# COMMONWEALTH of VIRGINIA

## Department of Medical Assistance Services

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October 1, 2017

**Virginia Medical Assistance Eligibility Manual**

**Transmittal #DMAS-6**

The following acronyms are used in this cover letter:

- CCC – Commonwealth Coordinated Care
- DMAS – Department of Medical Assistance Services
- FAMIS – Family Access to Medical Insurance Security Plan
- LTC – Long-term Care
- MA – Medical Assistance
- PARIS – Public Assistance Reporting Information System
- RAU – Recipient Audit Unit
- TN – Transmittal

TN #DMAS-6 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 October 1, 2017.

The following changes are contained in TN #DMAS-6:

| Changed Pages | Changes |
|---|---|
| Subchapter M0120<br>Page 1 | Clarified the enrollment time frame for a deemed newborn. |
| | |
| Subchapter M0130<br>Pages 1, 13<br>Page 14 is a runover page. | On page 1, clarified the data sources that can be used for verifications. On page 13, added policy on the Advance Healthcare Directive insert. |
| | |
| Subchapter M0220<br>Page 15<br>Appendix 1, page 4 | On page 15, clarified the policy regarding pending applicants for asylum as lawfully residing individuals. On Appendix 1, Page 4, corrected obsolete language. |
| | |
| Subchapter M0310<br>Pages 23, 24, 28a | On page 23, clarified when a disability referral is required. On page 24, corrected the formatting. On page 28a, clarified the policy on disability decisions. |
| | |
| Subchapter M0330 | Page 8, clarified that individuals who were in foster care in a United States territory can meet the criteria for the Former Foster Care Child Under 26 covered group. Page 14, clarified the policy regarding newborns. |
| | |
| Chapter M04<br>Pages 12, 13, 14b | On pages 12 and 13, clarified the verification requirements. On page 14b, clarified the instructions on household formation. |
| | |
| Subchapter M0530<br>Pages 2, 24, 30 | On page 2, revised obsolete language. On page 24, clarified the policy on changes in deeming status. On page 30, corrected the page number. |
| | |
| Subchapter M0820<br>Pages 10, 11 | On both pages, clarified the use of electronic data sources for verification of earned income. |
| | |
| Subchapter M1120<br>Page 22 | Updated the policy on special needs trusts. |
| | |
| Subchapter M1130<br>Page 55 | Corrected the page number. |
| | |
| Subchapter M1320<br>Page 2 | Clarified the policy on reapplications for individuals on a spenddown. |
| | |
| Subchapter M1350<br>Page 2 | Clarified the policy on increases in assistance unit size for the purposes of spenddown liability calculations. |
| | |
| Subchapter M1410<br>Page 11 | Clarified the procedures used when an enrollee enters LTC. |

| Changed Pages | Changes |
|---|---|
| Subchapter M1440<br>Pages 2, 4, 6 | On page 2, revised obsolete language. On pages 4-6, clarified the criteria for the CCC Plus Waiver. |
| | |
| Subchapter M1470<br>Pages 7, 22, 23 | On pages 7 and 22, clarified when the Medicare buy-in begins for new enrollees. On page 23, revised obsolete language. |
| | |
| Subchapter M1480<br>Table of Contents, page i<br>Pages 2, 50, 50a, 52, 52a, 55, 57, 59, 63, 66, 76, 79, 80, 82, 84, 86, 88, 89 | Updated the Table of Contents. On page 50, clarified the covered group hierarchy for evaluating LTC eligibility. On page 66, updated the Utility Standard Deduction, effective October 1, 2017. On all other pages, revised obsolete language. |
| | |
| Subchapter M1510<br>Table of Contents<br>Pages 1, 2<br>Page 2a is a runover page.<br>Page 2b was added as a runover page. | Updated the Table of Contents. On page 1, clarified the procedures uses when a new applicant has open coverage in another state. On page 2, clarified the PARIS data match procedures. |
| | |
| Subchapter M1520<br>Table of Contents<br>Pages 6, 7, 8, 8a, 12<br>Pages 7a and 8 were renumbered to 8 and 8a.<br>Page 12a was added as a runover page. | Updated the Table of Contents. On page 6, clarified the policy on verifying continuing blindness or disability. On pages 7-8a, clarified the policy on verifications. On page 12, added policy on extending the FAMIS renewal period for children living in declared disaster areas. |
| | |
| Chapter M17<br>Table of Contents<br>Pages 4, 7<br>Appendix 1 was deleted<br>Appendices 2 and 3 were renumbered Appendices 1 and 2, respectively. | Updated the Table of Contents. On page 4, added the fax number for the RAU. On page 7, added PARIS data match procedures. In Appendices 1 and 2, revised the forms. |
| | |
| Chapter M18<br>Table of Contents<br>Pages 3-5<br>Page 6 is a runover page.<br>Page 6a was added. | Updated the Table of Contents. On page 3, reformatted text. On page 4, added information on contacting Cover Virginia and the effective end date of CCC program. On page 5, added policy on the CCC Plus managed care program. On page 6a, clarified that pregnant women do not have copays. |
| | |
| Chapter M21<br>Page 7 | Added policy on extending the FAMIS renewal period for children living in declared disaster areas. |

| Changed Pages | Changes |
|---|---|
| Chapter M22<br>Page 7<br>Appendix 1, page 1 | On page 7, clarified the enrollment time frame for a deemed newborn. In Appendix 1, corrected the header. |

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,

Linda Nablo
Chief Deputy Director

Attachment

# M0120 Changes

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

# M0120.000 Medical Assistance Application

# M0120.100 Applying for Medical Assistance

**A. Right to Apply**

An individual cannot be refused the right to complete an application for medical assistance (MA) for himself (the applicant) or any other individual for whom he is authorized to apply. Under no circumstances can an individual be discouraged from asking for assistance for himself or any person for whom he is a legally responsible or authorized to represent. An applicant may be assisted with the application by an individual of his choice. A face-to-face interview is not required.

**B. Signed Application Required**

An application for MA must be signed to be valid. Paper forms must bear the signature of the applicant or an individual authorized to apply on his behalf. Applications submitted electronically or through the approved telephonic process meet the signature requirement.

**1. Unsigned Application**

A paper application that bears no signature is invalid. Return the application to the applicant with a letter requesting a signature.

**2. Invalid Signature**

An application that is signed by an individual who is not authorized to sign on behalf of the applicant is invalid. For paper applications, return the application with a letter indicating who must sign the application to the individual who filed the application on behalf of the applicant. See M0120, Appendix 1 for a sample letter.

If an electronic application does not bear a valid signature, the agency must obtain a valid signature from the applicant or his authorized representative for the case record. The signature page of a paper application form can be used.

# M0120.150 When An Application Is Required

**A. New Application Required**

A new application is required when there is:

- an initial request for medical assistance, or
- a request to add a person to an existing case.

When an application is received because there is a new person in the family for whom medical assistance is requested, the annual renewal for the existing enrollees is done using the same application form. See subchapter M1520 for renewal policy and procedures.

**B. Application NOT Required**

A new application is not required when an individual is already an active Medicaid enrollee or is enrolled in another medical assistance program. An application is not needed for a child turning age one when the child was deemed to be eligible based on the mother's enrollment at the time of birth. A renewal following the procedures in M1520 must be completed when the child turns one. *Act on the enrollment of a deemed newborn as soon as feasible when the birth is reported to the local DSS office or to DMAS.*

Changes in the enrollee's circumstances do not require a new application. Changes that do not require a new application include, but are not limited to,

**M0130 Changes**
**Page 1 of 2**

| Changed With | Effective Date | Pages Changed |
|---|---|---|
| TN #DMAS-6 | 10/1/17 | Pages 1, 13<br>Page 14 is a runover page. |
| 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<br>Pages 2. 4, 5, 7-10, 12, 13<br>Page 2a is a runover page.<br>Page 14 was added as a runover page. |
| TN #DMAS-1 | 6/1/16 | Table of Contents<br>Pages 4, 6, 10, 12<br>Page 11 is a runover page.<br>Page 13 was added as a runover page. |
| TN #100 | 5/1/15 | Pages 1, 2-2b, 5, 11<br>Pages 3, 6 and 2c are runover Pages. |
| UP #10 | 5/1/14 | Table of Contents<br>Pages 8-12<br>Page 13 was added. |
| TN #99 | 1/1/14 | Pages 10-12<br>Page 13 was added. |
| TN #98 | 10/1/13 | Table of Contents<br>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 |
| TN #DMAS-4 | 4/1/17 | Page 6 |
| TN #DMAS-3 | 1/1/17 | Pages 5, 7, 11 |

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

# M0130.001 Medical Assistance Application Processing Principles

**A. Introduction**

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

**B. Principles**

**1. Single Application**

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

**2. No Wrong Door**

Individuals may apply for MA through their local department of social services (LDSS), through the Health Insurance Marketplace (HIM), through CommonHelp, or through the Cover Virginia Call Center. HIM applications and telephonic applications received by the Cover Virginia Central Processing Unit (CPU) are sent to the LDSS for either case management or LDSS processing.

**3. Use of Electronic Data Source Verification**

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

LDSS are to request information from the applicant only when it is not available through an approved data source or the information is inconsistent with agency records.

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

**4. Processing Time**

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

When all necessary information is available through EDSV, it is expected that the application be processed without delay. When it is necessary to request information from the applicant and/or a disability determination is required, the processing standards in M0130.100 are applicable.

**a. Approvals**

As applicable, the notice must state that:

- the application has been approved, including the effective date(s) of coverage;
- retroactive Medicaid coverage was approved, including the effective dates.
- For approvals of limited coverage, the notice or a separate system-generated notice must state that the application has been referred to the HIM for determination of eligibility for the APTC.

**b. Denials**

As applicable, the notice must state that:

- the application has been denied, including the specific reason for denial cited from policy;
- retroactive Medicaid coverage was denied, including the specific reason for denial cited from policy.
- When the applicant (other than a Medicare beneficiary or deceased individual) is ineligible for MA for any reason other than the inability to determine eligibility, either the notice or a separate system-generated notice must state that the application has been referred to the HIM for determination of eligibility for the APTC.

**c. Delays**

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

**d. Other Actions**

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

***e. Advance Health Care Directive***

*An Advance Health Care Directive insert is required to be included with an initial notice of eligibility. The insert (available at* http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi*) must be included with the initial approval or denial Notice of Action. This insert is not required when adding a person to an existing case, at redetermination, when a change is reported or when coverage is cancelled.*

**E. Notification for Retroactive Entitlement Only**

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

## M0130.400 Applications Denied Under Special Circumstances

**A. General Principle**

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

**B. Withdrawal**

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

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

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

**C. Inability to Locate**

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

**D. Duplicate Applications**

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

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

| Changed With | Effective Date | Pages Changed |
|---|---|---|
| TN #94 | 9/1/10 | Pages 3-3b, 7-9, 14a-14d, 18, 21, 22a, 23<br>Appendix 1<br>Appendix 3, page 3 |
| Update (UP) #3 | 3/1/10 | Pages 1-3a |
| TN #93 | 1/1/10 | Table of Contents<br>Pages 7-8, 14a, 14c-14d, 15-20, 22a<br>Appendix 1<br>Appendix 3, page 3<br>Appendix 4, pages 1 and 2<br>Appendix 6, page 2 |
| TN #92 | 5/22/09 | Table of Contents<br>Pages 1-6a<br>Appendix 8 (18 pages)<br><br>Pages 4a-4t were removed and not replaced. |
| TN #91 | 5/15/09 | Page 7<br>Pages 14a, 14b<br>Page 18<br>Page 20<br>Appendix 3, page 3 |

c. aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24),

d. Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended,

e. aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President,

f. aliens currently in deferred action status, except for individuals receiving deferred status as a result of the Deferred Action for Childhood Arrivals (DACA) process, announced by the U.S. Department of Homeland Security on June 15, 2012, or

g. aliens whose visa petition has been approved and who have a pending application for adjustment of status.

5. a pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158), or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231), or under the Convention Against Torture who has been granted employment authorization, *or* such an applicant under the age of *19* who has had an application pending for at least 180 days;

6. an alien who has been granted withholding of removal under the Convention Against Torture;

7. a child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J);

8. an alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806 (e); or

9. an alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

## M0220.400 EMERGENCY SERVICES ALIENS

**A. Policy**

Any alien who does NOT meet the requirements for full benefits as described in section M0220.300 through 314 above is an "emergency services" alien and is eligible for emergency Medicaid services only, if he or she meets all of the Medicaid nonfinancial and financial eligibility requirements.

**B. Procedure**

Section M0220.410 describes the qualified aliens who entered the U.S. on or after 8-22-96 who are emergency services aliens.

Section M0220.411 defines "unqualified" aliens.

Section M0220.500 contains the Medicaid eligibility requirements applicable to full benefit and emergency services aliens.

Section M0220.*7*00 contains the entitlement and enrollment procedures for emergency services aliens.

- Applicants and Recipients. All applicants and recipients, **except** SSI recipients, Medicare beneficiaries, SSDI beneficiaries, individuals born to Medicaid-eligible mothers, all foster care children and IV-E Adoption Assistance children, must provide documents that show proof of United States citizenship and proof of the person's identity if the local DSS is unable to verify citizenship and identity using a data match with the SSA. Contact information for obtaining the various acceptable documents is available on the VDSS local agency intranet and the DSS public website and may be given to individuals to facilitate their obtaining documentation.

- DMAS, for individuals born in Puerto Rico who are unable to provide a birth certificate issued on or after July 1, 2010.

  Puerto Rico invalidated all birth certificates issued prior to July 1, 2010 and reissued the birth certificates. For individuals born in Puerto Rico **who are applying for Medicaid for the first time**, only a birth certificate issued on or after July 1, 2010 may be accepted from the individual. Should an individual born in Puerto Rico be unable to present a birth certificate issued on or after July 1, 2010, contact your Regional Medical Assistance Specialist, who will refer the case to DMAS. DMAS will obtain official birth verification on behalf of the local DSS. If the person is reapplying and the agency has a birth certificate issued prior to July 1, 2010 on record, no additional verification is required.

**2. Authorized Representative**

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

***3.* Individuals Who No Longer Meet Exception**

When an individual loses the exception status, and his citizenship and identity has not been previously verified, it must be verified for him to remain eligible for Medicaid. If the individual's eligibility in another covered group must be determined (due to the loss of SSI benefits, for example), obtain the documentation of citizenship and identity at the time of the eligibility review. If the verification is not readily available, the individual must be allowed a reasonable opportunity to obtain the documentation. See M0220.100 A 3.

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

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

Individuals do not have to submit their citizenship and identity to the agency worker in person. They may mail the original document for the agency to copy and mail back to the individual, **or they may submit a photocopy of the document(s).**

***5.* Special Populations Needing Assistance**

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

**M0310 Changes**

| Changed With | Effective Date | Pages Changed |
|---|---|---|
| TN #DMAS-6 | 10/1/17 | Pages 23, 24, 28a |
| TN #DMAS-5 | 7/1/17 | Pages 13, 37, 38 |
| TN #DMAS-4 | 4/1/17 | Pages 24, 30a<br>Page 23 is a runover page.<br>Page 24a was added as a runover page. |
| TN #DMAS-3 | 1/1/17 | Pages 8, 13, 28b |

**M0310 Changes**

| | | |
|---|---|---|
| TN #DMAS-2 | 10/1/16 | Pages 4, 7, 29<br>Page 30 is a runover page.<br>Appendix 2, page 1 |
| TN #DMAS-1 | 6/1/16 | Table of Contents, page ii<br>Pages 13, 26, 28<br>Appendix 2, page 1 |
| TN #100 | 5/1/15 | Table of Contents, pages i, ii<br>pages 11, 23, 28b,<br>Pages 27a-27c were renumbered to 28-28a for clarity.<br>Page 10 is a runover page.<br>Appendix 2 |
| UP #10 | 5/1/14 | Pages 29, 30 |
| TN #99 | 1/1/14 | Pages 6, 7, 21, 24, 25, 27a, 39 |
| TN #98 | 10/1/13 | Pages 2, 4, 27a, 27b, 28, 35, 36, 39 |
| UP #9 | 4/1/13 | Pages 24-27<br>Appendix 2 |
| TN #97 | 9/1/12 | Table of Contents, page i<br>Pages 1-5a, 10-13<br>Pages 23, 28, 29, 30a, 31<br>Pages 33, 36, 38, 39 |
| UP #7 | 7/1/12 | Table of Contents, page ii<br>Pages 23, 26, 27<br>Appendices 1-3 were removed.<br>Appendices 3 and 4 were renumbered and are now Appendices 1 and 2, respectively. |
| TN #96 | 10/1/11 | Appendix 4 |
| TN #95 | 3/1/11 | Pages 30, 30a |
| TN #94 | 9/1/10 | Pages 21-27c, 28 |
| TN #93 | 1/1/10 | Page 35<br>Appendix 5, page 1 |
| Update (UP) #2 | 8/24/09 | Table of Contents<br>Page 39 |
| TN #91 | 5/15/09 | Pages 23-25<br>Appendix 4, page 1<br>Appendix 5, page 1 |

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

**C. Procedures for Verifying Disability Status**

**1. Receives SSDI/SSI Disability Benefits**

Verify SSDI/SSI disability status through a SVES (State Verification Exchange System) or SOLQ (State Online Verification Query) request or through documentation provided to the applicant by the SSA.

