



COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

September 1, 2012

MEDICAID ELIGIBILITY MANUAL – VOLUME XIII

TRANSMITTAL #97

The following acronyms are used in this transmittal:

- ABD – Aged, Blind or Disabled
- CN – Categorically Needy
- CNNMP – Categorically Needy Non-Money Payment
- DCSE – Division of Child Support Enforcement
- DMAS – Department of Medical Assistance Services
- F&C – Families & Children
- LDSS – Local Departments of Social Services
- MI – Medically Indigent
- MN – Medically Needy
- RAU – Recipient Audit Unit
- SFI – Strengthening Families Initiative
- SNAP – Supplemental Nutrition Assistance Program
- SPARK – Services Programs Answers Resources Knowledge
- SSI – Supplemental Security Income
- SSN – Social Security Number
- TANF – Temporary Assistance for Needy Families
- TN - Transmittal
- VDSS – Virginia Department of Social Services

This transmittal includes new, revised and clarified Medicaid eligibility policy and procedures effective September 1, 2012, unless otherwise indicated.

New Policy

Information and policy on the VDSS Strengthening Families Initiative Practice Model have been added to the Medicaid Eligibility Manual in TN #97. The SFI Practice Model sets forth guidance to LDSS for working with families and individuals to promote their health, safety and stability. Medicaid eligibility workers frequently become aware of the needs of their clients beyond Medicaid coverage. Under the SFI Practice Model, workers are expected to refer their clients to any services or programs that might be beneficial.

Revised Policy

The policy on Medicaid covered groups was significantly reorganized in TN #97. The policy revisions are designed to improve the flow of the Medicaid Eligibility Manual and enhance the Manual's clarity.

All Medicaid covered groups fall under one of two categories—CN and MN. Subchapter M0320 now covers all ABD CN and MN covered groups, while subchapter M0330 now covers all F&C CN and MN covered groups. References to the CNNMP and MI classifications have been removed in those subchapters, as well as in subchapters M0310 and M1460. The hierarchy for determining eligibility in the various covered groups has also been more clearly delineated.

Effective with TN #97, the SNAP allotment is deducted from rental income when board is provided. This change better aligns Medicaid policy with the other benefit programs' policies.

Clarified Policy

A number of policies have been clarified in TN #97, including the following:

- Foster care children living in Virginia who receive SSI meet the state residency requirement regardless of which state holds custody.
- Medicaid eligibility for individuals who are required to cooperate with DCSE for TANF eligibility is not impacted if the individuals refuse to cooperate with DCSE for TANF purposes.
- Government benefits placed on a government-sponsored debit card are treated as income in the month of receipt and cash on hand beginning the following month.
- The policy on how to verify the value of a bank account, including a non-government issued debit card account, has been clarified.
- How to determine the value of a countable annuity has been clarified.
- Several policies on resource assessments and evaluations in subchapter M1480 have been clarified.
- The time frame for acting on reported changes and completing renewals is 30 calendar days.
- The procedures for referring cases involving Medicaid and other benefits to the DMAS RAU have been clarified.

Correction

The obsolete telephone number for the Railroad Retirement Board contained in subchapter M0310 has been corrected in TN #97.

Electronic Version

Transmittal #97 is available electronically on SPARK and the VDSS public web site. It has not been printed for distribution. The electronic version is the Transmittal of record. Significant changes to the manual are as follows:

Pages With Significant Changes	Changes
Subchapter M0110 pages 13 Page 14 was added.	On pages 13 and 14, added information and policy on the VDSS Strengthening Families Initiative.
Subchapter M0210 page 3	On page 3, deleted individuals who are in an asset transfer penalty period from the list of ineligible individuals.
Subchapter M0230 page 4	On page 4, clarified that a foster care child receiving SSI benefits meets the Virginia residency requirement.
Subchapter M0250 page 5	On page 5, clarified that a TANF applicant or recipient's Medicaid eligibility is not impacted by failure to cooperate with DCSE.
Subchapter M0310 Multiple pages page 2a, 12, 23	Throughout M0310, policy was revised to reflect the new organization of subchapters M0320 and M0330. On page 2a, added an organizational chart for CN and MN covered groups. On page 23, revised the telephone number for the Railroad Retirement Board.
Subchapter M0320 All pages	Subchapter M0320 was revised in its entirety. The subchapter was reorganized and now contains the policy on the ABD CN and MN covered groups. The MN policy was previously in M0330. Policy changes that were made in addition to the reorganization are italicized.
Subchapter M0330 All pages	Subchapter M0330 was revised in its entirety. The subchapter was reorganized and now contains the policy on the F&C CN and MN covered groups. The CN policy was previously in M0320. Policy changes that were made in addition to the reorganization are italicized.
Subchapter M0730 page 10	On page 10, revised the policy on income from a boarder; the SNAP allowance is subtracted from rental income, rather than the obsolete standard food allowance, when board is provided.
Subchapter S1130 page 14	On 14, clarified the policy on the retroactive exclusion for making reasonable but unsuccessful efforts to sell real property.
Subchapter S1140 pages 2, 16-18, 26	On page 2, clarified that funds retained government-issued debit card accounts are treated as cash on hand. On pages 16-18, included debit card accounts in the policy on bank accounts and clarified acceptable forms of verification for bank accounts. On page 26, clarified that the countable value of an annuity is the balance of the annuity regardless of whether or not the individual has access to the balance.
Subchapter M1460 Most pages	Throughout M1460, policy was revised to reflect the new organization of subchapters M0320 and M0330. Policy changes that were made in addition to the reorganization are italicized.

Pages With Significant Changes	Changes
Subchapter M1480 pages 3, 6, 8b, 16 pages 20, 22-25	On pages 3, 6, 20, and 25 clarified that the spousal protected resource amount can be increased by a court order only after going through the DMAS appeals process. On page 8b, clarified the treatment of resources once an institutionalized spouse's eligibility is established. On page 16, clarified the policy on when the applicant fails to provide verification of resources held at the beginning of institutionalization. On pages 22-24, revised the examples.
Subchapter M1520 page 1	On page 1, clarified that the timeframe for acting on reported changes and renewals is 30 calendar days
Chapter M17 page 3 Appendix 1, page 1	On pages 3 and Appendix 1, page 1, clarified the procedures for referring cases involving Medicaid and other benefits to the DMAS RAU.
Chapter M21 pages 3, 4	On pages 3 and 4, corrected the number formatting.

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



Martin D. Brown
Commissioner

Electronic Attachment

VIRGINIA DSS, VOLUME XIII

MEDICAID ELIGIBILITY MANUAL

TABLE OF CONTENTS Changes

Changed With	Effective Date	Pages Changed
TN #97	9/1/12	page i
TN #93	1/1/10	page iii
Update (UP) #2	8/24/09	page iii

TABLE OF CONTENTS

VIRGINIA DSS, VOLUME XIII MEDICAID ELIGIBILITY MANUAL

CHAPTER

SUBCHAPTER

M01 APPLICATION FOR MEDICAL ASSISTANCE

GENERAL INFORMATION	M0110
MEDICAL ASSISTANCE APPLICATION.....	M0120
APPLICATION PROCESSING	M0130
RETENTION OF CASE INFORMATION	M0140

M02 NONFINANCIAL REQUIREMENTS

GENERAL RULES & PROCEDURES	M0210
CITIZENSHIP & ALIEN REQUIREMENTS	M0220
VIRGINIA RESIDENCY REQUIREMENTS	M0230
SOCIAL SECURITY NUMBER REQUIREMENTS	M0240
ASSIGNMENT OF RIGHTS AND PURSUIT OF SUPPORT FROM THE ABSENT PARENT REQUIREMENTS	M0250
RESERVED	M0260
APPLICATION FOR OTHER BENEFITS	M0270
INSTITUTIONAL STATUS REQUIREMENTS	M0280
HIPP REQUIREMENTS.....	Removed 08/09

M03 MEDICAID COVERED GROUPS

GENERAL RULES & PROCEDURES	M0310
<i>AGED, BLIND & DISABLED COVERED GROUPS</i>	M0320
<i>FAMILIES & CHILDREN GROUPS</i>	M0330

M05 MEDICAID ASSISTANCE UNIT

GENERAL RULES & PROCEDURES	M0510
FAMILIES & CHILDREN (F&C) FAMILY/BUDGET UNIT	M0520
ABD ASSISTANCE UNIT	M0530

M06 FAMILIES AND CHILDREN RESOURCES

GENERAL--F&C RESOURCE.....	M0610
IDENTIFYING RESOURCES	M0620
F&C EXCLUDED RESOURCES	M0630
TYPES OF COUNTABLE RESOURCES.....	M0640

Virginia DSS, Volume XIII

M0110 Changes

Changed With	Effective Date	Pages Changed
TN #97	9/1/12	Table of Contents page 13 Page 14 was added. Appendix 1 was added.
Update #7	7/1/12	pages 3, 6a, 7, 8
TN #96	10/1/11	Table of Contents pages 2-6a
TN #95	3/1/11	pages 2-4a
TN #94	9/1/10	pages 2, 3
TN #93	1/1/10	pages 1, 6

TABLE OF CONTENTS

M01 APPLICATION FOR MEDICAL ASSISTANCE

M0110.000 GENERAL INFORMATION

	Section	Page
Legal Base and Agency Responsibilities	M0110.100.....	1
Confidentiality	M0110.110.....	2
Address Confidentiality Program	M0110.120.....	6
Definitions	M0110.200.....	6a
Availability of Information	M0110.300.....	7
Retention of Case Information	M0110.400.....	10
<i>Virginia DSS Strengthening Families Initiative Practice Model.....</i>	<i>M0110.500.....</i>	<i>13</i>
<i>Appendices</i>		
<i>Virginia DSS Strengthening Families Initiative Practice Model (Full)</i>	<i>Appendix 1.....</i>	<i>1</i>

- 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.

M0110.500 VIRGINIA DSS STRENGTHENING FAMILIES INITIATIVE PRACTICE MODEL

A. Introduction

The Virginia DSS Strengthening Families Initiative (SFI) Practice Model sets forth standards of professional practice and serves as a values framework to define relationships, guide thinking and decision-making, and structure beliefs about individuals, families, and communities. The Practice Model suggests a desired approach to working with and delivering services to Virginia's citizens.

B. Practice Model Principles

The principles of the Practice Model are:

- 1. All children, adults and communities deserve to be safe and stable.*
- 2. All individuals deserve a safe, stable and healthy family that supports them through their lifespan.*

3. *Self-sufficiency and personal accountability are essential for individual and family well-being.*
4. *All individuals know themselves best and should be treated with dignity and respect.*
5. *When partnering with others to support individual and family success, we use an integrated service approach.*
6. *How we do our work has a direct impact on the well-being of the individuals, families, and communities we serve.*

M0110, Appendix 1 contains the full SFI Practice Model.

C. Policy

Medicaid and other benefit programs are designed to provide supportive benefits to assist families who are unable to provide the necessities of life and maintain minimum standards of health and well-being through their own efforts. Gathering relevant information about a family's situation and evaluating that information against the eligibility criteria for the benefit programs are the basis for making the eligibility determinations.

The process of gathering relevant information also includes an assessment of need for service programs and other resources to assist the family. This process includes following the Practice Model described above. If other needs exist, the eligibility worker must refer the family for appropriate services or resources within the agency or community. Eligibility workers may consult with their supervisors and other agency staff as necessary to gather information to facilitate making such referrals.



VIRGINIA DEPARTMENT OF
SOCIAL SERVICES

**Virginia Department of Social Services
Strengthening Families Initiative Practice Model**

The Virginia Department of Social Services Practice Model sets forth our standards of professional practice and serves as a values framework that defines relationships, guides thinking and decision-making and structures our beliefs about individuals, families and communities. We approach our work every day based on various personal and professional experiences. While our experiences impact the choices we make, our Practice Model suggests a desired approach to working with others and provides a clear model of practice, inclusive of all agency programs and services, that outlines how our system successfully practices. Central to our practice is the family. Guided by this model, we strive to continuously improve the ways in which we deliver programs and services to Virginia's citizens.

1. All children, adults and communities deserve to be safe and stable.

- Every child has the right to live in a safe home, attend a safe school and live in a safe community. Ensuring safety requires a collaborative effort among family, agency staff, and community partners and across all programs and services.
- Every adult has the right to live and work in a safe environment. We value all programs that address domestic and family violence and the abuse, neglect and exploitation of older or incapacitated adults.
- We value individual and family strengths, perspectives, goals and plans as central to creating and maintaining a safe environment. The meaningful engagement and participation of children, adults, extended family and community stakeholders is a necessary component of assuring safety.
- When legal action is necessary to ensure the safety of a child and/or an adult, we use our authority with respect and sensitivity.
- Individuals are best served when services are person-centered, family-focused and community-based and aim to preserve the family unit and prevent family disruption.

2. All individuals deserve a safe, stable and healthy family that supports them through their lifespan.

- We believe mothers, fathers, and children thrive in safe, stable, healthy families. We value family structures that support the best interests of children; however, we believe that children do best when raised in intact, two-parent families.
- Both parents should be actively involved in the lives of their children, even if they are not the primary caregiver.

- Healthy, lifelong family connections are crucial to the development of children, the stability of the family and the support of infirm, dependent or aging adults. Through the services we provide, we seek out, promote and preserve these healthy ties to family members and to others in the community to whom the family is connected or who may provide support.

3. Self-sufficiency and personal accountability are essential for individual and family well-being.

- Family members support each other in ways the social services system cannot. We value the intra-family resources and supports that are available within the context of any family as a pathway to self-sufficiency and personal accountability.
- We believe employment, training and education are keys to self-sufficiency. We believe in employment and training programs that remove barriers and create opportunities for individuals and families.
- Individuals and families face unique challenges that impact their ability to maintain self-sufficiency. We value all programs and services that assist individuals and families to regain and maintain self-sufficiency and achieve personal accountability.
- Both custodial and noncustodial parents should provide necessary financial resources to support their children.
- We believe that parents and caregivers serve as role models in teaching the importance of self-sufficiency and personal accountability.
- We support asset development strategies to help individuals and families weather short-term emergencies and improve long-term stability.

4. All individuals know themselves best and should be treated with dignity and respect.

- All programs and services should be culturally and linguistically sensitive to all individuals.
- Individuals and families are empowered when they have access to information and resources.
- We support programs for vulnerable populations including children, the elderly and individuals with disabilities.
- The measure of success differs with every individual. We strive to understand children, adults, and families within the context of their own values, traditions, history and culture.
- The voices of children, individuals and families are heard, valued and included in decision-making processes related to programs and services.

5. When partnering with others to support individual and family success, we use an integrated service approach.

- Cooperation, coordination and collaboration within and outside of the social services system are essential to providing the most comprehensive services to families. We are committed to working across programs, divisions, agencies, stakeholder groups and communities to improve outcomes for the children, individuals, families and communities we serve.

- Through the development of policies, procedures, standards and agreements across systems, we will share information, solve problems and overcome barriers.
- We value prevention networks that link effective public and private programs and community-based organizations that identify individuals and families before they need services.
- We believe in partnering across programs and systems in order to provide a full array of services along the continuum of care. We are committed to working within and outside of the social services system to identify and address service gaps.

6. How we do our work has a direct impact on the well-being of the individuals, families and communities we serve.

- Children, individuals and families deserve trained, skillful professionals to engage and assist them. We hire, develop and maintain a workforce that aligns with our practice model.
- Clear expectations, effective supervision, leadership and proper resource supports are critical for the workforce to do their job effectively.
- We believe in creating and maintaining a supportive working and learning environment with accountability at all levels.
- We value the provision of high-quality, timely, efficient and effective services. We believe relationships and communication should be conducted with honesty, transparency, integrity, empathy and respect within and outside of our social services system.
- The collection and sharing of accurate, outcome-driven data and evidence-based information is a critical part of how we continually learn and improve. We use data to inform, manage, improve practice, measure effectiveness and guide decisions.
- Continuous quality improvement is fundamental to our work.

Virginia DSS, Volume XIII

M0210 Changes

Changed With	Effective Date	Pages Changed
TN #97	9/1/12	page 3
Update (UP) #2	8/24/09	pages 1, 2

- 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 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;

M0230 Changes

Changed With	Effective Date	Pages Changed
TN #97	9/1/12	page 4
TN #95	3/3/11	pages 1, 2
TN #93	1/1/10	page 2

B. Under Age 21 In An Institution

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

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

1. the individual's parent or legal guardian was a Virginia resident at the time of the individual's institutional placement;
2. the individual's parent or legal guardian who applies for Medicaid is a Virginia resident and the individual is institutionalized in Virginia; or
3. the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, the individual is institutionalized in Virginia, and the party who files the Medicaid application resides in Virginia.
4. for an individual under 21, if a legal guardian has been appointed for the child and parental rights have been terminated, the guardian's state of residence is used instead of the parent's to determine residency.

C. Under Age 21, Custody or Adoption Agreement with Another State

When another state's child-placing agency has custody of a child who lives in Virginia with a foster family, the child is NOT a Virginia resident unless the child is eligible as a IV-E Foster Care child and receives a IV-E Foster Care maintenance payment.

1. IV-E Eligible Children

A Title IV-E Foster Care child who lives in Virginia and who receives a Title IV-E maintenance payment from another state meets the Virginia residency requirements for Medicaid.

A Title IV-E Adoption Assistance child who lives in Virginia and has a Title IV-E Adoption Assistance agreement in effect with another state's child-placing agency meets the Virginia residency requirements for Medicaid.

2. Non-IV-E Foster Care Children

A non-IV-E Foster Care child placed in Virginia from another state does NOT meet the Virginia residency requirements for Medicaid.

3. Foster Care Children with SSI

A foster care child who receives Supplemental Security Income (SSI) benefits meets the Virginia residency requirement regardless of which state's child-placing agency maintains custody.

4. Non-IV-E Adoption Assistance and Adoptive Placement Children

A child who lives in Virginia with an adoptive family is considered to be living with a parent, regardless of whether a final order of adoption has been entered in court. When his adoptive parent is a Virginia resident, the child is a Virginia resident for Medicaid eligibility purposes. A Non-IV-E Adoption Assistance child whose adoption assistance agreement is signed by another state's child-placing agency is a Virginia resident when the child lives in Virginia with the adoptive parent(s).

Virginia DSS, Volume XIII

M0250 Changes

Changed With	Effective Date	Pages Changed
TN #97	9/1/12	page 5
TN #96	10/1/11	page 3
TN #94	9/1/2010	pages 3-5

the absent parent, unless there is good cause for not cooperating. If the agency is notified by DCSE that the enrollee is not cooperating, the agency worker must take appropriate action on the enrollee's Medicaid coverage; the child(ren)'s eligibility for Medicaid is NOT affected.

If the recipient wants to claim good cause for not cooperating, contact a Medical Assistance Program Consultant for instructions.

**3. TANF
Recipients**

If an applicant for or recipient of Temporary Assistance for Needy Families (TANF) fails to cooperate with DCSE, the individual's eligibility for Medicaid is not impacted unless the individual previously requested assistance from DCSE for Medicaid purposes per M0250.300 C.2.b above.

D. DCSE

DCSE District Offices have the responsibility of pursuing support from absent legally responsible parent(s), establishing paternity when the alleged father is absent from the home, and notifying the local DSS when the enrollee does not cooperate. This responsibility entails locating the parent(s), determining ability to support, collecting support from legally responsible parent(s), establishing medical support and/or health insurance covering the applicant child(ren), and court action to secure support from the absent legally responsible parent.

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

Virginia DSS, Volume XIII

M0310 Changes

Changed With	Effective Date	Pages Changed
TN #97	9/1/12	Table of Contents, page i pages 1, 2a, 3-5a, 10-13 pages 23, 28, 29, 30a, 31 pages 33, 36, 38, 39
UP #7	7/1/12	Table of Contents, page ii pages 23, 26, 27 Appendices 1-3 were removed. Appendices 3 and 4 were renumbered and are now Appendices 1 and 2, respectively.
TN #96	10/1/11	Appendix 4
TN #95	3/1/11	Pages 30, 30a
TN #94	9/1/10	pages 21-27c, 28
TN #93	1/1/10	page 35 Appendix 5, page 1
Update (UP) #2	8/24/09	Table of Contents page 39
TN #91	5/15/09	pages 23-25 Appendix 4, page 1 Appendix 5, page 1

TABLE OF CONTENTS

M03 MEDICAID COVERED GROUPS

M0310.000 GENERAL RULES & PROCEDURES	Section	Page
General Principles of Medicaid Covered Groups	M0310.001	1
List of Medicaid Covered Groups.....	M0310.002	2a
Definitions of Terms.....	M0310.100	5
ABD	M0310.101	5
Adoption Assistance	M0310.102	5
AFDC.....	M0310.103	6
AG	M0310.104	6a
Age & Aged.....	M0310.105	7
*BCCPTA.....	M0310.133	39
Blind.....	M0310.106	7
Caretaker-Relative.....	M0310.107	8
Categorically Needy (CN).....	M0310.108	10
Covered Group	M0310.109	11
Child	M0310.110	11
Dependent Child.....	M0310.111	11
Disabled	M0310.112	21
EWB.....	M0310.113	28
Families & Children (F&C)	M0310.114	28
Foster Care.....	M0310.115	29
*HIPP Program.....	M0310.135	39

* out of numerical order

M0310.000 GENERAL RULES & PROCEDURES**M0310.001 GENERAL PRINCIPLES OF MEDICAID COVERED GROUPS****A. Introduction**

An individual who meets all the non-financial eligibility requirements in Chapter M02 and who is not an ineligible person listed in M0210.100, must meet a Medicaid covered group in order to be eligible for Medicaid. Chapter M03 explains in detail each of the Medicaid covered groups and how to determine if an individual meets the covered group requirements.

The Medicaid covered groups are divided into two classifications: the categorically needy (CN) and the medically needy (MN). *CN individuals meet all Medicaid non-financial requirements (see M02) and the definition for a covered group. MN individuals meet all Medicaid non-financial requirements and resource requirements, but have income in excess of the Medicaid limits. MN individuals may be placed on a spenddown (SD). The covered groups are also divided into Aged, Blind and Disabled (ABD) and Families & Children (F&C) covered groups. Within some covered groups are several definitions of eligible individuals. Some individuals may meet the requirements of more than one group. The agency must verify the individual meets a definition for a covered group and the group's financial requirements.*

B. Refugees

If the Medicaid applicant is a refugee, first determine if the refugee meets the requirements in a Medicaid covered group using the policy and procedures in this chapter. If the refugee does not meet the requirements of a Medicaid covered group, the refugee is not eligible for Medicaid under a Medicaid covered group. Go to the Refugee Resettlement Program Manual Volume XVIII to determine the refugee's eligibility for assistance under the Refugee Resettlement Program.

The requirements for the Refugee Other (Cash Assistance) and Refugee Medicaid Other and Refugee Medicaid Unaccompanied Minors programs are found in another manual: the Refugee Resettlement Program Manual Volume XVIII.

C. Covered Group Information

This subchapter contains the general principles for determining if the individual meets a definition and covered group(s).

- M0310.002 contains the list of Covered Groups;
- M0310.100 - M0310.134 contains the Definitions;
- M0320 contains the detailed policy and *covered group requirements for the Aged, Blind and Disabled* Groups;
- M0330 contains the detailed policy and *covered group requirements for the Families & Children* Groups.

M0310.002 LIST OF MEDICAID COVERED GROUPS

<i>Group and Description</i>		<i>Categorically Needy (CN)</i>	<i>Medically Needy(MN)</i>
<i>Aged, Blind, or Disabled (ABD)</i>	<i>SSI</i>	X	
	<i>AG</i>	X	
	<i>Protected</i>	X	
	<i>≤ 80% FPL</i>	X	
	<i>≤ 300% of SSI (institutionalized only)</i>	X	
	<i>Medicaid Works</i>	X	
	<i>Medicare Savings Programs (QMB, SLMB, QI, QDWI)</i>	X	
	<i>Aged Blind Disabled</i>		X
<i>Families & Children (F&C)</i>	<i>IV-E Foster Care or Adoption Assistance</i>	X	
	<i>LIFC</i>	X	
	<i>Pregnant woman/newborn child</i>	X	X
	<i>Child under age 19</i>	X	
	<i>≤ 300% of SSI (institutionalized only)</i>	X	
	<i>BCCPTA</i>	X	
	<i>Plan First</i>	X	
	<i>Child under 18</i>		X
	<i>Individuals under age 21, Special Medical Needs Adoption Assistance</i>	X	X

**A. Categorically
Needy (CN)**

The ABD and the F&C covered groups in the CN classification are listed below.

1. ABD Groups

- a. *SSI cash assistance recipients who meet more restrictive Medicaid resource eligibility requirements.*
- b. *Auxiliary Grants (AG) cash assistance recipients.*
- c. *ABD individuals who are institutionalized in a medical institution, who meet all Medicaid eligibility requirements and have income before exclusions that is less than 300% of the SSI individual payment limit.*
- d. *ABD individuals who receive or are applying for Medicaid-approved community-based care services, who meet all Medicaid eligibility requirements and who have income before exclusions that is less than 300% of the SSI individual payment limit.*
- e. *ABD individuals who have a "protected" status:*
 - 1) *individuals who received OAA, AB, APTD, or ADC as of August 1972, and meet specified requirements.*
 - 2) *individuals who are former SSI/AG recipients and meet specified requirements.*
 - 3) *individuals who are widows(ers) and meet specified requirements.*
 - 4) *individuals who are classified as 1619(b) by Social Security and meet specified requirements.*
 - 5) *individuals who are adult disabled children and meet specified requirements*
- f. *Hospice--a hospice patient is a person who is terminally ill and has elected to receive hospice care; if the individual is not aged, presume that the individual is disabled.*
- g. *Qualified Medicare Beneficiaries (QMBs).*
- h. *Special Low-income Medicare Beneficiaries (SLMBs).*
- i. *Qualified Disabled and Working Individuals (QDwIs).*
- j. *Qualified Individuals (QIs).*
- k. *ABD With Income \leq 80% Federal Poverty Limit (ABD 80% FPL).*
- l. **MEDICAID WORKS.**

2. F&C Groups

- a. *foster care children receiving IV-E and adoption assistance children receiving IV-E.*
- b. *Low income families with children (LIFC) eligible children, parents, non-parent caretaker-relatives, and EWBs.*
- c. *Children under age 1 born to mothers who were eligible for and receiving Medicaid at the time of the child's birth.*
- d. *Individuals under age 21*
 - 1. *Title IV-E Eligible Foster Care children who do not receive a Title IV-E maintenance payment*
 - 2. *Non-IV-E Foster Care*
 - 3. *Juvenile Justice Department children*
 - 4. *Non-IV-E Adoption Assistance children*
 - 4. *Individuals in an ICF or ICF-MR*
- e. *F&C individuals who are institutionalized in a medical institution, who meet all Medicaid eligibility requirements and have income before exclusions that is less than 300% of the SSI individual payment limit.*
- f. *F&C individuals who receive or are applying for Medicaid-approved community-based care waiver services, who meet all Medicaid eligibility requirements and who have income before exclusions that is less than 300% of the SSI individual payment limit.*
- g. *Pregnant women and newborns under age 1 year*
- h. *Plan First; Family Planning Services*
- i. *Children under age 19 years*
- j. *Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). Women screened and diagnosed with breast or cervical cancer under the Centers for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program (BCCEDP) and eligible to receive Medicaid under the BCCPTA.*

B. Medically Needy (MN)

The *ABD* and the *F&C* covered groups in the *MN* classification are listed below.

1. ABD Groups

- a. *Aged - age 65 years or older.*
- b. *Blind - meets the blind definition*
- c. *Disabled - meets the disability definition.*
- d. *Individuals who received Medicaid in December 1973 as AB/APTD-related MN and who continue to meet the December 1973 eligibility requirements.*

2. **F&C Groups**
- a. Children under age 18
 - b. Children under age 1
 - c. Pregnant Women
 - d. *Special Medical Needs Adoption Assistance Children*
 - e. Individuals under age 21

E. Refugees

“Refugees” are a special group of individuals who have an alien status of “refugee”, and are eligible for Medicaid under a different federal funding source. Virginia receives full federal funding with no state matching funds for the medical assistance provided to these individuals during the first 8 months they are in the U.S.

There are two aid categories (ACs) for this group. AC 078 is used for Refugee Other and Refugee Medicaid Other and AC 079 is used for Refugee Medicaid Unaccompanied Minors. The policy and procedures used to determine whether an individual is eligible in this group are found in the Refugee Resettlement Program Manual, Volume XVIII.

M0310.100 DEFINITION OF TERMS**A. Introduction**

The terms used in the covered groups policy and procedures and the procedures for determining if an individual meets a definition are stated in sections M0310.101 through 131 below.

M0310.101 ABD**A. ABD Definition**

"ABD" is the short name used to refer to aged, blind or disabled individuals.

B. Procedures

See the following sections for the procedures to use to determine if an individual meets an ABD definition:

- M0310.105 Age and Aged
- M0310.106 Blind
- M0310.112 Disabled

M0310.102 ADOPTION ASSISTANCE**A. Definition**

Adoption Assistance is a Title XX of the Social Security Act social services program that provides cash assistance and/or social services to adoptive

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

1. Residing in Virginia

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

2. Child-placing Agency Definition

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

3. When Adoption Assistance Is Effective

A child under 21 is usually considered an adoption assistance child when the adoption assistance agreement is signed, even if the interlocutory or judicial decree of adoption has not been issued or adoption subsidy payments are not being made. The adoptive parents are considered to be the adoption assistance child's parent(s) as of the date the adoption agreement is signed.

If the child is not eligible because of the adoptive family's income, treat the adoption assistance child as a foster care child until the interlocutory or judicial decree of adoption has been issued. As a foster child, the child's assistance unit consists of one person and the adoptive parent's income is not deemed to the child.

B. IV-E and Non-IV-E

1. IV-E Adoption Assistance

a. Definition

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

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

M0310.108 CATEGORICALLY NEEDY (CN)**A. CN Definition**

"CN" is the short name for "categorically needy." CN is one of the two federal classifications of Medicaid covered groups. The CN covered groups include both the mandatory categorically needy groups listed in the federal Medicaid regulations *as well as the optional groups Virginia has chosen to cover in the Medicaid State Plan.*

B. Procedures

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

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

M0310.109 COVERED GROUP

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

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

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

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

M0310.110 CHILD

A. Definition 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 *or in the month* he attains age 19; **AND**

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

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

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

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

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

C. Procedures for Verifying Disability Status

- 1. Receives SSDI/SSI Disability Benefits** Verify SSDI/SSI disability status through a SVES (State Verification Exchange System) or SOLQ (State Online Verification Query) request or through documentation provided to the applicant by the SSA.
- 2. Receives RRB Disability Benefits** Verify RRB disability by contacting the RRB *National Telephone Service at 1-877-772-5772* or through documentation provided to the applicant by the RRB.
- 3. Determined Disabled by DDS** If disability status cannot be ascertained **after** reviewing SVES or SOLQ, contact your regional DDS office to verify disability status. Contact information for the regional DDS offices is contained in Appendix 2 of this subchapter.

