Cheryl Roberts
DIRECTOR

Department of Medical Assistance Services

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

October 1, 2023

Virginia Medical Assistance Eligibility Manual
Transmittal #DMAS-28

The following acronyms are contained in this letter:

- DMAS – Department of Medical Assistance Services
- FPL – Federal Poverty Level
- HIM – Health Insurance Marketplace
- LDSS – Local Department of Social Services
- LTSS – Long-term Services and Supports
- MAGI – Modified Adjusted Gross Income
- MES – Medicaid Enterprise System
- PHE – Public Health Emergency
- TN – Transmittal
- VaCMS – Virginia Case Management System
- WIN - Work Incentive Account

TN #DMAS-29 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 October 1, 2023.

The following changes are contained in TN #DMAS-29:

Changed Pages	Changes
Subchapter M0130.300	Enrollments in MES are completed through the VaCMS interface or by a coverage correction form submitted to enrollment@dmas.virginia.gov
Subchapter M0310.102	Refugee Medical Assistance 12 months for those who entered as of 10/1/2021
Subchapter M0320	Update Medicaid Works initial income limit to 138% FPL; Countable income for Medicaid Works; remove policy regarding cost-sharing (no premiums required for participation in Medicaid Works). Clarify that WIN account can be open and designated prior to or during the application process. Clarify resources must be retained in the WIN account and if and how the funds can be used.

Subchapter M0450.400	If the income as determined by the HIM is not known, the EW must calculate the annual income. Do not convert this income unless you received an employer statement that only provides the rate of pay and number of hours worked per week.
Subchapter S0810.025	Deeming or Court Ordered Payments
Subchapter S0810.120	A member holding property of any kind for someone else must keep it in a form that clearly shows ownership by the other person.
Subchapter M0820.100	In-Kind Items Provided as Remuneration for Employment
Subchapter M0820.102	Cafeteria Benefit Plans
Subchapter M0820.115	Wage Advances and Deferred Wages
Subchapter M0820.147	Evidence of Wages from Wage Verification Companies
Subchapter M0820.155	How to arrive at an estimate
Subchapters M0820.450;.500	Royalties and Honoraria
Subchapter M1410.300	The DMAS-225 should be sent to DMAS by the LDSS when a person is enrolled in a full coverage AC that provides LTSS but they are not eligible.
Subchapter M1450.630	Update Average Monthly Private Nursing Facility Cost
Subchapter M1470.900	Remove patient pay underpayment references
Subchapter M1480.410	Revise the utility standard, effective 10-1-23; Monthly Maintenance Needs Allowance and Excess Shelter Standard effective 7-1-23.
Subchapter M1520.100	Added example if Foster Care child leaves DSS custody; updated “relative” to relative or legal guardian”.
Subchapter M1520.200	An manual ex parte renewal must be attempted if the automated ex parte process is not successful.
Subchapter M1520.300	Incarceration now has own heading
Chapter M17	Remove Patient Pay underpayment references and referral

Please retain this TN letter for future reference. Should you have questions about information contained in this transmittal, please contact Yolanda Chandler, Director, DMAS Eligibility and Enrollment Services Division, at yolanda.chandler@dmas.virginia.gov or (804) 588-4879.

Sincerely,

Sarah Hatton

Sarah Hatton, M.H.S.A.
Deputy of Administration

Attachment

M0130 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-29	10/1/23	Page 12
TN #DMAS-27	4/1/23	Page 6a
TN #DMAS-25	10/1/22	Pages 9,10
TN #DMAS-23	4/1/22	Pages 5, 12
TN #DMAS-21	10/1/21	Page 14
TN #DMAS-20	7/1/21	Page 2 Page 2a is a runover page.
TN #DMAS-18	1/1/21	Pages 4, 8, 13

D. Application Disposition

1. General Principle

Each application must be disposed of by a finding of eligibility or ineligibility as supported by the facts in the case record, unless the application is withdrawn or terminated (see M0130.400).

If an applicant dies during the application process, his eligibility can only be established for the period during which he was alive.

If an applicant (other than a Medicare beneficiary, HPE, or deceased individual) is ineligible for MA for any reason other than the inability to determine eligibility, a referral to the HIM must be made so that his eligibility for the APTC in conjunction with a Qualified Health Plan (QHP) can be determined. Individuals who have Medicare, who are incarcerated, who are enrolled as HPE, and deceased individuals and are not referred to the HIM.

2. Entitlement and Enrollment

a. Entitlement

Entitlement to medical assistance is based on the application month. However, entitlement cannot begin prior to an individual's date of birth, and cannot continue after an individual's date of death. See section M1510.100 for detailed entitlement policy and examples.

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

b. Enrollment

MA enrollees must be enrolled in the MES, either through the system interface with the eligibility determination system or *by submitting a coverage correction form to the DMAS Newborn and Enrollment Unit at enrollment@dmas.virginia.gov.*

Note: The MES was implemented in April 2022. Prior to April 2022, the Medicaid Management Information System (MMIS) was used for enrollment and claims processing. References to MMIS in the Medical Assistance Eligibility Manual will be updated as other policy revisions are made.

When an individual who does not have Medicare is eligible for only limited MA benefits, such as Plan First, a referral to the HIM must be made so that his eligibility for the APTC in conjunction with a QHP can be determined.

3. Notification to Applicant

Either a Notice of Action generated by the eligibility determination system or the equivalent form #032-03-006 (available at the DSS Fusion website) must be used to notify the applicant of the specific action taken on the application. The notice must be sent to the authorized representative, if one has been designated.

Changed With	Effective Date	Pages Changed
TN #DMAS-29	10/1/23	Page 5
TN #DMAS-26	1/1/23	Pages 2, 28b Appendix 1
TN #DMAS-24	7/1/22	Page 36 Page 37 is a runover page.
TN #DMAS-23	4/1/22	Pages 2, 5, 6, 6a
TN #DMAS-22	1/1/22	Page 28
TN #DMAS-20	7/1/21	Page 6 Pages 5 and 5a are runover pages.
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.

2. F&C Groups

a. Children under age 18

b. Children under age 1

c. Pregnant Women

d. Children with Special Needs for Medical or Rehabilitative Care

e. Individuals under age 21

E. Refugees

"Refugees" are a special group of individuals who have an alien status of "refugee" and are eligible for Medicaid under a different federal funding source. Virginia receives full federal funding with no state matching funds for the medical assistance provided to these individuals during the first *12* months they are in the U.S *who entered as of 10/1/2021*.

There are two aid categories (ACs) for this group. AC 078 is used for Refugee Other and Refugee Medicaid Other and AC 079 is used for Refugee Medicaid Unaccompanied Minors. The policy and procedures used to determine whether an individual is eligible in this group are found in the Refugee Resettlement Program Manual, Volume XVIII.

M0310.100 DEFINITION OF TERMS

A. Introduction

The terms used in the covered groups policy and procedures and the procedures for determining if an individual meets a definition are stated in sections M0310.101 through 131 below.

