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Virginia Medical Assistance Eligibility

Manual Transmittal #DMAS-11

- CN – Categorically Needy
- COLA - Cost of Living Adjustment
- DMAS – Department of Medical Assistance Services
- GAP - Governor's Access Plan
- LIFC – Low Income Families with Children
- MSP – Medicare Savings Plan
- NABD- Non-Aged, Blind, or Disabled
- SSI – Supplemental Security Income
- TN – Transmittal

TN #DMAS-11 includes policy clarifications, updates and revisions. Unless otherwise noted in the Cover Letter and/or policy, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after January 1 2019.

The following changes are contained in TN #DMAS-11:

Changed Pages	Changes
Subchapter M0120 Table of Contents Page 20a	In the Table of Contents, added section title. On page 20a, explained change of GAP enrollees effective January 1, 2019.

Changed Pages	Changes
Subchapter M0130 Pages 1	Added the process for eligibility determinations being completed at the Health Care Marketplace and routed to Virginia.
Subchapter M0320 Pages 2a, 11, 35, 37	On page 2a, clarified that conditionally and presumptively eligible SSI recipients do not meet the SSI Medicaid covered group. On page 11, updated the COLA formula and Medicare premiums for 2019. On pages 35 and 37, corrected the waiver name.
Subchapter M0330 Pages 1, 2, 12, 14-16, 24, 25	On pages 1, 2 and 16, clarified when an LIFC parent meets the F&C 300% SSI covered group. On pages 12, 13 and 15, clarified the financial requirements for CN Pregnant Women and Newborns. On pages 24 and 25, clarified procedures for processing individuals in the Plan First covered group.
Chapter M04 Pages 8, 15, 32-35 Pages 36 and 37 were added.	On pages 8, 32 and 33, clarified when gap-filling methodology is used. On page 15, removed unnecessary language regarding the tax-filing threshold. On pages 35-37, added examples of applying gap-filling methodology.
Subchapter M0530 Appendix 1, page 1	Updated the NABD deeming standards for 2019.
Subchapter M720 Page 4	Clarified verification of terminated income.
Subchapter M0810 Pages 1, 2	On both pages, updated the SSI-based income figures and income limits for 2019.
Subchapter M0820 Pages 30, 31	On both pages, updated the student child earned income exclusion for 2019.
Subchapter M1110 Page 2	Updated the MSP resource limits for 2019.
Subchapter M1120 Page 29	Clarified real property ownership in a reverse mortgage situation.
Subchapter M1140 Page 17	Clarified the policy on debit account deposits and joint owners.
Subchapter M1410 Pages 6, 7	On page 6, corrected the numbering. On page 7, removed the policy on the obsolete Alzheimer's Assisted Living Waiver.

Changed Pages	Changes
Subchapter M1420 Entire subchapter	Revised entire subchapter to include new screening procedures and changes made to the DMAS-96
Subchapter M1460 Pages 3-5, 10, 26, 31	On pages 3 and 4, updated the home equity limit for 2019 and clarified the policy. On all other pages, clarified the sources of income eligibility policy for institutionalized individuals.
Subchapter M1470 Pages 19, 20, 51	On page 19, updated the personal maintenance allowance for 2019. On page 20, updated the special earnings allowance for 2019. On page 51, clarified that the patient pay cannot be increased retroactively after a lump sum was received.
Subchapter M1480 2, 7, 8, 18c, 66, 69, 70	On page 2, clarified that resource and income information must be obtained even if the community spouse is incarcerated. On pages 7 and 8, updated the home equity limit for 2019 and clarified the policy. On page 18c, updated the spousal resource standards for 2019. On page 66, updated the maximum monthly maintenance needs allowance for 2019. On page 69, updated the personal maintenance allowance for 2019. On page 70, updated the special earnings allowance for 2019.
Subchapter M1510 Page 7	Deleted the policy requiring the incarcerated individual to have inpatient hospitalization prior to applying for Medicaid.
Subchapter M1520 Pages 2, 5-7, 9	On page 2, clarified the eligibility worker's responsibility for using online systems for reported changes. On pages 5 and 6, explained the change of GAP coverage to Medicaid coverage effective January 1, 2019. On page 7, clarified that copies of verifications must be kept in case file.
Chapter M1800 Page 3	Clarified that incarcerated enrollees are exempt from managed care.

Please retain this TN letter for future reference. Should you have questions about information contained in this transmittal, please contact Cindy Olson, Director, DMAS Eligibility and Enrollment Services Division, at cindy.olson@dmas.virginia.gov or (804) 225-4282.

Sincerely,

Karen Kimsey
Chief Deputy Director

Attachment

M0120 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS- 11	1/01/19	Table of Contents Page 20a
TN #DMAS-10	10/1/18	Pages 2, 4, 15, 17-20 Page 20a was added as a runover page.
TN #DMAS-8	4/1/18	Page 12
TN #DMAS-6	10/1/17	Page 1
TN #DMAS-5	7/1/17	Page 2a
TN #DMAS-4	4/1/17	Pages 2a, 7, 10, 13
TN #DMAS-3	1/1/17	Page 15
TN #DMAS-2	9/1/16	Pages 2, 15 Page 2a is a runover page.
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

TABLE OF CONTENTS

M01 APPLICATION FOR MEDICAL ASSISTANCE

M0120.000 MEDICAL ASSISTANCE APPLICATION

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

Appendices

Sample Letter Requesting Signature……………………………Appendix 1……………….1

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application, form #032-03-384………………………….…Appendix 2.………………1

Interstate Compact on Adoption and Medical Assistance (ICAMA) Member States and Reciprocity………………..Appendix 3………………..1

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. There is no retroactive coverage in GAP. The AC for GAP coverage is 087. *Renewals are completed every 12 months.*

Effective January 1, 2019, individuals receiving GAP coverage will be enrolled in the MAGI Adult coveed group if eligibility requirements are met. Case information will remain with the Cover Virginia GAP Unit and stored in the GAP CHAMPS database until a conversion into VaCMS takes place.

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

M0130 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-11	1/1/19	Page 1
TN #DMAS-10	10/1/18	Table of Contents Pages 1, 2-2b, 9-12 Pages 2c-2e were added as runover pages.
TN #DMAS-9	7/1/18	Page 2b
TN #DMAS-8	4/1/18	Page 13
TN #DMAS-7	1/1/18	Pages 1, 9
TN #DMAS-5	7/1/17	Pages 1, 10
TN #DMAS-4	4/1/17	Page 6
TN #DMAS-3	1/1/17	Pages 5, 7, 11
TN #DMAS-2	10/1/16	Table of Contents Pages 2. 4, 5, 7-10, 12, 13 Page 2a is a runover page. Page 14 was added as a runover page.
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

M0130.001 Medical Assistance Application Processing Principles

A. Introduction

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

B. Principles

1. Single Application

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

2. No Wrong Door

Individuals may apply for MA through their local department of social services (LDSS), the Health Insurance Marketplace (HIM), at the CommonHelp *website,* or the Cover Virginia Call Center. Applications *may be* routed to *either* the LDSS *or Cover Virginia* for processing.

Effective 11/1/2018, applications made through the HIM that require MAGI eligibility determinations will have the eligibility determination made by the HIM. If an application is approved, the case will be routed to either the CPU or LDSS, where it should be accepted and enrolled without delay. ABD applications received by the HIM will be routed to the local agencies for processing.

3. Use of Electronic Data Source Verification

The eligibility determination process for MA is based on electronic data source verification (EDSV) to the fullest extent possible. The Federally-managed Data Services Hub (the Hub) provides verification of a number of elements related to eligibility for MA applications processed in the Virginia Case Management System (VaCMS). Data from on-line sources including the Virginia Employment Commission (VEC) and the Work Number are also acceptable for both initial applications and renewals.

Eligibility workers are to request information from the applicant or authorized representative(s) only when it is not available through an approved data source or the information is inconsistent with agency records.

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

4. Processing Time

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

M0320 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-11	1/1/19	Pages 2a, 11, 35, 37
TN #DMAS-10	10/1/18	Page 1 1a added as a runover page
TN #DMAS-9	7/1/18	Page 2, 17
TN #DMAS-7	1/1/18	Page 2, 3, 4, 11, 26-27.
TN #DMAS-4	4/1/17	Page 26
TN #DMAS-3	1/1/17	Pages 11, 27, 29, 40, 41, 44, 45, 52
TN #DMAS-2	10/1/16	Pages 4, 15, 16, 18, 20, 22, 30, 33, Pages 39- 41, 43-45, 48, 51, 52, 55
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

M0320.101 SSI RECIPIENTS

A. Introduction

42 CFR 435.121 - SSI recipients are a mandatory CN Medicaid covered group. Many states automatically *enroll an individual in* Medicaid when the individual is approved for SSI. However, in Virginia, not all SSI recipients are eligible for Medicaid. Virginia has chosen to impose real property eligibility requirements that are more restrictive than the federal SSI real property eligibility requirements. SSI recipients living in Virginia must apply separately for Medicaid because they are subject to a resource evaluation.

The Social Security Administration may approve an SSI applicant as conditionally or presumptively eligible for SSI. Conditionally-eligible SSI recipients are being allowed time to dispose of excess resources. Presumptively blind or disabled SSI recipients are presumed to be blind or disabled; no final blindness or disability determination has been made. An individual who has been conditionally or presumptively approved for SSI is NOT eligible for Medicaid in the SSI Recipients covered group. Evaluate the individual's eligibility in the MAGI Adults covered group.

SSI payments for eligible individuals are effective the first day of the month following the month in which the SSI application was filed. When the Medicaid application is filed in the same month as the SSI application, the applicant is not eligible for Medicaid as an SSI recipient until the month for which he receives his first SSI payment. See policy M0320.101.C. When the SSA record indicates a payment code(s) of "C01" and no payment amount is shown, the individual is considered to be a SSI recipient for Medicaid purposes. If the SSA record indicates a code of EO1 or E02 and no SSI payment has been received in more than twelve months, the individual's SSI status must be confirmed.

Eligibility for months prior to SSI entitlement must be evaluated *in the MAGI Adults* covered group.

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

The Cost-of-living calculation formula
(The formula is Current Title II Benefit divided by the percentage increase to equal the Benefit Before COLA change):

a. Current Title II Benefit / *1.028* *(1/1/19* Increase) = Benefit Amount before *1/19* COLA

b. *Benefit Before 1/18 COLA* / 1.020 (1/18 Increase) = Benefit Before 1/17 COLA

c. Benefit Before 1/17 COLA / 1.003 (1/17 Increase) = Benefit Before 1/18 COLA

d. Benefit Before *1/15* COLA / 1.017 (1/15 Increase) = Benefit Before 1/15 COLA

5. Medicare Premiums

a. Medicare Part B premium amounts:

1-1-19 $135.50
1-1-18 $134.00
1-1-17 $109.00
1-1-16 $121.80
1-1-15 $104.90

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 amount:

1-1-19 $437.00
1-1-18 $422.00
1-1-17 $413.00
1-1-16 $411.00
1-1-15 $407.00
1-1-14 $426.00

Contact a Medical Assistance Program Consultant for amounts for years prior to *2014*.

6. Evaluation

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

- 022 for an aged individual also QMB;
- 042 for a blind individual also QMB;
- 062 for a disabled individual also QMB;
- 025 for an aged individual also SLMB;
- 045 for a blind or disabled individual also SLMB.

2. Not QMB or SLMB

If the individual is NOT a QMB or SLMB - the individual does NOT have Medicare Part A, OR has countable income over the QMB and SLMB income limits - the AC is:

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

D. Ineligible In This Covered Group

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

M0320.503 ABD HOSPICE

A. Policy

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

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

Individuals receiving hospice services in the ABD Hospice Covered group may also receive services the *Commonwealth Coordinated Care Plus (CCC Plus)* Waiver, if the services are authorized by the Department of Medical Assistance Services (DMAS) (see M1440.101).

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

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

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

D. Enrollment

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

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

1. ABD Individual

a. Dual-eligible As QMB or SLMB

If the individual is also a Qualified Medicare Beneficiary (QMB) or Special Low Income Medicare Beneficiary (SLMB) - the individual has Medicare Part A and has countable income within the QMB or SLMB income limits - the AC is:

- 022 for an aged individual also QMB;
- 042 for a blind individual also QMB;
- 062 for a disabled individual also QMB
- 025 for an aged individual also SLMB;
- 045 for a blind or disabled individual also SLMB.

b. Not QMB or SLMB

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

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

2. "Deemed" Disabled Individual

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

E. Post-eligibility Requirements (Patient Pay)

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

Individuals who have elected hospice services and who also receive services available under the *CCC Plus* Waiver must have a patient pay calculation for the *CCC Plus* services (see subchapter M1470).

F. Ineligible In This Covered Group

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

M0330 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-11	1/1/19	Pages 1, 2, 12, 14-16, 24, 25
TN #DMAS-10	10/1/18	Table of Contents Page 1-2, 30 Page 10a-b were added as runover pages.

M0330 Changes

TN #DMAS-8	4/1/18	Pages 1, 9, 10, 25
TN #DMAS-6	10/1/17	Pages 8, 14
TN #DMAS-5	7/1/17	Pages 9, 14
TN #DMAS-4	4/1/17	Page 5
TN #DMAS-3	1/1/17	Pages 9, 10 Page 9a was removed.
TN #DMAS-2	10/1/16	Pages 8 Page 9b was renumbered to 9a.
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
TN #DMAS-4	4/1/17	Page 5
TN #DMAS-3	1/1/17	Pages 9, 10 Page 9a was removed.
TN #DMAS-2	10/1/16	Pages 8 Page 9b was renumbered to 9a.
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

M0330.000 FAMILIES & CHILDREN GROUPS

M0330.001 GENERAL POLICY PRINCIPLES

A. Overview

A State Plan for Medicaid must include the mandatory federal categorically needy (CN) groups of individuals as well as the optional groups a state has elected to cover. This subchapter divides the Families & Children (F&C) covered groups into categorically needy and medically needy (MN) groups.

