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January 1, 2020

Virginia Medical Assistance Eligibility Manual
Transmittal #DMAS-15

The following acronyms are contained in this letter:

- COLA – Cost of Living Adjustment
- CSB – Community Services Board
- DMAS – Department of Medical Assistance Services
- LTSS – Long-term Services and Supports
- MAGI – Modified Adjusted Gross Income
- PARIS - Public Assistance Reporting Information System
- SSI – Supplemental Security Income
- TN – Transmittal

TN #DMAS-15 includes policy clarifications, updates and revisions. Unless otherwise noted in the Cover Letter and/or policy, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after January 1 2020.

The following changes are contained in TN #DMAS-15:

Changed Pages	Changes
Subchapter M0110 Pages 4, 8 Page 4a was added.	On pages 4, 4a, and 8, clarified the roles of the authorized representative and application assisters and their access to information.

Changed Pages	Changes
Subchapter M0130 Pages 9, 10	On pages 9 and 10, clarified the policy on attested income and reasonable compatibility and removed the obsolete policy in $0 income.
Chapter M02 Table of Contents Pages i, ii	On pages i and ii, updated the Table of Contents.
Subchapter M0280 Page 9 Appendix 1	On page 9 and in Appendix 1, clarified that an individual released from a correctional facility on furlough is not an inmate of a public institution while on furlough.
Subchapter M0310 Pages 29, 30	On pages 29 and 30, added policy on Kinship Guardianship Payments.
Subchapter M0320 Pages 11, 26, 27, 29	On page 11, revised the COLA amounts for 2020. On page 26, clarified the current resource limit for Medicaid Works; the date that the amount is revised varies each year and has not yet been increased for 2020. On page 27, revised the income limit for 2020 (no change). On page 29, clarified that DMAS approval is not needed for Medicaid Works—the eligibility worker needs to send DMAS information for tracking purposes.
Chapter M04 Pages 16, 16a, 19	On page 16, corrected page formatting. On page 16a, clarified that Difficulty of Care payments, which are excluded as income for MAGI-based income evaluations, include payments made to care providers who provide care to individuals receiving Waiver services in the care provider's home. On pages 16a and 19, added Kinship Guardianship payments to the list of excluded income.
Subchapter M0530 Appendix 1, page 1	Revised the deeming allocations for 2020.
Subchapter M0810 Pages 1, 2	On pages 1 and 2, revised the SSI income limits for 2020. On page 2, also corrected the monthly categorically needy income limits.
Subchapter M0820 Pages 30, 31	On pages 30 and 31, revised the student child earned income exclusion for 2020.
Subchapter M1110 Page 2	Revised the Medicare Savings Programs resource limits for 2020.
Subchapter M1340 Pages 16, 18 Page 17 is a runover page.	On pages 16 and 18, clarified that in the case of an individual covered by Medicare who receives a service from a CSB, the service may be used as a spenddown deduction without requiring that Medicare first be billed for the service as long as the CSB provides a statement that the service is not covered by Medicare.

Changed Pages	Changes
Subchapter M1450 Page 46	Revised the address for DMAS.
Subchapter M1460 Page 3, 35	On page 3, revised the home equity limit for 2020. On page 35, revised the student child earned income exclusion for 2020.
Subchapter M1470 Pages 19, 20	On page 19, revised the basic maintenance allowance for 2020. On page 20, revised the special earnings allowances for 2020.
Subchapter M1480 Pages 1, 7, 18c, 66, 69, 70 Page 2 is a runover page.	On page 1, clarified that the policy M1480 applies when an individual receiving Medicaid-covered LTSS marries. On page 7, revised the home equity limit for 2020. On page 18c, revised the spousal resource standards for 2020. On page 66, revised the maximum monthly maintenance needs allowance for 2020. On page 69, revised the basic maintenance allowance for 2020. On page 70, revised the special earnings allowances for 2020.
Subchapter M1520 Pages 8, 8a	On pages 8 and 8a, removed the obsolete policy regarding renewals when $0 income was previously reported.
Chapter M17 Page 7 Page 8 was added as a runover page.	On page 7, clarified that the Cover Virginia Incarcerated Unit is responsible for evaluating PARIS matches for offenders whose cases are maintained by the unit.

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

M0110 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-15	1/1/20	Pages 4, 8 Page 4a was added.
TN #DMAS-14	10/1/19	Page 15
TN #DMAS-12	4/1/19	Table of Contents Page 1, 2, 9 Page 2a is a runover page
TN #DMAS-4	4/1/17	Page 15
TN #DMAS-3	1/1/17	Page 15
TN #DMAS-2	10/1/16	Pages 3, 13
TN #100	5/1/15	Pages 2, 7 Page 1 is a runover page.
TN #98	10/1/13	Table of Contents Pages 1-15 Page 6a was removed. Page 16 was added.
TN #97	9/1/12	Table of Contents Page 13 Page 14 was added. Appendix 1 was added.
Update #7	7/1/12	Pages 3, 6a, 7, 8
TN #96	10/1/11	Table of Contents Pages 2-6a
TN #95	3/1/11	Pages 2-4a
TN #94	9/1/10	Pages 2, 3
TN #93	1/1/10	Pages 1, 6

1. Authorized Representatives

Individuals not determined to be incapacitated by a court can designate whomever they choose to be their authorized representatives, including a provider or a provider's contractor (such as an application assistance company). The designation must be in writing, with the applicant or recipient specifying the information to be released to the authorized representative.

It is not sufficient to indicate that any information in the case record may be released; the designation must state the specific information to be released (i.e. notices, the ability to make application or provide information necessary to determine eligibility, and what, if any, other information can be released to the authorized representative). The authorized representative designation is valid *until:*

- *the application is denied;*
- *medical assistance coverage is canceled; or*
- *the individual changes his authorized representative.*

The authorized representative can file an appeal on behalf of an individual whose application was denied or canceled. The DMAS Appeals Division will determine whether or not the authorized representative can represent the individual during the appeal.

2. Application Assisters

Application assisters are authorized under the Affordable Care Act (ACA) to provide assistance with completing the MA application and renewal, and with explaining and helping the individual to meet documentation requirements. They must be authorized by the individual *to provide assistance with completing the application and/or renewal.* There are two categories of application assisters:

a. Certified Application Counselors (CAC)

CAC are individuals authorized to assist individuals with obtaining health insurance coverage, including Medical Assistance. CAC are generally under the supervision of a non-profit organization and do not receive a fee for providing application counseling.

b. Navigators

Navigators receive federal funding to assist individuals with obtaining health insurance coverage, including Medical Assistance.

Application assisters **cannot** sign forms, receive notices or other communications or otherwise act on behalf of the individual *and* do not have the same CommonHelp system privileges as authorized representatives.

Certified Application Counselors and Navigators are designated on the MA application and are deemed to have client consent to release information without an additional release of information form. The client may revoke his consent to the release of information at any time by notifying the LDSS verbally or in writing. The revocation of consent or statement is to be documented in the case record.

F. Safeguarding Client Information

All information associated with an applicant or recipient that could disclose the individual's identity is confidential and shall be safeguarded. Such information includes but is not limited to:

- name, address, and all types of identification numbers assigned to the client;
- medical services provided to the client;
- social and economic conditions or circumstances of the client;
- agency evaluation of the client's personal information;

C. Application for Medical Assistance means an official form prescribed by DMAS for requesting medical assistance that is used for initial eligibility determinations and redeterminations. An application for medical assistance is an application for the Medicaid, Family Access to Medical Insurance Security (FAMIS) and FAMIS MOMS programs.

D. Attorney-In-Fact (Named in a Power of Attorney Document) means a person authorized by a power of attorney document (also referred to as a "POA") to act on behalf of another individual, either for some particular purpose or for the transaction of business in general. **A power of attorney document does not necessarily authorize the attorney-in-fact to apply for MA on behalf of the applicant.** The eligibility worker must read the power of attorney document to determine (1) if the person has the power to act as the applicant in any of the applicant's business and (2) whether or not the document grants durable power of attorney. If the document is a general power of attorney or includes the power to conduct the applicant's financial business, the attorney-in-fact is considered the applicant's authorized representative as long as the person for whom the attorney-in-fact is authorized to act is not legally incapacitated.