M0310.101 ABD

A. ABD Definition

"ABD" is the short name used to refer to aged, blind or disabled individuals.

B. Procedures

See the following sections for the procedures to use to determine if an individual meets an ABD definition:

- M0310.105 Age and Aged
- M0310.106 Blind
- M0310.112 Disabled

M0310.102 ADOPTION ASSISTANCE

A. Definition

Adoption Assistance is a Title XX of the Social Security Act social services program that provides cash assistance and/or social services to adoptive parents who adopt "hard to place" foster care children who were in the custody of a local department of social services or a child placing agency licensed by the state of Virginia.

1. Residing in Virginia

Adoption assistance children are children who reside in Virginia who are adopted under a Title IV-E or Non-IV-E (state-local) adoption assistance agreement with a department of social services or in conjunction with a child-placing agency.

M0320 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-29	10/1/23	Pages 1, 25, 26, 26a, 27, 28
TN #DMAS-27	4/1/23	Pages 11, 24, 25, 27
TN #DMAS-26	1/1/23	Page 11
TN #DMAS-24	7/1/22	Pages 2, 30, 31, 33
TN #DMAS-23	4/1/22	Page 27
TN #DMAS-22	1/1/22	Pages 11, 26a, 27
TN #DMAS-20	7/1/21	Pages 24, 26-29
TN #DMAS-19	4/1/21	Pages 26a, 29
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

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

A. Overview

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

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

B. Procedure

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

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

1. If the individual is a current SSI/AG recipient, evaluate in this covered group. Exception-- if the individual requests MEDICAID WORKS, go to *5* below.
2. If the individual is a former SSI or AG recipient, evaluate first in the protected covered groups Exception-- if the individual requests MEDICAID WORKS, go to *5* below.
3. If the individual does not meet the criteria for SSI/AG or protected, is between ages 19 and 64, and is not eligible for or enrolled in Medicare, evaluate next in the MAGI Adults covered group.
4. If the individual is aged and/or is eligible for or has Medicare, evaluate next in the ABD with income ≤ 80% FPL covered group.
5. If a disabled individual has income at or below *138%* FPL (including SSI recipients and 1619(b) individuals) and is going back to work, evaluate the individual in the MEDICAID WORKS covered group.
6. If the individual does not meet the requirements for MAGI Adults, 80% FPL group or MEDICAID WORKS, but meets the definition of an institutionalized individual, evaluate in the 300% of SSI covered groups.
7. If the individual is a Medicare beneficiary with income or resources in excess of the full-benefit Medicaid covered groups, evaluate in the Medicare Savings Programs (MSP) groups (QMB, SLMB, QI, QDWI).
8. If the individual is not eligible for Medicaid coverage in an MSP group AND he is at least age 19 years but under age 65 years or he requests a Plan First evaluation, evaluate in the Plan First covered group.
9. If the individual meets all the requirements, other than income, for coverage in a full benefit Medicaid group, evaluate as MN.

C. Referral to Health Insurance Marketplace

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

- who are working or have a documented date for employment to begin in the future.
- Current participation in the Social Security Administration (SSA) programs Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) will satisfy the condition for disability. Any applicant without SSA documentation of disability should be evaluated by the state's Disability Determination Services program before eligibility can be established.

These individuals can retain Medicaid coverage as long as they remain employed and their earned income is less than or equal to $6,250 per month. MEDICAID WORKS is Virginia's Medicaid Buy-In (MBI) program.

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

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

C. Nonfinancial Eligibility

The individual must also meet the following additional nonfinancial criteria:

- The individual must be competitively employed in an integrated setting. Work must occur in a work setting in the community or in a personal business alongside people who do not have disabilities.
  Work performed in a sheltered workshop or similar setting is **not** considered competitive employment in an integrated setting. Contact a Regional Medical Assistance Program Consultant if there is a question about whether the employment meets the criteria for MEDICAID WORKS.
- The individual must receive pay at the minimum wage or at the prevailing wage or "going rate" in the community, and the individual must provide documentation that payroll taxes are withheld. Self-employment must be documented according to the policy contained in S0820.210.
- The individual must establish a Work Incentive (WIN) Account at a bank or other financial institution, such as a checking or savings account which *can be established prior to the application date.* The individual must provide documentation for the case record designating the account(s) as a WIN Account. The account must either be a new account or an existing account with only earned *income* deposited into it. Increases 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 may also be deposited into the WIN account and will be excluded as described in M0320.400 D.3.b.3) as long as the increase is regularly deposited upon receipt into the WIN account. The WIN account cannot contain the individual's other Social Security benefits. *The individual must provide statements from the institution where the account is held at application and renewal if the information is not available from AVS.*

- 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.

D. Financial Eligibility

1. Assistance Unit

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 non-institutionalized individuals. Individuals receiving SSI or who have 1619(b) status also meet the income requirement for entry into MEDICAID WORKS.

Income from a non-ABD spouse, non-applicant/member ABD spouse, or parents is **not** considered deemable income and is not counted for the initial eligibility determination for individuals requesting to participate in 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.

b. Ongoing eligibility

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

2. Resources

a. Initial eligibility determination

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

b. Ongoing eligibility

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

1) For **earnings** accumulated **after** enrollment in MEDICAID WORKS, up to the current 1619(b) income threshold amount will be disregarded if deposited and retained in the WIN Account. The current 1619(b) threshold amount is *$48,092*.

2) Resources accumulated while in MEDICAID WORKS and held in Internal Revenue Service (IRS)-approved retirement accounts, medical or health savings accounts, medical reimbursement (flex) accounts, education accounts, independence accounts, and other similar State-approved accounts are excluded. Examples of these accounts include Archer Medical Savings Accounts, 401(k)/403(b)/457(b)/503(b) accounts, traditional Individual Retirement Accounts (IRAs), Roth IRAs, SEP-IRAs, SIMPLE IRAs, and Thrift Savings Plans. The account must be designated as a WIN Account in order to be excluded. **Resources accumulated while in MEDICAID WORKS and held in IRS-approved accounts that have been designated as WIN Accounts are also excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees**. The account must be exclusively used to hold resources accumulated while in MEDICAID WORKS (including interest) in order for the exclusion to continue. *Resources can be spent however the individual chooses. Transfers will be evaluated if the individual applies for LTSS.*

4) 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.

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 on or after July 1, 2021, the limit for total countable income (unearned and earned) is less than or equal to 138% of the FPL ($1,677 per month for an individual or $2,269 when the applicant has an ABD spouse who is also applying for or covered by Medicaid). *Use the rules* in chapter S08 *to determine income in the month of application*. 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 2023) 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 138% 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.

4. Income Exceeds *138%* FPL at Eligibility Determination

Spenddown does not apply to the Medicaid Works covered group. Therefore, admission into MEDICAID WORKS is not available to individuals whose income exceeds *138%* of the FPL. Evaluate the individual's eligibility in all other Medicaid covered groups.