**2. Receives RRB Disability Benefits**

Verify RRB disability by contacting the RRB National Telephone Service at 1-877-772-5772 or through documentation provided to the applicant by the RRB.

**3. Determined Disabled by DDS**

If disability status cannot be ascertained **after** reviewing SVES or SOLQ, contact your regional DDS office to verify disability status. Contact information for the regional DDS offices is contained in Appendix 2 of this subchapter.

**4. Incarcerated Disabled Individual**

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

**D. When a DDS Disability Determination is Required**

- The DDS makes a disability determination for Medicaid when the individual alleges a disabling condition and has never applied for disability benefits from SSA or has not been denied disability within the past 12 months; **or**
- the individual alleges a disabling condition and SSA has not yet made a determination on a pending SSDI/SSI claim; **or**
- the individual alleges a disabling condition which is different from that considered by SSA or is in addition to that considered by SSA.

An individual must have his disability determined by DDS if he:

- is claiming to have a disabling condition but does not receive SS/SSI disability benefits or RR total disability benefits, **and**
- has not been denied SSDI or SSI disability benefits in the past 12 months.

***1.*** **Individual Under Age 19 and Not Receiving Long-term Care**

A child under age 19 who is not receiving LTC services and who is claiming to have a disabling condition must have his disability determined by DDS if:

- he is not eligible for FAMIS Plus or FAMIS, or
- it is 90 calendar days prior to his 19th birthday.

Do **NOT** refer a disabled child under age 19 to DDS for the sole purpose of participation in the Health Insurance Premium Payment (HIPP) program

***2.*** **Individual Under 21 in LTC**

**a. Facility-based Care**

An individual under age 21 in a nursing facility or intermediate care facility for the intellectually disabled (ICF-ID) must have his disability determined if

- he is not eligible in the Individuals Under 21 covered group, or
- it is 90 calendar days prior to his **21st** birthday.

b. **Community-based Care (CBC)**

A child who is receiving CBC waiver services must have his disability determined 90 days prior to his **18th** birthday.

## E. When an LDSS Referral to DDS is Required

**1. Disability Determination Has Not Been Made**

The DDS must make a determination of disability when the applicant alleges a disability and a disability determination has not been made by SSA or the RRB. The DDS must make a disability determination within a time frame that will allow the LDSS to process the application within 90 days, provided all medical information has been submitted.

**2. SSA Denied Disability Within the Past 12 Months**

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

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

**OR**

b) The applicant alleges his condition has **changed** or **deteriorated** causing a new period of disability **AND** he requested SSA reopen or reconsider his claim **AND** SSA has refused to do so or denied it for non-medical reasons. Proof of the decision made by SSA is required.

If the applicant indicates that one of the above exceptions applies, the Medicaid referral should be documented appropriately and sent to the DDS. After reviewing the Medicaid referral and Social Security decision, the DDS

**J. Applicant is Deceased**

When a Medicaid applicant who has been referred to DDS dies or when the applicant is deceased at the time of the Medicaid application, DDS will determine if the disability requirement for Medicaid eligibility was met. The LDSS must immediately notify DDS of the individual's death and make every effort to provide a copy of the death certificate.

**K. Subsequent SSA or RRB Disability Decisions**

When SSA or the RRB make a disability decision subsequent to the *DDS* (Medicaid) decision which differs from the *DDS* decision, the SSA or RRB decision must be followed in determining Medicaid eligibility unless one of the conditions in M0310.112 E.2 above applies.

**1. SSA/RRB Approval**

If SSA approves disability or the RRB approves total disability, the disability definition is met. If DDS initially denied disability and the decision is reversed, re-evaluate the denied Medicaid application. The individual's Medicaid entitlement is based on the Medicaid application date, including the retroactive period, if all eligibility requirements were met during the retroactive period. However, eligibility as a disabled individual cannot begin prior to the disability onset date (month) established by SSA. Do not send the claim back to DDS for an earlier onset date.

**Disability Approved More Than 12 Months Past**

If, based upon the re-evaluation, the individual is determined to be eligible and more than 12 months have passed since the application was filed, complete an eligibility renewal to determine whether or not the individual remains eligible.

**Spenddown**

If, based upon the re-evaluation, the individual is determined not eligible for Medicaid but met the requirements in Chapter M13 for placement on a spenddown, a first prospective and additional 6 month spenddown budget periods may be established to cover the period of time between the date of application and the date action is taken on his case. A new application is not required for each 6 month spenddown budget period leading up to the date of processing, however, verification of all income and resources for those time periods must be obtained.

**2. SSA Denial or Termination And Appeal**

If SSA denies disability, the disability definition is not met. If the individual has been enrolled in Medicaid as disabled and is not eligible in another covered group, send an advance notice to the enrollee to cancel Medicaid.

If the individual appeals the SSA's disability decision timely (within 60 calendar days from the SSA notification or with good cause for exceeding 60 days) and SSA agrees to reconsider the decision, the Medicaid coverage must be reinstated until the final decision on the SSA appeal is made. **The individual must provide verification that he filed the appeal and SSA agreed to reconsider the case**. The individual must also provide verification of the decisions made at all levels of appeal in order for Medicaid to continue during the process. The Medicaid coverage will continue until a final decision is made and the individual has no right to further SSA appeals.

**M0330 Changes**

| Changed With | Effective Date | Pages Changed |
|---|---|---|
| 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<br>Page 9a was removed. |
| TN #DMAS-2 | 10/1/16 | Pages 8<br>Page 9b was renumbered to 9a. |
| TN #DMAS-1 | 6/1/16 | Pages 2, 8, 9, 15, 31, 32-35<br>Page 9b was added as a runover page. |
| TN #100 | 5/1/15 | Table of Contents<br>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<br>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<br>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<br>Page 9a was removed. |
| TN #DMAS-2 | 10/1/16 | Pages 8<br>Page 9b was renumbered to 9a. |
| TN #DMAS-1 | 6/1/16 | Pages 2, 8, 9, 15, 31, 32-35<br>Page 9b was added as a runover page. |
| TN #100 | 5/1/15 | Table of Contents<br>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<br>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<br>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 |

**2. Resources**

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

**3. Income**

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

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

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

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

**D. Entitlement & Enrollment**

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

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

## M0330.109 FORMER FOSTER CARE CHILDREN UNDER AGE 26 YEARS

**A. Policy**

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

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

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

**2. Newborn Child**

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

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

**a. Eligible To Age 1**

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

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

**b. No Other Eligibility Requirements**

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

**C. Financial Eligibility**

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

**1. Assistance Unit**

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

**2. Resources**

There is no resource test.

**3. Income**

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

**4. Income Changes After Eligibility Established**

a. Pregnant Woman

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

## M04 Changes

| Changed With | Effective Date | Pages Changed |
|---|---|---|
| TN #DMAS-6 | 10/1/17 | Pages 12, 13, 14b |
| TN #DMAS-5 | 7/1/17 | Table of Contents<br>Pages 5, 6, 12, 13, 14-14b<br>Appendices 3, 4 and 5<br>Page 6a was added as a runover page.<br>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<br>Pages 3 -5, 13a, 20<br>Appendix 6, page 1<br>Page 20a was added. |
| TN #DMAS-2 | 10/1/16 | Appendix 2, pages 1, 2<br>Appendices 3, 5 |
| TN #DMAS-1 | 6/1/16 | Pages 3, 5, 6, 12, 13, 14a<br>Appendices 1, 2, 6 and 7<br>Appendix 2, page 2 was added.<br>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<br>Appendices 1, 2, 3, 5, 6 and 7<br>Page 1 is a runover page. |
| Update (UP) #10 | 5/1/14 | Table Contents<br>Pages 2, 3, 5, 6, 10-15<br>Appendices 1, 2 and 6<br>Appendix 7 was added. |
| TN #99 | 1/1/14 | Pages 2, 5, 6, 8, 14, 15<br>Appendix 6 |

and the attestation is below the medical assistance income level, documentation of income is required. *The reported income of a child must be verified to determine whether or not it is less than the tax-filing threshold amount.*

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

## A. MAGI Income Rules

### 1. Income That is Counted

a. Gross earned income is counted. There are no earned income disregards.

b. Earnings and unearned income, including Social Security benefits, of everyone in the household are counted, except the income of a

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

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

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

d. Foreign income and interest, including tax-exempt interest, are counted.

e. Stepparent income is counted.

### 2. Income That is Not Counted

a. Child support received is not counted as income (it is not taxable income).

b. Workers Compensation is not counted.

c. When a child is included in a parent or stepparent's household, the child's income is not countable as household income unless the child is required to file taxes because the tax-filing threshold is met. Any Social Security benefits the child may have do not count in determining whether or not the tax filing threshold is met.

d. Veterans benefits which are **not** taxable in IRS pub 907 are not counted:

- Education, training, and subsistence allowances,
- Disability compensation and pension payments for disabilities paid either to veterans or their families,
- Veterans' insurance proceeds and dividends paid either to veterans or their beneficiaries, including the proceeds of a veteran's endowment policy paid before death,

- Interest on insurance dividends left on deposit with the VA,
- Benefits under a dependent-care assistance program,
- The death gratuity paid to a survivor of a member of the Armed Forces who died after September 10, 2001, or
- Payments made under the VA's compensated work therapy program.

e. Alimony **paid** to a separated or former spouse outside the home is deducted from countable income.

f. Interest paid on student loans is deducted from countable income.

g. Proceeds from life insurance are not counted.

i. A parsonage allowance is not counted.

**3. Income From Self-employment**

An individual reporting self-employment income must documentation of business expenses and income, *such as* IRS Form 1040 for the adjusted gross income, Schedule C (business expenses), Schedule E (expenses from rental income) and Schedule F (expenses from farming). *If the individual alleges that his current income is not accurately represented by tax records, obtain additional information (such as business records) that documents current income.*

Business expenses are expenses directly related to producing goods or services and without which the goods or services could not be produced. Allowable business expenses include, but are not limited to, the following:

- payments on the interest of the purchase price of, and loans for, capital assets such as real property, equipment, machinery and other goods of a durable nature;
- insurance premiums;
- legal fees;
- expenses for routine maintenance and repairs;
- advertising costs;
- bookkeeping costs.
- depreciation and capital losses. If the losses exceed income, the resulting negative dollar amount offsets other countable income.

Expenses that are not deducted for MAGI purposes include the following: payments on the principal of the purchase price of, and loans for, capital assets, such as real property, equipment, machinery and other goods of a durable nature; the principal and interest on loans for capital improvements of real property; net losses from previous periods; federal, state, and local taxes; personal expenses, entertainment expenses, and personal transportation; and money set aside for retirement purposes.

**4. Private Accident/Health Plan Benefits**

Private accident, health plan, and disability benefits are benefits paid from a plan provided by an employer or purchased by the individual. Social Security benefits and Supplemental Security Income (SSI) are not private benefits.

# M0450.100 STEPS FOR DETERMINING MAGI-BASED ELIGIBILITY

## A. Determine Household Composition

**1. Does the individual expect to file taxes?**

a. If No - Continue to Step 2

b. If Yes - Does the individual expect to be claimed as a tax dependent by anyone else?

1) If No - the household consists of the tax filer, a spouse living with the tax filer, and all persons whom the tax filer expects to claim as a tax dependent. *For a tax filer under age 19, parents living in the home are also in the individual's household.*

2) If Yes - Continue to Step 2

**2. Does the Individual Expect to be Claimed As a Tax Dependent?**

a. If No - Continue to Step 3

b. If Yes - Does the individual meet any of the following exceptions?

1) the individual expects to be claimed as a tax dependent of someone other than a spouse or a biological, adopted, or stepparent;

2) the individual is a child (under age 19) living with both parents, but the parents do not expect to file a joint tax return; or

3) the individual is a child who expects to be claimed by a non-custodial parent?

i. If no - the household is the household of the tax filer claiming her/him as a tax dependent.

ii. Is the individual married? If yes – does the household also include the individual's spouse?

iii. If yes - Continue to Step 3.

4) the child is a Special Medical Needs AA child?

If yes, continue to Step 3 below.

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

For individuals, other than Special Medical Needs AA children, who neither expect to file a tax return nor expect to be claimed as a tax dependent, as well as tax dependents who meet one of the exceptions in 2.b above, the household consists of the individual and, if living with the individual:

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

The household of a Special Medical Needs AA child consists only of the child.

**M0530 Changes**

| Changed With | Effective Date | Pages Changed |
|---|---|---|
| TN #DMAS-6 | 10/1/17 | Pages 2, 24, 30 |
| TN #DMAS-3 | 1/1/17 | Appendix 1, page 1 |
| TN #DMAS-2 | 10/1/16 | Pages 23, 24 |
| TN #DMAS-1 | 6/1/16 | Appendix 1, page 1 |
| TN #100 | 5/1/15 | Pages 14, 16, 29, 30<br>Appendix 1, page 1 |
| TN #99 | 1/1/14 | Appendix 1, page 1 |
| UP #9 | 4/1/13 | Appendix 1, page 1 |
| UP #6 | 4/1/12 | Appendix 1, page 1 |
| Update (UP) #5 | 7/1/11 | Page 14 |
| TN #95 | 3/1/11 | Page 1<br>Appendix 1, page 1 |
| TN #93 | 1/1/10 | Pages 11, 19<br>Appendix 1, page 1 |

**3. Living With Family and Children**

If the ABD individual lives with his/her spouse and/or dependent child(ren) who request Medicaid in a families and children covered group, the policy in this subchapter applies only to the ABD individual. Use the assistance unit policy in M0520 and the financial requirements in chapters M06 and M07 for the family members who meet an F&C covered group.

**4. Living Arrangement**

An ABD individual's, couple's or child's living arrangement on the first day of the month is used to determine the individual's status for the entire month. If they are living together (or child is living with parent) on the first of the month, they are living together for the entire month except when separation due to institutionalization occurs within the month. If they are living apart on the first of the month, they are considered separated for the entire month.

When an individual is admitted to an *assisted living facility (ALF)* or other residential facility, he is considered separated and living apart from his spouse (or parent if the individual is under age 21) as of the first of the month following the admission month.

**5. Institutional-ization**

When an individual is institutionalized in a medical facility, he is considered separated and living apart from his spouse (or parent if the individual is under age 21) as of the first day of the month in which he is admitted to a nursing facility or to Medicaid-approved community-based care waiver services. He is considered separated as of the first of the month during which he has been hospitalized in an acute care or rehabilitation hospital for 30 consecutive days.

Do **not** use this subchapter *for* an institutionalized individual; use the policy and procedures in chapter M14 to determine eligibility. *See M0530.204 F to determine the eligibility of a non-institutionalized spouse who has an institutionalized spouse.*

**6. Deeming From Married Parent**

When determining how much of the child's parent's income is deemed available to the child's unit, any income of the parent's spouse who is not the child's parent is not counted.

**C. Pregnant Blind or Disabled Woman**

If the blind or disabled individual also meets the pregnant woman definition, first determine the woman's eligibility in the MI Pregnant Woman covered group using the F&C assistance unit and financial eligibility rules. If she is not eligible as an MI pregnant woman, then determine her eligibility as an ABD individual.

**D. Spenddown Expenses**

If an ABD assistance unit is ineligible because of excess income, the assistance unit's member(s)'s medical expenses will count toward the spenddown. If an individual in the unit is legally liable for another person in the household who is not in the assistance unit, the other person's medical bills can count toward the unit's spenddown. If the ABD individual's spouse's or parent's income is deemed to the individual, the spouse's or parent's medical expenses are also deducted from the ABD individual's spenddown.

A medical expense can only be used once to meet only one unit's spenddown. A child's medical expenses are first deducted from the child's unit. If the child's unit spenddown is not met, the child's medical expenses

385
÷ 2 1/2 remainder earned income exclusion
192.50 couple's countable earned income
+108.00 couple's countable unearned income
*300.50* couple's total countable monthly income
x 6 months
1,803.00 countable monthly income
-1,700.00 income limit 2 in Group I
$ 103.00 excess

The couple's countable monthly income exceeds the medically needy income limit for a couple. Mr. Ingalls is placed on a spenddown of $103 for the 6-month period January 1 through June 30.

**3. Both ABD Individual and NABD Spouse Have Income--Individual Is Eligible**

**EXAMPLE #9: (Using January 2000 figures)**
Harold Bergman, a disabled individual, applies for Medicaid. He lives in Group III with his NABD spouse, who earns $259 per month. They have no children. Mr. Bergman receives a pension (unearned income) of $165 a month and earns $100 gross per month. He does not have Medicare Part A. The couple's resources are within the Medicaid limit. Because Mrs. Bergman's income exceeds the deeming standard of $257, Mrs. Bergman's income is deemed to Mr. Bergman by combining Mrs. Bergman's income with Mr. Bergman's income to calculate his MN eligibility:

$165.00 Mr. Bergman's unearned income
+ 0 Mrs. Bergman's unearned income
$165.00 couple's unearned income
- 20.00 general income exclusion
$145.00 couple's countable unearned income

$259.00 Mrs. Bergman's earned income
+100.00 Mr. Bergman's earned income
359.00 couple's earned income
- 65.00 earned income exclusion
294.00
)÷ 2 ½ remainder earned income exclusion
147.00 couple's countable earned income
+145.00 couple's countable unearned income
$292.00 couple's total countable monthly income
x 6 months
$1752.00 countable income
- 2400.00 income limit for 2 in Group III
0 excess

The couple's countable income is within the MN income limit for 2 persons, so Mr. Bergman is eligible for Medicaid as medically needy beginning January 1.

