CHAPTER M14

LONG-TERM CARE

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GENERAL RULES FOR LONG-TERM CARE

M1410 Changes

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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.
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TN #DMAS-12	4/1/19	Page 4, 10-11 Page 4a was added as a runover page.
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M14 LONG-TERM CARE

M1410.000 GENERAL RULES FOR LONG-TERM CARE

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

individual has been authorized to receive LTC or Long-term Services and Supports (LTSS) and it is anticipated that he is likely to receive the services for 30 or more consecutive days. If it is known at the time the application is processed that the individual did not or will not meet the 30 consecutive day requirement, the individual is not to be treated as an institutionalized individual *unless community LTSS has been authorized*.

The 30-consecutive-days requirement is expected to be met if the authorization for LTSS is provided verbally or in writing. This allows the agency to begin the evaluation of the applicant in the 300% SSI covered group for institutionalized individuals and to use the special rules for married institutionalized individuals who have a community spouse, if appropriate. However, prior to approval of the individual for Medicaid payment of LTSS, the worker must have received the DMAS-96 that was signed by the supervising physician (or an electronic equivalent) or the signed Waiver Level of Care form (or an electronic equivalent). Applicants must be evaluated as non-institutionalized individuals for the months prior to the month in which the completed form is dated.

The worker must verify that LTSS started within *180* days of the date on the Notice of Action on Medicaid. If services do not start within *180* days of the Notice of Action on Medicaid, the individual can no longer be considered an institutionalized individual and continued eligibility must be re-evaluated as a non-institutionalized individual.

CBC Waiver applicants cannot receive Medicaid payment of CBC services prior to the date the DMAS-96 was signed by the supervising physician. For applicants for whom a Waiver Level of Care form is the appropriate authorization document, Medicaid payment of CBC services cannot begin prior to the date the form has been signed.

For purposes of this definition, continuity is broken by *180* or more consecutive day's absence from a medical institution or by non-receipt of waiver services. For applicants in a nursing facility, if it is known at the time of application processing that the individual left the nursing facility and did not stay for 30 consecutive days *or begin receiving another type of LTSS*, the individual is evaluated as a non-institutionalized individual. Medicaid recipients without a community spouse who request Medicaid payment of LTSS, except MN individuals, and are in the nursing facility for less than 30 consecutive days will have a patient pay determination (see M1470.320).

3. Institution

An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor is an **institution**.

4. In An Institution

"In an institution" refers to an individual who is admitted to live in an institution and receives treatment or services provided there that are appropriate to his requirements.

5. **Long-term Care**

Long-term care is medical treatment and services directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or lessening of illness, disability or pain which have been received, or are expected to be received, for longer than 30 consecutive days.

6. Medical Institution (Facility)

A **medical institution** is an institution (facility) that:

- is organized to provide medical care, including nursing and convalescent care,
- has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,
- is authorized under state law to provide medical care, and
- is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

An acute care hospital is a medical institution.

7. Patient

An individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or lessening of illness, disability, or pain, is a **patient.**

8. Inpatient

An **inpatient** is a patient who has been admitted to a medical institution on the recommendation of a physician or dentist **and** who:

- receives room, board, and professional services in the institution for a 24-hour period or longer, **or**
- is expected by the institution to receive room, board, and professional services in the institution for a 24-hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility, and does not actually stay in the institution for 24 hours.

9. Assisted Living Facility (ALF) / Memory Care Unit

An assisted living facility (ALF) or memory care unit are not long-term care facilities or a Medicaid medical institution. An ALF or memory care unit may be located within the same setting or campus such as a continuing care or a long-term care facility, however the level of care differs from that of a Medicaid medical institution.

10. Independent living facility

A senior living center/senior apartment/retirement community are independent living arrangements or residences and are not medical institutions.

- is expected by the institution to receive room, board, and professional services in the institution for a 24-hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility, and does not actually stay in the institution for 24 hours.

M1410.020 NON-FINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

To be eligible for Medicaid payment of long-term care, an individual must be eligible for Medicaid. The Medicaid non-financial eligibility requirements in chapter M02 apply to all Medicaid applicants and recipients, including those individuals in long-term care. The non-financial requirements and the location of the manual policy for each requirement are:

B. Citizenship/ Alienage

The citizenship and alien status policy is found in M0220.

C. Virginia Residency

The Virginia state resident policy for patients in medical institutions is found in subchapter M1430.101; the state resident policy for CBC patients is found in M0230.

D. Social Security Number

The social security number policy is found in M0240.

E. Assignment of Rights

The assignment of rights and support cooperation policy is found in M0250.

F. Application for Other Benefits

The application for other benefits policy is found in M0270.

G. Institutional Status

The institutional status policy for facility patients is in subchapter M1430.100. The institutional status policy for CBC waiver services patients is found in subchapter M1440.010.

H. Covered Group (Category)

The Medicaid covered groups eligible for long-term care services are listed in subchapter M1460. The category requirements for the covered groups are found in chapter M03.

M1410.030 FACILITY CARE

A. Introduction

Medicaid covers care provided in a medical institution to persons whose physical or mental condition requires nursing supervision and assistance with activities of daily living. Some institutions have both medical and residential sections. An individual in the medical section of the institution is a patient in a medical facility; however, an individual in the residential portion of the institution is a resident of a residential facility NOT a patient in a medical facility.

This section contains descriptions of the types of **facilities** (medical institutions) in which Medicaid provides payment for services received by eligible patients. See subchapter M1430 for specific policy and procedures which apply to patients in facilities.

B. Ineligible Individuals

Individuals under age 65 who are patients in an institution for mental diseases (IMD) *are not eligible for Medicaid* unless they are under age 22 and receiving inpatient psychiatric services.

C. Types of Medical Institutions

The following are types of medical institutions in which Medicaid will cover part of the cost of care for eligible individuals:

1. Chronic Disease Hospitals

Specially certified hospitals, also called **"long-stay hospitals"**. There are two of these hospitals enrolled as Virginia Medicaid providers:

- Hospital for Sick Children in Washington, D.C., and
- Lake Taylor Hospital in Norfolk, Virginia.

2. Hospitals and/or Training Centers for the Intellectually Disabled

Facilities (medical institutions) that specialize in the care of intellectually disabled individuals. Intermediate Care Facilities for the Intellectually Disabled (ICF/IDs) are certified by the Department of Health to provide care in a group home setting. Patients in these facilities may have income from participating in work programs.

NOTE: Medically needy (MN) individuals are not eligible for Medicaid payment of LTC services in an ICF/ID because ICF/ID services are not covered for the medically needy.

3. Institutions for Mental Diseases (IMDs)

A hospital, nursing facility or other medical institution that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, of persons with mental diseases. An institution for the mentally retarded is not an IMD.

NOTE: Medically needy (MN) patients age 65 or older are not eligible for Medicaid payment of LTC in an IMD because these services are not covered for medically needy individuals age 65 or over.

4. Intermediate Care Facility (ICF)

A medical institution licensed by the state to provide, on a regular basis, health-related services to patients who do not require hospital or skilled nursing facility care, but whose mental or physical condition requires services in addition to room and board which can be made available only in an institutional setting.

5. Nursing Facility

A medical institution licensed by the state to provide, on a regular basis, health-related services to patients who do not require hospital care, but whose mental or physical condition requires services, such as nursing supervision and assistance with activities of daily living, in addition to room and board and such services can be made available only in an institutional setting. Nursing facilities provide either skilled nursing care services or intermediate care services, or both.

6. Rehabilitation Hospitals

A hospital certified as a rehabilitation hospital, or a unit of a hospital certified by the Department of Health as excluded from the Medicare prospective payment system, which provides inpatient rehabilitation services.

M1410.040 COMMUNITY-BASED CARE WAIVER SERVICES

A. Introduction

Medicaid covers long-term care in a community-based setting to individuals whose mental or physical condition requires nursing supervision and assistance with activities of daily living.

This section provides general information about the Community-based Care (CBC) Waiver Services covered by Medicaid. The detailed descriptions of the waivers and the policy and procedures specific to patients in CBC are contained in subchapter M1440.

B. Community-Based Care Waivered Services (CBC)

Community-Based Care Waiver Services or Home and Community-based Care or CBC are titles that are used interchangeably. These terms are used to mean a variety of in-home and community-based services reimbursed by the Department of Medical Assistance Services (DMAS) that are authorized under a Section 1915(c) waiver designed to offer individuals an alternative to institutionalization. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid nursing facility placement.

C. Virginia's Waivers

Virginia has approved Section 1915(c) home and community-based *care* waivers. These waivers contain services that are otherwise not available to the general Medicaid population. The target population and service configuration for each waiver is outlined in subchapter M1440. An individual cannot receive services under two or more waivers simultaneously; the individual can receive services under only one waiver at a time.

1. *Commonwealth Coordinated Care Plus Waiver*

Effective July 1, 2017, the Elderly or Disabled with Consumer-Direction (EDCD) Waiver and the Technology Assisted (Tech) Waiver were combined and are known as the Commonwealth Coordinated Care Plus (CCC Plus) Waiver. The CCC Plus Waiver serves aged individuals and disabled individuals who would otherwise require institutionalization in a nursing facility. The waiver also serves "technology-assisted" individuals who are chronically ill or severely impaired and who need both a medical device to compensate for the loss of a vital body function, as well as substantial and ongoing skilled nursing care to avert death or further disability.

The individual may choose to receive agency-directed services, consumer-directed services or a combination of the two. Under consumer-directed services, supervision of the personal care aide is provided directly by the recipient and/or the person directing the care for the recipient. If an individual is incapable of directing his own care, a spouse, parent, adult child, or guardian may direct the care on behalf of the recipient. Services available through this waiver include:

- agency-directed and consumer-directed personal care
- adult day health care
- agency-directed respite care (including skilled respite) and consumer-directed respite care
- Personal Emergency Response System (PERS).

Services provided through CCC Plus Waiver for technology-assisted individuals are expected to prevent placement, or to shorten the length of stay, in a hospital or nursing facility and include:

- private duty nursing
- nutritional supplements
- medical supplies and equipment not otherwise available under the Medicaid State Plan.

2. Community Living Waiver (Formerly the Intellectual Disabilities Waiver)

As part of the My Life, My Community Developmental Disabilities Waiver Redesign, the Intellectual Disabilities (ID) Waiver was renamed the Community Living Waiver in 2016. The waiver is targeted to provide home and community-based services to individuals with developmental disabilities and individuals under the age of six years at developmental risk who have been determined to require the level of care provided in an ICF/ID, and to individuals with related conditions currently residing in nursing facilities who require specialized services. See M1440, Appendix 1 for a list of services available through this waiver.

5. Family and Individual Supports Waiver (Formerly the Individual and Family Developmental Disabilities Support Waiver)

As part of the My Life, My Community Waiver Developmental Disabilities Redesign, the Individual and Family Developmental Disabilities Support (DD) Waiver was renamed the Family and Individual Supports Waiver in 2016. The waiver provides home and community-based services to individuals with developmental disabilities. See M1440, Appendix 1 for a list of services available through this waiver.

6. Building Independence Waiver (Formerly the Day Support Waiver for Individuals with Intellectual Disabilities)

As part of the My Life, My Community Waiver Developmental Disabilities Redesign, the Day Support Waiver for Individuals with Intellectual Disabilities (DS Waiver) was renamed the Building Independence Waiver in 2016. The waiver is targeted to provide home and community-based services to individuals with intellectual disabilities who have been determined to require the level of care provided in an ICF/ID. See M1440, Appendix 1 for a list of services available through this waiver.

- nursing services for assessments and evaluations
- therapeutic social and recreational programming which provides daily activities for individuals with dementia.

D. Children's Mental Health Program—Not Medicaid CBC

Children's Mental Health Program services are home and community-based services to children who have been discharged from psychiatric residential treatment facilities. **Children's Mental Health Program services are NOT Medicaid CBC services.** See M1520.100 E. for additional information.

E. Program for All-Inclusive Care for the Elderly (PACE)

PACE is the State's community model for the integration of acute and long-term care. Under the PACE model, Medicaid and Medicare coverage/funding are combined to pay for the individual's care. PACE is centered around the adult day health care model and provides the entire spectrum of acute and long-term care services to enrollees without limitations on the duration of services or the dollars spent. Participation in PACE is in lieu of the EDCD Waiver and is voluntary. PACE serves individuals aged 55 and older who (1) meet the nursing facility level of care criteria and (2) reside in their own communities. PACE provides all of an individual's health care and medical long-term care needs.

PACE is NOT a HCBS Waiver; however, the preadmission screening, financial eligibility and post eligibility requirements for individuals enrolled in PACE are the same as those for individuals enrolled in the CCC Plus (formerly EDCD) Waiver.

M1410.050 FINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

An individual in LTSS must meet the financial eligibility requirements that are specific to institutionalized individuals; these requirements are contained in this chapter:

B. Asset Transfer

The asset transfer policy is found in subchapter M1450.

C. Resources

The resource eligibility policy for individuals in LTSS who do not have a community spouse and for MAGI Adults regardless of their marital status is found in subchapter M1460 of this chapter.

Only certain resource eligibility requirements are applicable to individuals in the Modified Adjusted Gross Income (MAGI) Adults covered group who are institutionalized.

The resource eligibility requirements for married individuals in LTSS who have a community spouse, other than MAGI Adults, are found in subchapter M1480 of this chapter. The policy in subchapter M1480 for married institutionalized individuals is NOT used to determine eligibility for MAGI Adults, regardless of their marital status

D. Income

The income eligibility policy for individuals in LTSS who do not have a community spouse is found in subchapter M1460 of this chapter. MAGI Adults in LTSS are evaluated using the MAGI income policy in Chapter M04.

The income eligibility policy for individuals in LTSS who have a community spouse is found in subchapter M1480.

M1410.060 POST-ELIGIBILITY TREATMENT OF INCOME (PATIENT PAY)

A. Introduction

Most Medicaid-eligible individuals must pay a portion of their income to the LTSS provider; Medicaid pays the remainder of the cost of care. The portion of their income that must be paid to the provider is called "patient pay." Patient pay policy does NOT apply to MAGI Adults.

B. Patient Pay

The policies and procedures for patient pay determination are found in subchapter M1470 of this chapter for individuals who do not have community spouses and in subchapter M1480 for individuals who have community spouses.

M1410.100 LONG-TERM CARE APPLICATIONS

A. Introduction

The general application requirements applicable to all Medicaid applicants/ recipients found in chapter M01 also apply to applicants/recipients who need LTSS services. This section provides those additional or special application rules that apply only to persons who meet the institutionalization definition.

B. Responsible Local Agency

The local social services department in the Virginia locality where the institutionalized individual (patient) last resided outside an institution retains responsibility for receiving and processing the application.

If the patient did not reside in Virginia prior to admission to the institution, the local social services department in the county/city where the institution is located has responsibility for receiving and processing the application.

Home and Community-Based Services (HCBS) applicants apply in their locality of residence.

C. Procedures

1. Application Completion

A signed application is received. A face-to-face interview with the applicant or the person authorized to conduct his business is not required, but is strongly recommended, in order to correctly determine eligibility.

2. Pre-admission Screening

Notice from pre-admission screener is received by the local Department of Social Services (DSS).

NOTE: Verbal communications by both the screener and the local DSS Eligibility Worker (EW) may occur prior to the completion of screening. Also, not all LTC cases require pre-admission screening; see M1420.

3. Processing

EW completes the application processing. Processing includes receipt of required verifications, completion of the non-financial and financial eligibility determinations, and necessary case record documentation. See chapter M15 for the processing procedures.

An individual's eligibility is determined as an institutionalized individual if he is in a medical facility or has been authorized for Medicaid LTSS. For any month in the retroactive period, an individual's eligibility can only be determined as an institutionalized individual if he met the definition of institutionalization in that month (i.e. he had been a patient in a medical institution—including nursing facility or an ICF-ID-- for at least 30 consecutive days).

If it is known at the time the application is processed that the individual did not or will not receive LTSS (i.e. the applicant has died since making the application) do not determine eligibility as an institutionalized individual.

If the individual's eligibility was determined as an institutionalized individual prior to the receipt of waiver services, the EW must verify that LTSS started within *180* days of the date of the Notice of Action on Medicaid. If LTSS did not start within *180* days of the date of the Notice of Action on Medicaid, the individual's continued eligibility must be re-evaluated as a non-institutionalized individual.

4. Notices

See section M1410.300 for the required notices.

M1410.200 INITIATING LONG-TERM CARE FOR CURRENT RECIPIENTS

A. Introduction

Individuals who currently receive Medicaid and enter LTSS must have their eligibility redetermined using the special rules that apply to LTSS.

For example, an enrollee may be ineligible for Medicaid payment of LTSS because he/she transferred assets without receiving adequate compensation. The asset transfer policy found in M1450 applies to individuals who receive any type of LTSS. Individuals who are ineligible for Medicaid payment of LTSS may remain eligible for other Medicaid-covered services.

B. Authorization for LTSS

An individual must have an assessment to determine that LTSS are appropriate, and LTSS must be authorized for Medicaid payment for LTSS. Subchapter M1420 contains the policies and procedures regarding LTSS authorization.

C. Recipient Enters LTC

A re-evaluation of eligibility must be done when the EW learns that a Medicaid recipient has started receiving LTSS services. An LTSS screening **is required.**

If an annual renewal **has been** done within the past six months, a partial review to address factors pertinent to receipt of LTC, such as asset transfer, spousal resource assessment, etc., must be done. If an annual renewal **has not** been done within the past six months, a complete renewal must be done. A new application is not required. See subchapter M1520 for renewal procedures.

- 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. See section M1430.103 for additional information regarding an SSI recipient who enters a nursing facility.

- Rules for married institutionalized recipients, with the exception of MAGI Adults, who have a community spouse are found in subchapter M1480.

D. Notification

When the re-evaluation is done, the EW must complete and send all required notices. See section 1410.300 below. If it is known at the time of application processing that the individual did not or will not receive LTSS services, do not determine eligibility as an institutionalized individual.

M1410.300 NOTICE REQUIREMENTS

A. Introduction

A notice to an applicant or recipient provides formal notification of the intended action or action taken on his/her case, the reason for this action and the authority for proposing or taking the action. The individual needs to clearly understand when the action will take place, the action that will be taken, the rules which require the action, and his right for redress.

Proper notice provides protection of the client's appeal rights as required in 1902(a)(3) of the Social Security Act.

The Notice of Action on Medicaid provides an opportunity for a fair hearing if action is taken to deny, suspend, terminate, or reduce services.

The Medicaid Long-term Care Communication Form (DMAS-225) notifies the LTSS provider of changes to an enrollee’s eligibility for Medicaid and for Medicaid payment of LTSS services.

The notice requirements found in this section are used for all LTSS cases.

Individuals in the AAL Waiver have Medicaid eligibility determined in the AG covered group (see M0320.202) and do not have Medicaid eligibility determined as institutionalized individuals. There are no post-eligibility requirements. The enrollment and notification procedures used with non-institutionalized Medicaid recipients are followed (see M0130.300).

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.

b. Where to Send the DMAS-225.

If the individual is enrolled in a *Cardinal Care managed care organization* (MCO), send the DMAS-225 to the individual's MCO. If known, send it to the individual's care coordinator. Contact information for the *Cardinal Care* MCOs is available at *MCO Member Contact Information - Updated August 1, 2023 (virginia.gov)*.

If the individual is not in managed care, send the DMAS-225 as indicated below:

1) For hospice services patients, including hospice patients in a nursing facility or those who are also receiving CBC services, send the original form to the hospice provider.
2) For facility patients, send the original form to the nursing facility.
3) For PACE or adult day health care recipients, send the original form to the PACE or adult day health care provider.
4) For Medicaid CBC, send the original form to the following individuals
   - the case manager at the Community Services Board, for the Family and Individual Supports (formerly Developmental Disabilities) Waivers;
   - the case manager (support coordinator), for the FIS (DD) Waiver,
   - the personal care provider, for agency-directed *CCC Plus Waiver* personal care services and other services. If the patient receives both personal care and adult day health care, send the DMAS-225 to the personal care provider.
   - the service facilitator, for consumer-directed *CCC Plus Waiver* services,
   - the case manager, for any enrollee with case management services, and
   - the case manager at DMAS, for CCC Plus Waiver *Private Duty Nursing (PDN)* services), at the following address:

     Office for Community Living
     600 E. Broad St,
     Richmond, VA 23219

Retain a copy of the completed DMAS-225 in the case record.

4. Advance Notices of Proposed Action

The recipient must be notified in advance of any adverse action that will be taken on his/her Medicaid eligibility or patient pay.

a. Advance Notice of Proposed Action

The system-generated Advance Notice of Proposed Action or hard equivalent **(#032-03-0018)**, available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, must be used when:

- eligibility for Medicaid will be canceled,
- eligibility for full-benefit coverage Medicaid changes to QMB, SLMB, or QWDI limited coverage, or
- Medicaid payment for *LTSS* services will not be allowed for a period of time because of an asset transfer.

b. Notice of Patient Pay Responsibility

When a change in the patient pay amount is entered in VaCMS, a "Notice of Patient Pay Responsibility" will be generated and sent as the advanced notice to the recipient or the authorized representative.

Patient pay must be entered into VaCMS no later than close-of-business on the system cut-off date, to meet the advance notice requirement.

Do not send the "Advance Notice of Proposed Action" when patient pay increases.

5. Administrative Renewal Form

A system-generated paper Administrative Renewal Form is used to redetermine Medicaid eligibility of an individual who is in long-term care. The individual or his authorized representative completes and signs the form where indicated. The EW completes and signs the eligibility evaluation sections on the form.

A renewal can also be completed online using CommonHelp or by telephone by calling the Cover Virginia Call Center. See M1520.200 for information regarding Medicaid renewals.

CHAPTER M14
LONG-TERM *SERVICES AND SUPPORTS (LTSS)*
SUBCHAPTER 20

SCREENING *FOR MEDICAID LTSS*

M1420 Changes

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TN #DMAS-30	1/1/24	Page 1
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TN #DMAS-11	1/1/19	Entire subchapter
TN #DMAS-7	1/1/18	Table of Contents Pages 2, 5. Appendix 2.
TN #DMAS-5	7/1/17	Pages 2-6
TN #DMAS-1	1/1/17	Table of Contents Pages 3-6 Appendix 3 Appendices 4 and 5 were removed.
TN #DMAS-1	6/1/16	Pages 3-5 Page 6 is a runover page. Appendix 3, page 1
TN #99	1/1/14	Page 4
UP#7	7/1/12	Pages 3, 4
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LONG-TERM SERVICES AND SUPPORTS

M1420.000 *AUTHORIZATION* FOR MEDICAID LTSS

M1420.000 AUTHORIZATION FOR MEDICAID LTSS

M1420.100 MEDICAID LTSS AUTHORIZATION REQUIREMENTS

A. Introduction

Medicaid covers long-term services and supports (LTSS) in a medical facility or community-based setting for individuals whose mental or physical condition requires assistance with activities of daily living. For Medicaid to cover LTSS, the individual must:

- meet the definition of an institutionalized individual in subchapter M1410. The individual's eligibility as an institutionalized individual may be determined when the individual is already in a medical facility at the time of the application, or the individual has been authorized to receive LTSS and it is anticipated that they are likely to receive the services for 30 or more consecutive days. If it is known at the time the application is processed that the individual did not or will not meet the 30 consecutive day requirement, the individual is not to be treated as an institutionalized individual *unless community LTSS has been authorized*;
- meet all Medicaid non-financial eligibility requirements in Chapter M02;
- be financially eligible based on the policy and procedures in subchapter M1460 for unmarried individuals and married institutionalized individuals without a community spouse or subchapter M1480 for institutionalized individuals with a community spouse; and
- Meet the asset transfer policies in subchapter M1450.

This subchapter describes the LTSS authorization required for the types of LTSS, which are facility-based care, home-and-community-based (HCBS) services covered under a Section 1915(c) waiver, and the Program for All Inclusive Care for the Elderly (PACE).

B. Operating Policies

1. Payment Authorization

An LTSS authorization is needed for Medicaid payment of nursing facility (medical institution), HCBS waiver, and PACE services for Medicaid recipients. The authorization is not required for the local DSS to determine financial eligibility using the more liberal rules for institutionalized individuals, including the 300% SSI covered group and the special rules for married institutionalized individuals with a community spouse. If the individual meets the definition of institutionalization they are evaluated using these rules. The appropriate authorization document (form or screen print) or documentation of institutionalization must be maintained in the individual's case record.

2. Required Authorization Documents

a. Nursing facility-based care, the Commonwealth Coordinated Care Plus Waiver, and PACE

The Medicaid LTSS Authorization Form, DMAS 96 or the equivalent information printed from the electronic Medicaid LTSS Screening system (eMLS) or the Minimum Data Survey (MDS) is used to authorize nursing facility-based care, the Commonwealth Coordinated Care (CCC) Plus Waiver, and PACE. The Authorization form certifies the type of LTSS service.

If documentation is not available when placement needs to be made, verbal assurance from a screener that the form approving LTSS will be mailed or electronically available is sufficient to determine Medicaid eligibility as an institutionalized individual. This information must be received prior to approval and enrollment in Medicaid as an institutionalized individual.

b. The Community Living Waiver, Building Independence Waiver, and Family and Individual Supports Waiver.

The Waiver Authorization System (WaMS) (see M1420, Appendix 3) or Intellectual Disability On-line System (IDOLS) are used to authorize services received under the Community Living (CL) Waiver, Building Independence (BI) Waiver, and Family and Individual Supports Waiver. Copies of the authorization screens *or a 225 Communication form stating services have started* are acceptable.

3. Authorization Not Received

If the appropriate documentation authorizing LTSS is not received, Medicaid eligibility for an individual who is living in the community must be determined as a non-institutionalized individual.

4. *Continuing* Authorization

Providers re-evaluate the individual's level of care periodically. The authorization for Medicaid payment of LTSS may be rescinded by the physician or by DMAS at any point that the individual is determined to no longer meet the required Medicaid level of care criteria via level of care review process.

When an individual is no longer eligible for a HCBS Waiver service, the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

When an individual leaves the PACE program and no longer receives LTSS services, the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

Facilities document the level of care using the Minimum Data Survey (MDS). For an individual in a nursing facility who no longer meets the level of care but continues to reside in the facility, **continue to use the eligibility rules for institutional individuals** even though the individual no longer meets the level of care criteria. Medicaid will not make a payment to the facility for LTSS.

M1420.200 RESPONSIBILITY FOR THE LTSS AUTHORIZATION

A. Introduction

The process for completing the required assessment and authorizing services depends on the type of LTSS.

B. Nursing Facility

In order to qualify for nursing facility care, an individual must be determined to meet functional criteria, have a medical or nursing need and be at risk of nursing facility or hospital placement within 30 days without services. An assessment known as the LTSS Screening is completed by a designated screener. For individuals who apply for Medicaid after entering a nursing facility, medical staff at facilities document the level of care needed using the Minimum Data Survey (MDS). The Eligibility Worker does not need to see any screening authorization if the individual applying is already a resident of a nursing facility when the Medicaid application is filed.

The screener's approval for Medicaid LTSS for new admissions must be substantiated in the case record by a DMAS-96 or the equivalent information from the eMLS system, *WaMS printout or the Minimum Data Survey (MDS)*. Medicaid payment for LTSS cannot begin prior to the date the DMAS-96 *is signed by the physician* and prior authorization of services for the individual has been given to the provider by DMAS or the managed care plan.

An overview of the screening requirements when an individual needs nursing home care is listed below:

- For hospital patients who are currently enrolled in Medicaid and will be admitted to a nursing facility with Medicaid as the payment source, the screening is completed by hospital staff.
- Nursing facilities are permitted to admit individuals who are discharged directly from a hospital to a nursing facility for skilled services without an LTSS screening if the skilled services are not covered in whole or partially by Virginia Medicaid. Once the individual is admitted to the nursing facility, if the individual requests an LTSS screening or applies for Medicaid coverage for LTSS, nursing facility staff *will conduct a LTSS screening. The Eligibility Worker does not need to see the screening authorization if the individual applying is already a resident of a nursing facility when the Medicaid application is filed. DMAS will not pay for LTSS services unless the facility has documented that the applicant meets the nursing facility level of care.*
- For individuals who are not inpatients in a hospital or are incarcerated prior to nursing facility admission, the screening is completed by local community-based teams (CBT) composed of agencies contracting with the Department of Medical Assistance Services (DMAS). The community-based teams usually consist of the local health department physician, a local health department nurse, and a local social services department service worker. Incarcerated individuals will be screened by the community-based team in the locality in which the facility is located.

C. CCC Plus Waiver

Effective July 1, 2017, the Elderly or Disabled with Consumer-Direction (EDCD) Waiver and the Technology Assisted (Tech) Waiver were combined and are known as the Commonwealth Coordinated Care Plus (CCC Plus) Waiver. Community-based teams, hospital screening teams and nursing facility screening teams are authorized to screen individuals for the CCC Plus Waiver. See M1420.400 C for more information.

An individual screened and approved for the CCC Plus Waiver will have a DMAS-96 signed and dated by the screener and the physician *(or the nurse practitioner or the physician's assistant working with the physician)* or the equivalent information printed from the eMLS system.

If the individual elects consumer-directed services, DMAS or its contractor must give final authorization. If services are not authorized, the service facilitator will notify the LDSS, and the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

For individuals who qualify for Private Duty Nursing (PDN) under the CCC Plus Waiver, a Medicaid LTSS Communication form (DMAS-225) and a Commonwealth Coordinated Care Plus Waiver PDN Level of Care Eligibility form (DMAS-108 for Adults or DMAS-109 for children) will be completed and sent to the LDSS.

D. *Program for All Inclusive Care for the Elderly* (PACE)

Community-based screening teams, hospital screening teams and nursing facility screening teams are authorized to screen individuals for PACE. If the individual is screened and approved for LTSS, the team will inform the individual about any PACE program that serves the individual's locality. Individuals approved for PACE will have a DMAS-96 signed and dated by the screener and the supervising physician (or the nurse practitioner or the physician's assistant working with the physician) or the equivalent information printed from the eMLS system.

E. Community Living Waiver

Local Community Services Boards (CSBs) are authorized to screen individuals for the Community Living Waiver. Final authorizations for waiver services are made by Department of Behavioral Health and Developmental Services (DBHDS) staff.

Individuals screened and approved for the Community Living Waiver will have a printout of the WaMS or Intellectual Disability On-line System (IDOLS) authorization screen completed by the DBHDS representative. The screen print will be accompanied by a completed DMAS-225 form identifying the client, the Community Services Board providing the service, and begin date of service.

F. Family and Individual Supports Waiver

CSBs are authorized to screen individuals for the Family and Individual Supports Waiver. Final authorizations for waiver services are made by DBHDS staff.

Individuals screened and approved for the Family and Individual Supports Waiver will have a printout of the WaMS or IDOLS authorization screen completed by the DBHDS representative. The screen print will be accompanied by a completed DMAS-225 form identifying the client, the Community Services Board providing the service, and begin date of service.

G. Building Independence Waiver

Local CSB and DBHDS case managers are authorized to screen individuals for the Building Independence Waiver. Final authorizations for waiver services are made by DBHDS staff.

Individuals screened and approved for the Building Independence Waiver will have a printout of the WaMS or IDOLS authorization screen completed by the DBHDS representative. The screen print will be accompanied by a completed DMAS-225 form identifying the client, the Community Services Board providing the service, and begin date of service.

M1420.300 COMMUNICATION PROCEDURES

A. Introduction

To ensure that nursing facility, PACE placement or receipt of Medicaid HCBS services are arranged as quickly as possible, there must be prompt communication between screeners and eligibility staff.

B. Procedures

1. LDSS Contact

The LDSS should designate an appropriate staff member for screeners to contact. Local social services, hospital staff, CBTs and nursing facilities should be given the name and contact information for that person to facilitate timely communication between screeners and eligibility staff.

2. Screeners

Screeners must inform the individual's eligibility worker when the screening process has been completed.

3. Eligibility Worker (EW) Action

The EW must inform both the individual and the provider once eligibility for Medicaid payment of LTSS has been determined. If the individual is found eligible for Medicaid and written assurance of approval by the screening team, DMAS, or the managed care plan has been received (DMAS-96, WaMS printout or *the Minimum Data Survey [MDS])*, the eligibility worker must give the LTSS provider the enrollee's Medicaid identification number.

M1420.400 LTSS SCREENING EXCLUSIONS (Special Circumstances)

A. Purpose

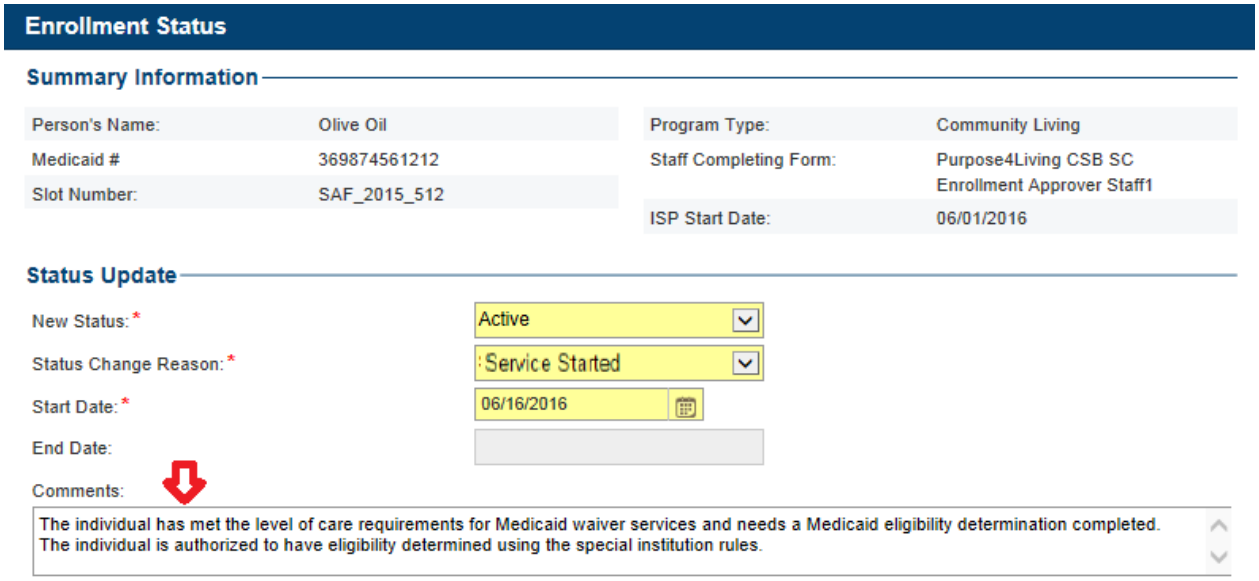
The screening certification authorizes the local DSS to determine financial eligibility using the more liberal rules for institutionalized individuals, including the 300% SSI covered group and the special rules for married institutionalized individuals with a community spouse. The Eligibility Worker does not need to see any screening authorization if the individual applying is already a resident of a nursing facility when the Medicaid application is filed.

B. Screening Special Circumstances

Screening for LTSS is NOT required when:

- *the individual is a resident in a nursing facility, receiving CCC Plus Waiver services or in PACE at the time of application and was admitted to the service prior to July 1, 2019;*
- *the individual resides out of state (either in a community, hospital or nursing facility setting) and seeks direct admission to a nursing facility;*
- *the individual is an inpatient at an in-state owned/operated facility licensed by DBHDS, in-state or out of state Veterans hospital, military hospital or VA Medical Center, and seeks direct admission to a nursing facility;*
- *the individual enters a nursing facility directly from the CCC Plus Waiver or PACE services;*
- *the individual is being enrolled in Medicaid hospice.*

Waiver Management System (WaMS) Screen Print for Community Living Waiver, Building Independence Waiver, and Family and Individual Supports Waiver Authorizations



Enrollment Status

Summary Information

Person's Name:	Olive Oil	Program Type:	Community Living
Medicaid #	369874561212	Staff Completing Form:	Purpose4Living CSB SC Enrollment Approver Staff1
Slot Number:	SAF_2015_512	ISP Start Date:	06/01/2016

Status Update

New Status: * Active

Status Change Reason: * Service Started

Start Date: * 06/16/2016

End Date:

Comments:

The individual has met the level of care requirements for Medicaid waiver services and needs a Medicaid eligibility determination completed. The individual is authorized to have eligibility determined using the special institution rules.

M1430 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-30	1/1/24	Page 3
TN #DMAS-26	10/1/22	Page 1
TN #DMAS-24	7/1/22	Page 3
TN #DMAS-20	7/1/21	Table of Contents Page 2 Appendix 1 was removed.
TN #DMAS-19	4/1/21	Pages 1, 2
TN #DMAS-10	10/1/18	Pages 3-5 Appendix 1
TN #DMAS-7	1/1/18	Pages 1, 2, 4 Appendix 1
TN #93	1/1/10	Appendix 1, page 1
Update (UP) #1	7/1/09	Appendix 1, page 1

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LONG-TERM CARE

M1430.000 FACILITY CARE

M1430.000 FACILITY CARE

A. Introduction

Medicaid covers care provided in a facility to persons whose physical or mental condition requires nursing supervision and assistance with activities of daily living.

This subchapter (M1430) contains the specific policy and rules that apply to individuals needing or receiving long-term supports and services (LTSS), also referred to as long-term care (LTC) services in medical institutions (facilities).

B. Definitions

Definitions for terms used when policy is addressing types of *LTSS*, institutionalization, and individuals who are receiving that care are found in Subchapter M1410.

M1430.010 TYPES OF FACILITIES & CARE

A. Introduction

This section contains descriptions of the types of medical facilities in which Medicaid provides payment for services received by eligible patients. *Also refer to M1410.010.B for additional guidance.*

B. Medical Facility Defined

A **medical facility** is an institution that:

- is organized to provide medical care, including nursing and convalescent care,
- has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,
- is authorized under state law to provide medical care, and
- is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

C. Types of Medical Facilities

The following are types of medical facilities in which Medicaid will cover part of the cost of care:

1. Chronic Disease Hospitals

Chronic disease hospitals are specially certified hospitals, also called "long-stay hospitals". There are two of these hospitals enrolled as Virginia Medicaid providers:

- Hospital for Sick Children in Washington, D.C.;
- Lake Taylor Hospital in Norfolk, Virginia.

2. Intermediate Care Facilities for the Intellectually Disabled (ICF-ID)

An **ICF-ID** is an institution for the intellectually disabled or persons with related conditions is an institution or a distinct part of an institution that

- is primarily for the diagnosis, treatment or rehabilitation of individuals with intellectual disabilities or related conditions, and
- provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or rehabilitative services to help each individual function at his greatest ability.

Some community group homes are certified as Intermediate Care Facilities for the Intellectually Disabled (ICF-IDs) by the Department of Health. Patients in these facilities may have income from participating in work programs.

NOTE: Medically needy (MN) individuals are not eligible for Medicaid payment of LTC services in an ICF-ID because ICF-ID services are not covered for the medically needy.

3. Institutions for Treatment of Mental Diseases (IMDs)

An **IMD** is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, of persons with mental diseases. An institution for those intellectually disabled is NOT an IMD. For a list of state-operated IMDs in Virginia, see *M0280, Appendix 2*.

Federal regulations in 42 CFR 435.1008 prohibit federal financial participation (FFP) in most Medicaid services provided to individuals under age 65 years who are patients in an institution for the treatment of mental diseases (IMD), unless they are under age 22 and are receiving inpatient psychiatric services. However, an individual who is age 22 or over, but under age 65 and who is enrolled in Medicaid at the time of admission to an IMD may remain enrolled in Medicaid. The Department of Medical Assistance Services (DMAS) will coordinate with the Centers for Medicare and Medicaid Services (CMS) to ensure that no unauthorized FFP occurs.

Medically needy (MN) patients over 65 years of age are not eligible for Medicaid payment of LTSS services in an IMD because these services are not covered for medically needy individuals age 65 or over.

4. Nursing Facility

A **nursing facility** is a medical institution licensed by the state to provide, on a regular basis, health-related services to patients who do not require hospital care, but whose mental or physical condition requires services, such as nursing supervision and assistance with activities of daily living, in addition to room and board and such services can be made available only in an institutional setting. Nursing facilities provide either skilled nursing care services or intermediate care services, or both.

5. Rehabilitation Hospitals

A **rehabilitation hospital** is a hospital certified as a rehabilitation hospital, or a rehabilitation unit of a hospital certified by the Department of Health as excluded from the Medicare prospective payment system, which provides inpatient rehabilitation services.

M1430.100 BASIC ELIGIBILITY REQUIREMENTS

A. Overview

To be eligible for Medicaid payment of long-term care, an individual must be eligible for Medicaid. The Medicaid non-financial eligibility requirements in Chapter M02 apply to all individuals in long-term care. The eligibility requirements and the location of the manual policy are listed below in this section.

B. Citizenship/ Alienage

The citizenship and alien status policy is found in subchapter M220.

C. Virginia Residency

The Virginia state resident policy specific to facility patient is found in subchapter M0230 and section M1430.101 below.

D. Social Security Number

The social security number policy is found in subchapter M0240.

E. Assignment of Rights

The assignment of rights is found in subchapter M0250.

F. Application for Other Benefits

The application for other benefits policy is found in subchapter M0270.

G. Institutional Status

The institutional status requirements specific to long-term care in a facility are in subchapter M0280.

H. Covered Group (Category)

The Medicaid covered groups eligible for LTC services, also called long-term services and supports (LTSS), are listed in M1460. The requirements for the covered groups are found in chapter M03.

I. Financial Eligibility

An individual who has been a patient in a medical institution (such as a nursing facility) for at least 30 consecutive days of care or who has been authorized for LTSS is treated as an institutionalized individual for the Medicaid eligibility determination. Financial eligibility for institutionalized individuals is determined as a one-person assistance unit separated from his/her legally responsible relative(s).

The 30-consecutive-days requirement is expected to be met if authorization for LTSS is provided verbally or in writing. If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has *180* days from the date on the Notice of Action to begin services.

For unmarried individuals, and for married individuals without community spouses other than MAGI Adults, the resource and income eligibility criteria in subchapter M1460 is applicable.

MAGI Adults in LTC are evaluated using the resource policy in M1460 and the MAGI income policy in M04. Only certain resource eligibility requirements are applicable to individuals in the Modified Adjusted Gross Income (MAGI) Adult covered group who are institutionalized.

For married individuals with community spouses, *other than MAGI Adults*, the resource and income eligibility criteria in subchapter M1480 is applicable.

The asset transfer policy in M1450 applies to all facility patients, *including MAGI Adults.*

M1430.101 VIRGINIA RESIDENCE

A. Policy

An individual must be a resident of Virginia to be eligible for Virginia Medicaid while he/she is a patient in a medical facility. There is no durational requirement for residency. Additional Virginia residency requirements are in subchapter M0230.

B. Individual Age 21 or Older

An institutionalized individual age 21 years or older is a resident of Virginia if:

- the individual is in an institution in Virginia with the intent to remain permanently or for an indefinite period; or
- the individual became incapable of declaring his intention to reside in Virginia at or after becoming age 21 years, he/she is residing in Virginia and was not placed here by another state government agency.

1. Determining Incapacity to Declare Intent

An individual is incapable of declaring his/her intent to reside in Virginia if:

- he has an I.Q. of 49 or less or has a mental age of less than 7 years;
- he has been judged legally incompetent; or
- medical documentation by a physician, psychologist, or other medical professional licensed by Virginia in the field of *intellectual disabilities* supports a finding that the individual is incapable of declaring intent to reside in a specific state.