E. Good Cause

An individual may remain eligible for MEDICAD WORKS if one of the following good cause exceptions is met:

- If the individual is unable to maintain employment due to illness or unavoidable job loss, the individual may remain in MEDICAID WORKS for up to six months. The six-month period begins the first day of the month following the month in which the job loss occurred. The individual should be asked to provide documentation that he is unable to work from a medical or mental health practitioner or employer. However, do not cancel the individual's eligibility under MEDICAID WORKS due to the lack of documentation if the individual indicates that he is still seeking employment.
- DMAS may establish other good cause reasons. Requests for good cause other than the temporary loss of employment due to a documented illness or unavoidable job loss must be submitted to DMAS on the enrollee's behalf by the local department of social services. *Submit Good Cause request to DMASEvaluation@dmas.virginia.gov.*

G. Safety Net

Enrollees who are unable to sustain employment for longer than six months must be evaluated for continued coverage in all other Medicaid covered groups for which the individual meets the definition. Resources held in the WIN Account that are accumulated from the enrollee's earnings while in MEDICAID WORKS will be disregarded up to the 1619(b) threshold amount for this eligibility determination.

If found eligible and enrolled in another Medicaid covered group, the individual shall have a "safety-net" period of up to one year from MEDICAID WORKS termination and enrollment in another group to dispose of these excess resources before they are counted toward ongoing eligibility.

If the individual resumes working within the safety-net period, he may be re-enrolled in MEDICAID WORKS provided that all eligibility requirements are met, except that the resources in the WIN Account are disregarded up to the 1619(b) threshold amount. If the individual wishes to be re-enrolled in MEDICAID WORKS after the one-year safety net period, any resources retained in the WIN Account *remain exempt*.

Changed With	Effective Date	Pages Changed
TN #DMAS-29	10/1/23	Pages 33, 34 34a is a runover page
TN #DMAS-28	7/1/23	Page 37 Appendices 1,2,3,5,6 and 7

B. Non-financial Requirements

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

C. Household Income Calculation

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

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

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

1. Verification of Income

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

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

2. Countable Income

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

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

3. Income Evaluation

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

- First, add together income already received for the year. Do not convert the income *unless you received an employer statement that only provides the rate of pay and number of hours worked per week. Example: Laurel provides an employer statement indicating she has been employed the entire year paid $10.00 an hour working 20 hours a week and paid weekly so her income is 10x20=200x4.3=$860 monthly*

- Next, calculate the projected income for the remainder of the year based on the current monthly income, unless the individual's income is expected to change (e.g. current employment is terminating).

- Add income already received to projected income to obtain the **annual** projected income for the current calendar year.

- Compare the **annual** projected income to the 100% FPL **annual** income limits for the MAGI household size in M04, Appendix 1.

- If the **annual** income is less than or equal to 100% FPL, compare the **annua**l income to the **annual** income limit for the individual's covered group.

- For the individual to be eligible for Medicaid as a result of applying the gap-filling rule, the countable income must be no more than the **annual i**ncome limit for the individual's covered group. The 5% income disregard used for the Medicaid MAGI determination does not apply. See M04 Appendices 2- 6 for income limits.

3. Renewals

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

For a pregnant woman determined eligible based on gap-filling methodology, coverage ends the last day of the 12th month after the end of the month in which the pregnancy ends. Complete a renewal 30 days prior to the end of coverage.

4. Individual Not Eligible Using Gap-filling Methodology

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

A. Example Situation – Coverage Gap and Gap Filling Rule

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

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

M0810 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-29	10/1/23	Pages 6, 9
TN #DMAS-27	4/1/23	Page 2, 25, 27, 28 Page 25a is a runover page
TN #DMAS-25	1/1/23	Pages 1, 2
TN #DMAS-24	7/1/22	Page 2
TN #DMAS-23	4/1/22	Page 2
TN #DMAS-22	1/1/22	Pages 1, 2, 3
TN #DMAS-20	7/1/21	Page 2
TN #DMAS-19	4/1/21	Page 2
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

M0810.020 FORMS AND AMOUNTS OF INCOME

A. Operating Policies

1. Forms of Income

Income, whether earned or unearned, may be received in the form of cash--currency, checks, money orders, or electronic funds transfers (EFT), such as:

- Social Security checks
- unemployment compensation checks
- payroll checks or currency.

2. Amounts of Income

The value of cash income is generally the amount of the currency or the face value of checks, money orders or EFT's the individual receives. There are some exceptions listed in B. below.

B. References

- Expenses of obtaining income, S0830.100.
- Determining amount of wages, S0820.100.
- Amounts withheld to recover an overpayment, S0830.110.
- Garnishment or seizure, S0810.025.
- Income exclusions, S0810.400.

S0810.025 EFFECT OF GARNISHMENT OR SEIZURE

A. Definition

A **garnishment** or **seizure** is a withholding of an amount from earned or unearned income in order to satisfy a debt or legal obligation.

B. Policy Principles

Amounts withheld from earned or unearned income to satisfy a debt or legal obligation are income for Medicaid purposes.

C. Related Policy

1. Earned Income

Wages are what an individual receives (before any deductions) for working as someone else's employee. See S0820.100.

2. Unearned Income

See S0830.115 for instructions on determining the amount of unearned income if garnishment or other withholding is involved.

3. Deeming or Court Ordered Payments

When the court orders garnishment of income of an ineligible spouse, parent, ineligible child, or eligible alien (sponsored by an ineligible spouse or parent) to pay court-ordered or title IV-E enforced support payments.

D. Development and Documentation

Determine the type of garnished or seized income and document the gross amount of the income.

WHOSE INCOME IS IT?

S0810.120 INCOME DETERMINATIONS INVOLVING AGENTS

A. Introduction

This section deals with the actions of agents who conduct financial transactions on behalf of others, and the policies that apply in making determinations of countable income as a result of such transactions.

A Medicaid recipient may be an agent for another person **or have an agent** acting on his or her behalf. Whenever an agent takes part in a financial transaction, the EW must determine whether the transaction was conducted on the agent's behalf or on behalf of the person he or she represents.

NOTE: References in this section to a "Medicaid recipient" also include a Medicaid applicant and individuals whose income and/or resources are subject to deeming.

B. Definition

An "agent" is a person or organization acting on behalf of and/or with the authorization of another person or organization. The term "agent" applies to all individuals who act in a fiduciary capacity, whether formal or informal, regardless of their titles (representative payees, guardians, conservators, etc.)

