COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

JENNIFER S. LEE, M.D.
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786/7933
800/343-0634 (TDD)

www.dmas.virginia.gov

July 1, 2018

Virginia Medical Assistance Eligibility Manual

Transmittal #DMAS-9

- ABD – Aged, Blind or Disabled
- APTC – Advance Premium Tax Credit
- DDS – Disability Determination Services
- DMAS – Department of Medical Assistance Services
- DSS – Department of Social Services
- F&C – Families and Children
- FAMIS – Family Access to Medical Insurance Security
- FPL – Federal Poverty Level
- GAP – Governor's Access Plan
- HCBS – Home and Community Based Services
- LIFC – Low Income Families with Children
- LTSS – Long Term Services and Support
- MA – Medical Assistance
- TN – Transmittal

TN #DMAS-9 includes policy clarification, updates and revisions to the MA Eligibility Manual. Unless otherwise noted, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after July 1, 2018.

The following changes are contained in TN #DMAS-9:

Changed Pages	Changes
Subchapter M0130 Page 2b	Remove reference to knowing initial date of in-patient hospitalization for incarcerated persons
Subchapter M0220 Pages 1, 2, 14c	On pages 1 and 2, correct title block. On page 14c, clarified that Medicaid coverage of emergency services Medicaid does not impact the 40 quarters requirement.
Subchapter M0240 Table of Contents Pages 6, 6a	Add new section regarding Social Security Number Discrepancies.
Subchapter M0310 Page 35, Appendix 2	Grammatical correction. Update of DDS Regional Office information.
Subchapter M0320 Pages 2, 17	Clarify SSI recipients and meaning of presumptive and conditional approval. Clarify data field on SVES / SOLQ-I screens.
Subchapter M0330 Pages 6, 10, 32	Update of Appendix number. Clarify adult and parent in home for LIFC. Clarify example #1.
Subchapter M0410 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.	On page 5, clarified the household size for tax dependents. On page 6, clarified the household size for children living with a relative who is not a parent. On page 11, corrected an error in Example G. On page 14a, added policy on crowdsourcing income. On pages 25-27, revised the policy and procedures for the gap-filling evaluation. In Appendix 3 update of LIFC Income Limits effective July 1, 2018. Appendix 5 update of Individuals Under 21 Income Limits effective July 1, 2018.
Subchapter M0710 Appendices 2 & 3	Update of F&C MN Income Limits. Update of F&C 100% SOA Amounts.
Subchapter M0730 Table of Contents Pages 11, 15	Revise Table of Contents. On page 11 added reference about crowdfunding source. On page 15 added new section regarding crowd- funding and how to treat.
Subchapter M0810 Page 2	Update of Categorically Needy 300% and ABD Medically Needy income limits.
Subchapter M1130 Page 1, 3	Add reference of policy regarding principal place of residence;
Subchapter M1340 Page 6a	Clarify use of a credit card as part of an old bill when used for spenddown.

Changed Pages	Changes
Subchapter M1350 Page 4	Clarification of person being incarcerated and not having met a MN spenddown.
Subchapter M1360 Page 4, 4a	Add subsection regarding change in case when person is incarcerated. Add example of incarceration change.
Subchapter M1410 Page 1	Modification of term LTC to LTSS (long-term services and support) and term CBC to HCBS (home and community based services)
Subchapter M1450 Pages 35-36, 36a, Pages 37-38. Page 43	Add explanation of policy change effective April 17, 2018 and treatment of HCBS penalty period. Update for use of terms HCBS & LTSS. Update to Monthly Nursing Home Costs. Update example of penalty period calculation. Clarify a subsequent claim for an undue hardship claim.
Subchapter M1470 Pages 12a, 28	Clarify doctor's order(s) must be current and not standing order(s).
Subchapter M1480 Page 14. Page 15. Page 18a. Page 66	Replace reference to SPARK with VDSS Intranet. Remove necessity of sending loan information to DMAS. Clarify process for resource assessment undue hardship claims. Update of Maintenance Standards & Allowances amounts.
Subchapter M1510 Table of Contents Page 5. Page 9a	Update to Table of Contents. Clarify eligibility of newborn at date of birth. Add section on process for enrollment changes.
Subchapter M1520 Page 5, 5a, 21	Clarify procedure of changes for GAP and DSS. Added Page 5a. Policy reference for renewal if person loses SSI. Page 21 clarified need to verify child care costs.
Chapter M2140 Page 5	Clarify use of MAGI rules for determining household composition.

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

Karen Kimsey
Chief Deputy Director

M0130 Changes

Changed With	Effective Date	Pages Changed
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

Information about the individual's incarceration along with the verifications needed for the Medicaid application *must be provided.* Medicaid coverage for inpatient hospitalization for incarcerated individuals is based on the month of application and can include up to three months prior to the month of application, provided all eligibility requirements were met. Enroll eligible individuals in aid category (AC) 109 regardless of the covered group. AC 109 identifies the individual as eligible for coverage limited to inpatient hospitalization and ensures claims will be paid correctly.

Eligibility in AC 109 may continue as long as the individual continues to meet all Medicaid eligibility requirements and remains incarcerated. Set the first annual renewal date for 11 months from the date of application for incarcerated individuals other than pregnant women. If the individual is a pregnant woman, set the renewal date based on the expected delivery date and the post-partum period to determine if she will meet a full benefit CN covered group after the pregnancy ends. Incarcerated individuals are not referred to the Health Insurance Marketplace.

Non-citizen incarcerated individuals who meet all Medicaid eligibility requirements other than alien status may be eligible for Medicaid payment limited to emergency services received during an inpatient hospitalization. Determine eligibility for emergency services using the policy in M0220.500 B and enroll eligible individuals using the procedures in M0220.600.

All communication regarding individuals incarcerated in DOC facilities who have inpatient hospitalizations must be sent to the DOC Health Services Reimbursement Unit, 6900 Atmore Drive, Richmond, Virginia 23225.

Applications for juveniles in DJJ facilities will be coordinated through the DJJ Re-entry Services Unit, 600 E. Main Street, Richmond VA 23219.

Applications for individuals in regional or local jails may be submitted by the individual or his authorized representative.

M0130.100 Processing Time Standards

A. Processing Time Standards

1. 10 Day Requirement (Expedited Application)

a. Pregnant Women

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

If the pregnant woman also applies for other children or other persons in her family and the agency cannot determine the other persons' eligibility within

Changed With	Effective Date	Pages Changed
TN #DMAS-9	7/1/17	Page 1, 2, 14c
TN #DMAS-6	10/1/17	Page 15 Appendix 1, page 4
TN #DMAS-5	7/1/17	Pages 18, 19, 23, 24
TN #DMAS-3	1/1/17	Table of Contents Page 22a Appendix 1, page 1
TN #DMAS-2	10/1/16	Pages 13, 19-22, 23, 24
TN #DMAS-1	6/1/16	Pages 4, 4b, 5, 23
TN #100	5/1/15	Table of Contents Pages 4b, 12, 17, 18 Appendix 5, page 3 Page 4 was renumbered for clarity. Page 4a is a runover page.
TN #99	1/1/14	Table of Contents Pages19, 23, 24 Appendix 4 was removed.
TN #98	10/1/13	Pages 2-3b Appendix 1 Pages 1-5 Pages 6-18 were removed.
UP #9	4/1/13	Page 3 Appendix 1, pages 3, 17 Appendix 3, pages 3, 4
UP #8	10/1/12	Table of Contents Pages 4, 7-8, 12, 14d-20 Page 17a was deleted. Appendix 5 , page 3 Appendix 7 pages 1-5
UP #7	7/1/12	Table of Contents Pages 14d, 16-19 Appendix 5 , page 3
TN #96	10/1/11	Table of Contents Pages 2, 3, 7, 8, 14d, 18-22a, 23 Appendix 5, page 3
TN #95	3/1/11	Table of Contents Pages 3, 3a, 4-6a, 14a-14c, 17, 19, 20 Pages 22a, 23, 24 Appendices 1-2a removed. Appendix 3 and Appendices 5-8 reordered and renumbered.

M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS

M0220.001 GENERAL PRINCIPLES

A. Introduction

This subchapter explains in detail how to determine if an individual is a citizen or alien eligible for full Medicaid benefits (referred to as "full benefit aliens") or emergency services only (referred to as "emergency services aliens"). The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) made major changes to the Medicaid eligibility of non-citizens of the United States. These changes eliminated the "permanently residing under color of law" (PRUCOL) category of aliens. The Medicaid benefits for which an alien is eligible are based upon whether or not the alien is a "qualified" alien as well as the alien's date of entry into the United States.

With some exceptions, the Deficit Reduction Act of 2005 (DRA) required applicants for Medicaid and Medicaid recipients to verify their United States citizenship and identity to be able to qualify for Medicaid benefits. The citizenship and identity *(C&I)* verification requirements became effective July 1, 2006. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) allows additional exemptions from the *C&I* verification requirements *and provides states with the option to verify C&I through the use of an electronic data match with the Social Security Administration (SSA)*. It also requires states to enroll otherwise eligible individuals prior to providing *C&I* verification, and grant them a "reasonable opportunity" period after enrollment to provide documentation, if necessary.

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

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

B. Declaration of Citizenship/Alien Status

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

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

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

M0220.100 CITIZENSHIP AND NATURALIZATION

A. Introduction

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

B. Citizenship Determination

1. Individual Born in the United States

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

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

2. Individual Born Outside the U.S.

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

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

b. Individual Born to Naturalized Parents

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

c. Naturalized Individual

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

C. Verification

1. Requirements

The DRA requires that satisfactory documentation of citizenship and identity must be obtained for all enrollees who claim to be U.S. citizens. Enrollees who claim U.S. citizenship must have a declaration of citizenship AND documentary evidence of citizenship and identity in their case records.

2. Exceptions to Verification Requirements

The following groups of individuals are NOT required to provide verification of C&I. Document in the case record why an individual is exempt from verifying C&I:

See Appendix 3 to this subchapter for procedures for verifying quarters of coverage under Title II of the Social Security Act.