B. Procedure

Determine an individual's eligibility first in a CN covered group. If the individual is not eligible as CN or for the Family Access to Medical Insurance Security Plan (FAMIS), go to the MN groups.

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

1. If the child meets the definition of a foster care child, adoption assistance child, special medical needs adoption assistance child or an individual under age 21, evaluate in these groups first.
2. If the child meets the definition of a newborn child, evaluate in the pregnant woman/newborn child group.
3. If the child is under age 18 or is an individual under age 21 who meets the adoption assistance or foster care definition or is under age 21 in an intermediate care facility (ICF) or facility for individuals with intellectual disabilities (ICF-ID), AND is in a medical institution or has been screened and approved for Home and Community Based Services (HCBS) or has elected hospice, evaluate in the appropriate F&C 300% of SSI covered group.
4. If a child is under the age of 19, evaluate in this group.
5. If a child is a former foster care child under age 26 years, evaluate for coverage in this group.
6. If a child has income in excess of limits individual, evaluate for the Family Access to Medical Insurance Security Plan (FAMIS) eligibility (chapter M21).
7. If the child is a child under age 1, child under age 18, an individual under age 21 or a special medical needs adoption assistance child, but has income in excess of the appropriate F&C income limit, evaluate as MN.

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

1. If the individual is a former foster care child under 26 years, evaluate is this covered group.
2. If the individual is not a former foster care child under 26 years and meets the definition of a parent/caretaker relative, evaluate in the LIFC covered group.
3. If the individual is not eligible as LIFC, but meets the definition of a pregnant woman, evaluate in the pregnant woman/newborn child group.
4. If the individual has been screened and diagnosed with breast or cervical cancer or pre-cancerous conditions by the Every Woman's Life program and does not meet the definition of for coverage as SSI, LIFC, Pregnant Woman or Child under 19, evaluate in the *Breast and Cervical Cancer Prevention and Treatment Act* (BCCPTA) covered group.
5. If the individual is between the ages of 19 and 64 and is not eligible for or entitled to Medicare, evaluate in the MAGI Adults group.
6. If the individual is not eligible as a MAGI Adult, as LIFC or as a pregnant woman, is in medical institution, has been screened and approved for Home and Community Based Services or has elected hospice, evaluate in the appropriate F&C 300 % of SSI covered group.

   If the individual is a parent or caretaker-relative of a dependent child and in a medical institution, the stay must be temporary while receiving treatment, rehabilitation, etc. for him to

meet the definition of living in the home with the dependent child. There are no time limits on the amount of time the parent can be in a medical institution as long as he intends to return home. Verify with the parent the reason he is in a medical facility and ask about the intent to return home.

7. If the individual has excess income for full coverage in a Medicaid covered group and is between the ages of 19 and 64, evaluate for Plan First coverage.

8. If the individual is a pregnant woman but has excess income for coverage in a CN group or FAMIS MOMS evaluate as MN.

M0330.100 FAMILIES & CHILDREN CATEGORICALLY NEEDY

A. Introduction

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

The F&C covered groups are divided into the categorically needy (CN) and medically needy (MN) classifications. Always evaluate eligibility in the categorically needy groups 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;
M0330.250 MAGI Adults Group
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;
M0330.700 Breast and Cervical Cancer Prevention and Treatment Act

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.

C. Financial Eligibility

Modified Adjusted Gross Income (MAGI) methodology is applicable to this covered group. The MAGI policies and procedures are contained in Chapter M04.

1. Assistance Unit

The assistance unit for this covered group is the MAGI household.

2. Resources

There is no resource test.

3. Income

MAGI income rules are applicable to this covered group. The income limits for the Child Under Age 19 covered group are contained in M04, Appendix 2.

4. Income Changes

Any changes in a Medicaid-eligible child's income that occur after his eligibility has been established affect eligibility. Recalculate income and compare to the income limits.

5. Income Exceeds Limit

A child under age 19 whose income exceeds the income limit for this covered group may be eligible for FAMIS. The income limit for FAMIS is 200% FPL *plus a 5% FPL income disregard.* See Chapters M21 *and M04* to determine FAMIS eligibility.

If countable income exceeds the limit for Medicaid and FAMIS *and the child is under age 18*, the opportunity for a Medically Needy (MN) evaluation must be offered (see M0330.803). Ineligible *children, other than incarcerated children*, must be referred to the Health Insurance Marketplace for evaluation for the APTC.

D. Entitlement

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

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

2. Newborn Child

42 CFR 435.117 - A child born to a woman who was eligible for Medicaid or to an individual covered by FAMIS at the time the child was born (including a newborn child born to an alien eligible for Medicaid payment of emergency services only) is eligible as a newborn child under age 1 year.

An exception is a child born to a women enrolled under the Hospital Presumptive Eligibility (HPE) aid category 035; an application must be submitted for the child's Medicaid eligibility to be determined since no Medicaid application was submitted for the child's mother.

a. Eligible To Age 1

A child no longer meets this covered group effective the end of the month in which the child reaches age 1, provided he was under age 1 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 1.

Any child born a Medicaid-eligible woman will continue to be eligible up to age 1. If the child's mother was covered by Medicaid as a categorically needy individual in a state other than Virginia at the time of the child's birth, verification of the mother's Medicaid coverage must be provided by the parent or authorized representative.

b. No Other Eligibility Requirements

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

C. Financial Eligibility

Eligibility for CN Pregnant Women is based on the Modified Adjusted Gross Income (MAGI) methodology contained in Chapter M04.

1. Assistance Unit

The unborn child or children are included in the household size for a pregnant woman's eligibility determination. Refer to the procedures for determining the MAGI household in Chapter M04.

2. Resources

There is no resource test.

3. Income

Women enrolled as Pregnant Women are not subject to renewals during the pregnancy. The income limits for Pregnant Women are contained in M04, Appendix 2.

4. Income Changes After Eligibility Established

a. Pregnant Woman

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

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

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

b. Newborn

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

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

5. 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. If the pregnant woman is not eligible for FAMIS MOMS, evaluate her eligibility as MN (see M0330.801). Ineligible women, *other than incarcerated women*, 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."

M0330.500 300% of SSI INCOME LIMIT GROUPS

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

A. Policy

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

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

B. Nonfinancial Eligibility

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

The individual must be a child under age 18, under age 21 who meets the adoption assistance or foster care definition or under age 21 in an ICF or ICF-ID, or must be a parent or caretaker-relative of a dependent child, or a pregnant woman as defined in M0310. *If the individual is a parent or caretaker-relative of a dependent child, the stay in the medical institution must be temporary while receiving treatment, rehabilitation, etc. for him to meet the definition of living in the home with the dependent child.*

C. Financial Eligibility

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

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

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

1. Resources

a. Resource Eligibility – Married Individual Age 18 and Older

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

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

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

M0330.600 PLAN FIRST - FAMILY PLANNING SERVICES

A. Policy

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

The income limit for Plan First is 200% FPL. While there are no specific age requirements for Plan First, eligibility for Plan First is not determined for children under 19 years or for individuals age 65 years and older unless the child's parent or the individual requests an evaluation for Plan First.

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

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

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

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

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

B. Nonfinancial Requirements

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

Division of Child Support Enforcement (DCSE) services are available to all Medicaid recipients, but cooperation with DCSE is not a condition of eligibility for this covered group.

C. Financial Eligibility

Refer to chapters M05 and M07 for applications submitted before October 1, 2013 and for renewals completed before April 1, 2014. Refer to Chapter M04 for eligibility determinations completed on applications submitted on or after October 1, 2013.

1. Assistance Unit

Use the assistance unit policy in chapter M05 to determine the individual's financial eligibility for applications submitted before October 1, 2013 and for renewals completed before April 1, 2014. Refer to chapter M04 for eligibility determinations completed on applications submitted on or after October 1, 2013.

2. Resources

There is no resource test.

3. Income

The income limit for this group is 200% FPL. The income limits are contained in M04, Appendix 5.

4. Spenddown

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

D. Entitlement and Enrollment

1. Begin Date

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

2. Retroactive Coverage

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

3. Enrollment

The AC for Plan First enrollees is "080."

M04 Changes

Changed With	**Effective Date**	**Pages Changed**
TN #DMAS-11	1/1/19	Pages 8, 15, 32-35 Pages 36 and 37 were added.
TN #DMAS-10	10/1/18	Table of Contents Pages 1-5, 9, 10, 15, 16, 19, 22, 23, 30-32 Appendix 7 Appendix 8 was renumbered. Pages 6-8, 11-14, 17, 18, 20, 21, 24-29, 33-35 are runover pages.

M04 Changes

TN #DMAS-9	7/1/18	Table of Contents. Pages 5, 6, 11, 14a, 25-27 Appendices 3 and 5 Page 6a is a runover page. Page 28 was added as a runover page.
TN #DMAS-8	4/1/18	Table of Contents Pages 2-6a, 12-14b, 25 Pages 26 and 27 were added. Pages 14c was added as a runover pages. Appendices 1, 2, 6 and 7 Appendix 1, page 2 was added.
TN #DMAS-6	10/1/17	Pages 12, 13, 14b
TN #DMAS-5	7/1/17	Table of Contents Pages 5, 6, 12, 13, 14-14b Appendices 3, 4 and 5 Page 6a was added as a runover page. Page 13a, 14, and 14a were renumbered to pages 14, 14a and 14b.
TN #DMAS-4	4/1/17	Appendices 1, 2 and 6
TN #DMAS-3	1/1/17	Table of Contents Pages 3 -5, 13a, 20 Appendix 6, page 1 Page 20a was added.
TN #DMAS-2	10/1/16	Appendix 2, pages 1, 2 Appendices 3, 5
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

- For non-filers, a "child" is defined as under age 19.

1. 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. This includes a tax dependent living with both a tax filer parent AND the dependent's spouse. The tax dependent's household includes his spouse, the tax filer, any other parent in the home, and any siblings in the home who are also claimed by the same tax filer.

2. Tax Filer is Under Age 19

If the tax filer is under age 19, lives in the home with his parent(s) AND is not expected to be claimed as a dependent by anyone, the parent(s) are included in the child's household.

6. Gap-filling Rule

States are required to use household income, as calculated by the federal HIM for the APTC eligibility determination, to determine eligibility for Medicaid or FAMIS if **all** of the following conditions apply:

a. The individual *is in a tax filer household* (including those who meet a tax dependent household exception in M0430.100 B.2). APTC methodology does not apply to non-filer households.

b. Current monthly household income, using Medicaid/FAMIS MAGI-based methods is over the applicable income limit (including the 5% FPL disregard) *for the individual's covered group*.

c. The *total of* income already received *plus* projected income for the **calendar** year in which eligibility is being determined, using MAGI methods applied by the HIM for the purposes of APTC eligibility, is below 100% FPL (i.e. the lower income threshold for APTC eligibility). See M04, Appendix 1.

This requirement is referred to the gap-filling rule. See M0450.400 for gap-filling rule evaluation procedures and examples.

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

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

The reported income of a child must be verified regardless of whether or not the attested income is above or below the tax-filing threshold amount.

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. The sources of income listed in this section are organized in table form in M04, Appendix 7.

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 tax dependent who is claimed by his parent(s), or
- a child under 19 in a non-filer household who is living with a parent or parents

who is not required to file taxes because the tax filing threshold is not met.

c. Income of a child under 19 in a non-filer household who is NOT living with a parent or parents and who is not required to file taxes because the tax filing threshold is not met. Any Social Security benefits the child may have do not count in determining whether or not the tax filing threshold is met.

d. Interest, including tax-exempt interest, is counted.

e. Foreign income is counted.

f. Stepparent income is counted.

g. Effective January 1, 2019, alimony received will no longer be counted as income. Alimony **received prior to January 1, 2019** is counted. An individual whose divorce decree was finalized prior to that date has the option with the IRS to adopt this new rule. If the individual does not want alimony to be countable for Medicaid purposes, the individual must provide a copy of the modified agreement to the eligibility worker.

h. An amount received as a lump sum is counted only in the month received.

Dee's eligibility determination:

Potential covered groups:

Child < Age 19
FAMIS

Monthly Income limits:

Child < Age 19 143% FPL for a HH of 2 = $1,962
FAMIS, 200% FPL for HH of 2 = $2,585
5% FPL for 2 = $65

HH monthly income:

$300 (Jane's gross earnings)

$300 is less than the Medicaid Child < Age 19 143% FPL income limit for 2 ($1,962) so Dee is eligible for Medicaid in the Child < Age 19 covered group. The 5% disregard is not applied because it is not necessary; her gross HH income is within the Medicaid Child < Age 19 income limit.

M0450.400 GAP-FILLING RULE EVALUATION

1. When to Complete Gap-filling Evaluation

Complete a gap-filling evaluation to determine eligibility for Medicaid or FAMIS whenever **all** of the following conditions apply:

- *The individual is in a tax filer household* (regardless of whether or not a tax dependent exception in M0430.100 B.2 is met). APTC methodology does not apply to non-filer households.

- Current monthly household income, using Medicaid/FAMIS MAGI-based methods is over the applicable income limit (including the 5% FPL disregard) *for the individual's covered group.*

- *The total of* income already received *plus* projected income for the **calendar** year in which eligibility is being determined, using MAGI methods applied by the HIM for the purposes of APTC eligibility, is below 100% FPL (i.e. the lower income threshold for APTC eligibility). See M04, Appendix 1

Note: The individual does not need to apply for the APTC prior to applying for Medicaid or having the gap-filling evaluation completed.