C. Operating Policies Medicaid Recipient Is an Agent

1. General

Monies received by a Medicaid recipient in his/her capacity as an agent are not income to him/her. Regular income rules (S0810.001 ff) apply for counting income a Medicaid recipient receives which is not paid on behalf of another. *A member holding property of any kind for someone else must keep it in a form that clearly shows ownership by the other person.*

2. Agent With Bank Account for Another

a. Account Correctly Titled
When a Medicaid recipient acts as an agent for another and the title or designation of a bank account for the other person reflects the agency relationship, deposits to the account are not income to the Medicaid recipient.

b. Account Incorrectly Titled
If the account is incorrectly titled, deposits to the account are income to the Medicaid recipient--unless the Medicaid recipient makes the deposits for another person and disburses or intends to disburse the money on the other person's behalf. (See S1120.020 for instructions concerning the treatment of resources when an agent is involved.)

M0820 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-29	10/1/23	Pages 3, 4, 11, add 15a, 17, 28, 29
TN #DMAS-23	1/1/23	Pages 30, 31
TN #DMAS-22	1/1/22	Pages 30, 31
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

WAGES
S0820.100 GENERAL

A. Definition

Wages are what an individual receives (before deductions) for working as someone else's employee.

NOTE: Under certain circumstances, services performed as an employee are deemed to be self-employment rather than wages (e.g., ministers, real estate agents, sharefarmers, *newspaper vendors*, etc.). An S Corporation may pay wages to an individual who performs work-related services and is considered an employee of the S Corporation (i.e. President), even if the individual is a shareholder of the S Corporation.

B. Policy

1. Kinds of Wages

Wages may take the form of:

a. **Salaries--**These are payments (fixed or hourly rate) received for work performed for an employer.

b. **Commissions--**These are fees paid to an employee for performing a service (e.g., a percentage of sales).

c. **Bonuses--**These are amounts paid by employers as extra for past employment (e.g., for outstanding work, length of service, holidays, etc.)

d. **Severance pay--**This payment made by an employer to an employee whose employment is terminated independently of his wishes.

e. **Military basic pay--**This is the service member's wages, which is based solely on the member's pay grade and length of service. See S0830.540 C.3.

f. **Special payments received because of employment.**

g. **Sick pay received within 6 months after stopping work, which is not attributable to the employee's contribution--**See S0820.005

h. *food, clothing, shelter, or other items received in lieu of cash are counted as earned income if not considered as in-kind payments and counted as unearned income*

2. When To Count

Wages for each month count at the earliest of the following points:

- when they are received, or
- when they are credited to the individual's account, or
- when they are set aside for the individual's use.

C. Procedure

Absent evidence to the contrary, if FICA taxes have been deducted from an item, assume it meets the definition of wages. If FICA taxes have not been deducted from an item, determine if it is wages per S0820.102.

D. References

- Work related unearned income, S0830.530.
- Advance dated checks, S0810.030 B.2.

- Wage advances and deferred wages, S0820.115.

S0820.102 CAFETERIA PLANS

A. Definitions

A cafeteria plan is a written benefit plan offered by an employer in which:

1. Cafeteria Plans

- all participants are employees; and
- participants can choose, cafeteria-style, from a menu of two or more cash or qualified benefits.

2. Qualified Benefits

A qualified benefit is a benefit that the Internal Revenue Service (IRS), by express provision of Section 125 of Chapter 1 of the Internal Revenue Code (IRC) or IRS regulations, does not consider part of an employee's gross income. Qualified benefits include, but are not limited to:

- accident and health plans (including medical plans, vision plans, dental plans, accident and disability insurance);
- group term life insurance plans (up to $50,000);
- dependent care assistance plans; and
- certain stock bonus plans under section 401(k)(2) of the IRC (but not 401(k)(1) plans).

Cash is **not** a qualified benefit.

3. Salary Reduction

A salary reduction agreement is an agreement between employer and employee whereby the employee, in exchange for the right to participate in a cafeteria plan, accepts a lower salary or forgoes a salary increase.

B. Background

1. IRS Authority

Section 125 of the IRC permits cafeteria plans.

2. Monitoring

IRS relies on employers to ensure that IRS-approved plans continue to meet the requirements of Section 125 of the IRC.

3. Funding

Most cafeteria plans are funded by salary-reduction agreements. *However, employers may contribute to fund basic benefit levels under a cafeteria plan without a salary-reduction agreement.*

4. Significance for Tax Purposes

Because Section 125 of the IRC provides that qualified benefits and the amount of a salary-reduction agreement are not part of gross income, they are not subject to Social Security/Medicare and income taxes.

5. Cafeteria Plan Indicators

It can be difficult to tell whether payslip entries represent payroll deductions, which are part of gross wages, or cafeteria-plan itemizations, which are not. The following indicators suggest a cafeteria plan.

a. A payslip uses terms such as:
   - FLEX
   - CHOICES
   - Sec. 125
   - Cafe Plan

M0820.130 EVIDENCE OF WAGES OR TERMINATION OF WAGES

A. Policy

1. Primary Evidence of Wages

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

a. Verifications of income *received* from or reasonable compatibility with electronic data sources, including the Virginia Employment Commission (VEC), Federal Data HUB or The Work Number. *If worker discovers a discrepancy in the wage data, resolve the discrepancy by obtaining other primary and secondary data.*

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

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

d. Written statement from employer.

2. Secondary Evidence of Wages

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

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

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

3. Acceptable Evidence of Termination of Wages

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

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

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

c. Written statement from employer.

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

B. Procedure

1. Order of Priority

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

2. Pay Slips

a. Stress to the individual that he/she is responsible for providing proof of wages if not available from an electronic source and is expected to retain all pay stubs and provide them as requested.

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

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

SO820.147 INTRODUCTION OF WAGE VERIFCATION COMPANY

A.Introduction

Employment and wage verification companies generally maintain an up-to-date database of wage information for employers who subscribe to the service. They provide an efficient means to verify wages. Obtaining information from wage verification companies may reduce time-consuming contacts with participating employers when pay stubs are not readily available. The Work Number, the approved employment verification agency, provides immediate online access.

- *Consider wage information from The Work Number as valid wage verification as primary evidence of wages, unless the evidence contains missing or discrepant information.*
- *If you discover a discrepancy in the wage data, resolve the discrepancy by obtaining additional primary or secondary evidence.*
- *Wage information received from online verification companies other than the Work Number or the Virginia Employment Commission (VEC) is not considered as primary verification. Workers should not access any other online wage verification system.*
- *Applicant/Member can provide consent for the worker to access all approved online resources when applying.*

Wage verification companies do not always provide cafeteria plan information and income from tips.

If evidence on the record (e.g., the Wages page, prior pay stubs, etc.) or evidence from the wage verification company indicates that a cafeteria plan may exist, and the wage evidence does not provide exact amounts and evidence on record or evidence from the wage verification company indicates unreported tips, obtain additional primary or secondary evidence.

