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Department of Medical Assistance Services

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Virginia Medical Assistance Eligibility Manual

Transmittal #DMAS-1

The following acronyms are used in this cover letter:

- ABD – Aged, Blind or Disabled
- AC – Aid Category
- CN – Categorically Needy
- COLA – Cost of Living Adjustment
- DDS – Disability Determination Services
- DMAS – Department of Medical Assistance Services
- HIM – Health Insurance Marketplace
- ID – Intellectual Disability
- IRWE – Impairment Related Work Expense
- JTPA – Job Training Partnership Act
- LTC – Long-term Care
- LIFC – Low Income Families with Children
- LIS – Low-income Subsidy
- MA – Medical Assistance
- MN – Medically Needy
- MSP – Medicare Savings Program
- NPI – National Provider Identifier
- PRTF – Psychiatric Residential Treatment Facility
- QI – Qualified Individual
- SPARK – Services, Programs, Answers, Resources, Knowledge
- TN – Transmittal
- URM – Unaccompanied Refugee Minor
- VDSS – Virginia Department of Social Services
- WIA – Workforce Investment Act

TN #DMAS-1 includes policy clarification, updates and revisions to the MA Eligibility Manual. Unless otherwise noted, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after June 1, 2016. Effective April 1, 2016, the MA Eligibility Manual underwent a change in administration from VDSS to DMAS. TN #DMAS-1 is the first MA transmittal published by DMAS; the numbering format is reflective of the administrative change.

The following changes are contained in TN #DMAS-1:

Changed Pages	Changes
Subchapter M0120 Pages 7, 10, 11, 16-20	On page 7, corrected a hyperlink. On page 10, updated the procedures for handling LIS Medicaid applications. On page 11, added Appendix E to the bullet for the Cover Virginia Application for Health Coverage & Help Paying Costs. On pages 16-20, corrected the formatting and headers.
Subchapter M0130 Table of Contents Pages 4, 6, 10, 12 Pages 11 is a runover page. Page 13 was added as a runover page.	Revised the Table of Contents. On page 4, clarified when a retroactive eligibility determination must be completed. On pages 6 and 12, clarified when referrals to the HIM must be made. On page 10, added verification procedures for applicants who report \$0 income.
Subchapter M0220 Pages 4, 4b, 5, 23	On page 4, corrected a hyperlink. On pages 4b and 5, clarified the process for alien status verification in the federal data Hub. On page 23, clarified that transportation to receive dialysis is not a covered service for emergency services aliens.
Chapter M03 Table of Contents	Revised the Table of Contents.
Subchapter M0310 Table of Contents, page ii Pages 13, 26, 28 Appendix 2, page 1	Revised the Table of Contents. On page 13, clarified that the policy in that paragraph applies to children in Level C PRTFs. On pages 26 and 28, updated the procedures for making a disability referral. In Appendix 2, the contact information for DDS was updated.
Subchapter M0320 Table of Contents, page i Pages 1, 1, 25-27, 46-49 Page 50 is a runover page.	Revised the Table of Contents. On page 1, clarified the hierarchy or enrollment for SSI and protected individuals who request MEDICAID WORKS. On page 11, updated the COLA and Medicare amounts. On pages 25-27, updated MEDICAID WORKS amounts and other information. On pages 46-49, revised the policy on QIs, which is now a permanently funded covered group.

Changed Pages	Changes
Subchapter M0330 Pages 2, 8, 9, 15, 31, 32-35 Page 9b was added as a runover page.	On page 2, added Former Foster Care Children Under Age 26 to the list of CN covered groups. On pages 8 and 9, updated the policy on Former Foster Care Children to include former URM's and clarified the verification requirements and covered services. On pages 15, 33 and 34, clarified that a renewal is needed when a deemed-eligible newborn turns one. On pages 31 and 32, clarified the entitlement policy for MN pregnant women. On pages 34 and 35, clarified the policy on MN Children Under 18.
Chapter M04 Pages 3, 5, 6, 12, 13, 14a Appendices 1, 2, 6 and 7 Appendix 2, page 2 was added. Page 13a is a runover page.	On pages 3, 5, 6, 14a, clarified that children in Level C PRTFs are in their own household with no parents or siblings. On page 12, clarified when a child's income is counted. On page 13 and in Appendix 7, clarified that a parsonage allowance is not countable income. In Appendices 1, 2 and 6, updated the income limits. In Appendix 2, also included the 109% FPL amounts for differentiating between ACs for the Child Under 19 covered group.
Subchapter M0530 Appendix 1, page 1	In Appendix 1, updated the deeming allowances.
Chapter M07 Table of Contents	Revised the Table of Contents.
Subchapter M0720 Page 2	On page 2, clarified that electronic data verification should be used when available.
Subchapter M0810 Pages 1, 2	On pages 1 and 2, updated the ABD income limits.
Subchapter M1120 Pages 30, 31, 47	On pages 30 and 31, updated the student child earned income allowance. On page 47, clarified that transportation is an allowable IRWE.
Subchapter M0830 Table of Contents, page iii Pages 18, 82	Revised the Table of Contents. On page 18 and 82, changed JTPA to WIA. On page 82, also clarified that payments made to vendors by WIA are not income.
Subchapter M1110 Page 2	On page 2, updated the MSP resource limits.
Subchapter M1130 Pages 4, 14, 15	On page 4, clarified the definition of a disabled child. On pages 14 and 15, clarified the correlation between initial and continuing efforts to sell.
Subchapter M1410 Pages 12-14	On page 12, deleted the reference to the NPI number, which is no longer used on the DMAS-225. On pages 13 and 14, updated the information on the notices and renewal form.

Changed Pages

Changes

Subchapter M1420
 Pages 3-5
 Page 6 is a runover page.
 Appendix 3, page 1

On page 3, updated the name of the ID Waiver. On pages 4 and 5 and in Appendix 3, revised the information about the level of care authorization, which is now electronic.

Subchapter M1450
 Pages 13, 15, 35
 Pages 14 and 16 are runover pages.

On page 13, corrected a citation. On page 15, added policy on court-ordered or approved sales, which are considered compensated transfers. On page 35, clarified when a penalty period begins for individuals who have a transfer of assets while already receiving Medicaid LTC services.

Subchapter M1460
 Table of Contents, page i
 Pages 3, 8a, 17, 32

Revised the Table of Contents. On page 3, revised the home equity limit. On page 8a, corrected the section number. On page 17, corrected the numbering. On page 32, clarified the policy on patients in veteran's care centers.

Subchapter M1470
 Table of Contents, page i
 Pages 19, 20, 48, 49, 54
 Page 50 is a runover page.

Revised the Table of Contents. On page 19, updated the personal maintenance allowance. On page 20, updated the special earnings allowance. On pages 48 and 49, revised the policy on adjusting patient pay when there is a change in provider. On page 54, corrected the procedures on determining patient pay.

Subchapter M1480
 Pages 7, 11, 14, 18, 18c,
 30, 66, 69, 70, 92, 93

On page 7, updated the home equity limit. On pages 11 and 14, updated the procedures for calculating the spousal share. On page 18, corrected the hyperlink. On page 18c, updated the spousal resource standards. On page 30, deleted the link to the worksheet that is no longer on SPARK. On page 66, updated the maintenance standards and allowances.

Subchapter M1510
 Pages 2
 Pages 1 and 2a are runover pages.

On page 2, clarified when a retroactive eligibility determination must be completed

Subchapter M1520
 Pages 3, 6, 7, 9, 11-14, 17
 Appendix 2, page 1
 Pages 3a and 7a were added.
 Page 8 is a runover page.

On page 3, clarified the procedures for acting on changes in covered group and aid category. . On page 3a, corrected a citation. On page 6, clarified the criteria for using system-based data. On page 7, clarified the renewal procedures for applicants who report \$0 income. On page 7a, clarified the procedures for individuals who are found ineligible using an ex parte renewal. On page 9, clarified the reconsideration process. On page 11, revised the policy on QI renewals. On page 12, reformatted some text to improve clarity. On page 13, corrected a hyperlink. On page 14, clarified the location of the System Cancellation Report. On page 17, clarified that LIFC Medicaid must not have been received erroneously. In Appendix 2, updated the Extended Medicaid income limits.

Changed Pages

Changes

Chapter M16
Page 1

On page 1, clarified that an appeal based on a self-directed application is the responsibility of the local agency that houses the case.

Chapter M21
Appendix 1, page 1

In Appendix 1, updated the income limits.

Chapter M22
Page 4
Appendix 1, page 1

On page 4, reformatted some text to improve clarity. In Appendix 1, updated the income limits.

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

Sincerely,



Linda Nablo
Chief Deputy Director

Attachment

M0120 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-1	6/1/16	Pages 7, 10, 11, 16-20
TN #100	5/1/15	Table of Contents Pages 1, 2, 15, 20 Page 2a and 16 are runover pages.
UP #10	5/1/14	Table of Contents Pages 11, 16-18 Pages 11a and 11b were deleted. Pages 19 and 20 were added.
TN #99	1/1/14	Page 11 Pages 11a and b were added.
TN #98	10/1/13	Table of Contents Pages 1-17
UP #9	4/1/13	Page 13, 15, 16
UP #7	7/1/12	Pages 1, 10-12
TN #96	10/1/11	Table of Contents Pages 6-18
TN #95	3/1/11	Pages 1, 8, 8a, 14
TN #94	9/1/10	Pages 8, 8a
TN #93	1/1/10	Pages 1, 7, 9-16
Update (UP) #1	7/1/09	Page 8
TN #91	5/15/09	Page 10

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c. Action Not Initiated – Refer to Child Welfare Services

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

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

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

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

2. Minor Parent Applying for His Child

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

3. Foster Care Child

a. IV-E

The Title IV-E Foster Care & Medicaid Application form, posted on SPARK at http://spark.dss.virginia.gov/divisions/dfs/iv_e/ is used for the IV-E Foster Care eligibility determination. A separate MA application is **not** required for a child who has been determined eligible for Title IV-E Foster Care. However, if there is a non-custodial agreement for the IV-E eligible child, the parent or legal guardian must sign an MA application for the child.

b. Non-IV-E

*The Cover Virginia Application for Health Coverage & Help Paying Costs is used for the MA eligibility determination of a **non-IV-E** Foster Care child. Applications for non-IV-E Foster Care children may also be filed online.* The MA application for a non-IV-E child who is in foster care must be signed by an authorized employee of the public or private agency that has custody of the child. If there is a non-custodial agreement, an MA application form must be filed and the parent or legal guardian must sign the application.

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1. Title IV-E Foster Care & Medicaid Application

The Title IV-E Foster Care & Medicaid Application, form #032-03-636 (available at: http://spark.dss.virginia.gov/divisions/dfs/iv_e/) is used for foster care or adoption assistance children who are eligible under Title IV-E of the Social Security Act. If any additional information is necessary (individual requires a resource evaluation for medically needy spenddown), the appropriate pages from *Appendix E* can be used to collect the information. The pages must be signed by the applicant's guardian.

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

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

2. Auxiliary Grant (AG)

An application for AG is also an application for Medicaid. A separate MA application is not required.

3. Exception for Certain Newborns

A child born to a mother who was Medicaid or FAMIS eligible at the time of the child's birth (including a child born to an emergency-services-only alien mother) is deemed to have applied and been found eligible for Medicaid on the date of the child's birth (see M0320.301). An application for the child is not required. The child remains eligible for medical assistance to age 1 year.

If the child was born to a mother who was covered by Medicaid outside Virginia or by another state's Children's Health Insurance Program at the time of the child's birth, verification of the mother's MA Medicaid coverage must be provided by the parent or authorized representative or an application must be filed for the child's eligibility to be determined in another MA group.

4. Forms that Protect the Application Date

a. Low Income Subsidy (LIS) Medicaid Application

The Medicare Patient and Provider Improvement Act (MIPPA) requires LIS application data submitted by the Social Security Administration (SSA) to states to be treated as an application for Medicaid, if the LIS applicant agrees. *LIS application data is sent to LDSS via the SSA Referral Inbox in VaCMS. The LDSS must generate an LIS Medicaid application and cover sheet and mail them to the individual. The individual must return the application or apply for Medicaid online or by telephone in order for his Medicaid eligibility to be determined. If the individual submits the application, the date of LIS application with the SSA is treated as the date of the Medicaid application.*

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b. Model Application for Medicare Premium Assistance Form

The Model Application for Medicare Premium Assistance Form was developed by the federal Centers for Medicare & Medicaid Services (CMS) that states can choose to use for the Medicare Savings Program applicants. The model application is **NOT** a prescribed Virginia Medicaid application form at this time.

Should a local department of social services (LDSS) receive a model application form, the agency is to send a valid Virginia MA application to the applicant with a request that it be completed, signed, and returned to the agency within 30 calendar days. The date of application on the model Application for Medicare Premium Assistance is to be preserved as the application date for purposes of Medicaid entitlement.

The processing time for the LDSS begins when the agency receives the Virginia application form back from the applicant. If the Virginia application form is not returned within 30 days, no further action is necessary on that application. The agency does not send a Notice of Action because no Virginia application was received. The model application date is not preserved beyond 30 calendar days. Should the person later submit a valid Virginia application, the date the Virginia application is received by the LDSS is the application date.

The model application form may be viewed on the SSA web site at:
<http://www.socialsecurity.gov/prescriptionhelp/MSP-Model-Application-ENG.pdf>.

B. Application Forms

Medical assistance must be requested using an application method or form approved by the Departments of Medical Assistance Services (DMAS) and Social Services (VDSS). Applications may be made electronically through CommonHelp or the Health Insurance Marketplace. When an individual applies for assistance through the Marketplace and is assessed as being Medicaid-eligible, his application data is electronically transmitted to the local DSS for a final determination of eligibility.

Applications may also be made telephonically through the Cover Virginia Call Center or with a paper application form.

The following paper forms have been prescribed as application forms for Medicaid and FAMIS:

1. Streamlined Applications

The following forms are used to apply for affordable health insurance, including qualified health plans with the Advance Premium Tax Credit (APTC), through the Health Insurance Marketplace or the local DSS:

- the Cover Virginia Application for Health Coverage & Help Paying Costs and all applicable appendices, including Appendix D for applications submitted for aged, blind or disabled and/or long-term care applicants, *and Appendix E for when a Families and Children (F&C) Medically Needy determination is requested.*
- the federal Application for Health Coverage & Help Paying Costs for multiple individuals and all applicable appendices and
- the federal Application for Health Coverage & Help Paying Costs (Short Form) for individuals and all applicable appendices.

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M0120.500 Receipt of Application

A. General Principle

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

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

B. Application Date

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

The application may be received by mail, fax, hand delivery, electronically or telephonically. The date of receipt by the agency must be recorded. If an application is received after the agency's business hours, the date of the application is the next business day. *Exception: For CommonHelp applications, if the application is received after business hours and the next business day is in the following month, the date of the application is the actual date it was submitted.*

The date of application for foster care children in the custody of a local department of social services is the date the application is received by the eligibility worker.

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If an application for a pregnant woman or child is denied due to excess income, the applicant must be given the opportunity to request a medically needy evaluation. If the evaluation is requested within 10 calendar days of the date the notice of denial was mailed, the application date is protected, and the date of application is the date the denied application was received.

C. Hospital Presumptive Eligibility

The Affordable Care Act requires states to allow approved hospitals to enroll patients who meet certain Families & Children covered groups in Medicaid for a limited time on the basis of their presumptive eligibility. The Department of Medical Assistance Services (DMAS) is responsible coordinating the HPE Agreement with hospitals, providing training and technical assistance, and Monitoring the appropriate use of the HPE enrollments. HPE is not available to individuals who are already enrolled in Medicaid or FAMIS.

a. HPE Enrollment

To enroll an individual in HPE coverage, the hospital obtains basic Demographic information about the individual, as well as attestations from the individual of Virginia residency including locality, U.S. citizenship or lawful presence, Social Security number, household size and income, and Requirements related to covered group. No verifications are required

Hospital staff determines eligibility and enrolls eligible individuals in HPE via The provider portal in the Medicaid Management Information System (MMIS). The enrollment is not entered in the Virginia Case Management System (VaCMS). The individual is enrolled in the appropriate Aid Category (AC) for His covered group. Once the hospital receives confirmation of the HPE Enrollment, the hospital is responsible for notifying the individual of his HPE Coverage and that he must file a full MA application by the end of the following month in order for his continued eligibility to be determined and his coverage to remain uninterrupted.

The HPE covered groups and the ACs are:

- Pregnant Women (AC 035)
- Child Under Age 19 (AC 064)
- Low Income Families with Children (LIFC) (065)
- Former Foster Care Children Under Age 26 (077)
- Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) (067)
- Plan First (084) (effective May 1, 2014).

Individuals enrolled on the basis of HPE receive a closed period of coverage Beginning with the date of the HPE determination through the last day of the Following month or the date MA eligibility is determined by an LDSS, Whichever comes first. Enrollment in HPE is not based on the date of the Hospital admission or on the first day of the month.

While enrolled as HPE, individuals in the Child Under Age 19 years, LIFC, Former Foster Care Children Under Age 26 and BCCPTA covered groups

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receive full Medicaid benefits. HPE pregnant women coverage (AC035) is limited to outpatient prenatal services; labor and delivery are not covered under HPE for AC 035. HPE coverage for Plan First enrollees is limited to family planning services only. Transportation to receive covered medical services is covered for all HPE enrollees.

Enrollment as HPE is limited to one HPE period per calendar year for all individuals other than pregnant women. For pregnant women, enrollment is limited to one HPE eligibility period per pregnancy.

b. LDSS Procedures

The MMIS User's Guide for DSS, available at http://dmasva.dmas.virginia.gov/Content_pgs/dss-elgb_enrl.aspx, contains procedures for completing the MA enrollment of an individual who was enrolled in HPE at the time of application.

1) Application Processing

For MA coverage to continue beyond the following month, the Individual must submit a full MA application to the LDSS. While the LDSS does not determine eligibility for HPE, when the application is received and pended in VaCMS, the individual's coverage in the HPE AC must be extended by the eligibility worker, as necessary, while the application is processed. The worker must enter data directly into MMIS to extend the coverage; MMIS will calculate the 45 day period.

Example: Mary Smith is enrolled in HPE coverage in AC 065 (LIFC) by the hospital for the period of 3-5-14 through 4-30-14. On 4-20-14, she submits an MA application to her LDSS> the 45th processing day will fall after the HPE End date; therefore the worker reinstates HPE coverage in MMIS in AC 065, using the MA application date. The effective date of the reinstatement is 5-1-14, the day after the HPE coverage ends. MMIS will automatically populate the end date with 6-3-14, the MA application date plus 44 days.

Note: the 10-working day processing standard applies to applications submitted by pregnant women and BCCPTA individuals enrolled in HPE.

2) Applicant is Eligible

Full MA applications submitted by HPE enrollees are subject to the standard eligibility and entitlement policies. When an individual is determined eligible for MA coverage, his MA coverage under the appropriate MA AC includes any days to which he is entitled that are not already covered by HPE. If the individual submitted the MA application in the same month HPE coverage began and HPE began on any day other than the first day of the month, his MA coverage begins the first day of that month and the eligibility worker enrolls him in a closed period of coverage in the appropriate MA AC beginning with the first day of the month and ending the day before the HPE begin date.

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If an individual who is eligible for ongoing coverage was enrolled in a full-benefit HPE covered group, his ongoing coverage is reinstated in the appropriate MA AC beginning the first day of the month after the effective date of the HPE coverage cancellation.

Example: Billy Jones is a child enrolled in HPE coverage (AC 064) by the hospital for the period of 2-14-14 through 3-31-14. His parent submits an MA application on 2-18-14. The parent did not indicate receipt of any medical services in the retroactive period. Billy is determined eligible for Medicaid coverage in AC 092.

The child's Medicaid entitlement begins with the month of the MA application. The worker enrolls him using AC 092 in a closed period of coverage from 2-1-14 through 2-13-14, the day before the begin date of HPE coverage. The worker also reinstates the child's ongoing coverage beginning 4-1-14.

If an individual who was enrolled in HPE in a partial-benefit covered group, (i.e. pregnant women or Plan First) is determined eligible for full MA coverage in the period covered by HPE, cancel HPE coverage retroactively and reinstate in full coverage for the retroactive months and ongoing, if eligible.

Example: Jane Scott was enrolled in HPE AC 035 (pregnant women) for the period of 3-13-14 through 4-30-14. She filed an MA application on 3-28-14. Based on the expected delivery date on the application, she was also pregnant during the month prior to her HPE determination. The worker determines that she was eligible for Medicaid as a pregnant woman in AC 091 and completes a retro cancel reinstate, using Cancel Reason 024, beginning 2-1-14.

An individual's eligibility for retroactive coverage for the three months prior to the month of the MA application is determined when the individual had a medical service within the three months prior to the month of the full MA application. If the individual had full coverage while enrolled as HPE, only enroll him for the portion of the retroactive period that he was not enrolled as HPE.

3) Applicant is Not Eligible

If the applicant is determined to not be eligible for ongoing MA coverage, his entitlement to HPE coverage ends. Cancel the HPE coverage effective the current date (i.e. day of the eligibility determination), using Cancel Reason 008.

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

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

1) MA Application Not Submitted

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

E. Governor's Access Plan (GAP)

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

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

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

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

M0130 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-1	6/1/16	Table of Contents Pages 4, 6, 10, 12 Page 11 is a runover page. Page 13 was added as a runover page.
TN #100	5/1/15	Pages 1, 2-2b, 5, 11 Pages 3, 6 and 2c are runover Pages.
UP #10	5/1/14	Table of Contents Pages 8-12 Page 13 was added.
TN #99	1/1/14	pages 10-12 Page 13 was added.
TN #98	10/1/13	Table of Contents Pages 1-12
UP #9	4/1/13	Page 3, 5
UP #7	7/1/12	Pages 4, 5
TN #96	10/1/11	Pages 6-8
TN #95	3/1/11	Page 8
TN #94	9/1/10	Pages 2-6, 8
TN #93	1/1/10	Pages 4-6, 8
Update (UP) #2	8/24/09	Pages 8, 9

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

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

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

B. Application for Retroactive Coverage

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

Retroactive Medicaid eligibility must be determined when an applicant for medical assistance *indicates on the application* that he, or anyone for whom he requests assistance, received a covered medical service within the retroactive period. *The covered service may be listed by the applicant as an actual medical service on the application, or information on the application may indicate that a service was received, such as the birth of a child or Medicare coverage during the retroactive period.*

An individual may request retroactive coverage at any time subsequent to an application even if the application was denied or the applicant signed a statement saying he did not want retroactive coverage. The retroactive period is based on the application month regardless of whether the application was denied or approved. **There is no administrative finality on determining retroactive eligibility if eligibility for the months in the retroactive period has not been determined.**

If the application was denied, the application is reopened for determination of eligibility in the entire retroactive period – all three months prior to the application month – even if a covered medical service was received in only one retroactive month. The applicant must provide all verifications necessary to determine eligibility during the retroactive period.