D. When a DDS Disability Determination is Required

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

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 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 M0320.304 contains the detailed requirements for the LIFC covered group in which an EWB can be eligible for Medicaid.

M0310.114 FAMILIES & CHILDREN (F&C)

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

- children under 19,
- pregnant women,
- specified subgroups of children under age 21, and
- *parent/caretakers of dependent children*

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

M0310.115 FOSTER CARE**A. Definition**

Foster Care provides maintenance and care for children whose custody is held by:

- a local board of social services;
- a licensed private, non-profit child placement agency;
- the Department of Juvenile Justice; or
- the child's parent(s), under a non-custodial agreement.

Federal regulations define "foster care" as "24-hour substitute care for children placed away from their parents or guardians and for whom the State agency has placement and care responsibility" (45 C.F.R. §1355.20). Transfer of the legal custody of the child is not a component when determining if a child is considered to be in foster care. The federal definition is based upon the child being placed outside of the home and who has placement and care responsibility for the child. If a child is placed outside of the home and LDSS is the case manager with placement and care responsibility, then the federal government considers the child to be in foster care. For the federal government, the term "placement and care" means that LDSS is legally accountable for the day-to-day care and protection of the child through either a court order or a voluntary placement agreement.

1. Custody

Custody may be given to an agency by the court or may be retained by the parent(s) or guardian when a non-custodial agreement is involved. If custody is retained by the parent under a parental agreement with the Community Policy and Management Team (CPMT), the child is NOT in foster care.

2. Child Placing Agency

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

A child who is eligible for IV-E Foster Care but who does not receive a IV-E Foster Care maintenance payment is considered a “Non-IV-E Foster Care” child for *Medicaid eligibility purposes*.

Children in the custody of another state’s social services agency, who are eligible for and receive Title IV-E Foster Care maintenance payments and who now reside in Virginia, are IV-E Foster Care for Medicaid eligibility purposes. Verify the child’s IV-E eligibility from the other state’s department of social services which makes the IV-E payment.

- 2. **Non IV-E Foster Care** Children who are eligible for but do not receive IV-E maintenance payments or who are eligible for Non-IV-E (state/local) Foster Care (whether or not they receive a Non-IV-E payment), and who reside in Virginia are Non-IV-E Foster Care for Medicaid eligibility purposes.
- 3. **Non-IV-E Children in Another State’s Custody** Children in the custody of another state’s social services agency who are not receiving IV-E foster care maintenance *or SSI* payments, do NOT meet the Virginia residency requirement for Medicaid (M0230) and are not eligible for Virginia Medicaid.
- 4. **Trial Home Visits** A foster care or DJJ child continues to meet the foster care definition (either IV-E or non-IV-E) when placed by the agency in the child’s own home for a trial period of up to six months, if the child continues to be in the agency’s custody or remains the financial responsibility of DJJ or the court. Do not redetermine Medicaid eligibility during the 6 month trial home visit.

M0310.116 HOSPICE

A. Definition

"Hospice" is a covered group of terminally ill individuals whose life expectancy is 6 months or less and who have voluntarily elected to receive hospice care. The term “hospice” is also used to refer to the covered service for a terminally ill Medicaid recipient, regardless of his covered group. Hospice services can be provided in the individual’s home or in a medical facility, including a nursing facility.

- 1. **Hospice Care** "Hospice care" means items and services are provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan of care for the individual that is established and periodically reviewed by the individual's attending physician and the hospice program's medical director:
- 2. **Hospice Program** A "hospice program" is a public agency or private organization which
 - is primarily engaged in providing hospice care, makes hospice care services available as needed on a 24-hour basis, and provides bereavement counseling for the terminally ill individual's immediate family;
 - provides hospice care in individuals' homes or in medical facilities on a short-term inpatient basis;
 - meets federal and state staffing, record-keeping and licensing requirements.

- B. Procedure** The individual must elect hospice care in a non-institutional setting. Election of hospice care is verified either verbally or in writing from the hospice care provider. If verification is verbal, document the case record.

M0310.117 INSTITUTION

- A. Definition** An **institution** is an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.
- B. Medical Institution (Facility)** A **medical institution** is an institution that:
- is organized to provide medical care, including nursing and convalescent care,
 - has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,
 - is authorized under state law to provide medical care, and
 - is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.
- C. Procedures** The procedures used to determine if an individual meets a covered group of individuals in institutions are contained in subchapters M0320 and M0330.

M0310.118 LIFC

- A. Low Income Families with Children (LIFC)** Low Income Families with Children (LIFC) is a covered group of individuals in families who have a dependent child(ren) living in the home, and whose income is within the Medicaid F&C income limits.
- B. Procedure** Section *M0330.200* contains the detailed requirements for the LIFC covered group.

M0310.120 MEDICALLY NEEDY (MN)**A. Definition**

"MN" is the short name for "medically needy." MN is one of the two federal classifications of Medicaid covered groups. All MN covered groups are optional; the state can choose whether or not to cover MN individuals in its State Plan. However, if the state chooses to cover MN individuals, it must at least cover children under age 18, pregnant women and the protected group of individuals who were eligible as MN blind or disabled in December 1973 and continue to meet the December 1973 eligibility criteria. The state may choose to cover additional groups of individuals as MN.

The MN individual is one who has income and resources enough to meet his maintenance needs, but not enough to meet his medical needs. MN individuals whose income exceeds the MN income limit *may be placed on a spenddown (SD) and establish eligibility when incurred medical and/or remedial expenses equal or exceed the SD amount.*

B. Procedure

The procedures used to determine if an individual meets a MN covered group are in subchapter M0320 for ABD and M0330 for F&C.

M0310.121 MEDICARE BENEFICIARY**A. Definition**

A Medicare beneficiary is an individual who is entitled to Medicare (Title XVIII of the Social Security Act). Medicare is a federally funded and administered health insurance program and consists of hospital insurance (Part A), medical insurance (Part B) and, beginning January 1, 2006, prescription drug coverage (Part D).

1. Part A

A person is entitled to Medicare Part A if he

- a. is age 65 or older and:
 - eligible for monthly Social Security benefits on the basis of covered work under the Social Security Act,
 - a qualified Railroad Retirement beneficiary,
 - not eligible for Social Security or Railroad Retirement benefits but meets the requirements of a special transitional provision,
 - not eligible for Social Security or Railroad Retirement benefits but voluntarily enrolls and pays a monthly premium, or

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.

See section M0330.301 for the pregnant woman covered group requirements *and* M0330.801 for the MN Pregnant Woman 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 M0320.604 for the procedures to use to determine if an individual meets the QDWI covered group.

- B. Procedure** RSDI is not used in the Medicaid manual. Because Title II of the Social Security Act is still officially called “Old Age, Survivors & Disability Insurance”, the Medicaid manual uses the abbreviation “OASDI” interchangeably with “Title II” to refer to Title II Social Security benefits.

M0310.129 SLMB

- A. Special Low-income Medicare Beneficiary (SLMB)** SLMB is the short name used to designate the Medicaid covered group of “Special Low-income Medicare Beneficiary”. A special low-income Medicare beneficiary 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 exceeds the QMB income limit (100% of the FPL) but does NOT exceed the higher SLMB income limit, which is 120% of the FPL.

- B. Procedure** SLMB is a mandatory covered group that the state plan must cover for the purpose of paying the beneficiary’s Medicare Part B premium. See section *M0320.602* for the procedures to use to determine if an individual meets the SLMB covered group.

M0310.130 SSI

- A. Supplemental Security Income (SSI)** Supplemental Security Income (SSI) is the federal cash assistance benefit program under Title XVI of the Social Security Act that provides cash assistance to eligible aged, blind or disabled individuals to meet their shelter, food and clothing needs.
- B. Procedures** Individuals who receive SSI (SSI recipients) are not “automatically” eligible for Medicaid in Virginia. SSI recipients must meet all of the Medicaid nonfinancial eligibility requirements and must meet the Medicaid resource eligibility requirements that are more restrictive than SSI’s resource requirements. See section *M0320.101* for the procedures to use to determine if an SSI recipient meets a covered group.

M0310.131 STATE PLAN

- A. Definition** The State Plan for Medical Assistance is a comprehensive written statement submitted by the Department of Medical Assistance Services (DMAS) describing the nature and scope of Virginia’s Medicaid program. It contains all the information necessary for the federal Centers for Medicare and Medicaid Services (CMS) to determine whether the state plan can be approved for federal financial participation (FFP) in the state’s Medicaid program expenses.

B. State Plan Governs Medicaid Eligibility Rules

The State Plan consists of preprinted material that covers the basic Medicaid requirements and individualized material written by DMAS that reflects the particular requirements and choices made by Virginia for its Medicaid program. The State Plan is included in DMAS' state regulations promulgated according to the Virginia Administrative Process Act (APA). The State Plan is kept and updated by DMAS.

The State Plan shows the eligibility requirements for Virginia Medicaid, including the mandatory and optional groups of individuals covered by Virginia Medicaid and the medical services covered by Medicaid for those groups. The covered groups eligibility requirements in this chapter are based on the State Plan.

M0310.132 TANF**A. Temporary Assistance for Needy Families (TANF)**

TANF is the federally-funded (with matching funds from the states) block grant program in Title IV Part A of the Social Security Act that provides temporary cash assistance to needy families. In Virginia, TANF replaced the previous Title IV-A program called Aid to Families With Dependent Children (AFDC) on February 1, 1997.

M0310.133 BCCPTA**A. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)**

The BCCPTA created a Medicaid covered group for women age 18 through 64 who have been identified by the Centers for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program (BCCEDP) as being in need of treatment for breast or cervical cancer.

B. Procedures

Section *M0330.312* contains the detailed requirements for the BCCPTA covered group.

M0310.134 VIEW PARTICIPANT**A. Virginia Initiative for Employment not Welfare (VIEW) Participants**

A VIEW participant is an individual who has signed the TANF Agreement of Personal Responsibility. VIEW participants have a higher earned income limit than non-VIEW participants. An individual under a TANF VIEW sanction is a VIEW participant for Medicaid purposes. An individual only receiving TANF transitional support services is not a VIEW participant for Medicaid purposes.

M0310.135 HIPP PROGRAM**A. Health Insurance Premium Payment (HIPP) Program**

HIPP is a cost savings program administered by the DMAS for Medicaid enrollees which reimburses some or all of the employee portion of group health insurance premiums. HIPP is available to Medicaid enrollees when a family member is employed at least 30 hours per week and is enrolled in an employer's group health plan. Eligibility for HIPP is determined by the HIPP Unit at DMAS. Participation in HIPP is voluntary.

B. Procedures

M0130.200 G contains additional information about HIPP.

CHAPTER M03
MEDICAID COVERED GROUPS
SUBCHAPTER 20

AGED, BLIND & DISABLED GROUPS

M0320 Changes

Changed With	Effective Date	Pages Changed
TN #97	9/1/12	Table of Contents pages 1-56 (all pages)
UP #6	4/1/12	pages 11, 12, 46a
TN #96	10/1/11	Table of Contents pages 46f-50b page 50c deleted
TN #95	3/1/10	pages 11, 12, 42c, 42d, 50, 53, 69 pages 70, 71 page 72 added.
TN #94	9/1/10	pages 49-50b
UP #3	3/1/10	pages 34, 35, 38, 40, 42a, pages 42b, 42f
TN #93	1/1/10	pages 11-12, 18, 34-35, 38 pages 40, 42a-42d, 42f-44, 49 pages 50c, 69-71
UP #2	8/24/09	pages 26, 28, 32, 61, 63, 66
Update (UP) #1	7/1/09	pages 46f-48
TN #91	5/15/09	pages 31-34 pages 65-68

TABLE OF CONTENTS

M03 MEDICAID COVERED GROUPS

M0320.000 AGED, BLIND & DISABLED GROUPS

	<i>Section</i>	<i>Page</i>
<i>Aged, Blind & Disabled (ABD) General Policy Principles</i>	<i>M0320.000</i>	<i>11</i>
<i>Categorically Needy Groups</i>	<i>M0320.001</i>	<i>1</i>
<i>ABD Cash Assistance Groups</i>	<i>M0320.100</i>	<i>2</i>
<i>SSI Recipients</i>	<i>M0320.101</i>	<i>2</i>
<i>AG Recipients</i>	<i>M0320.102</i>	<i>5</i>
<i>Protected Covered Groups</i>	<i>M0320.200</i>	<i>5</i>
<i>Former Money Payment Recipients -August 1972</i>	<i>M0320.201</i>	<i>5</i>
<i>Conversion Cases</i>	<i>M0320.202</i>	<i>6</i>
<i>Former SSI/AG Recipients</i>	<i>M0320.203</i>	<i>7</i>
<i>Protected Widows or Widowers</i>	<i>M0320.204</i>	<i>12</i>
<i>Qualified Severely Impaired Individuals (QSII)</i>		
<i>1619(b)</i>	<i>M0320.205</i>	<i>17</i>
<i>Protected Adult Disabled Children</i>	<i>M0320.206</i>	<i>19</i>
<i>Protected SSI Disabled Children</i>	<i>M0320.207</i>	<i>21</i>
<i>ABD With Income ≤80% FPL</i>	<i>M0320.300</i>	<i>23</i>
<i>MEDICAID WORKS</i>	<i>M0320.400</i>	<i>24</i>
<i>300% of SSI Income Limit Groups</i>	<i>M0320.500</i>	<i>30</i>
<i>ABD In Medical Institution, Income ≤300% SSI</i>	<i>M0320.501</i>	<i>31</i>
<i>ABD Receiving Waiver Services (CBC)</i>	<i>M0320.502</i>	<i>33</i>
<i>ABD Hospice</i>	<i>M0320.503</i>	<i>35</i>
<i>Medicare Savings Plan (MSP) Groups</i>	<i>M0320.600</i>	<i>38</i>
<i>QMB (Qualified Medicare Beneficiary)</i>	<i>M0320.601</i>	<i>38</i>
<i>SLMB (Special Low-income Medicare Beneficiary)</i>	<i>M0320.602</i>	<i>38</i>
<i>QI (Qualified Individuals)</i>	<i>M0320.603</i>	<i>46</i>
<i>QDWI (Qualified Disabled & Working Individual)</i>	<i>M0320.604</i>	<i>50</i>
<i>Medically Needy Covered Groups</i>	<i>M0320.700</i>	<i>53</i>
<i>ABD Individuals</i>	<i>M0320.701</i>	<i>54</i>
<i>December 1973 Eligibles</i>	<i>M0320.702</i>	<i>56</i>

M0320.000 AGED, BLIND & DISABLED (ABD) GENERAL POLICY PRINCIPLES**A. Overview**

A State Plan for Medicaid must include the mandatory federal categorically needy (CN) groups of individuals *as well as the optional groups a state has elected to cover.*

This subchapter divides the ABD covered groups into categorically needy and medically needy (MN) groups.

B. Procedure

Determine an individual's eligibility first in a CN covered group. If the individual is not eligible in a full-benefit CN covered group, determine the individual's eligibility as MN (on a spenddown).

An evaluation of eligibility for an aged, blind or disabled individual should follow this hierarchy:

- 1. If the individual is a current SSI/AG recipient, evaluate in this covered group.*
- 2. If the individual is a former SSI or AG recipient, evaluate first in the protected covered groups.*
- 3. If the individual does not meet the criteria for SSI/AG or protected, evaluate next in the ABD with income \leq 80% FPL covered group.*
- 4. If the disabled individual has income at or below 80% FPL and is going back to work, evaluate the individual in the Medicaid Works covered group.*
- 5. If the individual does not meet the requirements for the 80% FPL group or MEDICAID WORKS, but meets the definition of an institutionalized individual, evaluate in the 300% of SSI covered groups.*
- 6. If the individual is a Medicare beneficiary with income or resources in excess of the full-benefit Medicaid covered groups, evaluate in the Medicare Savings Programs (MSP) groups (QMB, SLMB, QI, QDWI).*
- 7. If the individual is not eligible for Medicaid coverage in an MSP group AND he is at least age 19 years but under age 65 years or he requests a Plan First evaluation, evaluate in the Plan First covered group.*
- 8. If the individual meets all the requirements, other than income, for coverage in a full benefit Medicaid group, evaluate as MN.*

M0320.001 ABD CATEGORICALLY NEEDY**A. Introduction**

To be eligible in an ABD covered group, the individual must meet all Medicaid non-financial requirements in chapter M02 and an "Aged," "Blind" or "Disabled" definition in subchapter M0310. If he does not, then go to the Families & Children covered groups in subchapter M0330.

B. Procedures

The policy and procedures for determining whether an individual meets an ABD CN covered group are contained in the following sections:

- M0320.101 SSI Recipients
- M0320.102 AG Recipients
- M0320.201 Former Money Payment Recipients August 1972

- *M0320.202* Conversion Cases
- *M0320.203* Former SSI/AG Recipients
- *M0320.206* Protected Adult Disabled Children
- *M0320.207* Protected SSI Disabled Children
- *M0320.300* ABD with Income \leq 80% FPL
- *M0320.400* MEDICAID WORKS
- *M0320.501* ABD In Medical Institution, Income \leq 300% SSI
- *M0320.502* ABD Receiving CBC Services
- *M0320.503* ABD Hospice
- *M0320.601* Qualified Medicare Beneficiary (QMB)
- *M0320.602* Special Low-income Medicare Beneficiary (SLMB)
- *M0320.603* Qualified Individuals (QI)
- *M0320.604* Qualified Disabled & Working Individual (QDWI)

M0320.100 ABD CASH ASSISTANCE COVERED GROUPS

- A. Legal base** Medicaid eligibility for certain individuals is based on their receipt of cash assistance from another benefit program that has a cash assistance component.
- B. Procedure** The policy and procedures for cash assistance recipients are found in the following sections:
- *M0320.101* SSI Recipients
 - *M0320.102* AG Recipients

M0320.101 SSI RECIPIENTS

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

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

SSI payments for eligible individuals are effective the first day of the month following the month in which the SSI application was filed. When the Medicaid application is filed in the same month as the SSI application, the applicant is not eligible for Medicaid as an SSI recipient until the month for which he receives his first SSI payment. When the SSA record indicates a payment code of "C01" but shows no payment amount due to a recovery of an overpayment, the individual is considered to be an SSI recipient.

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

B. Financial Eligibility**1. Resources**

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

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

When an SSI recipient has any of the real property listed in 1) through 5) above, ALL of the recipient's resources must be verified, evaluated, and counted together to determine if the SSI recipient meets the Medicaid resource requirements. Calculate resources according to the assistance unit policy in chapter M05. If current resources are within the limit, go on to determine income eligibility. If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he may be eligible as MSP (which has more liberal resource methods and standards).

When an SSI recipient has no real property resource listed in 1) through 5) above, do NOT determine the SSI recipient's resources. The SSI recipient meets the Medicaid resource requirements because he receives SSI and does not have a real property resource listed above.

2. Income

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

C. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month, including the receipt of, or entitlement to, an SSI payment in that month. An individual is considered to be an SSI recipient when the SSA record indicates a payment code of "C01" but shows no payment amount due to a recovery of an overpayment.

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

The ACs are:

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

D. Ineligible as SSI Recipient

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

M0320.102 AG RECIPIENTS

- A. Policy** 42 CFR 435.234 - An Auxiliary Grants (AG) recipient is eligible for Medicaid if he meets the assignment of rights to medical support and third party payments requirements (see M0250). AG eligibility is determined using the AG eligibility policy in the Auxiliary Grant Eligibility Manual.
- B. Financial Eligibility** Verify the AG recipient's eligibility for AG by agency records. *Individuals who receive AG as "Conditional" SSI recipients do not meet the requirements for this covered group.*
- C. Entitlement & Enrollment** Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.
- The ACs are:
- 012 for an aged AG recipient;
 - 032 for a blind AG recipient;
 - 052 for a disabled AG recipient.

M0320.200 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**
- M0320.201 Former Money Payment Recipients August 1972
 - M0320.202 Conversion Cases
 - M0320.203 Former SSI/AG Recipients
 - M0320.204 Protected Widows or Widowers
 - M0320.205 Qualified Severely Impaired Individuals (QSII)-1619(b)
 - M0320.206 Protected Adult Disabled Children
 - M0320.207 Protected SSI Disabled Children.

M0320.201 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
- would meet all *current LIFC* or SSI requirements if he were not in a medical institution or intermediate care facility and the Medicaid plan covers this optional group. The Virginia plan covers this group

B. Nonfinancial Requirements

The protected individual must meet all of the following criteria:

- he was a recipient of OAA, AB, APTD, or AFDC cash assistance as of August, 1972;
- his money payment was subsequently discontinued as a result of the 20% increase in Social Security benefits received in October, 1972;
- his current countable resources are less than or equal to the current resource limit for Medicaid; and
- his current countable income is less than or equal to the F&C income limit or the current SSI income limit, as appropriate, after excluding the 20% increase amount received in 1972. The current SSI standards are in subchapter S0810; the F&C income limits are in subchapter M0710, Appendix 3.

Contact your Regional Medical Assistance Program Consultant if you have an applicant you believe meets this covered group.

M0320.202 CONVERSION CASES

A. Policy

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

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

B. Eligibility Determination

The agency must continue the individual's Medicaid if

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

- the essential spouse continues to meet the conditions that were in effect in December 1973 under the applicable cash assistance plan for having his needs included in computing the payment to the ABD individual.

C. Essential Spouse

The agency must provide Medicaid to any person who was eligible for Medicaid in December 1973 as an essential spouse of an aged, blind or disabled individual who was receiving cash assistance, if the conditions below are met. An “essential spouse” is defined as one who is living with the individual, whose needs were included in determining the amount of cash payment to the individual under OAA, AB, or APTD in December 1973, and who is determined essential to the individual’s well-being.

The spouse of the protected conversion person is included in the conversion case if:

- his/her needs were included in the OAA, AB, or APTD grant as of December, 1973, and
- he/she continues to live in the home of the protected individual

D. Blind or Disabled In December 1973

The agency must provide Medicaid to individuals who:

- meet all current Medicaid eligibility requirements except the criteria for blindness or disability;
- were eligible for Medicaid in December 1973 as blind or disabled individuals; and

for each consecutive month after December 1973, continue to meet the criteria for blindness or disability and the other eligibility requirements used under the Medicaid plan in December 1973.

Contact your Regional Medical Assistance Program Consultant if you have an applicant you believe meets this covered group.

M0320.203 FORMER SSI/AG RECIPIENTS

A. Policy

1. Nonfinancial Requirements

The protected former SSI/AG recipient must meet the nonfinancial eligibility requirements in chapter M02. The protected former SSI recipient is one who was eligible for and received **either**:

- SSA and SSI, or
- SSA and AG, or
- SSA, SSI, and AG

concurrently, but who became ineligible for SSI or AG due to any reason on or after April, 1, 1977. The individual did not have to be receiving Medicaid at that time.

An individual who concurrently received these benefits does not meet this covered group's requirements if one of the benefit payments was later recouped because the individual was not entitled to the payment.

2. Financial Requirements

The former SSI/AG recipient is eligible for Medicaid if:

- a. the individual meets the Medicaid resource requirements currently in effect, and the individual's income, less all SSA cost-of-living adjustments (COLAs) received since the most recent month SSI or AG was cancelled (including the COLA received in the month SSI or AG was cancelled) is within the current SSI income limit; OR
- b. the individual meets the AG requirements in effect at the time of application or redetermination, including residing in an approved AG home, and the individual's income less the amount of all SSA COLAs received since the most recent month SSI or AG was cancelled (including the COLA received in the month SSI or AG was cancelled) is within the current AG income limit applicable to a resident of that home.
- c. Any change in SSA benefits other than cost-of-living increases are not excluded, such as an increase due to change from disability benefits to widow's benefits.

EXAMPLE #1: Ms. C is age 71. She has never been enrolled in Medicaid before. She applied for Medicaid on February 12, 1997. She received SSA on her own record, in the amount of \$280, until March 1, 1994 when she began receiving widow's benefits of \$410. She received SSI until March 1, 1994, when SSI was cancelled due to her increased SSA benefit. She received COLA increases in her SSA in January of 1995, 1996, and 1997. 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 protected former SSI recipient.

B. Eligibility Procedures

1. Assistance Unit

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.

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.

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.

3. Income Eligibility

a. 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.

b. 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.

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 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.

Note: There was no COLA in 2010 or 2011.

Cost-of-living calculation formula:

- a. $\frac{\text{Current Title II Benefit}}{1.036 \text{ (1/12 Increase)}} = \frac{\text{Benefit Before}}{1/12 \text{ COLA}}$
- b. $\frac{\text{Benefit Before 1/12 COLA}}{1.058 \text{ (1/09 Increase)}} = \frac{\text{Benefit Before}}{1/09 \text{ COLA}}$
- c. $\frac{\text{Benefit Before 1/09 COLA}}{1.023 \text{ (1/08 Increase)}} = \frac{\text{Benefit Before}}{1/08 \text{ COLA}}$
- d. $\frac{\text{Benefit Before 1/08 COLA}}{1.033 \text{ (1/07 Increase)}} = \frac{\text{Benefit Before}}{1/07 \text{ COLA}}$
- e. $\frac{\text{Benefit Before 1/07 COLA}}{1.041 \text{ (1/06 Increase)}} = \frac{\text{Benefit Before}}{1/06 \text{ COLA}}$

5. Medicare Premiums

a. Medicare Part B premium amounts:

1-1-12	\$99.90
1-1-11	\$115.40*
1-1-10	\$110.50
1-1-09	\$96.40
1-1-08	\$96.40
1-1-07	\$93.50
1-1-06	\$88.50

*This amount is for individuals enrolled in Medicare on or after 1-1-11 or for individuals subject to increased Medicare premiums based on their income. The Medicare Part B premium for individuals enrolled in Medicare prior to January 1, 2010, was \$96.40 for 2010 and 2011. The Medicare Part B premium for individuals enrolled in Medicare between January 1, 2010, and December 31, 2010 was \$110.50 for 2011. Verify the individual's Medicare Part B premium in SVES or SOLQ-I if it is necessary to know the premium amount for Medicaid eligibility or post-eligibility purposes.

b. Medicare Part A premium amounts:

1-1-12	\$451.00
1-1-10	\$461.00
1-1-09	\$443.00
1-1-08	\$423.00
1-1-07	\$410.00
1-1-06	\$393.00

Contact a Medical Assistance Program Consultant for amounts for years prior to 2006.

6. Evaluation

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

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 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.

The cost-of-living increase(s) is not excluded when determining income eligibility in ANY other covered group. However, these individuals must be identified for possible future protection as the SSI and AG income limits increase.

C. Entitlement & Enrollment

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

The ACs are:

- 021 for an aged individual;
- 041 for a blind individual;
- 061 for a disabled individual.

D. Eligibility for Non-Protected Family Members

The amount of an SSA cost-of-living increase that must be excluded when determining eligibility for a former SSI recipient **cannot** be excluded when determining Medicaid eligibility of the individual's non-protected spouse and/or children living with the former SSI recipient.

The former SSI recipient is included in his/her non-protected spouse's unit if the non-protected spouse is aged, blind, or disabled.

The former SSI recipient is included as a member of the family unit when determining a child's eligibility in an F&C covered group. All of the protected recipient's income, including the cost-of-living increase(s), is counted.

M0320.204 PROTECTED WIDOWS OR WIDOWERS

A. Policy

Two groups of disabled widow(er)s who lost SSI eligibility because of receipt of or increase in Title II disabled widow(er)s' or Title II widow(er)'s benefits have their Medicaid categorically needy eligibility protected.

The first group consists of disabled widow(er)s who would be eligible for SSI except for the increase in disability benefits resulting from elimination of the reduction factor under P.L. 98-21 in January 1984.

The second group consists of (1) disabled widow(er)s age 60 through 64 years and (2) disabled widow(er)s age 50 through 59 years who would be eligible for SSI except for early receipt of Social Security benefits.

B. July 1989 Protected Widow(er)s

42 CFR 435.137 - A "July 1989 protected widow(er)" is an individual who became entitled to SSA benefits when he/she had attained age 50 but not age 60 years, and

- who applied for Medicaid before July 1, 1989,
-
- was entitled to monthly OASDI benefits under Title II of the Social Security Act for December 1983,
- was entitled to and received widow's or widower's disability benefits under section 202(e) or 202(f) of the Social Security Act for January 1984,
- lost SSI and/or AG because of the January 1984 increase in disabled widow(er)'s benefits due to elimination of the reduction factor,
- has been continuously entitled to an SSA widow(er)'s disability benefit under section 202(e) or 202(f) of the Social Security Act since the first month that increase was received, and
- would be eligible for SSI or AG if the amount of the increase and any subsequent COLAs in the widow(er)s' SSA benefits were excluded.

1. Nonfinancial Eligibility

Determine the widow(er)'s eligibility using the procedures below. The widow(er):

- a. applied for Medicaid as a protected individual prior to July 1, 1989;
- b. was entitled to and received a widow's or widower's benefit based on a disability under Section 202 (e) or (f) of the Social Security Act, for January 1984;
- c. became ineligible for SSI and/or AG payments because of the increase in the amount of his/her widow(er)'s benefit and:
 - the increase resulted from the elimination of the reduction factor for disabled widow(er)s entitled before age 60,
 - he/she became ineligible for SSI and/or AG payments in the first month in which that increase was paid to him/her, and
 - a retroactive payment of that increase for prior months was not made in that month;
- d. has been continuously entitled to a widow(er)'s disability benefit under Section 202 (e) or (f) of the Social Security Act from the first month that the increase in his/her widow(er)'s benefit was received;
- e. would be eligible for SSI or AG if the amount of that increase, and any subsequent cost-of-living adjustments (COLAs) in the widow(er)'s benefits, were deducted from his/her income.

2. Financial Eligibility**a. Assistance Unit**

Determine whose resources and income will be counted or deemed available according to the assistance unit policy in chapter M05.

b. Resource Eligibility

Resource eligibility is determined by comparing the widow(er)'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). 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 group; he/she may be eligible as *an MSP* (which has more liberal resource methods and standards).

c. Income Eligibility

- 1) If the individual received SSI (or SSI and AG) and is not currently residing in an approved AG home, the individual's gross SSA benefit amount that was effective in December 1983 plus other current countable income must be within the current SSI individual limit, or couple limit if the individual is married and living with his/her spouse. Calculate income according to the assistance unit policy in chapter M05. Instead of the protected individual's current SSA benefit amount, use the amount effective in December 1983.

Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected individual is eligible for Medicaid in this protected covered group.

- 2) If the individual received AG (or AG and SSI) and is currently residing in an approved AG home, the individual's income must be within the current AG limit (home's rate plus personal care allowance). Instead of the protected individual's current SSA benefit amount, use the amount effective in December 1983.

Compare the total countable income to the current AG limit (home's rate plus personal care allowance). If countable income is within that limit, the protected individual is eligible for Medicaid in this protected covered group.