Document evidence from a wage verification company as follows:

B. Documentation

- *Document verified wages in case record.*
- *Download the verified wage information in the electronic record.*
- *If a discrepancy exists between the information provided by the wage verification company and other wage evidence obtained, you must resolve the discrepancy by obtaining other wage evidence.*

M0820.155 HOW TO ARRIVE AT AN ESTIMATE

A. Procedure--General

1. Consider Known Facts

a. Consider any **recent work history,** unless inappropriate to the current situation (e.g., work stopped due to retirement or disability).

b. Try to establish a **logical wage pattern** by reviewing with the recipient, representative, or worker the

- rate of pay,
- hours worked per week,
- number of pay periods in each month, and
- ***the scheduled receipt dates (weekly, biweekly, bimonthly)***

c. Be alert to individuals who perform **seasonal work** (e.g., school bus drivers).

d. Take into account any Blind Work Expenses/Impairment Related Work Expenses (**BWE/IRWE)** the individual anticipates he/she will incur.

2. Obtain More Information

Contact the employer by telephone, or by mail **only if you cannot establish an estimate using 1. above.**

3. Determine Estimate

Use the information obtained above and your own judgement to determine an estimate.

To convert to monthly income:

- multiply weekly wage by 4.3; or
- multiply biweekly wage by 2.15, or
- divide biweekly wage by 2 and multiply result by 4.3; or
- multiply semi-monthly wage by 2.

B. Procedure--Anticipated Decrease in Wages

If a worker anticipates a decrease *or increase* in wages which is not supported by evidence in the file, tell the individual to inform us as soon as the decrease *or increase* can be verified. We will make any adjustments at that time. An example of this situation would be a wage cutback which is still being negotiated.

Meanwhile, use your judgement in selecting the verified period on which to base the estimate. For example, it could be the total period just redetermined, or a shorter period if there has been a pertinent change in circumstances such as a transfer.

EARNED INCOME TAX CREDITS

S0820.400 EARNED INCOME TAX CREDITS

A. Definition

The earned income tax credit (EITC) is a special tax credit which reduces the Federal tax liability of certain low income working taxpayers. This tax credit may or may not result in a payment to the taxpayer. EITC payments can be received as an advance from an employer or as a refund from IRS.

B. Policy Effective January 1, 1991

Exclude from income any EITC payments received January 1, 1991 or later, either as an advance or as a refund, regardless of the tax year involved.

C. Procedure

No development necessary.

ROYALTIES AND HONORARIA

S0820.450 ROYALTIES AND HONORARIA

A. Definitions

1. Royalties

Royalties include compensation paid to the owner for the use of property, usually copyrighted material (e.g., books, music, or art) or natural resources (e.g., minerals, oil, gravel, or timber). Royalty compensation may be expressed as a percentage of receipts from using the property or as an amount per unit produced.

Note: An outright sale of natural resources by the owner of the land or by the owner of rights to use the land constitutes conversion of a resource. Proceeds from the conversion of a resource are not income.

2. Honorarium

An honorarium is an honorary payment, reward, or donation usually received in consideration of services rendered (e.g., guest speaker), for which no payment can be enforced by law. However, the amount also may include payment for items other than services rendered (e.g., travel expenses and lodging).

B. Policy

1. Royalties

Royalties earned by an individual in connection with any publication of his/her work are earned income (e.g., publication of a manuscript, magazine article, artwork, etc.) *or received as a part of a trade or business*

2. Honoraria

The portion of any honorarium **which is received in consideration of services rendered** is earned income. An honorarium which is **not** in consideration of services rendered (e.g., for travel expenses) is unearned income to the extent that it exceeds expense. (See S0830.100 B. for expenses of obtaining income.) *Note: Absent evidence to the contrary, assume that the amount of any honorarium received is in consideration of the actual services provided by the individual.*

C. Procedure

1. Verification

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

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

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

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

2. Assumption

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

3. Expenses of Obtaining Income

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

4. Documentation

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

D. References

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

EARNED INCOME EXCLUSIONS

M0820.500 GENERAL

A. Policy

1. General

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

2. Other Federal Laws

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

3. 2020 Census Income

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

M1410 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-29	10/1/23	Page 11
TN #DMAS-25	10/1/22	Page 2a
TN #DMAS-24	7/1/22	Pages 2, 9, 13
TN #DMAS-21	10/1/21	Page 9
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

B. Forms to Use

1. Notice of Action on Medicaid & FAMIS (#032-03-0008)

The EW must send the Notice of Action on Medicaid generated by VaCMS or the equivalent hard form, available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms to the applicant/ recipient or his authorized representative to notify him of the agency's decision on the initial Medicaid application, and on a redetermination of eligibility when a recipient starts LTC services.

2. Notice of Patient Pay Responsibility (#032-03-0062)

The Notice of Patient Pay Responsibility is sent to the applicant/enrollee or the authorized representative to notify them of the amount of patient pay responsibility. The form is generated and sent by the Virginia Case Management System (VaCMS) on the day the case is authorized, or by the Medicaid enrollment system if a change is input directly into that system.

3. Medicaid LTC Communication Form (DMAS-225)

The Medicaid Long-term Care (LTC) Communication Form is available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms. The form is used by LTC providers and local departments of social services (LDSS) to exchange information, other than patient pay information, such as:

- a change in the LTC provider, including when an individual moves from CBC to a nursing facility or the reverse;
- the enrollee's physical residence, if different than the LDSS locality;
- changes in the patient's deductions (e.g. a medical expense allowance);
- admission, death or discharge to an institution or community-based care service;
- *when a person is enrolled in a full coverage AC that provides LTSS but they are not eligible, for example, a MAGI Adult passed a screening for CBC but failed to return information to determine asset transfer;*
- changes in eligibility status; and
- changes in third-party liability.

Do not use the DMAS-225 to relay the patient pay amount. Providers are able to access patient pay information through the Department of Medical Assistance Services (DMAS) provider verification systems.

a. When to Complete the DMAS-225

The EW completes the DMAS-225 at the time initial patient pay information is added to VaCMS, when there is a change in the enrollee's situation, including a change in the enrollee's LTC provider, or when a change affects an enrollee's Medicaid eligibility.