Any quarter of coverage, beginning after December 31, 1996, in which the alien, spouse or parent of the alien applicant received any federal means-tested public benefit (such as SSI, TANF, Supplemental Nutrition Assistance Program [SNAP] and ***full-benefit*** Medicaid) **cannot** be credited to the alien for purposes of meeting the 40 quarter requirement. *Medicaid coverage for **emergency services** does not impact the 40 quarter requirement.*

B. Services Available To Eligibles

1. Refugee, Amerasian, Asylee, Deportee, Cuban or Haitian Entrant, Victim of a Severe Form of Trafficking; Afghan or Iraqi Special Immigrant

The following immigrants:

- qualified refugee,
- Amerasian,
- asylee,
- deportee,
- Cuban or Haitian entrant,
- victim of a severe form of trafficking, or
- Afghan or Iraqi Special Immigrant (as defined in M0220.310 above),

who entered the U.S. on or after 8-22-96 and who meets all other Medicaid eligibility requirements is eligible for the full package of Medicaid covered services available to the alien's covered group during the first 7 years of residence in the U.S. After 7 years of residence in the U.S., the refugee, Amerasian, asylee, deportee, Cuban or Haitian entrant, victim of a severe form of trafficking, or Afghan or Iraqi Special Immigrant who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and is eligible for emergency services only.

2. LPR With 40 Work Quarters

After five years of residence in the U.S., an LPR with 40 or more qualifying quarters of work who entered the U.S. on or after 8-22-96 is eligible for the **full package of Medicaid benefits** available to the covered group he/she meets if he/she meets all other Medicaid eligibility requirements.

C. Entitlement & Enrollment of Eligibles

The Medicaid entitlement policy and enrollment procedures for full benefit qualified aliens who entered the U.S. on or after 8-22-96 are found in section M0220.600 below.

The Medicaid entitlement policy and enrollment procedures for emergency services qualified aliens who entered the U.S. on or after 8-22-96 are found in section M0220.700 below.

M0240 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-9	7/1/18	Table of Contents Page 6 Page 6a is a runover page
TN #DMAS-2	10/1/16	Pages 1, 4 Page 2 is a runover page.
TN #100	5/1/15	Page 2
TN #98	10/1/13	Table of Contents Pages 1-5 Page 6 was deleted.
TN #96	10/1/11	Pages 2-4
TN #94	9/1/10	Pages 1-6
TN #93	1/1/10	Pages 1-4
Update (UP) #1	7/1/09	Pages 1, 2
TN #91	5/15/09	Pages 1, 2

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M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

M0240.000 SOCIAL SECURITY NUMBER REQUIREMENTS

M0240.400 SOCIAL SECURITY NUMBER DISCREPANCIES

A. Policy

To be eligible for medical assistance (MA), an individual must provide his Social Security number (SSN) as well as the SSN of any person for whom MA is requested, or must provide proof of application for an SSN.

As required by 42 CFR 435.910(g), "The agency must verify each SSN of each applicant and recipient with the SSA [Social Security Administration], as prescribed by the Commissioner, to insure that each SSN was furnished to that individual, and to determine whether any others were issued."

In addition, 42 CFR 435.920 states, "In redetermining eligibility, the agency must review case records to determine whether they contain the recipient's SSN or, in the case of families, each family member's SSN."

The Medical Assistance enrollment system generates a Social Security number and citizenship report (RS-O-485-A) and makes the report available to the local departments of social services (LDSS) on a monthly basis. LDSS agencies are responsible for reviewing the monthly report and correcting any discrepancies. If the agency is not able to resolve SSN discrepancies in a timely manner, an ineligible individual should not receive Medicaid services. Refer to Medicaid Policy M0240.300 regarding SSN Verification Requirements.

Staff at the Department of Medical Assistance Services will oversee and monitor the process of SSN resolution on a monthly basis to ensure that action has been taken to correct Social Security Numbers in the system.

B. Process

1. *Generation of the RS-O-485-A Report*

The RS-O-485-A Report is produced monthly and posted for LDSS review.

2. *VDSS Requirements*

It is the responsibility of the LDSS to review the report and research each entry to resolve any discrepancies concerning an individual's social security number. An ineligible individual should not receive Medicaid services

VDSS is responsible for implementing the necessary procedures to ensure that all corrections or changes will be made within a 30-day period and updated in the MMIS system accordingly. Policy guidelines are located in the Medicaid Policy Manual. See Policy M0240.300

3. *DMAS review*

DMAS staff will concurrently review an internal report showing how long each individual discrepancy continues to appear. The number of new (first time) and repeat (not first time on report) occurrences will be noted. Repeat occurrences will be further broken down by those that have appeared from prior month, in the prior two months, in the prior three months, and the total that have been on the report for four or more months.

4. *Forward List to VDSS*

DMAS will provide a monthly outcome report of the number of discrepancies reported and the individuals with discrepancies that remain on the report after 90 days.

This report will be forwarded to the VDSS Medical Assistance Programs Manager and to the VDSS Regional Medicaid consultants for review. VDSS will review the report and provide to DMAS a corrective action plan for resolving the discrepancies. All discrepancies must be resolved within 30 days of receiving the report from DMAS.

M0310 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-9	7/1/18	Page 35, Appendix 2, Page 1
TN #DMAS-8	4/1/18	Page 9
TN #DMAS-7	1/1/18	Pages 34, Appendix 2, page 1
TN #DMAS-5	7/1/17	Pages 13, 37, 38
TN #DMAS-4	4/1/17	Pages 24, 30a Page 23 is a runover page. Page 24a was added as a runover page.
TN #DMAS-3	1/1/17	Pages 8, 13, 28b
TN #DMAS-2	10/1/16	Pages 4, 7, 29 Page 30 is a runover page. Appendix 2, page 1
TN #DMAS-1	6/1/16	Table of Contents, page ii Pages 13, 26, 28 Appendix 2, page 1

M0310.123 PARENT

A. Definition

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

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

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

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

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

***3.* Paternity Evidence**

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

B. Procedures

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

Section M0330.200 contains the detailed requirements for the LIFC covered group in which a parent of a dependent child can be eligible for Medicaid.

M0310.124 PREGNANT WOMAN

A. Definition

A woman of any age who attests that she is pregnant meets the definition of a pregnant woman.

1. Effective Date

At the time of application, applicants are asked if they are pregnant and if so, how many babies are expected. The pregnant woman definition is met the first day of the month *in which* the woman attests she is pregnant. She meets the definition of a pregnant woman for the retroactive period if she was pregnant during the retroactive months.

Disability Determination Services (DDS) Regional Offices

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

DDS Regional Office	Local DSS Agency Assignments	Hearing Contacts
Central Regional Office Disability Determination Services 9960 Mayland Drive, Suite 200 Richmond, Virginia 23233 Phone: 800-523-5007 804-367-4700 General FAX: 804-527-4523 Expedited FAX: 804-527-4518 Professional Relations: Alvin Gritz Office Manager: Karry Rouse Regional Director: Brett Fielding	*Accomack*, Amelia, Brunswick, *Caroline*, Charles City, Chesterfield, Colonial Heights, *Courtland*, Cumberland, Dinwiddie, Emporia, Essex, Franklin City, *Fredericksburg*, Goochland, Greensville, Hanover, Henrico, Hopewell, *Isle of Wight*, King and Queen, *King George*, King William, Lancaster, Lunenburg, Middlesex, New Kent, *Northampton*, Northumberland, Nottoway, Petersburg, Powhatan, Prince Edward, Prince George, Richmond County, Richmond City, *Spotsylvania*, *Southampton*, Surry, *Suffolk*, Sussex, *and Westmoreland.*	Primary Contact (scheduler): Jacqueline Fitzgerald 804-367-4838 Backup: Lauren Decker 804-367-4755 Fax Number for Hearings: 804-527-4518
Tidewater Regional Office Disability Determination Services 5850 Lake Herbert Drive, Suite 200 Norfolk, Virginia 23502 Phone: 800-379-4403 757-466-4300 General FAX: *866-773-0244* Expedited FAX: 757-455-3829 Professional Relations: Sandy Bouldin Office Manager: Heidi Salas Regional Director: Cheryl McCall	Chesapeake, Gloucester, Hampton, James City, Mathews, Newport News, Norfolk, Portsmouth, Poquoson, Virginia Beach, Williamsburg, *and* York	Primary Contact: *Cheryl McCall* 757-466-*3310* Backup: (vacant at this time) Fax Number for Hearings: 757-455-3829
Northern Regional Office Disability Determination Services 11150 Fairfax Boulevard, Suite 200 Fairfax, Virginia 22030-*5066* Phone: 800-379-9548 703-934-7400 General FAX: *866-843-3075* Expedited FAX: 703-*934-7410* Professional Relations: Vida Cyrus Office Manager: Rachel Cuervo Regional Director: Sharon Gottovi	Alexandria, Arlington, Clarke, Fairfax City, Fairfax County, Falls Church, Frederick, Harrisonburg, Loudoun, Manassas City, Manassas Park, Page, Prince William, Rockingham, Shenandoah, Stafford, Warren, and Winchester	Primary Contact: Vida Cyrus 703-934-*7408* Backup: Tara Lassiter 703-934-*0071* Fax Number for Hearings: 703-934-7410
Southwest Regional Office Disability Determination Services 612 S. Jefferson Street, Suite 300 Roanoke, Virginia 24011-2437 Phone: 800-627-1288 540-857-7748 General FAX: 540-*983-4977* Expedited FAX: 540-*857-2158* Professional Relations: Melissa Phillips Office Manager: Marcia Hubbard Regional Director: Betsy Stone	*Albermarle*, Alleghany, Amherst, Appomattox, *Augusta*, Bath, Bedford City, Bedford County, Bland, Botetourt, Bristol, Buchanan, Buckingham, Buena Vista, Campbell, Carroll, *Charlotte*, Charlottesville, Covington, Craig, *Culpeper*, *Danville*, Dickenson, *Fauquier*, Floyd, *Fluvanna*, *Franklin County*, *Greene*, *Halifax*, Henry, *Highland*, Lee, Lexington, Lynchburg, *Louisa*, *Madison*, Martinsville, *Mecklenburg*, Montgomery, Nelson, *Orange*, Patrick, *Pittsylvania*, Pulaski, Radford, *Rappahannock*, Roanoke County, Roanoke City, Rockbridge, Russell, Salem, Scott, Smyth, *Staunton*, *South Boston*, Tazewell, Washington, *Waynesboro*, Wise, and Wythe	Primary Contact: Lesley Gears 540-857-6027 Backup: Brenda Ragland 540-857-6470 Fax Number for Hearings: 540-857-6374

M0320 Changes

Changed With	Effective Date	Pages Changed
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

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

M0320.100 ABD CASH ASSISTANCE COVERED GROUPS

A. Legal base

Medicaid eligibility for certain individuals is based on their receipt of cash assistance from another benefit program that has a cash assistance component.