- 3) If the individual is not income-eligible, Medicaid eligibility may exist in another covered group. However, when determining eligibility in another covered group, count all current income including the current SSA benefit amount. If the individual does not meet an F&C covered group, is not institutionalized, is not receiving CBC or does not have Medicare Part A, he/she must be determined eligible in a medically needy covered group.

**C. Protected Disabled
Widow(er)**

42 CFR § 435.138 specifies that categorically needy eligibility for Medicaid is protected for the group of disabled widow(er)s age 60 through 64 years who meet the criteria specified below. Under 42 USC § 1383c(d), Medicaid protected status was extended to the group of disabled widower(er)s age 50 through 59 years who meet the same criteria.

A protected disabled widow(er) is an individual who:

- is at least age 50 years (and has not attained age 65);
- is **not** eligible for Medicare Part A hospital insurance;
- becomes ineligible for SSI and/or AG because of mandatory application for and receipt of SSA Title II widow(er)'s disability benefits under section 202(e) or 202(f) of the Social Security Act (or any other provision of section 202 if they are also eligible for benefits under subsections (e) or (f) of the Act).
- would be eligible for SSI or AG if the SSA widow(er)'s benefit were excluded from income.

**1. Nonfinancial
Eligibility**

The protected disabled widow(er) must:

- a. have received SSI and/or AG for the month before the month in which he/she began receiving SSA Title II disabled widow(er)'s benefits or widow(er)'s benefits;
- b. be eligible for SSI or AG if the SSA widow(er)'s disability benefit were not counted as income.

**2. Financial
Eligibility**

a. Assistance Unit

Determine whose resources and income will be counted or deemed available according to the assistance unit policy in chapter M05.

b. Resource Eligibility

Financial eligibility is determined by comparing the widow(er)'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). 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 group; he/she may be eligible in an *MSP covered group* (which has more liberal resource methods and standards).

c. Income Eligibility

When determining a protected widow(er)'s eligibility in this covered group, the agency must deduct from the individual's income all of the Social Security benefits that made him or her ineligible for SSI.

- 1) If the individual received SSI (or SSI and AG) and is not currently residing in an approved AG home, the individual's SSA benefit that made him/her ineligible for SSI must be excluded. Other current countable income must be within the current SSI individual limit, or couple limit if the individual is married and living with his/her spouse. Exclude the protected individual's current SSA widow(er)'s benefit amount.

Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected individual is eligible for Medicaid in this protected covered group.

- 2) If the individual received AG (or AG and SSI) and is currently residing in an approved AG home, the individual's countable income must be within the current AG limit (home's rate plus personal care allowance). Exclude the protected individual's current SSA widow(er)'s benefit amount.

Compare the total countable income to the current AG limit (home's rate plus personal care allowance). If countable income is within that limit, the protected individual is eligible for Medicaid in this protected group.

- 3) If the individual is not income eligible, the individual must be evaluated for Medicaid eligibility in other covered groups. However, when determining eligibility in another covered group, count all current income including the current SSA benefit amount.

D. Entitlement & Enrollment

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

The ACs are:

- 021 for an aged individual;
- 041 for a blind individual;
- 061 for a disabled individual.

M0320.205 QUALIFIED SEVERELY IMPAIRED INDIVIDUALS (QSII)- 1619(B) STATUS

A. Introduction

42 CFR 435.121 - Under Section 1619(a) of the Social Security Act, a disabled individual who would otherwise lose SSI because of work and the demonstration of the ability to perform substantial gainful activity but continues to have a disabling impairment can continue to receive special SSI benefits if he continues to be financially eligible for SSI benefits based on income.

Section 1619(b) of the Act allows a disabled individual whose income is too high to retain financial eligibility for the special SSI benefit under Section 1619(a) and a blind individual who lost regular SSI payments to continue to receive Medicaid benefits under certain criteria specified in Section 1619(b).

The Social Security Administration (SSA) determines whether an individual who lost SSI because of earned income is eligible for 1619(b) status.

The local department of social services determines whether an individual who has a 1619(b) status continues to be Medicaid eligible.

B. Identifying QSII Individuals

To identify a QSII individual, check the "Medicaid Test Indicator" field on the State Verification Exchange System (SVES) WMVE9068 screen SOLQ-I screen. If there is a code of A, B, or F, the individual has 1619(b) status.

Since eligibility for 1619(b) can change, check the SVES or SOLQ-I at each redetermination and when there is an indication that a change may have occurred.

C. Determining Eligibility

1. Nonfinancial Eligibility

The QSII individual must have been eligible for and receiving Medicaid coverage as an SSI recipient (must have met the more restrictive real property requirement) in the month immediately preceding the first month of the 1619(b) status. The "Current Pay Status Effective Date" field on the SVES WMVE9065 screen shows the first month of the 1619(b) status.

NOTE: If you cannot determine the first month of 1619(b) status, contact SSA.

2. Financial Eligibility

a. Resource Eligibility

Use the following to determine if the QSII recipient has real property resource(s):

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

When a QSII recipient has any of the real property listed in 1) through 5) previously, ALL of the recipient's resources must be verified, evaluated, and counted together to determine if the recipient meets the Medicaid resource requirements. Calculate resources according to the assistance unit policy in chapter M05. If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible for *Medicare Savings Program (MSP)* limited-benefit Medicaid (which has more liberal resource methods and standards).

When a QSII recipient has no real property resource listed in 1) through 5) previously, do NOT determine the recipient's resources. The QSII recipient meets the Medicaid resource requirements because his resource eligibility for QSII has been determined by SSA and he does not have a real property resource as listed previously.

b. Income Eligibility

There are no income eligibility requirements for QSII individuals once they have been determined eligible as 1619(b).

D. Entitlement & Enrollment

Eligible individuals are entitled to full Medicaid coverage. The ACs are:

- 21 for an aged individual;
- 41 for a blind individual; or
- 61 for a disabled individual.

E. Individuals Ineligible as QSII

Individuals who are ineligible as QSII because they:

- did not receive Medicaid in the month immediately preceding the month in which SSA first determined them eligible under 1619(b) or
- lost 1619(b) status

must be evaluated for Medicaid eligibility in other covered groups.

NOTE: An individual who has 1619(b) status continues to meet the disabled definition. An individual who no longer has 1619(b) status may not meet the disabled definition.

M0320.206 PROTECTED ADULT DISABLED CHILDREN**A. Policy**

Section 1634(c) of the Social Security Act was amended in 1987 (P.L. 99-643 §6(b)) to state that if any individual who has attained the age of 18 and is receiving benefits under Title XVI (the Supplemental Security Income program) on the basis of blindness or a disability which began before he or she attained the age of 22

- becomes entitled, on or after the effective date of this subsection (July 1, 1987), to child's insurance benefits which are payable under section 202(d) on the basis of such disability or to an increase in the amount of the child's insurance benefits which are so payable; and
- ceases to be eligible for SSI because of such child's insurance benefits under the title or because of the increase in such child's insurance benefits,

shall be treated as receiving SSI benefits for Medicaid eligibility purposes so long as he/she would be eligible for SSI in the absence of such child's insurance benefits or such increase.

B. Nonfinancial Eligibility

A protected adult disabled child is one who:

- has reached the age of 18 years and receives SSI payments on the basis of blindness or a disability which began before he or she reached the age of 22 years;
- on or after July 1, 1987, becomes entitled to SSA Title II disabled child's insurance benefits on the basis of such disability, or receives an increase in Title II disabled child's insurance benefits;

- becomes ineligible for SSI on or after July 1, 1987 because of the receipt of, or increase in, Title II disabled child's benefits;
- has resources within the current Medicaid resource limit; and
- has income which, in the absence of the Title II disabled child's benefit, or in the absence of the increase in such benefit, is within the current SSI income limit.

C. Financial Eligibility

Determine whose resources and income will be counted or deemed available according to the assistance unit policy in chapter M05.

1. Resources

Financial eligibility is determined by comparing the protected individual'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 in *an MSP covered group* (which has more liberal resource methods and standards).

2. Income

a. Receipt of SSA Child's Benefits Causes SSI Ineligibility

If the individual began receiving adult disabled child's benefits and this receipt caused SSI ineligibility, then the entire adult disabled child's benefit amount and any subsequent increases in the benefit are excluded when determining the individual's countable income.

In determining whether the adult disabled child's income, in absence of the Title II adult disabled child's benefit is within the current SSI income limit, all of the adult disabled child's other current countable income must be within the current SSI individual limit, or couple limit if the individual is married and living with his/her spouse. Calculate income according to the assistance unit policy in chapter M05, including deeming of parent(s)' income when the individual is under age 21 and living with a parent(s). **Exclude all of the protected individual's current SSA adult disabled child's benefit amount.**

Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected individual is eligible for Medicaid in this protected covered group.

If countable income exceeds the SSI limit, determine the individual's eligibility in another Medicaid covered group.

b. Increase In SSA Child's Benefits Causes SSI Ineligibility

If the individual received an increase in disabled child's benefits and this increase caused SSI ineligibility, only the increase which caused SSI

ineligibility is excluded when determining the individual's countable income. Calculate income according to the assistance unit policy in chapter M05, including deeming of parent(s)' income when the individual is under age 21 and living with a parent(s). Exclude the amount of the increase which caused SSI ineligibility.

- 1) Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected individual is eligible for Medicaid in this protected covered group.

In this situation, the adult disabled child received SSI and SSA concurrently, and lost SSI because of an increase in SSA disabled child's benefits. The amount of the increase that caused SSI ineligibility is excluded. No subsequent increases in the disabled child's benefit are excluded when reviewing the individual's eligibility as a protected adult disabled child. However, if the protected adult disabled child becomes ineligible for Medicaid, evaluate his/her Medicaid eligibility as a protected former SSI recipient using the policy and procedures in Section M0320.201 of this chapter.

- 2) If countable income exceeds the SSI limit, determine the individual's eligibility in another covered group. If the individual does not meet an F&C MI covered group, is not institutionalized, is not receiving CBC or does not have Medicare Part A, he/she must be evaluated in a medically needy covered group.

D. Entitlement & Enrollment

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

The ACs are:

- 021 for an aged individual;
- 041 for a blind individual;
- 061 for a disabled individual.

M0320.207 PROTECTED SSI DISABLED CHILDREN

A. Introduction

The Balanced Budget Act of 1997 (P.L. #105-33) created a new covered group which protects Medicaid eligibility for disabled children who received SSI, whose SSI is canceled solely because the children do not meet the SSI definition of childhood disability (revised per section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996), and who would be paid SSI but for the change in the childhood disability definition.

B. Nonfinancial Eligibility Requirements

To be eligible in this protected covered group, the protected SSI disabled child must

- have had his/her SSI canceled solely because he/she does not meet the SSI definition of childhood disability (revised per section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996);
- continue to meet the SSI childhood disability definition and regulations that were in effect prior to the effective date of the change in the disability definition (August 22, 1996); and
- be under age 18 years.

1. Disability Determination Referral to Disability Determination Services (DDS)

An SSI disabled child is presumed to meet the childhood disability definition in effect prior to August 22, 1996, until he/she reaches age 18 years, unless there is an improvement in the child's condition. If the child's condition improves, complete

- *DDS Referral Form, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>*
- *the Disability Report Child (SSA-3820-BK), available at <http://www.socialsecurity.gov/online/ssa-3820.pdf> and*
- *a minimum of 3 signed, original Authorization to Disclose Information to the Social Security Administration forms (SSA-827), available at <http://www.socialsecurity.gov/online/ssa-827.pdf> or a form for each medical provider if more than 3. "General Authorization for Medical Information" (form #032-03-311) for each medical practitioner reported by the individual on the report.*

Send the report(s) and authorization forms to the DDS.

2. DDS Decision

If the *DDS* decides that the child continues to meet the childhood disability definition in effect prior to August 22, 1996, the child continues eligible in the protected group of SSI disabled children, provided the child meets the financial eligibility requirements in item C. below.

If the *DDS* decides that the child no longer meets the childhood disability definition in effect prior to August 22, 1996, the child no longer meets the protected group of SSI disabled children. Determine the child's eligibility in another covered group. If the child is not eligible in any covered group, send an advance notice to the authorized representative and take action to cancel the child's Medicaid coverage.

C. Financial Eligibility Procedures

1. Assistance Unit

Follow the policy and procedures in M0530.

2. Resource Eligibility

Resource eligibility is determined by comparing the SSI disabled child's countable resources to the current ABD 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 subchapter M0530. If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the child is NOT eligible in the protected SSI disabled children covered group; he/she may be eligible as *FAMIS Plus* (see M0330.300) if he/she is under age 19 years.

3. Income Eligibility

Income eligibility is determined by comparing the SSI disabled child's income to the current SSI payment limit for an individual. Determine countable income using policy in Chapter S08. Calculate income according to the assistance unit policy in subchapter M0530. If countable income is within the SSI payment limit, the child is eligible for Medicaid in the covered group of protected SSI disabled children.

D. Entitlement & Enrollment

Children eligible for Medicaid in the covered group of protected SSI disabled children are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible protected SSI disabled children are enrolled with program designation "61."

M0320.300 ABD WITH INCOME \leq 80% FEDERAL POVERTY LIMIT (FPL)**A. Policy**

Section 1902(m) of the Social Security Act allows a State to provide full Medicaid benefits to the categorically needy covered group of aged, blind and disabled individuals whose income is less than or equal to a percentage of the federal poverty limit (FPL).

The 2000 Appropriations Act mandated that effective July 1, 2001, the State Plan for Medical Assistance be amended to add the covered group of aged, blind and disabled individuals with income less than or equal to 80% FPL.

An eligible individual's resources must be within the SSI resource limits.

B. Financial Eligibility

- 1. Assistance Unit** The assistance unit policy and procedures in chapter M05 apply to ABD individuals with income less than or equal to 80% FPL. If not institutionalized, deem or count any resources and income from the individual's spouse with whom he lives. If institutionalized with a community spouse, go to subchapter M1480.
- 2. Resources** The resource limit is \$2,000 for an individual and \$3,000 for a couple.
The resource requirements in chapter S11 and Appendix 2 to chapter S11 apply to this covered group.
All of the individual's resources must be verified and evaluated. All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements.
- 3. Income** The income limits are \leq 80% of the FPL and are in section M0810.002. The income requirements in chapter S08 must be met.
- 4. Income Exceeds 80% FPL** **Spendedown does not apply** to this covered group. If the individual's income exceeds the 80% FPL limit, he is not eligible in this covered group. Determine the individual's eligibility in all other Medicaid covered groups.

D. Entitlement

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

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

E. Enrollment

The ABD 80% group AC is:

- 029 for an aged enrollee;
- 039 for a blind enrollee; or
- 049 for a disabled enrollee.

M0320.400 MEDICAID WORKS

A. Policy

The Appropriations Act of 2006 authorized an amendment to the Virginia State Plan for Medical Assistance that allows disabled (including blind) individuals 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. Relationship Between
MEDICAID
WORKS and 1619(b)
Status**

The 1619(b) work incentive status available to SSI recipients allows the individual to earn a significantly higher income than the MEDICAID WORKS income limit. However, 1619(b) uses the same resource limit as SSI, while the resource limit for MEDICAID WORKS is significantly higher. An individual with SSI who meets the criteria for Medicaid coverage as a Qualified Severely Impaired Individual (1619(b)) may choose to participate in MEDICAID WORKS because of the higher resource limit. An individual with SSI must not be discouraged from enrolling in MEDICAID WORKS.

**C. Nonfinancial
Eligibility**

The individual must also meet the following additional nonfinancial criteria:

- The individual must be competitively employed in an integrated setting. Work must occur in a work setting in the community or in a personal business alongside people who do not have disabilities. Work performed in a sheltered workshop or similar setting is **not** considered competitive employment in an integrated setting. Contact a Regional Medical Assistance Program Consultant if there is a question about whether the employment meets the criteria for MEDICAID WORKS.
- The individual must receive pay at the minimum wage or at the prevailing wage or "going rate" in the community, and the individual must provide documentation that payroll taxes are withheld. Self-employment must be documented according to the policy contained in S0820.210.
- The individual must establish a Work Incentive (WIN) Account at a bank or other financial institution, such as a checking or savings 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 *SPARK* at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>. The agreement outlines the individual's responsibilities as an enrollee in the program.

- The individual must participate in cost sharing through the payment of a monthly premium to the Department of Medical Assistance Services. Note: Monthly premiums are not being charged at this time.

D. Financial Eligibility

1. Assistance Unit

a. Initial eligibility determination

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

- 1) For **earnings** accumulated **after** enrollment in MEDICAID WORKS, up to the current 1619(b) income threshold amount will be disregarded if deposited and retained in the WIN Account. The 1619(b) threshold amount for 2012 is \$34,272.
- 2) Resources accumulated while in MEDICAID WORKS and held in Internal Revenue Service (IRS)-approved retirement accounts, medical savings accounts, medical reimbursement accounts, education accounts, independence accounts, and other similar State-approved accounts are excluded. Examples of these accounts include Archer Medical Savings Accounts, 401(k) accounts, traditional Individual Retirement Accounts (IRAs), Roth IRAs, SEP-IRAs, SIMPLE IRAs, Thrift Savings Plans, and 503(b) plans. The account must be designated as a WIN Account in order to be excluded. **Resources accumulated while in MEDICAID WORKS and held in IRS-approved accounts that have been**

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

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

All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements. The resource limit for resources not excluded in 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 M0320.101).

b. Ongoing eligibility

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

- 1) The income limit for earned income is 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.

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

- 4. Income Exceeds 80% FPL at Eligibility Determination** **Spendedown 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.
- E. 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.**
- F. Good Cause** An individual may remain eligible for MEDICAD 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 should be asked to provide documentation that he is unable to work from a medical or mental health practitioner or employer. However, do not cancel the individual's eligibility under MEDICAID WORKS due to the lack of documentation if the individual indicates that he is still seeking employment.
 - DMAS may establish other good cause reasons. Requests for good cause other than the temporary loss of employment due to a documented illness or unavoidable job loss must be submitted to DMAS on the enrollee's behalf by the local department of social services.
- G. 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 M0320.400 D. 2. b. 2 that has been designated as a WIN Account are excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees.

H. Benefit Package

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

I. Entitlement and Enrollment

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

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

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

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

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

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

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

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

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

If the individual is no longer eligible for MEDICAID WORKS, the eligibility worker must determine whether the individual remains eligible in any other covered group. **The policy in M0320.400 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.

M0320.500 300% of SSI INCOME LIMIT GROUPS

A. Introductions

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

B. Covered Groups

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

M0320.501 ABD IN MEDICAL INSTITUTION, INCOME ≤ 300% SSI LIMIT

A. Policy

42 CFR 435.236 - The state plan includes the covered group of aged, blind or disabled individuals in medical institutions who

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

Individuals who are screened and approved for nursing facility care prior to admittance and are likely to receive the services for 30 days or more consecutive days may also be included in this covered group.

B. Financial Eligibility

1. Asset Transfer

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

2. Resources

a. Resource Eligibility – Married Individual

If the individual is married, use the resource policy in subchapter M1480. Evaluate countable resources using ABD resource policy in chapter S11.

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

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

b. Resource Eligibility - Unmarried Individual

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

- 1) equity In non-exempt property contiguous to the individual's home which exceeds \$5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property; and
- 2) ownership of his/her former residence when the individual is in an institution for longer than 6 months. Determine if the former home is excluded in M1130.100 D.

If the individual is a blind or disabled child, DO NOT DEEM any resources or income from the child's parent; count only actual resources the parent makes available to the child. If current resources are within the limit, go on to determine income eligibility.

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

3. Income

To determine if an individual has income within the 300% of SSI limit, use **gross** income, not countable income. Determine what is income according to chapter S08 *and* subchapter M1460.

DO NOT subtract the \$20 general exclusion or any other income exclusions. The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Compare the total gross income to the 300% of SSI limit (see M0810.002 A. 3). If countable income is equal to or less than this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in this covered group. Evaluate his/her eligibility as medically needy.

C. Entitlement & Enrollment

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

If the individual has Medicare Part A, re-calculate the individual's income - subtract appropriate exclusions. Compare the countable income to the QMB limit.

1. Dual-eligible As QMB

If the individual is also a Qualified Medicare Beneficiary (QMB) - the individual has Medicare Part A and has countable income within the QMB income limit the - ACs are:

- 022 for an aged individual also QMB;
- 042 for a blind individual also QMB;
- 062 for a disabled individual also QMB.

2. Not QMB

If the individual is NOT a Qualified Medicare Beneficiary (QMB) - the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - the ACs are:

- 020 for an aged individual NOT also QMB;
- 040 for a blind individual NOT also QMB;
- 060 for a disabled individual NOT also QMB.

D. Ineligible In This Covered Group

If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy spenddown. If the individual is not eligible for Medicaid in this covered group because of resources, determine the individual's eligibility as QMB, SLMB, QDWI or QI if he/she has Medicare Part A.

M0320.502 ABD RECEIVING MEDICAID WAIVER SERVICES (CBC)**A. Policy**

42 CFR 435.217 - The state plan includes the covered group of aged, blind or disabled individuals in the community who

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

Do not wait until the individual starts to receive the waiver services to determine eligibility in this covered group. Determine eligibility in this covered group if the individual is screened and approved (see subchapter M1420) to receive Medicaid waiver services and has selected the option to receive Medicaid waiver services in lieu of nursing facility services. Presume the individual will receive the services and go on to determine financial eligibility using the policy and procedures in C. below.

If the individual's eligibility was determined as an institutionalized individual prior to the receipt of waiver services, the EW must verify the receipt of Medicaid CBC services within 30 days of the date of the Notice of Action on Medicaid. If Medicaid CBC services did not start within 30 days of the date of the Notice of Action on Medicaid, the individual's continued eligibility must be re-evaluated as a non-institutionalized individual.

B. Financial Eligibility**1. Asset Transfer**

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

2. Resources**a. Resource Eligibility - Unmarried Individual**

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements in chapter S11 (ABD Resources). Pay close attention to:

- 1) equity in non-exempt property contiguous to the individual's home which exceeds \$5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property, and
- 2) ownership of his/her former residence when the individual has been away from his home property for longer than 6 months. Determine if the home property is excluded in M1130.100.

DO NOT DEEM any resources from a blind or disabled child's parent

living in the home. Count actual resources the parent makes available to the child.

If current resources are within the limit, *then* determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible for Medicaid in this covered group.

b. Resource Eligibility - Married Individual

If the individual is married and has a community spouse, use the resource policy in subchapter M1480. If the individual is married, but has no community spouse, use the resource policy in subchapter M1460. Evaluate countable resources using ABD resource policy in chapter S11.

If current resources are within the limit, *then* determine income eligibility.

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

3. Income

To determine if an individual has income within the 300% of SSI limit, use **gross** income, not countable income. Determine what is income according to chapter S08 and subchapter M1460.

DO NOT subtract the \$20 general exclusion or any other income exclusions. The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Compare the total gross income to the 300% of SSI limit (see M0810.002 A. 3). If countable income is equal to or less than this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in this covered group. Evaluate his/her eligibility as medically needy.

C. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met. Retroactive coverage does not apply to this covered group because an individual cannot be eligible in this covered group until he/she applies for Medicaid. [The individual cannot have received Medicaid covered waiver services in the retroactive period because he was not receiving Medicaid on or before the date he applied.]

If the individual has Medicare Part A, re-calculate the individual's income - subtract the appropriate exclusions. Compare the countable income to the QMB limit.

1. Dual-eligible As QMB

If the individual is also a Qualified Medicare Beneficiary (QMB) - the individual has Medicare Part A and has countable income within the QMB income limit - the *ACs are*:

- 022 for an aged individual also QMB;
- 042 for a blind individual also QMB;
- 062 for a disabled individual also QMB.

2. Not QMB

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

- 020 for an aged individual NOT also QMB;
- 040 for a blind individual NOT also QMB;
- 060 for a disabled individual NOT also QMB.

D. Ineligible In This Covered Group

If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy spenddown. Determine the individual's eligibility as QMB, SLMB, QDWI or QI if he/she has Medicare Part A.

M0320.503 ABD HOSPICE

A. Policy

SMM 3580-3584 - The state plan includes the covered group of aged, blind or disabled individuals who are terminally ill and elect hospice benefits.

The ABD Hospice covered group is for individuals who have a signed a hospice election statement in effect for at least 30 consecutive days, and who are not eligible in any other full-benefit Medicaid covered group. Hospice care is a covered service for individuals in all full-benefit covered groups; individuals who need hospice services but who are eligible in another full-benefit covered group do not meet the Hospice covered group.

Individuals receiving hospice services in the ABD Hospice Covered group may also receive services under the Elderly and Disabled with Consumer Direction (EDCD) Waiver, if the services are authorized by the Department of Medical Assistance Services (DMAS) (see M1440.101).

The individual must elect hospice care. Election of hospice care is verified either verbally or in writing from the hospice. If the verification is verbal, document the case record. Eligibility in the Hospice covered group is ongoing as long as the individual continues to receive hospice care, subject to a renewal of eligibility at least once every 12 months. The eligibility worker must verify that the hospice agreement is current at the time of the annual Medicaid renewal.

The 30-day requirement begins on the day the hospice care election statement is signed. Once the hospice election has been in effect for 30 consecutive days, the 300% of SSI income limit is used to determine Medicaid eligibility. If the individual's income is within 300% of SSI, eligibility in the Hospice covered group may be determined beginning with the month in which the hospice election was signed.

Individuals who already meet the definition of institutionalization in M1410.010 B.2 at the time of hospice election meet the 30-day requirement, provided there is no break between institutionalization and hospice election.

Individuals who meet the Hospice covered group may have their eligibility determined using the same financial requirements as institutionalized individuals.

B. Financial Eligibility

1. Asset Transfer

The individual in the hospice covered group must meet the asset transfer policy in subchapter M1450.

2. Resources

The hospice services recipient is an assistance unit of 1 person. All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements.

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 for Medicaid in this covered group. He/she may be eligible in *an MSP* covered group (which has more liberal resource methods and standards).

a. Unmarried Individual

If the individual is unmarried or is married and has no community spouse, use the resource policy in chapter S11 and subchapter M1460.

b. Married Individuals

If the individual is married and has a community spouse, use the resource policy in chapter S11 and subchapter M1480.

3. Income

To determine if an individual has income within the 300% of SSI limit, use **gross** income, not countable income. Determine what is income according to chapter S08 and subchapter M1460.

DO NOT subtract the \$20 general exclusion or any other income exclusions. The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Compare the total gross income to the 300% of SSI limit (see M0810.002 A. 3). If countable income is equal to or less than this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in this covered group. Evaluate his/her eligibility as medically needy.

C. Entitlement

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the month in which all eligibility requirements are met. Retroactive coverage is applicable to this covered group.

If the individual has Medicare Part A, re-calculate the individual's income, applying the appropriate exclusions. Compare the countable income to the QMB limit.

D. Enrollment

Eligible individuals must be enrolled in the appropriate AC. If the individual is aged, blind, or disabled as defined in M0310, he is enrolled under the AC. *AC (054) is used for “deemed-disabled” individuals only.* Use the appropriate Hospice AC when the individual is also authorized to receive EDCD Waiver services.

For individuals who are ABD and entitled/enrolled in Medicare Part A, income must be recalculated (allowing appropriate disregards) to determine if the individual is dually eligible as a QMB.

1. ABD Individual**a. Dual-eligible As QMB**

If the individual is also a Qualified Medicare Beneficiary (QMB) - the individual has Medicare Part A and has countable income within the QMB income limit – the ACs are:

- 022 for an aged individual also QMB;
- 042 for a blind individual also QMB;
- 062 for a disabled individual also QMB.

b. Not QMB

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

- 020 for an aged individual NOT also QMB;
- 040 for a blind individual NOT also QMB;
- 060 for a disabled individual NOT also QMB;

2. “Deemed” Disabled Individual

An individual who is “deemed” disabled based on the hospice election is enrolled using AC 054. Individuals in this AC who have also been approved to receive services under the EDCD Waiver do not need a disability determination.

E. Post-eligibility Requirements (Patient Pay)

A patient pay must be calculated for individuals who receive hospice services in a nursing facility (see subchapter M1470). Individuals who receive hospice services outside of a nursing facility do not have a patient pay.

Individuals who have elected hospice services and who also receive Medicaid Long-term Care services available under the EDCD Waiver must have a patient pay calculation for the EDCD services (see subchapter M1470).

F. Ineligible In This Covered Group

There is no corresponding medically needy hospice covered group. If the individual is aged or has been determined blind or disabled, the individual must be evaluated in a medically needy covered group for medically needy spenddown.

M0320.600 MEDICARE SAVINGS PROGRAM (MSP)**A. Introductions**

The Medicare Saving Program is limited Medicaid coverage for individuals who are eligible for Medicare Part A and have income and resources within specific limits.

B. Covered Groups

- M0320.601 QMB
- M0320.602 SLMB
- M0320.603 QI

M0320.601 QUALIFIED MEDICARE BENEFICIARY (QMB)**A. Policy**

42 CFR 435.121 - Qualified Medicare Beneficiaries are a mandatory CN covered group. Medicaid will pay the Medicare Part A premium (as well as the Part B premium) and deductibles and coinsurance for individuals eligible as QMB only.

A QMB is an individual who:

- 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 that are within the resource limits for the Medicare Savings Programs (MSPs). See section M1110.003 for the current resource limits; and
- has income that does not exceed 100% of the federal poverty level (FPL).

B. Nonfinancial Eligibility**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. However, Medicare entitlement is limited to individuals who are age 65 or older, or who have received Title II social security benefits because of a disability for 24 months, or who have end stage renal (kidney) disease.

Enrollment in Part A of Medicare is verified by the individual's Medicare card, or by communication (such as SVES) with the Social Security Administration (SSA).

2. Individual Not Currently Enrolled In Medicare Part A

Individuals who are not currently enrolled in Medicare Part A must apply for and enroll in Medicare Part A at the local Social Security Administration (SSA) office, and must present verification of Medicare Part A enrollment to the local department of social services (DSS) in order to be eligible for

Medicaid as QMB.

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 M0320.604 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 *MSP* QMB determination; the other is for the ABD spouse's CN or MN covered group.

2. Resources

The resource requirements in chapter S11 and Appendix 2 to chapter S11 must be met by the *MSP* 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 the resource limit for the *MSPs*. See section M1110.003 for the current resource limits.

3. Income

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

4. Income Exceeds QMB Limit

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

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

D. QMB Entitlement

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

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

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

E. Enrollment**1. Aid Categories**

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

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

2. 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". Reinststate 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 *covered group* and covered group which has full Medicaid coverage, except when he/she meets a spenddown, e.g., a QMB-only individual's resources change to below the MN limits:

- cancel the QMB-only coverage effective the last day of the month immediately **prior** to the month in which he/she became eligible in the full coverage covered group, using cancel reason "024";
- reinststate 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 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". Reinststate 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, reinststate 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 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". Reinstate the coverage with the begin date as the first day of the month of admission to long-term care.