2. Became Incapable Before Age 21

An institutionalized individual age 21 years or older who became incapable of stating intent before age 21 is a resident of Virginia if:

- the individual's legal guardian or parent, if the parents reside in separate states, who applies for Medicaid for the individual resides in Virginia;
- the individual's legal guardian or parent was a Virginia resident at the time of the individual's institutional placement;
- the individual's legal guardian or parent who applies for Medicaid for the individual resides in Virginia and the individual is institutionalized in Virginia; or
- the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, the individual is institutionalized in Virginia, and the person who files the individual's Medicaid application resides in Virginia.
- if a legal guardian has been appointed for the individual and parental rights have been terminated, the guardian's state of residence is used to determine residency instead of the parent's.

C. Individual Under Age 21

An institutionalized individual under age 21 years who is not emancipated is a resident of Virginia if:

- the individual's legal guardian or parent was a Virginia resident at the time of the individual's institutional placement;
- the individual's legal guardian or parent who applies for Medicaid for the individual resides in Virginia and the individual is institutionalized in Virginia; or
- the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, the individual is institutionalized in Virginia, and the person who files the individual's Medicaid application resides in Virginia.
- if a legal guardian has been appointed for the individual and parental rights have been terminated, the guardian's state of residence is used to determine residency instead of the parent's.

D. Placed by Another State's Government

When an individual is placed in a facility by another (not Virginia) state or local government agency, the placing state retains responsibility for the individual's Medicaid. Placement by a government agency is any action taken by the agency beyond providing general information to the individual and the individual's family to arrange the individual's admission to an institution. A government agency includes any entity recognized by State law as being under contract with the state government.

E. Individual Placed Out-of-state by Virginia

An individual retains Virginia residency for Medicaid if he/she is placed by a Virginia government agency in an institution outside Virginia. Placement into an out-of-state LTC medical facility must be pre-authorized by DMAS.

When a competent individual voluntarily leaves the facility in which Virginia placed him/her, he/she becomes a resident of the state where he/she is physically located.

F. Disputed or Unclear Residency

If the individual's state residency is unclear or is disputed, contact your Regional *Consultant* for help. When two states cannot resolve the residency dispute, the state where the individual is physically located becomes his/her state of residency for Medicaid purposes.

M1430.10*2* ADVANCE PAYMENTS

A. Introduction

There are instances when a family member, or other individual, makes an advance payment to the facility for a prospective Medicaid patient prior to or during the Medicaid application process. This assures the patient's admission to, and continued care in, the facility. The individual may have been promised by the facility that the advance payment will be refunded if the patient is found eligible for Medicaid.

Advance payments which are expected to be reimbursed to an individual other than the Medicaid applicant once Medicaid is approved, and payments made to the facility to hold the bed while the patient is hospitalized, are not counted as income for either eligibility or patient pay determinations.

B. Reimbursement

Any monies contributed toward the cost of the patient's care pending Medicaid eligibility determination must be reimbursed to the contributing party by the facility when Medicaid eligibility is established. The only exception is when the payment is made from the patient's own funds which exceeded the resource limit.

M1430.*103* SSI RECIPIENTS

A. Introduction

This section provides information about SSI recipients who are admitted to medical facilities.

B. Unmarried SSI Recipient

When an unmarried Medicaid-eligible SSI recipient enters a facility for LTC, review his/her Medicaid eligibility, especially institutional status, asset transfer and home property ownership.

1. Temporary Period

An SSI recipient who is admitted to a medical facility temporarily, for 3 months or less, retains his/her usual monthly SSI payment and remains eligible for Medicaid if resources are within Medicaid limits. This "temporary" SSI payment is not counted available for patient pay. See M1470.

2. Indefinite Period

If not admitted temporarily, or when the 3-month temporary period ends, the SSI income limit is reduced to $30 per month. If the individual has no other countable income, his SSI payment will usually be $30 per month. If he has countable income of $30 or more, his SSI payment will terminate.

Review his income eligibility when the SSI payment terminates. See M1460.

C. Married SSI Recipient

When a married Medicaid-eligible SSI recipient enters a facility for LTC, review his/her Medicaid eligibility, especially institutional status, asset transfer and resources. Use the married institutionalized individuals' policy in M1480 to determine resource eligibility and patient pay.

1. Temporary Period

An SSI recipient who is admitted to a medical facility temporarily, for 3 months or less, usually retains his/her usual monthly SSI payment and remains eligible for Medicaid if resources are within Medicaid limits. This "temporary" SSI payment is not counted available for patient pay. See M1470.

2. Indefinite Period

If not admitted temporarily, or when the 3-month temporary period ends, the SSI income limit is reduced to $30 per month. If the individual has no other countable income, his SSI payment will usually be $30 per month. If he has countable income of $30 or more, his SSI payment will terminate. Review his income eligibility when the SSI payment terminates. See M1460.

CHAPTER M14
LONG-TERM CARE
SUBCHAPTER 40

COMMUNITY-BASED CARE WAIVER SERVICES

M1440 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-30	1/1/24	Page 3
TN #DMAS-28	7/1/23	Appendix 1, Pages 1-4
TN #DMAS-10	10/1/18	Pages 3, 5
TN #DMAS-7	1/1/18	Page 1. Appendix 1, Page 4.
TN #DMAS-5	7/1/17	Table of Contents Pages 3-9, 11, 12
TN #DMAS-3	1/1/17	Table of Contents Pages 3-12 Appendix 1 was added. Page 2 is a runover page. Pages 13-23 were deleted.
UP #9	4/1/13	Page 5
Update (UP) #7	7/1/12	Table of Contents Pages 2, 14, 15, 18a-18c Pages 19, 20
TN #94	9/1/2010	Table of Contents Pages 13, 16, 18b, 19-22
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M14 LONG-TERM CARE

M1440.000 COMMUNITY-BASED CARE WAIVER SERVICES

M1440.000 COMMUNITY-BASED CARE WAIVER SERVICES

M1440.001 GOVERNING LAWS

A. Introduction

This subchapter provides information about the Medicaid Community-Based Care (CBC) waivers, the individuals eligible for waiver services, and information about the services provided in the waivers.

B. Community-Based Care Waiver Services (CBC)

Community-Based Care Waiver Services or Home and Community-Based Care or CBC are titles that are used interchangeably. These terms are used to mean a variety of in-home and community-based services reimbursed by DMAS that are authorized under a Section 1915(c) waiver designed to offer individuals an alternative to institutionalization in a medical facility. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid nursing facility placement.

C. Federal Law

Section 1915 of the Social Security Act has provisions which allow states to waive certain requirements of Title XIX as a cost saving measure. Virginia uses 1915(c) which allows the state to provide services not otherwise available under the State Plan to specifically targeted individuals. Individuals who may be targeted are those which it (the state) can show would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the *intellectually disabled,* the cost of which would be reimbursed under the State plan.

Under a 1915(c) waiver, the state may waive the requirements of Section 1902 of Title XIX, related to state wideness and comparability of services, and may apply the institutional deeming income and resource rules for home and community-based recipients. This allows individuals with catastrophic medical needs to retain income for their maintenance in the home.

Any waiver granted under Section 1915(c) must satisfy requirements established by the Secretary regarding cost-effectiveness (the cost to Medicaid of home and community-based services for recipients must not exceed 100% of the cost to Medicaid for their institutional care), the necessary safeguards taken to protect the health and welfare of individuals, financial accountability, evaluations and periodic re-evaluations of the need for an institutional level of care, the impact of the waiver and recipient choice informing procedure.

D. Virginia's Waivers

Virginia has approved Section 1915(c) home and community-based waivers. These waivers contain services that are otherwise not available to the general Medicaid population. The target population and service configuration for each waiver is outlined in this subchapter.

M1440.010 BASIC ELIGIBILITY REQUIREMENTS

A. Introduction

Services provided through the Waivers can be covered by Medicaid when the applicant or recipient meets the Medicaid eligibility requirements in this section.

B. Waiver Requirements

The individual must meet the pre-admission screening criteria for CBC waiver services and the targeted population group requirement. Some of the targeted population groups are:

- individuals age 65 or older, blind or disabled
- individuals with mental retardation
- individuals who need a medical device to compensate for loss of a vital bodily function
- individuals with developmental disabilities who do not have a diagnosis of mental retardation

The eligibility worker does NOT make the determination of whether the individual meets the waiver requirements; this is determined by the pre-admission screener or by DMAS.

NOTE: The individual cannot be authorized to receive services under more than one waiver at a time.

C. Non-financial Eligibility

The individual must meet the Medicaid non-financial and financial eligibility requirements listed below:

1. Citizenship/ Alienage

The citizenship and alien status policy is found in subchapter M0220.

2. Virginia Residency

The Virginia state resident policy specific to CBC waiver services patients is found in subchapter M0230.

3. Social Security Number

The social security number policy is found in subchapter M0240.

4. Assignment of Rights/ Cooperation

The assignment of rights and support cooperation policy is found in subchapters M0250 and M0260.

5. Application for Other Benefits

The application for other benefits policy is found in subchapter M0270.

6. Institutional Status

To be eligible for Medicaid, an individual approved for CBC waiver services must meet the institutional status requirement. A CBC waiver services recipient usually is not in a medical institution; most CBC recipients live in a private residence in the community. However, an individual who resides in a residential facility such as an assisted living facility (ALF) may be eligible for some CBC waiver services. The institutional status requirements applicable to CBC waiver services recipients are in subchapter M0280.

7. Covered Group

The requirements for the covered groups are found in subchapters M0320 and M0330.

D. Financial Eligibility

An individual who has been screened and approved for CBC services is treated as an institutionalized individual for the Medicaid eligibility determination. Financial eligibility is determined as a one-person assistance unit separated from his legally responsible relative(s) with whom he lives.

If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has *180* days from the date on the Notice of Action to begin receiving CBC services.

For unmarried individuals, and for married individuals without community spouses other than MAGI Adults, the resource and income eligibility criteria in subchapter M1460 is applicable.

MAGI Adults in LTC are evaluated using the resource policy in M1460 the MAGI income policy in M04. Only certain resource eligibility requirements are applicable to individuals in the Modified Adjusted Gross Income (MAGI) Adult covered group who are institutionalized.

For married individuals with community spouses, other than MAGI Adults, the resource and income eligibility criteria in subchapter M1480 is applicable.

The asset transfer policy in M1450 applies to all CBC waiver services recipients.

M1440.100 CBC WAIVER DESCRIPTIONS

A. Introduction

This section provides a brief overview of the Medicaid CBC waivers. The overview is a synopsis of the target populations, basic eligibility rules, available services, and the assessment and service authorization procedure for each waiver.

The eligibility worker does not make the determination of whether the individual is eligible for the waiver services; this is determined by the pre- admission screener or by DMAS. The policy in the following sections is only for the eligibility worker's information to better understand the CBC waiver services.

B. Definitions

Term definitions used in this section are:

1. Developmental Disability

"Developmental disability," as defined in Virginia Code § 37.2-100, means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated; and (vi) an individual from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v), if the individual, without services and supports, has a high probability of meeting those criteria later in life.

2. Financial Eligibility Criteria

means the rules regarding asset transfers; what is a resource; when and how that resource counts; what is income; when and how that income is considered.

3. Non-financial Eligibility Criteria

means the Medicaid rules for non-financial eligibility. These are the rules for citizenship and alienage; state residence; social security number; assignment of rights and cooperation; application for other benefits; institutional status; cooperation DCSE; and covered group and category requirements.

4. Patient

an individual who has been approved by a pre-admission screener to receive Medicaid waiver services.

C. Developmental Disabilities Waivers

In 2016, as part of the My Life, My Community Waiver Redesign, the Intellectual Disabilities Waiver, Day Support Waiver and Individual and Family Developmental Disabilities Support Waiver (DD waiver) were renamed. They were renamed to the Community Living Waiver, Building Independence Waiver, and Family and Individual Supports Waivers, respectively. These waivers are referred to collectively as the Developmental Disabilities Waivers. The services offered under these waivers are contained in M1440, Appendix 1.

M1440.101 *COMMONWEALTH COORDINATED CARE PLUS WAIVER (FORMERLY THE EDCD AND TECHNOLOGY ASSISTED WAIVERS)*

A. General Description

Effective July 1, 2017, the Elderly or Disabled with Consumer-Direction (EDCD) Waiver and the Technology Assisted (Tech) Waiver were combined and are known as the Commonwealth Coordinated Care Plus (CCC Plus) Waiver. The CCC Plus Waiver is targeted to provide home and community-based services to individuals age 65 or older, or who are disabled, who have been determined to require the level of care provided in a medical institution and are at risk of facility placement. The waiver also serves "technology-assisted"

individuals who are chronically ill or severely impaired and who need both a medical device to compensate for the loss of a vital body function, as well as substantial and ongoing skilled nursing care to avert death or further disability.

Recipients may select agency-directed services, consumer-directed services, or a combination of the two. Under consumer-directed services, supervision of the personal care aide is provided directly by the recipient. Individuals who are incapable of directing their own care may have a spouse, parent, adult child, or guardian direct the care on behalf of the recipient. Consumer-directed services are monitored by a Service Facilitator.

B. Targeted Population

This waiver serves persons who are:

a. age 65 and over, or

b. disabled; disability may be established either by SSA, DDS, or a pre-admission screener (provided the individual meets a Medicaid covered group and another category).

Waiver services are provided to any individual who meets a Medicaid covered group and is determined to need an institutional level of care by a pre-admission screening. The individual does not have to meet the Medicaid disability definition.

Technology assisted services are provided to individuals who need both
1) a medical device to compensate for the loss of a vital body function and
2) substantial and ongoing skilled nursing care.

C. Eligibility Rules

All individuals receiving waiver services must meet the Medicaid non-financial and financial eligibility requirements for an eligible patient in a medical institution. The income limit used for this waiver is 300% of the current SSI payment standard for one person, or the medically needy income limit (spenddown).

The resource and income rules are applied to waiver-eligible patients as if the patients were in a medical institution.

NOTE: CCC Plus Waiver services shall not be offered to any patient who resides in a nursing facility, an intermediate care facility for the intellectually disabled (ICF/ID), a hospital, board and care facility, or an adult care residence licensed by DSS.

Individuals needing technology-assisted services must have a live-in primary care giver who accepts responsibility for the individual's health and welfare.

D. Services Available

LTC services available through this waiver include:

- adult day health care
- agency-directed and consumer-directed personal care
- agency-directed respite care (including skilled respite) and consumer-directed respite care
- Personal Emergency Response System (PERS).

Services provided through CCC Plus Waiver for technology-assisted individuals include:

- *private duty nursing*
- *nutritional supplements*
- *medical supplies and equipment not otherwise available under the Medicaid State Plan.*

E. ***Assessment and Service Authorization*** *The nursing home pre-admission screeners assess and authorize CCC Plus Waiver services based on a determination that the individual is at risk of nursing facility placement.*

M1440.102 COMMUNITY LIVING WAIVER

A. General Description The Community Living Waiver program, formerly the Intellectual Disabilities (ID) Waiver, is targeted to provide home and community-based services to individuals with developmental disabilities and individuals under the age of six years at developmental risk who have been determined to require the level of care provided in an ICF/ID.

B. Eligibility Rules All patients receiving waiver services must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid-eligible in a medical institution. The resource and income rules are applied to waiver eligible individuals as if the individual were residing in a medical institution.

The income limit used for this waiver is 300% of the current SSI payment standard for one person**. Medically Needy individuals are not eligible for this waiver.** If the individual's income exceeds 300% SSI, the individual is not eligible for services under this waiver.

C. Services Available The services available under the Community Living Waiver are included in M1440, Appendix 1.

D. Assessment and Service Authorization The individual's need for CBC is determined by the Community Services Board (CSB), Behavioral Health Authority (BHA) or Department for Aging and Rehabilitative Services (DARS) case manager after completion of a comprehensive assessment.

All recommendations are submitted to Department of Behavioral Health and Developmental Services (DBHDS) or DMAS staff for final authorization.

1. CSB The CSB/BHA support coordinator/case manager may only recommend waiver services if:

- the individual is found Medicaid eligible; and
- the individual is intellectually disabled, or is under age 6 and at developmental risk; and
- the individual is not an inpatient of a nursing facility or hospital.

2. DARS The DARS case manager may only recommend waiver services if:

- the individual is found Medicaid eligible, and
  - the individual is in a nursing facility and has a related condition such as defined in the federal Medicaid regulations.

M1440.103 BUILDING INDEPENDENCE WAIVER

A. General Description The Building Independence Waiver, formerly the Day Support (DS) Waiver, is targeted to provide home and community-based services to individuals with developmental disabilities who have been determined to require the level of care provided in an ICF/ID. These individuals may reside in an ICF/ID or may be in the community at the time of the assessment for Building Independence Waiver services.

B. Eligibility Rules All patients receiving waiver services must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid-eligible in a medical institution. The resource and income rules are applied to waiver eligible individuals as if the individual were residing in a medical institution.

The income limit used for this waiver is 300% of the current SSI payment standard for one person. **Medically needy individuals are not eligible for this waiver**. If the individual's income exceeds 300% SSI, the individual is not eligible for services under this waiver.

C. Services Available The services available under the Building Independence Waiver are included in M1440, Appendix 1.

D. Assessment and Service Authorization The individual's need for CBC is determined by the CSB, BHA or DBHDS support coordinator/case manager after completion of a comprehensive assessment. All recommendations are submitted to DBHDS staff for final authorization.

M1440.104 ALZHEIMER'S ASSISTED LIVING WAIVER

A. General Description The Alzheimer's Assisted Living (AAL) Waiver is available only to individuals who are Auxiliary Grants (AG) recipients. The AAL Waiver allows for the provision of services to individuals in approved assisted living facilities who, without the waiver, might require nursing home placement. **Individuals on this waiver do not have Medicaid eligibility determined as institutionalized individuals, and there are no post-eligibility requirements**.

The AAL waiver serves persons who are:

- Auxiliary Grants (AG) recipients,
- have a diagnosis of Alzheimer's or a related dementia and no diagnosis of mental illness or intellectual disability, and
- age 55 or older.

B. Eligibility Rules

Individuals in the AAL Waiver have Medicaid eligibility determined in the AG covered group (see M0320.202) and do not have Medicaid eligibility determined as institutionalized individuals. There are no post-eligibility requirements.

The enrollment and notification procedures used with non-institutionalized Medicaid recipients are followed (see M0130.300).

C. Services Available

Services available under the AAL waiver are**:**

- assistance with activities of daily living
- medication administration by licensed professionals
- nursing services for assessments and evaluations
- therapeutic social and recreational programming which provides daily activities for individuals with dementia.

D. Assessment and Service Authorization

Local and hospital screening committees or teams are authorized to screen individuals for the AAL waiver; however, a copy of the pre-admission screening is not required for the Medicaid eligibility record.

M1440.105 FAMILY AND INDIVIDUAL SUPPORTS WAIVER

A. General Description

The Family and Individual Supports Waiver, formerly the Individual and Family Developmental Disabilities Support Waiver (DD waiver), provides home and community-based services to individuals with developmental disabilities, who do not have a diagnosis of developmental disability. The objective of the waiver is to provide medically appropriate and cost-effective coverage of services necessary to maintain these individuals in the community and prevent placement in a medical institution.

B. Eligibility Rules

All patients receiving waiver services must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid eligible in a medical institution. The resource and income rules are applied to waiver eligible individuals as if the individuals were residing in a medical institution.

The income limit used for this waiver is 300% of the SSI limit (see M0810.002 A. 3.). **Medically Needy individuals are not eligible for this waive**r. If the individual's income exceeds 300% SSI, the individual is not eligible for services under this waiver.

C. Services Available

The services available under the Family and Individual Supports Waiver are included in M1440, Appendix 1.

D. Assessment and Service Authorization

The individual's need for CBC is determined by the CSB, BHA or DBHDS support coordinator/case manager after completion of a comprehensive assessment. All recommendations are submitted to DBHDS staff for final authorization.

M1440.106 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

A. General Description

PACE is NOT a CBC Waiver, but rather is the State's community model for the integration of acute and long-term care. PACE combines Medicaid and Medicare funding. PACE provides the entire spectrum of acute and long-term care services to enrollees without limitations on the duration of services or the dollars spent and is centered on an adult day health care model.

B. Targeted Population

PACE serves individuals aged 55 and older who (1) meet the nursing facility level of care criteria and (2) reside in their own communities. PACE provides all of their health care and long-term care medical needs. Individuals who meet the criteria for the *CCC Plus* Waiver may be enrolled in PACE in lieu of the *CCC Plus* Waiver.

C. Eligibility Rules

For Medicaid to cover PACE services, the individual must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid eligible in a medical institution. The resource and income rules are applied to PACE-eligible individuals as if the individuals were residing in a medical institution.

The income limit used for PACE is 300% of the SSI limit (see M0810.002 A. 3.) or the MN income limit and spenddown.

PACE is not available to individuals who reside in an assisted living facility (ALF) and receive Auxiliary Grant (AG) payments. Individuals who reside in an ALF may be enrolled in PACE if they meet the functional, medical/nursing, and financial requirements, but they will not be permitted to receive an AG payment.

D. Services Available

The following services are provided through PACE:

- adult day care that offers nursing, physical, occupational, speech and recreational therapies;
- meals and nutritional counseling; social services;
- medical care provided by a PACE physician; personal care and home health care;
- all necessary prescription drugs;
- access to medical specialists such as dentists, optometrists and podiatrists; respite care;
- hospital and nursing facility care when necessary; and
- transportation.

E. Assessment and Service Authorization

Participation in PACE is **voluntary**. The nursing home pre-admission screening team will advise the individual of the availability of PACE and will facilitate enrollment if the Medicaid enrollee chooses PACE. The PACE team is responsible for authorizing as well as providing the services.

Eligibility for PACE must begin on the first day of a month and end on the last day of a month.

M1440.200 COVERED SERVICES

A. Introduction

This section provides general information regarding the LTC services provided under the waivers. This is just for your information, understanding, and referral purposes. The information does not impact the Medicaid eligibility decision.

Note: Services covered under the Building Independence, Community Living and Family and Individual Supports Waivers are described separately in M1440, Appendix 3.

B. Waiver Services Information

Information about the services available under a waiver is contained in the following sections:

- M1440.201 Personal Care/Respite Care Services
- M1440.202 Adult Day Health Services
- M1440.*203* Private Duty Nursing Services
- M1440.*204* Nutritional Supplements
- M1440.*205* Personal Emergency Response System (PERS)

M1440.201 PERSONAL CARE/RESPITE CARE SERVICES

A. What Are Personal Care Services

Personal Care services are defined as long term maintenance or support services which are necessary in order to enable the individual to remain at home rather than enter an institution. Personal Care services provide eligible individuals with aides who perform basic health-related services, such as helping with ambulation/exercises, assisting with normally self-administered medications, reporting changes in the recipient's conditions and needs, and providing household services essential to health in the home.

B. What are Respite Care Services

Respite Care services are defined as services specifically designed to provide temporary but periodic or routine relief to the primary caregiver of an individual who is incapacitated or dependent due to frailty or physical disability. To receive this service the individual must meet the same criteria as the individual who is authorized for Personal Care, but the focus in Respite Care is on the needs of the caregiver for temporary relief. This focus on the caregiver differentiates Respite Care from programs which focus on the dependent or disabled care receiver.

C. Relationship to Other Services

An individual may receive Personal Care or Respite Care in conjunction with Adult Day Health Care services as needed.

When an individual receives Hospice services, the hospice is required to provide the first 21 hours per week of personal care needed and a maximum of an additional 38.5 hours per week.

D. Who May Receive the Service

An individual must meet the criteria of the *CCC Plus* Waiver to qualify for Personal/Respite Care services.

M1440.202 ADULT DAY HEALTH CARE SERVICES

A. What Is Adult Day Health Care

Adult Day Health Care (ADHC) is a congregate service setting where individuals receive assistance with activities of daily living (e.g., ambulating, transfers, toileting, eating/feeding), oversight of medical conditions, administration of medications, a meal, care coordination including referrals to rehabilitation or other services if needed, and recreation/social activities. A person may attend half or whole days, and from one to seven days a week, depending on the patient's capability, preferences, and available support system.

B. Relationship to Other Services

ADHC centers may provide transportation and individuals may receive this service, if needed, to enable their attendance at the center. An individual may receive ADHC services in conjunction with Personal Care or Respite Care services as needed.

C. Who May Receive the Service

An individual must meet the criteria of the *CCC Plus* Waiver to qualify for ADHC services.

M1440.203 PRIVATE DUTY NURSING SERVICES

A. What is Private Duty Nursing

Private Duty Nursing services are called "nursing services" in the ID/MR waiver. These services are offered to medically fragile patients who require substantial skilled nursing care. Patients receive nursing services from Registered Nurses or Licensed Practical Nurses. Services are offered as needed by the patient, but always exceed what is available through the Home Health program.

For example, in the CCC Plus Waiver, most technology-assisted patients receive 8 hours or more of continuous nursing services at least four times per week.

B. Relationship to Other Services

There are no requirements that other waiver services be or not be received.

C. Who May Receive the Service

An individual must meet the *CCC Plus* Waiver technology-assisted criteria for nursing services. A Medicaid recipient who qualifies under EPSDT (Early & Periodic Screening, Diagnosis & Treatment) to receive private duty nursing services may also receive private duty nursing.

M1440.204 NUTRITIONAL SUPPLEMENTS

Nutritional Supplements (enteral nutrition products) are provided through DME (durable medical equipment) providers for patients who have an identified nutritional risk. Nutritional supplements are ordered by the individual's physician to cover a six-month period and Medicaid payment is authorized by the pre-admission screener or DMAS.

M1440.205 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

A. What is PERS

PERS is an electronic device that enables certain recipients who are at high risk of institutionalization to secure help in an emergency through the use of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the recipient's home telephone line. PERS may include medication monitoring to remind certain recipients at high risk of institutionalization to take their medications at the correct dosages and times.

B. Relationship to Other Services

An individual may receive PERS services in conjunction with agency-directed or consumer-directed Personal Care or Respite Care services.

C. Who May Receive the Service

PERS is available only to *CCC Plus* Waiver recipients who live alone or are alone for significant parts of the day, who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Developmental Disabilities Waivers – Services and Support Options – Updated *July 2023*

(BI = Building Independence Waiver; FI = Family & Individual Supports Waiver; CL = Community Living Waiver)

	BI	FI	CL	Description
Employment and Day *Services*				
Individual Supported Employment	✓	✓	✓	Individual Supported Employment services is provided one-on-one by a job coach *and offers training and support in a competitive job where persons without disabilities are employed.*
Group Supported Employment	✓	✓	✓	Group Supported Employment services *is* continuous *employment-related* support *in a competitive job where persons* without disabilities *are employed.*
Workplace Assistance		✓	✓	Workplace Assistance *is* provided to someone who requires more than typical job coach services to *maintain individual, competitive employment.*
Community Engagement	✓	✓	✓	Community Engagement Services *provides a wide variety of opportunities relationships and natural support in the community, while utilizing the community as a learning environment.*
Community Coaching	✓	✓	✓	Community Coaching is designed for *people* who need one to one support in order build a specific skill or set of skills to address barrier(s) that prevents *that* person from participating in Community Engagement.
Group Day	✓	✓	✓	Group Day Services *include skill-building and support activities to enhance independence and increase community integration. Can occur in a center and the community.*
Services via *consumer and agency directed models*				
Companion Services		✓	✓	*Provides nonmedical care, socialization, or support to adults, ages 18 and older in person's home and/or in the community.*
Personal Assistance Services		✓	✓	Includes monitoring health status, *assisting with maintaining a clean and safe home and providing direct support with personal care needs, at home, in the community, and at work.*
Respite *Services*		✓	✓	Respite services are specifically designed to provide temporary, *short-term care for a person* when his/her primary caregiver *is unavailable.*

	BI	FI	CL	Description
Residential *Services*				
Independent Living Supports	✓			Independent Living Supports are provided to adults (18 and older) *and* offers skill building and support to secure a self-sustaining, independent living situation in the community and/or may provide the support necessary to maintain those skills.
Shared Living	✓	✓	✓	Shared Living *is support to a person who resides in his/her own home/apartment in the community provided by a roommate of the person's choosing. The individual receives a Medicaid reimbursement for the roommate's portion of the total cost of rent, food, and utilities in exchange for the roommate providing minimal supports.*
Supported Living		✓	✓	Supported Living services take place in an apartment/house setting operated by a DBHDS licensed provider and provides *24/7* around the clock availability of staff *support performed* by paid staff who have the ability to respond in a timely manner. *May be provided individually or at the same time to more than one individual living in the home, depending on the required support.*
In-home Support Services		✓	✓	In-Home Supports take place in the person's and/or family's home or community settings. Services are designed to ensure the health, safety and welfare of the person and expand daily living skills.
Sponsored Residential			✓	Sponsored Residential Services take place in a licensed DBHDS *family home where the homeowners are the paid caregivers ("sponsors") who provide support as necessary so that the person can reside successfully in the home and community.*
Group Home Residential			✓	Group Home Residential Services *are provided in a DBHDS licensed home with staff available 24 hours per day to provide a skill building component, along with the provision of general health and safety supports, as needed.*
Crisis *Services*				
Community-Based Crisis Supports	✓	✓	✓	Community-based crisis supports provided in the individual's home and community setting. Crisis staff work directly with and assist the *person* and *his/her* current support provider or family. These services provide temporary intensive support to emergency psychiatric hospitalization, institutional placement or prevent other out-of-home placement.
Center-based Crisis Supports	✓	✓	✓	Center-based crisis supports provide long term crisis prevention and stabilization in a residential setting (Crisis Therapeutic Home) through planned and emergency admissions.
Crisis Support Services	✓	✓	✓	Crisis support services provide intensive supports to stabilize the person who may experience an episodic behavioral or psychiatric crisis in the community which has the potential to jeopardize his/her current community living situation.

	BI	FIS	CL	Description
Medical and Behavioral *Services*				
Skilled Nursing		✓	✓	Skilled Nursing is part-time or intermittent care *provided by an LPN or RN to address or delegate needs that require direct support or oversight of a licensed nurse. Nursing service can occur at the same time as other waiver services.*
Private Duty Nursing		✓	✓	Private Duty Nursing is individual and continuous care (in contrast to part-time or intermittent care) for *people* with a medical condition and/or complex health care need, to enable the *person* to remain at home.
Therapeutic Consultation		✓	✓	Therapeutic consultation services *in consultation with a professional* designed to assist the individual's *staff* and*/or* the individual's family/caregiver, as appropriate, *through* assessments, *development of TC supports plan* and teaching for the purpose of assisting the individual enrolled in the waiver with the designated specialty area. The specialty areas are psychology, behavioral consultation, therapeutic recreation, speech and language pathology, occupational therapy, physical therapy, and rehabilitation engineering.
Personal Emergency Response System (PERS)	✓	✓	✓	PERS is a service that monitors individual's safety in *his/her* home, and provides access to emergency assistance for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the *person's* home telephone system.

	BI	FI	CL	Description
Additional *Services*				
Assistive Technology	✓	✓	✓	Assistive technology is specialized medical equipment, supplies, devices, controls, and appliances*, not covered by insurance* which enable individuals to increase their *independence in* their environment *and community.*
Benefits Planning	✓	✓	✓	*A service that assists recipients of DD Waiver and social security to understand their personal benefits and explore their options regarding employment.*
Community Guide				*Direct assistance (1:1) to persons in navigating and utilizing community resources. Provides information and assistance that help the person in problem solving, decision making, and developing supportive community relationships and other resources that promote implementation of the person-centered plan.*
Electronic Home-Based Services	✓	✓	✓	Electronic Home-Based Services are goods and services based on *current* technology *to enable a person to safely live and participate in the community while decreasing the need for support staff services.* This includes purchases of electronic devices, software, services, and supplies not otherwise provided through this waiver or through the State Plan, that would allow individuals to access greater independence and self-
Environmental Modifications	✓	✓	✓	Environmental modifications physical adaptations to the *person's* primary home *or* primary vehicle that are necessary to ensure the health and welfare of the *person* or enable the individual to function with greater independence.
Individual and Family/Caregiver Training	✓	✓	✓	Training and counseling to individual, families and caregivers to improve supports or educate the person to gain a better understanding of his/her *abilities* or increase his/her self-determination/self-advocacy abilities.
Transition Services	✓	✓	✓	Transition services are nonrecurring set-up expenses for *persons* who are transitioning from an institution or provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.
Employment and Community Transportation	✓	✓	✓	*Promotes the individual's independence and participation in the life of his or her community. Transportation to waiver and other community services or events, activities and resources, inclusive of transportation to employment or volunteer sites, homes of family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities or events as specified by the service plan and when no other means of access is available.*
Peer Mentor Supports	✓	✓	✓	*Designed to foster connections and relationships which build individual resilience. This service is delivered by people with developmental disabilities who are or have received services, have shared experiences with the person, and provide support and guidance to him/her.*

CHAPTER M14
LONG-TERM CARE
SUBCHAPTER 50

TRANSFER OF ASSETS

M1450 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-31	4/1/24	Pages 42 and 46
TN #DMAS-29	10/1/23	Page 37
TN #DMAS-28	7/1/23	Page 35 and Appendix 2
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

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M1450.000 TRANSFER OF ASSETS

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M1450.000 TRANSFER OF ASSETS

M1450.001 OVERVIEW

A. Introduction

Individuals who are eligible for Medicaid may NOT be eligible for Medicaid payment of long-term care (LTC) services, *also referred to as long-term services and supports (LTSS),* for a specific period of time (penalty period) if they or their spouses have transferred assets for less than fair market value without receiving adequate compensation. The asset transfer policy applies to all individuals in all types of *LTSS: facility based and community based care (CBC), also referred to as home and community based services (HCBS).*

B. Policy

The EW must evaluate an asset transfer according to the instructions found in the sections below. The applicable policy rules depend on

- when the transfer occurred;
- who transferred the asset;
- to whom the asset was transferred;
- what was transferred.

Information must be obtained from all Medicaid applicants and recipients who require LTC services about transfers of both income and resources that occurred during the **five years** before the Medicaid application date. Whether the transfer will affect LTC services eligibility depends on:

- the date the transfer occurred,
- to whom the asset was transferred,
- the type of asset that was transferred,
- the reason for the transfer,
- the value of the transferred asset
- the amount of compensation received.

M1450.002 LEGAL BASE

A. Public Law 96-611

This federal law established a transfer of property eligibility rule for the SSI program and also permitted states to adopt a transfer eligibility rule for their Medicaid programs which could be, in certain respects, more restrictive than in SSI or the money payment programs. The rule adopted by Virginia was more restrictive than the SSI rule.

B. Public Law 100-360

Public law 100-360 (The Medicare Catastrophic Coverage Act), enacted on July 1, 1988, changed the federal Medicaid law relating to property transfers. Further revisions were made by the Family Support Act of 1988 (Welfare Reform) Public Law 100-485, enacted on October 13, 1988.

C. Public Law 103-66 (OBRA)

Section 13611 of this federal law, enacted on August 10, 1993, revised transfer provisions for the Medicaid Program. It amended section 1917 of the Social Security Act by incorporating in section 1917 new requirements for asset transfers and for trusts.

D. Public Law 109-171 (DRA)

The Deficit Reduction Act (DRA) of 2005, enacted on February 8, 2006, further revised asset transfer provisions for the Medicaid program.

E. The Code of Virginia

Virginia state law governing the Department of Medical Assistance Services (DMAS) and the Medicaid program in Virginia is contained in sections 32.1-323 through 32.1-330. It includes a definition of assets, and it states that an asset transfer includes a disclaimer of interest(s) in assets.

Section 20-88.01 empowers DMAS to request a court order requiring the transferees of property to reimburse Medicaid for expenses Medicaid paid on behalf of recipients who transferred property.

F. 2018 Appropriations Act

The 2018 Appropriations Act provided funding for New Health Coverage Options for Virginia Adults. Effective January 1, 2019, determination of eligibility for adults between the ages of 19-64 without Medicare will be evaluated using MAGI income methodology. Adults eligible under the expansion of coverage will be referred to as Modified Adjusted Gross Income (MAGI) Adults.

Individuals in the MAGI Adults covered group are not subject to a resource test unless the individual requests Medicaid payment for LTC/LTSS. The resource and home equity requirements for MAGI Adults are contained in M1460. ***The asset transfer policy contained in this subchapter IS fully applicable to the MAGI Adults who are seeking Medicaid payment of LTC services.***

M1450.003 DEFINITION OF TERMS

A. Adequate Compensation

For purposes of asset transfer, an individual is considered to have received "adequate compensation" for an asset when the fair market value of the asset or greater has been received.

B. Assets

For the purposes of asset transfer, assets are all income and resources of the individual and the individual's spouse, including any income and resources to which the individual or the spouse is entitled but does not receive because of an action by:

- the individual or the spouse,
- any person, including a court or administrative body, with legal authority to act in the place of or on behalf of the individual or spouse, or
- a person, including a court or administrative body, acting at the direction or request of the individual or spouse.

The term "asset" may also include:

- life estate (life rights) in another individual's home, and
- the funds used to purchase a promissory note, loan, or mortgage.

C. Asset Transfer

An **asset transfer** is any action by an individual or other person that reduces or eliminates the individual's ownership or control of an asset(s). Transfers include:

- giving away or selling property
- disclaiming an inheritance or not asserting inheritance rights in court
- clauses in trusts that stop payments to the individual
- putting money in a trust
- payments from a trust for a purpose other than benefit of the individual
- irrevocably waiving pension income
- not accepting or accessing injury settlements
- giving away income during the month it is received
- refusing to take legal action to obtain a court-ordered payment that is not being paid, such as alimony or child support
- placement of lien or judgment against individual's property when not an "arm's length" transaction (see below)
- other similar actions.

When the placement of a lien or a judgment against an individual's asset is not an "arm's length" transaction, it is an uncompensated transfer of assets. An arm's length transaction, as defined by Black's Law Dictionary, is a transaction negotiated by **unrelated** parties, each acting in his or her own self interest. When an individual's relative has a lien or judgment against the individual's property, the lien or judgment is an asset transfer that must be evaluated.

D. Baseline Date

The **baseline date** is the first date as of which the individual was both

- an institutionalized individual (as defined below) AND
- a Virginia Medicaid applicant.

When an individual is already a Medicaid recipient and becomes institutionalized, the baseline date is the first day of institutionalization.

E. Fair Market Value

Fair market value (FMV) is an estimate of an asset's value if it were sold at the prevailing price at the time it was actually transferred. Value is based on criteria used in determining the value of assets for the purpose of determining Medicaid eligibility.

NOTE: For an asset to be considered transferred for fair market value, or to be considered to be transferred for valuable consideration, the compensation received for the asset must be in tangible form with intrinsic value. A transfer for love and affection is not considered a transfer for fair market value.

Also, while relatives and family members legitimately can be paid for care they provide to the individual, it is presumed that services provided for free at the time were intended to be provided without compensation. Thus, a transfer to a relative for care provided for free in the past is a transfer of assets for less than fair market value. However, an individual can rebut this presumption with tangible evidence that is acceptable. For example, the individual proves that a payback arrangement had been agreed to in writing at the time services were provided.

F. Income

Any monies received by an individual or the individual's spouse to meet the individual's basic needs for food or shelter, is **income**. See subchapter M1460 for items that are not income.

G. Institutionalized Individual

For the purposes of asset transfer, an **institutionalized individual** is:

- a person who is an inpatient in a nursing facility;
- a person who is an inpatient in a medical institution and for whom payment for care is based on a level of care provided in a nursing facility. Included are persons in long-stay hospitals (including rehabilitation hospitals and rehabilitation units of general hospitals) and patients in Virginia *Department of Behavioral Health and Developmental Services (DBHDS)* facilities who

are housed in an area certified as a nursing facility or intermediate care facility for the *intellectually disabled*; or

- a Medicaid applicant/enrollee who has been screened and approved for or is receiving Medicaid community-based care (CBC) waiver services, services through the Program of All Inclusive Care for the Elderly (PACE) or hospice services.

H. Legally Binding Contract

Virginia law requires written contracts for the sale of goods (not services) valued over $500, and for transactions involving real estate. Contracts for services may be oral.

To prove a contract is **legally binding**, the individual must show:

***1.* Parties Legally Competent**

The parties to the contract were legally competent to enter into the contract. (Generally, this excludes (1) individuals declared to have mental incapacity or a diminished mental capacity and (2) children less than 18 years of age, who may not enter into a contract under Virginia law. The purpose here is to ensure that both parties knew what they were doing when they entered into the contract).

***2.* Valuable Consideration**

"Valuable consideration" is received by each party when the "adequate compensation" requirement for the asset transfer rule is met.

***3.* Definite Contract Terms**

Contract terms are sufficiently definite so that the contract is not void because of vagueness. Payments under contracts with immediate family members must be at reasonable rates. Those rates must be discernable from the terms of the contract. For example, it is not sufficient for a mother to agree to give her son all the stocks she owns upon her death in exchange for his agreeing to take care of her for an undefined period of time (such a contract might have to be written, depending on the value). The contract must set forth the per diem rate, specify a time period, or in some other manner establish definable and certain terms.

***4.* Mutual Assent**

Contract terms were agreed to by mutual assent. Confirm that both parties understood and agreed upon the same specific terms of the contract when they entered into the contract.

I. Look-Back Date

The look-back date is the date that is 60 months before the first date the individual is both (a) an institutionalized individual and (b) has applied for Medicaid. The look-back date is the earliest date on which a penalty for transferring assets for less than fair market value can be imposed. Penalties can be imposed for transfers that take place on or after the look-back date. Penalties cannot be imposed for transfers that take place before the look-back date.

J. Look-back Period

The **look-back period** is the period of time that begins with the look-back date and ends with the baseline date. The look-back period is 60 months.

K. Other Person

Other person means:

- the individual's spouse or co-owner of an asset;
- a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; and
- a person, including a court or administrative body, acting at the direction, or upon the request, of the individual or the individual's spouse.

L. Payment Foreclosed

Payment to any individual from an irrevocable trust that is not for the benefit of the individual for whom the trust was created is an uncompensated transfer of assets. See M1140.404 B. 4. c. for information regarding when a trust is foreclosed.

M. Penalty Period

The **penalty period** is the period of time during which Medicaid payment for LTC services is denied because of a transfer of assets for less than market value. The length of the penalty period is based on the value of the uncompensated transfer of assets and the average cost of nursing facility care in Virginia.

N. Property/ Resources

"Property" and "resources" both refer to real and personal property legally available to the individual or the individual's spouse.

O. Uncompensated Value

The uncompensated value is the amount of an asset's fair market value that was not or will not be received as a result of the asset transfer.

The uncompensated value for **real property** at the time of transfer is:

- the difference between the asset's FMV and the Gross Amount Due to Seller, when the lien/other encumbrance against the asset is satisfied from the seller's proceeds, or
- the difference between the asset's equity value (FMV minus the lien) and the Gross Amount Due to Seller, when the lien is assumed by the buyer. Refer to examples in M1450.610 H.

