COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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Virginia Medical Assistance Eligibility Manual
Transmittal #DMAS-16

The following acronyms are contained in this letter:

- DMAS – Department of Medical Assistance Services
- FAMIS – Family Access to Medical Insurance Security
- FPL – Federal Poverty Level
- LTSS – Long-term Services and Supports
- MAGI – Modified Adjusted Gross Income
- PARIS - Public Assistance Reporting Information System
- QMB – Qualified Medicare Beneficiaries
- TN – Transmittal

TN #DMAS-16 includes policy clarifications, updates and revisions. Unless otherwise noted in the Cover Letter and/or policy, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after April 1 2020.

The following changes are contained in TN #DMAS-16:

Changed Pages	Changes
M0270 Page 3 Page 4 was added.	Added Medicare as a benefit for which the individual must apply.
Chapter M04 Pages 16a, 20 Appendix 1, pages 1-2 Appendix 2, pages 1-2 Appendices 6 and 7	On page 16a, clarified the definition of the care provider's home. On page 20, revised the procedures for enhanced clarity. In Appendices 1, 2, 6, and 7, revised the income limits.

Changed Pages	Changes
Subchapter M0510 Page 5	Corrected the formatting of a sentence.
Subchapter M0720 Page 11	Revised the policy to address 2020 Census income.
Subchapter M0810 Page 2	On page 2, revised the income limits that are based on the FPL.
Subchapter M0820 Page 29	Revised the policy to address 2020 Census income.
Subchapter M1510 Pages 5, 6, 12, 13 Pages 14 and 15 are runover pages.	On pages 5 and 6, clarified that QMB-only coverage for new applicants and individuals who reapply cannot be retroactive. On pages 14 and 15, revised the policy to clarify that application for Medicare is a condition of eligibility unless the state does not pay the Medicare premiums, deductibles or co-insurance (except those applicable under Part D) for persons covered by the Medicaid eligibility group under which the individual is applying.
Subchapter M1520 Pages 3, 4, 7, 9 Appendix 2 Pages 3a and 4 were renumbered to pages 4 and 4a. Page 4a is a runover page	On pages 3 and 4, replaced text that was inadvertently deleted in a previous transmittal. On page 4, clarified entitlement to QMB coverage. On page 7, clarified documentation of verifications for ex parte renewals. On page 9, clarified entitlement to QMB. In Appendix 2, revised the income limits.
Subchapter M1550 Page 2 Appendix 1, page 1	Revised the contact information for the Medicaid technicians.
Chapter M17 Appendix 4, page 1 Appendix 4, page 2 was added.	Revised the Public Assistance Reporting Information System (Paris) Notice Of Medicaid Recipient Fraud/Non-Fraud form.
Chapter M21 Appendix 1	Revised the income limits.
Chapter M22 Appendix 1	Revised the income limits.

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

Sincerely,

Rachel Pryor
Deputy Director of Administration

Attachment

M0270 Changes

Changed With	Effective Date	Pages Changed
Transmittal (TN) #DMAS-16	4/1/20	Page 3 Page 4 was added.
Update (UP) #9	4/1/13	page 3

i. *Coverage under Medicare A, B or D, or any combination of Medicaid A, B, and D, if it is likely that the individual would meet the eligibility criteria for any or all of those programs.*

3. Other Benefits

Other benefits to which an individual may be entitled and for which he must apply, if he appears to be entitled, include but are not limited to:

a. private insurance company disability, income protection, etc., benefits when the individual has such a policy;

b. private pension plan benefits;

c. union benefits.

M0270.300 AGENCY PROCEDURES

A. Written Notice

The local agency Eligibility Worker (EW) must advise the individual in writing on a dated notice that the individual must apply for other benefits for which he or she is potentially eligible. The written notice must list the benefits for which the individual must apply.

B. Identify Potential Eligibility For Other Benefits

Obtain clues to an individual's possible eligibility for other benefits from:

- information obtained from the interview, including responses to leading questions on the application;
- the recipient's responses on a redetermination form and/or interview;
- inquiries received from another agency;
- agency knowledge of pension plans and benefits;
- third party reports;
  - computer system inquiries.

C. Disability Referral Processing

Do not hold the Disability Determination Services (DDS) referral while waiting for the applicant to provide proof of his/her application for disability benefits; send it immediately to the *DDS*.

D. *Medicare*

Individuals are required to apply for coverage under Medicare A, B or D, or any combination of Medicaid A, B, and D, if it is likely that the individual would meet the eligibility criteria for any or all of those programs. The following individuals may be covered by Medicare:

- *people age 65 or older,*
- *individual under age 65 with disabilities who have been entitled to Social Security or Railroad Retirement Board disability benefits for 24 months. For individuals diagnosed with amyotrophic lateral sclerosis (ALS), Medicare coverage begins the first month the individual receives disability benefits.*

- *individuals with End Stage Renal Disease (permanent kidney failure requiring dialysis or transplant).*

The state agrees to pay any applicable premiums and cost-sharing (except those applicable under Part D) for individuals required to apply for Medicare.

Application for Medicare is a condition of eligibility unless the state does not pay the Medicare premiums, deductibles or co-insurance (except those applicable under Part D) for persons covered by the Medicaid eligibility group under which the individual is applying.

_E._ Verification

The individual must provide verification of application for the benefits specified on the notice prior to enrollment.

Verify the application for benefits via a systems search whenever possible. Written or verbal verification from the agency or organization issuing the benefit(s) is also acceptable. When verbal verification is provided, document the case record with the name of the individual who provided the verification and the date. Retain documentation of the application for other benefits in the case record.

If the individual cannot apply for the benefit before the end of the allowed processing time due to circumstances beyond his control (i.e. the agency or organization issuing the benefit cannot give him appointment within that time frame) accept verification of the appointment and enroll the individual if he is otherwise eligible. Follow up with the individual after the application for the benefit to obtain verification.

Changed With	Effective Date	Pages Changed
TN #DMAS-16	4/1/20	Pages 16a, 20 Appendix 1, pages 1-2 Appendix 2, pages 1-2 Appendices 6 and 7
TN #DMAS-15	1/22/19	Pages 16, 16a, 19
TN #DMAS-14	10/1/19	Pages 1, 3, 4, 5, 14, 16, 32, 33 Appendix 8
TN #DMAS-13	7/1/19	Pages 32-34, 36 Appendices 3 and 5
TN #DMAS-12	4/1/19	Pages 2, 3, 5-8, 15-16, 19, 32-37 Page 16a was added as a runover page. Page 37 was removed. Appendices 1, 2, 6, 7, 8
TN #DMAS-11	1/1/19	Pages 8, 15, 32-35 Pages 36 and 37 were added.
TN #DMAS-10	10/1/18	Table of Contents Pages 1-5, 9, 10, 15, 16, 19, 22, 23, 30-32 Appendix 7 Appendix 8 was renumbered. Pages 6-8, 11-14, 17, 18, 20, 21, 24-29, 33-35 are runover pages.

