in a change in the agency's decision to take the action in question, however an agency can reverse its decision at any time between making the original decision and when a decision is rendered by the Hearing Officer.*

*If the agency's decision is not to take the adverse action indicated on the notice, the applicant or enrollee must be informed in writing. The agency must send a new notice regarding the changed action. A copy of the new notice must be sent to the DMAS Appeals Division.*

If the agency's decision is to stand by its action, the applicant/*enrollee* must be *informed*, but written notice of this decision is not required.

- F. Conference Decision** *If the applicant/enrollee is not satisfied with the agency action following the conference and wants to request a fair hearing, he must be given that opportunity. See M1630.100 C. below. The applicant/enrollee may request an appeal before or after the conference. Participation in a conference does not extend the 30 day time limit for requesting an appeal.*

## M1630.100 APPEAL REQUEST PROCEDURES

- A. Appeal Definition** An appeal is a request for a fair hearing. The request must be a *clear, written* expression by an applicant or *enrollee*, his legal representative (such as a guardian, conservator, or person having power of attorney), or his authorized representative acting at his request, of a desire to present his case to a higher authority. It may be a letter or a completed "Medicaid/SLH/FAMIS Appeal Request Form."
- B. Where to File an Appeal** Appeals must be sent to the:
- Department of Medical Assistance Services  
Appeals Division, 11<sup>th</sup> Floor  
600 East Broad Street  
Richmond, Virginia 23219
- Appeals may also be faxed to (804) 371-8491.*
- C. Assuring the Right to Appeal** The *right to appeal* must not be limited or interfered with in any way. When requested to do so, the agency *must* assist the *applicant/enrollee* in preparing and submitting his request for a fair hearing.
- D. Appeal Time Standards** A request for an *appeal* must be made within 30 days of receipt of notification that Medicaid *coverage* or medical services has been denied, terminated, reduced, adversely affected, or that it has not been acted upon with reasonable promptness.
- Notification is presumed received by the *applicant/enrollee* within three days of the date the notice was mailed, unless the *applicant/enrollee* substantiates that the notice was not received in the three-day period through no fault of his/her own.
- An appeal request shall be deemed to be filed timely if it is mailed, faxed, or otherwise delivered to the DMAS Appeals Division before the end of last day of filing (30 days plus 3 mail days after the date the agency mailed the notice of adverse action). The date of filing will be determined by:*
- *the postmark date,*
  - *the date of an internal DMAS receipt date-stamp, or*
  - *the date the request was faxed or hand-delivered.*

*In computing the time period, the day of the act or event from which the period of time begins to run shall be excluded, and the last day included. If the time limit would expire on a weekend or state or federal holiday, it shall be extended until the next regular business day.*

The DMAS will, at its discretion, grant an extension of the time limit for requesting *an appeal* if failure to comply with the time limit is due to a good cause such as illness of the appellant or his representative, failure to have been notified of the right to appeal, delay due to the postal service or to an incorrect address, or other unusual or unavoidable circumstances.

## **M1640.100 CONTINUED COVERAGE PENDING APPEAL DECISION**

### **A. Appeal Validation**

Following receipt of a written request for a hearing, the DMAS Appeals Division will determine whether the request *is valid*. A *valid* appeal is one that *involves* an action over which the DMAS has hearing authority, and that is received within the required time limit or extended time limit. During the process of validating an appeal request, a representative of the DMAS may contact the agency to request a copy of the notice of the adverse action. Upon receipt of such a request, the agency must immediately send a copy of the notice to the DMAS Appeals Division.

*When an appeal is determined to be valid, the DMAS will send official notification to the agency and identify the issue and Hearing Officer.*

### **B. Coverage May Continue**

When an appeal is received and validated, the DMAS Appeals Division decides if Medicaid coverage must continue and notifies the agency. The agency should not continue coverage due to the appeal until it has been contacted by the Appeals Division. Upon being informed, by telephone or correspondence, that the *enrollee* is eligible to receive continued coverage, the agency must reinstate coverage immediately.

*An enrollee's Medicaid coverage must continue until a final appeal decision is made when an appeal hearing is requested prior to the effective date of the action stated on the "Advance Notice of Proposed Action". In the case of a patient pay adjustment, the patient pay obligation must return to the amount that was effective prior to the change shown on the "Notice of Obligation for Long Term Care Costs" that is the subject of the appeal.*

### **C. When Continued Coverage Does Not Apply**

Coverage **will not** continue when:

- an appeal hearing is requested on or after the effective date of action;
- an *enrollee* does not dispute the facts used by the local agency, but is appealing the policy on which the agency based its action;
- at the hearing, the Hearing Officer determines that the sole issue of the appeal is disagreement with existing State or Federal policy or law and that no facts are disputed. The Hearing Officer will *promptly* notify

the *enrollee* or his representative and the agency in writing that continued Medicaid coverage must terminate immediately. The agency *must* terminate the *enrollee's* Medicaid immediately, using cancel reason "015" effective the date of the hearing.

- D. Recovery of Continued Coverage Costs**      *When the Hearing Officer upholds the agency's action, the cost of medical care received during the period of continued coverage may be recovered by the DMAS. (See M1670.100)*

### **M1650.100 PRE-HEARING ACTIONS**

- A. Invalidation**      *A request for an appeal may be invalidated if it was not filed within the time limit imposed or if it was not filed by the applicant/enrollee or an authorized representative.*
- 1. Appeal Not Filed Timely**      *If DMAS determines that the appellant has failed to file a timely appeal, DMAS shall notify the appellant or the appellant's representative of the opportunity to show good cause for the late appeal.*
- If there is no response, or if after evaluating the response, the Hearing Officer determines that the reason for failing to file a timely appeal does not meet good cause criteria, the appeal request will be considered invalid.*
- 2. Factual Dispute of Timeliness**      *If a factual dispute exists about the timeliness of the request for an appeal, the Hearing Officer shall receive testimony and evidence at the hearing prior to receiving testimony and evidence about the substantive issue of the appeal. A decision on the timeliness issue will be made prior to a determination of whether to make a decision about the substantive issue of the appeal.*
- 3. When Individual Filing Appeal Is Not the Appellant**      *If the individual filing the appeal is not the appellant or an authorized representative of the appellant, DMAS will request that the appellant and/or representative provide proof of authorization to represent the appellant. If proof is not provided, the appeal request will be considered invalid.*
- B. Administrative Dismissal**      *A request for an appeal may be administratively dismissed without a hearing if the appellant has no right to a hearing. DMAS will administratively close an appeal case in the following situations:*
- 1. No Adverse Action Taken**      *If DMAS learns that no adverse action was taken prior to the date of the appeal request, the appeal will be closed.*
- 2. Disability Decision Rescinded By DDS**      *If the appellant's Medicaid application is returned to a pending status because the Disability Determination Services analyst rescinds the denial of disability, the appeal will be closed.*
- 3. Withdrawn**      *If the appellant requests that the appeal be withdrawn, the appeal will be closed by the DMAS Appeals Division.*