B. Procedure

The policy and procedures for cash assistance recipients are found in the following sections:

- M0320.101 SSI Recipients
- M0320.102 AG Recipients

M0320.101 SSI RECIPIENTS

A. Introduction

42 CFR 435.121 - SSI recipients are a mandatory CN covered group. *Many states automatically grant Medicaid when the individual is approved for SSI based on disability*. 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 at their local departments of social services *because they are subject to a resource evaluation.*

A Virginia SSI recipient is NOT conditionally or presumptively eligible for SSI, which means presumptively blind or disabled SSI recipients may be presumed to be blind or disabled; *though* no final blindness or disability determination *may have* been made. *As* Virginia has chosen to impose real property eligibility requirements *which* are more restrictive than the federal SSI real property eligibility requirements, *a* conditionally eligible SSI recipients *is* allowed time to dispose of excess resources.

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 other covered groups.

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

A. Introduction

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

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

The Social Security Administration (SSA) determines whether an individual who lost SSI because of earned income is eligible for 1619(b) status. The local department of social services determines whether an individual who has a 1619(b) status continues to be Medicaid eligible.

B. Identifying QSII Individuals

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

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

C. Determining Eligibility

1. Nonfinancial Eligibility

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

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

2. Financial Eligibility

a. Resource Eligibility

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

M0330 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-9	7/1/18	Pages 6, 10, 32
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

1. Adoptive Placement

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

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

For applications received prior to October 1, 2013 and renewals completed prior to April 1, 2013, financial eligibility is determined using the assistance unit procedures in subchapter M0520, which require the inclusion of the child's adoptive parent(s) and sibling(s). An adoption assistance child must have his/her eligibility determined by counting or deeming (as appropriate) his/her parent's and sibling's income.

For applications received on or after October 1, 2013, use the policies and procedures contained in chapter M04.

3. Child in ICF or ICF- ID

A child in an ICF or an ICF-ID is an institutionalized individual in a medical facility when he meets the definition of "institutionalized individual" in section M1410.010 B.2. When he meets the institutionalized individual definition, he is an assistance unit of one person.

D. Resources

There is no resource test for the Individuals Under Age 21 covered group.

E. Income

1. Income Limits

For the Individuals Under Age 21 covered group, the income limit is the income limit found in M04, *Appendix 5*.

The foster care or adoption subsidy payment is excluded when determining the unit's income eligibility.

Foster care and Adoption Assistance children in residential facilities do not have a different income limit. For a foster care/adoption assistance child living outside the State of Virginia, the income limit for the assistance unit is the income limit for the Virginia locality which holds custody, pays the adoption subsidy, or signed the adoption assistance agreement.

2. Income Exceeds F&C 100% Income Limit

For foster care (including DJJ) and adoption assistance children whose income exceeds the Individuals Under Age 21 income limit, determine the child's Medicaid eligibility in the Child Under 19 covered group and for FAMIS if the child under 19 or as an MN Individual Under Age 21 if the child is over 19 but under 21 (see M0330.804). Ineligible individuals must be referred to the Health Insurance Marketplace for evaluation for the Advance Premium Tax Credit (APTC).

F. Entitlement & Enrollment

1. Entitlement

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

A LIFC child must meet the definition of a dependent child in M0310.111. The adult with whom the child lives must be the child's parent or caretaker-relative, as defined in M0310.107. The presence of a parent in the home does not impact a stepparent's eligibility in the LIFC covered group. Both the parent and stepparent may be eligible in the LIFC covered group. When a parent*(s)* is in the home, no relative *(i.e. caretaker/relative)* other than *another parent or* a stepparent can be eligible for Medicaid in the LIFC covered group.

C. Financial Eligibility

Modified Adjusted Gross Income (MAGI) methodology is applicable to the LIFC covered group. The policies and procedures contained in Chapter M04 are used to determine eligibility for LIFC individuals.

1. Basis For Eligibility ("Assistance Unit")

The basis for financial eligibility is the LIFC individual's MAGI household. See M0430.100.

2. Resources

There is no resource test for the LIFC covered group.

3. Income

The income limits, policies and procedures used to determine eligibility in the LIFC covered group are contained in Chapter M04.

4. Income Exceeds Limit

If the individual's income exceeds the LIFC income limit, the individual is not eligible as LIFC. Ineligible individuals must be referred to the Health Insurance Marketplace for evaluation for the APTC. Spenddown does not apply to the LIFC income limits.

Note: LIFC families who have been enrolled in Medicaid for at least three of the past six months and who are no longer eligible due to excess earned income must be evaluated for continued eligibility in LIFE Extended Medicaid. See M1520.400.

D. Entitlement

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

E. Enrollment

The ACs for individuals in the LIFC covered group are:

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

Example 1:

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

Her income increased in August. Because her income increased after she established eligibility *(on May 11)* but before the date her pregnancy ended, the increase in income does not affect her Medicaid eligibility – *reference M0330.801.B5.* Her income that was verified in March is used to calculate her *for the next consecutive* spenddown *period*. She is placed on spenddown for the period September 1 through February 28, using the same spenddown amount from her previous spenddown and establishes eligibility *unless she is no longer eligible due to non-financial or resource criteria*. Her child is born on October 10. Her Medicaid coverage as a pregnant woman is canceled effective December 31, the last day of the month in which the 60th day after her pregnancy ended occurred. She no longer meets the pregnant woman covered group requirements.

Example 2:

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

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

D. Enrollment

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

M04 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-9	7/1/18	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

- Stepparents and parents are treated the same.
- Children and siblings with or without income are included in the same household as the rest of the family.
- Older children are included in the family if claimed as tax dependent by the parents.
- Married couples living together are **always** included in each other's household even if filing separately.
- Married couples that are separated and not living together but file jointly are not included in each other's household.
- Dependent parents may be included in the household if they are claimed for income tax purposes.

1. Tax Filer Household Composition

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

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

2. Tax Dependent Household Composition

means all dependents expected to be claimed by another tax filer for the taxable year. Except for Special Medical Needs AA children and children who have been in a Level C PRTF for at least 30 consecutive days, *the household of a tax dependent who does not meet an exception in M0430.100 B.2 below is the same as the tax filer's household.*

If the tax dependent is living with a tax filer other than a parent or spouse or is living separately from the parent claiming him as a dependent, the tax dependent is included in the tax filer household, but the tax filer is NOT included in the tax dependent's household.

A Special Medical Needs AA child or a child who has been in a Level C PRTF for at least 30 consecutive days is in his own household with no parents or siblings.

Exceptions to the tax household composition rules apply when:

- individuals other than biological, adopted or stepchildren are claimed as tax dependents,
- children are claimed by non-custodial parents,
- children live with both parents and expect to be claimed as a tax dependent by one parent, but parents (married or unmarried) do not expect to file jointly,
- the tax dependent is a Special Medical Needs AA child or a child who has been in a Level C PRTF for at least consecutive 30 days.

3. Non Filer Household Composition

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

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

4. Married Couple

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

5. 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 claimed as a tax dependent (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).

c. *Income already received and* 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

The following table shows each person's MAGI household:

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

Person	# - Household Composition	Reason
Gerry	4 – Gerry, Bree, Tad and Tansy	Tax filers and dependent children
Bree	4 – Gerry, Bree, Tad and Tansy	Tax filers and dependent children
Tad	4 – Gerry, Bree, Tad, Tansy	Tax filer and dependents

G. Tax Filer, Her Son and Her Nephew

Daria lives with her son, Jack age 11, and her nephew Billy age 8. All applied for MA.

Daria is a tax filer who claims her son and nephew as dependents. Her MAGI household is the same as her tax household. Jack is a tax dependent and no exceptions exist; his MAGI household is the same as the tax household. Billy is a tax dependent claimed by a tax filer who is not his parent so an exception exists and non-filer rules are used. Billy's MAGI household consists of Billy only because he has no parents or siblings in the home. The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Daria	3 – Daria, Jack and Billy	Tax filer and dependents
Jack	*3 – Daria, Jack and Billy*	*Tax filer and dependents*
Billy	1 – Billy	Non filer rules; Daria is not his parent, Jack is not his sibling

H. Tax Filer, Spouse, Their Child, His Parent Not Living In the Home

Dave lives with his wife Jean and their child, Cathy age 8. Dave files taxes separately from his wife who files her own taxes each year. Dave claims their child Cathy and his mother, Becky, as his tax dependents. Dave, Jean and Cathy applied for MA.

Dave's MAGI household includes the individuals in his tax household and his wife, Jean because married spouses are always included in each other's MAGI household. Jean is also a tax filer with no additional dependents. Jean's MAGI household includes Dave because married spouses are always included in each other's MAGI household. Cathy is a tax dependent whose parents are not filing jointly so non-filer rules are used; her MAGI household includes herself and her parents. The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Dave	4 – Dave, Jean, Cathy and Becky	Tax filer, spouse, dependent child and dependent parent
Jean	2 – Dave, Jean,	Tax filer and spouse
Cathy	3 – Cathy, Dave, Jean	Non filer rules; child and parents in home

M0440.100 HOUSEHOLD INCOME

A. General Rule

The income counted under MAGI rules is the income counted for federal tax purposes with few exceptions. All taxable income sources and some non-taxable income sources are counted for the MA eligibility determinations.

Whenever possible, income reported on the application will be verified through a data match with the federal Hub. If no data sources exists to verify the attestation,

a. payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or right or rights that support subsistence or a traditional lifestyles according to applicable Tribal Law or custom.

b. Student financial assistance provided under the Bureau of Indian Affairs Education Program.

6. Income from Crowdsourcing

Crowdsourcing or crowdfunding is a practice to raise funds online for donations, fund a project, or underwrite a venture by requesting small amounts of money from a large number of people. Examples of crowdsourcing websites include GoFundME, YouCaring, Kickstarter, or IndieGoGo. The treatment of the funds as income depends on the reason the funds were solicited.

If the individual or someone on his behalf is raising donations to go toward medical costs or bills, money raised is considered a gift and is not countable under MAGI rules.