Changed With	Effective Date	Pages Changed
TN #DMAS-9	7/1/18	Table of Contents. Pages 5, 6, 11, 14a, 25-27 Appendices 3 and 5 Page 6a is a runover page. Page 28 was added as a runover page.
TN #DMAS-8	4/1/18	Table of Contents Pages 2-6a, 12-14b, 25 Pages 26 and 27 were added. Pages 14c was added as a runover pages. Appendices 1, 2, 6 and 7 Appendix 1, page 2 was added.
TN #DMAS-6	10/1/17	Pages 12, 13, 14b
TN #DMAS-5	7/1/17	Table of Contents Pages 5, 6, 12, 13, 14-14b Appendices 3, 4 and 5 Page 6a was added as a runover page. Page 13a, 14, and 14a were renumbered to pages 14, 14a and 14b.
TN #DMAS-4	4/1/17	Appendices 1, 2 and 6
TN #DMAS-3	1/1/17	Table of Contents Pages 3 -5, 13a, 20 Appendix 6, page 1 Page 20a was added.
TN #DMAS-2	10/1/16	Appendix 2, pages 1, 2 Appendices 3, 5
TN #DMAS-1	6/1/16	Pages 3, 5, 6, 12, 13, 14a Appendices 1, 2, 6 and 7 Appendix 2, page 2 was added. Page 13a is a runover page.
UP #11	7/1/15	Appendices 3 and 5
TN #100	5/1/15	Pages 2, 11, 12, 13, 14 Appendices 1, 2, 3, 5, 6 and 7 Page 1 is a runover page.
Update (UP) #10	5/1/14	Table Contents pages 2, 3, 5, 6, 10-15 Appendices 1, 2 and 6 Appendix 7 was added.
TN #99	1/1/14	Pages 2, 5, 6, 8, 14, 15 Appendix 6

i. A parsonage allowance is not counted.

j. Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are not counted.

k. Effective January 1, 2019, student loan debt forgiven due to death or disability of student is not counted as income.

l. Difficulty of Care Payments, which include (1) payments designated by the payer as compensation for providing additional care that is required for a physically, mentally or emotionally disabled qualified foster care individual living in the provider's home and (2) payments to care providers who provide care under a Medicaid home and-community-based Waiver to an individual in the care provider's home. *The care provider's home is the residence in which the care provider resides and regularly performs the routines of the care provider's life. If the care provider moves into an individual's home to care for that individual and performs the routines of the care provider's life in that residence, it is considered the care provider's home.*

m. General Welfare Payments for Indian Tribes are not countable To qualify under the general welfare exclusion, the payments must be made pursuant to a governmental program for the promotion of the general welfare based on need and not represent compensation for services (See https://www.irs.gov/pub/irs-drop/n-12-75.pdf)

n. Kinship Guardianship Payments are not income. These payments are a stipend paid to a relative caregiver who has assumed custody of a child as an alternative to that child remaining in foster care.

1. Income From Self-employment

An individual reporting self-employment income must provide verification 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.

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; ***or***

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; ***or***

4) the child is a Special Medical Needs Adoption Assistance child.

If No to 1) through 4) above - the household is the household of the tax filer claiming her/him as a tax dependent.

If Yes to any of 1) through 4) above - Continue to Step 3.

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.

5% FPL INCOME DISREGARD AMOUNTS
ALL LOCALITIES

EFFECTIVE *1/17/20*

Household Size	**Monthly Amount**
1	*$54*
2	*72*
3	*91*
4	*110*
5	*128*
6	*147*
7	*166*
8	*184*
Each additional, add	*19*

GAP-FILLING RULE EVALUATION
100% FPL
INCOME LIMITS

EFFECTIVE *1/17/20*

Household size	Annual (Use for Gap-filling Evaluation)	Monthly
1	*$12,760*	*$1,064*
2	*17,240*	*1,437*
3	*21,720*	*1,810*
4	*26,200*	*2,184*
5	*30,680*	*2,557*
6	*35,160*	*2,930*
7	*39,640*	*3,304*
8	*44,120*	*3,677*
Each additional	*4,480*	*374*

PREGNANT WOMEN
143% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/17//20*

Household Size	143% FPL Yearly Amount	143% FPL Monthly Amount	148% FPL (143% FPL + 5% FPL Disregard)
2*	*$24,654*	*$2,055*	*$2,127*
3	*31,060*	*2,589*	*2,680*
4	*37,466*	*3,123*	*3,233*
5	*43,873*	*3,657*	*3,785*
6	*50,279*	*4,190*	*4,337*
7	*56,686*	*4,724*	*4,890*
8	*63,092*	*5,258*	*5,442*
Each additional, add	*6,407*	*534*	*553*

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

CHILD UNDER AGE 19
143% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/17/20*

# of Persons in House-hold	**109% FPL (for Determining Aid Category)**	**143% FPL**		**148% FPL (143% FPL + 5% FPL Disregard)**
	Monthly Limit	*Annual Limit*	Monthly Limit	Monthly Limit
1	*$1,160*	*$18,247*	*$1,521*	*$1,575*
2	*1,566*	*24,654*	*2,055*	*$2,127*
3	*1,973*	*31,060*	*2,589*	*2,680*
4	*2,380*	*37,466*	*3,123*	*3,233*
5	*2,787*	*43,873*	*3,657*	*3,785*
6	*3,194*	*50,279*	*4,190*	*4,337*
7	*3,601*	*56,686*	*4,724*	*4,890*
8	*4,008*	*63,092*	*5,258*	*5,442*
Each add'l, add	*407*	*6,407*	*534*	*553*

PLAN FIRST
200% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/17/20*

Household Size	200% FPL Yearly Amount	200% FPL Monthly Amount	205% FPL (200% FPL + 5% FPL Disregard)
1	*$25,520*	*$2,127*	*$2,181*
2	*34,480*	*2,874*	*2,946*
3	*43,440*	*3,620*	*3,711*
4	*52,400*	*4,367*	*4,477*
5	*61,360*	*5,114*	*5,242*
6	*70,320*	*5,860*	*6,007*
7	*79,280*	*6,607*	*6,773*
8	*88,240*	*7,354*	*7,538*
Each additional, add	*8,960*	*747*	*766*

MAGI ADULTS
133% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/17/20*

Household Size	*133% FPL Yearly Amount*	133% FPL Monthly Amount	138% FPL (133% FPL + 5% FPL Disregard)
1	*$16,971*	*$1,415*	*$1,469*
2	*22,930*	*1,911*	*1,983*
3	*28,888*	*2,408*	*2,499*
4	*34,846*	*2,904*	*3,014*
5	*40,805*	*3,401*	*3,529*
6	*46,763*	*3,897*	*4,044*
7	*52,722*	*4,394*	*4,560*
8	*58,680*	*4,890*	*5,074*
Each additional, add	*5,959*	*497*	*$516*

M0510 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-16	4/1/20	Page 5
TN #98	10/1/13	Pages 1-3

M0520. If the child has excess income for MI, then determine the child's ABD MN eligibility for spenddown, using the ABD assistance unit policy in M0530.

b. Receives SSI

If the child receives SSI, determine the child's eligibility as an SSI recipient. If the child is not eligible for Medicaid as an SSI recipient (e.g. because of excess resources), determine the child's eligibility as F&C. *If* the child is pregnant or under age 19, use the F&C family/budget unit policy in M0520.