- *The appellant must sign a statement clearly indicating that he wishes to withdraw his appeal. The statement or form must be mailed or faxed to the DMAS Appeals Division. Verbal notification to the LDSS by the appellant to withdraw an appeal is **not** sufficient.*
- *The Hearing Officer will close the appeal and send a letter to the appellant with a copy to the LDSS.*

**4. Abandoned**

*If the appellant or his representative fails to appear at the scheduled hearing, and does not reply within 10 days to the Hearing Officer's request for an explanation that meets good cause criteria, or if the appellant does reply and the Hearing Officer decides that the reply does not meet good cause criteria, the appeal will be closed as "abandoned."*

**5. Administratively Resolved**

*If, upon reevaluation by the LDSS, the appellant's coverage is reinstated to the full amount of coverage that was in effect prior to closure or reduction of benefits, the appeal will be closed as administratively resolved.*

**NOTE:** *The agency should not assume that a reinstatement automatically ends the appeal. The Appeals Division will decide whether to terminate the appeal. The agency will receive a copy of final letters for administrative closures.*

**C. Judgment on the Record**

*If the Hearing Officer determines from the record that the agency's action was clearly in error and that the case should be resolved in the appellant's favor, he shall issue a judgment on the record instead of holding a hearing. The Hearing Officer will provide the local agency with a clear explanation of the reason(s) for issuing a judgment on the record and which actions must be taken by the local agency to correct the case. The decision to issue a judgment on the record is at the Hearing Officer's discretion.*

**D. Remand to the Agency Prior to the Hearing**

*If the Hearing Officer determines from the record that the case might be resolved in the appellant's favor if the agency obtains and develops additional information, documentation, or verification, he may remand the case to the agency for action consistent with the Hearing Officer's written instructions. The agency must complete the remand evaluation within 30 days or 45 days as applicable.*

**M1660.100 SCHEDULING THE HEARING**

**A. Scheduling and Location**

*The Hearing Officer will select a date and time for the hearing. Typically, hearings are scheduled three weeks in advance.*

*For eligibility issues, hearings will be held at the local agency. The applicant/enrollee will be at the agency. The Hearing Officer will conduct the hearing by telephone unless the appellant requests a face-to-face hearing.*

**B. Confirmation Letter**

*The schedule letter is mailed to the appellant or representative, and a copy is mailed to the agency.*

*The schedule letter contains information about summary due dates and other pertinent information.*

*If the agency representative can not be available on the date and time selected by the Hearing Officer, he/she must notify the DMAS as soon as possible and request an alternate date and time for the hearing.*

### **M1670.100 LOCAL AGENCY APPEAL SUMMARY**

**A. Agency Appeal  
Summary Form**

*Once a hearing has been scheduled, the agency must complete an “Agency Appeal Summary,” form #032-03-805 available at:  
<http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.*

**B. Send to Appeals  
Division and  
Appellant**

*At least ten days prior to the hearing, the agency must send one copy of this form to each of the following:*

- Department of Medical Assistance Services  
Appeals Division, 11<sup>th</sup> Floor  
600 East Broad Street  
Richmond, Virginia 23219.
- The appellant or his authorized representative.

*The agency must keep a copy of the appeal summary and all relevant documentation, including applications and notices, for its records.*

### **M1680.100 THE HEARING PROCEDURE**

**A. Hearing Procedure**

*The hearing will be conducted in an informal manner. Formal rules of evidence do not apply in these proceedings. The appellant is entitled to guarantees of fair hearings established in Goldberg v. Kelly, 397 US 245 (1970). The proceedings will be governed by the following rules:*

**1. Record**

*The Hearing Officer will swear-in all hearing participants who will be presenting evidence or facts and will record the hearing proceedings.*

**2. Appellant**

*The appellant will present his own case or have it presented by an authorized representative. He will be allowed to bring witnesses, establish all pertinent facts and circumstances, advance any testimony or evidence, and question witnesses.*

**3. Agency  
Representatives**

*The local DSS agency worker who took the action being appealed and/or the worker’s supervisor should be present at the hearing. The local agency may be represented by its county or city attorney. The agency has the authority to ask its county or city attorney to attend the hearing.*

*When the action being appealed is a disability decision made by the DDS, a representative from DDS must be present at the hearing. When the action being appealed is a denial of a medical or dental covered service, a representative from DMAS or its contractor who made the decision must be present at the hearing.*

**4. Opportunity to Examine Documents**

The appellant or his representative must be given the opportunity to examine all documents and records to be used at the hearing, at a time before the hearing or during the hearing. Copies of case record information must be made available free of charge to the appellant at his request.

**B. Hearing Officer Evaluation and Decision**

**1. Evaluation**

Following the hearing, the Hearing Officer prepares a decision taking into account the summary prepared by the agency or medical provider involved, evidence provided by the appellant or his representative, and additional information provided by the *agency*. The Hearing Officer evaluates all evidence, researches laws, regulations and policy, and decides on the *accuracy of the agency's action*.

**2. Hearing Officer Decision**

Examples of the Hearing Officer's decisions include, but are not limited to:

**a. Sustain**

*When the Hearing Officer's decision upholds the agency's action, the decision is "sustained."*

**b. Reverse**

*When the Hearing Officer's decision overturns the agency's action, the decision is "reversed."*

**c. Remand**

*When The Hearing Officer sends the case back to the agency for additional evaluation, the decision is "remanded." The Hearing Officer's decision will include instructions that must be followed when completing the remand evaluation.*

**3. Failure to Provide Requested Information**

If the local department of social services denies an application because of failure to provide requested information, the hearing will address:

- whether or not the applicant was given appropriate notification of what was needed for the eligibility determination; and
- whether or not the applicant was given sufficient time to submit the information requested.

**a. Sustained**

If the local department of social services followed correct procedures (see M0130.200) and the applicant brings the requested information to the hearing, the action of the local department of social services will be sustained and the applicant will be required to file a new application.

***b. Remanded***

If the Hearing Officer determines that the local department of social services did not follow appropriate procedures, the case may be remanded for appropriate action.

If the Hearing Officer determines that the local department of social services did not follow correct procedures, and the applicant brings the relevant information to the hearing, the case may be remanded for an eligibility determination using the original application date.

**C. Local Agency Action**

The decision of the Hearing Officer is the final administrative action taken on the appeal. The local agency must comply with the Hearing Officer's decision.

**1. Agency Action - Sustained Cases**

*If the Hearing Officer's decision is to sustain the agency's action, and coverage was continued during the appeal process, the case must be closed without an additional notice to the enrollee from the local agency. The Hearing Officer's decision letter to the appellant is the appropriate official notice of cancellation.*

The local agency must take action to close the case in the Medicaid computer using cancel reason "015" effective the date the agency receives the decision.

