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Department of Medical Assistance Services

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July 1, 2019

Virginia Medical Assistance Eligibility Manual
Transmittal #DMAS-13

The following acronyms are contained in this letter:

- DDS – Disability Determination Services
- F&C – Families and Children
- HCBS – Home and Community-based Services
- LIFC – Low Income Families with Children
- MN – Medically Needy
- SSI – Supplemental Security Income
- SSN – Social Security Number
- TN – Transmittal

TN #DMAS-13 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 July 1 2019.

The following changes are contained in TN #DMAS-13:

Changed Pages	Changes
Subchapter M0110 Pages 13, 14	Corrected outdated websites.
Subchapter M0130 Table of Contents Pages 2-2c were removed. Pages 2d-2e renumbered as Pages 2-3. Pages 7, 11, 14	On pages 2 and 3, policy on incarcerated individuals was relocated to new Subchapter M0140. On page 7, revised the policy on exceptions to the SSN requirement. On pages 11 and 14, clarified the process for handling duplicate applications.
Subchapter M0140 Table of Contents Pages 1-5	Subchapter M0140, Incarcerated Individuals, is added in this TN. The subchapter will serve as the primary location for information, policies and procedures regarding Medicaid coverage for incarcerated individuals or offenders.
Subchapter M0220 Page 21	Clarified that an eligibility worker can certify Emergency Services coverage for pregnancy-related labor and delivery services
Subchapter M0240 Page 1 Pages 2 and 3 are runover pages.	On page 1, added individuals who refuse to obtain an SSN on the basis of well-established religious objections to the list of exceptions to the SSN requirement.
Subchapter M0310 Page 24 Page 24a is a runover page.	Clarified that children receiving HCBS who have not had a disability determination must be referred to DDS 90 days prior to turning 18.
Subchapter M0320 Pages 1, 24-27	On page 1, corrected a typographical error. On pages 24-27, clarified that individuals who receive SSI or who have 1619(b) status meet the income requirement for entry into MEDICAID WORKS.
Chapter M04 Pages 32-34, 36 Appendices 3 and 5	On pages 32-34 and 36, clarified information about gap-filling methodology. In the appendices, updated the LIFC and Individuals Under Age 21 income limits effective July 1, 2019.
Subchapter M0710 Appendices 2 and 3	Updated the appendices with the new MN and F&C Deeming Standard amounts effective July 1, 2019.
Subchapter M0810 Page 2	Updated the MN income limits effective July 1, 2019.
Subchapter M1350 Table of Contents Page 2, 4,14 Add Pages 14a and 14b	Updated the Table of Contents. On pages 2, 4, and 14-14b, revised the policy on procedures for when an individual on a spenddown becomes incarcerated.
Subchapter M1360 Page 4 Page 4a was deleted	Clarified the process for reviewing the spenddown when an assistance unit member become incarcerated.

Changed Pages	Changes
Subchapter M1460 Page 42	Revised references.
Subchapter M1480 Page 66	Updated the Monthly Maintenance Needs Allowance and Excess Shelter Standard for July 1, 2019.
Chapter M15 Table of Contents	Corrected a typographical error.
Subchapter M1510 Page 7 Page 7a was deleted.	Added a reference to M0140.
Subchapter M1520 Page 14	Clarified the enrollment/entitlement dates for incarcerated individuals.

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-13	7/1/19	Pages 13, 14
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

Any request for a mail-in application for assistance must include a mail-in voter registration application. When an authorized representative is applying on another individual's behalf, the local agency is to offer a mail-in voter registration application. In both situations, the bottom of the certification form is to be completed accordingly.

f. Voter Registration Application Sites

Local social services agencies are required to offer voter registration application services at each local office (including satellite offices) for applicants/recipients of TANF, SNAP, and Medical Assistance. Voter registration application services are also offered by out-stationed staff taking MA applications at hospitals or local health departments and by Medicaid staff at the state's Department of Behavioral Health and Developmental Services' facilities.

B. Information Made Available to the Public in General

1. Availability of Manual

Federal regulations require copies of the State Plan and eligibility rules and policies to be available in agency offices and other designated locations. Policy manuals must be made available in agency offices and other designated locations to individuals who ask to see them.

Upon request, copies of program policy materials must be made available without charge or at a charge related to the cost of reproduction. Copies of manual pages may be made at the local departments of social services. The full *Medical Assistance* Eligibility Manual is available on the DMAS web site at *http://www.dmas.virginia.gov/#/assistance*.

2. MA Handbooks and Fact Sheets

Federal regulation 42 CFR 435.905 requires the state agency to publish bulletins or pamphlets describing eligibility in easy to understand language. The handbooks available for each MA program include basic information about the programs and provide a listing of rights and responsibilities. To supplement the MA handbooks, fact sheets that explain specific policy areas are available to local social services agencies from the state department of social services. A copy of the handbook corresponding to the program in which the individual was enrolled must be given to all recipients after enrollment and must be given to others upon request. The Medicaid handbooks are available on the internet at *http://www.dmas.virginia.gov/#/clientservices*. The FAMIS Handbook is available at http://www.coverva.org/programs_famis.cfm.

C. Inquiries

1. General Inquiries

The following information has been developed to give guidance to employees of the State and local departments of social services about how to respond to inquiries:

- Limit verbal and written information to explaining the written materials provided. Those written materials may include copies of manual pages, MA handbooks, or fact sheets. The individual may also be referred to the Virginia Department of Social Services website at www.dss.virginia.gov and the Virginia Department of Medical Assistance Services website at www.dmas.virginia.gov for additional information.

- Do not go beyond the scope of the written materials. Questions about hypothetical situations, such as (but not limited to) "what would happen if a certain value of resources were transferred?" or "what would be the effect on Medicaid if a trust were written in a certain way?" should not be answered.

Medicaid rules and policies are applied to the facts of a specific application after an application is received. Prior to receipt, do not give hypothetical advice or answers to hypothetical questions to applicants, their attorneys or anyone applying on behalf of the applicant. Answering hypothetical questions is inappropriate for two reasons:

- Until a complete application is received, the local agency cannot be sure it has all the relevant facts. An attempt to be helpful could be futile or lead to incorrect advice. In the event of a dispute, the applicant may then assert that the agency is bound by the incorrect advice. The applicant or other persons affected by the applicant's actions (such as those affected by a property transfer or those otherwise responsible for the care of the applicant) may attempt to hold the agency employee or employees involved individually liable for damages suffered as a result of alleged negligent advice.

- Providing responses to hypothetical questions may under some circumstances constitute the practice of law. The practice of law includes advising another for compensation, direct or indirect, in any matter involving the application of legal principles to facts or purposes or desires. Local agency workers, regional MA consultants, and central office MA employees, even if they are attorneys, are not functioning as legal counsel and must not give legal advice which may affect the rights of applicants, recipients, or others who may not be applying or eligible for MA.

All MA staff are bound by these guidelines for the dissemination of information. Do not refer inquiries from attorneys, applicants or others acting on behalf of the applicant to regional or state MA staff.

2. *Case Specific Inquiries*

Send questions that occur as a direct result of the receipt of an application to the regional MA consultant. Do not refer questions from attorneys (or legal questions in general) to the Office of the Attorney General. These attorneys are responsible for providing legal advice to the regional MA consultant and are not authorized to give legal advice to the public.

M0130 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-13	7/1/19	Table of Contents Pages 2-2c were removed. Pages 2d-2e renumbered as Pages 2-3 Pages 7, 11, 14
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
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TN #93	1/1/10	Pages 4-6, 8
Update (UP) #2	8/24/09	Pages 8, 9

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M0130.100 Processing Time Standards

A. Processing Time Standards

1. 10 Day Requirement (Expedited Application)

a. Pregnant Women

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

If the pregnant woman also applies for other children or other persons in her family and the agency cannot determine the other persons' eligibility within 10 working days, the agency must determine just the MA eligibility of the pregnant woman within the working 10 days.