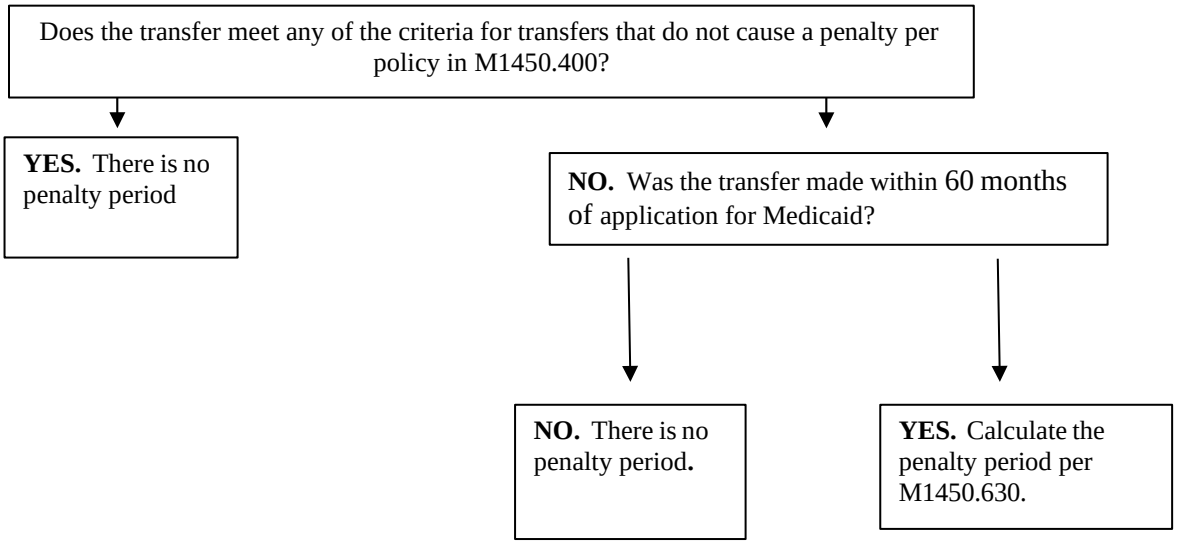
P. Undue Hardship

An undue hardship exists when the imposition of a penalty period would deprive the individual of medical care such that his health or his life would be endangered or be deprived of food, clothing, shelter, or other necessities of life.

M1450.004 TRANSFER OF ASSETS FLOW CHART

The flow chart below illustrates when an asset transfer penalty period is required.

Transfer of Assets Flow Chart



M1450.100 RESERVED

M1450.200 POLICY PRINCIPLES

A. Policy

An institutionalized individual who transfers (or has transferred), or whose spouse transfers or has transferred, an asset in ways not allowed by policy is not eligible for Medicaid payment of long-term care services. The DRA established new policy for evaluating transfers made on or after February 8, 2006. The look-back period for all transfers is 60 months; there is no distinction between transfers involving trusts and other transfers.

B. Procedures

When a Medicaid enrollee is institutionalized, review the individual's eligibility to determine if an asset transfer occurred within the 60 months prior to institutionalization. When a Medicaid applicant reports an asset transfer, or the worker discovers a transfer, determine if the transfer occurred within 60 months prior to the month in which the individual is both institutionalized and a Medicaid applicant/enrollee.

1. All Transfers

Determine if any assets of the individual or the individual's spouse were transferred during the 60 months (the "look-back period") prior to the first date on which the individual was both an institutionalized individual and a Medicaid applicant/enrollee.

2. Determine Effect

If an asset was transferred during the look-back periods specified above, determine if the transfer affects eligibility for LTC services' payment, using sections *M1450.300* through M1450.550 below.

If the transfer affects eligibility and was for less than market value, determine the uncompensated value (M1450.610) and establish a penalty period (period of ineligibility for Medicaid payment of LTC services, M1450.630).

M1450.300 ASSETS THAT ARE NOT RESOURCES FOR TRANSFER RULE

A. Policy

The assets listed in this section are NOT resources for asset transfer purposes. Therefore, the transfer of any of the assets listed in this section does NOT affect eligibility for Medicaid payment of LTC services.

B. Personal Effects and Household Items

A transfer of personal effects or household items does not affect eligibility.

C. Certain Vehicles

The transfer of a vehicle that meets the following requirements does not affect Medicaid payment for LTC services:

- a vehicle used by the applicant/enrollee to obtain medical treatment.
- a vehicle used by the applicant/enrollee for employment.
- a vehicle especially equipped for a disabled applicant or enrollee.
- a vehicle necessary because of climate, terrain, distance, or similar factors to provide necessary transportation to perform essential daily activities.

If the vehicle was not used as provided above at the time of transfer, $4,500 of the trade-in value of the vehicle used for basic transportation is excluded. Any value in excess of $4,500 must be evaluated as an asset transfer.

D. Property Essential to Self Support

The transfer of property essential to the institutionalized individual's self-support (tools, equipment, etc. used by the individual to produce income), including up to $6,000 equity in income-producing real property(ies) owned by the applicant/recipient, does not affect eligibility for LTC services' payment.

To be income-producing, the property(ies) must usually have a net annual return that is:

- 6% of the equity, if the equity is $6,000 or less or
- $360 if the equity is more than $6,000.

If an unusual circumstance caused a temporary reduction in the net annual return and the net annual return is expected to meet the requirements the following year, the property is still considered income-producing.

E. Resources Under PASS

Transfer of resources specifically designated for a disabled or blind SSI recipient's plan of self-support (PASS), as determined by SSI, does not affect eligibility for LTC services' payment.

F. Certain Life Insurance

Transfer of term or group insurance that has no cash value, or transfer of life insurance with a total face value of $1,500 or less (total of all policies) on an individual, does not affect eligibility for LTC services' payment. Life insurance includes policies that presently do not have a cash value but will have a cash value in the future.

G. Certain Cash and In-kind Items

Transfer of cash or in-kind items received to replace/repair lost, damaged, or stolen exempted resources (see M1130.630) does not affect eligibility for LTC services' payment.

H. Burial Spaces or Plots

Transfer of burial spaces or plots held for the use of the individual, the individual's spouse, or the individual's immediate family does not affect eligibility for LTC services' payment.

I. Excluded Burial Funds

Transfer of up to $1,500 in resources excluded under the burial fund exclusion policy does not affect eligibility for LTC services' payment.

J. Cash to Purchase Medical/Social Services

Transfer of cash received from a governmental or nongovernmental program to purchase medical care or social services does not affect eligibility for LTC services' payment IF the cash was transferred in the receipt month or the month following the receipt month.

K. Alaskan Natives' Stock

Transfer of certain shares of stock held by Alaskan natives does not affect eligibility for LTC services' payment.

L. Other Assets That Are Not Resources

The transfer of the following resources, **if they have been kept separate from other resources**, do not affect eligibility for LTC services' payment:

- Payments from the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

- Payments from sections 25-239, 25-240, and 25-241 of the Code of Virginia for relocation assistance.

- Payments from sections 404(g) and 418 of the Domestic Volunteer Service Act of 1973.

- Retroactive Supplemental Security Income and/or retroactive Social Security payments for nine (9) months after the month of receipt of the payment(s).

- Retained disaster assistance.

M1450.400 TRANSFERS THAT DO NOT AFFECT ELIGIBILITY

A. Policy

An asset transfer does NOT affect eligibility for Medicaid payment of LTC services if the transfer meets the following criteria:

- the transfer(s) of assets was made for reasons exclusive of becoming or remaining eligible for Medicaid payment of LTC services (M1450.400 B),

- the individual received adequate compensation for the asset(s), or

- the asset transfer meets the criteria in either section B, C or D below.

If the transfer **does not** meet the criteria in this section, see section 1450.500 below to evaluate the asset transfer.

B. Reason Exclusive of Becoming or Remaining Medicaid Eligible

Assume that when an institutionalized individual or his community spouse has transferred assets for less than the CMV during the look back period, the transfer is subject to a penalty period. During this penalty period, Medicaid will not pay for LTC services. The institutionalized individual must be given the opportunity to rebut this assumption by showing satisfactorily that he intended to receive CMV or that the reason for the transfer of assets was exclusively for a purpose other than to qualify for Medicaid.

The individual must provide convincing and objective evidence showing that there *was* no reason to believe that Medicaid payment of LTC services might be needed. *The fact the individual had not yet applied for Medicaid, had not been admitted to an institution or was not aware of the asset transfer* provisions *does not meet the evidence requirement*. The sudden loss of income or assets, the sudden onset of a disabling condition or personal injury may provide convincing evidence.

The individual must provide evidence that other assets were available at the time of transfer to meet current and expected needs of that individual, including the cost of nursing home or other medical institutional care.

C. **Home Property Transferred to Certain Individuals**

Transfer of the individual's home, whether it was excluded or not excluded at the time of transfer, does NOT affect eligibility for LTC services' payment when the home property is transferred to one or more of the individuals listed below.

1. Spouse, Minor Child, Disabled/Blind Child

The transfer of the home property does not affect eligibility when transferred to the individual's

- spouse,
- child(ren) under age 21 years, or
- child(ren) of any age who is blind or disabled as defined by SSI or Medicaid.

2. Sibling

The transfer of the home property does not affect eligibility when transferred to the individual's sibling or half-sibling (not step-sibling) who:

- has an equity interest in the home, and
- who resided in the individual's home for at least one year immediately before the date the individual became an institutionalized individual.

3. Adult Child

The transfer of the home property does not affect eligibility when transferred to the individual's son or daughter (not including step-child) who resided in the home for at least two years immediately before the date the individual became an institutionalized individual, and *all of* the criteria listed in items a. through d. below *are met.*

a. Provided Care for 2 Years

The individual's son or daughter must have been providing care to the individual during the entire two-year period which permitted the individual to reside at home rather than in a medical institution or nursing facility.

b. Physician's Statement

The individual or his/her representative must provide a statement from his/her treating physician which states

- the individual's physical and/or mental condition during this two-year period,
- why the individual needed personal and/or home health care during this period, and
- the specific personal/home health care service needs of the individual.

c. Statement of Services Provided

The son or daughter must provide a statement showing:

1) the specific services and care he/she provided to the individual during the entire two years;
2) how many hours per day he/she provided the service or care;

3) whether he/she worked outside the home or worked from the home during this period; how the individual's needs were taken care of while he/she worked; and

4) if the son or daughter paid someone to actually give the care to the individual, who was paid, the rate of pay, the specific services, and the length of time the services were provided.

d. Third Party Statement

The individual or his/her representative must provide an objective statement from a third party(ies) who had knowledge of the individual's condition and his/her living and care arrangements during this period which corroborates the son or daughter's statement. The statement must specify the care/services the son or daughter provided and who cared for the individual when the son or daughter was not at home.

***D.* Transfer to Certain Individuals or Trusts**

Transfer of any asset

- to the individual's spouse or to another person for the sole benefit of the individual's spouse;
- to another individual by the spouse for the sole benefit of the spouse;
- to the individual's child under 21 or child of any age who is blind or disabled as defined by SSI or Medicaid;
- to a trust that is established solely for the benefit of the individual's
  1) child under age 21, or
  2) child of any age who is blind or disabled as defined by SSI or Medicaid when the trust meets the conditions in M1120.202;
- to a trust established solely for the benefit of an individual under 65 who is disabled as defined by SSI or Medicaid, when the trust meets the conditions in M1120.202;

does not affect eligibility for Medicaid payment of LTC services.

1. For the Sole Benefit of Spouse, Blind/disabled Child, or Disabled Individual

A transfer is for the sole benefit of a spouse, blind or disabled child or a disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child or a disabled individual can benefit from the assets transferred in any way, whether at the time of transfer or at any time in the future. Similarly, a trust is established for the sole benefit of a spouse, blind or disabled child or a disabled individual if no one but the spouse, blind or disabled child or disabled individual can benefit from the assets in the trust, whether at the time of transfer or at any time in the future.

In order to be for the sole benefit of one of these individuals, the instrument or document must provide for the spending of the trust funds for the benefit of the individual that is actuarially sound based on the life expectancy of the individual involved. When the instrument or document does not so provide, any potential exemption from penalty or consideration for eligibility purposes is void. Exception: trusts established for disabled individuals, as described in M1120.202.

However, the trust may provide for reasonable compensation for a trustee(s) to manage the trust, as well as for reasonable costs associated with investing or otherwise managing the funds or property in the trust. In defining what is reasonable compensation, consider the amount of time and effort involved in managing a trust of the size involved, as well as the prevailing rate of compensation, if any, for managing a trust of similar size and complexity.

2. Not for the Sole Benefit of Spouse, Blind/disabled Child, or Disabled Individual

A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is NOT the spouse, a blind or disabled child or a disabled individual, is NOT considered established for the sole benefit of one of these individuals. Thus, the establishment of such a trust is a transfer of assets that affects eligibility for Medicaid payment of LTC services.

3. Trusts for Disabled Individuals Under Which the State Is Beneficiary

Trusts established for disabled individuals, as described in M1120.202, do not have to provide for an actuarially sound spending of the trust funds for the benefit of the individual involved. However, under these trusts, the trust instrument must provide that any funds remaining in the trust upon the death of the individual must go to the state, up to the amount of Medicaid benefits paid on the individual's behalf.

The trust does not have to provide for an actuarially sound spending of the trust funds for the benefit of the individual involved when:

* the trust instrument designates the state as the recipient of funds from the trust, and

* the trust requirements in M1120.202 require that the trust be for the sole benefit of an individual.

The trust may also provide for disbursal of funds to other beneficiaries provided that the trust does not permit such disbursals until the state's claim is satisfied. "Pooled" trusts may provide that the trust can retain a certain percentage of the funds in the trust account upon the death of the beneficiary.

4. Cross-reference

If the trust is not for the sole benefit of the individual's spouse, blind or disabled child or a disabled individual, and it does not meet the criteria in item M1450.400 D.3 above, go to M1450.*550* to determine if the transfer of assets into the trust affects Medicaid payment for LTC services.

NOTE: Evaluate the trust to determine if it is a resource. See M1120.200, M1120.201 and M1120.202.

E. Other Asset Transfers

For asset transfers other than those described in sections M1450.400 B and C, the transfer does not affect eligibility for Medicaid payment of LTC services if the individual shows that he intended to receive or received adequate compensation for the asset. To show intent to receive adequate compensation, the individual must provide objective evidence according to items 1 through 3 below, and provide evidence that the transfer was made for reasons exclusive of becoming or remaining eligible for Medicaid payment of LTC services.

1. Evidence of Reasonable Effort to Sell

The individual must provide objective evidence for real property that he/she made an initial and continuing reasonable effort to sell the property. See M1130.140.

2. Evidence of Legally Binding Contract

The individual must provide objective evidence that he/she made a legally binding contract (as defined in M1450.003 above) that provided for his/her receipt of adequate compensation in a specified form (goods, services, money, etc.) in exchange for the transferred asset.

If the goods received include term life insurance, see M1450.510 below.

3. Irrevocable Burial Trust

The individual must provide objective evidence that the asset was transferred into an irrevocable burial trust. The trust is NOT compensation for the transferred money unless the individual provides objective evidence that all the funds in the trust will be used to pay for identifiable funeral services.

Objective evidence is the contract with the funeral home which lists funeral items and services and the price of each, when the total price of all items and services equals the amount of funds in the irrevocable burial trust.

NOTE: Evaluate the trust to determine if it is a resource. See M1120.200, M1120.201 and M1120.202.

F. Post-Eligibility Transfers by the Community Spouse

Post-eligibility transfers of resources owned by the community spouse (institutionalized spouse has no ownership interest) do not affect the institutionalized spouse's continued eligibility for Medicaid payment of LTC services.

Exception: The purchase of annuity by the community spouse on or after February 8, 2006 may be treated as an uncompensated transfer. See G. below.

G. Purchase of an Annuity by Community Spouse

For applications made on or after July 1, 2006, an annuity purchased by the community spouse on or after February 8, 2006, will be treated as an uncompensated transfer unless:

* the state is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant; or
* the state is named the remainder beneficiary in the second position after the community spouse or minor or disabled child. If the spouse or the representative of a minor or disabled child disposes of any remainder for less than fair market value, the state must be named in the first position.

H. Transfers Made on or After February 8, 2006 with Cumulative Value Less Than or Equal to $4,000

The policy in this subsection applies to actions taken on applications, renewals or changes on or after July 1, 2006 for transfers made on or after February 8, 2006.

Asset transfers made on or after February 8, 2006 that have a total cumulative value of less than or equal to $1,000 per calendar year will not be considered a transfer for less than fair market value and no penalty period will be calculated.

Assets transferred on or after February 8, 2006, that have a total cumulative value of more than $1,000 but less than or equal to $4,000 per calendar year may not be considered a transfer for less than fair market value if documentation is provided that such transfers follow a pattern that existed for at least three years prior to applying for Medicaid payment of LTC services. Christmas gifts, birthday gifts, graduation gifts, wedding gifts, etc. meet the criteria for following a pattern that existed prior to applying for Medicaid payment of LTC services.

I. LTC Partnership Policy

The value of assets transferred that were disregarded as a result of an LTC Partnership Policy does not affect an individual's eligibility for Medicaid payment of LTC services. See M1460.160 for more information about LTC Partnership Policies.

J. Return of Asset

The transfer of an asset for less than fair market value does not affect eligibility for Medicaid LTC services' payment if the asset has been returned to the individual.

K. Home Foreclosure

The repossession and/or sale of a home by the mortgage lender for less than fair market value due to foreclosure is not evaluated as an uncompensated transfer. Documentation of the foreclosure must be retained in the case record.

L. *Court-ordered or Approved Sale*

When property is ordered to be sold at a judicial sale or when a court has approved the sale of property for less than FMV, the sale is considered a compensated transfer. The individual or guardian must provide documentation of the court order for the sale and any other documentation needed to verify the sale of the property.

***M*. Transfer of Income Tax Refund or Advance Payment Received After December 31, 2009 but Before January 1, 2013**

Under Section 728 of the Tax Relief, Unemployment Insurance Reauthorization and Job Creation Act of 2010 (P.L. 111-312, the transfer of an income tax refund or advance payment received after December 31, 2009 but Before January 1, 2013, to another individual or to a trust does NOT affect eligibility for Medicaid payment of LTC services. If the funds are given away or placed in a trust, other than a trust established for a disabled individual (see M1120.202), after the end of the exempt period, the transfer is subject to a transfer penalty or being counted under the Medicaid trust provisions, as applicable.

M1450.500 TRANSFERS THAT AFFECT ELIGIBILITY

A. Policy

If an asset transfer does not meet the criteria in sections M1450.300 or M1450.400, the transfer will be considered to have been completed for reasons of becoming or remaining eligible for Medicaid payment of LTC services, unless evidence has been provided to the contrary.

Asset transfers that affect eligibility for Medicaid LTC services payment include, but are not limited to, transfers of the following assets:

- cash, bank accounts, savings certificates,
- stocks or bonds,
- resources **over $1,500** that are excluded under the burial fund exclusion policy,
- cash value of life insurance when the total face values of all policies owned on an individual exceed $1,500
- interests in real property, including mineral rights,
- rights to inherited real or personal property or income**.**

B. Procedures

Use the following sections to evaluate an asset transfer:

- M1450.510 for a purchase of term life insurance.
- M1450.520 for a purchase of an annuity before February 8, 2006.
- M1450.530 for a purchase of an annuity on or after February 8, 2006.
- M1450.540 for promissory notes, loans, or mortgages.
- M1450.550 for a transfer of assets into or from a trust.
- M1450.560 for a transfer of income.

M1450.510 PURCHASE OF TERM LIFE INSURANCE

A. Policy

The purchase of any term life insurance after April 7, 1993, except term life insurance that funds a pre-need funeral under section 54.1-2820 of the Code of Virginia, is an uncompensated transfer for less than fair market value if the term insurance's benefit payable at death does not **equal or exceed twice the sum of all premiums paid for the policy.**

B. Procedures

1. Policy Funds Pre-need Funeral

Determine the purpose of the term insurance policy by reviewing the policy. If the policy language specifies that the death benefits shall be used to purchase burial space items or funeral services, then the purchase of the policy is a compensated transfer of funds and does not affect eligibility.

However, any benefits **paid** under such policy in excess of the actual funeral expenses are subject to recovery by the Department of Medical Assistance Services for Medicaid payments made on behalf of the deceased insured Medicaid enrollee.

2. Policy Funds Irrevocable Trust

Since **an irrevocable trust for burial is not a pre-need funeral**, the purchase of a term life insurance policy(ies) used to fund an irrevocable trust is an uncompensated transfer of assets for less than fair market value.

***3.* Determine If Transfer Is Uncompen-sated**

When the term life insurance policy does not fund a pre-need funeral, determine if the purchase of the term insurance policy is an uncompensated transfer:

a. Determine the benefit payable at death. The face value of the policy is the "benefit payable at death."

b. From the insurance company, obtain the sum of all premium(s) paid on the policy; multiply this sum by 2. The result is "twice the premium."

c. Compare the result to the term insurance policy's face value.

1) If the term insurance's face value equals or exceeds the result (twice the premium), the purchase of the policy is a transfer for fair market value and does not affect eligibility.

2) If the term insurance's face value is less than the result (twice the premium), the purchase of the policy is an uncompensated transfer for less than fair market value. Determine a penalty period per M1450.620 or M1450.630 below.

EXAMPLE #1: Mr. C. uses $5,000 from his checking account to purchase a $5,000 face value term life insurance policy on August 13, 1995. Since the policy was purchased after April 7, 1993, and $5,000 (benefit payable on death) is not twice the $5,000 premium, the purchase is an uncompensated transfer. The uncompensated value and the penalty period for Medicaid payment of long-term care services must be determined.

M1450.520 PURCHASE OF ANNUITY

A. Introduction

An annuity is a sum paid yearly or at other specific times in return for the payment of a fixed sum. Annuities may be purchased by an individual or by an employer. For Medicaid purposes, an annuity is a contract reflecting payment to an insurance company, bank or other registered or licensed entity by which one receives fixed, non variable payments on an investment for a lifetime or a specified number of years.

Although usually purchased to provide a source of income for retirement, annuities are sometimes used to shelter assets so that the individuals purchasing them can become eligible for Medicaid. To avoid penalizing individuals who validly purchased annuities as part of a retirement plan, determine the ultimate purpose of the annuity, i.e., whether the annuity purchase is a transfer of assets for less than fair market value.

B. Policy

All annuities purchased by an applicant/recipient or his spouse must be declared on the Medicaid application or renewal form. Annuities purchased by either the institutionalized individual or the community spouse must be evaluated even after initial eligibility as an LTC recipient has been established. In addition to determining if the annuity is a countable resource, the eligibility worker must evaluate the purchase of the annuity to determine if it is a compensated transfer.

The following rules apply to the purchase of an annuity:

1. Purchased by Institutionalized Individual or Community Spouse

An annuity purchased by the institutionalized individual or the community spouse will be treated as an uncompensated transfer unless:

* *the state is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual; or*

* *the state is named the remainder beneficiary in the second position after the community spouse or minor or disabled child. If the spouse or the representative of a minor or disabled child disposes of any remainder for less than fair market value, the state must be named in the first position.*

2. Purchased by Institutionalized Individual

An annuity purchased by the institutionalized individual will be considered an uncompensated transfer unless:

a. *the annuity is described in one of the following subsections of section 408 of the Internal Revenue Service (IRS) Code:*

- *individual retirement account,*
- *accounts established by employers and certain associations of employees,*
- *simple retirement accounts;* ***or***

b. *the annuity is a simplified employee pension (within the meaning of section 408(k) of the IRS Code; or a Roth Individual Retirement Account (IRA);* ***or***

c. *the annuity is:*

- *irrevocable and non-assignable;*
- *actuarially sound (see M1450.520 C); and*
- *provides for equal payments with no deferral and no balloon payments.*

C. Procedures

1. Determine If Actuarially Sound

Determine if the annuity is actuarially sound. Use the Life Expectancy Table in M1450, Appendix 2:

a. Find the individual's age at the time the annuity was purchased in the "Age" column for the individual's gender ("Male" or "Female").

b. The corresponding number in the "Life Expectancy" column is the average number of years of expected life remaining for the individual.

c. Compare the life expectancy number to the life of the annuity (the period of time over which the annuity benefits will be paid).

d. When the average number of years of expected life remaining for the individual (the "life expectancy" number in the table) equals or exceeds the life of the annuity, the annuity is actuarially sound. When the annuity is actuarially sound, the purchase of the annuity is a compensated transfer for fair market value and does not affect eligibility.

e. When the average number of years of expected life remaining for the individual (the "life expectancy" number in the table) is less than the life of the annuity, the annuity is NOT actuarially sound. The annuity purchase is a transfer for less than fair market value. The transfer occurred at the time the annuity was purchased.

f. When the annuity is not actuarially sound, determine the uncompensated value and the penalty period (sections M1450.610 and M1450.620 below).

EXAMPLE #2:

A man at age 65 purchases a $10,000 annuity to be paid over the course of 10 years. His life expectancy according to the table is 15.52 years. Thus, the annuity is actuarially sound; the purchase of the annuity is a compensated transfer for fair market value and does not affect eligibility for *LTSS* services payment.

EXAMPLE #3:

A man at age 80 purchases the same $10,000 annuity to be paid over the course of 10 years. His life expectancy according to the table is only 7.16 years. The annuity is not actuarially sound. The purchase of the annuity is a transfer for less than fair market value.

3. **Send Copy to DMAS**

A copy of the annuity agreement must be sent to:

DMAS, *Eligibility & Enrollment Services Division*
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

4. **Maintain Copy of Annuity**

The copy must be maintained by DMAS until the terms of the annuity have expired. A copy of the annuity must also be maintained in agency's case record.

M1450.530 RESERVED

M1450.540 PURCHASE OF A PROMISSORY NOTE, LOAN, OR MORTGAGE ON OR AFTER FEBRUARY 8, 2006

A. Introduction

This policy applies to the purchase of a promissory note, loan, or mortgage on or after February 8, 2006. Subchapter S1140.300 contains explanations of promissory notes, loans, and mortgages.

B. Policy

Funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, must be evaluated as an uncompensated transfer unless the note, loan, or mortgage:

- has a repayment term that is actuarially sound (see M1450.520),
- provides for payments to be made in equal amounts during the term of the loan with no deferral and no balloon payments, and
- prohibits the cancellation of the balance upon the death of the lender.

C. Uncompensated Amount

If the promissory note, loan, or mortgage does not meet the above criteria, the uncompensated amount is the outstanding balance as of the date of the individual's application for Medicaid.

Note: The countable value as a resource is the outstanding principal balance for the month in which a determination is being made.

M1450.545 TRANSFERS INVOLVING LIFE ESTATES

A. Introduction

This policy applies to the purchase of a life estate on or after February 8, 2006.

B. Policy

Funds used to purchase a life estate in another individual's home on or after February 8, 2006, must be evaluated as an uncompensated transfer unless the purchaser resides in the home for at least 12 consecutive months. If the purchaser resides in the home for less than 12 consecutive months, the entire purchase amount will be considered a transfer for less than fair market value.

For Medicaid purposes, the purchase of a life estate is said to have occurred when an individual acquires or retains a life estate as a result of a single purchase transaction or a series of financial and real estate transactions.

M1450.550 TRANSFERS INVOLVING TRUSTS

A. Introduction

A transfer of assets into or from a trust may be a transfer of assets for less than market value. See M1120.200 for trust resource policy, definitions pertaining to trusts, and for instructions for determining if the trust is a resource.

B. Revocable Trust

1. Transfer Into Revocable Trust

A transfer of assets **into** a revocable trust does not affect eligibility because the entire principal of a revocable trust is an available resource to the individual.

2. Payments From a Revocable Trust

Any payments from the revocable trust which are made to or for the benefit of the individual are counted as income to the individual and are not transfers for less than market value.

Any payments from the revocable trust's principal or income which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value.

3. Look-back Date

The look-back date is 60 months for assets transferred (payments made) **from** a revocable trust.

EXAMPLE #4: Mr. B established a revocable trust with a principal of $100,000 on March 1, 1994. He enters a nursing facility on November 15, 1997, and applies for Medicaid on February 15, 1998. The trustee has complete discretion in disbursing funds from the trust. Each month, the trustee disburses $100 to Mr. B and $500 to a property management firm for the upkeep of Mr. B's home. On June 14, 1994, the trustee gave $50,000 of the trust principal to Mr. B's brother.

The $100 and $500 payments are counted as income to Mr. B. Because the trust is revocable, the entire principal is a resource to Mr. B. Because the trustee gave $50,000 away, the countable value of the trust is the remaining $50,000. The transfer of the $50,000 to Mr. B's brother is a transfer for less than fair market value. The look-back date is February 15, 1993, which is 60 months prior to February 15, 1998, the date Mr. B was both in an institution and applied for Medicaid. The transfer occurred on June 14, 1994 which is after the look-back date. The uncompensated value is $50,000. The penalty

date is June 1, 1994, the first day of the month in which the transfer occurred. The penalty period is 19 months beginning June 1, 1994.

C. Irrevocable Trust

A transfer of funds **into** an irrevocable trust and a transfer of funds **from** an irrevocable trust MAY be asset transfers for less than fair market value, depending on whether the terms of the trust

* allow for payments to or for the benefit of the individual, OR
* do not allow for payments to or for the benefit of the individual.

1. When Payment to Individual Is Allowed

When the trust allows for circumstances under which payment can be made to or for the benefit of the individual from all or a portion of the trust,

1) the portion of the trust principal that could be paid to or for the benefit of the individual is a resource available to the individual;
2) income (produced by the trust principal), which could be paid to or for the benefit of the individual, is a resource available to the individual;
3) payments from the trust income or principal, which are made to or for the benefit of the individual, are counted as income to the individual;
4) payments from income or from the trust principal which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value.

a. Transfer Into Trust

A transfer of assets **into** an irrevocable trust that allows for payment to or for the benefit of the individual does NOT affect eligibility because the irrevocable trust is a resource to the individual.

b. Payments From Trust

Payments from income or from the trust principal which are made to or for the benefit of the individual are counted as income.

Payments from income or from the trust principal which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value.

The date the transfer occurs is the date that the payment to the individual was foreclosed (the date the payment was paid to another person not for the benefit of the individual).

c. Look-back Date When Payment to Individual Is Allowed

The look-back date is ***60*** **months** for assets transferred from an irrevocable trust under which some payment can be made to or for the benefit of the individual.

EXAMPLE #5: Mr. C established an irrevocable trust with a principal of $100,000 on March 1, 1994. He enters a nursing facility on November 15, 1997, and applies for Medicaid on February 15, 1998. The trustee has discretion to disburse the entire principal of the trust and all income from the trust to anyone, including Mr. C, the grantor. Each month, the trustee

disburses $100 to Mr. C and $500 to a property management firm for the upkeep of Mr. C's home. On June 14, 1994, the trustee gave $50,000 of the trust principal to Mr. C's brother.

The $100 and $500 payments are counted as income to Mr. C. Because the trustee gave $50,000 away, the value of the trust is the remaining $50,000. The $50,000 principal is a resource to Mr. C since the trust allows circumstances under which payment of all the trust principal could be made to Mr. C. The transfer of the $50,000 to Mr. C's brother is a transfer for less than fair market value. The look-back date is February 15, 1995, which is 36 months prior to the baseline date February 15, 1998, the date Mr. C was both in an institution and applied for Medicaid. The transfer occurred on June 14, 1994 which is before the look-back date. No penalty due to this transfer can be imposed; the transfer does not affect eligibility for LTC services payment. Mr. C is not eligible for Medicaid because the $50,000 available trust resource exceeds the Medicaid resource limit.

2. When Payment to Individual Is NOT Allowed

When the trust **DOES NOT allow payment to or for the benefit of the individual** from all or a portion of the trust principal (or income on the trust principal), treat the trust as a transfer of assets for less than fair market value.

a. Transfer Into Trust

A transfer of assets **into** an irrevocable trust that does NOT allow payment to or for the benefit of the individual is a transfer of assets for less than fair market value that affects eligibility.

The date the transfer occurred is

* the date the trust was established.
* the date payment to the individual was foreclosed (the date the exculpatory clause came into effect that made the trust funds no longer payable to the individual), if later.

A transfer of additional funds into an irrevocable trust is a new asset transfer and must be evaluated separately from the asset transfer that established the trust. The date the new transfer occurred is the date the additional funds were placed in the irrevocable trust.

b. Payments From Trust

Payments from the trust cannot be made to or for the benefit of the individual, so any payments from the trust do not affect the individual's eligibility.

c. Look-back Date When Payment to Individual Not Allowed

When the trust states that payment cannot be made to the individual, the look-back date is 60 months before the baseline date.

EXAMPLE #6: Mr. D established an irrevocable trust with a principal of $100,000 on March 1, 1994. He enters a nursing facility on November 15, 1997, and applies for Medicaid on February 15, 1998. The trust does not allow the trustee to disburse any of the principal of the trust to or for the benefit of Mr. D. The trustee disburses $100 to Mr. D and $500 to a property management firm for the upkeep of Mr. D's home each month from the trust income. On June 14, 1994, the trustee gave $50,000 of the trust principal to Mr. D's brother. On July 2, 1996, Mr. D placed another $10,000 of his savings into the trust.

The $100 and $500 payments are counted as income to Mr. D. Because none of the principal can be disbursed to Mr. D, the entire value of the trust at the time the trust was established ($100,000 in 3-1-94) is a transfer of assets for less than fair market value. The look-back date is February 15, 1993, which is 60 months prior to the baseline date of February 15, 1998, the date Mr. D was both in an institution and applied for Medicaid. The transfer occurred on 3-1-94 which is after the look-back date. The uncompensated value is $100,000.

The 7-2-96 transfer of $10,000 into the trust is another asset transfer for less than fair market value that occurred on 7-2-96. The transfer occurred on 7-2-96 which is after the look-back date. The uncompensated value is $10,000.

D. Pooled Trusts

A pooled trust is a trust that can be established for a disabled individual under the authority of Section 1917(d)(4)(C) of the Social Security Act (see M1120.202). The placement of an individual's funds into a pooled trust when the individual is age 65 years or older must be evaluated as an uncompensated transfer, if the trust is structured such that the individual irrevocably gives up ownership of funds placed in the trusts.

A trust established for a disabled individual under age 65 years is exempt from the transfer of assets provisions. However, any funds placed in the trust after the individual turns 65 must be evaluated as an asset transfer.

M1450.560 INCOME TRANSFERS

A. Policy

Income is an asset. When an individual's income is given or assigned in some manner to another person, such gift or assignment may be a transfer of an asset for less than market value.

B. Procedures

Determine whether the individual has transferred lump sum payments actually received in a month. Such payments are counted as income in the month received for eligibility purposes, and are counted as resources in the following month if retained. Disposal of a lump sum payment before it can be counted as a resource could be an uncompensated asset transfer.

Attempt to determine whether amounts of regularly scheduled income or lump sum payments, which the individual would otherwise have received, have been transferred. Normally, such a transfer takes the form of transferring the right to receive income. For example, a private pension may be diverted to a trust and no longer be paid to the individual. Question the individual concerning sources of income, income levels in the past versus the present, direct questions about giving away income or assigning the right to receive income, to someone else, etc.

In determining whether income has been transferred, do not attempt to ascertain in detail the individual's spending habits during the look-back period. Absent a reason to believe otherwise, assume that the individual's income was legitimately spent on the normal costs of daily living.

When income or the right to income has been transferred, and none of the criteria in M1450.300 or M1450.400 are met, determine the uncompensated value of the transferred income (M1450.610) and determine a penalty period (M1450.620 or 630).

M1450.570 SERVICES CONTRACTS

A. Policy

Services contracts (i.e. personal care contract, care contracts, etc.) are typically entered into for the completion of tasks such as, but not limited to, grocery shopping, housekeeping, financial management and cooking, that individuals no longer can perform for themselves. For purposes of Medicaid payment of LTC services, payments made under these types of contracts may be considered an uncompensated transfer of assets.

B. Procedures

When a services contract, sometimes referred to as a personal care contract, is presented as the basis for a transfer of assets, the eligibility worker must do the following:

1. **Determine Institutionalization**

Determine when the individual met the requirement for institutionalization.

2. **Verify Contract Terms and Value of Services**

Obtain a copy of the written contract, or written statements verifying the terms of the agreement by all parties. Determine when the agreement was entered into/signed, who entered into/signed the contract, and if the contract is legally binding as defined by policy at M1450.003 H. The terms of the contract must include the types of services, hourly rate of payment and the number of hours for each service. The hourly rate for the services must be the fair market value for such services at the time the services were provided. The terms must be specific and verifiable. Verification of payments made and services provided must be obtained. Any payment for a service which does not have a fair market value is an uncompensated transfer.

3. **Contract Services**

Once an individual begins receipt of Medicaid LTC services, the individual's personal *care* and medical needs are considered to be met by the LTC provider. Payment(s) to other individuals for services received after the individual enters LTC are considered an uncompensated transfer for Medicaid purposes.

4. **Physician Statement Required**

A statement must be provided by the individual's physician that indicates the types of services that were to be provided under the contract, and that these services were necessary to prevent the individual's entrance into LTC.

5. **Contract Made By Individual or Authorized Representative**

The contract must have been made by the applicant/recipient or his authorized representative.

6. Payments Prior To Contract Date

Any payment(s) made prior to the date the contract was signed (if contract is written) or date the contract was agreed upon (if contract is a legally binding oral contract) by all parties is considered an uncompensated transfer.

7. Advance Lump Sum Payments Made To Contractor

Certain contracts for services provide an advance lump sum payment to the person who is to perform the duties outlined in the contract. Any payment of funds for services that have not been performed is considered an uncompensated transfer of assets. The Medicaid applicant/recipient has not received adequate compensation, as he has yet to receive valuable consideration.

8. Determine Penalty Period

If it is determined that an uncompensated transfer of assets occurred, follow policy in this subchapter to determine the penalty period.

M1450.600 *APPLYING A* PENALTY PERIOD

A. Introduction

When a transfer of assets was for less than fair market value, the individual is not eligible for Medicaid payment of LTC services for a specific period of time (penalty period) based on the uncompensated value of the transferred asset and the date the transfer occurred. However, if the individual meets all other Medicaid eligibility requirements, the individual is enrolled in Medicaid and is eligible for Medicaid payment of all other Medicaid-covered services.

The asset transfer precludes Medicaid payment for LTC services during the penalty period unless and until the individual receives adequate compensation in return for the transferred asset.

Penalty periods that are imposed cannot overlap or run concurrently. The total cumulative uncompensated value of the assets transferred is used to determine the length of the penalty period.

Once a penalty period begins it does not change or stop. The penalty period continues regardless of whether Medicaid eligibility continues, the institutionalized individual is discharged from LTC, or the individual changes from nursing facility care to community-based care. If the individual is re-admitted to LTC and the penalty period has not expired or ended, Medicaid payment for LTC services will continue to be denied for the remainder of the penalty period. **EXCEPTION:** The penalty period may be shortened if subsequent compensation is received (see M1450.640) or eliminated if an undue hardship is granted (see M1450.700).

B. Determination Procedures

Determine the uncompensated value using policy and procedures in M1450.610 below. Go to M1450. 630 to determine the penalty period.

If the individual subsequently receives compensation in return for the transferred asset, re-evaluate the penalty period using policy and procedures in M1450.640 below.

M1450.610 UNCOMPENSATED VALUE

A. Policy

The uncompensated value is the amount of an asset's fair market value (FMV) that was not or will not be received as a result of the asset transfer. FMV is based on criteria used in determining the value of assets in determining Medicaid eligibility.

The uncompensated value for **real property** at the time of transfer:

- is the difference between the asset's FMV and the Gross Amount Due to Seller, when the lien/other encumbrance against the asset is satisfied from the seller's proceeds, or
- the difference between the asset's equity value (FMV minus the lien) and the Gross Amount Due to Seller, when the lien is assumed by the buyer.

See M1450.610 H for the procedures for determining the uncompensated value of transferred real property.

Determine the uncompensated value of the transferred asset in this section and go to M1450.630 to determine the penalty period.

B. Term Life Insurance Purchase On or Before April 7, 1993

For term life insurance policies purchased on or before April 7, 1993, the purchase is a compensated transfer of assets and the purchase does not affect eligibility.

C. Term Life Insurance Purchase After April 7, 1993

For term life insurance policies purchased after April 7, 1993, the purchase is a transfer of assets for less than fair market value if the term insurance's face value is less than twice the sum of all premium(s) paid on the policy. The uncompensated value is the total premium(s) paid on the policy.

If more than one premium was paid on the policy, and the premiums were paid in different months, each premium paid on the policy is a separate transfer of assets for less than fair market value. A transfer occurred in the month each premium was paid.

EXAMPLE #7: Mr. C applied for Medicaid on November 2, 1996. On August 13, 1995, Mr. C. used $3,000 from his checking account to pay a $3,000 premium on a $5,000 face value term life insurance policy. On October 5, 1995, he used $2,000 from his checking account to pay up premiums on the same $5,000 face value term life insurance policy. Since the policy was purchased after April 7, 1993, and $5,000 (benefit payable on death) is not twice the $5,000 total premiums, the premium payments are transfers of assets for less than fair market value.

The uncompensated value of the first transfer on 8-13-95 is $3,000. The uncompensated value of the second transfer on 10-5-95 is $2,000. The penalty period for the first transfer is based on the $3,000 uncompensated value and the transfer date of August 1995. The penalty period for the second transfer is based on the $2,000 uncompensated value and the transfer date of October 1995.

D. Annuity Purchase

When the average number of years of expected life remaining for the individual (the “life expectancy” number in the table) *is less than* the life of the annuity, the annuity is NOT actuarially sound. The annuity purchase is a transfer for less than fair market value.

The transfer occurred at the time the annuity was purchased.

To determine the transferred asset's uncompensated value:

1. divide the face value of the annuity by the number of years in the life of the annuity.

2. the result is the yearly payout amount.

3. from the number of years in the life of the annuity, subtract the individual's life expectancy from table.

4. the result is the uncompensated payout years (number of the annuity's "payout" years that are uncompensated).

5. multiply the uncompensated payout years by the yearly payout amount.

6. the result is the uncompensated value of the assets transferred to purchase the annuity.

EXAMPLE #8: An 80-year old man uses $9,000 from his savings account on May 6, 1996, to purchase a $10,000 annuity to be paid over the course of 10 years. His life expectancy according to the table is only 6.98 years. The annuity is not actuarially sound. The purchase of the annuity is a transfer for less than fair market value.

The uncompensated value is determined:

$10,000 annuity value
÷ 10 years life of annuity
$1,000 yearly payout
10 years life of annuity
- 6.98 life expectancy
3.02 uncompensated payout years
x$1,000 yearly payout
$3,020 uncompensated value

The penalty period is based on the $3,020 uncompensated value and the transfer date of May 1996.

E. Funds From Revocable Trust

Any payments **from** a revocable trust's principal or income which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value. The uncompensated value is the amount of the payment.

EXAMPLE #9: Mr. B established a revocable trust with a principal of $100,000 on March 1, 1994. Each month, the trustee disburses $100 to Mr. B and $500 to a property management firm for the upkeep of Mr. B's home. On June 14, 1994, the trustee gave $50,000 of the trust principal to Mr. B's brother.

The $100 and $500 payments are counted as income to Mr. B. The transfer of the $50,000 to Mr. B's brother is a transfer for less than fair market value. The uncompensated value is $50,000; the penalty period starts on June 1, 1994, the date the transfer occurred.

F. Irrevocable Trust

1. When Payment Is Allowed to Individual

When the irrevocable trust allows payments to the individual from all or a portion of the trust, any payments **from** the trust income or **from** the trust principal which are NOT made to or for the benefit of the individual are

assets transferred for less than fair market value. The uncompensated value is the amount of the payment.

EXAMPLE #10: Mr. C established an irrevocable trust with a principal of $100,000 on March 1, 1994. The trustee has discretion to disburse the entire principal of the trust and all income from the trust to anyone, including Mr. C, the grantor. All of the trust principal ($100,000) could be disbursed to Mr. C under the terms of the trust. Each month, the trustee disburses $100 to Mr. C and $500 to a property management firm for the upkeep of Mr. C's home. On June 14, 1994, the trustee gave $50,000 of the trust principal to Mr. C's brother.