**2. Agency Action - Remanded Cases**

***a. Do Not Send Documents to Hearing Officer***

If the Hearing Officer's decision is to remand the case to the local agency, the local agency must not send documentation of the evaluation or a copy of the remand notice to the Hearing Officer.

***b. Enrollment Actions***

If the Hearing Officer's decision is to remand the case for further evaluation and coverage was continued during the appeal process, coverage must be continued until the local agency completes the evaluation and makes a new decision.

If the remand evaluation results in the appellant's continuous eligibility, the local agency must notify the appellant of his/her continuing eligibility for coverage.

If the remand evaluation results in the appellant's continuous eligibility and coverage was NOT continued during the appeal process, the local agency must reinstate coverage back to the original termination date (no break in coverage) and notify the appellant of his continued eligibility.

If the remand evaluation results in the appellant's ineligibility and coverage was continued during the appeal process, the *enrollee's coverage* must be *cancelled* at the completion of the evaluation, and the appellant must be notified.

*c. Take Action in 30-45 Days*

*The agency must complete the remand evaluation within 30 days or 45 days as applicable.*

**3. Agency Action-Reversed Cases**

Following a Hearing Officer's decision to reverse an agency's action to deny, reduce, or terminate coverage, the agency must reinstate coverage retroactive to the date of closure or month of application (including retroactive coverage months, if applicable).

***M1690.100 RECOVERY OF BENEFITS PAID DURING APPEAL***

**A. Applicable Circumstances**

The Medicaid Program may recover expenses paid on behalf of appellants whose Medicaid coverage was continued during the appeal process, when the agency's proposed action is upheld by the Hearing Officer.

DMAS will be responsible for recovering these expenses from the appellant, not the service provider. The appellant will be notified, after the hearing decision is made, of how much money if any is owed to the Medicaid Program.

**B. Recovery Period**

Medicaid expenditures for services received from the original effective date of the proposed adverse action (as stated on the notice) until the actual cancellation of Medicaid coverage or payment will be recovered.

**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. The situations in which recovery of expenditures are possible include, but are not limited to:
- 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).**
- Section 1917(b)(1)(C)(ii) of the Social Security Act was amended by the Deficit Reduction Act of 2005 to exempt assets disregarded under a "qualified" Long-term Care (LTC) Partnership Policy from estate recovery, as defined in clause (iii) of 1917(b)(1)(C). The same amount of assets that was disregarded in the Medicaid eligibility determination for an individual under an LTC Partnership Policy will be protected during estate recovery.*
- 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 Notice of Medicaid Fraud/Non-fraud Overissuance (form # DMAS 751R; see M1700, Appendix 1) must be completed and sent to:
- Supervisor  
Recipient Audit Unit  
Department of Medical Assistance Services  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219

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#### MEDICAL SERVICES

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**1. Provider  
Enrollment**

In instances where an out-of-state provider is not currently enrolled as a DMAS provider, DMAS will accept the provider's initial billing and will contact the provider to determine the provider's wish to become enrolled so that subsequent services can be paid through the computerized Medicaid claims processing system.

## M1830.100 MANAGED CARE

**A. General  
Information**

Most Virginia Medicaid recipients are required to receive medical care through a managed care program. There are two managed care programs that operate simultaneously within the Commonwealth: The MEDALLION Program, a Primary Care Case Management program, and Medallion II, a program that requires mandatory enrollment into a contracted Managed Care Organization (MCO) for certain groups of Medicaid recipients. Both programs require recipients to choose a primary care provider (PCP) who provides primary health care services and makes referrals as needed. Enrollment in managed care is based on information provided by the eligibility worker to the Medicaid Management Information System (MMIS) during Medicaid enrollment.

**B. Recipients  
Exempt from  
Managed Care**

**General**

The following recipients are not required to enroll in a managed care program and may seek medical care from any provider enrolled by DMAS as eligible to receive payment:

- children in Foster Care (including Treatment Foster Care), Adoption Assistance, and Residential Treatment Facility programs;
- inpatients in State mental hospitals, including but not limited to:
  - Central State Hospital,
  - Eastern State Hospital,
  - Western State Hospital,
  - Hiram W. Davis Medical Center,
  - Northern Virginia Mental Health Institute,
  - Southern Virginia Mental Health Institute,
  - Southwestern Virginia Mental Health Institute, and
  - The Commonwealth Center for Children and Adolescents (formerly known as the DeJarnette Center).
- inpatients in long-stay hospitals, nursing facilities, and intermediate care facilities for the mentally retarded (ICF-MR), and *certain* recipients approved for Medicaid community-based care services;

- Qualified Medicare Beneficiaries (QMB), dually-eligible recipients, Special Low-income Medicare Beneficiaries (SLMB), Qualified Individuals, and Qualified Disabled and Working Individuals (QDWI);
- recipients with other comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents, and any insurance purchased through the Health Insurance Premium Payment Program;
- recipients enrolled in the Aged, Blind or Disabled (ABD) with Income  $\leq$  80 % Federal Poverty Level (FPL) covered group;
- women enrolled in the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) covered group;
- *individuals* enrolled in the *Plan First (family planning services)* covered group;
- recipients who receive hospice services in accordance with DMAS criteria;
- refugees; and
- recipients on a spenddown.

### MEDALLION

The following recipients are excluded from participating in MEDALLION:

- recipients who are not accepted to the caseload of any participating PCP, and
- recipients whose enrollment in the caseload of the assigned PCP has been terminated and whose enrollment has been declined by other PCPs.

### Medallion II

The following recipients are excluded from participating in Medallion II:

- recipients, other than students, who permanently live outside their area of residence for greater than sixty (60) consecutive days, except those placed there for medically necessary services funded by the MCO;

- newly eligible Medallion II enrollees who are in their third trimester of pregnancy and who request exclusion by the 15<sup>th</sup> of the month in which their MCO enrollment becomes effective. Exclusion may be granted only if the member's obstetrical provider (physician or hospital) does not participate with any of the state-contracted MCOs. The enrollee, MCO, or obstetrical provider can make exclusion requests. Following end of pregnancy, these individuals shall be required to enroll in Medallion II to the extent they remain eligible for full Medicaid benefits.
- recipients who have been pre-assigned to the MCO but have not yet been enrolled, who have been diagnosed with a terminal condition, and whose physician certifies a life expectancy of six (6) months or less may request exclusion from Medallion II. Requests must be made during the pre-assignment period.
- recipients who are inpatients in hospitals, other than those listed above, at the scheduled time of enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge.
- Certain children between birth and age three certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (IDEA) and who meet DMAS review.

