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Department of Medical Assistance Services

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Virginia Medical Assistance Eligibility Manual
Transmittal #DMAS-18

The following acronyms are contained in this letter:

- COLA – Cost of Living Adjustment
- COVID – Coronavirus Disease
- DDS – Disability Determination Services
- DMAS – Department of Medical Assistance Services
- MSP – Medicare Savings Programs
- SSI – Supplemental Security Income
- TANF –Temporary Assistance for Needy Families
- TN – Transmittal

TN #DMAS-18 includes policy clarifications, updates and revisions. Unless otherwise noted in the Cover Letter and/or policy, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after January 1, 2021. Note that COVID-19 Public Health Emergency guidelines continue until the emergency is over and are not referenced in Medicaid Eligibility Policy.

The following changes are contained in TN #DMAS-18:

Changed Pages	Changes
Subchapter M0120 Pages 11, 17 Page 12 is a runover page. Page 12a was added as a runover page.	On page 11, clarified the appendices used with the Cover Virginia Application for Health Coverage & Help Paying Costs. On page 17, revised the processing time requirement for applications submitted by pregnant women.
Subchapter M0130 Pages 4, 8, 13	Revised the form links.

Changed Pages	Changes
Subchapter M0140 Pages 3-5	Clarified the case maintenance policies and procedures for incarcerated individuals (offenders).
Subchapter M0210 Page 4	Revised the form link.
Subchapter M0220 Page 21	Clarified the process for the Emergency Services Certification Form.
Subchapter M0250 Page 4	Revised the link.
Subchapter M0310 Table of Contents, page ii Pages 26, 27 Appendix 1 was removed. Appendix 2 was renumbered to Appendix 1.	Revised the Table of Contents. On pages 26 and 27, revised the contact information for making a "manual" DDS referral. In Appendix 1, revised the contact information for DDS.
Subchapter M0320 Pages 11, 22, 26, 27	On page 11, revised the COLA figures for 2021. On pages 22 and 26, revised the links. On page 27, updated the Medicaid Works resource limit information.
Chapter M04 Pages 7, 16a, 18, 19 Page 16b was added. Page 18a was added as a runover page..	On page 7, clarified the tax dependent exceptions. On pages 16a and 19, added policy on student loans payments made by an employer in 2020. On pages 16b and 19, added policy on charitable contributions. On page 18, added policy on the treatment of withdrawals from retirement accounts. On page 19, also removed the references to an obsolete tax form.
Subchapter M0530 Appendix 1, page 1	Revised the deeming standards for 2021.
Subchapter M0730 Page 3	Clarified that TANF Relative Support Maintenance payments are excluded.
Subchapter M0810 Pages 1, 2	Revised the SSI-based figures for 2021.
Subchapter M0820 Pages 30, 31	Revised the blind or disabled student earned income exclusion for 2021.
Subchapter M1110 Page 2	Revised the MSP resource limits for 2021.

Changed Pages	Changes
Subchapter M1120 Table of Contents Pages 27, 28, 29 Pages 28a through 28d were added. Pages 28 d is a runover page	Updated the Table of Contents. On all other pages, revised the policy on the treatment of cash loans as a resource.
Subchapter M1130 Pages 31, 33, 34	Revised the links.
Subchapter M1410 Page 1	Clarified that a parent can be the authorized family substitute representative for their incapacitated child of any age.
Subchapter M1460 Pages 3, 35	On page 3, revised the home equity limit for 2021. On page 35, revised the blind or disabled student child earned income exclusion for 2021.
Subchapter M1470 Pages 19, 20	On page 19, revised the basic maintenance allowance for 2021. On page 20, revised the special earnings allowance for 2021.
Subchapter M1480 Pages 7, 18c, 66, 69, 70, 92	On page 7, revised the home equity limit. On page 18c, revised the spousal resource standards. On page 66, revised the Utility Standard Deduction, effective October 1, 2020. Note that the amount decreased. On page 69, revised the basic maintenance allowance for 2021. On page 70, revised the special earnings allowance for 2021. On page 92, revised the link.
Subchapter M1510 Page 2b, 9, 12	Clarified the verification requirements regarding retroactive entitlement. On pages 9 and 12, revised the links.
Subchapter M1520 Pages 1, 4, 4a, 5, 11, 13	On page 1, clarified when an individual must be evaluated for Plan First. On pages 4-5, restored content that was inadvertedly deleted in a previous transmittal. No policy was revised on those pages. On pages 11 and 13, revised the links.
Chapter M22 Page 6	Revised the processing time for applications.

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

M0120 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-18	1/1/21	Pages 11, 17 Page 12 is a runover page. Page 12a was added as a runover page.
TN #DMAS-17	7/1/20	Pages 2, 2a, 5, 7, 8, 13, 16 Page 6 is a runover page. Page 14 was removed. Pages 15-20 were renumbered.
TN #DMAS-14	10/1/2019	Pages 7, 10, 11, 18 Page 20a was deleted.
TN #DMAS-12	4/1/19	Pages 2, 12-13,15, 20a
TN #DMAS-10	10/1/18	Pages 2, 4, 15, 17-20 Page 20a was added as a runover page.
TN #DMAS-8	4/1/18	Page 12
TN #DMAS-6	10/1/17	Page 1
TN #DMAS-5	7/1/17	Page 2a
TN #DMAS-4	4/1/17	Pages 2a, 7, 10, 13
TN #DMAS-3	1/1/17	Page 15
TN #DMAS-2	9/1/16	Pages 2, 15 Page 2a is a runover page.
TN #DMAS-1	6/1/16	Pages 7, 10, 11, 16-20
TN #100	5/1/15	Table of Contents Pages 1, 2, 15, 20 Page 2a and 16 are runover pages.
UP #10	5/1/14	Table of Contents Pages 11, 16-18 Pages 11a and 11b were deleted. Pages 19 and 20 were added.
TN #99	1/1/14	Page 11 Pages 11a and b were added.
TN #98	10/1/13	Table of Contents Pages 1-17
UP #9	4/1/13	Page 13, 15, 16
UP #7	7/1/12	Pages 1, 10-12
TN #96	10/1/11	Table of Contents Pages 6-18
TN #95	3/1/11	Pages 1, 8, 8a, 14
TN #94	9/1/10	Pages 8, 8a
TN #93	1/1/10	Pages 1, 7, 9-16
Update (UP) #1	7/1/09	Page 8
TN #91	5/15/09	Page 10

b. Model Application for Medicare Premium Assistance Form

The Model Application for Medicare Premium Assistance Form was developed by the federal Centers for Medicare & Medicaid Services (CMS) that states can choose to use for the Medicare Savings Program applicants. The model application is **NOT** a prescribed Virginia Medicaid application form at this time.

Should a local department of social services (LDSS) receive a model application form, the agency is to send a valid Virginia MA application to the applicant with a request that it be completed, signed, and returned to the agency within 30 calendar days. The date of application on the model Application for Medicare Premium Assistance is to be preserved as the application date for purposes of Medicaid entitlement.

The processing time for the LDSS begins when the agency receives the Virginia application form back from the applicant. If the Virginia application form is not returned within 30 days, no further action is necessary on that application. The agency does not send a Notice of Action because no Virginia application was received. The model application date is not preserved beyond 30 calendar days. Should the person later submit a valid Virginia application, the date the Virginia application is received by the LDSS is the application date.

The model application form may be viewed on the SSA web site at: https://www.ssa.gov/forms/ssa-1020b-ocr-sm-inst.pdf.

B. Application Forms

Medical assistance must be requested using an application method or form approved by the Departments of Medical Assistance Services (DMAS) and Social Services (VDSS). Applications may be made electronically through CommonHelp or the Health Insurance Marketplace.

Applications may also be made telephonically through the Cover Virginia Call Center or with a paper application form.

The following paper forms have been prescribed as application forms for Medicaid and FAMIS:

1. Streamlined Applications

The following forms are used to apply for affordable health insurance, including qualified health plans with the Advance Premium Tax Credit (APTC), through the Health Insurance Marketplace or the local DSS:

- the Cover Virginia Application for Health Coverage & Help Paying Costs and all applicable appendices:
  - Appendix D, for applications submitted for aged, blind or disabled *(ABD)* applicants and ABD applicants who are requesting *long-term services and supports (LTSS)*
  - Appendix E, when a Families and Children (F&C) Medically Needy determination is requested
  - *Appendix F, for applicants in need of LTSS who are between the ages of 19 and 64 years and who are not eligible for or enrolled in Medicare;*

- the federal Application for Health Coverage & Help Paying Costs for multiple individuals and all applicable appendices; and

- the federal Application for Health Coverage & Help Paying Costs (Short Form) for individuals and all applicable appendices.

2. BCCPTA Medicaid Application

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application, form #032-03-384, is used only by individuals screened under the Breast and Cervical Cancer Early Detection Program. **This form is not to be given to applicants by the local departments of social services** (M0120, Appendix 2 is provided for reference purposes only).

3. Replaced Application Forms

The following forms were replaced by the streamlined application forms effective October 1, 2013. While agencies should accept and process any of these forms if they are submitted, additional information, such as tax filing information, may need to be obtained (see M0120.300 B.4 below).

- Application for Benefits (#032-03-824)
- The Application/Redetermination for Medicaid for SSI Recipients (#032-03-091)
- The Medicaid Application/Redetermination for Medically Indigent Pregnant Women (#032-03-040)
- The Health Insurance for Children and Pregnant Women (#FAMIS-1)
- The Application for Adult Medical Assistance form (#032-03-0222)
- The Plan First Application (#DMAS-65E)

4. Renewal Forms Returned After Reconsideration Period

Renewal forms filed after the end of the 90-day reconsideration period are treated as reapplications. Accept the form and request any additional information needed to determine the individual's eligibility. See M1520.200 C for additional information.

5. If Additional Information is Required

Applicants may apply for MA on any valid application form. Regardless of which application form is used, if additional information is required to determine an applicant's eligibility, send the applicant the relevant page(s) of the Cover Virginia Application for Health Coverage & Help Paying Costs, and/or Appendices D or E, as appropriate, along with a checklist asking for the information. Give the applicant at least 10 business days to return the information and any required verifications to the agency.

M0120.400 Place of Application

A. Principle

The place of application may be the office of the local social services department serving the locality in which the applicant resides. Verification of locality residence is not required. MA applications are also accepted online, telephonically through Cover Virginia, or at designated hospitals and health clinics (Medicaid outstationed sites). If an applicant is homebound and needs assistance with completing the application, the agency, upon request, must arrange to have the application taken where he resides or is a patient.

1. Locality of Residence

Medical assistance applications that are approved are sent to the LDSS in the applicant's locality of residence or where the individual last lived outside of an institution.

2. Joint Custody Situations

A child whose residence is divided between two custodial parents living in different localities is considered to reside in the locality in which he attends school. If the child is not enrolled in school, the parents must decide which locality is the child's residence for application/ enrollment purposes.

(AC 035) is limited to outpatient prenatal services; labor and delivery are not covered under HPE for AC 035. HPE coverage for Plan First enrollees AC084 is limited to family planning services only. Transportation to receive covered medical services is covered for all HPE enrollees.

Enrollment as HPE is limited to one HPE period per calendar year for all individuals other than pregnant women. For pregnant women, enrollment is limited to one HPE eligibility period per pregnancy.

There are no appeal rights for an HPE determination.

1. Eligibility Procedures – Post HPE Enrollment

a) MA Application Not Submitted

If the person does not submit an MA application prior to the end of the HPE coverage period, no further worker action or additional notice not required because the enrollment was for a closed period of coverage.

b) MA Application Submitted

For MA coverage to continue beyond the initial HPE coverage period, the individual must submit a full MA application. MA applications submitted by HPE enrollees are subject to the standard eligibility and entitlement policies. The *7-calendar* day processing standard applies to MA applications submitted by pregnant women. *The 10-work day requirement applies to applications submitted by* BCCPTA individuals enrolled in HPE.

While the LDSS does not determine eligibility for HPE, if an MA application is received and pended in VaCMS, the individual's coverage in the HPE AC may need to be extended or reinstated (if HPE coverage will end during the application processing period) while the application is processed. If HPE coverage needs to be extended/reinstated, alert a VDSS Regional Consultant or send an MMIS Coverage Correction Request form, available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, to the DMAS Eligibility and Enrollment Unit at enrollment@dmas.virginia.gov.