The $100 and $500 payments are counted as income to Mr. C. The transfer of the $50,000 to Mr. C's brother is a transfer for less than fair market value. The transfer occurred in June 1994. The uncompensated value is $50,000.

2. When Payment Is Not Allowed to Individual

When the irrevocable trust does NOT allow payment to the individual from the trust, the transfer of funds into the trust is a transfer of assets for less than fair market value.

a. Trust Value

In determining the value of the trust which cannot be paid to the individual, do not subtract from the trust value any payments made for whatever purpose after the date the trust was established or, if later, the date payment to the individual was foreclosed. The value of the transferred amount is no less than its value on the date the trust is established or the date payment to the individual was foreclosed.

b. Uncompensated value

The uncompensated value is the amount of assets transferred into a trust which cannot be paid to the individual. If payment from the trust was foreclosed after the trust was established, the uncompensated value is the value of the trust as of the date payment was foreclosed.

c. Transfer Date

The date the transfer occurred is the date the trust was established, or, if later, the date payment to the individual was foreclosed.

d. Example #11

EXAMPLE #11: Mr. D established an irrevocable trust with a principal of $100,000 on March 1, 1994. The trust allowed the trustee to disburse any of the principal of the trust to or for the benefit of Mr. D until Mr. D is admitted to a nursing facility. Mr. D was admitted to a nursing facility on May 30, 1996. Each month from the trust income, the trustee disburses $100 to Mr. D and $500 to a property management firm for the upkeep of Mr. D's home. On June 14, 1996, the trustee gave $50,000 of the trust principal to Mr. D's brother. Mr. D applied for Medicaid on February 15, 1998.

The $100 and $500 payments are counted as income to Mr. D. Because none of the principal can be disbursed to Mr. D on or after the date he was admitted to the nursing facility, the value of the trust at the time payment was foreclosed ($100,000 on 5-30-96) is a transfer of assets for less than fair market value. The date the transfer occurred is May 30, 1996, the date payment to Mr. D was foreclosed. The look-back period is 60 months. The look-back date is February 15, 1993, which is 60 months prior to the baseline date of February 15, 1998, the date Mr. D was both in an institution and applied for Medicaid.

The uncompensated value is $100,000. The fact that $50,000 was paid out of the trust to Mr. D's brother after payment to Mr. D was foreclosed does not alter the uncompensated amount upon which the penalty is based because the value of the transferred asset can be no less than its value on the date payment from the trust was foreclosed.

Mr. D placed an additional $25,000 in the same trust on June 20, 1996. Under the terms of the trust, none of this $25,000 can be disbursed to him. This is a new transfer of assets for less than fair market value. The uncompensated value is $25,000; the transfer date is 6-20-96.

G. Income Transfers

1. Lump Sum Transfer

When a single lump sum, or single amounts of regularly paid income, is transferred for less than fair market value, the uncompensated value is the amount of the lump sum, less any compensation received. For example, an individual gives a $2,000 stock dividend check that is paid once a year to the individual, to another person in the month in which the individual received the check. No compensation was received. The uncompensated value is $2,000.

2. Stream of Income Transfer

When a stream of income (income received regularly) or the right to a stream of income is transferred, determine the total amount of income expected to be transferred during the individual's life, based on an actuarial projection of the individual's life expectancy. The uncompensated value is the amount of the projected income, less any compensation received. Use the Life Expectancy Table in M1450, Appendix 2.

3. Income Transfer Example

EXAMPLE #12: A man aged 65 years, assigns his right to a $500 monthly annuity payment to his brother. He receives no compensation in return. Based on the life expectancy tables for males, the uncompensated value of the transferred income is $*93,120*.

$ 500
x12 months
$6,000 yearly income
x*15.52* life expectancy from table
$*93,120* value
- 0 compensation
$*93,120* uncompensated value

H. Real Property Transfers

The uncompensated value of transferred real property is determined by evaluating the settlement document which outlines the monetary transactions between the individual who sells the property and the individual who buys the property. A copy of the Settlement Document is in **M1450, Appendix 3.**

The eligibility worker must obtain:

- documentation of the tax assessed value of the property at the time of the transfer; and
- a copy of the closing or settlement documents from the client or the financial institution.

1. **Summary of Seller's Transactions**

Review the summary of the seller's transactions:

- Determine the Gross Amount Due to Seller.
- Is the Gross Amount Due to Seller less than the **tax assessed *or effective 10/4/16, the certified appraised* value**?
  - If **no**, the seller received adequate compensation for the property and there is **no** uncompensated transfer.
  - If **yes**, determine the uncompensated value of the asset transfer.

2. **Real Property Uncompensated Value Calculations**

a. When the lien is satisfied from the proceeds received by the seller, deduct the Gross Amount Due to Seller from the tax assessed *or certified appraised* value to determine the uncompensated amount of the asset transfer.

b. When the lien is assumed by the buyer, deduct the lien amount from the tax assessed *or certified appraised* value of the property, to determine the equity value. From the equity value deduct the Gross Amount Due to Seller for the property to determine the uncompensated amount of the asset transfer.

c. Determine the penalty period. The beginning of the penalty period depends upon whether the transfer took place prior to or on/after 2/08/2006.

Note: Any funds deducted from the Gross Amount Due to Seller that are paid to another individual, such as funds for repair of the property, are not considered usual and customary fees and must be evaluated as a separate asset transfer. If the transfer was uncompensated then the amount of this transfer may be added to any uncompensated value from the sale of property, as the transfer occurred at the same point in time.

Example #13a: Mrs. K. is receiving CBC services. The worker discovers that Mrs. K. has moved in with her daughter and has sold her home to her son. The tax assessed value of her home at the time of transfer was $200,000. The closing documents indicate that she sold her home for $125,000 (the gross amount due to seller). The closing costs were paid by Mrs. K. There was no lien against the property.

The uncompensated value of the transferred real property is calculated as follows:

$200,000 tax assessed value
-125,000 Gross Amount Due to Seller
$ 75,000 uncompensated value

The penalty period is based on the uncompensated value of $75,000.

Example #13b: On October 20, Mr. B. was admitted to a nursing facility. He transferred his home in July of the same year, which was within the look-back period. His home was assessed at $100,000 in July. The mortgage against his home had a balance due of $16,000 in July.

In reviewing the settlement statement for the sale of the property, it is noted that the sale price of the home was $70,000 (gross amount due to seller), which was less than the tax assessed value of the home. The lien of $16,000 was satisfied at closing from the $70,000 sale price. The other fees deducted were usual and customary and were determined to have been paid by the buyer. Mr. B. received a $54,000 net settlement for the sale of his home.

The uncompensated value of the transferred real property is calculated as follows:

$100,000 tax assessed value
- 70,000 Gross Amount Due to Seller (includes the lien amount)
$ 30,000 uncompensated value

The penalty period is based on the uncompensated transfer value of $30,000. When the penalty period begins depends on whether the transfer took place prior to or after February 8, 2006.

Example #13c: The scenario is the same as in example 13b. However, the lien will be assumed by the purchaser rather than satisfied from the seller's gross settlement amount (Gross Amount Due to Seller). The equity value of the home is used to determine the uncompensated value in this case, because the seller was not responsible for satisfaction of the lien.

$100,000 tax assessed value
-16,000 lien amount
$ 84,000 equity value (EV)

$ 84,000 EV
- 70,000 Gross Amount Due to Seller
$ 14,000 uncompensated value

M1450.620 *RESERVED*

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M1450.630 PENALTY PERIOD CALCULATION

A. Policy

When a transfer of assets affects eligibility, the penalty period begins when the individual would otherwise be eligible for Medicaid payment for LTSS (long term services and support) if not for the penalty period. The penalty period includes the fractional portion of the month, rounded down to a day. Penalty periods for multiple transfers cannot overlap.

As long as an individual in a penalty period meets a full or limited-benefit Medicaid covered group and all nonfinancial and financial requirements for that covered group, he is eligible for all services covered under that group EXCEPT the Medicaid payment of LTSS. Individuals in nursing and other medical facilities or who have been screened and approved for HCBS (home and community based services), meet the 300% SSI covered group during a penalty period because they meet the definition of an institutionalized person.

An individual with a penalty period who does not meet the 300% SSI covered group may meet other covered groups. See M1450.630 B.5.

B. Penalty Begin Date

For individuals not receiving LTSS at the time of transfer, the penalty period begins the first day of the month in which the individual would otherwise be eligible for Medicaid payment for LTSS, except for the imposition of a penalty period. This includes the application retroactive period for nursing facility patients who have been in the facility during the retroactive period.

For individuals who are receiving Medicaid payment for LTSS at the time of transfer, the penalty period begins the month following the month of transfer *unless the transfer took place during the COVID-19 Emergency continuous eligibility period. See M1520.200.*

1. Medicaid LTSS Not Received at Time of Transfer

If the individual is not receiving Medicaid-covered LTSS at the time of the asset transfer, the penalty period begins the first day of the month in which the individual would otherwise be eligible for Medicaid payment for LTSS but for the application of the penalty period, as long as the date does not fall into another period of ineligibility imposed for any reason.

2. Receiving Medicaid LTSS Services at Time of Transfer

If the individual is receiving Medicaid LTSS at the time of the asset transfer, the penalty period begins the first day of the month following the month in which the asset transfer occurred as long as the individual would otherwise be eligible for Medicaid payment for LTSS but for the application of the penalty period.

A referral to the DMAS Enrollee Audit Unit (RAU) must be made for the months in the penalty period during which the individual received Medicaid LTSS services. See Chapter M17 for instructions on RAU referrals.

3. **Penalty Periods Cannot Overlap**

When multiple asset transfers result in multiple penalty periods, the penalty periods cannot overlap. One penalty period must be completed prior to the beginning of the next penalty period.

4. **Nursing Facility**

If the individual in a nursing facility meets all Medicaid eligibility requirements, he is eligible for Medicaid payment of all other covered services.

5. **HCBS, PACE, Hospice**

a. Transfer Reported at Application

If the individual has been screened and approved for or is receiving Medicaid HCBS, PACE, or hospice services, he cannot be eligible for Medicaid in the 300% of SSI covered group or for the Medicaid payment of LTSS in any other covered group. The individual's Medicaid eligibility in other covered groups must be determined. His penalty period cannot be imposed unless and until he is (1) eligible for Medicaid in a full-benefit covered group other than the 300% of SSI covered group, (2) he meets a spenddown and would otherwise be eligible for the Medicaid payment of LTSS, or (3) he is admitted to a nursing facility.

An individual outside a medical facility (i.e. living in the community) does not meet the definition of an institutionalized person if he is not receiving Medicaid covered HCBS, PACE or hospice services. Therefore, an individual for whom a penalty period is imposed cannot be eligible for Medicaid unless the individual is eligible for Medicaid outside the 300% SSI covered group.

Any penalty periods imposed under the rules effective April 17, 2018 through October 1, 2022 are valid and continue until the penalty period is exhausted.

b. Transfer Reported After Eligibility is Established

If it is reported or discovered that an individual receiving *HCBS* services in the 300% of SSI covered group made an uncompensated asset transfer prior to beginning *HCBS*, determine a penalty period. Evaluate for another covered group prior to cancelling. His penalty period cannot be imposed unless and until he is (1) eligible for Medicaid in a full-benefit covered group other than the 300% of SSI covered group, (2) he meets a spenddown and would otherwise be eligible for the Medicaid payment of *LTSS*, or (3) he is admitted to a nursing facility.

A referral to the DMAS Enrollee Audit Unit (RAU) must be made for the months in the penalty period during which the individual received Medicaid *LTSS* services. See Chapter M17 for instructions on RAU referrals.

***6.* Penalty Period imposed by another state**

If the individual has completed an asset transfer penalty period in another state, a penalty period is not imposed by Virginia Medicaid for the same uncompensated transfer.

If an individual has relocated to Virginia and reports they have an active asset transfer penalty period in another state, he must complete the penalty period before being eligible for Medicaid payment of *LTSS* services. The eligibility worker must contact the previous state to find out the length of penalty period and time remaining. The remaining penalty period cannot be imposed unless and until the person is: 1) eligible for Medicaid in a full-benefit covered group other than the 300% of SSI covered group or; 2) meets a spenddown and would otherwise be eligible for the Medicaid payment of *LTSS* services or; 3) is admitted to a nursing facility. The individual's Medicaid eligibility in any other covered group(s) must be determined.

C. Penalty Period Calculation

The period is calculated by taking the uncompensated value of the assets transferred on or after the look-back date, divided by the average monthly cost of nursing facility services to a private-pay patient in his locality at the time of the application for Medicaid. The remainder is divided by the daily rate (the monthly rate divided by 31).

When the uncompensated value of an asset transfer is less than the monthly nursing facility rate, go to step #4 in E below to calculate the partial month penalty period.

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

Step #3 $48,294.00 uncompensated value
- 44,954.00 penalty amount for seven full months
$ 3,340.00 partial month penalty amount

Step #4 $3,340.00 partial penalty amount
÷ 207.16 daily rate ($6,422 ÷ 31)
= 16.12 number of days for partial month penalty

For *February 2019,* the partial month penalty of 16 days would be added to the seven (7) month penalty period. *This* means Medicaid would authorize payment for *LTSS* services beginning *February 17, 2019.*

F. Penalty Period for a Couple When Both Are Eligible and Institutionalized

When an institutionalized individual is ineligible for Medicaid payment of long-term care services because of a transfer made by the spouse, and the spouse is or becomes institutionalized and eligible for Medicaid, the penalty period must be apportioned between the spouses. The couple may choose to either:

- have the penalty period, or the remaining time in the penalty period, divided between the spouses, or
- assign the penalty period or remaining penalty period to one of the two spouses.

When one spouse is no longer subject to the penalty, such as one spouse is no longer institutionalized or one spouse dies, the remaining penalty period applicable to **both** spouses must be applied to the remaining spouse.

EXAMPLE #18: Mr. A. enters a nursing facility and applies for Medicaid. Mrs. A. transfers an asset that results in a 36 month penalty period for Mr. A. 12 months into the penalty period, Mrs. A. enters a nursing facility and is eligible for Medicaid. The penalty period against Mr. A. still has 24 months to run. Because Mrs. A. is now in a nursing facility and a portion of the penalty period remains, the penalty period is reviewed. Mr. and Mrs. A. decide to have the penalty period divided between them. Therefore, both Mr. A. and Mrs. A. are ineligible for Medicaid payment of *LTSS* for 12 months beginning the first day of Mrs. A's Medicaid eligibility.

After 6 months, Mr. A. leaves the facility and is no longer institutionalized. Mrs. A. remains institutionalized. Because Mr. A is no longer subject to the penalty, the remaining total penalty period for the couple, 12 months (6 months for Mr. A. and 6 months for Mrs. A.), must be imposed on Mrs. A. If Mr. A. becomes institutionalized again before the end of the 12 months, the remaining penalty period is again reviewed and divided or applied to one spouse, depending on the couple's choice.

M1450.640 SUBSEQUENT RECEIPT OF COMPENSATION

A. Policy

When all assets transferred are returned to the individual, no penalty for transferring assets can be assessed. When a penalty has been assessed and payment for services has been denied, a return of the assets requires a retroactive evaluation, including erasure of the penalty, back to the beginning of the penalty period.

However, such an evaluation does not necessarily mean that Medicaid payment for LTC services must be paid on behalf of the individual. Return of the assets in question to the individual leaves the individual with assets which must be evaluated in determining eligibility during the retroactive period. Counting those assets as available may result in the individual being ineligible (because of excess income or resources) at the time of evaluation as well as for a period of time after the assets are returned.

NOTE: To void imposition of a penalty, all of the assets in question or their fair market equivalent must be returned. For example, if the asset was sold by the individual who received it, the full market value of the asset must be returned to the transferor.

When only part of an asset or its equivalent value is returned, a penalty period can be modified but not eliminated. For example, if only half of the value of the asset is returned, the penalty period can be reduced to one-half.

B. Example #20 Full Compensation Received

Example #20 Mr. G., who is in a nursing facility, applied for Medicaid on November 24, *2011*. On October 10, 2011, he transferred his non-home real property worth *$46,404* to his son. The transfer did not meet any of the criteria in M1450.*400*, so a penalty period was imposed from October 1, 2011, through April 30, *2012*.

On December 12, *2011*, Mr. G.'s son paid *some outstanding* medical bills *that were not related to long-term care* for his father totaling $*47,000*. The agency re-evaluated the transfer and determined a penalty period was no longer appropriate since full compensation was received. Mr. G's eligibility for Medicaid payment of long-term care services was re-evaluated, beginning with October 1, *2011*.

C. Example #21 Partial Compensation Received

Example #21: Ms. H. applied for Medicaid on November 2, 2004, after entering a nursing facility on March 15, 2004. On October 10, 2004, she transferred her non-home real property worth $40,000 to her son and received no compensation in return for the property. Ms. H's Medicaid application was approved, but she was ineligible for Medicaid payment of long-term care services for 9 months beginning October 1, 2004 and continuing through June 30, 2005.

On December 12, 2004, the agency verified that Ms. H's son paid her $20,000 for the property on December 8, 2004. The agency re-evaluated the transfer and determined a remaining uncompensated value of $20,000 and a penalty period of 4 months, beginning October 1, 2004, and continuing through January 31, 2005.

The $20,000 payment must be evaluated as a resource in determining Ms. H.'s Medicaid eligibility for January 2005.

M1450.700 CLAIM OF UNDUE HARDSHIP

A. Policy

The opportunity to claim an undue hardship must be given when the imposition of a penalty period affects Medicaid payment for LTC services. *The opportunity to claim an undue hardship is in addition to the opportunity to appeal the transfer of assets decision itself.* An undue hardship may exist when the imposition of a transfer of assets penalty period would deprive the individual of medical care such that the individual's health or life would be endangered or he would be deprived of food, clothing, shelter, or other necessities of life. An undue hardship may be granted when documentation is provided that shows:

- that the assets transferred cannot be recovered, and
- that the immediate adverse impact of the denial of Medicaid coverage for payment of LTC services due to the uncompensated transfer would result in the individual being removed from the institution or becoming unable to receive life-sustaining medical care, food, clothing, shelter or other necessities of life.

Applicants, recipients, or authorized representatives may request an undue hardship evaluation. Additionally, the Deficit Reduction Act of 2005 authorized nursing facilities to act on behalf of their patients, when necessary, to submit a request for undue hardship. The nursing facility must have written authorization from the recipient or his authorized representative in order to submit the claim of undue hardship.

A claim of undue hardship:

- can be made for an individual who meets all Medicaid eligibility requirements and is subject to a penalty period,
- cannot be made on a denied or closed Medicaid case *or when the individual is deceased*,
- cannot be made when the penalty period has already expired, and
- cannot be used to dispute the value of a resource.

B. Procedures

If the individual chooses to make a claim of an undue hardship, documentation regarding the transfer and the individual's circumstances must be sent to the Department of Medical Assistance Services (DMAS) for an undue hardship determination **prior** to the eligibility worker taking action to impose a penalty period.

The individual has the burden of proof and must provide written evidence to clearly substantiate what was transferred, the circumstances surrounding the transfer, attempts to recover the asset or receive compensation, and the impact of the denial of Medicaid payment for LTC services.

1. Eligibility Worker

The eligibility worker must inform the individual of the undue hardship provisions and, if an undue hardship is claimed, send the claim and supporting documentation to DMAS for evaluation.

The eligibility worker must send a letter to the individual informing him of each asset transfer and the corresponding penalty period, as well as the right to claim an undue hardship. An Asset Transfer Undue Hardship Claim form, available at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*, must be included with the letter. The Asset Transfer Undue Hardship Claim Form serves as the request for an undue hardship evaluation.

a. Undue Hardship Claimed - Required Documentation

When requesting an undue hardship, the individual must provide the following documentation appropriate to the case situation:

- the reason(s) for the transfer;
- attempts made to recover the asset, including legal actions and the results of the attempts;
- notice of pending discharge from the facility, or discharge from PACE, hospice, or CBC services due to denial or cancellation of Medicaid payment for these services and include the actual date discharge will take place;
- physician's statement stating the inability to receive nursing facility or CBC services would result in the applicant/recipient's inability to obtain life-sustaining medical care;
- documentation that individual would not be able to obtain food, clothing, shelter, or other necessities of life;
- list of all assets owned and verification of their value at the time of the transfer if the individual claims he did not transfer resources to become Medicaid eligible; and
- documents such as deeds or wills if ownership of real property is an issue.

b. 10 Days to Return Undue Hardship Claim

The individual must be given at least 10 calendar days to return the completed form and documentation to the local agency. If the individual requests additional time to provide the form and documentation, the worker shall allow up to 30 calendar days from the date the checklist was sent. If the form and documentation are not returned within 30 calendar days, the penalty period must be imposed.

c. Documentation for DMAS

If an undue hardship is claimed, the eligibility worker must send to DMAS:

- a copy of the undue hardship claim form
- a description of each transfer:
  - what was transferred
  - parties involved and relationship
  - uncompensated amount
  - date of transfer

- calculation and duration of the penalty period(s) being imposed;
- a brief summary of the applicant/recipient's current eligibility status and living arrangements (nursing facility or community); and
- other documentation provided by the applicant/recipient.

Email the documentation to DMAS at *DMASEvaluation@dmas.virginia.gov or mail to:*

DMAS, *Eligibility Policy and Outreach Division*
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

A copy of all documentation submitted with the undue hardship claim must be retained in the case record.

d. When Applicant/Recipient Was Victim

If the applicant/recipient was a victim of an individual who is not the individual's attorney in fact, guardian, conservator or trustee and undue hardship is claimed, the **agency** must provide a statement documenting the facts and what actions were taken by the agency with regard to their findings. If the transfer was by a court-appointed guardian or conservator, documentation of any bond insurance that would cover the loss must be provided.

e. Undue Hardship Not Claimed or Not Granted by DMAS

If undue hardship is not claimed or if a penalty period must be imposed per DMAS, follow the procedures in M1450.800 through M1450.830 for notifying the individual and DMAS of the action. The individual must be informed that a denial of a claim for undue hardship may be appealed in accordance with the provisions of 12 VAC 30-110. If the individual meets all other eligibility requirements, he is eligible for Medicaid payment of all covered services other than LTC.

2. DMAS

DMAS will review the documentation provided with the undue hardship claim to determine if an undue hardship may be granted and send written notification to the eligibility worker. If additional information is needed to clarify the documentation received with the Undue Hardship claim, DMAS will notify the agency and provide a time frame for submitting the documentation. A copy of the decision must be retained in the individual's case record.

3. Subsequent Claims

If DMAS is unable to approve an undue hardship request because sufficient supporting documentation was not submitted, the claim must be denied and the penalty period must begin. Once a claim is denied, no further decision related to the same asset transfer will be made by DMAS unless the individual experiences a change in circumstances **while still in the penalty period**, such as receiving a discharge notice, that would result in the individual being removed from the institution or becoming unable to receive life-sustaining medical care, food, clothing, shelter or other necessities of life.

If the individual/authorized representative alleges a change in circumstances while still in the penalty period, *a claim of undue hardship can be requested and* will follow the procedures *as found* in M1450.700 B.1. *Once DMAS makes a decision on the claim, the worker will follow the policy as below.*

a. If a subsequent claim is received and penalty period has begun

If DMAS approves the subsequent claim of undue hardship, the penalty period ends effective with the date of the discharge notice or other documentation of undue hardship. The effective date is indicated in the approval letter from DMAS. Medicaid cannot pay for *LTSS* received prior to the end of the penalty period.

b. If a subsequent claim is received and penalty period has not begun

If the individual was screened and approved for Medicaid HCBS, PACE, or hospice services but his penalty period could not be imposed per M1450.630 B.5, and DMAS approves the subsequent claim of undue hardship, the penalty period is waived. However, Medicaid cannot pay for *LTSS* received prior to the date of the documentation of undue hardship, as designated by DMAS.

M1450.800 AGENCY ACTION

A. Policy If an individual's asset transfer is not allowable by policy, the individual is not eligible for Medicaid payment of long-term care services. The individual, the service provider, and the Department of Medical Assistance Services (DMAS) must be notified of his/her ineligibility for the Medicaid payment of long-term care services, as well as his eligibility or ineligibility for Medicaid per M1450.810 below.

B. Procedures The procedures used for notifying the recipient, the provider and DMAS are in sections M1450.810, 820, and 830 below.

M1450.810 APPLICANT/RECIPIENT NOTICE

A. Policy Whenever an institutionalized individual is not eligible for Medicaid payment of long-term care services because of an asset transfer, the notice to the individual must contain the following:

1. Notice Includes Penalty Period The form which notifies him/her of Medicaid eligibility must include the penalty period during which Medicaid will not cover *LTSS* for the individual.

2. Individual In Facility - Eligible An individual in a nursing or other medical facility continues to meet the definition of an institutionalized person. If the individual meets all other Medicaid eligibility requirements, he is eligible for Medicaid in the 300% SSI covered group, except for payment for *LTSS.*

3. Individual Not in Facility - Not Eligible An individual outside a medical facility (i.e. living in the community) **does not** meet the definition of an institutionalized person if he is not receiving Medicaid covered *HCBS,* PACE or hospice services. Therefore, an individual for whom a penalty period is imposed cannot be eligible for Medicaid unless the individual is eligible for Medicaid outside the 300% SSI covered group.

4. Referral to DMAS Recipient Audit Unit (RAU)

If the individual already received Medicaid long-term care services during a penalty period or made a claim of an undue hardship for imposition of a penalty period and the claim was approved, a referral to the DMAS RAU must be made. The LDSS must make all referrals for recovery.

B. Notice Contents

The Notice of Action on Medicaid sent to the individual must specify that:

- Medicaid will not pay for nursing facility or CBC waiver services for the months (state the begin and end dates of the penalty period) because of the uncompensated asset transfer(s) that occurred on (date/dates);
- the penalty period may be shortened if compensation is received.

The notice must also specify that either:

- the individual is eligible for Medicaid coverage of services other than nursing facility or waiver services beginning (the appropriate date); **or**
- the individual is ineligible for Medicaid in any covered group, citing M1450.810 A.3, above.

If an asset transfer undue hardship claim was approved and the amount of the uncompensated transfer was $25,000 or more and was made within 30 months of the individual becoming eligible for or receiving Medicaid LTC services, the notice must also include the following statement:

"Section 20-88.02 of the Code of Virginia allows DMAS to seek recovery from the transferee (recipient of the transfer) when a Medicaid enrollee transfer assets with an uncompensated value of $25,000 or more within 30 months of receiving or becoming eligible for Medicaid."

C. Advance Notice

When an institutionalized Medicaid recipient is found no longer eligible for Medicaid payment of long-term care services because of an asset transfer, the Advance Notice of Proposed Action must be sent to the individual at least 10 days before cancelling coverage of LTC services, and must specify that either:

- The individual is eligible for Medicaid coverage of services other than nursing facility or waiver services beginning (the appropriate date), **or**
- The individual is ineligible for Medicaid in any covered group, citing M1450.810 A.3, above, **and**
- Medicaid will not pay for long-term care services for the months (state the penalty period begin and end dates) because of the asset transfer(s) that occurred (date/dates), **and**
- The penalty period may be shortened if compensation is received.

M1450.820 PROVIDER NOTICE

A. Introduction

Use the Medicaid *LTSS* Communication Form (DMAS-225) to notify the provider of the individual's Medicaid eligibility and ineligibility for Medicaid payment of long-term care services.

B. Medicaid LTC Communication Form (DMAS-225)

The DMAS-225 should include:

- the individual's full name, Medicaid and Social Security numbers;
- the individual's birth date;
- the patient's Medicaid coverage begin date; and
- that the patient is not eligible for Medicaid payment of nursing facility/CBC waiver services for the months (state the penalty period begin and end dates) because of an asset transfer(s).

If the individual reports a change in circumstances to the local DSS, he or his authorized representative must be offered the chance to submit an additional claim of undue hardship. Follow the procedures in M1450.700 B above.

If DMAS grants the claim of undue hardship, the portion of the asset transfer penalty remaining **as of the date of the undue hardship request** is nullified. **Medicaid cannot pay for long-term care services received during the penalty period prior to the undue hardship request.** Nursing facility charges incurred during a penalty period may be evaluated as a patient pay deduction using the policy and procedures in M1470.230.

Once the penalty period has expired, no additional claims of undue hardship may be made.

M1450.830 DMAS NOTICE

A. Introduction

The worker must notify DMAS that the recipient is not eligible for *LTSS* services payment because of an asset transfer. DMAS must input the code in the Virginia Case Management System (VaCMS) that will deny payment of *LTSS* services claims.

The worker notifies DMAS via a copy of the DMAS-225 sent to the provider.

B. Copy of DMAS-225

The copy of the DMAS-225 that is sent to DMAS must contain the following information, in addition to the information on the provider's copy of the DMAS-225:

- date(s) the asset transfer(s) occurred;
- the uncompensated value(s); and
- penalty period(s) (begin and end dates) and computation of that period(s).

C. Send DMAS Notice The agency worker must send a copy of the DMAS-225 to:

Department of Medical Assistance Services
Eligibility Policy and Outreach Division

600 E. Broad St., Suite 1300
Richmond, VA 23219.

Or email to *Patientpay@dmas.virginia.gov*. The copy of the DMAS-225 must be signed and dated by the worker and must show the worker number and the local agency's FIPS code.

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

Average Monthly Private Nursing Facility Cost
Prior to January 1, 2011

Application Date		Average Monthly Cost
		(All Localities)
7-1-1988 to 6-30-1989		$2,029
7-1-1989 to 12-31-1990		$2,180
1-1-1991 to 9-30-1993		$2,230
10-1-1993 to 9-30-1996		$2,554
10-1-1996 to 9-30-1997		$2,564

Application Date	*Average Monthly Cost*	
	*Northern Virginia**	*All Other Localities*
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*

(Figures Provided by Virginia Health Information)

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

LIFE EXPECTANCY TABLE*

If the exact age is not on the chart, use the next lower age. For example, if an individual is age 47 at the time of the asset transfer, use the life expectancy that corresponds to age 40 on the chart.

AGE	Life Expectancy MALE	Life Expectancy FEMALE	AGE	Life Expectancy MALE	Life Expectancy FEMALE
0	*74.12*	*79.78*	74	*11.05*	*12.94*
10	*64.67*	*70.27*	75	*10.46*	*12.26*
20	*54.97*	*60.41*	76	*9.88*	*11.60*
30	*45.86*	*50.79*	77	*9.32*	*10.95*
40	*36.97*	*41.38*	78	*8.77*	*10.31*
50	*28.33*	*32.24*	79	*8.25*	*9.70*
60	*20.47*	*23.67*	80	*7.74*	*9.10*
61	*19.74*	*22.85*	81	*7.25*	*8.53*
62	*19.03*	*21.04*	82	*6.77*	*7.98*
63	*18.32*	*21.24*	83	*6.31*	*7.44*
64	*17.63*	*20.45*	84	*5.88*	*6.93*
65	*16.94*	*19.66*	85	*5.47*	*6.44*
66	*16.26*	*18.88*	86	*5.07*	*5.99*
67	*15.58*	*18.10*	87	*4.70*	*5.55*
68	*14.91*	*17.34*	88	*4.35*	*5.15*
69	*14.24*	*16.58*	89	*4.02*	*4.76*
70	*13.59*	*15.82*	90	*3.72*	*4.41*
71	*12.94*	*15.08*	95	*2.57*	*3.05*
72	*12.30*	*14.36*	100	*1.93*	*2.23*
73	*11.67*	*13.64*	110	*1.05*	*1.12*

**Data from www.ssa.gov Actuarial Life Table, 2020, as used in the 2023 Trustees Report*

Settlement Statement-

Form HUD-1 follows on pages 2 and 3 of this appendix. This form is frequently used as the settlement statement when closing a real estate transaction or transfer. Note that there is a specific section for the borrower and the seller. The Borrower is the individual(s) who is purchasing the property. The Seller is the owner of the property.

The Gross Amount Due to Seller for the property noted on line 420 of the first page of the statement represents the amount of funds being paid for purchase the property. This amount includes the funds which satisfy any outstanding liens against the property at the time of transfer, which are noted on lines 504 and 505 of the first page.

Usual and customary fees associated with real estate transactions are already indicated on the form, such as the lien amounts, any additional deductions must be added to the form. These types of deductions should be carefully examined by the eligibility worker, as they may represent a separate uncompensated transfer from the seller's portion of the proceeds from the sale of the property.

Any questions regarding this form and any deductions listed should be referred to the appropriate Medical Assistance Program Consultant.

A. Settlement Statement — **U.S. Department of Housing and Urban Development** — OMB Approval No. 2502-02 (expires 11/30/20

B. Type of Loan

1. ☐ FHA 2. ☐ FmHA 3. ☐ Conv. Unins. 4. ☐ VA 5. ☐ Conv. Ins.

6. File Number:	7. Loan Number:	8. Mortgage Insurance Case Number:

C. Note: This form is furnished to give you a statement of actual settlement costs. Amounts paid to and by the settlement agent are shown. Items marke "(p.o.c.)" were paid outside the closing; they are shown here for informational purposes and are not included in the totals.

D. Name & Address of Borrower:	E. Name & Address of Seller:	F. Name & Address of Lender:

Buyer

G. Property Location:	H. Settlement Agent:	
	Place of Settlement:	I. Settlement Date:

J. Summary of Borrower's Transaction		K. Summary of Seller's Transaction	
100. Gross Amount Due From Borrower		**400. Gross Amount Due To Seller**	
101. Contract sales price		401. Contract sales price	
102. Personal property		402. Personal property	
103. Settlement charges to borrower (line 1400)		403.	
104.		404.	
105.		405.	
Adjustments for items paid by seller in advance		**Adjustments for items paid by seller in advance**	
106. City/town taxes to		406. City/town taxes to	
107. County taxes to		407. County taxes to	
108. Assessments to		408. Assessments to	
109.		409.	
110.		410.	
111.		411.	
112.		412.	
120. Gross Amount Due From Borrower		**420. Gross Amount Due To Seller**	
200. Amounts Paid By Or In Behalf Of Borrower		**500. Reductions In Amount Due To Seller**	
201. Deposit or earnest money		501. Excess deposit (see instructions)	
202. Principal amount of new loan(s)		502. Settlement charges to seller (line 1400)	
203. Existing loan(s) taken subject to		503. Existing loan(s) taken subject to	
204.		504. Payoff of first mortgage loan	
205.		505. Payoff of second mortgage loan	
206.		506.	
207.		507.	
208.		508.	
209.		509.	
Adjustments for items unpaid by seller		**Adjustments for items unpaid by seller**	
210. City/town taxes to		510. City/town taxes to	
211. County taxes to		511. County taxes to	
212. Assessments to		512. Assessments to	
213.		513.	
214.		514.	
215.		515.	
216.		516.	
217.		517.	
218.		518.	
219.		519.	
220. Total Paid For Borrower		**520. Total Reduction Amount Due Seller**	
300. Cash At Settlement From/To Borrower		**600. Cash At Settlement To/From Seller**	
301. Gross Amount due from borrower (line 120)		601. Gross amount due to seller (line 420)	
302. Less amounts paid by/for borrower (line 220)	( )	602. Less reductions in amt. due seller (line 520)	( )
303. Cash ☐ From ☐ To Borrower		**603. Cash ☐ To ☐ From Seller**	

Gross Amount Due to Seller

Liens paid for by the seller.

Areas not pre-filled are where other transactions are listed.

Section 5 of the Real Estate Settlement Procedures Act (RESPA) requires the following: • HUD must develop a Special Information Booklet to help persons borrowing money to finance the purchase of residential real estate to better understand the nature and costs of real estate settlement services; • Each lender must provide the booklet to all applicants from whom it receives or for whom it prepares a written application to borrow money to finance the purchase of residential real estate; • Lenders must prepare and distribute with the Booklet a Good Faith Estimate of the settlement costs that the borrower is likely to incur in connection with the settlement. These disclosures are mandatory.

Section 4(a) of RESPA mandates that HUD develop and prescribe this standard form to be used at the time of loan settlement to provide full disclosure of all charges imposed upon the borrower and seller. These are third party disclosures that are designed to provide the borrower with pertinent information during the settlement process in order to be a better shopper.

The Public Reporting Burden for this collection of information is estimated to average one hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

This agency may not collect this information, and you are not required to complete this form, unless it displays a currently valid OMB control number.

The information requested does not lend itself to confidentiality.

Previous editions are obsolete — Page 1 of 2 — form **HUD-1** (3/86) ref Handbook 4305.2

A. Settlement Statement

U.S. Department of Housing and Urban Development

OMB Approval No. 2502-02 (expires 11/30/200

B. Type of Loan

1. ☐ FHA 2. ☐ FmHA 3. ☐ Conv. Unins. 4. ☐ VA 5. ☐ Conv. Ins.

6. File Number:	7. Loan Number:	8. Mortgage Insurance Case Number:

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D. Name & Address of Borrower:	E. Name & Address of Seller:	F. Name & Address of Lender:

G. Property Location:	H. Settlement Agent:	
	Place of Settlement:	I. Settlement Date:

J. Summary of Borrower's Transaction		K. Summary of Seller's Transaction	
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204.		504. Payoff of first mortgage loan	
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207.		507.	
208.		508.	
209.		509.	
Adjustments for items unpaid by seller		**Adjustments for items unpaid by seller**	
210. City/town taxes to		510. City/town taxes to	
211. County taxes to		511. County taxes to	
212. Assessments to		512. Assessments to	
213.		513.	
214.		514.	
215.		515.	
216.		516.	
217.		517.	
218.		518.	
219.		519.	
220. Total Paid By/For Borrower		**520. Total Reduction Amount Due Seller**	
300. Cash At Settlement From/To Borrower		**600. Cash At Settlement To/From Seller**	
301. Gross Amount due from borrower (line 120)		601. Gross amount due to seller (line 420)	
302. Less amounts paid by/for borrower (line 220)	( )	602. Less reductions in amt. due seller (line 520)	( )
303. Cash ☐ From ☐ To Borrower		**603. Cash** ☐ To ☐ From Seller	

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Previous editions are obsolete

Page 1 of 2

form **HUD-1** (3/86)
ref Handbook 4305.2

L. Settlement Charges

				Paid From Borrowers Funds at Settlement	Paid From Seller's Funds at Settlement
700. Total Sales/Broker's Commission based on price $		@	% =		
Division of Commission (line 700) as follows:					
701. $	to				
702. $	to				
703. Commission paid at Settlement					
704.					
800. Items Payable In Connection With Loan					
801. Loan Origination Fee	%				
802. Loan Discount	%				
803. Appraisal Fee	to				
804. Credit Report	to				
805. Lender's Inspection Fee					
806. Mortgage Insurance Application Fee to					
807. Assumption Fee					
808.					
809.					
810.					
811.					
900. Items Required By Lender To Be Paid In Advance					
901. Interest from to	@$		/day		
902. Mortgage Insurance Premium for			months to		
903. Hazard Insurance Premium for			years to		
904.			years to		
905.					
1000. Reserves Deposited With Lender					
1001. Hazard insurance	months @$		per month		
1002. Mortgage insurance	months @$		per month		
1003. City property taxes	months @$		per month		
1004. County property taxes	months @$		per month		
1005. Annual assessments	months @$		per month		
1006.	months @$		per month		
1007.	months @$		per month		
1008.	months @$		per month		
1100. Title Charges					
1101. Settlement or closing fee	to				
1102. Abstract or title search	to				
1103. Title examination	to				
1104. Title insurance binder	to				
1105. Document preparation	to				
1106. Notary fees	to				
1107. Attorney's fees	to				
(includes above items numbers:			)		
1108. Title insurance	to				
(includes above items numbers:			)		
1109. Lender's coverage	$				
1110. Owner's coverage	$				
1111.					
1112.					
1113.					
1200. Government Recording and Transfer Charges					
1201. Recording fees: Deed $	; Mortgage $		; Releases $		
1202. City/county tax/stamps: Deed $	; Mortgage $				
1203. State tax/stamps: Deed $	; Mortgage $				
1204.					
1205.					
1300. Additional Settlement Charges					
1301. Survey to					
1302. Pest inspection to					
1303.					
1304.					
1305.					
1400. Total Settlement Charges (enter on lines 103, Section J and 502, Section K)					

CHAPTER M14
LONG-TERM CARE
SUBCHAPTER 60

LTC FINANCIAL ELIGIBILITY

M1460 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-31	4/1/24	Page 3, 35
TN #DMAS-30	1/1/24	Pages 11 and 19
TN #DMAS-26	1/1/23	Pages 3, 35
TN #DMAS-24	7/1/22	Pages 11, 47, 48
TN #DMAS-23	4/1/22	Pages 12, 23
TN #DMAS-22	1/1/22	Pages 3, 35
TN #DMAS-18	1/1/21	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

TABLE OF CONTENTS

M14 LONG-TERM CARE

M1460.000 LTC FINANCIAL ELIGIBILITY

APPENDICES

M1460.000 LTC FINANCIAL ELIGIBILITY

M1460.001 OVERVIEW

A. Introduction

This subchapter contains the Medicaid financial eligibility requirements for individuals receiving facility or Medicaid waiver long-term care (LTC) services, *also referred to as Long-term Supportive Services (LTSS)*, who are not married or who are married but do not have community spouses. **For married individuals *other than Modified Adjusted Gross Income (MAGI) Adults* with community spouses (when both are not in a medical facility), go to subchapter M1480 to determine financial eligibility and patient pay.**

All individuals whose Medicaid eligibility has been determined PRIOR to entering LTC must have their financial eligibility redetermined, including asset transfer evaluation, home ownership and other resource evaluation. First, determine if the individual meets the Medicaid non-financial requirements including covered group in M1410.020. Then determine financial eligibility. Financial eligibility requirements for an individual differ depending on the individual's covered group, marital status and type of long-term care.

This subchapter contains policy and procedures for resources and income eligibility determination for institutionalized individuals. Patient pay (post-eligibility treatment of income) policy and procedures for unmarried individuals or married individuals without community spouses are in subchapter M1470.

B. Related Policies

- *MAGI (MAGI) Adults income rules in Chapter M04*
- ABD resource rules in Chapter S11.
- ABD income rules in Chapter S08.
- Family and Children resource rules in Chapter M06.
- Family and Children Medically Needy (MN) income rules in Chapter M07.
- Married Institutionalized Individuals' Eligibility & Patient Pay rules in subchapter M1480.

M1460.100 DEFINITIONS

A. Purpose

This section provides definitions for terms used in this subchapter.

B. Definitions

1. 300% SSI Group

The 300% SSI group is the short name for the categorically needy (CN) covered groups of Aged, Blind & Disabled (ABD) and Families & Children (F&C) individuals who are institutionalized in medical facilities or Medicaid-covered waiver services, who have resources within the Medicaid resource limits and whose gross income is less than or equal to 300% of the Supplemental Security Income (SSI) income limit for one person.

2. Budget Period

The budget period is the period of time during which an individual's income is calculated to determine eligibility.

3. Carry-over Expenses Carry-over expenses are the balance due on medical, dental, and remedial care expenses incurred in the retroactive or prospective budget period prior to the current budget period which were not used in establishing eligibility and which may be deducted in a consecutive budget period(s) when there has been no break in spenddown eligibility.

4. Certification Period The certification period is the period of time over which an application or redetermination is valid.

5. Current Payments Current payments are payments made in the current spenddown budget period on expenses incurred before the current spenddown budget period which were not used in establishing eligibility in a previous spenddown budget period and when there has been a break in spenddown eligibility. The payment amount allowed is the actual payment amount paid to the provider and is deducted from the spenddown liability on the date the payment is actually made.