The agency must have all necessary verifications within the 10 working days in order to determine eligibility. If the agency does not receive the verifications within the 10 working days, the worker must send the applicant written notice on the 10th day. The notice must state why action on the application was not taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 days by which to submit the documentation.

Once all necessary verifications for the pregnant woman are received, an eligibility decision must be made immediately and the applicant must be immediately notified of the decision. If the pregnant woman applied for other persons in the family, and the eligibility determination for those persons has not been completed, the written notice must state that the application is still pending.

If all necessary verifications are not received, the application continues to pend until the 45-day processing time limit is reached.

b. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Applications

BCCPTA Medicaid applications filed by individuals who do not meet the description of an individual in the Low-income Families with Children (LIFC), Medicaid pregnant women, or SSI recipients covered groups must be processed within 10 working days of the agency's receipt of the signed application.

BCCPTA Medicaid applications filed by individuals who meet the description of an individual in the LIFC, pregnant women, or the SSI recipients covered groups must be processed as soon as possible, but no later than 45 days of the agency's receipt of the signed application.

If the BCCPTA Medicaid application is the only application required and no additional information is required, the eligibility decision must be made immediately and the applicant must be notified of the decision within 10 working days of the agency's receipt of the application.

If a decision cannot be made within 10 working days of receipt of the BCCPTA application, the worker must send a written notice on the 10th day stating why action has not been taken, specifying what information is needed, and a deadline for submitting the information.

If all necessary verifications are not received, the application continues to pend until the 45-calendar-day processing time limit is reached.

See M0130.200 E below for instructions on the verification of legal presence. See subchapter M0220 for instructions on the verification of identity and citizenship. See subchapter M0310 for instructions on the verification of age and disability.

D. Social Security Numbers

Applicants must provide the SSN of any person for whom they request Medicaid, if an SSN is required for that individual's eligibility. An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

1. SSN Verification

The Federal Hub, SVES or SOLQ-I may be used to verify the individual's SSN.

2. Exceptions to SSN Requirements

The SSN requirement does not apply to:

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

See M0240 for additional information and verification requirements.

3. SSN Not Yet Issued

If an SSN has not been issued, the applicant must cooperate by applying for a number with the local Social Security Administration (SSA) office. Instruct the applicant to submit form SS-5, the Application for Social Security Number, to the SSA and to obtain a receipt from the SSA verifying that the application was submitted. The SS-5 is available online at: https://www.ssa.gov/forms/ss-5.pdf. The applicant must provide the SSN to the local social services department as soon as it is received and the number must be entered in the eligibility and enrollment system. Applicants who refuse to furnish an SSN or to show proof of application for a number will be ineligible for medical assistance.

In the case of a newborn child not eligible in a child under 1 covered group, the applicant can request hospital staff to apply for an SSN for the child through hospital enumeration procedures. Form #SSA-2853 will be given to the applicant as proof of application for an SSN.

When entering the individual in the eligibility/enrollment system, use the date the individual applied for an SSN, or the individual's date of birth, preceded by "999" as the individual's SSN. For example, an individual applied for an SSN on October 13, 2006, enter "999101306" as the individual's SSN.

E. Legal Presence (Effective January 1, 2006)

Effective January 1, 2006, Section 63.2-503.1 of the Code of Virginia requires most applicants for or recipients of public assistance who are age 19 or older to provide proof of citizenship or legal presence in the U.S. Applicants or recipients age 19 or older for whom medical assistance is requested must prove their citizenship or legal presence.

M0130.300 Eligibility Determination Process

A. Evaluation of Eligibility Requirements

When an MA application is received the worker must determine through a "file clearance" search of the eligibility and enrollment systems whether or not the individual already has Medicaid or FAMIS coverage.

With the exception of individuals enrolled on the basis of presumptive eligibility (PE), applications for MA submitted by individuals who already have an application recorded or who are currently active are denied as duplicate applications. *See M0130.400.D*

Applications submitted by individuals currently enrolled as HPE or as Newborn Children are not duplicate applications because they were initially enrolled without filing a full MA application. See M0120.300 A.5 for more information.

The eligibility determination process consists of an evaluation of an individual's situation that compares each of the individual's circumstances to an established standard or definition. The applicant must be informed of all known factors that affect eligibility.

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

The evaluation of eligibility requirements must be documented in writing for cases not processed in VaCMS. The Evaluation of Eligibility (form #032-03-823) may be used. The form is available online at the DSS Fusion website.

Agency or CPU created evaluation forms are also acceptable as long as all information needed to determine eligibility is documented on the evaluation form.

Eligibility decisions are made following a prescribed sequence:

- The applicant must meet all non-financial requirements, including a covered group.
- If applicable to the covered group, resource limits must be met.
- The income limits appropriate to the covered group must be met.

Subchapter M0210 contains the Medicaid non-financial requirements.

B. Hierarchy of Covered Group

An applicant must be evaluated for eligibility in all potential covered groups and enrolled in the group that is the most beneficial to the applicant. First, evaluate under covered groups offering full coverage and if the applicant is not eligible, evaluate under groups offering limited coverage. Specific instructions regarding the determination of covered group are contained in chapter M03.

C. Applicant's Choice of Covered Group

An individual who meets more than one covered group may choose the covered group under which he wishes his eligibility determined. Appropriate policy used is based on that individual's choice. If the choice is not clear on the application/redetermination form, the individual must state his covered group choice in writing. If the applicant does not make a choice, enroll him in the covered group that is the most beneficial.

E. Notification for Retroactive Entitlement Only

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

M0130.400 Applications Denied Under Special Circumstances

A. General Principle

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

B. Withdrawal

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

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

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

C. Inability to Locate

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

D. Duplicate Applications

The worker will review a duplicate application to verify there is no changes in circumstances, request(s) for coverage, or other actions which need to be acted upon. Applications received requesting MA for individuals who already have an application recorded *(i.e. pending)* or who are currently active *and receiving coverage* will be denied due to duplication of request.

A notice will be sent to the applicant when a duplicate application is denied.

CHAPTER M01

APPLICATION FOR MEDICAL ASSISTANCE
SUBCHAPTER 40

INCARCERATED INDIVIDUALS

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M01 APPLICATION FOR MEDICAL ASSISTANCE

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M0140.000 Incarcerated Individuals General Information

A. Introduction

An incarcerated individual, or offender, is an inmate of a public institution. Inmates include those under the authority of the Virginia Department of Corrections (DOC), held in a regional or local jail, those on work release, and inmates of a Virginia Department of Juvenile Justice (DJJ) facility.

For juveniles not in a facility but within the authority of DJJ, see section M0280.300 D. See section M0280.301 regarding an individual who is not considered to be an inmate of a public institution.

An individual released from jail under a court probation order due to a medical emergency is NOT an inmate of a public institution because he is no longer incarcerated.

B. Policy Principles

An individual is not eligible for full benefit Medicaid coverage while incarcerated. These individuals may apply for medical assistance and (if approved) receive coverage limited to inpatient hospitalization services.

The offender must meet eligibility requirements for a full-benefit covered group. Medicaid non-financial eligibility requirements include

- Virginia residency requirements (see M0230)
- Citizenship or immigration status (see M0220)
- A Social Security Number (SSN) or proof of application for an SSN (see M0240)
- Institutional status requirement of being an inmate in a public institution (see M0280)

Medicaid financial eligibility requirements for the individuals covered group include

- Resources (if applicable) within resource limit (Chapter M06 for F&C; Chapter S11 for ABD)
- Income within income limit (Chapter M04 & M07 for F&C covered groups; Chapter S08 for ABD covered groups)

C. Covered Group

The individual is evaluated for eligibility in the covered group in which they would otherwise be eligible except for being incarcerated. The primary covered groups an offender may meet include:

- MAGI Adults (M0330.250)
- Pregnant Women (M0330.400)
- Child Under Age 19 (M0330.300)
- Aged, Blind or Disabled (M0320.300)
- Former Foster Care Child Under Age 26 Years (M0330.109)

D. Immigration Status Requirements

An incarcerated person must meet immigration requirements (see M0220). A non-citizen who meets all Medicaid eligibility requirements except for immigration status and has received an inpatient hospitalization may be evaluated for coverage as an Emergency Services Alien (see M0140.200 A 3).