2. Individual Age 19 but Under 21

a. Receives SSI

If the child is age 19 or 20 and is not eligible for Medicaid as an SSI recipient, e.g., because of excess resources, determine his/her F&C eligibility IF he/she also meets an F&C covered group because the F&C real property requirements are different from the ABD requirements. Use the F&C family/budget unit policy in M0520.

If he/she does NOT meet an F&C covered group, he/she is not eligible for Medicaid.

b. Disabled or Blind Child

If the child is disabled or blind, first determine the child's ABD eligibility using the ABD assistance unit policy in M0530. If not eligible as ABD and the child meets an F&C covered group, use the F&C family/budget unit policy in M0520.

c. Pregnant Woman

If the individual is pregnant, determine F&C MI eligibility first. Use the family/budget unit policy in M0520. If the individual is not eligible as MI, she should meet the MN pregnant woman group. Use the F&C family/budget unit policy in M0520 when determining her MN eligibility.

3. Individual Age 21 and Older

a. Pregnant Woman

If the individual is pregnant, determine F&C MI eligibility first. Use the family/budget unit policy in M0520. If the individual is not eligible as MI, she should meet the MN pregnant woman group. Use the F&C family/budget unit policy in M0520 when determining her MN eligibility.

b. Other Individuals

If the individual is aged, disabled or blind, first determine the individual's ABD assistance unit in M0530. If the individual is not eligible as ABD and he/she meets an F&C covered group, use the F&C family/budget unit policy in M0520.

M0720 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-16	4/1/20	Page 11
TN# DMAS -14	10/1/19	Page 2
TN# DMAS -11	01/01/19	Page 4
TN #DMAS-2	10/1/16	Table of Contents, page i Pages 11, 13, 14 Appendix 1 Pages 15-19 were deleted.
TN #DMAS-1	6/1/16	Page 2
TN #98	10/1/13	Pages 6, 10
TN #94	9/01/10	Pages 5, 6
TN #91	5/15/09	Page 11

B. Earned Income Exclusions

Income exclusions are applied, in the following order, to earned income for family unit/budget unit (FU/BU) members as appropriate to the covered group.

See Families and Children (F&C) Earned Income Exclusions chart in Appendix 1 to this subchapter.

1. Workforce Investment Act Income

Earned income of an eligible child (less than 18, or 18 and expected to graduate prior to 19) derived from employment in a program under the Workforce Investment Act is excluded. Do not request verification of income from employment under the Workforce Investment Act.

2. Student Income

Earned income of an individual under age 19 who is a student is excluded. Do not request verification of student income.

For this exclusion, a student is any individual under age 19 who is attending any type or level of school, part-time or full-time. Do not verify school attendance; declaration of school attendance is sufficient.

3. *2020* Census Income

Income paid by the U.S. Census Bureau to temporary employees specifically hired for the 2020 census is NOT counted when determining eligibility for medical assistance for *F&C Medically Needy covered groups.*

4. Standard Work Exclusion

A standard work exclusion of the first $90 of gross monthly earned income is excluded for each employed member of the FU/BU whose income is not otherwise exempt. See M0720.520.

5. Child Care/ Incapacitated Adult Care Exclusion

Monthly anticipated child care expenses or incapacitated adult care expenses, up to the appropriate maximums, which are paid for by the caretaker-relative must be excluded. See M0720.540.

M0810 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-16	4/1/20	Page 2
TN #DMAS-15	1/1/20	Pages 1, 2
TN #DMAS-14	10/1/19	Pages 20, 25, 27 Page 28 is a runover page.
TN #DMAS-12	4/1/19	Page 2
TN #DMAS-11	1/1/19	Pages 1, 2
TN #DMAS-10	10/1/18	Page 2
TN #DMAS-9	7/1/18	Page 2
TN #DMAS-8	4/1/18	Page 2
TN #DMAS-7	1/1/18	Pages 1, 2
TN #DMAS-5	7/1/17	Page 2
TN #DMAS-4	4/1/17	Page 2
TN #DMAS-3	1/1/17	Pages 1, 2
TN #DMAS-2	10/1/16	Page 2
TN #DMAS-1	6/1/16	Pages 1, 2
UP #11	7/1/15	Page 2
TN #100	5/1/15	Pages 1, 2
UP #10	5/1/14	Page 2
TN #99	1/1/14	Pages 1, 2
TN #98	10/1/13	Page 2
UP #9	4/1/13	Pages 1, 2
UP #7	7/1/12	Page 2
UP #6	4/1/12	Pages 1, 2
TN #95	3/1/11	Pages 1, 2
TN #93	1/1/10	Pages 1, 2
Update (UP) #1	7/1/09	Page 2

3. Categorically Needy 300% of SSI

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

Family Size Unit	2019 Monthly Amount	2020 Monthly Amount
1	$2,313	$2,349

4. ABD Medically Needy

a. Group I	7/1/2018 – 6/30/19		7/1/2019	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$ 1,904.55	$317.42	$1,957.87	$326.31
2	2,424.75	404.12	2,492.57	415.42

b. Group II	7/1/2018 – 6/30/19		7/1/2019	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$ 2,197.56	$366.26	$2,259.09	$376.51
2	2,706.04	451.00	2,781.69	463.61

c. Group III	7/1/2018 – 6/30/19		7/1/2019	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$ 2,856.84	$476.14	$2,936.83	$489.47
2	3,444.33	574.05	3,540.71	590.11

5. ABD Categorically Needy

For:

ABD 80% FPL, QMB, SLMB, & QI <u>without</u> Social Security income; all QDWI; effective *1/17/20*

ABD 80% FPL, QMB, SLMB, & QI <u>with</u> Social Security income; effective *3/1/20*

All Localities	2019		2020	
ABD 80% FPL	Annual	Annual	Annual	Monthly
1	$9,992	$9,992	*$10,208*	*$851*
2	13,528	13,528	*13,792*	*1,150*
QMB 100% FPL	Annual	Annual	Annual	Monthly
1	$12,490	$12,490	*$12,760*	*$1,064*
2	16,910	16,910	*17,240*	*1,437*
SLMB 120% of FPL	Annual	Annual	Annual	Monthly
1	$14,988	$14,988	*$15,312*	*$1,276*
2	20,292	20,292	*20,688*	*1,724*
QI 135% FPL	Annual	Annual	Annual	Monthly
1	$16,862	$16,862	*$17,226*	*$1,436*
2	22,829	22,829	*23,274*	*1,940*
QDWI 200% of FPL	Annual	Annual	Annual	Monthly
1	$24,980	$24,980	*$25,520*	*$2,127*
2	33,820	33,820	*34,480*	*2,874*