6. Income Determination Period The income determination period is the budget period; for all LTC cases, the budget period is one month.

7. LTC Case A case in which the Medicaid applicant or recipient is an institutionalized individual receiving long-term care services is an LTC case.

8. Lump Sum Payment Income received on a "non-recurring basis" and/or income that is received once a year is a lump sum payment. All lump sum payments are income in the month of receipt and a resource in the following month(s), if retained.

Different types of lump sum payments must be treated differently. Refer to the ABD Income chapter S08 (for both ABD and F&C individuals) for policy specific to the type of lump sum payment that is being evaluated.

9. *MAGI Adults* *Effective January 1, 2019, MAGI Adults is the CN covered group of individuals between the ages of 19 and 64 with household income at or below 138% of the Federal Poverty Level (FPL) and who are not entitled to or receiving Medicare.*

***10*. Medicaid Rate** The Medicaid rate is a monthly rate which is calculated:

- for a facility, by multiplying the individual's daily Resource Utilization Group (RUG) code amount by the number of days in the month. A patient's RUG code amount is based on his room and board and ancillary services. The RUG code amount may differ from facility to facility and from patient to patient within the same facility. Confirmation of the individual's RUG code amount must be obtained by contacting the facility;

  NOTE: When projecting the facility's monthly Medicaid rate, the daily RUG code amount is multiplied by 31 days.

- for Medicaid CBC waiver services, by multiplying the provider's Medicaid hourly rate by the number of hours of service received by the patient in the month. Confirm the provider's hourly Medicaid rate and number of service hours by contacting the provider.

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 sp3enddown 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, 2022: $636,000
- Effective January 1, 2023: $688,000
- *Effective January 1, 2024: $713,000.*

1. **Reverse Mortgages**

Reverse mortgages **do not** reduce equity value until payments are being received from the reverse mortgage.

2. **Home Equity Credit Lines**

A home equity line of credit **does not** reduce the equity value until credit line has been used or payments from the credit line have been received.

C. Verification Required

Verification of the equity value of the home is required.

D. Notice Requirement

If an individual is ineligible for Medicaid payment of LTSS because of substantial home equity exceeding the limit, the Notice of Action must state why he is ineligible for Medicaid payment of LTSS. The notice must also indicate whether the applicant is eligible for other Medicaid covered services.

If the individual is in a nursing facility, send the facility a DMAS-225 indicating that the individual is not eligible for the Medicaid payment of LTSS.

E. References

See section M1120.225 for more information about reverse mortgages.

M1460.155 THIRD PARTY & LONG-TERM CARE INSURANCE PAYMENTS

A. Payments Made by Another Individual

Payment of an individual's bills (including Medicare supplementary medical insurance or other medical insurance premiums) by a third party directly to the supplier is not income.

Payments made directly to the service provider by another person for the individual's private room or "sitter" in a medical facility are NOT income to the individual. Refer all cases of Medicaid eligible enrollees in nursing facilities who have a "sitter" to DMAS, Division of *Aging and Disability Services,* for DMAS review to assure that DMAS is not paying the facility for services provided by the sitter.

B. LTC Insurance Policy Payments

The LTC insurance policy must be entered into the recipient's TPL file. The insurance policy type is "H" and the coverage type is "N." When entered in the Virginia Case Management System (VaCMS) on the TPL *screen,* Medicaid will not pay the nursing facility's claim unless the claim shows how much the policy paid.

If the patient receives the payment from the insurance company, it is **not** counted as income. The patient should assign it to the *provider*. If the patient cannot do this, or the policy prohibits assignment, the payment should be given directly to the *provider*. The *provider* should report the payment as a third party payment on its claim form.

If the patient received the payment and cannot give it to the *provider* for some reason, then the patient should send the insurance payment to:

DMAS Fiscal Division, *Cashiering Unit*
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

M1460.160 LONG-TERM CARE PARTNERSHIP POLICIES

A. Introduction

A Long-term Care Partnership Policy (Partnership Policy) is a type of LTC insurance. Under section 6021(a)(1)(A) of the Deficit Reduction Act (DRA) of 2005 states were permitted to develop LTC partnerships. In addition to paying for assisted living or long-term care services, a Partnership Policy allows for additional assets to be disregarded in the Medicaid eligibility determination.

The value of assets disregarded in the Medicaid eligibility determination is equal to the dollar amount of benefits paid to or on behalf of the individual as of the month of application, even if additional benefits remain available under the terms of the policy.

The Partnership Policy disregard is not applicable to the resource assessment for married individuals with a community spouse. See M1480 for more information regarding resource assessments and Partnership Policies.

B. LTC Insurance Policy Issued Prior to 9/01/2007

LTC policies issued prior to 9/01/2007 are **not** Partnership Policies. See M1470.230 B.6, M1470.430 B.5 and M1470.820 D for more information regarding these types of insurance policies.

C. LTC Insurance Policy Issued on or After 9/01/2007

LTC policies issued on or after 9/01/2007 may or may not be Partnership Policies. For a policy to be considered a Partnership Policy, it must meet the following conditions:

- issued on or after 09/01/2007,
- contain a disclosure statement indicating that it meets the requirements under § 7702B(b) of the Internal Revenue Service Code of 1986, and
- provide inflation protection:
    - under 61 years of age, compound annual inflation protection,
    - 61 to 76 years of age, some level of inflation protection, or
    - 76 years or older, inflation protection may be offered, but is not required.

Obtain a copy of the Partnership Disclosure Notice and the LTC Partnership Certification Form (See M1460, Appendices 1 and 2) for verification of the requirements noted above. Also, verification of the amount of benefit paid to or on behalf of an individual as of the month of application must be obtained. This can be found on the Explanation of Benefits statement or by calling the insurance carrier.

Partnership Policies that are issued in other states may or may not meet Virginia's requirements. Please contact your Medicaid Consultant to verify reciprocity with Virginia.

Verifications and documentation regarding a Partnership Policy must be kept with other permanent verifications in the case record.

M1460.200 DETERMINATION OF COVERED GROUP

A. Overview

An individual in LTC who meets the Medicaid non-financial eligibility requirements in M1410.010 must also meet the requirements of at least one covered group in order to be eligible for Medicaid and Medicaid payment of LTC services.

1. Covered Groups Eligible for LTC Services

The covered groups whose benefit packages include long-term care services are the following groups:

All categorically needy (CN) full benefit covered groups for ABD and F&C:

- SSI Recipients; see M0320.101 and M1460.201
- "Protected" covered Groups; see M0320.200
- *MAGI Adults; see M04*
- ABD 80% FPL; see M0320 and M1460.210
- MEDICAID WORKS; see M0320.400
- 300% SSI; see M0320.500 , M0330.500, and M1460.220
- IV-E Foster Care and Adoption Assistance; see M0330.105
- Individuals Under Age 21; see M0330.107
- Special Medical Needs Adoption Assistance; see M0330.108
- *Former Foster Care Children Under Age 26 Years; see M0330.109*
- Low Income Families With Children (LIFC); see M0330.200
- Child Under Age 19 (FAMIS Plus); see M0330.300
- Pregnant Women and Newborn Children; see M0330.400
- Breast and Cervical Cancer Prevention Treatment Act (BCCPTA); see M0330.700

All medically needy (MN) covered groups

- ABD Individuals; see M0320.701
- December 1973 Eligibles; see M0320.702
- Pregnant Women; see M0330.801
- Newborn Children Under Age 1; see M0330.802
- Children Under Age 18; see M0330.803
- Individuals Under Age 21; see M0330.804
- Special Medical Needs Adoption Assistance; see M0330.805

Medicaid will not pay for the following for MN individuals:

- services in an intermediate care facility for the intellectually disabled (ICF-ID)
- services in an institution for the treatment of mental disease (IMD)
- Community Living Waiver (formerly Intellectual Disabilities Waiver) services, and
- Family and Individual Supports Waiver (formerly Individual and Family Development Disability Support (DD) Waiver) services.

2. Applicants Who Do Not Receive Cash Assistance

a. Child Under Age 18

MAGI methodology is not applicable to F&C children needing LTC services. If the applicant is a child under age 18, determine the child's eligibility in the F&C 300% SSI group, using the covered group policy in subchapter M0330 and the financial eligibility policy and procedures in this subchapter. The resource requirement for the F&C 300% SSI covered group does **NOT** apply to children under age **18.**

If the child's income exceeds the limit for the F&C 300% SSI group, determine the child's eligibility in an MN covered group.

NOTE: A child who is age 18, 19 or 20 meets an MN covered group if he is blind, disabled, pregnant, in foster care, adoption assistance, or institutionalized in a nursing facility. An individual age 21 or older, must meet the pregnant, aged, blind or disabled definition in order to meet an MN covered group.

b. Individual Age 18 -19

If the individual is age 18 but under age 19, first determine the individual's eligibility in the F&C Child Under 19 or Pregnant Woman covered groups using MAGI income methodology in Chapter M04. If the individual's income exceeds the limits for F&C coverage, he must be determined disabled to meet the ABD 300% SSI covered group. Follow the procedures in M0310.112 for making a disability referral.

c. Individual Age 19 or Older

If the individual is age 19 or older, determine the individual's eligibility in an ABD or F&C covered group, depending on which definition the individual meets, using the financial eligibility policy and procedures in this subchapter.

For ABD individuals, determine the individual's eligibility in the ABD 80% FPL covered group. If not eligible in the ABD 80% FPL covered group, determine the individual's eligibility in the ABD 300% SSI covered group. If not eligible in the either of these covered groups, determine the individual's eligibility in all other groups for which he meets a definition.

For F&C individuals, first determine the individual's eligibility in the LIFC, Pregnant Woman, or MAGI Adult groups. If the individual's income exceeds the limits for the LIFC, Pregnant Woman, or MAGI Adult covered groups, determine the individual's eligibility in the F&C 300% SSI covered group.

To be eligible in the F&C 300% SSI covered group, the individual must be a child under age 18; under age 21 who meets the adoption assistance or foster care definition; under age 21 in an ICF or ICF- ID; a parent or caretaker-relative of a dependent child; or a pregnant woman as defined in M0310.

If the income exceeds the 300% SSI group limit and the individual meets a MN covered group, determine the individual's eligibility in an MN covered group (see M0330). There is no MN covered group for LIFC parents or MAGI Adults.

B. Relation to Income Limits

Determination of the appropriate covered group must be made prior to determination of income because the income limits are determined by the covered group:

1. ABD 80% FPL

The ABD income policy in Chapter S08 is used to determine countable income for the ABD 80% FPL covered group. *However, the income items listed in Sections M1460.610 and M1460.611 are NOT counted as income in determining income eligibility for the ABD 80% FPL covered group.*

1. MAGI Adults *The MAGI income policy in Chapter M04 is used to determine countable income for MAGI Adults. The income limit is 138% FPL (133% FPL plus a 5% FPL income disregard if needed).*

***3.* 300% SSI** The ABD income policy in Chapter S08 is used to determine income for all individuals (ABD and F&C) in the 300% SSI group. The items found in section M1460.611 ARE counted in determining income eligibility for long-term care. The income items listed in M1460.610 are not counted for the 300% SSI groups (ABD and F&C).

***4.* ABD MN Groups** The ABD income policy in Chapter S08 is used to determine countable income for the ABD MN covered groups. However, the income items listed in "What Is Not Income", Section M1460.610 and in "Countable Income for the 300% SSI Group", Section M1460.611 are NOT counted as income in determining income eligibility for ABD MN groups.

***5.* F&C MN Groups** The F&C income policy in Chapter M07 is used to determine countable income for individuals in F&C MN covered groups. However, the income items listed in "What Is Not Income", section M1460.610 and "Countable Income for the 300% SSI Group", Section M1460.611 are NOT counted when determining income eligibility for F&C MN groups.

C. Ongoing Recipient Enters LTC

1. SSI Recipients SSI recipients who are already enrolled in Medicaid when they enter Medicaid long-term care must have their eligibility reviewed. They already meet a covered group but they must also meet the asset transfer, resource and financial eligibility requirements in order for Medicaid to cover the cost of long-term care services.

2. Other Recipients Recipients who do not receive cash assistance but who are already enrolled in Medicaid when they enter long-term care in a medical facility **must have their eligibility redetermined**. They must meet a covered group and they must meet the asset transfer, resource, and financial eligibility requirements in order for Medicaid to cover the LTC services cost.

For a MAGI Adult, complete a review to evaluate substantial home equity and asset transfers, including transfers of assets into trusts or to purchase annuities.

Review the asset transfer policy in subchapter M1450 with the recipient if he has transferred assets. If the recipient is admitted to a nursing facility, or moves from his home to receive Medicaid CBC in another person's home, review asset transfer, home property and other resource requirements to determine if the individual remains eligible for Medicaid

A married recipient, *other than a MAGI Adult*, who enters LTC must have resource and income eligibility redetermined using the rules in subchapter M1480, if his spouse is a community spouse.

M1460.201 SSI RECIPIENTS

A. Introduction

An SSI recipient in a nursing facility, or who receives Medicaid CBC waiver services, must meet the Medicaid nonfinancial, asset transfer and resource eligibility requirements to be eligible for Medicaid payment of LTC services. The SSI recipient's resource eligibility must be determined if he owns a real property resource; the receipt of SSI meets the Medicaid income eligibility requirements. An SSI recipient is income-eligible for LTC as long as he is entitled to an SSI payment. *When the SSA record indicates a payment code of "C01" and no payment amount is shown, the individual is considered to be an SSI recipient for Medicaid purposes. If the SSA record indicates a code of "EO1" or "E02" and no SSI payment has been received in more than twelve months, the individual's SSI status must be confirmed.* The covered group eligibility requirements for SSI recipients are in section M0320.101.

1. Medicaid CBC

An SSI recipient who receives Medicaid CBC waiver services in his community residence usually continues to receive SSI with no change. If a recipient moves to another person's home to receive Medicaid CBC, his SSI payment may be affected. When a Medicaid SSI recipient begins receiving Medicaid CBC waiver services, asset transfer and resource eligibility must be evaluated. As long as the individual receives SSI, he is categorically needy if he meets the Medicaid nonfinancial and resource eligibility rules.

2. Facility

SSI recipients in nursing facilities are subject to the reduced SSI benefit rate of $30 for their personal needs. If they have other countable income that exceeds $30, their SSI will be canceled. SSI recipients may continue to receive their regular monthly SSI benefit for 3 months if they are considered temporarily institutionalized. Individuals who receive SSI after admission to a facility are categorically needy if they meet the Medicaid nonfinancial and resource eligibility rules.

B. Policy

1. Nonfinancial

Evaluate the non-financial Medicaid eligibility rules in section M1410.020. An SSI recipient meets an ABD covered group.

2. Asset Transfer

Determine if the recipient meets the asset transfer policy in subchapter M1450.

3. Resources

a. Determine Countable Resources

Determine if the SSI recipient has the following real property resource(s):

1) equity in non-exempt property contiguous to his home which exceeds $5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;

2) interest in undivided heir property and the equity value of the individual's share that, when added to all other countable resources, exceeds the appropriate Medicaid resource limit. (The interest in the

estate must be legally available. If a partition suit is necessary to sell the interest, costs of partition and attorneys' fees may be deducted as described in section M1120.215);

3) ownership (equity value) of *the individual's* former residence *when* the SSI recipient is in an institution for longer than 6 months. Determine if the former *residence* is excluded under policy in section M1130.100 D;

4) equity value in property owned jointly *by the SSI recipient and* another person *who is not the SSI recipient's spouse*, as tenants in common or joint tenants with the right of survivorship at common law. Determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;

5) other real property; determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property.

When an SSI recipient has any of the real property listed in 1) through 5) *previously*, ALL of the recipient's resources must be verified, evaluated, and counted together to determine if the SSI recipient meets the Medicaid resource requirements. Calculate resources for an assistance unit of 1 person.

When an SSI recipient has no real property resource listed in 1) through 5) previously, do NOT evaluate the SSI recipient's resources. The SSI recipient meets the Medicaid resource requirements because he receives SSI and does not have a countable real property resource listed above.

b. Countable Resources Within Resource Limit

If countable resources are less than or equal to the $2,000 resource limit, go to item 4 below for income eligibility.

c. Countable Resources Exceed the Resource Limit

If current resources exceed the $2,000 resource limit, the individual is NOT eligible in the SSI recipient covered group, nor is he eligible in the 300% SSI group or the medically needy group. He may be eligible for limited Medicaid coverage as medically indigent (which has more liberal resource methods and standards), however, Medicaid will not pay for LTC services for an ABD medically indigent recipient.

4. Income

An SSI recipient in LTC is income-eligible for Medicaid as long as he receives an SSI payment. Verify receipt of the payment. If the SSI recipient meets the nonfinancial and resource eligibility rules for Medicaid, then he is eligible for Medicaid as categorically needy.

a. When an SSI recipient who has no other income enters a nursing facility, the SSI check is usually reduced to $30 for the month following the month of entry. The SSI payment is **NOT** counted as income when determining income eligibility or patient pay.

b. If the recipient is temporarily in the nursing facility, the SSI check is not reduced or canceled. Temporary institutionalization for SSI purposes means 90 days or less. The SSI payment is **NOT** counted as income when determining eligibility or patient pay.

C. Development

A partial review of the SSI recipient's Medicaid eligibility is required when the recipient is admitted to facility care or Medicaid CBC waiver services. The EW must determine that asset transfer and resource requirements are met, and that the recipient's SSI continues.

If eligible, determine patient pay; see subchapter M1470. If the individual is eligible but is in an asset transfer penalty period, follow the notification instructions in M1450. If not eligible, follow the eligibility notice requirements in M1410.300.

M1460.205 OTHER CATEGORICALLY NEEDY (CN) COVERED GROUPS

A. Description

Categorically needy (CN) individuals receive or are deemed to be receiving public assistance cash benefits.

B. ABD Groups

1. QSII (1619(b))

Qualified Severely Impaired Individuals (QSII) are former SSI recipients who are working but are still disabled, and are eligible under 1619(b) of the Social Security Act. To be eligible for Medicaid, they must have met the more restrictive resource requirements for Medicaid in the month before the month they qualified under 1619(b). See section M0320.105 for details about this covered group.

2. AG Recipients

An Auxiliary Grants (AG) recipient is eligible for Medicaid if he meets the assignment of rights to medical support and third party payments requirements and the asset transfer policy. See section M0320.202 for details about this covered group.

C. F&C Groups

1. Individuals Under 21

a. IV- E Foster Care Recipients

Children who are eligible for foster care payments under Title IV-E of the Social Security Act are eligible for Medicaid. See section M0320.305 for details about this covered group.

b. IV-E Adoption Assistance Recipients

Children who are eligible for adoption assistance under Title IV-E of the Social Security Act are eligible for Medicaid. See section M0320.305 for details about this covered group.

b. If the recipient is temporarily in the nursing facility, the SSI check is not reduced or canceled. Temporary institutionalization for SSI purposes means 90 days or less. The SSI payment is **NOT** counted as income when determining eligibility or patient pay.

C. Development

A partial review of the SSI recipient's Medicaid eligibility is required when the recipient is admitted to facility care or Medicaid CBC waiver services. The EW must determine that asset transfer and resource requirements are met, and that the recipient's SSI continues.

If eligible, determine patient pay; see subchapter M1470. If the individual is eligible but is in an asset transfer penalty period, follow the notification instructions in M1450. If not eligible, follow the eligibility notice requirements in M1410.300.

M1460.207 MAGI ADULTS COVERED GROUP (EFFECTIVE JANUARY 1, 2019)

A. Description

The MAGI Adults covered group includes individuals between 19 and 64 years old who are not eligible for or receiving Medicare.

B. Policy

1. Nonfinancial

Evaluate the non-financial Medicaid eligibility rules in Chapter M02.

2. Asset Transfer

Determine if the recipient meets the asset transfer policy in subchapter M1450.

3. Resources

Although no resource test is applicable for MAGI Adults coverage, the worker must evaluate certain resources for any individuals seeking Medicaid payment for LTSS. These include asset transfers, trusts, annuities, and the home equity limit.

4. Income

Income is determined using the policy in Chapter M04, and countable income must not exceed 138% FPL. Spenddown does not apply to this covered group.

M1460.210 ABD 80% FPL COVERED GROUP

A. Description

The ABD 80% FPL covered group includes aged, blind and disabled individuals who have income less than or equal to 80% FPL and countable resources that do not exceed the SSI resource limits. See M0320.300 for details about this covered group.

B. Policy

1. Nonfinancial

Evaluate the non-financial Medicaid eligibility rules in Chapter M02.

2. Asset Transfer

Determine if the recipient meets the asset transfer policy in subchapter M1450.

3. Resources

Determine countable resources using the policy in chapter S11 and Appendix 2 to chapter S11. The resource limit is $2,000.

The home property resource exclusion for individuals in the ABD 80% FPL covered group includes the home and ALL contiguous property as long as the individual lives in the home or, if absent, intends to return to the home (see Appendix 2 to chapter S11). When the ABD 80% FPL individual leaves his home property, obtain a signed statement from the individual as to:

- when and why he left the home;
- whether he intends to return; and
- if he does not intend to return, when that decision was made.

The limited 6-month home property resource exclusion for institutionalized individuals does NOT apply to this covered group.

4. Income

The ABD income policy in Chapter S08 is used to determine countable income for the ABD 80% FPL covered group. However, the income items listed in Sections M1460.610 and M1460.611 are NOT counted as income in determining income eligibility for the ABD 80% FPL covered group.

Countable income must not exceed 80% FPL. Spenddown does not apply to this covered group.

M1460.220 300% of SSI PAYMENT LIMIT GROUP

A. Description

These are ABD or F&C individuals in medical facilities or who receive Medicaid CBC waiver services, who meet the appropriate CN resource requirements and resource limit and whose income is less than or equal to 300% of the SSI payment limit for an individual.

Individuals who have been authorized for Medicaid LTC or Long-term Services and Supports (LTSS) may be evaluated in this covered group. If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has *180* days from the date on the Notice of Action to begin services.

B. ABD Groups

Aged, blind or disabled individuals institutionalized in medical facilities, or who require institutionalization and are approved to receive Medicaid CBC waiver services are those who:

- meet the Medicaid ABD resource requirements; and

- have gross income, determined according to the ABD income requirements, that does not exceed 300% of the SSI individual payment limit.

See sections M0320.501 and M0320.502 for details about these covered groups.

C. F&C Groups

Individuals who meet an F&C definition (foster care or adoption assistance children under age 21, parents or caretaker-relatives of dependent children, and pregnant women) in medical facilities, or who require institutionalization and who are approved to receive Medicaid home and community-based care (CBC) waiver services, are those who:

meet the F&C CN resource requirements if unmarried,
(married individuals over age 18 must meet the ABD resource requirement *unless eligible in a MAGI group*); and

- have gross income, determined according to the ABD income requirements, that does not exceed 300% of the SSI individual payment limit.

Children under age 18 in the 300% of SSI covered group have no resource requirement.

See sections M0330.501 and M0330.502 for details about these covered groups.

M1460.300 ASSISTANCE UNIT

A. Policy

An institutionalized individual is an assistance unit of one person, considered living separately from his spouse and/or parent(s), beginning the month in which he meets the definition of *an institutionalized individual* in section M1410.010.

EXCEPTION: A pregnant woman's assistance unit includes the number of unborn children with which she is pregnant.

B. Financial Eligibility

The financial eligibility rules in this section apply to **both ABD and F&C individuals.**

1. Resources

The resources of an institutionalized child's parent(s**)** are **NOT** deemed available to the institutionalized child. The resources of an institutionalized individual's spouse are deemed available to the institutionalized individual in the initial eligibility determination (see subchapter M1480).

2. Income

The income of an institutionalized individual's spouse or parent(s) is **NOT** deemed available to the institutionalized individual.

For income eligibility, married institutionalized individuals are considered separated, not living together, and only that income which is voluntarily contributed to the institutionalized spouse by the separated spouse is considered available to the institutionalized spouse.

Institutionalized children are considered separated from, not living with, their parents and only that income which is voluntarily contributed to the child is considered available to the child.

M1460.400 STEPS FOR DETERMINING FINANCIAL ELIGIBILITY

A. Is person an SSI recipient?

Yes: Go to M1460.201 (determine ABD CN resources; if within limit, is eligible as SSI). If resources exceed the limit, does recipient also meet F&C *CN* covered group?

Yes: eligible as F&C *CN*; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay. (Remember to review asset transfer to evaluate whether Medicaid payment may be made for LTC services).

No: ineligible for Medicaid; STOP. Go to section M1460.660 for notice procedures.

No: Does person receive IV-E cash assistance?

Yes: eligible as CN; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay. (Remember to review asset transfer to evaluate whether Medicaid payment may be made for LTC services).

No: Go to B below.

B. Covered Group

Is person already enrolled in Medicaid in a covered group eligible for LTC services?

Yes: Go to E "Resources" below, *unless the person is a MAGI Adult.*

No: Is person F&C *or an adult 19-64 years old and not receiving Medicare*?

Yes: Determine if he meets F&C *or MAGI Adult group* first (section M0330), go to D "Income" below.

No: Go to C below.

C. Is person ABD?

Yes: Go to D "Income" below.

No: Is person in Hospice?

Yes: Determine as Hospice; see section M0320.503.

No: ineligible for Medicaid, does not meet a covered group; STOP. Go to section M1460.660 for notice procedures.

D. Income (See M1460.600)

1. Person is F&C *or MAGI Adult*

Determine countable income using chapters *M04 and* M07.

Compare income to appropriate M04 income limit.

Is income within limit?

Yes: eligible as F&C*/MAGI Adult,* STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay *for F&C (MAGI Adults do not have a patent pay).*

No: not eligible as F&C, go to item 2 below.

2. Person Is Not F&C

a. Is person ABD and does he meet the definition of institutionalization in M1410.010?

Yes: Determine if gross income is less than or equal to the 80% FPL income limit using chapter S08 and section M1460.600 below to determine gross income.

Is gross income less than or equal to 80% FPL income limit?

Yes: Go to section E "Resources" below.

No: Go to item 3 "Determine 300% SSI income" below.

No: Does person meet the F&C 300% SSI or Hospice covered group (*does person meet the definition of institutionalization in M1410.010)?*

Yes: Go to item 3 *"*Determine 300% SSI income" *below.*

No: Go to section M1460.410 "Steps for Determining MN Eligibility."

3. Determine if Gross Income is Less Than or Equal to 300% SSI

Determine if gross monthly income is less than or equal to the 300% SSI income limit using chapter S08 and section M1460.600 below for **ABD and F&C** individuals.

Is gross income less than or equal to 300% SSI income limit?

Yes: go to section E "Resources" below.

No: go to section M1460.410 "Steps for Determining MN Eligibility" below.

E. Resources (See M1460.500)

1. Determine CN Resources

a. ABD groups

1) Unmarried Individual or Married Individual with no Community Spouse

a) ABD 80% FPL group: Using chapter S08 and M1460.600, determine if countable income is within the ABD 80% FPL income limit contained in M0810.002.A.5. If countable income is less than or equal to 80% FPL, determine countable resources using chapter S11 and Appendix 2 to chapter S11. **NOTE:** the 6-month home exclusion does not apply to this covered group.

Compare to ABD CN resource limit = $2,000 for 1 person.

b) 300% SSI group: Determine ABD countable resources using chapter S11.

Compare to ABD CN resource limit = $2,000 for 1 person. If the individual is not eligible due to excess resources, evaluate eligibility in the ABD 80% FPL covered group. See item b) below.

2) Married Individual with Community Spouse

Determine ABD countable resources using chapter S11 and subchapter M1480.

Compare to ABD CN resource limit = $2000 for 1 person

b. F&C groups

1) Unmarried Individual *age 18 or over* or Married Individual *age 18 or over* with no Community Spouse

- Determine F&C CN countable resources using chapter M06 for the unmarried institutionalized individual.
- Compare to F&C CN resource limit = $1,000.

2) Married Individual *age 18 or over* with Community Spouse

- Determine ABD countable resources, Chapter S11, M1480.
- Compare to ABD CN resource limit = $2000 for 1 person.

2. Are resources within CN limit?

Yes: eligible in the covered group whose income limit is met; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

No: go to item 3 below.

3. Does person meet an MN covered group?

Yes: go to section M1460.410 "Steps for Determining MN Eligibility," below.

No: person is not eligible for Medicaid because of excess resources; STOP. Go to section M1460.660 for notice procedures.

M1460.410 STEPS FOR DETERMINING MN ELIGIBILITY

A. Does person meet an MN covered group?

Yes: go to B below "Determine MN Resources."

No: person is not eligible for Medicaid because his gross income exceeds 300% of SSI and he does not meet a medically needy covered group; STOP, unless he has Medicare Part A. If he has Medicare Part A, determine eligibility for ABD *MSP*. If he does not have Medicare Part A, go to section M1460.660 for notice procedures.

B. Determine MN Resources

1. ABD Groups

Determine ABD countable resources, Chapter S11.

Compare to ABD MN resource limit = $2,000 for 1 person.

2. F&C Groups

a. Unmarried Individual or Married Individual with No Community Spouse

Determine F&C MN countable resources, Chapter M06.

Compare to F&C MN resource limit = $2,000 for 1 person.

b. Married Individual over age 18 with Community Spouse

Determine ABD countable resources, Chapter S11, M1480.

Compare to ABD MN resource limit=$2000

3. Are resources within MN limit?

Yes: go to C "Determine MN Income" below.

No: person not eligible for Medicaid due to excess resources; STOP. Go to section M1460.660 for notice procedures.

C. Determine MN Income

1. ABD groups

Determine ABD MN countable income, Chapter S08.

Compare to MN income limit for 1 person in individual's home locality - where the individual last resided in Virginia outside of an institution (use Group III MN limit if individual was admitted to Virginia facility from out-of-state).

2. F&C groups

Determine F&C MN income, Chapter M07.

Compare to MN income limit for 1 person in individual's home locality - where the individual last resided in Virginia outside of an institution (use Group III MN limit if individual was admitted to Virginia facility from out-of-state).

3. Is Income Less Than or Equal to MN Income Limit?

NOTE: A person who has gross income exceeding the 300% SSI limit will **always** have countable income that exceeds the MN limit.

Yes: eligible as MN; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

No: Spenddown; excess amount is "spenddown liability." Go to 4. below for facility patients, 5. below for CBC recipients.

***4.* Spenddown--Facility Patients**

The RUG code amount may differ from facility to facility and from patient to patient within the same facility. For MN patients, the nursing facility must be contacted to obtain the RUG code amount.

a. Spenddown Liability Less Than or Equal to the Individual's Medicaid Rate

If the spenddown liability is less than or equal to the individual's Medicaid rate, determine spenddown eligibility by projecting the facility's costs at the individual's Medicaid rate for the month. Spenddown balance after deducting projected costs at the individual's Medicaid rate should be zero or less.

The patient is eligible as MN for the whole month. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

b. Spenddown Liability More Than the Individual's Medicaid Rate

When the spenddown liability is **more than** the individual's Medicaid rate, determine spenddown eligibility AFTER the month has passed, on a daily basis (do not project expenses) by chronologically deducting old bills and carry-over expenses, then deducting the facility daily cost at the **private** daily rate and other medical expenses as they were incurred.

If the spenddown is met on any date within the month, the patient is eligible effective the first day of the month in which the spenddown was met. Eligibility ends the last day of the month.

Each month must be evaluated separately. These patients will always be enrolled after the month being evaluated has passed.

5. Spenddown--CBC Patients

Do not project CBC waiver services costs. Eligibility is evaluated on a monthly basis. Determine spenddown eligibility AFTER the month has passed, by deducting old bills and carry-over expenses first, then (on a daily basis) chronologically deducting the daily CBC cost at the **private** daily rate and other medical expenses **as they are incurred.** If the spenddown balance is met on a date within the month, the patient is eligible effective the first day of the month in which the spenddown was met. Eligibility ends the last day of the month.

Each month must be evaluated separately. These patients will always be enrolled after the month being evaluated has passed.

M1460.500 RESOURCE DETERMINATION

A. Introduction

The following sections describe the resource eligibility rules that are applicable to individuals in long-term care.

B. Resource Limits

1. ABD Groups

ALL aged, blind and disabled (ABD) covered groups = $2,000 per individual.

2. F&C Groups

F&C 300% SSI and Hospice groups = $1,000 for individuals age 18 and over, regardless of the number of individuals in the assistance unit. Children under age 18 do not have a resource requirement.

There are no resource *limits* for any other F&C covered group. *All LTSS evaluations require evaluation of substantial home equity and asset transfers, including annuities and trusts.*

1. **MN Groups**

MN groups = $2,000 for an individual and $3,000 for 2 persons (pregnant woman with 1 unborn child; add $100 for each additional unborn child).

C. Budget Period

The budget period for determining long-term care resource eligibility is always one month.

M1460.510 DETERMINING COUNTABLE RESOURCES

A. Married Individual

1. Married MAGI Adult

MAGI Adults do not have a resource assessment or resource limit. Evaluate substantial home equity and asset transfers, including annuities and trusts, made by the MAGI Adult and/or the spouse.

2. With A Community Spouse

See **subchapter M1480** for the rules to determine the **institutionalized individual's resource eligibility** when he is married and his spouse is a community spouse (the spouse is not in a medical institution or nursing facility).

a. Community Spouse Not Receiving Medicaid CBC Waiver Services

When both husband and wife have applied for Medicaid and one is institutionalized, and the community spouse does NOT receive Medicaid CBC waiver services, the community spouse's eligibility is processed as a noninstitutionalized individual.

NOTE: Follow resource determination rules found in chapter S11 for ABD covered groups, and in chapter M06 for F&C covered groups. The community spouse's resource eligibility is determined as a couple in the month the other spouse becomes institutionalized, and as an unmarried individual for the following months.

b. Community Spouse Receives Medicaid CBC Waiver Services

When both husband and wife have applied for Medicaid and one is institutionalized in a medical facility, and the community spouse receives Medicaid CBC waiver services, the community spouse's eligibility is processed as a married institutionalized Medicaid CBC recipient in the initial month of Medicaid CBC and afterwards, using the policy and procedures in subchapter M1480.

2. Both Spouses In A Medical Facility (No Community Spouse)

When the institutionalized individual's spouse is NOT a community spouse (the spouse is in a medical institution or nursing facility), the policy and procedures in subchapter M1460 that apply to an **unmarried individual** apply to the institutionalized individual effective the month of institutionalization and apply to the individual's spouse if the spouse also applies for Medicaid. Do not use subchapter M1480 because the individual is not an "institutionalized spouse" as defined in M1480.

When both husband and wife are institutionalized in a facility, the policy and procedures in subchapter M1460 that apply to **unmarried** individuals apply to each spouse in the initial month of institutionalization and afterwards.

3. Both Spouses Receive Medicaid CBC

When both spouses have applied for Medicaid and both receive Medicaid CBC waiver services, each spouse must be evaluated using policy and procedures in subchapter M1480**.**

B. Unmarried Individual

1. MAGI Adult Group

MAGI Adults do not have a resource assessment or resource limit. Evaluate substantial home equity and asset transfers, including annuities and trusts.

***2.* ABD Covered Groups**

An institutionalized individual is an assistance unit of 1 person, considered living separately from his family. No resources are deemed available from the individual's spouse. To determine the ABD resource eligibility of an unmarried individual, or married individual with no community spouse, use the ABD Resource policy and procedures found in chapter S11 and in section M1460.500.

For the ABD 80% FPL covered group, use the ABD resource policy and procedures in chapter S11 and Appendix 2 to chapter S11.

The maximum allowable resource limit for an ABD individual is $2,000.

NOTE: If the individual's resources exceed the resource limit, and the individual has Medicare Part A, evaluate for eligibility as QMB, SLMB, or QI (limited coverage) which have a higher resource limit.

3. **F&C Covered Groups**

An institutionalized individual is an assistance unit of 1 person, considered living separately from his family. No resources are deemed available from a child's parent(s).

NOTE: A pregnant woman's assistance unit includes the number of unborn children with which she is pregnant.

Use the resource policy and procedures in chapter M06 for the resource determination.

M1460.520 RETROACTIVE RESOURCE DETERMINATION

A. Policy

When an applicant reports that he received a medical service within the retroactive period, evaluate Medicaid eligibility for that period.

Evaluate resource eligibility for each month using resources available during that month.

B. Reduction of Resources

An individual cannot retroactively reduce resources. If countable resources exceeded the resource limit **throughout** a retroactive month, the individual is **not** eligible for that month. However, if an applicant reduces excess resources **within** a retroactive month, he may be eligible in the month in which the value of his resources is reduced to or below the Medicaid resource limit.

In order to reduce resources, liquid resources such as bank accounts and prepaid burial accounts must actually have been expended. Non-liquid resources must have been liquidated and the money expended.

M1460.530 HOME OWNERSHIP (NOT APPLICABLE TO ABD 80% FPL GROUP *OR MAGI ADULTS*)

A. Policy

The policy in this section does not apply to the ABD 80% FPL group. See Appendix 2 to chapter S11 for home ownership resource policy for the ABD 80% FPL group.

The policy in this section does not apply to MAGI Adults. However, the substantial home equity policy in M1460.160 DOES apply to MAGI Adults.

The institutionalized individual's former home in which he has an ownership interest, and which he occupied as his residence before becoming institutionalized, is not a countable resource for the first six months **following** admission to a medical facility or nursing facility. The former home is excluded indefinitely when it is occupied by a spouse, minor child, disabled adult child, or disabled parent.

B. Definitions for This Section

1. Dependent

A dependent child or parent is one who may be claimed as a dependent for tax purposes under the Internal Revenue Service's Code by either the institutionalized individual or his spouse.

2. Institutionalization

a. Definition

Institutionalization means receipt of 30 consecutive days of :

- care in a medical facility (such as a nursing facility), or
- Medicaid waiver services (such as community-based care); 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 consecutive days requirement is expected to be met if the pre-admission screening committee provides verbal or written confirmation of its approval for the individual's receipt of long-term care (LTC) services (see M1410.010).

NOTE: For purposes of this definition, continuity is broken by *180* or more consecutive days of:

- absence from a medical institution, or
- non-receipt of Medicaid waiver services.

EXCEPTION: When an individual is readmitted in less than 30 days due to a different diagnosis or a change in condition unforeseen at the time of discharge, a new 6-month home exclusion will begin if it was medically documented that the discharge occurred because facility services were no longer required and a physician documents that the change in circumstances could not be anticipated.

b. When Institutionalization Begins

Institutionalization begins the date of admission to a nursing facility or Medicaid waiver services when the pre-admission screening committee provides verbal or written confirmation of its approval for the individual's receipt of long-term care (LTC) services, or when the individual has been in the nursing facility for at least 30 consecutive days.

Institutionalization begins the date of admission to a hospital (acute care) when the individual has actually been a patient in the hospital for 30 consecutive days or more. For example, an individual was admitted to the general hospital on March 5. He applied for Medicaid on March 6. On April 3, he was still a patient in the general hospital. He was in the hospital for 30 consecutive days on April 3; his institutionalization began on the date he was admitted to the hospital, March 5. His eligibility for March is determined as an institutionalized individual.

The date of discharge from a medical institution into the community (and not receiving CBC waiver services) or death is **NOT** included in the 30 days.

3. Home Property

The home property is defined based on the individual's covered group, except when the individual is married with as community spouse. When the individual is married with a community spouse, **go to subchapter M1480.**

a. ABD Groups

The home property definition in section M1130.100 applies to ABD covered groups. An individual's home is property that serves as his or her principal place of residence. A home shall mean 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. If the individual has property contiguous to his home, the value of the non-home contiguous property over $5,000 is a countable resource, unless it can be excluded for another reason listed in subchapter S1130.

b. F&C Groups

The home property definition in section M0630.115 applies to F&C covered groups. Home property is the home used as the principal residence and all contiguous property. Contiguous property is the land, and improvements on that land, which adjoins the home and which is not separated by land owned by others.

4. Former Home

The patient's former home (including a mobile home) is his primary residence:

- which he owns, and
- which he occupied as his residence prior to admission to an LTC facility, or prior to moving out to receive Medicaid CBC waiver services in another person's home.

C. Exclude Former Home Indefinitely

The former home property can be excluded indefinitely when one of the following conditions is met:

1. Occupied By Spouse or Minor Child

The former home is occupied by the individual's spouse, minor dependent child under age 18, or dependent child under age 19 if attending school or vocational training.

2. Occupied By Disabled Adult Child or Disabled Parent

The former home is occupied by the individual's parent or adult child who:

- *has been determined to be* disabled according to the Medicaid disability definition;
- lived in the home with the recipient for at least one year prior to the recipient's institutionalization; and
- is dependent upon the recipient for his shelter needs.

3. ABD Groups--Home Exclusion Does Not Apply To Contiguous Property

For unmarried individuals and married individuals with no community spouses, the home exclusion for ABD covered groups applies to the home (dwelling) and the plot of land on which the home is located, and to the property contiguous to the home that comes under the home exclusion by using one of the two different calculations in section M1130.100. The home exclusion DOES NOT apply to the property contiguous to the home that does **not** come under the home definition in section M1130.100 A.2.

If the ABD individual owns property contiguous to his home, the value of the non-home contiguous property is a countable resource, regardless of whether the home is occupied by a dependent relative, unless the contiguous property can be excluded for another reason listed in subchapter S1130.

D. 6-Months Home Exclusion

The home is excluded as a primary residence during temporary absences for visits or to obtain medical treatment. The former home property is excluded as a resource for 6 months, beginning with the month **following** the month institutionalization begins.

1. ABD Groups--Exclusion Does Not Apply To Contiguous Property

The 6-month home exclusion for ABD covered groups applies to the home (dwelling) and the plot of land on which the home is located, and to the property contiguous to the home that comes under the home exclusion by using one of the two different calculations in section M1130.100. The 6-month home exclusion DOES NOT apply to the property contiguous to the home that does **not** come under the home definition in section M1130.100 A.2.

Therefore, if the ABD individual owns property contiguous to his home, the value of the non-home contiguous property is a countable resource, regardless of the individual's temporary absence, unless the contiguous property can be excluded for another reason in subchapter S1130.

2. Facility Admission

The former home property is excluded for 6 full months beginning with the month **following** the month of institutionalization in a medical facility. The property is no longer "home property" after 6 months of absence due to institutionalization. An individual who has been receiving Medicaid CBC waiver services in his own home and who then enters a nursing facility receives the six months former home exclusion starting with the month following the month of admission to the facility.

Individuals re-admitted to a medical facility 30 days or more after discharge will have the six-months former home exclusion start over again.

EXAMPLE #1: Mr. G is an unmarried aged individual who has been receiving Medicaid CBC waiver services in his home since February 2, 1997. He was admitted to a nursing facility on June 20, 1998. He owns his home, which has no contiguous property. His former home property is excluded for 6 months after admission, beginning July 1, 1998 and ending December 31, 1998

3. Medicaid CBC Waiver Services Admission

A Medicaid CBC waiver services recipient who is living away from the home established as his primary place of residence, in order to receive medical care, is entitled to the six months' home exclusion. The six months will start with the month **following** the month in which he left his home.

An individual who is discharged from a nursing facility to go home and receive Medicaid CBC waiver services is considered as living on the home property. The home property, as defined by the appropriate manual section, is excluded while the individual lives there.

EXAMPLE #2: Mr. B is an unmarried aged individual living in his home. He was admitted to Medicaid CBC waiver services on January 20, 1999, the day he moved into his daughter's home. He owns his home, which has no contiguous property. His former home property is excluded for 6 months after the month in which he moved to his daughter's home. The 6-months exclusion begins February 1, 1999 and ends July 31, 1999.