Example 1: Mary Smith is enrolled in HPE coverage in AC 065 (LIFC) for the period of 3-5-18 through 4-30-18. On 4-20-18, she submits an MA application; however, the 45th processing day will fall after the HPE end date of 4-30-18. Therefore, the worker must have the HPE coverage reinstated in MMIS under the same aid category (AC 065), using the MA application date. The effective date of the reinstatement is 5-1-18, the day after the HPE coverage ends. Once the application has been processed. the worker must act to cancel the HPE coverage, and if the individual remains eligible reinstate coverage in the appropriate AC.

M0130 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-18	1/1/21	Pages 4, 8, 13
TN #DMAS-17	7/1/20	Pages 2, 6, 10 Page 6a was added as a runover page.
TN #DMAS-15	1/1/20	Pages 9, 10
TN #DMAS-14	10/1/19	Pages 9, 10
TN #DMAS-11	1/1/19	Page 1
TN #DMAS-10	10/1/18	Table of Contents Pages 1, 2-2b, 9-12 Pages 2c-2e were added as runover pages.
TN #DMAS-9	7/1/18	Page 2b
TN #DMAS-8	4/1/18	Page 13
TN #DMAS-7	1/1/18	Pages 1, 9
TN #DMAS-5	7/1/17	Pages 1, 10
TN #DMAS-4	4/1/17	Page 6
TN #DMAS-3	1/1/17	Pages 5, 7, 11
TN #DMAS-2	10/1/16	Table of Contents Pages 2. 4, 5, 7-10, 12, 13 Page 2a is a runover page. Page 14 was added as a runover page.
TN #DMAS-1	6/1/16	Table of Contents Pages 4, 6, 10, 12 Page 11 is a runover page. Page 13 was added as a runover page.
TN #100	5/1/15	Pages 1, 2-2b, 5, 11 Pages 3, 6 and 2c are runover Pages.
UP #10	5/1/14	Table of Contents Pages 8-12 Page 13 was added.
TN #99	1/1/14	Pages 10-12 Page 13 was added.
TN #98	10/1/13	Table of Contents Pages 1-12
UP #9	4/1/13	Page 3, 5
UP #7	7/1/12	Pages 4, 5
TN #96	10/1/11	Pages 6-8
TN #95	3/1/11	Page 8
TN #94	9/1/10	Pages 2-6, 8
TN #93	1/1/10	Pages 4-6, 8
Update (UP) #2	8/24/09	Pages 8, 9

If action is not taken within the time standard, the case record must show the cause for the delay and the applicant must be notified in writing of the status of his application, the reason for the delay, and his right of appeal.

When an application is delayed after 90 days because of a disability decision and the agency has determined that excess resources exist at the time the delay notice is sent, the NOA must inform the applicant that he/she has excess resources and the amount. The notice must also state that:

- a final action cannot be taken until the disability decision is made;
- if the applicant is determined to be disabled, he/she will not be eligible unless the excess resources are reduced; and
- he will be notified when the disability decision is made.

B. Application for Retroactive Coverage

The retroactive period is based on the month in which the application is filed with the agency. The retroactive period is the three months prior to the application month.

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

An individual may request retroactive coverage at any time subsequent to an application even if the application was denied or the applicant signed a statement saying he did not want retroactive coverage. The retroactive period is based on the application month regardless of whether the application was denied or approved. **There is no administrative finality on determining retroactive eligibility if eligibility for the months in the retroactive period has not been determined.**

If the application was denied, the application is reopened for determination of eligibility in the entire retroactive period – all three months prior to the application month – even if a covered medical service was received in only one retroactive month. The applicant must provide all verifications necessary to determine eligibility during the retroactive period.

If the applicant is found eligible for retroactive coverage and a Medicaid-covered medical service was received over one year prior to the date the retroactive eligibility is determined, the applicant must be given an "Eligibility Delay" letter to give to the medical provider so that Medicaid will pay the claim (see the sample letter on the intranet at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*. Once retroactive eligibility is established, Medicaid coverage begins the first day of the earliest retroactive month in which retroactive eligibility exists.

Individuals who, on June 30, 1997, were Medicaid-eligible and were residing in long-term care facilities or participating in home and community-based waivers, and who continue to maintain that status (eligible for Medicaid and reside in long-term care facilities or participate in home and community-based waivers) are exempt from this requirement.

Non-citizens applying for Medicaid payment limited to emergency services are not subject to the legal presence requirement. An individual who is applying on behalf of another and is not requesting assistance for himself is not subject to the legal presence requirement.

2. Documents That Demonstrate Legal Presence

An applicant may demonstrate legal presence by presenting one of the following documents:

- valid evidence of U.S. citizenship;
- valid evidence of legal permanent resident status;
- valid evidence of conditional resident alien status;
- a valid SSN verified by SSA;
- a U.S. non-immigrant visa;
- a pending or approved application for legal asylum;
- a refugee or temporary protected status document; or
- a pending application for an adjustment of residence status.

3. Failure to Provide Proof of Legal Presence

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 meet the requirement for proof of legal presence for either:

- a period of 90 days or until it is determined that he is not legally present in the U.S., whichever is earlier; or

- indefinitely if the applicant provides a copy of a completed application for a birth certificate that has been filed and is pending and being actively pursued in accordance with federal or state law. Such extension shall terminate upon the applicant's receipt of a birth certificate or determination that a birth certificate does not exist because the applicant is not a U.S. citizen.

The affidavit form is on the intranet at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*.

NOTE: The individual's address on the affidavit form must be the individual's **residence** address, not the mailing address.

4. Relationship to Other Medicaid Requirements

Providing proof of legal presence or submitting a signed affidavit meets the legal presence eligibility requirement. To be eligible for Medicaid, however, the individual must meet all other state and federal Medicaid eligibility requirements. Submission of the affidavit without proof of application for an SSN as required by M0130.200 D. does **NOT** meet the SSN requirement.

F. Third Party Liability (TPL)

Applicants must be asked to provide information about any health insurance they may have. Verification of health insurance information is not required.

a. Approvals

As applicable, the notice must state that:

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

b. Denials

As applicable, the notice must state that:

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

c. Delays

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

d. Other Actions

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

e. Advance Health Care Directive

An Advance Health Care Directive insert is required to be included with an initial notice of eligibility. The insert (available at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*, must be included with the initial approval or denial Notice of Action. This insert is not required when adding a person to an existing case, at redetermination, when a change is reported or when coverage is cancelled.

M0140 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-18	1/1/21	Pages 3-5
TN #DMAS-14	10/1/19	Pages 4, 5

A. 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 *approved but is unable to or does not* provide an address where he will reside (*e.g.* reports as homeless or moving to a temporary shelter) the case will be transferred to the LDSS of his pre-incarceration, if known. If there is *no known address,* or the individual lived outside of Virginia prior to incarceration *and intends to remain in the state,* transfer the case to the *LDSS* 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.

For an offender case that involves a spenddown, see M1350.850.

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 *and processed* based on the living arrangement *and information as reported or known at the time of release.*

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 *will* 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 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 approved, the case will be assigned to the locality where the ex-offender plans to reside.

If the person is approved but cannot or will not provide an address where he will reside (e.g. reports as homeless or moving to a temporary shelter), the case will be transferred to the LDSS of his pre-incarceration, if known. If there is no known address or the individual lived outside of Virginia prior to incarceration and intends to remain in the state, transfer the case to the LDSS where the correctional facility is physically located.

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

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

E. Split Cases

For case maintenance, an offender with active Medicaid coverage in aid category 108 or 109 should be placed in his own case in VaCMS and assigned to the CVIU. If the incarcerated individual is the case name and other household members with active coverage are on the case, the local agency will be responsible for removing any other member(s), setting up a new case, and transferring the offender's case to the CVIU.

M0210 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-18	1/1/21	Page 4
TN #DMAS-2	10/1/16	Page 4
TN #98	10/1/13	Pages 1-3
TN #97	9/1/12	Page 3
Update (UP) #2	8/24/09	Pages 1, 2

- a refugee or temporary protected status document; or
- a pending application for an adjustment of residence status.

C. Failure to Provide Proof of Legal Presence

At the time of application, an applicant who cannot provide documentation that he is a citizen or legally present must sign an affidavit under oath attesting that he is a U.S. citizen or legally present in the United States in order to meet the requirement for proof of legal presence for either:

- a period of 90 days or until it is determined that he is not legally present in the U.S., whichever is earlier; or

- indefinitely if the applicant provides a copy of a completed application for a birth certificate within the United States or its territories that has been filed and is pending. The affidavit's validity shall terminate upon the applicant's receipt of a birth certificate or determination that a birth certificate does not exist because the applicant is not a citizen of the United States.

The Affidavit Of United States Citizenship Or Legal Presence In The United States is available at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*.

NOTE: The individual's address on the affidavit form must be the individual's **residence** address, not the mailing address.

D. Relationship to Other Medicaid Requirements

Providing proof of legal presence or submitting a signed affidavit meets the legal presence eligibility requirement. To be eligible for Medicaid, however, the individual must meet all other state and federal Medicaid eligibility requirements. Submission of the affidavit without proof of application for an SSN as required by M0130.200.D does **NOT** meet the SSN requirement.

M0210.200 COVERED GROUPS

A. Introduction

An individual who meets the nonfinancial eligibility requirements must also meet the definition for a Medicaid covered group. Covered groups include individuals who are age 65 or older, blind, disabled, under age 19, pregnant women, and the parent(s) or caretaker-relative of a dependent child. Medicaid financial eligibility requirements vary depending upon the covered group for which eligibility is being determined.

See chapter M03 for the covered groups' definitions, policy and procedures.

Changed With	Effective Date	Pages Changed
TN #DMAS-18	1/1/21	Page 21
TN #DMAS-17	7/1/20	Table of Contents Page 21
TN #DMAS-14	10/1/19	Table of Contents Pages 3, 4, 23, 24 Page 25 was added as a runover page. Appendix 8 was added.
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
TN #DMAS-5	7/1/17	Pages 18, 19, 23, 24
TN #DMAS-3	1/1/17	Table of Contents Page 22a Appendix 1, page 1
TN #DMAS-2	10/1/16	Pages 13, 19-22, 23, 24
TN #DMAS-1	6/1/16	Pages 4, 4b, 5, 23
TN #100	5/1/15	Table of Contents Pages 4b, 12, 17, 18 Appendix 5, page 3 Page 4 was renumbered for clarity. Page 4a is a runover page.
TN #99	1/1/14	Table of Contents Pages19, 23, 24 Appendix 4 was removed.
TN #98	10/1/13	Pages 2-3b Appendix 1 Pages 1-5 Pages 6-18 were removed.
UP #9	4/1/13	Page 3 Appendix 1, pages 3, 17 Appendix 3, pages 3, 4
UP #8	10/1/12	Table of Contents Pages 4, 7-8, 12, 14d-20 Page 17a was deleted. Appendix 5 , page 3 Appendix 7 pages 1-5

Changed With	Effective Date	Pages Changed
UP #7	7/1/12	Table of Contents Pages 14d, 16-19 Appendix 5 , page 3
TN #96	10/1/11	Table of Contents Pages 2, 3, 7, 8, 14d, 18-22a, 23 Appendix 5, page 3
TN #95	3/1/11	Table of Contents Pages 3, 3a, 4-6a, 14a-14c, 17, 19, 20 Pages 22a, 23, 24 Appendices 1-2a removed. Appendix 3 and Appendices 5-8 reordered and renumbered.
TN #94	9/1/10	Pages 3-3b, 7-9, 14a-14d, 18, 21, 22a, 23 Appendix 1 Appendix 3, page 3
Update (UP) #3	3/1/10	Pages 1-3a
TN #93	1/1/10	Table of Contents Pages 7-8, 14a, 14c-14d, 15-20, 22a Appendix 1 Appendix 3, page 3 Appendix 4, pages 1 and 2 Appendix 6, page 2
TN #92	5/22/09	Table of Contents Pages 1-6a Appendix 8 (18 pages) Pages 4a-4t were removed and not replaced.
TN #91	5/15/09	Page 7 Pages 14a, 14b Page 18 Page 20 Appendix 3, 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 (DMAS Form 2019NR - available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms) 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. *The eligibility worker will complete and sign the form and send a copy to the hospital or provider.* 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:

- patient name, address and date of birth,
- facility name and address where the delivery took place
- type of delivery (vaginal or cesarean), and
- inpatient hospital admission and discharge dates.