If the eligibility and enrollment system is unable to determine eligibility using the gap-filling evaluation, the evaluation must be completed outside the system and documented in the electronic record. If the individual is eligible, the coverage must be entered directly into MMIS.

2. Non-financial Requirements

The individual must meet a MAGI covered group (Children under 19, LIFC, Pregnant Women, Individuals Under Age 21, Adults age 19-64, Plan First).and all non-financial eligibility criteria for that covered group.

3. Household Income Calculation

Under the gap-filling rule, the individual's household income must be calculated according to the MAGI rules used for APTC purposes and compared to the APTC 100% FPL income threshold for the household size in M04, Appendix 1. If the income at or below the threshold amount, the income is then compared to the Medicaid income limits for the individual's covered group or to the FAMIS or FAMIS MOMS income limits to determine the individual's eligibility.

Tax-filer rules for determining household composition are used. Neither the tax dependent exceptions used for Medicaid/FAMIS MAGI-specific household composition nor non-filer rules are applicable. For example, if a child lives with both parents, and the parents are unmarried, the child is in the tax-filer household of the parent who claims the child as a tax dependent.

Financial eligibility is based on income already received and projected income for the calendar year in which benefits are sought. If the local agency knows the determination of annual income made by the HIM, it may use that information for the purposes of applying the gap filling rule. Otherwise, the worker must obtain income information from the individual or authorized representative.

1. Verification of Income

Income reported as received for the calendar year in which benefits are sought as well as current monthly income must be verified.

- Virginia Employment Commission (VEC) income data may be used to the extent that the verified income was earned in the calendar year in which benefits are sought.
- Income cannot be verified by a match with IRS data contained in the federal HUB since IRS data is based on income received for the previous year.

2. Countable Income

Income that is listed in M0440.100 B as countable for the Medicaid/FAMIS MAGI evaluation is also countable for the gap-filling evaluation. Additionally, the following income **is counted** for the gap-filling evaluation:

- Payments made to American Indian/Alaska Natives as described in M0440.100 B.5.
- Scholarship and fellowship income, regardless of its intended use
- Lump sum payments received in the calendar year for which benefits are sought are included in the annual income calculation.

3. Income Evaluation

If the annual income as determined by the HIM is not known, the eligibility worker must calculate the annual income.

- First, add together income already received for the year. Do not convert the income.
- Next, calculate the projected income for the remainder of the year based on the current monthly income, unless the individual's income is expected to change (e.g. current employment is terminating).

- Add income already received to projected income to obtain the *annual projected income for the current calendar year.*

- *Compare the annual projected income to the APTC 100% FPL income threshold for the APTC MAGI household size in M04, Appendix 1. If the income is less than or equal to 100% FPL, compare the income to the income limit for the individual's covered group*.

- For the individual to be eligible for Medicaid or FAMIS, the countable income must be no more than the income limit for the individual's covered group. **The 5% income disregard used for the Medicaid/FAMIS MAGI determination does not apply**. See M04 Appendices 2-6 for income limits.

3. Renewals

A renewal of eligibility must be completed in January of the following year and annually thereafter. *At the time of enrollment, change the renewal date to January of the following year*. Evaluate the individual's eligibility using Medicaid/FAMIS MAGI methodology before applying gap-filling methodology. A gap-filling evaluation may not be necessary for future eligibility determinations/renewals since tax dependency status and/or income may have changed.

4. Individual Not Eligible Using Gap-filling Methodology

If the individual's household income is determined to be over the Medicaid and FAMIS income limits after the gap-filling rule evaluation or the individual does not provide the necessary verifications for the gap-filling evaluation **and** he meets a MN covered group, he must be offered the opportunity to be placed on a MN spenddown.

4. Example – Coverage Gap and Gap Filling Rule

A 10-year-old child lives with both parents, who are not married, and the child is expected to be claimed as a tax dependent by one parent. His parents apply for the APTC through the federal HIM. The HIM only processes applications for tax filers because the ATPC only applies to tax filing households. The child is determined to not be eligible for the ATPC because his countable income is below the lower income threshold (it is too low) for APTC eligibility

The HIM makes an application referral to Virginia for a Medicaid/FAMIS eligibility determination. The child meets a tax dependent exception in M0430.100 B.2 (he lives with both parents, is claimed as a tax dependent by one parent, and the parents do not expect to file jointly). The child's eligibility for Medicaid or FAMIS is determined using non-filer methodology. Because he is under 19 and both parents are in his household, the income of both parents is counted. His household income with the 5% FPL disregard is over the limit for both Medicaid and FAMIS.

Since the child does not qualify for the APTC because his countable income is under the lower financial threshold for the APTC AND he has excess income using non-filer rules household composition/ income rules, the gap-filling rule must be applied.

5. Example – Gap Filling Evaluation ***– Married Couple and Child in Common***

Maria and Tony are an unmarried couple who live with their 12-year-old daughter, Anita. Maria and Tony are both employed. Anita is claimed as a tax dependent by Maria, who works part time. Maria applies for Medicaid only for Anita. Because Anita lives with both parents, but the parent's file taxes separately and only one parent claims her as a tax dependent, Anita meets a tax dependent exemption. Her eligibility must be evaluated using non-filer rules.

Because she is under age 19, Anita's MAGI household consists of Anita and both parents. Both Maria's and Tony's income is counted for Anita's eligibility. Her countable income, including with the 5% FPL disregard, is over the limits for both Medicaid and FAMIS.

The eligibility worker notes that a potential gap-filling situation exists. The worker evaluates Anita's eligibility for Medicaid or FAMIS using the APTC rules. Under the APTC rules, Anita's household consists of Anita (tax dependent) and Maria (tax filer); Tony is not in Anita's household because he does not claim Anita on his taxes. Maria's income from her part time job is under *the APTC* 100% FPL *threshold. Her income is also under the Medicaid income limit for a Child Under 19 (143% FPL). Therefore, Anita is eligible for Medicaid under the gap-filling rule.*

The following tables show the household formation and income used.

For the Medicaid/FAMIs evaluation:

Person	# - MAGI Household Composition Non-filer rules	Income to count for Medicaid/FAMIS eligibility
Anita	3 – Anita, Maria, Tony	Maria, Tony

For the gap-filling evaluation

Person	# - APTC Household Composition	Income to count for Medicaid/FAMIS eligibility
Anita	2 – Maria, Anita	Maria, and (non-excluded) income from Anita

6. Example – Gap Filling Evaluation— Pregnant Woman (Using January 1, 2019 Figures)

Alyssa is an unmarried pregnant woman, a tax-filer, and applies for coverage on June 1 with her baby due in December. She was working; however her doctor ordered immediate bed rest and she will not return to work for the remainder of the year.

Because she is pregnant, Alyssa is a household of 2. Her household income is calculated as $2,830 for May. The FAMIS MOMS 200% income limit is $2,813 ($2,744 + 5% disregard). She is determined to have excess countable income for Medicaid and FAMIS MOMS.

A potential gap-filling situation exists, and the worker evaluates eligibility for Medicaid or FAMIS using the APTC rules. The applicant sends her paystubs for the period January through May. She has received $11,600 YTD and will receive one more check at the end of June in the amount of $1,000. She will have no other income for the rest of the year. Her total projected income for the entire year is $12,600 ($11,600 + $1,000).

Under gap-filling rules, the 100% APTC income threshold for a HH of 2 is $16,460. Because her projected full year income is $12,600 and below the Medicaid income limit for pregnant women (143%) FPL of $23,538, Alyssa is determined eligible for Medicaid.

7. *Example – Gap Filling Evaluation—Adult With Child (using January 1, 2019 Figures)*

Bob is a tax-filer adult from Group 1 locality and lives with 15 year old son, whom he claims as a dependent. He applies for Medicaid on November 1 for himself and his son. Bob was unemployed for part of the year before securing a new construction job starting in October. Unfortunately he is laid off for November and December and is not expected to return to work until January.

Bob provided his October income, and the worker calculates the monthly income as $1,975. The HH income is above 143% FPL but below 200% FPL, so his son is approved for FAMIS. Bob's income is above the LIFC income limit (HH of 2 - Group 1 locality) of $381. His income is also above the MAGI Adults income limit (HH of 2, 133% FPL + 5% disregard) of $1,894, so is denied Medicaid.

A potential gap-filling situation exists, and the worker evaluates Bob's eligibility using the APTC rules for projecting yearly income. He provides paystubs for January ($600), February ($800), March ($805), April ($790), and October ($1,975). Bob did not work from May – September. The worker projects the November and December income as $0.

His total projected income for the year is $4,970. The APTC 100% FPL income threshold for a HH of 2 is $16,460. As Bob's projected full year income is $4,970, it is below the APTC threshold and thus could meet the gap-filling rule.

The income limit for MAGI Adults covered group is 133% FPL, or an annual amount of $21,892 for a HH of 2. Since Bob's projected annual income is $4,970, he is eligible in the MAGI Adults covered group.

H. *Example – Gap Filling Evaluation—Childless Adult (using January 1, 2019 Figures)*

Lee is a 27 year old tax-filer and applies for Medicaid on September 1. He is attending graduate school and works part-time as a teaching assistant. His income for August is $1,625. The income limit for the MAGI Adults covered group for a HH of 1 is $1,397 ($1,346 + 5% disregard of $51). Lee is not eligible for Medicaid using MAGI methodology.

Lee calls the worker when he receives the denial notice and tells the worker that his income is higher in the summer and during the remainder of the year, he makes about half that amount. A potential gap-filling situation exists, so the worker requests verification of Lee's income from January through July. He provides his paystubs for January ($800), February ($900), March ($905), April ($990), May ($955), June ($1,550), July ($1,650), and August ($1,625). His total year to date income is $9,375.

Lee also provides a letter from his employer that states his teaching income for September thru December will be a guaranteed amount of $850 per month. The worker uses a projected amount for September – December as $850 per month, which equals $3,400.

The worker adds Lee's income for January through August ($9,375) and his anticipated income for September through December ($3,400). Lee's total projected annual income is $12,775. The APTC 100% FPL threshold is $12,140. The 5% FPL income disregard does not apply to the APTC threshold amount. Because Lee's projected income is over the APTC 100% FPL threshold, gap-filling methodology is not applicable. Since Lee has already received a denial notice, the worker calls Lee to confirm that he is not eligible for Medicaid.

M0530 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-11	1/1/19	Appendix 1, page 1
TN #DMAS-8	4/1/18	Appendix 1, page 1
TN #DMAS-6	10/1/17	Pages 2, 24, 30
TN #DMAS-3	1/1/17	Appendix 1, page 1
TN #DMAS-2	10/1/16	Pages 23, 24
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

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

2019: $1,157 - $771 = $386
2018: $1,125 - $750 = $375

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 = *$771 for 2019*; $750 for 2018.

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

SSI payment for both parents = $*1,157 for 2019*; $1,125 for 2018.

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

2019: $1,157 - $771 = $386
2018: $1,125 - $750 = $375

M0720 Changes

Changed With	Effective Date	Pages Changed
TN# DMAS -11	01/01/19	Page 4
TN #DMAS-2	10/1/16	Table of Contents, page i Pages 11, 13, 14 Appendix 1 Pages 15-19 were deleted.
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

1. Migrant Or Seasonal Farm Worker

For migrant and seasonal farm workers, the income that is reasonably certain to be received is based on formal or informal commitments for work for an individual, rather than on the general availability of work in an area.

Base income on the information obtained from the income provider and worker judgment to determine the anticipated income. Document the file to support how the income was anticipated.

Do not base income on an assumption of optimum weather or field conditions.

2. New or Increased Income

Use the income provider's statement of the beginning date, the amount of income to be received, the frequency of receipt, and the day/dates of receipt to establish the amount to be received per pay period.

3. Terminated Income

Income from a terminated source must only be verified when it was received in a month in which eligibility is being determined *and information is not compatible with information obtained from online system searches*.

4. Decreased Income

Use the income provider's statement of the beginning date of the decrease, the new amount of income to be received, the frequency of receipt, and the day/date of receipt to establish the amount to be received per income period. Document the file to support how the income was anticipated.

If an employed person anticipates a decrease in wages that is not supported by evidence in the file, the individual must be advised to report the decrease as soon as it can be verified. Adjustments are made when the decrease is verified.

D. Calculating Estimated Monthly Income

1. Average Income

When the income amounts received in each pay period are different, calculate the average amount of income received per pay period. Average the income received in no more than 3 previous months. Use the income received in previous months that provide an accurate indication of the individual's future income situation.

2. Full Month's Income

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

To convert to monthly income:

- Multiply weekly wage by 4.3; or
- multiply biweekly wage by 2.15; or
- multiply semi-monthly wage by 2.

M0810 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-11	1/1/19	Pages 1, 2
TN #DMAS-10	10/1/18	Page 2
TN #DMAS-9	7/1/18	Page 2
TN #DMAS-8	4/1/18	Page 2
TN #DMAS-7	1/1/18	Pages 1, 2
TN #DMAS-5	7/1/17	Page 2
TN #DMAS-4	4/1/17	Page 2
TN #DMAS-3	1/1/17	Pages 1, 2
TN #DMAS-2	10/1/16	Page 2
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
Update (UP) #1	7/1/09	Page 2

GENERAL

M0810.001 INCOME AND ELIGIBILITY

A. Introduction

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

B. Policy Principles

1. Who is Eligible

An individual is eligible for Medicaid if the person:

- meets a covered group; and
- meets the nonfinancial requirements; and
- meets the covered group's resource limits; and
- meets the covered group's income limits.