## M0530.204 CHANGES IN STATUS--MARRIED COUPLES

**A. Introduction**

Several events can change deeming status *for applicants and enrollees*. All such changes affect deeming the month after the month in which the change

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

**D. Deeming**

A parent's income and resources are deemed to an BD child beginning:

- the month following the month the child comes home;
- the month following the month a child born in a hospital comes home from the hospital;
- the month of birth when a child is born in the parent's home;
- the month after the month of adoption; the month of adoption in Virginia is the month the interlocutory order or final adoption order, whichever comes first, is entered.

**E. BD Child Assistance Unit Examples**

**EXAMPLE #17:** A blind 16-year-old child lives with his 65-year-old father and 52-year-old mother. His mother is neither blind, disabled, nor pregnant. His father does not apply for Medicaid for himself. The child is an assistance unit of one for both resource and income determinations. A portion of his parents' resources and income is deemed available to him.

**EXAMPLE #18:** A 19-year-old disabled child lives with his mother and his two brothers who are under age 18. The children's father died. The mother applies for Medicaid for herself and all children. She is not eligible in the LIFC group and she meets no other covered group. When determining the disabled child's eligibility, the disabled child is not included in an assistance unit with his mother and brothers; the disabled child is an assistance unit of one, with deemed income and resources from the mother.

## M0530.301 DEEMING RESOURCES FROM PARENTS

**A. Policy**

In determining eligibility of a BD child under 21 who lives with his parent(s), the resources of the child include the value of the countable resources of the parent(s), to the extent that the resources of the parent(s) exceed the resource limit of:

- an individual, if one parent lives in the household; or
- a couple, if two parents live in the household.

## S0820 Changes

| Changed With | Effective Date | Pages Changed |
|---|---|---|
| TN #DMAS-6 | 10/1/17 | Pages 10, 11 |
| TN #DMAS-5 | 7/1/17 | Pages 11, 13, 29, 30<br>Page 12 is a runover page. |
| TN #DMAS-3 | 1/1/17 | Pages 30, 31 |
| TN #DMAS-1 | 6/1/16 | Pages 30, 31, 47 |
| TN #100 | 5/1/15 | Pages 30, 31, 47<br>Page 48 is a runover page. |
| TN #99 | 1/1/14 | Pages 30, 31 |
| UP #9 | 4/1/13 | Pages 30, 31 |
| Update (UP) #6 | 4/1/12 | Pages 30, 31 |
| TN #95 | 3/1/11 | Pages 3, 30, 31 |
| TN #93 | 1/1/10 | Pages 30, 31 |
| TN #91 | 5/15/09 | Table of Contents<br>Pages 29, 30 |

## S0820.125 WAGE VERIFICATION IS REQUIRED

**A. Policy**

**1. When to Verify Wages**

Verification of wage amounts and frequency of receipt is required whenever an individual alleges (or you believe) he received wages, sick pay, or temporary disability.

**2. When Not to Verify Wages**

**Wage Verification Is Not Required When an Individual :**

- Alleges he has not worked or received earnings (e.g., wage/sick pay) in any month from the first month of the retroactive period through the application month and you have no reason to question the allegation, or
- Is being denied Medicaid for reasons other than earnings/income.

## M0820.127 PERIOD FOR WAGE VERIFICATION

**Procedure**

***If income cannot be verified using electronic data sources, including the Federal Data Hub, the Virginia Employment Commission, and the Work Number, verify:***

At initial application

- wages received in all retroactive months, (if a medical expense exists),
- wages for the month of application, if the applicant alleges that wages have been paid.
- wages received in the month of application, and
- wages received after month of application but prior to processing the application **if** the applicant alleges that a change in wages has occurred.
- wages used to estimate anticipated income.

At redetermination or review of income

- all unverified wages through the month immediately preceding the month the redetermination or review of income is initiated, unless
- employment began in current month.

**NOTE:** Obtain employer statement regarding wages (i.e., hourly wage, number of work hours per pay period, receipt of pay.

# S0820.130 EVIDENCE OF WAGES OR TERMINATION OF WAGES

## A. Policy

**1. Primary Evidence of Wages**

The following proofs, in order of priority, are acceptable evidence of wages:

*a. Verifications from electronic data sources, including the Virginia Employment Commission (VEC), the Federal Data Hub, and the Work Number.*

b. Pay slips--Must contain the individual's name or Social Security number, gross wages, and period of time covered by the earnings.

c. Oral statement from employer, recorded in case record.

d. Written statement from employer.

**2. Secondary Evidence of Wages**

If primary evidence is not available, the following proofs, in order of priority, are acceptable evidence of wages:

a. W-2 forms, Federal or State income tax forms showing annual wage amounts.

b. Individual's signed allegation of amount and frequency of wages.

**3. Acceptable Evidence of Termination of Wages**

The following proofs, in order of priority, are acceptable evidence of termination of wages:

*a. Verifications from electronic data sources, including the Virginia Employment Commission (VEC) or the Work Number.*

b. Oral statement from employer, recorded in case record.

c. Written statement from employer.

d. Individual's signed allegation of termination of wages (including termination date and date last paid).

## B. Procedure

**1. Order of Priority**

Seek type "a" evidence before type "b," etc.

**2. Pay Slips**

a. Stress to the individual that he/she is responsible for providing proof of wages and is expected to retain all pay stubs and provide them as requested.

b. Accept the individual's signed allegation of when earnings were received if it is not shown on the pay slip.

**NOTE:** If not all pay slips are available, but the wages attributable to the missing pay slip(s) can be determined by other evidence (e.g., year-to-date totals), it is not necessary to obtain the missing pay slip.

**M1120 Changes**

| Changed With | Effective Date | Pages Changed |
|---|---|---|
| TN #DMAS-6 | 10/1/17 | Page 22 |
| TN #DMAS-2 | 10/1/16 | On page 6, updated the format of the header. Neither the date nor the policy was changed. |
| TN #96 | 10/1/11 | Table of Contents<br>Pages 24-26 |
| TN #93 | 1/1/2010 | Page 22 |

# M1120.202 TRUSTS ESTABLISHED FOR DISABLED INDIVIDUAL ON OR AFTER AUGUST 11, 1993

**A. Introduction**

Irrevocable trusts established after August 11, 1993 solely for the benefit of disabled individuals will not affect Medicaid eligibility. The following policy must be met for trusts of disabled individuals.

Disability must be met as defined by SSA or SSI.

**B. Policy**

**1. Trusts for Disabled Individual Under Age 65 (Individual Trust)**

A trust containing the assets of an individual under age 65 who is disabled and which is established for the benefit of such individual by a

- a parent,
- a grandparent
- legal guardian of the individual,
- a court, or
- *the individual (when the trust was established on or after December 12, 2016)*

The trust policy in M1120.201 will not be applied, if the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual.

**2. Trusts for Disabled Individuals ("Pooled" Trust Funds)**

A pooled trust is one containing the assets of a disabled individual (no age requirement). The trust must meet the following conditions to be exempt from the trust policy in M1120.201.

- The trust was established by and is managed by a non-profit association.
- A separate account is maintained for each beneficiary of the trust but, for purposes of investment and management of funds, the trust pools these accounts.
- Accounts in the trust are established solely for the benefit of disabled individuals by the parent, grandparent, or legal guardian of such individuals, by such individuals or by a court.
- To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State Plan.

For an individual who meets the definition of an institutionalized individual in M1410,010 B.2, the placement of the individual's funds into a pooled trust when the individual is age 65 years or older must be evaluated as an uncompensated transfer, if the trust is structured such that the individual irrevocably gives up ownership of funds placed in the trusts. See M1450.550 D for additional information.

**M1130 Changes**

| Changed With | Effective Date | Pages Changed |
|---|---|---|
| TN #DMAS-6 | 10/1/17 | Page 55 |
| TN #DMAS-5 | 7/1/17 | Pages 13, 15, 78, 79<br>Page 14 is a runover page. |
| TN #DMAS-3 | 1/1/17 | Table of Contents, page ii<br>Page 76<br>Page 77 is a runover page.<br>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<br>Pages 16 and 32 are runover pages. |
| UP #9 | 4/1/13 | Table of Contents, page ii<br>Pages 5, 62<br>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<br>Pages 4, 73, 74<br>Appendix 1, pages 1-14<br>Appendix 2, page 1<br>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<br>Pages 70, 74, 75 |
| TN #91 | 5/15/09 | Page 13 |

If all properties meet the 6% test but the total EV exceeds $6,000, that portion of the total EV in excess of $6,000 is not excluded under this provision.

**B. Examples**

**1. Rental Property With an EV in Excess of $6,000**

At redetermination, Mr. Cameron states that he now lives in an apartment and is renting out his formerly excluded home, which has an EV of $10,000. Even if the property produces a 6% rate of return, $4,000 of its equity cannot be excluded under this provision.

**2. Multiple Income Producing Activities**

Mr. Patterson owns a mobile home (not his residence) that has a CMV and EV of $3,000. He owns other property that has a CMV and EV of $2,000. The mobile home produces a net annual rental income of $750, and the other property produces less than $50 a year.

Since the mobile home produces more than a 6% return, its EV is excluded. Since the other property produces less than a 6% return, its EV is not excluded.

**C. Operating Policy—Time Limit for Resumption of 6% Return**

**1. General Rule**

If the earnings decline was for reasons beyond the individual's control, up to 24 months can be allowed for the property to resume producing a 6% return. The 24 month period begins with the first day of the tax year following the one in which the return dropped to below 6%. See E. below for development.

**2. Initial Applications**

In an initial application, if the tax returns show that the activity has operated at a loss for the two most recent years or longer, the property cannot be excluded unless the individual submits current receipts and records to show that it currently is producing a 6% return.

**3. Trade or Business in Operation for One Year or Less**

If a trade or business has operated for a year or less, develop to determine whether a trade or business actually exists.

**M1320 Changes**

| Changed With | Effective Date | Pages Changed |
|---|---|---|
| TN #DMAS-6 | 10/1/17 | Page 2 |
| TN #DMAS-2 | 10/1/16 | Page 2<br>Page 3 is a runover page. |
| TN #95 | 3/1/11 | Page 1 |

**C. Incur Noncovered Expenses First**

The worker must inform the applicant that it is to his advantage to use the spenddown liability (excess income) for medical and dental services not covered by the Medicaid program before he uses the spenddown liability for covered services. Medicaid will not pay for noncovered medical services even after the spenddown is met.

**D. Estimate When Spenddown Liability Will Be Met**

The worker can help the applicant estimate the approximate time when the spenddown liability will be met if:

- the individual has already spent or owes for medical services received prior to, on, or after the first day of the month of application, and
- the individual anticipates medical expenditures in the near future.

**E. Reapplying at the End of the Spenddown Period**

The worker must inform the individual of the spenddown period and the need to file a reapplication if additional coverage is needed. If the individual is enrolled in the QMB, SLMB, or QDWI covered groups; is enrolled in Plan First and also meets a Medically Needy (MN) covered group; or is an MN Child Under Age 18 with $0 spenddown liability (see M0330.803), the system-generated Medicaid/*FAMIS* Renewal form may be used to establish new spenddown budget periods.

*An individual on a spenddown who is living with Medicaid and/or FAMIS enrollees can use their Medicaid/FAMIS Renewal form to reapply; the reapplication is entered into VaCMS as a new application.*

For all others, the Application for Health Insurance & Help Paying Costs is required to establish additional spenddown budget periods.

## M1320.200 PROCESSING TIME STANDARDS

**A. Applications**

**1. Processing Standards**

The time standards for Medicaid eligibility determination must be met when determining spenddown. The processing time standards are:

- 90 days for applicants whose disability must be determined and
- 45 days for all other applicants

from the date the signed Medicaid application is received by the local agency.

**2. Third Party Payment Verifications**

The standards shall also apply to receipt of third party payment or verification of third party intent to pay in order to determine allowable expenses deductible from the spenddown liability. Efforts to determine the third party liability shall continue through the last day of the processing standard period of time. If information regarding third party liability for an incurred expense is not received by this date, eligibility must be determined without deducting the expense.

**B. Changes**

The time standard for evaluating a reported change is 30 days from the date the worker receives notice of a change in circumstances or a medical or dental expense submitted by the individual.

**M1350 Changes**

| Changed With | Effective Date | Pages Changed |
|---|---|---|
| TN #DMAS-6 | 10/1/17 | Page 2<br>Page 1 is a runover page. |
| TN #96 | 10/1/11 | Pages 7, 8 |

# M1350.000 CHANGES PRIOR TO MEETING SPENDDOWN

# M1350.100 CHANGES PRIOR TO MEETING SPENDDOWN

**A. Policy**

When changes occur in the individual's or family's situation after applying for Medicaid, but before meeting the spenddown liability, the amount of countable income, the spenddown liability and the spenddown budget period may change.

**1. Retroactive Spenddown Budget Period**

The retroactive spenddown budget period is prorated (shortened) when:

- one or two of the months in the retroactive period were included in a prior Medicaid medically needy spenddown budget period in which eligibility was established, or
- the only medically needy individual in the assistance unit dies in the first or second month of the retroactive period.

**2. Prospective Budget Period**

The prospective spenddown budget period is prorated when:

- the only medically needy individual in the assistance unit dies,
- the only medically needy individual in the assistance unit becomes ineligible before the end of the spenddown budget period because of excess resources or nonfinancial reasons, or
- the individual's or assistance unit's covered group classification changes from medically needy to categorically needy or categorically needy non-money payment.

**B. Case Transfer**

When the MN assistance unit moves to a new locality, transfer the case according to procedures in section M1520.600.

It is the responsibility of the sending agency to:

1. inform the applicant of the receiving agency's name, address, and telephone number;
2. deduct all known spenddown items from the spenddown balance on the worksheet before sending the case record to the new locality;
3. note the spenddown period and balance on the case transfer form.

It is the responsibility of the receiving agency to review the spenddown to determine if a recalculation based on a different income limit is required.

**C. References**

Procedures for handling changes that occur during the spenddown budget period are in the following sections:

## M1350.200 INCREASE IN ASSISTANCE UNIT SIZE

**A. Policy**

When the assistance unit size increases and Medicaid is requested for an additional *family* member(s) *not already on a spenddown*, the spenddown budget period remains the same but the spenddown liability amount must be recalculated.

*There can be only one spenddown budget period per assistance unit. If the additional family member was already on his own spenddown when he joined the assistance unit, wait until after one of the spenddown budget periods has expired to recalculate the spenddown liability amount for the remaining budget period.*

**1. Step 1**

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

For the months during which the additional member was added to the assistance unit, calculate the family's income based on the increased 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 number of months before the change occurred. Determine the income limit for the assistance unit size for the number of months in which the additional member was included. 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 income is within the recalculated income limit for the spenddown budget period, the assistance unit is eligible for the entire spenddown budget period. However, the additional assistance unit member(s) (who was not included during the entire period) is only eligible for the month(s) when he was included in the unit.

**M1410 Changes**

| Changed With | Effective Date | Pages Changed |
|---|---|---|
| TN #DMAS-6 | 10/1/17 | Page 11 |
| 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<br>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 |

screening is not required (See M1420.400). If an individual is receiving private-pay home health services, a pre-admission screening **is required** (see M1410.200 B. above).

If an annual renewal **has been** done within the past six months, a partial review to address factors pertinent to receipt of LTC, such as asset transfer, spousal resource assessment, etc., must be done. If an annual renewal **has not** been done within the past six months, a complete renewal must be done. A new application is not required. *See subchapter M1520 for renewal procedures.*

- 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. See section M1430.104 for additional information regarding an SSI recipient who enters a nursing facility.
- Rules for married institutionalized recipients who have a community spouse are found in subchapter M1480.

**D. Notification**

When the re-evaluation is done, the EW must complete and send all required notices. See section 1410.300 below. If it is known at the time of application processing that the individual did not or will not receive LTC services, do not determine eligibility as an institutionalized individual.

## M1410.300 NOTICE REQUIREMENTS

**A. Introduction**

A notice to an applicant or recipient provides formal notification of the intended action or action taken on his/her case, the reason for this action and the authority for proposing or taking the action. The individual needs to clearly understand when the action will take place, the action that will be taken, the rules which require the action, and his right for redress.

Proper notice provides protection of the client's appeal rights as required in 1902(a)(3) of the Social Security Act.

The Notice of Action on Medicaid provides an opportunity for a fair hearing if action is taken to deny, suspend, terminate, or reduce services.

The Medicaid Long-term Care Communication Form (DMAS-225) notifies the LTC provider of changes to an enrollee's eligibility for Medicaid and for Medicaid payment of LTC services.

The notice requirements found in this section are used for all LTC cases.