If the applicant is found eligible for retroactive coverage and a Medicaid-covered medical service was received over one year prior to the date the retroactive eligibility is determined, the applicant must be given an "Eligibility Delay" letter to give to the medical provider so that Medicaid will pay the claim (use the sample letter on the intranet at:

<http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>). Once retroactive eligibility is established, Medicaid coverage begins the first day of the earliest retroactive month in which retroactive eligibility exists.

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

1. Copy Verification Documents

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

2. Information Not Provided

If information necessary to make an eligibility determination is requested but not provided by the applicant and cannot be obtained from any other source, the application must be denied (or the coverage cancelled) due to the inability to determine eligibility. *Individuals whose applications are denied due to the inability to determine eligibility are not referred to the HIM. See M0130.300 D.2.*

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

C. Verification of Nonfinancial Eligibility Requirements

1. Verification Not Required

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

- Virginia state residency;
- pregnancy.

2. Verification Required

The following information must be verified:

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

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3. \$0 (Zero) Income Procedures – Applicable Only to F&C MAGI Cases Processed in VaCMS

When an individual whose income must be counted for the eligibility determination reports \$0 income at application, search the Virginia Employment Commission (VEC) online quarterly wage data and unemployment records and other agency records to verify the absence of income. If the individual receives benefits through other benefit programs and/ or childcare, income information in those records must also be reviewed.

If the VEC inquiry and review of other agency records confirms that the individual has not received wages, unemployment compensation, or other unearned income within the most recent reporting period, document the absence of verifiable income and determine or redetermine income eligibility.

If the inquiry indicates recent or current income that is countable for the MAGI determination, contact the individual and ask about the income (name of employer, amount of wages and period earned, date of unemployment payment, etc.). If it appears there is a mistake and the income belongs to someone other than the individual, discontinue further inquiry and document the finding in the record.

If the individual agrees that the discovered countable income was received, determine if the on-line information can be used to evaluate current/ongoing eligibility. If the discovered information is not sufficient to evaluate eligibility, send a written request for needed verifications and allow ten calendar days for the return of the verifications.

If the individual reports the income has stopped, ask when the income stopped to ensure all income needed to correctly determine prospective and retroactive eligibility (if appropriate) is evaluated. Note the date of termination of income (last pay received) in the record. If the income stopped during a month that is being evaluated for eligibility, the individual must provide verification of the termination of income.

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M0130.300 Eligibility Determination Process

A. Evaluation of Eligibility Requirements

When an MA application is received by the LDSS agency, the agency must determine through a “file clearance” search of the eligibility and enrollment systems whether or not the individual already has Medicaid or FAMIS coverage.

With the exception of individuals enrolled on the basis of presumptive eligibility (PE), applications for MA submitted by individuals who already have an application recorded or who are currently active are denied as duplicate applications.

Applications submitted by individuals currently enrolled as PE or as Newborn Children are not duplicate applications because they were initially enrolled without filing a full MA application. See M0120.300 A.5 for more information.

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

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

Eligibility decisions are made following a prescribed sequence:

- The applicant must meet all non-financial requirements, including a covered group.
- If applicable to the covered group, resource limits must be met.
- The income limits appropriate to the covered group must be met.

Subchapter M0210 contains the Medicaid non-financial requirements.

B. Hierarchy of Covered Group

An applicant must be evaluated for eligibility in all potential covered groups and enrolled in the group that is the most beneficial to the applicant. First, evaluate under covered groups offering full coverage and if the applicant is not eligible, evaluate under groups offering limited coverage. Further specific instructions regarding the determination of covered group are contained in chapter M03.

C. Applicant’s Choice of Covered Group

An individual who meets more than one covered group may choose the covered group under which he wishes his eligibility determined. Appropriate policy used is based on that individual's choice. If the choice is not clear on the application/redetermination form, the individual must state his covered group choice in writing. If the applicant does not make a choice, enroll him in the covered group that is the most beneficial.

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D. Application Disposition

1. General Principle

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

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

If an applicant (other than a Medicare beneficiary or deceased individual) is ineligible for MA for any reason other than the inability to determine eligibility, a referral to the HIM must be made so that his eligibility for the APTC in conjunction with a Qualified Health Plan (QHP) can be determined. Individuals with Medicare and deceased individuals and are not referred to the HIM.

2. Entitlement and Enrollment

a. Entitlement

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

If an applicant indicates that he has been receiving MA (Medicaid or Children's Health Insurance Program) coverage in another state prior to moving to Virginia, instruct him to contact his eligibility worker there and request that his coverage be cancelled, if he has not already done so. He is no longer considered a resident of the other state once he has moved to and intends to reside in Virginia and is not entitled to receive services paid for by the other state's MA program. His enrollment may begin with the month of application or the earliest month in the application's retroactive period that he met the residency requirement per M0230.

b. Enrollment

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

When an individual who does not have Medicare is eligible for only limited MA benefits, such as Plan First, a referral to the HIM must be made so that his eligibility for the APTC in conjunction with a QHP can be determined.

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c. Delays

The notice must state that there is a delay in processing the application, including the reason.

d. Other Actions

Other actions for which a notice must be sent include when a request for re-evaluation of an application in spenddown status has been completed.

E. Notification for Retroactive Entitlement Only

There are instances when an applicant is not eligible for ongoing eligibility but is eligible for retroactive benefits or a change in the applicant's situation during the application process results in the applicant being eligible for only a limited period of time. Only one notice is sent to the applicant covering both actions. Statements of the exact dates of eligibility, the date of ineligibility, and the reason(s) for ineligibility must be included on this notice.

M0130.400 Applications Denied Under Special Circumstances

A. General Principle

When an application is withdrawn or the applicant cannot be located, the application is denied. The reason for the denial must be recorded in the case record, and a notice must be sent to the applicant's last known address.

B. Withdrawal

An applicant may withdraw his application at any time. The request can be verbal or written. An applicant may voluntarily withdraw only his application for retroactive coverage by signing a statement or by a verbal statement specifically indicating the wish to withdraw the retroactive coverage part of the application.

A written withdrawal request must be placed in the case record. A verbal request for withdrawal can be accepted only from the applicant or case head, or his authorized representative. A verbal request must be documented in the case record with the date and time the withdrawal request was received, the name of the person who made the withdrawal request, and the signature and title of the agency staff person who took the call.

When the applicant withdraws an application, the eligibility worker must send a notice of action on MA to the applicant.

C. Inability to Locate

The agency must send a letter to the last known address informing the applicant of the agency's attempt to locate him and asking that he contact the office. For applicants who are documented as homeless, maintain all correspondence at the local agency. If the applicant does not respond within 45 days of the date of application, deny the application.

D. Duplicate Applications

Applications received requesting MA for individuals who already have an application recorded or who are currently active will be denied due to duplication of request. A notice will be sent to the applicant when a duplicate application is denied.

M0220 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-1	6/1/16	Pages 4, 4b, 5, 23
TN #100	5/1/15	Table of Contents Pages 4b, 12, 17, 18 Appendix 5, page 3 Page 4 was renumbered for clarity. Page 4a is a runover page.
TN #99	1/1/14	Table of Contents Pages 19, 23, 24 Appendix 4 was removed.
TN #98	10/1/13	Pages 2-3b Appendix 1 Pages 1-5 Pages 6-18 were removed.
UP #9	4/1/13	Page 3 Appendix 1, pages 3, 17 Appendix 3, pages 3, 4
UP #8	10/1/12	Table of Contents Pages 4, 7-8, 12, 14d-20 Page 17a was deleted. Appendix 5, page 3 Appendix 7 pages 1-5
UP #7	7/1/12	Table of Contents Pages 14d, 16-19 Appendix 5, page 3
TN #96	10/1/11	Table of Contents Pages 2, 3, 7, 8, 14d, 18-22a, 23 Appendix 5, page 3
TN #95	3/1/11	Table of Contents Pages 3, 3a, 4-6a, 14a-14c, 17, 19, 20 Pages 22a, 23, 24 Appendices 1-2a removed. Appendix 3 and Appendices 5-8 reordered and renumbered.
TN #94	9/1/10	Pages 3-3b, 7-9, 14a-14d, 18, 21, 22a, 23 Appendix 1 Appendix 3, page 3
Update (UP) #3	3/1/10	Pages 1-3a
TN #93	1/1/10	Table of Contents Pages 7-8, 14a, 14c-14d, 15-20, 22a Appendix 1 Appendix 3, page 3 Appendix 4, pages 1 and 2 Appendix 6, page 2

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TN #92	5/22/09	Table of Contents Pages 1-6a Appendix 8 (18 pages) Pages 4a-4t were removed and not replaced.
TN #91	5/15/09	Page 7 Pages 14a, 14b Page 18 Page 20 Appendix 3, page 3

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

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

1. MMIS Data Matches SSA

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

2. MMIS Data Does Not Match SSA

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

a. SSA Cannot Verify C&I

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

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

The notice must specify the date of the 90th day, and must state that, if the requested information is not provided by the 90th day, the individual's Medicaid coverage will be canceled. Include with the notice the "Proof of U.S. Citizenship and Identity for Medicaid" document available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/citizenship/index.cgi> under "Guidance and Procedures." Acceptable forms of documentation for C&I are also included in Appendix 1 to this subchapter.

b. Individual Does Not Provide Verification in 90 Days

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

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M0220.201 IMMIGRATION STATUS VERIFICATION

A. Verification Procedures

An alien's immigration status is verified by the official document issued by the United States Citizenship and Immigration Services (USCIS) and a comparison with the Systematic Alien Verification for Entitlements (SAVE) system. *SAVE interfaces with the Federal Hub for applications processed in VaCMS. The EW does not need to obtain the alien status document when immigration status is verified through the Hub. If immigration status cannot be verified through the Hub, the EW must see the original document or a photocopy; submission of just an alien number is NOT sufficient verification.*

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

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

B. Documents That Verify Status

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

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

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

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

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C. Letters that Verify Status The USCIS and the Office of Refugee Resettlement (ORR) issue letters that are used in lieu of or in conjunction with USCIS forms to identify alien status. If the letter is the only document provided, it is necessary to verify the status of the alien. For USCIS letters, contact the USCIS at 1-800-375-5283 for assistance in identifying the alien's status. For ORR letters, contact the toll-free ORR Trafficking Verification Line at 866-401-5510 (see Appendix 2 of this subchapter). Do not verify ORR letters via the SAVE system.

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

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

If the applicant provides an alien registration number with supporting verification of his identity, use the SAVE procedures in M0220.202 below to verify immigration status.

If an applicant presents an expired I-551 or I-151, follow procedures for initiating a primary verification. If the alien presents any expired document other than an expired I-551 or I-151, follow procedures for initiating a secondary verification.

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

M0220.202 SYSTEMATIC ALIEN VERIFICATION FOR ENTITLEMENTS (SAVE)

A. SAVE Aliens must submit documentation of immigration status before eligibility for the full package of Medicaid benefits can be determined. *SAVE interfaces with the Federal Hub for applications processed in VaCMS. The following procedures are applicable when immigration status cannot fully be verified by the Hub.*

If the documentation provided appears valid and meets requirements, eligibility is determined based on the documentation provided AND a comparison of the documentation provided with immigration records maintained by the USCIS.

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

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

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- 3. Entry Date** THIS FIELD MUST BE ENTERED. Enter the date on which the alien entered the U.S., except for asylees and deportees. For asylees, enter the date asylum was granted. For deportees, enter the date deportation withholding was granted.
- 4. Appl Dt** In this field, Application Date, enter the date of the alien's Medicaid application upon which the eligibility coverage period is based.
- 5. Coverage Begin Date** In this field, Coverage Begin Date, enter the date the alien's Medicaid entitlement begins.
- 6. Coverage End Date** Enter data in this field only if eligibility is a closed period of eligibility in the past. Enter the date the alien's Medicaid entitlement ended.
- 7. AC** Enter the AC code applicable to the alien's covered group.

M0220.700 EMERGENCY SERVICES ALIENS ENTITLEMENT & ENROLLMENT

- A. Policy** Unqualified aliens, and qualified aliens eligible for emergency services only are eligible for Medicaid coverage of emergency medical care only. This care must be provided in a hospital emergency room or as an inpatient in a hospital.
- B. Entitlement-Enrollment Period** If the applicant is found eligible and is certified for emergency services, eligibility exists only for the period of coverage certified by the LDSS or DMAS staff on the Emergency Medical Certification form, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi>.
- Once an eligibility period is established, additional requests for coverage of emergency services within 6 months will not require a new Medicaid application. However, each request for Medicaid coverage of an emergency service or treatment requires a new, separate certification and a review of the alien's income and resources and any change in situation that the alien reports.
- With the exception of dialysis patients, an emergency services alien must file a new Medicaid application after the 6-month eligibility period is over if the individual receives an emergency service and wants Medicaid coverage for that service.
- DMAS will certify dialysis patients for up to a one year period of services without the need for a new Medicaid application. The dialysis patient must reapply for Medicaid after their full certification period expires. *Transportation to receive dialysis treatments is not covered for emergency services aliens.*
- C. Enrollment Procedures** Once an emergency services alien is found eligible for coverage of emergency services, the individual must be enrolled in MMIS using the following data:
- 1. Country** In this field, Country of Origin, enter the code of the alien's country of origin.

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TN #DMAS-1	6/1/16	Table of Contents
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Changed With	Effective Date	Pages Changed
TN #DMAS-1	6/1/15	Table of Contents, page ii Pages 13, 26, 28 Appendix 2, page 1
TN #100	5/1/15	Table of Contents, pages i, ii pages 11, 23, 28b, Pages 27a-27c were renumbered to 28-28a for clarity. Page 10 is a runover page. Appendix 2
UP #10	5/1/14	Pages 29, 30
TN #99	1/1/14	Pages 6, 7, 21, 24, 25, 27a, 39
TN #98	10/1/13	Pages 2, 4, 27a, 27b, 28, 35, 36, 39
UP #9	4/1/13	Pages 24-27 Appendix 2
TN #97	9/1/12	Table of Contents, page i Pages 1-5a, 10-13 Pages 23, 28, 29, 30a, 31 Pages 33, 36, 38, 39
UP #7	7/1/12	Table of Contents, page ii Pages 23, 26, 27 Appendices 1-3 were removed. Appendices 3 and 4 were renumbered and are now Appendices 1 and 2, respectively.
TN #96	10/1/11	Appendix 4
TN #95	3/1/11	Pages 30, 30a
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2. Living in the Home

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

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

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

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

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

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

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1. LDSS Referrals to DDS for Non-expedited Cases

- a. Send the following forms to the applicant for completion immediately, giving the applicant 10 calendar days to return the completed forms:
 - a copy of the Frequently Asked Questions—Disability Determinations for Medicaid (form #032-03-0426), available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>, explaining the disability determination process and the individual’s obligations;
 - the Disability Report Adult (SSA-3368-BK), available at <http://www.socialsecurity.gov/online/ssa-3368.pdf>, or the Disability Report Child (SSA-3820-BK), available at <http://www.socialsecurity.gov/online/ssa-3820.pdf>,
 - an Authorization to Disclose Information to the Social Security Administration forms (SSA-827), available at <http://www.socialsecurity.gov/online/ssa-827.pdf>.
- b. *In most cases, the DDS referral is transmitted electronically to DDS through VaCMS. Form 3368-BK or 3830-BK and SSA-827 are uploaded to VaCMS for submission to DDS. No DDS Referral Form is used for electronic submissions. Follow the instructions in the Quick Reference Guide “Sending a DDS Referral in the VaCMS,” available in VaCMS.*
- c. If the DDS referral cannot be completed in VaCMS, manually submit the referral. Complete the DDS Referral Form, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi> Use the DDS Referral Form that corresponds with the DDS Regional Office to which the LDSS has been assigned (#032-03-0095, #032-03-0096, #032-03-0097, or #032-03-0098). To the form, attach the following:
 - the completed Disability Report
 - the signed Authorization to Disclose Information
 - copies of paystubs, if the applicant is currently working.

If the individual’s application was filed with the assistance of a hospital-based eligibility assistance organization, a copy of the consent to release information to the organization must be included with the referral so DDS staff can communicate with them, if necessary.

Mail the DDS Referral form and attachments to the appropriate DDS Regional Office. See Appendix 2 to this subchapter for the locality assignments and addresses for DDS Regional Offices. **Do not send referrals to DDS via the courier.**

2. Expedited Referrals for Hospitalized Individuals Awaiting Transfer to a Rehabilitation Facility

The 2004 Budget Bill mandated that DDS make a disability determination within seven (7) working days of the receipt of a referral from the LDSS when the Medicaid applicant is hospitalized, needs to be transferred directly to a rehabilitation facility AND the individual does not already have a disability application pending with DDS. To ensure that the DDS is able to make the disability determination within the mandated timeframe, the procedures below shall be followed:

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

4. LDSS Responsibilities for Communication with DDS

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

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

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

H. Notification of DDS Decision to LDSS

1. Hospitalized Individuals

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

2. Individuals Not Hospitalized

For all other disability determinations, DDS will *notify* the LDSS responsible for processing the application and enrolling the eligible individual *by an alert in VaCMS*. If the claim is denied, DDS will also *include* a personalized denial notice to be sent to the applicant explaining the outcome of his disability determination.

3. Disability Cannot Be Determined Timely

A disability determination cannot be completed within the allotted time when there is missing or incomplete medical information. DDS will notify the applicant about 75 days from the application date of the delay. *DDS will notify the LDSS by an alert in VaCMS*. The LDSS *must* send the applicant a Notice of Action to extend the pending application.

4. DDS Rescinds Disability Denial

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

I. LDSS Action & Notice to the Applicant

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

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DDS Regional Offices

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

DDS Regional Office	Local DSS Agency Assignments	Hearing Contacts
<p>Central Regional Office Disability Determination Services 9960 Mayland Drive, Suite 200 Richmond, Virginia 23233</p> <p>Phone: 800-523-5007 804-367-4700 Expedited FAX: 804-527-4518</p> <p>Professional Relations: Alvin Gritz Office Manager: Karry Rouse Regional Director: Miguel Johnson</p>	<p>Amelia, Brunswick, Buckingham, Charles City, Charlotte, Chesterfield, Colonial Heights, Cumberland, Danville, Dinwiddie, Emporia, Essex, Goochland, Greensville, Halifax, Hanover, Henrico, Hopewell, King and Queen, King William, Lancaster, Lunenburg, Mecklenburg, Middlesex, New Kent, Northumberland, Nottoway, Petersburg, Pittsylvania, Powhatan, Prince Edward, Prince George, Richmond County, Richmond City, South Boston, Surry, and Sussex</p>	<p><i>Primary Contact (scheduler): Karolyn Wood 804-367-4848</i></p> <p><i>Backups: Evelyn Funn 804-367-4706</i></p> <p><i>Fax Number for Hearings: 804-527-4518</i></p>
<p>Tidewater Regional Office Disability Determination Services 5850 Lake Herbert Drive, Suite 200 Norfolk, Virginia 23502</p> <p>Phone: 800-379-4403 757-466-4300 Expedited FAX: 757-455-3829</p> <p>Professional Relations: Sandy Bouldinz Office Manager: Heidi Dukelow Regional Director: Cheryl McCall</p>	<p>Accomack, Chesapeake, Franklin, Gloucester, Hampton, Isle of Wight, James City, Mathews, Newport News, Norfolk, Northampton, Portsmouth, Poquoson, Southampton, Suffolk, Courtland, Virginia Beach, Williamsburg, York</p>	<p><i>Primary Contact: Angela Osby 757-466-4837</i></p> <p><i>Backup: (vacant at this time)</i></p> <p><i>Fax Number for Hearings: 757-455-3829</i></p>
<p>Northern Regional Office Disability Determination Services 11150 Fairfax Boulevard, Suite 200 Fairfax, Virginia 22030</p> <p>Phone: 800-379-9548 703-934-7400 Expedited FAX: 703-934-7410</p> <p>Professional Relations: <i>Gloria Ford</i> Office Manager: Nicholas Marshal Regional Director: Sharon Gottovi</p>	<p>Albemarle, Alexandria, Arlington, Augusta, Caroline, Charlottesville, Clarke, Culpepper, Fairfax City, Fairfax County, Falls Church, Fauquier, Fluvanna, Frederick, Fredericksburg, Greene, Harrisonburg, Highland, King George, Loudoun, Louisa, Madison, Manassas City, Orange, Page, Prince William, Rappahannock, Rockingham, Shenandoah, Spotsylvania, Stafford, Staunton, Warren, Waynesboro, Westmoreland, and Winchester</p>	<p><i>Primary Contact: Tara Lassiter 703-934-0071</i></p> <p><i>Backup: Taishia Jenerette 703-934-0601</i></p> <p><i>Fax Number for Hearings: 703-934-0616</i></p>
<p>Southwest Regional Office Disability Determination Services 612 S. Jefferson Street, Suite 300 Roanoke, Virginia 24011-2437</p> <p>Phone: 800-627-1288 540-857-7748 Expedited FAX: 540-983-4799</p> <p>Professional Relations: Teresa Sizemore-Hernandez Office Manager: Marcia Hubbard Regional Director: Betsy Stone</p>	<p>Alleghany, Amherst, Appomattox, Bath, Bedford City, Bedford County, Bland, Botetourt, Bristol, Buchanan, Buena Vista, Campbell, Carroll, Covington, Craig, Dickenson, Floyd, Franklin, Galax, Giles, Grayson, Henry, Lee, Lexington, Lynchburg, Martinsville, Montgomery, Nelson, Patrick, Pulaski, Radford, Roanoke County, Roanoke City, Rockbridge, Russell, Salem, Scott, Smyth, Tazewell, Washington, Wise, and Wythe</p>	<p><i>Primary Contact: Lesley Gears 540-857-6027</i></p> <p><i>Backup: Brenda Ragland 540-857-6470</i></p> <p><i>Fax Number for Hearings: 540-857-6374</i></p>

M0320 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 1, 11, 25-27, 46-49 Page 50 is a runover page.
TN #100	5/1/15	Pages 6, 11, 24, 25-27, 29-30
TN #99	1/1/14	Page 11
TN #98	10/1/13	Pages 1, 54, 55.
UP #9	4/1/12	Pages 11, 26, 32, 34-37, 45, 46, 55
TN #97	9/1/12	Table of Contents Pages 1-56 (all pages)
UP #6	4/1/12	Pages 11, 12, 46a
TN #96	10/1/11	Table of Contents Pages 46f-50b Page 50c deleted
TN #95	3/1/10	Pages 11, 12, 42c, 42d, 50, 53, 69 Pages 70, 71 Page 72 added.
TN #94	9/1/10	Pages 49-50b
UP #3	3/1/10	Pages 34, 35, 38, 40, 42a, Pages 42b, 42f
TN #93	1/1/10	Pages 11-12, 18, 34-35, 38 Pages 40, 42a-42d, 42f-44, 49 Pages 50c, 69-71
UP #2	8/24/09	Pages 26, 28, 32, 61, 63, 66
Update (UP) #1	7/1/09	Pages 46f-48
TN #91	5/15/09	Pages 31-34 Pages 65-68

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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. *Exception-- if the individual requests MEDICAID WORKS, go to 4 below.*
2. If the individual is a former SSI or AG recipient, evaluate first in the protected covered groups *Exception-- if the individual requests MEDICAID WORKS, go to 4 below.*
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 (*including SSI recipients and 1619(b) individuals*) 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.