M0250 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-18	1/1/21	Page 4
TN #98	10/1/13	Pages 1-4 Page 5 was deleted.
TN #97	9/1/12	Page 5
TN #96	10/1/11	Page 3
TN #94	9/1/10	Pages 3-5

1. **Applicants**

Explain and offer the Division of Child Support Enforcement (DCSE) services to all Medicaid applicants who apply for Medicaid for themselves and/or on behalf of children who have an absent parent. A child's parent is not considered absent if the absence is due to death, single parent adoption, artificial insemination, or termination of parental rights.

Give the applicant the DCSE Fact Sheet available on the intranet at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/References*.

2. **Enrollees**

If the local agency or DMAS requires from the enrollee information related to medical support from the absent parent, such as the policy number of the health insurance policy the absent parent has that covers the child, and the enrollee refuses to give it to the requesting agency but does not have good cause for refusing, the enrollee is no longer eligible for Medicaid because of failure to cooperate in pursuing medical support and third party liability. The child(ren) remain eligible for Medicaid.

a. Enrollees who were approved before January 1, 2007

For a Medicaid enrollee who was approved for Medicaid before January 1, 2007, and was referred to DCSE, the local agency must take action when notified by DCSE that the enrollee is not cooperating in the pursuit of medical support from the absent parent. The child(ren)'s eligibility for Medicaid is NOT affected.

b. Enrollees who applied on or after January 1, 2007

If the enrollee who applied for Medicaid on/after January 1, 2007, chooses to apply for DCSE services and DCSE opens a case for the applicant, the enrollee must cooperate with DCSE in the pursuit of medical support from the absent parent, unless there is good cause for not cooperating. If the agency is notified by DCSE that the enrollee is not cooperating, the agency worker must take appropriate action on the enrollee's Medicaid coverage; the child(ren)'s eligibility for Medicaid is NOT affected.

If the recipient wants to claim good cause for not cooperating, contact a Medical Assistance Program Consultant for instructions.

3. TANF Recipients

If an applicant for or recipient of Temporary Assistance for Needy Families (TANF) fails to cooperate with DCSE, the individual's eligibility for Medicaid is not impacted unless the individual previously requested assistance from DSCE for Medicaid purposes per M0250.300 C.2.b above.

D. DCSE

DCSE District Offices have the responsibility of pursuing support from absent legally responsible parent(s), establishing paternity when the alleged father is absent from the home, and notifying the local DSS when the enrollee does not cooperate. This responsibility entails locating the parent(s), determining ability to support, collecting support from legally responsible parent(s), establishing medical support and/or health insurance covering the applicant child(ren), and court action to secure support from the absent legally responsible parent.

The booklet, "Child Support and You", form #032-01-945, gives an overview of DCSE services and the addresses for the district offices.

M0310 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-18	1/1/21	Table of Contents, page ii Pages 26, 27 Appendix 1 was removed. Appendix 2 was renumbered to Appendix 1.
TN #DMAS-17	7/1/20	Page 7 Pages 8 and 9 are runover pages.
TN #DMAS-15	1/1/20	Pages 29, 30
TN #DMAS-14	10/1/19	Pages 24, 26, 27, 40
TN #DMAS-13	7/1/19	Pages 24 Page 24a is a runover page.
TN #DMAS-12	4/1/19	Pages 8, 9, 13
TN #DMAS-10	10/1/18	Table of Contents, page ii Pages 1-4 Page 40 was added.
TN #DMAS-9	7/1/18	Page 35 Appendix 2, Page 1
TN #DMAS-8	4/1/18	Page 9
TN #DMAS-7	1/1/18	Pages 34, Appendix 2, page 1
TN #DMAS-5	7/1/17	Pages 13, 37, 38
TN #DMAS-4	4/1/17	Pages 24, 30a Page 23 is a runover page. Page 24a was added as a runover page.
TN #DMAS-3	1/1/17	Pages 8, 13, 28b
TN #DMAS-2	10/1/16	Pages 4, 7, 29 Page 30 is a runover page. Appendix 2, page 1
TN #DMAS-1	6/1/16	Table of Contents, page ii Pages 13, 26, 28 Appendix 2, page 1

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

*** out of numerical order**

Appendices

1. LDSS Referrals to DDS for Non-expedited Cases

a. Send the following forms to the applicant for completion immediately, giving the applicant 10 calendar days to return the completed forms:

- a copy of the Frequently Asked Questions—Disability Determinations for Medicaid (form #032-03-0426), available on SPARK at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/References*, explaining the disability determination process and the individual's obligations;

- the Disability Report Adult (SSA-3368-BK), available at http://www.socialsecurity.gov/online/ssa-3368.pdf, or the Disability Report Child (SSA-3820-BK), available at http://www.socialsecurity.gov/online/ssa-3820.pdf,

- an Authorization to Disclose Information to the Social Security Administration form (SSA-827), available at http://www.socialsecurity.gov/online/ssa-827.pdf.

b. In most cases, the DDS referral is transmitted electronically to DDS through VaCMS. Form 3368-BK or 3830-BK and SSA-827 are uploaded to VaCMS for submission to DDS. No DDS Referral Form is used for electronic submissions. Follow the instructions in the Quick Reference Guide "Sending a DDS Referral in the VaCMS," available in VaCMS.

c. If the DDS referral cannot be completed in VaCMS, manually submit the referral. Complete the DDS Referral Form, available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms. Use the DDS Referral Form that corresponds with the DDS Regional Office to which the LDSS has been assigned (#032-03-0095, #032-03-0096, #032-03-0097, or #032-03-0098). To the form, attach the following:

- the completed Disability Report
- the signed Authorization to Disclose Information
- copies of paystubs, if the applicant is currently working.

If the individual's application was filed with the assistance of a hospital-based eligibility assistance organization, a copy of the consent to release information to the organization must be included with the referral so DDS staff can communicate with them, if necessary.

Mail the DDS Referral form and attachments to the *DDS Central Regional (Richmond)* Office. See *Appendix 1* to this subchapter for the *contact information*. **Do not send referrals to DDS via the courier.**

2. Expedited Referrals for Hospitalized Individuals Awaiting Transfer to a Rehabilitation Facility

The 2004 Budget Bill mandated that DDS make a disability determination within seven (7) working days of the receipt of a referral from the LDSS when the Medicaid applicant is hospitalized, needs to be transferred directly to a rehabilitation facility AND the individual does not already have a disability application pending with DDS. To ensure that the DDS is able to make the disability determination within the mandated timeframe, the procedures below shall be followed:

a. Hospital staff shall simultaneously send:

- the Medicaid application and a cover sheet, available on Fusion at to the LDSS or the hospital outstationed eligibility worker
- the medical documentation (disability report, authorizations to release information and medical records) and cover sheet to the DDS.

b. LDSS shall **immediately** upon receipt of the Medicaid application:

- fax a completed DDS Referral Form (#032-03-0095, #032-03-0096, #032-03-0097, or #032-03-0098) *available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, to the DDS Central Regional Office at 804- 527-4518* to verify receipt of the Medicaid application unless it is known to the agency that the individual already has a pending disability claim with DDS. If the individual already has a pending disability claim with DDS, the claim cannot be treated as an expedited referral.
- give priority to processing the applications and immediately request any verifications needed; and
- process the application as soon as the DDS disability determination and all necessary verifications are received; and
- notify the hospital contact identified on the cover sheet of the action on the application and provide the Medicaid enrollee number, if eligible.

c. DDS shall make a disability determination within seven (7) working days and fax the result of the disability decision to the LDSS. DDS is not responsible for notifying either the applicant or the hospital of the outcome of the disability determination.

If DDS is unable to render a decision within 7 working days, DDS will send a communication to the LDSS advising that the disability determination has been delayed.

3. Application Processing When DDS Referral is Pending

If the completed forms are not returned by the applicant within 45 calendar days from the date of application, the applicant is considered not to meet the covered group and the application must be denied.

Individuals who require a disability determination must meet all non-financial requirements other than covered group, within 45 calendar days or the application must be denied. If these requirements are met, the application timeframe may be extended to 90 days while DDS is making the disability determination. If any non-financial requirement other than covered group is not met by the 45th calendar day, his application must be denied and DDS must be notified of the denial.

DDS does NOT stop the disability determination process when the individual meets all non-financial requirements, but has excess resources (see M0130.100 B.4) because he might reduce his resources while the

Disability Determination Services (DDS) *Contact Information*

Send ALL expedited and non-expedited disability referrals to the DDS Central Regional Office.

DDS Regional Office	Hearing Contacts
Central Regional Office Disability Determination Services 9960 Mayland Drive. Suite 200 Richmond, Virginia 23233 Phone: 800-523-5007 or 804-367-4700 General FAX: 804-527-4523 Expedited FAX: 804-527-4518 Professional Relations: Zachary Reynolds Office Manager: Karry Rouse Regional Director: Brett Fielding	Primary Contact (schedule): Jacqueline Fitzgerald 804-367-4838 Backup: Patrice Harris 804-367-4714 Hearings FAX: 804-527-4518

M0320 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-18	1/1/21	Pages 11, 22, 26, 27
TN #DMAS-17	7/1/20	Pages 24. 25. 26, 27 Page 26a was added as a runover page.
TN #DMAS-15	1/1/20	Pages 11, 26, 27, 29
TN #DMAS-14	10/1/19	Page 40
TN #DMAS-13	7/1/19	Pages 1, 24-27
TN #DMAS-11	1/1/19	Pages 2a, 11, 35, 37
TN #DMAS-10	10/1/18	Page 1 1a added as a runover page
TN #DMAS-9	7/1/18	Page 2, 17
TN #DMAS-7	1/1/18	Page 2, 3, 4, 11, 26-27.
TN #DMAS-4	4/1/17	Page 26
TN #DMAS-3	1/1/17	Pages 11, 27, 29, 40, 41, 44, 45, 52
TN #DMAS-2	10/1/16	Pages 4, 15, 16, 18, 20, 22, 30, 33, Pages 39- 41, 43-45, 48, 51, 52, 55
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 1, 11, 25-27, 46-49 Page 50 is a runover page.
TN #100	5/1/15	Pages 6, 11, 24, 25-27, 29-30
TN #99	1/1/14	Page 11
TN #98	10/1/13	Pages 1, 54, 55.
UP #9	4/1/12	Pages 11, 26, 32, 34-37, 45, 46, 55
TN #97	9/1/12	Table of Contents Pages 1-56 (all pages)
UP #6	4/1/12	Pages 11, 12, 46a
TN #96	10/1/11	Table of Contents Pages 46f-50b Page 50c deleted
TN #95	3/1/10	Pages 11, 12, 42c, 42d, 50, 53, 69 Pages 70, 71 Page 72 added.
TN #94	9/1/10	Pages 49-50b
UP #3	3/1/10	Pages 34, 35, 38, 40, 42a, Pages 42b, 42f
TN #93	1/1/10	Pages 11-12, 18, 34-35, 38 Pages 40, 42a-42d, 42f-44, 49 Pages 50c, 69-71
UP #2	8/24/09	Pages 26, 28, 32, 61, 63, 66
Update (UP) #1	7/1/09	Pages 46f-48
TN #91	5/15/09	Pages 31-34 Pages 65-68

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

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

a. *Current Title II Benefit* = *Benefit Before 1/21 COLA*
1.013 (1/21 Increase)

b. Benefit Before 1/21/ COLA = Benefit Before 1/20 COLA
1.016 (1/20 Increase)

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

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

5. Medicare Premiums

a. Medicare Part B premium amounts:

1-1-21…$148.50
1-1-20 $144.60
1-1-19 $135.50
1-1-18 $134.00
1-1-17 $109.00

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

b. Medicare Part A premium amount:

1-1-21 *$471.00*
1-1-20 $458.00
1-1-19 $437.00
1-1-18 $422.00
1-1-17 $413.00

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

6. Evaluation

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

B. Nonfinancial Eligibility Requirements

To be eligible in this protected covered group, the protected SSI disabled child must

- have had his/her SSI canceled solely because he/she does not meet the SSI definition of childhood disability (revised per section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996);
- continue to meet the SSI childhood disability definition and regulations that were in effect prior to the effective date of the change in the disability definition (August 22, 1996); and
- be under age 18 years.

Note: All affected children are now over age 18 years.