S0820 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-12	4/1/20	Page 29
TN #DMAS-15	1/1/20	Pages 30, 31
TN #DMAS-14	10/1/19	Pages 10, 11, 13, 22, 24
TN #DMAS-12	4/1/19	Page 21
TN #DMAS-11	1/1/19	Pages 30, 31
TN #DMAS-7	1/1/18	Page 11, 30-32
TN #DMAS-5	7/1/17	Pages 11, 13, 29, 30 Page 12 is a runover page.
TN #DMAS-3	1/1/17	Pages 30, 31
TN #DMAS-1	6/1/16	Pages 30, 31, 47
TN #100	5/1/15	Pages 30, 31, 47 Page 48 is a runover page.
TN #99	1/1/14	Pages 30, 31
UP #9	4/1/13	Pages 30, 31
Update (UP) #6	4/1/12	Pages 30, 31
TN #95	3/1/11	Pages 3, 30, 31
TN #93	1/1/10	Pages 30, 31
TN #91	5/15/09	Table of Contents Pages 29, 30

C. Procedure

1. Verification

a. Verify these payments by examining documents in the individual's possession which reflect:

- the amount of the payment,
- the date(s) received, and
- the frequency of payment, if appropriate.

b. If the individual has no such evidence in his possession, contact the source of the payment.

c. If verification cannot be obtained by the above means, accept any evidence permitted by either S0820.130 A. or S0820.220.

2. Assumption

Assume that any honorarium received is in consideration of services rendered, absent evidence to the contrary. Evidence to the contrary would include a statement or document indicating that part or all of the honorarium is for something other than services rendered (e.g., travel expenses or lodging).

3. Expenses of Obtaining Income

DO NOT DEDUCT any expenses of obtaining income from royalties or honoraria that are earned income. (Such expenses are deductible from royalties/honoraria that are unearned income.)

4. Documentation

Document the file by including copies of documents or indicating in the file information provided by the payment source concerning the amount and, if appropriate, frequency of payment.

D. References

- Royalties as unearned income, S0830.510.
- To determine deductible IRWE/BWE, see S0820.535 - .565.

EARNED INCOME EXCLUSIONS

M0820.500 GENERAL

A. Policy

1. General

The source and amount of all earned income must be determined, but not all earned income counts when determining Medicaid eligibility.

2. Other Federal Laws

First, income is excluded as authorized by other Federal laws.

3. *2020* Census Income

Income paid by the U.S. Census Bureau to temporary employees specifically hired for the *2020* census is NOT counted when determining eligibility for medical assistance.

M1510 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-16	4/1/20	Pages 5, 6, 12, 13 Pages 14 and 15 are runover pages.
TN #DMAS-14	10/1/19	Pages 2b, 4, 5-7
TN #DMAS-12	4/1/19	Pages 7, 9a. Page 7a is a runover page.
TN #DMAS-11	1/1/19	Page 7
TN #DMAS-10	10/1/18	Pages 7, 8a, 9a, 14 Pages 8b and 8c are runover pages.
TN #DMAS-9	7/1/18	Table of Contents Page 5. Page 9a was added.
TN #DMAS-8	4/1/18	Pages 2, 8a, 8b Page 8c was added.
TN #DMAS-6	10/1/17	Table of Contents Pages 1, 2 Page 2a is a runover page. Page 2b was added as a runover page.
TN #DMAS-5	7/1/17	Page 1 Page 2 is a runover page.
TN #DMAS-4	4/1/17	Pages 2a, 10
TN #DMAS-2	1/1/17	Table of Contents Pages 1, 8, 8a, 12-15 Page 11a was deleted.
TN #DMAS-2	10/1/16	On pages 3-15, corrected the subchapter number in the headers. Neither the dates nor the policies were changed.
TN #DMAS-1	6/1/16	Pages 2 Pages 1 and 2a are runover pages.
TN #100	5/1/15	Table of Contents Pages 1-2a, 5-8b
UP #10	5/1/14	Table of Contents Pages 7-8a Page 8b was added.
TN #99	1/1/14	Table of Contents Pages 1, 2, 8, 8a, 9-11 Page 11a was added.
UP #9	4/1/13	Pages 2-7, 10-12, 14
UP #7	7/1/12	Pages 8, 9
TN #96	10/01/11	Pages 8a, 10
TN #95	3/1/11	Table of Contents Pages 8, 11-15
TN #94	9/1/10	Pages 2a, 8-8a
TN #93	1/1/10	Page 6
Update (UP) #2	8/24/09	Page 11
TN #91	5/15/09	Page 14

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

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

H. Retroactive Entitlement

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

QMB-only coverage for new applicants or individuals with closed coverage who reapply outside a renewal reconsideration period cannot be retroactive.

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

1. Retroactive Coverage Begin Date

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

2. Retroactive Coverage End Date

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

3. Example

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

M1510.102 ONGOING ENTITLEMENT

A. Coverage Begin Date

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

- when an applicant has excess income;
- when the applicant is eligible only as a QMB;
- when the applicant is age 21-64 years and is admitted to an institution for mental diseases (IMD;
- when the individual is incarcerated (see M0140.200.C.1 and M0140.300.D);
- for a newborn, coverage will begin on the child's date of birth.

1. Applicant Has Excess Income

When all eligibility requirements are met except for income, entitlement begins the date the spenddown is met. Only medically needy applicants can be eligible after meeting a spenddown. See subchapter M1330 to determine retroactive spenddown eligibility.

2. QMB Applicant

Entitlement to Medicaid for QMB coverage begins the first day of the month **following** the month in which the individual's QMB eligibility is determined and approved, **not** the month of application. *QMB-only coverage for new applicants or individuals with closed coverage who reapply outside a renewal reconsideration period cannot be retroactive.*

EXAMPLE #6: Ms. C is 55 years old and is disabled. She applied for Medicaid on May 8, 2019, and requested retroactive coverage. She began receiving Medicare in May 2019. She is approved for QMB coverage on June 9; therefore, her QMB coverage will begin on July 1. She is eligible to receive coverage in the MAGI Adults covered group for the retroactive months of February, March, and April. However, she is not eligible for MAGI Adults coverage in May or June due to her Medicare enrollment. QMB eligibility cannot extend to the retroactive period (see M1510.101.H). If she did not opt out of Plan First, she should be enrolled in Plan First coverage for May and June, 2019.

3. SLMB and QDWI

Ongoing entitlement for the Special Low Income Medicare Beneficiary (SLMB) and the Qualified Disabled and Working Individuals (QDWI) covered groups is the first day of the application month when all eligibility factors are met at any time in the month of application.