C. Referral to Health Insurance Marketplace When an ABD individual who does not have Medicare is not eligible for full Medicaid coverage, the individual must be referred to the Health Insurance Marketplace (HIM) so that the applicant's eligibility for the APTC can be determined. Individuals with Medicare are not referred to the HIM.

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:

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Note: There was no COLA in 2010, 2011 *or* 2016.

Cost-of-living calculation formula:

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

5. Medicare Premiums

a. Medicare Part B premium amounts:

1-1-16	\$121.80
1-1-15	\$104.90
1-1-14	\$104.90
1-1-13	\$104.90
1-1-12	\$ 99.90

Note: These figures are based on the individual becoming entitled to Medicare during the year listed. The individual's actual Medicare Part B premium may differ depending on when he became entitled to Medicare. **Verify the individual's Medicare Part B premium in SVES or SOLQ-I if it is necessary to know the premium amount for Medicaid eligibility or post-eligibility purposes.**

b. Medicare Part A premium amounts:

1-1-16	\$411.00
1-1-15	\$407.00
1-1-14	\$426.00
1-1-13	\$441.00
1-1-12	\$451.00

Contact a Medical Assistance Program Consultant for amounts for years prior to 2012.

6. Evaluation

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

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- 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 *\$6,250 per month*. This type of cost-sharing arrangement is known as a **Medicaid** buy-in (MBI) program. MEDICAID WORKS is Virginia's MBI program.

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

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

C. Nonfinancial Eligibility

The individual must also meet the following additional nonfinancial criteria:

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

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D. Financial Eligibility

1. Assistance Unit

a. Initial eligibility determination

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

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

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

b. Ongoing eligibility

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

2. Resources

a. Initial eligibility determination

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

b. Ongoing eligibility

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

- 1) For **earnings** accumulated **after** enrollment in MEDICAID WORKS, up to the current 1619(b) income threshold amount will be disregarded if deposited and retained in the WIN Account. The 1619(b) threshold amount for 2016 is \$35,118.
- 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**

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

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

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

3. Income

a. Initial eligibility determination

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

b. Ongoing eligibility

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

- 1) The income limit for earned income *in 2016* is \$6,250 per month (\$75,000 per year) as long as the funds are deposited in a WIN Account. The policy for determining countable earned income is contained in subchapter S0820.

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

- 2) The income limit for unearned income remains less than or equal to 80% of the FPL. The policy for determining countable unearned income is contained in subchapter S0830.
- 3) Any increase in an enrollee's Social Security Disability benefits resulting from employment as a MEDICAID WORKS participant OR as a result of a COLA adjustment to the Social Security Disability benefits will not be counted as long as it is regularly deposited upon receipt into the individual's WIN account.
- 4) Unemployment insurance benefits received due to loss of employment through no fault of the individual's own are not counted during the six-month safety net period (see M0320.400 G) as income as long as the payments are regularly deposited upon receipt into the individual's WIN account.

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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 the 300% of SSI 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 the coverage with the begin date as the first day of the month of admission to long-term care using the appropriate AC for SLMB Plus.
 - 025 for an aged individual also SLMB;
 - 045 for a blind or disabled individual also SLMB.

M0320.603 QUALIFIED INDIVIDUAL (QI)

A. Policy

P.L. 105-33 (Balanced Budget Act of 1997) mandated Medicaid coverage of Qualified Individuals who would be 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.

Prior to 2015, funding for the QI covered group was subject to annual availability by Congress. QI funding became permanent in 2015, and the QI covered group is subject to the same policies regarding entitlement and enrollment as the SLMB covered group.

A 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).

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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 a 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 a 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 a 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 *QIs*.

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 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.

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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 If the individual's income is equal to or exceeds the QI limit (135% of FPL), he/she is not eligible as QI. *If the individual's resources are within the MN limit and the individual meets a MN covered group, place the individual on two (2) 6-month spenddowns based on the MN income limit for his locality. See M0320.603 E.5 below.*

D. QI Entitlement *If all eligibility factors are met in the application month, entitlement to Medicaid as a QI begins the first day of the application month. QIs are entitled to retroactive coverage if they meet all the QI requirements in the retroactive period.*

E. Enrollment

1. Aid Category *The AC for all QIs is 056.*

2. Enrollee's Covered Group Changes To QI If Medicaid recipient becomes ineligible for full-coverage Medicaid 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.

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

QIs who have not been 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.

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4. ***QI Meets Spenddown*** *When a QI meets a spenddown, cancel his AC 056 coverage effective the day before the spenddown was met, using cancel reason 024. Reinstate 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, using the appropriate AC:*

- *018 for an aged MN individual;*
- *038 blind MN individual*
- *058 for a disabled MN individual.*

5. ***Spenddown Period Ends*** *After the spenddown period ends, reinstate the QI coverage using AC 056.*
- The begin date of the reinstated QI 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 QI eligibility.*

6. ***QI Enters LTC or Otherwise Becomes Eligible for Full Coverage*** *When an enrolled QI becomes institutionalized or eligible in another covered group which has full Medicaid coverage, cancel the QI coverage effective the last day of the month immediately prior to the month in which he became eligible in the full coverage covered group, using cancel reason 024. Reinstate the coverage with the begin date as the first day of the month of admission to long-term care using the appropriate AC for the full-coverage group.*

- 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.

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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.

M0330 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-1	6/1/16	Pages 2, 8, 9, 15, 31, 32-35 Page 9b was added as a runover page.
TN #100	5/1/15	Table of Contents Pages 4-8, 15-22, 24,25 36-38
UP #10	5/1/14	Pages 5, 8, 9
TN #99	1/1/14	Pages 1, 8, 9, 13, 24
TN #98	10/1/13	Table of Contents Pages 1-3, 6-16, 19, 22, 24-29
UP #8	10/1/12	Pages 4, 6
TN #97	9/1/12	Table of Contents Pages 1-40 (all pages)
UP #2	8/24/09	Pages 3, 6, 8, 16, 22
Update (UP) #1	7/1/09	Pages 20, 21

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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 and FAMIS before moving to MN.

B. Procedure The policy and procedures for determining whether an individual meets an F&C CN 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;
M0330.109 Former Foster Care Children Under Age 26 Years
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 Covered Groups
M0330.600 Plan First--Family Planning Services (FPS);
M0330.700 Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA).

C. Eligibility Methodology Used *With the exception of the F&C 300% of SSI covered groups for institutionalized individuals, the F&C covered groups that require a financial eligibility determination use Modified Adjusted Gross Income (MAGI) methodology for evaluating countable income. The policies and procedures for MAGI methodology are contained in chapter M04 unless otherwise specified.*

MAGI methodology is not applicable to the F&C 300% of SSI covered groups. See M0330.501 – M0330.503 for information regarding the applicable financial eligibility policies.

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.

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

3. Income Adoption assistance children in residential facilities do not have a different income limit. The income limit for Individuals Under Age 21 for one person in the child's locality is used to determine eligibility in the Special Medical Needs covered group. See M04, Appendix 4.

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

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

If the child's countable income exceeds the income limit for Individuals Under Age 21, evaluate the child in the Special Medical Needs Adoption Assistance MN covered group (see M0330.805). Ineligible individuals must be referred to the Health Insurance Marketplace for evaluation for the APTC.

D. Entitlement & Enrollment

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

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

M0330.109 FORMER FOSTER CARE CHILDREN UNDER AGE 26 YEARS

A. Policy

P.L. 111-148 (The Affordable Care Act) - The federal Medicaid law requires the State Plan to cover individuals who were formerly in Title IV-E or non-IV-E foster care or the *Unaccompanied Refugee Minors Program (URM)* when the individual:

- was in the custody of a local department of social services in Virginia or another state and receiving Medicaid until his discharge from foster care upon turning 18 years or older, or
- *was in the URM program in Virginia or another state and receiving Medicaid until his discharge upon turning 18 years or older.*
- is not eligible for Medicaid in another mandatory Medicaid covered group (LIFC parent, Pregnant Woman, Child Under age 19 or SSI), and
- is under age 26 years.

A child age 18 and over who is in an Independent Living arrangement with a local department of social services may be eligible in this covered group.

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B. Nonfinancial Eligibility Requirements The individual must meet all the nonfinancial eligibility requirements in chapter M02.

D. Entitlement Entitlement as a former foster care child begins the first day of the month following the month the child was no longer in the custody of a local department of social services *or the URM Program* if the child was enrolled in Medicaid during the month foster care ended.

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

If Medicaid coverage of a former foster care child was previously discontinued when the child turned 18, he may reapply for coverage and be eligible in this covered group if he meets the requirements in this section. The policies regarding entitlement in M1510 apply.

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

E. Enrollment The AC for former foster care children is "070."

M0330.200 LOW INCOME FAMILIES WITH CHILDREN (LIFC)

A. Policy Section 1931 of the Act - The federal Medicaid law requires the State Plan to cover dependent children under age 18 and parents or caretaker-relatives of dependent children who meet the financial eligibility requirements of the July 16, 1996 AFDC state plan. 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).

Public Law 111-148 (The Affordable Care Act) requires that coverage for all children under the age of 19 be consolidated in the Child Under Age 19 (FAMIS Plus) covered group. Virginia has chosen to implement this coverage effective October 1, 2013.

An exception is made for children under age 18 whose parents are receiving LIFC Extended Medicaid coverage (see M1520.500). In these situations, if family income exceeds the limit for coverage in the Child Under Age 19 group, the child must be evaluated for LIFC Extended Medicaid coverage with his family.

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

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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. For applications submitted prior to October 1, 2013, 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. Effective October 1, 2013, EWB is not included in the definition of LIFC.

C. Financial Eligibility

The financial eligibility policy used for this covered group depends on when the application is submitted or renewal is processed. Refer to Chapters M05 and M07 for applications submitted before October 1, 2013 and renewals completed before April 1, 2014. Refer to Chapter M04 for eligibility determinations completed on applications submitted on or after October 1, 2013, and renewals completed on or after April 1, 2014.

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

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

b. Newborn

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

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

6. Income Exceeds Limit

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

D. Entitlement

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

The newborn's Medicaid coverage begins the date of the child's birth. A renewal must be completed for the newborn in the last month in which the child meets the Newborn Children Under Age 1 covered group and must include SSN or proof of application, as well as verification of income.

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

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

E. Enrollment

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

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

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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 *women* in this MN group are entitled to full Medicaid coverage beginning the first day the spenddown is met. *Coverage ends on the last day of the spenddown period, as long as the woman's pregnancy did not end while she was enrolled in MN coverage.*

If the woman delivers the child while enrolled in MN coverage, she is entitled to MN coverage as long as she continues to meet the definition of a pregnant woman in M0310.124. Her MN coverage ends on the last day of the month in which the 60th day following the end of the pregnancy occurs, regardless of when the spenddown period ends, without the need for a new application or an additional spenddown period.

Retroactive coverage is applicable to this covered group.

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Example 1:

A pregnant woman applied for Medicaid on March 3. Her estimated date of delivery 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 after her pregnancy ended occurred. She no longer meets the pregnant woman covered group requirements.

Example 2:

A pregnant woman applied for Medicaid on January 5. Her estimated date of delivery is May 10. Her income exceeds the income limit for 2 persons for Medicaid and FAMIS MOMS. Her resources are within the medically needy resource limit for the retroactive period and ongoing, and she is placed on a retroactive spenddown for the period October 1 through December 31 of the previous year and a prospective spenddown for the period January 1 through June 30. She delivered the child and met the spenddown on May 20. She was enrolled in MN coverage effective May 20. Although her spenddown period ends on June 30, her postpartum period does not end until July 31 (the end of the month in which the 60th day after her pregnancy ended falls). Therefore, her coverage is cancelled effective July 31.

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

D. Enrollment

Eligible individuals in this group are *enrolled in aid category 097.*

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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. *A renewal of the child's coverage must be completed for his coverage to continue past age one.*

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.

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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. *A renewal must be completed for the newborn before system cut-off in the last month in which the child meets the Newborn Children Under Age 1 covered group and must include SSN or proof of application, as well as verification of income and resources.*

Eligible children in this group are 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 is eligible in this MN covered group if he/she has not attained age 18 years and meets the nonfinancial requirements in chapter M02.

A child under age 18’s Medicaid eligibility is first determined in the Child Under Age 19 covered group *and for FAMIS*, which *have* no resource limits and *have* income limits that are higher than the medically needy income limit. If a child under age 18 is not eligible *for Medicaid in the Child Under 19 covered group or for FAMIS* because the child’s countable income is too high, *and* the child’s resources are within the MN resource limit, *evaluate the child’s in the MN Children Under Age 18 covered group.*

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.

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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 and FAMIS Limits

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.

5. Income is under the MN and FAMIS Limits

Because of the differences between the Child Under 19 covered group/FAMIS (MAGI) and MN (non-MAGI) income-counting rules, such as the treatment of a stepparent's income, a child may be ineligible for Medicaid as a Child Under 19 or for FAMIS coverage but have countable income under the income limit for MN coverage. In this case, the child's spenddown liability is \$0.00 (zero dollars). Even if the spenddown liability is \$0.00, MN coverage cannot be open-ended. Enroll the child in two back-to-back six-month periods of coverage, without the need for a new application. Complete a renewal following the procedures in M1520 at the end of the second spenddown period. Continue to enroll the child in two consecutive six-month periods of coverage per year as long as he continues to be eligible as MN at renewal.

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 *enrolled in aid category 088.*

M04 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-1	6/1/16	Pages 3, 5, 6, 12, 13, 14a Appendices 1, 2, 6 and 7 Appendix 2, page 2 was added. Page 13a is a runover page.
UP #11	7/1/15	Appendices 3 and 5
TN #100	5/1/15	pages 2, 11, 12, 13, 14 Appendices 1, 2, 3, 5, 6 and 7 Page 1 is a runover page.
Update (UP) #10	5/1/14	Table Contents pages 2, 3, 5, 6, 10-15 Appendices 1, 2 and 6 Appendix 7 was added.
TN #99	1/1/14	pages 2, 5, 6, 8, 14, 15 Appendix 6

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Subchapter Subject M04 MODIFIED ADJUSTED GROSS INCOME (MAGI)	Page ending with M0420.100	Page 3

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

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

M0420.100 Definitions

A. Introduction

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

B. Definitions

1. Caretaker Relative

means a relative of a “dependent” child by blood, adoption, or marriage with whom the child lives, who assumes primary responsibility for the child’s care. This includes the caretaker relative’s spouse.

2. Child

means a natural, biological, adopted, or stepchild.

3. Dependent Child

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

4. Family

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

5. Family Size

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

6. Household

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

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

7. Non-filer Household

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

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- Stepparents and parents are treated the same.
- Children and siblings with or without income are included in the same household as the rest of the family.
- Older children are included in the family if claimed as tax dependent by the parents.
- Married couples living together are **always** included in each other's household even if filing separately.
- Dependent parents may be included in the household if they are claimed for income tax purposes.

1. Tax Filer Household Composition

The tax filer household is determined based on the rules of tax dependency. Parents, children and siblings are included in the same household. The tax filer's household consists of the tax filer and all tax dependents who **are expected to be claimed for the current year**. This could include non-custodial children claimed by the tax filer, but living outside the tax filer's home and dependent parents claimed by the tax filer, but living outside the tax filer's home.

The tax filer household is composed of the individual who expects to file a tax return this year and does not expect to be claimed as dependent by another tax filer. The household consists of the tax filer and all individuals the individual expects to claim as a tax dependent.

2. Tax Dependent Household Composition

means all dependents expected to be claimed by another tax filer for the taxable year. Except for Special Medical Needs AA children *and children who have been in a Level C PRTF for at least 30 consecutive days*, the tax dependent's household consists of the tax dependent, his parents and his siblings living in the home. If the tax dependent is living with a tax filer other than a parent or spouse, the tax dependent is included in the tax filer household, but the tax filer is NOT included in the tax dependent's household. **A Special Medical Needs AA child or a child who has been in a Level C PRTF for at least 30 consecutive days is in his own household with no parents or siblings.**

Exceptions to the tax household composition rules apply when:

- individuals other than biological, adopted or stepchildren are claimed as tax dependents,
- children are claimed by non-custodial parents,
- married couples and children of parents are not filing jointly.
- the tax dependent is a Special Medical Needs AA child *or a child who has been in a Level C PRTF for at least consecutive 30 days*.

3. Non Filer Household Composition

The Non Tax Filer household rules mirror the tax filer rules to the maximum extent possible.

- The household consists of parents and children under age 19. Exception: A Special Medical Needs AA child *or a child who has been in a Level C PRTF for at least 30 consecutive days* is in his own household with no parents or siblings.

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- Non-filer rules are used when a child is claimed as a tax dependent of someone not living in the home.
- Non-filer rules are used in the case of a multi-generational household where the tax dependent is also the parent of a child.
- Children under age 19 living with a relative other than a parent are included only in their own household.
- Spouses, parents, stepparents and children living together are included in the same household. Exception: *A Special Medical Needs AA child or a child who has been in a Level C PRTF for at least 30 consecutive days* is in his own household with no parents or siblings.
- For non-filers, a “child” is defined as under age 19.

4. Married Couple

In the case of a married couple living together, the spouse is always included in the household of the other spouse, regardless of their tax filing status.

M0430.200 TAX FILER HOUSEHOLD EXAMPLES

A. Married Parents and Their Tax Dependent Children

Sam and Sally are a married couple. They file taxes jointly and claim their two children Susie and Sarah as tax dependents. All of them applied for MA.

The MAGI household is the same as their tax household because the tax filers are a married couple filing jointly and claiming their dependent children. No additional individuals live in the home.

Ask the following questions for each tax dependent to determine if exceptions exist:

- Is Susie the tax dependent of someone other than a spouse or a biological, adopted, or stepparent? No, also applies to Sarah
- Is Susie a child living with both parents, but the parents do not expect to file a joint tax return? No, also applies to Sarah
- Is Susie a child who expects to be claimed by a non-custodial parent? No, also applies to Sarah

The following table shows each person’s MAGI household:

Person	# - Household Composition	Reason
Sam	4 - Sam, Sally, Susie, Sarah	Tax-filer & dependents
Sally	4 – Sally, Sam, Susie, Sarah	Tax filer & dependents
Susie	4 – Susie, Sam, Sally, Sarah	Tax dependent, tax-filer parents and other tax dependent
Sarah	4 - Sarah, Sam, Sally, Susie	Tax dependent, tax-filer parents and other tax dependent

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

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

A. MAGI Income Rules

1. Income That is Counted

- a. Gross earned income is counted. There are no earned income disregards.
- b. Earnings and unearned income, including Social Security benefits, of everyone in the household are counted, except the income of a
 - a tax dependent who is claimed by his parent(s), or
 - *the income of a child under 19 in a non-filer household*

who is not required to file taxes *because the tax filing threshold is not met.*
- c. Depreciation and capital losses are deducted in calculating countable income from self-employment and farming.
- d. Losses are subtracted from self-employment income. If the losses exceed income, the resulting negative dollar amount offsets other countable income.
- e. Foreign income and interest, including tax-exempt interest, are counted.
- f. Stepparent income is counted.

2. Income That is Not Counted

- a. Child support received is not counted as income (it is not taxable income).
- b. Workers Compensation is not counted.
- c. When a child is included in a parent or stepparent's household, the child's *income is not* countable as household income unless the child is required to file taxes because the tax-filing threshold is met. *Any* Social Security benefits the child *may have* do not count in determining whether or not the tax filing threshold is met.
- d. Veterans benefits which are **not** taxable in IRS pub 907 are not counted:
 - Education, training, and subsistence allowances,
 - Disability compensation and pension payments for disabilities paid either to veterans or their families,
 - Veterans' insurance proceeds and dividends paid either to veterans or their beneficiaries, including the proceeds of a veteran's endowment policy paid before death,

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- Interest on insurance dividends left on deposit with the VA,
 - Benefits under a dependent-care assistance program,
 - The death gratuity paid to a survivor of a member of the Armed Forces who died after September 10, 2001, or
 - Payments made under the VA's compensated work therapy program.
- e. Alimony **paid** to a separated or former spouse outside the home is deducted from countable income.
- f. Interest paid on student loans is deducted from countable income.
- g. Proceeds from life insurance.
- i. *A parsonage allowance.*

3. American Indian-Alaska Native Payments

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

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

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B. Monthly Income Determinations

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

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

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M0450.100 STEPS FOR DETERMINING MAGI-BASED ELIGIBILITY

A. Determine Household Composition

1. **Does the individual expect to file taxes?**
 - a. If No - Continue to Step 2
 - b. If Yes - Does the individual expect to be claimed as a tax dependent by anyone else?
 - 1) If No - the household consists of the tax filer, a spouse living with the tax filer, and all persons whom the tax filer expects to claim as a tax dependent
 - 2) If Yes - Continue to Step 2

2. **Does the Individual Expect to be Claimed As a Tax Dependent?**
 - a. If No - Continue to Step 3
 - b. If Yes - Does the individual meet any of the following exceptions?
 - 1) the individual expects to be claimed as a tax dependent of someone other than a spouse or a biological, adopted, or stepparent;
 - 2) the individual is a child (under age 19) living with both parents, but the parents do not expect to file a joint tax return; or
 - 3) the individual is a child under age 19 who expects to be claimed by a non-custodial parent?
 - i. If no - the household is the household of the tax filer claiming her/him as a tax dependent.
 - ii. Is the individual married? If yes – does the household also include the individual’s spouse?
 - iii. If yes - Continue to Step 3.
 - 4) the child is a *Special Medical Needs AA* child or *has been in a Level C PRTF for at least 30 consecutive days?*

If yes, continue to Step 3 below.