If there is an exchange of goods or services, money raised is considered earned income and is countable. Funds deposited into an account to which the individual has access and which the individual has control over the use of are countable in the month of receipt. Platform fees or costs, including the cost per transaction, percentage of donation to the online host site, and costs to a payment processer, are not counted as income.

B. Monthly Income Determinations

Medicaid and FAMIS income eligibility is determined using current monthly income. Sources and amounts of income that are verified electronically and are reasonably compatible do not require additional verification.

When income cannot be verified electronically **or** the information reported is not reasonably compatible (see M0420.100 for the definition), the individual must be asked to provide current verification of the household income so a point-in-time income eligibility determination can be made.

Dee's eligibility determination:

Potential covered groups:

Child < Age 19
FAMIS

Monthly Income limits:

Child < Age 19 143% FPL for a HH of 2 = $1,849
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 ($1,849) 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

A. 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:

a. *The individual is claimed as a tax dependent (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.*

b. Current monthly household income, using Medicaid/FAMIS MAGI-based methods is over the applicable income limit (including the 5% FPL disregard).

c. *Income already received and* 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.

B. Non-financial Requirements

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

C. Household Income Calculation

Under the gap-filling rule, financial eligibility for Medicaid and FAMIS is determined using household income as calculated by the federal HIM for APTC purposes.

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 income for the calendar year.*
- *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.*

4. Renewals

A renewal of eligibility must be completed in January of the following year and annually thereafter. 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.

5. 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*

D. Example Situation – 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.

E. Example – Gap Filling Evaluation

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 100% FPL. Therefore, Anita is eligible for Medicaid under the gap-filling rule. The eligibility worker enrolls Anita in Medicaid.

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

LIFC INCOME LIMITS

EFFECTIVE *7/1/18*

Group I

Household Size	Income Limit
1	*$ 250*
2	*381*
3	*484*
4	*587*
5	*692*
6	*780*
7	*880*
8	*985*
Each additional person add	*104*

Group II

Household Size	
1	*$ 327*
2	*469*
3	*589*
4	*704*
5	*828*
6	*933*
7	*1,045*
8	*1,166*
Each additional person add	*117*

Group III

Household Size	
1	*$ 493*
2	*659*
3	*807*
4	*947*
5	*1,119*
6	*1,245*
7	*1,386*
8	*1,532*
Each additional person add	*142*

INDIVIDUALS UNDER AGE 21 INCOME LIMITS EFFECTIVE *7/1/18*

Group I

Household Size	Income Limit
1	*$ 239*
2	*371*
3	*475*
4	*576*
5	*678*
6	*760*
7	*860*
8	*965*
Each additional person add	*99*

Group II

Household Size	
1	*$ 324*
2	*470*
3	*588*
4	*705*
5	*832*
6	*1,026*
7	*1,045*
8	*1,165*
Each additional person add	*115*

Group III

Household Size	
1	*$ 431*
2	*578*
3	*700*
4	*819*
5	*967*
6	*1,068*
7	*1,184*
8	*1,303*
Each additional person add	*116*

M0710 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-9	7/1/18	Appendices 2 and 3
TN #DMAS-5	7/1/17	Appendices 1, 2 and 3
TN #DMAS-2	10/1/16	Appendices 2 and 3
UP #11	7/1/15	Appendix 5
TN #100	5/1/15	Table of Contents pages 1-8 Pages 9-13 were deleted. Appendices 1, 2 and 3 Appendices 4-7 were removed.
TN #98	10/1/13	pages 1-4, 8, 9 Page 1a was added. Appendices 1, 3, 5
UP #9	4/1/13	Appendix 6, pages 1, 2 Appendix 7
UP #7	7/1/12	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1
UP #6	4/1/12	Appendix 6, pages 1, 2 Appendix 7
TN #96	10/01/11	Appendix 6, page 1
UP #5	7/1/11	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1
TN #95	3/1/11	Appendix 6, pages 1, 2 Appendix 7
Update (UP) #1	7/1/09	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1

F&C MEDICALLY NEEDY INCOME LIMITS
EFFECTIVE *7/1/18*

GROUP 1			GROUP II		GROUP III	
# of Persons in Family/Budget Unit	Semi-Annual Income	Monthly Income	Semi-Annual Income	Monthly Income	Semi-Annual Income	Monthly Income
1	*1904.55*	*317.42*	*2197.56*	*366.26*	*2856.84*	*476.14*
2	*2424.75*	*404.12*	*2706.04*	*451.00*	*3444.33*	*574.05*
3	*2856.84*	*476.14*	*3149.84*	*524.97*	*3882.40*	*647.06*
4	*3223.12*	*537.18*	*3516.14*	*586.02*	*4248.69*	*708.11*
5	*3589.39*	*598.23*	*3882.24*	*647.04*	*4614.93*	*769.15*
6	*3955.65*	*659.27*	*4248.66*	*708.11*	*4981.20*	*830.20*
7	*4321.91*	*720.31*	*4614.93*	*769.15*	*5347.47*	*891.24*
8	*4761.44*	*793.57*	*5054.45*	*842.40*	*5713.74*	*952.29*
9	*5200.96*	*866.82*	*5546.76*	*924.46*	*6244.45*	*1040.74*
10	*5713.74*	*952.29*	*6006.75*	*1001.12*	*6666.04*	*1111.00*
Each add'l person add	*492.22*	*82.03*	*492.22*	*82.03*	*492.22*	*82.03*

F&C 100% STANDARD OF ASSISTANCE EFFECTIVE *7/1/18*

(Used as the F&C Deeming Standard)

Group I

Household Size	Income Limit
1	*$ 245*
2	*374*
3	*476*
4	*577*
5	*679*
6	*767*
7	*864*
8	*967*
Each additional person add	*101*

Group II

Household Size	
1	*$ 321*
2	*461*
3	*579*
4	*692*
5	*813*
6	*916*
7	*1,027*
8	*1,146*
Each additional person add	*115*

Group III

Household Size	
1	*$ 474*
2	*635*
3	*777*
4	*912*
5	*1,078*
6	*1,199*
7	*1,334*
8	*1,476*
Each additional person add	*136*

M0730 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-9	7/1/18	Table of Contents Pages 11, 15
TN #DMAS-4	4/1/17	Pages 7, 8
TN #98	10/1/13	Pages 7, 8 Page 8a was removed.
TN #97	9/1/12	Page 10
TN #94	9/1/2010	Pages 7, 8
TN #93	1/1/2010	Page 2
TN #91	5/15/2009	Table of Contents pages 7-8a

TABLE OF CONTENTS

M07 FAMILIES AND CHILDREN INCOME

M0730.000 F& C UNEARNED INCOME

M0730.522 CONTRIBUTIONS

A. Policy

1. Contribution from agencies or organization

Any cash contribution made directly to the FU/BU by an agency or organization must be counted as unearned income to the FU/BU if such contribution is for any of the following:

- food, including special diets
- clothing
- personal care
- household supplies and equipment
- insurance
- school supplies and expenses
- laundry
- utilities (including telephone)
- housekeeping and personal services
- obligations incurred within the month of application
- guardianship fees
- average shelter costs appropriate to the locality in which the assistance unit resides (including rent, house payments, taxes, fire or comprehensive insurance repairs, installations, water sewage and trash disposal

NOTE: If the contribution to the assistance unit is for one of the items listed above, it is unearned income and counted dollar for dollar. If it is not for one of the items listed above, it is not unearned income.

2. All Other Cash Contributions

All other cash contributions are counted in amount received as unearned income.

3. Income from Crowdsourcing

For contributions or donations received from crowdfunding source(s) see M0730.900

B. Procedure

- Verify with the administering agency or person contributing, the purpose of the contribution; AND
- Verify the amount of the contribution.

M0730.600 HOME ENERGY ASSISTANCE

A. Policy

Payments made directly to a household for home heating or cooling provided by suppliers of home energy, such as electric and gas companies and fuel oil dealers, must be counted as income.

B. Value of Assistance

When payments are received jointly by a household composed of Medicaid and non-Medicaid applicants/recipients, the FU/BU's pro rata share, based on the total number of persons in the household, must be considered as unearned income to the Medicaid FU/BU.

The countable income of the family unit is compared to the MI income limit for three people. $6300 exceeds the MI limit for three people ($1477). Since Baby Bear has a stepparent in the home, budget units must be formed. One budget unit contains Mr. and Mrs. Bear; the other budget unit contains Baby Bear.

Deem a portion of Mrs. Bear's income to Baby Bear:

$5000.00	Mrs. Bear's lump sum income
- 128.50	deeming standard (1/2 of 100% standard of assistance for 2 in Group II)
$4871.50	deemable income

Baby Bear's monthly income for September is $4871.50. That amount exceeds the MI Child Under 6 income limit for a budget unit of one ($874) so Baby Bear is not eligible for Medicaid in September. For October, Baby Bear has no countable income because his mother has no income in October; he is eligible for Medicaid again in October as an MI child under age 6.

M0730.900 TREATMENT OF CROWDSOURCING INCOME

A. Policy

Crowdsourcing or crowdfunding is a practice to raise funds online for donations, funding a project, or underwrite a venture, by requesting small amounts of money by a large number of people. Examples of crowdsourcing websites include GoFundME, YouCaring, Kickstarter, or IndieGoGo.

Treatment of funds received depends on the reason the funds were solicited.

B. Definition

If the individual, or someone on their behalf, is raising donations for medical costs or bills, money raised is considered a gift. See M0730.520.

If there is an exchange of goods or services, the money received is considered earned income.

If it is a fundraiser for investing in an invention and the donor gets a product or a return, it is not taxable income and but would be considered "contribution to capital" as the donor has an equity interest in the product.

C. Procedure

Funds deposited into an account to which an individual has access and control over its use would be countable to the individual in the month received. If any of the funds are retained beyond the month of receipt, the retained portion is counted as a resource to the individual.

"Platform fees"are fees or costs that would not be considered part of the income received if the monies are crowdfunding are being considered as income. Fees may include the cost per transaction or percentage of donation the online host site receives and/or costs to a payment processor.