E. After Six Months

At the end of six months of continuous absence due to institutionalization, the former home property must be counted as an available resource if owned by the recipient, unless it can be excluded for another reason.

1. Exclude Indefinitely

The former home property (residence) can be excluded indefinitely when one of the conditions in section M1460.530 C. above is met.

2. Exclude Under Resource Rules

If the former residence is not excluded because it is not occupied by an individual who meets the requirements in section M1460.530 C. above, determine if it can be excluded under the resource rules applicable to the individual's covered group.

a. ABD Covered Groups

1) Reasonable but Unsuccessful Efforts to Sell (section M1130.140).

2) Indians' Interest in Trust or Restricted Lands (section S1130.150).

3) Other Real Property (section M1130.160).

4) Property Essential to Self-support (sections S1130.500 through S1130.510).

b. F&C Covered Groups

1) Excluded Resources (section M0630.100).

2) Reasonable Effort To Sell (CN) (section M0630.105).

3) Reasonable Effort To Sell For the Medically Needy (section M0630.110).

F. Home No Longer Excluded

If the individual's home property is no longer excluded and the individual has excess resources, cancel Medicaid because of excess resources when the individual does not have Medicare Part A. If the individual has Medicare Part A, evaluate the individual's eligibility as ABD Medicare Savings Program (MSP) which has more liberal resource requirements and limits (see M0320.600).

1. Individual Has Medicare Part A

When the individual has Medicare Part A:

a. compare income with the ABD MSP limits; if the income is below one of the ABD MSP income limits, then

b. evaluate the resources using ABD MSP policy as found in Chapter S11, Appendix 2.

c. If eligible as ABD MSP only, Medicaid will not pay for nursing facility or CBC waiver services costs. Do the following:

- prepare and send an Advance Notice of Proposed Action to the recipient;
- cancel the recipient's coverage, then reinstate the recipient to ABD MSP limited coverage;
- send a Medicaid LTC Communication Form (DMAS-225) to the provider, stating that the recipient is no longer eligible for full Medicaid coverage because of excess resources, but is eligible for limited ABD MSP coverage; beginning (specify the date following the cancel date of the recipient's full coverage), Medicaid will not pay for the individual's care.

d. If NOT eligible as ABD MSP because of resources and/or income, cancel the recipient's Medicaid. Do the following:

- prepare and send an "Advance Notice of Proposed Action" to the recipient;
- cancel the recipient's Medicaid coverage because of excess resources or income;

- send a DMAS-225 to the provider, stating that the recipient's Medicaid will be canceled because of excess resources (and/or income) and the effective date of cancellation.

2. Individual Does Not Have Medicare Part A

When the individual DOES NOT have Medicare Part A:

a. cancel the recipient's Medicaid coverage because of excess resources;

b. prepare and send an Advance Notice of Proposed Action to the recipient;

c. send a DMAS-225 to the provider, stating that the recipient's Medicaid will be canceled because of excess resources, and the effective date of cancellation.

M1460.540 SUSPENSION PROCEDURES

A. Policy

This section applies ONLY to Medicaid recipients:

- who are enrolled in ongoing Medicaid coverage and
- whose patient pay exceeds the Medicaid rate.

B. Procedures

If a Medicaid recipient's patient pay exceeds the Medicaid rate and his resources go over the Medicaid resource limit, take the following actions:

1. For Recipients Who Have Medicare Part A

a. Resources Less Than or Equal to ABD MSP Resource Limit

If the recipient's resources are less than or equal to the higher ABD **MSP** resource limit, **determine** if the recipient's income is less than or equal to the QMB, SLMB, or QI income limit.

1) When the recipient's income is less than or equal to the QMB, SLMB, or QI income limit:

a) prepare and send an advance notice to reduce the recipient's Medicaid coverage from full benefits to limited benefits (specify the appropriate QMB, SLMB, or QI coverage). Write a note on the notice telling the recipient that:

- the limited (QMB, SLMB, or QI) benefits will NOT pay for long-term care services, and
- if he verifies that his resources are less than or equal to the $2,000 resource limit, he should request reinstatement of full Medicaid benefits.

b) **cancel** the recipient's full coverage effective the last day of the month in which the 10-day advance notice period expires. Reinstate the recipient's coverage with the begin date as the first day of the month following the cancellation effective date, using the appropriate QMB, SLMB or QI AC.

2) When the recipient's income exceeds the QMB, SLMB and QI income limits, follow the procedures in 2 below (the procedures for recipients who do not have Medicare Part A).

b. Resources Exceed ABD MSP Resource Limit

If resources are greater than the ABD MSP resource limit, follow the procedures in item 2 below (the procedures for recipients who do not have Medicare Part A).

2. For Recipients Who Do NOT Have Medicare Part A

a. Prepare and Send Advance Notice

Prepare and send an advance notice to cancel the recipient's Medicaid eligibility. Specify the effective date, which is the last day of the month in which the 10-day advance notice period expires. Write a note on the notice telling the recipient that if he verifies that his resources are less than or equal to the $2,000 resource limit before the specified date (specify the date which is 3 months from the cancel effective date), he should request reinstatement of Medicaid eligibility.

b. Cancel Medicaid Eligibility

Cancel the recipient's eligibility effective the last day of the month in which the 10-day advance notice period expires.

c. Suspend Case Administratively

Suspend the case administratively for a maximum of 3 months; do not close the case statistically. The suspension effective date is the effective date of the Medicaid cancellation in *VaCMS*. While suspended, the case remains open for a maximum of 3 months.

If, by the end of 3 months from the suspension effective date, the individual provides verification that his resources have been reduced to or below the resource limit, document the reduction in resources in the individual's *VaCMS* case record. Reinstate his Medicaid eligibility effective the first day of the month in which his resources are less than or equal to the resource limit.

If the individual does NOT provide verification within 3 months of the suspension effective date that his resources have been reduced to or below the resource limit, close the case administratively and statistically. Do not take any action on his enrollment in *VaCMS*, because his eligibility has already been canceled. The individual will have to file a new Medicaid application.

M1460.600 INCOME DETERMINATION

A. Introduction

This section provides the income requirements specific to determinations of eligibility for Medicaid participation in payment of long-term care services.

B. F&C *CN*

If an institutionalized individual meets an F&C *CN* covered group, determine if his income is within the appropriate F&C income limit. The institutionalized individual is an assistance unit of one person; no income is deemed from responsible relatives. Use the policy and procedures in chapters M04 and M07 to determine countable income.

C. MAGI Adult Group

If an individual is between the ages of 19 and 64 and is not entitled to or receiving Medicare, determine if his MAGI household income is less than or equal to 138% of the Federal Poverty Level (FPL). Use the policy in Chapter M04 to determine countable income.

D. ABD 80% FPL Group

If an individual is aged, blind or disabled, determine if his income is less than or equal to 80% of the FPL. See M0810.002 A.5 for the ABD 80% FPL income limits. The ABD income policy in Chapter S08 is used to determine countable income for the ABD 80% FPL covered group. *However, the income items listed in Sections M1460.610 and M1460.611 are NOT counted as income in determining income eligibility as an institutionalized individual for the ABD 80% FPL covered group.*

E. 300% SSI Income Limit Group

For purposes of this section, we refer to the ABD covered group and the F&C covered group of "individuals in medical facilities who have income less than or equal to 300% of the SSI individual payment limit" and "individuals receiving Medicaid waiver services who have income less than or equal to 300% of the SSI individual payment limit" as one covered group. We refer to this one group as "institutionalized individuals who have income within 300% of SSI" or the "300% SSI group."

1. Assistance Unit

The institutionalized individual is an assistance unit of one person; no income is deemed from responsible relatives.

2. Income Limit

The income limit for ABD and F&C individuals in the 300% SSI group is 300% of the SSI individual payment limit (see M0810.002 A. 3).

3. Countable Income

Income sources listed in section M1460.610 are NOT considered income.

Income sources listed in section M1460.611 ARE counted as income.

All other income is counted. The individual's gross income is counted; no exclusions are deducted.

To determine an income type or source and to determine how to count the income, use the policy and procedures in chapter S08 for all individuals (both ABD and F&C) in this covered group.

Income is projected for the month for which eligibility for LTC is being determined. This calculation is based upon the income received in the past month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount expected to be received.

E. **MN Income - All MN Covered Groups**

The medically needy (MN) individual income limits are listed in Appendix 5 to subchapter M0710 and in section M0810.002 A.4.

1. ABD MN Covered Groups

Evaluate MN resource and income eligibility for ABD individuals who have income over the 300% SSI income limit.

The income sources listed in sections M1460.610 "What is Not Income" and M1460.611 "Countable Income for the 300% SSI Group" are NOT counted. Countable income is determined by the income policy in chapter S08; applicable exclusions are deducted from gross income to calculate the individual's countable income.

The income actually received in the retroactive period is considered for retroactive eligibility. The income expected to be received within the application month is considered when determining eligibility in that month. The income expected to be received within a month is counted in that month for ongoing eligibility.

2. F&C MN Covered Groups

Evaluate MN resource and income eligibility for F&C individuals who have income over the 300% SSI income limit.

Countable income is determined by the income policy in chapter M07, using a monthly budget period; applicable exclusions are deducted from gross income to calculate the individual's countable income. In addition, the income sources listed in sections M1460.610 B and M1460.611 are NOT counted.

Anticipated income is projected for the month for which eligibility is being determined. This calculation is based upon the income received in the prior month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount to be received.

M1460.610 WHAT IS NOT INCOME

A. Introduction

This section contains a list of items that are not considered as income when determining income eligibility for institutionalized individuals in medical facilities or Medicaid CBC waiver services.

NOTE: The income items in C. below ARE COUNTED as income only when determining F&C medically needy eligibility.

B. What Is Not Income - All Covered Groups

Do not consider the types of items in this subsection as income **when determining eligibility or patient pay for all covered groups.**

1. Federal/State Government Payments & Programs

Benefits provided under the following federal and state government program payments are not income:

a. Supplemental Security Income (SSI) payments.
b. Auxiliary grants (AG) payments.
c. Temporary Assistance to Needy Families (TANF) payments.
d. *Supplemental Nutrition Assistance Program (SNAP) (formerly* Food Stamps*).*
e. Women, Infants and Children (WIC) coupons.
f. IV-E and Non IV-E Foster Care payments [ref. 1612(b)(10)].
g. IV-E and Non IV-E Adoption Assistance payments.
h. Food and Meal programs with government involvement:

- school breakfasts,
- school lunches,
- milk programs.

2. Medical or Social Services

(S0815.050) Cash or in-kind items received from governmental medical or social services programs, unless it is remuneration for work or activities performed as a participant in a sheltered workshop or an incentive payment to encourage individuals to use specific facilities or to participate in specific medical or social services programs, is not income. For example, Title XX, Title IV-B, Child Welfare Services, Title V, Maternal and Child Health Services, services under the Rehabilitation Act of 1973 are cash or in-kind medical or social services received from a government program and are NOT income.

NOTE: Education in public schools, vocational training and government income maintenance programs such as VA are NOT social services programs. The provision of food, shelter, laundry, or recreation is not a social service.

3. Non-government Medical or Social Services

(S0815.050 F1) Cash received from **non-governmental** medical or social services programs, such as Red Cross or Salvation Army, for medical or social services already received by individuals and approved by the organizations is not income.

4. Personal Services

(S0815.150) Personal services performed for an individual is not income, e.g., mowing the lawn, doing housecleaning, going to the grocery store, babysitting are not counted as income to the individual who receives the personal service.

5. Conversion of a Resource

(S0815.200) Receipts from the sale, exchange, or replacement of a resource are not income; they are a conversion of a resource from one form of resource to another form of resource.

6. Income Tax Refund

(S0815.270) Any amount refunded on income taxes already paid is not income.

7. Credit Life/Disability Payments

(S0815.300) Payments made under a credit life or credit disability insurance policy on behalf of an individual are not income.

8. Loan Proceeds

(S0815.350) Proceeds of a bona fide loan are not income to the borrower because of the borrower's obligation to repay.

9. Third Party Payments

a. Payments made by another individual

(S0815.400) Payment of an individual's bills (including Medicare supplementary medical insurance or other medical insurance premiums) by a third party directly to the supplier is not income.

Payments made directly to the service provider by another person for the individual's private room or "sitter" in a medical facility are **not** income to the individual. Refer all cases of Medicaid eligible recipients who have a "sitter" to DMAS, Division of *Aging and Disability Services*, for DMAS review to assure that DMAS is not paying the facility for services provided by the sitter.

EXCEPTION: For F&C covered groups **except** the 300% SSI group: If the person paying the bill(s) is the child's absent father and the Division of Child Support Enforcement (DCSE) has not established an obligation for the absent parent, the amount(s) paid by the absent parent for the child is counted as income.

b. Long-term care (LTC) insurance payments

Institutionalized individuals who have LTC insurance coverage must have the LTC insurance coverage information entered into the recipient's TPL file in VaCMS. The insurance policy type is "H" and the coverage type is "N."

If the patient receives the payment from the insurance company, it is not counted as income. The patient should assign it to the provider. If the patient cannot do this, or the policy prohibits assignment, the payment should be given directly to the provider. The provider should report the payment as a third party payment on its claim form. If the patient received the payment and cannot give it to the provider for some reason, then the patient should send the insurance payment to the DMAS Fiscal Division, *Cashiering Unit*, 600 E. Broad Street, Suite 1300, Richmond, Virginia 23219.

10. Replacement Income

(S0815.450) If an individual's income is lost, stolen, or destroyed and the individual receives a replacement, the replacement is not income if the original payment was counted in determining the individual's Medicaid eligibility.

11. Erroneous Payments

(S0815.460) A payment is not income when the individual is aware that he is not due the money and returns the check uncashed or otherwise refunds all of the erroneously received money.

12. Weatheriza-tion Assistance

(S0815.500) Weatherization assistance (e.g., insulation, storm doors, and windows, etc.) is not income.

13. Certain Employer Payments

(S0815.600) The following payments by an employer are not income UNLESS the funds for them are deducted from the employee's salary:

a. funds the employer uses to purchase qualified benefits under a "cafeteria" plan;

b. employer contribution to a health insurance or retirement plan;

c. the employer's share of FICA taxes or unemployment compensation taxes in all cases;

d. the employer's share of FICA taxes or unemployment compensation taxes paid by the employer on wages for domestic service in the private home of the employer or for agricultural labor only, to the extent that the employee does not reimburse the employer.

14. Payments to Victims of Nazi Persecution

Any payments made to individuals because of their status as victims of Nazi persecution are not income [P.L.103-286 and 1902(r)(1)].

15. Advance Payments That will Be Reimbursed

Advance payments made by a person other than the patient which are expected to be reimbursed once Medicaid is approved, and payments made by outside sources to hold the facility bed while the patient is hospitalized, are **not counted as income** in determining eligibility or patient pay.

There are instances when the family of a prospective Medicaid patient, or other interested party(ies), makes an advance payment on the cost of facility care prior to or during the Medicaid application process to assure the Patient's admission and continued care. The individual may have been promised that the advance payment will be refunded if Medicaid eligibility is established. Any monies contributed toward the cost of patient care pending a Medicaid eligibility determination must be reimbursed to the patient or the contributing party by the facility once Medicaid eligibility is established.

16. Medical Expense Reimburse-ment

Medical expense reimbursement from either VA or an insurance policy is not income. Medical expense reimbursements are resources.

The income in items 17 through 23 below are not income by other federal statutes or law:

17. Energy Assistance

Energy Assistance through Block Grants (Virginia's Fuel Assistance payments) is excluded [P.L. 93-644].

18. Radiation Exposure Trust Fund

Radiation Exposure Compensation Trust Fund payments are excluded [P.L. 101-426].

19. Agent Orange Agent Orange Payments are excluded [P. L. 101-239].

20. Native American Funds The following funds for Native Americans are excluded *for all covered groups:*

a. Alaska Native Claims Settlement Act (cash payments not to exceed $2,000) [P.L. 100-241]

b. Maine Claims Settlement Act [P.L. 96-420]

c. Blackfeet and Gros Ventre [P.L. 92-254]

d. Grand River Band of Ottawa [P.L. 94-540]

e. Red Lake Band of Chippewa [P.L. 98-123]

For MAGI Adults, the following payments to American Indian/Alaska Natives are also not counted as income:

a. distributions received from the Alaska Native Corporations and Settlement Trusts (Public Law 100-241),

b. distributions from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the Supervision of the Interior,

c. 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.*

d. 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.

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

C. What Is NOT Income For All Covered Groups EXCEPT F&C MN

The items below are NOT income when determining eligibility *as an institutionalized individual* for all covered groups EXCEPT for the F&C MN covered groups. Count these income sources in the F&C medically needy income determination, **but NOT in the patient pay calculation.**

1. Specific VA Payments

The following VA payments are NOT income for all covered groups EXCEPT the F&C MN covered groups:

a. Payments for Aid and Attendance or housebound allowances. Refer to section M1470.100 for counting Aid and Attendance payments as income in the patient pay calculation.

NOTE: This applies to all LTC recipients, including those patients who reside in state veterans' care centers.

b. Payments for unusual medical expenses.

c. Payments made as part of a VA program of vocational rehabilitation.

d. VA clothing allowance.

e. Any pension paid to a nursing facility patient who is

- a veteran with no dependents,
- a veteran's surviving spouse who has no child, or
- *a veteran's dependent child.*

NOTE: Refer to section M1470.100 for counting VA pension payments as income for post-eligibility determinations. This applies to all LTC recipients, including those patients who reside in state veterans' care centers.

f. Any portion of a VA educational benefit which is a withdrawal of the veteran's own contribution is a conversion of a resource and is not income.

2. VA Augmented Benefits

An absent dependent's portion of an augmented VA benefit received by the individual on or after 11-17-94 is NOT income to the individual when determining his eligibility in any covered group EXCEPT an F&C MN covered group.

VA Augmented benefits are COUNTED as income when determining eligibility in the F&C MN covered groups.

3. Return of Money

(S0815.250) A rebate, refund, or other return of money that an individual has already paid is NOT income to the individual when determining his eligibility in any covered group EXCEPT an F&C MN covered group. The key idea is a return of the individual's own money. Some "rebates" do not fit this category, such as a cooperative operating as a jointly owned business pays a "rebate" as a return on a member's investment; this "rebate" is unearned income similar to a dividend.

4. Death Benefits

Death benefits **equal** to cost of last illness and burial are NOT income in all covered groups EXCEPT the F&C MN covered groups.

Any amount of the death benefit that **exceeds** the costs of last illness and burial **is counted as income** for eligibility and patient pay **in all covered groups**.

5. Austrian Social Insurance

Austrian Social Insurance payments that meet the requirements in S0830.715 are NOT income in all covered groups EXCEPT the F&C MN covered groups.

6. Native American Funds

a. Seneca Nation Settlement Act [ref. P.L. 101-503]

b. Yakima Indian Nation [ref. P.L. 99-433]

c. Papago Tribe of Arizona [ref. P.L. 97-408]

d. Shawnee Indians [ref. P.L. 97-372]

e. Miami Tribe of Oklahoma and Indiana [ref. P.L. 97-376]

f. Clallam Tribe [ref. P.L. 97-402]

g. Pembina Chippewa [ref. P.L. 97-403]

h. Confederated Tribes of Warm Springs Reservation [ref. P.L. 97-436].

M1460.611 COUNTABLE INCOME FOR THE 3OO% SSI GROUP

A. Applicability

This section contains a list of income sources and amounts of income that are COUNTED when determining income eligibility for the 300% SSI group, but may be excluded when determining income eligibility for the other covered groups.

B. Items Under 1612(b) and Footnote 57 (counted also as patient pay income)

Count the following income sources in this subsection when determining eligibility for the **300% SSI income limit group**.

DO NOT COUNT the income sources in this section when determining the income eligibility in **all other Medicaid covered groups.**

1. ACTION Program

Action Program. This is the federal domestic volunteer agency which provides programs such as the Special and Demonstration Volunteer Programs. This includes the following programs: [Refer to P.L. 93-113]

- Retired Senior Volunteer Program (RSVP)
- Foster Grandparent Program
- Senior Companion Program
- University Year for Action
- VISTA
- Special and Demonstration Volunteer Programs.

2. BIA Student Assistance

Bureau of Indian Affairs Student Assistance [ref. P.L. 89-329].

3. Disaster Assistance

Presidentially declared disaster assistance. This includes assistance from federal programs and agencies, joint federal and state programs, state or local government programs, and private organizations such as the Red Cross [1612(b) (11)].

4. EITC

Earned income tax credit payments [1612(b) (19)].

5. Federal Relocation

Federal Relocation Assistance [ref. P.L. 91-646].

6. Infrequent or Irregular Income

Any infrequent/irregular income. See Chapter S08 for the ABD policy. See Chapter M07 for the F&C policy.

7. Native Americans' Funds

Funds for Native Americans, including funds from:

- Indian Tribal Judgment Funds Use or Distribution Act [ref. P.L. 93-134]
- ·Indian Tribes Submarginal Land Act [ref. P.L. 94-114].

8. Specific Restitution

Japanese-American and Aleutian Restitution payments [ref. P.L. 100-383].

9. Grants, Scholarships, Fellowships

Any portion of a grant, scholarship or fellowship that is for the cost of tuition and fees at any educational institution, including those for vocational or technical training [1612(b)(7)].

10. Student Loans & Grants

The following student loans or grants:

a. National Defense Student Loans [ref. P.L. 89-329].
b. Pell Grants [ref. P.L. 89-329].
c. Supplemental Education Opportunity Grants (SEOG) [ref. P.L. 89-329].
d. State Student Incentive Grants [ref. P.L. 89-329].

C. Count for 300% SSI Group; (counted as patient pay income)

Count the income sources in this subsection when determining eligibility and patient pay for the **300% SSI group AND all F&C covered groups**.

Do not count the income sources in this section when determining the Income eligibility of the **ABD MN** covered groups.

1. Interest on Disaster Assistance

Interest income on disaster assistance within first nine months of receipt of the payment [1612(b) (12)].

2. Tax Refund

Tax refund on food or real property.

3. Assistance Payments

State or local assistance payments that are based on need [1612(b) (6)].

4. Energy Assistance

Support or maintenance assistance which is based on need and which is furnished in kind by a nonprofit agency, or furnished by supplier of home heating oil or gas, by an entity providing home energy, or by a municipal utility providing home energy [1612(b)(13)]. Energy assistance that is provided by a source other than the "Block Grants" (Virginia's Fuel Program) [1612(b) (13)].

5. Housing Assistance

Housing assistance (including Farmer's Home Assistance payments) under the U.S. Housing Act of 1937, the National Housing Act, section 101 of the Housing and Urban Development Act of 1965, title V of the Housing Act of 1949, or section 202(h) of the Housing Act of 1959 [1612(b) (14)] *paid directly to the applicant/recipient. Do not count housing assistance payments that are not paid directly to the applicant/recipient.*

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 2024, up to $2,290 per month, but no more than $9,230 in a calendar year, of the earned income of a blind or disabled child.*

For 2023, up to $2,220 per month, but not more than $8,950 in a calendar year, of the earned income of a blind or disabled student child.

For 2022, up to $2.040 per month, but not more than $8,230 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)].

13. **Native American Funds**

The following Native American funds (only exclude for ABD MN groups):

a. Puyallup Tribe [ref. P.L. 101-41]
b. White Earth Reservational Land Settlement [ref. P.L. 99-264]
c. Chippewas of Mississippi [ref. P.L. 99-377]
d. Saginaw Chippewas of Michigan [ref. P.L. 99-346]
e. Shoalwater Bay Indian Tribe [ref. P.L. 98-432]
f. Wyandotte Tribe [ref. P.L. 98-602]
g. Chippewas of Lake Superior [ref. P.L. 99-146]
h. Cow Creek Band of Umpqua [ref. P.L. 100-139]
i. Coushatta Tribe of Louisiana [ref. P.L. 100-411]
j. Wisconsin Band of Potowatomi [ref. P.L. 100-581]
k. Seminole Indians [ref. P.L. 101-277]
l. receipts from land distributed to:

- Pueblo of Santa Ana [ref. P.L. 95-498]
- Pueblo of Zia [ref. P.L. 95-499].

14. **State/Local Relocation**

State or local relocation assistance [1612(b) (18)].

15. **USC Title 37 Section 310**

Special pay received pursuant to section 310 of title 37, United States Code [1612(b)(20)].

NOTE: For additional F&C medically needy (MN) income exclusions, go to Chapter M07. For additional ABD medically needy (MN) income exclusions, go to Chapter S08.

M1460.620 RESERVED

M1460.640 INCOME DETERMINATION PROCESS FOR STAYS LESS THAN 30 DAYS

A. Policy - Individual in An Institution for Less Than 30 Days

This subsection is applicable ONLY if it is known that the time spent in the institution has been, or will be, less than 30 days. If the individual is institutionalized for less than 30 days, Medicaid eligibility is determined as a non-institutionalized individual because the definition of "institutionalization" is not met. If there is no break between a hospital stay and admission to a nursing facility or Medicaid CBC waiver services, the hospital days count toward the 30 days in the "institutionalization" definition.

B. Recipient

If a Medicaid recipient is admitted to a medical institution for less than 30 days, go to subchapter M1470 for patient pay policy and procedures.

C. Applicant

If the individual is NOT a Medicaid recipient and applies for Medicaid determine the individual's income eligibility as a non-institutionalized individual. Go to Chapter M07 for F&C or S08 for ABD to determine the individual's income eligibility.

M1460.650 RETROACTIVE INCOME DETERMINATION

A. Policy

The retroactive period is the three months immediately prior to the Application month. The three-month retroactive period cannot include a portion of a prior Medicaid medically needy spenddown budget period in which eligibility was established.

1. Institutionalized Individual

For the retroactive months in which the individual was institutionalized in a medical facility, determine income eligibility on a monthly basis using the policy and procedures in this subchapter (M1460). An individual who lived outside of a medical institution during the retroactive period must have retroactive Medicaid eligibility determined as a non-institutionalized individual.

A spenddown must be established for any month(s) during which excess income existed. Go to M1460.700 for spenddown policies and procedures for medically needy institutionalized individuals.

2. Individual Not Institutionalized

For the retroactive months in which the individual was NOT institutionalized, determine income eligibility for the ABD groups using the ABD policy and procedures in chapter S08. Determine income eligibility for the F&C groups using policy and procedures in chapters *M04 and* M07. *Determine income eligibility for MAGI Adults using the policy and procedures in chapter M04.*

If the individual meets a MN covered group, a spenddown must be established for any month(s) during which excess income existed. See Chapter M13 for spenddown policies and procedures. *There is no MN covered group for MAGI Adults.*

3. Retroactive Entitlement

If an applicant meets all eligibility requirements, he is entitled to Medicaid coverage for the month(s) in which all eligibility factors were met.

B. Countable Income

Countable income is that income which was actually received in the retroactive month(s). Count the income received in the months in which the individual meets all other Medicaid eligibility requirements.

If the individual was CN in the retroactive month, the countable income is compared to the appropriate income limit for the retroactive month. **Medicaid income eligibility is determined on a monthly basis for the MN institutionalized individual.**

C. Entitlement

Retroactive coverage cannot begin earlier than the first day of the third month prior to the application month. When an applicant reports that he received a medical service within the retroactive period, entitlement for Medicaid will begin with the first day of the third month prior to the application month, provided all eligibility factors were met in all three months. If the institutionalized applicant had excess income in the retroactive period, entitlement may begin the first day of the month in which the retroactive spenddown was met.

For additional information, refer to section M1510.101.

D. Retroactive Income Determination Example

EXAMPLE #3: A disabled institutionalized individual applies for Medicaid on June 5 and requests retroactive coverage for unpaid medical bills that he incurred in March, April, and May. His disability onset date was April 10. He was institutionalized on April 10.

The retroactive period is March, April and May. He is not eligible for March because he did not meet a covered group in March. The income he received in April and May is counted monthly because he was institutionalized in each month. He is resource eligible for all three months.

His April income is calculated and compared to the monthly 300% SSI income limit. It exceeds that limit. His May income is calculated and compared to the monthly 300% SSI income limit; it is within the limit. Therefore, he is placed on a one-month retroactive spenddown for April, and is enrolled in the 300% SSI covered group for May.

M1460.660 NOTICES & ENROLLMENT PROCEDURES FOR CATEGORICALLY NEEDY

A. CN Eligible Enrollment

Enroll the recipient with the appropriate CN aid category (AC) as follows:

1. SSI

011 Aged
031 Blind
051 Disabled

2. "Protected" ABD Covered Groups

021 Aged
041 Blind
061 Disabled

3. MAGI Adults

100 *Parent/Caretaker-relative; income at or below 100% FPL*
101 *Parent/Caretaker-relative; income greater than 100% FPL, but less than or equal to 138% FPL (133% + 5% disregard)*
102 *Childless Adult; income at or below 100% FPL (no disregard)*
103 *Childless Adult; income greater than 100% FPL, but less than or equal to 138% FPL (133% + 5% disregard)*
106 *Presumptive Eligible MAGI Adult; income at or below 138% FPL (133% + 5% disregard)*

4. ABD 80% FPL

029 Aged
039 Blind
049 Disabled

5. MEDICAID WORKS

059

6. 300% SSI

a. ABD

Not dually eligible as a Qualified Medicare Beneficiary (QMB) or Special Low Income Medicare Beneficiary (SLMB); individual does not have Medicare Part A and/or income equal to or greater than 120% FPL:

020 Aged
040 Blind
060 Disabled

Dually eligible; individual has Medicare Part A and income within 100% FPL

022 Aged also QMB
042 Blind also QMB
062 Disabled also QMB

Dually eligible; individual has Medicare Part A and income greater than 100% FPL but less than 120% FPL

- **025** aged individual also SLMB
- **045** blind or disabled also SLMB

b. F&C

060 F&C who does not meet "Individuals Under Age 21 in an ICF or ICR/MR covered group, not blind or disabled

082 Institutionalized child under age 21 in an ICF or ICF/MR, not blind or disabled

NOTE: Children who are eligible in the Child Under Age 19, FAMIS Plus, covered group should be enrolled in the appropriate AC for their age and income (see *M1460.660 A.10* below)

7. All Foster Care and Adoption Assistance

072 Adoption Assistance
076 Foster Care

8. Individuals Under age 21

075 child under supervision of Juvenile Justice Department
082 Child in an ICF or ICF/MR

9. LIFC

081 Parent/caretaker of a dependent child
083 Unemployed parent of a dependent child; 2 parent household

10. Child Under Age 19 FAMIS Plus

091 Child under age 6 w/income less than or equal to the **100% FPL**

090 Child under age 6, income greater than the **100% FPL b**ut less than or equal to the **133% FPL**

092 Child age 6 to 19 **insured or uninsured** w/income less than or equal to the **100% FPL; or insured** w/income greater than 100% and less than or equal to the **133% FPL**

094 Uninsured child age 6 to 19 w/income greater than 100% FPL and less than or equal to the **133% FPL**

11. Pregnant Women **091**

12. BCCPTA **066**

B. CN Eligible Complete & Send Notice

Complete a "Notice of Action on Medicaid and FAMIS to notify the individual of his Medicaid eligibility and coverage begin date. Go to subchapter M1470 to determine the individual's patient pay.

C. Income Exceeds CN Covered Groups Limits

If income exceeds the 300% SSI limit, evaluate as MN. If the individual meets an MN covered group, re-calculate countable income for MN.

Subtract the income exclusions listed in sections M1460.610 and 611 that apply to the individual's MN covered group. Go to section M1460.700 below.

If the individual does NOT meet an MN covered group, he is not eligible for Medicaid; go to subsection D. below.

D. Ineligible--Notice

Complete and send a "Notice of Action on Medicaid and FAMIS" to the individual notifying him that he is not eligible for Medicaid and of his appeal rights.

M1460.700 MEDICALLY NEEDY INCOME & SPENDDOWN

A. Policy

Institutionalized individuals whose income exceeds the 300% SSI income limit must be placed on a monthly medically needy (MN) spenddown if they meet a MN covered group and have countable resources that are less than or equal to the MN resource limit. Countable income for the MN is different than countable income for the 300% SSI covered group. Recalculate income using medically needy income principles.

For individuals who were within a spenddown budget period prior to the month in which they become institutionalized, prorate and shorten the spenddown budget period for the months prior to admission to long-term care services.

Income for all LTC recipients is determined on a monthly basis. Upon receipt of long term care services, the spenddown budget period is one month. A separate monthly spenddown budget period is established for each month of receipt of LTC services.

A spenddown case is considered denied; however, the application is valid for a certification period of 12 months from the last application or redetermination.

B. Spenddown Procedures

The spenddown procedures for facility patients differ from the spenddown procedures for CBC patients. The expected monthly cost of the facility care is projected at the beginning of the month. The cost of CBC is NOT projected and must be deducted daily as incurred. Specific instructions for determining MN income eligibility for facility and CBC patients are provided in the following sections:

- M1460.710 Spenddown For Facility Patients
- M1460.740 Spenddown For Patients Receiving CBC
- M1460.750 Medically Needy Spenddown Enrollment and Post-eligibility Procedures.

M1460.710 SPENDDOWN FOR FACILITY PATIENTS

A. Policy

Facility patients in the MN classification fall into two distinct subgroups for the purpose of spenddown eligibility determination. These subgroups are:

1. individuals with a spenddown liability less than or equal to the *individual's* Medicaid rate.

2. individuals with a spenddown liability greater than the *individual's* Medicaid rate.

The RUG code amount may differ from facility to facility and from patient to patient within the same facility. The nursing facility must be contacted to obtain the RUG code amount whenever a daily facility cost of care is needed to determine eligibility and patient pay for medically needy individuals.

Entitlement and enrollment procedures depend on whether the individual's spenddown liability is less than, equal to or greater than the Medicaid rate.

Applications for individuals who are placed on spenddown are valid for a 12 month period and the cases are subject to annual redetermination.

B. Determine the Spenddown Liability

Calculate the individual's monthly MN income:

1. ABD MN Groups

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

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

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

2. F&C MN Groups

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

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

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

a. The remainder is the MN monthly countable income.

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

C. Determine the Individual's Projected Medicaid Rate

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

D. Compare

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

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

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

Go to section M1460.750 below for enrollment procedures.

F. SD Liability Is Greater Than Medicaid Rate

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

To determine spenddown eligibility for a medically needy individual whose spenddown liability is greater than the *individual's* Medicaid rate, go to G. below.

G. Facility Spenddown Determination Procedures

To determine spenddown eligibility for a medically needy institutionalized individual whose spenddown liability is greater than the *individual's* Medicaid rate, take the following actions:

1. Calculate Private Cost of Care

Multiply the facility's **private** per diem rate by the number of days the individual was actually in the facility in the month. Do not count any days the individual was in a hospital during the month.

The result is the private cost of care for the month.

2. Compare to Spenddown Liability

Compare the private cost of care to the individual's spenddown liability for the month.

a. Private Cost of Care Greater Than or Equal To Spenddown Liability

If the private cost of care is **greater than or equal to** the individual's spenddown liability, the individual meets the spenddown in the month because of the private cost of care. He is entitled to **full-month coverage** for the month in which the spenddown was met.

Enroll the individual in Medicaid with the begin date of the first of the month, the end date the last day of the month. Go to section M1460.*750* below for enrollment procedures. Determine patient pay according to subchapter M1470.

b. Private Cost of Care Less Than Spenddown Liability

If the private cost of care is less than the individual's spenddown liability, **determine spenddown on a day-by-day basis** in the month by deducting allowable incurred expenses from the spenddown liability.

From the spenddown liability, deduct old bills, carry-over expenses and incurred medical/remedial care expenses per subchapter M1340. When the monthly spenddown liability is reduced to $0, eligibility is established. Eligibility can be established only AFTER the expenses are actually incurred.

If the spenddown is met any time during the month, the individual is eligible for full month coverage. Enroll the individual in Medicaid with the begin date of the first of the month, the end date the last day of the month. Go to section M1460.*750* below for enrollment procedures.

Determine patient pay according to subchapter M1470.

3. Example - Spenddown Liability Greater than Cost of Care, (using July *2014* figures)

EXAMPLE #4: Mr. Not lives in Group III and applied for Medicaid on April 21 *and was* determined disabled *by Disability Determination Services (DDS)*. He is in a nursing facility and was admitted on April 1. His income is $2,800 per month disability benefit from a private company. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His resources are within the Medicaid limit in April (application month).

He is not eligible as CN because his $2,800 gross income exceeds the 300% SSI income limit. The *individual's* Medicaid rate is *$100* per day. His MN income eligibility is calculated:

$2,800.00	disability benefit
- 20.00	general income exclusion
$2,780.00	MN countable income
- *457.63*	MNIL for 1 month for 1 person in Group III
$2,322.37	spenddown liability

The *individual's* Medicaid rate for the admission month is calculated as follows:

$100.00	*daily RUG code amount*
x 30	days
$3,000.00	*individual's* projected Medicaid rate

The *$2,322.37* spenddown liability is *less* than the *individual's* Medicaid rate of *$3,000.00*. Because his spenddown liability is *less* than the Medicaid rate, his application is *approved for ongoing coverage*.

4. Example - On Prior Spenddown, Spenddown Liability Greater Than Cost of Care *(Using July 2014 Figures)*

EXAMPLE #5: Ms. Was, *age 62*, lives in Group I and applied for Medicaid on May 6, *2015*. She is in a nursing facility and was admitted on May 1. She had applied for Medicaid previously and was on a spenddown from December 1, *2013* through May 31, *2014*, which she met on May 2, *2014*. She did not re-apply until May *2015*. She verifies that she has an unpaid $2,300 hospital bill and a $1,500 physician's bill for September 10 to September 12, *2014* (total = $3,800) on which she pays $50 a month. She also has a retroactive incurred expense - a $678 outpatient hospital bill for services dated February 13, *2015*. She has no health insurance and is not eligible for Medicare.

She was not institutionalized in the retroactive period. Her income in the retroactive spenddown budget period was $1,600 per month Civil Service Annuity (CSA) disability. The retroactive spenddown budget period is February, March and April; the income limit is *$915.27*.

Her retroactive spenddown liability is *$3,824.73*.

$1,600.00	CSA disability
- 20.00	general income exclusion
1,580.00	countable income
x 3	months
4,740.00	countable income for retroactive spenddown budget period
- *915.27*	MNIL for retroactive spenddown budget period
$3,824.73	retroactive spenddown liability

Her May 2015 application is a re-application. The September *2014* medical expenses are old bills based on her May *2015* re-application because they were incurred prior to the re-application's retroactive period, were not incurred during a prior spenddown budget period in which eligibility was established. These old bills, totaling $3,800, are deducted from the retroactive spenddown liability. Her retroactive spenddown eligibility is calculated:

$3,824.73	retroactive spenddown liability
- 3,800.00	September *2014* old bills (hospital & physician bills)
24.73	spenddown balance on February *1, 2015*
- 678.00	February 13, 2015 outpatient expense
0	spenddown balance on February 13, *2015*

The retroactive spenddown was met on February 13, *2015*. Ms. Was is enrolled in retroactive Medicaid for the period February 13, *2015* through April 30, *2015*.

Her income starting May 1, *2015* increased. Her Civil Service Annuity is $1,620 per month and she began to receive Social Security of *$600* per month; total income is *$2,220* per month. Because this exceeds the 300% SSI income limit, her medically needy income eligibility is calculated as follows:

$2,220.00	total monthly income
- 20.00	general income exclusion
2,200.00	countable income
- *305.09*	MNIL for 1 month for 1 person in Group I
$1,894.91	spenddown liability

Ms. Was' daily RUG code amount is $45. The projected Medicaid rate for the month is calculated as follows:

$ 45	*daily RUG code amount*
x 31	days
$1,395	*individual's* projected Medicaid rate

The *$1,894.91* spenddown liability is greater than *her* Medicaid rate of $1,395. Because her spenddown liability is greater than the Medicaid rate, her May application is denied and she is placed on a monthly spenddown for the certification period of May 1, *2015* through April 30, *2016.*

On June 3, her authorized representative requests re-evaluation of her spenddown for May. She was in the facility for 31 days in May. The private cost of care for May is calculated:

$ 53	private per diem cost
x 31	days in May
$1,643	private cost of care

The private cost of care, $1,643, is less than her spenddown liability of *$1,894.91*. Therefore, her spenddown eligibility in May must be determined on a daily basis. The prospective budget period is May 1 through May 31, *2015*. Since all of *her old bills* were used to meet her retroactive spenddown, they cannot be deducted from her current spenddown. The only incurred medical expenses which can be deducted are the medical expenses she incurred in May. In addition to the facility care, she incurred a doctor's expense on May 30 of *$400*. Her spenddown eligibility for May is determined:

$1,894.91	spenddown liability
- 1,590.00	30 days @ $53 per day (5-1 through 5-30)
- *400.00*	noncovered doctor's expense 5-30-*2015*
0	spenddown balance on 5-30-*2015*

Because the spenddown was met on May 30, Ms. Was is entitled to Medicaid coverage beginning May 1, *2015* and ending May 31, *2015*.

M1460.740 SPENDDOWN FOR PATIENTS RECEIVING CBC

A. Policy

An individual meets the definition of "institutionalized" when he is *authorized* for Medicaid waiver services and the services are being provided. An individual who has been *authorized* for Medicaid waiver services and whose income exceeds the 300% SSI income limit is not eligible for Medicaid until he meets the monthly spenddown liability. These determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred. The private cost of his home-based medical care is deducted as a noncovered medical expense.

For an individual on spenddown **before** starting Medicaid CBC waiver services, the spenddown budget period and the spenddown liability are prorated and recalculated to include the months prior to the receipt of Medicaid CBC services. A separate monthly spenddown budget period is calculated for each month of receipt of Medicaid CBC services.

A MN CBC patient must incur medical expenses, including old bills, carry-over expenses and the cost of CBC at the private rate, which equal or exceed the spenddown liability for the month. From the spenddown liability, deduct old bills, carry-over expenses and incurred medical/remedial care expenses per section M1340.210. When the monthly spenddown liability is reduced to $0, eligibility is established. Eligibility can be established only AFTER the expenses are actually incurred. Do not project CBC expenses. The eligibility begin date is the first day of the month in which the spenddown was met and the end date is the last day of the month.

B. CBC Spenddown Eligibility Procedures

To determine spenddown eligibility for a CBC institutionalized individual, take the following actions:

1. Calculate Private Cost of Care

Multiply the CBC provider's (or providers' if the individual has multiple CBC providers) **private** hourly rate by the number of hours of service the individual actually received from the provider in the month.

The result is the private cost of care for the month.

2. Compare to Spenddown Liability

Compare the private cost of care to the individual's spenddown liability for the month.

3. Spenddown Liability Less Than Private Cost of Care

If the individual's spenddown liability is less than or equal to the private cost of care, the individual meets the spenddown in the month because of the private cost of care. He is entitled to **full-month coverage** for the month in which the spenddown was met.

Enroll the individual in Medicaid with the begin date of the first of the month, the end date the last day of the month. Go to section M1460.750 below for enrollment procedures. Determine patient pay according to subchapter M1470.

4. Spenddown Liability Greater Than Private Cost of Care

If the individual's spenddown liability is greater than the private cost of care, **determine spenddown on a day-by-day basis** in the month by deducting allowable incurred expenses from the spenddown liability. Refer to section M1340.210 to determine allowable deductions from the individual's spenddown liability.

If the spenddown is met any time in the month, the individual is eligible for full-month Medicaid coverage beginning the first day of the month in which the spenddown was met and ending the last day of the month.