M0320.602 SPECIAL LOW INCOME MEDICARE BENEFICIARY (SLMB)

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 (M0320.601 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 that are within the resource limits for the Medicare Savings Programs (MSPs). See section M1110.003 for the current resource limits; and
- has income that exceeds the QMB limit (100% of the FPL) but is less than 120% of the FPL.

**B. Nonfinancial
Eligibility**

**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.

Enrollment in Part A of Medicare is verified by the individual's Medicare card, or by communication (such as SVES) with the Social Security Administration (SSA).

- 2. Individual Not Currently Enrolled In Medicare Part A** Individuals who are not currently enrolled in Medicare Part A must apply for and enroll in Medicare Part A at the local Social Security Administration (SSA) office, and must present verification of Medicare Part A enrollment to the local department of social services (DSS) in order to be eligible for Medicaid as SLMB.

If an individual appears to be eligible for Medicare but is not enrolled in Medicare, refer him/her 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 an SLMB.

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 SLMB; he/she may be eligible as a Qualified Disabled and Working Individual (QDWI). See M0320.604 below for information on the QDWI covered group.

- 3. Verification Not Provided** If the applicant does not provide information documenting enrollment in Medicare Part A within the application processing time standard, he/she is not eligible for Medicaid as SLMB, but may be eligible in another covered group.

C. Financial Eligibility

- 1. Assistance Unit** The assistance unit policy in chapter M05 applies to SLMBs.

If the SLMB individual is living with his/her 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 *MSP* SLMB determination; the other is for the ABD spouse's CN or MN covered group.

- 2. Resources** The resource requirements in chapter S11 and Appendix 2 to Chapter S11 must be met by the SLMB. Some of the real and personal property requirements are different for SLMBs. The different requirements are identified in Appendix 2.

The resource limits are the resource limits for the Medicare Savings Programs (MSPs). See section M1110.003 for the current resource limits.

3. Income

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

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

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

**4. Income
Equals or
Exceeds
SLMB Limit**

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

**D. SLMB
Entitlement**

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

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

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

E. Enrollment**1. Aid Category**

The AC for all SLMBs is "053".

**2. Recipient's
AC Changes
To SLMB**

An enrolled recipient's AC cannot be changed to AC "053" using a "change" transaction in the MMIS. If a Medicaid recipient becomes ineligible for full-coverage Medicaid or QMB-only coverage because of an increase in income, but is eligible as an SLMB, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare Part B premiums as an SLMB.

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

- 3. SLMB's AC Changes To Full Coverage AC** When an enrolled SLMB becomes eligible in another covered group which has full Medicaid coverage, except when he/she meets a spenddown, e.g., an SLMB's resources change to below the MN limits:
- cancel the SLMB coverage effective the last day of the month immediately prior to the month in which he/she became eligible in the full coverage covered group, using cancel reason "024";
 - reinstate the 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 MN spenddowns.
- All spenddown periods are based on the application or renewal date, as appropriate. See M1370.
- SLMBs who are not determined disabled must be determined disabled or blind, or must be pregnant, under age 18 or under age 21 if in foster care or adoption assistance in order to meet a medically needy covered group for spenddown.
- 5. SLMB Meets Spenddown** When an SLMB meets a spenddown, cancel his AC "053" coverage effective the date before the spenddown was met, using cancel reason "024". 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 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.

M0320.603 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. Implemented on January 1, 1998, individuals in the QI covered group receive Medicaid coverage for the payment of their Medicare Part B premium. QI funds are maintained in the MMIS for the current and previous year only.

Eligible QIs are 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.

**2. Qualified
Individual (QI)**

A Qualified Individual (QI)

- is entitled to Medicare Part A hospital insurance benefits, but not entitled to Medicare Part A solely because he/she is a QDWI (enrolled in Part A under section 1818A of the Act);
- has resources that are within the resource limits for the *Medicare Savings Programs (MSPs)*. See chapter section M1110.003 for the current resource limits; and
- has income that is equal to or exceeds the SLMB limit (120% of the FPL) but is less than the QI limit (135% of the FPL).

B. Nonfinancial Eligibility

1. Entitled to Medicare Part A

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

Enrollment in Part A of Medicare is verified by the individual's Medicare card, or by communication (such as SVES) with the Social Security Administration (SSA).

2. Individual Not Currently Enrolled In Medicare Part A

Individuals who are not currently enrolled in Medicare Part A must apply for and enroll in Medicare Part A at the local Social Security Administration (SSA) office, and must present verification of Medicare Part A enrollment to the local department of social services (DSS) in order to be eligible for Medicaid as QI.

If an individual appears to be eligible for Medicare but is not enrolled in Medicare, refer him/her 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 QI.

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 QI; he/she may be eligible as a Qualified Disabled and Working Individual (QDWI). See M0320.604 below for information on the QDWI covered group.

3. Verification Not Provided

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

C. Financial Eligibility

1. Assistance Unit

The ABD assistance unit policy in chapter M05 applies to Qualified Individuals.

If the QI is living with his/her 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 QI determination; the other is for the ABD spouse's CN or MN covered group.

- 2. Resources** The resource requirements for QMBs in chapter S11 and Appendix 2 to Chapter S11 must be met by the QI.
- The resource limits for QI are the resource limits for the Medicare Savings Programs (MSPs). See section M1110.003 for the current resource limits.
- 3. Income** The income requirements in chapter S08 must be met by the QI. The income limits for QIs are in M0810.002. A QI's countable income must exceed the SLMB limit and must be less than the QI limit.
- By law, for QIs who have Title II benefits, the new income limits are effective the first day of the **second** month following the month in which the federal poverty limit is updated. For QIs who do NOT have Title II benefits, the new income limits are effective the date the updated federal poverty limit is published. Local DSS are notified each year of the new poverty limits via the broadcast system. Check that system to ascertain when the Title II COLA must be counted in determining QI income eligibility.
- 4. Income Within QI Limit** When the individual's countable income is equal to or more than 120% of the FPL and is less than 135% of FPL (the QI limit), the individual is eligible for Medicaid as a QI. Go to subsection D below.
- 5. Income Equals or Exceeds QI Limit** Spenddown does not apply to the *MSP* income limits. If the individual's income is equal to or exceeds the QI limit (135% of FPL), **he/she is not eligible as QI** and cannot spenddown to the QI limit.
- D. QI Entitlement** Coverage under this group cannot begin earlier than January 1 of the calendar year.
- QIs are eligible for retroactive coverage as a QI. Retroactive eligibility cannot begin earlier than January 1 of the current calendar year. If all eligibility factors are met in the application month, eligibility for Medicaid as a QI begins the first day of the application month, **and ends December 31 of the calendar year**, if funds are still available for this covered group.
- The Notice of Action on Medicaid must state the recipient's **begin and end dates** of Medicaid coverage.
- E. Enrollment**
- 1. Aid Category** QI = 056

2. **Begin and End Dates** The begin date of coverage cannot be any earlier than January 1 of the calendar year. An edit is in place in the MMIS to prevent enrollment prior to January 1 of the current year. **Do not enter an end date of coverage.**

3. **MMIS** The MMIS will:

- automatically cancel the QI recipient's coverage effective December 31 of each calendar year, and
- send a notice to the recipient to reapply for Medicaid coverage for the next calendar year.

F. QI Applications & Renewals

1. **New Applicants** Applications for individuals who are not currently enrolled in Medicaid can be taken at any time. If the application is processed in November or December, the coverage may be renewed for the following year without obtaining a separate renewal form. See M1520.200 C.11 for instructions on completing renewals for QIs.

2. **QI Enrollees** Coverage of individuals enrolled in the Qualified Individuals (QI) covered group (AC 056) is automatically cancelled effective December 31 of the current year. However, coverage for QIs can be renewed annually provided that there is no break in Medicaid eligibility. See M1520.200 C.11 for instructions on completing renewals for QIs.

G. Enrollee's Covered Group Changes To QI

1. **Before November Cut-off** An enrolled recipient's AC cannot be changed to "056" using a "change" transaction in the MMIS. If, **before November cut-off**, a Medicaid recipient becomes ineligible for full-coverage Medicaid or QMB-only coverage because of an increase in income or resources, but is eligible as a QI, 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 a QI.

Cancel the recipient's full coverage effective the last day of the month, using cancel reason "007". Reinstate the recipient's coverage with the begin date as the first day of the month following the cancellation effective date. Specify the appropriate QI AC.

2. **After November Cut-off** If, **after November cut-off**, a Medicaid recipient becomes ineligible for full-coverage Medicaid or QMB-only coverage because of an increase in income or resources, but is eligible as a QI, the agency must send an advance notice of proposed action to the recipient to cancel the recipient's Medicaid coverage effective December 31. The notice must specify that he must reapply for Medicaid if he/she wants Medicaid to pay his/her Medicare Part B premium. Cancel the recipient's full coverage effective December 31, using cancel reason "007".

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

M0320.604 QDWI (QUALIFIED DISABLED & WORKING INDIVIDUALS)

- A. Policy** 42 CFR 435.121 - Coverage of Qualified Disabled & Working Individuals is mandated by the federal Medicaid law. Medicaid will only pay the Medicare Part A premium for individuals eligible as QDWI.

B. Nonfinancial Eligibility

1. Definition Requirements

The individual must:

- be less than 65 years of age.
- be employed.
- have been entitled to Social Security disability benefits and Medicare Part A but lost entitlement solely because earnings exceeded the substantial gainful activity (SGA) amount.
- continue to have the disabling physical or mental impairment or be blind as defined by SSI and Medicaid but because he/she is working and earning income over the SGA limit does not meet the disability definition.
- be eligible to enroll or be enrolled in Medicare Part A (hospital insurance) under Section 1818A of the Social Security Act.
- not be eligible for Medicaid in any other covered group.

The above definition requirements must be verified by the Social Security Administration (SSA). The individual must be enrolled in Medicare Part A under Section 1818-A of the Social Security Act. Enrollment in Part A of Medicare is verified by the individual's Medicare card, or by communication (such as SVES) with SSA.

NOTE: Blind individuals who lose SSA and Medicare because of earnings over SGA still meet the blind category for Medicaid purposes. Therefore, a blind individual whose countable income is within the medically needy, or QMB limits cannot be eligible as a qualified disabled and working individual.

2. Verification Not Provided

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

C. Financial Eligibility

The assistance unit policy in chapter M05 applies to QDWIs.

1. Assistance Unit

If the QDWI individual is living with his/her 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 QDWI determination; the other is for the ABD spouse's covered group.

2. Resources

The resource requirements in chapter S11 and Appendix 1 to Chapter S11 must be met by the QDWI Medicare beneficiary. Some of the real and personal property requirements are different for QDWIs. The different requirements are identified in Chapter S11, Appendix 1.

The resource limit for an individual is \$4,000 (twice the SSI resource limit for an individual); the resource limit for a couple is \$6,000 (twice the SSI resource limit for a couple).

3. Income

QDWIs must meet the income requirements in chapter S08. The income limits are in M0810.002. QDWIs do not receive Title II benefits.

4. Income Exceeds QDWI Limit

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

D. Entitlement

Entitlement to Medicaid as a QDWI begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month, including enrollment in Medicare Part A under Section 1818A of the Social Security Act. Retroactive entitlement, up to three months prior to application, is applicable if all QDWI eligibility criteria were met during the period.

If the individual is not enrolled in Medicare Part A under Section 1818A as of the month he/she meets the Medicaid eligibility requirements, the individual's entitlement to Medicaid cannot begin until the first day of the month in which his Medicare Part A enrollment under Section 1818A is effective.

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

E. Enrollment

1. Aid Category

The AC for all QDWIs is "055."

- 2. Recipient's AC Changes To QDWI**
- An enrolled recipient's AC cannot be changed to AC "055" using a "change" transaction in the MMIS. If a Medicaid recipient becomes ineligible for full-coverage Medicaid, but is eligible as a QDWI, 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 A premiums as a QDWI.
- Cancel the recipient's full coverage effective the last day of the month, using cancel reason "007." Reinstatement the recipient's coverage as QDWI with the begin date as the first day of the month following the cancellation effective date. AC is "055."
- 3. QDWI's AC Changes To Full Coverage AC**
- When an enrolled QDWI becomes eligible in another covered group which has full Medicaid coverage (except when he/she meets a spenddown); e.g., he/she is no longer able to work and starts to receive SSA and SSI disability benefits:
- cancel the QDWI coverage effective the last day of the month immediately prior to the month in which he/she became eligible in the full coverage covered group, using cancel reason "024;"
 - reinstate the 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**
- Eligible QDWIs who meet an MN covered group and who have resources that are within the lower MN resource limits are also placed on two 6-month medically needy spenddowns.
- 5. QDWI Meets Spenddown**
- When a QDWI meets a spenddown, cancel his AC "055" coverage effective the date before spenddown was met using cancel reason "024." Reinstatement coverage as medically needy beginning the day the spenddown was met and ending the last day of the spenddown budget period.
- The AC is NOT dual-eligible:
- 018 for an aged MN individual NOT eligible as QMB;
 - 038 for a blind MN individual NOT eligible as QMB;
 - 058 for a disabled MN individual NOT eligible as QMB.
- 6. Spenddown Period Ends**
- After the spenddown period ends, reinstate the QDWI-only coverage using the AC "055."
- The begin date of the reinstated AC "055" coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial QDWI eligibility.

- 7. QDWI Enters Long-term Care** The enrollment of a QDWI who is admitted to long-term care and who becomes eligible for Medicaid in another covered group is handled like a QDWI who meets a spenddown. Cancel the QDWI-only coverage effective the last day of the month before the 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.

M0320.700 MEDICALLY NEEDED (MN) GROUPS

A. Introduction

- 1. Medically Needed Individuals** All medically needed covered groups are optional; the federal Medicaid law does not require the state to cover the MN groups in its Medicaid State Plan. Virginia has chosen to cover *individuals who*
- *meet all the nonfinancial requirements in chapter M02,*
 - *meet the “Aged,” “Blind” or “Disabled” definitions in subchapter M0310,*
 - *have countable resources within the MN resource limits,*
 - *are not financially eligible in a full-benefit CN covered group; and*
 - *have insufficient income to meet their medical care needs.*
- 2. Spenddown Feature** The major feature of the MN covered groups is a spenddown. An individual who meets the nonfinancial and MN resource eligibility requirements but whose income exceeds the MN income limit may “spenddown” the excess income by deducting incurred medical expenses and become eligible for a limited period of MN Medicaid coverage. An individual who has excess income becomes eligible when he/she has incurred medical expenses equal to the difference between his/her income and the MN income limit.
- 3. Different Benefit Package** Some medical services that are covered for the CN covered groups are not available to the MN groups. ICF-MR services and IMD services are not covered for MN eligibles. However, the basic services such as inpatient and outpatient hospital, physicians, X-rays, prescription drugs, home health services and Medicare premiums, coinsurance and deductibles are covered for the MN. LTC nursing facility and most *CBC* waiver services are also covered for the MN.

B. ABD MN Covered Groups *The ABD MN covered groups are:*

- *M0320.701 ABD*
- *M0320.702 December 1973 Eligibles*

M0320.701 ABD MN INDIVIDUALS

A. Legal Base The federal authority for covering ABD MN individuals is found in 42CFR435.330.

B. Financial Eligibility

1. Assistance Unit The assistance unit policy and procedures in chapter M05 apply to ABD MN. If married and not institutionalized, deem or count any resources and income from the individual's spouse with whom he/she lives. If married and institutionalized, go to subchapter M1480 for resource and income determination policy and procedures.

2. Resources All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. The resources policy in chapter S11 applies.

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

If the individual is not eligible because of excess real property contiguous to the home, and he/she meets a medically needy Families & Children (F&C) definition, determine if the individual meets an F&C covered group since the F&C home property definition is more liberal for F&C. If the individual is not eligible because of other excess resources, he or she is not eligible as MN.

3. Income Determine gross income according to chapter S08. Subtract the \$20 general exclusion and other exclusions. Compare the total countable income to the MN income limit for the individual's locality group (see section S0810.002) and calculate the MN spenddown amount. See chapter M13 for spenddown policy and procedures.

4. Income Eligibility An individual becomes eligible in this MN covered group when he/she has incurred medical expenses equal to the difference between his/her income and the MN income limit (spenddown).

C. Entitlement

Individuals who become eligible after meeting a spenddown are entitled to full Medicaid coverage beginning the day the spenddown was met and ending the last day of the sixth month in the spenddown budget period. Retroactive coverage is applicable to this covered group.

Note: Individuals receiving LTC services are placed on monthly spenddowns (see M1460.700).

D. Enrollment

Eligible individuals in this group are classified as medically needy (MN). If the individual has Medicare Part A, compare the individual's countable income to the QMB limit.

The following ACs are used when the individual is ABD MN and QMB

- 028 for an aged individual also QMB
- 048 for a blind individual also QMB
- 068 for a disabled individual also QMB

The following ACs are used when the individual is ABD MN and not QMB

- 018 for an aged individual NOT QMB
- 038 for a blind individual NOT QMB
- 058 for a disabled individual NOT QMB

M0320.702 DECEMBER 1973 ELIGIBLES**A. Policy**

42 CFR 435.340 - If the State Plan covers the medically needy, the Plan must provide protected medically needy coverage for blind and disabled individuals eligible in December 1973.

B. *Blind or Disabled in December 1973*

This is an MN covered group of blind and disabled individuals who:

- were eligible as medically needy under the state plan in December 1973 on the basis of the blindness or disability criteria of the AB or APTD plan;
- for each consecutive month after December 1973 continue to meet the December 1973 blindness or disability criteria and the December 1973 financial eligibility requirements; and
- meet the **current** medically needy eligibility requirements except the blindness or disability criteria.

Continuing eligibility is determined on the basis of eligibility requirements in effect as of December, 1973 and current medically needy requirements.

Contact your Regional Medical Assistance Program Consultant if you have an applicant you believe meets this covered group.

CHAPTER M03
MEDICAID COVERED GROUPS

SUBCHAPTER 30

FAMILIES & CHILDREN GROUPS

Virginia DSS, Volume XIII

M0330 Changes

Changed With	Effective Date	Pages Changed
TN #97	9/1/12	Table of Contents pages 1-40 (all pages)
Update (UP) #2	8/24/09	pages 3, 6, 8, 16, 22
Update (UP) #1	7/1/09	pages 20, 21

TABLE OF CONTENTS

M03 MEDICAID COVERED GROUPS

M0330.000 FAMILIES & CHILDREN GROUPS

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

M0330.000 FAMILIES & CHILDREN GROUPS**M0330.001 GENERAL POLICY PRINCIPLES****A. Overview**

A State Plan for Medicaid must include the mandatory federal categorically needy (CN) groups of individuals as well as the optional groups a state has elected to cover.

This subchapter divides the Families & Children (F&C) covered groups into categorically needy and medically needy (MN) groups.

B. Procedure

Determine an individual's eligibility first in a CN covered group. If the individual is not eligible as CN, go to the MN groups.

A determination of eligibility for a F&C child should follow this hierarchy:

- 1. If a child meets the definition of a foster care child, adoption assistance child, special medical needs adoption assistance child or an individual under age 21, evaluate in these groups first.*
- 2. If the child meets the definition of a newborn child, evaluate in the pregnant woman/newborn child group.*
- 3. If a child is under the age of 19, evaluate in the FAMIS Plus group.*
- 4. If a child has income in excess of FAMIS Plus limits, but meets the definition of an institutionalized individual (including hospice), evaluate in the F&C 300% groups.*
- 5. If a child has income in excess of FAMIS Plus limits and does NOT meet the definition of an institutionalized individual, evaluate for FAMIS eligibility (M21).*
- 6. If the child is a child under age 1, child under age 18, an individual under age 21 or a special medical needs adoption assistance child, but has income in excess of the appropriate F&C income limit, evaluate as MN.*

A determination of eligibility for a F&C adult should follow this hierarchy:

- 1. If the individual meets the definition of a parent/caretaker relative, evaluate first in the LIFC covered group.*
- 2. If the individual is not LIFC, but meets the definition of a pregnant woman, evaluate in the pregnant woman/newborn child group.*
- 3. If an individual has income in excess of LIFC limits, but meets the definition of an institutionalized individual (including hospice), evaluate in the F&C 300% SSI groups.*
- 4. If a pregnant woman has income in excess of 133% FPL, evaluate as FAMIS Moms (M22).*
- 5. If the individual has been screened and diagnosed with breast or cervical cancer or pre-cancerous conditions by the Every Woman's Life program and does not meet the definition of for coverage as SSI, LIFC, Pregnant Woman or Child Under 19 individual, evaluate in the BCCPTA covered group.*
- 6. If the individual has excess income for full coverage in a Medicaid covered group and is between the ages of 19 and 64, evaluate for Plan First coverage.*
- 7. If the individual is a pregnant woman but has excess income for coverage in a CN group or FAMIS MOMS, evaluate as MN.*

M0330.100 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, or BCCPTA definition, or must have applied for Plan First.

The F&C covered groups are divided into the categorically needy (CN) and medically needy (MN) classifications. Always evaluate eligibility in the categorically needy groups before moving to MN.

B. Procedure

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

M0330.100 Families & Children Categorically Needy Groups
M0330.105 IV-E Foster Care & IV-E Adoption Assistance;
M0330.107 Individuals Under Age 21;
M0330.108 Special Medical Needs Adoption Assistance;
M0330.200 Low Income Families With Children (LIFC);
M0330.300 Child Under Age 19 (FAMIS Plus);
M0330.400 Pregnant Women & Newborn Children;
M0330.500 300% of SSI Income Limit Groups
M0330.501 F&C In Medical Institution, Income \leq 300% SSI;
M0330.502 F&C Receiving Waiver Services (CBC);
M0330.503 F&C Hospice;
M0330.600 Plan First--Family Planning Services (FPS);
M0330.700 Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA).

M0330.105 IV-E FOSTER CARE OR IV-E ADOPTION ASSISTANCE RECIPIENTS**A. Policy**

42 CFR 435.145---The federal Medicaid law requires the State Plan to cover children who are eligible for foster care or adoption assistance payments under Title IV-E of the Social Security Act.

B. Children Who Receive SSI

Foster care or adoption assistance children who receive SSI meet the eligibility requirements for IV-E foster care or adoption assistance. They cannot receive both SSI and IV-E payments, so most of them elect to receive the higher SSI payment. These children are enrolled in Medicaid in the appropriate Foster Care or Adoption Assistance AC.

C. Nonfinancial Eligibility Requirements

The child must be under age 21 years and must meet the IV-E foster care or IV-E adoption assistance definition in M0310.115 or M0310.102. The child meets the age requirement until the end of the month in which the child turns age 21.

The child must meet all the nonfinancial eligibility requirements in chapter M02. The IV-E eligibility determination meets the Medicaid requirements for Virginia residency and cooperation in pursuing support.

NOTE: IV-E eligible foster care or adoption assistance recipients meet the Medicaid institutional status requirements when they live in a public residential facility if the facility has less than 25 beds.

D. IV-E Foster Care

42 CFR 435.145---The federal Medicaid law requires the State Plan to cover children who are eligible for foster care maintenance payments under Title IV-E of the Social Security Act.

The child must meet the IV-E foster care definition in M0310.115 and must be receiving IV-E foster care maintenance payments. A child of a IV-E foster care child is also considered to be a IV-E foster care child when the mother's IV-E payment includes an allocation for her child.

The IV-E eligibility determination meets the Medicaid requirements for Virginia residency and cooperation in pursuing support.

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

E. IV-E Adoption Assistance

42 CFR 435.145--The federal Medicaid law requires the State Plan to cover children who are eligible for adoption assistance under Title IV-E of the Social Security Act and for whom a IV-E adoption assistance agreement between the LDSS and the adoptive parent(s) is in effect.

The child must meet the IV-E adoption assistance definition in M0310.102. The child does not have to receive a IV-E Adoption Assistance payment in order to meet the IV-E Adoption Assistance definition.

The IV-E Adoption Assistance eligibility determination meets the Medicaid requirements for Virginia residency and cooperation in pursuing support.

F. Financial Eligibility

A separate Medicaid financial eligibility determination is not made for IV-E eligible foster care or IV-E adoption assistance children, regardless of the state that makes the IV-E payment. Verify the child's IV-E foster care payment eligibility, or the child's IV-E adoption assistance eligibility via agency records.

G. Entitlement

- 1. IV-E Foster Care Child**

Entitlement to Medicaid as a IV-E Foster Care child begins the first day of the month of commitment or entrustment if a Medicaid application is filed within 4 months of commitment or entrustment. Retroactive entitlement prior to the month of commitment or entrustment is not allowed. If the Medicaid application is filed more than 4 months after entrustment or commitment, entitlement may be retroactive up to 3 months prior to application if the child met all Medicaid eligibility requirements in the retroactive months. However, Medicaid entitlement cannot go back to the month of entrustment or commitment when the application is filed more than 4 months after entrustment or commitment.
- 2. IV-E Adoption Assistance Child**

Entitlement to Medicaid as a IV-E Adoption Assistance child begins the first day of the application month if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

H. Enrollment

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

M0330.107 INDIVIDUALS UNDER AGE 21

A. Policy

42 CFR 435.222 – The federal Medicaid law allows the State Plan to cover reasonable classifications of individuals under age 21 years who do not receive cash assistance but who meet the income requirements of the state’s July 16, 1996 AFDC State Plan. However, children under age 19 must first have eligibility determined in the FAMIS Plus covered group of children because the income limits are higher for that group. Individuals ages 19 and 20 should be evaluated in the Individuals Under Age 21 covered group when they are not eligible for Medicaid in any other full-benefit covered group.

The reasonable classifications of individuals under age 21 are:

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

The individual must be under age 21 and meet the nonfinancial requirements in chapter M02.
-
- C. Reasonable Classifications**

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

1. Non IV-E Foster Care

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

a. Children Living In Public Institutions

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

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

b. Child in Independent Living Arrangement

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

2. Non-IV-E Adoption Assistance

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

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

3. In ICF or ICF-MR

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

D. Assistance Unit

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

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

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

- 2. Adoptive Placement** While in adoptive placement, the child may continue to be treated as a foster care child. However, once the interlocutory or the final order of adoption is entered, the child must be treated as a Non-IV-E adoption assistance child; see 3. below.
- 3. Non-IV-E Adoption Assistance-Interlocutory or Final Order Entered** Financial eligibility is determined using the assistance unit procedures in subchapter M0520, which require the inclusion of the child's adoptive parent(s) and sibling(s). An adoption assistance child must have his/her eligibility determined by counting or deeming (as appropriate) his/her parent's and sibling's income.
- 4. Child in ICF or ICF-MR** A child in an ICF or an ICF-MR is an institutionalized individual in a medical facility when he meets the definition of "institutionalized individual" in section M1410.010 B.2. When he meets the institutionalized individual definition, he is an assistance unit of one person.
- E. Resources** There is no resource test for the Individuals Under Age 21 covered group.
- F. Income**
- 1. Income Limits** For the Individuals Under Age 21 covered group, the income limit is the F&C 100% income limit found in chapter M0710, Appendix 3.
- The foster care or adoption subsidy payment is excluded when determining the unit's income eligibility.
- Foster care and Adoption Assistance children in residential facilities do not have a different income limit. For a foster care/adoption assistance child living outside the State of Virginia, the income limit for the assistance unit is the income limit for the Virginia locality which holds custody, pays the adoption subsidy, or signed the adoption assistance agreement.
- 2. Income Exceeds F&C 100% Income Limit** For foster care (including DJJ) and adoption assistance children whose income exceeds the F&C 100% income limit, determine the child's Medicaid eligibility as a medically needy Individual Under Age 21 (see M0330.204).
- For children who are institutionalized in an ICF or ICF-MR and whose income exceeds the F&C 100% income limit, determine the child's Medicaid eligibility in the 300% SSI covered group (see M0330.501).
- G. Entitlement & Enrollment**
- 1. Entitlement** Entitlement to Medicaid begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

2. Enrollment

The aid category (AC) for individuals in the covered group of Individuals Under Age 21 is:

- 076 for a non-IV-E Foster Care child;
- 075 for a Department of Juvenile Justice child;
- 072 for a Non-IV-E Adoption Assistance child;
- 082 for a child under age 21 in an ICF or ICF-MR.

M0330.108 SPECIAL MEDICAL NEEDS ADOPTION ASSISTANCE CHILDREN

A. Policy

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

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

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

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

B. Nonfinancial Eligibility Requirements

The child must

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

C. Financial Eligibility Requirements

1. Assistance Unit

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

2. Resources

There is no resource test for the Special Medical Needs Adoption Assistance Children covered group.

3. Income

Adoption assistance children in residential facilities do not have a different income limit. The F&C 100% standard of need income limit for one person in the child's locality is used to determine eligibility in the Special Medical Needs covered group.

For a Virginia Special Medical Needs adoption assistance child living outside the State of Virginia, the income limit for the unit is the income limit for the Virginia locality that signed the adoption assistance agreement.

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

If the child's countable income exceeds the F&C 100% standard of need income limit, evaluate the child in the medically needy covered group of "special medical needs adoption assistance" in subchapter *M0330.805*.

D. Entitlement & Enrollment

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

The AC for individuals in the covered group of Special Medical Needs Adoption Assistance children is "072."

M0330.200 LOW INCOME FAMILIES WITH CHILDREN (LIFC)**A. Policy**

Section 1931 of the Act - The federal Medicaid law requires the State Plan to cover dependent children under age 18 and parents or caretaker-relatives of dependent children who meet the financial eligibility requirements of the July 16, 1996 AFDC state plan. In addition, Medicaid covers dependent children and parents or caretaker-relatives of dependent children who participate in the Virginia Initiative for Employment not Welfare (VIEW) component of the Virginia Independence Program (VIP) and meet the requirements of the 1115 waiver. This covered group is called "Low Income Families With Children" (LIFC).

B. Nonfinancial Eligibility

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

The child(ren) must meet the definition of a dependent child in M0310.111. The adult with whom the child lives must be the child's parent or must meet the definition of a caretaker-relative of a dependent child in M0310.107. A child or adult who lives in the household but who is not the dependent child's parent or caretaker-relative may be eligible as LIFC if he/she meets the definition of an EWB in *M0310.113*.

C. Financial Eligibility**1. Assistance Unit**

The assistance unit policy in subchapter M0520 applies to the LIFC covered group. The assistance unit's financial eligibility is determined first. If the family unit has income that cannot be verified or that exceeds the amount for the individual's covered group, the family unit is divided into budget units, if appropriate.

If the LIFC individual is living with his/her spouse or child who is aged, blind, or disabled, two different financial calculations must be completed for the unit if the family unit does not meet the LIFC income limits, because of the different resource and income limits used in the F&C and ABD determinations.

2. EWB

An EWB meets the LIFC covered group only when the dependent child's family has income within the LIFC income limits and the family is eligible for Medicaid as LIFC.

When the LIFC household includes an individual who meets the EWB definition, the EWB's income eligibility is determined in a separate assistance unit. See M0520.103.

3. Resources

There is no resource test for the LIFC covered group.