M0810 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-9	7/1/18	Page 2
TN #DMAS-8	4/1/18	Page 2
TN #DMAS-7	1/1/18	Page 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

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	2017 Monthly Amount
1	$2,250	$2,205

4. ABD Medically Needy

a. Group I	*7/1/2018*		7/1/2017 – 6/30/18	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$ *1,904.55*	$*317.42*	$1,867.21	$311.20
2	*2,424.75*	*404.12*	2,377.24	396.20
b. Group II	*7/1/2018*		7/1/2017 – 6/30/18	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$ *2,197.56*	$*366.26*	$2,154.48	$359.08
2	*2,706.04*	*451.00*	2,653.01	442.16
c. Group III	*7/1/2018*		7/1/2017 – 6/30/18	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$ *2,856.84*	$*476.14*	$2,800.83	$466.80
2	*3,444.33*	*574.05*	3,376.83	562.80

5. ABD Categorically Needy

All Localities	2018		2017	

For:

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

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

ABD 80% FPL	Annual	Monthly	Annual	Monthly
1	$ 9,712	$810	$9,648	$804
2	13,168	1,098	12,992	1,083
QMB 100% FPL	Annual	Monthly	Annual	Monthly
1	$12,140	$1,012	$12,060	$1,005
2	16,460	1,372	16,240	1,354
SLMB 120% of FPL	Annual	Monthly	Annual	Monthly
1	$14,568	$1,214	$14,472	$1,206
2	19,752	1,646	19,488	1,624
QI 135% FPL	Annual	Monthly	Annual	Monthly
1	$16,389	$1,366	$16,281	$1,357
2	22,221	1,852	21,924	1,827
QDWI 200% of FPL	Annual	Monthly	Annual	Monthly
1	$24,280	$2,024	$24,120	$2,010
2	32,920	2,744	32,480	2,707

M1130 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-9	7/1/18	Pages 1, 3
TN #DMAS-7	1/1/18	Pages 45,78-79 Appendix 1, pages 3,5
TN #DMAS-5	7/1/17	Pages 13, 15, 78, 79 Page 14 is a runover page.
TN #DMAS-3	1/1/17	Table of Contents, page ii Page 76 Page 77 is a runover page. Pages 78 and 79 were added.
TN #DMAS-1	6/1/16	Pages 4, 14, 15
TN #100	5/1/15	Pages 13, 15, 21, 31, 33, 34 Pages 16 and 32 are runover pages.
UP #9	4/1/13	Table of Contents, page ii Pages 5, 62 Pages 62a was added.
TN#97	9/1/12	Page 14
Update #7	7/1/12	Page 24
TN #96	10/1/11	Table of Contents, page ii Pages 4, 73, 74 Appendix 1, pages 1-14 Appendix 2, page 1 Appendix 4, pages 1-8 added
TN #95	3/1/11	Pages 28, 29, 33
TN #94	9/1/10	Pages 20, 20a, 28-29a
TN #93	1/1/10	Pages 63-65 Pages 70, 74, 75
TN #91	5/15/09	Page 13

M1130.000 RESOURCES EXCLUSIONS

REAL PROPERTY

M1130.100 THE HOME

A. Policy Principles -- General Rules

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

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

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

1. Home Exclusion

Ownership of a dwelling occupied by the applicant as his home does not affect eligibility.

2. Definition of the Home

An individual's home is property that serves as his or her principal place of residence.

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

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

3. Principal Place of Residence

An individual's principal place of residence is the dwelling the individual considers his established or principal home and to which, if absent, he intends to return. It can be real or personal property, fixed or mobile, and located on land or water. Only one resource can be exempted as home property. *See M1130.100.D2 and M1460.530.B.*

4. Individual Owns the Land but Not the Shelter

For purposes of excluding "the land on which the shelter is located" (see A.2. above), it is not necessary that the individual own the shelter itself.

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

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

b. driveways connecting the homesite to public roadways.

c. land necessary to **the** homesite to meet local zoning requirements (e.g. building site, mobile home sites, road frontage, distance **from** road, etc.).

d. land necessary for compliance with state local health requirements (e.g., distance between home and septic tank(s));

e. water supply for the household.

f. existing burial plots.

g. outbuildings used in connection with dwelling, such as garages or tool sheds.

3. ABD Home Property Evaluation Worksheet

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

D. Limitations On Home Property Exclusion

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

Property ceases to be the principal place of residence, and is no longer excludable as the home, as of the date that an individual who has left the home determines that he does not intend to return to it. *See M1460.530.B for additional information.*

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

2. 6-Month Exemption

An institutionalized individual's former *home in which he has an ownership interest, and which he occupied as his residence before becoming institutionalized* is an excluded resource for six months beginning with the month following the month of the *individual's* admission to a medical institution. The following are types of medical institutions:

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

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

M1340 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-9	7/1/18	Pages 6a
TN #DMAS-7	1/1/18	Pages 18, 20, 22
TN #100	5/1/15	Pages 4, 5
TN #95	3/1/11	Page 6
TN #94	9/1/10	Page 6
TN #93	1/1/10	Page 18

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

1. Verification Request the following verification from the individual or his representative:

- proof that the bill is still owed *to the medical provider;*
  - *Use of a credit card: if the individual has used a credit card to pay an old bill and the provider is satisfied the bill as being paid, the individual has paid the provider. The amount is now owed to the credit card company and no longer considered an old bill.*
  - *Unpaid bill in collections: The worker will need to determine the status of the unpaid bill in collections. If the provider is using a third party entity to collect an old bill and the amount is still owed directly to the provider, it would be counted as an old bill. If the provider has "written" or "charged" off an old bill, it would no longer be recognized as being owed, thus would not be counted as an old bill. If a collection agency has 'purchased' a charged off debt from the provider and is attempting to collect, the individual owes the collection agency, and not the provider. Though still an owed amount, it is not recognized as an old bill.*
- if applicable, the amount owed that was not covered by the patient's insurance or liable third party,
- the service provider's name, address, and profession
- proof the service was medically necessary (prescription, physician's referral, statement from the patient's physician or dentist).

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

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

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

M1350 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-9	7/1/18	Page 4
TN #DMAS-7	1/1/18	Pages 11,12
TN #96	10/1/11	pages 7, 8

be recalculated. *Decrease in assistance unit size may include a change if an assistance unit member becomes incarcerated during a spenddown budget period.*
See section M1350.220 for procedures to follow when an assistance unit member is institutionalized.

1. **Step 1** For the months prior to the month in which the change occurred, calculate the family's income based on the number in the assistance unit at the time of application.

   For the months during which the assistance unit decreased, calculate the family's income based on the decreased number in the assistance unit.

2. **Step 2** Total the family's income for the entire 6-month spenddown budget period. The result is the family's recalculated income for the spenddown budget period.

3. **Step 3** Determine the income limit for the assistance unit size for the months prior to the change and for the month the change occurred. Determine the income limit for the assistance unit size for the number of months after the change occurred. Add together the income limits. The result is the recalculated income limit for the spenddown budget period.

4. **Step 4** Subtract the recalculated income limit from the family's recalculated income. The result is the recalculated spenddown liability for the spenddown budget period.

   If the recalculated spenddown liability is within the recalculated income limit for the six-month spenddown budget period, the assistance unit is eligible for the entire spenddown budget period. However, the assistance unit member(s) who left the unit is only eligible for the month(s) when he was included in the unit.

   $11,100 countable income for June through August
   + 9,000 countable income for September through November
   20,100 countable income for spenddown budget period of June through September
   - 3,150 MNIL for 5 persons Group III
   $16,950 spenddown liability for spenddown budget period June through November

   The family's recalculated spenddown liability for the June 1 - November 30 spenddown budget period is $16,950.

1360 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-9	7/1/18	Page 4, 4a

E. Income Increases

Recalculate the spenddown liability for the spenddown budget period based on the actual income received. If the new spenddown liability has not been met, cancel eligibility. Notify the recipient of the new spenddown liability and the balance of the spenddown liability which must be met by the last day of the spenddown budget period.

NOTE: **This subsection does not apply to medically needy pregnant women who apply for and are enrolled in Medicaid on or before the date the *pregnancy terminates.* Income increases are excluded for these MN pregnant women.**

F. Resource Changes

Redetermine the assistance unit's eligibility based on a change in resources.

1. Resources Within Limit

When resources are within the Medicaid limit, the unit remains eligible as medically needy for the remainder of the spenddown budget period.

2. Resources Exceed Limit

When the resources exceed the limit, cancel the unit's Medicaid eligibility after the advance notice is sent if the effective date of cancellation is prior to the end of the spenddown budget period. Do not change the spenddown liability or the spenddown budget period.

3. Example--Resource Change

EXAMPLE #3: Mr. and Mrs. Jones applied for Medicaid on July 10. They were put on a spenddown for the spenddown budget period July - December, which they met on August 3. They were enrolled effective August 3 through December 31. On September 2, they reported that they inherited some real property worth $20,000. It is not excluded since it is saleable. They are sent an advance notice on September 4 stating their Medicaid eligibility is canceled effective September 30 because of excess resources.

G. Change Due to Incarceration

Redetermine all persons in the assistance unit and their eligibility based on a change of household size due to incarceration of one of the persons.

1. Assistance Unit

For all individuals in the assistance unit (other than incarcerated person), see Policy M1360.100.B - Decrease of Assistance Unit.

2. Incarcerated Person

If the person is in a PG or ABD Medicaid aid category, the worker must review the case in the event income has changed. If the person is still qualified, change the person to AC109 (with no end date).

If the person had met a MN spenddown and is enrolled in a MN aid category other than PG or ABD, the worker will close the coverage.

If the person is enrolled in a MN category and continue to have income, the worker will review the case. If the person is still qualified, change to the person to AC109 with an end date (closed period of coverage).

.

Whenever a change in coverage occurs, such as the ending of coverage, changing to a different aid category, etc. it is the responsibility of the worker to alert the individual through a Notice of Action.

3. Example - Incarcerated Change

EXAMPLE #4:

Mr. Thomas is determined for AC058 and placed on a spenddown for the budget period March 1 – August 31. On May 10, he meets the SD and is enrolled effective May 10 through August 31.

On June 3, he is incarcerated. The worker reviews the case and finds him still eligible (income had not changed). The worker changes the enrollment (effective June 3) to AC109 with an end date of August 31. The worker sends a Notice of Action to alert to the new aid category AC109.

On July 17, Mr. Thomas is released. As his coverage period is still active, the worker changes coverage from AC109 and reinstates back into the same aid category (058) that was prior to the incarceration. The enrollment period as an AC058 is now July 18 – August 31. A notice of action is generated to alert individual of this change.