5. Example - No Prior Spenddown, Spenddown Liability Greater than Private Cost of Care (Using July 2014 Figures)

EXAMPLE #6: Mr. May lives in Group III and applied for Medicaid on April 21, 2015. He was *authorized* for the EDCD waiver on April 10, 2015. The DDS determined that he is disabled. He has no health insurance. His income is $2,800 per month disability benefit from a private company. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His resources are within the Medicaid limit in April 2015 (application month).

He is not eligible as CN because his $2,800 gross income exceeds the 300% SSI income limit. His MN income is calculated:

$2,800.00	disability benefit
- 20.00	general income exclusion
$2,780.00	MN countable income
- 457.63	MNIL for 1 month for 1 person in Group III
$2,322.37	spenddown liability

His CBC costs cannot be projected. Eligibility can be established only after the expenses are actually incurred. He received 20 days of CBC services in April.

His April application is denied and he is placed on a monthly spenddown for the certification period of 4-1-2015 through 3-31-2016.

$ 8	per hour private rate
x 6	hours per day
$ 48	private per diem cost
x 20	days in April
$ 960	private cost of care

Mr. May's spenddown liability of $2,322.37 is greater than the private cost of care, $960. His Medicaid eligibility was not established in April.

6. Example - On Prior Spenddown, Spenddown Liability Less Than Private Cost of Care (Using July 2014 Figures)

EXAMPLE #7: Ms. Gray lives in Group I and applied for Medicaid on May 6, 2015. She was *authorized* for Medicaid EDCD waiver services on May 2, 2015; the services started on May 4, 2015. She had applied for Medicaid previously and was on a spenddown from December 1, 2013 through May 31, 2014, which she met on May 2, 2014. She did not re-apply until May 2015. She verifies that she has an unpaid $2,300 hospital bill and a $1,500 physician's bill for September 10 to September 12, 2014 (total = $3,800) on which she pays $50 a month. She also has an incurred expense in the retroactive period - a $678 outpatient hospital bill for services dated February 13, 2015. She has no health insurance and is not eligible for Medicare.

She was not institutionalized in the retroactive period. Her income in the retroactive spenddown budget period was $1,600 per month CSA disability. The retroactive spenddown budget period is February, March and April, 2015; the income limit is *$915.27*.

Mrs. Gray's retroactive spenddown liability is $4,090:

$1,600.00	CSA disability
- 20.00	general income exclusion
1,580.00	countable income
x 3	months
4,740.00	countable income for retroactive spenddown budget period
- *915.27*	MNIL for retroactive spenddown budget period
$3,824.73	retroactive spenddown liability

There was a break between spenddown budget periods (June, July, August, September, October, November and December *2014* and January *2015*). The September *2014* medical expenses are old bills based on her May *2015* re-application because they were incurred prior to the re-application's retroactive period and were not incurred during a prior spenddown budget period in which eligibility was established. These old bills, totaling $3,800, are deducted from the retroactive spenddown liability. Her retroactive spenddown eligibility is calculated:

$3,824.73	retroactive spenddown liability
- 3,800.00	September *2014* old bills (hospital & physician bills)
24.73	spenddown balance on February 1, *2015*
- 678.00	February 13, *2015* outpatient expense
0	spenddown balance on February 13, *2015*
(*$653.27* carry over balance)	

A balance of *$653.27* ($678-24.73) on the 2-13-*2015* outpatient expense remains and can be used as a carry-over expense for the first prospective budget period.

The retroactive spenddown was met on 2-13-*2015*. Ms. Gray is enrolled in retroactive Medicaid for the period 2-13-2015 through 4-30-2015.

Her income starting May 1, 2015 increased. Her CSA is $1,620 per month and she began to receive Social Security of *$630* per month; total income is *$2,250* per month. Because this exceeds the 300% SSI income limit, her medically needy income eligibility is calculated as follows:

$2,250.00	total monthly income
- 20.00	general income exclusion
2,230.00	countable income
- *305.09*	MNIL for 1 month for 1 person in Group I
$1,924.91	spenddown liability
- 6*53.27*	carry-over expense from retroactive period
$1,271.64	spenddown liability balance

Her May application is denied and she is placed on a monthly spenddown for the certification period of May 1, 2015 through April 30, 2016.

On June 3, she submits verification of expenses for May. In May, she received CBC services from one provider for 28 days, 6 hours per day, at the private hourly rate of $10. The private cost of care for May is calculated:

$ 10	per hour private rate
x 6	hours per day
$ 60	private per diem cost
x 28	days received services in May
$1,680	private cost of care

The spenddown liability of *$1,271.64 is less than* the private cost of care, $1,680. Therefore, she is eligible for the period 5-1-*2015* through 5-31-*2015*.

M1460.750 MEDICALLY NEEDY ENROLLMENT *AND POST-ELIGIBILITY* PROCEDURES

A. AC

1. Use Appropriate MN AC

- Aged = **018**
- Blind = **038**
- Disabled = **058**
- Child Under 21 in ICF/ICF-MR = **098**
- Child Under 18 = **088**
- Juvenile Justice Child = **085**
- Foster Care/ Adoption Assistance Child = **086**
- Pregnant Woman = **097**

B. Patient Pay

Determine patient pay according to subchapter M1470.

C. MN Post-eligibility Requirements

1. *Facility Patient with* Spenddown Liability Less Than or Equal to Medicaid Rate

When the spenddown liability for *an* individual *who is in a facility* is less than or equal to the *individual's* Medicaid rate, the individual has ongoing eligibility for the 12-month certification period. The individual must file a redetermination after the 12-month certification period ends.

2. ***All CBC Patients and Facility Patients with* Spenddown Liability Greater Than Medicaid Rate**

When an individual (1) receives CBC or (2) an individual in a facility has a spenddown liability that exceeds *individual's Medicaid rate and meets* a spenddown, the individual does NOT have ongoing eligibility. Therefore, the individual will need to submit monthly reports of actual expenses and changes in income and resources so that spenddown eligibility can be determined each month. This report, "Medical Expense Record - Medicaid" (form # 032-03-023) is found in subchapter M1330, Appendix 1. Instructions for use and completion are also in subchapter M1330, Appendix 1.

The notification to the applicant (and his representative) approving the application with spenddown must include a copy of the "Medical Expense Record - Medicaid" for the individual to use to provide verification of the expenses used to meet the spenddown.

a. When Spenddown Liability is Met

When expenses have been incurred, the individual must submit the "Medical Expense Record - Medicaid" with bills or receipts for medical services either paid or incurred, and evidence of third party payment or denial of payment if applicable. Entitlement begins the first day of the month in which the spenddown is met, and ends on the last day of the month.

Appropriate notice of action must be sent to the applicant every time spenddown eligibility is evaluated. After eligibility is established, the usual reporting and notification processes apply. The individual must provide verification of income and resources for any month for which bills are presented.

b. Certification Period

The certification period is 12 months; therefore, a new application is not required each month. However, the applicant must file a redetermination for Medicaid when the 12-month certification period ends. If the redetermination is not filed, the individual's Medicaid must be canceled, the case must be closed and the individual will have to file a new application.

Form 200-B
(eff. 9/07)

Partnership Disclosure Notice

[Company Name]
[Company Address]

[Policyholder/Certificateholder] Name:
[Policy/Certificate] Number/Identifier:
Effective Date:

Important Information Regarding Your Policy's [Certificate's]
Long-Term Care Insurance Partnership Status

NOTE: Please keep this Notice with Your Long-Term Care Insurance Policy

Partnership Policy [Certificate] Status. Your long-term care insurance policy [certificate] is intended to qualify as a Partnership Policy [Certificate] under the Virginia Long-Term Care Partnership Program as of your Policy's [Certificate's] effective date.

The long-term care insurance policy [certificate] recently purchased and enclosed qualifies for the Virginia Long-Term Care Insurance Partnership Program. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance policies [certificates] that qualify as Partnership Policies [Certificates] may protect your assets through a feature known as "Asset Disregard" under Virginia's Medicaid program.

Asset Disregard means that an amount of the policyholder's [certificateholder's] assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy [Certificate] will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership Policy [Certificate] without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply and special rules may apply to persons whose home equity exceeds $500,000. **In addition, the purchase of this Partnership Policy does not automatically qualify you for Medicaid.**

What Could Disqualify Your Policy [Certificate] as a Partnership Policy. If you make any changes to your policy [certificate], such changes could affect whether your policy [certificate] continues to be a Partnership Policy. ***Before you make any changes, you should consult with [carrier name] to determine the effect of a proposed change.*** In addition, if you move to a state that does not maintain a Partnership Program or does not recognize your policy [certificate] as a Partnership Policy [Certificate], you would not receive beneficial treatment of your policy [certificate] under the Medicaid program of that state. The information contained in this Notice is based on current Virginia and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your policy [certificate] under Virginia's Medicaid program.

Additional Information. If you have questions regarding your insurance policy [certificate], please contact [carrier name]. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Virginia Department of Medical Assistance Services.

Form 200-C
(eff. 9/07)

LONG-TERM CARE PARTNERSHIP
CERTIFICATION FORM

Note: This Form must be completed and submitted with each long-term care policy or certificate form for which the insurer is seeking Partnership qualification. A separate form must be completed for each policy form and a specimen copy of the form, including all riders and endorsements, must be attached. A long-term care policy or certificate form may not be issued in Virginia as a partnership policy or certificate unless and until this form has been submitted to and approved by the Bureau of Insurance.

Under § 1917(b)(5)(B)(iii) of the Social Security Act (42 U.S.C. 1396p(b)(5)(B)(iii)) and in accordance with the 14 VAC 5-200-205 D, the insurer hereby submits information relating to policy or certificate form _____ (form number) to substantiate that the form includes all required consumer protection requirements set forth in § 1917(b)(5)(A) of the Social Security Act (42 U.S.C. 1396p(b)(5)(A)) and that it includes certain specified provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act promulgated by the National Association of Insurance Commissioners (adopted as of October 2000) (referred to herein as the "2000 Model Regulation" and "2000 Model Act," respectively).

Part I:

Name of Insurer _____

Company NAIC # _____

Address _____

_____

_____

Telephone _____

Company Contact Name _____

Title _____

Telephone _____

E-Mail _____

CHAPTER M14
LONG-TERM CARE
SUBCHAPTER 70

PATIENT PAY — POST-ELIGIBILITY TREATMENT OF INCOME

M1470 Changes
Page 1 of 2

Changed With	Effective Date	Pages Changed
TN #DMAS-31	4/1/24	Page 10
TN #DMAS-30	1/1/24	Page 20
TN #DMAS-29	10/1/23	Pages 46-48
TN #DMAS-28	7/1/23	Page 19, Appendix 1
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-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

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M14 LONG-TERM CARE

M1470 PATIENT PAY--POST-ELIGIBILITY TREATMENT OF INCOME

APPENDIX

M1470.000 PATIENT PAY-POST-ELIGIBILITY TREATMENT OF INCOME

M1470.001 OVERVIEW

A. Introduction

"Patient pay" is the amount of the long-term care (LTC) patient's income which must be paid as his share of the LTC services cost. This subchapter provides basic rules regarding the post-eligibility determination of the amount of the LTC patient's income which must be paid toward the cost of his care. **MAGI Adults have no responsibility for patient pay.** If an individual receiving LTC, also called long-term supports and services (LTSS), loses eligibility in the MAGI Adults covered group and is eligible in another full coverage group, patient pay policy will apply.

B. Policy

The state's Medicaid program must reduce its payment to the LTC provider by the amount of the eligible patient's monthly income, after allowable deductions. Patient pay is calculated after an individual has been determined eligible for Medicaid and for Medicaid LTC services. A Medicaid recipient who is admitted to a nursing facility, facility for individuals with intellectual disability (ICF-ID) or Medicaid waiver services for less than 30 days must have a patient pay determined for the month(s) in which the recipient is in the facility or waiver services**.** The provider collects the patient pay from the patient or his authorized representative. Patient pay information is fed to the Automated Response System (ARS) and the MediCall Systems for provider verification of patient pay. These systems report the amount of patient pay and the date of service to the provider responsible for collecting patient pay.

C. VaCMS Patient Pay Process

The patient pay calculation is completed in VaCMS. Refer to the VaCMS Help feature for information regarding data entry. The patient pay must be updated in the system whenever the patient pay changes, but at least once every 12 months. If VaCMS is not able to process required transactions, a Patient Pay Correction form (DMAS 9PP), available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, should be submitted to patientpay@dmas.virginia.gov.

D. Patient Notification

The patient or the authorized representative is notified of the patient pay amount on the Notice of Patient Pay Responsibility. VaCMS will generate and send the Notice of Patient Pay Responsibility. M1470, Appendix 1 contains a sample Notice of Patient Pay Responsibility generated by VaCMS. DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into *the Medicaid Enterprise System (MES, formerly MMIS)*.

The provider is the only entity with the authority to take action when residents do not pay their patient pay amount. If a resident, or his authorized representative is negligent in paying his patient pay amount to the provider, the provider will provide written documentation regarding the requirement to pay the patient pay amount to the resident or authorized representative and follow the provider's collection procedures to collect the funds. The provider will report the resident's negligence in paying the patient pay amount to the LDSS.

The provider's failure to collect the patient pay, or the patient's failure to pay the patient pay, does not itself affect the patient's Medicaid eligibility. However, the

EW must review the patient's resources each month to determine if the resources are within the Medicaid limit.

If the individual resides in a nursing facility and the above attempts to collect the patient pay amount are unsuccessful, DMAS has advised that the facility may take one of the following options:

1. **Facility Option #1**

The facility will notify the LDSS no later than 120 days from the due date of the payment. The facility will include in this notification a copy of the third collection statement, a written notification of the situation, documentation of contacts made with the resident or authorized representative, and the reasons why payment has not been made.

The LDSS will take the following steps:

- Upon receipt of the written notice from the facility, the local DSS will review the case to determine if the individual's resources are within Medicaid eligibility limits or if a transfer of assets has occurred.

- If the individual alleges that he does not receive sufficient income to pay his patient pay, the eligibility worker will review the patient pay amount and make any necessary adjustments.

2. **Facility Option #2**

Discharge or transfer the resident, including transferring the resident within the facility, except as prohibited by the Virginia State Plan for Medical Assistance Services.

Prior to discharge or transfer, the facility must provide reasonable and appropriate notice of the required patient pay, and the resident or authorized representative must be given at least 30 days written notice prior to the discharge or transfer, which shall include appeal rights. If the resident or authorized representative does not agree with this action, he may submit an appeal request to DMAS. The individual will be allowed to continue residing in the facility during the appeal process.

M1470.100 AVAILABLE INCOME FOR PATIENT PAY

A. Gross Income

Gross monthly income is considered available for patient pay. Gross monthly income is the same income used to determine an individual's eligibility in the 300% SSI income group. It includes types and amounts of income which are excluded when determining medically needy eligibility.

1. 300% SSI Group

If the individual is eligible in the 300% SSI group, to determine patient pay start with the gross monthly income calculated for eligibility. Then add and deduct any amounts that are listed in subsection C. below.

2. Groups Other Than 300% SSI Group

If the individual is eligible in a covered group other than the 300% SSI group, determine the individual's patient pay income using subsections B. and C. below.

B. Income Counted For Patient Pay

All countable sources of income for the 300% SSI group listed in section M1460.611 are considered income in determining patient pay. Any other income NOT specified in C. below is counted as income for patient pay.

1. Aid & Attendance and VA Pension Payments

Count the total VA Aid & Attendance payments and/or VA pension payments in excess of $90.00 per month as income for patient pay when the patient is:

- a veteran who does not have a community spouse or dependent child,
- a deceased veteran's surviving spouse who does not have a dependent child, or
- *a veteran's dependent child.*

Do not count any VA Aid & Attendance payments and/or VA pension payments when the patient is:

- a veteran who has a community spouse or dependent child, or
- a deceased veteran's surviving spouse who has a dependent child.

NOTE: This applies to all LTC recipients, including patients who reside in a Veterans Care Center.

2. Non-Refundable Advance Payments To LTC Providers

Advance payments and pre-payments paid by a recipient to the LTC provider that will not be refunded are counted as income for patient pay. M1470.1100 contains instructions for calculating the patient pay when an advance payment has been made to reduce resources within a month.

C. Income Excluded For Patient Pay

Income from sources listed in subchapter M1460.610 "What is Not Income" is not counted when determining patient pay, **EXCEPT** for the VA Aid & Attendance and VA pension payments to veterans which are counted in the patient pay calculation (see B. above). Additional types of income excluded from patient pay are listed below.

1. SSI & AG Payments

All SSI and Auxiliary Grants (AG) payments are excluded from income when determining patient pay.

2. Certain Interest Income

a. Interest or dividends accrued on excluded funds which are set aside for burial are not income for patient pay.

b. Interest income when the total interest accrued on all interest-bearing accounts is less than or equal to $10 monthly is not income for patient pay. Interest income that is not accrued monthly must be converted to a monthly amount to make the determination of whether it is excluded.

- Verify interest income at application and each scheduled redetermination.

- If average interest income per month exceeds $10.00 and is received less often than monthly, it must be treated as a lump sum payment for patient pay purposes. Refer to Section M1470.1000 of this subchapter for procedures and instructions.

3. Repayments

Amounts withheld from monthly benefit payments to repay prior overpayments ***are*** income for patient pay *unless the exception in S0830.110 is met*. The patient or his representative should be advised to appeal the withholding *with the benefit source.*

4. CBC Additional Care

Additional care purchased outside of a CBC recipient's plan of care is not counted as income available for patient pay if it is purchased by someone other than the recipient. This additional care may be purchased from any source including the agency providing the CBC.

5. Refundable Payments to LTC Facilities

The family of a prospective Medicaid patient or other interested party may make an advance payment on the cost of facility care prior to or during the Medicaid application process to assure the patient's admission and continued care. The individual may have been promised that the advance payment will be refunded if Medicaid eligibility is established.

Advance payments made by a person other than the patient and which are expected to be reimbursed once Medicaid is approved, as well as payments made by outside sources to hold the facility bed while the patient is hospitalized, are **not counted as income** in determining eligibility or patient pay.

The facility must reimburse any payment contributed toward the cost of patient care pending a Medicaid eligibility determination once Medicaid eligibility is established.

6. Survivor's Benefit Plan Deductions from Military Pensions

Any portion of a military retiree's pension that is withheld as a contribution to participate in the Survivor's Benefit Plan (SBP) is not income for patient pay. To participate in SBP in conjunction with their retirement, military members must elect to receive reduced retirement pay for their lifetime so that a percentage of their retirement pay can continue to be paid to their survivors following their death. Once SBP is elected, retirees cannot discontinue the deductions from their pensions.

M1470.200 FACILITY PATIENTS - ALLOWABLE DEDUCTIONS FROM INCOME

A. Introduction

Sections M1470.210 through 240 are the only allowable deductions from a facility patient's gross monthly income when calculating patient pay in the month of entry and subsequent months when the patient does not have a community spouse.

If the individual is married and his spouse is in a nursing facility, then there is no community spouse and each spouse is treated as an unmarried individual for patient pay purposes. When the patient is an institutionalized spouse with a community spouse, as defined in subchapter M1480, go to subchapter M1480 to determine the institutionalized spouse's patient pay.

B. Order of Patient Pay Deductions

Deductions from gross monthly income are subtracted in the order presented below. Deductions are made only to the extent that income remains after a prior deduction has been subtracted. Therefore, if the patient has no income remaining after a deduction, no additional deductions can be made.

1. Personal Needs

See section M1470.210 "Facility Personal Needs Allowance."

2. Dependent Child Allowance

See section M1470.220 "Dependent Child Allowance."

3. Noncovered Medical Expenses

See section M1470.230 "Facility - Noncovered Medical Expenses."

4. Home Maintenance Deduction

See section M1470.240 "Facility - Home Maintenance Deduction."

C. Appeal Rights

The patient or his representative has the right to appeal the patient pay determination, the amounts used in the calculation and denial of any request for adjustment. If a recipient or his representative appeals the patient pay, the EW or Medicaid Technician who made the decision prepares the appeal summary and attends the hearing.

M1470.210 FACILITY PERSONAL NEEDS ALLOWANCE

A. Policy

The personal needs allowance is calculated according to the instructions in this section for the month of entry and subsequent months. The amount of the personal needs allowance depends on whether or not:

- the patient has a guardian or conservator who charges a fee; or
- the patient has earnings from employment that is part of the treatment plan.

The personal needs allowance is the sum of the basic personal allowance plus the guardianship fee and/or special earnings allowance, if applicable.

1. Basic Personal Allowance

Deduct $40 per individual.

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

Working patients are allowed a higher personal needs allowance if they meet the following criteria. These patients will be identified by the facility. The patient must regularly participate in vocational activity which is a planned habilitation program and is carried out as a therapeutic work program, such as:

- sheltered workshops
- vocational training
- pre-vocational training.

Deduct a special earnings allowance if the patient participates in a work program as part of treatment. The special earnings allowance is deducted from earned income only. Subtract:

- the first $75 of gross monthly earnings, PLUS
- ½ the remaining gross earnings,
- up to a maximum of $190 per month.

The special earnings allowance cannot exceed $190 per month.

4.* Example - *Calculation of Personal Needs Allowance

A patient in the nursing facility is employed as a telephone salesperson as part of his plan of care in the facility. He has a legally appointed guardian who charges a 2% fee. His only income is gross earnings of $875 per month. *The patient receives deductions for the basic allowance, the guardianship fee, and the special earning allowance.*

His special earnings allowance is calculated first:

$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 computed as follows:

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

M1470.220 DEPENDENT CHILD ALLOWANCE

A. Unmarried Individual or Married Individual With No Community Spouse

An unmarried individual, or married individual without a community spouse, who has a minor dependent child(ren) under age 21 in the community, can have a dependent child allowance**.** When the individual verifies that he/she has a dependent child(ren) in the community:

- Calculate the difference between the appropriate monthly medically needy income limit (MNIL) for the child's locality for the number of minor dependent children in the home, and the child(ren)'s gross monthly income. If the child lives outside of Virginia, use the Group III MNIL.

- The result is the dependent child allowance. If the result is greater than $0, deduct it from the patient's monthly income as the dependent child allowance. If the result is $0 or less, there is NO dependent child allowance.

The dependent child allowance *cannot be given when* the dependent child(ren)'s gross monthly income exceeds the monthly MNIL for the number of children in the child(ren)'s locality, if money is not made available or he does not accept the monthly income allowance.

Do NOT deduct any allowance for other family member(s).

1. Example--One Dependent Child (Based on July 2008 figures)

Mrs. K is a married individual who is now residing in a nursing facility. Her spouse is in another medical facility. Their dependent child lives with her sister in a Group II locality. The child receives a $95.00 of Social Security income per month.

The allowance for the dependent child is calculated as follows:

$ 265.39 MN limit for 1 (Group II)
- 95.00 child's SSA income
$ 170.39 dependent child's allowance

NOTE: If Mrs. K's institutionalized spouse is eligible for Medicaid, an allowance for their child may also be deducted from his income in determining his patient pay. However, the income the child receives from Mrs. K will be counted in the child's gross income when determining any allowance from Mr. K.

2. Example--Two Dependent Children (Based on July 2008 figures)

Mr. H is a single individual with gross monthly income of $920, living in a nursing facility. He is divorced and has two children under age 21 who live with his ex-wife in Group I. His two children each receive $75 of monthly Social Security income.

The allowance for the dependent children is calculated as follows:

$ 337.92 MN limit for 2 (Group I)
- 150.00 children's total monthly SSA income
$ 187.92 dependent children's allowance

M1470.230 FACILITY - NONCOVERED MEDICAL EXPENSES

A. Policy

Amounts for incurred medical and dental expenses not covered by Medicaid or another third party are deducted from the patient's gross monthly income when determining patient pay.

B. Health Insurance Premiums

1. *Private or Commercial Insurance*

Payments for medical/health insurance, *including dental insurance*, which meet the definition of a health benefit plan are deducted from patient pay when:

- the premium amount is deducted from the patient's benefit check;
- the premium is paid from the patient's own funds; OR
- the premium is paid by a relative (other than a spouse or parent for minor child) when that relative receives a benefit payment (income) which includes a benefit amount for the patient.

The amount deducted is the amount of the **monthly** premium. If the patient pays the premium less often than monthly, such as quarterly, prorate the amount paid by the number of months covered by the payment to obtain the monthly amount to deduct in the patient pay calculation.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA (Multiple Employer Welfare Arrangement) or plan provided by another benefit arrangement.

Health benefit plan does not mean accident only, credit, or disability insurance; long-term care insurance; vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance (14VAC5-234-30).

Income protection insurance (indemnity) policy premiums are not medical expenses and are not deducted from the patient pay.

Membership fees for an organization that sponsors or provides the health insurance are not part of the premium and are not deductible.

2. Medicare Part A and/or B Premiums

Medicare Part B premiums and/or Medicare Part A premiums are paid by Medicaid for eligible individuals. The premiums are paid by Medicaid via the "buy-in" and are not usually deducted from patient pay. However, Medicaid does not start paying the premiums immediately for all eligible patients, so the Medicare premium(s) must be deducted from patient pay in those months for which Medicaid does not pay the premium.

For Categorically Needy (CN) individuals enrolled in the 300% SSI covered group in Aid Categories (ACs) 020, 040, and 060 and Medically Needy (MN)-*only individuals in ACs 018, 038, and 058*, the Medicare buy-in is effective **2 months after the begin date** of Medicaid coverage. If the begin date of coverage is other than the first day of a month, the buy-in is effective the first of the month in which the 60th day occurs. Part B premiums (and Part A premiums if the recipient must pay the Part A premium) must be deducted from patient pay in the month(s) in which the buy-in is not effective.

Deduct the Medicare premium(s) for the first two months of coverage for *individuals in the following ACs:*

- *CN 300% SSI and not dually eligible as a Qualified Medicare Beneficiary (QMB) or a Special Low-income Medicare Beneficiary (SLMB) Plus - ACs 020, 040, 060*
- *MN and not also QMB or SLMB - ACs 018, 038, 058.*

For individuals *in other ACs*, the buy-in is effective with the begin date of Medicaid coverage. Therefore, do NOT deduct Medicare premiums in the patient pay determination for months in the retroactive and ongoing coverage periods.

The Medicaid Medicare buy-in does NOT pay for Medicare premiums in closed periods of coverage for LTC patients who are on spenddown and whose eligibility is for a closed period. Deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from patient pay in the month(s) in which the buy-in is NOT effective.

The Medicaid Medicare buy-in pays for Medicare premiums in retroactive coverage and closed periods of coverage EXCEPT for LTC patients who are on spenddown. DO NOT deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from the patient pay in the month(s) in which the buy-in is effective for LTC patients who are NOT on spenddowns.

3. Example--Dual Eligible QMB

Mrs. Q has Medicare coverage and SSA income of $580 per month. Her Medicare premiums are deducted from her SSA check. She was admitted to the nursing facility on September 9. Her daughter filed a Medicaid application for her on September 10.

Mrs. Q is eligible in the *CN* 300% SSI group in September and is eligible as QMB. Her Medicare premiums are not deducted for September because they will be paid by Medicaid.

4. Example--Not Dual Eligible QMB

Mr. A was admitted to a nursing facility on March 5. He applied for Medicaid on June 2. His monthly income is $1,295, and his Medicare Part B premium is deducted from his SSA check. He is determined to be eligible in the *CN* 300% SSI covered group effective March 1.

His patient pay for March (the month of entry) includes a deduction for the Medicare premium. Because he is not QMB eligible, the buy-in is effective in May, the second month following the month in which his ongoing Medicaid coverage began. The cost of his Medicare Part B premium is deducted from his patient pay for the months of March and April, as his buy-in will be in effect beginning with the month of May.

If the buy-in is delayed for any reason, the individual will be reimbursed by SSA for premiums deducted after the second month.

5. Medicare Advantage (Part C) Premiums

Medicare Advantage plans, also referred to as Medicare Part C, are voluntary managed-care Medicare plans. In addition to Medicare Part B premiums, some individuals may pay an extra Medicare Advantage premium. The Medicaid Medicare buy-in is initiated for individuals with Medicare Advantage ; however, the buy-in covers only the allowable Medicare Part A and/or B premiums. The individual is responsible for any additional Medicare Advantage monthly premium. The Medicare Advantage monthly premium remains the individual's responsibility and is an allowable deduction from patient pay.

***6.* Medicare Part D Premiums**

An individual who is eligible for Medicare and Medicaid is entitled to enrollment in a basic Medicare Part D prescription drug plan (PDP) *at no cost*. However, the individual may elect enrollment in a plan with a premium.

When a full-benefit Medicaid enrollee is enrolled in *a Medicare Part D* PDP, *any* premium that is the individual's responsibility is an allowable deduction from patient pay.

7. LTC Insurance

a. Deduct LTC premium in admission month only

When an individual has an LTC insurance policy, the individual stops paying premiums beginning the month after he is admitted to LTC. The premium paid for the policy in the admission month can be deducted from the admission month's patient pay only. The LTC insurance premium is not deducted from patient pay for the months following the admission month.

b. LTC insurance benefits

LTC insurance benefits are treated as *Third Party Liability* (TPL). If the individual receives the payment from the insurance company, the payment is not income for patient pay or eligibility determinations. The individual should assign it to the nursing facility. If the individual cannot do this, or the policy prohibits assignment, the LTC insurance payment should be given directly to the nursing facility. The facility should report the payment as a third party payment on its claim form.

If the provider is unable to accept payment directly from the individual, the individual must send the insurance payment to:

DMAS Fiscal Division, Accounts Receivable
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

C. Non-covered Medical/Dental Services

Deductions for the cost of a patient's medically necessary medical or dental services not covered by Medicaid, other insurance (such as Medicare), or another person are subtracted from income to determine patient pay. Some deductions for noncovered services must be approved by DMAS before they can be subtracted from the patient's income.

Services that are covered by Medicaid in the facility's per diem rate cannot be deducted from patient pay as a noncovered service. See M1470.230 C.3 for examples of services that are included in the facility per diem rate.

1. Zero Patient Pay Procedures

If deductions from patient pay cannot be allowed because the recipient has no income remaining after deducting the personal needs allowance, dependent child allowance(s) and health insurance premiums, or the recipient has no income available for patient pay, deny the request.

Notify the patient or the patient' authorized representative of the denial of the request using the Notice of Action.

If a noncovered service is already being deducted, leaving no patient pay, and a new deduction for another noncovered service has been approved, notify the patient or his authorized representative that the deduction for the new noncovered service will be made after the first noncovered service deductions are completed.

2. Allowable Non-covered Expenses

When a patient has income available for patient pay, the following can be deducted as noncovered expenses:

a. Old Bills

"Old bills" are deducted from patient pay as noncovered expenses. "Old bills" are unpaid medical, dental, or remedial care expenses which:

- were incurred prior to the Medicaid *full coverage effective date*, or the service was not a Medicaid- covered service;
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met; **and**
- remain a liability to the individual.
- **"Old bills" do not require approval from DMAS in order to be deducted in the patient pay calculation even when the amount of the "old bill" exceeds $500.**

b. Services Provided By A Non-participating Provider

Medical and dental services that are covered by Medicaid, but that the *Medicaid* enrollee receives from a provider who does not participate in Virginia Medicaid, *CANNOT be* deducted from patient pay as non-covered services.

c. Covered Services Outside of Medicaid's Scope

Medically necessary medical and dental services exceeding Medicaid's amount, duration, or scope can be deducted from patient pay. Scope includes benefits or services provided by the enrollee's MCO (managed care organization).

d. Other Allowable Noncovered Services

1) The following medically necessary medical and dental services that are NOT covered by Medicaid *or by benefits provided by the enrollee's MCO* can be deducted from patient pay by the local department of social services without DMAS approval when the cost does NOT exceed $500. **If the service is not identified in the list below and/or the cost of the service exceeds $500, send the request**

and the documentation to DMAS for approval (see M1470.230 C.5). DMAS will advise the eligibility worker if the adjustment is allowable and the amount that is to be allowed.

- dental services ***not covered by Medicaid.*** *Effective July 1, 2021, Medicaid covers dental services for full-benefit adults, as well as children (see M1850.100.D).* **Pre-approval for dental services that exceed $500 must be obtained from DMAS prior to receipt of the service;**
- routine eye exams, eyeglasses and eyeglass repair;
- hearing aids (when medically necessary), hearing aid batteries and hearing aid repair;
- batteries for power wheelchairs or other power mobility items owned by the recipient, not to exceed four batteries in a 12-month period;
- chiropractor services, except for Medicare recipients (Medicare covers chiropractor services and Medicaid covers the Medicare deductible and coinsurance amounts);
- dipyridamole (Persantine) and other prescription medications not covered by Medicaid but ordered by the recipient's physician;
- **transportation to medical, dental or remedial services not covered by Medicaid.**

2) Services received by a Medicaid enrollee during a period of limited Medicaid eligibility (e.g., LTC services not covered because of a property transfer) can be deducted in the patient pay calculation by the local agency without DMAS approval even when the amount of the service exceeds $500.

e. Medicare Part D

Individuals who:

- qualify for Medicare Part D,
- are NOT enrolled in a Medicare Prescription Drug Plan (PDP), and
- are NOT Medicaid eligible at the time of admission to a nursing facility,

will be fully responsible for their drug costs until Medicaid eligibility is determined and the Medicare Part D PDP enrollment process is completed. The individual remains responsible for any drugs purchased prior to the effective date of the PDP enrollment; Medicaid cannot pay for these drugs. The cost of drugs purchased before the PDP begin date can be deducted from patient pay.

Medicaid-enrolled nursing facility patients who are enrolled in a Medicare Part D PDP are **not** responsible for the payment of deductibles or co-pays, nor will

they be subject to a coverage gap in their Part D benefits. Do NOT deduct from patient pay any Medicare PDP deductibles, co-pays or coverage gap costs beyond the month of admission into the nursing facility.

If a full-benefit Medicaid/Medicare recipient was subject to PDP co-pays prior to his admission to a nursing facility, he may continue to be assessed co-pays until the PDP is notified of his admission to the nursing facility. Deduct PDP co-pays incurred during the month of admission to the nursing facility only.

If an individual is enrolled in Part D and is in a nursing facility but was not eligible for Medicaid at the time of admission to the nursing facility, he may continue to be charged co-pays or deductibles until the PDP is notified of his eligibility as a full-benefit Medicaid enrollee. Deduct PDP co-pays incurred during first month of Medicaid eligibility in the nursing facility only.

3. Services NOT Allowed

Types of services that CANNOT be deducted from patient pay include:

a. medical supplies and equipment that are part of the routine facility care and are included in the Medicaid per diem, such as:

- diabetic and blood/urine testing strips,
- bandages and wound dressings,
- standard wheelchairs,
- air or egg-crate mattresses,
- IV treatment,
- splints,
- certain prescription drugs (placebos).

b. TED stockings (billed separately as durable medical supplies),
c. acupuncture treatment,
d. massage therapy,
e. personal care items, such as special soaps and shampoos,
f. ancillary services, such as physical therapy, speech therapy and occupational therapy provided by the facility or under arrangements made by the facility.

i. services that are NOT medical/remedial care services, even if ordered by a physician:

- *air conditioners or humidifiers,*
- *refrigerators, whole house generators and other non-medical equipment,*
- *assisted living facility (ALF) room & board and services,*
- *personal comfort items, such as reclining chairs or special pillows,*
- *health club memberships and costs,*
- *animal expenses such as for seeing eye dogs,*
- *cosmetic procedures.*

3a. Managed Care Organizations and *Cardinal Care* (effective *October 1, 2023*)

As of *October 1, 2023*, the majority of Medicaid-eligible individuals who receive long-term service and support (LTSS) are covered under *Cardinal Care* through one of *five (5)* managed care organizations (MCOs). As part of *Cardinal Care*, each health plan offers enhanced benefits, such as adult dental services or hearing aids, outside of the required contracted Medicaid services. Some of these enhanced benefits are frequently submitted to the LDSS as patient pay adjustment.

If there are other coverage sources available for these services or items, Medicaid policy requires the request for coverage first be submitted to those sources and exhausted there, before the LDSS/DMAS may consider or approve a patient pay adjustment.

A process is in development to develop a procedure for distinguishing MCO enhanced benefit services from allowable patient pay deductions. Until further notice, providers and nursing facilities will continue sending all patient pay adjustment requests to the patient's LDSS eligibility worker.

Eligibility workers will review and process patient pay adjustment requests without requiring submission of the request to the individual's CCC Plus plan.

4. Documentation Required

a. Requests For Adjustments From A Patient or Authorized Representative

Request the following documentation from the patient or his representative:

- a copy of the bill;
- if applicable, the amount owed that was not covered by the patient's insurance;
- proof that the service was medically necessary. Proof may be the prescription, doctor's referral**,** or a statement from the patient's doctor or dentist. Proof applies to a physician, doctor, or dentist's current, and not "standing", order(s).

The local agency can make the adjustment for services identified in subsection C. 2. b. through d.1), above providing the cost of the service does not exceed $500. If the cost of the service is not identified in subsection C. 2. b. through d. 1), or exceeds $500, send the documentation to DMAS to obtain approval and the allowable amount of the adjustment (reimbursement is limited to the prevailing Medicaid or Medicare rate).

b. Requests For Adjustments From LTC Providers

If the request for an adjustment to patient pay to deduct one of the above expenses is made by a nursing facility, ICF-MR, long-stay hospital, or *Department of Behavioral Health and Developmental Services (DBHDS)* facility, the request must be accompanied by:

1) the recipient's correct Medicaid ID number;

2) the current physician's order for the non-covered service (not required for replacement of hearing aid batteries or eyeglass frames or for repair of hearing aids or eyeglasses);

3) actual cost information;

4) documentation that the recipient continues to need the equipment for which repair, replacement, or battery is requested; and

5) a statement of denial or non-coverage by other insurance. The denial may be from the insurance carrier or may be a written statement from the facility that the insurance company was contacted and the item/service is not covered.

If the request from a facility does not include all the above documentation, return the request to the facility asking for the required documentation.

When the cost of the service cannot be authorized by the local department of social services and/or exceeds $500, send the request and the documentation to DMAS to obtain approval for the adjustment and the allowable amount of the adjustment (reimbursement is limited to the prevailing Medicaid or Medicare rate). DMAS must be notified of the name and address of the recipient's spouse, POA or guardian so that proper notification of the decision can be given.

5. Procedures

a. DMAS Approval Required

Requests for adjustments to patient pay for services not included in subsection C.2. b. through d.1) above, or for any service which exceeds $500, must be submitted by the provider to the DSS worker. The DSS worker sends the request and documentation to:

Health Care Compliance Program Analyst
Division of Program Operations, Customer Service Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Do not send requests for adjustments to DMAS when the patient has no available income for patient pay. Refer to M1470.230 C.5.c for notification procedures to be followed by the local worker.

When a request for an adjustment is approved or denied by DMAS, the local DSS worker will receive a copy of the letter sent to the recipient by DMAS:

1) If approved, adjust the patient pay using the VaCMS Patient Pay process.

2) If the adjustment request is denied, DMAS prepares the notification.

b. DMAS Approval Not Required

Determine if the expense is deducted from patient pay using the following sequential steps:

1) Upon receipt of the requested documentation, determine the amount of the bill that is a valid deduction. Do not deduct more than the available income that remains after the personal needs, dependent child allowance(s), and health insurance premiums are deducted.

   If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service is requested, deduct the new noncovered services after the first noncovered service deductions have been completed.

2) Subtract the deduction for the month following the month the change is reported. If the deduction exceeds the available income, the remaining balance can be carried over to the following month(s).

c. Notice Procedures

Upon the final decision to allow the deduction, use the VaCMS Patient Pay process to adjust the patient pay. VaCMS will generate and send the Notice of *Patient Pay Responsibility*.

6. *Cardinal Care* Managed Care Organizations (effective *October 1,2023*)

As of *October 1, 2023*, the majority of Medicaid-eligible individuals who receive long-term care (LTC) services are covered under *Cardinal Care* through one of six (6) managed care organizations (MCOs). As part of *Cardinal Care*, each health plan offers enhanced benefits outside of the required contracted Medicaid services. Some of these enhanced benefits are frequently submitted to the LDSS as patient pay adjustment.

If there are other coverage sources available for these services or items, Medicaid policy requires the request for coverage first be submitted to those sources and exhausted there, before the LDSS/DMAS may consider or approve
a patient pay adjustment.

A process is in development to develop a process for distinguishing MCO enhanced benefit services from allowable patient pay deductions. Until further notice, providers and nursing facilities will continue sending all patient pay adjustment requests to the patient's LDSS eligibility worker.

Eligibility workers will review and process patient pay adjustment requests without requiring submission of the request to the individual's *Cardinal Care* plan.

M1470.240 FACILITY - HOME MAINTENANCE DEDUCTION

A. Policy

A single institutionalized individual can be allowed a deduction for the cost of maintaining a home for not more than six months, if a physician has certified he or she is likely to return home within that period.

Home maintenance means that the individual has the responsibility to pay shelter costs on his former place of residence in Virginia, such as rent, mortgage, utilities, taxes, room and board, or assisted living facility (ALF) payments, and that the home, apartment, room or bed is being held for the individual's return to his former residence in Virginia. Individuals who have no responsibility to pay shelter costs are not permitted a home maintenance deduction. If responsibility for shelter costs is questionable, documentation must be requested and provided.

EXCEPTION: For an individual admitted to a nursing facility from an ALF, deduct a home maintenance allowance for the month of entry even if the admission to the nursing facility is not temporary.

Only one spouse of an institutionalized married couple (both spouses are in a medical facility) is allowed the deduction to maintain a home for up to six months, if a physician certifies that he is likely to return home within that period.

B. Temporary Care

Temporary care is defined as not exceeding 6 months of institutionalization, beginning the **month** of admission to the medical facility. A physician's written statement or a DMAS 225 from the individuals managed care plan indicating that the individual is expected to return to his home within 6 months of admission is required to certify temporary care. If the individual is in the facility less than 6 months and returns to a community living arrangement, temporary care status is assumed and patient pay should be adjusted with the home maintenance allowance for the entire period of institutionalization. When the temporary care period ends, the home maintenance deduction must be discontinued.

The DMAS 96 no longer relays information about the expected length of stay. Assume that the stay is not temporary unless notified by the individual, authorized representative, or managed care plan. A written statement from a physician or a DMAS 225 notification from the managed care plan that the individual is expected to return home within 6 months is acceptable in lieu of a physician's statement.

C. Amount Deducted

The home maintenance deduction is the MNIL for one person in the individual's locality of residence. See Appendix 5 to subchapter M0710 or section M0810.002 A. 4 for the MN income limits.

M1470.300 FACILITY PATIENTS

A. Overview

This section provides policy and procedures for calculating patient pay for the facility patient.

B. Policy and Procedures

Policy and procedures for determining patient pay in the most common admission situations are contained in the following sections:

- Facility Admission From A Community Living Arrangement (M1470.310)
- *Patient pay for facility stay of less than 30 days* (M1470.320)

M1470.310 FACILITY ADMISSION FROM A COMMUNITY LIVING ARRANGEMENT

A. Policy

The policy in this section describes the procedures for calculating patient pay for the month of admission and ongoing months for all persons admitted to an LTC facility except:

- persons who received Medicaid CBC in the community during the admission month;
- persons who were admitted from another facility;
- persons admitted to a facility from a state institution.

B. Procedures

To determine patient pay for the admission month, use the procedures in this subsection.