4. Income

a. Non-VIEW Participants

The income requirements in chapter M07 must be met by the LIFC group. The income limits are in M0710.002.

b. VIEW Participants

The income requirements in chapter M07 must be met by VIEW participants. The method for determining income eligibility is different for VIEW participants and is found in M0710.730 D. The income limits are in M0710.002.

5. Income Exceeds Limit

Spenddown does not apply to the LIFC income limits. If the family/budget unit's (FU/BU's) income exceeds the LIFC income limit, the unit is not eligible as LIFC and cannot spenddown to the LIFC limit. If resources are within the medically needy limit, the unit may be placed on spenddown if at least one member meets an MN covered group, such as MN children under age 18. *Once the spenddown is met, only the person who meets a MN definition will be enrolled in Medicaid.*

D. Entitlement

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

E. Enrollment

The ACs for individuals in the LIFC covered group are:

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

M0330.103 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 Child Under Age 19 covered group is also referred to as FAMIS Plus.

B. Nonfinancial Eligibility

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.

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

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 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. 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.
- 3. Income Changes** Any changes in a 133% FPL child's income that occur after his eligibility has been established affect eligibility. Recalculate income and compare to the income limits.
- 4. Income Exceeds Limit** A child under age 19 whose income exceeds the 133% FPL 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 133% FPL category. If the child's income exceeds the limit, he/she is not eligible as 133% FPL 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 133% FPL 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.

Eligible 133% FPL children are entitled to all Medicaid covered services as described in chapter M18.

E. Enrollment

The ACs for the *133% FPL* children are:

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

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

M0330.400 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 pregnant woman must meet all the nonfinancial eligibility requirements in chapter M02.

Non-citizen pregnant women who meet the lawfully residing policy in M0220.314 meet the citizenship requirements for full coverage in the pregnant woman group.

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.

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. If the child's mother was covered by Medicaid as a categorically needy individual in a state other than Virginia at the time of the child's birth, verification of the mother's Medicaid coverage must be provided by the parent or authorized representative.

b. No Other 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 pregnant woman determination; the other is based on the other members' covered group(s).

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

6. Income Exceeds Limit

A pregnant woman whose income exceeds the income limit may be eligible for Virginia's Title XXI program, FAMIS MOMS. The income limit for FAMIS MOMS is 200% FPL. See chapter M22 to determine FAMIS MOMS eligibility.

If the pregnant woman's income exceeds the *133% FPL* limit she is not eligible in this covered group. Determine eligibility for *FAMIS Moms* (see M22). If not eligible in FAMIS MOMS, determine eligibility as Medically Needy. See M0330.801.

D. Entitlement

Eligible pregnant women are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group if 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 pregnant women and newborns are entitled to all Medicaid covered services as described in chapter M18.

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

E. Enrollment

The aid category (AC) for *133% FPL* pregnant women is "091." The AC for newborns born to women who were enrolled in Medicaid as categorically needy or MI is "093."

M0330.500 300% of SSI INCOME LIMIT GROUPS

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

A. Policy

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

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

B. Nonfinancial Eligibility

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

The individual must be a child under age 19, under age 21 who meets the adoption assistance or foster care definition or under age 21 in an ICF or ICF-MR, or must be a parent or caretaker-relative of a dependent child, or a pregnant woman as defined in M0310.

C. Financial Eligibility

When determining income to compare to the 300% of SSI income limit, use the ABD income policy and procedures, regardless of the individual's definition or covered group. When determining resources, use F&C resource policy for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

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

1. Resources

a. Resource Eligibility - Married Individual

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

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

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

b. Resource Eligibility - Unmarried Individual

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

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

2. Income

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

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

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

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

D. Entitlement & Enrollment

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

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

1. Dual-eligible As QMB

If the individual is also a Qualified Medicare Beneficiary (QMB) – the individual has Medicare Part A and has countable income within the QMB income limit - the program designation is “62.”

2. Not QMB

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

E. Ineligible In This Covered Group

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

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

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

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

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

B. Nonfinancial Eligibility

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

1. meets the nonfinancial requirements in M02.
2. is not in a medical institution, may be *in a residential* institution that meets the institutional status requirements;
3. meets an F&C definition in M0310.

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

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

C. Financial Eligibility

When determining **income** to compare to the 300% of SSI income limit, use the ABD income policy and procedures, regardless of the individual's definition or covered group. When determining **resources**, use F&C resource policy for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

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

1. Resources

a. Resource Eligibility - Unmarried Individual

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

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

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

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

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

c. Resource Eligibility - Married Individual

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

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

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

2. Income

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

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

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

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

D. Entitlement & Enrollment

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

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

1. Dual-eligible As QMB

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

2. Not QMB

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

E. Ineligible In This Covered Group

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

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

M0330.503 F&C HOSPICE**A. Policy**

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

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

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

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

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

B. Nonfinancial Eligibility

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

1. Is not in a medical institution, may be in a residential institution that meets the institutional status requirements;
2. Meets either the child, pregnant woman, or parent or caretaker-relative of a dependent child definition in subchapter M0310.

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

C. Financial Eligibility

When determining **income** to compare to the 300% of SSI income limit, use the ABD income policy and procedures, regardless of the individual's definition or covered group. When determining **resources**, use F&C resource policy for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

1. Resources

a. Resource Eligibility - Unmarried Individual

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

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

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

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

c. Resource Eligibility - Married Individual

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

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

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

2. Income

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

The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Compare the total gross income to the 300% SSI income limit (see M0810.002 A. 3.). If countable income is equal to or less than this limit, the individual is eligible for Medicaid in the hospice covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in the hospice covered group. Evaluate his/her eligibility as medically needy.

D. Entitlement & Enrollment

The hospice services recipient must elect hospice services and the election must be in effect for 30 days. The 30 day period begins on the effective date of the hospice election. Upon 30 days elapsing from the effective date of the hospice election, and the election is in effect for the entire 30 days, eligibility in the hospice covered group begins with the effective date of the hospice election if all other eligibility factors are met.

1. Entitlement

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

Eligible individuals in this group are classified as categorically needy CN. If the individual has Medicare Part A, evaluate his/her eligibility as ABD hospice in *M0320.402*.

2. Enrollment

If the individual is eligible in any other full-coverage Medicaid covered group, he is enrolled under that aid category (AC) and not the Hospice AC (054). Enroll with AC 054 for an individual who meets an F&C definition, *has income within 300% of the SSI limit*, but who is not eligible in any other full-coverage Medicaid covered group.

E. Post-eligibility Requirements (Patient Pay)

Individuals who receive hospice services in a nursing facility have a patient pay calculation (see subchapter M1470). Individuals who receive hospice services outside of a nursing facility do not have a patient pay.

Individuals who have elected hospice services and who also receive Medicaid Long-term Care services available under the EDCD Waiver must have a patient pay calculation for the EDCD services (see subchapter M1470).

F. Ineligible In This Covered Group

There is no corresponding medically needy hospice covered group. Evaluate the individual in another covered group.

M0330.600 PLAN FIRST - FAMILY PLANNING SERVICES

A. Policy

Effective October 1, 2011, Plan First, Virginia's family planning services health program covers individuals whose income is less than or equal to 200% FPL for their family size and who are not eligible for another full or limited-benefit Medicaid covered group, FAMIS or FAMIS MOMS. This optional covered group is available to individuals regardless of their age, gender, disability status, insured status or if they previously had a sterilization procedure. Plan First covers only family planning services, including transportation to receive family planning services.

While there are no specific age requirements for Plan First, eligibility for Plan First is not determined for children under 19 years or for individuals age 65 years and older unless the child's parent or the individual requests an evaluation for Plan First.

1. Application Forms

Eligibility for Plan First can be determined using any valid application form. An individual does not need to request Plan First for his eligibility to be determined. The Plan First and Application for Benefits forms allow individuals to specifically request a Plan First eligibility determination on the forms. If an individual indicates on the application or to the agency that he does not want his eligibility for Plan First determined, do not do so.

2. Determine Eligibility in Other Medicaid Covered Groups, FAMIS or FAMIS MOMS First

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

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

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

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

B. Nonfinancial Requirements

Individuals in this covered group must meet the following Medicaid nonfinancial requirements in chapter M02.

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

C. Financial Eligibility**1. Assistance Unit**

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

2. Resources

There is no resource limit.

3. Income

The income requirements in chapter M07 must be met for this covered group. The income limits are 200% FPL and are found in subchapter M0710, Appendix 6.

4. Spenddown

Spenddown does not apply to Plan First. However, because an individual enrolled in the Plan First covered group does not receive full Medicaid coverage, if he meets a MN covered group listed in *M0320 or M0330*, he must be evaluated to determine if he could become eligible for full Medicaid coverage as medically needy (MN) by meeting a spenddown. At application and redetermination, Plan First enrollees who meet the MN covered group and resource requirements are placed on two six-month spenddown budget periods within the 12 month renewal period. They may also be eligible for a retroactive MN spenddown determination. See Chapter M13 for spenddown instructions.

D. Entitlement and Enrollment**1. Begin Date**

Eligibility in the Plan First covered group begins the first day of the month in which the application is filed, if all eligibility factors are met in the month.

2. Retroactive Coverage

Individuals in this covered group are entitled to retroactive coverage if they meet all the requirements in the retroactive period. If eligible for retroactive coverage, however, coverage can begin no earlier than October 1, 2011.

3. Enrollment

The AC for Plan First enrollees is "080."

M0330.700 BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT (BCCPTA)

A. Policy

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000 (P.L. 106-354) provides for payment of medical services, including long-term care (LTC) (see Chapter M14) for certain women with breast and cervical cancer. Virginia chose to cover this group beginning July 1, 2001.

Women eligible for the BCCPTA program must be age 18 through 64. They must have been screened and certified as needing treatment for breast or cervical cancer (including pre-cancerous conditions) by a medical provider operating under the Center for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program (BCCEDP) and referred to LDSS for a Medicaid eligibility determination. These women must not have creditable health insurance coverage for treatment of breast or cervical cancer. Virginia's BCCEDP program, Every Woman's Life, is administered by the Virginia Department of Health.

Through an agreement between Virginia and the District of Columbia (D.C.), residents of northern Virginia (the cities of Alexandria, Fairfax, Falls Church, Manassas, Manassas Park and the counties of Arlington, Fairfax, Loudoun and Prince William) are allowed to be screened and diagnosed for breast or cervical cancer and pre-cancerous conditions through the DC Center for Disease Control and Prevention's "Project Wish" program. Women who are screened and certified as needing treatment for breast or cervical cancer through Project Wish may be eligible for Virginia Medicaid, provided they meet the requirements of the BCCPTA covered group. These women will receive a Virginia BCCPTA application form from the DC providers and will be instructed to submit the application directly to the local department of social services in their home locality.

Women diagnosed with cancer by a provider who is not operating under the BCCEDP are not eligible in this covered group.

B. Nonfinancial Eligibility

1. Required Nonfinancial Requirements

BCCPTA women must meet the Medicaid nonfinancial requirements in chapt M02.

In addition, BCCPTA women must not be eligible for Medicaid under the following mandatory categorically needy covered groups:

- LIFC;
- 133% FPL Pregnant Women;
- FAMIS Plus (Child Under Age 19);
- SSI recipients.

2. Creditable Health Insurance Coverage

BCCPTA women must not have creditable health insurance coverage. Creditable health insurance coverage includes:

- a group health plan;
- health insurance coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;
- Medicare;
- Medicaid;
- armed forces insurance a medical care program of the Indian Health Service (IHS) or of a tribal organization;
- a state health risk pool.

There may be situations where a woman has creditable health insurance coverage as defined above, but the coverage does not include treatment of breast or cervical cancer due to a period of exclusion or exhaustion of lifetime benefits, or the woman may have a high deductible. The woman is not eligible for Medicaid in the BCCPTA covered group because she has creditable health insurance.

C. Financial Eligibility

There are no Medicaid financial requirements for the BCCPTA covered group. The BCCEDP has income and resource requirements that are used to screen women for this program.

Women requesting Medicaid coverage of LTC services must provide verification of their resources and income and must meet all the LTC eligibility requirements in chapter M14.

D. Application Procedure

The application procedures for women who meet the BCCPTA non-financial requirements have been streamlined to facilitate the prompt enrollment and immediate access to services for women who are in need of treatment for breast or cervical cancer. In addition to the nonfinancial information required to evaluate eligibility in the BCCPTA covered group, the following information is needed for enrollment in Medicaid:

- name,
- address,
- sex and race,
- date of birth,
- country of origin and entry date, if an alien.

Women who meet the description of individuals in the LIFC, 133% FPL Pregnant Women, FAMIS Plus, or SSI recipients covered groups must complete the appropriate Medicaid application for the covered group and must have a Medicaid eligibility determination completed prior to determining their eligibility in the BCCPTA covered group. If not eligible in the LIFC,

Pregnant Women, FAMIS Plus, or SSI recipients covered groups, then determine their eligibility in the BCCPTA covered group.

1. Application Form

This covered group has a special application, BCCPTA Medicaid Application (form #032-03-384), **that must be initiated by a BCCEDP provider**, including those affiliated with Project Wish operating in the District of Columbia. The application includes the BCCEDP certification of the woman's need for treatment and the information needed to determine the nonfinancial eligibility in the BCCPTA covered group. Appendix 7 to subchapter M0120 contains a sample of the BCCPTA Medicaid Application form.

If eligibility in another Medicaid covered group must first be determined, the applicant must be given the appropriate Medicaid application.

2. Application Processing Time Frames

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

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

3. Notices

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

If a decision cannot be made within 10 working days of receipt of the BCCPTA application, the worker must send a "Notice of Action on Medicaid", form #032-03-008, on the 10th day stating why action has not been taken, specifying what information is needed and a deadline for submitting the information.

E. Entitlement

1. Entitlement Begin Date

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

Eligible BCCPTA women are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month.

2. Retroactive Entitlement

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

- F. Enrollment** The aid category for BCCPTA women is "066".
- G. Benefit Package** The BCCPTA group is a full-benefit covered group. All Medicaid-covered services are available to BCCPTA enrollees, including long-term care in a facility or in a community-based care waiver.
- H. Renewal** Annual renewal requirements are applicable to the BCCPTA covered group. At the time of the annual renewal, the recipient must provide a statement from her medical provider verifying continued treatment for breast or cervical cancer. The BCCPTA Redetermination (form #032-03-653) is used for the renewal. See M1520.200 for renewal requirements.

***M0330.800* FAMILIES & CHILDREN MEDICALLY NEEDY GROUPS**

- A. Introduction** An F&C medically needy individual must
- be a child under age 18, *or 21*, or
 - meet the adoption assistance, foster care or pregnant woman definition in subchapter M0310.
- B. Procedure** The policy and procedures for determining whether an individual meets an F&C MN covered group are contained in the following sections:
- *M0330.801* Pregnant Women;
 - *M0330.802* Newborn Children Under Age 1;
 - *M0330.803* Children Under Age 18;
 - *M0330.804* Individuals Under Age 21;
 - *M0330.805* Special Medical Needs Adoption Assistance.

M0330.801 PREGNANT WOMEN

A. Nonfinancial Eligibility

42 CFR 435.301(b)(1)(i)--If the state chooses to cover the medically needy, the State Plan must provide medically needy coverage to all pregnant women during the course of their pregnancy who, except for income and resources, would be eligible for Medicaid as categorically needy.

A pregnant woman's Medicaid eligibility is first determined in the 133% FPL pregnant women covered group which has no resource limit and has an income limit that is higher than the medically needy income limit. If a pregnant woman is not eligible as *133% FPL* because her income is too high, *evaluate as FAMIS MOMS*. *If the individual is not eligible for FAMIS MOMS, then evaluate as MN*. She may spenddown to the lower MN income limit IF her resources are within the MN resource limit.

A pregnant woman is eligible in this MN covered group if she meets the pregnant woman definition in M0310.119 and meets the nonfinancial requirements in chapter M02.

B. Financial Eligibility

1. Assistance Unit

The assistance unit policy and procedures in chapter M05 apply to medically needy pregnant women. If the pregnant woman is not institutionalized, consider the resources and income of a pregnant woman's spouse with whom she lives and, if the pregnant woman is under age 21, the pregnant woman's parent(s) with whom she lives. If a pregnant woman also applies for other assistance unit members living with her who do not meet an F&C medically needy covered group, separate financial eligibility determinations are done for the unit. One is the F&C medically needy determination for the pregnant woman. The other financial eligibility determination is based on the other individual's(s) covered group(s).

2. Resources

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. The resources policy in chapter M06 applies.

If the individual is married and institutionalized, use the resource policy in subchapter M1480.

a. Resources Within The Limit

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

b. Resources Exceed The Limit

If current resources exceed the limit, she is not eligible in this covered group.

3. Income

Determine MN countable income according to chapter M07. Subtract the appropriate exclusions. Compare the total countable income to the MN income limit for the individual's locality group (see M0710, Appendix 5 for the MN income limits).

4. Income Exceeds MN Limit

Because the MN pregnant woman's income exceeds the *133% FPL* limit, it also exceeds the MN limit. She becomes eligible in this MN covered group when she has incurred medical expenses equal to the difference between her income and the MN income limit (spenddown). See chapter M13 for spenddown policy and procedures.

5. Income Changes

Any changes in a medically needy pregnant woman's income that occur after her eligibility has been established, **do not** affect her eligibility as long as she meets the pregnant woman definition, the nonfinancial and MN resource eligibility requirements.

The spenddown liability must be recalculated when an income change is reported prior to eligibility being established.

C. Entitlement

Eligible individuals in this MN group are entitled to full Medicaid coverage beginning the first day the spenddown is met, and ending the last day of the month in which the 60th day occurs or the spenddown period ends, whichever comes first. Retroactive coverage is applicable to this covered group.

EXAMPLE:

A pregnant woman living in Group III applied for Medicaid on March 3. Her estimated date of conception is January 24, and her due date is October 20. Her income exceeds the *income* limit for 2 persons *for Medicaid and FAMIS MOMS*. Her resources are within the medically needy resource limit and she is placed on a spenddown for the period March 1 through August 31. She meets the spenddown on May 11 and is enrolled in Medicaid as a medically needy pregnant woman through August 31.

She reapplies for Medicaid on September 5. Her income increased in August. Because her income increased after she established eligibility, but before the date her pregnancy ended, the increase in income does not affect her Medicaid eligibility. Her income that was verified in March is used to calculate her spenddown. She is placed on spenddown for the period September 1 through February 28, using the same spenddown amount from her previous spenddown and she establishes eligibility. Her child is born on October 10. Her Medicaid coverage as a pregnant woman is canceled effective December 31, the last day of the month in which the 60th day occurred after her pregnancy ended. She no longer meets the pregnant woman covered group requirements.

Note: The eligibility worker must evaluate the individual's eligibility in all other covered groups prior to taking action to cancel the coverage.

D. Enrollment

Eligible individuals in this group are classified as medically needy (MN), program designation "097."

M0330.802 NEWBORN CHILDREN UNDER AGE 1

A. Policy

42 CFR 435.301 (b)(1)(iii) - If the state chooses to cover the MN, the State Plan must provide MN coverage to all newborn children born on or after October 1, 1984 to a woman who is eligible as MN and is receiving Medicaid on the date of the child's birth. Coverage must be provided to those newborn children whose mothers were eligible as MN but whose coverage was restricted to Medicaid payment for labor and delivery as an emergency service. The child remains eligible for one year.

B. Nonfinancial Eligibility

A child who meets this covered group:

- is under age of 1 year;
- was born to a mother who is found eligible for Medicaid as medically needy or meets spenddown effective on or before the date of the child's birth.

If the child's mother was covered by Medicaid as a medically needy individual in a state other than Virginia at the time of the child's birth, verification of the mother's Medicaid coverage must be provided by the parent or authorized representative.

1. Continued Eligibility When Mother Becomes Ineligible

Any child born to an eligible pregnant woman will continue to be eligible in this covered group **up to age 1**.

EXAMPLE #4: A pregnant woman applied for Medicaid on October 24, 2008. Her estimated date of conception is March 24, 2008, and her due date is December 20, 2008. Her income exceeds the *CN limit* for 2 persons. Her resources are within the medically needy resource limit and she is placed on a spenddown for the period October 1, 2008 through March 31, 2009. She meets the spenddown on November 15, 2008, and is enrolled in Medicaid as MN effective November 15, 2008 through March 31, 2009.

Her child is born on November 30, 2008, and is enrolled in Medicaid as an MN newborn. The mother's Medicaid coverage is canceled effective January 31, 2009, the last day of the month in which the 60th day occurred after her pregnancy ended. The newborn's Medicaid coverage continues through November 30, 2009, the end of the month in which he turns one year old. The parent must be given the opportunity to file a Medicaid application prior to the cancellation of the newborn's coverage.

2. Covered Group Eligibility Ends

The child no longer meets this covered group effective:

- a. the end of the month in which the child reaches age 1 year; or
- b. the end of the month in which the child no longer resides in Virginia.

- B. Financial Eligibility** No other nonfinancial or financial eligibility requirements need to be met by the child.
- C. Entitlement & Enrollment** Eligible newborns in this MN group are entitled to full Medicaid coverage beginning the date of the child's birth. Retroactive coverage is applicable to this covered group, but coverage cannot begin prior to the date of the child's birth.
- Eligible children in this group are classified as medically needy (MN) and enrolled in aid category "099."

M0330.803 CHILDREN UNDER AGE 18

- A. Nonfinancial Eligibility** 42 CFR 435.301(b)(1)(ii) - If the state chooses to cover the medically needy, the State Plan must provide medically needy coverage to all children under 18 years of age who, except for income and resources, would be eligible for Medicaid as categorically needy.
- A child under age 18's Medicaid eligibility is first determined in the categorically needy Child Under Age 19 covered group which has no resource limit and has an income limit that is higher than the medically needy income limit. If a child under age 18 is not eligible because the child's countable income is too high, then the child may spenddown to the lower MN income limit **IF** the child's resources are within the MN resource limit.
- A child is eligible in this MN covered group if he/she has not attained age 18 years and meets the nonfinancial requirements in chapter M02.

B. Financial Eligibility

1. Assistance Unit The assistance unit policy and procedures in chapter M05 apply to this covered group. If not institutionalized, count or deem any resources and income from the child's spouse and/or parent with whom he/she lives.

2. Resources All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. The resources policy in chapter M06 applies.

If the child is married and institutionalized, use the resource policy in subchapter M1480.

a. Resources Within The Limit

If the child's resources are within the MN limit, go on to determine income eligibility.

b. Resources Exceed The Limit

If the child's resources are NOT within the limit, the child is NOT eligible for Medicaid because of excess resources.

3. Income Determine MN countable income according to chapter M07. Subtract the appropriate exclusions. Compare the total countable income to the MN income limit for the child's locality group (see section M0710, Appendix 5 for the MN income limits).

4. Income Exceeds MN Limit Because the *Child Under Age 19 and FAMIS* income limits are higher than the MN income limits, the child becomes eligible in the MN children under age 18 covered group when the child has incurred medical expenses equal to the difference between his/her income and the MN income limit (spenddown). See chapter M13 for spenddown policy and procedures.

C. Entitlement & Enrollment

Children who become eligible after meeting a spenddown are entitled to full medically needy Medicaid coverage beginning the day the spenddown was met. Retroactive coverage is applicable to this covered group.

Eligible children in this group are classified as medically needy (MN), *aid category "088."*

M0330.804 INDIVIDUALS UNDER AGE 21

A. Policy

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

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

- Non-IV-E Foster Care children
- Department of Juvenile Justice (DJJ) children,
- Non-IV-E Adoption Assistance children,
- Children in intermediate care nursing facilities (ICF), and
- Children in intermediate care facilities for the mentally retarded (ICF-MR).

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

B. Nonfinancial Eligibility

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

H. Reasonable Classifications

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

1. Non IV-E Foster Care

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

c. Children Living In Public Institutions

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

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

d. Child in Independent Living Arrangement

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

2. Non-IV-E Adoption Assistance

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

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

3. In ICF or ICF-MR

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

C. Assistance Unit

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

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

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

2. Adoptive Placement

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

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

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

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

M0330.805 SPECIAL MEDICAL NEEDS ADOPTION ASSISTANCE

A. Policy

42 CFR 435.308(b) - A state may choose to provide medically needy coverage to a child under age 21 years

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

If the child was not enrolled in Medicaid and would not have been eligible for Medicaid prior to the adoption assistance agreement being entered into, the child is **not** eligible for Medicaid in the MN covered group of “special medical needs adoption assistance children.” The child may be eligible in the MN Non-IV-E Adoption Assistance classification of Individuals Under Age 21 in section *M0330.804*.

B. Nonfinancial Eligibility

The child must

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

C. Financial Eligibility

1. Assistance Unit

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

A child in an ICF or an ICF-MR is an institutionalized individual in a medical facility when he meets the definition of “institutionalized individual” in section M1410.010 B.2. When he meets the institutionalized individual definition, he is an assistance unit of one person. The child’s eligibility is determined in the F&C 300% SSI covered group in M0330.501.

2. Resources

The resource limits and requirements are found in chapter M06.

If the resources exceed the limit, the child is not eligible for Medicaid as medically needy. If the child is under age 19, determine the child's eligibility as F&C CN because that classification has no resource limits.

3. Income

Adoption assistance children in residential facilities do not have a different income limit. The MN income limit for one person in the child's locality is used to determine the child's MN eligibility. For an adoption assistance child living outside the State of Virginia, the income limit for the child is the income limit for the Virginia locality which signed the adoption assistance agreement.

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

If the child's countable income exceeds the MN income limit, the child is placed on a spenddown. Only the child's medical expenses are used to meet the spenddown. Once the spenddown is met, the special medical needs adoption assistance child is enrolled in Medicaid.

D. Entitlement & Enrollment

Eligible individuals in this MN group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Individuals who become eligible after meeting a spenddown are entitled to full Medicaid coverage beginning the day the spenddown was met and ending the last day of the sixth month in the spenddown period. Retroactive coverage is applicable to this covered group.

The AC for individuals in the MN covered group of special medical needs adoption assistance children is "086."

M0730 Changes

Changed With	Effective Date	Pages Changed
TN #97	9/1/12	page 10
TN #94	9/1/2010	pages 7, 8
TN #93	1/1/2010	page 2
TN #91	5/15/2009	Table of Contents pages 7-8a

Verify the anticipated income by documents in the applicant's possession or by a statement from the tenant.

Verify the anticipated cost by a tax receipt for the property owned.

2. Room Rent

The net rental income is 65% of the total rent received if heating fuel is furnished by the applicant/recipient. The net rental income is 75% of the total rent received if heating fuel is not furnished.

Verify the rent paid by documents in the applicant/recipient's possession or a statement from the tenant.

3. Boarders

The net rental income is the total board received less the *Supplemental Nutrition Assistance Program (SNAP) benefit allotment for the number of boarders*. The SNAP Manual is available at <https://jupiter.dss.state.va.us/FoodStampManual/mainpage.jsp#>.

Verify anticipated income from documents in the *individual's* possession or statement from boarder.

4. Roomer/ Boarders

The net rental income from room and board is calculated as follows:

- *Subtract the SNAP benefit allotment for the number of boarders from the monthly gross rental income.*
- *Multiply the balance by .65 (65% of the balance) if heating fuel is furnished or .75 (75% of the balance) if heating fuel is not furnished.*

Verify anticipated income by documents in the applicant/recipient's possession or by a statement from the boarder.

M0730.520 GIFTS

A. Policy

The first \$30 received by each individual in the assistance unit per calendar quarter for special occasions, such as birthdays, Christmas, etc. is excluded.

B. Definition

Calendar quarters are:

January - March;
April - June;
July - September;
October - December.

C. Procedure

Any amount in excess of the \$30 per calendar quarter anticipated to be received will be counted as unearned income in the month in which it is anticipated to be received.

S1130 Changes

Changed With	Effective Date	Pages Changed
TN#97	9/1/12	page 14
Update #7	7/1/12	page 24
TN #96	10/1/11	Table of Contents, page ii pages 4, 73, 74 Appendix 1, pages 1-14 Appendix 2, page 1 Appendix 4, pages 1-8 added
TN #95	3/1/11	pages 28, 29, 33
TN #94	9/1/10	pages 20, 20a, 28-29a
TN #93	1/1/10	pages 63-65 pages 70, 74, 75
TN #91	5/15/09	page 13

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

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

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

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

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

2. Retroactive Exclusion

There will be applications received with property already listed for sale. Inform the applicant of Reasonable Efforts to Sell policy. *If the real property was already listed for more than the CMV when the individual applied for Medicaid, a reasonable effort to sell was made for the retroactive period and the month of application if:*

- *the property was listed at no more than 100% CMV*
or
- *the property was listed at or below 150% of CMV and the initial effort to sell requirement described above is met except for the listing price.*

If the list price was initially higher than 100% of the CMV, the listed sales price must be reduced to no more than 100% of the CMV to meet the continuing efforts to sell requirement.

If property was not listed when the application was filed or was listed higher than 150% of CMV, a reasonable effort to sell exclusion cannot be established for the retroactive period.

S1140 Changes

Updated With	Effective Date	Pages Changed
TN #97	9/1/12	Table of Contents, page i Table of Contents page ii was removed. pages 2, 16-19, 26, 26a
TN #96	10/1/11	pages 12-12a, 24
TN #93	1/1/10	pages 13-15 pages 24, 25
TN #91	5/15/09	pages 11-12a

TABLE OF CONTENTS

S1140.000 TYPES OF COUNTABLE RESOURCES

Section Page

GENERAL RULES ON COUNTABLE RESOURCES

Purpose of Subchapter	S1140.001.....	1
General Verification Requirements - Initial Application	M1140.010.....	1
General Verification Requirements – Post eligibility	M1140.020.....	3
Ownership	S1140.030.....	4
Determining Equity Value	S1140.042.....	5
Resources with Zero Value	S1140.044.....	5

REAL PROPERTY

Non-home Real Property	S1140.100.....	6
Other Property Rights.....	S1140.110.....	11
Life Estate and Remainder Interest Tables.....	S1140.120.....	13

FINANCIAL INSTITUTION ACCOUNTS

Checking, Savings <i>and Debit Card</i> Accounts -- General	S1140.200.....	16
Joint Checking and Savings Accounts	S1140.205.....	19
Time Deposits.....	S1140.210.....	20
Conservatorship Accounts	S1140.215.....	21a

OTHER COMMON INVESTMENT VEHICLES

Stocks.....	S1140.220.....	22
Mutual Fund Shares.....	S1140.230.....	23
U.S. Savings Bonds	S1140.240.....	24
Municipal, Corporate and Government Bonds	S1140.250.....	25
Annuities.....	M1140.260.....	26

CONTRACTS

Promissory Notes, Loans, and Property Agreements.....	S1140.300.....	26a
Continuing-Care Retirement Community Entrance Fees	M1140.305.....	27
Life Insurance	M1140.310.....	28

TRUSTS

Trusts Established By A Will	M1140.400.....	29
Trusts Which Were Not Created by a Will	M1140.401.....	29
Medicaid Qualifying Trusts (Created Prior to August 11, 1993)	M1140.402.....	30
Trusts Created After July 1, 1993 and Before August 11, 1993 With Corpus In Excess of \$25,000	M1140.403.....	31
Trusts Established on or After August 11, 1993	M1140.404.....	32
Workers’ Compensation Medicare Set-Aside Arrangement Accounts	M1140.500.....	33

RESOURCE GUIDE

Resources Guide -- Optional Desk Guide.....	S1140.990.....	34
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B. Development and Documentation- Exceptions for Liquid Resources Only

1. Cash on Hand

Accept an allegation of cash on hand, regardless of amount. Never ask to see or count cash.