M1410 Changes

Changed With	Effective Date	Pages Changed
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

M1410.010 GENERAL--LONG-TERM CARE

A. Introduction

Chapter M1410 contains the rules that apply to individuals needing long-term *services and support (LTSS*). The rules are contained in the following subchapters:

- M1410 General Rules
- M1420 Pre-admission Screening
- M1430 Facility Care
- M1440 Community-based Care Waiver Services
- M1450 Transfer of Assets
- M1460 Financial Eligibility
- M1470 Patient Pay - Post-eligibility Treatment of Income
- M1480 Married Institutionalized Individuals' Financial Eligibility

The rules found within this Chapter apply to those individuals applying for or receiving Medicaid who meet the definition of institutionalization.

B. Definitions

The definitions found in this section are for terms used when policy is addressing types of long-term *services and support (LTSS*), institutionalization, and individuals who are receiving that care.

1. Authorized Representative

An **authorized representative** is a person who is authorized to conduct business for an individual. A competent individual must designate the authorized representative in a written statement, which is signed by the individual applicant. The authorized representative of an incompetent or incapacitated individual is the individual's

- spouse
- parent, if the individual is a child under age 18 years
- attorney-in fact (person who has the individual's power-of-attorney)
- legally appointed guardian
- legally appointed conservator (formerly known as the committee)
- trustee.

EXCEPTION: Patients in the Department of Behavioral Health and Developmental Services (DBHDS) facilities may have applications submitted by DBHDS staff.

2. Institutionali-zation

Institutionalization means receipt of 30 consecutive days of

- care in a medical institution (such as a nursing facility), or
- Medicaid *Home and Community-Based Services (HCBS);* or
- a combination of the two.

The definition of institutionalization is also met when an individual has a signed hospice election that has been in effect for 30 consecutive days.

The 30 days begins with the day of admission to the medical institution or receipt of Medicaid *HCBS*. The date of discharge into the community (not in *LTSS)* or death is **NOT** included in the 30 days.

The institutionalization provisions may be applied when the individual is already in a medical facility at the time of the application, or the

M1450 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-9	7/1/18	Page 35-36a, 37-38, 43
TN #DMAS-7	1/1/18	Page 4, 24, 36, 36a, 37, 41, 42 Appendix 1, Page 1.
TN #DMAS-5	7/1/17	Table of Contents Pages 13, 35, 41-44 Page 43a was renumbered. Pages 45 and 46 were added as runover pages.
TN #DMAS-3	1/1/17	Pages 30, 40-42, 44
TN #DMAS-1	6/1/16	Pages 13, 15, 35 Pages 14 and 16 are runover pages.
TN #100	5/1/15	Table of Contents Pages 17-19, 36, 37 Page 35 is a runover page.
TN #99	1/1/14	Page 7, 10, 21
UP #7	6/1/12	Table of Contents Pages 37-43 Page 43a was added.
TN #96	10/1/11	Table of Contents Pages 4-8 Pages 15, 16, 25, 26 Pages 31-38 Page 31a removed.
TN #95	3/1/11	Pages 4, 24, 32, 36, 37, 37a, Pages 39, 42, 43
TN #94	9/1/10	Table of Contents Pages 36-37a, 39-44
TN #93	1/1/10	Table of Contents Pages 3, 17-18, 29 Appendix 2, page 1
TN #91	5/15/09	Pages 41, 42

M1450.630 PENALTY PERIOD CALCULATION

A. Policy

When a transfer of assets affects eligibility, the penalty period begins when the individual would otherwise be eligible for Medicaid payment for *LTSS (long term services and support)* if not for the penalty period. The penalty period includes the fractional portion of the month, rounded down to a day. Penalty periods for multiple transfers cannot overlap.

As long as an individual in a penalty period meets a full or limited-benefit Medicaid covered group and all nonfinancial and financial requirements for that covered group, he is eligible for all services covered under that group EXCEPT the Medicaid payment of *LTSS*. Individuals in nursing and other medical facilities *or who has been screened and approved for HCBS (home and community based services)*, meet the 300% SSI covered group during a penalty period because they meet the definition of an institutionalized person.

An individual with a penalty period who does not meet the 300% SSI covered group but may meet other covered groups. See M1450.630 B.5.

B. Penalty Begin Date

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

individuals who are receiving Medicaid payment for *LTSS* at the time of transfer, the penalty period begins the month following the month of transfer.

1. **Medicaid *LTSS* Not Received at Time of Transfer**

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

2. **Receiving Medicaid *LTSS* Services at Time of Transfer**

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

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

3. **Penalty Periods Cannot Overlap**

When multiple asset transfers result in multiple penalty periods, the penalty periods cannot overlap. One penalty period must be completed prior to the beginning of the next penalty period.

4. **Nursing Facility**

If the individual in a nursing facility meets all Medicaid eligibility requirements, he is eligible for Medicaid payment of all other covered services.

5. ***HCBS*, PACE, Hospice**

a. Transfer Reported at Application

If the individual has been screened and approved for or is receiving Medicaid *HCBS*, PACE, or hospice services, he cannot be eligible for Medicaid in the 300% of SSI covered group or for the Medicaid payment of *LTSS* in any other covered group. The individual's Medicaid eligibility in other covered groups must be determined. His penalty period cannot be imposed unless and until he is (1) eligible for Medicaid in a full-benefit covered group other than the 300% of SSI covered group, (2) he meets a spenddown and would otherwise be eligible for the Medicaid payment of *LTSS*, or (3) he is admitted to a nursing facility.

Effective with eligibility determinations or re-evaluations made on or after April 17, 2018, the penalty period begin date for an individual needing HCBS is the date the individual would otherwise be receiving HCBS coverage except for the imposition of the penalty period. A penalty period would not begin prior to April 17, 2018 with this policy change. "Otherwise receiving" means that ***all*** *of the following criteria have been met:*

1. *The individual has been determined to meet all non-financial and financial eligibility requirements for Medicaid, other than asset transfer, in a full-benefit covered group,* ***including the 300% of SSI covered group****.*

2. *The individual has been screened and approved for HCBS, PACE or Hospice care.*

3. *For waivers with a waiting list, an open slot has been secured for the individual. A penalty period cannot begin while an individual is on a waiting list for waiver services.*

This change does not apply to applications denied before April 17, 2018. However, an individual who was determined ineligible for Medicaid coverage of LTSS services due to a penalty period may reapply for Medicaid and be evaluated under the new policy.

An individual who has only been eligible for limited Medicaid benefits may request to be evaluated under the new policy. All of the requirements listed above must be met in order for the penalty period to begin. If an individual was previously offered the chance to claim undue hardship, he may not claim undue hardship again on the same uncompensated asset transfer unless his circumstances have changed. Renewals as of July 2018 should be re-evaluated to see if this policy applies.

b. Transfer Reported After Eligibility is Established

If it is reported or discovered that an individual receiving *HCBS* services in the 300% of SSI covered group made an uncompensated asset transfer prior to beginning *HCBS*, determine a penalty period. Evaluate for another covered group prior to cancelling. His penalty period cannot be imposed unless and until he is (1) eligible for Medicaid in a full-benefit covered group other than the 300% of SSI covered group, (2) he meets a spenddown and would otherwise be eligible for the Medicaid payment of *LTSS*, or (3) he is admitted to a nursing facility.

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

6. **Penalty Period imposed by another state**

If the individual has completed an asset transfer penalty period in another state, a penalty period is not imposed by Virginia Medicaid for the same uncompensated transfer.

If an individual has relocated to Virginia and reports they have an active asset transfer penalty period in another state, he must complete the penalty period before being eligible for Medicaid payment of *LTSS* services. The eligibility worker must contact the previous state to find out the length of penalty period and time remaining. The remaining penalty period cannot be imposed unless and until the person is: 1) eligible for Medicaid in a full-benefit covered group other than the 300% of SSI covered group or; 2) meets a spenddown and would otherwise be eligible for the Medicaid payment of *LTSS* services or; 3) is admitted to a nursing facility. The individual's Medicaid eligibility in any other covered group(s) must be determined.

C. Penalty Period Calculation

The period is calculated by taking the uncompensated value of the assets transferred on or after the look-back date, divided by the average monthly cost of nursing facility services to a private-pay patient in his locality at the time of the application for Medicaid. The remainder is divided by the daily rate (the monthly rate divided by 31).

When the uncompensated value of an asset transfer is less than the monthly nursing facility rate, go to step #4 in E below to calculate the partial month penalty period.

D. Average Monthly Nursing Facility Cost
(Figures provided by Virginia Health Information**)**

Average Monthly Private Nursing Facility Cost

Application Date	Northern Virginia*	All Other Localities
10-1-96 to 9-30-97	$2,564	$2,564
10-1-97 to 12-31-99	$3,315	$2,585
1-1-00 to 12-31-00	$3,275	$2,596
1-1-01 to 12-31-01	$4,502	$3,376
1-1-02 to 12-31-03	$4,684	$3,517
1-1-04 to 9-30-07	$5,403	$4,060
10-1-07 to 12-31-10	$6,654	$4,954
1-1-11 to 12-31-14	$7,734	$5,933
1-1-15 *to 6-30-18*	$8,367	$5,933 (no change)
7-1-18 and after	*$9,032*	*$6,422*

*The northern Virginia localities are: Alexandria, Arlington, Fairfax, Fairfax County, Falls Church, Loudoun County, Manassas, Manassas Park and Prince William County.

See M1450, Appendix 1 for amounts prior to October 1, 1996.

E. Partial Month Transfer

The following example shows how to compute a penalty period for an uncompensated transfer that occurred on or after *July 1, 2018* and *involves* a partial month.