4. Applicant Age 21-64 Is Admitted To An IMD

An applicant who is age 21-64 years and who is admitted to an IMD is NOT eligible for Medicaid. If otherwise eligible for Medicaid in the application month, his entitlement to Medicaid begins the date he is discharged from the ineligible institution in the month.

EXAMPLE #6a: Mr. A is a 50 year old man who applies for Medicaid at his local agency on October 1, 2006. He receives Social Security disability benefits. He was admitted to Central State Hospital (an IMD) on October 20, 2006, and was discharged on November 2, 2006, back to his home locality. The agency completes the Medicaid determination on November 5 and finds that he is eligible for Medicaid in October 2006 and ongoing, except for the period of time he was in Central State Hospital.

The worker enrolls him in Medicaid for a closed period of coverage beginning October 1, 2006, and ending October 20, 2006. The worker also enrolls him in an ongoing period of Medicaid coverage beginning November 2, 2006.

5. Applications From CSBs For IMD Patients Ages 21-64 Years

A patient who is age 21 years or older but is less than 65 years and who is in an IMD is not eligible for Medicaid while in the IMD. Local agencies will take the **applications received from the CSBs** for Department of Behavioral Health and Developmental Services (DBHDS) IMD patients who will be discharged within 30 days and process the applications within the established time frames. Eligibility will be determined based on the type of living arrangement to which the patient will be discharged. If eligible, do not enroll the patient until the date the patient is discharged from the IMD.

M1510.300 FOLLOW-UP RESPONSIBILITIES

M1510.301 THIRD PARTY LIABILITY (TPL)

A. Introduction

Medicaid is a "last pay" program and cannot pay any claim for service until the service provider has filed a claim with the recipient's liable third parties such as health insurance companies or legally liable person. The procedures depend on the type of third party liability (TPL) the recipient has.

B. Private Health Insurance

Information on an eligible individual's private health insurance coverage must be obtained and recorded in the case record and in VaCMS. This must include the company name (code number for the TPL file), the policy number, and the begin date of coverage. This information does NOT require verification.

Health insurance policy or coverage changes must be updated in VaCMS.

1. Verification Required - Policy or Coverage Termination

Verification of the date the health insurance policy and/or a coverage type terminated is required. The verification of the termination date can be a written letter from, or verbal statement by, the insurance company that states the termination date. If verification is obtained, the worker is to **end-date** the TPL coverage in VaCMS (note: do not delete the TPL from VaCMS).

Absent receipt of documentation showing that the TPL coverage has ended, it must be left open in VaCMS and MMIS and cannot be ended by the worker. If the worker is unable to obtain verification of the coverage termination date from the insurance company or the enrollee/authorized representative, the worker is to notify DMAS that the enrollee's TPL coverage was terminated, but verification cannot be obtained. The notification should be sent via e-mail to: tplunit@dmas.virginia.gov. If it is determined that TPL coverage no longer exists, the coverage will be closed in MMIS by DMAS staff. The worker must then close the coverage in VaCMS.

2. Health Insurance Premium Payment (HIPP)Program

If an applicant or enrollee reports that he or a family member is employed more than 30 hours each week and is eligible for health insurance coverage under an employer's group health plan, he or she must be given a HIPP Fact Sheet which provides a brief description of the program and the contact information for the HIPP Unit at DMAS. The HIPP Fact Sheet is available on-line at: http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi.

If the enrollee opts to enroll in HIPP, update **VaCMS** with the TPL information when it is provided by the enrollee. Call the HIPP Unit at 1-800-432-5924 when an enrollee reports changes to the TPL information so that MMIS can be updated.

C. Medicare

Individuals are required to apply for coverage under Medicare A, B or D, or any combination of Medicaid A, B, and D, if it is likely that the individual would meet the eligibility criteria for any or all of those programs. The state agrees to pay any applicable premiums and cost-sharing (except those applicable under Part D) for individuals required to apply for Medicare.

Application for Medicare is a condition of eligibility unless the state does not pay the Medicare premiums, deductibles or co-insurance (except those applicable under Part D) for persons covered by the Medicaid eligibility group under which the individual is applying.

For persons age 65 or over, for persons under age 65 who have received SSA or Railroad Retirement benefits because of disability for 24 consecutive months, and for persons with chronic end-stage renal disease, the Department of Medical Assistance Services has a buy-in agreement with Medicare toprovide to those eligible individuals who are also eligible for Medicare the medical services available under Medicare, Part B (Title XVIII of the Social Security Act) through payment of the Part B premium.

When the recipient has to pay a Medicare Part A premium, Medicaid will pay the Part A premium for

- all QMBs; the "dually-eligible" (those who are eligible in a CN or MN covered group and also are QMB), and the QMB-only (those QMBs who are not eligible for Medicaid in another covered group);
- Qualified Disabled and Working Individuals (QDWI).

1. Buy-In Procedure

The Centers for Medicare and Medicaid Services(CMS) maintains a current list of individuals for whom the State is paying the Part B premiums. The list is updated on a monthly basis by adding newly enrolled individuals and deleting those no longer eligible. Before CMS will admit an individual to the buy-in list for Part B coverage, the individual must have established his eligibility for Medicare. His name and claim number, if one has been assigned, must be identical to the information in the SSA files. A difference between the name and number on the MMIS and in the SSA files results in a mismatch and rejection of Part B premium coverage.

2. Medicare Claim Numbers

Only two types of claim numbers correctly identify an individual's entitlement to Medicare coverage: a Social Security claim number or a Railroad Retirement claim number.

a. SSA claim numbers consist of a nine-digit number followed by a letter, or a letter and numerical symbol. The most common symbols are T, M, A, B, J1, K1, D, W, and E.

b. RR annuity-claim numbers have a letter (alpha) prefix followed by a six or nine digit number. The most common prefixes are A, M, H, WCD, NCA, CA, WD, WCH, and PD.

c. Certain letters following nine digit numbers identify an individual as an SSI recipient and are not acceptable as a Medicare claim number. These claim symbols are AI, AS, BC, BI, BS, DC, DI, and DS.

3. Procedures for Obtaining Claim Numbers

a. Requesting Medicare Card

Each Medicaid applicant who appears to qualify for Medicare must be asked if he has applied for Medicare. Those that have applied and are eligible have received a white card with a red and a blue stripe at the top, with his name as it appears in the SSA files and the assigned claim number on the card. The name as it appears and the claim number must be included in the TPL section of the MMIS eligibility file maintained by the Department of Medical Assistance Services

b. Applicants Who Cannot Produce a Claim Number

In the event the applicant either does not have a Medicare card or does not know his claim number, inquire SSA via the SVES (State Verification Exchange System) using the applicant's own SSN.

If the applicant has never applied for Medicare, complete the Referral to Social Security Administration Form DSS/SSA-1 (form #032-03-099) and write in, "Buy-In" on the upper margin. Mail the form to the Social Security Office serving the locality in which the applicant resides. The SSA office will provide the correct claim number if the individual is on their records. Should the (local/area) SSA office have no record of an application for Medicare, a representative will contact the applicant to secure an application.