2. Government-Issued Debit Cards

Government-administered benefits may be issued via government-sponsored debit cards, such as the Direct Express Debit MasterCard used for Social Security, Supplemental Security Income, Railroad Retirement and other government benefits. If the debit card account is funded solely by deposits from a government program, the money in the debit card account, minus any income deposited to the account for the month, is considered cash on hand and is countable unless otherwise excluded. See subchapter S1130 for information about benefits that are excluded as resources.

Debit cards that are funded by the client's own funds (e.g. the Green Dot pre-paid Visa or MasterCard) are considered bank accounts. See S1140.200.

C. Development and Documentation-- Photocopying Restrictions

U.S. Government Securities and Obligations

It is legal to photocopy checks issued by the Federal Government, U.S. Savings Bonds, Treasury notes, and other securities and obligations of the U.S. Government **only if** the photocopies are:

- in black and white; and
- of a size less than three-fourths or more than one and one-half, in linear dimension, of each part of the item illustrated.

Photocopying Not Legal

If equipment limitations or restrictions imposed by State or Federal law do not permit legal photocopying of a document, make a certification from the original document involved. If the document appears to have been altered in some way, certify it "as is" with a notation as to the apparent alteration.

FINANCIAL INSTITUTION ACCOUNTS

M1140.200 CHECKING, SAVINGS AND DEBIT CARD ACCOUNTS

A. Operating Policies

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

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

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

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

Even with ownership interest and the legal ability to access property, a legal restriction against the property's use for the owner's own support and maintenance means the property is not the owner's resources (S1110.100).

6. Examples of Evidence to the Contrary

a. Use Restricted by Court Order

Even with ownership interest and the legal ability to access property, a legal restriction against the property's use for the owner's own support and maintenance means the property is not the owner's resources (S1110.100).

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

b. Special Purpose Accounts

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

7. Debit Card Accounts

Debit cards that are funded by the client's own funds (e.g. the Green Dot pre-paid Visa or MasterCard) are considered bank accounts.

If the debit card account is funded solely by deposits from a government program, the money in the debit card account, minus any income deposited to the account for the month, is considered cash on hand and is verified by the client's statement of the balance in the account. See M1140.010.

B. Development and Documentation Initial Applications and Post-eligibility

1. Informing the Individual of Reporting Responsibilities

Be sure the individual understands that:

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

2. Curtailing Development

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

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

3. Minimum Documentation - Account Balances Must Be Verified

Document, in addition to the balances themselves;

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

4. Determining the Value of a Bank Account

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

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

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

5. Requesting Information from Financial Institutions

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

If a financial institution refuses to provide the information needed for a determination, try to obtain its cooperation by explaining why assistance is required. If the institution still refuses to provide the information, inform the individual and ask him or her to try to get the information from the institution.

6. Acceptable Financial Institution Information

a. Acceptable Forms of FI Records

1. *FI original records that appear to be complete and unaltered;*
2. *FI records other than bank statements issued by the FI, when individual:*
 - *alleges that no transactions have occurred that the records do not show; or*
 - *alleges that such transactions have occurred and provides appropriate evidence of them; and*
 - *the records, the allegation regarding additional transactions, and the alleged current account balance (on the application or renewal form) reflect a complete and consistent picture of the account;*
3. *Records verified by telephone contact with the FI and documented in the case record.*

b. Examples of Acceptable FI Records Other than Bank Statements

- *passbooks,*
- *the individual's check register,*
- *bank statements or account activity information printed from the FI's website and submitted by the individual,*
- *account ledgers,*
- *ATM transaction receipts, and*
- *deposit or withdrawal slips.*

Accept an FI document in the format in which it is provided by the FI or the individual if it meets the criteria in M1140.200 B.6 above.

c. Balance Information

The financial institution may show the opening balance for the first day of a given month or the closing balance for the last business day of the previous month. Accept either, the amount will be the same. See M1110.001 for monthly determinations of resource eligibility.

C. Development and Documentation-- Posteligibility Only

If you discover a previously undeveloped checking or savings account after eligibility has been established, develop account balances and interest for the period that a determination can cover.

S1140.205 JOINT CHECKING AND SAVINGS ACCOUNTS**A. Introduction**

The instructions in S1140.200, except for A.1. (ownership), apply to all checking and savings accounts. The instructions in this section, which apply to joint accounts only, supplement those in S1140.200.

B. Operating Policy-- Rebuttable Ownership Assumptions**1. Account Holders Include One Or More Applicants or Recipients and No Deemors**

Assume that all the funds in the account belong to the applicant(s)/recipient(s), in equal shares if there is more than one applicant or recipient.

2. Account Holders Include One or More Deemors

Provided that none of the account holders is an applicant or recipient (in which case the assumption in 1. above would apply), assume that all the funds in the account belong to the deemor(s), in equal shares if there is more than one deemor.

C. Development and Documentation-- Initial Applications and Posteligibility**1. Informing the Individual**

Inform the individual:

- of the applicable ownership assumption;
- of the corresponding income implications (S0810.130); and
- of his or her right to provide evidence rebutting the ownership assumption, if he or she disagrees with it.

M1140.260 ANNUITIES**A. Introduction**

An annuity is a sum paid yearly or at other specific times in return for the payment of a fixed sum. Annuities may be purchased by an individual or by an employer. For Medicaid purposes, an annuity means a contract or an agreement by which one receives fixed, non-variable payments on an investment for a lifetime or a specified number of years. An annuity must be issued by an insurance company, bank, or other registered or licensed entity approved to do business in the state in which the annuity was established.

B. Operating Policy**1. *Revocable Annuity***

An annuity that names revocable beneficiaries is considered to be an available resource because it can be surrendered, cashed in, assigned, transferred or have the beneficiary changed. Annuities are presumed to be revocable when the annuity contract does not state that it is irrevocable. The countable value of the revocable annuity is the amount of the funds in the annuity minus any fees required for surrender.

2. *Annuities Purchased with Assets of a Third Party*

Annuities purchased with the assets of a third party such as those received through a legal settlement are not considered to be countable resources.

3. *Annuity Purchased Prior to February 8, 2006*

An annuity *purchased* prior to February 8, 2006, is considered a countable resource if the annuity can be surrendered. The countable value of the annuity is the amount of the funds in the annuity minus any fees required for surrender.

4. *Annuity Purchased on or after February 8, 2006*

A non-employment related annuity purchased by or for an individual on or after February 8, 2006, using that individual's assets will be considered an available resource unless it meets all of the following criteria: the annuity

- a. is irrevocable;
- b. is non-assignable;
- c. is actuarially sound; and
- d. provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.

If the annuity does not meet the criteria listed above, the balance of the annuity is a countable asset regardless of whether or not the individual can access the balance (e.g. because periodic payments have begun).

Prior to receiving long-term care services paid by Medicaid, all annuities purchased by the institutionalized individual or the community spouse on or after February 8, 2006, must name the Commonwealth of Virginia as the primary beneficiary for at least the total amount of medical assistance paid on behalf of the institutionalized individual. If there is a community spouse or minor or disabled child, the Commonwealth must be named as the remainder beneficiary behind the spouse or minor or disabled child.

For individuals applying for long-term care services, annuities owned by either the applicant or the applicant's spouse must also be evaluated using the policy in M1450.200 to determine whether an uncompensated asset transfer has occurred.

S1140.300 PROMISSORY NOTES, LOANS, AND PROPERTY AGREEMENTS

A. Introduction

1. General

The context of the instruction in this section is the individual as the creditor (lender of money, seller of property) and, therefore, as the owner of the promissory note, loan, or property agreement.

See S1120.220 for additional information on notes, loans and property agreements.

2. Promissory Note

A promissory note is a written, unconditional agreement whereby one party promises to pay a specified sum of money at a specified time (or on demand) to another party. It may be given in return for goods, money loaned, or services rendered.

3. Loan

A loan is a transaction whereby one party advances money to or on behalf of another party, who promises to repay the lender in full, with or without interest. The loan agreement may be written or oral, and must be enforceable under State law. A written loan agreement is a form of promissory note.

4. Property Agreement

A property agreement is a pledge or security of particular property for the payment of a debt or the performance of some other obligation within a specified period. Property agreements on real estate generally are referred to as mortgages but also may be called land contracts, contracts for deed, deeds of trust, and so on. Personal property agreements—e.g., pledges of crops, fixtures, inventory, etc.—are commonly known as chattel mortgages.

B. Operating Policy

1. Real Estate Contracts Prior to Settlement

When an individual enters into a contract for the sale of real estate, he or she owns two items until the settlement of the sale is completed: the real estate and the contract. The real estate is not a resource because the individual cannot convert it to food or shelter. The contract is a property agreement whose status and value as a resource must be determined in accordance with this section.

2. Value as a Resource Assumption

Assume that the value of a promissory note, loan, or property agreement as a resource is its outstanding principal balance unless the individual furnishes reliable evidence that it has a CMV of less than the outstanding principal balance (or no CMV at all).

Virginia DSS, Volume XIII

M1460 Changes

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TN #97	9/1/12	Table of Contents, page i pages 1, 4-7, 9-17 pages 18a-20, 23-27, 29-31 pages 37-40, 43-51 Pages 52 and 53 were deleted
TN #96	10/1/11	pages 3, 20, 21
TN #95	3/1/11	pages 3, 4, 35
TN #94	9/1/10	page 4a
TN #93	1/1/10	pages 28, 35
TN #91	5/15/09	pages 23, 24

TABLE OF CONTENTS

M14 LONG-TERM CARE

M1460.000 LTC FINANCIAL ELIGIBILITY

	Section	Page
Overview.....	M1460.001.....	1
Definitions	M1460.100.....	1
Substantial Home Equity Precludes Eligibility for LTC	M1460.150.....	3
<i>Third Party & Long-Term Care Insurance Payments</i>	<i>M1460.155</i>	4
Long-Term Care Partnership Policies.....	M1460.160.....	4a
Determination of Covered Group	M1460.200.....	4b
SSI Recipients	M1460.201.....	7
<i>ABD 80% FPL Covered Group</i>	<i>M1460.205</i>	9
Other Categorically Needy (CN) Covered Groups.....	M1460.210.....	9
300% SSI	M1460.220.....	10
Medically Needy Covered Groups	M1460.230.....	11
Assistance Unit	M1460.300.....	12
Steps for Determining Financial Eligibility	M1460.400.....	12
Steps for Determining MN Eligibility	M1460.410.....	15a

RESOURCES

Resource Determination.....	M1460.500.....	17
Determining Countable Resources.....	M1460.510.....	17
Retroactive Resource Determination.....	M1460.520.....	18a
Home Ownership	M1460.530.....	18a
Suspension Procedures.....	M1460.540.....	24

INCOME

Income Determination.....	M1460.600.....	26
What is Not Income	M1460.610.....	27
Countable Income for 300% SSI Group	M1460.611.....	33
Reserved	M1460.620.....	36
Income Determination Process For Stays Less Than 30 Days.....	M1460.640.....	36
Retroactive Income Determination.....	M1460.650.....	37
Notices & Enrollment Procedures for CN and Medicare Savings Programs (MSPs)	M1460.660.....	38
Medically Needy Income & Spenddown	M1460.700.....	40
Spenddown for Facility Patients	M1460.710.....	41
Spenddown For Patients Receiving CBC	M1460.740.....	47
Medically Needy Enrollment Procedures	M1460.750.....	50

M1460.000 LTC FINANCIAL ELIGIBILITY

M1460.001 OVERVIEW

A. Introduction

This subchapter contains the Medicaid financial eligibility requirements for individuals receiving facility or Medicaid waiver long-term care (LTC) services, who are not married or who are married but do not have community spouses. **For married individuals with community spouses (*when both are not in a medical facility*), go to subchapter M1480 to determine financial eligibility and patient pay.**

All individuals whose Medicaid eligibility has been determined PRIOR to entering LTC must have their financial eligibility redetermined, including asset transfer evaluation, home ownership and other resource evaluation. First, determine if the individual meets the Medicaid non-financial requirements including covered group in M1410.020. Then determine financial eligibility. Financial eligibility requirements for an individual differ depending on the individual's covered group, marital status and type of long-term care.

This subchapter contains policy and procedures for resources and income eligibility determination for institutionalized individuals. Patient pay (post-eligibility treatment of income) policy and procedures for unmarried individuals or married individuals without community spouses are in subchapter M1470.

B. Related Policies

- ABD resource rules in Chapter S11.
- ABD income rules in Chapter S08.
- Family and Children resource rules in Chapter M06.
- Family and Children income rules in Chapter M07.
- Married Institutionalized Individuals' Eligibility & Patient Pay rules in subchapter M1480.

M1460.100 DEFINITIONS

A. Purpose

This section provides definitions for terms used in this subchapter.

B. Definitions

1. 300% SSI Group

The 300 SSI group is the short name for the categorically needy covered groups of Aged, Blind & Disabled (ABD) and Families & Children (F&C) individuals who are institutionalized in medical facilities or Medicaid-covered waiver services, who have resources within the Medicaid resource limits and whose gross income is less than or equal to 300% of the SSI income limit for one person.

2. Budget Period

The budget period is the period of time during which an individual's income is calculated to determine eligibility.

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 *the limit*, the Notice of Action must state why he is ineligible for Medicaid payment of LTC. The notice must also indicate whether the applicant is eligible for other Medicaid covered services.
- E. References** See section M1120.225 for more information about reverse mortgages.

M1460.155 THIRD PARTY & LONG-TERM CARE INSURANCE PAYMENTS

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

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

- B. LTC Insurance Policy Payments**

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

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

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

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

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.

M1460.200 DETERMINATION OF COVERED GROUP

A. Overview

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

1. Covered Groups Eligible for LTC Services

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

All categorically needy (CN) *full benefit* covered groups for ABD and F&C:

- *SSI Recipients; see M0320.101 and M1460.201*
- *“Protected” covered Groups; see M0320.200*
- *ABD 80% FPL; see M0320 and M1460.250*
- *MEDICAID WORKS; see M0320.400*
- *300% SSI; see M0320.500, M0330.500, and M1460.220*
- *IV-E Foster Care and Adoption Assistance; see M0330.105*
- *Individuals Under Age 21; see M0330.107*
- *Special Medical Needs Adoption Assistance; see M0330.108*
- *Low Income Families With Children (LIFC); see M0330.200*
- *Child Under Age 19 (FAMIS Plus); see M0330.300*
- *Pregnant Women and Newborn Children; see M0330.400*
- *Breast and Cervical Cancer Prevention Treatment Act (BCCPTA); see M0330.700*

All medically needy (MN) covered groups

- *ABD Individuals; see M0320.701*
- *December 1973 Eligibles; see M0320.702*
- *Pregnant Women; see M0330.801*
- *Newborn Children Under Age 1; see M0330.802*
- *Children Under Age 18; see M0330.803*
- *Individuals Under Age 21; see M0330.804*
- *Special Medical Needs Adoption Assistance; see M0330.805*

Medicaid will not pay for the following for MN individuals:

- *services in an intermediate care facility for the mentally retarded (ICF-MR)*
- *services in an institution for the treatment of mental disease (IMD)*
- *Intellectual Disabilities/Mental Retardation (ID/MR) Waiver services, and*
- *Individual and Family Development Disability Support (DD) Waiver services.*

2. Applicants Who Do Not Receive Cash Assistance

a. Child Under Age 19

If the applicant is a child under age 19, first determine the child's eligibility as a child, using the covered group policy in *M0330* and the financial eligibility policy in chapters M05 and M07. If not eligible as *a child under 19*, determine the child's eligibility in the 300% SSI group, using the covered group policy in subchapter *M0330* and the financial eligibility policy and procedures in this subchapter.

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

NOTE: A child who is age 18, 19 or 20 meets an MN covered group if he is blind, disabled, pregnant, in foster care, adoption assistance, or institutionalized in a nursing facility. An individual age 21 or older, must meet the pregnant, aged, blind or disabled definition in order to meet an MN covered group.

b. Individual Age 19 or Older

If the applicant is an individual age 19 or older, determine the individual's eligibility in the ABD or F&C covered group depending on which definition the individual meets, using the financial eligibility policy and procedures in this subchapter.

For ABD individuals, determine the individual's eligibility in the *ABD 80% FPL* covered group. If not eligible in the *ABD 80% FPL* covered group, determine the individual's eligibility in the *300% SSI* covered group. If not eligible in the *either of these* covered groups, determine the individual's eligibility in all other groups for which he meets a definition.

For F&C individuals, first determine the individual's eligibility in the *LIFC or Pregnant Woman groups*. If the individual's income exceeds the limits for the *LIFC or Pregnant Woman covered groups*, determine the individual's eligibility in the 300% SSI covered group. *If the income exceeds the 300% SSI group limit*, determine the individual's eligibility in an MN covered group (see M0330).

B. Relation to Income Limits

Determination of the appropriate covered group must be made prior to determination of income because the income limits are determined by the covered group:

1. ABD 80% FPL

The ABD income policy in chapter S08 is used to determine countable income for the ABD 80% FPL covered group. The income items listed in Sections M1460.610 and M1460.611 are NOT counted as income in determining income eligibility for the ABD 80% FPL covered group.

2. 300% SSI

The ABD income policy in chapter S08 is used to determine income for all individuals (ABD and F&C) in the 300% SSI group. The items found in section M1460.611 ARE counted in determining income eligibility for long-term care. The income items listed in M1460.610 are not counted for the 300% SSI groups (ABD and F&C).

3. **ABD MN Groups**

The ABD income policy in chapter S08 is used to determine countable income for the ABD MN covered groups. However, the income items listed in "What Is Not Income", Section M1460.610 and in "Countable Income for the 300% SSI Group", Section M1460.611 are NOT counted as income in determining income eligibility for ABD MN groups.
4. **F&C CN and MN Groups**

The F&C income policy in chapter M07 is used to determine countable income for individuals in F&C CN and MN covered groups. However, the income items listed in "What Is Not Income", section M1460.610 and "Countable Income for the 300% SSI Group", Section M1460.611 are NOT counted when determining income eligibility for F&C CN and MN groups.

C. Ongoing Recipient Enters LTC

1. **SSI Recipients**

Recipients who are already enrolled in Medicaid when they enter Medicaid long-term care and who receive cash assistance payments must have their eligibility reviewed. They already meet a covered group but they must also meet the asset transfer, resource and financial eligibility requirements in order for Medicaid to cover the cost of long-term care services.
2. **Other Recipients**

Recipients who do not receive cash assistance but who are already enrolled in Medicaid when they enter long-term care in a medical facility **must have their eligibility redetermined**. They must meet a covered group and they must meet the asset transfer, resource, and financial eligibility requirements in order for Medicaid to cover the LTC services cost.

Review the asset transfer policy in subchapter M1450 with the recipient if he has transferred assets. If the recipient is admitted to a nursing facility, or moves from his home to receive Medicaid CBC in another person's home, review asset transfer, home property and other resource requirements to determine if the individual remains eligible for Medicaid.

A married recipient who enters LTC must have resource and income eligibility redetermined using the rules in subchapter M1480, if his spouse is a community spouse.

M1460.201 SSI RECIPIENTS

A. Introduction

An SSI recipient in a nursing facility, or who receives Medicaid CBC waiver services, must meet the Medicaid nonfinancial, asset transfer and resource eligibility requirements to be eligible for Medicaid payment of LTC services. The SSI recipient's resource eligibility must be determined if he owns a real property resource; the receipt of SSI meets the Medicaid income eligibility requirements. An SSI recipient is income-eligible for LTC as long as he is entitled to an SSI payment. When the SSA record indicates a payment code of "C01" but shows no payment amount due to a recovery of an overpayment, the individual is considered to be an SSI recipient. The covered group eligibility requirements for SSI recipients are in section M0320.101.

1. Medicaid CBC

An SSI recipient who receives Medicaid CBC waiver services in his community residence usually continues to receive SSI with no change. If a recipient moves to another person's home to receive Medicaid CBC, his SSI payment may be affected. When a Medicaid SSI recipient begins receiving Medicaid CBC waiver services, asset transfer and resource eligibility must be evaluated. As long as the individual receives SSI, he is categorically needy if he meets the Medicaid nonfinancial and resource eligibility rules.

2. Facility

SSI recipients in nursing facilities are subject to the reduced SSI benefit rate of \$30 for their personal needs. If they have other countable income that exceeds \$30, their SSI will be canceled. SSI recipients may continue to receive their regular monthly SSI benefit for 3 months if they are considered temporarily institutionalized. Individuals who receive SSI after admission to a facility are categorically needy if they meet the Medicaid nonfinancial and resource eligibility rules.

B. Policy

1. Nonfinancial

Evaluate the non-financial Medicaid eligibility rules in section M1410.020. An SSI recipient meets an ABD covered group.

2. Asset Transfer

Determine if the recipient meets the asset transfer policy in subchapter M1450.

3. Resources

a. Determine Countable Resources

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

- 1) equity in non-exempt property contiguous to his home which exceeds \$5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;
- 2) interest in undivided heir property and the equity value of the individual's share that, when added to all other countable resources, exceeds the appropriate Medicaid resource limit. (The interest in the

- b. If the recipient is temporarily in the nursing facility, the SSI check is not reduced or canceled. Temporary institutionalization for SSI purposes means 90 days or less. The SSI payment is **NOT** counted as income when determining eligibility or patient pay.

C. Development

A partial review of the SSI recipient's Medicaid eligibility is required when the recipient is admitted to facility care or Medicaid CBC waiver services. The EW must determine that asset transfer and resource requirements are met, and that the recipient's SSI continues.

If eligible, determine patient pay; see subchapter M1470. If the individual is eligible but is in an asset transfer penalty period, follow the notification instructions in M1450. If not eligible, follow the eligibility notice requirements in M1410.300.

M1460.205 ABD 80% FPL COVERED GROUP

A. Description

The ABD 80% FPL covered group includes aged, blind and disabled individuals who have income less than or equal to 80% FPL and countable resources that do not exceed the SSI resource limits. See M0320.300 for details about this covered group.

B. Policy

1. **Nonfinancial** *Evaluate the non-financial Medicaid eligibility rules in Chapter M02.*
2. **Asset Transfer** *Determine if the recipient meets the asset transfer policy in subchapter M1450.*
3. **Resources** *Determine countable resources using the policy in chapter S11 and Appendix 2 to chapter S11. The resource limit is \$2,000.*

The home property resource exclusion for individuals in the ABD 80% FPL covered group includes the home and ALL contiguous property as long as the individual lives in the home or, if absent, intends to return to the home (see Appendix 2 to chapter S11). When the ABD 80% FPL individual leaves his home property, obtain a signed statement from the individual as to:

- *when and why he left the home;*
- *whether he intends to return; and*
- *if he does not intend to return, when that decision was made.*

The 6-month home property resource exclusion for institutionalized individuals does NOT apply to this covered group.

4. **Income** *Income is determined using the policy in chapter S08, and countable income must not exceed 80% FPL. Spenddown does not apply to this covered group.*

M1460.220 300% of SSI PAYMENT LIMIT GROUP

A. Description

These are ABD or F&C individuals in medical facilities or who receive Medicaid CBC waiver services, who meet the appropriate CN resource requirements and resource limit and whose income is less than or equal to 300% of the SSI payment limit for an individual.

Individuals who have been screened and approved for Medicaid LTC services may be evaluated in this covered group. If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has 30 days from the date on the Notice of Action to begin services.

B. ABD Groups

Aged, blind or disabled individuals institutionalized in medical facilities, or who require institutionalization and are approved to receive Medicaid CBC waiver services are those who:

- meet the Medicaid ABD resource requirements; and
- have gross income, determined according to the ABD income requirements, that does not exceed 300% of the SSI individual payment limit.

See sections M0320.501 and M0320.502 for details about these covered groups.

C. F&C Groups

Individuals who meet an F&C definition (children under age 19, foster care or adoption assistance children under age 21, parents or caretaker-relatives of dependent children, and pregnant women) in medical facilities, or who require institutionalization and who are approved to receive Medicaid home and community-based care (CBC) waiver services, are those who:

- meet the F&C CN resource requirements if unmarried, (married individuals must meet the ABD resource requirement); and
- have gross income, determined according to the ABD income requirements, that does not exceed 300% of the SSI individual payment limit.

See sections M0330.501 and M0330.502 for details about these covered groups.

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M1460.300 ASSISTANCE UNIT

A. Policy An institutionalized individual is an assistance unit of one person, considered living separately from his spouse and/or parent(s), beginning the month in which he meets the definition of “institutionalization” in section M1410.010.

EXCEPTION: A pregnant woman's assistance unit includes the number of unborn children with which she is pregnant.

B. Financial Eligibility The financial eligibility rules in this section apply to **both ABD and F&C individuals.**

1. Resources The resources of an institutionalized child’s parent(s) are **NOT** deemed available to the institutionalized child. The resources of an institutionalized individual’s spouse are deemed available to the institutionalized individual in the initial eligibility determination (see subchapter M1480).

2. Income The income of an institutionalized individual’s spouse or parent(s) is **NOT** deemed available to the institutionalized individual.

For income eligibility, married institutionalized individuals are considered separated, not living together, and only that income which is voluntarily contributed to the institutionalized spouse by the separated spouse is considered available to the institutionalized spouse.

Institutionalized children are considered separated from, not living with, their parents and only that income which is voluntarily contributed to the child is considered available to the child.

M1460.400 STEPS FOR DETERMINING FINANCIAL ELIGIBILITY

A. Is person an SSI recipient? **Yes:** Go to M1460.201 (determine ABD CN resources; if within limit, is eligible as SSI). If resources exceed the limit, does recipient also meet F&C CN covered group?

Yes: eligible as F&C CN; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay. (Remember to review asset transfer to evaluate whether Medicaid payment may be made for LTC services).

No: ineligible for Medicaid; STOP. Go to section M1460.660 for notice procedures.

No: Does person receive IV-E cash assistance?

Yes: eligible as CN; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay. (Remember to review asset transfer to evaluate whether Medicaid payment may be made for LTC services).

No: Go to B below.

B. Covered Group Is person already enrolled in Medicaid in a covered group eligible for LTC services?

Yes: Go to E "Resources" below.

No: Is person F&C?

Yes: Determine if he meets F&C group first (section M0330) go to D "Income" below.

No: Go to C below.

C. Is person ABD? **Yes:** Go to D "Income" below.

No: Is person in Hospice?

Yes: Determine as Hospice; see section M0320.503.

No: ineligible for Medicaid, does not meet a covered group; STOP. Go to section M1460.660 for notice procedures.

D. Income
(See M1460.600)

1. Person is F&C Determine countable income using chapter M07.

Compare income to appropriate F&C income limit.

Is income within F&C limit?

Yes: eligible as F&C, STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

No: not eligible as F&C, go to item 2 below.

2. Person Is Not F&C **a.** Is person ABD and *does he meet the definition of institutionalization in M1410.010?*

Yes: Determine if gross income is less than or equal to the 80% FPL income limit using chapter S08 and section M1460.600 below to determine gross income.

Is gross income less than or equal to 80% FPL income limit?

Yes: Go to section E "Resources" below.

No: Go to item 3 "Determine 300% SSI income" below.

No: Does person meet the F&C 300% SSI or Hospice covered group
(does person meet the definition of institutionalization in M1410.010)?

Yes: Go to item 3 “Determine 300% SSI income” below.

No: Go to section M1460.410 “Steps for Determining MN Eligibility.”

**3. Determine if
Gross Income
is Less Than or
Equal to 300%
SSI**

Determine if gross monthly income is less than or equal to the 300% SSI income limit using chapter S08 and section M1460.600 below for **ABD and F&C** individuals.

Is gross income less than or equal to 300% SSI income limit?

Yes: go to section E “Resources” below.

No: go to section M1460.410 “Steps for Determining MN Eligibility” below.

**E. Resources
(See M1460.500)**

**1. Determine CN
Resources**

a. ABD groups

1) Unmarried Individual or Married Individual with no Community Spouse

a) ABD 80% FPL group: Using chapter S08 and M1460.600, determine if countable income is within the ABD 80% FPL income limit contained in M0810.002.A.5. If countable income is less than or equal to 80% FPL, determine countable resources using chapter S11 and Appendix 2 to chapter S11. **NOTE:** the 6-month home exclusion does not apply to this covered group.

Compare to ABD CN resource limit = \$2,000 for 1 person.

b) 300% SSI group: Determine ABD countable resources using chapter S11.

Compare to ABD CN resource limit = \$2,000 for 1 person. If the individual is not eligible due to excess resources, evaluate eligibility in the ABD 80% FPL covered group. See item b) below.

2) Married Individual with Community Spouse

Determine ABD countable resources using chapter S11 and subchapter M1480.

Compare to ABD CN resource limit = \$2000 for 1 person

b. F&C groups

1) Unmarried Individual or Married Individual with no Community Spouse

- Determine F&C CN countable resources using chapter M06 for the unmarried institutionalized individual.
- Compare to F&C CN resource limit = \$1,000.

2) Married Individual with Community Spouse

- Determine ABD countable resources, Chapter S11, M1480.
- Compare to ABD CN resource limit = \$2000 for 1 person.

2. Are resources within CN limit?

Yes: eligible in the covered group whose income limit is met; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

No: go to item 3 below.

3. Does person meet an MN covered group?

Yes: go to section M1460.410 "Steps for Determining MN Eligibility," below.

No: person is not eligible for Medicaid because of excess resources; STOP. Go to section M1460.660 for notice procedures.

M1460.410 STEPS FOR DETERMINING MN ELIGIBILITY

- A. Does person meet an MN covered group?**
- Yes:** go to B below “Determine MN Resources.”
- No:** person is not eligible for Medicaid because his gross income exceeds 300% of SSI and he does not meet a medically needy covered group; STOP, unless he has Medicare Part A. If he has Medicare Part A, determine eligibility for ABD *MSP*. If he does not have Medicare Part A, go to section M1460.660 for notice procedures.
- B. Determine MN Resources**
- 1. ABD Groups** Determine ABD countable resources, Chapter S11.
- Compare to ABD MN resource limit = \$2,000 for 1 person.
- 2. F&C Groups**
- a. Unmarried Individual or Married Individual with No Community Spouse**
- Determine F&C MN countable resources, Chapter M06.
- Compare to F&C MN resource limit = \$2,000 for 1 person.
- b. Married Individual with Community Spouse**
- Determine ABD countable resources, Chapter S11, M1480.
- Compare to ABD MN resource limit=\$2000
- 3. Are resources within MN limit?**
- Yes:** go to C “Determine MN Income” below.
- No:** person not eligible for Medicaid due to excess resources; STOP. Go to section M1460.660 for notice procedures.