If the individual on whose behalf the attorney-in-fact is acting is incapacitated and not able to act on his own behalf, the eligibility worker must examine the document to determine if it grants a durable power of attorney. The contents of the document must indicate that the power of attorney does not stop upon the incapacity of the person. **If the power of attorney is not durable, it is no longer valid when the individual on whose behalf it is executed becomes legally incapacitated.**

E. Authorized Representative An authorized representative is a person age 18 years or older who is authorized to conduct business for an individual. A competent individual age 18 years or older must designate the authorized representative in a written statement (which defines the representative's responsibilities). The authorized representative statement is valid until:

- the application is denied;
- medical assistance coverage is canceled; or
- the individual changes his authorized representative.

The authorized representative can file an appeal on behalf of an individual whose application was denied or canceled. The DMAS Appeals Division will determine whether or not the authorized representative can represent the individual during the appeal.

The authorized representative of an incompetent or incapacitated individual is the individual's spouse, parent, attorney-in-fact (person who has the individual's power-of-attorney), legally appointed guardian, legally appointed conservator (committee), or family substitute representative. An individual's spouse is permitted to be an authorized representative for MA purposes as long as the spouse and applicant are living together, or lived together immediately before the applicant's institutionalization; no written designation is required.

EXCEPTION: Staff in DBHDS facilities may also act as authorized representatives in their facilities without a written statement.

M0130 Changes

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

If the client is eligible for benefits to be used exclusively for the payment of medical expenses (i.e. an insurance settlement), but there is no TPL code for that benefit, the worker must email the information to the DMAS TPL Unit at TPLUnit@dmas.virginia.gov, or send the information to:

DMAS Third Party Liability Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

G. Health Insurance Premium Payment (HIPP) Program

The HIPP program is a cost-savings program for individuals enrolled in Medicaid which may reimburse some or all of the employee portion of the employer group health insurance premium. Eligibility for HIPP is determined by the HIPP Unit at DMAS. Participation in HIPP is voluntary.

The local DSS agency must give each applicant or enrollee who reports that he or someone in his family is employed more than 30 hours each week and is eligible for health insurance coverage under an employer's group health plan 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 at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms. Enrollees and other members of the public may contact the HIPP Unit for additional information at hippcustomerservice@dmas.virginia.gov.

If the health insurance policy holder lives outside of the home, a HIPP Consent Form must be completed by both the policy holder and the parent/authorized representative so the DMAS HIPP Unit can process the HIPP application. If the form is required, the DMAS HIPP Unit will send it to the applicant for completion.

H. Verification of Financial Eligibility Requirements

The eligibility worker must verify the following financial eligibility requirements:

- the value of all countable, non-excluded resources;
- asset transfer information for individuals in need of long-term care services, including the date of transfer, asset value, and compensation received.
- earned and unearned income. For all case actions effective October 26, 2019, if the income attested to by the applicant is within 10% of the income information obtained from electronic sources OR both sources are below the applicable income limit, *no additional verification is required.*

  If the attested income is under the income limit and the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return. *If the applicant meets a Medically Needy (MN) covered group, verification of income* ***is required*** *to determine spenddown liability.*

  If the attested income is over the income limit and the individual does not meet a Medically Needy (MN) covered group, deny the application.

The agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information, and information from SSA through SVES or SOLQ-I. Verification of income

from these available sources, including the VEC, may be used if the information is less than 12 months old. The agency must include in each applicant's case record facts to support the agency's decision on the case.

1. Resources

The value of all countable, non-excluded resources must be verified. If an applicant's attested resources are over the resource limit, the applicant or authorized representative must be given the opportunity to provide verification of the resources. All available resource verification system(s) must be searched prior to requesting information from the applicant.

2. Use of Federal Income Tax Data

The Hub provides verification of income reported to the IRS. Income information reported to the IRS may be used for eligibility determinations for Families and Children (F&C), MAGI Adults, and ABD covered groups when IRS information is available. The income reported on the application is compared to the data obtained from the Hub for reasonable compatibility per M0420.100. When IRS verification is used for an ABD individual, reasonable compatibility is acceptable as verification of earned (i.e. taxable) income.

Note: Reasonable compatibility only applies to applications or reapplications; it does not apply to renewals.

3. SSA Data

Social Security and/or Supplemental Security Income must be verified through SSA. The Federal Hub links to SSA data. SOLQ-I may also be used. The State Data Exchange (SDX) system should only be used as an alternate method when the Hub or SOLQ-I is not available.

4. Income

For all case actions effective October 26, 2019, *the applicant's attested income, including when the applicant attests to having zero ($0.00) income, is considered the verified income if the income attested to by the applicant is within 10% of the income information obtained from electronic sources OR both sources are below the applicable income limit.*

If the attested income is under the income limit and the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return. If the applicant meets a MN covered group, verification of income ***is required*** *to determine spenddown liability based on actual income received.*

*For individuals requesting long-term services and supports (*LTSS), verification of income is required to calculate the patient pay. See M1470.

If the attested income is over the income limit and the individual does not meet a Medically Needy (MN) covered group, deny the application.

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

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

M02 Table of Contents Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-15	1/1/20	Pages i, ii
TN #DMAS-10	10/1/18	Page ii
TN #95	3/1/11	Page i
Update (UP) #2	8/24/09	Page ii

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M0260 RESERVED

NOTE: Policy references to M0260 that are still in effect have been moved to subchapter M0250.

M0270.000 APPLICATION FOR OTHER BENEFITS

M0280.000 INSTITUTIONAL STATUS REQUIREMENTS

M0290.000 HIPP REQUIREMENTS—Subchapter Removed 08/2009

M0280 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-15	1/1/20	Pages 9 Appendix 1
TN #DMAS-14	10/1/19	Pages 6, 7, 9, 11
TN #DMAS-2	10/1/16	Pages 7, 9
TN #100	5/1/15	Table of Contents Pages 1-11 Appendix 1 was added Pages 12 and 13 were deleted.
UP #9	4/1/13	Page 5
Update (UP) #7	7/1/12	Table of Contents Page 8 Appendix 1 was deleted.
TN #94	9/1/10	Page 1
TN #93	1/1/10	Page 13

G. Probation, Parole, Conditional Release, *Furlough*

An individual released from prison or jail on probation, parole, or release order, with a condition of:

- home arrest
- community services
- outpatient treatment
- inpatient treatment (not inpatient hospitalization)

is not an inmate of a public institution and may be eligible for Medicaid.

An individual released from prison or jail under a court probation order due to a medical emergency is NOT an inmate of a public institution and may be eligible for Medicaid.

An individual released from a correctional facility on furlough, for example during a pregnancy, is not an inmate of a public institution while furloughed and may be eligible for Medicaid.

H. Juvenile in Detention Center Due to Care, Protection, Best Interest

A minor in a juvenile detention center prior to disposition (judgment) due to care, protection or the best interest of the child (e.g., Child Protective Services [CPS]), if there is a specific plan for that child that makes the detention center stay temporary, is NOT an inmate of a public institution and may be eligible for Medicaid.

This could include a juvenile awaiting placement but who is still physically present in the juvenile detention center.

I. Juvenile on Probation in Secure Treatment Center

A minor placed on probation by a juvenile court and placed in a secure treatment facility is NOT an inmate of a public institution and may be eligible for Medicaid.

J. Juvenile On Conditional Probation

A minor placed on probation by a juvenile court with, as a condition of probation, treatment in a psychiatric hospital or a residential treatment center, or treatment as an outpatient may be eligible for Medicaid.

However, if the minor is NOT on probation but is ordered to the treatment facility, he remains an inmate of a public institution and not eligible for full benefit Medicaid. He may be eligible for Medicaid coverage limited to inpatient hospitalization.

K. Juvenile On Probation in Secure Treatment Center

A minor placed on probation by a juvenile court and placed in a secure treatment facility may be eligible for Medicaid.