2. General Income Rules

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

M0810.002 INCOME LIMITS

A. Income Limits

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

1. Categorically Needy

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

2. Categorically Needy Protected Cases Only

Categorically-Needy Protected Covered Groups Which Use SSI Income Limits		
Family Unit Size	2018 Monthly Amount	*2019* Monthly Amount
1	$750	*$771*
2	1,125	*1,157*
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size	2018 Monthly Amount	*2019* Monthly Amount
1	$500.00	*$514.00*
2	750.00	*771.34*

3. Categorically Needy 300% of SSI

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

Family Size Unit	2018 Monthly Amount	*2019* Monthly Amount
1	$2,250	*$2,313*

4. ABD Medically Needy

a. Group I	7/1/2017 – 6/30/18		7/1/2018	
Family Unit Size	Semi-annual	Semi-annual	Semi-annual	Monthly
1	$1,867.21	$ 1,904.55	$ 1,904.55	$311.20
2	2,377.24	2,424.75	2,424.75	396.20

b. Group II	7/1/2017 – 6/30/18		7/1/2018	
Family Unit Size	Semi-annual	Semi-annual	Semi-annual	Monthly
1	$ 2,154.48	$ 2,197.56	$ 2,197.56	$359.08
2	2,653.01	2,706.04	2,706.04	442.16

c. Group III	7/1/2017 – 6/30/18		7/1/2018	
Family Unit Size	Semi-annual	Semi-annual	Semi-annual	Monthly
1	$ 2,800.83	$ 2,856.84	$ 2,856.84	$466.80
2	3,376.83	3,444.33	3,444.33	562.80

5. ABD Categorically Needy

For:

ABD 80% FPL, QMB, SLMB, & QI without Social Security income; all QDWI; effective 1/18/18

ABD 80% FPL, QMB, SLMB, & QI with Social Security income; effective 3/1/18

All Localities	2017		2018	
ABD 80% FPL	Annual	Monthly	Annual	Monthly
1	$9,648	$804	$9,712	$804
2	12,992	1,083	13,168	1,083
QMB 100% FPL	Annual	Monthly	Annual	Monthly
1	$12,060	$1,005	$12,140	$1,005
2	16,240	1,354	16,460	1,354
SLMB 120% of FPL	Annual	Monthly	Annual	Monthly
1	$14,472	$1,206	$14,568	$1,206
2	19,488	1,624	19,752	1,624
QI 135% FPL	Annual	Monthly	Annual	Monthly
1	$16,281	$1,357	$16,389	$1,357
2	21,924	1,827	22,221	1,827
QDWI 200% of FPL	Annual	Monthly	Annual	Monthly
1	$24,120	$2,010	$24,280	$2,010
2	32,480	2,707	32,920	2,707

S0820 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-11	1/1/19	Pages 30, 31
TN #DMAS-7	1/1/18	Page 11, 30-32
TN #DMAS-5	7/1/17	Pages 11, 13, 29, 30 Page 12 is a runover page.
TN #DMAS-3	1/1/17	Pages 30, 31
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

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 *2019*, up to *$1,870* per month, but not more than *$7,550* in a calendar year, of the earned income of a blind or disabled student child.

For 2018, up to $1,820 per month, but not more than $7,350 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
- M0810.430 amount to fulfill a plan for achieving self-support

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

S0820.510 STUDENT CHILD EARNED INCOME EXCLUSION

A. Policy

1. General

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

For Months	Up to per month	But not more than in a calendar year
In calendar year *2019*	*$1,870*	*$7,550*
In calendar year 2018	$1,820	$7,350

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.

M1110 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-11	1/1/19	Page 2
TN #DMAS-7	1/1/18	Page 2
TN #DMAS-4	4/1/17	Pages 10, 10a
TN #DMAS-3	1/1/17	Pages 2, 7, 10, 11 Page 10a was added as a runover page.
TN #100	5/1/15	Page 2
TN #99	1/1/14	Page 2
UP #9	4/1/13	Page 2
UP #6	4/1/12	Page 2
TN #96	10/1/11	Page 2
TN #95	3/1/11	Page 2
Update (UP) #3	3/2/10	Table of Contents page 2
TN #93	1/1/10	Page 2
TN #91	5/15/09	Pages 14-16

M1110.003 RESOURCE LIMITS

A. Introduction

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

B. Policy Principles

1. Resource Ineligibility

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

2. Resource Limits

ABD Eligible Group	One Person	Two People
Categorically Needy Medically Needy	$2,000	$3,000
ABD with Income ≤ 80% FPL	$2,000	$3,000
QDWI	$4,000	$6,000
QMB SLMB QI	**Calendar Year** **2018** $7,560 ***2019*** *$7,730*	**Calendar Year** **2018** $12,840 ***2019*** *$11,600*

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.

M1120 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-11	1/1/19	Page 29
TN #DMAS-8	4/1/18	Page 22a
TN #DMAS-7	1/1/18	Table of Contents i, pages 3, 22a, 30
TN #DMAS-5	7/1/17	Pages 15, 17, 18
TN #DMAS-2	10/1/16	On page 6, updated the format of the header. Neither the date nor the policy was changed.
TN #96	10/1/11	Table of Contents pages 24-26
TN #93	1/1/2010	page 22

F. Example--Installment Sale Contract

1. Situation

Henry Little, a Medicaid applicant, recently became a widower and moved out of the family home to live in a rented apartment. He has just entered into an installment sale contract on his former home with Thomas Higgins, a Medicaid recipient. Mr. Higgins made a $6,000 down payment on the house, using retroactive SSI benefits paid under a court order, and immediately moved into his new home in which he already has an equitable ownership interest, even though he does not yet have title. The outstanding principal balance on the installment agreement is $8,000.

2. Analysis

The EW must determine resources eligibility for both men. Although Mr. Little still has title to the house, he cannot sell it; rather, its value as a resource to Mr. Little has folded into the value of the installment contract. However, the installment sale contract (which the EW confirms has no legal restrictions against its sale) is Mr. Little's resource in the amount of the outstanding principal balance unless he presents convincing evidence that its CMV is a lower amount.

The installment sale contract has no bearing on Mr. Higgins' eligibility, as either income or resources. His ownership interest in the house he is buying from Mr. Little is an excluded resource since it is his principal place of residence.

M1120.225 REVERSE MORTGAGES

A. Definition

A reverse mortgage is a contract with a bank or other lending institution whereby the bank provides the borrower with monthly payments which do not have to be repaid as long as the individual lives in the home. These payments are a loan against the equity in the home and must be repaid when the individual dies, sells his home, or moves.

The individual, not the bank or lending institution, continues to retain ownership of the home and is responsible for property taxes and insurance.

B. Policy

The payments from a reverse mortgage are loan proceeds and are not income to the borrower. Proceeds retained after the month of receipt are a resource.

S1140 Changes

Updated With	Effective Date	Pages Changed
TN #DMAS-11	1/1/19	Page 17
TN #DMAS-7	1/1/18	Page 30
TN #DMAS-5	7/1/17	Page 7
UP #9	4/1/13	pages 2, 17
TN #97	9/1/12	Table of Contents, page i Table of Contents page ii was removed. pages 2, 16-19, 26, 26a
TN #96	10/1/11	pages 12-12a, 24
TN #93	1/1/10	pages 13-15 pages 24, 25
TN #91	5/15/09	pages 11-12a

6. Examples of Evidence to the Contrary

a. Use Restricted by Court Order
Even with ownership interest and the legal ability to access property, a legal restriction against the property's use for the owner's own support and maintenance means the property is not the owner's resources (S1110.100).

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

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

7. Debit Card Accounts

Debit cards that are not government-sponsored (e.g. the Green Dot pre-paid Visa or MasterCard) are considered bank accounts even if the individual's government benefits are deposited into the debit account. *Some debit card accounts may allow other monies to be deposited. In addition, joint owners may be able to access funds in the account.*

If the debit card is sponsored by a government program such as the Social Security Administration and the individual cannot deposit other money into the account, the money in the debit card account, minus any income deposited to the account for the month, is considered cash on hand and is verified by the client's statement of the balance in the account. See M1140.010.

B. Development and Documentation Initial Applications and Post-eligibility

1. Informing the Individual of Reporting Responsibilities

Be sure the individual understands that:

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

2. Curtailing Development

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

a. the individual alleges that his name does not appear on any accounts, and there is no evidence to the contrary;

b. the individual is ineligible for a non-financial reason.

3. Minimum Documentation - Account Balances Must Be Verified

Document, in addition to the balances themselves;

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

M1410 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-11	1/1/19	Pages 6, 7
TN #DMAS-10	10/1/18	Pages 8-14
TN #DMAS-9	7/1/18	Page 1
TN #DMAS-8	4/1/18	Page 9
TN #DMAS-7	1/1/18	Page 7
TN #DMAS-5	7/1/17	Pages 4-7
TN #DMAS-3	1/1/17	Pages 6, 7, 12-14
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

- agency-directed and consumer-directed personal care
- adult day health care
- agency-directed respite care (including skilled respite) and consumer-directed respite care
- Personal Emergency Response System (PERS).

Services provided through CCC Plus Waiver for technology-assisted individuals are expected to prevent placement, or to shorten the length of stay, in a hospital or nursing facility and include:

- private duty nursing
- nutritional supplements
- medical supplies and equipment not otherwise available under the Medicaid State Plan.

2. Community Living Waiver (Formerly the Intellectual Disabilities Waiver)

As part of the My Life, My Community Developmental Disabilities Waiver Redesign, the Intellectual Disabilities (ID) Waiver was renamed the Community Living Waiver in 2016. The waiver is targeted to provide home and community-based services to individuals with developmental disabilities and individuals under the age of six years at developmental risk who have been determined to require the level of care provided in an ICF/ID, and to individuals with related conditions currently residing in nursing facilities who require specialized services. See M1440, Appendix 1 for a list of services available through this waiver.

***3.* Family and Individual Supports Waiver (Formerly the Individual and Family Developmental Disabilities Support Waiver)**

As part of the My Life, My Community Waiver Developmental Disabilities Redesign, the Individual and Family Developmental Disabilities Support (DD) Waiver was renamed the Family and Individual Supports Waiver in 2016. The waiver provides home and community-based services to individuals with developmental disabilities. See M1440, Appendix 1 for a list of services available through this waiver.

***4.* Building Independence Waiver (Formerly the Day Support Waiver for Individuals with Intellectual Disabilities)**

As part of the My Life, My Community Waiver Developmental Disabilities Redesign, the Day Support Waiver for Individuals with Intellectual Disabilities (DS Waiver) was renamed the Building Independence Waiver in 2016. The waiver is targeted to provide home and community-based services to individuals with intellectual disabilities who have been determined to require the level of care provided in an ICF/ID. See M1440, Appendix 1 for a list of services available through this waiver.

5. **Building Independence Waiver (Formerly the Day Support Waiver for Individuals with Intellectual Disabilities)**

As part of the My Life, My Community Waiver Developmental Disabilities Redesign, the Day Support Waiver for Individuals with Intellectual Disabilities (DS Waiver) was renamed the Building Independence Waiver in 2016. The waiver is targeted to provide home and community-based services to individuals with intellectual disabilities who have been determined to require the level of care provided in an ICF/ID. See M1440, Appendix 1 for a list of services available through this waiver.

CHAPTER M14
LONG-TERM *SERVICES AND SUPORTS (LTSS)*
SUBCHAPTER 20

SCREENING *FOR MEDICAID LTSS*

M1420 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-11	1/1/19	Entire subchapter
TN #DMAS-7	1/1/18	Table of Contents Pages 2, 5. Appendix 2.
TN #DMAS-5	7/1/17	Pages 2-6
TN #DMAS-1	1/1/17	Table of Contents Pages 3-6 Appendix 3 Appendices 4 and 5 were removed.
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

TABLE OF CONTENTS

LONG-TERM *SERVICES AND SUPPORTS*

M1420.000 SCREENING *FOR MEDICAID LTSS*

	Section	Page
***LTSS* Screening Process**	**M1420.100**	**1**
Responsibility for *LTSS* Screening	**M1420.200**	**2**
Communication Procedures	**M1420.300**	**3**
***LTSS* Screening Certification**	**M1420.400**	**4**

Forms

DMAS-96 Medicaid Funded Long-Term *Services and Supports* Authorization Form (DMAS-96)	**Appendix 1**	**1**
Waiver Management System (WaMS) Screen Print	**Appendix *2***	**1**

M1420.000 SCREENING *FOR MEDICAID LTSS*

M1420.100 MEDICAID LTSS SCREENING *PROCESS*

A. Introduction

The Medicaid screening process *for LTSS* was implemented in 1977 to ensure that Medicaid eligible individuals entering nursing facilities met the required level of care for Medicaid payment of long-term *services and supports (LTSS.).* In 1982, the screening process for *LTSS* was expanded to require screening for individuals requesting Medicaid payment of *LTSS* through the Medicaid Home and Community-based *Services* Waivers (*HCBS* or institutional long-term care. In 2007, the screening process was expanded *to include* individuals requesting Medicaid payment of *LTSS* services through the Program for the All-Inclusive Care of the Elderly (PACE).

This subchapter describes the *LTSS* screening process; the eligibility implications; the communication requirements; the inter-agency cooperation requirements; and eligibility worker responsibilities in the *LTSS* screening process.

B. Operating Policies

1. Payment Authorization

A *LTSS* screening provides authorization for Medicaid payment of facility (medical institution), *the Commonwealth Coordinated Care Plus (CCC Plus) waiver* and PACE long-term care services for Medicaid recipients.

2. When a *LTSS* Screening is Required

A screening is used to determine if an individual entering *LTSS* care meets the nursing facility level of care criteria, or if living outside of a nursing facility meets the criteria to receive nursing facility, *CCC Plus Waiver*, or PACE services. *A screening is not needed when an individual is already in a nursing facility or* is currently authorized to receive Medicaid LTSS The exceptions to the screening requirement are listed in M1420.400 B. 1.

The approval by the screening team for receipt of Medicaid *LTSS* services allows the individual to be evaluated using the eligibility rules for institutionalized individuals. See M1420.100 B.3.