3. **Individual Is Neither Tax Filer Nor Tax Dependent Or Meets An Exception In 2. b Above**

For individuals, *other than Special Medical Needs AA children and children who have been in a Level C PRTF for at least 30 consecutive days and who are in their own household with no other individuals*, who neither expect to file a tax return nor expect to be claimed as a tax dependent, as well as tax dependents who meet one of the exceptions in 2.b above, the household consists of the individual and, if living with the individual:

 - the individual’s spouse;
 - the individual’s natural, adopted and step children under the age 19; and
 - In the case of individuals under age 19, the individual’s natural, adopted and stepparents and natural, adoptive and stepsiblings under age 19.

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5% FPL DISREGARD	
EFFECTIVE 1/25/16 (NO CHANGE FROM 2015)	
Household Size	Monthly Amount
1	\$ 50
2	67
3	84
4	102
5	119
6	136
7	154
8	171
Each additional, add	18

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PREGNANT WOMEN 143% FPL INCOME LIMITS ALL LOCALITIES EFFECTIVE 1/25/16		
Household Size	143% FPL Monthly Amount	149% FPL (143% FPL + 5% FPL Disregard as Displayed in VaCMS)
2*	1,910	1,977
3	2,403	2,487
4	2,896	2,998
5	3,390	3,509
6	3,883	4,019
7	4,377**	5,531
8	4,873**	5,044
Each additional, add	496**	18

**A pregnant woman's household is at least two individuals when evaluated in the Pregnant Women covered group.*

***No change for 2016.*

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**CHILD UNDER AGE 19
143% FPL
INCOME LIMITS
ALL LOCALITIES
EFFECTIVE 1/25/16**

# of Persons in House- hold	109% FPL (for Determining Aid Category)	143% FPL	149% FPL (143% FPL + 5% FPL Disregard as Displayed in VaCMS)
	<i>Monthly Limit</i>	<i>Monthly Limit</i>	<i>Monthly Limit</i>
<i>1</i>	<i>\$1,080</i>	<i>\$ 1,416</i>	<i>\$1,466</i>
<i>2</i>	<i>1,465</i>	<i>1,910</i>	<i>1,977</i>
<i>3</i>	<i>1,832</i>	<i>2,403</i>	<i>2,487</i>
<i>4</i>	<i>2,208</i>	<i>2,896</i>	<i>2,998</i>
<i>5</i>	<i>2,584</i>	<i>3,390</i>	<i>3,509</i>
<i>6</i>	<i>2,960</i>	<i>3,883</i>	<i>4,019</i>
<i>7</i>	<i>3,337*</i>	<i>4,377*</i>	<i>5,531</i>
<i>8</i>	<i>3,715*</i>	<i>4,873*</i>	<i>5,044</i>
<i>Each add'l, add</i>	<i>378*</i>	<i>496*</i>	<i>18</i>

**No change for 2016.*

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PLAN FIRST 200% FPL INCOME LIMITS ALL LOCALITIES EFFECTIVE 1/25/16		
Household Size	200% FPL Monthly Amount	205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)
1	\$ 1,980	\$2,030
2	2,670	2,737
3	3,360	3,744
4	4,050	4,152
5	4,740	4,869
6	5,430	5,566
7	6,122*	6,276
8	6,815*	6,986
Each additional, add	694*	712

**No change for 2016.*

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TREATMENT OF INCOME FOR FAMILIES & CHILDREN COVERED GROUPS

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

M0530 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-1	6/1/16	Appendix 1, page 1
TN #100	5/1/15	Pages 14, 16, 29, 30 Appendix 1, page 1
TN #99	1/1/14	Appendix 1, page 1
UP #9	4/1/13	Appendix 1, page 1
UP #6	4/1/12	Appendix 1, page 1
Update (UP) #5	7/1/11	Page 14
TN #95	3/1/11	Page 1 Appendix 1, page 1
TN #93	1/1/10	Pages 11, 19 Appendix 1, page 1

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Subchapter Subject M0530.000 ABD ASSISTANCE UNIT	Page ending with Appendix 1	Page 1

Deeming Allocations

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

NBD (Non-blind/disabled) Child Allocation

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

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

2016 (no change): \$1,100 - \$733 = \$367

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

Parental Living Allowance

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

SSI payment for one person = *\$733 for 2016 (no change); \$733 for 2015*

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

SSI payment for both parents = *\$1,100 for 2016 (no change); \$1,100 for 2015.*

Deeming Standard

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

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

2016 (no change): \$1,100 - \$733 = \$367

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

M07 Table of Contents Changes

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TN #DMAS-1	6/1/16	Table of Contents, pages i and ii

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M0720 Changes

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TN #DMAS-1	6/1/16	Page 2
TN #98	10/1/13	Pages 6, 10
TN #94	9/01/2010	Pages 5, 6
TN #91	5/15/2009	Page 11

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

2. When to Count Wages are calculated on a monthly basis and counted at the earliest of the following points:

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

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

EXAMPLE #1:

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

C. Verification

Use available electronic data sources to verify earned income. If earnings cannot be verified through the use of electronic data sources, verify earnings using pay stubs, pay envelopes, a written statement from the employer, or by the eligibility worker's verbal contact with the employer.

When attempts to verify income are unsuccessful because the person or organization who is to provide the information cannot be located or refuses to provide the information to both the applicant/enrollee and the eligibility worker, a third party statement, a collateral contact, or as a last resort, the applicant's/enrollee's written statement can be used as verification and to determine the amount of income to be counted.

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

M0720.105 INCOME FROM A CORPORATION

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

M0720.110 HOW TO COUNT INCOME IN THE RETROACTIVE PERIOD

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

M0720.155 HOW TO ESTIMATE EARNED INCOME

A. General

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

M0810 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-1	6/1/16	Pages 1, 2
UP #11	7/1/15	Page 2
TN #100	5/1/15	Pages 1, 2
UP #10	5/1/14	Page 2
TN #99	1/1/14	Pages 1, 2
TN #98	10/1/13	Page 2
UP #9	4/1/13	Pages 1, 2
UP #7	7/1/12	Page 2
UP #6	4/1/12	Pages 1, 2
TN #95	3/1/11	Pages 1, 2
TN #93	1/1/10	Pages 1, 2
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Subchapter Subject M0810 GENERAL - ABD INCOME RULES	Page ending with M0810.002	Page 1

GENERAL

M0810.001 INCOME AND ELIGIBILITY

A. Introduction The following sections explain how to treat income in the Medicaid program. This chapter explains how we count income.

B. Policy Principles

- 1. Who is Eligible** An individual is eligible for Medicaid if the person:
 - meets a covered group; and
 - meets the nonfinancial requirements; and
 - meets the covered group's resource limits; and
 - meets the covered group's income limits.

- 2. General Income Rules**
 - Count income on a monthly basis.
 - Not all income counts in determining eligibility.
 - If an individual's countable income exceeds a classification's monthly limit, a medically needy spenddown may be established, if appropriate.

M0810.002 INCOME LIMITS

A. Income Limits The Medicaid covered group determines which income limit to use to determine eligibility.

- 1. Categorically Needy** Supplemental Security Income (SSI) and State Supplement (Auxiliary Grant) recipient's money payments meet the income eligibility criteria in the ABD Categorically Needy covered group.

- 2. Categorically Needy Protected Cases Only**

Categorically-Needy Protected Covered Groups Which Use SSI Income Limits		
Family Unit Size	2016 Monthly Amount	2015 Monthly Amount
1	\$733	\$733
2	1,100 (no change)	1,100
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size	2016 Monthly Amount	2015 Monthly Amount
1	\$488.67	\$488.67
2	733.34 (no change)	733.34

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**3. Categorically
Needy 300% of
SSI**

For the covered groups that use the 300% of SSI income limit, all income is counted (even excluded income) when screening at 300% of SSI. Do not count any monies which are defined as “what is not income” in S0815.000.

Family Size Unit 1	2016 Monthly Amount \$2,199 (no change)	2015 Monthly Amount \$2,199
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**4. ABD Medically
Needy**

a. Group I	7/1/2015		7/1/2014 – 6/30/15	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	\$1,861.63	\$310.27	\$1830.52	\$305.09
2	2,370.20	395.03	2,330.62	388.44
b. Group II	7/1/2015		7/1/2014 – 6/30/15	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	\$2,148.04	\$358.00	\$2,112.14	\$352.02
2	2,645.09	440.84	2,600.95	433.49
c. Group III	7/1/2015		7/1/2014 – 6/30/15	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	\$2,792.45	\$465.40	\$2,745.78	\$457.63
2	3,366.75	561.12	3,310.53	551.76

**5. ABD
Categorically
Needy**

All Localities	2016	2015
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For:

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

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

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

S0820 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-1	6/1/16	Pages 30, 31, 47
TN #100	5/1/15	Pages 30, 31, 47 Page 48 is a runover page.
TN #99	1/1/14	Pages 30, 31
UP #9	4/1/13	Pages 30, 31
Update (UP) #6	4/1/12	Pages 30, 31
TN #95	3/1/11	Pages 3, 30, 31
TN #93	1/1/10	Pages 30, 31
TN #91	5/15/09	Table of Contents Pages 29, 30

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3. Other Earned Income

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

- a. Federal earned income tax credit payments.
- b. Up to \$10 of earned income in a month if it is infrequent or irregular.
- c. *For 2016, up to \$1,780 per month, but not more than \$7,180 in a calendar year, of the earned income of a blind or disabled student child (no change).*

For 2015, up to \$1,780 per month, but not more than \$7,180 in a calendar year, of the earned income of a blind or disabled student child

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

4. Unused Exclusion

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

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

5. Couples

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

B. References

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

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

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

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S0820.510 STUDENT CHILD EARNED INCOME EXCLUSION

A. Policy

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

For Months	Up to per month	But not more than in a calendar year
<i>In calendar year 2016</i>	<i>\$1,780</i>	<i>\$7,180 (no change)</i>
In calendar year 2015	\$1,780	\$7,180

- 2. Qualifying for the Exclusion** The individual must be:
- a child under age 22; and
 - a student regularly attending school.
- 3. Earnings Received Prior to Month of Eligibility** Earnings received prior to the month of eligibility do not count toward the yearly limit.
- 4. Future Increases** The monthly and yearly limits will be adjusted annually based on increases in the cost of living index. Under this calculation, these amounts will never be lower than the previous year's amounts. However, there may be years when no increases result from the calculation.

B. Procedure

- 1. Application of the Exclusion** Apply the exclusion:
- consecutively to months in which there is earned income until the exclusion is exhausted or the individual is no longer a child; and
 - only to a student child's own income.
- 2. School Attendance and Earnings** Develop the following factors and record them:
- whether the child was regularly attending school in at least 1 month of the current calendar quarter, or expects to attend school for at least 1 month in the next calendar quarter, and
 - the amount of the child's earned income (including payments from Neighborhood Youth corps, Work-Study, and similar programs).

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

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TYPE OF EXPENSES	DEDUCTIBLE AS		AMOUNT OF DEDUCTIBLE
	BWE	IRWE	
Transportation to and from work	X	X	<ul style="list-style-type: none"> In own vehicle the rate is the Internal Revenue Service (IRS) standard mileage rate: 2016 – 54 cents per mile 2015 – 57.5 cents per mile For other than in own vehicle the actual cost of the bus, car, pool, or cab fare.
Vehicle modification	X	X	Whatever seems reasonable.

M0820.560 ALLOCATING WORK EXPENSES

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

B. Procedure

1. Expenses Paid Prior to Receipt of Income

a. No downpayment involved

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

2. Monthly Recurring Expenses

b. Downpayment involved

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

3. Other Recurring Expenses

a. Less frequently than monthly

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

b. Daily/Weekly/Biweekly

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

S0830 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-1	3/23/16	Table of Contents, page iii Pages 18, 82
Update #7	7/1/12	Page 24
TN #94	9/1/10	Page 29
TN #93	1/1/10	Table of Contents, page iv Pages 28, 67, 119-120 Pages 122-125
TN #91	5/15/09	Table of Contents, page i Page 29

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Subchapter Subject M0830 UNEARNED INCOME	Page ending with S0830.165	Page 18

S0830.165 ASSISTANCE PROGRAMS WITH GOVERNMENTAL INVOLVEMENT -- GENERAL

A. Introduction Federal, State, and local governments are involved in a number of programs which provide assistance (cash or in-kind goods and services) to Medicaid recipients. For Medicaid purposes, treatment of this assistance will vary depending on the nature of the program and the payment. Sections S0830.170, S0830.175 and S0830.180 provide guidelines for determining the nature of these programs and the income, if any, to count when program specific instructions do not exist elsewhere. A guide is provided in B. below.

B. Programs-Specific Instructions Use this table to locate specific instructions pertaining to frequently encountered programs with governmental involvement.

Adoption assistance.....	S0830.415
Action Programs.....	S0830.610
Aid to Families with Dependent Children (AFDC).....	S0830.400
Bureau of Indian Affairs General Assistance (BIAGA)....	S0830.800
Community Services Block Grant.....	S0830.615
Community Work Experience Program (CWEP)	S0830.185
Cuban/Haitian Entrant Cash Assistance	S0830.645
Disaster Assistance.....	S0830.620
Educational Assistance.....	S0830.450
Emergency Assistance Under Title IV A	S0830.405
Federal Emergency Management Agency (FEMA).....	S0830.625
Food Stamps	S0830.635
Foster Care	S0830.410
Foster Grandparents Program	S0830.610
General Assistance, Home, Relief, etc.	S0830.175
Housing Assistance	S0830.630
<i>Workforce Investment Act (Formerly Job Training Partnership Act).....</i>	<i>S0830.535</i>
Low Income Home Energy Assistance Program (LIHEAP).....	S0830.600
Older Americans Act.....	S0830.640
Refugee Cash Assistance.....	S0830.645
Refugee Reception and Placement Grants	S0830.650
Refugee Matching Grants.....	S0830.650
Rehabilitation Act of 1973	S0815.050
Relocation Assistance.....	S0830.655
School Lunches	S0830.635
Social Service Block Grant (Title XX)	S0815.050
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Subchapter Subject M0830 UNEARNED INCOME	Page ending with S0830.535	Page 82

S0830.535 WORKFORCE INVESTMENT ACT (FORMERLY JOB TRAINING PARTNERSHIP ACT)

A. Introduction

The purpose of the *Workforce Investment Act (WIA, formerly the Job Training Partnership Act [JTPA])* is to prepare individuals for entry into the labor force. *WIA* funding is much like a block grant and programs will vary among areas within the State. *WIA* payments may be called "needs-based" for *WIA* purposes but are not "income based on need" or "assistance based on need" for Medicaid purposes. *WIA* payments may be in cash or in kind, and participants in *WIA* may receive supportive services in cash or in kind. Usually, adult participants receive **only** supportive services.

B. Policy

WIA payments are **subject to the general rules** pertaining the income and income exclusions.

C. Procedure

1. Allegations

Accept an individual's allegation of participation in *WIA* and receipt of supportive services unless there is reason to question the information.

2. Assumption

- **Assume** that supportive services such as child care, transportation, medical care, meals and other reasonable expenses, provided in cash or in kind, are **social services** and **not income**.
- Disregard the supportive services without further development or documentation.

NOTE: However, items such as salaries, stipends, incentive payments, etc., must be evaluated under the general rules of unearned and earned income. Any payments made directly to vendors by *WIA* are not income.

D. References

Medical and Social Services S0815.050
Earned income, S0820.001.
Blind Work Expenses, S0820.535
IRW E, S0820.540
PASS, S0870.001.

M1110 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-1	6/1/15	Page 2
TN #100	5/1/15	Page 2
TN #99	1/1/14	Page 2
UP #9	4/1/13	Page 2
UP #6	4/1/12	Page 2
TN #96	10/1/11	Page 2
TN #95	3/1/11	Page 2
Update (UP) #3	3/2/10	Table of Contents page 2
TN #93	1/1/10	Page 2
TN #91	5/15/09	Pages 14-16

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Subchapter Subject ABD RESOURCES - GENERAL	Page ending with M1110.003	Page 2

M1110.003 RESOURCE LIMITS

A. Introduction The resource limit is the maximum dollar amount of countable assets an individual, couple, or family may own and still meet the established criteria for Medical Assistance in an ABD category. These amounts are established by law.

B. Policy Principles

1. Resource Ineligibility An individual (or couple) with countable resources in excess of the applicable limit is not eligible for Medicaid.

2. Resource Limits

ABD Eligible Group	One Person	Two People
Categorically Needy Medically Needy	\$2,000	\$3,000
ABD With Income \leq 80% FPL	\$2,000	\$3,000
QDWI	\$4,000	\$6,000
QMB SLMB QI	Calendar Year 2016 <i>(no change)</i> \$7,280 2015 \$7,280	Calendar Year 2016 <i>(no change)</i> \$10,930 2015 \$10,930

3. Change in Marital Status A change in marital status can result in a change to the applicable resource limit. The resource limit change is effective with the month that we begin treating both members of a couple as individuals. For example, separation from an ineligible spouse can change the limit from \$3,000 to \$2,000. See M1110.530 B.

4. Reduction of Excess Resources **Month of Application**

Excess resources throughout the month of application causes ineligibility for the application month. Reduction of excess resources within the application month can cause resource eligibility for that month.

M1130 Changes

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

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Subchapter Subject M1130.000 ABD RESOURCE EXCLUSIONS	Page ending with M1130.100	Page 4

The six-month home exclusion allowed for an institutionalized individual's former home also applies to the home owned by an individual receiving Medicaid community-based care (CBC) services in another person's home, providing the individual resided in the home prior to receipt of Medicaid CBC. See M1460.530 for additional information.

3. Extended Exclusion for Institutionalized Individual

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

- spouse;
- minor dependent child under age 18;
- dependent child, **under** age 19, **who attends** school or vocational training; or
- individual's parent or adult child *who*:
 - *has been determined to be disabled* according to the Medicaid disability definition, *and*
 - *lived* in the home with the individual for at least one year prior to the individual's institutionalization, *and*
 - is dependent upon the individual for his shelter needs.

E. Development and Documentation-- Initial Applications

1. Ownership

a. Verify Ownership

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

b. Evidence of real property ownership;

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

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

- title,
- current registration.

d. Evidence of life estate or similar property rights:

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

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- 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 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.
- e. For property owned by an individual who is incompetent *and has no one authorized to sell real property on his behalf*, 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 *through the sixth month after the initiation of the court action, whichever comes first*. 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 *place the property on the market according to the criteria in M1130.140 B.1.a-d and make a continuing effort to sell the property as described in M1130.140 B.3.*

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.

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3. Continuing Effort to Sell

Notwithstanding the fact that the recipient made a reasonable effort to sell the property and failed to sell it, and although the recipient has become eligible, the recipient must make a continuing reasonable effort to sell until the property is sold or Medicaid coverage is canceled. *Depending on how the initial effort to sell was met, a continuing effort to sell is met as follows:*

- a. *When the property was listed at no more than the CMV and the listing realtor verified that the property is unlikely to sell within 90 days of listing per M1130.140 B.1.a, the listing agreement must continually be renewed at no more than 100% of the taxed assessed value, until the property is sold. If the list price was initially higher than the tax-assessed value, the listed sales price must be reduced to no more than 100% of the tax-assessed value.*
- b. *In the case where at least two realtors have refused to list the property per M1130.140 B.1.b, the recipient must personally try to sell the property by efforts described in B.1.c. above, for 12 months.*
- c. *In the case of recipient who has personally advertised his property for a year without success per M1130.140 B.1.c, (the newspaper advertisements, "for sale" sign, do not have to be continuous; these efforts must be done for at least 90 days within a 12 month period), the recipient must then:*
 - *subject his property to a realtor's listing agreement (must be actively marketed) priced at or below current market value; or*
 - *meet the requirements of M1130.140 B.1.b. above, which are that the recipient must try to list the property and at least two realtors must refuse to list it because it is unsaleable at current market value; other reasons for refusal to list are not sufficient.*
- d. *When there is jointly owned property which a co-owner has refused to sell or when the property is an interest in an undivided estate, and the initial effort to sell was met per M1130.140 B.1.d., a partition suit is necessary in order to liquidate the property. A continuing reasonable effort to sell the property shall be demonstrated by filing suit with the court to partition the property within 60 days of proving the property is otherwise unsaleable (in accordance with section B.1.e.) and shall continue until the property is sold or 9 months, whichever is less. Any period of time in excess of 9 months to sell shall not be deemed reasonable and the property loses this exemption.*

4. After Continuing Effort Has Been Established

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

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

M1410 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-1	6/1/16	Pages 12-14
TN #100	5/1/15	Page 2
TN #99	1/1/14	Page 10
Update #7	7/1/12	Pages 6, 7
TN #96	10/1/11	Page 11, 12
TN #95	3/1/11	Pages 13, 14 Page 15 was removed.
TN #94	9/1/10	Pages 6, 7, 13
TN #93	1/1/10	Pages 1, 7, 9, 12
TN #91	5/15/09	Pages 11-14

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Subchapter Subject M1410.000 GENERAL RULES FOR LONG-TERM CARE	Page ending with M1410.300	Page 12

B. Forms to Use

1. **Notice of Action on Medicaid & FAMIS (#032-03-0008)**
The EW must send the Notice of Action on Medicaid, available on SPARK at: <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>, to the applicant/ recipient and the person who is authorized to conduct business for the applicant to notify him of the agency's decision on the initial Medicaid application, and on a redetermination of eligibility when a recipient starts LTC services.

2. **Notice of Obligation for Long-Term Care Costs (#032-03-0062)**
The Notice of Obligation for Long-term Care Costs is sent to the applicant/enrollee or the authorized representative to notify them of the amount of patient pay responsibility. The form is generated and sent by the Medicaid Management Information System (MMIS) on the day the patient pay information is entered into MMIS. The report of all Notices sent by MMIS each day is posted by FIPS code on SPARK in the Medicaid Management Reports.

3. **Medicaid LTC Communication Form (DMAS-225)**
The Medicaid Long-term Care (LTC) Communication Form is available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi. The form is used by LTC providers and local departments of social services (LDSS) to exchange information, other than patient pay information, such as:
 - a change in the LTC provider, including when an individual moves from CBC to a nursing facility or the reverse;
 - the enrollee's physical residence, if different than the LDSS locality;
 - changes in the patient's deductions (e.g. a medical expense allowance);
 - admission, death or discharge to an institution or community-based care service;
 - changes in eligibility status; and
 - changes in third-party liability.