Institutional Status Quick Reference Guide

Placement or living arrangement	Full Benefit	Inpatient Only	Ineligible
IMDs			
age 22-65			**X**
under age 22 and receiving inpatient psychiatric treatment	**X**		
age 65 and older	**X**		
conditional release	**X**		
ICF-ID – all ages	**X**		
Residential			
medical section	**X**		
private group home with no more than 3 beds	**X**		
private residential	**X**		
public residential			
less than 16 beds	**X**		
16 or more beds			**X**
educational or vocational Institution	**X**		
Correctional Facilities			
adults			
DOC		**X**	
regional jails		**X**	
local jails		**X**	
juveniles (DJJ) in secure facilities			
held for care, protection, best, interest	**X**		
on probation	**X**		
held for criminal activity		**X**	
juvenile on probation placed in psychiatric hospital or residential treatment center	**X**		
juvenile not on probation ordered to treatment in a psychiatric hospital/residential treatment facility		**X**	
Adult arrested, but not held in corrections			
in medical facility prior to correctional facility placement	**X**		
in regional or local jail prior to medical facility		**X**	
TDO			
not in jail prior to hospitalization	**X**		
in jail prior to hospitalization		**X**	
Individual out on bail/released on own recognizance	**X**		
Adult on probation, parole, conditional release, *or furlough*	**X**		

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TN #DMAS-15	1/1/20	Pages 29, 30
TN #DMAS-14	10/1/19	Pages 24, 26, 27, 40
TN #DMAS-13	7/1/19	Pages 24 Page 24a is a runover page.
TN #DMAS-12	4/1/19	Pages 8, 9, 13
TN #DMAS-10	10/1/18	Table of Contents, page ii Pages 1-4 Page 40 was added.
TN #DMAS-9	7/1/18	Page 35 Appendix 2, Page 1
TN #DMAS-8	4/1/18	Page 9
TN #DMAS-7	1/1/18	Pages 34, Appendix 2, page 1
TN #DMAS-5	7/1/17	Pages 13, 37, 38
TN #DMAS-4	4/1/17	Pages 24, 30a Page 23 is a runover page. Page 24a was added as a runover page.
TN #DMAS-3	1/1/17	Pages 8, 13, 28b
TN #DMAS-2	10/1/16	Pages 4, 7, 29 Page 30 is a runover page. Appendix 2, page 1
TN #DMAS-1	6/1/16	Table of Contents, page ii Pages 13, 26, 28 Appendix 2, page 1

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

M0310.115 FOSTER CARE

A. Definition

Foster Care provides maintenance and care for children whose custody is held by:

- a local board of social services;
- a licensed private, non-profit child placement agency;
- the Department of Juvenile Justice; or
- the child's parent(s), under a non-custodial agreement.

Federal regulations define "foster care" as "24-hour substitute care for children placed away from their parents or guardians and for whom the State agency has placement and care responsibility" (45 C.F.R. §1355.20). Transfer of the legal custody of the child is not a component when determining if a child is considered to be in foster care. The federal definition is based upon the child being placed outside of the home and who has placement and care responsibility for the child. If a child is placed outside of the home and LDSS is the case manager with placement and care responsibility, then the federal government considers the child to be in foster care. For the federal government, the term "placement and care" means that LDSS is legally accountable for the day-to-day care and protection of the child through either a court order or a voluntary placement agreement.

1. Custody

Custody may be given to an agency by the court or may be retained by the parent(s) or guardian when a non-custodial agreement is involved. If custody is retained by the parent under a parental agreement with the Community Policy and Management Team (CPMT), the child is NOT in foster care.

2. Child Placing Agency

A child placing agency is an agency that is licensed by the State Department of Social Services for child placing services. Not all child placing agencies provide adoption services; some may provide foster home placement. The services offered must be identified in the description given for the license. The foster care service unit of the local department of social services should be familiar with the function of the child placing agency, and whether or not it is licensed.

***3.* Independent Living and Fostering Futures**

A foster care child who is under age 18 who is in an Independent Living arrangement and receives full or partial support from a local social services agency, continues to meet the foster care definition and may be eligible in the covered group of Individuals Under Age 21. A child age 18 and over who is in an Independent Living arrangement with a local department of social services or in the Fostering Futures Program is considered a former foster care child and may be eligible in the Former Foster Care Child Under Age 26 covered group.

4. Kinship Guardianship Payments

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.

Children who are eligible for Title IV-E KinGAP (federal funds) Payments are categorically eligible for Medicaid.

5. **Independent Living**

A foster care child who is under age 21, who is in an Independent Living arrangement and receives full or partial support from a local social services agency, continues to meet the foster care definition and may be eligible in the covered group of Individuals Under Age 21.

6. **Non-custodial and Parental Agreements**

a. Non-custodial Agreement

A non-custodial agreement is an agreement between the child's parent or guardian and the local Board of Social Services. The parent(s) or guardian retains legal custody of the child. The social services agency agrees to provide financial assistance and/or services to the child, such as placement in and payment for residential facility services.

Non-custodial agreements are used when LDSS serves as the case manager and has placement and care responsibilities to place a child outside of his home for treatment.

Children with non-custodial agreements are considered to be in foster care for Medicaid eligibility purposes.

b. Parental Agreement

A parental agreement is an agreement between the child's parent or guardian and an agency **other than DSS** which is designated by the CPMT. The other agency designated by the CPMT has placement and care responsibility for the child and agrees to provide financial assistance and/or services to the child, such as placement in and payment for residential facility services.

Parental agreements are used when an agency other than LDSS is designated by the CPMT as case manager and the child is placed outside of the home for treatment.

Children with parental agreements ARE NOT considered to be in foster care for Medicaid eligibility purposes.

c. Placement

Federal Title IV-E funds can only be claimed if LDSS has placement and care responsibility for the child **and** the child is placed by LDSS outside the child's home. If the LDSS has placement and care responsibility for the child and the child is placed in the child's home, the child is not eligible for Title IV-E funds and is a Non-IV-E foster child for Medicaid eligibility purposes.

7. **Department of Juvenile Justice**

A child in the custody of the Virginia Department of Juvenile Justice or who is the responsibility of a court is a "Department of Juvenile Justice (DJJ) child."

B. Procedures

1. IV-E Foster Care

Children who are eligible for and receive Title IV-E (AFDC-FC) foster care maintenance payments *or Title IV-E KinGAP payments* are IV-E Foster Care for Medicaid eligibility purposes. A child of a IV-E foster care child is also considered to be a IV-E foster care child when the mother's IV-E payment includes an allocation for her child.

M0320 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-15	1/1/20	Pages 11, 26, 27, 29
TN #DMAS-14	10/1/19	Page 40
TN #DMAS-13	7/1/19	Pages 1, 24-27
TN #DMAS-11	1/1/19	Pages 2a, 11, 35, 37
TN #DMAS-10	10/1/18	Page 1 1a added as a runover page
TN #DMAS-9	7/1/18	Page 2, 17
TN #DMAS-7	1/1/18	Page 2, 3, 4, 11, 26-27.
TN #DMAS-4	4/1/17	Page 26
TN #DMAS-3	1/1/17	Pages 11, 27, 29, 40, 41, 44, 45, 52
TN #DMAS-2	10/1/16	Pages 4, 15, 16, 18, 20, 22, 30, 33, Pages 39- 41, 43-45, 48, 51, 52, 55
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 1, 11, 25-27, 46-49 Page 50 is a runover page.
TN #100	5/1/15	Pages 6, 11, 24, 25-27, 29-30
TN #99	1/1/14	Page 11
TN #98	10/1/13	Pages 1, 54, 55.
UP #9	4/1/12	Pages 11, 26, 32, 34-37, 45, 46, 55
TN #97	9/1/12	Table of Contents Pages 1-56 (all pages)
UP #6	4/1/12	Pages 11, 12, 46a
TN #96	10/1/11	Table of Contents Pages 46f-50b Page 50c deleted
TN #95	3/1/10	Pages 11, 12, 42c, 42d, 50, 53, 69 Pages 70, 71 Page 72 added.
TN #94	9/1/10	Pages 49-50b
UP #3	3/1/10	Pages 34, 35, 38, 40, 42a, Pages 42b, 42f
TN #93	1/1/10	Pages 11-12, 18, 34-35, 38 Pages 40, 42a-42d, 42f-44, 49 Pages 50c, 69-71
UP #2	8/24/09	Pages 26, 28, 32, 61, 63, 66
Update (UP) #1	7/1/09	Pages 46f-48
TN #91	5/15/09	Pages 31-34 Pages 65-68