**1. Foster Care/  
Adoption  
Assistance  
Children**

All Foster Care and Adoption Assistance children enrolled in MMIS with an *Aid Category (AC)* of 072, 074, 076, or 086 or enrolled through ADAPT are automatically excluded from participating in managed care. Foster Care/Adoption Assistance children who are enrolled *outside ADAPT* under any other PD can be exempted from Medicaid managed care programs. If a worker finds that a Foster Care/Adoption Assistance child is enrolled in a managed care program, the worker may request that the child be removed from managed care and placed in fee-for-service Medicaid through the following process:

- Complete the Foster Care Child-Exemption from Managed Care form available on the intranet at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>. The custody order, emergency removal order, or a statement on agency letterhead signed by the director or foster care supervisor verifying the child is in the agency's custody and the date the agency received custody must be attached to the form in order to have the child exempted from managed care.
- Fax the form to (804) 786-5799.

Exemption requests may take up to 5 business days to complete. Disenrollment is effective at the end of the month of notification (not retroactively). The LDSS can verify disenrollments by checking the MMIS Managed Care Assignment screen for a managed care end date.

**2. Other Exempt Recipients**

Recipients who are exempt from enrollment in managed care are excluded based on information supplied to MMIS at the time of enrollment.

**C. Choice of Managed Care Programs/PCPs**

Recipients who are required to participate in a managed care program will be notified within 15 - 45 days of enrollment in Medicaid and asked to choose either a MEDALLION PCP or one of the Medallion II MCOs operating in the recipient's geographical region. A list of MCOs operating in each region can be obtained online at [www.dmas.state.va.us](http://www.dmas.state.va.us) or by contacting the Managed Care Helpline at 1-800-643-2273 to request a comparison chart.

**D. Good Cause**

**MEDALLION**

The MEDALLION program has an annual open enrollment period of 90 days that applies to individuals in MEDALLION only areas. During the open enrollment period, MEDALLION enrollees may change Primary Care Physicians (PCPs). If an enrollee wishes to change his PCP outside of the open enrollment period, he must make a good cause request to DMAS.

**Medallion II**

In the Medallion II program, good cause consists of a pre-defined set of operational conditions that allows an enrollee to change from one Managed Care Organization (MCO) to another. In areas where there is only one MCO, an enrollee may change from either MEDALLION or the MCO to the other program. The good cause provision applies only after the initial 90-day enrollment period has ended.

If a good cause reason exists, the enrollee must write a letter to the DMAS Managed Care Division providing supporting documentation. All written correspondence should be directed to the following address and/or fax number:

Department of Medical Assistance Services  
Managed Care Division  
600 East Broad Street, 11<sup>th</sup> Floor  
Richmond, VA 23219  
(fax) 804-786-5799

For recipients who have been placed in the Client Medicaid Management Program, Medicaid payment for physicians' services will be limited to those services rendered by the primary physician (including a physician providing services to the patients of the primary physician when the primary physician is not available), physicians seen on referral from the primary physician, and emergency medical services.

Prescriptions may be filled by a non-designated pharmacy only in emergency situations when the designated pharmacy is closed or cannot readily obtain the drug.

## **M1850.100 COVERED SERVICES**

### **A. General Information**

Information on Medicaid covered services is provided to assist the eligibility worker in responding to general inquiries from applicants/recipients. Recipients who have problems with bills or services from providers of care should be referred as follows:

#### **Fee-for-Service Medicaid Recipients**

Fee-for-service Medicaid recipients should be referred to the DMAS Recipient Helpline at 804-786-6145. Recipients who need assistance with transportation should be referred to the DMAS transportation broker at 866-386-8331.

#### **Recipients Enrolled in Managed Care**

Recipients enrolled in managed care should be referred to the Managed Care Helpline at 800-643-2273. Medallion II enrollees may also contact their MCO directly. MEDALLION enrollees who need assistance with transportation should be referred to the DMAS transportation broker at 866-386-8331. Medallion II enrollees who need assistance with transportation must contact their MCO directly.

### **B. Copayments**

Most Medicaid covered services have a "copayment," which is the portion of the cost of the service for which the recipient is responsible. Copayment amounts range from \$1.00 to \$3.00 for most services. There is a \$100.00 copayment per admission for inpatient hospital stays. The provider collects the copayment directly from the recipient at the time the service is provided.

**B. Individuals Exempt from Copayments**

The following individuals are exempt from the Medicaid copayments:

- children under 21 years old,
- individuals who receive long-term care services in a nursing facility, rehabilitation hospital, or long-stay hospital, and
- individuals receiving Medicaid community-based care (CBC) waiver services and hospice care.

**C. Services with No Copayments**

The following services do not have copayments:

- emergency-room services,
- pregnancy-related services,
- family planning services, and
- dialysis services.

**D. Covered Services**

The services listed below are covered:

- case management services;
- certified pediatric nurse and family nurse practitioner services;
- *Children's Mental Health Program services*;
- clinical psychologist services;
- community mental retardation services, including day health rehabilitation services and case management;
- dental services for individuals under age 21 years;
- emergency hospital services;
- Early Periodic Screening, Diagnostic and Treatment (EPSDT) services;
- family planning services;
- Federally Qualified Health Center clinic services;
- home and community-based care waiver services, including personal care, adult day health care, respite care, private duty nursing, case management, mental retardation services, and services for the developmentally disabled;
- home health services: nurse, aide, supplies, treatment, physical therapy, occupational therapy, and speech therapy services;

- hospice services;
- inpatient hospital services;
- intermediate care facility-mental retardation (ICF-MR) services;
- laboratory and x-ray services;
- Medicare premiums: Hospital Insurance (Part A); Supplemental Medical Insurance (Part B) for the Categorically Needy (CN) and Medically Needy (MN);
- mental health services, including clinic services, case management, psychosocial rehabilitation, day treatment/partial hospitalization, therapeutic day treatment for children and adolescents, intensive in-home services for children and adolescents, and crisis intervention services;
- nurse-midwife services;
- nursing facility care;
- other clinic services: services provided by rehabilitation agencies, ambulatory surgical centers, renal dialysis clinics, and local health departments;
- outpatient hospital services;
- physical therapy and related services;
- physician services;
- podiatrist services;
- prescribed drugs;
- prosthetic devices;
- Rural Health Clinic services;
- skilled nursing facility services for individuals under age 21 years;
- *substance abuse services*;
- transplant services;
- transportation to receive medical services; and
- *vision services*.

Explanations of some covered services are provided below:

**1. Children's  
Mental Health  
Program  
Services**

*Intensive community-based services for children and youth who have been in a psychiatric residential treatment facility may be provided. The services available are:*

- *respite,*
- *in-home residential supports,*
- *companion services,*
- *training and counseling for unpaid caregivers,*
- *environmental modifications, and*
- *consultative clinical and therapeutic services.*

**2. Clinic Services**

Covered clinic services include therapeutic, rehabilitative, or palliative items or services, and renal dialysis furnished to an outpatient by or under the direction of a physician, in a certified facility which is organized and operated to provide medical care to outpatients.