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

a. When to Complete the DMAS-225

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

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b. Where to Send the DMAS-225

- 1) For hospice services patients, including hospice patients in a nursing facility or those who are also receiving CBC services, send the original form to the hospice provider.
- 2) For facility patients, send the original form to the nursing facility.
- 3) For PACE or adult day health care recipients, send the original form to the PACE or adult day health care provider.
- 4) For Medicaid CBC, send the original form to the following individuals
 - the case manager at the Community Services Board, for the ID/MR and DS waivers;
 - the case manager (support coordinator), for the DD Waiver,
 - the personal care provider, for agency-directed EDCD personal care services and other services. If the patient receives both personal care and adult day health care, send the DMAS-225 to the personal care provider.
 - the service facilitator, for consumer-directed EDCD services,
 - the case manager, for any enrollee with case management services, and
 - the case manager at DMAS, for the Tech Waiver, at the following address:

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

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

4. Advance Notices of Proposed Action

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

a. Advance Notice of Proposed Action

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

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

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Subchapter Subject M1410.000 GENERAL RULES FOR LONG-TERM CARE	Page ending with M1410.300	Page 14

b. Notice of Obligation for Long-Term Care Costs

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

Patient pay must be entered into MMIS no later than close-of-business on the **15th** day of the month, to meet the advance notice requirement.

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

**5. Administrative
Renewal Form**

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

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

M1420 Changes

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

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- 3. Intellectual Disabilities/ (ID) Waiver** Local Community Mental Health Services Boards (CSBs) and the Department of Rehabilitative Services (DRS) are authorized to screen individuals for the ID waiver. Final authorizations for ID waiver services are made by DBHDS staff.
- 5. Individual and Family Developmental Disabilities Support (DD) Waiver** DMAS and the Virginia Health Department child development clinics are authorized to screen individuals for the DD waiver.
- 6. Alzheimer's Assisted Living (AAL) Waiver** Local screening committees or teams and hospital screening committees or teams are authorized to screen individuals for the AAL waiver; however, a copy of the pre-admission screening is not required for the Medicaid eligibility record. Documentation of the verbal assurance by the screeners must be included in the case record.
- 7. Day Support Waiver for Individuals with Intellectual Disabilities/ Mental Retardation (DS) Waiver** Local CSB and DBHDS case managers are authorized to screen individuals for the DS waiver. Final authorizations for DS waiver services are made by DBHDS staff.
- D. PACE** Local screening committees or teams and hospital screening committees or teams are authorized to screen individuals for PACE. If the individual is screened and approved for LTC, the committee/team will inform the individual about any existing PACE program that serves the individual's locality.

M1420.300 COMMUNICATION PROCEDURES

- A. Introduction** To ensure that nursing facility/PACE placement or receipt of Medicaid CBC services are be arranged as quickly as possible, there must be prompt communication between screeners and eligibility staff.
- B. Procedures**
- 1. LDSS Contact** The LDSS agency should designate an appropriate staff member for screeners to contact. Local social services staff, hospital staff and DRS staff should be given the name and contact information for that person to facilitate timely communication between screeners and eligibility staff.
- 2. Screeners** Screeners must inform the individual's eligibility worker when the screening process has been initiated and completed.

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**3. Eligibility
Worker (EW)
Action**

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

M1420.400 SCREENING CERTIFICATION

A. Purpose

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

**B. Exceptions to
Screening**

Pre-admission screening is NOT required when:

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

C. Documentation

If the individual has not been institutionalized for at least 30 consecutive days and a screening is required, the screener's certification of approval for Medicaid long-term care must be substantiated in the case record by one of the following documents:

- Medicaid Funded Long-term Care Service Authorization Form (DMAS-96) for nursing facilities, PACE and EDCD and Tech Waivers (see Appendix 1);

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- Technology Assisted Waiver Level of Care Eligibility Form (see Appendix 2);
- *Copy of the authorization screen from the Intellectual Disability On-line System (IDOLS) (see Appendix 3);*

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

1. Nursing Facility/PACE

Individuals who require care in a nursing facility or elect PACE will have a DMAS-96 signed and dated by the screener and the supervising physician.

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

2. EDCD Waiver

Individuals screened and approved for the EDCD waiver must have a DMAS-96 signed and dated by the screener and the physician.

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

3. Tech Waiver

Individuals screened and approved for the Tech Waiver will have either a DMAS-96 signed and dated by the screener and physician, or a Technology Assisted Waiver Level of Care Eligibility Form signed and dated by a DMAS representative.

4. ID Waiver Authorization Screen Print

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

5. DS Waiver Level of Care Eligibility Form

Individuals screened and approved for the DS waiver will have the DS Waiver Level of Care Eligibility Form signed and dated by the DBHDS representative. The DS Waiver Level of Care Eligibility Form will include the individual's name, address and the date of DBHDS approval.

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**6. DD Waiver
Level of Care
Eligibility Form**

Individuals screened and approved for the DD waiver will have the DD Waiver Level of Care Eligibility Form signed and dated by a DMAS Health Care Coordinator. The form letter will include the individual's name, address and the date of approval for waiver services.

**D. Authorization for
LTC Services**

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

**1. Authorization
Not Received**

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

**2. Authorization
Rescinded**

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

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

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

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

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*Intellectual Disability On-line System (IDOLS)
Authorization Screen*

Slot Assignment Approval

Approval Status:	<input type="text" value="Approved"/>	Submitted By: Williams, Eric
Approved/ Denied By:	Williams, Eric	Submitted Date:
Approved/ Denied Date:	6/13/2011	

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

M1450 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-1	6/1/16	Pages 13, 15, 35 Pages 14 and 16 are runover pages.
TN #100	5/1/15	Table of Contents Pages 17-19, 36, 37 Page 35 is a runover page.
TN #99	1/1/14	Page 7, 10, 21
UP #7	6/1/12	Table of Contents Pages 37-43 Page 43a was added.
TN #96	10/1/11	Table of Contents Pages 4-8 Pages 15, 16, 25, 26 Pages 31-38 Page 31a removed.
TN #95	3/1/11	Pages 4, 24, 32, 36, 37, 37a, Pages 39, 42, 43
TN #94	9/1/10	Table of Contents Pages 36-37a, 39-44
TN #93	1/1/10	Table of Contents Pages 3, 17-18, 29 Appendix 2, page 1
TN #91	5/15/09	Pages 41, 42

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However, the trust may provide for reasonable compensation for a trustee(s) to manage the trust, as well as for reasonable costs associated with investing or otherwise managing the funds or property in the trust. In defining what is reasonable compensation, consider the amount of time and effort involved in managing a trust of the size involved, as well as the prevailing rate of compensation, if any, for managing a trust of similar size and complexity.

2. Not for the Sole Benefit of Spouse, Blind/disabled Child, or Disabled Individual

A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is NOT the spouse, a blind or disabled child or a disabled individual, is NOT considered established for the sole benefit of one of these individuals. Thus, the establishment of such a trust is a transfer of assets that affects eligibility for Medicaid payment of LTC services.

3. Trusts for Disabled Individuals Under Which the State Is Beneficiary

Trusts established for disabled individuals, as described in M1120.202, do not have to provide for an actuarially sound spending of the trust funds for the benefit of the individual involved. However, under these trusts, the trust instrument must provide that any funds remaining in the trust upon the death of the individual must go to the state, up to the amount of Medicaid benefits paid on the individual's behalf.

The trust does not have to provide for an actuarially sound spending of the trust funds for the benefit of the individual involved when:

- the trust instrument designates the state as the recipient of funds from the trust, and
- the trust requirements in M1120.202 require that the trust be for the sole benefit of an individual.

The trust may also provide for disbursement of funds to other beneficiaries provided that the trust does not permit such disbursements until the state's claim is satisfied. "Pooled" trusts may provide that the trust can retain a certain percentage of the funds in the trust account upon the death of the beneficiary.

4. Cross-reference

If the trust is not for the sole benefit of the individual's spouse, blind or disabled child or a disabled individual, and it does not meet the criteria in item *M1450.400 D.3* above, go to M1450.550 to determine if the transfer of assets into the trust affects Medicaid payment for LTC services.

NOTE: Evaluate the trust to determine if it is a resource. See M1120.200, M1120.201 and M1120.202.

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1. **Evidence of Reasonable Effort to Sell** The individual must provide objective evidence for real property that he/she made an initial and continuing reasonable effort to sell the property. See M1130.140.
2. **Evidence of Legally Binding Contract** The individual must provide objective evidence that he/she made a legally binding contract (as defined in M1450.003 above) that provided for his/her receipt of adequate compensation in a specified form (goods, services, money, etc.) in exchange for the transferred asset.

If the goods received include term life insurance, see M1450.510 below.

3. **Irrevocable Burial Trust** The individual must provide objective evidence that the asset was transferred into an irrevocable burial trust. The trust is NOT compensation for the transferred money unless the individual provides objective evidence that all the funds in the trust will be used to pay for identifiable funeral services.

Objective evidence is the contract with the funeral home which lists funeral items and services and the price of each, when the total price of all items and services equals the amount of funds in the irrevocable burial trust.

NOTE: Evaluate the trust to determine if it is a resource. See M1120.200, M1120.201 and M1120.202.

F. Post-Eligibility Transfers by the Community Spouse

Post-eligibility transfers of resources owned by the community spouse (institutionalized spouse has no ownership interest) do not affect the institutionalized spouse's continued eligibility for Medicaid payment of LTC services.

Exception: The purchase of annuity by the community spouse on or after February 8, 2006 may be treated as an uncompensated transfer. See G. below.

G. Purchase of an Annuity by Community Spouse

For applications made on or after July 1, 2006, an annuity purchased by the community spouse on or after February 8, 2006, will be treated as an uncompensated transfer unless:

- the state is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant; or
- the state is named the remainder beneficiary in the second position after the community spouse or minor or disabled child. If the spouse or the representative of a minor or disabled child disposes of any remainder for less than fair market value, the state must be named in the first position.

H. Transfers Made on or After February 8, 2006 with Cumulative Value Less Than or Equal to \$4,000

The policy in this subsection applies to actions taken on applications, renewals or changes on or after July 1, 2006 for transfers made on or after February 8, 2006.

Asset transfers made on or after February 8, 2006 that have a total cumulative value of less than or equal to \$1,000 per calendar year will not be considered a transfer for less than fair market value and no penalty period will be calculated.

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

- I. LTC Partnership Policy** The value of assets transferred that were disregarded as a result of an LTC Partnership Policy does not affect an individual's eligibility for Medicaid payment of LTC services. See M1460.160 for more information about LTC Partnership Policies.
- J. Return of Asset** The transfer of an asset for less than fair market value does not affect eligibility for Medicaid LTC services' payment if the asset has been returned to the individual.
- K. Home Foreclosure** The repossession and/or sale of a home by the mortgage lender for less than fair market value due to foreclosure is not evaluated as an uncompensated transfer. Documentation of the foreclosure must be retained in the case record.
- L. Court-ordered or Approved Sale** *When property is ordered to be sold at a judicial sale or when a court has approved the sale of property for less than FMV, the sale is considered a compensated transfer. The individual or guardian must provide documentation of the court order for the sale and any other documentation needed to verify the sale of the property.*
- M. Transfer of Income Tax Refund or Advance Payment Received After December 31, 2009 but Before January 1, 2013** Under Section 728 of the Tax Relief, Unemployment Insurance Reauthorization and Job Creation Act of 2010 (P.L. 111-312), the transfer of an income tax refund or advance payment received after December 31, 2009 but Before January 1, 2013, to another individual or to a trust does NOT affect eligibility for Medicaid payment of LTC services. If the funds are given away or placed in a trust, other than a trust established for a disabled individual (see M1120.202), after the end of the exempt period, the transfer is subject to a transfer penalty or being counted under the Medicaid trust provisions, as applicable.

M1450.500 TRANSFERS THAT AFFECT ELIGIBILITY

- A. Policy** If an asset transfer does not meet the criteria in sections M1450.300 or M1450.400, the transfer will be considered to have been completed for reasons of becoming or remaining eligible for Medicaid payment of LTC services, unless evidence has been provided to the contrary.

Asset transfers that affect eligibility for Medicaid LTC services payment include, but are not limited to, transfers of the following assets:

- cash, bank accounts, savings certificates,
- stocks or bonds,
- resources **over \$1,500** that are excluded under the burial fund exclusion policy,
- cash value of life insurance when the total face values of all policies owned on an individual exceed \$1,500
- interests in real property, including mineral rights,
- rights to inherited real or personal property or income.

- B. Procedures** Use the following sections to evaluate an asset transfer:

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- M1450.510 for a purchase of term life insurance.
- M1450.520 for a purchase of an annuity before February 8, 2006.
- M1450.530 for a purchase of an annuity on or after February 8, 2006.
- M1450.540 for promissory notes, loans, or mortgages.
- M1450.550 for a transfer of assets into or from a trust.
- M1450.560 for a transfer of income.

M1450.510 PURCHASE OF TERM LIFE INSURANCE

A. Policy

The purchase of any term life insurance after April 7, 1993, except term life insurance that funds a pre-need funeral under section 54.1-2820 of the Code of Virginia, is an uncompensated transfer for less than fair market value if the term insurance's benefit payable at death does not **equal or exceed twice the sum of all premiums paid for the policy.**

B. Procedures

1. Policy Funds Pre-need Funeral

Determine the purpose of the term insurance policy by reviewing the policy. If the policy language specifies that the death benefits shall be used to purchase burial space items or funeral services, then the purchase of the policy is a compensated transfer of funds and does not affect eligibility.

However, any benefits **paid** under such policy in excess of the actual funeral expenses are subject to recovery by the Department of Medical Assistance Services for Medicaid payments made on behalf of the deceased insured Medicaid enrollee.

2. Policy Funds Irrevocable Trust

Since **an irrevocable trust for burial is not a pre-need funeral**, the purchase of a term life insurance policy(ies) used to fund an irrevocable trust is an uncompensated transfer of assets for less than fair market value.

3. Determine If Transfer Is Uncompensated

When the term life insurance policy does not fund a pre-need funeral, determine if the purchase of the term insurance policy is an uncompensated transfer:

- Determine the benefit payable at death. The face value of the policy is the "benefit payable at death."
- From the insurance company, obtain the sum of all premium(s) paid on the policy; multiply this sum by 2. The result is "twice the premium."
- Compare the result to the term insurance policy's face value.
 - If the term insurance's face value equals or exceeds the result (twice the premium), the purchase of the policy is a transfer for fair market value and does not affect eligibility.
 - If the term insurance's face value is less than the result (twice the premium), the purchase of the policy is an uncompensated transfer for less than fair market value. Determine a penalty period per M1450.620 or M1450.630 below.

EXAMPLE #1: Mr. C. uses \$5,000 from his checking account to purchase a \$5,000 face value term life insurance policy on August 13, 1995. Since the policy was purchased after April 7, 1993, and \$5,000 (benefit payable on death) is not twice the \$5,000 premium, the purchase is an uncompensated transfer. The uncompensated value and the penalty period for Medicaid payment of long-term care services must be determined.

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M1450.630 PENALTY PERIOD CALCULATION

A. Policy

When a transfer of assets on or after February 8, 2006, affects eligibility, the penalty period begins when the individual would otherwise be eligible for Medicaid payment for LTC services if not for the penalty period. The penalty period includes the fractional portion of the month, rounded down to a day. Penalty periods for multiple transfers cannot overlap.

Individuals in a penalty period who meet all other Medicaid eligibility requirements may be eligible for Medicaid payment for all other Medicaid covered services.

B. Penalty Begin Date

For individuals not receiving LTC services at the time of transfer, the penalty period begins the first day of the month in which the individual would otherwise be eligible for Medicaid payment for LTC services, except for the imposition of a penalty period. This includes the application retroactive period for nursing facility patients who have been in the facility during the retroactive period.

For individuals who are receiving Medicaid payment for LTC services at the time of transfer, the penalty period begins the month following the month of transfer.

1. Medicaid LTC Not Received at Time of Transfer

If the individual is not receiving Medicaid-covered LTC services at the time of the asset transfer, the penalty period begins the first day of the month in which the individual would otherwise be eligible for Medicaid payment for LTC services but for the application of the penalty period, as long as the date does not fall into another period of ineligibility imposed for any reason.

2. Receiving Medicaid LTC Services at Time of Transfer

If the individual is receiving Medicaid LTC services at the time of the asset transfer, the penalty period begins the first day of the month following the month in which the asset transfer occurred *as long as the individual would otherwise be eligible for Medicaid payment for LTC services but for the application of the penalty period.*

A referral to the DMAS Enrollee Audit Unit (RAU) must be made for the months in the penalty period during which the individual received Medicaid LTC services. See Chapter M17 for instructions on RAU referrals.

M1460 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-1		Table of Contents, page i Pages 3, 8a, 17, 32
TN #100	5/1/15	Table of Contents, page i Pages 1, 2, 5, 6, 10, 15, 16-17a, 25,41-51
TN #99	1/1/14	Pages 3, 35
UP #9	4/1/13	Table of Contents Pages 3, 35, 38, 41, 42, 50, 51
TN #97	9/1/12	Table of Contents Pages 1, 4-7, 9-17 Page 8a was deleted. Pages 18a-20, 23-27, 29-31 Pages 37-40, 43-51 Pages 52 and 53 were deleted
UP #6	4/1/12	Pages 3, 35
TN #96	10/1/11	Pages 3, 20, 21
TN #95	3/1/11	Pages 3, 4, 35
TN #94	9/1/10	Page 4a
TN #93	1/1/10	Pages 28, 35
TN #91	5/15/09	Pages 23, 24

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10. Old Bills

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

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

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

11. Projected Expenses

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

12. Spenddown Liability

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

M1460.150 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LTC

A. Applicability

The policy in this section applies to nursing facility and CBC/PACE patients, who meet the requirements for LTC on or after January 1, 2006. This includes individuals who filed reapplications after a break in Medicaid eligibility. It does **not apply** to Medicaid recipients who were approved for LTC prior to January 1, 2006, and who maintain continuous Medicaid eligibility.

For Medicaid applicants or enrollees approved for LTC on or after July 1, 2006, the amount of equity in the home at the time of the initial LTC determination and at each renewal must be evaluated.

B. Policy

Individuals with equity value (tax assessed value minus encumbrances) in home property that exceeds the limit are NOT eligible for Medicaid payment of long-term care services unless the home is occupied by

- a spouse,
- a dependent child under age 21 years, or
- a blind or disabled child of any age.

Individuals with substantial home equity may be eligible for Medicaid payment of other covered services if they meet all the other Medicaid eligibility requirements.

1. Home Equity Limit

The home equity limit applied is based on the date of the application or request for LTC coverage. Effective January 1, 2011, the home equity limit is subject to change annually. The home equity limit is:

- Effective January 1, 2012: \$525,000.
- Effective January 1, 2013: \$536,000
- Effective January 1, 2014: \$543,000
- *Effective January 1, 2015: \$552,000*
- *Effective January 1, 2016: \$552,000 (no change)*

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- 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 OTHER CATEGORICALLY NEEDY (CN) COVERED GROUPS

A. Description

Categorically needy (CN) individuals receive or are deemed to be receiving public assistance cash benefits.

B. ABD Groups

1. QSII (1619(b))

Qualified Severely Impaired Individuals (QSII) are former SSI recipients who are working but are still disabled, and are eligible under 1619(b) of the Social Security Act. To be eligible for Medicaid, they must have met the more restrictive resource requirements for Medicaid in the month before the month they qualified under 1619(b). See section M0320.105 for details about this covered group.

2. AG Recipients

An Auxiliary Grants (AG) recipient is eligible for Medicaid if he meets the assignment of rights to medical support and third party payments requirements and the asset transfer policy. See section M0320.202 for details about this covered group.

C. F&C Groups

1. Individuals Under 21

a. IV- E Foster Care Recipients

Children who are eligible for foster care payments under Title IV-E of the Social Security Act are eligible for Medicaid. See section M0320.305 for details about this covered group.

b. IV-E Adoption Assistance Recipients

Children who are eligible for adoption assistance under Title IV-E of the Social Security Act are eligible for Medicaid. See section M0320.305 for details about this covered group.

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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

The RUG code amount may differ from facility to facility and from patient to patient within the same facility. For MN patients, the nursing facility must be contacted to obtain the RUG code amount.

a. Spenddown Liability Less Than or Equal to the Individual's Medicaid Rate

If the spenddown liability is less than or equal to the individual's Medicaid rate, determine spenddown eligibility by projecting the facility's costs at the individual's Medicaid rate for the month. Spenddown balance after deducting projected costs at the individual's Medicaid rate should be zero or less.

The patient is eligible as MN for the whole month. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

b. Spenddown Liability More Than the Individual's Medicaid Rate

When the spenddown liability is **more than** the individual's Medicaid rate, determine spenddown eligibility **AFTER** the month has passed, on a daily basis (do not project expenses) by chronologically deducting old bills and carry-over expenses, then deducting the facility daily cost at the **private** daily rate and other medical expenses as they were incurred.

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- b. Payments for unusual medical expenses.
- c. Payments made as part of a VA program of vocational rehabilitation.
- d. VA clothing allowance.
- e. Any pension paid to a nursing facility patient who is
 - a veteran with no dependents, or
 - a veteran's surviving spouse who has no child.

NOTE: Refer to section M1470.100 for counting VA pension payments as income for post-eligibility determinations. This applies to all LTC recipients who reside in state veterans' care centers. This applies to all LTC recipients, *including those patients* who reside in state veterans' care centers.

- f. Any portion of a VA educational benefit which is a withdrawal of the veteran's own contribution is a conversion of a resource and is not income.

2. VA Augmented Benefits

An absent dependent's portion of an augmented VA benefit received by the individual on or after 11-17-94 is NOT income to the individual when determining his eligibility in any covered group EXCEPT an F&C MN covered group.

VA Augmented benefits are COUNTED as income when determining eligibility in the F&C MN covered groups.

3. Return of Money

(S0815.250) A rebate, refund, or other return of money that an individual has already paid is NOT income to the individual when determining his eligibility in any covered group EXCEPT an F&C MN covered group. The key idea is a return of the individual's own money. Some "rebates" do not fit this category, such as a cooperative operating as a jointly owned business pays a "rebate" as a return on a member's investment; this "rebate" is unearned income similar to a dividend.

4. Death Benefits

Death benefits **equal** to cost of last illness and burial are NOT income in all covered groups EXCEPT the F&C MN covered groups.

Any amount of the death benefit that **exceeds** the costs of last illness and burial **is counted as income** for eligibility and patient pay **in all covered groups**.

5. Austrian Social Insurance

Austrian Social Insurance payments that meet the requirements in S0830.715 are NOT income in all covered groups EXCEPT the F&C MN covered groups.