M1450 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-29	10/1/23	Page 37
TN #DMAS-27	4/1/23	Page 44
TN #DMAS-26	1/1/23	Page 46
TN #DMAS-25	10/1/22	Page 36
TN #DMAS-17	7/1/20	Page 45
TN #DMAS-15	1/1/20	Page 46
TN #DMAS-14	10/1/19	Pages 19, 41, 42, 46
TN #DMAS-10	10/1/18	Pages 1, 2 Appendix 3, page 2 Page 24a was added back; it was inadvertently removed in a previous transmittal. Page 2a was added as a runover page.
TN #DMAS-9	7/1/18	Page 35-36a, 37-38, 43
TN #DMAS-7	1/1/18	Page 4, 24, 36, 36a, 37, 41, 42 Appendix 1, Page 1.
TN #DMAS-5	7/1/17	Table of Contents Pages 13, 35, 41-44 Page 43a was renumbered. Pages 45 and 46 were added as runover pages.
TN #DMAS-3	1/1/17	Pages 30, 40-42, 44
TN #DMAS-1	6/1/16	Pages 13, 15, 35 Pages 14 and 16 are runover pages.
TN #100	5/1/15	Table of Contents Pages 17-19, 36, 37 Page 35 is a runover page.
TN #99	1/1/14	Page 7, 10, 21
UP #7	6/1/12	Table of Contents Pages 37-43 Page 43a was added.
TN #96	10/1/11	Table of Contents Pages 4-8 Pages 15, 16, 25, 26 Pages 31-38 Page 31a removed.
TN #95	3/1/11	Pages 4, 24, 32, 36, 37, 37a, Pages 39, 42, 43
TN #94	9/1/10	Table of Contents Pages 36-37a, 39-44
TN #93	1/1/10	Table of Contents Pages 3, 17-18, 29 Appendix 2, page 1
TN #91	5/15/09	Pages 41, 42

D. Average Monthly Nursing Facility Cost (Figures Provided by Virginia Health Information)

Average Monthly Private Nursing Facility Cost

Application Date	Northern Virginia*	All Other Localities
10-1-96 to 9-30-97	$2,564	$2,564
10-1-97 to 12-31-99	$3,315	$2,585
1-1-00 to 12-31-00	$3,275	$2,596
1-1-01 to 12-31-01	$4,502	$3,376
1-1-02 to 12-31-03	$4,684	$3,517
1-1-04 to 9-30-07	$5,403	$4,060
10-1-07 to 12-31-10	$6,654	$4,954
1-1-11 to 12-31-14	$7,734	$5,933
1-1-15 to 6-30-18	$8,367	$5,933 (no change)
7-1-18 to *12-31-2020*	$9,032	$6,422
1-1-2-21 to present	*$9,268*	*$7,023*

*The northern Virginia localities are: Alexandria, Arlington, Fairfax, Fairfax County, Falls Church, Loudoun County, Manassas, Manassas Park and Prince William County.

See M1450, Appendix 1 for amounts prior to October 1, 1996.

E. Partial Month Transfer

The following example shows how to compute a penalty period for an uncompensated transfer that occurred on or after July 1, 2018 and involves a partial month.

Example #19 (using July 2018 figures): An individual living outside Northern Virginia made an uncompensated asset transfer of $48,294 in July 2018, the same month he applies for Medicaid. The uncompensated value of $48,294 is divided by the average monthly rate of $6,422 which equals 7.52 months. The full 7-month penalty period runs from July 2018, the month of the transfer, through January 2019, with a partial month penalty calculated for February 2019. The partial month penalty is calculated by dividing the partial month penalty amount ($3,340.00) by the daily rate ($207.16, which is the monthly rate of $6,422 divided by 31). The calculations are as follows:

Step #1	$48,294.00	uncompensated value of transferred asset
	÷ 6,422.00	avg. monthly nursing facility rate at time of application
	= 7.52	penalty period (7 full months, plus a partial month)
Step #2	$ 6,422.00	avg. monthly nursing facility rate at time of application
	X 7	seven-month penalty period
	$44,954.00	penalty amount for seven full months

M1470 Changes Page 1 of 2

Changed With	Effective Date	Pages Changed
TN #DMAS-29	10/1/23	Pages 46-48
TN #DMAS-28	7/1/23	Page 19
TN #DMAS-27	4/1/23	Page 15
TN #DMAS-26	1/1/23	Pages 19, 20
TN #DMAS-25	10/1/22	Page 20
TN #DMAS-24	7/1/22	Pages 1, 15, 28a, 44, 48-50 Page 14a is a runover page.
TN #DMAS-22	1/1/22	Pages 19, 20
TN #DMAS-21	10/1/21	Page 17
TN #DMAS-20	7/1/21	Pages 11, 20, 26
TN #DMAS-19	4/1/21	Pages 7, 8, 22, 23
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.

D. Patient Pay Increases

Using the VaCMS Patient Pay process, reflect a patient pay increase effective the month following the month in which the 10-day advance notice period ends when the patient's income increases or an allowable deduction stops or decreases. *No underpayments are to be calculated or referred to the DMAS Recipient Audit Unit.*

1. Prospective Month(s)

Calculate the new patient pay based on the current income and make the change effective the month following the month in which the 10-day advance notice period ends. This will be the new ongoing patient pay.

2. Current and Past Month(s)

Do not revise the patient pay retroactively for the current and past month(s) unless the requirements in section M1470.910 below are met.

3. Procedures

a. Determine the new *patient pay amount*:

1) Calculate the new monthly patient pay based on the change(s), beginning with the month *following the month in which the the 10 day advance notice period ends. Increases to the patient pay are made prospectively. For example, September has 30 days. Increases processed prior to September 20th take effect for October. Patient pay increases processed between September 21st and September 30th take effect for November.*

2) Do not calculate or enter any underpayment amounts, even when the change is not reported timely.

Page removed with Transmittal #DMAS-29

M1470.910 RETROACTIVE ADJUSTMENTS FOR PRIOR MONTHS

A. Retroactive Adjustment

If a change was reported and the patient pay for prior months is incorrect, adjust the patient pay for the prior months only in the following situations:

1. a deceased individual had health insurance premiums or noncovered medical expenses that should have reduced patient pay; or
2. a community spouse is owed money for a spousal allowance and the institutionalized spouse is deceased or no longer in long-term care. However, if the community spouse had decreased income and did not report the change in a timely manner, do not adjust the patient pay.
3. If an individual has moved from NF to CBC, adjust the patient pay effective the month after the change.

In these situations, adjust the patient pay retroactively using the VaCMS Patient Pay process for the prior months in which the patient pay was incorrect. **In all other situations when a change is reported, do not adjust the patient pay retroactively.** If VaCMS is not able to process required transactions, submit a Patient Pay Correction form (DMAS 9PP), available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical- Assistance/Forms, to patientpay@dmas.virginia.gov.

B. Notification Requirements

VaCMS automatically generates and sends the Notice of Patient Pay Responsibility. DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into *MES*.

M1470.920 LTC PROVIDER CHANGE WITHIN A MONTH

A. Policy

A change in LTC providers requires a review of the type of provider and living arrangements to determine the correct personal needs allowance and new patient pay, if applicable.

Changed With	Effective Date	Pages Changed
TN #DMAS-29	10/1/23	Page 66
TN #DMAS-26	1/1/23	Pages 7, 18c, 66, 69, 70
TN #DMAS-25	10/1/22	Page 66
TN #DMAS-24	7/1/22	Pages 8a, 8b, 13, 50b, 51, 55, 57, 66, 87, 89, 91
TN #DMAS-22	1/1/22	Pages 7, 18c, 66, 69, 70
TN #DMAS-21	10/1/21	Page 66
TN #DMAS-20	7/1/21	Pages 66, 70
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

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

&4.4: : 097	7-1-24
%4.687022	*9/3/45*

C. Maximum Monthly Maintenance Needs Allowance

$3,259.50	1-1-21
$3,435.00	1-1-22
$3,715.50	1-1-23

D. Excess Shelter Standard

$8: 8085	7-1-24
&95; 072	*9/3/45*

E. Utility Standard Deduction (SNAP)

$374.00	1 - 3 household members	10-1-22
$473.00	4 or more household members	10-1-22
$414.00	1 - 3 household members	10-1-2*3*
$*524.00*	4 or more household members	10-1-2*3*

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).