M0140.100 COMMUNICATION

A. Introduction

Direct communication between an offender and staff at the Cover Virginia Incarcerated Unit (CVIU) or LDSS may be limited or prohibited depending on the facility. Staff employed by the facility or DOC may assist in coordinating the application process and communicating information to the offender, or to CVIU/LDSS.

B. Policy

The facility may designate staff who are permitted to assist with applications.. Communication with facility staff is limited only to information related to the case or application. Access to case information by facility staff is terminated when the offender is released and/or no longer incarcerated.

Case assistance for offenders held by the DOC will be coordinated by the Department of Corrections, Medicaid Program Unit, 6900 Atmore Drive, Richmond, Virginia 23225.

Case assistance for offenders in regional and local jails is handled in coordination with the facility, their staff, and any authorized representative(s) (see M0110.110).

Send all notices and other correspondence to the mailing address or via secure email as indicated on the application. If the applicant has designated an authorized representative to act on his behalf and receive notices, send a copy of the correspondence and notices to the authorized representative.

M0140.200 APPLICATION GUIDELINES

A. Introduction

Any application, renewal, or case review for an offender will be processed in the required time standards following applicable Medicaid eligibility policy (see M0130.100).

B. Policy

Offenders may file their own applications. An authorized representative may assist in applying or renewing coverage. An offender may add or change an authorized representative at any time.

An authorized representative designation is valid for the life of the application (see M0110.110.E) unless a written statement indicates such designation will cease when incarceration ends.

See Broadcast in Fusion dated 3/8/2019 Cover Virginia Incarcerated Unit (CVIU) and 5/19/2019 Updates to Cover Virginia Incarcerated Unit (CVIU) Procedures (https://fusion.dss.virginia.gov/broadcasts) for instructions explaining how to send offender applications received by the local agency to Cover Virginia for processing.

If the offender is approved, the Commonwealth of Virginia (COV) Medicaid Card is suppressed (not mailed).

C. Offender Application Processing

An application is not to be refused or denied because an applicant is incarcerated. A person is not required to have had an inpatient hospitalization in order to apply for Medicaid. The agency must evaluate the eligibility of all MA enrollees, with respect to circumstances that may change, at least every 12 months unless the enrollee is pregnant (see M1520.200 p.9).

1. New Application

An offender who does not have active Medicaid coverage may apply while incarcerated. Coverage is based on the month of application and can include up to three months of coverage (if requested) prior to the month of application, provided eligibility requirements are met.

Ongoing coverage in AC 108 or AC 109 is effective the first day of the month of application or the date when incarceration begins, whichever is later.

2. Re-entry Application

A medical assistance application for an offender with no active Medicaid coverage and an anticipated release date within 45 days is a "Re-Entry" application. This is a new application and an eligibility determination for Medicaid coverage will be made based on the anticipated living arrangement after release from the facility.

If the person is unable to provide an address where he will reside (e.g. reported he will be homeless or moving to a temporary shelter) post-incarceration, the case will be assigned and transferred to the LDSS of his pre-incarceration locality. If the individual lived outside of Virginia prior to incarceration and indicates he will remain in Virginia after incarceration, the application will be transferred to the locality where the correctional facility is physically located.

If the application is approved the worker will confirm that a new Commonwealth of Virginia Medicaid Card has been generated and a copy of the Notice of Action sent to the anticipated post-release address.

3. Emergency Services

A non-citizen who meets all Medicaid eligibility requirements except for immigration status, and has received an inpatient hospitalization, may qualify for coverage of emergency medical care. This care must have been provided in a hospital emergency room or as an inpatient in a hospital. Determine eligibility for emergency services using policy in M0220.500 B and enroll eligible individuals using the procedures in M0220.700.

M0140.300 CASE MAINTENANCE

A. Ongoing Case Maintenance

Case maintenance may include updates such as when the inmate is moved to another facility, change of an authorized representative, updates to demographics, or other changes affecting Medicaid eligibility or coverage.

Update to an offender's case are handled by the CVIU. Facilities will use a CVIU Communication Form to report changes. Local agencies will use the LDSS to Cover Virginia Communication Form #032-03-0458-00-eng to report changes.

B. Partial Reviews

If a change occurs it may be necessary to re-evaluate the offender's Medicaid coverage. This may include release from incarceration, change of anticipated release date, death, an inmate turning age 65 years old, becoming eligible for Medicare, or end of a pregnancy (see M0140.001 G).

The eligibility worker will handle such changes within 30 days and re-evaluate the offender for continued coverage.

C. Redetermination

An offender with ongoing approved Medicaid coverage is subject to an annual (every 12 months) redetermination of coverage. The CVIU processes redeterminations of incarcerated individuals (see M1520.200 A).

Do not initiate a renewal of eligibility of a pregnant woman during her pregnancy. Eligibility as a pregnant woman ends effective the last day of the month in which the 60th day following the end of the pregnancy occurs. When eligibility as a pregnant woman ends, prior to the cancellation of her coverage, determine if the woman meets the definition for another Medicaid covered group (see M0310.002). If the woman meets the definition of a full-benefit covered group, determine if an ex parte renewal can be completed or if a renewal form is required and take appropriate action.

Follow Ex Parte Renewal procedure as found in M1520.200 B. 1 if applicable. If unable to process an Ex Parte renewal, see M1520.200 B. 2 and 3 for procedures.

D. Pre-Release Review

An offender with active Medicaid coverage and a reported release date of 45 days or less requires a "Pre-Release" partial review. Eligibility will be evaluated for ongoing Medicaid coverage based on the anticipated living arrangement after release from incarceration.

If the offender is approved and remains eligible for ongoing Medicaid coverage, the worker will cancel the existing aid category (AC108 or AC109) on the day prior to the actual release date and reinstate coverage in the new AC as of the date of release.

The worker should confirm a new Commonwealth of Virginia Medicaid Card has been generated and copy of the Notice of Action sent to the post-release address.

If the offender does not provide, or is unable to provide an address where he will reside (e.g. reported he will be homeless or moving to a temporary shelter) after incarceration, the case will be assigned and transferred to the LDSS prior to his incarceration. If the offender did not have a pre-incarceration address (e.g. transferred from out of state), assign the case to LDSS where the facility is located.

If eligibility for ongoing Medicaid is denied, cancel existing Medicaid coverage the day prior to actual date of release.

1. Release to a Community Living Arrangement

An offender entering a household with existing benefits after incarceration may affect Medicaid eligibility for those in the household.

The CVIU will process Pre-Release Reviews if the offender will be residing in a household where no other members in the household have active Medicaid or other benefits (such as SNAP or TANF). If Medicaid is approved, the case will be assigned to the locality where the ex-offender plans to reside.

If the offender will be joining a household in which other members have active Medicaid or other benefits, the CVIU will assign the case to LDSS for processing since the household size change may impact existing benefits.

2. Release to an Institutional Placement, LTSS, or HCBS

When an offender needs to be placed in an institution or receive home and community-based services (HCBS), the CVIU will route such applications to LDSS in the locality where the individual will be residing for processing to ensure the eligible individual can receive necessary medical support/services when released.

M0220 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-13	7/1/19	Page 21
TN #DMAS-12	4/1/19	Pages 20, 21, 23
TN #DMAS-10	10/1/18	Page 1
TN #DMAS-9	7/1/17	Page 1, 2, 14c
TN #DMAS-6	10/1/17	Page 15 Appendix 1, page 4
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TN #DMAS-3	1/1/17	Table of Contents Page 22a Appendix 1, page 1
TN #DMAS-2	10/1/16	Pages 13, 19-22, 23, 24
TN #DMAS-1	6/1/16	Pages 4, 4b, 5, 23
TN #100	5/1/15	Table of Contents Pages 4b, 12, 17, 18 Appendix 5, page 3 Page 4 was renumbered for clarity. Page 4a is a runover page.
TN #99	1/1/14	Table of Contents Pages19, 23, 24 Appendix 4 was removed.
TN #98	10/1/13	Pages 2-3b Appendix 1 Pages 1-5 Pages 6-18 were removed.
UP #9	4/1/13	Page 3 Appendix 1, pages 3, 17 Appendix 3, pages 3, 4
UP #8	10/1/12	Table of Contents Pages 4, 7-8, 12, 14d-20 Page 17a was deleted. Appendix 5 , page 3 Appendix 7 pages 1-5
UP #7	7/1/12	Table of Contents Pages 14d, 16-19 Appendix 5 , page 3

7. Financial Eligibility

the asset transfer requirements (see subchapter M1450) apply.