C. Determine MN
Income

1. ABD groups

Determine ABD MN countable income, Chapter S08.

Compare to MN income limit for 1 person in individual's home locality - where the individual last resided in Virginia outside of an institution (use Group III MN limit if individual was admitted to Virginia facility from out-of-state).

2. F&C groups

Determine F&C MN income, Chapter M07.

Compare to MN income limit for 1 person in individual's home locality - where the individual last resided in Virginia outside of an institution (use Group III MN limit if individual was admitted to Virginia facility from out-of-state).

3. Is Income Less
Than or Equal
to MN Income
Limit?

NOTE: A person who has gross income exceeding the 300% SSI limit will **always** have countable income that exceeds the MN limit.

Yes: eligible as MN; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

No: Spenddown; excess amount is "spenddown liability." Go to 4. below for facility patients, 5. below for CBC recipients.

4. Spenddown--
Facility
Patients

a. Spenddown Liability Less Than or Equal to Facility Medicaid Rate

If the spenddown liability is less than or equal to the facility's Medicaid rate, determine spenddown eligibility by projecting facility costs at the Medicaid rate for the month. Spenddown balance after deducting projected costs at the Medicaid rate should be zero or less.

The patient is eligible as MN for the whole month. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

b. Spenddown Liability More Than Facility Medicaid Rate

When the spenddown liability is **more than** the facility Medicaid rate, determine spenddown eligibility AFTER the month has passed, on a daily basis (do not project expenses) by chronologically deducting old bills and carry-over expenses, then deducting the facility daily cost at the **private** daily rate and other medical expenses as they were incurred.

If the spenddown is met on any date within the month, the patient is eligible effective the first day of the month in which the spenddown was met. Eligibility ends the last day of the month.

Each month must be evaluated separately. These patients will always be enrolled after the month being evaluated has passed.

**5. Spenddown--
CBC Patients**

Do not project CBC waiver services costs. Eligibility is evaluated on a monthly basis. Determine spenddown eligibility AFTER the month has passed, by deducting old bills and carry-over expenses first, then (on a daily basis) chronologically deducting the daily CBC cost at the **private** daily rate and other medical expenses **as they are incurred**. If the spenddown balance is met on a date within the month, the patient is eligible effective the first day of the month in which the spenddown was met. Eligibility ends the last day of the month.

Each month must be evaluated separately. These patients will always be enrolled after the month being evaluated has passed.

M1460.500 RESOURCE DETERMINATION

A. Introduction

The following sections describe the resource eligibility rules that are applicable to individuals in long-term care.

B. Resource Limits

1. ABD Groups

ALL aged, blind and disabled (ABD) covered groups = \$2,000 per individual.

2. F&C Groups

F&C 300% SSI and Hospice groups = \$1,000, regardless of the number of individuals in the assistance unit.

There are no resource requirements for any other F&C covered group.

3. MN Groups

MN groups = \$2,000 for an individual. \$3,000 for 2 persons (pregnant woman with 1 unborn child; add \$100 for each additional unborn child).

C. Budget Period

The budget period for determining long-term care resource eligibility is always one month.

M1460.510 DETERMINING COUNTABLE RESOURCES

A. Married Individual

**1. With A
Community
Spouse**

See **subchapter M1480** for the rules to determine the **institutionalized individual's resource eligibility** when he is married and his spouse is a community spouse (the spouse is not in a medical institution or nursing facility).

NOTE: If the individual's resources exceed the resource limit, and the individual has Medicare Part A, evaluate for eligibility as QMB, SLMB, or QI (limited coverage) which have a higher resource limit.

2. F&C Covered Groups

An institutionalized individual is an assistance unit of 1 person, considered living separately from his family. No resources are deemed available from a child's parent(s).

NOTE: A pregnant woman's assistance unit includes the number of unborn children with which she is pregnant.

Use the resource policy and procedures in chapter M06 for the resource determination.

M1460.520 RETROACTIVE RESOURCE DETERMINATION

A. Policy

When an applicant reports that he received a medical service within the retroactive period, evaluate Medicaid eligibility for that period.

Evaluate resource eligibility for each month using resources available during that month.

B. Reduction of Resources

An individual cannot retroactively reduce resources. If countable resources exceeded the resource limit **throughout** a retroactive month, the individual is **not** eligible for that month. However, if an applicant reduces excess resources **within** a retroactive month, he may be 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, liquid resources such as bank accounts and prepaid burial accounts must actually have been expended. Non-liquid resources must have been liquidated and the money expended.

M1460.530 HOME OWNERSHIP (NOT APPLICABLE TO ABD 80% FPL GROUP)

A. Policy

The policy in this section does not apply to the ABD 80% FPL group. See Appendix 2 to chapter S11 for home ownership resource policy for the ABD 80% FPL group.

The institutionalized individual's former home in which he has an ownership interest, and which he occupied as his residence before becoming institutionalized, is not a countable resource for the first six months **following** admission to a medical facility or nursing facility. The former home is excluded indefinitely when it is occupied by a spouse, minor child, aged or disabled adult child, or an aged or disabled parent.

B. Definitions for This Section

1. Dependent

A dependent child or parent is one who may be claimed as a dependent for tax purposes under the Internal Revenue Service's Code by either the institutionalized individual or his spouse.

2. Institutionalization

a. Definition

Institutionalization means receipt of 30 consecutive days of :

- care in a medical facility (such as a nursing facility), or
- Medicaid waiver services (such as community-based care); or
- a combination of the two.

The definition of institutionalization is also met when an individual has a signed hospice election that has been in effect for 30 consecutive days.

The 30 consecutive days requirement is expected to be met if the pre-admission screening committee provides verbal or written confirmation of its approval for the individual's receipt of long-term care (LTC) services (see M1410.010).

NOTE: For purposes of this definition, continuity is broken by 30 or more consecutive days of:

- absence from a medical institution, or
- non-receipt of Medicaid waiver services.

EXCEPTION: When an individual is readmitted in less than 30 days due to a different diagnosis or a change in condition unforeseen at the time of discharge, a new 6-month home exclusion will begin if it was medically documented that the discharge occurred because facility services were no longer required and a physician documents that the change in circumstances could not be anticipated.

b. When Institutionalization Begins

Institutionalization begins the date of admission to a nursing facility or Medicaid waiver services when the pre-admission screening committee provides verbal or written confirmation of its approval for the individual's receipt of long-term care (LTC) services, or when the individual has been in the nursing facility for at least 30 consecutive days.

Institutionalization begins the date of admission to a hospital (acute care) when the individual has actually been a patient in the hospital for 30 consecutive days or more. For example, an individual was admitted to the general hospital on March 5. He applied for Medicaid on March 6. On April 3, he was still a patient in the general hospital. He was in the hospital for 30 consecutive days on April 3; his institutionalization began on the date he was admitted to the hospital, March 5. His eligibility for March is determined as an institutionalized individual.

The date of discharge from a medical institution into the community (and not receiving CBC waiver services) or death is **NOT** included in the 30 days.

3. Home Property

The home property is defined based on the individual's covered group, except when the individual is married with as community spouse. When the individual is married with a community spouse, **go to subchapter M1480.**

a. ABD Groups

The home property definition in section M1130.100 applies to ABD covered groups. An individual's home is property that serves as his or her principal place of residence. A home shall mean the house and lot used as the principal residence and all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed \$5,000. If the individual has property contiguous to his home, the value of the non-home contiguous property over \$5,000 is a countable resource, unless it can be excluded for another reason listed in subchapter S1130.

b. F&C Groups

The home property definition in section M0630.115 applies to F&C covered groups. Home property is the home used as the principal residence and all contiguous property. Contiguous property is the land, and improvements on that land, which adjoins the home and which is not separated by land owned by others.

4. Former Home

The patient's former home (including a mobile home) is his primary residence:

- which he owns, and
- which he occupied as his residence prior to admission to an LTC facility, or prior to moving out to receive Medicaid CBC waiver services in another person's home.

C. Exclude Former Home Indefinitely

The former home property can be excluded indefinitely when one of the following conditions is met:

1. Occupied By Spouse or Minor Child

The former home is occupied by the individual's spouse, minor dependent child under age 18, or dependent child under age 19 if attending school or vocational training.

2. Occupied By Disabled Adult Child or Disabled Parent

The former home is occupied by the individual's parent or adult child who:

- *has been determined to be* disabled according to the Medicaid disability definition;
- lived in the home with the recipient for at least one year prior to the recipient's institutionalization; and
- is dependent upon the recipient for his shelter needs.

b. F&C Covered Groups

- 1) Excluded Resources (section M0630.100).
- 2) Reasonable Effort To Sell (CN) (section M0630.105).
- 3) Reasonable Effort To Sell For the Medically Needy (section M0630.110).

F. Home No Longer Excluded

If the individual's home property is no longer excluded and the individual has excess resources, cancel Medicaid because of excess resources when the individual does not have Medicare Part A. If the individual has Medicare Part A, evaluate the individual's eligibility as ABD *Medicare Savings Program (MSP)* which has more liberal resource requirements and limits (*see M0320.600*).

1. Individual Has Medicare Part A

When the individual has Medicare Part A:

- a. compare income with the ABD *MSP* limits; if the income is below one of the ABD *MSP* income limits, then
- b. evaluate the resources using ABD *MSP* policy as found in Chapter S11, Appendix 2.
- c. If eligible as ABD *MSP* only, Medicaid will not pay for nursing facility or CBC waiver services costs. Do the following:
 - prepare and send an Advance Notice of Proposed Action to the recipient;
 - cancel the recipient's coverage in the MMIS, then reinstate the recipient to ABD *MSP* limited coverage;
 - send a Medicaid LTC Communication Form (DMAS-225) to the provider, stating that the recipient is no longer eligible for full Medicaid coverage because of excess resources, but is eligible for limited ABD *MSP* coverage; beginning (specify the date following the cancel date of the recipient's full coverage), Medicaid will not pay for the individual's care.
- d. If NOT eligible as ABD *MSP* because of resources and/or income, cancel the recipient's Medicaid. Do the following:
 - prepare and send an "Advance Notice of Proposed Action" to the recipient;
 - cancel the recipient's Medicaid coverage in the MMIS because of excess resources or income;

- send a DMAS-225 to the provider, stating that the recipient's Medicaid will be canceled because of excess resources (and/or income) and the effective date of cancellation.

2. Individual Does Not Have Medicare Part A

When the individual DOES NOT have Medicare Part A:

- a. cancel the recipient's Medicaid coverage in the MMIS because of excess resources;
- b. prepare and send an Advance Notice of Proposed Action to the recipient;
- c. send a DMAS-225 to the provider, stating that the recipient's Medicaid will be canceled because of excess resources, and the effective date of cancellation.

M1460.540 SUSPENSION PROCEDURES

A. Policy

This section applies ONLY to Medicaid recipients:

- who are enrolled in ongoing Medicaid coverage and
- whose patient pay exceeds the Medicaid rate.

B. Procedures

If a Medicaid recipient's patient pay exceeds the Medicaid rate and his resources go over the Medicaid resource limit, take the following actions:

1. For Recipients Who Have Medicare Part A

a. Resources Less Than or Equal to ABD MSP Resource Limit

If the recipient's resources are less than or equal to the higher ABD MSP resource limit, **determine** if the recipient's income is less than or equal to the QMB, SLMB, or QI income limit.

- 1) When the recipient's income is less than or equal to the QMB, SLMB, or QI income limit:
 - a) prepare and send an advance notice to reduce the recipient's Medicaid coverage from full benefits to limited benefits (specify the appropriate QMB, SLMB, or QI coverage). Write a note on the notice telling the recipient that:
 - the limited (QMB, SLMB, or QI) benefits will NOT pay for long-term care services, and
 - if he verifies that his resources are less than or equal to the \$2,000 resource limit, he should request reinstatement of full Medicaid benefits.

- b) **cancel** the recipient's full coverage line in the MMIS effective the last day of the month in which the 10-day advance notice period expires, using cancel reason "07". Reinstatement the recipient's coverage with the begin date as the first day of the month following the cancellation effective date, using the appropriate QMB, SLMB or QI AC.
- 2) When the recipient's income exceeds the QMB, SLMB and QI income limits, follow the procedures in 2 below (the procedures for recipients who do not have Medicare Part A).

b. Resources Exceed ABD MI Resource Limit

If resources are greater than the ABD MI resource limit, follow the procedures in item 2 below (the procedures for recipients who do not have Medicare Part A).

2. For Recipients Who Do NOT Have Medicare Part A

a. Prepare and Send Advance Notice

Prepare and send an advance notice to cancel the recipient's Medicaid eligibility. Specify the effective date, which is the last day of the month in which the 10-day advance notice period expires. Write a note on the notice telling the recipient that if he verifies that his resources are less than or equal to the \$2,000 resource limit before the specified date (specify the date which is 3 months from the cancel effective date), he should request reinstatement of Medicaid eligibility.

b. Cancel Medicaid Eligibility

Cancel the recipient's eligibility in the MMIS effective the last day of the month in which the 10-day advance notice period expires.

c. Suspend Case Administratively

Suspend the case administratively for a maximum of 3 months; do not close the case statistically. The suspension effective date is the effective date of the Medicaid cancellation in the MMIS. While suspended, the case remains open for a maximum of 3 months.

If, by the end of 3 months from the suspension effective date, the individual provides verification that his resources have been reduced to or below the resource limit, document the reduction in resources in the individual's case record. Reinstatement his Medicaid eligibility in the MMIS effective the first day of the month in which his resources are less than or equal to the resource limit.

If the individual does NOT provide verification within 3 months of the suspension effective date that his resources have been reduced to or below the resource limit, close the case administratively and statistically. Do not take any action on his enrollment in the MMIS, because his eligibility has already been canceled. The individual will have to file a new Medicaid application.

M1460.600 INCOME DETERMINATION

- A. Introduction** This section provides the income requirements specific to determinations of eligibility for Medicaid participation in payment of long-term care services.
- B. F&C CN** If an institutionalized individual meets an F&C *CN* covered group, determine if his income is within the appropriate F&C income limit. The institutionalized individual is an assistance unit of one person; no income is deemed from responsible relatives. Use the policy and procedures in chapter M07 to determine countable income.
- C. ABD 80% FPL Group** *If an individual is aged, blind or disabled, determine if his income is less than or equal to 80% of the FPL. See M0810.002 A.5 for the ABD 80% FPL income limits. Use the policy in chapter S08 to determine countable income.*
- D. 300% SSI Income Limit Group** For purposes of this section, we refer to the ABD covered group and the F&C covered group of “individuals in medical facilities who have income less than or equal to 300% of the SSI individual payment limit” and “individuals receiving Medicaid waiver services who have income less than or equal to 300% of the SSI individual payment limit” as one covered group. We refer to this one group as “institutionalized individuals who have income within 300% of SSI” or the “300% SSI group.”
- 1. Assistance Unit** The institutionalized individual is an assistance unit of one person; no income is deemed from responsible relatives.
 - 2. Income Limit** The income limit for ABD and F&C individuals in the 300% SSI group is 300% of the SSI individual payment limit (see M0810.002 A. 3).
 - 3. Countable Income**

Income sources listed in section M1460.610 are NOT considered income.

Income sources listed in section M1460.611 ARE counted as income.

All other income is counted. The individual’s gross income is counted; no exclusions are deducted.

To determine an income type or source and to determine how to count the income, use the policy and procedures in chapter S08 for all individuals (both ABD and F&C) in this covered group.

Income is projected for the month for which eligibility for LTC is being determined. This calculation is based upon the income received in the past month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount expected to be received.
- E. MN Income - All MN Covered Groups** The medically needy (MN) individual income limits are listed in Appendix 5 to subchapter M0710 and in section M0810.002 A.4.

**1. ABD MN
Covered
Groups**

Evaluate MN resource and income eligibility for ABD individuals who have income over the 300% SSI income limit.

The income sources listed in sections M1460.610 “What is Not Income” and M1460.611 “Countable Income for the 300% SSI Group” are NOT counted. Countable income is determined by the income policy in chapter S08; applicable exclusions are deducted from gross income to calculate the individual’s countable income.

The income actually received in the retroactive period is considered for retroactive eligibility. The income expected to be received within the application month is considered when determining eligibility in that month. The income expected to be received within a month is counted in that month for ongoing eligibility.

**2. F&C MN
Covered
Groups**

Evaluate MN resource and income eligibility for F&C individuals who have income over the 300% SSI income limit.

Countable income is determined by the income policy in chapter M07, using a monthly budget period; applicable exclusions are deducted from gross income to calculate the individual’s countable income. In addition, the income sources listed in sections M1460.610 B and M1460.611 are NOT counted.

Anticipated income is projected for the month for which eligibility is being determined. This calculation is based upon the income received in the prior month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount to be received.

M1460.610 WHAT IS NOT INCOME

A. Introduction

This section contains a list of items that are not considered as income when determining income eligibility for institutionalized individuals in medical facilities or Medicaid CBC waiver services.

NOTE: The income items in C. below ARE COUNTED as income only when determining F&C medically needy eligibility.

**B. What Is Not
Income - All
Covered Groups**

Do not consider the types of items in this subsection as income **when determining eligibility or patient pay for all covered groups.**

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

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

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

- | | |
|--|---|
| 17. Energy Assistance | Energy Assistance through Block Grants (Virginia's Fuel Assistance payments) is excluded [P.L. 93-644]. |
| 18. Radiation Exposure Trust Fund | Radiation Exposure Compensation Trust Fund payments are excluded [P.L. 101-426]. |
| 19. Agent Orange | Agent Orange Payments are excluded [P. L. 101-239]. |
| 20. Native American Funds | The following funds for Native Americans are excluded: <ul style="list-style-type: none">a. Alaska Native Claims Settlement Act (cash payments not to exceed \$2,000) [P.L. 100-241]b. Maine Claims Settlement Act [P.L. 96-420]c. Blackfeet and Gros Ventre [P.L. 92-254]d. Grand River Band of Ottawa [P.L. 94-540]e. Red Lake Band of Chippewa [P.L. 98-123] |

**C. What Is NOT
Income For All
Covered Groups
EXCEPT F&C
MN**

The items below are NOT income when determining eligibility for all covered groups EXCEPT for the F&C MN covered groups. Count these income sources in the F&C medically needy income determination, **but NOT in the patient pay calculation.**

**1. Specific VA
Payments**

The following VA payments are NOT income for all covered groups EXCEPT the F&C MN covered groups:

- a. Payments for Aid and Attendance or housebound allowances. Refer to section M1470.100 for counting Aid and Attendance payments as income in the patient pay calculation.

NOTE: This applies to all LTC recipients, including those patients who reside in *state* veterans' care centers.

M1460.650 RETROACTIVE INCOME DETERMINATION

- A. Policy**
- The retroactive period is the three months immediately prior to the Application month. The three-month retroactive period cannot include a portion of a prior Medicaid medically needy spenddown budget period in which eligibility was established.
- 1. Institutionalized Individual**
- For the retroactive months in which the individual was institutionalized *in a medical facility*, determine income eligibility on a monthly basis using the policy and procedures in this subchapter (M1460). *An individual who lived outside of a medical institution during the retroactive period must have retroactive Medicaid eligibility determined as a non-institutionalized individual.*
- A spenddown must be established for any month(s) during which excess income existed. Go to M1460.700 for spenddown policies and procedures for medically needy institutionalized individuals.
- 2. Individual Not Institutionalized**
- For the retroactive months in which the individual was NOT institutionalized, determine income eligibility for the ABD groups using the ABD policy and procedures in chapter S08. Determine income eligibility for the F&C groups using policy and procedures in chapter M07. A spenddown must be established for any month(s) during which excess income existed. See Chapter M13 for spenddown policies and procedures.
- 3. Retroactive Entitlement**
- If an applicant meets all eligibility requirements, he is entitled to Medicaid coverage for the month(s) in which all eligibility factors were met.
- B. Countable Income**
- Countable income is that income which was actually received in the retroactive month(s). Count the income received in the months in which the individual meets all other Medicaid eligibility requirements.
- If the individual was CN in the retroactive month, the countable income is compared to the appropriate income limit for the retroactive month. **Medicaid income eligibility is determined on a monthly basis for the MN institutionalized individual.**
- C. Entitlement**
- Retroactive coverage cannot begin earlier than the first day of the third month prior to the application month. When an applicant reports that he received a medical service within the retroactive period, entitlement for Medicaid will begin with the first day of the third month prior to the application month, provided all eligibility factors were met in all three months. If the institutionalized applicant had excess income in the retroactive period, entitlement may begin the first day of the month in which the retroactive spenddown was met.
- For additional information, refer to section M1510.101.
- D. Retroactive Income Determination Example**
- EXAMPLE #3:** A disabled institutionalized individual applies for Medicaid on June 5 and requests retroactive coverage for unpaid medical bills that he incurred in March, April, and May. His disability onset date was April 10. He was institutionalized on April 10. The retroactive period is March, April and

b. F&C

060 F&C who does not meet "Individuals Under Age 21 in an ICF or ICR/MR covered group, not blind or disabled"

082 Institutionalized child under age 21 in an ICF or ICF/MR, not blind or disabled

NOTE: Children who are eligible in the Child Under Age 19, FAMIS Plus, covered group should be enrolled in the appropriate AC for their age and income (see 9 below)

6. All Foster Care and Adoption Assistance

*072 Adoption Assistance
076 Foster Care*

7. Individuals Under age 21

*075 child under supervision of Juvenile Justice Department
082 Child in an ICF or ICF/MR*

8. LIFC

*081 Parent/caretaker of a dependent child
083 Unemployed parent of a dependent child; 2 parent household*

9. Child Under Age 19 FAMIS Plus

- a. Child under age 6 w/income less than or equal to the 100% FPL
091*
- b. Child under age 6, income greater than the 100% FPL but less than or equal to the 133% FPL
090*
- c. Child age 6 to 19
insured or uninsured w/income less than or equal to the 100% FPL; or
insured w/income greater than 100% and less than or equal to the 133% FPL
092*
- d. Uninsured child age 6 to 19 w/income greater than 100% FPL and less than or equal to the 133% FPL
094*

10. Pregnant Women

091

11. BCCPTA

066

B. CN Eligible Complete & Send Notice

Complete a "Notice of Action on Medicaid and FAMIS to notify the individual of his Medicaid eligibility and coverage begin date. Go to subchapter M1470 to determine the individual's patient pay.

**C. Income Exceeds
CN Covered
Groups Limits**

If income exceeds the 300% SSI limit, evaluate as MN. If the individual meets an MN covered group, re-calculate countable income for MN.

Subtract the income exclusions listed in sections M1460.610 and 611 that apply to the individual's MN covered group. Go to section M1460.700 below.

If the individual does NOT meet an MN covered group, he is not eligible for Medicaid; go to subsection *D.* below.

D. Ineligible--Notice

Complete and send a "Notice of Action on Medicaid and FAMIS" to the individual notifying him that he is not eligible for Medicaid and of his appeal rights.

M1460.700 MEDICALLY NEEDY INCOME & SPENDDOWN

A. Policy

Institutionalized individuals whose income exceeds the 300% SSI income limit must be placed on a monthly medically needy (MN) spenddown if they meet a MN covered group and have countable resources that are less than or equal to the MN resource limit. Countable income for the MN is different than countable income for the 300% SSI covered group. Recalculate income using medically needy income principles.

For individuals who were within a spenddown budget period prior to the month in which they become institutionalized, prorate and shorten the spenddown budget period for the months prior to admission to long-term care services.

**G. Facility
Spenddown
Determination
Procedures**

To determine spenddown eligibility for a medically needy institutionalized individual whose spenddown liability is greater than the Medicaid rate, take the following actions:

**1. Calculate
Private Cost
of Care**

Multiply the facility's **private** per diem rate by the number of days the individual was actually in the facility in the month. Do not count any days the individual was in a hospital during the month.

The result is the private cost of care for the month.

**2. Compare to
Spenddown
Liability**

Compare the private cost of care to the individual's spenddown liability for the month.

a. Private Cost of Care Greater Than or Equal To Spenddown Liability

If the private cost of care is **greater than or equal to** the individual's spenddown liability, the individual meets the spenddown in the month because of the private cost of care. He is entitled to **full-month coverage** for the month in which the spenddown was met.

Enroll the individual in Medicaid with the begin date of the first of the month, the end date the last day of the month. Go to section M1460.720 below for enrollment procedures. Determine patient pay according to subchapter M1470.

b. Private Cost of Care Less Than Spenddown Liability

If the private cost of care is less than the individual's spenddown liability, **determine spenddown on a day-by-day basis** in the month by deducting allowable incurred expenses from the spenddown liability.

From the spenddown liability, deduct old bills, carry-over expenses and incurred medical/remedial care expenses per subchapter M1340. When the monthly spenddown liability is reduced to \$0, eligibility is established. Eligibility can be established only **AFTER** the expenses are actually incurred.

If the spenddown is met any time during the month, the individual is eligible for full month coverage. Enroll the individual in Medicaid with the begin date of the first of the month, the end date the last day of the month. Go to section M1460.720 below for enrollment procedures.

Determine patient pay according to subchapter M1470.

**3. Example -
Cost of Care
Less Than
Spended
Liability, No
Prior
Spended
(using July
2012 figures)**

EXAMPLE #4: Mr. Not lives in Group III and applied for Medicaid on April 21 as a disabled individual. He is in a nursing facility and was admitted on April 1. The DDS determined that he is disabled. He has not previously been on spenddown. He has a \$8,400 hospital bill and a \$1,500 physician's bill for October 10 to October 20 (total \$9,900) on which he still owes a total of \$9,000. He has a \$578 outpatient hospital bill for November 3. He has no health insurance. His income is \$2,800 per month disability benefit from a private company. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His resources are within the Medicaid limit in April (application month).

He is not eligible as CN because his \$2,800 gross income exceeds the 300% SSI income limit. The facility's Medicaid rate is \$75 per day. His MN income eligibility is calculated:

$$\begin{array}{r}
 \$2,800.00 \text{ disability benefit} \\
 - \quad 20.00 \text{ general income exclusion} \\
 \hline
 \$2,780.00 \text{ MN countable income} \\
 - \quad 443.33 \text{ MNIL for 1 month for 1 person in Group III} \\
 \hline
 \$2,336.67 \text{ spenddown liability}
 \end{array}$$

The Medicaid rate for the admission month is calculated as follows:

$$\begin{array}{r}
 \$75.00 \text{ Medicaid per diem} \\
 \times \quad 30 \text{ days} \\
 \hline
 \$2,250.00 \text{ projected facility Medicaid rate}
 \end{array}$$

The \$2,336.67 spenddown liability is greater than the Medicaid rate of \$2,250.00. Because his spenddown liability is greater than the Medicaid rate, his April application is denied and he is placed on a spenddown.

On May 1 his authorized representative requests re-evaluation of his April spenddown eligibility. Mr. Not was in the facility for the entire month of April. The facility's private rate is calculated:

$$\begin{array}{r}
 \$100.00 \text{ private per diem} \\
 \times \quad 30 \text{ days in April} \\
 \hline
 \$3,000.00 \text{ facility private rate}
 \end{array}$$

His spenddown eligibility must be determined on a daily basis. Because he was not previously on spenddown, his verified old bills are deducted first from the spenddown liability. As of April 1 (the first day of the budget period), he owes the hospital \$8,000 and the physician \$1,000 for services he received on October 1. His eligibility is calculated:

$$\begin{array}{r}
 \$2,336.67 \text{ spenddown liability} \\
 - \quad 9,000.00 \text{ old bills owed 4-1} \\
 \hline
 0 \text{ spenddown balance on 4-1}
 \end{array}$$

Because the spenddown was met on April 1, Mr. Not is entitled to medically needy Medicaid for the period 4-1 through 4-30. The old bills' balance, or \$6,663.33 (\$9,000- 2,336.67= \$6,663.33) not used to establish eligibility can be used in subsequent months to reduce the spenddown liability.

6. Example - On Prior Spenddown, Cost of Care Less Than Spenddown Liability

EXAMPLE #5: Ms. Was lives in Group I and applied for Medicaid on May 6, 2001, as disabled. She is in a nursing facility and was admitted on May 1, 2001. She had applied for Medicaid previously and was on a spenddown from December 1, 1999 through May 31, 2000, which she met on May 2, 2000. She did not re-apply until May 2001. She verifies that she has an unpaid \$2,300 hospital bill and a \$1,500 physician's bill for September 10 to September 12, 2000 (total = \$3,800) on which she pays \$50 a month. She also has a retroactive incurred expense - a \$678 outpatient hospital bill for services dated February 13, 2001. She has no health insurance and is not eligible for Medicare.

She was not institutionalized in the retroactive period. Her income in the retroactive spenddown budget period was \$1,600 per month CSA disability. The retroactive spenddown budget period is February, March and April; the income limit is \$650.

Her retroactive spenddown liability is \$4,090.

\$1,600	CSA disability
<u>- 20</u>	general income exclusion
1,580	countable income
<u>x 3</u>	months
4,740	countable income for retroactive spenddown budget period
<u>- 650</u>	MNIL for retroactive spenddown budget period
\$4,090	retroactive spenddown liability

Her May 2001 application is a re-application. The September 2000 medical expenses are old bills based on her May 2001 re-application because they were incurred prior to the re-application's retroactive period, were not incurred during a prior spenddown budget period in which eligibility was established. These old bills, totaling \$3,800, are deducted from the retroactive spenddown liability. Her retroactive spenddown eligibility is calculated:

\$4,090	retroactive spenddown liability
<u>- 3,800</u>	September 2000 old bills (hospital & physician bills)
290	spenddown balance on February 2, 2001
<u>- 678</u>	February 13, 2001 outpatient expense
0	spenddown balance on February 13, 2001

The retroactive spenddown was met on February 13, 2001. Ms. Was is enrolled in retroactive Medicaid for the period February 13, 2001 through April 30, 2001.

Her income starting May 1, 2001 increased. Her Civil Service Annuity is \$1,620 per month and she began to receive Social Security of \$300 per month; total income is \$1,920 per month. Because this exceeds the CN300% SSI income limit, her medically needy income eligibility is calculated as follows:

\$1,920.00	total monthly income
<u>- 20.00</u>	general income exclusion
1,900.00	countable income
<u>- 216.67</u>	MNIL for 1 month for 1 person in Group I
\$1,683.33	spenddown liability

The facility's Medicaid per diem rate is \$45. The projected Medicaid rate for the month is calculated as follows:

\$ 45	Medicaid per diem
<u>x 31</u>	days
\$1,395	projected facility Medicaid rate

The \$1,683.33 spenddown liability is greater than the Medicaid rate of \$1,395. Because her spenddown liability is greater than the Medicaid rate, her May application is denied and she is placed on a monthly spenddown for the certification period of May 1, 2001 through April 30, 2002.