1. Disability Determination Referral to Disability Determination Services (DDS)

An SSI disabled child is presumed to meet the childhood disability definition
in effect prior to August 22, 1996, until he/she reaches age 18 years, unless there is an improvement in the child's condition. If the child's condition improves, complete

- DDS Referral Form, available on SPARK at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*
- the Disability Report Child (SSA-3820-BK), available at http://www.socialsecurity.gov/online/ssa-3820.pdf **and**
- a minimum of 3 signed, original Authorization to Disclose Information to the Social Security Administration forms (SSA-827), available at http://www.socialsecurity.gov/online/ssa-827.pdf **or** a form for each medical provider if more than 3. "General Authorization for Medical Information" (form #032-03-311) for each medical practitioner reported by the individual on the report.

Send the report(s) and authorization forms to the DDS.

2. DDS Decision

If the DDS decides that the child continues to meet the childhood disability definition in effect prior to August 22, 1996, the child continues eligible in the protected group of SSI disabled children, provided the child meets the financial eligibility requirements in item C. below.

If the DDS decides that the child no longer meets the childhood disability definition in effect prior to August 22, 1996, the child no longer meets the protected group of SSI disabled children. Determine the child's eligibility in another covered group. If the child is not eligible in any covered group, send an advance notice to the authorized representative and take action to cancel the child's Medicaid coverage.

C. Financial Eligibility Procedures

1. Assistance Unit

Follow the policy and procedures in M0530.

- All individuals requesting enrollment in MEDICAID WORKS must also sign a MEDICAID WORKS Agreement, available at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*. 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.

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 limit for total countable income (unearned and earned) is $\leq$ 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 *2021*) 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 the increase 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.

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

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

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

1. Tax Dependent Household Composition

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

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

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

Exceptions to the tax household composition rules apply when:

- individuals other than biological, adopted or stepchildren are claimed as tax dependents,
- children are claimed by non-custodial parents,
- children *under age 19* live with both parents and expect to be claimed as a tax dependent by one parent, but parents (married or unmarried) do not expect to file jointly,
- the tax dependent is a Special Medical Needs AA child or a child who has been in a Level C PRTF for at least consecutive 30 days.

2. Non Filer Household Composition

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

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

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

e. Gifts, inheritances, and proceeds from life insurance are not counted.

h. A parsonage allowance is not counted.

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

j. *Student loans*

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

Amounts that an employer paid in 2020 for an employee's student loan principal and interest are not counted in the employee's MAGI.

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

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

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

n. Under the Federal Pandemic Unemployment Compensation Program, eligible individuals who are collecting certain Unemployment Compensation, including regular unemployment compensation, will receive an additional $600 in federal benefits per week for weeks of unemployment ending on or before July 31, 2020. **The $600 weekly Pandemic Unemployment Compensation payments (monthly equivalent of $2,580) are not counted as income.**

o. Recovery Rebate payments provided under Section 2201 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Public Law No. 116-136) are not counted as income.

p. Tax filers who do not itemize their deductions are permitted to deduct from their MAGI up to $300 in charitable contributions made by an eligible individual in tax years beginning in 2020.

3. Income From Self-employment

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

a. distribution and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extractions and harvest from:

- rights of any lands held in trust located within the most recent boundaries of a prior Federal reservation or under the supervision of the Secretary of the Interior,
- federally protected rights regarding off-reservation hunting, fishing, gathering or usage of natural resources,
- distributions resulting from real property ownership interests related to natural resources and improvements,
- located on or near a reservation of within the most recent boundaries of a prior Federal reservation, or
- resulting from the exercise of federally-protected rights relating to such property ownership interests.

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

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

6. Income from Crowdsourcing

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

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

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

7. *Withdrawals from Retirement Funds*

Money that is withdrawn from retirement funds, such as Individual Retirement Accounts (IRAs) and 401K accounts, on an early or emergency basis (i.e. before the individual is eligible to receive periodic payments) are not income. They are the conversion of the individual's resource from one form to another.

C. Monthly Income Determinations

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

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

A. Steps for Calculating MAGI

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

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

Adjusted Gross Income (AGI)	
Include: • Wages, salaries, tips, etc. • Taxable interest • Taxable amount of pension, annuity or Individual Retirement Account (IRA) distributions and Social Security benefits • Business Income, farm income, capital gain, other gains (or loss) • Unemployment Compensation • Ordinary dividends • Rental real estate, royalties, partnerships • S corporations, trusts, etc. • Taxable refunds, credits, or offset of state and local income taxes • Other income	**Deduct:** • Certain self-employment expenses • Student loan interest deduction • Educator expenses • IRA deduction • Moving expenses • Penalty on early withdrawal of savings • Health savings account deduction • Domestic production activities deduction • Certain business expenses of reservists, performing artists, and fee-basis government officials • Alimony paid prior to January 1, 2019 (but not child support paid) • *For tax filers who do not itemize and report the deduction, up to $300 in charitable contributions made by an eligible individual in tax years beginning in 2020.*
Do Not Include: Veteran's disability payments, Worker's Compensation or child support received. Pre-tax contributions, such as those for child care, commuting, employer-sponsored health insurance, flexible spending accounts and retirement plans such as 401(k) and 403(b), are not included in AGI but are not listed above because they are already subtracted out of W-2 wages and salaries, amounts *that an employer paid in 2020 for an employee's student loan principal and interest.*	

Note: Check the IRS website for detailed requirements for the income and deduction categories above.

Add (+) back certain income	• Non-taxable Social Security benefits • Tax –exempt interest Foreign earned income and housing expenses for Americans living abroad

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

M0530 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-15	1/1/21	Appendix 1, page 1
TN #DMAS-15	1/1/20	Appendix 1, page 1
TN #DMAS-11	1/1/19	Appendix 1, page 1
TN #DMAS-8	4/1/18	Appendix 1, page 1
TN #DMAS-6	10/1/17	Pages 2, 24, 30
TN #DMAS-3	1/1/17	Appendix 1, page 1
TN #DMAS-2	10/1/16	Pages 23, 24
TN #DMAS-1	6/1/16	Appendix 1, page 1
TN #100	5/1/15	Pages 14, 16, 29, 30 Appendix 1, page 1
TN #99	1/1/14	Appendix 1, page 1
UP #9	4/1/13	Appendix 1, page 1
UP #6	4/1/12	Appendix 1, page 1
Update (UP) #5	7/1/11	Page 14
TN #95	3/1/11	Page 1 Appendix 1, page 1
TN #93	1/1/10	Pages 11, 19 Appendix 1, page 1

Deeming Allocations

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

NBD (Non-blind/disabled) Child Allocation

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

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

2021: $1,191 - $794 = $397
2020: $1,175 - $783 = $392

Parental Living Allowance

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

SSI payment for one person = *$794 for 2021*; $783 for 2020.

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

SSI payment for both parents = *$1,191 for 2021*; $1,175 for 2020.

Deeming Standard

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

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

2021: $1,191 - $794 = $397
2020: $1,175 - $783 = $392

M0730 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-18	1/1/21	Page 3
TN #DMAS-17	7/1/20	Page 7
TN #DMAS-14	10/1/19	Page 1
TN #DMAS-9	7/1/18	Table of Contents Pages 11, 15
TN #DMAS-4	4/1/17	Pages 7, 8
TN #98	10/1/13	Pages 7, 8 Page 8a was removed.
TN #97	9/1/12	Page 10
TN #94	9/1/2010	Pages 7, 8
TN #93	1/1/2010	Page 2
TN #91	5/15/2009	Table of Contents pages 7-8a

9. Vocational Rehabilitation Training Allowances

Training allowances (transportation, books, required training expenses and motivational allowances) provided by Vocational Rehabilitation for persons participating in Vocational Rehabilitation Programs are excluded.

The exclusion is not applicable to the allowances provided by VR to the family of the participating individual.

10. SSI, TANF or Auxiliary Grant

Any portion of an SSI, TANF and/or Auxiliary Grant payment is excluded. *This includes TANF Relative Support Maintenance payments.*

A VIEW Transitional Payment (VTP) is NOT TANF and is counted as unearned income.

11. VISTA Payments

Payments to VISTA Volunteers under Title I, when the monetary value of such payments is less than minimum wage as determined by the Director of the action office, and payments for services of reimbursement for out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and other programs pursuant to Titles II and III, of Public Law 93-113, the Domestic Volunteer Service Act of 1973 are excluded. The worker must contact the Action Office at the following address or telephone number when VISTA payments are reported; Action Office, 400 N. 8th Street, Richmond, Virginia 23219, (804) 771-2197.

12. VA Educational Allowances

The Veterans Administration educational amount for the caretaker 18 or older is excluded when it is used specifically for educational purposes. Any additional money included in the benefit amount for dependents is counted as income to the individual for whom intended.

13. Foster Care/ Adoption Assistance Payments

Foster care or adoption assistance payments received by anyone in the assistance unit are excluded.

14. Job Corps Payments to Eligible Children

Any unearned income received from Title IV, Part B (Job Corps) of the Job Training Partnership Act (JTPA) by an eligible child (less than 18 or 18 and expected to graduate by the end of the month in which he turns 19) is excluded as an incentive payment. However, any payment received by any other Job Corps participant or any payment made on behalf of the participant's eligible child(ren) is counted as income to the individual.

15. Fuel Assistance Program

Any payment made under the Fuel Assistance Program is excluded.

16. Child Nutrition Act

The value of supplemental food assistance received under the Child Nutrition Act of 1966 is excluded. This includes all school meal programs, the Women, Infants and Children (WIC) Program, the child care food program, and U.S.D.A. reimbursement payments to day care providers which are authorized by the National School Lunch Act.

M0810 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-18	1/1/21	Pages 1, 2
TN #DMAS-17	7/1/20	Page 2
TN #DMAS-16	4/1/20	Page 2
TN #DMAS-15	1/1/20	Pages 1, 2
TN #DMAS-14	10/1/19	Pages 20, 25, 27 Page 28 is a runover page.
TN #DMAS-12	4/1/19	Page 2
TN #DMAS-11	1/1/19	Pages 1, 2
TN #DMAS-10	10/1/18	Page 2
TN #DMAS-9	7/1/18	Page 2
TN #DMAS-8	4/1/18	Page 2
TN #DMAS-7	1/1/18	Pages 1, 2
TN #DMAS-5	7/1/17	Page 2
TN #DMAS-4	4/1/17	Page 2
TN #DMAS-3	1/1/17	Pages 1, 2
TN #DMAS-2	10/1/16	Page 2
TN #DMAS-1	6/1/16	Pages 1, 2
UP #11	7/1/15	Page 2
TN #100	5/1/15	Pages 1, 2
UP #10	5/1/14	Page 2
TN #99	1/1/14	Pages 1, 2
TN #98	10/1/13	Page 2
UP #9	4/1/13	Pages 1, 2
UP #7	7/1/12	Page 2
UP #6	4/1/12	Pages 1, 2
TN #95	3/1/11	Pages 1, 2
TN #93	1/1/10	Pages 1, 2
Update (UP) #1	7/1/09	Page 2

GENERAL

M0810.001 INCOME AND ELIGIBILITY

A. Introduction

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

B. Policy Principles

1. Who is Eligible

An individual is eligible for Medicaid if the person:

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

2. General Income Rules

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

M0810.002 INCOME LIMITS

A. Income Limits

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

1. Categorically Needy

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

2. Categorically Needy Protected Cases Only

Categorically-Needy Protected Covered Groups Which Use SSI Income Limits		
Family Unit Size	2020 Monthly Amount	*2021* Monthly Amount
1	$783	*$794*
2	1,175	*1,191*
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size	2020 Monthly Amount	*2021* Monthly Amount
1	$522.00	*$529.34*
2	783.34	*794.00*

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	2020 Monthly Amount	*2021 Monthly Amount*
1	$2,349	*$2,382*

4. ABD Medically Needy

a. Group I	7/1/19 – 6/30/20		7/1/20	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$1,957.87	$326.31	$1,993.11	$332.18
2	2,492.57	415.42	2,537.36	422.89

b. Group II	7/1/19 – 6/30/20		7/1/20	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,259.09	$376.51	$2,299.75	$383.29
2	2,781.69	463.61	2,831.85	471.97

c. Group III	7/1/19 – 6/30/20		7/1/20	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,936.83	$489.47	$2,989.69	$498.28
2	3,540.71	590.11	3,604.37	600.72

5. ABD Categorically Needy

For:

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

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

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

S0820 Changes

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

3. Other Earned Income

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

a. Federal earned income tax credit payments.