4. Buy-in Begin Date

Some individuals have a delay in Buy-in coverage:

Classifications	Buy-in Begin Date
SSI and AG recipients (includes dually-eligible)	1st month of eligibility
CN and MN with Medicare Part A who are dually-eligible as either Qualified Medicare Beneficiaries (QMB) or Special Low Income Medicare Beneficiaries (SLMB Plus)	1st month of eligibility
CN and MN with no Medicare Part A or who are not dually-eligible as either QMB or SLMB Plus	3rd month of eligibility

If the medically needy coverage begin date is other than the first day of a month, Buy-in is effective the first day of the month in which the 60th day after the begin date occurs.

D. Other Third Party Liability

When the agency identifies another third party which has responsibility to pay for a recipient's medical bill, the agency must report the third party to:

Department of Medical Assistance Services
Third Party Liability Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Examples of other third parties include liability insurance settlements, trust funds established for the recipient's medical care, awards resulting from liability lawsuits, and persons ordered by the court to pay for the recipient's medical care.

E. Pursuing Third Party Liability and Medical Support

In order to continue to be eligible for Medicaid, an individual who is required to assign rights to, and cooperate in, pursuing medical support and third party liability must continue to cooperate with the local agency and DMAS. See subchapter M0250 for details.

M1510.302 SOCIAL SECURITY NUMBERS

A. Policy

Applicants must provide the Social Security number (SSN) of any person for whom they request Medicaid, or must apply for a Social Security number if he/she does not have one.

Exceptions – the SSN requirement does not apply to:

- an alien who is eligible only for Medicaid payment of emergency services, as defined in subchapter M0220, or
- a non-citizen who is only eligible to receive an SSN for a valid non-work reason, or
- a child under age one born to a Medicaid-eligible or FAMIS-covered mother (see M0330.301 B. 2 and M2220.100).

An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

When an individual has applied for an SSN and is determined eligible for medical assistance, the worker must take follow-up action to obtain the individual's SSN.

B. Procedures

See subchapter M0240 for the SSN application follow-up procedures required after enrolling an eligible individual who has applied for an SSN.

M1510.303 PATIENT PAY INFORMATION

A. Policy

After an individual in long-term care is found eligible for Medicaid, the recipient's patient pay must be determined. When the patient pay amount is initially established or when it is changed, the worker enters the information in VaCMS. VaCMS sends the "Notice of Obligation for Long-Term Care Costs" to the enrollee or the enrollee's authorized representative.

B. Procedure

When patient pay increases, the "Notice of Obligation for Long-Term Care Costs" is sent in advance of the date the new amount is effective.

Changed With	Effective Date	Pages Changed
TN #DMAS-16	4/1/20	Pages 3, 4, 7, 9 Appendix 2 Pages 3a and 4 were renumbered to pages 4 and 4a. Page 4a is a runover page.
TN #DMAS-15	1/1/20	Pages 8, 8a
TN #DMAS-14	10/1/19	Pages 2, 3, 4, 6a, 8, 9, 10, 13 Page 4a is a runover page. Page 10a was added as a runover page. Page 7a was deleted.
TN #DMAS-13	7/1/19	Page 14
TN #DMAS-12	4/1/19	Table of Contents Pages 2, 5, 6, 6a, 7, 8, 8a, 11, 12, 15-18, 20 Appendix 2 Page 24a was added. Pages, 19, 21-24, 25 are runover pages.
TN #DMAS-11	1/1/19	Pages 2, 5, 6, 7, 9
TN #DMAS-8	4/1/18	Pages 2, 18 Appendix 2
TN #DMAS-7	1/1/18	Pages 2, 3, 3a, 5, 6, 7 Pages 6a and 7a are runover pages.
TN #DMAS-5	7/1/17	Pages 1, 2, 6, 8 Pages 3, 7, 7a and 9 are runover pages.
TN #DMAS-4	4/1/17	Pages 25-27 Appendix 2, page 1 Pages 28-30 were added.
TN #DMAS-3	1/1/17	Pages 1, 2, 4, 6, 7, 8, 14, 26
TN #DMAS-2	10/1/16	Pages 1, 3, 6, 8, 12, 14, 15 Pages 19-24
TN #DMAS-1	6/1/16	Pages 3, 6, 7, 9, 11-14, 17 Appendix 2, page 1 Pages 3a and 7a were added. Page 8 is a runover page.

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

The eligibility worker must report to the HIPP Unit at DMAS *any changes in an enrollee's situation that may affect* the premium payment. The worker may report changes by e-mail to hipp@dmas.virginia.gov. This e-mail address is for use by the local agency staff only. See M0130.200 G for additional information about HIPP requirements.

4. Program Integrity

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

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

C. Covered Group and Aid Category Changes

1. Enrollee's Situation Changes

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

- a pregnant woman reaches the end of her post-partum period (the month in which the 60th day after the end of the pregnancy occurs),
- an infant who has been enrolled as a Newborn Child reaches age one year,
- a Families & Children (F&C) enrollee becomes entitled to SSI,
- an SSI Medicaid enrollee becomes a Qualified Severely Impaired Individual (QSII) (1619(b),
- an individual enrolled in a Modified Adjusted Gross Income (MAGI) Adults aid category turns 65 years old, or becomes entitled for/begins receiving Medicare.

***2.* Enrollee in Limited Coverage Becomes Entitled to Full Coverage**

When an individual who has been enrolled in limited coverage, such as Plan First, experiences a change, such as pregnancy, that results in eligibility for full coverage, the individual's entitlement to full coverage begins the month the individual is first eligible for full coverage, regardless of when or how the agency learns of the change. If change in income is reported, the agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family.

If the information provided is consistent with information obtained by the worker from electronic sources such as the VEC, or documentation is available from other social services program, such as TANF or SNAP, and the systems information is dated within the past 12 months, the agency must determine or renew eligibility based upon the information available. If there is a discrepancy between what is stated on the application and the information obtained from online systems/agency knowledge, contact the enrollee to obtain clarification of changes in income, if applicable.

3. Enrollee Turns Age 6

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

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

4. **MAGI Adult Becomes Entitled to Medicare**

When an individual enrolled as a MAGI Adult becomes entitled to Medicare, he is no longer eligible for coverage in the MAGI Adults covered group effective the month in which his Medicare begins. Evaluate his eligibility in other covered groups. If he is eligible in another covered group, *including the QMB covered group, entitlement in the other covered group begins the month following month in which his MAGI Adults coverage ends.*

Example: Ms. C is a 48 year old disabled adult enrolled as a MAGI Adult. She reports to the agency being approved for Medicare beginning June 2019. The worker sends advance notice to cancel the MAGI Adults coverage effective June 30. QMB coverage begins *effective July 1, 2019*. Ms. C also has resources under the Medically Needy resource limit and is therefore placed on a spenddown per M1370.100.