On June 3, her authorized representative requests re-evaluation of her spenddown for May. She was in the facility for 31 days in May. The private cost of care for May is calculated:

\$ 53	private per diem cost
<u>x 31</u>	days in May
\$1,643	private cost of care

The private cost of care, \$1,643, is less than her spenddown liability of \$1,683.33. Therefore, her spenddown eligibility in May must be determined on a daily basis. The prospective budget period is May 1 through May 31, 2001. Since all of her September 2000 incurred medical expenses were used to meet her retroactive spenddown, they cannot be deducted from her current spenddown, even though she still owes money on those expenses and makes payments on them. The only incurred medical expenses which can be deducted are the medical expenses she incurred in May. In addition to the facility care, she incurred a doctor's expense on May 30 of \$100. Her spenddown eligibility for May is determined:

\$1,683.33	spenddown liability
- 1,590.00	30 days @ \$53 per day (5-1 through 5-30)
<u>- 100.00</u>	noncovered doctor's expense 5-30-2001
0	spenddown balance on 5-30-2001

Because the spenddown was met on May 30, Ms. Was is entitled to Medicaid coverage beginning May 1, 2001 and ending May 31, 2001.

M1460.740 SPENDDOWN FOR PATIENTS RECEIVING CBC

A. Policy

An individual meets the definition of "institutionalized" when he is screened and approved for Medicaid waiver services and the services are being provided. An individual who has been screened and approved for Medicaid waiver services and whose income exceeds the 300% SSI income limit is not eligible for Medicaid until he meets the monthly spenddown liability. These determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred. The private cost of his home-based medical care is deducted as a noncovered medical expense.

For an individual on spenddown **before** starting Medicaid CBC waiver services, the spenddown budget period and the spenddown liability are prorated and recalculated to include the months prior to the receipt of Medicaid CBC services. A separate monthly spenddown budget period is calculated for each month of receipt of Medicaid CBC services.

A medically needy (MN) CBC patient must incur medical expenses, including old bills, carry-over expenses and the cost of CBC at the private rate, that equal or exceed the spenddown liability for the month. From the spenddown liability, deduct old bills, carry-over expenses and incurred medical/remedial care expenses per section M1340.210. When the monthly spenddown liability is reduced to \$0, eligibility is established. Eligibility can be established only **AFTER** the expenses are actually incurred. Do not project CBC expenses. The eligibility begin date is the first day of the month in which the spenddown was met and the end date is the last day of the month.

B. CBC Spenddown Eligibility Procedures

To determine spenddown eligibility for a CBC institutionalized individual, take the following actions:

1. Calculate Private Cost of Care

Multiply the CBC provider's (or providers' if the individual has multiple CBC providers) **private** hourly rate by the number of hours of service the individual actually received from the provider in the month.

The result is the private cost of care for the month.

2. Compare to Spenddown Liability

Compare the private cost of care to the individual's spenddown liability for the month.

3. Private Cost of Care Greater Than or Equal To Spenddown Liability

If the private cost of care is **greater than or equal to** the individual's spenddown liability, the individual meets the spenddown in the month because of the private cost of care. He is entitled to **full-month coverage** for the month in which the spenddown was met.

Enroll the individual in Medicaid with the begin date of the first of the month, the end date the last day of the month. Go to section M1460.743 below for enrollment procedures. Determine patient pay according to subchapter M1470.

4. Private Cost of Care Less Than Spenddown Liability

If the private cost of care is less than the individual's spenddown liability, **determine spenddown on a day-by-day basis** in the month by deducting allowable incurred expenses from the spenddown liability. Refer to section M1340.210 to determine allowable deductions from the individual's spenddown liability.

If the spenddown is met any time in the month, the individual is eligible for full-month Medicaid coverage beginning the first day of the month in which the spenddown was met and ending the last day of the month.

5. Example - Private Cost of Care Less Than Spenddown Liability, No Prior Spenddown

EXAMPLE #6: Mr. May lives in Group III and applied for Medicaid on April 21, 2000, as a disabled individual. He was screened and approved for the EDCD waiver on April 10, 2000. The DDS determined that he is disabled. He has no health insurance. His income is \$1,800 per month disability benefit from a private company. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His resources are within the Medicaid limit in April 2000 (application month).

He is not eligible as CN because his \$1,800 gross income exceeds the 300% SSI income limit. His MN income is calculated:

\$1,800	disability benefit
- 20	general income exclusion
\$1,780	MN countable income
- 325	MNIL for 1 month for 1 person in Group III
\$1,455	spenddown liability

His CBC costs cannot be projected. Eligibility can be established only after the expenses are actually incurred. He received 20 days of CBC services in April.

His April application is denied and he is placed on a monthly spenddown for the certification period of 4-1-2000 through 3-31-2001.

\$ 8	per hour private rate
x 6	hours per day, 7 days a week
\$ 48	private per diem cost
x 20	days in April
\$ 960	private cost of care

The private cost of care, \$960, is less than Mr. May's spenddown liability of \$1,455. His Medicaid eligibility was not established in April.

6. Example - On Prior Spenddown, Private Cost of Care More Than Spenddown Liability

EXAMPLE #7: Ms. Gray lives in Group I and applied for Medicaid on May 6, 2000, as disabled. She was screened and approved for Medicaid EDCD waiver services on May 2, 2000; the services started on May 4, 2000. She is not married and has no dependents. She had applied for Medicaid previously and was on a spenddown from December 1, 1998 through May 31, 1999, which she met on May 2, 1999. She did not re-apply until May 2000. She verifies that she has an unpaid \$2,300 hospital bill and a \$1,500 physician's bill for September 10 to September 12, 1999 (total = \$3,800) on which she pays \$50 a month. She also has an incurred expense in the retroactive period - a \$678 outpatient hospital bill for services dated February 13, 2000. She has no

health insurance and is not eligible for Medicare.

She was not institutionalized in the retroactive period. Her income in the retroactive spenddown budget period was \$1,600 per month Civil Service Annuity (CSA) disability. The retroactive spenddown budget period is February, March and April, 2000; the income limit is \$650.

Mrs. Gray's retroactive spenddown liability is \$4,090:

\$1,600	CSA disability
<u>- 20</u>	general income exclusion
1,580	countable income
<u>x 3</u>	months
4,740	countable income for retroactive spenddown budget period
<u>- 650</u>	MNIL for retroactive spenddown budget period
\$4,090	retroactive spenddown liability

There was a break between spenddown budget periods (June, July, August, September, October, November and December 1999 and January 2000). The September 1999 medical expenses are old bills based on her May 2000 re-application because they were incurred prior to the re-application's retroactive period and were not incurred during a prior spenddown budget period in which eligibility was established. These old bills, totaling \$3,800, are deducted from the retroactive spenddown liability. Her retroactive spenddown eligibility is calculated:

\$4,090	retroactive spenddown liability
<u>- 3,800</u>	September 1999 old bills (hospital & physician bills)
290	spenddown balance on February 1, 2000
<u>- 678</u>	February 13, 2000 outpatient expense
0	spenddown balance on February 13, 2000 (\$388 carry-over balance)

A balance of \$388 (\$678-290) on the 2-13-2000 outpatient expense remains and can be used as a carry-over expense for the first prospective budget period.

The retroactive spenddown was met on 2-13-2000. Ms. Gray is enrolled in retroactive Medicaid for the period 2-13-2000 through 4-30-2000.

Her income starting May 1, 2000 increased. Her Civil Service Annuity is \$1,620 per month and she began to receive Social Security of \$300 per month; total income is \$1,920 per month. Because this exceeds the 300% SSI income limit, her medically needy income eligibility is calculated as follows:

\$1,920.00	total monthly income
<u>- 20.00</u>	general income exclusion
1,900.00	countable income
<u>- 216.67</u>	MNIL for 1 month for 1 person in Group I
\$1,683.33	spenddown liability
<u>- 388.00</u>	carry-over expense from retroactive period
\$1,295.33	spenddown liability balance

Her May application is denied and she is placed on a monthly spenddown for the certification period of May 1, 2000 through April 30, 2001.

On June 3, she submits verification of expenses for May. In May, she received CBC services from one provider for 28 days, 6 hours per day, 7 days per week, at the private hourly rate of \$10. The private cost of care for May is calculated:

\$ 10	per hour private rate
<u>x 6</u>	hours per day, 7 days a week
\$ 60	private per diem cost
<u>x 28</u>	days received services in May
\$1,680	private cost of care

The private cost of care, \$1,680, is more than her spenddown liability of \$1,295.33. Therefore, she is eligible for the period 5-1-2000 through 5-31-2000.

M1460.750 MEDICALLY NEEDED ENROLLMENT PROCEDURES

A. AC

1. Individual Does Not Have Medicare Part A

If the individual does Not have Medicare Part A, use the appropriate MN AC:

- Aged = **018**
- Blind = **038**
- Disabled = **058**
- Child Under 21 in ICF/ICF-MR = **098**
- Child Under 18 = **088**
- Juvenile Justice Child = **085**
- Foster Care/ Adoption Assistance Child = **086**
- Pregnant Woman = **097**

2. Individual Has Medicare Part A

If the individual has Medicare Part A, compare the individual's monthly MN countable income to the QMB monthly income limit for 1 person (see section M0810.002 for the current QMB limit):

- a. When income is less than or equal to the QMB limit, enroll using the following ACs:
 - Aged = **028**
 - Blind = **048**
 - Disabled = **068**
- b. When income is greater than the QMB limit, enroll using the following ACs:
 - Aged = **018**
 - Blind = **038**
 - Disabled = **058**

B. Patient Pay Determine patient pay according to subchapter M1470.

C. Notices & Re-applications

1. Spenddown Liability Less Than or Equal to Medicaid Rate

When the individual's spenddown liability is less than or equal to the 31-day Medicaid rate for the facility, the individual has ongoing eligibility for the 12-month certification period. The individual must file a redetermination after the 12-month certification period ends.

2. Spenddown Liability Greater Than Medicaid Rate

When the individual's spenddown liability exceeds the facility's Medicaid rate and the spenddown is met, the individual does NOT have ongoing eligibility. Therefore, the individual will need to submit monthly reports of actual expenses and changes in income and resources so that spenddown eligibility can be determined each month. This report, "Medical Expense Record - Medicaid" (form # 032-03-023) is found in subchapter M1330, Appendix 1. Instructions for use and completion are also in subchapter M1330, Appendix 1.

The notification to the applicant (and his representative) approving the application with spenddown must include a copy of the "Medical Expense Record - Medicaid" for the individual to use to provide verification of the expenses used to meet the spenddown.

a. When Spenddown Liability is Met

When expenses have been incurred, the individual must submit the "Medical Expense Record - Medicaid" with bills or receipts for medical services either paid or incurred, and evidence of third party payment or denial of payment if applicable. Entitlement begins the first day of the month in which the spenddown is met, and ends on the last day of the month.

Appropriate notice of action must be sent to the applicant every time spenddown eligibility is evaluated. After eligibility is established, the usual reporting and notification processes apply. The individual must provide verification of income and resources for any month for which bills are presented.

b. Certification Period

The certification period is 12 months; therefore, a new application is not required each month. However, the applicant must file a redetermination for Medicaid when the 12-month certification period ends. If the redetermination is not filed, the individual's Medicaid must be canceled, the case must be closed and the individual will have to file a new application.

M1480 Changes

Changed	Effective Date	Pages Changed
TN #97	9/1/12	pages 3, 6, 8b, 16 pages 20-24, 26 Page 20a was deleted.
UP #7	7/1/12	pages 11, 14, 18c, 21 pages 32, 66, 67, 69
UP #6	4/1/12	pages 7, 18c, 66, 68, 69, 70
TN #96	10/1/11	pages 7, 14, 66, 71
UP #5	7/1/11	page 66
TN #95	3/1/11	pages 7-9, 13, 18a, 18c, 66, pages 69, 70
TN #94	9/1/10	pages 64, 66, 69, 70
TN #93	1/1/10	Table of Contents, page ii pages 3, 8b, 18, 18c, 20a pages 21, 50, 51, 66, pages 69, 70, 93 Appendix 4 was removed.
Update (UP) #1	7/1/09	page 66
TN # 91	5/15/09	pages 67, 68 pages 76-93

- an amount designated by a DMAS Hearing Officer, or
- an amount *actually* transferred to the community spouse by the institutionalized spouse *following* a court spousal support order *issued as the result of an appeal of a DMAS Hearing Officer's decision*

exceeds the amount of resources otherwise available to the community spouse.

- 5. Continuous Period of Institutionalization** means 30 consecutive days of institutional care in a medical institution, or 30 consecutive days of receipt of Medicaid waiver services (CBC), or 30 consecutive days of a combination of institutional and waiver services. Continuity is broken only by 30 or more days absence from a medical institution or 30 or more days of non-receipt of waiver services.
- 6. Couple's Countable Resources** means all of the couple's non-excluded resources, regardless of state laws relating to community property or division of marital property. For purposes of determining the combined and separate resources of the institutionalized and community spouses when determining the institutionalized spouse's eligibility, the couple's home, contiguous property, household goods, and one automobile are excluded.
- 7. Dependent Child** **means a child 21 years old or older**, of either spouse, who lives with the community spouse and who may be claimed as a dependent by either member of the couple for tax purposes pursuant to the Internal Revenue Code. Tax dependency is verified by a verbal or a written statement of either spouse.
- 8. Dependent Family Member** means a dependent parent, minor child, dependent child, or dependent sibling (including half brothers/sisters and adopted siblings) of either member of a couple who resides with the community spouse and who may be claimed as a dependent by either member of the couple for tax purposes under the Internal Revenue Code. Tax dependency is verified by a verbal or a written statement of either spouse.
- 9. Excess Shelter Allowance** means the actual monthly expense of maintaining the community spouse's residence that exceeds the excess shelter standard (30% of the monthly maintenance needs standard). Actual monthly expenses are the total of:
- rent or mortgage including interest and principal;
 - taxes and insurance;
 - any maintenance charge for a condominium or cooperative; and
 - the utility standard deduction under the Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps) that would be appropriate to the number of persons living in the community spouse's household, if utilities are not included in the rent or maintenance charge [Section 1924(d)(4) of the Social Security Act].

- 20. Monthly Maintenance Needs Standard** The monthly maintenance needs standard is 150% of 1/12 of the federal poverty level for a family of two in effect on July 1 of each year [Section 1924(d)(3)(A)(i)].
- See section M1480.410 below for the current monthly maintenance needs standard.
- 21. Otherwise Available Income or Resources** means income and resources which are legally available to the community spouse and to which the community spouse has access and control.
- 22. Promptly Assess Resources** means within 45 days of the request for resource assessment, unless the delay due to non-receipt of documentation or verification, if required, from the applicant or from a third party.
- 23. Protected Period** means a period of time, not to exceed 90 days after an initial determination of Medicaid eligibility. During the protected period, the amount of the community spouse resource allowance (CSRA) will be excluded from the institutionalized spouse's countable resources IF the institutionalized spouse expressly indicates his intention to transfer resources to the community spouse.
- 24. Resource Assessment** means a calculation, completed by request or upon Medicaid application, of a couple's combined countable resources at the beginning of the **first** continuous period of institutionalization of the institutionalized spouse beginning on or after September 30, 1989.
- 25. Spousal Protected Resource Amount (PRA)** means at the time of Medicaid application as an institutionalized spouse, the greater of:
- the spousal resource standard in effect at the time of application;
 - the spousal share, not to exceed the maximum spousal resource standard in effect at the time of application;
 - the amount of resources designated by a DMAS Hearing Officer, or
 - an amount *actually* transferred to the community spouse by the institutionalized spouse pursuant to a court spousal support order *issued as the result of an appeal of the DMAS Hearing Officer's decision.*
- 26. Spousal Resource Standard** means the minimum amount of the couple's combined countable resources (\$12,000 in 1989) necessary for a community spouse to maintain himself in the community. This amount increases each calendar year after 1989 by the same percentage increase as in the Consumer Price Index (CPI). [1924(f)(2)(A)(i)].
- See section M1480.231 for the current spousal resource standard.

- 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 within the month of application for Medicaid, whichever is later.

NOTE: Once an institutionalized spouse has established Medicaid eligibility as an institutionalized spouse, count only the institutionalized spouse’s resources when redetermining the institutionalized spouse’s Medicaid eligibility. Do not count or deem the community spouse’s resources available to the institutionalized spouse.

If an institutionalized spouse’s Medicaid coverage was cancelled and he reapplies as an institutionalized individual, use only the resources in his name (including his share of jointly owned resources) for the eligibility determination.

The following table contains examples that indicate when an individual is treated as an institutionalized individual for the purposes of the resource assessment:

Screened and Approved in:	In a Facility?	Application Month	Resource Assessment Month	Processing Month	Month of Application/ ongoing as Institutionalized	Retroactive Determination as Institutionalized (in a medical facility)
January	no	January	January	January	yes	no
January	no	February	February	February	yes	no
N/A	yes	January	first continuous period of institution- alization	February	yes	yes
January	no	March	March	April	yes	no
April	no	March	April	Whenever	no, but yes for April	no

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 Behavioral Health and Developmental Services (DBHDS) 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.

requested data, the worker is unable to complete the resource assessment and *eligibility as a married institutionalized individual cannot be determined. The application must be processed using rules for non-institutionalized individuals and payment for LTC services must be denied for failure to verify resources held at the beginning of institutionalization.*

b. Applicant Notifies Agency of Difficulty Securing Verifications

If the applicant is unable to provide verification of the value of the couple's resources held at the beginning of the first continuous period of institutionalization and notifies the EW of difficulty in securing the requested data, the applicant may claim undue hardship.

Undue hardship can be claimed when both spouses have exhausted all avenues to verify the value of the resources owned on the first day of the first month of the first continuous period of institutionalization. When undue hardship is claimed, the applicant must provide documentation of the attempts made to obtain the verification. **Claims of undue hardship must be evaluated and can only be granted by DMAS.** The EW must send a summary of the needed verifications and documentation of the attempts to secure the verifications, along with the applicant's name and case number to:

Division of Policy and Research, Eligibility Section
DMAS
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

If DMAS determines undue hardship does not exist, the resource assessment cannot be completed and the application must be denied due to failure to verify resources held at the beginning of institutionalization. If DMAS determines undue hardship exists, the completion of a resource assessment is waived, and the spousal resource standard is to be substituted for the spousal share in determining the individual's resource eligibility. Go to section M1480.230 below.

**5. Completing
the Medicaid
Resource
Assessment**

When verification is provided, completion of the resource assessment establishes the spousal share which is equal to ½ of a couple's total countable resources as of **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. The spousal share is one factor in determining the spousal protected resource amount (PRA) in section M1480.230 below.

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 designated by a DMAS Hearing Officer;*
- *an amount **actually transferred** to the community spouse from the institutionalized spouse under a **court spousal support order** issued as the result of an appeal of the DMAS Hearing Officer's decision.*

The EW cannot accept a court order for a greater PRA unless the individual has exhausted the Medicaid administrative appeals process, the individual appealed the DMAS Hearing Officer's decision to the circuit court and the circuit court ordered a higher amount.

If the individual does not agree with the PRA, see subsection F. below.

Once the PRA is determined, it remains a constant amount for the current Medicaid application (including retroactive months). If the application is denied and the individual reapplies, the spousal share remains the same but a new PRA must be determined.

3. Deduct Partnership Policy Disregard Amount

When the institutionalized spouse is entitled to a Partnership Policy disregard, deduct a dollar amount equal to the benefits paid as of the month of application.

**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 and the institutionalized spouse does not have Medicare Part A, the institutionalized spouse is not eligible for Medicaid coverage because of excess resources.

If the institutionalized spouse has Medicare Part A, he may be eligible for limited coverage QMB, SLMB or QI Medicaid (which will not cover the cost of the LTC services) because the resource requirements and limits are different. **The resource policies in subchapter M1480 do not apply to limited-coverage Medicaid eligibility determinations.** Follow the procedures for determining resource eligibility for an individual in Chapter S11. More information about the QMB, SLMB, and QI covered groups is contained in subchapter M0320.

Note: The institutionalized spouse cannot be eligible for QDWI Medicaid.

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:

- determine the community spouse resource allowance (CSRA). To calculate the CSRA, see sections M1480.240 and 241 below;
- determine a protected period of eligibility for the institutionalized spouse, if the institutionalized spouse expressly states his intent to transfer resources that are in his name to the community spouse; see section M1480.240 below.

**C. Example--
Calculating the
PRA**

EXAMPLE #4: (Use the "Institutionalized Spouse Resource Eligibility Worksheet," available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi or the electronic Resource Assessment and Eligibility Workbook located on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/training/index.cgi>.)

Mr. A is married to a community spouse. He applied for Medicaid on December 2, 1997. The beginning of his first continuous period of institutionalization which began on or after 9-30-89 was October 12, 1993, when he was admitted to a nursing facility. He was discharged from the facility on February 5, 1995, then readmitted to the nursing facility on December 5, 1997 and remains there to date. Eligibility is being determined for December 1997.

Step 1:

The couple's total countable resources on October 1, 1993 (the first moment of the first day of the first continuous period of institutionalization) were \$130,000.

Step 2: \$150,000 ÷ 2 = \$75,000. The spousal share is \$75,000.

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);
- \$16,152 (*the spousal resource standard at the time of the application*);
- \$0 *DMAS hearing decision amount (there is none in this case).*
- \$0 *amount actually transferred to community spouse pursuant to court-ordered spousal support (there is none in case).*

Since \$75,000 is the greatest, \$75,000 is the PRA.

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 *full-benefit* Medicaid in November 1996 (the month for which eligibility is being determined).

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). He is not eligible for full-benefit Medicaid and the denial was sustained.

E. Example--PRA Is Amount Transferred Per Court-Ordered Spousal Support

EXAMPLE #6: Mrs. C in Example #5 above is not satisfied with the Hearing Officer’s decision to increase the PRA to \$76,740 and files an appeal in circuit court. The hearing is held and the court orders Mr. C to transfer \$79,000 of his resources to Mrs. C. He immediately completes the transfers, provides the documentation to his eligibility worker, and requests his eligibility be re-evaluated.

Step 1: The couple's total countable resources as of December 1, 1994 (the first moment of the first day of the first continuous period of institutionalization) were \$150,000..

Step 2: $\$150,000 \div 2 = \$75,000$. The spousal share is \$75,000.

Step 3: The couple's total countable resources as of November 1, 1996 (the 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 \$80,760 in the application month);
- \$16,152 (the spousal resource standard at the time of the application);
- \$76,740 DMAS hearing decision amount
- \$79,000 amount actually transferred to community spouse pursuant to court-ordered spousal support.

Since \$79,000 is the greatest, \$79,000 is the PRA.

**F. PRA Revisions
Policy**

Revisions to the community spouse's calculated protected resource amount (PRA) can be made when:

1. A DMAS Hearing Officer determines that the income generated from the resources is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance (MMMNA). Substitute the amount the DMAS Hearing Officer determines for the PRA calculated in section M1480.232 above.
2. A DMAS Hearing Officer confirms that the initial PRA determination was incorrect.
3. A court orders spousal support in an amount that is greater than the PRA established in subsection B above *after the applicant completes the administrative appeals process.*

Virginia DSS, Volume XIII

M1520 Changes

Changed With	Effective Date	Pages Changed
TN #97	9/1/12	page 1
UP #7	7/1/12	pages 1, 7, 7c, 7g
TN #96	10/1/11	Table of Contents pages 1-7g pages 11-13 pages 21-24
TN #95	3/1/11	pages 6a, 7, 21, 22
TN #94	9/1/10	Table of Contents pages 3, 4b, 5, 6-6a, 10 Appendix 1 was removed.
UP #4	7/1/10	page 4
TN #93	1/1/10	pages 3, 4b, 5-6, 10, 15 pages 21, 22
Update (UP) #2	8/24/09	pages 1, 2, 13, 14, 17, 18
Update (UP) #1	7/01/09	page 3

M1520.000 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. The renewal should be initiated in the 11th month to ensure timely completion of the renewal. *The timeframe for acting on a change or renewal is 30 calendar days from the report of the change or upon receipt of the completed renewal form. When a telephone interview is conducted for a renewal, the 30 day period begins upon completion of the telephone interview.*

Exception: Children meeting the definition of a newborn in M0330.802 are to be enrolled as soon as possible upon report of the birth.

When a Medicaid enrollee no longer meets the requirements for his current covered group, prior to cancelling his coverage, he must be evaluated in all covered groups for which he may meet the definition. If the individual is not eligible for full benefit Medicaid coverage and is not eligible as a Medicare beneficiary, he must be evaluated for Plan First, unless he has declined that coverage.

1. *Negative Action Requires Advance Notice*

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).

2. *Renewal Approval Requires Notice*

When a change is reported and eligibility continues, no notice is necessary. When a renewal is completed and eligibility continues, the Notice of Action is used to inform the enrollee of continued eligibility and the next scheduled renewal.

3. *Voter Registration*

If the individual reports a change of address in person, voter registration application services must be provided (see M0110.300 A.3).

B. Procedures For Partial Review and Renewals

The policy and procedures in this subchapter are contained in the following sections:

- the requirements for **partial reviews** are in section M1520.100;
- the requirements for **renewals** are in section M1520.200;
- the policy and procedures for **cancelling** an 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.

Virginia DSS, Volume XIII

M17 Changes

Changed With	Effective Date	Pages Changed
TN #97	9/1/12	page 3 Appendix 1, page 1
UP #7	7/1/12	Table of Contents Pages 1-8 Appendix 1 Appendices 3 and 4 were removed.
TN #94	9/1/10	Title Page Table of Contents pages 1-7 Appendix 1 Appendix 2
TN #93	1/1/10	page 3

For those cases where Medicaid claims only include Managed Care Organization (MCO) capitation fees, the MCO Capitation Fees Recovery Form (*DMAS 752RMCO*) will be included with the claims and the custodian certificate (see Appendix 2 to this chapter). The MCO Capitation Fees Recovery Form provides an explanation of the MCO capitation fees submitted and paid as claims on the recipient's behalf during the recovery period. The TANF/Medicaid related claims information should be included with this form.

2. Recipient Fraud

a. *Medical Assistance Only*

The LDSS must refer cases of suspected fraud involving only medical assistance to the RAU for investigation using the DMAS 751R form. The LDSS must provide the RAU with the recipient's identifying information, address, and information regarding the circumstances of the suspected fraud. The LDSS is also responsible for reviewing and taking appropriate action for ongoing eligibility or termination of coverage, as appropriate. The RAU will determine the amount of the misspent funds and pursue recovery and/or legal action as appropriate.

b. *Cases in which Medicaid is received with TANF, AG, and other money payment public assistance programs.*

The LDSS is responsible for the investigation of suspected fraud involving cases with combined Medicaid and Auxiliary Grant (AG); Medicaid and TANF; and other money payment public assistance programs. The final disposition on all money payment fraud cases shall be communicated to the RAU no later than 5 business days after disposition for inclusion in federal reporting.

c. **Cases in which Medicaid is received with Supplemental Nutrition Assistance Program (SNAP), Energy Assistance, and other non money payment public assistance programs**

The LDSS must refer suspected fraud involving Medicaid cases combined with SNAP, Energy Assistance or other non money payment public assistance programs to the RAU using the DMAS 751R form. The local agency shall coordinate cases pending referral for prosecution with the RAU so that Medicaid may take concurrent action.

3. Provider Fraud

Cases of suspected fraud involving enrolled providers of medical services to Medicaid recipients shall be referred to the Medicaid Fraud Control Unit in the Office of the Attorney General, and a copy of the referral correspondence shall be sent to the Provider Review Unit at the Department of Medical Assistance Services.

Medicaid Fraud Referrals			
Error discovered M1700.200	Refer to DMAS RAU	Refer to LDSS Fraud Investigator	Refer to Medicaid Fraud Control Unit at the Attorney General's Office 1-800-371-0824
Medicaid only case	 Refer to RAU on the DMAS 751R		
Case includes TANF, AG or other money payment public assistance program		 Report disposition to RAU on the DMAS 751R	
Case includes SNAP, Energy Assistance, or any other non-money payment public assistance program	 Refer to RAU on the DMAS 751R		
Provider Fraud			

M21 Changes

Changed With	Effective Date	Pages Changed
TN #97	9/1/12	pages 3, 4
UP #7	7/1/12	pages 3, 4 Appendix 2, pages 1 Appendix 3, pages 1 and 2
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	pages 3, 8
TN #95	3/1/11	Table of Contents pages 5, 6, 14, 15, page 16 added Appendix 1
TN #94	9/1/10	page3 Appendix 3, pages 1 and 2
UP #3	3/1/10	pages 2-5
TN #93	1/1/10	page 2-4, 8
Update (UP) #2	8/24/09	page 4

opportunity period must be given to the applicant. The C&I verification requirements in M0220.100 apply to FAMIS, including use of the Social Security Administration (SSA) data match when a Social Security number (SSN) has been provided. If an SSN has not been provided for the child, a reasonable opportunity to provide acceptable documentation of C&I must be given. The reasonable opportunity period will last until the time of the first annual renewal.

If the child is not a U.S. citizen, the child must meet the FAMIS alienage requirements.

2. Alienage Requirements

Alien status must be verified. 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.

Lawfully residing non-citizen children under the age of 19 meet the alienage requirements for coverage in FAMIS.

3. No Emergency Services Only For Unqualified Aliens

Unqualified aliens, including illegal and non-immigrant aliens, do not meet the alienage requirements and are not eligible for FAMIS.

4. **Alien Eligibility Chart** Appendix 3, FAMIS Alien Eligibility Chart, lists alien groups that meet or do not meet the alienage requirements.
 5. **SSN** A Social Security number (SSN) or proof of application for an SSN (M0240) is **not** a requirement for FAMIS.
 6. **Assignment of Rights** Assignment of rights to payment for medical care from any liable third party is a condition of eligibility for the child.
- D. FAMIS Nonfinancial Requirements** The child must meet the following FAMIS nonfinancial requirements:
1. **Age Requirement** The child must be under age 19 for at least one day during the month. No verification is required.

A child no longer meets the age requirements for FAMIS effective the end of the month in which the child reaches age 19 years, provided he was under age 19 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 19.
 2. **Uninsured Child** The child must be uninsured, that is, he must not be covered under any health insurance plan offering hospital and medical benefits. See M2120.200.
 3. **State Employee Prohibition** A child is ineligible for FAMIS if he is a member of a family eligible for health insurance coverage under any Virginia State Employee Health Insurance Plan on the basis of the family member's employment with a State agency.
 4. **IMD Prohibition** The child cannot be an inpatient in an institution for mental diseases (IMD).

M2120.200 HEALTH INSURANCE COVERAGE

- A. Introduction** The intent of FAMIS is to provide health coverage to low-income uninsured children. Eligibility for this program is prohibited when creditable health insurance coverage is dropped within 4 months of the application for FAMIS unless good cause for discontinuing the insurance is demonstrated, or the child is pregnant.
- B. Definitions**
1. **Creditable Coverage** For the purposes of FAMIS, creditable coverage means coverage of the individual under any of the following:
 - church plans and governmental plans;
 - health insurance coverage, either group or individual insurance;
 - military-sponsored health care;
 - a state health benefits risk pool;
 - the federal Employees Health Benefits Plan;