Changed With	Effective Date	Pages Changed
TN #DMAS-29	10/1/23	Pages 3, 4, 7, 8, 12, 14, 15
TN #DMAS-28	7/1/23	Pages 1, 2, 2a, 4, 7, 8, 8a, 12, 13, 14 ; Appendix 2
TN #DMAS-27	4/1/23	Page 1, 15, 24a
TN #DMAS-26	1/1/23	Pages 15 and 24a
TN #DMAS-24	7/1/22	Pages 1, 3, 10 Pages 2 and 11 are a runover pages.
TN #DMAS-23	4/1/22	Pages 10, 11, 12, 13, 26, 27, 30 Appendix 2, page 1
TN #DMAS-22	1/1/22	Page 14
TN #DMAS-21	10/1/21	Pages 6, 12
TN #DMAS-20	7/1/21	Pages 2, 3. 5. 6, 13, 14 Page 2a is a runover page. Page 6a was added as a runover page
TN #DMAS-19	4/1/21	Appendix 2
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.

3. HIPP

The eligibility worker must provide the enrollee with a copy of the HIPP FACT Sheet when it is reported that he or a family member is employed more than 30 hours per week and is eligible for coverage under an employer's group health plan. The HIPP Fact Sheet is available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/References.

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

3. Program Integrity

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

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

C. Covered Group and Aid Category Changes

1. Enrollee's Situation Changes

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

- a pregnant woman reaches the end of her 12th month of post-partum coverage,
- an infant who has been enrolled as a Newborn Child reaches age one year,
- a Families & Children (F&C) enrollee becomes entitled to SSI,
- an SSI Medicaid enrollee becomes a Qualified Severely Impaired Individual (QSII) (1619(b),
- an individual enrolled in a Modified Adjusted Gross Income (MAGI) Adults aid category turns 65 years old or becomes entitled for/begins receiving Medicare.
- *a child leaves Foster Care.*

2. Change in Level of Benefits

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

D. Child Moves From Case Home

When an enrolled child moves out of the home in which he was living at application or last renewal 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 *countable parental income* or 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 *or Legal Guardian*

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 *or legal guardian*, the child may be placed on a case with the relative *or guardian* and *that individual* 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.

B. Renewal Procedures

Renewals may be completed in one of the following ways:

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

1. Ex Parte Renewals

An ex parte renewal is an internal review of eligibility based on information available to the agency. Conduct renewals of ongoing Medicaid eligibility through the ex parte renewal process for all covered groups, including covered groups with a resource test and individuals receiving LTSS. If an automated ex parte renewal *is not successfully completed*, a manual ex parte renewal must be attempted and documented in VaCMS.

a. MAGI-based Cases

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

The agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family, and must make efforts to align renewal dates for all programs. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information, information from SSA through SVES or SOLQ-I and information from child support and child care files. Verification of income from available sources, including the VEC, may be used if it is dated within the previous 12 months. See M0130.001.B.3.

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

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

b. SSI Medicaid Enrollees

An ex parte renewal for an SSI recipient (including a LTSS recipient) can be completed by verifying the individual's continued receipt of SSI through SVES or SOLQ-I, checking AVS and other electronic verification sources, and documenting the case record. For a 1619(b) individual, check the Medicaid Test Indicator field in SVES or SOLQ-I to verify there is a code of A, B or F.

If the individual is no longer an SSI recipient or no longer has 1619(b) status a manual ex parte renewal must still be attempted. If the ex parte renewal is unsuccessful or results in negative action, a contact-based renewal must be completed and necessary verifications obtained to evaluate the individual's eligibility in all other covered groups prior to canceling his Medicaid coverage.

***c.* All other Medicaid Enrollees**

Evaluation for continued Medical Assistance for all covered groups must be attempted using the ex parte renewal process, including covered groups with a resource test and individuals receiving LTSS. If a case drops out of the automated ex parte renewal process, a manual ex parte renewal must be attempted and documented in VaCMS *UNLESS the automated process leaves an ex parte attempt date.*

d. Continuing Eligibility Not Established Through Ex Parte Process

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

2. Paper Renewals

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

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

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

If a paper or electronic renewal application is submitted by the enrollee, the renewal should be evaluated even if the scheduled renewal date is in the future.

12. FAMIS Renewal Period Extension For Declared Disaster Areas

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

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

E. LTC

Evaluation for continued Medical Assistance for all covered groups must be attempted using the ex parte renewal process, including covered groups with a resource test and individuals receiving LTSS. If a case drops out of the automated ex parte renewal process, a manual ex parte renewal must be attempted and documented in VaCMS *UNLESS the automated process leaves an ex parte attempt date.*

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

F. Incarcerated Individuals

Incarcerated individuals who have active Medicaid are subject to annual renewals. Renewals for individuals in Department of Corrections and Department of Juvenile Justice facilities will be handled with assistance through the designated facility staff liaison *if the ex parte renewal is not successful.*

- For individuals incarcerated in DOC facilities, send the renewal form and related correspondence to the DOC Health Services Reimbursement Unit, 6900 Atmore Drive, Richmond, Virginia 23225.
- For individuals in DJJ facilities, send the renewal form and related correspondence to the DJJ Re-entry Services Unit, 600 E. Main Street, Richmond VA 23219.
- For individuals in regional or local jails, send the renewal form and related correspondence to the individual or his authorized representative.

If the recipient does not have an SSN, or if the Hub, 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.

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

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

4. Enrollee Enters an IMD

When an enrollee enters an institution for the treatment of mental diseases (IMD), **do not** cancel coverage. DMAS will coordinate with the Centers for Medicare and Medicaid Services (CMS) to ensure that no unauthorized FFP occurs.

5. Enrollee Becomes Incarcerated

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

***6.* End of Spenddown Period**

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

***7.* Reason "012" Cancellations**

DMAS staff are no longer performing cancellations due to returned mail. Cancellations for other reasons (such as aging out of the current aid category) are reported in the monthly System Cancellation Report (RS-O-112) available in the Data Warehouse Medicaid Management Reports. The report is issued between the 21st and 25th day of each month and is to be monitored so that appropriate follow up may be made.

***8.* Enrollee Requests Cancellation**

An enrollee may request cancellation of his and/or his children's medical assistance coverage at any time. The request can be verbal or written. Documentation of a written withdrawal request must be placed in the case record. A verbal request for withdrawal can be accepted only from the enrollee or case head, or his authorized representative. A verbal request must be documented in the case record with the date and time the withdrawal request was received, the name of the person who made the withdrawal request, and the *name* of the agency staff person who took the call.