6. Native American Funds

- a. Seneca Nation Settlement Act [ref. P.L. 101-503]
- b. Yakima Indian Nation [ref. P.L. 99-433]
- c. Papago Tribe of Arizona [ref. P.L. 97-408]
- d. Shawnee Indians [ref. P.L. 97-372]

M1470 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 19, 20, 48, 49, 54 Page 50 is a runover page.
UP #11	7/1/15	Pages 43-46 Page 46a was deleted.
TN #100	5/1/15	Pages 2a, 4, 29, 31, 32, 34, 43, 44, 45, 53, 54 Pages 1a, 2, 3a and 4 were renumbered for clarity. Pages 3, 4a, 46 and 46a are runover pages. Pages 1 and 3 are reprinted.
TN #99	1/1/14	Pages 9, 19, 20, 23, 24, 40
TN #98	10/1/13	Pages 9, 24
UP #9	4/1/13	Pages 9, 16, 19, 20, 24, 43
UP #7	7/1/12	Pages 19, 46-48
UP #6	4/1/12	Pages 4, 9, 19, 20, 24, 26
TN #96	10/1/11	Pages 3, 4, 7-9, 19, 22-24, 43
TN #95	3/1/11	Pages 9, 19, 20, 23
TN #94	9/1/10	Table of Contents Pages 1, 1a, 3, 3a, 11, 12, Pages 19, 20, 24, 28, 31
TN #93	1/1/10	Pages 9, 13, 19-20, 23, 43, 44
TN #91	5/15/09	Table of Contents Pages 1-56 Appendix 1

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M1470.410 MEDICAID CBC - PERSONAL MAINTENANCE ALLOWANCE

A. Individuals

For the month of entry and subsequent months, deduct from the patient's gross monthly countable income a personal maintenance allowance (PMA). The amount of the allowance depends upon under which Medicaid CBC waiver the patient receives LTC services.

The total amount of the PMA cannot exceed 300% SSI.

1. Basic Maintenance Allowance

Patients receiving Medicaid CBC under the following waivers are allowed a monthly basic PMA:

- Elderly or Disabled with Consumer-Direction (EDCD) Waiver,
- Intellectual Disabilities/Mental Retardation (ID/MR) Waiver, Technology-Assisted Individuals Waiver,
- Individual and Family Developmental Disabilities Support (DD) Waiver , and
- Day Support (DS) Waiver.

The PMA is:

- *January 1, 2016 through December 31, 2016: \$1,210 (no change)*
- *January 1, 2015 through December 31, 2015: \$1,210*

Contact a Medical Assistance Program Consultant for the PMA in effect for years prior to 2009.

2. Guardianship Fee

Deduct an amount up to 5% of the patient's gross monthly income (including amounts not counted as income and excluded income) for guardianship fees, if the patient has a legally appointed guardian or conservator AND the guardian or conservator charges a fee. The guardianship **filing** fees CANNOT be deducted from the individual's income. Document how it was determined that the guardian/conservator charges a fee and the amount of the fee.

No deduction is allowed if the patient's guardian receives a payment for providing guardianship services from a public agency or organization that receives funding for guardianship services.

No deduction is allowed for representative payee or "power of attorney" fees or expenses.

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- 3. Special Earnings Allowance for Recipients in EDCD, DD, ID/MR or DS Waivers**
- Deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:
- for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (\$2,199 in 2016) per month.
 - for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI (\$1,466 in 2016) per month.

- 4. Example – Special Earnings Allowance (Using January 2009 figures)**
- A working patient receiving EDCD waiver services is employed 18 hours per week. His income is gross earnings of \$928.80 per month and SSA of \$300 monthly. His special earnings allowance is calculated by comparing his gross earned income (\$928.80) to the 200% of SSI maximum (\$1,348.00). His gross earned income is less than 200% of SSI; therefore, he is entitled to a special earnings allowance. His personal maintenance allowance is computed as follows:

\$ 1,112.00 CBC basic maintenance allowance
+ 928.80 special earnings allowance
\$ 2,040.80 PMA

Because the PMA may not exceed 300% of SSI, the PMA for the patient in this example must be reduced to \$2,022.00.

- B. Couples**
- The Medicaid CBC waivers do not specify personal maintenance allowances for a married couple living together when both spouses receive Medicaid CBC because each spouse is considered an individual for patient pay purposes. The individual maintenance allowance in section M1470.410 applies to each spouse in a couple when each receives Medicaid CBC.

M1470.420 DEPENDENT CHILD ALLOWANCE

- A. Unmarried Individual, or Married Individual With No Community Spouse**
- For an unmarried Medicaid CBC patient, or a married Medicaid CBC patient without a community spouse, who has a dependent child(ren) under age 21 years in the community:
- Calculate the difference between the appropriate MN income limit for the **child's** home locality for the number of children in the home and the child(ren)'s gross monthly income. If the children are living in different homes, the children's allowances are calculated separately using the MN income limit for the number of the patient's dependent children in each home.
 - The result is the dependent child allowance. If the result is greater than \$0, deduct it from the patient's income as the dependent child allowance. If the result is \$0 or less, do not deduct a dependent child allowance.

Do not deduct an allowance if the child(ren)'s monthly income exceeds the MN income limit in the child's home locality for the number of dependent children in the home.

Do not deduct an allowance for any other family member.

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**5. Example--
Patient Pay
Increase -Total
Underpayment
\$1,500 or More**

Mr. M is an institutionalized individual. On February 25, he reports his pension increased \$600 per month in February. On March 22 the EW recalculated the patient pay based on the current income. His new monthly patient pay is \$1,800. His “old” monthly patient pay was \$1200.

Because of the 10-day advance notice requirement the change could not be made for April and must be made for May 1. His "old" patient pay is subtracted from his "new" patient pay for February, March and April to determine his underpayment for those months. The \$600 underpayment for three months totals \$1,800. Since the total underpayment exceeds \$1,500, a patient pay adjustment can not be made. A referral must be made to the DMAS Recipient Audit Unit for collection and the recipient must be notified of the referral (see M1470.900 D. 3. c).

M1470.910 RETROACTIVE ADJUSTMENTS FOR PRIOR MONTHS

**A. Retroactive
Adjustment**

If a change was reported timely and the patient pay for prior months is incorrect, adjust the patient pay for the prior months only in the following situations:

1. a deceased individual had health insurance premiums or noncovered medical expenses that should have reduced patient pay; or
2. a community spouse is owed money for a spousal allowance and the institutionalized spouse is deceased or no longer in long-term care. However, if the community spouse had decreased income and did not report the change in a timely manner, do not adjust the patient pay.

In these situations, adjust the patient pay retroactively using MMIS Patient Pay process for the prior months in which the patient pay was incorrect. **In all other situations when a change is reported timely, do not adjust the patient pay retroactively.**

**B. Notification
Requirements**

MMIS automatically generates and sends the Notice of Obligation for LTC Costs.

M1470.920 LTC PROVIDER CHANGE WITHIN A MONTH

A. Policy

A change in LTC providers requires a review of the type of provider and living arrangements to determine the correct personal needs allowance and new patient pay, if applicable.

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B. Procedures

Patient pay is deducted from the first LTC provider's claim to be filed, up to the entire monthly patient pay obligation. If there more than one provider files a claim for the same month of service, the patient pay will be deducted based on the order in which the claims are filed, rather than the dates of service. If monthly patient pay exceeds the amount of the claim, then the remaining balance will be deducted from subsequent claims, in the order filed.

Example: A patient receives services from Provider A from the 1st -15th day of the month and from Provider B from the 16th-31st day of the month. The patient pay will be deducted based on the order in which the claims are filed, rather than the dates of service. If Provider B bills first, then the patient pay will be deducted from Provider B's claim.

*Eligibility staff will continue to calculate monthly patient pay. **There is no need to divide or apportion the patient pay when a patient changes providers or moves from one type of provider/care to another (e.g. CBC to a nursing facility) nor any a need to inform the provider via a DMAS-225.** Changes in patient pay will be made prospectively, based on advance notice requirements. Patient Pay underpayment corrections should follow the procedures contained in M1470.900.*

C. PACE

Enrollment in PACE begins on the first day of a month and ends on the last day of a month. Patient pay for PACE participants is not adjusted due to provider changes within a month.

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M1470.930 DEATH OR DISCHARGE FROM LTC

- A. Policy** The LTC provider may not collect an amount of patient pay that is more than the Medicaid rate for the month. When a patient dies or is discharged from LTC to another living arrangement that does not include LTC services, do not recalculate patient pay for the month in which the patient died or was discharged. The provider is responsible for collecting an amount of patient pay for the month of death or discharge that does not exceed the Medicaid rate for the month.
- B. Procedure** Refer to Chapter G in the MMIS User's Guide for DSS for procedures regarding death or discharge from LTC. Send a DMAS-225 to the provider regarding the eligibility status of the patient. Send a notice to the patient or the patient's representative that reflects the reduction or termination of services.

M1470.1000 LUMP SUM PAYMENTS

- A. Policy** Lump sum payments of income or accumulated benefits are counted as income in the month they are received. Patient pay must be adjusted to reflect this income change for the month following the month in which the 10-day advance notice period expires. Any amount retained becomes a resource in the following month.
- B. Lump Sum Defined** Income such as interest, trust payments, royalties, etc., which is received regularly but is received less often than quarterly (i.e., once every four months or three times a year, once every five months, once every six months or twice a year, or once a year) is treated as a lump sum for patient pay purposes.
- EXCEPTION:** Income that has previously been identified as available for patient pay, but which was not actually received because the payment source was holding the payment(s) for some reason or had terminated the payment(s) by mistake, is **NOT** counted again when the corrective payment is received.
- See section M1470.1030 below for instructions for determining patient pay when a lump sum is received.

M1470.1010 LUMP SUM REPORTED IN RECEIPT MONTH

- A. Lump Sum Available** Lump sum payments reported in the month the payment was received are counted available for patient pay effective the first of the month following the month in which the 10-day advance notice period expires.
- If the individual is no longer in the facility and is not receiving Medicaid CBC, adjust the patient pay for the lump sum receipt month if the money is still available.
- B. Lump Sum Not Available** If the money is not available, complete and send a "Notice of Recipient Fraud/Non-Fraud Overissuance" to the DMAS, Recipient Audit Unit.

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Prior to initiating the following procedures, contact the individual or his authorized representative and tell him of the alternatives available. In the case record, document the conversation and the decision made. If unable to make contact by phone, send the Advance Notice of Proposed Action for cancellation due to excess resources.

2. Reduce Excess Resources

When the patient agrees to use the excess resources toward the cost of care, take the following steps for the month in which the 10-day advance notice period expires:

Step 1

Determine amount of excess resources (total resources minus the resource limit).

Step 2

Determine the monthly Medicaid rate:

- * for a facility patient, the monthly rate is the *patient's daily RUG* rate multiplied by 31 days.
- for a CBC patient, the monthly rate is each CBC service provider's hourly rate multiplied by the number of hours of services provided to the patient in the month.

Step 3

Add the amount of excess resources to the current patient pay.

Step 4

If the result of Step 3 is less than the monthly Medicaid rate obtained in Step 2, adjust the patient pay for one month to allow the excess resources to be reduced.

Step 5

If the result of Step 3 is more than the monthly Medicaid rate obtained in Step 2, the patient is ineligible due to excess resources. Send an "Advance Notice of Proposed Action" to cancel Medicaid coverage due to excess resources.

D. Example-- Recipient Reduces Resources

An institutionalized Medicaid recipient's resources accumulate to \$2,200 in February. His monthly income is \$500 from Social Security (SS) and \$100 VA Compensation. His patient pay of \$560 is less than the Medicaid rate. He pays the amount of his excess resources (\$200) to the nursing facility as part of his March patient pay, so he remains eligible.

\$ 500	SS
<u>+ 100</u>	VA Compensation
\$ 600	total gross income
<u>- 40</u>	personal needs allowance
\$ 560	current patient pay (prior to adding excess resources)

\$ 560	current patient pay
<u>+ 200</u>	excess resources
\$760	patient pay for March only

M1480 Changes

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TN #DMAS-1	6/1/16	Pages 7, 11, 14, 18, 18c, 30, 66, 69, 70, 92, 93
UP #11	7/1/15	Page 18c
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TN #99	1/1/14	Pages 7, 18c, 66, 69, 70
TN #98	10/1/13	Page 66
UP #9	4/1/13	Pages 7, 18c, 66, 69, 70
UP #8	10/1/12	Page 66
TN #97	9/1/12	Pages 3, 6, 8b, 16 Pages 20-25 Page 20a was deleted.
UP #7	7/1/12	Pages 11, 14, 18c, 21 Pages 32, 66, 67, 69
UP #6	4/1/12	Pages 7, 18c, 66, 68, 69, 70
TN #96	10/1/11	Pages 7, 14, 66, 71
UP #5	7/1/11	Page 66
TN #95	3/1/11	Pages 7-9, 13, 18a, 18c, 66, 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

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27. Spousal Share means ½ of the couple's combined countable resources at the beginning of the **first** continuous period of institutionalization, as determined by a resource assessment.

28. Spouse means a person who is legally married to another person under Virginia law.

29. Waiver Services means Medicaid-reimbursed home or community-based services covered under a 1915(c) waiver approved by the Secretary of the United States Department of Health and Human Services.

M1480.015 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LONG-TERM CARE

A. Applicability The policy in this section applies to nursing facility and CBC/PACE patients, who meet the requirements for LTC on or after January 1, 2006. This includes individuals who filed reapplications after a break in Medicaid eligibility. It does **not apply** to Medicaid recipients who were approved for LTC prior to January 1, 2006, and who maintain continuous Medicaid eligibility.

For Medicaid applicants or enrollees approved for LTC on or after July 1, 2006, the amount of equity in the home at the time of the initial LTC determination and at each renewal must be evaluated. *For the purposes of the home equity evaluation, the definition of the home in M1130.100 A.2 is used; the home means the house and lot used as the principal residence and all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed \$5,000.*

B. Policy Individuals with equity value (tax assessed value minus encumbrances) in home property that exceeds the limit are NOT eligible for Medicaid payment of long-term care services unless the home is occupied by:

- a spouse,
- a dependent child under age 21 years, or
- a blind or disabled child of any age.

Individuals with substantial home equity may be eligible for Medicaid payment of other covered services if they meet all the other Medicaid eligibility requirements.

2. Home Equity Limit The home equity limit applied is based on the date of the application or request for LTC coverage. Effective January 1, 2011, the home equity limit is subject to change annually. The home equity limit is:

- Effective January 1, 2012: \$525,000.
- Effective January 1, 2013: \$536,000
- Effective January 1, 2014: \$543,000
- *Effective January 1, 2015: \$552,000*
- *Effective January 1, 2016: \$552,000 (no change)*

2. Reverse Mortgages Reverse mortgages **do not** reduce equity value until the individual begins receiving the reverse mortgage payments from the lender.

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3. Verification

The EW must advise the requesting party of the verification necessary to complete the assessment. Ownership interest and value of resources held **on the first moment of the first day of** the first month of the first continuous period of institutionalization must be verified.

Verify all non-excluded resources. Acceptable verification, for example, is a copy of the couple's bank statement(s) for the period. Do not send bank clearances; the requesting party is responsible to obtain verification of resources.

The EW is not required to assist the requesting party in obtaining any required verification for the resource assessment.

4. Failure To Provide Verification

If the applicant refuses to or fails to provide requested verification of resources held at the beginning of the first continuous period of institutionalization and does not notify the EW of difficulty in securing the requested data, the worker is unable to complete the resource assessment and is unable to determine the spousal share of resources. Go to item 8 below, "Notification Requirements."

5. Processing Time Standard

A resource assessment must be processed within 45 days of the date on which the agency receives the written and signed Medicaid Resource Assessment Request form.

If the requestor fails to provide requested verification within 45 days of receipt of notification, notify the applicant that the assessment cannot be completed, and of the reason(s) why. Use the Notice of Medicaid Resource Assessment (#032-03-817).

6. 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.

a. Compile the Couple's Resources

The value of non-excluded resources must be verified *and entered into VaCMS*. Enter all resources in which the couple has an ownership interest, including resources in their joint names, those in the institutionalized spouse's name and those in the community spouse's name, including those resources owned jointly with others. List each resource separately.

VaCMS will calculate the spousal share. The process used to calculate the spousal share is found in M1480.210 6.b below.

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Resources owned in the name of one or both spouses are considered available regardless of whether either spouse agrees to sell or liquidate the resource, and regardless of whether either spouse refuses to make the resource available. The resource assessment is not affected by the amount disregarded in the eligibility determination as a result of a Partnership Policy.

C. Appeal Rights

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

D. Eligibility Worker Responsibility

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

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

- all reported countable resources owned by the couple **on the first moment of the first day of the first month (FOM)** of the first continuous period of institutionalization. Request this information using the Medicaid Resource Assessment form (#032-03-816) when the FOM is prior to the application's retroactive period.
- all reported countable resources owned by the couple on the first moment of the first day of the month of application, and
- all reported countable resources owned by the couple as of the first moment of the first day of each retroactive month for which eligibility is being determined.

To expedite the application processing, the EW may include a copy of the "Intent to Transfer Assets to A Community Spouse" form, available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi with the request for verifications.

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

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

E. Procedures

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

1. Forms

The applicant or his representative does not complete a Medicaid Resource Assessment Request form. The Medicaid application is the resource assessment request. *The resource assessment will be calculated in VaCMS as part of the eligibility determination process.*

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3. The applicant has assigned to DMAS, to the full extent allowed by law, all claims he or she may have to financial support from the spouse; and
4. The applicant cooperates with DMAS in any effort undertaken or requested by DMAS to locate the spouse, to obtain information about the spouse's resources and/or to obtain financial support from the spouse.

B. Procedures

1. Assisting the Applicant

The EW must advise the applicant of the information needed to complete the resource assessment and assist the applicant in contacting the separated spouse to obtain resource and income information.

If the applicant cannot locate the separated spouse, document the file. Refer to Section B below.

If the applicant locates the separated spouse, the EW must contact the separated spouse to explain the resource assessment requirements for the determination of spousal eligibility for long-term care services.

If the separated spouse refuses to cooperate in providing information necessary to complete the resource assessment, document the file. Refer to Section B below.

EXCEPTION: If the separated spouse is institutionalized and is a Medicaid applicant/recipient, the definition of "community spouse" is not met, and a resource assessment is not needed.

2. Undue Hardship

If the applicant is unable to provide the necessary information to complete the resource assessment, he/she must be advised of the hardship policy and the right to claim undue hardship.

a. Undue hardship not claimed:

If the applicant does not wish to claim undue hardship, the EW must document the record and deny the application due to failure to verify resources held at the beginning of institutionalization.

b. Undue hardship claimed:

If the applicant claims an undue hardship, he must provide a written statement requesting an undue hardship evaluation. A Resource Assessment Undue Hardship Request Form, including affidavit and assignment forms, may be given to the applicant to be used instead of an original statement but is **not required**. *The forms are available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi>.*

The applicant or his representative must make an effort to locate and contact the estranged spouse or provide documentation as to why this is not possible. Contact or action to locate the estranged spouse by the EW alone is not sufficient to complete the undue hardship evaluation. When it is reported that the applicant has a medical condition that prevents participation in the process, then a physician's statement must be provided documenting the medical condition.

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2. After Eligibility is Established

Once an institutionalized spouse has established Medicaid eligibility as an institutionalized spouse, count only the institutionalized spouse's resources when determining the institutionalized spouse's Medicaid eligibility. Do not count or deem the community spouse's resources available to the institutionalized spouse.

If an institutionalized spouse's Medicaid coverage was cancelled and he reapplies as an institutionalized individual, use only the resources of the institutionalized spouse for his eligibility determination.

M1480.231 SPOUSAL RESOURCE STANDARDS

A. Introduction

This section provides the amounts and the effective dates of the standards used to determine an institutionalized spouse's initial and ongoing resource eligibility. Use the standard in effect on the date of the institutionalized spouse's Medicaid application. Definitions of the terms are found in section M1480.010.

B. Spousal Resource Standard	\$23,844	<i>1-1-16 (no change)</i>
	\$23,844	1-1-15
C. Maximum Spousal Resource Standard	\$119,220	<i>1-1-15 (no change)</i>
	\$119,220	1-1-15

M1480.232 INITIAL ELIGIBILITY DETERMINATION PERIOD

A. Policy

The initial eligibility determination period begins with the month of application. If the institutionalized spouse is eligible for the month of application, the initial eligibility determination period will both begin and end with that month.

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- the amount of resources that may be transferred to bring the community spouse up to the PRA will reduce the resources in the institutionalized spouse's name to no more than \$2,000, and
- the institutionalized spouse has expressly indicated in writing his intent to transfer resources to the community spouse.

The protected period is designed to allow the institutionalized spouse time to legally transfer some or all of his resources to the community spouse. Resources in the institutionalized spouse's name are excluded only for one 90-day period.

If the institutionalized spouse does not transfer resources to the community spouse within the 90-day period, all of the institutionalized spouse's resources will be counted available to the institutionalized spouse when the protected period ends. If the institutionalized spouse loses eligibility after the 90-day protected period is over, and then reapplies for Medicaid, he CANNOT have resource eligibility protected again and a PRA is NOT subtracted from his resources.

B. Protected Period Is Not Applicable

A protected period of eligibility is not applicable to an institutionalized spouse when:

- the institutionalized spouse is not eligible for Medicaid;
- the institutionalized spouse previously established Medicaid eligibility as an institutionalized spouse, had a protected period of eligibility, became ineligible, and reapplies for Medicaid; or
- at the time of application, a community spouse has title to resources equal to or exceeding the PRA.

C. Intent to Transfer Resources To Community Spouse

The institutionalized spouse or authorized representative must expressly indicate in writing his intention to transfer resources to the community spouse. If not previously obtained, send an "Intent to Transfer Assets to A Community Spouse" form, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi> to the institutionalized spouse or authorized representative, allowing 10 days from the date of mailing for return of the form.

If the completed Intent to Transfer Assets form is not returned by the time the application is processed, no protected period of eligibility may be established. All resources in the institutionalized spouse's name must be counted in his eligibility determination beginning with the month following the initial eligibility determination period. If eligible, enroll the institutionalized spouse for a closed period of coverage beginning with the retroactive period and ending with the last day of the month of the initial eligibility period.

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After eligibility is established, the usual reporting and notification processes apply. Send written notice for the month(s) during which the individual establishes Medicaid eligibility. MMIS will generate the “Notice of Obligation for LTC Costs” and it will be sent to the individual or his authorized representative.

M1480.400 PATIENT PAY

- A. Introduction** This section contains the policy and procedures for determining an institutionalized spouse’s (as defined in section M1480.010 above) patient pay in all covered groups.
- B. Married With Institutionalized Spouse in a Facility** For a married LTC patient with an institutionalized spouse in a facility, **NO** amount of the patient’s income is deducted for the spouse’s needs in the patient pay calculation.