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

The Cost-of-living calculation formula
(The formula is the current Title II Benefit divided by the percentage increase to equal the benefit amount before the COLA change):

a. *Current Title II Benefit* = *Benefit Before 1/20 COLA*
1.016 (1/20 Increase)

b. Benefit Before 1/20 COLA = Benefit Before 1/19 COLA
1.028 (1/19 Increase)

c. Benefit Before 1/19 COLA = Benefit Before 1/18 COLA
1.020 (1/18 Increase)

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

5. Medicare Premiums

a. Medicare Part B premium amounts:

1-1-20 $144.60
1-1-19 $135.50
1-1-18 $134.00
1-1-17 $109.00
1-1-16 $121.80

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

b. Medicare Part A premium amount:

1-1-19 $458.00
1-1-19 $437.00
1-1-18 $422.00
1-1-17 $413.00
1-1-16 $411.00

Contact a Medical Assistance Program Consultant for amounts for years prior to *2016*.

6. Evaluation

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

D. Financial Eligibility

1. Assistance Unit

a. Initial eligibility determination

In order to qualify for MEDICAID WORKS, the individual must meet, the assistance unit policy and procedures in chapter M05 that apply to ABD individuals with income less than or equal to 80% FPL. Individuals receiving SSI or who have 1619(b) status also meet the income requirement for entry into MEDICAID WORKS.

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

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

b. Ongoing eligibility

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

2. Resources

a. Initial eligibility determination

For the initial eligibility determination, the resource limit is $2,000 for an individual and $3,000 for a couple. Resources must be evaluated for all individuals, including SSI recipients and QSII/(1619(b) individuals, who wish to qualify for MEDICAID WORKS. The resource requirements in chapter S11 and Appendix 2 to chapter S11 apply for the initial eligibility determination. The individual's countable, nonexempt resources must be verified. All countable resources, must be added together to determine if the individual's countable resources are within the limit.

b. Ongoing eligibility

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

1) For **earnings** accumulated **after** enrollment in MEDICAID WORKS, up to the current 1619(b) income threshold amount will be disregarded if deposited and retained in the WIN Account. The *current* 1619(b) threshold amount is $36,548.

2) Resources accumulated while in MEDICAID WORKS and held in Internal Revenue Service (IRS)-approved retirement accounts, medical or health savings accounts, medical reimbursement (flex) accounts, education accounts, independence accounts, and other similar State-approved accounts are excluded. Examples of these accounts include Archer Medical Savings Accounts, 401(k)/403(b)/457(b)/503(b) accounts, traditional Individual Retirement Accounts (IRAs), Roth IRAs, SEP-IRAs, SIMPLE IRAs, and Thrift Savings Plans. The account must be designated as a WIN Account in order to be excluded. **Resources accumulated while in MEDICAID WORKS and held in IRS-approved accounts that have been designated as WIN**

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

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

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

3. Income

a. Initial eligibility determination

For the initial eligibility determination, the income limit is ≤ 80% of the FPL (see M0810.002). The income requirements in chapter S08 must be met. Individuals who receive SSI or who have 1619(b) status are considered to meet the income requirements and no evaluation of income is necessary for the initial eligibility determination (see M0320.101).

b. Ongoing eligibility

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

1) The income limit for earned income is $6,250 per month ($75,000 per year) (no change for 2020) as long as the funds are deposited in a WIN Account. The policy for determining countable earned income is contained in subchapter S0820.

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

2) The income limit for unearned income remains less than or equal to 80% of the FPL. The policy for determining countable unearned income is contained in subchapter S0830.

3) Any increase in an enrollee's Social Security Disability benefits resulting from employment as a MEDICAID WORKS participant OR as a result of a COLA adjustment to the Social Security Disability benefits will not be counted as long as it is regularly deposited upon receipt into the individual's WIN account.

4) Unemployment insurance benefits received due to loss of employment through no fault of the individual's own are not counted during the six-month safety net period (see M0320.400 G) as income as long as the payments are regularly deposited upon receipt into the individual's WIN account.

Resources accumulated while in MEDICAID WORKS and retained in an IRS-approved account described in M0320.400 D. 2. b. 2) that has been designated as a WIN Account are excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees.

H. Benefit Package

Individuals enrolled in MEDICAID WORKS are entitled to the standard benefits available to full-benefit Medicaid enrollees (see Chapter M18), as well as Personal Assistance Services; MEDICAID WORKS enrollees do **not** have a patient pay. Intensive Behavioral Dietary Counseling is also covered for MEDICAID WORKS enrollees when a physician determines that the service is medically necessary.

I. Entitlement and Enrollment

Entitlement for MEDICAID WORKS is dependent upon meeting the requirements listed above.

There is no retroactive coverage under MEDICAID WORKS. The application date in the Virginia Case Management System (VaCMS) is the date the individual signed the MEDICAID WORKS Agreement. Coverage shall begin on the first day of the month following the month in which all requirements are met. If the applicant has a future start date for employment, the effective date of eligibility shall be no earlier than the first day of employment. However, unless employment begins on the first day of the month, MEDICAID WORKS enrollment will begin on the first of the following month.

The AC for MEDICAID WORKS is 059. Use the following procedures to enroll the individual in VaCMS:

<u>New Application – Applicant Eligible as 80% FPL</u>

1. For the month of application and any retroactive months in which the person is eligible in the 80% FPL covered group, enroll the individual in a closed period of coverage using AC 039 (blind) or 049 (disabled), beginning the first day of the month in which eligibility exists. The cancel date is the last day of the month in which the MEDICAID WORKS Agreement was signed. Use Cancel Code 042.
2. Reinstate the individual's coverage in MEDICAID WORKS using AC 059 beginning the first day of the following month (the first day of the month following the month in which the MEDICAID WORKS Agreement is signed). Use the same application date (the actual date of the initial application) that was used for the month of application.

DMAS approval is not required for participation in MEDICAID WORKS; however, information must be sent to DMAS after the individual is enrolled for tracking purposes. Use the MEDICAID WORKS fax cover sheet, and fax it together with the following information to DMAS at 804-786-1680:

- the signed MEDICAID WORKS Agreement,
- the Work Incentive Account (WIN) information (a bank account statement or verification from the bank that the account was opened), and
- one of the following verifications of employment:
  - a pay stub showing current employment or
  - an employment letter with start date or
  - self-employment document(s).

Changed With	Effective Date	Pages Changed
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, 5, 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

g. Effective January 1, 2019, alimony received is not countable.

Alimony received prior to January 1, 2019, is countable. An individual whose divorce decree was finalized prior to January 1, 2019, has the option with the IRS to adopt the new IRS alimony rule by modifying the divorce agreement. If an individual whose divorce decree was finalized prior to January 1, 2019, does not want alimony received on or after January 1, 2019 to be countable for the MAGI income determination, the individual must provide a copy of the modified divorce agreement to the eligibility worker.

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

i. Military pay based upon age or years of service (other types of military pay are also counted and excluded; see M0720.290)

j. Census income.

1. 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 Publication 525 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,
- Grants for homes designed for wheelchair living and motor vehicles for veterans who lost their sight or the use of their limbs,
- 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. For divorce agreements finalized on or after January 1, 2019, no deduction is allowed for alimony paid. For divorce agreements finalized prior to January 1, 2019, 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. Gifts, inheritances, and proceeds from life insurance are not counted.

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.*

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.*

2. 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.

A. Steps for Calculating MAGI

For non-filers or any other individuals whose income cannot be verified by the Hub, use the following steps for calculating an individual's MAGI. Subtract any deductions listed below if they are reported by the individual.

For tax filers whose income is verified in the Hub as being reasonably compatible~~,~~ no MAGI calculation is required.