**3. Community-  
Based Care  
Waiver  
Services**

Virginia provides services under community-based care (CBC) waivers to specifically targeted individuals. These services are not available to all Medicaid recipients. The CBC waivers are:

- Acquired Immunodeficiency Syndrome (AIDS) Waiver,
- Elderly or Disabled With Consumer Direction (EDCD) Waiver,
- Mental Retardation (MR) Waiver,
- Technology Assisted Individuals Waiver,
- Individual and Family Developmental Disabilities Support (DD) Waiver
- Day Support (DS) Waiver, and
- Alzheimer's Assisted Living (AAL) Waiver.

Services covered under the waivers are listed in M1410.040.

**4. Community  
Mental  
Health and  
Mental  
Retardation  
Services**

Certain mental health and mental retardation services are covered for Medicaid-eligible recipients when provided by Medicaid-enrolled mental health providers.

Examples of community mental health services are mental health case management, psychosocial rehabilitation, mental health support, day treatment/partial hospitalization, therapeutic day treatment for children and adolescents, intensive in-home services for children and adolescents, and crisis intervention services.

Mental retardation case management is available to recipients who are not enrolled in the Mental Retardation (MR) Waiver. Other community mental retardation services are available to recipients enrolled in the MR Waiver and include mental retardation case management, day support, residential support, and supported employment services.

**5. Dental Services****a. Smiles for Children Program**

Beginning July 1, 2005, all Medicaid and FAMIS covered dental services are provided under the “**Smiles For Children**” program, administered by Doral Dental USA. The managed care organizations (MCOs) no longer provide dental services to Medicaid and FAMIS recipients who are enrolled in an MCO. All recipients use their Commonwealth of Virginia Department of Medical Assistance Services or MCO-issued ID card to receive dental services. Coverage for medical services is not impacted by this change.

The toll-free telephone number for the **Smiles For Children** member services is 888-912-3456 (Monday through Friday from 8:00 a.m. to 6:00 p.m.). Recipients can obtain provider lists, appointment assistance, member handbooks, and information about dental services and claims.

**b. Covered Dental Services For Recipients Under Age 21**

Covered services include services for relief of pain and elimination of infection, preventative services such as oral prophylaxis and fluoride treatment, routine therapeutic services for the restoration of carious teeth, and diagnostic services.

Procedures such as orthodontics, dentures, braces, partial and permanent bridge work must be preauthorized by Smiles for Children.

**c. Covered Dental Services For Recipients Over Age 21**

Covered services include limited oral surgery services when performed by a participating dentist and when generally covered under Medicare and/or are medically necessary. Examples of covered services include removal of cysts and tumors not related to the teeth, biopsies for suspected malignancies, repair of traumatic wounds, and extraction of teeth for severe abscesses.

Items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not covered.

**6. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services****a. General**

- 1) Health screening services are provided to all eligible individuals under age 21 including those who are married or emancipated. The local agency must inform eligible individuals of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program; however, participation is voluntary. Screening services and treatment may be provided by local health departments and private practitioners.
- 2) Medicaid must cover any medical service identified as medically necessary by an EPSDT screening. When the identified service is not a Medicaid-covered service, DMAS must pre-authorize payment for the service. The service provider and the EPSDT screener are responsible for obtaining this pre-authorization.

- 3) Some examples of non Medicaid-covered medical services that must be covered by Medicaid under EPSDT are inpatient psychiatric hospitalization, chiropractic care, and specific therapies such as speech and language therapy.

**b. Types of Screening**

- 1) Initial physical examinations to screen all children committed to the care and custody of an LDSS to ascertain any physical or mental defects and other health needs of each child are covered.
- 2) Usually, not more than one screening examination per 12-month period is covered for each foster care child between the ages of 3 and 21 years.
- 3) Children from birth to age 3 may be covered for screening at more frequent intervals. Immunizations given during visits for screening examinations will be covered for foster care children.
- 4) Procedures for the EPSDT screening of children are specified in the Social Services Manual, Volume VII.

**7. Family Planning Services**

Covered family planning services are those family planning drugs, supplies, and devices provided under the supervision of a physician. They do not include any services to promote or restore fertility or sexual function.

**8. Home Health Services**

Covered home health services include all services provided by an authorized home health agency under a plan of treatment prescribed by a physician.

**9. Hospice Services**

Care in a Medicaid-certified and enrolled hospice is covered for terminally- ill Medicaid recipients. DMAS must pre-authorize the payment for eligible recipients.

**10. Inpatient Hospital Services**

- a. Inpatient hospital stays for recipients age 21 and over must be preauthorized by DMAS. Emergency admissions must be authorized within 24 hours of admission.

Inpatient hospital stays for children under age 21 years must be medically necessary and preauthorized by the DMAS.

- b. Inpatient psychiatric hospital stays are covered only for recipients over age 65 years, and for children under age 21 if identified as necessary by EPSDT screening or exam and pre-authorized by DMAS.

**11. Laboratory and X-Ray Services**

Laboratory and x-ray services are covered when ordered by a physician and may be provided in a physician's office, certified independent laboratory, State Health Department laboratory, or local health department.

- 12. Medical Supplies and Equipment**
- Medicaid will cover blood glucose self-monitoring test strips for children under the age of 21 with diabetes and pregnant women with gestational diabetes. Medicaid will cover blood glucose self-monitoring test strips for individuals over the age of 21 who are eligible for durable medical equipment, when certain criteria are met.
- Medicaid will cover prosthetic devices (artificial arms, legs, and supportive devices) when prescribed by the physician, preauthorized by the Department of Medical Assistance Services, and furnished by a qualified participating provider.
- Respiratory equipment and oxygen supplies are covered.
- Ostomy supplies are covered.
- Other medical supplies and equipment are covered only for patients receiving renal dialysis or home health care services, and for children under age 21 when the need for the supply or equipment is identified as medically necessary through an EPSDT screening or exam. Medicaid will cover the balance of charges for supplies and equipment covered by Medicare when Medicare has made partial payment on the supplies and/or equipment.
- 13. Nurse-Midwife Services**
- Services are covered when provided by a licensed Medicaid-enrolled nurse-midwife, as allowed under Virginia law.
- 14. Nursing Facility Care**
- a. Nursing facility services are covered when provided in medical institutions licensed as nursing facilities by the State Health Department and certified by DMAS.
  - b. Nursing care in intermediate care facilities for the mentally retarded (ICF/MR) is not a covered service for recipients enrolled as MN.
- 15. Outpatient Hospital Services**
- Outpatient hospital services are covered when furnished by or under the direction of a physician or a doctor of dental surgery. Diagnostic services are covered only when ordered by a physician.
- 16. Physical, Occupational and Speech Therapy**
- Therapy services are covered only as an element of hospital care (inpatient or outpatient), nursing facility care, or home health care, or if prescribed by a physician and provided by a Medicaid-enrolled therapy provider.
- 17. Physician Services**
- Services are covered when provided by physicians licensed to practice medicine, osteopathy, and psychiatry.
- 18. Podiatrist Services**
- Medicaid payment is limited to medically necessary diagnostic, medical, or surgical treatment of the foot. Routine and preventive foot care is not covered.
- 19. Prescribed Drugs**
- Services are limited to generic legend drugs except when the physician specifies "brand necessary" name drugs. When prescribed by a physician, insulin, insulin syringes and needles, and family planning drugs and supplies are covered.