D. Child Moves From Parental Home

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

1. Case Management

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

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

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

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

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

A. Renewal Procedures

Renewals may be completed in one of the following ways:

- ex parte,
- using a paper form,
- online,
- telephonically by calling 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. See M0130.001.B.3.

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

The agency must include in each applicant's case record facts to support the agency's decision on the case. The eligibility worker must document the date and method used to obtain the verification information (viewed pay stub dated xx/xx/xxxx, telephone call on xx/xx/xxxx date, etc.), the type of verification, the source and a description of the information. If the renewal is not processed and documented electronically, the documentation must be placed *and maintained* in the case record.

1. Renewal Completed

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

2. Renewal Not Completed

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

3. Referral to Health Insurance Marketplace (HIM)

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

4. Renewal Filed During the Three-month Reconsideration Period

If the individual's coverage is cancelled because the individual did not return the renewal form (or complete an online or telephonic renewal) or requested verifications, the Affordable Care Act (ACA) requires a reconsideration period of 90 days be allowed for an individual to file a renewal or submit verifications. For MA purposes, the 90 days is counted as three calendar months. The individual must be given the entire reconsideration period to submit the renewal form and any required documentation. When the renewal or verifications are provided within the 90 day reconsideration period, process the renewal as soon as possible but at least within 30 calendar days from receipt.

The reconsideration period applies to renewals for all covered groups.

If the individual files a renewal or returns verifications at any time during the reconsideration period and is determined to be eligible, reinstate the individual's coverage back to the date of cancellation.

For individuals who were enrolled as Qualified Medicare Beneficiaries (QMB) at the time of cancellation, reinstate coverage back to the date of cancellation.

If an individual began receiving Medicare during the reconsideration period and is eligible as QMB, the QMB coverage is effective the month ***in which Medicare began***. Evaluate eligibility for the other months of the reconsideration period in other possible covered groups, including Medically Needy.

Send a Notice of Action informing him of the reinstatement, his continued coverage and the next renewal month and year. See M1520, Appendix 1 for the Renewal Process Reference Guide.

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

TWELVE MONTH EXTENDED MEDICAID INCOME LIMITS 185% of FEDERAL POVERTY LIMITS EFFECTIVE *1-17-20* ALL LOCALITIES	
# of Persons in Family Unit/Budget Unit	**185% FPL Monthly Limit**
1	*$1,968*
2	*2,658*
3	*3,349*
4	*4,040*
5	*4,730*
6	*5,421*
7	*6,112*
8	*6,802*
Each additional person add	*691*

M1550 Transmittal Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-16	4/1/20	Page 2 Appendix 1, page 1
TN #DMAS-14	10/1/19	Appendix 1, page 1 Appendix 1, page 2 was added.
TN #DMAS-8	4/1/18	Page 3
TN #DMAS-7	1/1/18	Page 1 Appendix 1, page 1
TN #DMAS-4	4/1/17	Appendix 1,page 1
TN #DMAS-3	1/1/17	Pages 4-6, 8, 9
TN #100	5/1/15	Appendix 1,page 1
UP #9	4/1/13	Appendix 1, page 1
Update (UP) #7	7/1/12	Appendix 1, page 1
TN #96	10/1/11	Appendix 1, page 1
TN #93	1/1/10	Title page Table of Contents Pages 1-9 Appendix 1, page 1
TN #91	5/15/09	Appendix 1

Patients in psychiatric hospitals may be Medicaid eligible only if they are

- under age 21 years (if treatment began before age 21 and continues, they may be eligible up to age 22), or
- age 65 years or older,

and they meet all non-financial and financial Medicaid eligibility requirements.

The following are psychiatric hospitals, offering differing levels of care:

a. Eastern State Hospital – Williamsburg
b. Central State Hospital – Petersburg
c. Western State Hospital – Staunton
d. Northern Virginia Mental Health Institute – Falls Church
e. Southern Virginia Mental Health Institute – Danville
f. Southwestern Virginia Mental Health Institute – Marion
g. Piedmont Geriatric Hospital – Burkeville
h. Catawba Hospital – Catawba
i. Commonwealth Center for Children and Adolescents (CCCA) – Staunton (formerly Dejarnette Center)

CCCA is a psychiatric hospital for adolescents between the ages of 4 and 18. Children are provided schooling, counseling and medication. Most children have not been determined disabled. A child in CCCA can be Medicaid-eligible if the child meets all nonfinancial and financial Medicaid eligibility requirements.

2. General Hospital

General hospitals are medical facilities which provide care and services to acutely physically ill patients in the DBHDS facilities. The general hospitals may have patients of any age. There are general hospital acute care units within Eastern State and Western State Hospitals, and the Hiram Davis Medical Center general hospital located on the campus of Central State Hospital in Petersburg. Hiram Davis provides medical and surgical treatment for patients from any DBHDS facility. Hiram Davis also has some beds certified for nursing facility level of care.

Patients in the general hospitals may be Medicaid eligible if they meet all non-financial and financial Medicaid eligibility requirements.

M1550.300 MEDICAID TECHNICIANS

The Medicaid Technicians share responsibilities for the DBHDS facilities. See M1550, Appendix 1, *for the contact information* for the Medicaid Technicians. *Send all correspondence to:*

Attn: Medicaid Technician
Southwestern Virginia
Mental Health Institute
340 Bagley Circle
Marion, VA 24354

DBHDS FACILITIES
MEDICAID TECHNICIANS

NAME	LOCATION	PHONE #
Frances Jones fwj900 frances.jones@dss.virginia.gov	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0841 FAX: 276-782-9732 Pouch Mail FIPS 992
Kim Bartleson kba900 kim.bartleson1@dss.virginia.gov	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0842 FAX: 276-782-9732 Pouch Mail FIPS 992

Address all correspondence to:

Attn: Medicaid Technician
Southwestern Virginia
Mental Health Institute
340 Bagley Circle
Marion, VA 24354

DBHDS STATE HOSPITAL FACILITIES

FIPS	FACILITY INITIALS and FULL NAME
161	**Catawba –** Catawba Hospital
009	**CVTC –** Central Virginia Training Center
830	**ESH –** Eastern State Hospital
730	**HDMC –** Hiram Davis Medical Center
	NVMHI – Northern Virginia Mental Health Institute*
135	**PGH –** Piedmont Geriatric Hospital
550	**SEVTC –** Southeastern Virginia Training Center
	SVMHI – Southern Virginia Mental Health Institute*
173	**SWVMHI –** Southwestern Virginia Mental Health Institute
135	**VCBR –** Virginia Center for Behavioral Rehabilitation
	WSH – Western State Hospital *

*These facilities no longer have Medicaid patients.