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

- A. Introduction** This subsection contains the standards and their effective dates that are used to determine the community spouse’s and other family members’ income allowances. The income allowances are deducted from the institutionalized spouse’s gross monthly income when determining the monthly patient pay amount. Definitions of these terms are in section M1480.010 above.
- B. Monthly Maintenance Needs Allowance**
- | | | | |
|------------|--------|--|--|
| \$1,991.25 | 7-1-15 | | |
| \$1,966.25 | 7-1-14 | | |
- C. Maximum Monthly Maintenance Needs Allowance**
- | | | | |
|------------|--------------------|--|--|
| \$2,980.50 | 1-1-16 (no change) | | |
| \$2,980.50 | 1-1-15 | | |
- D. Excess Shelter Standard**
- | | | | |
|----------|--------|--|--|
| \$597.38 | 7-1-15 | | |
| \$589.88 | 7-1-14 | | |
- E. Utility Standard Deduction (SNAP)**
- | | | | |
|----------|-----------------------------|---------|--|
| \$294.00 | 1 - 3 household members | 10-1-15 | |
| \$369.00 | 4 or more household members | 10-1-15 | |
| \$298.00 | 1 - 3 household members | 10-1-14 | |
| \$375.00 | 4 or more household members | 10-1-14 | |

M1480.420 PATIENT PAY FOR ABD 80% FPL AND 300% SSI INSTITUTIONALIZED SPOUSE

- A. Policy** After a 300% SSI or ABD 80% FPL institutionalized spouse has been found eligible for Medicaid, determine his patient pay (post-eligibility treatment of income).

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\$875 gross earned income
 - 75 first \$75 per month
 800 remainder
 ÷ 2
 400 ½ remainder
 + 75 first \$75 per month
 \$475 which is > \$190

His personal needs allowance is calculated as follows:

\$ 40.00 basic personal needs allowance
 +190.00 special earnings allowance
 + 17.50 guardianship fee (2% of \$875)
 \$247.50 personal needs allowance

**2. Medicaid CBC
Waiver
Services and
PACE**

a. Basic Maintenance Allowance

For the Elderly or Disabled with Consumer Direction Waiver (EDCD Waiver), Intellectual Disabilities/Mental Retardation (ID/MR) Waiver, Technology-Assisted Individuals Waiver, Individual and Family Developmental Disabilities Support (DD) Waiver, Day Support (DS) Waiver or PACE, deduct the appropriate maintenance allowance for one person as follows:

- *January 1, 2016 through December 31, 2016: \$1,2010 (no change)*
- *January 1, 2015 through December 31, 2015: \$1,210*

Contact a Medical Assistance Program Consultant for the amount in effect for years prior to 2013.

b. Guardian Fee

Deduct the actual fee a guardian or conservator charges, up to a maximum of 5% of the patient's actual gross income (including amounts not counted as income and excluded amounts) for guardianship fees, IF:

- * the patient has a legally appointed guardian or conservator AND
- * the guardian or conservator charges a fee.

Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

NOTES: No deduction is allowed for representative payee or "power of attorney" fees or expenses. No deduction is allowed if the patient's guardian receives a payment for providing guardianship services from a public agency or organization that receives funding for guardianship services. The guardianship filing fees CANNOT be deducted from the individual's income.

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c. Special Earnings Allowance For EDCD, DD, DS and ID/MR Waivers

[EXAMPLE #19 was deleted]

For EDCD, DD, DS and ID/MR Waivers, deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

- 1) for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (\$2,199 in 2016) per month.
- 1) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI (\$1,466 in 2016) per month.

The total of the basic maintenance allowance, the guardianship fee and the special earnings allowance cannot exceed 300% SSI.

EXAMPLE #20: (Using January 2000 figures)

A working patient in the ID/MR Waiver is employed 18 hours per week. He has gross earnings of \$928.80 per month and SS of \$300 monthly. His special earnings allowance is calculated first:

\$ 928.80	gross earned income
- 1,024.00	200% SSI maximum
\$ 0	remainder

\$928.80 = special earnings allowance

His personal maintenance allowance is calculated as follows:

\$ 512.00	maintenance allowance
+ 928.80	special earnings allowance
\$1,440.80	personal maintenance allowance

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4) any allowable noncovered medical expenses (per section M1470.530) including any old bills, carry-over expenses and other noncovered expenses that were used to meet the spenddown, but NOT including the cost of the community-based care.

5) a home maintenance deduction, if any (per section M1480.430 G.).

The result is the remaining income for patient pay.

2. Patient Pay

Compare the remaining income for patient pay to the monthly PACE rate (minus the Medicare Part D premium) for the month. The patient pay is the lesser of the two amounts.

M1480.500 NOTICES AND APPEALS

M1480.510 NOTIFICATION

A. Notification

Send written notices to the institutionalized spouse, the authorized representative and the community spouse advising them of:

- the action taken on the institutionalized spouse’s Medicaid application and the reason(s) for the action;
- the resource determination, the income eligibility determination, and the patient pay income, spousal and family member allowances and other deductions used to calculate patient pay;
- the right to appeal the actions taken and the amounts calculated.

B. Forms to Use

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

The EW must send the “Notice of Action on Medicaid (Title XIX) and Children’s Medical Security Insurance Plan (Title XXI Program)” *or system-generated equivalent* to the applicant/recipient and the person who is authorized to conduct business for the applicant to notify him of the Agency's decision on the initial Medicaid application, and on a redetermination of eligibility when a recipient starts Medicaid-covered LTC services.

2. Notice of Obligation for Long-Term Care Costs

The “Notice of Obligation for Long-term Care Costs” notifies the patient of the amount of patient pay responsibility. The form is generated and sent by *the enrollment system* when the patient pay is used entered or changed.

3. Medicaid LTC Communication Form (DMAS-225)

The Medicaid Long-term Care (LTC) Communication Form (DMAS-225) is used to facilitate communication between the local agency and the LTC services provider. The form may be initiated by the local agency or the provider. The form is available on SPARK at:
http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi.

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The DMAS-225:

- notifies the LTC provider of a patient's Medicaid eligibility status;
- reflects changes in the patient's level of care or LTC provider;
- documents admission or discharge of a patient to an institution or community-based care services, or death of a patient;
- provides other information known to the provider that might cause a change in eligibility status or patient pay amount.

Do not use the DMAS-225 to relay the patient pay amount. Providers will be able to access the patient pay amount via the verification systems available to providers.

a. When to Complete the DMAS-225

Complete the DMAS-225 at the time of eligibility determination and/or the recipient's entry into LTC. Complete a new DMAS-225 when the enrollee's eligibility status changes, such as when the recipient's Medicaid coverage is canceled or changed to limited coverage (e.g. QMB coverage).

When a change in LTC providers occurs, complete a new DMAS-225 advising the new provider of the enrollee's eligibility status and that patient pay information is available through the verification systems.

b. Where To Send the DMAS-225

Refer to M1410.300 B.3.b to determine where the form is to be sent.

4. Resource Assessment Forms

The forms used for a resource assessment when no Medicaid application is filed are described in section M1480.210 (above). The resource assessment form that is used with a Medicaid application is described in section M1480.220. *The forms are generated by VaCMS when the resource assessment is completed in VaCMS.* Copies of the forms are included in Appendix 1 and Appendix 2 to this subchapter.

M1480.520 APPEALS

A. Client Appeals

The institutionalized spouse, the community spouse, or the authorized representative for either, has the right to appeal any action taken on a Medicaid application. The Medicaid client appeals process applies.

B. Appealable Issues

Any action taken on the individual's Medicaid **application** and receipt of Medicaid services may be appealed, including:

- spousal share determination,
- initial resource eligibility determination,
- spousal protected resource amount (PRA),
- resource redetermination,
- community spouse resource allowance (CSRA),
- income eligibility determination,
- patient pay and/or allowances calculations.

M1510 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-1	6/1/16	Pages 2 Pages 1 and 2a are runover pages.
TN #100	5/1/15	Table of Contents Pages 1-2a, 5-8b
UP #10	5/1/14	Table of Contents Pages 7-8a Page 8b was added.
TN #99	1/1/14	Table of Contents Pages 1, 2, 8, 8a, 9-11 Page 11a was added.
UP #9	4/1/13	Pages 2-7, 10-12, 14
UP #7	7/1/12	Pages 8, 9
TN #96	10/01/11	Pages 8a, 10
TN #95	3/1/11	Table of Contents Pages 8, 11-15
TN #94	9/1/10	Pages 2a, 8-8a
TN #93	1/1/10	Page 6
Update (UP) #2	8/24/09	Page 11
TN #91	5/15/09	Page 14

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M1510.000 ENTITLEMENT POLICY & PROCEDURES

M1510.100 MEDICAID ENTITLEMENT

A. Policy

If an individual meets all eligibility factors within a month covered by the application, eligibility exists for the entire month unless the individual became eligible by meeting a spenddown.

1. Spenddown Met

If the applicant had excess income and met the spenddown within the month, he remains responsible for his spenddown liability and his coverage begin date cannot be any earlier than the date he met the spenddown.

2. Individual is Deceased

If an application is filed on behalf of a deceased individual or the applicant dies during the application process, his eligibility is determined only for the days he was alive. He must have been eligible for Medicaid while he was alive in order to be entitled to enrollment in Medicaid. Any changes in the individual's resources or income after his death do not affect the eligibility determination.

Example: An individual applies on July 23 for retroactive and ongoing Medicaid. The worker determines that the individual had excess resources (cash value of life insurance) throughout the retroactive period and the application month. The individual dies on August 5. The family asserts that he no longer owned the life insurance policies on August 5 and meets the resource requirements for the month of August. The worker determines that the individual owned the policies on the date of his death, the countable value exceeded the resource limit and he was not eligible for medical assistance on or before the date of his death.

3. Applicant Has Open MA Coverage in Another State

If an applicant indicates that he has been receiving Medical Assistance (MA- Medicaid or Children's Health Insurance Program) coverage in another state prior to moving to Virginia, instruct him to contact his eligibility worker there and request that his coverage be cancelled, if he has not already done so. He is no longer considered a resident of the other state once he has moved to and intends to reside in Virginia and is not entitled to receive services paid for by the other state's MA program. His enrollment may begin with the month of application or the earliest month in the application's retroactive period that he met the residency requirement per M0230.

B. SSI Entitlement Date Effect on Medicaid

SSI payments for eligible individuals are effective the first day of the month following the month in which the SSI application was filed. Medicaid coverage for eligible individuals is effective the first day of the month in which the Medicaid application is filed. When the Medicaid application is filed in the same month as the SSI application, the applicant is not eligible for Medicaid as an SSI recipient until the month in which his SSI entitlement began - the month following the application month. His eligibility for Medicaid in the application month must be determined in another covered group.

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C. Procedures

The procedures for determining an eligible individual's Medicaid coverage entitlement are contained in the following sections:

- M1510.101 Retroactive Eligibility & Entitlement
- M1510.102 Ongoing Entitlement
- M1510.103 Hospital Presumptive Eligibility
- M1510.104 Disability Denials
- M1451.105 Foster Care Children
- M1510.106 Delayed Claims

M1510.101 RETROACTIVE ELIGIBILITY & ENTITLEMENT

A. Definitions

1. Retroactive Period

The retroactive period is the three months immediately prior to the application month. Within this retroactive period, the individual may be Categorically Needy (CN) in one or two months and Medically Needy (MN) in the third month, or any other combination of classifications.

Retroactive Medicaid eligibility must be determined when an applicant for medical assistance indicates on the application that he, or anyone for whom he requests assistance, received a covered medical service within the retroactive period. The covered service may be listed by the applicant as an actual medical service on the application, or information on the application may indicate that a service was received, such as the birth of a child or Medicare coverage during the retroactive period.

2. Retroactive Budget Period

The "budget period" is the period of time during which an individual's income is calculated to determine income eligibility. The retroactive budget period depends on the individual's covered group.

B. Policy

An application for Medicaid or Auxiliary Grants (AG) is also an application for retroactive Medicaid coverage whenever the applicant reports that he/she received a Medicaid-covered service *or had Medicare coverage* in retroactive period. Eligibility for retroactive coverage is determined at the same time as the ongoing eligibility is determined, using the same application.

When an applicant reports that he/she, or anyone for whom he/she is applying, received a Medicaid covered service in any one of the three retroactive months, determine the applicant's eligibility for all three retroactive months, regardless of the service date. Determine nonfinancial, resource and income eligibility for each month in the retroactive period.

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C. Budget Periods By Classification

1. CN

The retroactive budget period for CN covered groups (categories) is one month. CN eligibility is determined for each month in the retroactive period, including a month(s) that is in a prior spenddown that was not met. Do not determine eligibility for a retroactive month that was included in a previous Medicaid coverage period; the applicant has already received Medicaid for that month.

NOTE: There is never any retroactive eligibility or entitlement as a Qualified Medicare Beneficiary (QMB) only. An individual who is eligible as Special Low-income Medicare Beneficiary (SLMB) or Qualified Disabled & Working (QDWI) can have retroactive coverage as an SLMB or QDWI.

2. MN

For the retroactive period, the **MN budget period is always all three months**. Unlike the retroactive CN period, the retroactive MN budget period may include a portion of a prior Medicaid coverage or spenddown period, and may also include months in which he is eligible as CN.

D. Verification

The applicant must verify all eligibility requirements in a retroactive month in order to be eligible for Medicaid coverage in that month.

For eligibility determinations completed for individuals subject to Modified Adjusted Gross Income (MAGI) methodology, income verification by the Federal Hub is acceptable for retroactive eligibility determinations provided that reasonable compatibility is met (see M0420.100 B.9). The applicant must provide verification of income received in the retroactive period, as well as for ongoing eligibility if his income is not verified by the Hub.

An individual who provides proof of application for an SSN, after he applies for medical assistance, meets the application for SSN requirement in the three months retroactive to his medical assistance application.

If the applicant fails to verify any required eligibility factor for a retroactive month, coverage **for that month** must be denied because of failure to verify eligibility. If he verifies all eligibility factors for the other months in the retroactive period, he may be eligible for CN retroactive coverage for those months.

EXAMPLE #1: Ms. A applied for Medicaid for herself and her children on July 8. She reported receiving a Medicaid covered service in each retroactive month. The retroactive period is April 1 through June 30. She currently receives Unemployment Compensation; she lost her job in May. She provided all required verification for May and June, but did not provide income verification for April. Their application was approved for CN Medicaid coverage beginning May 1; April coverage was denied because of failure to verify income for April.

M1520 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-1	6/1/16	Pages 3, 6, 7, 9, 11-14, 17 Appendix 2, page 1 Pages 3a and 7a were added. Page 8 is a runover page.
TN #100	5/1/15	Table of Contents Pages 1-27 (entire subchapter –pages 28-34 were deleted) Appendices 1 and 2 were added.
TN #99	1/1/14	Table of Contents Pages 1-34 (entire subchapter)
UP #9	4/1/13	Pages 7b and 10a
TN #97	9/1/12	Page 1
UP #7	7/1/12	Pages 1, 7, 7c, 7g
TN #96	10/1/11	Table of Contents Pages 1-7g Pages 11-13 Pages 21-24
TN #95	3/1/11	Pages 6a, 7, 21, 22
TN #94	9/1/10	Table of Contents Pages 3, 4b, 5, 6-6a, 10 Appendix 1 was removed.
UP #4	7/1/10	Page 4
TN #93	1/1/10	Pages 3, 4b, 5-6, 10, 15 Pages 21, 22
Update (UP) #2	8/24/09	Pages 1, 2, 13, 14, 17, 18
Update (UP) #1	7/01/09	Page 3

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1. Program Integrity

The MA eligibility of enrollees is subject to periodic review through the program integrity process (such as Medicaid Quality Control and the DMAS Recipient Audit Unit). It may be necessary for program integrity staff to request information, such as income verification, from the enrollee. The enrollee will be notified in writing and given a reasonable amount of time, as determined by the program integrity staff, to provide the information.

Should the enrollee not provide the requested information to the program integrity staff within the specified time, program integrity staff will notify the eligibility worker, and the worker must take action to follow up by requesting the appropriate verifications and/or sending advance notice, if necessary, to cancel coverage due to the inability to determine continued eligibility. An individual's failure to provide information to program integrity staff does not affect any future Medicaid applications.

C. Covered Group and Aid Category Changes

1. Enrollee's Situation Changes

When a change in an enrollee's situation results in a potential change in covered group, his eligibility in all other covered groups must be evaluated. Examples of such changes include when:

- a pregnant woman reaches the end of her post-partum period (the month in which the 60th day after the end of the pregnancy occurs),
- a newborn child reaches age one year,
- a families & children's (F&C) enrollee becomes entitled to SSI, and
- an SSI Medicaid enrollee becomes a Qualified Severely Impaired Individual (QSII) (1619(b)).

2. Enrollee in Limited Coverage Becomes Entitled to Full Coverage

When an individual who has been enrolled in limited coverage, such as Plan First, experiences a change, such as pregnancy, that results in eligibility for full coverage, the individual's entitlement to full coverage begins the month the individual is first eligible for full coverage, regardless of when or how the agency learns of the change. The enrollee must provide verification of income or other information necessary to establish eligibility for full coverage.

Example: *in June 2016, a woman enrolled in Plan First reports that she became pregnant in December 2015. She provides verification of her income for December through June. Her coverage in AC 080 (Plan First) is cancelled retroactively using cancel code 024, and she is reinstated in AC 091 effective December 1, 2015, the earliest month her entitlement to full coverage began.*

3. Enrollee Turns Age 6

*When an enrolled child turns six years old, MMIS automatically changes the child's AC from 090 or 091 to AC 092 (ages 6-19, insured or uninsured with income less than or equal to 109% FPL OR **insured** with income greater than 109% FPL and less than or equal to 143% FPL).*

*If the child is **uninsured** with income greater than 109% FPL and less than or equal to 143% FPL, manually change the child's AC to AC 094 no later than at the next renewal.*

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D. Child Moves From Parental Home

When an enrolled child moves out of the parental home but is still living in Virginia, do not cancel MA coverage solely on the basis of the move, and do not require a new application. Complete a partial review to determine the child's continuing eligibility if any changes in income, such as the child becoming employed, are reported.

1. Case Management

The necessary case management actions depend on the child's age and whether or not the child has moved to an arrangement in which an authorized representative is necessary.

a. Child Age 18 years or Under 18 and Living with a Relative

If the child is age 18, he may be placed in his own MA case if he was previously on a case with other enrollees. If the child is under age 18 and moved in with an adult relative, the child may be placed on a case with the relative and the relative authorized to conduct MA business on behalf of the child.

b. Child Under Age 18 years Living with Non-relative

When a child under age 18 moves to the home of a non-relative adult without legal custody, the non-relative adult does not have to be an authorized representative to report changes in the child's situation. However, the worker cannot discuss the case or send the non-relative adult a copy of the child's MA card unless the person is authorized to handle the MA business for the child. Follow the procedures in *M1520.100 D.2* through *D.4* below.

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1. Required Verifications

An individual's continued eligibility for MA requires verification of income for all covered groups and resources for covered groups with resource requirements.

Whenever the necessary renewal information is available to the worker through data verification sources and policy permits, the client is not to be contacted and the renewal is to be completed ex parte (*see M1520.200 B.1*). *Verification of income obtained through available verification sources may be used if it is dated within the previous 12 months.*

When it is necessary to obtain information and/or verifications, such as verification of resources, from the enrollee, a contact-based renewal must be completed and **the renewal must be signed by the enrollee.**

Blindness and disability are considered continuing unless it is reported that the individual is no longer blind or disabled.

2. SSN Follow Up

If the enrollee's SSN has not been assigned by the renewal date, the worker must obtain the enrollee's assigned SSN at renewal in order for coverage to continue. See subchapter M0240 for detailed procedures for obtaining the SSN.

3. Evaluation and Documentation

An evaluation of the information used to determine continued eligibility must be completed and included in the case record. For SSI Medicaid ex parte renewals, the Record of Ex Parte Medicaid Renewal (#032-03-0740) is recommended.

For other renewals of cases outside of VACMS, the Evaluation of Eligibility (#032-03-0823), available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi>, is recommended to document the case record.

4. Renewal Period

Renewals must be completed prior to cut-off in the 12th month of eligibility. The first 12-month period begins with the month of application for Medicaid.

B. Renewal Procedures

Renewals may be completed in the following ways:

- ex parte,
- using a paper form,
- online,
- by telephone through the Cover Virginia Call Center.

1. Ex Parte Renewals

An ex parte renewal is an internal review of eligibility based on information available to the agency. Conduct renewals of ongoing Medicaid eligibility through the ex parte renewal process when:

- the local agency has access to on-line systems information for verifications necessary to determine ongoing eligibility and/or income verifications obtained for other benefit programs, and
- the enrollee's covered group is not subject to a resource test.

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- a. MAGI-based Cases** *For cases subject to Modified Adjusted Gross Income (MAGI) methodology, an ex parte renewal should be completed when income verification is available through the federal hub. An individual may authorize the use of Internal Revenue Services (IRS) data for up to five years on the application form and at each renewal. In order for the federal Hub to be used for income, there must be a valid authorization in the electronic or paper case record.*

The agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family, and must make efforts to align renewal dates for all programs. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information, information from SSA through SVES or SOLQ-I and information from child support and child care files. *Verification of income from available sources may be used if it is dated within the previous 12 months.*

The eligibility worker is to take every opportunity to renew Medicaid eligibility when information is reported/verified that will allow a renewal of eligibility to be completed. For example, when an ongoing Medicaid enrollee applies for SNAP or TANF or reports a change in income, use the income information obtained to complete an early ex parte Medicaid renewal and extend the Medicaid renewal for another 12 months.

The eligibility worker must document the date and method used to obtain the verification information (viewed pay stub dated xx/xx/xxxx, telephone call on xx/xx/xxxx date, etc.), the type of verification, the source and a description of the information. It is not necessary to retain a copy of income verifications in the case record. If the renewal is not processed and documented electronically, the documentation must be in the case record.

- b. \$0 Income Reported** *When an individual whose income must be counted for the renewal reported \$0 income at application, search the Virginia Employment Commission (VEC) online quarterly wage data and unemployment records and other agency records to verify the absence of income. If the individual receives benefits through other benefit programs and/ or childcare, income information in those records must also be reviewed.*

When the household members all reported \$0 income at application, search the Virginia Employment Commission (VEC) online quarterly wage data and unemployment records and other agency records to verify the absence of income. If an individual receives benefits through other benefit programs and/ or childcare, income information in those records must also be reviewed.

If the VEC inquiry and review of other agency records confirms that the household has not received wages, unemployment compensation, or other unearned income within the most recent reporting period, document the absence of verifiable income and determine or redetermine income eligibility. No statement regarding income is necessary from the individual.