**20. Rehabilitation Services**

**Preauthorization requirement**

All rehabilitative services must be pre-authorized by DMAS.

**Intensive Inpatient Rehabilitation**

Medicaid covers intensive inpatient rehabilitation services provided in facilities certified as rehabilitation hospitals or in rehabilitation units in acute care hospitals, which are certified by the Department of Health as excluded from the Medicare prospective payment system.

**Intensive Outpatient Rehabilitation**

Intensive outpatient rehabilitation services provided by facilities certified as comprehensive rehabilitation facilities (CORFs), or by an outpatient program administered by a rehabilitation hospital or exempted rehabilitation unit of an acute care hospital, which are certified and participating in Medicaid are covered.

**21. Substance Abuse Services**

*Substance abuse (SA) services are covered as follows:*

- *assessment and evaluation,*
- *outpatient therapy (individual, family, and group),*
- *crisis intervention,*
- *intensive outpatient services,*
- *day treatment,*
- *case management, and*
- *opioid treatment.*

*Treatment for nicotine and caffeine dependence/abuse is not covered.*

**22. Transplant Services**

Transplant services are covered as follows:

- kidney, cornea, heart, lung, liver without age limits;
- liver, heart, lung, small bowel, bone marrow, and any other medically necessary transplant procedures that are not experimental or investigational for recipients under age 21; and
- bone marrow transplants for individuals over age 21 for a diagnosis of lymphoma, breast cancer, leukemia, or myeloma.

DMAS must preauthorize all transplants except corneal transplants.

**23. Transportation to Receive Medical Services**

Non-emergency transportation to a medical service is covered only when preauthorized by the DMAS transportation broker. The toll-free telephone number for the transportation broker is 866-386-8331.

Transportation is only covered when the recipient is being transported for the purpose of receiving or returning home from a Medicaid-covered service.

**24. Vision  
Services**

Eye examinations that licensed optometrists and *ophthalmologists* are legally authorized to provide are covered. A routine, comprehensive eye examination is allowed once every 24 months. Preauthorization is not required. Eyeglasses (lenses and frames) are covered for children under age 21 years. Preauthorization for eyeglasses is not required.

**E. Babycare  
Services**

Medicaid has a program of expanded services for all Medicaid-eligible pregnant women and high risk infants under age 2 years. The package of services is called Babycare. Physician, hospital, clinic, and nurse-midwife services are covered, as described above. Risk-assessment, nutrition counseling, patient education, homemaker services, and substance abuse residential and day-treatment services are also covered when prescribed by the physician.

Women and infants who are determined by the physician to be at high-risk for birth-related complications, as defined by DMAS, are eligible for maternity care coordination services, when referred by the physician, in addition to the other Babycare services. The maternity care coordinator is a case manager (usually a nurse or social worker) who develops a plan of care for the pregnant woman or the infant, ensures that the recipient has access to necessary services, provides counseling, and assures that the recipient keeps medical services appointments.

DMAS prints a Babycare pamphlet which is available to local social services agencies and must be ordered from DMAS. It is available in several languages. Recipients may also call the Babycare toll-free Helpline at 1-800-421-7376 between 10:00 a.m. and 3:30 p.m., Monday through Friday, to receive information about Babycare services.

**F. Medical Coverage  
for Specified  
Aliens**

Medicaid covers emergency services for unqualified aliens and qualified aliens eligible for emergency medical services only who meet all other Medicaid eligibility requirements when these services are provided in a hospital emergency room or inpatient hospital setting. DMAS determines both whether services are considered emergency services and the period of coverage.

## **M1860.100 SERVICES RECEIVED OUTSIDE VIRGINIA**

**A. General**

Medicaid must pay for covered medical services received by any eligible person who is temporarily absent from Virginia if the medical service provider agrees to accept Medicaid payment.

**B. Out-of-  
State Institutional  
Placements**

**Preauthorization Requirement**

Virginia Medicaid will cover a recipient who is placed in a long-term care facility in another state only if the placement is preauthorized by the DMAS Long Term Care Section.

**Foster Care Children**

A child in IV-E Foster Care who is placed in an institution outside Virginia is eligible for Medicaid through the state in which he resides. A child in non-IV-E Foster Care is eligible for Virginia Medicaid when the child is in an institution outside Virginia, since the child is considered to be a resident of the locality which holds custody.

<b>EXTRA HELP INCOME LIMITS ALL LOCALITIES EFFECTIVE 1/24/07 MONTHLY GUIDELINES</b>					
<b>FAMILY SIZE</b>	<b>PERCENT OF FEDERAL POVERTY LEVEL (FPL)</b>				
	<b>100%</b>	<b>135%</b>	<b>140%</b>	<b>145%</b>	<b>150%</b>
<b>1</b>	<b>\$850.83</b>	<b>\$1,148.63</b>	<b>\$1,191.17</b>	<b>\$1,233.71</b>	<b>\$1,276.25</b>
<b>2</b>	<b>1,140.83</b>	<b>1,540.13</b>	<b>1,597.17</b>	<b>1,654.21</b>	<b>1,711.25</b>
<b>3</b>	<b>1,430.83</b>	<b>1,931.63</b>	<b>2,003.17</b>	<b>2,074.71</b>	<b>2,146.25</b>
<b>4</b>	<b>1,720.83</b>	<b>2,323.13</b>	<b>2,409.17</b>	<b>2,495.21</b>	<b>2,581.25</b>
<b>5</b>	<b>2,010.83</b>	<b>2,714.63</b>	<b>2,815.17</b>	<b>2,915.71</b>	<b>3,016.25</b>
<b>6</b>	<b>2,300.83</b>	<b>3,106.13</b>	<b>3,221.17</b>	<b>3,336.21</b>	<b>3,451.25</b>
<b>7</b>	<b>2,590.83</b>	<b>3,497.63</b>	<b>3,627.17</b>	<b>3,756.71</b>	<b>3,886.25</b>
<b>8</b>	<b>2,880.83</b>	<b>3,889.13</b>	<b>4,033.17</b>	<b>4,177.21</b>	<b>4,321.25</b>

For family units of more than 8 members, contact a Medical Assistance Program Consultant.

**MAXIMUM VALUE OF CONTRIBUTED FOOD AND SHELTER**

<b>SINGLE/COUPLE</b>	<b>MONTHLY AMOUNT</b>
<b>SINGLE</b>	<b>\$212.33</b>
<b>COUPLE</b>	<b>318.67</b>

## 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.

Retroactive coverage is only available to an eligible child who was born within the 3 months prior to the FAMIS application month. Eligibility for FAMIS coverage will be effective retroactive to the child's date of birth if the child would have met all eligibility criteria during that time.