After an individual is admitted to a nursing facility, *CCC Plus Waiver* or PACE, the provider is responsible for certifying that the individual continues to meet the level of care for *LTSS* services.

3. Eligibility Rules

The *Medicaid LTSS Authorization Form, DMAS 96,* is used to determine the appropriate rules used for the eligibility determination (which *LTSS* rules to use, or whether to use non-institutional Medicaid eligibility rules). An individual who is screened and approved for *LTSS* is treated as an institutionalized individual in the Medicaid eligibility determination. The Authorization form also certifies the type of *LSS* service and provides information for the personal needs/maintenance allowance.

M1420.200 RESPONSIBILITY FOR *LTSS SCREENING*

A. Introduction

In order to qualify for Medicaid payment of *LTSS* an individual must be determined to meet functional *criteria, have a medical or nursing need and be at risk of nursing facility or hospital placement within 30 days without services.* The *LTSS* screening is completed by a designated screening team.. The team that completes the screening depends on the type(s) of services *chosen and* needed by the individual. Below is a listing of the types of *LTSS* services an individual may receive and the teams responsible for completion of the screening for those services.

B. Nursing Facility Screening

This evaluation is completed by local *community-based* teams *(CBT)* composed of agencies contracting with the Department of Medical Assistance Services (DMAS) or by staff of hospitals *for inpatients.*

The *community-based teams* usually consist of the local health department *physician*, a local health department nurse, and a local social services department service worker.

C. *Community Based LTSS* Screening

Entities other than hospital or local *community-based teams* are authorized to screen individuals for *HCBS*. The following entities are authorized to screen patients for Medicaid *HCBS*:

1. Commonwealth Coordinated Care Plus Waiver

Effective July 1, 2017, the Elderly or Disabled with Consumer-Direction (EDCD) Waiver and the Technology Assisted (Tech) Waiver were combined and are known as the Commonwealth Coordinated Care Plus (CCC Plus) Waiver. *Community-based teams* and hospital screening teams are authorized to screen individuals for the CCC Plus Waiver. The authorization processes were not changed. See M1420.400 C.

2. Community Living Waiver (Formerly the Intellectual Disabilities Waiver)

Local Community Services Boards (CSBs) are authorized to screen individuals for the Community Living Waiver. Final authorizations for waiver services are made by DBHDS staff.

3. Family and Individual Supports Waiver (Formerly the Individual and Family Developmental Disabilities Support Waiver)

CSBs are authorized to screen individuals for the Family and Individual Supports Waiver.

4. Building Independence Waiver (Formerly the Day Support Waiver for Individuals with Intellectual Disabilities)

Local CSB and DBHDS case managers are authorized to screen individuals for the Building Independence Waiver. Final authorizations for the waiver services are made by DBHDS staff.

D. PACE

Community-based screening teams and hospital screening teams are authorized to screen individuals for PACE. If the individual is screened and approved for *LTSS*, the team will inform the individual about any 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 *HCBS* services are arranged as quickly as possible, there must be prompt communication between screeners and eligibility staff.

B. Procedures

1. LDSS Contact

The LDSS should designate an appropriate staff member for screeners to contact. Local social services, hospital staff and *CBTs* 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.

3. Eligibility Worker (EW) Action

The EW must inform both the individual and the provider once eligibility for Medicaid payment of *LTSS* has been determined. If the individual is found eligible for Medicaid and written assurance of approval by the screening *team* has been received *(DMAS-96 or WaMS print out)*, the eligibility worker must give the *LTSS* provider the enrollee's Medicaid identification number.

M1420.400 *LTSS* 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.

B. Exceptions to Screening

Screening *for LTSS* is NOT required when:

- the individual is a *resident* in a nursing facility at the time of application ***and*** *a screening for LTSS was completed prior to the nursing facility admission*;
- the individual received Medicaid *LTSS* in one or more of the preceding 12 months and *LTSS* was terminated for a reason other than no longer meeting the level of care;
- the individual enters a nursing facility directly from the CCC Plus Waiver or PACE ***and*** *a LTSS screening was completed prior to the CCC Plus Waiver or PACE services starting*;
- the individual leaves a nursing facility and begins receiving CCC Plus Waiver services or enters PACE **and** a *LTSS* screening was completed prior to the nursing facility admission;
- the individual resides out of state *(either in a community or nursing facility setting)* and seeks direct admission to a nursing facility ;
- the individual *is an inpatient at an* in state *owned/operated facility licensed by DBHDS, in-state or out of state Veterans hospital or in-state or out of state military hospital and seeks direct admission to a nursing facility*
- an individual *who will not become financially eligible within six months of admission.*
- the individual is no longer in need of *LTSS* and is requesting assistance for a prior period of long term care.

Screening is not required for enrollment into Medicaid hospice services or home health services.

C. Documentation

If a screening is required, the screener's approval for Medicaid *LTSS* must be substantiated in the case record by one of the following documents:

- Medicaid Funded Long-term *Services and Supports* Authorization Form (DMAS-96) for nursing facilities, PACE and CCC Plus Waiver (see Appendix 1) or the equivalent information printed from the *electronic* Pre-admission Screening (*e*PAS) system;

- Copy of the authorization screen from the Waiver Authorization System (WaMS) (see Appendix 3). A Copy of the authorization screen from the Intellectual Disability On-line System (IDOLS) is also acceptable.

Medicaid payment for *LTSS* services cannot begin prior to the date the the DMAS-96 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 or the equivalent information printed from the *e*PAS system.

The "Medicaid Authorization" section will have a number in the box that matches one of the numbers listed under the "*LTSS* 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. CCC Plus Waiver

Individuals screened and approved for the CCC Plus Waiver must have a DMAS-96 signed and dated by the screener and the physician or the equivalent information printed from the *e*PAS system.

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.

Individuals who qualify for Private Duty Nursing (PDN) under the CCC Plus Waiver will have a Medicaid Long Term Care Communication form (DMAS-225) and a Commonwealth Coordinated Care Plus Waiver PDN Level of Care Eligibility form completed (if applicable) and sent to the LDSS.

3. Community Living Waiver Authorization Screen Print

Individuals screened and approved for the Community Living Waiver will have a printout of the WaMS 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.

4. Building Independence Waiver Level of Authorization Screen Print

Individuals screened and approved for the Building Independence Waiver will have a printout of the WaMS 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. Family and Individual Supports Waiver Authorization Screen Print

Individuals screened and approved for the Family and Individual Supports Waiver will have a printout of the WaMS 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.

D. Authorization for *LTSS*

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

The appropriate authorization document (form or screen print) must be maintained in the individual's case record.

1. Authorization Not Received

If a *LTSS* 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 *LTSS* 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 *HCBS* 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 *LTSS* 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 *LTSS*.

MEDICAID FUNDED LONG-TERM SERVICES AND SUPPORTS (LTSS) AUTHORIZATION FORM (DMAS-96)

The Medicaid Funded Long-Term Services And Supports (LTSS) Authorization Form (DMAS-96), revised for January 1, 2019, is contained on the following three pages. The pages do not have headers or page numbers.

MEDICAID FUNDED LONG-TERM SERVICES AND SUPPORTS (LTSS) AUTHORIZATION FORM

I. INDIVIDUAL INFORMATION:

Last Name: ________________________________ First Name: _____________________ Birth Date: ___/___/_______

Social Security________________________________ Medicaid ID ________________________ Gender: __________

II. MEDICAID ELIGIBILITY INFORMATION:

Is Individual Currently Medicaid Eligible?
- 1 = Yes
- 2 = Not currently Medicaid eligible, anticipated within 180 days of nursing facility admission ~~OR within 45 days of application or when personal care begins.~~
- 3 = Not currently Medicaid eligible, not anticipated within 180 days of nursing facility admission

If no, has Individual formally applied for Medicaid?
0 = No 1 = Yes

Is Individual currently Auxiliary Grant eligible?
- 0 = No
- 1 = Yes, or has applied for Auxiliary Grant
- 2 = No, but is eligible for General Relief

Dept of Social Services:
(Eligibility Responsibility)________________________________

(Services Responsibility)__________________________________

III. LTSS SCREENING INFORMATION: (to be completed only by authorized Medicaid or ALF screeners)

MEDICAID AUTHORIZATION

Level of Care
- 1 = Nursing Facility (NF) Services
- 2 = PACE
- 4 = Commonwealth Coordinated Care (CCC) Plus Waiver
- 11 = ALF Residential Living * (see note below)
- 12 = ALF Regular Assisted Living * (see note below)
- 15 = Private Duty Nursing

Exceptions: Authorizations for NF, PACE, CCC Plus Waivers are interchangeable. Screening updates are not required for individuals to move between these services because the alternate institutional placement is a NF. **NF = CCC Plus Waiver or PACE.**

NO MEDICAID SERVICES AUTHORIZED
- 8 = Other Services Recommended
- 9 = Active Treatment for MI/ID/DD Condition
- 0 = No other services recommended

Targeted Case Management for ALF
0 = No 1 = Yes

ALF Reassessment Completed
1 = Full Reassessment 2 = Short Reassessment

ALF provider name: ____________________________________

ALF provider number: __________________________________

ALF admit date: _______________________________________

SERVICE AVAILABILITY
- 1 = Individual on waiting list for service authorized
- 2 = Desired service provider not available
- 3 = Service provider available, services to start immediately

LENGTH OF STAY (If approved for Nursing Facility)
- 1 = Temporary (less than 3 months)
- 2 = Temporary..(less than 6 months)
- 3 = Continuing (more than 6 months)
- 8 = Not Applicable

NOTE: Physicians may write progress notes to address the length of stay for individuals moving between NF, PACE, or CCC Plus Waiver. The progress notes should be provided to the eligibility workers with the local departments of social services.

LTSS/ALF SCREENING IDENTIFICATION

Name of LTSS/ALF screener agency and provider number:

1.____

2.____

LEVEL II ASSESSMENT DETERMINATION – FOR NF AUTHS ONLY – DOES NOT APPLY TO WAIVERS.

Name of Level II Screener and ID number who have completed the Level II for a diagnosis of MI, ID/DD, or RC.

1.____

- 0 = Not referred for Level II assessment
- 1 = Referred, Active Treatment needed
- 2 = Referred, Active Treatment not needed
- 3 = Referred, Active Treatment needed but individual chooses NF

Did the individual expire after the Medicaid LTSS/ALF screening decision but before services were received? 1 = Yes 0 = No

SCREENING CERTIFICATION - This authorization is appropriate to adequately meet the Individual's needs and assures that all other resources have been explored prior to Medicaid authorization for this Individual.

____ ____/____/________

Medicaid LTSS/ALF Screener **Title** **Date**

____ ____/___/________

Medicaid LTSS/ALF Screener **Title** **Date**

____ ____/___/________

Medicaid LTSS Physician **Date**

DMAS-96 (revised 1/2019)

Instructions for completing the Medicaid Funded Long-Term Services and Supports Authorization (DMAS-96)

I. Individual Information:

A. Enter Individual's Last Name. **Required**.

B. Enter Individual's First Name. **Required**.

C. Enter Individual's Birth Date in MM/DD/CCYY format. **Required**.

D. Enter Individual's Social Security Number. **Required**.

E. Enter Individual's Medicaid ID number if the Individual currently has a Medicaid card. This number should have 12 digits.

F. Gender: Enter "F" if Individual is Female or "M" if Individual is Male. **Required**.

II. Medicaid Eligibility Information:

A. Is Individual Currently Medicaid Eligible?

- Enter a "1" in the box if the Individual is currently Medicaid eligible.
- Enter a "2" in the box if the Individual is not currently Medicaid eligible it is anticipated that private funds will be depleted within 180 days after nursing facility admission or within 45 days of application or when waiver services begin.
- Enter a "3" in the box if the Individual is not eligible for Medicaid and it is not anticipated that private funds will be depleted within 180 days after nursing facility admission.

B. If no, has Individual formally applied for Medicaid? Formal application for Medicaid is made when the Individual or authorized representative has taken the required financial information to the local Eligibility Department and completed forms needed to apply for benefits. The authorization for long-term services and supports can be made regardless of whether the Individual has been determined Medicaid eligible, but placement may not be available until the provider is assured of the Individual's Medicaid status.

C. Is Individual currently auxiliary grant eligible? Enter appropriate code ("0", "1", or "2") in the box.

D. Local Depts. of Social Services: The local departments of social services with service and eligibility responsibility may not always be the same agency. Please indicate, if known, the departments for each in the areas provided.

III. Medicaid LTSS Screening Information:

A. Medicaid Authorization: Enter the numeric code that corresponds to the Medicaid LTSS Screening Level of Care authorized. Enter only one code in this box. **Required**.

1	**Nursing Facility (NF)**	Authorize only if Individual meets the NF criteria.
2	**PACE**	Authorize only if Individual meets NF criteria and requires a community-based service to prevent institutionalization.
4	**Commonwealth Coordinated Care Plus Waiver**	Authorize only if Individual meets NF criteria and requires a community-based service to prevent institutionalization.
11	**ALF Residential Living**	Authorize only if Individual has dependency in either 1 ADL, 1 IADL or medication administration
12	**ALF Regular Assisted Living**	Authorize only if Individual has dependency in either 2 ADLs or behavior.
15	**Private Duty Nursing**	Authorize only if the Individual meets NF criteria, has extensive medical/nursing needs and requires a community-based service to prevent institutionalization.