Adjusted Gross Income (AGI) Line 4 on Internal Revenue Service (IRS) Form 1040 EZ Line 21 on IRS Form 1040A Line 37 on IRS Form 1040	**Include:** • Wages, salaries, tips, etc. • Taxable interest • Taxable amount of pension, annuity or Individual Retirement Account (IRA) distributions and Social Security benefits • Business Income, farm income, capital gain, other gains (or loss) • Unemployment Compensation • Ordinary dividends • Rental real estate, royalties, partnerships • S corporations, trusts, etc. • Taxable refunds, credits, or offset of state and local income taxes • Other income	**Deduct:** • Certain self-employment expenses • Student loan interest deduction • Educator expenses • IRA deduction • Moving expenses • Penalty on early withdrawal of savings • Health savings account deduction • Domestic production activities deduction • Certain business expenses of reservists, performing artists, and fee-basis government officials • Alimony paid prior to January 1, 2019 (but not child support paid)

Note: Check the IRS website for detailed requirements for the income and deduction categories above. Do not include Veteran's disability payments, Worker's Compensation or child support received. Pre-tax contributions, such as those for child care, commuting, employer-sponsored health insurance, flexible spending accounts and retirement plans such as 401(k) and 403(b), are not included in AGI but are not listed above because they are already subtracted out of W-2 wages and salaries.

Add (+) back certain income	• Non-taxable Social Security benefits (line 20a minus 20b on Form 1040) • Tax –exempt interest (Line 8b on Form 1040) • Foreign earned income and housing expenses for Americans living abroad (calculated in IRS Form 2555)

Exclude (-)from income	• Social Security benefits received by a child are not countable for his eligibility when a parent is in the household, unless the child is required to file taxes. • Scholarships, awards, or fellowship grants used for education purposes and not for living expenses • Certain American Indian and Alaska Native income derived from distributions, payments, ownership interests, real property usage rights and student financial assistance • Gifts, inheritances, and proceeds from life insurance • An amount received as a lump sum is counted only in the month received. • Parsonage allowance • Effective January 1, 2019, student loan debt forgiven due to death or disability of student is not counted as income. • Grants for homes designed for wheelchair living and motor vehicles for veterans who lost their sight or the use of their limbs • Difficulty of Care Payments • General Welfare Payments for Indian Tribes • *Kinship Guardianship Payments*

M0530 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-15	1/1/20	Appendix 1, page 1
TN #DMAS-11	1/1/19	Appendix 1, page 1
TN #DMAS-8	4/1/18	Appendix 1, page 1
TN #DMAS-6	10/1/17	Pages 2, 24, 30
TN #DMAS-3	1/1/17	Appendix 1, page 1
TN #DMAS-2	10/1/16	Pages 23, 24
TN #DMAS-1	6/1/16	Appendix 1, page 1
TN #100	5/1/15	Pages 14, 16, 29, 30 Appendix 1, page 1
TN #99	1/1/14	Appendix 1, page 1
UP #9	4/1/13	Appendix 1, page 1
UP #6	4/1/12	Appendix 1, page 1
Update (UP) #5	7/1/11	Page 14
TN #95	3/1/11	Page 1 Appendix 1, page 1
TN #93	1/1/10	Pages 11, 19 Appendix 1, page 1

Deeming Allocations

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

NBD (Non-blind/disabled) Child Allocation

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

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

2020: $1,175 - $783 = $392
2019: $1,157 - $771 = $386

Parental Living Allowance

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

SSI payment for one person = *$783 for 2020*; $771 for 2019.

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

SSI payment for both parents = *$1,175 for 2020*; $1,157 for 2019.

Deeming Standard

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

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

2020: $1,175 - $783 = $392
2019: $1,157 - $771 = $386

M0810 Changes

Changed With	Effective Date	Pages Changed
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

GENERAL

M0810.001 INCOME AND ELIGIBILITY

A. Introduction

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

B. Policy Principles

1. Who is Eligible

An individual is eligible for Medicaid if the person:

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

2. General Income Rules

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

M0810.002 INCOME LIMITS

A. Income Limits

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

1. Categorically Needy

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

2. Categorically Needy Protected Cases Only

Categorically-Needy Protected Covered Groups Which Use SSI Income Limits		
Family Unit Size	2019 Monthly Amount	*2020* Monthly Amount
1	$771	*$783*
2	1,157	*1,175*
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size	2019 Monthly Amount	*2020* Monthly Amount
1	$514.00	*$522.00*
2	771.34	*783.34*

3. Categorically Needy 300% of SSI

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

Family Size Unit	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 1/11/19

ABD 80% FPL, QMB, SLMB, & QI <u>with</u> Social Security income; effective 3/1/19

All Localities	2018		2019	
ABD 80% FPL	Annual	Monthly	Annual	Monthly
1	$9,712	*$810*	$9,992	$833
2	13,168	*1,098*	13,528	1,128
QMB 100% FPL	Annual	Monthly	Annual	Monthly
1	$12,140	*$1,012*	$12,490	$1,041
2	16,460	*1,372*	16,910	1,410
SLMB 120% of FPL	Annual	Monthly	Annual	Monthly
1	$14,568	*$1,214*	$14,988	$1,249
2	19,752	*1,646*	20,292	1,691
QI 135% FPL	Annual	Monthly	Annual	Monthly
1	$16,389	*$1,366*	$16,862	$1,406
2	22,221	*1,852*	22,829	1,903
QDWI 200% of FPL	Annual	Monthly	Annual	Monthly
1	$24,280	*$2,024*	$24,980	$2,082
2	32,920	*2,744*	33,820	2,819

S0820 Changes

Changed With	Effective Date	Pages Changed
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

3. Other Earned Income

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

a. Federal earned income tax credit payments.

b. Up to $10 of earned income in a month if it is infrequent or irregular.

c. For *2020*, up to *$1,900* per month, but not more than *$7,670* in a calendar year, of the earned income of a blind or disabled student child.

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

d. Any portion of the $20 monthly general income exclusion which has not been excluded from unearned income in that same month.

e. $65 of earned income in a month.

f. Earned income of disabled individuals used to pay impairment-related work expenses.

g. One-half of remaining earned income in a month.

h. Earned income of blind individuals used to meet work expenses.

i. Any earned income used to fulfill an approved plan to achieve self-support.

4. Unused Exclusion

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

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

5. Couples

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

B. References

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

- S0810.410 for infrequent/irregular income
- S0810.420 $20 general exclusion
- M0810.430 amount to fulfill a plan for achieving self-support

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

S0820.510 STUDENT CHILD EARNED INCOME EXCLUSION

A. Policy

1. General

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

For Months	Up to per month	But not more than in a calendar year
In calendar year *2020*	*$1,900*	*$7,670*
In calendar year 2019	$1,870	$7,550

2. Qualifying for the Exclusion

The individual must be:

- a child under age 22; and
- a student regularly attending school.

3. Earnings Received Prior to Month of Eligibility

Earnings received prior to the month of eligibility do not count toward the yearly limit.

4. Future Increases

The monthly and yearly limits will be adjusted annually based on increases in the cost of living index. Under this calculation, these amounts will never be lower than the previous year's amounts. However, there may be years when no increases result from the calculation.

B. Procedure

1. Application of the Exclusion

Apply the exclusion:

- consecutively to months in which there is earned income until the exclusion is exhausted or the individual is no longer a child; and
- only to a student child's own income.

2. School Attendance and Earnings

Develop the following factors and record them:

- whether the child was regularly attending school in at least 1 month of the current calendar quarter, or expects to attend school for at least 1 month in the next calendar quarter, and
- the amount of the child's earned income (including payments from Neighborhood Youth corps, Work-Study, and similar programs).