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 FAMIS Plus (children's 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 FAMIS Plus *and he has income in excess of the FAMIS Plus limits;*
- 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**:

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**

**1. Begin Date**

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.**

**2. Retroactive Coverage For Newborns Only**

*Retroactive FAMIS coverage is effective with applications received on or after September 1, 2006.*

*Retroactive coverage is available ONLY to an eligible child who was born within the 3 months prior to the FAMIS application month. Eligibility for FAMIS coverage will be effective retroactive to the child's date of birth if the child was born within the retroactive period and would have met all eligibility criteria during the retroactive period.*

*The following eligibility requirements must be met in order for a newborn child to be enrolled in FAMIS for retroactive FAMIS coverage:*

- a. Retroactive coverage must be requested on the application form or in a later contact.*
- b. The child's date of birth must be within the three months immediately preceding the application month (month in which the agency receives the signed application form for the child), but **no earlier than June 1, 2006.***
- c. The child must meet all the FAMIS eligibility requirements during the retroactive period.*

**3. FAMIS Aid Categories**

The aid categories (ACs) for FAMIS are:

AC	Meaning
006	child under age 6 with income > 150% FPL and ≤ 200% FPL
007	child 6 – 19 with income > 150% FPL and ≤ 200% FPL
008	child under age 6 with income > 133% FPL and ≤ 150% FPL
009	child 6 – 19 with income > 133% FPL and ≤ 150% FPL

**4. Separate FAMIS and FAMIS Plus MMIS Case Numbers**

Because *FAMIS Plus* and FAMIS are separate programs, *FAMIS Plus* 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 *FAMIS Plus* 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 V0000 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**

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 FAMIS Plus 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 FAMIS Plus 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.

**E. FAMIS Case Transfer Procedures**

**1. ADAPT Cases**

**a. Electronic Case Transfer**

*If the application is processed in ADAPT, individuals approved for FAMIS are enrolled in MMIS by ADAPT. ADAPT will automatically transfer the FAMIS enrollees' data to the FAMIS CPU.*

*If a family has both Medicaid (including FAMIS Plus) FAMIS-eligible individuals, a separate FAMIS case is created in MMIS via the ADAPT "Medicaid Authorization" (AEAUTM) screen. When granted, ADAPT changes the worker number to V0000 on the FAMIS case in the MMIS and automatically transfers the FAMIS case and enrollee data to the FAMIS CPU. The LDSS has responsibility for ongoing case maintenance of the FAMIS Plus case.*

*Do not send a paper case file to the FAMIS CPU when the case is automatically transferred by ADAPT. The LDSS retains the original application, verifications and notices.*

**b. Resolve Enrollment Rejections BEFORE Granting**

*It is important that workers resolve any MMIS Enrollment Rejections immediately when they are received. ADAPT will NOT transfer a FAMIS-*

*eligible individual when ADAPT has received an enrollment rejection message from MMIS on the individual. ADAPT **will transfer** the other FAMIS-enrolled individuals in the ADAPT case if there are no enrollment rejections on the individuals. In order for all FAMIS-eligible individuals in the case to be transferred to the FAMIS CPU **at the same time**, all individuals must be successfully enrolled in MMIS before close of business on the day the case is granted in ADAPT.*

*After the worker corrects the error(s) that caused the enrollment rejection(s), reruns EDBC and the MMIS enrollment is accepted, ADAPT will automatically transfer the FAMIS-eligible individuals in the case during the “batch” FAMIS case transfer process at the end of the work day.*

**2. Cases Not in ADAPT**

*If the application is NOT processed in ADAPT, the worker must manually enroll the FAMIS eligible individuals in MMIS, then change the worker number on the case to “V0000” in MMIS.*

*The worker must transfer the paper case record to the FAMIS CPU as follows:*

**a. Case Material Sent to CPU**

To allow the FAMIS CPU to enroll the child in their computer system and into managed care, the eligibility worker must send the CPU the following documents:

- 1) Send a copy of the most recent application form. If transferring a case after a renewal, send a copy of the most recent completed application form plus the most recent renewal form. The CPU cannot accept the Medicaid Renewal Form by itself because it does not contain all the demographic information necessary to enter the family into the CPU’s computer system.
- 2) The CPU needs to know the source of the income, the employer’s name (if the income is earned), the amount of income received each time it is paid to the individual, and the frequency of the income. Include a copy of a written eligibility evaluation form that has the income source details (source name, employer name, date(s) the income was received, frequency, and the eligibility calculations).
- 3) **Income verifications if any individual in the assistance unit has income.**
- 4) Copy of a written eligibility evaluation form.
- 5) Copy of the written NOA that was sent to the applicant about the FAMIS or FAMIS MOMS eligibility.
- 6) A completed Case Record Transfer sheet.

Additional case information that is not used to determine FAMIS eligibility should **not** be sent to the CPU.

**b. Sending Case to the CPU**

When transferring a case, confidentiality must be ensured by placing the case documents in a sealed interdepartmental envelope that is addressed to the FAMIS CPU (FIPS 976) and sent via the courier no later than the business day following the FAMIS eligibility determination. This ensures timely receipt of the case by the CPU so that the managed care assignment can be initiated, and the eligible individuals can be sent a FAMIS eligibility confirmation “packet” of information about their managed care assignment and the amount of their co-pay for covered services.

If the case is mailed via the United States Postal Service’s certified mail, the envelope must contain the full mailing address of the FAMIS CPU:

FAMIS CPU  
P.O. Box 1820  
Richmond, VA 23218-1820

**F. Transitions Between FAMIS Plus And FAMIS (Changes and Renewals)**

When excess income for FAMIS Plus causes the child’s eligibility to change from FAMIS Plus to FAMIS, the new income must be verified. Copies of the income verifications must be sent to the FAMIS CPU with the transferred case material.

**1. Actions Required**

Transitions between FAMIS Plus and FAMIS require cancellation of the current coverage and reinstatement in the new coverage, and may require additional coordination between the LDSS and the FAMIS CPU. Certain MMIS transactions can only be done by the FAMIS CPU, the DMAS FAMIS Plus Unit or the LDSS. Only the FAMIS CPU can cancel FAMIS or FAMIS MOMS coverage when the case is in worker number V0000. Only the LDSS can cancel FAMIS Plus coverage for cases that are active or connected to active cases in ADAPT or MMIS.

The DMAS FAMIS Plus Unit can add or reinstate FAMIS Plus coverage only on cases processed by the DMAS FAMIS Plus Unit. The LDSS is responsible for reinstating FAMIS Plus coverage on cases processed by the LDSS and may cancel FAMIS Plus coverage and reinstate FAMIS coverage.