Individuals in the AAL Waiver have Medicaid eligibility determined in the AG covered group (see M0320.202) and do not have Medicaid eligibility determined as institutionalized individuals. There are no post-eligibility requirements. The enrollment and notification procedures used with non-institutionalized Medicaid recipients are followed (see M0130.300).

**M1440 Changes**

| Changed With | Effective Date | Pages Changed |
|---|---|---|
| TN #DMAS-6 | 10/1/17 | Pages 2, 4-6 |
| TN #DMAS-5 | 7/1/17 | Table of Contents<br>Pages 3-9, 11, 12 |
| TN #DMAS-3 | 1/1/17 | Table of Contents<br>Pages 3-12<br>Appendix 1 was added.<br>Page 2 is a runover page.<br>Pages 13-23 were deleted. |
| UP #9 | 4/1/13 | Page 5 |
| Update (UP) #7 | 7/1/12 | Table of Contents<br>Pages 2, 14, 15, 18a-18c<br>Pages 19, 20 |
| TN #94 | 9/1/2010 | Table of Contents<br>Pages 13, 16, 18b, 19-22 |
| TN #93 | 1/1/2010 | Pages 14, 16 |
| TN #91 | 5/15/2009 | Table of Contents<br>Page 12<br>Pages 17-18c |

# M1440.010 BASIC ELIGIBILITY REQUIREMENTS

**A. Introduction**

Services provided through the Waivers can be covered by Medicaid when the applicant or recipient meets the Medicaid eligibility requirements in this section.

**B. Waiver Requirements**

The individual must meet the pre-admission screening criteria for CBC waiver services and the targeted population group requirement. Some of the targeted population groups are:

- individuals age 65 or older, blind or disabled
- individuals with *intellectual disabilities*
- individuals who need a medical device to compensate for loss of a vital bodily function
- individuals with developmental disabilities.

The eligibility worker does NOT make the determination of whether the individual meets the waiver requirements; this is determined by the pre-admission screener or by DMAS.

NOTE: The individual cannot be authorized to receive services under more than one waiver at a time.

**C. Non-financial Eligibility**

The individual must meet the Medicaid non-financial and financial eligibility requirements listed below:

**1. Citizenship/ Alienage**

The citizenship and alien status policy is found in subchapter M0220.

**2. Virginia Residency**

The Virginia state resident policy specific to CBC waiver services patients is found in subchapter M0230.

**3. Social Security Number**

The social security number policy is found in subchapter M0240.

**4. Assignment of Rights/ Cooperation**

The assignment of rights and support cooperation policy is found in subchapters M0250 and M0260.

**5. Application for Other Benefits**

The application for other benefits policy is found in subchapter M0270.

**1. Developmental Disability**

"Developmental disability," as defined in Virginia Code § 37.2-100, means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated; and (vi) an individual from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v), if the individual, without services and supports, has a high probability of meeting those criteria later in life.

**2. Financial Eligibility Criteria**

means the rules regarding asset transfers; what is a resource; when and how that resource counts; what is income; when and how that income is considered.

**3. Non-financial Eligibility Criteria**

means the Medicaid rules for non-financial eligibility. These are the rules for citizenship and alienage; state residence; social security number; assignment of rights and cooperation; application for other benefits; institutional status; cooperation DCSE; and covered group and category requirements.

**4. Patient**

an individual who has been approved by a pre-admission screener to receive Medicaid waiver services.

**C. Developmental Disabilities Waivers**

In 2016, as part of the My Life, My Community Waiver Redesign, the Intellectual Disabilities Waiver, Day Support Waiver and Individual and Family Developmental Disabilities Support Waiver (DD waiver) were renamed. They were renamed to the Community Living Waiver, Building Independence Waiver, and Family and Individual Supports Waivers, respectively. These waivers are referred to collectively as the Developmental Disabilities Waivers. The services offered under these waivers are contained in M1440, Appendix 1.

## M1440.101 COMMONWEALTH COORDINATED CARE PLUS WAIVER (FORMERLY THE EDCD AND TECHNOLOGY ASSISTED WAIVERS)

**A. General Description**

Effective July 1, 2017, the Elderly or Disabled with Consumer-Direction (EDCD) Waiver and the Technology Assisted (Tech) Waiver were combined and are known as the Commonwealth Coordinated Care (CCC) Plus Waiver. The CCC Plus Waiver is targeted to provide home and community-based services to individuals *who are* age 65 or older or disabled, *or* who have been determined to require the level of care provided in a medical institution and are at risk of facility placement. The waiver also serves "technology-assisted"

individuals who are chronically ill or severely impaired and who need both a medical device to compensate for the loss of a vital body function, as well as substantial and ongoing skilled nursing care to avert death or further disability.

Recipients may select agency-directed services, consumer-directed services, or a combination of the two. Under consumer-directed services, supervision of the personal care aide is provided directly by the recipient. Individuals who are incapable of directing their own care may have a spouse, parent, adult child, or guardian direct the care on behalf of the recipient. Consumer-directed services are monitored by a Service Facilitator.

**B. Targeted Population**

This waiver serves persons who are:

a. age 65 and over, or

b. disabled; disability may be established either by SSA, DDS, or a pre-admission screener (provided the individual meets a Medicaid covered group and another category).

Waiver services are provided to any individual who meets a Medicaid covered group and is determined to need an institutional level of care by a pre-admission screening. The individual does not have to meet the Medicaid disability definition.

Technology assisted services are provided to individuals who need both 1) a medical device to compensate for the loss of a vital body function and 2) substantial and ongoing skilled nursing care.

**C. Eligibility Rules**

All individuals receiving waiver services must meet the Medicaid non-financial and financial eligibility requirements for an eligible patient in a medical institution. The income limit used for this waiver is 300% of the current SSI payment standard for one person, or the medically needy income limit (spenddown).

The resource and income rules are applied to waiver-eligible patients as if the patients were in a medical institution.

NOTE: CCC Plus Waiver services shall not be offered to any patient who resides in a nursing facility, an intermediate care facility for the intellectually disabled (ICF/ID), a hospital, board and care facility, or an adult care residence licensed by DSS.

Individuals needing technology-assisted services must have a live-in primary care giver who accepts responsibility for the individual's health and welfare.

**D. Services Available**

LTC services available through this waiver include:

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

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

**E. Assessment and Service Authorization**

The nursing home pre-admission screeners assess and authorize CCC Plus Waiver services based on a determination that the individual is at risk of nursing facility placement.

## M1440.102 COMMUNITY LIVING WAIVER

**A. General Description**

The Community Living Waiver program, formerly the Intellectual Disabilities (ID) Waiver, is targeted to provide home and community-based services to individuals with developmental disabilities and individuals under the age of six years at developmental risk who have been determined to require the level of care provided in an ICF/ID.

**B. Eligibility Rules**

All patients receiving waiver services must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid-eligible in a medical institution. The resource and income rules are applied to waiver eligible individuals as if the individual were residing in a medical institution.

The income limit used for this waiver is 300% of the current SSI payment standard for one person**. Medically Needy individuals are not eligible for this waiver.** If the individual's income exceeds 300% SSI, the individual is not eligible for services under this waiver.

**C. Services Available**

The services available under the Community Living Waiver are included in M1440, Appendix 1.

**D. Assessment and Service Authorization**

The individual's need for CBC is determined by the Community Services Board (CSB), Behavioral Health Authority (BHA) or Department for Aging and Rehabilitative Services (DARS) case manager after completion of a comprehensive assessment.

All recommendations are submitted to Department of Behavioral Health and Developmental Services (DBHDS) or DMAS staff for final authorization.

**1. CSB**

The CSB/BHA support coordinator/case manager may only recommend waiver services if:

- the individual is found Medicaid eligible; and
- the individual is intellectually disabled, or is under age 6 and at developmental risk; and
- the individual is not an inpatient of a nursing facility or hospital.

**M1470 Changes**

| Changed With | Effective Date | Pages Changed |
|---|---|---|
| TN #DMAS-6 | 10/1/17 | Pages 7, 22, 23 |
| 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<br>Pages 1, 14, 17, 19, 20, 28a, 45-47, 50<br>Appendix 1, pages 1 and 2 |
| TN #DMAS-2 | 10/1/16 | Pages 12, 27, 28<br>Pages 12a and 28a were added as runover pages. |
| UP #11 | 7/1/15 | Pages 43-46<br>Page 46a was deleted. |
| TN #100 | 5/1/15 | Pages 2a, 4, 29, 31, 32, 34, 43, 44, 45, 53, 54<br>Pages 1a, 2, 3a and 4 were renumbered for clarity.<br>Pages 3, 4a, 46 and 46a are runover pages.<br>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<br>pages 1, 1a, 3, 3a, 11, 12,<br>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<br>Pages 1-56<br>Appendix 1 |

The amount deducted is the amount of the **monthly** premium. If the patient pays the premium less often than monthly, such as quarterly, prorate the amount paid by the number of months covered by the payment to obtain the monthly amount to deduct in the patient pay calculation.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA (Multiple Employer Welfare Arrangement) or plan provided by another benefit arrangement.

Health benefit plan does not mean accident only, credit, or disability insurance; long-term care insurance; vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance (14VAC5-234-30).

Income protection insurance (indemnity) policy premiums are not medical expenses and are not deducted from the patient pay.

Membership fees for an organization that sponsors or provides the health insurance are not part of the premium and are not deductible.

**2. Medicare Part A and/or B Premiums**

Medicare Part B premiums and/or Medicare Part A premiums are paid by Medicaid for eligible individuals. The premiums are paid by Medicaid via the "buy-in" and are not usually deducted from patient pay. However, Medicaid does not start paying the premiums immediately for all eligible patients, so the Medicare premium(s) must be deducted from patient pay in those months for which Medicaid does not pay the premium.

For Categorically Needy (CN) individuals *who do not receive a cash payment and whose income is income > 100% FPL (i.e. not dually eligible QMB)* and Medically Needy (MN) enrollees, the Medicare buy-in is effective **2 months after the begin date** of Medicaid coverage. If the begin date of coverage is other than the first day of a month, the buy-in is effective the first of the month in which the 60$^{th}$ day occurs. Part B premiums (and Part A premiums if the recipient must pay the Part A premium) must be deducted from patient pay in the month(s) in which the buy-in is not effective.

Deduct the Medicare premium(s) for the first two months of coverage for the following recipients:

- CN, non-cash payment individuals who are not dually eligible QMB,
- MN recipients who are not dually eligible QMB.

The Medicaid Medicare buy-in does NOT pay for Medicare premiums in closed periods of coverage for LTC patients who are on spenddown and whose eligibility is for a closed period. Deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from patient pay in the month(s) in which the buy-in is NOT effective.

- the premium is paid from the patient's own funds; OR

- the premium is paid by a relative (other than a spouse or parent for minor child) when that relative receives a benefit payment (income) which includes a benefit amount for the patient.

The amount deducted is the amount of the monthly premium. If the patient pays the premium less often than monthly, such as quarterly, prorate the amount paid by the number of months covered by the payment to obtain the monthly amount to deduct in the patient pay calculation.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA (Multiple Employer Welfare Arrangement) or plan provided by another benefit arrangement.

Health benefit plan does not mean accident only, credit, or disability insurance; long-term care insurance; vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance (14VAC5-234-30).

Income protection insurance (indemnity) policy premiums are not medical expenses and are not deducted from the patient pay.

Membership fees for an organization that sponsors or provides the health insurance are not part of the premium and are not deductible.

**1. Medicare Part A and/or Part B Premiums**

For Categorically Needy (CN) individuals *who do not receive a cash payment and whose income is income > 100% FPL (i.e. not dually eligible QMB)* and MN recipients, the Medicare buy-in is effective **2 months after the begin date** of Medicaid coverage. If the begin date of coverage is other than the first day of a month, the buy-in is effective the first of the month in which the 60th day occurs. Part B premiums (and Part A premiums if the recipient must pay the Part A premium) must be deducted from patient pay in the month(s) in which the buy-in is not effective.

Deduct the Medicare premium(s) for the first two months of coverage eligibility for the following recipients:

- CN, non-cash payment individuals who are not dually eligible QMB,
- MN recipients who are not dually eligible QMB.

The Medicaid Medicare buy-in does NOT pay for Medicare premiums in closed periods of coverage for LTC patients who are on spenddown and whose eligibility is for a closed period. Deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from patient pay in the month(s) in which the buy-in is NOT effective.

For cash assistance and QMB (either just QMB or dually-eligible) enrollees, the buy-in is effective with the begin date of Medicaid coverage. Therefore, do NOT deduct Medicare premiums in the patient pay determination for months in the retroactive and ongoing coverage periods.

Do not deduct Medicare premiums in retroactive and ongoing coverage periods for the following recipients:

- SSI recipients,
- AG recipients,
- ABD 80% FPL recipients,
- IV-E cash assistance recipients,
- QMB eligible recipients (either dually-eligible or just QMB).

The Medicaid Medicare buy-in pays for Medicare premiums in retroactive coverage and closed periods of coverage EXCEPT for LTC patients who are on spenddown. DO NOT deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from the patient pay in the month(s) in which the buy-in is effective for LTC patients who are NOT on spenddowns.

**2. Example - Medicare Buy-in (Using January 2009 Figures)**

Mr. A is 80 years old and started receiving CBC on February 15. He applied for Medicaid on February 2. His only income is $1500 per month. He has no Medicare Part A premium. His Part B premium is withheld from his SSA benefit. Therefore, his gross SSA entitlement is actually $1596.40. He is CN eligible, but he is not dually-eligible as QMB.

Mr. A submitted bills for January and met a retroactive spenddown in January. Ongoing Medicaid began in February because he began receiving Medicaid CBC in February and became CN. The Medicare Buy-in begins on April 1.

His Medicare Part B premium is deducted in February's and March's patient pay. April and subsequent months will not include a deduction for the Medicare premium.

**3. Medicare Advantage (Part C) Premiums**

Medicare Advantage plans, also referred to as Medicare Part C, are voluntary managed-care Medicare plans. In addition to Medicare Part B premiums, some individuals may pay an extra Medicare Advantage premium. The Medicaid Medicare buy-in is initiated for individuals with Medicare Advantage; however, the buy-in covers only the allowable Medicare Part A and/or B premiums. The individual is responsible for any additional Medicare Advantage monthly premium. The Medicare Advantage monthly premium remains the individual's responsibility and is an allowable deduction from patient pay.

**4. Medicare Part D Premiums**

An individual who is eligible for Medicare and Medicaid is entitled to enrollment in a basic Medicare Part D prescription drug plan (PDP) at no cost. However, the individual may elect enrollment in a plan with a premium.

When a full-benefit Medicaid enrollee is enrolled in a Medicare Part D PDP, *any* premium that is the individual's responsibility is an allowable deduction from patient pay.

**M1480 Changes**

| Changed With | Effective Date | Pages Changed |
|---|---|---|
| TN #DMAS-6 | 10/1/17 | Table of Contents, page i<br>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<br>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<br>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<br>Pages 20-25<br>Page 20a was deleted. |
| UP #7 | 7/1/12 | Pages 11, 14, 18c, 21<br>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,<br>Pages 69, 70 |
| TN #94 | 9/1/10 | Pages 64, 66, 69, 70 |
| TN #93 | 1/1/10 | Table of Contents, page ii<br>Pages 3, 8b, 18, 18c, 20a<br>Pages 21, 50, 51, 66,<br>Pages 69, 70, 93<br>Appendix 4 was removed. |
| Update (UP) #1 | 7/1/09 | Page 66 |
| TN # 91 | 5/15/09 | Pages 67, 68<br>Pages 76-93 |

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## M14 LONG-TERM CARE

## M1480 MARRIED INSTITUTIONALIZED INDIVIDUALS' ELIGIBILITY & PATIENT PAY

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

## M1480.010 DEFINITIONS

**A. Introduction**

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

**B. Definitions**

**1. Beginning of a Continuous Period of Institutionaliz-ation**

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

**2. Community Spouse**

means a person who:

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

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

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

**3. Community Spouse Monthly Income Allowance**

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

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

**4. Community Spouse Resource Allowance (CSRA)**

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

- the spousal share;
- the spousal resource standard;

The community spouse's income is used only to determine the community spouse monthly income allowance, if any.

**4. Income Determination**

For purposes of the income eligibility determination of a married institutionalized spouse, regardless of the individual's covered group, income is determined using the income eligibility instructions in section M1480.310 below and chapter S08.

For individuals who are within a spenddown budget period prior to the month in which they become institutionalized, prorate and shorten the spenddown budget period to include months **prior to admission** to long-term care services. A separate monthly budget period is established for each month of receipt of long-term care services.

**5. Post-eligibility Treatment of Income**

After an institutionalized spouse is determined eligible for Medicaid, his or her patient pay must be determined. See the married institutionalized individuals' patient pay policy and procedures in section M1480.400 below.

# M1480.310 ABD 80% FPL AND 300% SSI AND INCOME ELIGIBILITY DETERMINATION

**A. Introduction**

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

*For ABD individuals, first determine the individual's eligibility in the ABD 80% FPL covered group. If the individual is ineligible in the ABD 80% FPL covered group, determine the individual's eligibility in the 300% SSI covered group.*

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

**B. 300% SSI Group**

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

**1. Gross Income**

**Income sources listed in section M1460.610 are not considered as income.**

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

All other income is counted. The institutionalized spouse's gross income is counted; no exclusions are subtracted.