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- c. SSI Medicaid Enrollees** An ex parte renewal for an SSI recipient (including an LTC recipient with no community spouse) who has reported no ownership interest in countable real property can be completed by verifying the individual's continued receipt of SSI through SVES or SOLQ-I and documenting the case record. For a 1619(b) individual, check the Medicaid Test Indicator field in SVES or SOLQ-I to verify there is a code of A, B or F.

If the individual is no longer an SSI recipient or no longer has 1619(b) status and the information needed to determine continued eligibility is not known to the agency, a contact-based renewal must be completed and necessary verifications obtained to evaluate the individual's eligibility in all other covered groups prior to canceling his Medicaid coverage.

The ex parte renewal process cannot be used for an SSI Medicaid enrollee who owns non-excluded real property because the individual is subject to a resource evaluation.

- d. Continuing Eligibility Not Established Through Ex Parte Process** *If the ex parte renewal results in the individual no longer being eligible for coverage, the individual must be given the opportunity to submit current income information and verifications. Follow the steps in M1520.200 B.2 below for completing a paper-based renewal.*

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2. Paper Renewals

When an ex parte renewal cannot be completed, send the enrollee a pre-filled paper Administrative Renewal form to sign and return. If the enrollee submits a completed application form, accept it as a renewal form and obtain any additional information needed to complete the renewal.

The enrollee must be allowed 30 days to return the renewal form and the necessary verifications. The form needs to be sent to the enrollee no later than the beginning of the 11th month of the eligibility cycle to allow for the 30 day return period and processing prior to the MMIS cutoff on the 16th of the month. The specific information requested and the deadline for receipt of the verification must be documented in the case record.

New or revised information provided by the enrollee must be entered into the system. Local agencies are to accept the Application for Health Coverage & Help Paying Costs if it is submitted in lieu of a renewal form.

When an individual does not return the renewal form and action is taken to cancel coverage, a three-month reconsideration period applies (see M1520.200 C.4).

Note: Follow Auxiliary Grants (GR) policy regarding the appropriate renewal form to use for AG/Medicaid enrollees.

3. Online and Telephonic Renewals

Enrollees may opt to complete a renewal online using CommonHelp or by telephone through the Cover Virginia Call Center.

Renewals completed through CommonHelp are electronically signed by the enrollee or authorized representative. For cases in VaCMS, renewals completed through CommonHelp will automatically be entered into VaCMS for the worker to complete processing. For non-VaCMS cases, the renewal must be completed manually. It is not necessary to print a renewal completed through CommonHelp for the case record because it will be maintained electronically; however, the evaluation of eligibility and verifications must be documented in the case record.

Telephonic renewals may be taken only by the Cover Virginia Call Center. Telephonic renewals cannot be taken directly by the local agency because a telephonic signature is required.

C. Disposition of Renewal

The enrollee must be informed in writing of the findings of the renewal and the action taken using the Notice of Action when continued eligibility exists. Advance written notice must be used when there is a reduction of benefits or termination of eligibility (see M1520.300).

1. Renewal Completed

Notify the enrollee in writing of the findings of the renewal and the action taken. When eligibility continues, use the Notice of Action, and include the month and year of the next scheduled renewal. When the individual is no longer eligible, use the Advance Notice of Proposed Action and include spenddown information, if applicable. When there is a reduction of benefits, use the Advance Notice of Proposed Action and include the month and year of the next scheduled renewal.

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2. Renewal Not Completed

If information necessary to redetermine eligibility is not available through online information systems that are available to the agency and the enrollee has been asked but has failed to provide the information, the renewal must be denied and the coverage cancelled using cancel reason “005” due to the inability to determine continued eligibility. Action cannot be taken to cancel coverage until after the deadline for the receipt of verifications has passed, except for situations when the deadline falls on a weekend or holiday.

3. Referral to Health Insurance Marketplace (HIM)

Unless the individual has Medicare, a referral to the HIM—also known as the Federally Facilitated Marketplace (FFM)—must be made when an individual’s coverage is cancelled so that the individual’s eligibility for the Advance Premium Tax Credit (APTC) in conjunction with a Qualified Health Plan (QHP) can be determined. If the individual’s renewal was not processed in VaCMS, his case must be entered in VaCMS in order for the HIM referral to be made.

4. Renewal Filed During the Three-month Reconsideration Period

If the individual’s coverage is cancelled because the individual did not return the renewal form (or complete an online or telephonic renewal) or requested verifications, the Affordable Care Act (ACA) requires a reconsideration period of 90 days be allowed for an individual to file a renewal or submit verifications. For MA purposes, the 90 days is counted as three calendar months. *The individual must be given the entire reconsideration period to submit the renewal form and any required documentation.* The reconsideration period applies to all renewals, including renewals for the Qualified Medicare Beneficiary (QMB) and Qualified Individuals (QI) covered groups.

If the individual files a renewal or returns verifications *at any time* during the reconsideration period and is determined to be eligible, reinstate the individual’s coverage back to the date of cancellation. Send a Notice of Action informing him of the reinstatement, his continued coverage and the next renewal month and year. See M1520, Appendix 1 for the Renewal Process Reference Guide.

If the individual is not eligible, send a Notice of Action indicating the correct reason for the cancellation (e.g. countable income exceeds the limit). Renewal forms filed after the end of the reconsideration period are treated as reapplications. Accept the form and request any additional information needed to determine the individual’s eligibility.

D. Special Requirements for Certain Covered Groups

1. Pregnant Woman

Do not initiate a renewal of eligibility of an MI pregnant woman, or a pregnant woman in any other covered group, during her pregnancy. Eligibility in a

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If the child does not meet the definition for another covered group, determine the child's eligibility in Plan First using the eligibility requirements in M0320.302. If the child is eligible for Plan First, reinstate coverage in Plan First and send the Advance Notice of Proposed Action indicating that he has been enrolled in Plan First. On the notice, state that if he does not wish to remain covered by Plan First, to contact the eligibility worker and request that the coverage be cancelled. Include a Plan First Fact Sheet, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>, with the Advance Notice of Proposed Action.

6. IV-E FC & AA Children and Special Medical Needs Children

The renewal of Medicaid coverage for Title IV-E foster care or adoption assistance children and non-IV-E special medical needs adoption assistance children requires only the following information:

- verification of continued IV-E eligibility status or non-IV-E special medical needs status,
- the current address, and
- any changes regarding third-party liability (TPL).

7. Child Under 21 Turns Age 21

When an individual who is enrolled in the Child Under Age 21 covered group turns 21, redetermine his continuing Medicaid eligibility in other covered groups, including Plan First.

This information can be obtained from agency records, the parent or the Interstate Compact office from another state, when the child's foster care or adoption assistance agreement is held by another state. A renewal form is not required. The information must be documented in the case record.

8. Foster Care Child in an Independent Living Arrangement Turns Age 18

A foster care child who is in an Independent Living arrangement with a local department of social services (*LDSS*) no longer meets the definition of a foster care child when he turns 18. Determine the child's eligibility in the Former Foster Care Children Under Age 26 Years covered group.

9. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)

The BCCPTA Redetermination Form (#032-03-653), is used to redetermine eligibility for the BCCPTA covered group. The form is available on SPARK at: <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.html>. The enrollee must provide a statement from her medical provider verifying continued treatment for breast or cervical cancer. There are no Medicaid financial requirements for the BCCPTA covered group.

10. Hospice Covered Group

At the annual renewal for an individual enrolled in the Hospice covered group (AC 054), the worker must verify the enrollee's continued election and receipt of hospice services, in addition to determining continued Medicaid eligibility.

11. Qualified Individuals

Funding for the QI covered group became permanent in 2015; the QI covered group is subject to the same policies regarding renewals as other ABD covered groups.

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E. LTC

The ex parte renewal process is used for institutionalized individuals who receive SSI and have no countable real property. It can also be used for F&C enrollees subject to MAGI methodology when the local agency has access to on-line information for verifications necessary to determine ongoing eligibility and/or income verifications obtained for other benefit programs.

ABD, as well as F&C individuals over age 18, in the 300% of SSI covered group LTC must complete a contact-based renewal due to the resource requirement.

The patient pay must be updated in MMIS at least every 12 months, even if there is no change in patient pay. Send the provider a DMAS-225 when there has been a change in circumstances resulting in a change in eligibility. If there has been no change in circumstances, do not send a DMAS-225 to the provider.

F. Incarcerated Individuals

Incarcerated individuals who have active Medicaid are subject to annual renewals. Renewals for individuals in Department of Corrections and Department of Juvenile Justice facilities will be handled through the designated liaison.

- For individuals incarcerated in DOC facilities, send the renewal form and related correspondence to the DOC Health Services Reimbursement Unit, 6900 Atmore Driver, Richmond, Virginia 23225.
- For individuals in DJJ facilities, send the renewal form and related correspondence to the DJJ Re-entry Services Unit, 600 E. Main Street, Richmond VA 23219.
- For individuals in regional or local jails, send the renewal form and related correspondence to the individual or his authorized representative.

Although benefits administered by the Social Security Administration are suspended while an individual is incarcerated, a disabled individual continues to meet the definition of a disabled individual while incarcerated.

M1520.300 MA CANCELLATION OR SERVICES REDUCTION

A. Policy

At the time of any action affecting an individual's MA coverage, federal regulations in 42 CFR 431.206 through 431.214 require the agency to inform every applicant or enrollee in writing

- of his right to a hearing;
- of the method by which he may obtain a hearing; and
- that he may represent himself or use legal counsel, a relative, a friend or other spokesperson.

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B. Procedures

1. Change Results in Adverse Action

Following a determination that eligibility no longer exists or that the enrollee's Medicaid services must be reduced, the Advance Notice of Proposed Action, available on SPARK at: <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi> or system-generated advance notice must be sent to the enrollee at least 10 days plus one day for mail, before action is taken to cancel or reduce Medicaid coverage.

If the action to cancel or reduce benefits cannot be taken in the current month due to MMIS cut-off, then the action must be taken by MMIS cut-off in the following month. The Advance Notice of Proposed Action must inform the enrollee of the last day of Medicaid coverage.

Unless the individual has Medicare, a referral to the HIM must be made when coverage is cancelled. The notice must state that the individual has been referred to the HIM for determination of eligibility for the APTC.

2. Enrollee Appeals Action

If the enrollee requests an appeal hearing before the effective date of the action, subject to approval by the DMAS Appeals Division, the enrollee may choose to have eligibility continued at the current level of services until a decision is reached after a hearing. The DMAS Appeals Division will notify the local agency that the enrollee's coverage must be reinstated during the appeal process. **Do not reinstate coverage until directed to do so by the Department of Medical Assistance Services (DMAS) Appeals Division.**

If the decision is adverse to the recipient, the amount Medicaid paid on the services being appealed that were received by the recipient during the continuation is subject to recovery by DMAS.

Medicaid coverage at the prior level is not continued when a request for appeal is filed on or after the effective date of the action.

When notification is received from DMAS that the agency's proposed adverse action was sustained, the recipient's eligibility must be terminated effective the date of the receipt of that letter. No further advance notice to the recipient is necessary since he/she is also informed of DMAS' decision.

3. Death of Enrollee

The eligibility worker must take the following action when it is determined that an enrollee is deceased:

If the enrollee has an SSN, the worker must verify the date of death. The worker must run a SVES or SOLQ-I request to verify the date of death. SVES will display an "X" and the date of death in the "SSN VERIFICATION CODE" field on Screen 1.

If the recipient does not have an SSN, or if SOLQ-I or SVES does not return information showing that the recipient is deceased, contact the parent/caretaker relative or authorized representative to obtain the date of death. Information from a medical professional/facility is also acceptable.

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The worker must document the case file. Send adequate notice of cancellation to the estate of the enrollee at the enrollee's last known address and to any authorized representative(s) using the "Notice of Action on Medicaid."

Cancel the enrollee's coverage, using the date of death as the effective date of cancellation.

1. Enrollee Enters Ineligible Institution

When an enrollee who is not incarcerated enters an institution and is no longer eligible (e.g. an individual between the ages of 22 and 65 enters an institution for the treatment of mental diseases), cancel coverage as soon as possible after learning of the enrollee's admission to an ineligible institution. **DO NOT cancel coverage retroactively.** Cancel coverage in the MMIS effective the current date (date the worker enters the cancel transaction in MMIS), using cancel reason code "008."

If an enrollee becomes incarcerated, a partial review must be completed to determine if he continues to meet the requirements for coverage in a full-benefit CN covered group. If he continues to be eligible, cancel the existing coverage the date of the report and reinstate in AC 109 for ongoing coverage the following day. If the individual no longer meets the requirements for a full benefit CN covered group, cancel the coverage, effective the date the determination is made.

2. End of Spenddown Period

When eligibility terminates at the end of a six-month spenddown period, advance notice is not required. The individual is notified of the limited period of spenddown eligibility on the Notice of Action sent at the time the spenddown application is approved. Explanation of this limitation and information relative to re-application is provided at the time of the spenddown eligibility determination and enrollment.

6. Reason "012" Cancellations

Cancellations by DMAS staff due to returned mail are reported in the monthly System Cancellation Report (RS-O-112) available in *the Data Warehouse Medicaid Management Reports*. The report is issued between the 21st and 25th day of each month and is to be monitored so that appropriate follow up may be made.

When information is received from DMAS that a case is canceled for cancel reason "012", the local social services department must determine if the cancellation is valid. When cancellation is not valid, the case must be re-enrolled immediately.

When the cancellation is valid, the local department must mail the individual adequate notice of cancellation using the Notice of Action. Adequate notice consists of specifying the date the cancel action took place, which is the date the notice is mailed, in the section marked "Other" on the notification form.

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5. Case Handling

Prior to the end of the fourth month of the extension, evaluate the individuals in the family for continuing Medicaid eligibility. Cancel coverage for any individuals in the family who are no longer eligible and send advance notice of the cancellation. Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made so that the individual's eligibility for the APTC in conjunction with a QHP can be determined.

M1520.402 TWELVE-MONTHS EXTENSION

A. Policy

An LIFC Medicaid family is entitled to six additional months, with possible extension to twelve months, of Medicaid coverage after they lose Medicaid LIFC eligibility when the following conditions are met:

- The parent or caretaker-relative received Medicaid as LIFC in at least three of the six months immediately preceding the month in which they became ineligible for LIFC;
- The parent or caretaker-relative lost eligibility solely or partly due to receipt of or increased income from earnings; and
- All other Medicaid eligibility factors except income are met.

The family consists of those individuals included in the family unit as defined in M0520.100 at the time that the LIFC Medicaid eligibility terminated. It also includes individuals born, adopted into, or returning to the family after extended benefits begin who would have been considered a member of the family at the time the LIFC Medicaid eligibility terminated. The earned income received by a member of the family unit added after the loss of LIFC eligibility must be counted in determining the family's gross income.

B. Eligibility Conditions

The following conditions must be met:

1. Received LIFC Medicaid in Three of Six Months

The family received LIFC Medicaid in at least three of the six months immediately before the month in which the family became ineligible for LIFC. *A family who received Medicaid erroneously during three or more of the six months before the month of ineligibility does **not** qualify for the Medicaid extension.* Months during which the family received Extended Medicaid are not considered months in which the family received LIFC Medicaid.

2. Cancel Reason

LIFC Medicaid was canceled solely because of:

- the parent's or caretaker/relative's new employment,
- the parent's or caretaker/relative's increased hours of employment, or
- the parent's or caretaker/relative's increased wages of employment.

3. Has A Child Living in Home

There continues to be at least one child under age 18 or if in school, a child who is expected to graduate before or in the month he turns 19, living in the home with the parent or caretaker/relative.

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TWELVE MONTH EXTENDED MEDICAID INCOME LIMITS 185% of FEDERAL POVERTY LIMITS EFFECTIVE 1-25-16 ALL LOCALITIES	
# of Persons in Family Unit/Budget Unit	185% FPL Monthly Limit
1	\$1,832
2	2,470
3	3,108
4	3,747
5	4,385
6	5,023
7	5,663*
8	6,304*
Each additional person add	642*

**No change for 2016*

M16 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-1	6/1/16	Page 1
TN #100	5/1/15	Page 3
Update #9	4/1/13	Page 8

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Subchapter Subject M16 APPEALS PROCESS	Page ending with M1610.100	Page 1

M1600.00 APPEALS PROCESS

M1610.100 PURPOSE AND SCOPE

A. Legal Base

The Social Security Act requires that the State Plan for Medical Assistance provide individuals affected by the administration of the Medical Assistance Program an opportunity for a fair hearing. The act establishes the right of any individual to appeal and receive a fair hearing before the administering agency, the Department of Medical Assistance Services (DMAS), when DMAS or any of its designated agents:

- takes an action to terminate, deny, suspend, or reduce benefits,
- fails to take an application for medical assistance,
- fails to act on an application for medical assistance with reasonable promptness, or
- takes any other action that adversely affects receipt of medical assistance.

The State law governing the State/Local Hospitalization (SLH) program requires that DMAS use the Medicaid applicant/enrollee appeals and hearings procedures for SLH applicants and enrollees. The procedures in this Chapter also apply to SLH appeals.

B. Participants

The DMAS Appeals Division provides the Hearing Officer who makes arrangements for the fair hearing. The Appeals Division is separate and apart from operational divisions and units within and outside of DMAS. The Division provides a neutral forum for appeals. The Hearing Officer is an impartial decision-maker who will conduct hearings, decide on questions of evidence, procedure and law, and render a written final decision. The Hearing Officer is one who has not been directly involved in the initial adverse action which is the issue of the appeal.

The local agency taking the action being appealed, including Disability Determination Services (DDS) disability decisions, and the appellant (the individual appealing some aspect of his entitlement to medical assistance or its scope of services) or his representative must participate in the hearing. Most hearings will be conducted by telephone.

Appeals that result from a self-directed application in the eligibility and enrollment system are handled by the local department of social services (LDSS) that houses the application.

C. Ex Parte Communication

Ex parte communication with the Hearing Officer is strictly prohibited. Ex parte communication is any off-the-record communication (oral or written) between the Hearing Officer and an interested party outside the presence of the other parties to the proceeding during the life of the appeal proceeding.

The Hearing Officer cannot discuss the substantive issues of an appeal with anyone outside of the hearing. Therefore, it is not appropriate to contact the Hearing Officer to discuss the agency's action prior to or after the hearing.

M21 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-1	6/1/16	Appendix 1, page 1
TN #100	5/1/15	Table of Contents Pages 1-7 Appendices 1 Pages 8-10 and Appendices 2 and 3 were deleted.
UP #10	5/1/14	Pages 1-3 Appendix 1
TN #99	1/1/14	Pages 1-3 Appendix 1
TN # 98	10/1/13	Table of Contents Pages 1-10 Pages 10a and 11-16 were deleted.
UP #9	4/1/13	Pages 3, 4
UP #8	10/1/12	Table of Contents Pages 2-4 Appendix 3 deleted
TN #97	9/1/12	Pages 3, 4
UP #7	7/1/12	Pages 3, 4 Appendix 2, pages 1 Appendix 3, pages 1 and 2
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	Pages 3, 8
TN #95	3/1/11	Table of Contents Pages 5, 6, 14, 15, Page 16 added Appendix 1
TN #94	9/1/10	Page3 Appendix 3, pages 1 and 2
UP #3	3/1/10	Pages 2-5
TN #93	1/1/10	Page 2-4, 8
Update (UP) #2	8/24/09	Page 4

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**FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN
(FAMIS)
INCOME LIMITS
ALL LOCALITIES**

EFFECTIVE 1/25/16

# of Persons in FAMIS <i>House- hold</i>	FAMIS 150% FPL		FAMIS 200% FPL		
	Annual Limit	Monthly Limit	Annual Limit	Monthly Limit	205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)
1	\$17,820	\$1,485	\$23,760	\$ 1,980	\$2,030
2	24,030	2,003	32,040	2,670	2,737
3	30,240	2,520	40,320	3,360	3,744
4	36,450	3,038	48,600	4,050	4,152
5	42,660	3,555	56,880	4,740	4,869
6	48,870	4,073	65,160	5,430	5,566
7	55,095*	4,592*	73,460*	6,122*	6,276
8	61,335*	5,112*	81,780*	6,815*	6,986
Each add'l, add	6,240*	520*	8,320*	694*	712

*No change for 2016.

M22 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-1	6/1/16	Page 4 Appendix 1, page 1
TN #100	5/1/15	Table of Contents Pages 1, 2, 5, 6, 7 Appendix 1 Pages 3 and 4 are runover Pages.
TN #98	10/1/13	Table of Contents Pages 1-7 Appendix 1 Pages 8-10 were deleted.
UP #9	4/1/13	Appendix 1
UP #8	10/1/12	Pages 2, 3 Page 3a deleted
UP #7	7/1/12	Pages 2, 3
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	Pages 3, 3a
TN #95	3/1/11	Pages 4-6 Appendix 1
UP #4	7/1/10	Page 10
TN #94	9/1/10	Page 3
UP #3	3/01/10	Page 2
TN #93	1/1/10	Pages 2-10
UP #2	8/24/09	Page 3
Update (UP) #1	7/1/09	Pages 1, 2, 7 Appendix 1, page 1

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Subchapter Subject FAMIS MOMS	Page ending with M2220.300	Page 4

Health benefit plan does NOT mean:

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

4. Insured means having creditable health insurance coverage or coverage under a health benefit plan. A woman is considered to be insured if she is covered by a creditable health insurance plan, even if the policy or plan does not cover pregnancy-related services.

5. Uninsured means having no insurance; having insurance that is not creditable; having coverage which is not defined as a health benefit plan, or having a health insurance plan that does not have a network of providers in the area where the pregnant woman resides.

C. Policy

1. Must be Uninsured A nonfinancial requirement of FAMIS MOMS is that the pregnant woman be uninsured. A pregnant woman **cannot**:

- have creditable health insurance coverage; or
- have coverage under a group health plan (TRICARE, federal employee benefit plan, private group insurance such as Anthem, etc.) or Medicare.

2. Prior Insurance Prior insurance coverage is not a factor as long as the pregnant woman is uninsured during the month for which FAMIS MOMS eligibility is being determined.

M2220.300 NO CHILD SUPPORT COOPERATION REQUIREMENTS

A. Policy There are no requirements for FAMIS MOMS applicants or recipients to cooperate in pursuing support from an absent parent.

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<p align="center">FAMIS MOMS 200% FPL INCOME LIMITS ALL LOCALITIES EFFECTIVE 1/25/16</p>		
Household Size	200% FPL Monthly Amount	205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)
2	2,670	2,737
3	3,360	3,744
4	4,050	4,152
5	4,740	4,869
6	5,430	5,566
7	6,122*	6,276
8	6,815*	6,986
Each additional, add	694*	712

** No change for 2016.*