Resources must be within the resource limit appropriate to the individual's covered group. (Chapter M06 for F&C covered groups; Chapter S11 for ABD covered groups).

Income must be within the income limit appropriate to the individual's covered group (Chapter M04 for Modified Adjusted Gross Income [MAGI] covered groups; Chapter M07 for F&C Medically Needy covered groups, and Chapter S08 for ABD covered groups). Spenddown provisions apply to individuals who meet a Medically Needy covered group. All medical expenses count toward meeting the spenddown, but once an entitlement date is determined after the individual meets the spenddown, only emergency services rendered on or after the entitlement date and which are within the period of coverage on the Emergency Medical Certification form are covered for emergency services aliens.

B. Emergency Services Certification--Not Applicable to Full Benefit Aliens

Certification (with completion of an Emergency Services Certification form) that the service provided was an emergency service is an additional eligibility requirement for emergency services aliens (not applicable to full benefit aliens). *An eligibility worker* can certify emergency services coverage for pregnancy-related labor and delivery services for limited, specified periods of time. DMAS must certify emergency services coverage for all other requests and determine the period of coverage.

1. *Eligibility Worker* Certification for Pregnancy-Related Labor and Delivery Services

An eligibility worker can certify emergency services payment for pregnancy-related labor and delivery services, including inpatient hospitalizations that did not exceed:

- 3 days for a vaginal delivery, or
- 5 days for a cesarean delivery.

To determine the length of stay, count the day of admission, but not the day of discharge. If the length of stay exceeded 3 days for a vaginal delivery or 5 days for a cesarean delivery, DMAS must approve the coverage following the procedures in M0220.500 B.2 below. Note that the enrollment period for the emergency service(s) includes the day of discharge even though it is not counted to determine the length of stay (see M0220.700).

For eligibility worker certifications, verification of the labor and delivery services must be obtained from the physician or hospital and include the following information:

M0240 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-13	7/1/19	Page 1 Pages 2 and 3 are runover pages.
TN #DMAS-10	10/1/18	Pages 3, 4
TN #DMAS-9	7/1/18	Table of Contents Page 6 Page 6a is a runover page
TN #DMAS-2	10/1/16	Pages 1, 4 Page 2 is a runover page.
TN #100	5/1/15	Page 2
TN #98	10/1/13	Table of Contents Pages 1-5 Page 6 was deleted.
TN #96	10/1/11	Pages 2-4
TN #94	9/1/10	Pages 1-6
TN #93	1/1/10	Pages 1-4
Update (UP) #1	7/1/09	Pages 1, 2
TN #91	5/15/09	Pages 1, 2

M0240.000 SOCIAL SECURITY NUMBER REQUIREMENTS

M0240.001 GENERAL PRINCIPLES

A. Policy

To be eligible for medical assistance (MA), an individual must provide his Social Security number (SSN) as well as the SSN of any person for whom MA is requested, or must provide proof of application for an SSN. This requirement applies to both the Medicaid and FAMIS Programs.

Exceptions – the SSN requirement does not apply to:

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

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

B. Failure to Meet SSN Requirement

Any individual for whom an application for an SSN has not been filed or for whom the SSN is not furnished **is not eligible** for MA EXCEPT *for the following individuals.*

1. Child Under Age 1

A child under age one born to a Medicaid-eligible or to a FAMIS-covered mother is deemed to have applied and been found eligible for MA, whether or not the eligibility requirements, including SSN, have actually been met.

2. Individual With Religious Objections

An individual who refuses to obtain an SSN due to well-established religious objections must provide documentation of (1) membership of a recognized religious sect of division of the sect and (2) adherence to the tenets or teachings of the sect or division of the sect and for that reason being conscientiously opposed to applying for or using a national identification number.

***3.* Emergency-Services Aliens and other Non-Citizens**

An alien eligible for Medicaid payment of emergency services only, as defined in M0220.410 and M0220.41, is not required to provide or apply for an SSN.

Any non-citizen who is only eligible to receive an SSN for a valid non-work reason is not required to provide or apply for an SSN. These individuals include, but are not limited to, undocumented aliens, non-citizens admitted to the U.S. on non-immigrant visas and individuals who do not intend to work in the U.S. and would only have needed an SSN for the purposes of receiving public assistance.

C. Relationship to Other Medicaid Requirements

An applicant who cannot provide documentation that he is a citizen or legally present at the time of application must sign an affidavit under oath attesting that he is a U.S. citizen or legally present in the U.S. in order to temporarily meet the requirement for proof of legal presence (see M0210.150). **Submission of the affidavit without proof of application for an SSN does NOT meet the SSN requirement.**

D. Verification

1. Name

The name entered in the official case record and computer enrollment systems for an applicant must match the applicant's name on his Social Security card or Social Security Administration (SSA) records verification. It is important to spell the name correctly so that when the Medicaid Management Information System (MMIS) sends the enrollee information to SSA for the Medicare Buy-in or the citizenship and identity match, the enrollee can be matched to SSA records.

The Federally managed Data Services Hub verifies the individual's name and SSN with the SSA for cases processed in the Virginia Case Management System (VaCMS). For an individual whose name and SSN cannot be verified in VaCMS and for all individuals whose cases are not processed in VaCMS, either the State Verification Exchange System (SVES) or the State Online Query-Internet system (SOLQ-I) SSA Title II and Title XVI results may be used.

2. SSN

The individual's SSN must be verified. The worker may use the SOLQ-I or SVES to verify an individual's SSN.

3. Verification Systems - SVES & SOLQ-I

SVES verifies the individual's SSN, name spelling, entitlement to SSA benefits and the amount of the benefit, entitlement to SSI and the amount, and entitlement to Medicare & the Medicare premium amounts. SVES tells the worker what is wrong with the name, if the name is incorrectly spelled.

The SOLQ-I verifies the individual's SSN, entitlement to SSA benefits and the amount of the benefit, entitlement to SSI and the amount, and entitlement to Medicare & the Medicare premium amounts. SOLQ-I does not verify the individual's name according to the SSA records.

E. Procedure

Section M0240.100 below explains in detail how to determine if an individual meets the SSN requirements when the individual or child does not have an SSN.

M0240.100 APPLICATION FOR SSN

A. Policy

If an SSN has not been issued for the individual or the individual's child(ren), the applicant must cooperate in applying for a number with the local Social Security Administration Office (SSA). Instruct the applicant to submit form SS-5, the Application for Social Security Number, to the SSA and to obtain a receipt from SSA verifying that the application was submitted. The SS-5 is available online at: http://www.socialsecurity.gov/ssnumber/ss5.htm.

The applicant must provide the SSN to the local social services department as soon as it is received and the number must be verified and entered in the eligibility/enrollment system.

1. Newborns

In the case of a newborn child, the applicant/recipient may satisfy this requirement by requesting that an SSN be applied for by hospital staff in conjunction with the filing of the birth record at the time of the child's birth. Form SSA-2853 will be given to the mother by hospital staff as verification of application for the child's SSN.

2. Failure to Apply for SSN

Applicants who refuse to furnish an SSN or to show proof of application for a number are ineligible for Medicaid.

3. Retroactive Eligibility

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

M0240.200 FOLLOW-UP REQUIREMENTS FOR SSN APPLICATION

A. Applicant Applied for SSN

When an applicant who has applied for an SSN is determined eligible for medical assistance, he is enrolled with a pseudo-SSN. The worker must obtain the enrollee's SSN when it is assigned and enter it into the enrollee's records.