To determine an income type or source and to determine how to count the income, use the policy and procedures in chapter S08 for all individuals (ABD and F&C) in the 300% SSI group.

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

**2. Income Less Than or Equal to 300% SSI Limit**

If the individual's gross income is less than or equal to the 300% SSI income limit, enroll the individual in the appropriate CN *aid category (AC)* and determine patient pay according to the policy and procedures found in section M1480.400.

**a. Individual Has Medicare Part A**

If the individual has Medicare Part A, determine if his income is within the QMB income limit. Calculate the individual's countable income for QMB according to chapter S08, and compare to the QMB limit. If the individual's gross income is less than or equal to the QMB limit, enroll the recipient with the appropriate dual-eligible QMB AC:

- Aged = 022
- Blind = 042
- Disabled = 062

If the income is over the QMB limit, enroll the recipient with the appropriate CN non-QMB AC:

- Aged = 020
- Blind = 040
- Disabled = 060

**b. Individual Does Not Have Medicare Part A**

If the individual does NOT have Medicare Part A, enroll the ABD recipient with the appropriate CN AC:

- Aged = 020
- Blind = 040
- Disabled= 060

Enroll the F&C recipient with the appropriate CN AC:

- Institutionalized child under age 21= 082
- Institutionalized F&C individual age 21 or older = 060.

**3. Income Exceeds 300% SSI Limit**

If income exceeds the 300% SSI limit, evaluate the institutionalized spouse as MN. Go to section M1480.330 below.

# M1480.320 RETROACTIVE MN INCOME DETERMINATION

**A. Policy**

The retroactive spenddown budget period is the three months immediately prior to the application month, when none of the months overlap (was included in) a previous MN spenddown budget period in which spenddown eligibility was established. When some of the months overlap a previous MN spenddown budget period in which spenddown eligibility was established, the retroactive spenddown budget period is shortened (prorated) to include only the month (s) which were not included in the previous MN spenddown budget period.

**1. Institutionalized**

For the retroactive months in which the individual was institutionalized, determine income eligibility on a **monthly basis** using the policy and procedures in this subchapter. A spenddown must be established for a month during which excess income existed.

**2. Individual Not Institutionalized**

For the retroactive months in which the individual was NOT institutionalized, determine income eligibility for ABD groups using the ABD policy and procedures in chapter S08. Determine income eligibility for F&C groups using policy and procedures in chapter M07. A spenddown must be established for a month(s) during which excess income existed.

**3. Retroactive Entitlement**

If the applicant meets all eligibility requirements, he is entitled to Medicaid coverage for the month(s) in which all eligibility factors were met.

**B. Countable Income**

Countable income is that which was actually received in the retroactive month(s). Count the income received in the months in which the individual meets all other Medicaid eligibility requirements.

The countable income is compared to the appropriate income limit for the retroactive month, if the individual was CN in the month. **For the institutionalized MN individual, Medicaid income eligibility is determined monthly.**

**C. Entitlement**

Retroactive coverage cannot begin earlier than the first day of the third month prior to the application month. When an applicant reports that he received a medical service within the retroactive period, entitlement for Medicaid will begin with the first day of the third month prior to the application month, provided all eligibility factors were met in all three months. If the applicant had excess income in the retroactive period and met his spenddown, he is enrolled beginning the first day of the month in which his retroactive spenddown was met. For additional information refer to section M1510.101.

**D. Retroactive Example**

**EXAMPLE #15:** A disabled institutionalized spouse applies for Medicaid on June 5 and requests retroactive coverage for unpaid medical bills that he incurred in March, April, and May. His disability onset date was April 10. He was institutionalized on April 10. The retroactive period is March, April and May. He is not eligible for March because he did not meet a covered group in March. His countable resources are less than $2,000 in April, May and June. The income he received in April and May is counted monthly because he was institutionalized in each month.

His April income is calculated and compared to the monthly 300% SSI income limit. It exceeds that limit. His May income is calculated and compared to the monthly 300% SSI income limit; it is within the limit. Therefore, he is placed on a one-month retroactive spenddown for April, and is enrolled in retroactive Medicaid in the 300% SSI covered group for May.

## M1480.330 MEDICALLY NEEDY INCOME & SPENDDOWN

**A. Policy**

An institutionalized spouse whose income exceeds the 300% SSI income limit must be placed on a monthly MN spenddown if he meets a medically needy MN covered group and has countable resources that are less than or equal to the MN resource limit. His income is over the MN income limit because 300% of SSI is higher than the highest MN income limit for one person for one month.

MN countable income must be calculated to exclude income and portions of income that were counted in the 300% SSI income limit group calculation. Income is determined on a monthly basis and an institutionalized individual's spenddown budget period is one month. The certification period for all long term care cases is 12 months from the last application or redetermination month. This includes MN cases placed on spenddown.

**B. Recalculate Income**

Evaluate income eligibility for an institutionalized spouse who has income over the 300% SSI income limit using a one-month budget period and the following procedures:

**1. ABD MN Covered Groups**

The income sources listed in both sections M1460.610 "What is Not Income" and M1460.611 "Countable Income for 300% SSI Group" are NOT counted when determining income eligibility for the ABD MN covered groups. Countable income is determined by the income policy in chapter S08; applicable exclusions are deducted from gross income to calculate the individual's countable income.

The income actually received in the retroactive period is considered for retroactive eligibility. The income expected to be received within the application month is considered when determining eligibility in that month.

- Disabled = **058**
- Child Under 21 in ICF/ICF-MR = **098**
- Child Under Age 18 = **088**
- Juvenile Justice Child = **085**
- Foster Care/Adoption Assistance Child = **086**
- Pregnant Woman = **097**.

4) If the institutionalized spouse has Medicare Part A, compare the individual's monthly MN countable income to the QMB monthly income limit for 1 person (see section M0810.002 for the current QMB limit):

   a) When income is less than or equal to the QMB limit, enroll using the appropriate AC that follows:

      - Aged = **028**
      - Blind = **048**
      - Disabled = **068**

   b) When income is greater than the QMB limit, enroll using the appropriate AC that follows:

      - Aged = **018**
      - Blind = **038**
      - Disabled = **058**

5) Patient Pay: Determine patient pay according to section M1480.400 below.

**d. SD Liability Is Greater Than Medicaid Rate**

If the spenddown liability is **greater than** the facility's Medicaid rate, the institutionalized spouse is NOT eligible unless he incurs medical expenses which meet the spenddown liability in the month. To determine if the spenddown is met, go to section M1480.335 below.

**2. Medicaid CBC Waiver Patients**

The institutionalized spouse meets the definition of "institutionalized" when he is screened and approved for Medicaid waiver services and the services are being provided. An institutionalized spouse who has been screened and approved for Medicaid waiver services and whose income exceeds the 300% SSI income limit is not eligible for Medicaid until he meets the monthly spenddown liability.

To determine if the spenddown is met, go to section M1480.335 below.

**3. PACE Recipients**

The individual's spenddown liability and the PACE monthly rate (minus the Medicare Part D premium) establish whether the spenddown eligibility determination can be projected or must be determined retrospectively.

To determine if the spenddown is met, go to section M1480.340 below.

**B. All MN CBC Patients**

An MN institutionalized spouse who has been screened and approved for Medicaid CBC waiver services is not eligible for Medicaid until he actually incurs medical expenses that meet the spenddown liability within the month. These determinations are made monthly, retrospectively, **after** the month has passed and the expenses have actually been incurred. The private cost of his home-based medical care is deducted on a day-by-day basis as a noncovered medical expense, along with any other incurred medical expenses.

The institutionalized spouse's resources and income must be verified each month before determining if the spenddown was met. To determine if the institutionalized spouse met the spenddown:

- Go to section M1480.341 below if the institutionalized spouse was NOT previously on a spenddown.
- Go to section M1480.342 below if the institutionalized spouse was previously on a spenddown.

## M1480.340 MN PACE RECIPENTS

**A. Policy**

**1. Monthly Spenddown Determination**

PACE recipients who have income over the 300% of SSI income limit are placed on a monthly spenddown as institutionalized individuals because they have been screened and approved for LTC services.

Unlike CBC, PACE has a capitated monthly rate that is due and payable on the first day of the month. The monthly PACE rate is available from the PACE provider. When a MN individual is in PACE, the amount of allowed PACE expenses is the rate that is due as of the first day of each month.

PACE recipients are not responsible for Medicare Part D premiums, which are included in the monthly PACE rate. **Therefore, the cost of the Medicare Part D premium cannot be used to meet a spenddown and must be subtracted from the monthly PACE rate when determining if the spenddown has been met.**

The individual's spenddown liability and the PACE monthly rate (minus the Medicare Part D premium) establish whether the spenddown eligibility determination can be projected or must be determined retrospectively.

**2. Projected Spenddown Determination**

If the MN individual's spenddown liability is less than or equal to the monthly PACE rate (minus the Medicare Part D premium), the individual is eligible for Medicaid effective the first day of the month in which the spenddown is met. As long as the individual's spenddown liability and the PACE monthly rate do not change, the individual is enrolled in ongoing coverage.

**3. Retrospective Spenddown Determination**

If the MN individual's spenddown liability exceeds the monthly PACE rate (minus the Medicare Part D premium), he is not eligible for Medicaid until he actually incurs medical expenses that meet the spenddown liability within the month. The monthly medical expenses are determined retrospectively; they cannot be projected for the spenddown budget period.

Retrospective spenddown eligibility determinations are made monthly after the month has passed and the expenses have actually been incurred. The PACE

amount paid for the expense.

**3. Amount Deducted**

The amount that is deducted is the amount that was not or will not be paid by a third party, up to the spenddown liability amount. When determining the amount of long-term care expense incurred, use the daily private rate.

**4. When Deducted**

The incurred expenses are deducted in chronological order on the date the expense is incurred. The incurred expenses are deducted even if they have been paid.

**EXAMPLE #16:** Mr. Not lives in Group III and applied for Medicaid on November 21, 1999, as a disabled institutionalized spouse. He is in a nursing facility and was admitted on November 1, 1999. The MDU determined that he is disabled. He has not been on spenddown before. He has a $8,400 hospital bill and a $1,500 physician's bill for July 10 to July 20, 1998 (total $9,900) on which he still owes a total of $9,000. He has a $578 outpatient hospital bill for October 3, 1998. He has no health insurance. His income is $1,800 per month disability benefit from a private company. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His resources are within the Medicaid limit in November 1999 (application month).

He is not eligible as CN because his $1,800 gross income exceeds the 300% SSI income limit. The facility's Medicaid rate is $45 per day. His MN income eligibility is calculated:

| | |
|---|---|
| $1,800 | disability benefit |
| - 20 | general income exclusion |
| 1,780 | MN countable income. |
| - 325 | MNIL for 1 month for 1 person in Group III |
| $1,455 | spenddown liability |

The facility rate for the admission month is calculated as follows:

| | |
|---|---|
| $ 45 | Medicaid per diem |
| x 30 | days |
| $1,350 | facility Medicaid rate admission month |

The $1,455 spenddown liability is greater than the Medicaid rate of $1,350.

Because he was not previously on spenddown, his verified old bills for July 1999 are deducted first from the spenddown liability. He owes the hospital $8,000 and the physician $1,000, total $9,000, as of November 1, 1999 (the first day of the budget period). His eligibility is calculated:

| | |
|---|---|
| $1,455 | spenddown liability |
| - 9,000 | old bills owed 11-01-99 |
| $ 0 | spenddown balance on 11-1-99 |

She verifies that she has unpaid balances of $2,300 on a hospital bill and $1,500 on a physician's bill (total = $3,800) for services received August 10 to August 12, 1998 (prior to the retroactive period based on the December 1998 application) on which she pays $50 a month. These balances were not used to meet her December 1998 through May 1999 spenddown. She also has a $678 outpatient hospital bill for services dated November 13, 1999, in the retroactive period. She has no health insurance and is not eligible for Medicare. She has no old bills based on her January 2000 re-application (no unpaid medical expenses incurred in June, July, August or September 1999).

She was not institutionalized in the retroactive period. Her income in the retroactive budget period was $400 per month SSA disability. The retroactive budget period based on her January 2000 re-application is October, November and December 1999; the income limit is $650.

Her retroactive spenddown liability is $490.

| | |
|---|---|
| $400 | SSA disability |
| - 20 | general income exclusion |
| 380 | countable income |
| x 3 | months |
| $1,140 | countable income for retroactive budget period |
| - 650 | MNIL for retroactive budget period Group I |
| $ 490 | retroactive spenddown liability |

Since there was a break in her spenddown eligibility (the period June, July, August and September 1999 were not covered by a Medicaid application), only the current payments she is making on the August 1998 bills can be deducted from her retroactive spenddown liability. She paid the hospital and the physician $50 each ($100 total) on October 5, November 4 and December 5, 1999. Her retroactive eligibility is calculated:

| | |
|---|---|
| $ 490 | retroactive spenddown liability |
| - 100 | current payment 10-5-99 (Aug.1998 hospital & physician bills) |
| 390 | spenddown balance on 10-5-99 |
| - 100 | current payment 11-4-99 (Aug.1998 hospital & physician bills) |
| 290 | spenddown balance on 11-3-99 |
| - 678 | outpatient expense 11-13-99 ($388 of expense carried over) |
| $ 0 | spenddown balance on 11-13-99 |

The retroactive spenddown was met on November 13, 1999. Ms. Was' retroactive Medicaid entitlement was November 13, 1999 through December 31, 1999.

Her income starting January 1, 2000 increased. Her SSA is $620 per month and she began receiving a Civil Service Annuity of $1,300 per month; total income is $1,920 per month. Because this exceeds the 300% SSI income limit, her medically needy income eligibility is calculated as follows:

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

**A. Introduction**

This section contains the policy and procedures for determining an institutionalized spouse's (as defined in section M1480.010 above) patient pay in all covered groups.

**B. Married With Institutionalized Spouse in a Facility**

For a married LTC patient with an institutionalized spouse in a facility, **NO** amount of the patient's income is deducted for the spouse's needs in the patient pay calculation.

## M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

**A. Introduction**

This subsection contains the standards and their effective dates that are used to determine the community spouse's and other family members' income allowances. The income allowances are deducted from the institutionalized spouse's gross monthly income when determining the monthly patient pay amount. Definitions of these terms are in section M1480.010 above.

| | | | |
|---|---|---|---|
| **B. Monthly Maintenance Needs Allowance** | $2030.00 | 7-1-17 | |
| | $2002.50 | 7-1-16 | |
| **C. Maximum Monthly Maintenance Needs Allowance** | $3,022.50 | 1-1-17 | |
| | $2,980.50 | 1-1-16 | |
| **D. Excess Shelter Standard** | $609.00 | 7-1-17 | |
| | $600.75 | 7-1-16 | |
| **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).

**I. Example--300% SSI Group Patient Pay**

**EXAMPLE #25: (Using July 2000 figures)**

Mrs. Bay is a disabled institutionalized spouse who first applied for Medicaid for long term care services in July. She was admitted to the facility in June, but she is not eligible for Medicaid in the retroactive months because of excess resources. She has a monthly SSA benefit of $1,000 and a monthly private pension payment of $400. She has Medicare Parts A & B and private Medicare supplement health insurance which costs $75 per month. Her spouse, Mr. Bay, still lives in their Group II home with their dependent son, age 19 years. Mr. Bay has income of $1,500 per month from CSA. Their son has no income. Mrs. Bay's income is less than the 300% SSI income limit, so she is eligible for ongoing Medicaid coverage beginning July 1. She is enrolled in Medicaid in AC 060.

Her patient pay for July and subsequent months is determined. The community spouse monthly income allowance is calculated first:

| | |
|---|---|
| $1,406.25 | monthly maintenance needs standard |
| + 200.00 | excess shelter allowance |
| 1,606.25 | MMMNA (minimum monthly maintenance needs allowance) |
| -1,500.00 | community spouse's gross income |
| $ 106.25 | community spouse monthly income allowance |

The family member monthly income allowance for their son is calculated:

| | |
|---|---|
| $1,406.25 | monthly maintenance needs standard |
| - 0 | son's income |
| 1,406.25 | amount by which the standard exceeds the son's income |
| ÷ 3 | |
| $ 468.75 | family member's monthly income allowance |

Mrs. Bay has old bills totaling $200, dated the prior January. She has no noncovered expenses from the retroactive period because she paid the nursing facility in full through June. She is eligible in the 300% SSI group and is not a QMB; therefore, her Medicare premium is deducted from her patient pay for the first two months of Medicaid coverage (July and August). Her patient pay for July is calculated as follows:

| | |
|---|---|
| $1,000.00 | SSA |
| + 400.00 | private pension |
| 1,400.00 | total gross income |

| | |
|---|---|
| 1,400.00 | total gross income |
| - 30.00 | PNA (personal needs allowance) |
| -106.25 | community spouse monthly income allowance |
| -468.75 | family member's monthly income allowance |
| 795.00 | |
| -120.50 | Medicare premium & health insurance premium |
| -200.00 | old bills |
| $474.50 | remaining income for patient pay (July) |

**2. Subtract Patient Pay Deductions**

Subtract the following from the patient pay gross monthly income in the following order as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.

a. a personal needs allowance (per section M1480.430 C.),

b. a community spouse monthly income allowance, if appropriate (per section M1480.430 D.),

c. a family member's income allowance, if appropriate (per section M1480.430 E.),

d. any allowable noncovered medical expenses (per section M1470.230) **including** any old bills and carry-over expenses,

e. a home maintenance deduction, if appropriate (per section M1480.430 G.).