**2. Case Transfer When Program Changes**

**a. Cases in ADAPT**

*If the case is processed in ADAPT, individuals approved for FAMIS are enrolled in MMIS by ADAPT, the worker number is changed to “V0000” by ADAPT and the case is transferred to the FAMIS CPU. ADAPT will automatically transfer the FAMIS enrollees’ data to the FAMIS CPU. The worker does not send any paper document to the FAMIS CPU.*

*If a family has at least one child who is FAMIS Plus or Medicaid-eligible and at least one child who is FAMIS-eligible, the Medicaid case remains at the LDSS and a separate FAMIS case is created in MMIS via the ADAPT “Medicaid Authorization” (AEAUTM) screen. When granted, ADAPT changes the worker number to V0000 on the FAMIS case in the MMIS. ADAPT automatically transfers the FAMIS case and enrollee data to the*

*FAMIS CPU. The worker does not send any paper case material to the FAMIS CPU. The LDSS retains the original application, verifications and the notice, and has responsibility for ongoing case maintenance of the FAMIS Plus case.*

**b. Cases Not in ADAPT**

When eligibility transitions between FAMIS Plus and FAMIS, there must be communication between the FAMIS CPU, the LDSS, and the applicant. The Case Record Transfer Form (#032-32-227) must be completed by the sender and attached to the case record. The sender must also notify the applicant of the case transfer. The receiver must confirm receipt of the case by completing the Case Record Transfer Form and returning it to the sender. The receiving agency is not required to complete a FAMIS Plus redetermination until a change is reported or at the time of the next annual redetermination.

So that the FAMIS CPU will be able to enroll the child in their computer system and into managed care, the eligibility worker must send the CPU the documents listed in section M2140.100 E., above.

**G. Communicating Changes to the CPU**

The Children's Health Insurance Communication Form (#032-03-630) is used by the LDSS to communicate changes to the FAMIS CPU on FAMIS and FAMIS MOMS cases. This form can be downloaded from the DSS intranet at:  
<http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.

The form must include the case name, the MMIS name and enrollee identification number, the reason for the communication, and all other relevant information. The FAMIS CPU must receive the Communication Form by the 10<sup>th</sup> calendar day of the month in order for the FAMIS/FAMIS MOMS cancellation to be effective by the end of the current month. If the form is received after the 10<sup>th</sup> calendar day of the month, the cancellation will be effective the last day of the following month.

**H. FAMIS CPU Responsibilities and Procedures**

Applications, Redetermination applications (sent to a FAMIS recipient when a change is reported to the CPU), and renewals are faxed or mailed to the FAMIS CPU by applicants or recipients. Within three days of receipt, the CPU staff logs the application, redetermination or renewal into the FAMIS eligibility system. There are no drop-offs and no face-to-face contact with applicants or recipients at the CPU. All applications are scanned and linked for electronic data recovery.

If an application is complete when it arrives at the FAMIS CPU, it takes approximately 12 business days or less to process the case. In order for an application to be complete, it must be signed and must include all required verifications. If the application is not complete when it is received, a "deficiency letter" is sent and the family is given 30 days to respond. In such cases, it can take more than 30 days to process the case. If the required verification is not received by the 30<sup>th</sup> day, the application is denied for failure to provide information, and the family is notified of the action.

When an application is approved for FAMIS or FAMIS MOMS, the FAMIS CPU initiates the managed care assignment and provides ongoing case maintenance. When an application is not FAMIS Plus-likely and is not eligible for FAMIS or FAMIS MOMS, the CPU sends the denial or cancellation notice to the applicant. When an application is determined as FAMIS Plus-likely, the application is sent over to the DMAS FAMIS Plus Unit for a Medicaid eligibility determination.

**I. DMAS FAMIS Plus Unit Responsibilities and Procedures**

FAMIS Plus-likely applications referred to the DMAS FAMIS Plus Unit from the FAMIS CPU are recorded on a daily log. Steps are being taken to allow the DMAS FAMIS Plus Unit to build and transfer applications in ADAPT and MEDPEND. All referred applications are screened for FAMIS Plus eligibility by the DMAS FAMIS Plus Unit. FAMIS Plus-likely applications connected to active cases in ADAPT or MMIS are transferred to LDSS for processing, and notice of the transfer is sent to the family. The application, the verifications, and a copy of the notice are placed in a sealed envelope and transferred to the LDSS via the courier no later than the next business day.

The DMAS FAMIS Plus Unit processes FAMIS Plus-likely applications that have been pending 25 days or more, and transfers enrolled FAMIS Plus cases to the LDSS. If the unit's screening determines that the application is not FAMIS Plus-likely, then a FAMIS eligibility determination is completed and the case is returned to the FAMIS CPU in an approved or denied status.

FAMIS redeterminations and renewals are also screened for FAMIS Plus eligibility and, if FAMIS Plus-likely, are referred to the DMAS FAMIS Plus Unit. If the FAMIS Plus-likely FAMIS redetermination or renewal is connected to an active case in ADAPT or MMIS, the case is transferred to the LDSS for the FAMIS Plus determination. If the FAMIS Plus-likely FAMIS redetermination/renewal is not connected to an active case, the DMAS FAMIS Plus Unit completes the FAMIS Plus determination and transfers the approved ongoing case to the LDSS.

**J. DMAS Contacts at the CPU**

The DMAS FAMIS Plus Unit eligibility workers are designated as the liaisons between the LDSS workers and the FAMIS CPU staff. The FAMIS Plus Unit workers are assigned to specific geographic areas. These assignments were made to improve communication and facilitate resolution to problems involving cases that have been transferred between the CPU and LDSS. The DMAS FAMIS Plus workers are assigned to five geographic areas of the state. The geographic areas correspond to the LDSS regions. The list of the DMAS FAMIS Plus workers and the areas they serve is available on the DSS intranet in the Benefit Programs, Medicaid Eligibility, ME Contacts folder at:

<http://localagency.dss.virginia.gov/divisions/bp/me/contacts.cgi>.

The DMAS FAMIS Plus workers will:

- act as contact persons for cases transferred to the CPU and the LDSS,

- answer non-policy related questions regarding transferring or closing cases, and
- change worker number V0000 to M0000 when necessary.

The DMAS FAMIS Plus workers will not provide policy clarification and will not handle client complaints. Please continue to contact your supervisor or Medical Assistance Program Consultant for assistance with policy clarifications, computer system problems, and client complaints.

Please note that the DMAS FAMIS Plus workers' telephone numbers are for the LDSS workers only and **are not to be given to clients**. The CPU has a separate toll-free FAMIS helpline number (1-866-87FAMIS or 1-866-873-2647) designated for client use. This toll-free FAMIS telephone number is **not** for use by LDSS workers.

#### K. 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.

#### L. 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 FAMIS Plus or Medicaid and are found eligible must have their FAMIS coverage cancelled so they can be reinstated in FAMIS Plus or 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.