B. Follow-Up Procedures

The follow-up procedures below do not apply to individuals listed in M0240.100 B.

1. Documentation

If the applicant does not have an SSN, the agency must document in the record the date he applied for an SSN.

2. Entering Computer Systems

When entering the individual the eligibility/enrollment system, use the date the individual applied for an SSN, or the individual's date of birth, preceded by "000" as the individual's SSN.

For example, an individual applied for an SSN on October 13, 2006. Enter "000101306" as the individual's SSN in the eligibility/enrollment system.

3. Follow-up

a. Follow-up in 90 Days

After enrollment of the eligible individual, the agency must follow-up within 90 days of the Social Security number application date or 120 days if application was made through hospital enumeration:

b. Check for Receipt of SSN

Check the system records for the enrollee's SSN. If the SSN still has "000" the first 3 digits, contact the enrollee to obtain the enrollee's SSN verbally or by mail.

c. Verify SSN by a computer system inquiry of the SSA records.

d. Enter Verified SSN in the eligibility/enrollment system.

M0310 Changes
Page 1 of 2

Changed With	Effective Date	Pages Changed
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

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

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

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

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

3. Individual Under 21 in LTC

a. Facility-based Care

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

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

b. *Home and Community-based Services (HCBS)*

*A child who is receiving HCBS waiver services and has not previously had a disability determination must have his disability determined prior to his **18th** birthday because he will no longer be eligble in the F&C 300% SSI covered group once he turns 18. Modified Adjusted Gross Income (MAGI) income counting rules require that parental income be counted. The child must be evaluated for coverage as a blind or disabled individual using the income and resource rules applicable to blind/disabled institutionalized individuals.*

Ninety days (90) prior to the child turning age 18, the eligibility worker must contact the parent or responsible party and send a verification checklist to request the required documents to start the DDS referral process. Follow the procedure in M0310.112 G below to make a referral to DDS.

Note: Children under 18 who receive SSI will be required by DDS to have a review of their disability. The child remains disabled for Medicaid purposes unless and until his disability status is discontinued by SSA.

E. When an LDSS Referral to DDS is Required

1. Disability Determination Has Not Been Made

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

2. SSA Denied Disability Within the Past 12 Months

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

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

OR

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

If the applicant indicates that one of the above exceptions applies, the Medicaid referral should be documented appropriately and sent to the DDS. After reviewing the Medicaid referral and Social Security decision, the DDS may determine that the SSA decision addressed all the conditions reported to Medicaid. In this situation, the DDS will determine that no exception applies and that the SSA decision is still binding. In this situation, the DDS will not make an independent disability determination for Medicaid. Instead, the DDS will document that an exception does not apply and that the SSA determination is still binding until the end of the 12-month period.

If the conditions in a or b above do not exist, the SSA denial of disability is final for Medicaid purposes. **DO NOT** make a referral to DDS for a disability determination.

3. SSA Denied Disability More Than 12 Months Ago

If the applicant alleges a disability and SSA denied the disability more than 12 months ago, follow the procedure in M0310.112 G below to make a referral to DDS. DDS will accept and fully develop the Medicaid referral if more than 12 months have passed since the most recent SSA medical determination, regardless of appeal status with SSA, and for any reason.

F. Decision Pathway for DDS Referrals

When determining whether or not a referral to DDS is required, the worker should ask the following questions:

M0320 Changes

Changed With	Effective Date	Pages Changed
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

M0320.000 AGED, BLIND & DISABLED (ABD) GENERAL POLICY PRINCIPLES

A. Overview

A State Plan for Medicaid must include the mandatory federal categorically needy (CN) groups of individuals as well as the optional groups a state has elected to cover.

This subchapter divides the ABD covered groups into categorically needy and medically needy (MN) groups.

B. Procedure

Determine an individual's eligibility first in a CN covered group. This includes eligibility in the Modified Adjusted Gross Income (MAGI) Adults covered group (see M0330.250). If the individual is not eligible in a full-benefit CN covered group, determine the individual's eligibility as MN (on a spenddown).

An evaluation of eligibility for an aged, blind or disabled individual should follow this hierarchy:

1. If the individual is a current SSI/AG recipient, evaluate in this covered group. Exception-- if the individual requests MEDICAID WORKS, go to *5* below.
2. If the individual is a former SSI or AG recipient, evaluate first in the protected covered groups Exception-- if the individual requests MEDICAID WORKS, go to *5* below.
3. If the individual does not meet the criteria for SSI/AG or protected, is between ages 19 and 64, and is not eligible for or enrolled in Medicare, evaluate next in the MAGI Adults covered group.
4. If the individual is aged and/or is eligible for or has Medicare, evaluate next in the ABD with income $\leq$ 80% FPL covered group.
5. If a disabled individual has income at or below 80% FPL (including SSI recipients and 1619(b) individuals) and is going back to work, evaluate the individual in the MEDICAID WORKS covered group.
6. If the individual does not meet the requirements for MAGI Adults, 80% FPL group or MEDICAID WORKS, but meets the definition of an institutionalized individual, evaluate in the 300% of SSI covered groups.
7. If the individual is a Medicare beneficiary with income or resources in excess of the full-benefit Medicaid covered groups, evaluate in the Medicare Savings Programs (MSP) groups (QMB, SLMB, QI, QDWI).
8. If the individual is not eligible for Medicaid coverage in an MSP group AND he is at least age 19 years but under age 65 years or he requests a Plan First evaluation, evaluate in the Plan First covered group.
9. If the individual meets all the requirements, other than income, for coverage in a full benefit Medicaid group, evaluate as MN.

C. Referral to Health Insurance Marketplace

Unless an individual is incarcerated, an ABD individual who does not have Medicare and is not for eligible for full Medicaid coverage must be referred to the Health Insurance Marketplace (HIM) so the applicant's eligibility for the APTC can be determined. Incarcerated individuals and those with Medicare are not referred to the HIM.

B. Financial Eligibility

1. Assistance Unit

The assistance unit policy and procedures in chapter M05 apply to ABD individuals with income less than or equal to 80% FPL. If not institutionalized, deem or count any resources and income from the individual's spouse with whom he lives. If institutionalized with a community spouse, go to subchapter M1480.

2. Resources

The resource limit is $2,000 for an individual and $3,000 for a couple.

The resource requirements in chapter S11 and Appendix 2 to chapter S11 apply to this covered group.

All of the individual's resources must be verified and evaluated. All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements.

3. Income

The income limits are ≤ 80% of the FPL and are in section M0810.002. The income requirements in chapter S08 must be met.

4. Income Exceeds 80% FPL

Spenddown does not apply to this covered group. If the individual's income exceeds the 80% FPL limit, he is not eligible in this covered group. Determine the individual's eligibility in all other Medicaid covered groups.

D. Entitlement

If all eligibility factors are met in the application month, entitlement to full Medicaid coverage in this covered group begins the first day of the application month.

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

E. Enrollment

The ABD 80% group AC is:

- 029 for an aged individual;
- 039 for a blind individual;
- 049 for a disabled individual; or
- 109 for all incarcerated individuals.

M0320.400 MEDICAID WORKS

A. Policy

The Appropriations Act of 2006 authorized an amendment to the Virginia State Plan for Medical Assistance that allows disabled (including blind) individuals to work and earn higher income while retaining Medicaid coverage. This program is called MEDICAID WORKS and includes individuals:

- at least age 16 and are under age 65, **and**
- who have countable income less than or equal to 80% of the FPL, (*or who are* SSI recipients *and 1619(b) individuals*) **and**
- who have countable resources less than or equal to $2,000 for an individual and 3,000 for a couple; **and**

- who are working or have a documented date for employment to begin in the future.

These individuals can retain Medicaid coverage by cost-sharing through the payment of a premium as long as they remain employed and their earned income is less than or equal to $6,250 per month. This type of cost-sharing arrangement is known as a **Medicaid** buy-in (MBI) program. MEDICAID WORKS is Virginia's MBI program.