The result is the **remaining income** for patient pay.

**3. Patient Pay**

Compare the remaining income for patient pay to the Medicaid rate for the month. The patient pay is the lesser of the two amounts.

**C. Example—Facility Spenddown Liability Less Than Medicaid Rate, Community Spouse Allowance**

**EXAMPLE #24: (Using July 2000 figures)**
Mr. Hay is an institutionalized spouse who applied for Medicaid in July. He was admitted to the facility the prior November. He has a monthly CSA benefit of $1,700 and a monthly Seminole Indian payment of $235. He has Medicare Parts A & B and Federal Employees Health Insurance which costs $75 per month. He last lived outside the facility in a Group III locality. His wife, Mrs. Hay, still lives in their home; she has income of $500 per month from CSA. They have no dependent family members living with Mrs. Hay. Mr. Hay's total income exceeds the 300% of SSI income limit. His MN eligibility is determined for July. The MN determination results in a monthly spenddown liability of $1,355:

| | |
|---|---|
| $1,700 | monthly MN income (Seminole Indian payment excluded) |
| - 20 | exclusion |
| 1,680 | countable MN income |
| - 325 | MN limit for 1 (Group III) |
| $1,355 | spenddown liability for month |

The facility's Medicaid rate is $45 per day, or $1,395 for a 31-day month. By projecting the month's cost of facility care, Mr. Hay meets his spenddown effective the first day of the month and is eligible for Medicaid effective July 1. He is enrolled in Medicaid effective July 1 in AC 018.

The community spouse monthly income allowance is calculated:

| | |
|---|---|
| $1,406.25 | monthly maintenance needs standard |
| + 0 | no excess shelter allowance |
| 1,406.25 | MMMNA (minimum monthly maintenance needs allowance) |
| - 500.00 | community spouse's gross income |
| $ 906.25 | community spouse monthly income allowance |

His patient pay is calculated as follows:

| | |
|---|---|
| $1,700.00 | CSA |
| + 235.00 | Seminole Indian payment (counted for patient pay) |
| 1,935.00 | total patient pay gross income |
| - 30.00 | PNA (personal needs allowance) |
| - 906.25 | community spouse monthly income allowance |
| 998.75 | |
| - 45.50 | Medicare premium (not paid by Medicaid) |
| - 75.00 | health insurance premium |
| $ 878.25 | remaining income for patient pay (July) |

The facility's Medicaid rate for July is $1,395. Because Mr. Hay's remaining income for patient pay is less than the Medicaid rate for July, his patient pay for July is $878.25. From his July income of $1,935, Mr. Hay must pay $878.25 patient pay to the facility, leaving him $1,056.75 from which he can pay the community spouse income allowance of $906.25, his personal needs allowance of $30 and his Medicare and health insurance premiums of $120.50 (total of $1,056.75). Medicaid will pay $476.75 of his spenddown liability ($1,355 spenddown liability - 878.25 patient pay = $476.75). **This is allowed under section 1924 of the Social Security Act (Special Treatment For Married Institutionalized Spouses).**

## D. Example-Facility Spenddown Liability Less Than Facility Rate, Community Spouse & Family Member Allowance

**EXAMPLE #25: (Using July 2000 figures)**
Mrs. Zee is a disabled institutionalized spouse who applied for Medicaid for long term care services in July. She was admitted to the facility in June, but she is not eligible for Medicaid in the retroactive month because of excess resources. She has a monthly SSA benefit of $1,200 and a monthly private pension payment of $600. She has Medicare Parts A & B and private Medicare supplement health insurance which costs $75 per month. Her spouse, Mr. Zee, still lives in their Group II home with their dependent son, age 19 years. Mr. Zee has income of $1,500 per month from CSA. Their son has no income. Mrs. Zee's income exceeds the 300% SSI income limit. Her MN eligibility is determined for July. She has old bills totaling $300 dated the prior January. The MN determination results in a spenddown liability of $1,530:

bills and her medical insurance premiums, totaling $1025.50. Medicaid will pay $755.50 of her spenddown liability ($1,530 spenddown liability - 774.50 patient pay = $755.50). This is allowed under section 1924 of the Social Security Act (Special Treatment For Married Institutionalized Spouses).

# M1480.460 FACILITY PATIENT PAY - SPENDDOWN LIABILITY GREATER THAN MEDICAID RATE

**A. Policy**

**An MN facility institutionalized spouse whose spenddown liability is greater than the Medicaid rate is not eligible for Medicaid unless he incurs additional medical expenses that meet the spenddown liability within the month**. If he meets the spenddown liability, his Medicaid coverage begins the first day of the month in which the spenddown is met, and ends on the last day of that month. A patient pay for the month is calculated.

Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay his personal needs, community spouse and family member allowances, and noncovered expenses. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability. Payment of part or all of the spenddown liability is permitted under Section 1924 (d) of the Social Security Act.

**B. Procedures**

The institutionalized spouse's spenddown eligibility was determined in section M1480.340 above. Because he met the spenddown in the month, he is enrolled in a closed period of coverage for the full month. His patient pay for the month must be determined using the procedures below.

**1. Calculate Remaining Income for Patient Pay**

**a. Determine Gross Monthly Patient Pay Income**

Determine the institutionalized spouse's patient pay gross monthly income according to section M1480.330 (including any amounts excluded in determining MN countable income and the spenddown liability).

**b. Subtract Allowable Deductions**

Deduct the following from the patient pay gross monthly income, in the following order as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.

1) a personal needs allowance (per section M1480.430 C.),

2) a community spouse monthly income allowance, if appropriate (per section M1480.430 D.),

3) a family member's monthly income allowance, if appropriate (per section M1480.430 E.),

| | |
|---|---|
| $1,406.25 | monthly maintenance needs standard |
| + 0 | no excess shelter allowance |
| 1,406.25 | MMMNA (minimum monthly maintenance needs allowance) |
| - 500.00 | community spouse's gross income |
| $ 906.25 | community spouse monthly income allowance |

| | |
|---|---|
| $1,406.25 | monthly maintenance needs standard |
| - 0 | child's income |
| 1,406.25 | amount by which standard exceeds child's income |
| ÷ 3 | |
| $ 468.75 | child's family member monthly income allowance |

| | |
|---|---|
| $1,900.00 | CSA income |
| + 200.00 | Seminole Indian payment (not excluded for patient pay) |
| 2,100.00 | total patient pay gross income |
| - 30.00 | personal needs allowance |
| - 906.25 | community spouse monthly income allowance |
| - 468.75 | family member allowance |
| 695.00 | |
| - 45.50 | noncovered Medicare Part B premium |
| - 75.00 | noncovered health insurance premium |
| $ 574.50 | remaining income (July) |

The facility's Medicaid rate for July is $1,395. Because Mr. L's remaining income for patient pay is less than the Medicaid rate for July, his patient pay for July is $574.50.

From his July income of $2,100, he must pay the patient pay of $574.50. He has $1,525.50 left with which to meet his personal needs ($30), pay the community spouse and family member allowances, and pay his Medicare and health insurance premiums, a total of $1,525.50. In accordance with Section 1924 of the Social Security Act, Medicaid will assume responsibility for $980.50 of his spenddown liability ($1,555 - 574.50 patient pay = $980.50).

**D. Example—Facility Spenddown Liability Greater Than Medicaid Rate and Private Cost of Care**

**EXAMPLE #27: (Using July 2000 figures)**

Mrs. Bee is an institutionalized individual who files an initial application for Medicaid on July 6. She has a monthly SSA benefit of $2,000 and a monthly private pension payment of $500. She has Medicare Parts A & B and private Medicare supplement health insurance which costs her $100 per month. Mrs. Bee last resided outside the facility in a Group II locality. Her spouse, Mr. Bee, still lives in their home. He has income of $1,800 per month from CSA. Mrs. Bee's income exceeds the 300% SSI income limit.

Her MN eligibility is determined for July. The MN determination results in a spenddown liability of $2,230:

Mrs. Bee's remaining income for patient pay in July is $2,193.25, which is greater than the Medicaid rate for of July $1,705. The facility can only collect the Medicaid rate; therefore, her patient pay for July is the Medicaid rate of $1,705.

From her July income of $2,500, she must pay the Medicaid rate of $1,705. Medicaid will not pay for any of her facility care in July because she is responsible for the whole Medicaid rate; Medicaid will cover all other medical services except her Medicare & health insurance premiums. She has $795 left with which to meet her personal needs ($30), pay the community spouse allowance, and pay her Medicare and health insurance premiums, a total of $306.75. She has $488.25 left from her July income. Medicaid will assume responsibility for $525 of her spenddown liability ($2,230 - 1,705 Medicaid rate = $525).

Since Mrs. Bee paid the private rate of $2,170 to the facility in July, the facility is responsible to reimburse her for the difference between the private rate and the Medicaid rate ($465). On August 25, she requests evaluation of her spenddown for August. She was reimbursed $465 on August 20, which was deposited into her patient fund account. The worker verifies that her resources exceed the Medicaid resource limit in August. The worker sends her a notice denying Medicaid for August because of excess resources, and stating that she must reapply for Medicaid if she reduces her resources and wants to be placed on spenddown again.

## M1480.470 CBC - MN INSTITUTIONALIZED SPOUSE PATIENT PAY

**A. Policy**

When the Medicaid community-based care (CBC) institutionalized spouse has been screened and approved for waiver services and has **income less than or equal to 300% of the SSI income limit** for one person, he is eligible for Medicaid as CNNMP and entitled to Medicaid for full-month, ongoing Medicaid coverage.

An institutionalized spouse who is screened and approved for waiver services, and whose income **exceeds the 300% SSI income limit**, is placed on a monthly spenddown. **The monthly CBC costs cannot be projected** for the spenddown budget period. The CBC costs, along with any other spenddown deductions, are deducted daily and chronologically as the costs are incurred. If the spenddown is met any day in the month, Medicaid coverage begins the first day of the month in which the spenddown is met, and ends on the last day of that month. A patient pay for the month is calculated.

Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay his personal needs, community spouse and family member allowances, and noncovered expenses. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability. Payment of part or all of the spenddown liability is permitted under Section 1924 (d) of the Social Security Act.

His wife, Mrs. T, lives in their home with Mr. T and their dependent child age 18 years. Mrs. T has income of $500 per month from CSA. Their child has no income. Mr. T's income exceeds the 300% of SSI income limit. His MN eligibility is determined for July. The MN determination results in a spenddown liability of $1,555:

| | |
|---|---|
| $1,900 | monthly MN income (Japanese-American Restitution payment excluded) |
| - 20 | exclusion |
| 1,880 | countable MN income |
| - 325 | MN limit for 1 (Group III) |
| $ 1,555 | spenddown liability for month |

He has no old bills. He is placed on a monthly spenddown of $1,555 for each month in the 12-month certification period beginning July 1.

On July 31, he submits expenses for July. The worker verifies that his resources were below the limit in July. His spenddown liability of $1,555 is compared to $2,400, the total private rate for July ($16 per hour private rate x 5 hours per day x 31 days = $2,480). Because the private cost of CBC care for July is greater than his spenddown liability for July, he met his spenddown in July. He is eligible for the full month of July. On August 1, the worker enrolls him in Medicaid beginning July 1 and ending July 31.

His patient pay is then calculated. The community spouse and family member allowances are calculated first:

| | |
|---|---|
| $1,406.25 | monthly maintenance needs standard |
| + 0 | no excess shelter allowance |
| 1,406.25 | MMMNA (minimum monthly maintenance needs allowance) |
| - 500.00 | community spouse's gross income |
| 906.25 | community spouse monthly income allowance |

| | |
|---|---|
| $1,406.25 | monthly maintenance needs standard |
| - 0 | child's income |
| 1,406.25 | amount by which standard exceeds child's income |
| ÷ 3 | |
| $ 468.75 | family member monthly income allowance |

| | |
|---|---|
| $1,900.00 | CSA income |
| + 200.00 | Japanese-American Restitution payment (not excluded for patient pay) |
| 2,100.00 | total patient pay gross income |
| - 512.00 | personal maintenance allowance |
| - 906.25 | community spouse monthly income allowance |
| - 468.75 | family member allowance |
| 213.00 | |
| - 45.50 | noncovered Medicare Part B premium |
| - 75.00 | noncovered health insurance premium |
| $ 92.50 | remaining income for patient pay |

The CBC provider's Medicaid rate is $9.50 per hour, 5 hours per day or $47.50 per day, a total of $1,472.50 for July (31 days). Because Mr. T's remaining income is less than the Medicaid rate, his patient pay for July is $92.50.

From his July income of $2,100, Mr. T must pay the patient pay of $92.50. He has $2,007.50 left with which to meet his maintenance needs ($512), pay the community spouse and family member allowances, and pay his Medicare and health insurance premiums, a total of $2,007.50. In accordance with Section 1924 of the Social Security Act, Medicaid will assume responsibility for $1,462.50 of his spenddown liability ($1,555 - 92.50 patient pay = $1,462.50). Because he paid all of his income to the CBC provider in July, his resources are within the limit in August.

**D. Example-CBC Institutionalized Spouse on Spenddown**

**EXAMPLE #29: (Using July 2000 figures)**

Mrs. Bly is an aged individual who files an initial application for Medicaid on July 1. She was screened and approved for Medicaid E & D waiver services on July 1, and began receiving those services on July 1. She has a monthly SSA benefit of $2,000 and a monthly private pension payment of $500. She has Medicare Parts A & B and private Medicare supplement health insurance which costs her $100 per month. Mrs. Bly resides in a Group II locality. Her spouse, Mr. Bly, lives with her in their home. He has income of $1,800 per month from CSA. Mrs. Bly's income exceeds the 300% of SSI income limit.

Her MN eligibility is determined for July. The MN determination results in a spenddown liability of $2,230:

| | |
|---|---|
| $2,000.00 | SSA |
| + 500.00 | monthly private pension |
| 2,500.00 | total monthly income |
| - 20.00 | exclusion |
| 2,480.00 | countable MN income |
| - 250.00 | MN limit for 1 (Group II) |
| $2,230.00 | spenddown liability for month |

She is placed on a monthly spenddown for each month in the 12-month certification period beginning July 1. On August 2, she submits expenses for July. The private CBC rate is $14 per hour, 5 hours per day or $70 per day, for a total of $2,170 for July (31 days). The private cost of care, $2,170, is less than her spenddown liability of $2,230. Therefore, the worker must complete a day-by-day calculation to determine Mrs. Bly's eligibility for July:

| | |
|---|---|
| $2,230.00 | spenddown liability 7-1 |
| - 140.00 | CBC private pay rate for 7-1 & 7-2 @ $70 per day. |
| 2,090.00 | spenddown balance on 7-3 |
| - 145.50 | 45.50 Medicare + 100.00 health ins. premium paid 7-3 |
| - 1,890.00 | private pay for 27 days @ $70 per day 7-3 through 7-29 |
| 54.50 | spenddown balance at beginning of 7-30 |
| - 70.00 | CBC private pay for 7-30 |
| $ 0 | spenddown met on 7-30 |

**M1510 Changes**

| Changed With | Effective Date | Pages Changed |
|---|---|---|
| TN #DMAS-6 | 10/1/17 | Table of Contents<br>Pages 1, 2<br>Page 2a is a runover page.<br>Page 2b was added as a runover page. |
| TN #DMAS-5 | 7/1/17 | Page 1<br>Page 2 is a runover page. |
| TN #DMAS-4 | 4/1/17 | Pages 2a, 10 |
| TN #DMAS-2 | 1/1/17 | Table of Contents<br>Pages 1, 8, 8a, 12-15<br>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<br>Pages 1 and 2a are runover pages. |
| TN #100 | 5/1/15 | Table of Contents<br>Pages 1-2a, 5-8b |
| UP #10 | 5/1/14 | Table of Contents<br>Pages 7-8a<br>Page 8b was added. |
| TN #99 | 1/1/14 | Table of Contents<br>Pages 1, 2, 8, 8a, 9-11<br>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<br>Pages 8, 11-15 |
| TN #94 | 9/1/10 | Pages 2a, 8-8a |
| TN #93 | 1/1/10 | Page 6 |
| Update (UP) #2 | 8/24/09 | Page 11 |
| TN #91 | 5/15/09 | Page 14 |

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## M15 ENTITLEMENT POLICY & PROCEDURES

## M1510.000 MEDICAID ENTITLEMENT

## M1510.000 ENTITLEMENT POLICY & PROCEDURES

# M1510.100 MEDICAID ENTITLEMENT

**A. Policy**

An individual's entitlement to Medicaid coverage is based on the individual meeting all nonfinancial and financial eligibility requirements for the individual's covered group during a month covered by the application, as well as any additional entitlement policies that are applicable to the covered group.