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

c. For *2021*, up to *$1,930* per month, but not more than *$7,770* in a calendar year, of the earned income of a blind or disabled student child.

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

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

e. $65 of earned income in a month.

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

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

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

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

4. Unused Exclusion

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

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

5. Couples

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

B. References

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

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

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

S0820.510 STUDENT CHILD EARNED INCOME EXCLUSION

A. Policy

1. General

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

For Months	Up to per month	But not more than in a calendar year
In calendar year *2021*	*$1,930*	*$7,770*
In calendar year 2020	$1,900	$7,670

2. Qualifying for the Exclusion

The individual must be:

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

3. Earnings Received Prior to Month of Eligibility

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

4. Future Increases

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

B. Procedure

1. Application of the Exclusion

Apply the exclusion:

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

2. School Attendance and Earnings

Develop the following factors and record them:

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

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

M1110 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-18	1/1/21	Page 2
TN #DMAS-17	7/1/20	Page 1
TN #DMAS-15	1/1/20	Page 2
TN #DMAS-12	4/1/19	Pages 10-10a
TN #DMAS-11	1/1/19	Page 2
TN #DMAS-3	1/1/18	Page 2
TN #DMAS-4	4/1/17	Pages 10, 10a
TN #DMAS-3	1/1/17	Pages 2, 7, 10, 11 Page 10a was added as a runover page.
TN #100	5/1/15	Page 2
TN #99	1/1/14	Page 2
UP #9	4/1/13	Page 2
UP #6	4/1/12	Page 2
TN #96	10/1/11	Page 2
TN #95	3/1/11	Page 2
Update (UP) #3	3/2/10	Table of Contents page 2
TN #93	1/1/10	Page 2
TN #91	5/15/09	Pages 14-16

M1110.003 RESOURCE LIMITS

A. Introduction

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

B. Policy Principles

1. Resource Ineligibility

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

2. Resource Limits

ABD Eligible Group	One Person	Two People
Categorically Needy Medically Needy	$2,000	$3,000
ABD with Income ≤ 80% FPL	$2,000	$3,000
QDWI	$4,000	$6,000
QMB SLMB QI	**Calendar Year** **2020** $7,860 ***2021*** *$7,970*	**Calendar Year** **2020** $11,800 ***2021*** *$11,960*

3. Change in Marital Status

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

4. Reduction of Excess Resources

Month of Application

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

M1120 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-18	1/1/21	Table of Contents Pages 27, 28, 29 Pages 28a through 28d were added. Pages 28 d is a runover page
TN #DMAS-11	1/1/19	Page 29
TN #DMAS-8	4/1/18	Page 22a
TN #DMAS-7	1/1/18	Table of Contents i, pages 3, 22a, 30
TN #DMAS-5	7/1/17	Pages 15, 17, 18
TN #DMAS-2	10/1/16	On page 6, updated the format of the header. Neither the date nor the policy was changed.
TN #96	10/1/11	Table of Contents Pages 24-26
TN #93	1/1/2010	Page 22

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M1120.000 IDENTIFYING RESOURCES

2. Ownership Interest

There is an ownership interest in an unprobated estate if:

- documents (e.g., a will or court records) indicate an individual is an heir to property of a deceased; or
- an individual has use of a deceased's property or receive income from it; or
- documents establish, or the individual alleges, a relationship between himself and the deceased which, under State intestacy laws, awards the individual a share in the distribution of the deceased property; and
- the inheritance, use of income, and distributions are uncontested.

3. When Unprobated Estate Can Be a Resource

We do not consider that an inheritance is a resource until the month following the month in which it meets the definition of income. See S0830.550 for the income rules on inheritances. Thereafter, if retained, we evaluate the property as a resource.

S1120.220 *CASH LOANS*

A. Definitions

1. Loan

A loan is a transaction whereby one party advances money to, or on behalf of another party, who promises to repay the lender in full, with or without interest. The loan agreement may be written or oral, and must be enforceable under State law.

2. Negotiable Agreement

A negotiable agreement is (e.g., a loan) where the owner of the agreement itself can transfer it from one person to another to include the whole amount of money expressed on its face.

***3.* Bona Fide Agreement**

A bona fide agreement is legally valid *under the applicable State's law* and made in good faith.

B. Policy--General

The following rules relate only to the principal amounts involved in the credit arrangements described in A. above. They do not include a creditor's receipt of interest which is unearned income.

1. *Borrower*

a. Agreement *is a Bona Fide Loan*

- *The loan agreement itself is not a resource.*
- *The cash provided by the lender is not income but is the borrower's resource if retained in the month following the month of receipt.*

b. Agreement *is* Not *a* Bona Fide *Loan*

- *The loan agreement itself is not a resource.*
- *The cash provided by the lender is income in the month received and is a resource if retained in the month following the month it was received.*

2. ***Lender***

a. ***Agreement is a Negotiable, Bona Fide Loan***

- *A negotiable, bona fide loan agreement is a resource of the lender valued at the outstanding principal balance.*
- *The cash provided to the borrower is no longer the lender's resource because the lender cannot access it for his or her own use; the loan agreement replaces the cash as the lender's resource.*
- *Payments received from the borrower against the loan principal are conversions of a resource, not income. If retained, the payments are counted as the lender's resource starting in the month following the month of receipt.*

b. ***Agreement is Neither Bona Fide Nor Non-negotiable***

- *The agreement is not a resource of the lender because the loan cannot be sold.*
- *Payments received against the principal are income to the lender, not conversion of a resource.*
- *The cash provided to the borrower may be a resource if the lender can access it for his or her own use.*

c. Agreement is Non-negotiable and Bona Fide

- *The agreement is not a resource of the lender because the loan cannot be sold.*
- *The cash provided to the borrower is no longer the lender's resource because the lender cannot access it for his or her own use; the loan agreement is not a resource because it cannot be transferred.*
- *Payments received from the borrower against the loan principal are income. If retained, count the payments as the lender's resource starting in the month following the month of receipt.*

NOTE: *Interest income received by the lender is unearned income whether the loan is bona fide or not. If the loan payments received by the lender include both principal and interest, only consider the interest portion as income.*

C. ***Informal Loans***

1. Policy

An informal loan is a loan between individuals who are not in the business of lending money or providing credit. An informal loan can be oral or written. An informal loan is "written" when the parties to the loan commit to writing the terms of their agreement.

An informal loan (oral or written) is bona fide if it meets all of the following requirements.

- ***Enforceable under State law***
  A bona fide loan is an agreement that must be enforceable under the applicable State law.

- ***Loan agreement in effect at time of transaction***
  The loan agreement must be in effect at the time that the lender provides the cash to the borrower. Money given to an individual with no contemporaneous obligation to repay cannot become a loan at a later date.

- ***Acknowledgement of an obligation to repay***
  A loan is a cash advance from a lender that the borrower must repay, with or without interest. For a bona fide loan to exist, the lender and the borrower must acknowledge the obligation to repay. When money or property is given and accepted based on any understanding other than it is to be repaid by the receiver, there is no loan for Medicaid purposes. A statement by the individual that he or she feels personally responsible to pay back the friend or relative on its own does not create a legal obligation to repay the individual who provided the cash. Similarly, the lender's statement that the borrower must only repay the cash if he or she becomes financially able to do so does not, on its own, create a legal obligation to repay.

- ***Plan for repayment***
  The loan must include a plan or schedule for repayment, and the borrower's express intent to repay by pledging real or personal property or anticipated future income (such as retirement insurance benefits starting in a year when they turn 62). The claimant may use anticipated income such as Title II, Title XVI, Veterans benefits, etc., to establish a plan for a ***feasible*** *repayment of the loan as long as the loan states the claimant* ***must*** *pay the money back.*

- ***Repayment plan must be feasible***
  The plan or schedule must be feasible. In determining the plan's feasibility, consider the amount of the loan, the individual's resources and income, and the individual's living expenses.

2. Procedures *Follow these procedures to determine whether an informal loan is bona fide and to determine the resource value, if any, for the individual.*

a. Document the loan allegation

- *If there is a written agreement between the parties, obtain a copy*

- *If there is no written agreement, obtain signed statements from the borrower and the lender.*

b. Determine whether the loan is bona fide

Determine whether the loan is bona fide. If the loan is bona fide, the cash proceeds are not income to the borrower but are a resource if retained until the following month. For the lender, the loan agreement itself is a resource if it is bona fide and negotiable. The borrower's repayment of principal is not income to the lender, but the interest portion is unearned income.

c. Determine the resource value of the loan

(1). Eligible individual is the borrower

- *Count the loan proceeds, if retained, as a resource starting in the month after the month the borrower received the proceeds.*

- *Determine the resource value of the proceeds of the loan that the borrower still holds (if any).Use procedures appropriate to the type of resource being evaluated.*

(2) Eligible individual is the lender

- *Assume that the bona fide loan agreement is negotiable, is a resource, unless the lender raises questions about the negotiability of the agreement, and wants to rebut this assumption.*

- *The agreement is a resource starting in the month after the month that the lender provides the proceeds to the borrower.*

- *Assume that the agreement's resource value is its outstanding principal balance unless the lender disagrees and wants to rebut this assumption.*

  EXAMPLE: *Prior to filing for SSI, Mr. Jones made a $1,500 cash loan to his brother. Subsequently, Mr. Jones received $300 in repayment. At the time of filing for SSI, the outstanding principal balance for the loan was $1,200 and is a countable resource.*

d.. Offer rebuttal rights

If the outstanding principal balance combined with the individual's other resources causes ineligibility, inform the individual that the outstanding principal balance will be counted in determining resources unless he or she submits:

- *Evidence of a legal bar to the sale of the agreement; or*

- *An estimate from a knowledgeable source showing the current market value (CMV) of the agreement is less than its outstanding principal balance. Knowledgeable sources include anyone in the business of making such estimates (e.g., banks or other financial institutions, private investors, real estate brokers). The estimate must show the name, title, and address of the source.*

e. Document the loan determination in the case record.

D. ***Procedures for Formal Loans***

1. Applicant/ Member is Lender

With a formal loan, there is rarely a question about whether the loan is bona fide. The key issues are determining the resource value of the loan agreement for the lender and the amount of interest income received.
If the value of the loan agreement could affect resource eligibility:

- *Obtain the written loan agreement. Assume the agreement is bona fide and negotiable unless the creditor presents convincing evidence of a legal bar to transferring ownership.*
- *Assume if the agreement is a resource, that its value is its outstanding principal balance. If the individual wishes to rebut the value, follow the instructions in S1120.200 C.2.d above.*
- *Determine the amount of interest income the lender receives using the formal loan agreement or an amortization schedule. Document the case record.*

2. Applicant/ Member is Borrower

With a formal loan, the key issue is determining whether the borrower retains proceeds of the loan that are countable as resources. Follow these steps to determine the countable resources:

- *Assume a formal loan is bona fide. However, the proceeds of the loan are potentially countable resources of the borrower whether or not the loan is bona fide or negotiable.*
- *Determine the value of the loan proceeds using procedures appropriate to the type of resource being evaluated. Document the case record.*

E. **References**

- Interest income, S0830.500.
- Relationship between income and resources, M1120.005 and S1120.005
- Loan proceeds not being income, S0815.350 B.1.
- Promissory Note definition, S1140.300 A.2.
- Loan definition S1140.300 A.3.
- Property Agreement definition, S1140.300 A.4.

F. **Example-- Contractor Sale**

1. Situation

Mr. Dottle, an aged applicant, tells the EW that he has an agreement to sell unused farmland in a nearby county to a neighbor for $1,800 plus interest. His neighbor has already paid $1,200 to Mr. Dottle. The sales contract specifies that Mr. Dottle will receive one additional payment of $600 plus interest.

2. Analysis

The EW correctly recognizes that the farmland is no longer Mr. Dottle's resource even though it is still his property; because he is bound by an agreement to sell that land, he cannot transfer title to anyone else. Mr. Dottle has converted his ownership interest in the land into a contract. Unless there is a legal restriction against converting the contract into cash, it is his resource in the amount of the $600 principal balance (absent convincing evidence of a lesser CMV).

If the contract is a resource, any payment against the principal represents a conversion of that resource.

If the contract is not a resource, payment against the principal is income.

Regardless of the resource status of the contract, any interest payment he receives is income.