Exceptions: Authorizations for NF, PACE, or the CCC Plus Waivers are interchangeable. Screening updates are not required for Individuals to move between these services because the alternate institutional placement is a NF. **NF = CCC Plus Waiver or PACE.**

Instructions for completing the Medicaid Funded Long-Term Services and Supports Authorization (DMAS-96)

B. No Medicaid Services Authorized:

8	**Other Services Recommended**	Includes informal social support systems or any service excluding Medicaid-funded long term services and supports such as companion services, meals on wheels, ID/DD or Day Support waivers, rehab services, etc.).
9	**Active Treatment for MI/ID or Related Condition**	Applies to those Individuals who meet NF criteria but require active treatment for a condition of mental illness or intellectual/developmental disabilities and cannot appropriately receive such treatment in a NF.
0	**No Other Services Recommended**	Use when the screening team recommends no services or the Individual refuses services.

C. **Targeted Case Management for ALF:** If ALF services are authorized; you must indicate whether Targeted Case Management for ALF (quarterly visit) is also being authorized. The Individual must require coordination of multiple services and the ALF or other support must not be available to assist in the coordination/access of these services.
- ALF Targeted Case Management Services includes the annual reassessment.

D. **ALF Reassessment:** Mark the appropriate code for the long reassessment (“1”) or a short reassessment (“2”).
E. **ALF Provider Name:** Enter the name of the ALF in which the Individual entered. Otherwise leave blank.
F. **ALF Provider Number:** Enter the provider number of the ALF in which the Individual entered. Otherwise leave blank.
G. **ALF Admit Date:** Enter the date the Individual entered an ALF. Otherwise leave blank.
H. **Service Availability:** If a Medicaid-funded long term services and supports is authorized, indicate whether there is a waiting list (”1”) or that there is no provider (“2”), or whether the service can be started immediately (”3”).
I. **Length of Stay:** If approval of NF services is made, please indicate how it is felt that these services will be needed by the Individual. The physician’s signature certifies expected length of stay as well as Level of Care.

NOTE: Physicians may write progress notes to address the length of stay for individuals moving between NF, PACE or the CCC Plus Waiver. The progress notes should be provided to the eligibility workers with the local departments of social services.

J. **Medicaid LTSS/ALF Screening Identification:** Enter the name of the screening agency or facility (for example, hospital, local DSS, local health department, Area Agency on Aging, State MH/IDD facility, CIL) and below it, in the 10 boxes provided, that entity’s 10 digit NPI/API number.
- For Medicaid to make prompt payments to LTSS Screening Teams, all of the information in this section must be completed. *Failure to complete any part of this section will delay reimbursement.*
- If the LTSS Screening is completed in the locality, there should be two screeners, from both the local DSS and local health departments. Otherwise, there will be only one screener identification entered.

K. **Level II Assessment Determination:** If a Level II assessment was performed (MI, IDD or Related Condition), enter the name of the screener on the top line and below it, in the 10 boxes provided, that entity’s 10 digit NPI/API number. Level II assessments apply to NF authorizations ONLY.
- Enter the appropriate code in the box.

L. When a Screening Team is aware that an Individual has expired prior to receiving the services authorized by the screening team, a “1” should be entered in this box.
M. The Medicaid LTSS/ALF Screener must sign and date the form. **Required.**
N. The Medicaid LTSS/ALF Screener must sign and date the form. **Required for all services except ALF placement.**
O. The Medicaid LTSS physician must sign and date the form. **Required for all services expect ALF placement. Physician signature and date is the last item to be completed on this form. Physician must sign and date for himself or herself; others may not sign/date for the physician.**

IV. Final Items:

A. Once the Medicaid LTSS Screening has been completed, the Screening Team should supply a copy of the Screening Package to the Individual’s provider of choice if the individual is FFS. If the Individual is a CCC Plus member, the Screening Package should be sent to the Care Coordinator.
B. The Screening Team must maintain a complete copy of the Medicaid LTSS Screening in their files for a period of not less than 5 years from the date of screening. Files may be in either paper or electronic format.

*NOTE: DMAS no longer requires the submission of ALF Screening documents. Screening Teams are still required to follow all regulations with respect to completion of the documents for ALF services. The Screening Teams should follow instructions provided regarding reimbursement for ALF screenings.

Waiver Management System (WaMS) Screen Print for Community Living Waiver, Building Independence Waiver, and Family and Individual Supports Waiver Authorizations

Enrollment Status

Summary Information

Person's Name:	Olive Oil	Program Type:	Community Living
Medicaid #	369874561212	Staff Completing Form:	Purpose4Living CSB SC Enrollment Approver Staff1
Slot Number:	SAF_2015_512	ISP Start Date:	06/01/2016

Status Update

New Status:* Active

Status Change Reason:* Service Started

Start Date:* 06/16/2016

End Date:

Comments:

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

M1460 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-11	1/1/19	Pages 3-5, 10, 26, 31
TN #DMAS-10	10/1/18	Table of Contents, page i Pages 1-3, 4b, 5, 6, 9, 10, 13, 15, 17a, 18, 18a, 26, 27, 30a, 37, 38 Pages 8a, 11, 19, 30, 39 and 40 are runover pages.
TN #DMAS-8	4/1/18	Pages 18a, 32, 35
TN #DMAS-7	1/1/18	Pages 3, 7
TN #DMAS-3	1/1/17	Pages 3, 4, 4b, 24, 25, 29
TN #DMAS-2	10/1/16	Page 35
TN #DMAS-1	6/1/16	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

11. 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.

12. Projected Expenses

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

13. 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 LTSS

A. Applicability

The policy in this section applies to nursing facility and CBC/PACE patients, including MAGI Adults effective January 1, 2019, who meet the requirements for LTC *services, now called long term services and supports (LTSS)*, 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 LTSS prior to January 1, 2006, and who maintain continuous Medicaid eligibility.

For Medicaid applicants or enrollees approved for *LTSS* on or after July 1, 2006, the amount of equity in the home at the time of the initial *LTSS* 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 *LTSS* unless the home is occupied by

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

If substantial home equity exists, the individual is not *evaluated for or* eligible for the Medicaid payment of *LTSS*. Do not evaluate asset transfers.

An individual with excess home equity is not eligible in the 300% of SSI covered group, but may be eligible for Medicaid payment of covered services other than LTSS if he is eligible in another covered group. Evaluate eligibility for an individual with substantial home equity in other covered groups.

1. Home Equity Limit

The *applicable* home equity limit is based on the date of the application or request for LTC coverage. The home equity limit is:

- Effective January 1, 2017: $560,000
- Effective January 1, 2018: $572,000
- *Effective January 1, 2019: $585,000.*

2. Reverse Mortgages

Reverse mortgages **do not** reduce equity value until payments are being received from the reverse mortgage.

3. Home Equity Credit Lines

A home equity line of credit **does not** reduce the equity value until credit line has been used or payments from the credit line have been received.

C. Verification Required

Verification of the equity value of the home is required.

D. Notice Requirement

If an individual is ineligible for Medicaid payment of *LTSS* because of substantial home equity exceeding the limit, the Notice of Action must state why he is ineligible for Medicaid payment of *LTSS*. The notice must also indicate whether the applicant is eligible for other Medicaid covered services.

If the individual is in a nursing facility, send the facility a DMAS-225 indicating that the individual is not eligible for the Medicaid payment of LTSS.

E. References

See section M1120.225 for more information about reverse mortgages.

M1460.155 THIRD PARTY & LONG-TERM CARE INSURANCE PAYMENTS

A. Payments Made by Another Individual

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

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

B. LTC Insurance Policy Payments

The LTC insurance policy must be entered into the recipient’s TPL file on MMIS. The insurance policy type is “H” and the coverage type is “N.” When entered in the Virginia Case Management System (VaCMS) on the TPL system, Medicaid will not pay the nursing facility’s claim unless the claim shows how much the policy paid.

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

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

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

2. Applicants Who Do Not Receive Cash Assistance

a. Child Under Age 18

MAGI methodology is not applicable to F&C children needing LTC services. If the applicant is a child under age 18, determine the child's eligibility in the F&C 300% SSI group, using the covered group policy in subchapter M0330 and the financial eligibility policy and procedures in this subchapter. The resource requirement for the F&C 300% SSI covered group does **NOT** apply to children under age **18.**

If the child's income exceeds the limit for the F&C 300% SSI group, determine the child's eligibility in an MN covered group.

NOTE: A child who is age 18, 19 or 20 meets an MN covered group if he is blind, disabled, pregnant, in foster care, adoption assistance, or institutionalized in a nursing facility. An individual age 21 or older, must meet the pregnant, aged, blind or disabled definition in order to meet an MN covered group.

b. Individual Age 19

If the individual is 19, first determine the individual's eligibility in the F&C Child Under 19 or Pregnant Woman covered groups using MAGI income methodology in Chapter M04. If the individual's income exceeds the limits for F&C coverage, he must be determined disabled to meet the ABD 300% SSI covered group. Follow the procedures in M0310.112 for making a disability referral.

c. Individual Age 19 or Older

If the individual is age 19 or older, determine the individual's eligibility in an ABD or F&C covered group, depending on which definition the individual meets, using the financial eligibility policy and procedures in this subchapter.

For ABD individuals, determine the individual's eligibility in the ABD 80% FPL covered group. If not eligible in the ABD 80% FPL covered group, determine the individual's eligibility in the ABD 300% SSI covered group. If not eligible in the either of these covered groups, determine the individual's eligibility in all other groups for which he meets a definition.

For F&C individuals, first determine the individual's eligibility in the LIFC, Pregnant Woman, or MAGI Adult groups. If the individual's income exceeds the limits for the LIFC, Pregnant Woman, or MAGI Adult covered groups, determine the individual's eligibility in the F&C 300% SSI covered group.

To be eligible in the F&C 300% SSI covered group, the individual must be a child under age 18; under age 21 who meets the adoption assistance or foster care definition; under age 21 in an ICF or ICF- ID; a parent or caretaker-relative of a dependent child; or a pregnant woman as defined in M0310.

If the income exceeds the 300% SSI group limit and the individual meets a MN covered group, determine the individual's eligibility in an MN covered group (see M0330). There is no MN covered group for LIFC parents or MAGI Adults.

B. Relation to Income Limits

Determination of the appropriate covered group must be made prior to determination of income because the income limits are determined by the covered group:

1. ABD 80% FPL

The ABD income policy in Chapter S08 is used to determine countable income for the ABD 80% FPL covered group. *However, the income items listed in Sections M1460.610 and M1460.611 are NOT counted as income in determining income eligibility for the ABD 80% FPL covered group.*

M1460.210 ABD 80% FPL COVERED GROUP

A. Description

The ABD 80% FPL covered group includes aged, blind and disabled individuals who have income less than or equal to 80% FPL and countable resources that do not exceed the SSI resource limits. See M0320.300 for details about this covered group.

B. Policy

1. Nonfinancial

Evaluate the non-financial Medicaid eligibility rules in Chapter M02.

2. Asset Transfer

Determine if the recipient meets the asset transfer policy in subchapter M1450.

3. Resources

Determine countable resources using the policy in chapter S11 and Appendix 2 to chapter S11. The resource limit is $2,000.

The home property resource exclusion for individuals in the ABD 80% FPL covered group includes the home and ALL contiguous property as long as the individual lives in the home or, if absent, intends to return to the home (see Appendix 2 to chapter S11). When the ABD 80% FPL individual leaves his home property, obtain a signed statement from the individual as to:

- when and why he left the home;
- whether he intends to return; and
- if he does not intend to return, when that decision was made.

The limited 6-month home property resource exclusion for institutionalized individuals does NOT apply to this covered group.

4. Income

The ABD income policy in Chapter S08 is used to determine countable income for the ABD 80% FPL covered group. However, the income items listed in Sections M1460.610 and M1460.611 are NOT counted as income in determining income eligibility for the ABD 80% FPL covered group.

Countable income must not exceed 80% FPL. Spenddown does not apply to this covered group.

M1460.600 INCOME DETERMINATION

A. Introduction

This section provides the income requirements specific to determinations of eligibility for Medicaid participation in payment of long-term care services.

B. F&C *CN*

If an institutionalized individual meets an F&C *CN* covered group, determine if his income is within the appropriate F&C income limit. The institutionalized individual is an assistance unit of one person; no income is deemed from responsible relatives. Use the policy and procedures in chapters M04 and M07 to determine countable income.

C. MAGI Adult Group

If an individual is between the ages of 19 and 64 and is not entitled to or receiving Medicare, determine if his MAGI household income is less than or equal to 138% of the Federal Poverty Level (FPL). Use the policy in Chapter M04 to determine countable income.

D. ABD 80% FPL Group

If an individual is aged, blind or disabled, determine if his income is less than or equal to 80% of the FPL. See M0810.002 A.5 for the ABD 80% FPL income limits. The ABD income policy in Chapter S08 is used to determine countable income for the ABD 80% FPL covered group. *However, the income items listed in Sections M1460.610 and M1460.611 are NOT counted as income in determining income eligibility as an institutionalized individual for the ABD 80% FPL covered group.*

E. 300% SSI Income Limit Group

For purposes of this section, we refer to the ABD covered group and the F&C covered group of "individuals in medical facilities who have income less than or equal to 300% of the SSI individual payment limit" and "individuals receiving Medicaid waiver services who have income less than or equal to 300% of the SSI individual payment limit" as one covered group. We refer to this one group as "institutionalized individuals who have income within 300% of SSI" or the "300% SSI group."

1. Assistance Unit

The institutionalized individual is an assistance unit of one person; no income is deemed from responsible relatives.

2. Income Limit

The income limit for ABD and F&C individuals in the 300% SSI group is 300% of the SSI individual payment limit (see M0810.002 A. 3).

3. Countable Income

Income sources listed in section M1460.610 are NOT considered income.

Income sources listed in section M1460.611 ARE counted as income.

All other income is counted. The individual's gross income is counted; no exclusions are deducted.

To determine an income type or source and to determine how to count the income, use the policy and procedures in chapter S08 for all individuals (both ABD and F&C) in this covered group.

Income is projected for the month for which eligibility for LTC is being determined. This calculation is based upon the income received in the past month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount expected to be received.