B. Relationship Between MEDICAID WORKS and 1619(b) Status

An individual with SSI or eligible for Medicaid as a Qualified Severely Impaired Individual (QSII) (1619(b)) *meet the income requirement for entry into MEDICAID WORKS* and must not be discouraged from enrolling in MEDICAID WORKS. An individual who meets the criteria for 1619(b) status may choose to participate in MEDICAID WORKS because of the higher resource limit.

C. Nonfinancial Eligibility

The individual must also meet the following additional nonfinancial criteria:

- The individual must be competitively employed in an integrated setting. Work must occur in a work setting in the community or in a personal business alongside people who do not have disabilities. Work performed in a sheltered workshop or similar setting is **not** considered competitive employment in an integrated setting. Contact a Regional Medical Assistance Program Consultant if there is a question about whether the employment meets the criteria for MEDICAID WORKS.

- The individual must receive pay at the minimum wage or at the prevailing wage or "going rate" in the community, and the individual must provide documentation that payroll taxes are withheld. Self-employment must be documented according to the policy contained in S0820.210.

- The individual must establish a Work Incentive (WIN) Account at a bank or other financial institution, such as a checking or savings account. The individual must provide documentation for the case record designating the account(s) as a WIN Account. The account must either be a new account or an existing account with no other income but the wages earned while in MEDICAID WORKS. It cannot contain the individual's Social Security benefits.

- All individuals requesting enrollment in MEDICAID WORKS must also sign a MEDICAID WORKS Agreement, available on SPARK at: http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi. The agreement outlines the individual's responsibilities as an enrollee in the program.

- The individual must participate in cost sharing through the payment of a monthly premium to the Department of Medical Assistance Services. Note: Monthly premiums are not being charged at this time.

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 1619(b) threshold amount *for* 2019 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 2019) 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.

M04 Changes

Changed With	Effective Date	Pages Changed
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.

Dee's eligibility determination:

Potential covered groups:

Child < Age 19
FAMIS

Monthly Income limits:

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

HH monthly income:

$300 (Jane's gross earnings)

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

M0450.400 GAP-FILLING RULE EVALUATION

A. When to Complete Gap- Filling Evaluation

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

- The individual is in a tax filer household (regardless of whether or not a tax dependent exception in M0430.100 B.2 is met). APTC methodology does not apply to non-filer households
- Current monthly household income, using Medicaid/FAMIS MAGI-based methods is over the applicable *monthly* income limit (including the 5% FPL disregard) for the individual's covered group.
- The total of income already received plus projected income for the **calendar** year in which eligibility is being determined, using MAGI methods applied by the HIM for the purposes of APTC eligibility, is below 100% FPL (i.e. the lower income threshold for APTC eligibility). See M04, Appendix 1. The individual's prior income for the calendar year, or lack of income, is included in the calculation of annual income when determining financial eligibility.

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

If the eligibility and enrollment system is unable to determine eligibility using the gap-filling evaluation, the evaluation must be completed outside the system and documented in the electronic record. If the individual is eligible, the coverage must be entered directly into MMIS, and the *renewal date must be updated for January of the following year.*

B. Non-financial Requirements

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

A. Household Income Calculation

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

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

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

1. Verification of Income

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

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

2. Countable Income

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

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

3. Income Evaluation

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

- First, add together income already received for the year. Do not convert the income.
- Next, calculate the projected income for the remainder of the year based on the current monthly income, unless the individual's income is expected to change (e.g. current employment is terminating).
- Add income already received to projected income to obtain the **annual** projected income for the current calendar year.
- Compare the **annual** projected income to the 100% FPL **annual** income limits for the MAGI household size in M04, Appendix 1.
- If the **annual** income is less than or equal to 100% FPL, compare the **annua**l income to the **annual** income limit for the individual's covered group.
- For the individual to be eligible for Medicaid or FAMIS as a result of applying the gap-filling rule, the countable income must be no more than the **annual i**ncome limit for the individual's covered group. The 5% income disregard used for the Medicaid/FAMIS MAGI determination does not apply. See M04 Appendices 2-6 for income limits.

4. Renewals

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

If a woman who is eligible based on gap-filling methodology is pregnant or in the post-partum period in January, do not complete the renewal until the month in which the 60th day following the end of the pregnancy occurs.

5. Individual Not Eligible Using Gap-filling Methodology

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

B. Example Situation – Coverage Gap and Gap Filling Rule

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

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

Since the child's countable income is under the lower financial threshold for the APTC and he has excess income using non-filer rules, the child's eligibility must be evaluated using gap-filling rules.

G. Example – Gap Filling Evaluation—Childless Adult (Using 2019 Income Limits)

Lee, age 27, is a tax-filer and applies for Medicaid on June 1. He is attending graduate school and works part-time as a teaching assistant. His income for June is $1,625. The 5% FPL disregard amount of $53 is deducted ($1,625 - $53 =$1,572) and income exceeds the limit for the MAGI Adults covered group for a HH of 1 ($1,436). Lee is not eligible for Medicaid using MAGI methodology.

Lee calls the worker when he receives the denial notice and tells the worker that his income is higher in the summer and less during the remainder of the year *and requests to be evaluated for retroactive coverage for March- May.* A potential gap-filling situation exists, so the worker requests verification of Lee's income from January through May. He provides his paystubs for January ($710), February ($720), March ($697), April ($752), and May ($715). -His total year to date income is $3,594.

Lee also provides a letter from his employer that states his teaching income for September thru December will be a guaranteed amount of $715 per month. The worker uses a projected amount for September – December of $715 per month, which totals *$2,860*.

January - May	$3,594
June- August	$4,875
September- December (projected)	*$2,860*
Total Projected Annual Income	*$11,329*

The total annual projected income of *$11,329* is under the 100% annual FPL of $12,490 for household size of 1. The projected annual amount of *$11,329* is compared to the 133% annual FPL limit for household size of 1 ($16,612). *Lee is eligible for retroactive Medicaid coverage and ongoing coverage as a MAGI Adult.*

LIFC INCOME LIMITS

EFFECTIVE *7/1/19*

Group I

Household Size	Income Limit
1	*$257*
2	*392*
3	*498*
4	*604*
5	*712*
6	*802*
7	*905*
8	*1013*
Each additional person add	*107*

Group II

Household Size	
1	*$337*
2	*483*
3	*606*
4	*724*
5	*852*
6	*960*
7	*1075*
8	*1199*
Each additional person add	*121*

Group III

Household Size	
1	*$507*
2	*678*
3	*830*
4	*974*
5	*1151*
6	*1280*
7	*1425*
8	*1575*
Each additional person add	*146*

INDIVIDUALS UNDER AGE 21 INCOME LIMITS
EFFECTIVE *7/1/19*

Group I

Household Size	Income Limit
1	*$246*
2	*382*
3	*489*
4	*593*
5	*697*
6	*782*
7	*885*
8	*993*
Each additional person add	*102*

Group II

Household Size	Income Limit
1	*$334*
2	*484*
3	*605*
4	*725*
5	*856*
6	*1055*
7	*1075*
8	*1198*
Each additional person add	*119*

Group III

Household Size	Income Limit
1	*$444*
2	*595*
3	*720*
4	*842*
5	*995*
6	*1098*
7	*1218*
8	*1340*
Each additional person add	*120*