Example #19 *(using July 2018 figures):* An individual *living outside Northern Virginia* made an uncompensated asset transfer of *$48,294* in *July 2018*, the same month he applies for Medicaid. The uncompensated value of *$48,294* is divided by the average monthly rate of *$6,422 which* equals 7.52 months. The full 7-month penalty period runs from *July 2018*, the month of the transfer, through *January 2019*, with a partial month penalty calculated for *February 2019.* The partial month penalty is calculated by dividing the partial month penalty amount (*$3,340.00*) by the daily rate *($207.16, which is the monthly rate of $6,422 divided by 31*). The calculations are as follows:

Step #1	*$48,294.00*	*uncompensated value of transferred asset*
	÷ 6,422.00	*avg. monthly nursing facility rate at time of application*
	= 7.52	*penalty period (7 full months, plus a partial month)*
Step #2	*$ 6,422.00*	*avg. monthly nursing facility rate at time of application*
	X 7	*seven-month penalty period*
	$44,954.00	*penalty amount for seven full months*

Step #3 *$48,294.00* *uncompensated value*
- 44,954.00 *penalty amount for seven full months*
$ 3,340.00 *partial month penalty amount*

Step #4 *$3,340.00* *partial penalty amount*
÷ 207.16 *daily rate ($6,422 ÷ 31)*
= 16.12 *number of days for partial month penalty*

For *February 2019*, the partial month penalty of 16 days would be added to the seven (7) month penalty period. *This* means Medicaid would authorize payment for *LTSS* services beginning *February 17, 2019.*

F. Penalty Period for a Couple When Both Are Eligible and Institutionalized

When an institutionalized individual is ineligible for Medicaid payment of long-term care services because of a transfer made by the spouse, and the spouse is or becomes institutionalized and eligible for Medicaid, the penalty period must be apportioned between the spouses. The couple may choose to either:

- have the penalty period, or the remaining time in the penalty period, divided between the spouses, or
- assign the penalty period or remaining penalty period to one of the two spouses.

When one spouse is no longer subject to the penalty, such as one spouse is no longer institutionalized or one spouse dies, the remaining penalty period applicable to **both** spouses must be applied to the remaining spouse.

EXAMPLE #18: Mr. A. enters a nursing facility and applies for Medicaid. Mrs. A. transfers an asset that results in a 36 month penalty period for Mr. A. 12 months into the penalty period, Mrs. A. enters a nursing facility and is eligible for Medicaid. The penalty period against Mr. A. still has 24 months to run. Because Mrs. A. is now in a nursing facility and a portion of the penalty period remains, the penalty period is reviewed. Mr. and Mrs. A. decide to have the penalty period divided between them. Therefore, both Mr. A. and Mrs. A. are ineligible for Medicaid payment of *LTSS* for 12 months beginning the first day of Mrs. A's Medicaid eligibility.

After 6 months, Mr. A. leaves the facility and is no longer institutionalized. Mrs. A. remains institutionalized. Because Mr. A is no longer subject to the penalty, the remaining total penalty period for the couple, 12 months (6 months for Mr. A. and 6 months for Mrs. A.), must be imposed on Mrs. A. If Mr. A. becomes institutionalized again before the end of the 12 months, the remaining penalty period is again reviewed and divided or applied to one spouse, depending on the couple's choice.

If the individual/authorized representative alleges a change in circumstances while still in the penalty period, *a claim of undue hardship can be requested and* will follow the procedures *as found* in M1450.700 B.1. *Once DMAS makes a decision on the claim, the worker will follow the policy as below.*

a. If a subsequent claim is received and penalty period has begun

If DMAS approves the subsequent claim of undue hardship, the penalty period ends effective with the date of the discharge notice or other documentation of undue hardship. The effective date is indicated in the approval letter from DMAS. Medicaid cannot pay for *LTSS* received prior to the end of the penalty period.

b. If a subsequent claim is received and penalty period has not begun

If the individual was screened and approved for Medicaid HCBS, PACE, or hospice services but his penalty period could not be imposed per M1450.630 B.5, and DMAS approves the subsequent claim of undue hardship, the penalty period is waived. However, Medicaid cannot pay for *LTSS* received prior to the date of the documentation of undue hardship, as designated by DMAS.

M1450.800 AGENCY ACTION

A. Policy If an individual's asset transfer is not allowable by policy, the individual is not eligible for Medicaid payment of long-term care services. The individual, the service provider, and the Department of Medical Assistance Services (DMAS) must be notified of his/her ineligibility for the Medicaid payment of long-term care services, as well as his eligibility or ineligibility for Medicaid per M1450.810 below.

B. Procedures The procedures used for notifying the recipient, the provider and DMAS are in sections M1450.810, 820, and 830 below.

M1450.810 APPLICANT/RECIPIENT NOTICE

A. Policy Whenever an institutionalized individual is not eligible for Medicaid payment of long-term care services because of an asset transfer, the notice to the individual must contain the following:

1. **Notice Includes Penalty Period** The form which notifies him/her of Medicaid eligibility must include the penalty period during which Medicaid will not cover *LTSS* for the individual.

2. **Individual In Facility - Eligible** An individual in a nursing or other medical facility continues to meet the definition of an institutionalized person. If the individual meets all other Medicaid eligibility requirements, he is eligible for Medicaid in the 300% SSI covered group, except for payment for *LTSS.*

3. **Individual Not in Facility - Not Eligible** An individual outside a medical facility (i.e. living in the community) **does not** meet the definition of an institutionalized person if he is not receiving Medicaid covered *HCBS,* PACE or hospice services. Therefore, an individual for whom a penalty period is imposed cannot be eligible for Medicaid unless the individual is eligible for Medicaid outside the 300% SSI covered group.

M1470 Changes

Changed With	Effective Date	Pages Changed
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

4. Documentation Required

a. Requests For Adjustments From A Patient or Authorized Representative

Request the following documentation from the patient or his representative:

- a copy of the bill;
- if applicable, the amount owed that was not covered by the patient's insurance;
- proof that the service was medically necessary. Proof may be the prescription, doctor's referral**,** or a statement from the patient's doctor or dentist. *Proof applies to a physician, doctor, or dentist's current, and not "standing", order(s).*

4. Documentation Required

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

Request the following documentation from the patient or his representative:

- a copy of the bill;
- the amount still owed by the patient;
- if applicable, the amount owed that was not covered by the patient's insurance;
- proof that the service was medically necessary. Proof may be the prescription, doctor's referral or a statement from the patient's doctor or dentist. *Proof applies to a physician, doctor, or dentist's current, and not "standing", order(s).*

b. Requests For Adjustments From CBC Providers

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

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

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

5. Procedures

a. Determine Deduction

When the individual receives CBC services, DMAS approval **is not required** for deductions of noncovered services from patient pay, regardless of the amount of the deduction.

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

M1480 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-9	7/1/18	Pages 14, 15, 18a, 66
TN #DMAS-7	1/1/18	Pages 18c, 66
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

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

C. Appeal Rights

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

D. Eligibility Worker Responsibility

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

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

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

To expedite the application processing, the EW may include a copy of the "Intent to Transfer Assets to A Community Spouse" form, available on *the VDSS intranet* with the request for verifications.

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

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

E. Procedures

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

1. Forms

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

2. Send Judgments to DMAS

When the resource assessment or eligibility determination identifies a judgment against resources, send the documents pertaining to the judgment to DMAS for review *and how it relates to the resource* before taking action on the application. Send the documents, along with case identifying information (institutionalized spouse's and community spouse's names, address, SSN, case number) to:

Eligibility & Enrollment Services Division – Policy Unit
DMAS
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

3. Determining the First Continuous Period of Institutionaliz-ation

The spousal share is based on the couple's resources owned **on the first moment of the first day of** the first month of the first continuous period of institutionalization which occurred on or after September 30, 1989. This may be different from the current period of institutionalization. Use the information below to determine exactly when the individual's first continuous period of institutionalization began.

Inquire if the individual was ever institutionalized prior to current institutionalization but not earlier than September 30, 1989. If yes, ascertain the first date on or after September 30, 1989, on which the individual was admitted to a medical institution or the first date Medicaid CBC waiver services began.

Ask the following:

- From where was he admitted?

  If admitted from a home in the community which is not an institution as defined in section M1410.010, determine if Medicaid CBC waiver services were received and covered by Medicaid while the individual was in the home. If so, the days of Medicaid CBC receipt are "institutionalization" days.

  If admitted from another institution, ascertain the admission and discharge dates, institution's name and type of institution. The days he was in a medical institution are institutionalization days if there was less than a 30-day break between institutionalizations.

- What was the last date the individual resided outside a medical institution (in the community, at home, or in a non-medical institution)?

4. Failure to Provide Verification

a. Applicant Does Not Notify Agency of Difficulty Securing Verifications

If the applicant fails to provide requested verification of the value of the couple's resources held at the beginning of the first continuous period of institutionalization and does not notify the EW of difficulty in securing the

1) Applicant or Authorized Representative

The applicant or his authorized representative must provide a letter *or the Resource Assessment Undue Hardship Request Form – DMAS-E10* indicating the following:

- The applicant is requesting an undue hardship evaluation;
- The name of the applicant's attorney-in-fact (i.e. who has the power of attorney) or authorized representative *(if applicable*);
- The length of time the couple has been separated;
- The name of the estranged spouse and his
  - Last known address,
  - Last known employer,
  - The types (i.e. telephone, in-person visit) and number of attempts made to contact the spouse:
    - Who made the attempt
    - Date(s) the attempt(s) were made,
    - The name of the individual contacted and relationship to estranged spouse; and
- Any legal proceeding initiated, protective orders in effect, etc.

If not included with the request, the applicant or authorized representative may also be asked to provide:

- *A completed, signed, and notarized Affidavit Form (DMAS-E11);*
- *A signed and dated Assignment Form (DMAS-E12)*

A completed Resource Assessment Undue Hardship Request Form (including the affidavit and assignment forms) may be used instead of a letter from the worker but is ***not required****.*

2) Eligibility Worker

A cover sheet is to be prepared that includes the following information:

- The applicant's name and case number;
- Documentation of any actions the EW took to locate or contact the estranged spouse; *and*
- *Include any documentation provided by the applicant or authorized representative.*

The cover sheet and all information supporting the claim must be sent to:

Eligibility and Enrollment Services Division – Policy Unit
DMAS
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If DMAS determines that undue hardship does not exist, and the resource assessment cannot be completed, the EW must deny the application due to failure to verify resources held at the beginning of institutionalization.

If DMAS determines an undue hardship does exist, the EW will be sent instructions for continued processing of the case.

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	*$2057.50*	*7-1-18*	
	$2030.00	7-1-17	
C. Maximum Monthly Maintenance Needs Allowance	$3,090.00	1-1-18	
	$3,022.00	1-1-17	
D. Excess Shelter Standard	*$617.25*	*7-1-18*	
	$609.00	7-1-17	
E. Utility Standard Deduction (SNAP)	$306.00	1 - 3 household members	10-1-17
	$381.00	4 or more household members	10-1-17
	$287.00	1 - 3 household members	10-1-16
	$357.00	4 or more household members	10-1-16

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).