M17 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-16	4/1/20	Appendix 4, page 1 Appendix 4, page 2 was added
TN #DMAS-15	1/1/20	Page 7 Page 8 was added as a runover page.
TN #DMAS-14	10/1/19	Table of Contents Pages 1, 2, 4, 6, 7 Appendix 1, pages i and ii Appendix 2, pages i and ii Appendix 4 was added.
TN #DMAS-7	1/1/18	Table of Contents, page i Appendix 1, pages i and ii Appendix 2, pages i and ii Appendix 3 was added.
TN #DMAS-6	10/1/17	Table of Contents Pages 4. Appendix 1 was deleted Appendices 2 and 3 were renumbered Appendices 1 and 2, respectively.
TN #DMAS-5	7/1/17	Table of Contents Pages 1, 2, 4 Appendix 2 Appendix 3 was added.
TN #DMAS-4	4/1/17	Pages 4, 5 Pages 6 and 7 are runover pages.
TN #DMAS-2	10/1/16	Table of Contents, page i Pages 1-7 Appendix 2 Page 8 was deleted.
TN #97	9/1/12	Page 3 Appendix 1, page 1
UP #7	7/1/12	Table of Contents Pages 1-8 Appendix 1 Appendices 3 and 4 were removed.
TN #94	9/1/10	Title Page Table of Contents pages 1-7 Appendix 1 Appendix 2
TN #93	1/1/10	Page 3

PUBLIC ASSISTANCE REPORTING INFORMATION SYSTEM (PARIS) NOTICE OF MEDICAID RECIPIENT FRAUD/NON-FRAUD

Date:

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

If you fax or email, you do not need to mail a copy of the referral.

Case Name:	
Case Social Security Number:	
VaCMS Number:	
Medicaid Number:	
Case Address:	

☐ **PARIS Interstate** ☐ **PARIS Veterans** ☐ **PARIS Federal**

Match Person(s):		
Date of the PARIS match:		
Date of contact with the other state government agency:		
Individual(s) receiving Medicaid in the other state:		
Individual(s) receiving Veterans or federal benefits:		
Start date and end date of Medicaid from other state:		
Veterans or Federal benefit information:		
Did you verify individual (s) met Virginia residency for ongoing Medicaid coverage?	**Yes they met VA residency.** ☐ **If yes date of confirmation from individual (s) verfying they are residing in VA:**	**No they did not meet VA residency.** ☐ **If no date VA coverage will be cancelled:**
Documentation on file:		

Name of Eligibility Worker:	**Telephone Number:**
Agency Name:	**FIPS Code:**
Address:	**Name of Supervisor:**

RAU will send acknowledgment of receipt to the referring agency and will be in contact if any further action is required

M21 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-16	4/1/20	Appendix 1, page 1
TN #DMAS-14	10/1/19	Pages 4-6
TN #DMAS-12	4/1/19	Appendix 1, page 1
TN #DMAS-9	7/1/18	Page 5
TN #DMAS-8	4/1/18	Appendix 1, page 1
TN #DMAS-4	4/1/17	Appendix 1, page 1
TN #DMAS-2	1/1/17	Appendix 1, page 1
TN #DMAS-2	10/1/16	Page 3
TN #DMAS-1	6/1/16	Appendix 1, page 1
TN #100	5/1/15	Table of Contents Pages 1-7 Appendices 1 Pages 8-10 and Appendices 2 and 3 were deleted.
UP #10	5/1/14	Pages 1-3 Appendix 1
TN #99	1/1/14	Pages 1-3 Appendix 1
TN # 98	10/1/13	Table of Contents Pages 1-10 Pages 10a and 11-16 were deleted.
UP #9	4/1/13	Pages 3, 4
UP #8	10/1/12	Table of Contents Pages 2-4 Appendix 3 deleted
TN #97	9/1/12	Pages 3, 4
UP #7	7/1/12	Pages 3, 4 Appendix 2, pages 1 Appendix 3, pages 1 and 2
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	Pages 3, 8
TN #95	3/1/11	Table of Contents Pages 5, 6, 14, 15, Page 16 added Appendix 1
TN #94	9/1/10	Page3 Appendix 3, pages 1 and 2
UP #3	3/1/10	Pages 2-5
TN #93	1/1/10	Page 2-4, 8
Update (UP) #2	8/24/09	Page 4

FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS)
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/17/20*

# of Persons in FAMIS House-hold	**FAMIS 150% FPL**		**FAMIS 200% FPL**		
	Annual Limit	Monthly Limit	Annual Limit	Monthly Limit	205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)
1	*$19,140*	*$1,595*	*$25,520*	*$2,127*	*$2,181*
2	*25,860*	*2,155*	*34,480*	*2,874*	*2,946*
3	*32,580*	*2,715*	*43,440*	*3,620*	*3,711*
4	*39,300*	*3,275*	*52,400*	*4,367*	*4,477*
5	*46,020*	*3,835*	*61,360*	*5,114*	*5,242*
6	*52,740*	*4,395*	*70,320*	*5,860*	*6,007*
7	*59,460*	*4,955*	*79,280*	*6,607*	*6,773*
8	*66,180*	*5,515*	*88,240*	*7,354*	*7,538*
Each add'l, add	*6,720*	*560*	*8,960*	*747*	*766*

M22 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-16	4/1/20	Appendix 1, page 1
TN #DMAS-14	10/1/19	Page 5
TN #DMAS-12	4/1/19	Appendix 1, page 1
TN #DMAS-8	4/1/18	Appendix 1, page 1
TN #DMAS-6	10/1/17	Page 7 Appendix 1, page 1
TN #DMAS-4	4/1/17	Appendix 1, page 1
TN #DMAS-1	6/1/16	Page 4 Appendix 1, page 1
TN #100	5/1/15	Table of Contents Pages 1, 2, 5, 6, 7 Appendix 1 Pages 3 and 4 are runover Pages.
TN #98	10/1/13	Table of Contents Pages 1-7 Appendix 1 Pages 8-10 were deleted.
UP #9	4/1/13	Appendix 1
UP #8	10/1/12	Pages 2, 3 Page 3a deleted
UP #7	7/1/12	Pages 2, 3
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	Pages 3, 3a
TN #95	3/1/11	Pages 4-6 Appendix 1
UP #4	7/1/10	Page 10
TN #94	9/1/10	Page 3
UP #3	3/01/10	Page 2
TN #93	1/1/10	Pages 2-10
UP #2	8/24/09	Page 3
Update (UP) #1	7/1/09	Pages 1, 2, 7 Appendix 1, page 1

FAMIS MOMS
200% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/17/20*

Household Size	**200% FPL Yearly Amount**	**200% FPL Monthly Amount**	**205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)**
2	*$34,480*	*$2,874*	*$2,946*
3	*43,440*	*3,620*	*3,711*
4	*52,400*	*4,367*	*4,477*
5	*61,360*	*5,114*	*5,242*
6	*70,320*	*5,860*	*6,007*
7	*79,280*	*6,607*	*6,773*
8	*88,240*	*7,354*	*7,538*
Each additional, add	*8,960*	*747*	*766*