M0710 Changes

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

F&C MEDICALLY NEEDY INCOME LIMITS
EFFECTIVE *7/1/19*

GROUP 1			GROUP II		GROUP III	
# of Persons in Family/Budget Unit	Semi-Annual Income	Monthly Income	Semi-Annual Income	Monthly Income	Semi-Annual Income	Monthly Income
1	*$1,957.87*	*$326.31*	*$2,259.09*	*$376.51*	*$2,936.83*	*$489.47*
2	*2,492.57*	*415.42*	*2,781.69*	*463.61*	*3,540.71*	*590.11*
3	*2,936.83*	*489.47*	*3,238.03*	*539.67*	*3,991.10*	*665.18*
4	*3,313.36*	*552.22*	*3,614.59*	*602.43*	*4,367.65*	*727.94*
5	*3,689.89*	*614.98*	*3,990.94*	*665.15*	*4,724.15*	*787.35*
6	*4,066.40*	*677.73*	*4,367.62*	*727.93*	*5,120.67*	*853.44*
7	*4,442.92*	*740.48*	*4,724.15*	*787.35*	*5,497.17*	*916.19*
8	*4,894.76*	*815.79*	*5,195.50*	*865.91*	*5,873.72*	*978.95*
9	*5,346.58*	*891.09*	*5,702.06*	*950.34*	*6,419.29*	*1,069.88*
10	*5,873.72*	*978.95*	*6,174.94*	*1029.15*	*6,852.69*	*1,142.11*
Each add'l person add	*506.00*	*84.33*	*506.00*	*84.33*	*506.00*	*84.33*

F&C 100% STANDARD OF ASSISTANCE
EFFECTIVE *7/1/19*

(Used as the F&C Deeming Standard)

Group I

Household Size	Income Limit
1	*$252*
2	*385*
3	*490*
4	*594*
5	*699*
6	*789*
7	*889*
8	*995*
Each additional person add	*104*

Group II

Household Size	
1	*$330*
2	*474*
3	*596*
4	*712*
5	*836*
6	*942*
7	*1,056*
8	*1,179*
Each additional person add	*119*

Group III

Household Size	
1	*$498*
2	*704*
3	*816*
4	*958*
5	*1,131*
6	*1,258*
7	*1,400*
8	*1,549*
Each additional person add	*143*

M0810 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-13	7/1/19	Page 2
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
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TN #DMAS-3	1/1/17	Pages 1, 2
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TN #DMAS-1	6/1/16	Pages 1, 2
UP #11	7/1/15	Page 2
TN #100	5/1/15	Pages 1, 2
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TN #99	1/1/14	Pages 1, 2
TN #98	10/1/13	Page 2
UP #9	4/1/13	Pages 1, 2
UP #7	7/1/12	Page 2
UP #6	4/1/12	Pages 1, 2
TN #95	3/1/11	Pages 1, 2
TN #93	1/1/10	Pages 1, 2
Update (UP) #1	7/1/09	Page 2

3. Categorically Needy 300% of SSI

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

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

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	Annual	Annual	Monthly
1	$9,712	$9,712	$9,992	$833
2	13,168	13,168	13,528	1,128
QMB 100% FPL	Annual	Annual	Annual	Monthly
1	$12,140	$12,140	$12,490	$1,041
2	16,460	16,460	16,910	1,410
SLMB 120% of FPL	Annual	Annual	Annual	Monthly
1	$14,568	$14,568	$14,988	$1,249
2	19,752	19,752	20,292	1,691
QI 135% FPL	Annual	Annual	Annual	Monthly
1	$16,389	$16,389	$16,862	$1,406
2	22,221	22,221	22,829	1,903
QDWI 200% of FPL	Annual	Annual	Annual	Monthly
1	$24,280	$24,280	$24,980	$2,082
2	32,920	32,920	33,820	2,819

M1350 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-13	7/1/19	Table of Contents Page 2, 4,14 Add Pages 14a and 14b
TN #DMAS-9	7/1/18	Page 4
TN #DMAS-7	1/1/18	Pages 11,12
TN #96	10/1/11	pages 7, 8

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M13 SPENDDOWN

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- M1350.200 Increase in Assistance Unit Size
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- M1350.900 Changes Due To Death

M1350.200 INCREASE IN ASSISTANCE UNIT SIZE

A. Policy

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

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

1. Step 1

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

For the months during which the additional member was added to the assistance unit, calculate the family's income based on the increased number in the assistance unit.

2. Step 2

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

3. Step 3

Determine the income limit for the assistance unit size for the number of months before the change occurred. Determine the income limit for the assistance unit size for the number of months in which the additional member was included. Add together the income limits. The result is the recalculated income limit for the spenddown budget period.

4. Step 4

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

If the recalculated income is within the recalculated income limit for the spenddown budget period, the assistance unit is eligible for the entire spenddown budget period. However, the additional assistance unit member(s) (who was not included during the entire period) is only eligible for the month(s) when he was included in the unit.

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

1. Step 1

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

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

2. Step 2

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

3. Step 3

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

4. Step 4

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

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

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

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

$1,550	income per month
- 20	general income exclusion
1,530	countable monthly income
x 6	months
9,180	countable income for the spenddown budget period June 1 – November 30
- 1,300	1 person MNIL Group I for spenddown budget period
$7,880	spenddown liability for spenddown budget period June 1 - November 30

His application is denied. He is placed on spenddown for the first prospective budget period. On October 20, he becomes institutionalized when he is admitted to a nursing facility for permanent care. His worker's compensation income has not changed. He incurred $5,000 in medical bills during September. His spenddown budget period is prorated to June - September (4 months). His spenddown liability for the prorated spenddown budget period is recalculated:

$1,530.00	monthly countable income for June - September
x 4	months (June-September)
6,120.00	countable income prorated for spenddown budget period June - September
- 866.68	1 person MNIL Group I for 4 months
$5,253.32	spenddown liability for spenddown budget period June 1 – September 30

He incurred $5,000 in medical bills in September. He did not meet the prorated spenddown. The worker sends Mr. T a notice informing him that he did not meet his spenddown for the prorated spenddown budget period of June 1 through September 30. The $5,000 in medical bills did not meet the prorated spenddown of $5,253.32. He has a balance left of $253.32. His spenddown eligibility as an institutionalized individual is determined according to policy in subchapter M1460.

M1350.850 INDIVIDUAL BECOMES INCARCERATED

A. Policy

If an individual becomes incarcerated during his spenddown budget period, the spenddown liability must be recalculated.

For other individuals in the offender's (pre-incarceration) assistance unit who may be on a spenddown, follow the appropriate policy. For assistance unit change - M1350.210; income change – M1350.300; and resource change – M1350.500.

1. Recalculate the Spenddown Liability

Recalculate the offender's spenddown liability and follow policies for income (see M1350.210) and resources (see M1350.500). The offender will be an assistance unit of one and would use the same pre-incarceration group and MNIL.

2. Conduct a Partial Review

Determine if the offender is eligible in a CN covered group based upon the first day he became incarcerated. See (M0140.300.A.1).

If the offender is determined eligible for coverage, enroll as of the day the individual entered the correctional facility.

If offender does not meet a covered group, his spenddown budget period will remains in effect until it ends. The worker will not send the offender an application at the end of the spenddown period. The offender may reapply for coverage (see M0140.200)

B. Example (ABD)—Single Individual Becomes Incarcerated

EXAMPLE #9 (Using July 2018 figures): *A disabled single man living in Group I receives SSA payment of $1,020 per month and also receiving Medicare. He applies for Medicaid in June and the MNIL is $1904.55. He has not incurred any medical bills and has no old bills. The spenddown budget period is June through November. His spenddown liability is calculated:*

$1,020	*income per month*
- 20	*general income exclusion*
1,000	*countable monthly income*
x 6	*months*
6,000	*countable income for the SD budget period 6/1 – 11/30*
-1,904.55	*1 person MNIL Group I SD budget period liability semi-annual*
$4,095.45	*SD liability for the budget period 6/1 – 11/30*

On September 10 he is incarcerated, and SD amount is recalculated. SSA payments will suspend at the end of September, and he will have no income in October or November.

$1,020	*income per month*
- 20	*general income exclusion*
1,000	*countable monthly income*
x 4	*months (months of June, July, August, and September)*
4,000	*income for the period 6/1 – 9/30*
+ -0-	*No income for remaining two months 10/1 – 11/30*
$4,000	*countable income for the SD budget period 6/1 – 11/30*
- 1,904.55	*1 person MNIL Group I SD budget period liability semi-annual*
$2,095.45	*Recalculated SD liability for the budget period 6/1 – 11/30*

Worker conducts a partial review. The offender is not eligible for QMB (due to incarceration), not eligible for MAGI (he receives Medicare), and over income for ABD 80% (income limit $810). However, with zero income for October and ongoing, he qualifies for ABD coverage beginning 10/1.