M1510 Changes

Changed With	Effective Date	Pages Changed
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

TABLE OF CONTENTS

M15 ENTITLEMENT POLICY & PROCEDURES

M1510.000 MEDICAID ENTITLEMENT

Medicaid medically needy eligibility factors are met in that month(s), determine if the unit meets the MN income limit for the **3-month** retroactive budget period.

When the unit's countable income exceeds the MN limit for 3 months, place the unit on a spenddown for the month(s) in which excess income existed. See subchapter M1330 for retroactive spenddown eligibility determination policy and procedures.

H. Retroactive Entitlement

Retroactive coverage can begin the first day of the third month prior to application month if all eligibility requirements are met. *An exception is eligibility for a newborn; coverage will be effective on the child's date of birth.*

NOTE: A QMB is never eligible for retroactive coverage as a QMB-only.

The applicant is entitled to Medicaid coverage for only the month(s) in which all eligibility factors were met. If all factors except income were met in all the retroactive months, then the applicant is placed on spenddown for the retroactive period. **See subchapter M1330 to determine retroactive spenddown eligibility.**

1. Retroactive Coverage Begin Date

If the applicant is eligible for retroactive coverage, he is enrolled effective the first day of the month in which he met all eligibility factors. When excess income existed in a retroactive month(s), entitlement begins the date the retroactive spenddown was met.

2. Retroactive Coverage End Date

The Medicaid recipient's retroactive Medicaid coverage expires after the last day of the retroactive month(s) in which he was entitled to Medicaid.

3. Example

EXAMPLE #5: Mr. B applied for Medicaid for himself on July 8. He reported receiving a Medicaid covered service in each retroactive month. The retroactive period is April 1 through June 30. He met all eligibility requirements in the retroactive period. He is entitled to retroactive Medicaid coverage beginning April 1 and ending June 30.

M1510.102 ONGOING ENTITLEMENT

A. Coverage Begin Date

Ongoing Medicaid entitlement for all covered groups except the QMB group begins the first day of the application month when all eligibility factors are met at any time in the month of application. Exceptions:

- when an applicant has excess income;
- when the applicant is eligible only as a QMB;
- when the applicant is age 21-64 years and is admitted to an institution for mental diseases (IMD~~), or~~ ;
- when the individual is incarcerated;
- *for a newborn, coverage will begin on the child's date of birth.*

D. Enrollment Changes

VaCMS is the MA eligibility system of record, however some enrollment functions can only be handled by the DMAS Eligibility and Enrollment Unit. The VaCMS and MMIS systems ***must*** *reflect correct coverage. Appropriate change requests include:*

- *Retroactive coverage that cannot be approved through VaCMS*
- *Duplicate linking*
- *Erroneous death cancellations*
- *Spenddown end-dates (if open-ended coverage was sent to MMIS)*
- *Missing newborn coverage*
- *Approved non-labor and delivery Emergency Services coverage*
- *Same day void*

There may be instances when VaCMS should be able to successfully update the enrollment system but does not. When this occurs, the eligibility worker must follow the steps as listed below:

- *First attempt to make the correction in VaCMS with the help of supervisors or other agency resources. If not successful;*

- *Contact the VDSS Regional Consultant (RC) for assistance. The RC will help the local worker make the correction in MMIS or VaCMS. If not successful;*

- *If either the agency resources or Regional Consultant is unable to correct the enrollment in MMIS, they can instruct the worker to submit a coverage correction to DMAS.*

- *The worker will complete a MMIS Coverage Correction Request Form (DMAS-09-1111-eng). The form can be found on the VDSS intranet. Follow the instructions as provided on the form.*

- *Once completed, the form is sent via email to: DMAS Eligibility and Enrollment Unit at: enrollment@dmas.virginia.gov. All requests should be documented in the VaCMS system.*

For GAP enrollment or changes see M1520.200.F

M1520 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-9	7/1/18	Pages 5, 5a, 21
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

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 ≤ 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 has been approved for coverage in the GAP program but has active Plan First enrollment, staff in the GAP Unit at Cover Virginia will:

- *Send a Communication Form (DMAS-09-1111-eng) to the LDSS to report the GAP eligibility.*
- *The DSS worker will close the Plan First coverage in VaCMS and send notice to the individual regarding the cancellation.*
- *The DSS worker will send a LDSS to Cover Virginia CPU/GAP Communication form to inform that the cancellation has been completed.*
- *The GAP Unit will handle the enrollment of GAP coverage in MMIS.*
- *If the cancellation of the Plan First coverage has not been completed by the DSS worker, the GAP Unit will handle the closure and enroll the individual into GAP coverage.*

If a GAP enrolled individual is determined eligible for MA, the LDSS worker:

- *Report the Medicaid eligibility by completing the LDSS to Cover Virginia CPU/GAP Communication form and forward to the GAP Unit at USA.CoverVA.DSS.Comm@Conduent.com .*
- *GAP Unit staff will close the GAP coverage, send notification to the individual of the cancellation, and alert LDSS as to the completion.*
- *Once GAP coverage is closed, the DSS eligibility worker will complete the MA enrollment; and notify the individual regarding their enrollment.*

If MA enrollment is required which was outside of the GAP period of coverage, the DSS worker will submit a MMIS Coverage Correction Request form to: enrollment@DMAS.virginia.gov. Other enrollment changes see M1510.107.D
For other enrollment changes see M1510.107.D

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.

4. Sixth Month of Extension

In the sixth month of extension, the family must be notified that it must return the "Medicaid Extension Earnings Report" for the previous three-month period (the fourth through the sixth month), with the earnings verifications for those three months attached, to the agency by the 21st day of the seventh month of extension.

The notice must state that if this three-month period's report and verifications are not returned by the 21st day of the seventh month, Medicaid coverage will be canceled effective the last day of the eighth month of extension.

VaCMS will generate this notice if the Follow-up Code in the base case information is correct. If it is not correct, the agency must manually send this notice.

5. Seventh Month of Extension

***a*. Report Received Timely**

If the second three-month period's report is received by the 21st of the seventh month, *update VaCMS* immediately upon receipt of the report and verifications. The family will continue to be eligible for extended Medicaid coverage unless:

1) no child under age 18, or if in school, a child who is expected to graduate before or in the month he turns 19, lives with the family;

2) the parent or caretaker/relative had no earnings in one or more of the previous three months, unless the lack of earnings was due to:
   - the parent's or caretaker/relative's involuntary lay-off,
   - the business closed,
   - the parent's or caretaker/relative's illness or injury,
   - other good cause (such as serious illness of child in the home which required the parent's or caretaker/relative's absence from work);

3) the family's average gross monthly **earned** income (earned income only; unearned income is not counted) less *the verified* costs for child care that was necessary for the employment of the caretaker/relative, during the preceding three-month period exceeds the 185% Federal Poverty Level (FPL) appropriate to the family unit size. See M1520, Appendix 2, for the 185% FPL income limits.

b. Calculate Family's Gross Earned Income

1) The family's gross earned income means the earned income of all family members who worked in the preceding three-month period. "Gross" earned income is total earned income before any deductions or disregards and profit from self-employment. All earned income must be counted, including students' earned income, Workforce Investment Act (WIA) earned income, children's earned income, etc. No exclusions or disregards are allowed. Use policy in M0720.200 for determining profit from self-employment.

2) Child care costs that are "necessary for the caretaker/relative's employment" are expenses that are the responsibility of the

M21 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-9	7/1/18	Page 5
TN #DMAS-8	4/1/18	Appendix 1, page 1
TN #DMAS-4	4/1/17	Appendix 1, page 1
TN #DMAS-2	1/1/17	Appendix 1, page 1
TN #DMAS-2	10/1/16	Page 3
TN #DMAS-1	6/1/16	Appendix 1, page 1
TN #100	5/1/15	Table of Contents Pages 1-7 Appendices 1 Pages 8-10 and Appendices 2 and 3 were deleted.
UP #10	5/1/14	Pages 1-3 Appendix 1
TN #99	1/1/14	Pages 1-3 Appendix 1
TN # 98	10/1/13	Table of Contents Pages 1-10 Pages 10a and 11-16 were deleted.
UP #9	4/1/13	Pages 3, 4
UP #8	10/1/12	Table of Contents Pages 2-4 Appendix 3 deleted
TN #97	9/1/12	Pages 3, 4
UP #7	7/1/12	Pages 3, 4 Appendix 2, pages 1 Appendix 3, pages 1 and 2
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	Pages 3, 8
TN #95	3/1/11	Table of Contents Pages 5, 6, 14, 15, Page 16 added Appendix 1
TN #94	9/1/10	Page3 Appendix 3, pages 1 and 2
UP #3	3/1/10	Pages 2-5
TN #93	1/1/10	Page 2-4, 8
Update (UP) #2	8/24/09	Page 4

b. Household Size

FAMIS uses MAGI methodology for determining household size (see Chapter M04).

***c.* Available Gross Income**

Retroactive period (for newborns only) – available income is the gross income actually received in each month in the retroactive period.

Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months.

***d.* Income Limits**

The FAMIS income limit is 200% of the FPL (see Appendix 1 to this subchapter) for the number of individuals in the FAMIS assistance unit. Per MAGI policy in chapter M04, a 5% FPL income disregard is applicable.

5. Spenddown

Spenddown does not apply to FAMIS. If the household's gross income exceeds the FAMIS income limits, the child is not eligible for the FAMIS program regardless of medical expenses.

M2140.100 APPLICATION and CASE PROCEDURES

A. Application Requirements

The policies in subchapters M0120 and M0130 apply.

B. Eligibility Determination

When an application is received and the child is not eligible for Medicaid due to excess income, determine eligibility for FAMIS. In order to complete an eligibility determination, both the FAMIS nonfinancial requirements in M2120.100 and the financial requirements in M2130.100 must be met. Income must be verified.

The applicant/enrollee must be notified in writing of the required information and the deadline by which the information must be received. Applications must be acted on as soon as possible, but no later than 45 days from the date the signed application was received at the local DSS.

C. Entitlement and Enrollment

1. Begin Date

Children determined eligible for FAMIS are enrolled for benefits effective the first day of the child's application month if all eligibility requirements are met in that month, **but no earlier than the date of the child's birth.**