**1. Spenddown Met**

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

**2. Individual is Deceased**

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

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

**3. Applicant Has Open MA Coverage in Another State**

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

**4. PARIS Match Data**

*The Public Assistance Reporting Information System (PARIS) is a Federal computer matching initiative that the Virginia Department of Social Services (VDSS) participates in quarterly. VDSS participates in the data exchange with all active Medicaid enrollees and they are matched for the receipt of Veterans benefits and enrollment in multiple states' Medicaid programs. Each public assistance report is matched by social security number.*

*If a PARIS match is found, the worker will receive an alert in the Virginia Case Management System (VaCMS). The worker must evaluate all matches for current and ongoing eligibility and take appropriate case action within 30 days. Multiple matches must be assessed as a whole for the entire case. Workers must document findings in VaCMS under Case Comments. Procedures for researching and reporting PARIS matched individuals are found in the PARIS User Guide at:* *http://spark.dss.virginia.gov/divisions/bp/fm/files/intro_page/guidance_procedures/PARIS_User_Guide_5-2017.pdf .*

*Once the evaluation of the match is completed and the case comments are documented, complete and send the Notice of Recipient Fraud/Non-Fraud Recovery (form #DMAS 751R) located at* *http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi to*

*Department of Medical Assistance Services*
*Recipient Audit Unit,*
*600 E. Broad Street, Suite 1300,*
*Richmond, Virginia 23219*

*The form may be faxed to 804-452-5472 or emailed to* *recipientfraud@dmas.Virginia.gov.*

*The DMAS Program Integrity Division will conduct steps to complete the match and Benefit Impact Screen (BIS).*

**B. SSI Entitlement Date Effect on Medicaid**

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

**C. Procedures**

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

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

# M1510.101 RETROACTIVE ELIGIBILITY & ENTITLEMENT

**A. Definitions**

**1. Retroactive Period**

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

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

**2. Retroactive Budget Period**

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

**B. Policy**

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

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

**C. Budget Periods By Classification**

**1. CN**

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

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

**2. MN**

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

**D. Verification**

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

Income verification by the Federal Hub is acceptable for retroactive eligibility determinations provided that reasonable compatibility is met (see M0420.100 B.9). The applicant must provide verification of income received in the retroactive period, as well as for ongoing eligibility, if his income is not verified by the Hub. An applicant with a resource test must provide verification of resources held in the retroactive period.

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

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

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

**M1520 Changes**

| Changed With | Effective Date | Pages Changed |
|---|---|---|
| TN #DMAS-6 | 10/1/17 | Table of Contents<br>Pages 6, 7, 8, 8a, 12<br>Pages 7a and 8 were renumbered to 8 and 8a.<br>Page 12a was added as a runover page. |
| TN #DMAS-5 | 7/1/17 | Pages 1, 2, 6, 8<br>Pages 3, 7, 7a and 9 are runover pages. |
| TN #DMAS-4 | 4/1/17 | Pages 25-27<br>Appendix 2, page 1<br>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<br>Pages 19-24 |
| TN #DMAS-1 | 6/1/16 | Pages 3, 6, 7, 9, 11-14, 17<br>Appendix 2, page 1<br>Pages 3a and 7a were added.<br>Page 8 is a runover page. |
| TN #100 | 5/1/15 | Table of Contents<br>Pages 1-27<br>(entire subchapter –pages 28-34 were deleted)<br>Appendices 1 and 2 were added. |
| TN #99 | 1/1/14 | Table of Contents<br>Pages 1-34<br>(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<br>Pages 1-7g<br>Pages 11-13<br>Pages 21-24 |
| TN #95 | 3/1/11 | Pages 6a, 7, 21, 22 |
| TN #94 | 9/1/10 | Table of Contents<br>Pages 3, 4b, 5, 6-6a, 10<br>Appendix 1 was removed. |
| UP #4 | 7/1/10 | Page 4 |
| TN #93 | 1/1/10 | Pages 3, 4b, 5-6, 10, 15<br>Pages 21, 22 |
| Update (UP) #2 | 8/24/09 | Pages 1, 2, 13, 14, 17, 18 |
| Update (UP) #1 | 7/01/09 | Page 3 |

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## M15 ENTITLEMENT POLICY & PROCEDURES

## M1520.000 MEDICAL ASSISTANCE (MA) ELIGIBILITY REVIEW



## APPENDICES

**1. Required Verifications**

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

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

When it is necessary to obtain information and/or verifications from the enrollee, a contact-based renewal must be completed. If an enrollee's attested resources are over the resource limit, the applicant or authorized representative must be given the opportunity to provide verification of the resources. T**he renewal must be signed by the enrollee or authorized representative.**

*Continuing* blindness and disability *must be verified at the time of each annual renewal. For individuals receiving Supplemental Security Income (SSI) and Social Security Disability Insurance, the State Online Query-Internet (SOLQ-I) or the State Verification and Exchange System (SVES) may be used. The printout must be scanned into the case record.* For individuals determined blind or disabled for Medicaid by the Disability Determination Services (DDS) interface with VaCMS, blindness and disability are considered continuing unless DDS *has notified the LDSS* that the individual is no longer blind or disabled.

**2. SSN Follow Up**

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

**3. Evaluation and Documentation**

An evaluation of the information used to determine continued eligibility must be completed and included in the case record. It is crucial that individuals reviewing a case, including auditors, be able to follow the eligibility determination process in VaCMS. Changes and any questionable information must be appropriately documented as comments in the VaCMS case record.

**4. Renewal Period**

Renewals must be completed prior to cut-off in the 12th month of eligibility or within 30 calendar days from the receipt of the renewal, whichever is later. The first 12-month period begins with the month of application for Medicaid.

**B. Renewal Procedures**

Renewals may be completed in the following ways:

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

**1. Ex Parte Renewals**

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

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

**a. MAGI-based Cases**

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

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

*Verification printouts must be copied or scanned into VaCMS using the Document Management Imaging System (DMIS) and preserved for the record. Notes by the eligibility worker that the verifications were viewed are not sufficient.*

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

**b. $0 Income Reported**

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

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

If the inquiry indicates recent or current income that is countable for the MAGI determination, follow the steps in M1520.200 B.2 below for completing a paper-based renewal.

**c. SSI Medicaid Enrollees**

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

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

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

**d. Continuing Eligibility Not Established Through Ex Parte Process**

If the ex parte renewal results in the individual no longer being eligible for coverage, the individual must be given the opportunity to submit current income information and verifications. Follow the steps in M1520.200 B.2 below for completing a paper-based renewal.

**2. Paper Renewals**

When an ex parte renewal cannot be completed, send the enrollee a pre-filled paper Administrative Renewal form to sign and return. If an authorized representative has been designated, the renewal form is sent to the authorized representative.

The form needs to be sent to the enrollee in time to allow for the return and processing periods prior to the system cut-off in the 12th month of eligibility. The enrollee must be allowed 30 days to return the renewal form and any necessary verifications; Administrative Renewal forms are pre-filled with the return date. The specific information requested and the deadline for receipt of the verification must be documented in the case record.

If the enrollee submits a completed application form, accept it as a renewal form and obtain any additional information needed to complete the renewal.

New or revised information provided by the enrollee must be entered into the system. The enrollee is responsible for reporting any changes. If the enrollee does not check either "yes" or "no" in response to a particular question, there is considered to be no change with regard to that question.

*Verifications must be copied or scanned into VaCMS using the Document Management Imaging System (DMIS) and preserved for the record. Notes by the eligibility worker that the verifications were viewed are not sufficient.*

Renewals must be completed prior to cut-off in the 12th month of eligibility or within 30 calendar days from the receipt of the renewal, whichever is later.

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

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

**3. Online and Telephonic Renewals**

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

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

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

**C. Disposition of Renewal**

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

***12.* FAMIS *Renewal Period Extension For Declared Disaster Areas***

*Effective January 1, 2017, if the Governor or the Federal Emergency Management Agency (FEMA) declares Virginia or any area in Virginia to be a disaster area, children enrolled in FAMIS who reside in the declared disaster area may be granted a 90-day extension of the continuous coverage period before their next renewal is due. The next 12-month continuous eligibility period begins the month after the renewal completion date.*

*The extension of the renewal period applies only to children in a declared disaster area (1) for whom an ex parte renewal cannot be completed and (2) who do not return a renewal form or complete an online or telephonic renewal prior to the renewal due date. The three-month reconsideration period outlined in M1520.200 C.4 also applies to these children if their coverage is cancelled upon not completing a renewal at the end of the 90-day extension period.*

**E. LTC**

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

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

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

**F. Incarcerated Individuals**

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

- For individuals incarcerated in DOC facilities, send the renewal form and related correspondence to the DOC Health Services Reimbursement Unit, 6900 Atmore Driver, Richmond, Virginia 23225.

- For individuals in DJJ facilities, send the renewal form and related correspondence to the DJJ Re-entry Services Unit, 600 E. Main Street, Richmond VA 23219.

- For individuals in regional or local jails, send the renewal form and related correspondence to the individual or his authorized representative.

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

## M1520.300 MA CANCELLATION OR SERVICES REDUCTION

A. Policy

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

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

Send any notices and other correspondence to the authorized representative, if one has been designated.

**M17 Changes**

| Changed With | Effective Date | Pages Changed |
|---|---|---|
| TN #DMAS-6 | 10/1/17 | Table of Contents<br>Pages 4, 7<br>Appendix 1 was deleted<br>Appendices 2 and 3 were renumbered<br>Appendices 1 and 2, respectively. |
| TN #DMAS-4 | 4/1/17 | Table of Contents<br>Pages 1, 2, 4<br>Appendix 2<br>Appendix 3 was added. |
| TN #DMAS-4 | 4/1/17 | Pages 4, 5<br>Pages 6 and 7 are runover pages. |
| TN #DMAS-2 | 10/1/16 | Table of Contents, page i<br>Pages 1-7<br>Appendix 2<br>Page 8 was deleted. |
| TN #97 | 9/1/12 | page 3<br>Appendix 1, page 1 |
| UP #7 | 7/1/12 | Table of Contents<br>Pages 1-8<br>Appendix 1<br>Appendices 3 and 4 were removed. |
| TN #94 | 9/1/10 | Title Page<br>Table of Contents<br>pages 1-7<br>Appendix 1<br>Appendix 2 |
| TN #93 | 1/1/10 | page 3 |

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## M17 MEDICAID FRAUD AND NON-FRAUD RECOVERY

## M1700.000 MEDICAID FRAUD NON-FRAUD RECOVERY



## Appendix 1

**2. Family Unit**

If both spouses of an eligible couple are found guilty of fraud, neither is eligible for Medicaid. If only one member of a family unit is convicted of fraud, only that member's Medicaid coverage is canceled. The fraud conviction does not affect the composition of the family unit or the treatment of the family unit's income or resources. The convicted individual is included in the family unit according to Medicaid policy, but is not eligible for Medicaid coverage and is not enrolled.

## M1700.300 NON-FRAUD RECOVERY

**A. Authority**

Any person who, without intent to violate this article, obtains benefits or payments under medical assistance to which he is not entitled shall be liable for any excess benefits or payments received (COV 32.1-321.2).

**B. Recovery of Erroneous Payments**

DMAS has the authority to investigate cases and recover expenditures made for services received by ineligible enrollees without fraudulent intent. Examples of when recovery of expenditures is possible include, but are not limited to:

- eligibility errors due to recipient misunderstanding,
- agency errors,
- medical services received during the appeal process, if the agency's cancellation action is upheld.
- long-term care (LTC) patient pay underpayments totaling $1,500 or more.

Complete and send the *Notice of Recipient LTC Patient Pay Underpayment (form #DMAS752R)* located at http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi to:

Department of Medical Assistance Services
Recipient Audit Unit,
600 E. Broad Street, Suite 1300,
Richmond, Virginia 23219

*The form can be faxed to 804-452-5472 or emailed to recipientfraud@dmas.virginia.gov.*

Underpayments less than $1,500 can be collected by adjusting the ongoing patient pay (see M1470.900 for patient pay adjustments).

**C. Post-eligibility Investigations**

The RAU conducts post eligibility investigations. Medicaid nonfinancial and financial requirements are reviewed and applied in accordance to Medicaid policy. See Chapter M02 for the nonfinancial eligibility requirements, and Chapters M06 and M11 for resource requirements.

RAU investigations are based on projected income consistent with the eligibility polices for counting ongoing income referenced in Chapters M04, M07, and M08. Post-eligibility determinations are made using a point-to-point method in which the income estimation period begins with an event that would have triggered a partial review under M1450.100. The end point is the next scheduled renewal that the LDSS actually completed.

**D. Uncompensated Asset Transfers**

Individuals receiving long-term care services (LTC) who transfer assets and do not receive adequate compensation are subject to the imposition of a penalty period during which Medicaid cannot pay for long-term care services. When an uncompensated

***1. PARIS Match Data***

*The Public Assistance Reporting Information System (PARIS) is a Federal computer matching initiative that the Virginia Department of Social Services (VDSS) participates in quarterly. VDSS participates in the data exchange with all active Medicaid enrollees and they are matched for the receipt of Veteran benefits and enrollment in multiple state's Medicaid programs. Each public assistance report is matched by social security number.*

*The worker must evaluate all matches for current and ongoing eligibility and take appropriate case action within 30 days. Multiple matches must be assessed as a whole for the entire case. Workers must document findings in VaCMS under Case Comments. Once the evaluation of the match is completed and the case comments are documented, send the Notice of Recipient Fraud/Non-Fraud Recovery, (form #DMAS 751R) to the DMAS Program Integrity Division where steps will be conducted to complete the match and Benefit Impact Screen (BIS). Procedures for researching and reporting PARIS matched individuals are found in the PARIS User Guide at: http://spark.dss.virginia.gov/divisions/bp/fm/files/intro_page/guidance_procedures/PARIS_User_Guide_5-2017.pdf .*

*Complete and send the Notice of Recipient Fraud/Non-Fraud Recovery (form #DMAS 751R) located at http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi to*

*Department of Medical Assistance Services*
*Recipient Audit Unit,*
*600 E. Broad Street, Suite 1300,*
*Richmond, Virginia 23219*

*The form may be faxed to 804-452-5472 or emailed to recipientfraud@dmas.Virginia.gov*

***3.* Corrective Action**

Report to the DMAS RAU corrective action taken on all discovered eligibility errors. Corrective action is a function of the loss prevention process. All corrected errors shall be reported to DMAS.

***2.* Cancel Coverage**

Cancel the eligibility of all persons convicted of public assistance fraud or medical assistance fraud to the extent allowable under federal and state regulations, using the cancel code for fraud convictions (Cancel Code 014).

**C. DMAS Response**

The RAU shall send a referral acknowledgement letter to the LDSS worker making the referral. RAU may send out additional communication to the LDSS should additional verifications/documentation be required to complete the investigation.

**D. Recipient Audit Reporting**

The RAU has two prevention efforts for reporting fraud and abuse of Medicaid Services by individuals within the community. Both referral methods should be given to the individual by the LDSS. The individual may remain anonymous.

- *The individual may send an e-mail to* recipientfraud@dmas.virginia.gov.
- *The individual can call* the Recipient Audit fraud and abuse hotline. Both a local and a toll free number are available 24 hours daily for reporting suspected fraud and abuse: local (804) 786-1066; and toll free (866) 486-1971.

**E. Statute of Limitations**

There is no "statute of limitations" for Medicaid fraud; cases that are referred for fraud shall be flagged to ensure that the information is not purged.