C. Example (MAGI)-Single Individual Becomes Incarcerated

EXAMPLE #10 (Using July 2018 figures): *A 40 year old single man on Medicare, lives in Group II and has income from a trust fund in the amount of $1,500 per month. He applied for Medicaid in February but was over the ABD (MSP) income limits. His MNIL is $2,154.48. He has no medical bills or old bills. The spenddown budget period is February through July. His spenddown liability is calculated:*

$1,500	*income per month*
- 20	*general income exclusion*
1,480	*countable monthly income*
x 6	*months*
8,880	*countable income for the SD budget period 2/1 – 7/30*
-2,154.48	*1 person MNIL Group I SD budget period liability semi-annual*
$6,725.52	*SD liability for the budget period 2/1 – 7/30*

On March 1 he is incarcerated. His SD liability would be recalculated. However, his trust income payments continue even though he is incarcerated, so the spenddown liability will not change and remains at $6,752.52.

The worker conducts a partial review. The offender is not eligible for QMB (due to incarceration), not eligible for MAGI (he receives Medicare), and is still over the income limit for ABD 80% (income limit $810). His spenddown liability continues for the remainder of the budget period.

M1350.900 CHANGES DUE TO DEATH

A. Policy

1. Individual Applicant

When an individual who meets an MN covered group, dies within the spenddown budget period, the spenddown budget period and the spenddown liability change. The spenddown liability and spenddown budget period are recalculated using actual income received.

2. Death of a Assistance Unit Member

When an individual member of an assistance unit dies, and at least one other assistance unit member meets a MN covered group, the family's assistance unit size decreases. The policy and procedures in section M1350.210 above apply.

1360 Changes

Changed With	**Effective Date**	**Pages Changed**
TN #DMAS-13	7/1/19	Page 4 Page 4a was deleted
TN #DMAS-12	4/1/19	Page 4, 4a
TN #DMAS-9	7/1/18	Page 4 Page 4a was added.

E. Income Increases

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

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

F. Resource Changes

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

1. Resources Within Limit

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

2. Resources Exceed Limit

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

3. Example--Resource Change

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

G. Change Due to Incarceration

A review must be conducted for all individuals in the assistance unit when a member of the assistance unit becomes incarcerated. *See M1350.850 for changes due to incarceration prior to meeting a spenddown.*

M1460 Changes

Changed With	Effective Date	Pages Changed
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

1. ABD MN Groups

a. Start with the gross monthly income for the ABD MN income determination found in section M1460.*410 C*.

b. Subtract the applicable ABD MN income exclusions. The result is the MN countable income.

c. Subtract the monthly MN income limit for 1 person in the individual's home locality from the MN monthly countable income. The remainder is the ABD individual's spenddown liability.

2. F&C MN Groups

a. Start with the gross monthly income for the F&C MN income determination found in section M1460.*410 C*.

b. If the individual has earned income, subtract the F&C earned income exclusions in M0720.500 except for the 30 + 1/3 exclusion which is not applicable to this group.

If the individual has child support income, subtract the $50 child support exclusion. See section M0730.400.

a. The remainder is the MN monthly countable income.

d. Subtract the monthly MN income limit appropriate to the individual's home locality from the MN monthly countable income. The remainder is the F&C individual's spenddown liability.

C. Determine the Individual's Projected Medicaid Rate

The individual's projected monthly Medicaid rate is the daily RUG code amount at the time of the spenddown calculation multiplied by 31 days. **For the month of entry, use the actual number of days that care was received or is projected to be received in the facility.**

D. Compare

Compare the individual's spenddown liability to the individual's Medicaid rate.

E. SD Liability Is Less Than or Equal To Medicaid Rate

If the spenddown liability is less than or equal to the individual's Medicaid rate, the individual is income eligible as medically needy for the full month. Individuals with a spenddown liability less than or equal to the individual's Medicaid rate will meet their spenddown based on the Medicaid rate alone. The Medicaid rate is projected and compared to the spenddown liability. Because the spenddown liability is less than the individual's Medicaid rate, eligibility begins the first day of the month.

Go to section M1460.750 below for enrollment procedures.

F. SD Liability Is Greater Than Medicaid Rate

If the spenddown liability is greater than the Medicaid rate, the individual is NOT income eligible as MN. The individual must incur medical expenses, including old bills, carry-over expenses and the facility's cost of care at the private rate, which equal or exceed the spenddown liability for the month. These determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred.

M1480 Changes

Changed With	Effective Date	Pages Changed
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

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

$3,090.00	1-1-18
$3,160.50	1-1-19

D. Excess Shelter Standard

$617.25	7-1-18
$634.13	*7-1-19*

E. Utility Standard Deduction (SNAP)

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

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

A. Policy

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

M15 Table of Contents Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-13	7/1/19	Table of Contents
TN #100	5/1/15	Table of Contents
TN #99	1/1/14	Table of Contents

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Renewal Process Reference Guide	Appendix 1	1
Twelve Month Extended Medicaid Income Limits	Appendix 2	1
DMHMRSAS FACILITIES	**M1550.000**	
General Principles	M1550.100	1
Facilities	M1550.200	1
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M1510 Changes

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

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

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

4. Offenders (Incarcerated Individuals)

Individuals who meet all Medicaid eligibility requirements, including eligibility in a **full benefit** CN covered group, are eligible for Medicaid coverage limited to inpatient hospitalization while incarcerated. Enroll eligible MAGI Adults in aid category AC 108 and all other adult offenders in aid category AC 109 regardless of their covered group.

See M0140.000 regarding Incarcerated Individuals.

5. MAGI Adult Turns 65 or Eligible for Medicare

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

M1520 Changes
Page 1 of 2

Changed With	Effective Date	Pages Changed
TN #DMAS-13	7/1/2019	Page 14
TN #DMAS-12	4/1/2019	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	1/1/2019	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.

The worker must document the VaCMS case record. Send adequate notice of cancellation to the estate of the enrollee at the enrollee's last known address and to any authorized representative(s) using the Notice of Action on Medicaid.

Cancel the enrollee's coverage, using the date of death as the effective date of cancellation.

4. **Enrollee Enters Ineligible Institution**

When an enrollee who is not incarcerated enters an institution and is no longer eligible (e.g. an individual between the ages of 22 and 65 enters an institution for the treatment of mental diseases), cancel coverage as soon as possible after learning of the enrollee's admission to an ineligible institution. **DO NOT cancel coverage retroactively.** Cancel coverage effective the current date (date the worker enters the cancel transaction in the system).

If an enrollee becomes incarcerated, a partial review must be completed to determine if he continues to meet the requirements for coverage in a full-benefit CN covered group. If he continues to be eligible, cancel the existing coverage and reinstate in AC 109 for ongoing coverage the *date of incarceration.* If the individual no longer meets the requirements for a full benefit CN covered group, cancel the coverage, *effective the day prior to entering incarceration. See M0140.000.*

5. **End of Spenddown Period**

When eligibility terminates at the end of a six-month spenddown period, advance notice is not required. The individual is notified of the limited period of spenddown eligibility on the Notice of Action sent at the time the spenddown application is approved. Explanation of this limitation and information relative to re-application is provided at the time of the spenddown eligibility determination and enrollment.

6. Reason "012" Cancellations

Cancellations by DMAS staff due to returned mail are reported in the monthly System Cancellation Report (RS-O-112) available in the Data Warehouse Medicaid Management Reports. The report is issued between the 21st and 25th day of each month and is to be monitored so that appropriate follow up may be made.

When information is received from DMAS that a case is canceled for cancel reason "012", the local social services department must determine if the cancellation is valid. When cancellation is not valid, the case must be re-enrolled immediately.

When the cancellation is valid, the local department must mail the individual adequate notice of cancellation using the Notice of Action. Adequate notice consists of specifying the date the cancel action took place, which is the date the notice is mailed, in the section marked "Other" on the notification form.