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

M1110 Changes

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

M1110.003 RESOURCE LIMITS

A. Introduction

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

B. Policy Principles

1. Resource Ineligibility

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

2. Resource Limits

ABD Eligible Group	One Person	Two People
Categorically Needy Medically Needy	$2,000	$3,000
ABD with Income ≤ 80% FPL	$2,000	$3,000
QDWI	$4,000	$6,000
QMB SLMB QI	**Calendar Year** **2019** $7,730 ***2020*** *$7,860*	**Calendar Year** **2019** $11,600 ***2020*** *$11,800*

3. Change in Marital Status

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

4. Reduction of Excess Resources

Month of Application

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

M1340 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-15	1/1/20	Pages 16, 18 Page 17 is a runover page.
TN #DMAS-14	10/1/19	Page 2, 18
TN #DMAS-12	4/1/19	Page 2
TN #DMAS-9	7/1/18	Pages 6a
TN #DMAS-7	1/1/18	Pages 18, 20, 22
TN #100	5/1/15	Pages 4, 5
TN #95	3/1/11	Page 6
TN #94	9/1/10	Page 6
TN #93	1/1/10	Page 18

services recognized under state law.

An incurred medical expense cannot be deducted from the spenddown liability until the third party has made a decision to either deny or make some payment on the expense. Only that portion of the expense which is the applicant's legal responsibility shall be deducted from excess income in determining spenddown eligibility, unless the expense was covered by a state or local public program. If the expense was covered by a state or local public program, see section M1340.1100 below.

The application processing time standards apply to the receipt of third party payment or verification of third party intent to pay. Efforts to determine the liability of a third party shall continue through the last day of the application processing time standard (90 days for disability determinations; 45 days for all other applicants). If information regarding third party liability is not received by this date, eligibility must be determined based on the information available, if any, about the actual amount of the third party's payment.

If the amount subject to payment by a third party cannot be determined based on information available, the bill in question to which the third party liability applies cannot be used in determining spenddown eligibility. However, if information becomes available at a later date, the spenddown eligibility shall be redetermined and the effective date of spenddown eligibility revised.

Exception: In the case of an individual covered by Medicare who receives a service from a Community Services Board (CSB), the service may be used as a spenddown deduction per M1340.1100 without requiring that Medicare first be billed for the service as long as the CSB provides a statement that the service is not covered by Medicare.

B. Determining The Amount of The Third Party Payment

Determine the balance of the expense for which the individual is legally liable to pay. Use the third party's explanation of benefits paid (EOB) or similar statement received by the individual which shows the date of service, type of service, service provider, amount charged, amount approved, and amount paid by the liable third party.

Use the EOB's statement of the individual's responsibility as the amount to deduct from the spenddown liability. If the EOB does not show this amount, calculate the individual's responsibility.

1. Service Provider Accepts Approved Charges

When the service provider accepts the third party's approved charges, subtract the amount of the third party's payment from the approved charges. The remainder is the individual's responsibility and is the amount deducted from the spenddown liability.

2. Service Provider Does Not Accept Charges

When the service provider does NOT accept the third party's approved charges, subtract the amount of the third party's payment from the provider's charges. The remainder is the individual's responsibility and is the amount deducted from the spenddown liability.

C. Procedures

1. Worker

a. Inform the applicant that:

1) an expense cannot be deducted until his/her insurance or other third party, if applicable, has taken action on the claim

2) the applicant must provide evidence documenting:

- the claim was denied, or
- the amount paid by the third party on the claim.

3) only the amount not covered by the third party(ies) and which remains the liability of the individual may be deducted from the spenddown (unless the expense was covered by a state or local public program as described in section M1340.1100 below).

b. The EW must take reasonable measures to determine the liability of a third party to pay for the incurred expense. However, because of the application processing time standards, do not delay a spenddown determination simply because the third party has not yet made payment or has not yet denied the expense. Complete the determination without deducting the expense. Note the medical expenses submitted but not deducted due to pending TPL on the Medical Expense Record. Notify the applicant of the decision and of which bills (expenses) were not used in the determination because documentation of the third party's action was not received.

2. Applicant

The applicant is responsible to submit:

- verification that a claim for the incurred expense was submitted, and
- evidence of the third party's denial or amount of payment.

M1340.1100 STATE OR LOCAL PUBLIC PROGRAMS

A. Policy

Expenses for incurred medical services received

- for which the applicant is or was legally liable, and
- which were or will be provided, covered, or paid for by a state or local (or territorial) public program

can be deducted from the spenddown even though the applicant does not owe anything for the service.

Expenses covered by federally-funded and/or administered programs such as Medicare and Medicaid cannot be deducted from spenddown. Local health department programs, although administered by the Virginia Department of Health, are not state or local public programs because the health departments receive some federal funds.

B. State or Local Public Programs

State or local public programs are state or local public health care programs which are wholly or partially funded and administered by local government,

and which do not have any federal funding or administration. State or local public programs include, but are not limited to:

1. General Relief (GR)
2. Community Service Boards (CSB) services.
3. Department of Behavioral Health and Developmental Services (DBHDS) institutional services.
4. Virginia Commonwealth University (VCU) Health System and University of Virginia (UVA) Health System clinics, care centers, and hospitals
5. Crime victims compensation (Virginia Workers Compensation Commission)
6. Local "free" clinics funded and administered by local governments that do not charge any fee to any patient for any service.
7. Community Services or Neighborhood Assistance programs.

C. Procedures

1. Worker

a. Inform the applicant that expenses for medical services for which the applicant was legally liable and which were provided, covered, or paid for by a state or local public program will be deducted from the spenddown even though the applicant does not owe anything for the service.

b. The EW must take reasonable measures to determine the public program's payment or coverage of the medical or remedial care service. However, because of application processing time standards, do not delay a spenddown determination because the public program's payment is not verified. Complete the determination without deducting the expense, notify the applicant of the decision and that the public program expense(s) was not used in the determination because verification was not received

Exception: In the case of an individual covered by Medicare who receives a service from a CSB, the service may be used as a spenddown deduction without requiring that Medicare first be billed for the service as long as the CSB provides a statement that the service is not covered by Medicare.

2. Applicant

The applicant is responsible to submit:

- verification that the medical/remedial service was received and that a claim for the incurred expense was submitted, and
- evidence of the public program's amount of payment for the service.

M1340.1200 SPENDDOWN LIABILITY CALCULATION

A. Retroactive Spenddown Budget Period

The procedures for calculating a retroactive spenddown liability for a spenddown budget period follow:

M1450 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-15	1/1/20	Page 46
TN #DMAS-14	10/1/19	Pages 19, 41, 42, 46
TN #DMAS-10	10/1/18	Pages 1, 2 Appendix 3, page 2 Page 24a was added back; it was inadvertently removed in a previous transmittal. Page 2a was added as a runover page.
TN #DMAS-9	7/1/18	Page 35-36a, 37-38, 43
TN #DMAS-7	1/1/18	Page 4, 24, 36, 36a, 37, 41, 42 Appendix 1, Page 1.
TN #DMAS-5	7/1/17	Table of Contents Pages 13, 35, 41-44 Page 43a was renumbered. Pages 45 and 46 were added as runover pages.
TN #DMAS-3	1/1/17	Pages 30, 40-42, 44
TN #DMAS-1	6/1/16	Pages 13, 15, 35 Pages 14 and 16 are runover pages.
TN #100	5/1/15	Table of Contents Pages 17-19, 36, 37 Page 35 is a runover page.
TN #99	1/1/14	Page 7, 10, 21
UP #7	6/1/12	Table of Contents Pages 37-43 Page 43a was added.
TN #96	10/1/11	Table of Contents Pages 4-8 Pages 15, 16, 25, 26 Pages 31-38 Page 31a removed.
TN #95	3/1/11	Pages 4, 24, 32, 36, 37, 37a, Pages 39, 42, 43
TN #94	9/1/10	Table of Contents Pages 36-37a, 39-44
TN #93	1/1/10	Table of Contents Pages 3, 17-18, 29 Appendix 2, page 1
TN #91	5/15/09	Pages 41, 42

C. Send DMAS Notice

The agency worker must send a copy of the DMAS-225 to:

Department of Medical Assistance Services
Eligibility and Enrollment Services Division
600 E. Broad St., Suite 1300
Richmond, VA 23219.

The copy of the DMAS-225 must be signed and dated by the worker, and must show the worker number and the local agency's FIPS code.

Any information the agency receives about the individual's subsequent receipt of compensation which shortens the penalty period must be sent to the Long-Term Care Unit at the above address.