C. What Is NOT Income For All Covered Groups EXCEPT F&C MN

The items below are NOT income when determining eligibility *as an institutionalized individual* for all covered groups EXCEPT for the F&C MN covered groups. Count these income sources in the F&C medically needy income determination, **but NOT in the patient pay calculation.**

1. Specific VA Payments

The following VA payments are NOT income for all covered groups EXCEPT the F&C MN covered groups:

a. Payments for Aid and Attendance or housebound allowances. Refer to section M1470.100 for counting Aid and Attendance payments as income in the patient pay calculation.

   NOTE: This applies to all LTC recipients, including those patients who reside in state veterans' care centers.

M1470 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-11	1/1/19	Pages 19, 20, 51
TN #DMAS-10	10/1/18	Page 1
TN #DMAS-9	7/1/18	Page 12a, 28
TN #DMAS-8	4/1/18	Page 2a
TN #DMAS-7	1/1/18	Pages 19, 20, 43, 44.
TN #DMAS-5	7/1/17	Pages 1, 7-9, 11, 15, 19, 20, 28a, 43, 47-51, 53
TN #DMAS-4	4/1/17	Page 19
TN #DMAS-3	1/1/17	Table of Contents, page ii Pages 1, 14, 17, 19, 20, 28a, 45-47, 50 Appendix 1, pages 1 and 2
TN #DMAS-2	10/1/16	Pages 12, 27, 28 Pages 12a and 28a were added as runover pages.
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

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:

- Commonwealth Coordinated Care Plus (CCC Plus) Waiver (formerly the Elderly or Disabled with Consumer-Direction Waiver and the Technology-Assisted Individuals Waiver),
- Community Living (CL) Waiver (formerly Intellectual Disabilities Waiver),
- Family and Individual Supports (IS) Waiver (formerly Individual and Family Developmental Disabilities Support Waiver), and
- Building Independence (BI) Waiver (formerly Day Support Waiver).

Individuals enrolled in the Program for All Inclusive Care for the Elderly (PACE) are also allowed the basic PMA.

The PMA is:

- January 1, 2018 through December 31, 2018: $1,238
- *January 1, 2019 through December 31, 2019: $1,273.*

Contact a Medical Assistance Program Consultant for the PMA in effect for years prior to *2018.*

2. Guardianship Fee

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

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

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

3. Special Earnings Allowance for Recipients in CCC Plus, CL, IS and BI Waivers

Deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

a. for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (*$2,313* in 2019) per month.

b. for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI (*$1,542* in 2019) per month.

4. Example – Special Earnings Allowance (Using January 2018 figures)

A working patient receiving CCC Plus Waiver services is employed 18 hours per week. His income is gross earnings of $1228.80 per month and SSA of $300 monthly. His special earnings allowance is calculated by comparing his gross earned income ($1128.80) to the 200% of SSI maximum ($1,500.00). 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:

$ 1,238.00 CBC basic maintenance allowance
+ 1,128.80 special earnings allowance
$ 2,360.80 PMA

Because the PMA may not exceed 300% of SSI, the PMA for the patient in this example must be reduced to $2,250.00.

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.

M1470.1020 LUMP SUM NOT REPORTED TIMELY

A. Effective Date

Lump sum payments reported AFTER the month in which the payment was received are not reported timely. Evaluate total resources including the lump sum. If the resources are within the limit, determine availability for patient pay. See B. & C. below. If they exceed the resource limit, go to section M1470.1100 below.

B. Lump Sum Not Available

If the money is not available, complete and send a Notice of Recipient Fraud/Non-Fraud to the DMAS, Recipient Audit Unit.

C. Lump Sum Available

1. If the money is still available and the individual is no longer in the facility and is not receiving Medicaid CBC, complete and send a Notice of Recipient Fraud/Non-Fraud to the DMAS, Recipient Audit Unit.

2. If the money is still available and the individual is still in the facility or is still receiving Medicaid CBC, adjust the patient pay according to procedures in section M1470.1030 below.

M1470.1030 PATIENT PAY DETERMINATION FOR LUMP SUMS

A. Policy

When a lump sum payment is received, the patient pay for the month *following the month* in which the 10-day advance notice period expires must be adjusted using the procedures in this section. ***The patient pay cannot be increased retroactively.***

B. CN Procedures

1. Total Income

Add the lump sum to the patient's regular monthly income; the result is total income for the month.

2. Less Than Or Equal To 300% of SSI

If the total gross income (including the lump sum) is equal to or less than the 300% of SSI income limit, adjust the patient pay. None of the lump sum remains to be evaluated.

3. Greater Than 300% of SSI

If the total gross income (including the lump sum) exceeds the 300% of SSI income limit, adjust the patient pay. Compare the income available for patient pay to the Medicaid rate for the month.

If the income available for patient pay is less than or equal to the Medicaid rate, the available income is the patient pay. If the income available for patient pay exceeds the Medicaid rate, adjust the patient pay to equal the Medicaid rate for the month.

Evaluate the difference between the Medicaid rate and the available income as a resource for the next month. If the patient's total countable resources exceeds the resource limit, take appropriate action to cancel the patient's Medicaid.

M1480 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-11	1/1/19	Pages 2, 7, 8, 18c, 66, 69, 70
TN #DMAS-7	1/1/18	Pages 18c, 66
TN #DMAS-11	1/1/19	Page 2
TN #DMAS-6	10/1/17	Table of Contents, page i Pages 2, 50, 50a, 52, 52a, 55, 57, 59, 63, 66, 76, 79, 80, 82, 84, 86, 88, 89
TN #DMAS-5	7/1/17	Pages 66, 69, 70, 92
TN #DMAS-3	1/1/17	Pages 7, 9, 18, 18b, 18c, 20 Pages 47, 51, 66, 67, 77
TN #DMAS-2	10/1/16	Pages 66, 72
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
TN #100	5/1/15	Pages 7, 16, 18, 18a, 18c, 65, 66 Pages 8, 15, 17 and 18b are reprinted.
TN #99	1/1/14	Pages 7, 18c, 66, 69, 70
TN #98	10/1/13	Page 66
UP #9	4/1/13	Pages 7, 18c, 66, 69, 70
UP #8	10/1/12	Page 66
TN #97	9/1/12	Pages 3, 6, 8b, 16 Pages 20-25 Page 20a was deleted.
UP #7	7/1/12	Pages 11, 14, 18c, 21 Pages 32, 66, 67, 69
UP #6	4/1/12	Pages 7, 18c, 66, 68, 69, 70
TN #96	10/1/11	Pages 7, 14, 66, 71
UP #5	7/1/11	Page 66
TN #95	3/1/11	Pages 7-9, 13, 18a, 18c, 66, Pages 69, 70
TN #94	9/1/10	Pages 64, 66, 69, 70
TN #93	1/1/10	Table of Contents, page ii Pages 3, 8b, 18, 18c, 20a Pages 21, 50, 51, 66, Pages 69, 70, 93 Appendix 4 was removed.
Update (UP) #1	7/1/09	Page 66
TN # 91	5/15/09	Pages 67, 68 Pages 76-93

The rules in this subchapter apply only to the institutionalized spouse's financial eligibility. If the community spouse applies for Medicaid, use the financial eligibility rules for non-institutionalized persons in the community spouse's covered group to determine the community spouse's Medicaid eligibility.

M1480.010 DEFINITIONS

A. Introduction

This section provides definitions for those words and terms used in this subchapter.

B. Definitions

1. Beginning of a Continuous Period of Institutionalization

means the first calendar month of a continuous period of institutionalization (in a medical institution or receipt of a Medicaid Community-based Care (CBC) waiver service). See section M1410.010 for definition of a medical institution.

2. Community Spouse

means a person who:

* is married to an institutionalized spouse and
* is not an inpatient in a medical institution or nursing facility.

The community spouse can be living in the home with the institutionalized spouse who is a Medicaid CBC patient, can be living in a residential institution such as an assisted living facility (ALF), or can be living in the institutionalized spouse's former home.

If the community spouse is incarcerated, verification of resources and income are still required to be obtained from the couple.

NOTE: A spouse living in the couple's home who is also receiving Medicaid CBC waiver services is a community spouse. The community spouse monthly income allowance policy applies.

3. Community Spouse Monthly Income Allowance

means an amount by which the minimum monthly maintenance needs allowance (MMMNA) exceeds the amount of monthly income otherwise available to the community spouse. [Section 1924(d)(2) of the Social Security Act].

The community spouse monthly income allowance is the maximum amount of the institutionalized spouse's income which is allowed to supplement the community spouse's income, up to the minimum monthly maintenance needs allowance (MMMNA).

4. Community Spouse Resource Allowance (CSRA)

means the amount (if any) by which the greatest of

- the spousal share;
- the spousal resource standard;

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 *services, now called long term services and supports (LTSS)*, 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 LTSS prior to January 1, 2006, and who maintain continuous Medicaid eligibility.

For Medicaid applicants or enrollees approved for LTSS 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.

If substantial home equity exists, the individual is not evaluated for or eligible for the Medicaid payment of LTSS. Do not evaluate asset transfers.

An individual with excess home equity is not eligible in the 300% of SSI covered group, but may be eligible for Medicaid payment of covered services other than LTSS if he is eligible in another covered group. Evaluate eligibility for an individual with substantial home equity in other covered groups.

1. Home Equity Limit

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

- Effective January 1, 2017: $560,000
- *Effective January 1, 2018: $572,000*
- *Effective January 1, 2019: $585,000.*

2. Reverse Mortgages

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

3. Home Equity Lines of Credit

A home equity line of credit **does not** reduce the equity value until credit line has been used or payments from the credit line have been received

B. Verification Required

Do not assume that the community spouse is living in the home. Obtain a statement from the applicant indicating who lives in the home. If there is no spouse, dependent child under age 21, or blind or disabled child living in the home, verification of the equity value of the home is required.

C. Notice Requirement

If an individual is ineligible for Medicaid payment of *LTSS* because of substantial home equity exceeding the limit, the Notice of Action must state why he is ineligible for Medicaid payment of *LTSS*. The notice must also indicate whether the applicant is eligible for other Medicaid covered services.

If the individual is in a nursing facility, send the facility a DMAS-225 indicating that the individual is not eligible for the Medicaid payment of LTSS.

D. References

See section M1120.225 for more information about reverse mortgages.

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

$24,720 1-1-18

$25,284 1-1-19

C. Maximum Spousal Resource Standard

$123,600 1-1-18

$126,420 1-1-19

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.

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. VaCMS 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

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 long-term services and support (LTSS) 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

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

Amount	Effective
$2030.00	7-1-17
$2057.50	7-1-18

C. Maximum Monthly Maintenance Needs Allowance

Amount	Effective
$3,090.00	1-1-18
$3,160.50	*1-1-19*

D. Excess Shelter Standard

Amount	Effective
$609.00	7-1-17
$617.25	7-1-18

E. Utility Standard Deduction (SNAP)

Amount	Household	Effective
$306.00	1 - 3 household members	10-1-17
$381.00	4 or more household members	10-1-17
$311.00	1 - 3 household members	10-1-18
$387.00	4 or more household members	10-1-18

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

A. Policy

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

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

His personal needs allowance is calculated as follows:

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

2. Medicaid CBC Waiver Services and PACE

a. Basic Maintenance Allowance

For the Commonwealth Coordinated Care Plus (CC Plus) Waiver (formerly the Elderly or Disabled with Consumer Direction Waiver and the Technology-Assisted Individuals Waiver), Community Living (CL) Waiver (formerly Intellectual Disabilities Waiver), Family and Individual Supports (IS) Waiver (formerly Individual and Family Developmental Disabilities Support Waiver), Building Independence (BI) Waiver (formerly Day Support Waiver), or PACE, deduct the appropriate maintenance allowance for one person as follows:

- January 1, 2018 through December 31, 2018: $1,238
- *January 1, 2019 through December 31, 2019: $1,273.*

Contact a Medical Assistance Program Consultant for the amount in effect for years prior to *2017*.

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.

c. Special Earnings Allowance For CCC Plus, CL, IS, and BI Waivers

[EXAMPLE #19 was deleted]

For the CCC Plus, CL, IS, and BI 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 (*$2,313* in *2019*) per month.

1) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI (*$1,542* in *2019*) 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 CL 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

M1510 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-11	1/1/19	Page 7
TN #DMAS-10	10/1/18	Pages 7, 8a, 9a, 14 Pages 8b and 8c are runover pages.
TN #DMAS-9	7/1/18	Table of Contents Page 5. Page 9a was added.
TN #DMAS-8	4/1/18	Pages 2, 8a, 8b Page 8c was added.
TN #DMAS-6	10/1/17	Table of Contents Pages 1, 2 Page 2a is a runover page. Page 2b was added as a runover page.
TN #DMAS-5	7/1/17	Page 1 Page 2 is a runover page.
TN #DMAS-4	4/1/17	Pages 2a, 10
TN #DMAS-2	1/1/17	Table of Contents Pages 1, 8, 8a, 12-15 Page 11a was deleted.
TN #DMAS-2	10/1/16	On pages 3-15, corrected the subchapter number in the headers. Neither the dates nor the policies were 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

his local agency a Medicaid application which is received on August 18. The facility's statement notes that he will be discharged on September 17 to ABC Nursing Home, a nursing facility. The agency completes the determination on August 27 and finds that he will be eligible once he is discharged to the nursing facility.

The agency does not enroll Mr. A until the discharge is confirmed. The CSB case manager calls the agency on September 21 and informs the agency that the patient was discharged to the ABC Nursing Home on September 18. The patient is enrolled in Medicaid with a begin date of September 18.