G. **Example--Installment Sale Contract**

Henry Little, a Medicaid applicant, recently became a widower and moved out of the family home to live in a rented apartment. He has just entered into an installment sale contract on his former home with Thomas Higgins, a Medicaid recipient. Mr. Higgins made a $6,000 down payment on the house, using retroactive SSI benefits paid under a court order, and immediately moved into his new home in which he already has an equitable ownership interest, even though he does not yet have title. The outstanding principal balance on the installment agreement is $8,000.

1. Situation

2. Analysis

The EW must determine resources eligibility for both men. Although Mr. Little still has title to the house, he cannot sell it; rather, its value as a resource to Mr. Little has folded into the value of the installment contract. However, the installment sale contract (which the EW confirms has no legal restrictions against its sale) is Mr. Little's resource in the amount of the outstanding principal balance unless he presents convincing evidence that its CMV is a lower amount.

The installment sale contract has no bearing on Mr. Higgins' eligibility, as either income or resources. His ownership interest in the house he is buying from Mr. Little is an excluded resource since it is his principal place of residence.

M1120.225 REVERSE MORTGAGES

A. Definition

A reverse mortgage is a contract with a bank or other lending institution whereby the bank provides the borrower with monthly payments which do not have to be repaid as long as the individual lives in the home. These payments are a loan against the equity in the home and must be repaid when the individual dies, sells his home, or moves.

The individual, not the bank or lending institution, continues to retain ownership of the home and is responsible for property taxes and insurance.

B. Policy

The payments from a reverse mortgage are loan proceeds and are not income to the borrower. Proceeds retained after the month of receipt are a resource.

M1130 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-18	1/1/21	Pages 31, 33, 34
TN #DMAS-17	7/1/20	Table of Contents, page ii Pages 73, 74 Page 5 is a runover page.
TN #DMAS-12	4/1/19	Page 13
TN #DMAS-9	7/1/18	Pages 1, 3
TN #DMAS-7	1/1/18	Pages 45,78-79 Appendix 1, pages 3,5
TN #DMAS-5	7/1/17	Pages 13, 15, 78, 79 Page 14 is a runover page.
TN #DMAS-3	1/1/17	Table of Contents, page ii Page 76 Page 77 is a runover page. Pages 78 and 79 were added.
TN #DMAS-1	6/1/16	Pages 4, 14, 15
TN #100	5/1/15	Pages 13, 15, 21, 31, 33, 34 Pages 16 and 32 are runover pages.
UP #9	4/1/13	Table of Contents, page ii Pages 5, 62 Pages 62a was added.
TN#97	9/1/12	Page 14
Update #7	7/1/12	Page 24
TN #96	10/1/11	Table of Contents, page ii Pages 4, 73, 74 Appendix 1, pages 1-14 Appendix 2, page 1 Appendix 4, pages 1-8 added
TN #95	3/1/11	Pages 28, 29, 33
TN #94	9/1/10	Pages 20, 20a, 28-29a
TN #93	1/1/10	Pages 63-65 Pages 70, 74, 75
TN #91	5/15/09	Page 13

5. When to Develop Use for Another Purpose

Determine if excluded burial funds have been used for some purpose other than as burial funds only if:

- there is some indication that excluded funds may have been used for another purpose, and
- the sum of the excluded funds (including any that may have been spent) and countable resources exceeded the applicable (individual or couple) resources limit as of the month in which the excluded funds may have been used for another purpose, and
- the individual was eligible for the month in which the excluded burial funds may have been used for another purpose.

6. How to Develop Use for Another Purpose

If the criteria in 1. above indicate a need to pursue the issue of use for another purpose:

- obtain the individual's signed statement as to whether any of the funds were so used and, if so, the amount;
- obtain any pertinent evidence, including signed statements from other individuals who may know about the funds in question.
- follow resource policy if funds have been retained as a resource.
- follow asset transfer policy if funds were transferred.

***7.* Deeming Considerations**

If the individual is a blind or disabled child under age 21 who lives with his parent, resources (and income) of the parent are deemed to the child. The burial funds exclusion applies to resources that belong to the parent and are designated as set aside for the burial expenses of the parent and/or his or her spouse.

D. Designation of Burial Funds

1. How Designation May Be Made

Burial funds may be designated by the applicant at the time of application or during the initial application processing period or by an enrollee at any time after eligibility has been determined. Burial funds may be designated by:

- an indication on the burial fund document (e.g., the title on a bank account); or
- a signed statement.

See Appendix 3 for a sample burial funds designation form. A printable version of the form is located *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Training-Documents*.

1. Ask About Burial Funds

Unless the individual is ineligible for a reason other than resources, inquire to determine the presence of excluded burial funds.

NOTE: Make sure the individual understands what we mean by a burial fund and the effect a burial fund could have on countable resources and income.

2. Verify Form and Separation of Funds

Verify that the funds meet the definition of burial funds in B.1. above and that the funds are separated from all other non-burial-related assets (C.3. above). Burial funds must meet both of these requirements before we can exclude them. If funds cannot be excluded, tell the individual why (e.g., if the funds are not separate from non-burial assets).

3. Determine Date Funds Set Aside for Burial

If an individual alleges having set aside funds for burial, determine the date they were first considered as set aside and document the file with supporting evidence.

- If the funds are already clearly designated (e.g., by the title of a savings account), accept any official record which shows the title of the account and which establishes that the designation was in effect prior to the month of application.
- If the funds are **not** already clearly designated, obtain the statement described in D. above.
- See D.4. above regarding effective date of the exclusion for funds considered set aside for burial prior to filing.

4. Verify Value of Funds

Verify the value of any burial funds to be excluded, using the instructions that apply to the specific resources in question.

5. Determine Amount of Exclusion Available

Document the file with evidence of:

- the face value of life insurance owned by and insuring the individual or the individual's spouse if the cash surrender value of such policies has been excluded from countable resources (cash surrender value of life insurance is excluded when the total face value per insured individual age 21 or over does not exceed $1,500), and
- the face value (not including the value of burial space items) of an irrevocable burial trust established before 8/11/93 or other irrevocable arrangement specifically designated for the purpose of meeting the individual's or spouse's burial expenses, regardless of whether the arrangement is owned by the individual or someone else, and
- the face value of burial insurance whether owned by the individual or someone else, and
- the face value of burial contracts (not counting the value of burial space items) whether the contract is owned by the individual or someone else.

Should the $3,500 maximum exclusion be reduced by life insurance, any irrevocable arrangement including an irrevocable burial trust established before 8/11/93, burial insurance, or a burial contract, document the amount by which the exclusion will be reduced, including the computation of the amount. To make this computation, you may use the electronic Burial Funds Exclusion Worksheet located at: *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Training-Documents*..

F. Procedures-Renewal or a Reported Change

1. Verify Funds Already Excluded

If the case record shows excluded burial funds, verify the current amount. When $3,500 or less was initially designated as a burial fund, increases in the burial fund due to appreciation or accumulated interest are excluded even if they result in the total burial fund exclusion exceeding the $3,500 maximum.

If more than $3,500 was initially designated for burial funds exclusion, interest and appreciation that have subsequently accrued on the excluded portion of the burial fund are excluded. Interest and appreciation that have subsequently accrued on the countable portion are countable. To calculate the countable value of a burial fund at renewal or when a change is reported you may use the electronic "BFE Increased Value Determination Worksheet". The worksheet is located on the Virginia Department of Social Services Local Agency web site (SPARK) at: *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Training-Documents*.

Also, inquire whether designated burial funds continue to be maintained separately from non-burial-related assets (C3. above).

If the funds have decreased, see G. below.

2. Enrollee Wishes to Designate Funds

If an enrollee wishes to designate funds for burial, proceed as you would for an initial application. This applies whether no funds are currently excluded or less than $3,500 (excluding appreciation or accumulated interest) is currently excluded.

3. Apply Burial Funds-Related Income/ Resources Exclusions

See H. below.

G. Procedure-Burial Funds Are Used for Another Purpose

1. When to Evaluate Use for Another Purpose

Determine if excluded burial funds have been used for some other purpose only if:

- there is some indication that excluded funds may have been used for another purpose, and
- the sum of the excluded funds (including any that may have been spent) and countable resources exceeded the applicable (individual or couple) resources limit as of the month in which the excluded funds may have been used for another purpose, and
- the individual was eligible for the month in which the excluded burial funds may have been used for another purpose.

M1410 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-18	1/1/21	Page 1
TN #DMAS-17	7/1/20	Table of Contents Pages 1, 4, 8, 11-13 Pages 4a and 7 were removed. Pages 8-14 were renumbered 7-13.
TN #DMAS-14	10/1/19	Pages 10, 12-14
TN #DMAS-12	4/1/19	Page 4, 10-11 Page 4a was added as a runover page.
TN #DMAS-11	1/1/19	Pages 6, 7
TN #DMAS-10	10/1/18	Pages 8-14
TN #DMAS-9	7/1/18	Page 1
TN #DMAS-8	4/1/18	Page 9
TN #DMAS-7	1/1/18	Page 7
TN #DMAS-5	7/1/17	Pages 4-7
TN #DMAS-3	1/1/17	Pages 6, 7, 12-14
TN #DMAS-1	6/1/16	Pages 12-14
TN #100	5/1/15	Page 2
TN #99	1/1/14	Page 10
Update #7	7/1/12	Pages 6, 7
TN #96	10/1/11	Page 11, 12
TN #95	3/1/11	Pages 13, 14 Page 15 was removed.
TN #94	9/1/10	Pages 6, 7, 13
TN #93	1/1/10	Pages 1, 7, 9, 12
TN #91	5/15/09	Pages 11-14

M1410.010 GENERAL--LONG-TERM CARE

A. Introduction

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

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

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

B. Definitions

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

1. Authorized Representative

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

- spouse
- parent
- attorney-in fact (person who has the individual's power-of-attorney)
- legally appointed guardian
- legally appointed conservator (formerly known as the committee)
- trustee.

2. Institutionalization

Institutionalization means receipt of 30 consecutive days of

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

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

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

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

M1460 Changes

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

11. Old Bills

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

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

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

12. Projected Expenses

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

13. Spenddown Liability

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

M1460.150 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LTSS

A. Applicability

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

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

B. Policy

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

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

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

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

***1.* Home Equity Limit**

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

- Effective January 1, 2019: $585,000
- Effective January 1, 2020: $595,000
- Effective January 1, *2021: $603,000*.

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

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

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

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

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

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

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

a. For *2021*, up to *$1,930* per month, but not more than *$7,770* in a calendar year, of the earned income of a blind or disabled student child.

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

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

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

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

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

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

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

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

Changed With	Effective Date	Pages Changed
TN #DMAS-18	1/1/21	Pages 19, 20
TN #DMAS-17	7/1/20	Table of Contents, page ii Pages 1, 14, 28a, 47, 48, 50, 55 Appendix 1, page 1
TN #DMAS-15	1/1/20	Pages 19, 20
TN #DMAS-14	10/1/19	Table of Contents, page i Pages 1, 14, 28a, 31, 32, 43, 47, 48, 50 Appendix 1, page 2 Page 14a was added as a runover page.

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

M1470.410 MEDICAID CBC - PERSONAL MAINTENANCE ALLOWANCE

A. Individuals

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

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

1. Basic Maintenance Allowance

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

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

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

The PMA is:

- January 1, 2020 through December 31, 2020: $1,292
- *January 1, 2021 through December 31, 2021: $1,311.*

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

2. Guardianship Fee

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

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

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

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

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

a. for individuals employed 20 hours or more per week, all earned income up to 300% of SSI *($2,382* in *2021*) per month.

b. for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI *($1,588* in *2021*) per month.

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

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

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

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

B. Couples

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

M1470.420 DEPENDENT CHILD ALLOWANCE

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

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

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

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

M1480 Changes

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

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

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

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

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

A. Applicability

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

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

B. Policy

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

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

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

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

***2.* Home Equity Limit**

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

- Effective January 1, 2020: $595,000
- *Effective January 1, 2021: $603,000.*

2. Reverse Mortgages

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

2. After Eligibility is Established

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

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

M1480.231 SPOUSAL RESOURCE STANDARDS

A. Introduction

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

B. Spousal Resource Standard	$25,728	1-1-20
	$26,076	*1-1-21*
C. Maximum Spousal Resource Standard	$128,640	1-1-20
	$130,380	*1-1-21*

M1480.232 INITIAL ELIGIBILITY DETERMINATION PERIOD

A. Policy

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

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

M1480.400 PATIENT PAY

A. Introduction

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

B. Married With Institutionalized Spouse in a Facility

For a married 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	$2,113.75 $2,155.00	7-1-19 7-1-20	
C. Maximum Monthly Maintenance Needs Allowance	$3,216.00 *$3,259.50*	1-1-20 *1-1-21*	
D. Excess Shelter Standard	$634.13 $646.50	7-1-19 7-1-20	
E. Utility Standard Deduction (SNAP)	$303.00 $379.00	1 - 3 household members 4 or more household members	10-1-19 10-1-19
	$302.00 *$377.00*	1 - 3 household members 4 or more household members	*10-1-20* *10-1-20*

Note: the Utility Standard Deduction amount decreased effective 10-1-20.