M1460 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-15	1/1/20	Pages 3, 35
TN #DMAS-14	10/1/19	Pages 4, 29
TN #DMAS-13	7/1/19	Page 42
TN #DMAS-11	1/1/19	Pages 3-5, 10, 26, 31
TN #DMAS-10	10/1/18	Table of Contents, page i Pages 1-3, 4b, 5, 6, 9, 10, 13, 15, 17a, 18, 18a, 26, 27, 30a, 37, 38 Pages 8a, 11, 19, 30, 39 and 40 are runover pages.
TN #DMAS-8	4/1/18	Pages 18a, 32, 35
TN #DMAS-7	1/1/18	Pages 3, 7
TN #DMAS-3	1/1/17	Pages 3, 4, 4b, 24, 25, 29
TN #DMAS-2	10/1/16	Page 35
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 3, 8a, 17, 32
TN #100	5/1/15	Table of Contents, page i Pages 1, 2, 5, 6, 10, 15, 16-17a, 25,41-51
TN #99	1/1/14	Pages 3, 35
UP #9	4/1/13	Table of Contents Pages 3, 35, 38, 41, 42, 50, 51
TN #97	9/1/12	Table of Contents Pages 1, 4-7, 9-17 Page 8a was deleted. Pages 18a-20, 23-27, 29-31 Pages 37-40, 43-51 Pages 52 and 53 were deleted
UP #6	4/1/12	Pages 3, 35
TN #96	10/1/11	Pages 3, 20, 21
TN #95	3/1/11	Pages 3, 4, 35
TN #94	9/1/10	Page 4a
TN #93	1/1/10	Pages 28, 35
TN #91	5/15/09	Pages 23, 24

11. Old Bills

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

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

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

12. Projected Expenses

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

13. Spenddown Liability

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

M1460.150 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LTSS

A. Applicability

The policy in this section applies to nursing facility and CBC/PACE patients, including MAGI Adults effective January 1, 2019, who meet the requirements for LTC services, now called long term services and supports (LTSS), on or after January 1, 2006. This includes individuals who filed reapplications after a break in Medicaid eligibility. It does **not apply** to Medicaid recipients who were approved for LTSS prior to January 1, 2006, and who maintain continuous Medicaid eligibility.

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

B. Policy

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

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

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

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

***1.* Home Equity Limit**

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

- Effective January 1, 2018: $572,000
- Effective January 1, 2019: $585,000
- Effective January 1, *2020: $595,000*.

6. Domestic Travel Tickets Gifts of domestic travel tickets [1612(b)(15)].

7. Victim's Compensation Victim's compensation provided by a state.

8. Tech-related Assistance Tech-Related Assistance for Individuals with Disabilities [ref. P.L. 100-407].

9. $20 General Exclusion $20 a month general income exclusion for the unit.

EXCEPTION: Certain veterans (VA) benefits are not subject to the $20 income exclusion. Refer to subchapter S0830 for complete explanation of which VA payments are entitled to the $20 general exclusion.

10. PASS Income Any unearned income used to fulfill an SSI approved plan to achieve self-support (PASS). See item 12 below for earned income used to fulfill a PASS [1612(b) (4)(A) & (B)].

11. Earned Income Exclusions The following earned income exclusions are not deducted for the 300% SSI group:

a. For *2020*, up to *$1,900* per month, but not more than *$7,670* in a calendar year, of the earned income of a blind or disabled student child.

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

b. Any portion of the $20 monthly general income exclusion which has not been excluded from unearned income in that same month [1612(b) (2)(A)].

c. $65 of earned income in a month [1612(b) (4)(C)].

d. IRWE - earned income of disabled individuals used to pay impairment-related work expenses [1612(b) (4)(B)].

e. One-half of remaining earned income in a month [1612(b) (4)(C)].

f. BWE - Earned income of blind individuals used to meet work expenses [1612(b) (4)(A)].

g. Earned income used to fulfill an SSI approved plan to achieve self-support (PASS) [1612(b) (4)(A) & (B)].

12. Child Support Child support payments received from an absent parent for a blind or Disabled child [1612(b) (9)].

M1470 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-15	1/1/20	Pages 19, 20
TN #DMAS-14	10/1/19	Table of Contents, page i Pages 1, 14, 28a, 31, 32, 43, 47, 48, 50 Appendix 1, page 2 Page 14a was added as a runover page.
TN #DMAS-12	4/1/19	Pages 10, 12a, 14, 21, 28b
TN #DMAS-10	10/1/18	Page 10, 12a, 14, 21
TN #DMAS-8	4/1/18	Page 2a
TN #DMAS-7	1/1/18	Pages 19, 20, 43, 44.
TN #DMAS-5	7/1/17	Pages 1, 7-9, 11, 15, 19, 20, 28a, 43, 47-51, 53
TN #DMAS-4	4/1/17	Page 19
TN #DMAS-3	1/1/17	Table of Contents, page ii Pages 1, 14, 17, 19, 20, 28a, 45-47, 50 Appendix 1, pages 1 and 2
TN #DMAS-2	10/1/16	Pages 12, 27, 28 Pages 12a and 28a were added as runover pages.
UP #11	7/1/15	Pages 43-46 Page 46a was deleted.
TN #100	5/1/15	Pages 2a, 4, 29, 31, 32, 34, 43, 44, 45, 53, 54 Pages 1a, 2, 3a and 4 were renumbered for clarity. Pages 3, 4a, 46 and 46a are runover pages. Pages 1 and 3 are reprinted.
TN #99	1/1/14	Pages 9, 19, 20, 23, 24, 40
TN #98	10/1/13	Pages 9, 24
UP #9	4/1/13	Pages 9, 16, 19, 20, 24, 43
UP #7	7/1/12	Pages 19, 46-48
UP #6	4/1/12	Pages 4, 9, 19, 20, 24, 26
TN #96	10/1/11	Pages 3, 4, 7-9, 19, 22-24, 43
TN #95	3/1/11	Pages 9, 19, 20, 23
TN #94	9/1/10	Table of Contents pages 1, 1a, 3, 3a, 11, 12, pages 19, 20, 24, 28, 31
TN #93	1/1/10	Pages 9, 13, 19-20, 23, 43, 44
TN #91	5/15/09	Table of Contents Pages 1-56 Appendix 1

M1470.410 MEDICAID CBC - PERSONAL MAINTENANCE ALLOWANCE

A. Individuals

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

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

1. Basic Maintenance Allowance

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

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

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

The PMA is:

- January 1, 2019 through December 31, 2019: $1,273.
- *January 1, 2020 through December 31, 2020: $1,292.*

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

2. Guardianship Fee

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

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

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

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

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

a. for individuals employed 20 hours or more per week, all earned income up to 300% of SSI *($2,349* in *2020*) per month.

b. for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI *($1,566* in *2020*) per month.

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

A working patient receiving CCC Plus Waiver services is employed 18 hours per week. His income is gross earnings of $1228.80 per month and SSA of $300 monthly. His special earnings allowance is calculated by comparing his gross earned income ($1128.80) to the 200% of SSI maximum ($1,500.00). His gross earned income is less than 200% of SSI; therefore, he is entitled to a special earnings allowance. His personal maintenance allowance is computed as follows:

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

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

B. Couples

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

M1470.420 DEPENDENT CHILD ALLOWANCE

A. Unmarried Individual, or Married Individual With No Community Spouse

For an unmarried Medicaid CBC patient, or a married Medicaid CBC patient without a community spouse, who has a dependent child(ren) under age 21 years in the community:

- Calculate the difference between the appropriate MN income limit for the **child's** home locality for the number of children in the home and the child(ren)'s gross monthly income. If the children are living in different homes, the children's allowances are calculated separately using the MN income limit for the number of the patient's dependent children in each home.
- The result is the dependent child allowance. If the result is greater than $0, deduct it from the patient's income as the dependent child allowance. If the result is $0 or less, do not deduct a dependent child allowance.