# NOTICE OF MEDICAID RECIPIENT FRAUD/NON-FRAUD

**Date:** / /

**To:** **Recipient Audit Unit (RAU)**
**Department of Medical Assistance Services**
**600 East Broad Street, Suite 1300**
**Richmond, Virginia 23219**
**Fax Number: (804) 452-5472**
**Email: RecipientFraud@dmas.virginia.gov**

**Case Name:** _____

**Case Name SSN**: ___ - ___ - _____ **Medicaid Case Number:** ___ - _____ - ___ - ___

**Case Address:** _____

_____

_____

**Has the Case Head been informed a referral is being sent to RAU?** ☐ **Yes** ☐ **No**

**Check the appropriate box below and give an explanation in the summary section.**

☐ **Fraud** ☐ **Agency Error** ☐ **Other**
☐ **Uncompensated Transfer** ☐ **Non-Entitled Receipt of Medicaid**
☐ **Ineligible for Medicaid** **Dates:** _____

**Ineligible person(s):** _____

_____

_____

## PARIS Match

☐ **Interstate Match** ☐ **Veteran Match**

**Ineligible person(s):** _____

_____

_____

**Explanation summary of referral/PARIS match and any corrective action taken by the agency:**

# NOTICE OF MEDICAID RECIPIENT FRAUD/NON-FRAUD

## ATTACH THE FOLLOWING INFORMATION IF AVAILABLE:

- **Reason for and estimated period of ineligibility for Medicaid.**
- **Applicable Medicaid applications or review forms for the referral/ineligibility.**
- **Any record of communication between the agency and the recipient or recipient's representative, such as case narratives, letters, and notices.**
- **Information obtained for the agency's fraud investigation, including names and addresses of knowledgeable individuals for testimony and/or interviews.**
- **Relevant covered group, income, resource, and/or asset transfer documentation.**
- **A copy of any Regional Specialist's decision regarding trust that affects eligibility.**
- **Address and telephone number of any attorney-in fact, authorized representative, or other individual who assisted in the application process;**
- **Confirmation that ongoing eligibility has been reviewed in relation to the allegation and the results. This can be addressed in the summary of the referral.**

**Name of Eligibility Worker:** _____ **Telephone Number:** (___) ___ - ____

**Agency Name:** _____ **FIPS Code:** _____

**Address:** _____ **Name of Supervisor:** _____

**RAU will send acknowledgment of receipt to the referring agency. RAU will contact the agency if any further action is required.**

# NOTICE OF RECIPIENT LONG TERM CARE (LTC) PATIENT PAY UNDERPAYMENT

**Date:** / /

**To:** **Recipient Audit Unit**
**Department of Medical Assistance Services**
**600 East Broad Street, Suite 1300**
**Richmond, Virginia 23219**
**Fax Number: (804) 452-5472**
**Email: RecipientFraud@dmas.virginia.gov**

**Case Name:** _____

**Case Name SSN:** ___ - ___ - ____ **Medicaid ID Number:** ___ - ___ - ___

**Case Address:** _____
_____
_____

## LTC Patient Pay Underpayment Breakdown

| Month/Year | Underpayment Amount |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| **Total Time Frame:** | **Total Amount:** |

**Explanation for the Underpayment:**

# NOTICE OF RECIPIENT LTC PATIENT PAY UNDERPAYMENT

**THINGS TO REMEMBER:**

- **All LTC patient pay underpayments totaling $1,500 or more should be referred to the Recipient Audit Unit (RAU). For Underpayments less than $1,500, reference M1470.900 for patient pay adjustments.**
- **Provide a monthly break down of the underpayment calculation along with the total underpayment amount. If additional space is needed please attach your calculations to this form.**

**Name of Eligibility Worker:** _____ **Telephone Number:** (___) ___ - ____

**Agency Name:** _____ **FIPS Code:** _____

**Address:**

_____

_____

**Name of Supervisor:**_____

**RAU will send acknowledgment of receipt to the referring agency. RAU will contact the agency if any further action is required.**

## M18 Changes

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

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## M18 MEDICAL SERVICES

## MEDICAL SERVICES

# M1830.100 MANAGED CARE

**A. General Information**

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

DMAS operates one Medicaid mandatory managed care program, Medallion 3.0. The Medallion 3.0 program is administered through DMAS' contracted managed care organizations (MCO). Most Virginia Medicaid enrollees are required to receive medical care through a managed care organization.

**B. Enrollees Exempt from Managed Care**

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

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

The criteria for exclusion from Medallion 3.0 are contained in the Managed Care Resource Guide, available at http://www.dmas.virginia.gov/Content_atchs/mc/MC%20Resource%20Guide%2002192015_MCH_update_SG.pdf.

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

**C. Managed Care HelpLine**

Eligible individuals can enroll in an MCO or obtain additional information, as well as assistance with coverage issues, by calling the Managed Care HelpLine at 1-800-643-2273 (TTY/TDD 1-800-817-6608). The Helpline is available Monday through Friday from 8:30 a.m. until 6:00 p.m. Information is available online at www.virginiamanagedcare.com.

**D. Family Access to Medical Insurance Security Plan (FAMIS) Managed Care**

FAMIS benefits are administered through DMAS contracted MCOs or through FAMIS fee-for-service. The DMAS contracted MCOs for FAMIS are the same as those contracted with DMAS for Medallion 3.0.

In all areas of the Commonwealth, FAMIS enrollees have the choice between 2 or more MCOs. When a child is first enrolled in FAMIS, he or she is able to access health care through the FAMIS fee-for-service program. Within 1 or 2 months after FAMIS enrollment, the child will be enrolled with a FAMIS MCO.

FAMIS benefits are slightly different than the benefits that children enrolled in Medicaid receive. There are benefit limitations and small co-payments similar to those associated with commercial group health insurance. The following is a partial list of services (while covered under Medicaid) are **NOT** covered under FAMIS.

- Early and Period Screening Diagnosis and Treatment (EPSDT) *services are not covered* for FAMIS MCO members. Many of the services that are covered as EPSDT services by Medicaid are covered under FAMIS MCO's well child and immunization benefits. EPSDT services **are** covered for FAMIS FFS members because they receive the Medicaid benefit package.

- Psychiatric treatment in free standing facilities *is not covered under FAMIS. However*, psychiatric treatment is covered when provided in a psychiatric unit of an acute hospital.

- Routine transportation to and from medical appointments *is not covered* for FAMIS MCO enrollees. Children enrolled in FAMIS FFS may receive non-emergency transportation services. Emergency transportation is covered for both FAMIS MCO and FAMIS FFS enrollees.

- Intensive in-home, therapeutic day treatment, mental health crisis intervention, and case management for children at risk of or experiencing a serious emotional disturbance, *are covered under FAMIS. Other* community mental health rehabilitation services *are not covered.*

*Eligible FAMIS individuals can enroll in an MCO or obtain additional information, as well as assistance with coverage issues, by calling Cover Virginia at 1-855-242-8282, Monday through Friday from 8:00 a.m. until 7:00 p.m. and Saturdays from 9:00am – noon. Information is also available online at www.covervirginia.org.*

**E. Common-wealth Coordinated Care (CCC)**

The Commonwealth Coordinated Care (CCC) program is person-centered care for individuals who are dually eligible for both Medicare and full benefit Medicaid. It covers all the same benefits under Medicare and Medicaid in a single program that coordinates primary, preventative, acute, behavioral, and long term care services. Individuals who meet the criteria for participation in CCC are automatically enrolled in the program but may opt out at any time.

*The CCC program will end effective December 31, 2017.*

Questions about CCC should be referred to MAXIMUS at 1-855-889-5243 or online at: www.virginiaccc.com.

***F. CCC Plus***

*Effective August 1, 2017, the CCC Plus Medicaid managed care program was implemented. CCC Plus operates statewide through a network of managed care plans across six regions as a mandatory program serving adults and children with disabilities and complex care needs. Individuals in nursing facilities and the home and community based waivers, as well as dually-eligible individuals (those with both Medicare and Medicaid) receive Medicaid through CCC Plus. Individuals receiving services through the Developmental Disabilities waivers are currently enrolled in CCC Plus only for their non-waiver services.*

*The following is a **partial** list of enrollees excluded from enrollment in CCC Plus:*

- *Limited covered groups – Plan First, Qualified Medicare Beneficiaries (QMB) only, Special Low income Medicare Beneficiaries (SLMB), Qualified Individuals (QI), and individuals enrolled in the Governor's Access Plan (GAP).*
- *Enrollees in specialized settings – intermediate care facilities for individuals with intellectual disability (ICF-ID), Veterans' nursing facilities, Level C psychiatric residential treatment facilities (PRTF), the Virginia Home, and the Piedmont, Catawba and Hancock state facilities.*
- *Enrollees with special medical conditions – end stage renal disease or in hospice care (CCC Plus who develop end state renal disease or elect hospice will remain in CCC Plus).*
- *Enrollees in other programs – Medicaid Medallion and FAMIS managed care, the Program for All-inclusive Care for the Elderly (PACE), Money Follows the Person (MFP), and the Alzheimer's Assisted Living Waiver (AAL)*

*Enrollees and their families may contact the CCC Plus Helpline at 1-844-374-9159 for information and assistance.*

**E. Enrollment Corrections/ Changes**

DMAS pays a capitation rate for every month an *individual* is enrolled in managed care regardless of whether the *individual* receives medical services during the month. If *an individual* is incorrectly enrolled in a Medicaid managed care program, the eligibility worker must refer the case to DMAS at the following address for possible recovery of expenditures (see chapter M1700):

Recipient Audit Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

# M1840.100 UTILIZATION REVIEW AND CLIENT MEDICAL MANAGEMENT

**A. Utilization Review**

Federal regulations require the Department of Medical Assistance Services (DMAS) to regularly review recipients' use and need for the covered medical services they receive. Regulations require that Medicaid pay only for medically necessary covered medical services. Medicaid cannot pay for duplicate services since they are not necessary.

DMAS staff in the Program Integrity Division reviews provider claims and recipient utilization histories for medical necessity. If it is determined that services were not medically necessary, providers are obligated to reimburse DMAS for any Medicaid payment they have received.

**B. Client Medical Management (CMM) Program**

An enrollee's utilization of Medicaid cards for physicians' services and pharmaceutical services is monitored regularly by DMAS. Whenever the utilization of one or both of these services is unusually high, the services will be reviewed for medical necessity. If some services are considered not medically necessary, recipients who are not enrolled in a managed care program will be placed in the CMM Program and required to select a primary physician and/or pharmacy or both.

Individuals identified as high utilizers will receive a letter of notification with instructions about selecting primary providers and identifying those providers to DMAS. Individuals who do not respond to the letter within the specified time will have their primary physician and pharmacy designated by DMAS.

For recipients who have been placed in the CMM Program, Medicaid payment for physicians' services will be limited to those services rendered by the primary physician (including a physician providing services to the patients of the primary physician when the primary physician is not available), physicians seen on referral from the primary physician, and emergency medical services.

Prescriptions may be filled by a non-designated pharmacy only in emergency situations when the designated pharmacy is closed or cannot readily obtain the drug.

# M1850.100 COVERED SERVICES

**A. General Information**

Information on Medicaid covered services is provided to assist the eligibility worker in responding to general inquiries from applicants/recipients. Individuals who have problems with bills or services from providers of care should be referred as follows:

- Refer FFS Medicaid enrollees to the DMAS Recipient Helpline at 804-786-6145. Refer individuals who need assistance with transportation to the DMAS transportation broker at 1-866-386-8331.

- Refer individuals enrolled in managed care to the Managed Care HelpLine at 1-800-643-2273 or directly to their MCO. Individuals in managed care who need assistance with transportation must contact their MCO directly.

**B. Copayments**

**a. Medicaid Enrollees without Medicare**

Most Medicaid covered services have a "copayment," which is the portion of the cost of the service for which the recipient is responsible. Copayment amounts range from $1.00 to $3.00 for most services. There is a $100.00 copayment per admission for inpatient hospital stays. The provider collects the copayment directly from the enrollee at the time the service is provided.

**b. Medicare Beneficiaries**

Individuals with Medicare and full-benefit Medicaid (dual eligibles) and Qualified Medicare Beneficiaries (QMB) are responsible for Medicaid copayments only. Medicaid covers the remainder of the Medicare copayment for these individuals. However, a provider is allowed to collect the Medicare copayment at the time of service. If the provider requires the individual to pay the Medicare copayment, the individual must be reimbursed or credited the difference between the Medicare and Medicaid copayments once the provider receives payment of the Medicaid claim.

**B. Individuals Exempt from Copayments**

The following individuals are exempt from the Medicaid copayments:

- children under 21 years old,

- *pregnant women,*

- individuals who receive long-term care services in a nursing facility, rehabilitation hospital, or long-stay hospital, and

- individuals receiving Medicaid community-based care (CBC) waiver services and hospice care.

# M21 Changes

| Changed With | Effective Date | Pages Changed |
|---|---|---|
| TN #DMAS-6 | 10/1/17 | Page7 |
| TN #DMAS-4 | 4/1/17 | Appendix 1, page 1 |
| TN #DMAS-3 | 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<br>Pages 1-7<br>Appendices 1<br>Pages 8-10 and Appendices 2 and 3 were deleted. |
| UP #10 | 5/1/14 | Pages 1-3<br>Appendix 1 |
| TN #99 | 1/1/14 | Pages 1-3<br>Appendix 1 |
| TN # 98 | 10/1/13 | Table of Contents<br>Pages 1-10<br>Pages 10a and 11-16 were deleted. |
| UP #9 | 4/1/13 | Pages 3, 4 |
| UP #8 | 10/1/12 | Table of Contents<br>Pages 2-4<br>Appendix 3 deleted |
| TN #97 | 9/1/12 | Pages 3, 4 |
| UP #7 | 7/1/12 | Pages 3, 4<br>Appendix 2, pages 1<br>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<br>Pages 5, 6, 14, 15,<br>Page 16 added<br>Appendix 1 |
| TN #94 | 9/1/10 | Page3<br>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 |

**F. FAMIS Select**

Under the FAMIS program, a family, whose child(ren) are determined eligible for FAMIS and who has access to health insurance through an employer or wishes to purchase a private policy, has the option of enrolling the family in that health plan. "FAMIS Select" allows the choice of the private or employer's insurance instead of FAMIS. Children enrolled in FAMIS whose families have access to private or employer sponsored health insurance coverage may qualify to have the State pay part of the family's share of the health insurance premium.

Once a child is enrolled in FAMIS, the worker will identify if the family is interested in more information about FAMIS Select. Families who have access to health insurance will receive information from DMAS about the benefits of enrolling in the FAMIS Select component of FAMIS and information about how to participate in the program. Participation in the FAMIS Select component is voluntary.

**G. 12-Month Continuous Coverage**

Children under age 19 who are enrolled in FAMIS are entitled to 12 months of continuous coverage provided the family continues to reside in Virginia and the family income is less than or equal to 200% of the FPL.

Children enrolled in FAMIS who subsequently apply for Medicaid and are found eligible must have their FAMIS coverage cancelled so they can be reinstated in Medicaid.

**H. *Renewal Period Extension For Declared Disaster Areas***

*Effective January 1, 2017, if the Governor or the Federal Emergency Management Agency (FEMA) declares Virginia or any area in Virginia to be a disaster area, children enrolled in FAMIS who reside in the declared disaster area may be granted a 90-day extension of the continuous coverage period before their next renewal is due.*

*The extension of the renewal period applies only to children in a declared disaster area (1) for whom an ex parte renewal cannot be completed and (2) who do not return a renewal form or complete an online or telephonic renewal prior to the renewal due date.*

*The next 12-month continuous eligibility period begins the month after the renewal completion date.*

## M2150.100 REVIEW OF ADVERSE ACTIONS

**A. Case Reviews**

An applicant for FAMIS may request a review of an adverse determination regarding eligibility for FAMIS. FAMIS reviews follow the procedures established by Medicaid for client appeals (see chapter M16).

The payment of medical services on the part of any child or any right to participate in the program is not subject to review if funds for FAMIS are exhausted.

**M22 Changes**

| Changed With | Effective Date | Pages Changed |
|---|---|---|
| TN #DMAS-6 | 10/1/17 | Page 7<br>Appendix 1, page 1 |
| TN #DMAS-4 | 4/1/17 | Appendix 1, page 1 |
| TN #DMAS-1 | 6/1/16 | Page 4<br>Appendix 1, page 1 |
| TN #100 | 5/1/15 | Table of Contents<br>Pages 1, 2, 5, 6, 7<br>Appendix 1<br>Pages 3 and 4 are runover Pages. |
| TN #98 | 10/1/13 | Table of Contents<br>Pages 1-7<br>Appendix 1<br>Pages 8-10 were deleted. |
| UP #9 | 4/1/13 | Appendix 1 |
| UP #8 | 10/1/12 | Pages 2, 3<br>Page 3a deleted |
| UP #7 | 7/1/12 | Pages 2, 3 |
| UP #6 | 4/1/12 | Appendix 1 |
| TN #96 | 10/1/11 | Pages 3, 3a |
| TN #95 | 3/1/11 | Pages 4-6<br>Appendix 1 |
| UP #4 | 7/1/10 | Page 10 |
| TN #94 | 9/1/10 | Page 3 |
| UP #3 | 3/01/10 | Page 2 |
| TN #93 | 1/1/10 | Pages 2-10 |
| UP #2 | 8/24/09 | Page 3 |
| Update (UP) #1 | 7/1/09 | Pages 1, 2, 7<br>Appendix 1, page 1 |

**F. Application Not Required for Newborn**

The newborn child born to a FAMIS MOMS enrollee is deemed eligible for FAMIS coverage until his first birthday. Follow the procedures for enrolling a newborn in M0330.802, using the appropriate AC as follows:

AC 010 = mother's income > 143% FPL but ≤ 150% FPL

AC 014 = mother's income > 150% FPL but ≤ 200% FPL.

*Act on the enrollment of a deemed newborn as soon as feasible when the birth is reported to the local DSS office or to DMAS.*

## M2250.100 REVIEW OF ADVERSE ACTIONS

An applicant for FAMIS MOMS may request a review of an adverse determination regarding eligibility for FAMIS MOMS. FAMIS MOMS follows the procedures established by Medicaid for client appeals (see Chapter M16).

The payment of medical services on the part of any pregnant woman or any right to participate in the program is not subject to review if the reason for denial or cancellation is that funds for the FAMIS MOMS program are exhausted.

# FAMIS MOMS
# 200% FPL
# INCOME LIMITS
# ALL LOCALITIES

# EFFECTIVE 1/31/17

| Household Size | 200% FPL Monthly Amount | 205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS) |
|---|---|---|
| 2 | $2,707 | $2,775 |
| | | |
| 3 | 3,404 | 3,490 |
| | | |
| 4 | 4,100 | 4,203 |
| | | |
| 5 | 4,797 | 4,917 |
| | | |
| 6 | 5,494 | 5,632 |
| | | |
| 7 | 6,190 | 6,345 |
| | | |
| 8 | 6,887 | 7,060 |
| | | |
| Each additional, add | 697 | 715 |