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

A. Policy

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

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

His personal needs allowance is calculated as follows:

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

2. Medicaid CBC Waiver Services and PACE

a. Basic Maintenance Allowance

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

- January 1, 2020 through December 31, 2020: $1,292
- *January 1, 2021 through December 31, 2021: $1,311.*

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

b. Guardian Fee

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

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

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

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

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

[EXAMPLE #19 was deleted]

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

1) for individuals employed 20 hours or more per week, all earned income up to 300% of SSI *($2,382* in *2021*) per month.

1) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI *($1,588* in 2021) per month.

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

EXAMPLE #20: (Using January 2000 figures)

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

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

$928.80 = special earnings allowance

His personal maintenance allowance is calculated as follows:

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

4) any allowable noncovered medical expenses (per section M1470.530) including any old bills, carry-over expenses and other noncovered expenses that were used to meet the spenddown, but NOT including the cost of the community-based care.

5) a home maintenance deduction, if any (per section M1480.430 G.).

The result is the remaining income for patient pay.

2. Patient Pay

Compare the remaining income for patient pay to the monthly PACE rate (minus the Medicare Part D premium) for the month. The patient pay is the lesser of the two amounts.

M1480.500 NOTICES AND APPEALS

M1480.510 NOTIFICATION

A. Notification

Send written notices to the institutionalized spouse, the authorized representative and the community spouse advising them of:

- the action taken on the institutionalized spouse's Medicaid application and the reason(s) for the action;
- the resource determination, the income eligibility determination, and the patient pay income, spousal and family member allowances and other deductions used to calculate patient pay;
- the right to appeal the actions taken and the amounts calculated.

B. Forms to Use

1. Notice of Action on Medicaid

The EW must send the "Notice of Action on Medicaid (Title XIX) and Children's Medical Security Insurance Plan (Title XXI Program)" or system-generated equivalent to the applicant/recipient and the person who is authorized to conduct business for the applicant to notify him of the Agency's decision on the initial Medicaid application, and on a redetermination of eligibility when a recipient starts Medicaid-covered LTSS services.

2. Notice of Patient Pay Responsibility

The "Notice of Patient Pay Responsibility" notifies the patient of the amount of patient pay responsibility. The form is generated and sent by the enrollment system when the patient pay is used entered or changed.

3. Medicaid LTSS Communi-cation Form (DMAS-225)

The Medicaid Long-term Services and Supports (LTSS) Communication Form (DMAS-225) is used to facilitate communication between the local agency and the LTSS services provider. The form may be initiated by the local agency or the provider. The form is available at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*.

M1510 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-18	1/1/21	Pages 2b, 9, 12
TN #DMAS-17	7/1/20	Page 15
TN #DMAS-16	4/1/20	Pages 5, 6, 12, 13 Pages 14 and 15 are runover pages.
TN #DMAS-14	10/1/19	Pages 2b, 4, 5-7
TN #DMAS-12	4/1/19	Pages 7, 9a. Page 7a is a runover page.
TN #DMAS-11	1/1/19	Page 7
TN #DMAS-10	10/1/18	Pages 7, 8a, 9a, 14 Pages 8b and 8c are runover pages.
TN #DMAS-9	7/1/18	Table of Contents Page 5. Page 9a was added.
TN #DMAS-8	4/1/18	Pages 2, 8a, 8b Page 8c was added.
TN #DMAS-6	10/1/17	Table of Contents Pages 1, 2 Page 2a is a runover page. Page 2b was added as a runover page.
TN #DMAS-5	7/1/17	Page 1 Page 2 is a runover page.
TN #DMAS-4	4/1/17	Pages 2a, 10
TN #DMAS-2	1/1/17	Table of Contents Pages 1, 8, 8a, 12-15 Page 11a was deleted.
TN #DMAS-2	10/1/16	On pages 3-15, corrected the subchapter number in the headers. Neither the dates nor the policies were changed.
TN #DMAS-1	6/1/16	Pages 2 Pages 1 and 2a are runover pages.
TN #100	5/1/15	Table of Contents Pages 1-2a, 5-8b
UP #10	5/1/14	Table of Contents Pages 7-8a Page 8b was added.
TN #99	1/1/14	Table of Contents Pages 1, 2, 8, 8a, 9-11 Page 11a was added.
UP #9	4/1/13	Pages 2-7, 10-12, 14
UP #7	7/1/12	Pages 8, 9
TN #96	10/01/11	Pages 8a, 10
TN #95	3/1/11	Table of Contents Pages 8, 11-15
TN #94	9/1/10	Pages 2a, 8-8a
TN #93	1/1/10	Page 6
Update (UP) #2	8/24/09	Page 11
TN #91	5/15/09	Page 14

C. Budget Periods By Classification

1. CN

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

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

2. MN

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

D. Verification

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

Income verification from available electronic sources is acceptable for retroactive eligibility determinations provided that reasonable compatibility is met (see M0420.100 B.9). For all case actions effective October 26, 2019, if the income attested to by the applicant is within 10% of the income information obtained from electronic sources OR both sources are below the applicable income limit, *no additional verification is required.*

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

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

An applicant with a resource test must provide verification of resources held in the retroactive period.

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

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

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

M1510.105 FOSTER CARE CHILDREN

A. Policy

Entitlement begins the first day of the month of commitment or entrustment IF a Medicaid application is filed within 4 months of the commitment or entrustment date.

If the Medicaid application is filed more than 4 months after entrustment or commitment, entitlement begins the first day of the application month if retroactive coverage is NOT requested.

B. Retroactive Entitlement

If the Medicaid application is filed within 4 months of entrustment or commitment, retroactive eligibility exists only if the child met another covered group and all other Medicaid eligibility requirements in the retroactive period. If the Medicaid application is filed more than 4 months after entrustment or commitment, retroactive entitlement as a foster care child exists in the 3 months prior to Medicaid application. Entitlement cannot go back more than 3 months prior to the Medicaid application month.

M1510.106 DELAYED CLAIMS

A. When Applicable

Medicaid will not pay claims from providers that are filed more than 12 months after the date the service was provided, unless the reason for the delayed filing was a delay in the enrollee's eligibility determination and enrollment. If the applicant is eligible for Medicaid and the coverage begin date is 12 months or more prior to the month during which the enrollee is enrolled on the Medicaid computer, the agency must write a letter for the applicant to give to all medical providers who will bill Medicaid for services provided over 1 year ago.

B. Eligibility Delay Letter Requirements

The letter must:

* be on the agency's letterhead stationery and include the date completed.

* be addressed to the "Department of Medical Assistance Services, Claims Processing Unit."

* state the enrollee's name and Medicaid recipient I.D. number.

* state that "the claim for the service was delayed for more than one year because eligibility determination and enrollment was delayed."

C. Procedures

The "eligibility delay" letter and a sufficient number of copies must be given to the enrollee to give to each provider who provided a covered medical service to the recipient over one year ago. The provider must attach the letter to the claim invoice in order to receive Medicaid payment for the service. If the date the letter was prepared by the agency is not included on the letter, the claim will be denied. If the individual was enrolled in a closed period of coverage, include the dates of coverage in the letter.

A sample eligibility delay letter is available at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*.

M1510.300 FOLLOW-UP RESPONSIBILITIES

M1510.301 THIRD PARTY LIABILITY (TPL)

A. Introduction

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

B. Private Health Insurance

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

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

1. Verification Required - Policy or Coverage Termination

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

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

2. Health Insurance Premium Payment (HIPP)Program

If an applicant or enrollee reports that he or a family member is employed more than 30 hours each week and is eligible for health insurance coverage under an employer's group health plan, he or she must be given a HIPP Fact Sheet which provides a brief description of the program and the contact information for the HIPP Unit at DMAS. The HIPP Fact Sheet is available at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/References*.

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

C. Medicare

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

Changed With	Effective Date	Pages Changed
TN #DMAS-18	10/1/19	Pages 1, 4, 4a, 5, 11, 13 Content that was inadvertedly deleted in a previous transmittal was restored. No policy was revised.
TN #DMAS-17	7/1/20	Pages 2, 4, 25, 30 Page 3 is a runover page.
TN #DMAS-16	4/1/20	Pages 3, 4, 7, 9 Appendix 2 Pages 3a and 4 were renumbered to pages 4 and 4a. Page 4a is a runover page.
TN #DMAS-15	1/1/20	Pages 8, 8a
TN #DMAS-14	10/1/19	Pages 2, 3, 4, 6a, 8, 9, 10, 13 Page 4a is a runover page. Page 10a was added as a runover page. Page 7a was deleted.
TN #DMAS-13	7/1/19	Page 14
TN #DMAS-12	4/1/19	Table of Contents Pages 2, 5, 6, 6a, 7, 8, 8a, 11, 12, 15-18, 20 Appendix 2 Page 24a was added. Pages, 19, 21-24, 25 are runover pages.
TN #DMAS-11	1/1/19	Pages 2, 5, 6, 7, 9
TN #DMAS-8	4/1/18	Pages 2, 18 Appendix 2
TN #DMAS-7	1/1/18	Pages 2, 3, 3a, 5, 6, 7 Pages 6a and 7a are runover pages.
TN #DMAS-5	7/1/17	Pages 1, 2, 6, 8 Pages 3, 7, 7a and 9 are runover pages.
TN #DMAS-4	4/1/17	Pages 25-27 Appendix 2, page 1 Pages 28-30 were added.
TN #DMAS-3	1/1/17	Pages 1, 2, 4, 6, 7, 8, 14, 26

TN #DMAS-2	10/1/16	Pages 1, 3, 6, 8, 12, 14, 15 Pages 19-24
TN #DMAS-1	6/1/16	Pages 3, 6, 7, 9, 11-14, 17 Appendix 2, page 1 Pages 3a and 7a were added. Page 8 is a runover page.
TN #100	5/1/15	Table of Contents Pages 1-27 (entire subchapter –pages 28-34 were deleted) Appendices 1 and 2 were added.
TN #99	1/1/14	Table of Contents Pages 1-34 (entire subchapter)
UP #9	4/1/13	Pages 7b and 10a
TN #97	9/1/12	Page 1
UP #7	7/1/12	Pages 1, 7, 7c, 7g
TN #96	10/1/11	Table of Contents Pages 1-7g Pages 11-13 Pages 21-24
TN #95	3/1/11	Pages 6a, 7, 21, 22
TN #94	9/1/10	Table of Contents Pages 3, 4b, 5, 6-6a, 10 Appendix 1 was removed.
UP #4	7/1/10	Page 4
TN #93	1/1/10	Pages 3, 4b, 5-6, 10, 15 Pages 21, 22
Update (UP) #2	8/24/09	Pages 1, 2, 13, 14, 17, 18
Update (UP) #1	7/01/09	Page 3

M1520.000 MEDICAL ASSISTANCE ELIGIBILITY REVIEW

M1520.001 GENERAL PRINCIPLE

A. Policy

A MA recipient's eligibility must be partially reviewed whenever the agency becomes aware of any change in the enrollee's circumstances that might affect the enrollee's continued eligibility. The timeframe for acting on a change is 30 calendar days from the date the change is reported or the agency becomes aware of the change.

Exception: Children meeting the definition of a newborn in M0330.802 or M2240.100.F are to be enrolled as soon as possible upon report of the birth.

An annual review of all of the enrollee's eligibility requirements is called a "redetermination" or "renewal." A renewal of the enrollee's eligibility must be completed at least once every 12 months. The renewal can be initiated in the 10th month to ensure timely completion of the renewal.

When an enrollee no longer meets the requirements for his current covered group, prior to cancelling his coverage, evaluate *the enrollee* in all covered groups for which he may meet the definition. If the *enrollee* is not eligible for full benefit Medicaid coverage and is not eligible *in any other limited-benefit covered group (i.e. the Medicare Savings Programs),* evaluate the *enrollee* for Plan First, unless he has declined that coverage.