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

M1480 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-15	1/1/20	Pages 1, 7, 18c, 66, 69, 70 Page 2 is a runover page.
TN #DMAS-14	10/1/19	Pages 8a, 8b, 12, 15, 16, 18, 20, 21, 30, 32, 51
TN #DMAS-13	7/1/19	Page 66
TN #DMAS-11	1/1/19	Pages 2, 7, 8, 18c, 66, 69, 70
TN #DMAS-7	1/1/18	Pages 18c, 66
TN #DMAS-11	1/1/19	Page 2
TN #DMAS-6	10/1/17	Table of Contents, page i Pages 2, 50, 50a, 52, 52a, 55, 57, 59, 63, 66, 76, 79, 80, 82, 84, 86, 88, 89
TN #DMAS-5	7/1/17	Pages 66, 69, 70, 92
TN #DMAS-3	1/1/17	Pages 7, 9, 18, 18b, 18c, 20 Pages 47, 51, 66, 67, 77
TN #DMAS-2	10/1/16	Pages 66, 72
TN #DMAS-1	6/1/16	Pages 7, 11, 14, 18, 18c, 30, 66, 69, 70, 92, 93
UP #11	7/1/15	Page 18c
TN #100	5/1/15	Pages 7, 16, 18, 18a, 18c, 65, 66 Pages 8, 15, 17 and 18b are reprinted.
TN #99	1/1/14	Pages 7, 18c, 66, 69, 70
TN #98	10/1/13	Page 66
UP #9	4/1/13	Pages 7, 18c, 66, 69, 70
UP #8	10/1/12	Page 66
TN #97	9/1/12	Pages 3, 6, 8b, 16 Pages 20-25 Page 20a was deleted.
UP #7	7/1/12	Pages 11, 14, 18c, 21 Pages 32, 66, 67, 69
UP #6	4/1/12	Pages 7, 18c, 66, 68, 69, 70
TN #96	10/1/11	Pages 7, 14, 66, 71
UP #5	7/1/11	Page 66
TN #95	3/1/11	Pages 7-9, 13, 18a, 18c, 66, Pages 69, 70
TN #94	9/1/10	Pages 64, 66, 69, 70
TN #93	1/1/10	Table of Contents, page ii Pages 3, 8b, 18, 18c, 20a Pages 21, 50, 51, 66, Pages 69, 70, 93 Appendix 4 was removed.
Update (UP) #1	7/1/09	Page 66
TN # 91	5/15/09	Pages 67, 68 Pages 76-93

M1480 MARRIED INSTITUTIONALIZED INDIVIDUALS' ELIGIBILITY & PATIENT PAY

M1480.000 GENERAL

A. Introduction

Section 1924 of the Social Security Act contains special eligibility rules that apply ONLY to married institutionalized individuals whose first continuous period of institutionalization began on or after September 30, 1989. These rules are intended to prevent the impoverishment of a spouse living in the community when the other spouse enters long-term care. **For resource assessment and eligibility determination, the resource value is its value as of the first moment of the first day of a calendar month.**

Section 1924 supersedes all other sections of Medicaid law when determining countable resources and income of a married institutionalized individual who has a community spouse. Therefore, the usual Medicaid eligibility rules do not apply to an institutionalized individual with a community spouse whenever the usual Medicaid rules conflict with the law in section 1924.

An institutionalized spouse is an individual who is in a medical institution, who is receiving Medicaid waiver services or who has elected hospice services, and who is married to a spouse who is not in a medical institution or nursing facility. The term "community spouse" means the spouse of an institutionalized spouse. The community spouse can be living outside an institution or in a residential institution such as an adult care residence.

B. Applicability

1. MAGI Adult

DO NOT use this subchapter to determine the individual's financial eligibility for Medicaid if the individual is eligible in the MAGI Adult covered group. *If an individual who has been determined eligible for LTSS in the MAGI Adult covered group subsequently marries and is no longer financially eligible in the MAGI Adults covered group, use the policy in M1480 to determine continuing financial eligibility for LTSS. The resource assessment is completed based on resources owned by the couple as of the first moment of the first day of the month in which the marriage took place (see M1480.220).*

2. Admitted Before 9-30-89

DO NOT use this subchapter to determine the individual's financial eligibility for Medicaid when the married institutionalized individual was admitted to long-term care **prior to** September 30, 1989 and has been continuously institutionalized since admission. Use subchapters M1410 - M1460 to determine the individual's financial eligibility for Medicaid.

3. Admitted On/ After 9-30-89

Use this subchapter in determining Medicaid eligibility for an institutionalized spouse who

- was admitted to long-term care **on or after** September 30, 1989 and has been continuously institutionalized since admission, and
- has a community spouse.

Do NOT use this subchapter to determine the eligibility of a married institutionalized individual whose spouse is NOT a "community spouse" as defined in this subchapter. Use subchapters M1410 - M1470 to determine the individual's eligibility and 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.

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

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

3. Community Spouse Monthly Income Allowance

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

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

4. Community Spouse Resource Allowance (CSRA)

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

- the spousal share;
- the spousal resource standard;

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

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

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

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

A. Applicability

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

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

B. Policy

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

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

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

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

1. Home Equity Limit

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

- Effective January 1, 2019: $585,000
- Effective January 1, *2020: $595,000*.

2. Reverse Mortgages

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

2. After Eligibility is Established

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

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

M1480.231 SPOUSAL RESOURCE STANDARDS

A. Introduction

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

B. Spousal Resource Standard	$25,284	1-1-19
	$25,728	*1-1-20*
C. Maximum Spousal Resource Standard	$126,420	1-1-19
	$128,640	*1-1-20*

M1480.232 INITIAL ELIGIBILITY DETERMINATION PERIOD

A. Policy

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

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

M1480.400 PATIENT PAY

Introduction

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

B. Married With Institutionalized Spouse in a Facility

For a married long-term services and support (LTSS) patient with an institutionalized spouse in a facility, **NO** amount of the patient's income is deducted for the spouse's needs in the patient pay calculation.

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

Introduction

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

B. Monthly Maintenance Needs Allowance	$2,057.50	7-1-18		
	$2,113.75	7-1-19		
C. Maximum Monthly Maintenance Needs Allowance	$3,160.50	1-1-19		
	$3,216.00	*1-1-20*		
D. Excess Shelter Standard	$617.25	7-1-18		
	$634.13	7-1-19		
E. Utility Standard Deduction (SNAP)	$311.00	1 - 3 household members	10-1-18	
	$387.00	4 or more household members	10-1-18	
	$303.00	1 - 3 household members	10-1-19	
	$379.00	4 or more household members	10-1-19	

Note: the amounts decreased effective 10-1-19.

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

A. Policy

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

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

His personal needs allowance is calculated as follows:

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

2. Medicaid CBC Waiver Services and PACE

a. Basic Maintenance Allowance

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

- January 1, 2019 through December 31, 2019: $1,273
- *January 1, 2020 through December 31, 2020: $1,292.*

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

b. Guardian Fee

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

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

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

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

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

[EXAMPLE #19 was deleted]

For the CCC Plus, CL, IS, and BI waivers, deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

1) for individuals employed 20 hours or more per week, all earned income up to 300% of SSI *($2,349* in *2020*) per month.

1) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI *($1,566* in 2020) per month.

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

EXAMPLE #20: (Using January 2000 figures)

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

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

$928.80 = special earnings allowance

His personal maintenance allowance is calculated as follows:

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

Changed With	Effective Date	Pages Changed
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

b. SSI Medicaid Enrollees

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

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

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

c. 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 and the enrollee has not completed a renewal telephonically or online, 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. If the enrollee reports having no income ($0 income), follow the procedures in M1520.200 B.1.b).

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).

M17 Changes

Changed With	Effective Date	Pages Changed
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

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 **Public Assistance Reporting Information System (PARIS) Notice of Recipient Fraud/Non-Fraud Recovery, (form #DMAS 754R)** 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 https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms.

Complete and send the **Public Assistance Reporting Information System (PARIS) Notice of Recipient Fraud/Non-Fraud Recovery (form #DMAS 754R)** located at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, 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.

2. 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.

4. 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).

5. Incarcerated Individuals/ Offenders

The Cover Virginia Incarcerated Unit (CVIU) is responsible for evaluating PARIS matches for offenders whose cases are being held at the CVIU and reporting findings to the RAU as outlined in M1700.400 B.1 above.

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.