4. Incarcerated Individuals

a. Pre-release Planning

Incarcerated individuals, who are approved for Medicaid in advance of their release, are enrolled in the appropriate AC for the covered group beginning with the date of release. If the individual is already enrolled in AC 109 at the time of release, cancel the AC 109 coverage effective the day prior to the date of release and reinstate the ongoing coverage effective the following day.

b. Inpatient Hospitalization – Aid Category (AC) 109

Incarcerated individuals (see M0130.050) who meet all Medicaid eligibility requirements, including eligibility in a full benefit CN covered group are eligible for Medicaid coverage limited to inpatient hospitalization. Enroll eligible MAGI Adults in aid category AC 108 and all other individuals in aid category AC 109 regardless of their covered group. See M0130.050

Entitlement for newly eligible individuals begins the first day of the month of application/reapplication, provided all eligibility factors are met. Entitlement can also begin the first day of any month in the application's retroactive period, provided all eligibility requirements were met

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

5. MAGI Adult Turns 65 or Begins Receiving Medicare

When an individual enrolled in the Modified Adjusted Gross Income (MAGI) Adults covered group turns 65 years old or begins receiving Medicare, he is no longer eligible in the MAGI Adults covered group. Evaluate the individual for eligibility in an Aged, Blind or Disabled covered group. If the individual is not eligible in any other covered group, cancel his coverage following the policy in M1510.102 B below.

M1520 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-11	1/1/19	Pages 2, 5-7, 9
TN #DMAS-8	4/1/18	Pages 2, 18 Appendix 2
TN #DMAS-7	1/1/18	Pages 2, 3, 3a, 5, 6, 7 Pages 6a and 7a are runover pages.
TN #DMAS-5	7/1/17	Pages 1, 2, 6, 8 Pages 3, 7, 7a and 9 are runover pages.
TN #DMAS-4	4/1/17	Pages 25-27 Appendix 2, page 1 Pages 28-30 were added.
TN #DMAS-3	1/1/17	Pages 1, 2, 4, 6, 7, 8, 14, 26
TN #DMAS-2	10/1/16	Pages 1, 3, 6, 8, 12, 14, 15 Pages 19-24
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

M1520.100 PARTIAL REVIEW

A. Enrollee's Responsibility

Enrollees must report changes in circumstances which may affect eligibility and/or patient pay within 10 days from the day the change is known. For enrollees participating in the Health Insurance Premium Payment (HIPP) Program, changes that may affect participation in HIPP must also be reported to the DMAS HIPP Unit within the 10-day timeframe.

B. Eligibility Worker's Responsibility

The eligibility worker has a responsibility for keeping a record of changes that may be anticipated or scheduled, and for taking appropriate action on those changes.

Appropriate agency action on a reported change must be taken within 30 days of the report. If the enrollee reports any changes requiring verification, such as changes in income or resources, or an asset transfer for enrollees receiving long-term-care (LTC) services, *if possible, use online systems information verifications that are available to the agency to determine if information is consistent with the change reported. If the systems information is compatible, the agency must determine eligibility based upon the information available. If it is necessary to obtain verification from the enrollee*, send the enrollee a checklist requesting the necessary verifications, and allow at least 10 calendar days for the information to be returned.

If the information is not provided in the time allotted, cancel the enrollee's coverage for the inability to determine eligibility and send advance notice to the enrollee or his authorized representative. Document the information and evaluation in the VaCMS case record.

1. Changes That Require Partial Review of Eligibility

When changes in an enrollee's situation are reported by the enrollee or when the agency receives information indicating a change in an enrollee's circumstances (i.e. Supplemental Security Income [SSI] purge list, reported transfer of assets), the worker must take action to partially review the enrollee's continued eligibility.

A reported decrease in income or termination of employment must be verified when the change in income causes the individual to move from a limited-benefit covered group to another limited-benefit covered group, or to a full-benefit covered group. For terminated employment, if *the reported change is not compatible with information obtained from online system searches, obtain verification from the enrollee or authorized representative.*

The agency may not deny, terminate or reduce benefits for any individual unless the agency has sought additional information from the individual and provided proper notification.

A reported increase in income and/or resources can be acted on without requiring verification, unless the increase causes the individual to move from Medicaid to FAMIS *or the individual meets a Medically Needy covered group and is eligible to be placed on a spenddown*.

2. Changes That Do Not Require Partial Review

When changes in an enrollee's situation are reported or discovered, such as the enrollee's Social Security number (SSN) and card have been received, the worker must document the change in the case record and take action appropriate on the reported change in the appropriate computer system(s).

If an annual renewal has been done within the past 6 months, a partial review to address factors pertinent to receipt of LTC, such as asset transfer, spousal resource assessment, etc., must be completed. If an annual renewal has not been done within the past 6 months, a complete renewal must be completed (see M1520.200). When the re-evaluation is completed, send all required notices to the enrollee/authorized representative, and send a DMAS-225 to the provider (see M1410.300).

If the individual is already enrolled in a full benefit Medicaid covered group, do not change the AC. If the individual is enrolled *in a limited-benefit covered group*, the individual must be evaluated for eligibility in one of the covered groups for institutionalized individuals (i.e. income $\leq$ 300% of SSI) (see M1460).

For an SSI recipient who has no community spouse and owns no countable real property, verify continued receipt of SSI through SOLQ-I or SVES, obtain information regarding asset transfer from the enrollee or authorized representative, and document the case record. As long as the individual continues to receive SSI, do not change the AC. If the individual loses SSI, evaluate his Medicaid eligibility in other covered groups. See M1430.103 for additional information regarding an SSI recipient who enters a nursing facility.

When an individual on a spenddown enters LTC, his Medicaid eligibility must be determined using the procedures in subchapter M1460. An individual on a spenddown in an assistance unit with a spouse and/or children becomes a separate assistance unit when he enters LTC. The spouse's and/or children's spenddown liability is recalculated to reflect a decrease in assistance unit size. See M1350.220 for additional information.

F. Changes Between Coverage Under MA and the Governor's Access Plan (GAP)

If an individual enrolled in Plan First subsequently applies and is eligible for GAP, staff at the GAP Unit with the Cover Virginia Call Center will cancel the Plan First coverage and reinstate GAP coverage. The GAP Unit will send a Communication Form to the local agency to report the GAP enrollment. The worker will close Plan First coverage in VaCMS using the override function and notify the individual of the Plan First cancellation.

When an individual enrolled in GAP coverage becomes eligible for MA, prior to enrollment in Medicaid, the local eligibility worker will send a Communication form to the GAP Unit to report eligibility for Medicaid/FAMIS and the effective date of coverage. GAP Unit staff will cancel GAP coverage within two work days. Once GAP coverage is cancelled, the local eligibility worker will complete the MA enrollment and send notice of eligibility to the enrollee. The GAP Unit will send separate notice of the GAP cancellation.

Effective January 1, 2019, individuals enrolled in GAP will automatically be enrolled in the MAGI Adult coverage group if eligibility requirements are met. Case information will remain with the Cover Virginia GAP Unit and stored in the GAP CHAMPS database until conversion into VaCMS.

M1520.200 RENEWAL REQUIREMENTS

A. Policy

The agency must evaluate the eligibility of all MA enrollees, with respect to circumstances that may change, at least every 12 months. Each renewal must be authorized by an eligibility worker or supervisor, although administrative staff may assist in the gathering of information.

The scope of renewals is limited to information that is necessary to determine ongoing eligibility and that relates to circumstances that are subject to change, such as income and resources. Verification of information that is not subject to change, such as date of birth and SSN, is not required at renewal, unless it has not been verified previously.

If an annual renewal has been done within the past 6 months, a partial review to address factors pertinent to receipt of LTC, such as asset transfer, spousal resource assessment, etc., must be completed. If an annual renewal has not been done within the past 6 months, a complete renewal must be completed (see M1520.200). When the re-evaluation is completed, send all required notices to the enrollee/authorized representative, and send a DMAS-225 to the provider (see M1410.300).

If the individual is already enrolled in a full benefit Medicaid covered group, do not change the AC. If the individual is enrolled in a limited-benefit covered group, the individual must be evaluated for eligibility in one of the covered groups for institutionalized individuals (i.e. income $\leq$ 300% of SSI) (see M1460).

For an SSI recipient who has no community spouse and owns no countable real property, verify continued receipt of SSI through SOLQ-I or SVES, obtain information regarding asset transfer from the enrollee or authorized representative, and document the case record. As long as the individual continues to receive SSI, do not change the AC. (*See M0320.101.C)* . If the individual loses SSI, evaluate his Medicaid eligibility in other covered groups. See M1430.103 for additional information regarding an SSI recipient who enters a nursing facility.

When an individual on a spenddown enters LTC, his Medicaid eligibility must be determined using the procedures in subchapter M1460. An individual on a spenddown in an assistance unit with a spouse and/or children becomes a separate assistance unit when he enters LTC. The spouse's and/or children's spenddown liability is recalculated to reflect a decrease in assistance unit size. See M1350.220 for additional information.

B. Changes Between Coverage Under MA and the Governor's Access Plan (GAP)

If an individual enrolled in Plan First subsequently applies and is eligible for GAP, staff at the GAP Unit with the Cover Virginia Call Center will cancel the Plan First coverage and reinstate GAP coverage. The GAP Unit will send a Communication Form to the local agency to report the GAP enrollment. The worker will close Plan First coverage in VaCMS using the override function and notify the individual of the Plan First cancellation.

When an individual enrolled in GAP coverage becomes eligible for MA, prior to enrollment in Medicaid, the local eligibility worker will send a Communication form to the GAP Unit to report eligibility for Medicaid/FAMIS and the effective date of coverage. GAP Unit staff will cancel GAP coverage within two work days. Once GAP coverage is cancelled, the local eligibility worker will complete the MA enrollment and send notice of eligibility to the enrollee. The GAP Unit will send separate notice of the GAP cancellation.

Effective January 1, 2019, individuals receiving GAP coverage will be enrolled in the MAGI Adult coveed group if eligibility requirements are met. Case information will remain with the Cover Virginia GAP Unit and stored in the GAP CHAMPS database until a conversion into VaCMS takes place.

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.

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, including the VEC, may be used if it is dated within the previous 12 months (see *M0130.001 B).*

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 agency must include in each applicant's case record facts to support the agency's decision on the case. Copies of all verifications must be kept in the case file. 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. If the renewal is not processed and documented electronically, the documentation must be in the case record.

b. $0 Income Reported

If the information provided is consistent with information obtained by the worker from electronic sources, or documentation is available from other social services program (TANF, SNAP, Child Care, Energy Assistance) and dated within the past 12 months, the agency must determine or renew eligibility based upon the information available. If there is a discrepancy between what is stated on the application and the information obtained from online systems and agency knowledge, contact the enrollee for information about the discrepancy.

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.

1. Renewal Completed

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

2. Renewal Not Completed

If information necessary to redetermine eligibility is not available through online information systems that are available to the agency and the enrollee has been asked but has failed to provide the information, the renewal must be denied and the coverage cancelled 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. *When the renewal or verifications are provided within the 90 day reconsideration period, process the renewal as soon as possible but at least within 30 calendar days from receipt.*

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

CHAPTER M18
MEDICAL SERVICES

M18 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-11	1/1/19	Page 3
TN #DMAS-10	10/1/18	Pages 3-5
TN #DMAS-6	10/1/17	Table of Contents Pages 3-5 Page 6 is a runover page. Page 6a was added.
TN #100	5/1/15	Table of Contents Pages 1-9 Pages 10-17 were deleted. Appendix 1 was removed.
UP #9	4/1/13	Page 3
UP #7	7/1/12	Page 12
TN #96	10/01/11	Pages 3, 4, 16
TN #95	3/1/11	Page 9
TN #94	9/1/10	Page 12
TN #93	1/1/10	Pages 4, 5
TN #91	5/15/09	Page 2 Pages 5, 6 Page 8

M1830.100 MANAGED CARE

A. General Information

DMAS provides Medicaid coverage to enrollees primarily through two delivery systems: fee-for-service (FFS) and managed care. FFS benefits are administered by DMAS through participating providers within the traditional Medicaid program rules. Most Virginia Medicaid enrollees are required to receive medical care through a managed care organization.

B. *Medallion Programs*

DMAS currently operates two programs, Medallion 3.0 and Medallion 4.0. Both Medallion programs are administered through DMAS' contracted managed care organizations (MCO). Recipients currently in Medallion 3.0 will be transitioned to Medallion 4.0 by December 31, 2018.

Individuals eligible for Medallion 3.0 and 4.0 include non-institutionalized enrollees in both Families & Children (F&C) and Aged, Blind or Disabled (ABD) covered groups. Some enrollees in the groups below are not Medallion 3.0 or 4.0 eligible because they meet exclusionary criteria. The following is a **partial** list of enrollees excluded from managed care enrollment:

- Enrollees who are inpatients in state mental hospitals *and correctional facilities,*
- Enrollees who are in long-stay hospitals, nursing facilities, or intermediate care facilities for the intellectually disabled,
- Enrollees who meet a spenddown and are enrolled for a closed period of coverage,
- Enrollees who are *enrolled* in Plan First,
- Enrollees under age 21 in Level C residential facilities,
- Enrollees who have an eligibility period that is less than three months or who have an eligibility period that is only retroactive.

All Medallion 4.0 health plans offer enhanced benefits to members including, but not limited to:

- Adult Dental
- Vision for adults
- Cell phone
- Centering pregnancy program
- GED for Foster Care
- Sports physical at no cost (under age 21)
- Swimming lessons for members six (6) years and younger
- Boys and Girls Club membership (6-18 olds)
- Free meal delivery after inpatient hospital stays

Note: Not all health plans will offer all of the same enhanced benefits

Enrollees excluded from mandatory managed care enrollment shall receive Medicaid services under the current fee-for-service system. When enrollees no longer meet the criteria for exclusion, they shall be required to enroll in the appropriate managed care program.