1. Negative Action Requires Notice

When a change is reported that impacts eligibility or a renewal is completed and the enrollee is no longer eligible, the Advance Notice of Proposed Action must be sent to the enrollee, before the enrollee's benefits can be reduced or his eligibility can be terminated (see M1520.301). Send the notice to the authorized representative if one has been designated.

Adequate notice using the Notice of Action must be provided when an enrollee dies, enters an ineligible institution, is incarcerated and no longer meets a covered group, moves out of Virginia, requests termination of his coverage, or is unable to be located by the local agency.

2. Renewal Approval Requires Notice

When a change is reported and eligibility continues, no notice is necessary. When a renewal is completed and eligibility continues, a Notice of Action must be sent to enrollee or authorized representative, if one has been designated, informing him of continued eligibility and the next scheduled renewal.

3. Voter Registration

If the individual reports a change of address in person, voter registration application services must be provided (see M0110.300 A.3).

B. Procedures For Partial Review and Renewals

The policy and procedures in this subchapter are contained in the following sections:

- Partial reviews – M1520.100;
- Renewals – M1520.200;
- Canceling coverage or Reducing the level of benefits – M1520.300;
- Extended Medicaid coverage – M1520.400;
- Transferring cases within Virginia – M1520.500.

D. Child Moves From Parental Home

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

1. Case Management

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

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

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

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

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

2. Enrollment

a. Case Number

The child's member ID number does not change, but the child's Member ID number must be moved to a case number in the child's name as case head, if the person with whom the child is living does NOT have authority to act on the child's behalf.

b. Demographics Comment Screen

In VaCMS, enter a comment that will inform staff that information from the case cannot be shared with (the name of the person with whom the child lives) because he/she is NOT authorized to receive the information.

c. Renewal Date

If establishing a new case for the child, enter the child's existing renewal date from his former case. If moving the child to the adult relative's already established case, the child's renewal date will be the adult relative's case renewal date only if this action does not extend the child's renewal date past one year.

d. Medicaid Card

A new ID card is only generated when the enrollee's name, SSN or gender changes, or when a worker requests a replacement ID card. Changing the child's address or case number does not generate a new card. The worker must request a replacement card if one is needed. The existing card will be voided when the replacement is issued.

3. Obtain Authorization from Parent Prior to Renewal

Prior to the next scheduled renewal, the agency should try to obtain an authorization from the parent to allow the agency to communicate with the adult. However, as long as the parent has not formally lost custody of the child, the parent is still the responsible party and can transact the Medicaid business if he is capable and willing, or until there is a guardian/custodian established. If the parent cannot or will not designate an authorized representative, refer the case to the agency's Family Services Unit is so that guardianship can be established per M0120.200 C.

4. Renewal

Follow the rules in M0120.200, which apply to both applications and renewals. If the adult is a relative, the adult can complete the renewal for the child. If the adult is a non-relative and not an authorized representative, then the adult cannot complete the child's renewal. If the child's parent cannot or will not complete the renewal, a referral to the agency's Family Services Unit is needed to pursue guardianship.

E. Recipient Enters LTC

An evaluation of continued eligibility must be completed using the rules in chapter M14 when a Medicaid enrollee begins receiving Medicaid-covered LTC services or has been screened and approved for LTC services. Rules for determining Medicaid eligibility for married institutionalized recipients who have a community spouse are found in subchapter M1480.

If an annual renewal has been done within the past 6 months, a partial review to address factors pertinent to receipt of LTC, such as asset transfer, spousal resource assessment, etc., must be completed. If an annual renewal has not been done within the past 6 months, a complete renewal must be completed (see M1520.200). When the re-evaluation is completed, send all required notices to the enrollee/authorized representative, and send a DMAS-225 to the provider (see M1410.300).

If the individual is already enrolled in a full benefit Medicaid covered group, do not change the AC. If the individual is enrolled in a limited-benefit covered group, the individual must be evaluated for eligibility in one of the covered groups for institutionalized individuals (i.e. income $\leq$ 300% of SSI) (see M1460).

For an SSI recipient who has no community spouse and owns no countable real property, verify continued receipt of SSI through SOLQ-I or SVES, obtain information regarding asset transfer from the enrollee or authorized representative, and document the case record. As long as the individual continues to receive SSI, do not change the AC. If the individual loses SSI, evaluate his Medicaid eligibility in other covered groups. See M1430.103 for additional information regarding an SSI recipient who enters a nursing facility.

When an individual on a spenddown enters LTC, his Medicaid eligibility must be determined using the procedures in subchapter M1460. An individual on a spenddown in an assistance unit with a spouse and/or children becomes a separate assistance unit when he enters LTC. The spouse's and/or children's spenddown liability is recalculated to reflect a decrease in assistance unit size. See M1350.220 for additional information.

If the child does not meet the definition for another covered group, determine the child's eligibility in Plan First using the eligibility requirements in M0320.302. If the child is eligible for Plan First, reinstate coverage in Plan First and send the Advance Notice of Proposed Action indicating that he has been enrolled in Plan First. On the notice, state that if he does not wish to remain covered by Plan First, to contact the eligibility worker and request that the coverage be cancelled. Include a Plan First Fact Sheet, available at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/References*, with the Advance Notice of Proposed Action.

6. IV-E FC & AA Children and Special Medical Needs Children

The renewal of Medicaid coverage for Title IV-E foster care or adoption assistance children and non-IV-E special medical needs adoption assistance children requires only the following information:

- verification of continued IV-E eligibility status or non-IV-E special medical needs status,
- the current address, and
- any changes regarding third-party liability (TPL).

7. Child Under 21 Turns Age 21

When an individual who is enrolled in the Child Under Age 21 covered group turns 21, redetermine his continuing Medicaid eligibility in other covered groups, including Plan First.

This information can be obtained from agency records, the parent or the Interstate Compact office from another state, when the child's foster care or adoption assistance agreement is held by another state. A renewal form is not required. The information must be documented in the case record.

***8.* Foster Care Child in an Independent Living Arrangement Turns Age 18**

A foster care child who is in an Independent Living arrangement with a local department of social services (LDSS) no longer meets the definition of a foster care child when he turns 18. Determine the child's eligibility in the Former Foster Care Children Under Age 26 Years covered group.

***9.* Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)**

The BCCPTA Redetermination Form (#032-03-653) is used to redetermine eligibility for the BCCPTA covered group. The form is available at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*. The enrollee must provide a statement from his or her medical provider on the renewal form or else a separate written statement verifying continued treatment for breast or cervical cancer. There are no Medicaid financial requirements for the BCCPTA covered group.

10. Hospice Covered Group

At the annual renewal for an individual enrolled in the Hospice covered group (AC 054), the worker must verify the enrollee's continued election and receipt of hospice services, in addition to determining continued Medicaid eligibility.

11. Qualified Individuals

Funding for the QI covered group became permanent in 2015; the QI covered group is subject to the same policies regarding renewals as other ABD covered groups.

B. Procedures

1. Change Results in Adverse Action

Following a determination that eligibility no longer exists or that the enrollee's Medicaid services must be reduced, the Advance Notice of Proposed Action, available at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*, or system-generated advance notice must be sent to the enrollee at least 10 days plus one day for mail, before action is taken to cancel or reduce Medicaid coverage.

If the action to cancel or reduce benefits cannot be taken in the current month due to MMIS cut-off, then the action must be taken by MMIS cut-off in the following month. The Advance Notice of Proposed Action must inform the enrollee of the last day of Medicaid coverage.

Unless the individual has Medicare, a referral to the HIM must be made when coverage is cancelled. The notice must state that the individual has been referred to the HIM for determination of eligibility for the APTC.

2. Enrollee Appeals Action

If the enrollee requests an appeal hearing before the effective date of the action, subject to approval by the DMAS Appeals Division, the enrollee may choose to have eligibility continued at the current level of services until a decision is reached after a hearing. The DMAS Appeals Division will notify the local agency that the enrollee's coverage must be reinstated during the appeal process. **Do not reinstate coverage until directed to do so by the Department of Medical Assistance Services (DMAS) Appeals Division.**

If the decision is adverse to the recipient, the amount Medicaid paid on the services being appealed that were received by the recipient during the continuation is subject to recovery by DMAS.

Medicaid coverage at the prior level is not continued when a request for appeal is filed on or after the effective date of the action.

When notification is received from DMAS that the agency's proposed adverse action was sustained, the recipient's eligibility must be terminated effective the date of the receipt of that letter. No further advance notice to the recipient is necessary since he/she is also informed of DMAS' decision.

3. Death of Enrollee

The eligibility worker must take the following action when it is determined that an enrollee is deceased:

If the enrollee has an SSN, the worker must verify the date of death. The worker must run a SVES or SOLQ-I request to verify the date of death. SVES will display an "X" and the date of death in the "SSN VERIFICATION CODE" field on Screen 1.

If the recipient does not have an SSN, or if SOLQ-I or SVES does not return information showing that the recipient is deceased, contact the parent/caretaker relative or authorized representative to obtain the date of death. Information from a medical professional/facility is also acceptable.

M22 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-18	1/1/21	Page 6
TN #DMAS-16	4/1/20	Appendix 1, page 1
TN #DMAS-14	10/1/19	Page 5
TN #DMAS-12	4/1/19	Appendix 1, page 1
TN #DMAS-8	4/1/18	Appendix 1, page 1
TN #DMAS-6	10/1/17	Page 7 Appendix 1, page 1
TN #DMAS-4	4/1/17	Appendix 1, page 1
TN #DMAS-1	6/1/16	Page 4 Appendix 1, page 1
TN #100	5/1/15	Table of Contents Pages 1, 2, 5, 6, 7 Appendix 1 Pages 3 and 4 are runover Pages.
TN #98	10/1/13	Table of Contents Pages 1-7 Appendix 1 Pages 8-10 were deleted.
UP #9	4/1/13	Appendix 1
UP #8	10/1/12	Pages 2, 3 Page 3a deleted
UP #7	7/1/12	Pages 2, 3
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	Pages 3, 3a
TN #95	3/1/11	Pages 4-6 Appendix 1
UP #4	7/1/10	Page 10
TN #94	9/1/10	Page 3
UP #3	3/01/10	Page 2
TN #93	1/1/10	Pages 2-10
UP #2	8/24/09	Page 3
Update (UP) #1	7/1/09	Pages 1, 2, 7 Appendix 1, page 1

1. *7 Calendar* Day Processing

Applications for pregnant women must be processed as soon as possible, but no later than *seven* (*7) calendar* days from the date the signed application was filed. If all necessary verifications are not received, the application continues to pend until the 45 day processing time limit is met.

2. Notice Requirements

The applicant/recipient must be notified in writing of the required information and the deadline by which the information must be received.

The agency must have all necessary verifications within 7 *calendar* days in order to determine eligibility. If the agency does not receive the verifications within the *7 calendar* days, the worker must send the applicant written notice *on the 7th day*. The notice must state why action on the application could not be taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 calendar days to submit the verification.

Once all necessary verifications for the pregnant woman are received, an eligibility determination must be made immediately and the applicant must be notified of the decision.

C. Case Setup Procedures for Approved Cases

A woman enrolled as FAMIS MOMS may have the same base case number in the Virginia Medicaid Management Information System (MMIS) as Medicaid enrollees.

D. Entitlement and Enrollment

1. Begin Date of Coverage

Pregnant women determined eligible for FAMIS MOMS are enrolled for benefits in the Virginia Medicaid Management Information System (MMIS) effective the first day of the application month, if all eligibility requirements are met in that month.

2. No Retroactive Coverage

There is no retroactive coverage in the FAMIS MOMS program.

3. Aid Category

The FAMIS MOMS aid category (AC) is "005."

E. Notification Requirements

Written notice must be sent to the pregnant woman informing her of the action taken on the application. The notice must include the eligibility determination results for both Medicaid and FAMIS MOMS, as well as a referral to the Health Insurance Marketplace, if applicable.

If the pregnant woman is ineligible for both Medicaid and FAMIS MOMS due to excess income, she must be sent a written notice that she is not eligible for either program and that her case has been referred to the Health Insurance Marketplace. She must also be given the opportunity to have a Medicaid medically needy evaluation completed. Send the notice and a request for information about her resources to the pregnant woman and advise her that if the resource information is returned within 10 days the original application date will be honored.