When the enrollee requests cancellation of Medicaid, the local department must send adequate notice using the Notice of Action to the enrollee no later than the effective date of cancellation.

On the notice:

- check the "other" block and list the reason as "Medicaid coverage cancelled at the enrollee's request,"
- include the effective date of cancellation and instruct the enrollee to discontinue using the card after that date, and
- instruct the enrollee to retain the Medicaid card for future use in case coverage is reinstated within the next 12 months (the system will generate a new card after 12 months).

M1520.400 EXTENSIONS OF MEDICAID COVERAGE

A. Policy

Medicaid families may be eligible for an extended period of Medicaid coverage when the family meets all the requirements for the Low Income Families with Children (LIFC) covered group except income.

LIFC families who received Medicaid in three of the last six months and who became ineligible for Medicaid due to increased income from spousal support may be eligible for a four-month extension.

LIFC families who received Medicaid in three of the last six months and who became ineligible for Medicaid due to an increase in earnings may be eligible for a twelve-month extension. Earnings could increase because of a new job, a raise in the rate of pay or more hours are being worked.

Prior to evaluating the case for the Medicaid extensions, review the household's eligibility in the MAGI covered groups. If eligible, update the renewal date. If anyone in the household is ineligible in a MAGI group, evaluate eligibility for the Medicaid extensions.

MAGI methodology for the formation of households does not apply to individuals in Extended Medicaid. The family unit policies in M0520 apply to Extended Medicaid.

If ineligible for the Medicaid extensions, individuals must be must be evaluated for eligibility other covered groups or for FAMIS, if applicable. If a child under 18 is ineligible for FAMIS, the child must be

M17 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-29	10/1/23	Table of Contents; Page 4, 6 Remove Appendix 2
TN #DMAS-25	10/1/22	Page 4
TN #DMAS-23	4/1/22	Page 4 Page 4a was added.
TN #DMAS-20	7/1/21	Page 7
TN #DMAS-16	4/1/20	Appendix 4, page 1 Appendix 4, page 2 was added
TN #DMAS-15	1/1/20	Page 7 Page 8 was added as a runover page.
TN #DMAS-14	10/1/19	Table of Contents Pages 1, 2, 4, 6, 7 Appendix 1, pages i and ii Appendix 2, pages i and ii Appendix 4 was added.
TN #DMAS-7	1/1/18	Table of Contents, page i Appendix 1, pages i and ii Appendix 2, pages i and ii Appendix 3 was added.
TN #DMAS-6	10/1/17	Table of Contents Pages 4. Appendix 1 was deleted Appendices 2 and 3 were renumbered Appendices 1 and 2, respectively.
TN #DMAS-5	7/1/17	Table of Contents Pages 1, 2, 4 Appendix 2 Appendix 3 was added.
TN #DMAS-4	4/1/17	Pages 4, 5 Pages 6 and 7 are runover pages.
TN #DMAS-2	10/1/16	Table of Contents, page i Pages 1-7 Appendix 2 Page 8 was deleted.
TN #97	9/1/12	Page 3 Appendix 1, page 1
UP #7	7/1/12	Table of Contents Pages 1-8 Appendix 1 Appendices 3 and 4 were removed.
TN #94	9/1/10	Title Page Table of Contents pages 1-7 Appendix 1 Appendix 2
TN #93	1/1/10	Page 3

TABLE OF CONTENTS

M17 MEDICAID FRAUD AND NON-FRAUD RECOVERY

M1700.000 MEDICAID FRAUD NON-FRAUD RECOVERY

Section **Page**

Introduction..M1700.100........................1

Fraud Recovery..M1700.200........................1

Non-Fraud Recovery ....M1700.300........................4

Responsibility of the Local DSS...M1700.400........................6

Appendices

Notice of Recipient Fraud/Non-Fraud ....Appendix 1.......................1

Appendix 2 removed October 2023

Notice to DMAS of Estate Recovery/TPL/Trusts ....Appendix 3.......................1

Public Assistance Reporting Information
System (PARIS) Notice of Recipient Fraud/Non-Fraud
Recovery ....Appendix 4.......................1

2. Family Unit

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

M1700.300 NON-FRAUD RECOVERY

A. Authority

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

B. Recovery of Erroneous Payments

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

- eligibility errors due to recipient misunderstanding,
- agency errors,
- medical services received during the appeal process, if the agency's cancellation action is upheld.

C. Post-eligibility Investigations

1. Method-ology

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

RAU investigations are based on projected income consistent with the eligibility polices for counting ongoing income referenced in Chapters M04, M07, and M08. Post-eligibility determinations are made using a point-to-point method in which the income estimation period begins with an event that would have triggered a partial review under M1520.100. The end point is the next scheduled renewal that the LDSS actually completed.

4. Notification to DMAS

Referrals must be made to the Third Party Liability Unit when: a recipient has received funds from a settlement; DSS has received information concerning a recipient being in an accident; DSS has information where a recipient has other third party payers; or the recipient is the beneficiary of a trust. The cases should be referred to DMAS using the Notice to DMAS of Estate Recovery/TPL/Trust Form (DMAS 753R) located at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*, to make referrals to the TPL unit. The form should be completed and sent to:

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

The form may be faxed to 804-786-0729.

M1700.400 RECOVERY RESPONSIBILITIES: LDSS AND DMAS

A. VDSS/LDSS Responsibilities in Loss Prevention Efforts

VDSS Medicaid operates under an interagency agreement with DMAS which lists specific responsibilities of VDSS and, by extension, the LDSS, for active participation in loss prevention efforts. The responsibilities of the LDSS fall under the interagency agreement and are neither optional nor discretionary for the LDSS. VDSS shall supervise the programmatic activities of the LDSS to ensure compliance.

B. LDSS Requirements

LDSS must participate in the identification, tracking, and correction of eligibility errors. LDSS must also determine and review ongoing or current recipient eligibility. **The DMAS RAU does not determine ongoing recipient eligibility, but rather reviews recipient eligibility in relation to allegations of fraud**. LDSS shall:

1. Report Individuals

Report to DMAS RAU every known instance relating to a non-entitled individual's use of Medicaid services, regardless of the reason for non-entitlement such as:

- instances where evidence of fraud may exist;
- errors involving eligibility discovered by the LDSS in which it appears there has been deliberate misrepresentation by an applicant/recipient with intent to defraud;
- eligibility errors discovered by the LDSS, independent of other audit or quality control functions, including cases in which the individual was enrolled incorrectly, added in error, not cancelled timely, allowed to remain on Medicaid during the conviction sanction period or when information known to the agency would render ineligibility;
- cases in which the LDSS discovers that the enrollee failed to report information that impacts eligibility.