1. All Covered Groups Except MN Spenddown

For an individual admitted to a facility (except an individual who meets a spenddown), take the following steps in the order presented, to the extent that income remains:

a. Count all income received in the admission month (M1470.100).

b. Deduct a personal needs allowance:

- $40.00 basic personal needs;
- additional amount for guardianship fees, if appropriate;
- additional amount for special earnings allowance, if working.

c. Deduct a dependent child allowance, if appropriate (M1470.220).

d. Deduct the Medicare premium withheld if the applicant is a Medicare recipient and was not receiving Medicaid prior to admission (see M1470.230).

e. Deduct other health insurance premiums, deductibles or co-insurance charges, if appropriate (M1470.230).

f. Deduct other allowable noncovered medical expenses, if appropriate (M1470.230).

g. Deduct the home maintenance (MNIL) deduction **if appropriate**, if a doctor has certified that the individual is likely to return home within a six-month period (see M1470.240). For recipients who are admitted for a stay that has been for less than 30 days, a physician certification of length of stay is NOT required.

h. Any remainder is the patient pay for the month(s).

2. MN Spenddown Individual in Facility for Less than 30 Days

For a medically needy individual on a spenddown who is in a facility for less than 30 days, see section M1470.320 B. for procedures.

3. MN Spenddown Individual In Facility For More Than 30 Days

For an institutionalized medically needy individual, see Section M1470.600 for procedures.

M1470.320 PATIENT PAY FOR FACILITY STAY OF LESS THAN 30 DAYS

A. All *Full Coverage* Groups Except MN Spenddown

To determine patient pay for a non-institutionalized individual *with full Medicaid coverage* admitted to a facility for less than 30 days (except an individual who meets a spenddown), use the procedures in subsection M1470.310 B.1 for the admission month and for the subsequent month when the facility stay continues into the month after admission. *Individuals with limited-coverage Medicaid do not have a patient pay since facility care is not covered.*

B. Non-Institutionalized Individuals on MN Spenddown

A non-institutionalized MN individual who is on a spenddown is not eligible for Medicaid until the spenddown is met. Non-institutionalized MN individuals are either on a three-month retroactive or six-month ongoing spenddown.

1. Individual Who Meets the Spenddown

For a non-institutionalized MN individual who meets the spenddown on a date that is within the dates of facility service, take the following steps to determine patient pay:

a. Add together the number of days in the facility stay that are NOT covered by Medicaid. Multiply the result by the facility's private pay daily rate.

b. Determine the remaining balance of the spenddown prior to applying the bill that caused the spenddown to be met.

c. Add the amount in a. above to the figure obtained in b. above. The total is the individual's patient pay for the part of the facility stay that occurs in the spenddown coverage period.

d. Enter patient pay *using* VaCMS.

2. Example – Spenddown Met

Mr. B, an unmarried 70 year-old individual living in a Group II locality, filed an initial application for Medicaid on October 5, 1999. He had excess income and was placed on a spenddown of $2000 for the period October 1, 1999 through March 31, 2000. On October 8, 1999, he was admitted to a nursing facility for temporary care that is expected to be less than 30 days.

On November 10, 1999, his authorized representative asks for his spenddown to be re-evaluated due to his admission to the nursing facility. The representative also submits medical bills incurred before October 8, 1999, that the worker determines leave a spenddown balance of $500 as of October 8, 1999. The nursing facility charges him $120 per day; the Medicaid per diem is $85. His spenddown is determined:

$2000	spenddown liability October 1, 1999-March 31, 2000
- 1500	old bills incurred prior to October 1, 1999
500	spenddown balance on October 1, 1999
- 50	doctor's charge on October 5, 1999 (after TPL pays)
- 120	private pay rate on October 8, 1999
330	spenddown balance beginning October 9, 1999
- 120	private pay rate on October 9,1999
210	spenddown balance beginning October 10, 1999
- 120	private pay rate on October 10, 1999
90	spenddown balance beginning October 11, 1999
- 120	private pay rate on October 11, 1999
$ 0	spenddown met on October 11, 1999

Mr. B met his spenddown on October 11, 1999. Medicaid coverage begins on October 11, 1999 and ends on March 31, 2000, the end of the six month spenddown budget period.

He is discharged from the nursing facility to his home without CBC on November 1, 1999. He was in the nursing facility for less than 30 days. His patient pay for the October 8, 1999 through November 1, 1999 stay is determined:

a) 3 number of days in the nursing facility that are NOT covered by the individual's Medicaid coverage period (October 8 through October 10)
x 120 facility private pay daily rate
$ 360 amount of the spenddown liability for which the individual is responsible.

b) $90 is the spenddown balance on the date the spenddown was met, therefore, the individual is responsible to pay the $90 to the nursing facility. Medicaid will pay the remainder of the cost.

c) $360 amount of the spenddown liability for which the individual is responsible (October 8 - October 10)
+ 90 spenddown balance on October 11; begin date of coverage
$450 individual's patient pay for October 11 through October 31

If his dates in the nursing facility include part of a second month, his patient pay for the second month would be $0.

3. Individual Who Does Not Meet Spenddown

An individual who meets the spenddown on a date after the date he left the facility has full responsibility for the days he was in the facility. Send the individual a Notice of Action showing the dates of Medicaid coverage and that the facility care was not covered by Medicaid. Send the provider a DMAS-225 regarding the individual's eligibility status.

M1470.400 MEDICAID CBC PATIENTS - ALLOWABLE DEDUCTIONS FROM INCOME

A. Introduction

Sections M1470.410 through 430 are the only *allowable* deductions from a Medicaid CBC patient's gross monthly income when calculating patient pay when the patient does not have a community spouse. *If* the patient has a community spouse, go to subchapter M1480 to determine patient pay.

Medicaid CBC patients are not allowed a home maintenance deduction because shelter costs are included in the personal maintenance allowance.

B. Procedure

Subtract the deduction(s) from gross monthly income in the order presented below:

1. Medicaid CBC Personal Maintenance Allowance (M1470.410)

2. Dependent Child Allowance (M1470.420)

3. Medicaid CBC - Incurred Medical Expenses (M1470.430)

C. Appeal Rights

The patient or his representative has the right to appeal the patient pay determination, the amounts used in the calculation and denial of any request for adjustment. If a recipient or his representative appeals the patient pay, the EW who made the decision prepares the appeal summary and attends the hearing.

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, 2021 through December 31, 2021: $1,311
- January 1, 2022 through December 31, 2022: $1,388
- *January 1, 2023 through December 31, 2023: $1,509*

Contact a Medical Assistance Program Consultant for the PMA in effect for years prior to *2021*.

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 (*$2,829 in 2024*) per month.

b. for individuals employed at least *4* but less than 20 hours per week, all earned income up to 200% of SSI (*$1,886 in 2024*) 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

- 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.

1. Example--Two Dependent Children In One Home (Using January 2009 Figures)

Mr. H is a single individual with gross monthly income of $920, living in the community in Group II and receiving Medicaid CBC. He is divorced and has two children under age 18 who live with his ex-wife in Group I. His two children each receive $75 SSA.

The allowance for his dependent children is calculated as follows:

$ 337.92	MN limit for 2 (Group I)
- 150.00	children's SSA income
$ 187.92	dependent children's allowance

2. Example--Three Dependent Children In Two Homes (Using January 2009 Figures)

Mrs. K is a married individual who lives at home in a Group II locality and receives Medicaid CBC. Her spouse is in a medical facility and is not a community spouse. One of their three dependent children lives with Mrs. K. The other two children live with her sister in a Group III locality. The children each receive $95.00 per month SSA.

The allowance for the dependent children is calculated as follows:

$ 306.23	MN limit for 1 (Group II)
- 95.00	child's SSA income
$ 211.23	child's allowance

$ 480.00	MN limit for 2 (Group III)
- 190.00	children's SSA income
$ 290.00	children’s allowance

$ 211.23	child's allowance
+ 290.00	children's allowance
$ 501.23	total dependent children’s allowance

NOTE: If Mrs. K’s institutionalized spouse is eligible for Medicaid, an allowance for their children may also be deducted from his income in determining his patient pay. However, the allowance the children receive from Mrs. K will be counted as part of their income when determining any allowance from Mr. K’s income.

M1470.430 MEDICAID CBC - NONCOVERED MEDICAL EXPENSES

A. Policy

Amounts for incurred medical and dental expenses not covered by Medicaid or another third party, *including services or benefits provided as part of an enrollee’s managed care organization,* are deducted from the patient’s gross monthly income when determining patient pay.

B. Health Insurance Premiums

Payments for medical/health insurance which meet the definition of a health benefit plan, *including dental insurance*, are deducted from patient pay when:

- the premium amount is deducted from the patient's benefit check;

- the premium is paid from the patient's own funds; OR

- the premium is paid by a relative (other than a spouse or parent for minor child) when that relative receives a benefit payment (income) which includes a benefit amount for the patient.

The amount deducted is the amount of the monthly premium. If the patient pays the premium less often than monthly, such as quarterly, prorate the amount paid by the number of months covered by the payment to obtain the monthly amount to deduct in the patient pay calculation.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA (Multiple Employer Welfare Arrangement) or plan provided by another benefit arrangement.

Health benefit plan does not mean accident only, credit, or disability insurance; long-term care insurance; vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance (14VAC5-234-30).

Income protection insurance (indemnity) policy premiums are not medical expenses and are not deducted from the patient pay.

Membership fees for an organization that sponsors or provides the health insurance are not part of the premium and are not deductible.

1. Medicare Part A and/or Part B Premiums

Medicare Part B premiums and/or Medicare Part A premiums are paid by Medicaid for eligible individuals. The premiums are paid by Medicaid via the "buy-in" and are not usually deducted from patient pay. However, Medicaid does not start paying the premiums immediately for all eligible patients, so the Medicare premium(s) must be deducted from patient pay in those months for which Medicaid does not pay the premium.

For CN individuals enrolled in the 300% SSI covered group in ACs 020, 040, and 060 and MN-*only individuals in ACs 018, 038, and 058*, the Medicare buy-in is effective **2 months after the begin date** of Medicaid coverage. If the begin date of coverage is other than the first day of a month, the buy-in is effective the first of the month in which the 60th day occurs. Part B premiums (and Part A premiums if the recipient must pay the Part A premium) must be deducted from patient pay in the month(s) in which the buy-in is not effective.

Deduct the Medicare premium(s) for the first two months of coverage for *individuals in the following ACs:*

- *CN 300% SSI and not dually eligible as QMB or SLMB Plus - ACs 020, 040, 060*

- *MN and not also QMB or SLMB - ACs 018, 038, 058.*

For individuals *in other ACs*, the buy-in is effective with the begin date of Medicaid coverage. Therefore, do NOT deduct Medicare premiums in the patient pay determination for months in the retroactive and ongoing coverage periods.

The Medicaid Medicare buy-in does NOT pay for Medicare premiums in closed periods of coverage for LTC patients who are on spenddown and whose eligibility is for a closed period. Deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from patient pay in the month(s) in which the buy-in is NOT effective.

The Medicaid Medicare buy-in pays for Medicare premiums in retroactive coverage and closed periods of coverage EXCEPT for LTC patients who are on spenddown. DO NOT deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from the patient pay in the month(s) in which the buy-in is effective for LTC patients who are NOT on spenddowns.

2. Example - Medicare Buy-in (Using January 2009 Figures)

Mr. A is 80 years old and started receiving CBC on February 15. He applied for Medicaid on February 2. His only income is $1500 per month. He has no Medicare Part A premium. His Part B premium is withheld from his SSA benefit. Therefore, his gross SSA entitlement is actually $1596.40. He is CN eligible, but he is not dually-eligible as QMB.

Mr. A submitted bills for January and met a retroactive spenddown in January. Ongoing Medicaid began in February because he began receiving Medicaid CBC in February and became CN. The Medicare Buy-in begins on April 1.

His Medicare Part B premium is deducted in February's and March's patient pay. April and subsequent months will not include a deduction for the Medicare premium.

3. Medicare Advantage (Part C) Premiums

Medicare Advantage plans, also referred to as Medicare Part C, are voluntary managed-care Medicare plans. In addition to Medicare Part B premiums, some individuals may pay an extra Medicare Advantage premium. The Medicaid Medicare buy-in is initiated for individuals with Medicare Advantage; however, the buy-in covers only the allowable Medicare Part A and/or B premiums. The individual is responsible for any additional Medicare Advantage monthly premium. The Medicare Advantage monthly premium remains the individual's responsibility and is an allowable deduction from patient pay.

4. Medicare Part D Premiums

An individual who is eligible for Medicare and Medicaid is entitled to enrollment in a basic Medicare Part D prescription drug plan (PDP) at no cost. However, the individual may elect enrollment in a plan with a premium.

When a full-benefit Medicaid enrollee is enrolled in a Medicare Part D PDP, *any* premium that is the individual's responsibility is an allowable deduction from patient pay.

***5.* LTC Insurance**

a. Deduct LTC premium in admission month only

When an individual has an LTC insurance policy that covers long-term care services received in the home, the individual stops paying premiums beginning the month after he is admitted to the home-based LTC. The premium paid for the policy in the LTC admission month can be deducted from the admission month's patient pay only. The LTC insurance premium is not deducted from patient pay for the months following the admission month.

b. LTC insurance benefits

LTC insurance benefits are treated as TPL. If the individual receives the payment from the insurance company, the payment is not income for patient pay or eligibility determinations. The individual should assign it to the waiver services provider. If the individual cannot do this, or the policy prohibits assignment, the LTC insurance payment should be given directly to the provider. The provider should report the payment as a third party payment on its claim form.

If the provider is unable to accept payment directly from the individual, the individual must send the insurance payment to:

DMAS Fiscal Division, Accounts Receivable
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

C. Noncovered Medical/Dental Services

Deductions for the cost of a patient's medically necessary medical or dental services not covered by Medicaid, other insurance (such as Medicare), or another person are subtracted from income to determine patient pay.

See M1470.430 B.3 for the procedures used to deduct Medicare Part D prescription drug co-pays for patients who have Medicare.

DMAS approval **is not** required for deductions of noncovered services from patient pay when the individual receives CBC services, regardless of the amount of the deduction.

1. Zero Patient Pay Procedures

If deductions from patient pay cannot be allowed because the recipient has no income remaining after deducting the personal maintenance allowance, dependent child allowance(s) and health insurance premiums, or the recipient has no income available for patient pay, deny the request.

Notify the patient or the patient's representative using the Notice of Action.

If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service has been approved, notify the patient or his authorized representative that the deduction for the new non-covered service will be made after the first noncovered service deductions are completed.

2. Allowable Non-covered Expenses

When a patient has income available for patient pay, the following can be deducted as noncovered expenses:

a. Old Bills

Old bills are deducted from patient pay as non-covered expenses. Old Bills are unpaid medical, dental or remedial care expenses which:

- were incurred prior to the Medicaid application's retroactive period, or during the retroactive period if the individual was not eligible for Medicaid in the retroactive period or the service was not a Medicaid-covered service;
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and
- remain a liability to the individual.

b. Medically Necessary Covered Services Provided By A Non-participating Provider

Medically necessary medical and dental services that are covered by Medicaid, but that the recipient received from a provider who does not participate in Virginia Medicaid, are deducted from patient pay as non-covered services.

c. Covered Services Outside of Medicaid's Scope

Medically necessary medical and dental services that can be deducted from patient pay are:

- services exceeding Medicaid's amount, duration, or scope;
- services rendered during a prior period of Medicaid eligibility (i.e., LTC services not covered because of a property transfer).

d. Other Allowable Non-covered Services

Medically necessary medical and dental services that are NOT covered by Medicaid and can be deducted from patient pay include:

1) medical supplies, such as antiseptic solutions, incontinent supplies (adult diapers, pads, etc.), dressings, EXCEPT for patients under the Technology-assisted Individuals Waiver (Medicaid covers these services for Technology-assisted Individuals Waiver patients). For Medicaid CBC recipients who have Medicare Part B, do not deduct the cost of supplies/equipment obtained from a Medicare/Medicaid supplier since the supplier receives direct payment from Medicare and Medicaid.

2) dental services ***not covered by Medicaid.*** *Effective July 1, 2021, Medicaid covers dental services for full-benefit adults, as well as children (see M1850.100.D)*;

3) routine eye exams, eyeglasses and eyeglass repair;

4) hearing aids (when medically necessary), hearing aid batteries and hearing aid repair;

5) batteries for power wheelchairs or other power mobility items owned by the recipient, not to exceed four batteries in a 12-month period;

6) chiropractor services, except for Medicare recipients (Medicare covers chiropractor services and Medicaid covers the Medicare deductible and coinsurance amounts);

7) dipyridamole (Persantine) and other prescription medications not covered by Medicaid but ordered by the recipient's physician;

8) copayments for prescription drugs obtained under Medicare Part D.

e. Medicare Part D copays

Individuals who:

- qualify for Medicare Part D,
- are NOT enrolled in a Medicare PDP, and
- are NOT Medicaid eligible at the time of admission to CBC

will be fully responsible for their drug costs until Medicaid eligibility is determined and the Medicare Part D PDP enrollment process is completed. The individual remains responsible for any drugs purchased prior to the effective date of the PDP enrollment; Medicaid cannot pay for these drugs. The cost of drugs purchased before the PDP begin date can be deducted from patient pay.

Full benefit Medicaid enrollees who have Medicare, are receiving Medicaid CBC services, and are enrolled in a Medicare Part D PDP were responsible for the payment of co-pays for prescriptions filled prior to January 1, 2012. Effective January 1, 2012, individuals receiving Medicaid CBC services are not responsible for co-pays for prescriptions covered under their Medicare Part D PDP. CBC recipients are not subject to payment of deductibles or a coverage gap in their Part D benefits.

1) Monthly Statements

PDPs must issue a periodic (at least monthly) statement to the beneficiary explaining all benefits paid and denied. Part D drugs that are not covered by the PDP may not be covered by Medicaid and, absent other drug coverage, remain the responsibility of the individual. When a PDP denies coverage of a prescription, the beneficiary has the right to request an exception for coverage of the drug. The beneficiary is notified in writing of the decision on any exception requested.

2) Verifying Allowable Co-pays

To determine whether or not prescription expenses can be deducted from patient pay, apply the following rules:

- *If the drug expense appears on the statement as a denial, and no exception was requested, **do not** allow the expense.*
- *If the drug expense appears on the statement as a denial, and an exception was requested and denied, allow the expense.*

Enrollees should be advised to maintain these monthly statements if they wish to request patient pay adjustments for Medicare Part D co-pays and for drugs for which the PDP denied coverage.

3. Services NOT Allowed

a. medical supplies covered by Medicaid, or Medicare when the recipient has Medicare, such as:

- diabetic and blood/urine testing strips,
- bandages and wound dressings,
- standard wheelchairs,
- air or egg-crate mattresses,
- IV treatment,
- splints,
- certain prescription drugs (placebos).

b. TED stockings (billed separately as durable medical supplies),
c. acupuncture treatment,
d. massage therapy,
e. personal care items, such as special soaps and shampoos,
f. physical therapy,
g. speech therapy,
h. occupational therapy.

ii. services that are NOT medical/remedial care services, even if ordered by a physician:

- *air conditioners or humidifiers,*
- *refrigerators, whole house generators and other non-medical equipment,*
- *assisted living facility (ALF) room & board and services,*
- *personal comfort items, such as reclining chairs or special pillows,*
- *health club memberships and costs,*
- *animal expenses such as for seeing eye dogs,*
- *cosmetic procedures.*

j. personal care or other waiver services in excess of the number of hours authorized by DMAS (i.e. private pay).

4. Documentation Required

a. Requests For Adjustments From A Patient or An Authorized Representative

Request the following documentation from the patient or his representative:

- a copy of the bill;
- the amount still owed by the patient;
- if applicable, the amount owed that was not covered by the patient's insurance;
- proof that the service was medically necessary. Proof may be the prescription, doctor's referral or a statement from the patient's doctor or dentist. *Proof applies to a physician, doctor, or dentist's current, and not "standing", order(s).*

b. Requests For Adjustments From CBC Providers

If the request for an adjustment to patient pay to deduct a noncovered expense is made by a Medicaid CBC waiver service provider or case manager, the request must be accompanied by:

1) the recipient's correct Medicaid ID number;

2) the current physician's order for the non-covered service (not required for replacement of hearing aid batteries or eyeglass frames or for repair of hearing aids or eyeglasses);

3) actual cost information;

4) documentation that the recipient continues to need the equipment for which repair, replacement, or battery is requested; and

5) a statement of denial or non-coverage by other insurance. The denial may be from the insurance carrier or may be a written statement from the facility that the insurance company was contacted and the item/service is not covered.

If the request from a provider or case manager does not include all the above documentation, return the request to the provider or case manager asking for the required documentation.

5. Procedures

a. Determine Deduction

When the individual receives CBC services, DMAS approval **is not required** for deductions of noncovered services from patient pay, regardless of the amount of the deduction.

Determine if the expense is deducted from patient pay using the following sequential steps:

1) Upon receipt of the requested documentation, determine the amount of the bill that is a valid deduction. Do not deduct more than the available income that remains after the personal needs, dependent child allowance(s), and health insurance premiums are deducted.

   If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service is requested, deduct the new noncovered services after the first noncovered service deductions have been completed.

2) Subtract the deduction for the current month. If the deduction exceeds the available income, the remaining balance can be carried over to the following month(s).

b. Notice Procedures

Upon the final decision to allow the deduction, use the VaCMS Patient Pay process to adjust the patient pay. VaCMS will generate and send the Notice of Patient Pay Responsibility If VaCMS is not able to process required transactions, a Patient Pay Correction form (DMAS 9PP), available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, should be submitted to patientpay@dmas.virginia.gov. DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into *MES*.

6. ***Managed Care Organizations and CCC Plus (effective January. 1, 2018)***

As of January 1, 2018, the majority of Medicaid-eligible individuals who receive long-term care (LTC) services are covered under the CCC Plus program through one of six (6) managed care organizations (MCO). As part of the CCC Plus program, each health plan offers enhanced benefits, such as adult dental services or hearing aids, outside of the required contracted Medicaid services. Some of these enhanced benefits are frequently submitted to the LDSS as patient pay adjustment.

If there are other coverage sources available for these services or items, Medicaid policy requires the request for coverage first be submitted to those sources and exhausted there, before the LDSS/DMAS may consider or approve a patient pay adjustment.

A process is in development to develop a process for distinguishing MCO enhanced benefit services from allowable patient pay deductions. Until further notice, providers and nursing facilities will continue sending all patient pay adjustment requests to the patient's LDSS eligibility worker.

Eligibility workers will review and process patient pay adjustment requests without requiring submission of the request to the individual's CCC Plus plan.

D. Example--CBC Deduction of Noncovered Services (Using January *2009* Figures)

An aged, single individual, with no dependent child and no guardian or conservator, who lives in Group II, applied for Medicaid for the first time in June. He is approved by the screener for long-term care under the *EDCD* waiver. His gross income is $950 Civil Service Annuity (CSA) and $500 SSA. His resources are within the Medicaid limit. He has Medicare and federal employee's health insurance (Medicare is withheld from his SSA check at the rate of *$96.40* per month and $80 is withheld from his CSA for the Health Insurance). Because his income is less than 300% of the SSI income limit, he meets the 300% SSI group.

He is denied retroactive eligibility because he had no Medicaid covered service in the retroactive period. He owes $1,500 on a hospital bill he incurred the prior September *and is making payments*. His patient pay for June is determined in the following steps:

Step 1. gross income:

$ 950	CSA
+ 500	SSA
$1,450	total gross income

Step 2. deduct the correct personal maintenance allowance:

$ 1,450	total gross income
- *1,112*	personal maintenance allowance
$ *338*	remaining income

Step 3. deduct the appropriate medical expense deductions in the correct sequential order:

$ *338.00*	remaining income
- *176.40*	*96.40* Medicare + 80.00 health insurance premium
161.60	remaining income
- *161.60*	non-covered medical expenses ($1,500-*161.60*=*$1,338.40*)
$ 0	patient pay for June

The *$1,338.40* balance remaining from the $1,500 hospital bill that was not deducted from the June patient pay can be deducted in subsequent month(s) as long as it remains a liability.

M1470.500 MEDICAID CBC PATIENTS

A. Overview

This section is only for unmarried individuals and or married individuals who have no community spouse. For married patients who have a community spouse, go to subchapter M1480 for patient pay determination.

This section provides policy and procedures for calculating Medicaid CBC recipients' patient pay.

B. Policy and Procedures

Policy and procedures for determining Medicaid CBC admission month patient pay in the most common admission situations are contained in the following sections:

- Community Living Arrangement Admission to Medicaid CBC (M1470.510)
- *PACE (M1470.520)*

M1470.510 COMMUNITY LIVING ARRANGEMENT ADMISSION TO MEDICAID CBC WAIVER SERVICES

A. Policy

The policy in this section describes the procedures for calculating patient pay for the month of admission and ongoing months for **all** persons residing in the community who are screened and approved for Medicaid CBC waiver services.

B. Procedures

1. All Covered Groups Except MN Spenddown

For an individual admitted to Medicaid CBC waiver services (EXCEPT an individual who meets a spenddown**),** use these procedures:

a. Count all income received in the admission month (M1470.100).

b. Deduct a personal needs allowance (M1470.410):

- basic maintenance allowance based on the waiver;
- guardianship fees, if *any*;
- special earnings allowance, if *any*.

c. Deduct a dependent child allowance, if *any* (M1470.420).

d. Deduct the Medicare premium withheld if the individual is a Medicare recipient and was not receiving Medicaid prior to admission, if *any* (see M1470.430).

e. Deduct other health insurance premiums, deductibles or co-insurance charges, if *any* (M1470.430).

f. Deduct other allowable noncovered medical expenses, if *any* (M1470.430).

g. Any remainder is the patient pay for the month(s).

2. MN Individual Who Meets Spenddown

An MN individual who is on a spenddown is not eligible for Medicaid until the spenddown is met. If an individual is screened and approved for Medicaid waiver services, he is considered "institutionalized" and his eligibility for Medicaid is determined as an institutionalized individual. If the individual's income exceeds the 300% SSI income limit, he must meet an MN institutionalized individual monthly spenddown.

Go to section M1470.600 below to determine patient pay for a CBC patient who is on a spenddown.

M1470.520 PACE

A. Policy

The Program of All-inclusive Care for the Elderly (PACE) serves individuals aged 55 and older who (1) meet the nursing facility level of care criteria and (2) reside in their own communities. PACE provides all of an individual's health care and long-term care medical needs. PACE is not a CBC Waiver; individuals who meet the criteria for the EDCD Waiver may be enrolled in PACE in lieu of the EDCD Waiver. Individuals who are enrolled in Medicaid as *AG* recipients (Aid Categories 012, 032, and 052) are not eligible for PACE. See M1440.108 for additional information about PACE.

Individuals enrolled in PACE have a patient pay obligation.

B. Procedures

The patient pay for an individual enrolled in PACE who is not Medically Needy is calculated using the procedures in M1470.400 through M1470.520 for an individual in CBC, with the exceptions listed below.

1. Medicare Part D Premiums

PACE recipients are not responsible for Medicare Part D premiums because their prescriptions are provided through PACE and they are eligible for the full Medicare Part D subsidy. Therefore, the cost of the Medicare Part D premium is not allowable as a deduction from patient pay.

2. Covered Medical Expenses

Because PACE includes most medically-necessary services the individual needs, the allowable medical expense deductions differ from the allowable medical expense deductions for CBC.

The following services are provided through PACE:

- adult day care that offers nursing, physical, occupational, speech and recreational therapies;
- meals and nutritional counseling; social services;
- medical care provided by a PACE physician; personal care and home health care;
- all necessary prescription drugs;
- access to medical specialists such as dentists, optometrists and podiatrists;
- respite care;
- hospital and nursing facility care when necessary; and
- transportation.

Any medical expenses incurred by the individual for the services listed above are not allowable patient pay deductions. With the exception of the services listed above, the noncovered expenses listed in M1470.430 C.2 are allowable for PACE recipients. DMAS approval **is not required** for deductions of noncovered services from patient pay for PACE recipients, regardless of the amount of the deduction.

3. PACE Recipient Enters a Nursing Facility

Because PACE is a program of all-inclusive care, nursing facility services are part of the benefit package for PACE recipients who can no longer reside in the community. *PACE recipients may be placed in a nursing facility while still enrolled in PACE.* When a PACE recipient *is placed in* a nursing facility, the PACE provider has 60 days from the date of *placement* to notify the eligibility worker of the individual's placement in the nursing facility and the need for a recalculation of the patient pay.

Do not change the personal needs allowance to the facility amount unless notification is received from PACE. After notification *from PACE* of the individual's *placement in* a nursing facility, the eligibility worker will take action to recalculate the individual's patient pay prospectively for the month following the month the 10 day advance notice period ends. There is NO retroactive calculation of patient pay back to the date the individual entered the facility. *Do not refer to the Recipient Audit Unit.* When the change is made, the individual is entitled to a personal needs allowance of $40 per month.

M1470.600 MN PATIENTS - SPENDDOWN LIABILITY

A. Policy

This section is for unmarried individuals or married individuals who have no community spouse. **DO NOT USE this section** for a married individual with a community spouse, go to subchapter M1480.

MN individuals have a spenddown liability that must be met before they are eligible for Medicaid because their monthly income exceeds 300% of SSI, which exceeds the MN income limits. When an MN individual meets the spenddown, he is eligible for Medicaid (see section M1460.700 for spenddown determination policy and procedures). Patient pay for **each** month in which the individual meets the spenddown must be determined.

A patient under 22 years of age receiving inpatient psychiatric services in an IMD (Institution for Treatment of Mental Diseases) whose income exceeds 300% of SSI may be eligible for Medicaid as MN if he meets the spenddown liability.

Coverage in an IMD is not part of the Medicaid benefit package for any other MN individuals who are eligible for Medicaid while in an IMD, including individuals age 65 years or older. Individuals under age 22 years who are not receiving inpatient psychiatric services and all individuals over age 22 years but under age 64 years are not eligible for Medicaid while in an IMD (see M0280.201).

B. Definitions

The following definitions are used in this section and subsequent sections of this subchapter:

1. Medicaid Rate

The Medicaid rate for facility patients is the patient's daily Resource Utilization Group (RUG) code amount multiplied by the number of days in the month. A patient's RUG code amount is based on his room and board and ancillary services. The RUG code amount may differ from facility to facility and from patient to patient within the same facility. Confirmation of the individual's RUG code amount must be obtained by contacting the facility. For the month of entry, use the actual number of days that care was received or is projected to be received. For ongoing months, multiply the daily RUG code amount by 31 days.

The Medicaid rate for CBC patients is the number of hours per month actually provided by the CBC provider multiplied by the Medicaid hourly rate.

PACE has a capitated monthly rate that is due and payable on the first day of the month. The monthly PACE rate is available from the PACE provider.

2. Remaining Income

Remaining income is the amount of the patient's total monthly countable income for patient pay minus all allowable patient pay deductions.

3. Spenddown Liability The spenddown liability is the amount by which the individual's countable income exceeds the medically needy income limit.

C. Procedures The subsections identified below contain the procedures for determining patient pay when an LTC patient meets a spenddown liability and is determined eligible for Medicaid.

1. Facility Patients Patient pay determination procedures are different for medically needy facility patients, depending on whether the spenddown liability is less than or equal to or greater than the Medicaid rate. To determine patient pay for MN facility patients:

a. Determine the individual's spenddown liability using the policy and procedures in subchapter M1460.

b. Compare the spenddown liability to the Medicaid rate.

c. If the spenddown liability is less than or equal to the Medicaid rate, go to section M1470.610 below to determine patient pay.

d. If the spenddown liability is greater than the Medicaid rate, go to section M1470.620 to determine patient pay.

2. Medicaid CBC Patients Medicaid CBC patient pay determination procedures are different from facility procedures. For CBC patients with a spenddown liability, go to section M1470.630.

3. PACE Recipients For PACE recipients with a spenddown liability, go to section M1470.640.

M1470.610 FACILITY PATIENTS--SPENDDOWN LIABILITY LESS THAN OR EQUAL TO MEDICAID RATE

A. Policy This section is applicable ONLY to an unmarried individual, or a married individual without a community spouse. **DO NOT USE this section** for a married individual with a community spouse; go to subchapter M1480.

An MN facility patient whose spenddown liability is less than or equal to the Medicaid rate is eligible for Medicaid effective the first day of the month, based on the projected Medicaid rate for the month.
Medicaid must NOT pay any of the recipient's spenddown liability to the provider. In order to prevent any Medicaid payment of the spenddown liability, the spenddown liability is added to available income for patient pay.

B. Procedures Determine patient pay for the month using the procedures below.

1. Patient Pay Gross Monthly Income Determine the recipient's patient pay gross monthly income according to M1470.100 (including any amounts excluded in determining MN countable income and the spenddown liability).

2. Subtract Spenddown Liability

From the individual's gross monthly income for the month, subtract the spenddown liability. The result is the remaining income.

3. Subtract Allowable Deductions

Deduct the following from the remaining income:

a. a personal needs allowance (M1470.210),

b. a dependent child allowance, if appropriate (M1470.220),

c. any allowable noncovered medical expenses (M1470.230), not including the facility cost of care,

d. a home maintenance deduction, if appropriate (M1470.240).

The result is the **remaining income**.

4. Add Spenddown Liability

Add the spenddown liability to the remaining income (**because the individual is responsible to pay his spenddown liability to the facility**). The result is the **contributable income** for patient pay.

5. Patient Pay

Compare the contributable income to the Medicaid rate for the month. The patient pay is the lesser of the two amounts.

C. Examples

1. Facility--MN And Patient Pay Income Are The Same (Using April 2000 Figures)

Mr. Cay first applied for Medicaid in April. He was admitted to the facility a year earlier. He has a monthly Civil Service Annuity (CSA) benefit of $1,600. He last lived outside the facility in a Group III locality. His income exceeds the CNNMP 300% SSI income limit. He has no old bills, but he has a health insurance premium of $50 monthly plus a $25 noncovered medical expense he incurred on April 2, and a guardian who charges a guardian fee of 5% of Mr. Cay's income. His MN eligibility is being determined for April. The MN determination results in a spenddown liability of $1,255:

$1,600		monthly MN income
-	20	exclusion
1,580		countable MN income
-	325	MN limit for 1 (Group III)
$1,255		spenddown liability for month

The Medicaid rate is $45 per day, or $1,395 for a projected 31-day month. By projecting the month's cost of facility care, he meets his spenddown because his spenddown liability is less than the Medicaid rate. He is eligible effective the first day of the month and for the whole month of April. Because his spenddown liability is less than the Medicaid rate, Mr. Cay will have ongoing Medicaid eligibility. His patient pay for April is determined:

$1,600 total patient pay gross income
- 1,255 spenddown liability
345
- 110 personal needs allowance (basic plus guardian fee)
- 50 health insurance premium
- 25 noncovered medical expense incurred April 2
160 remaining income
+1,255 spenddown liability (his responsibility to pay)
$1,415 contributable income for patient pay (April)

Compare the contributable income for patient pay ($1,415) to the facility's Medicaid rate for April, $1,395. The facility can collect no more that the Medicaid rate. Because the Medicaid rate is less than the contributable income for patient pay, Mr. Cay's patient pay for April is the Medicaid rate of $1,395. Any income retained by Mr. Cay is a resource in May.

2. Facility--MN And Patient Pay Income Are Different (Using July 1999 Figures)

Mr. Day is a disabled individual who applied for Medicaid in July 1999. He was admitted to the facility in November 1998. He has a monthly CSA benefit of $1,500 and a monthly Seminole Indian payment of $235. He last lived outside the facility in a Group III locality. His income of $1,735 exceeds the CNNMP 300% of SSI income limit. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His MN eligibility is determined for July 1999. The MN determination results in a spenddown liability of $1,155:

$1,500 monthly MN income (Seminole Indian payment excluded)
- 20 exclusion
1,480 countable MN income
- 325 MN limit for 1 (Group III)
$1,155 spenddown liability for month

He has an old bill of $250 incurred in December 1998, which was not used to meet a spenddown, and a health insurance premium of $50 monthly plus a noncovered medical expense of $25 that he incurred on July 2. The facility's Medicaid rate is $40 per day, or $1,240 for a projected 31-day month. By projecting the month's cost of facility care, he meets his spenddown because his spenddown liability is less than the Medicaid rate. He is eligible for full month's coverage. His patient pay for July is determined:

$1,500 CSA
+ 235 Seminole Indian payment (not excluded for patient pay)
1,735 patient pay gross income
- 1,155 spenddown liability
580
- 30 personal needs allowance
- 50 health insurance
- 250 old bill from December 1998
- 25 non-covered medical expense incurred July 2
$ 225 remaining income
+1,155 spenddown liability (his responsibility to pay)
$1,380 contributable income for patient pay (July)

Compare the contributable income for patient pay to the facility's Medicaid rate for July. The facility can collect no more than the Medicaid rate. Because the Medicaid rate is less than the contributable income for patient pay for July, Mr. Day's patient pay for July is the Medicaid rate of $1,240. Any income that is retained becomes a resource the following month.

3. Facility-Not Eligible in Admission Month, Eligible in Following Month (Using April 2000 Figures)

Mr. C first applied for Medicaid on April 25. He was admitted to the facility on April 22. He last lived outside the facility in a Group III locality. He is a 40-year-old disabled individual with one dependent child age 10 years; the child lives with his sister in a Group II locality. He has a monthly CSA benefit of $1,700; the child has a CSA benefit of $150 per month. Mr. C has a guardian who charges a 5% guardian fee. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period.

Mr. C's income exceeds the CNNMP 300% of SSI income limit, so he is not eligible as CNNMP. He has a carry-over expense of $200 incurred in the retroactive period. He has a monthly health insurance premium of $50 paid on the 15th of the month plus a $25 noncovered medical expense he incurred on April 2. His MN eligibility is determined for April. The MN determination results in a spenddown liability of $1,355:

$1,700	monthly MN income
- 20	exclusion
1,680	countable MN income
- 325	MN limit for 1 (Group III)
$1,355	spenddown liability for month

The facility's Medicaid rate is $45 per day, or $405 for April 22 - 30 (9 days), the admission month. He does not meet his spenddown by projecting the cost of care at the Medicaid rate for the admission month because his spenddown liability ($1,355) exceeds the Medicaid rate of $405 for the admission month. Therefore, his spenddown cannot be met by projecting the nursing facility costs at the Medicaid rate. His spenddown eligibility must be determined retrospectively using the private pay rate for the number of days of facility care to reduce his spenddown liability. The private pay rate is $50 per day, or $450 for the days April 22 - 30. After subtracting all allowable expenses, he does not meet his spenddown in April and is not eligible for Medicaid in April.

His eligibility for May is determined. His April facility expenses are not deducted because he paid them in April. His $200 January bill is not deducted as a carry-over expense, but any current payments on that bill can be deducted. He incurred a noncovered medical expense on May 2, and paid $65 on his January medical bill.

The facility's Medicaid rate is $45 per day, or $1,395 for a projected 31-day month. By projecting the cost of care at the Medicaid rate, he meets his spenddown on the first of the month (May) because his spenddown liability of $1,355 is less than the Medicaid rate ($1,395). His patient pay for May is determined:

$1,700 total patient pay gross income
- 1,355 spenddown liability
345
- 105 personal needs allowance (basic plus guardian fee)
- 100 dependent child allowance ($250-150=100)
- 50 health insurance premium
- 25 noncovered medical expense incurred May 2
65
- 65 current payment on January medical bill
0 remaining income
+1,355 spenddown liability (his responsibility)
$1,355 contributable income for patient pay (May)

Compare the contributable income for patient pay to the facility's Medicaid rate for May. The facility can collect no more than the Medicaid rate. Because the contributable income for patient pay is less than the Medicaid rate, Mr. C's patient pay for May is his contributable income of $1,355.

M1470.620 FACILITY PATIENTS--SPENDDOWN LIABILITY GREATER THAN THE MEDICAID RATE

A. Policy

This section is applicable ONLY to an unmarried individual, or a married individual without a community spouse. **DO NOT USE this section** for a married individual with a community spouse; go to subchapter M1480.

1. Retrospective Determination

An MN facility patient whose spenddown liability exceeds the Medicaid rate is not eligible for Medicaid until he actually incurs medical expenses that meet the spenddown liability within the month. ALL of these determinations are made monthly, retrospectively, **after** the month has passed and the expenses have actually been incurred. The individual's resources and income must be verified each month before determining if the spenddown has been met.

2. Full Month's Coverage If Spenddown Met

When incurred expenses equal or exceed the spenddown liability, the individual is eligible for the full month of Medicaid coverage beginning the first day of the month in which the spenddown was met, and ending the last day of the month in which the spenddown was met. See subchapter M1460 for procedures to determine spenddown eligibility for these individuals. Patient pay for the month in which the spenddown was met is calculated after determining that the spenddown was met.

3. Patient Pay

Medicaid must not pay any of the recipient's spenddown liability to the provider. Because the spenddown determination is completed after the month and expenses are not projected, the spenddown liability is NOT added to remaining income for patient pay. Use the following procedures to calculate the patient pay for the month in which the spenddown was met.

B. Patient Pay Procedures

1. Patient Pay Gross Monthly Income

Determine the recipient's patient pay gross monthly income according to section M1470.100 (including any amounts excluded in determining MN countable income and the spenddown liability).

2. Calculate Remaining Income For Patient Pay

Calculate remaining income for patient pay by deducting the following from gross patient pay income:

a. a personal needs allowance (M1470.210),

b. a dependent child allowance, if appropriate (M1470.220),

c. any allowable noncovered medical expenses (M1470.230) **NOT** including the facility cost of care, and

d. a home maintenance deduction, if appropriate (M1470.240).

The result is individual's **remaining income**.

4. Patient Pay

Compare the remaining income to the facility's Medicaid rate for the month. The patient pay is the lesser of the two amounts.

C. Example—In a Facility, Spenddown Liability Exceeds Medicaid Rate; No Dependent *(Using July 1999 Figures)*

Ms. Day is an institutionalized individual with no dependents who filed an initial application for Medicaid on November 13, 1999. She was admitted to the facility on November 12, 1999. She has a monthly CSA benefit of $1,700 and a monthly payment of $225 from the Seminole Indians Land Trust. She has a $75 old bill incurred in July 1998, and she has a health insurance premium payment of $50 per month paid on the 20th of the month. She does not have Medicare. She last lived outside the facility in a Group II locality. Her income exceeds the 300% SSI income limit. Her MN eligibility is determined for November 1999. The MN determination results in a spenddown liability:

$1,700	monthly MN income (Seminole Indians payment excluded)
- 20	exclusion
1,680	countable MN income
- 250	MN limit for 1 (Group II)
$1,430	spenddown liability for November

The facility's Medicaid rate is $40 per day, or $760 for the 19 days in November, the admission month. Because her spenddown liability of $1,430 exceeds the $760 Medicaid rate for the admission month of November, Ms. Day is not eligible until she actually incurs medical expenses, including the private facility rate, on or before November 30 that equal or exceed the spenddown liability of $1,430. The private rate is $65 per day. The old bill of $75 is deducted on November 1. She incurs $1,235 for 19 days of care and the $50 insurance premium on November 21; she incurs no other expenses. She does not meet the spenddown in the admission month of November. She paid her all of her November medical expenses in November.

Her eligibility for December (the month following the admission month) is determined. The Medicaid rate of $40 per diem is projected for a 31-day month and equals $1,240. The spenddown liability for the month is compared to the Medicaid rate before deducting any incurred medical expenses. Because the monthly spenddown liability of $1,430 exceeds the Medicaid rate, eligibility must be determined, retrospectively, after the actual facility care costs have been incurred.

In January, to determine if the spenddown was met in December, the worker compares the spenddown liability to the private cost of care for December. The private daily rate of $65 per day is multiplied by 31 days in December to determine the private monthly cost of care. Because the monthly spenddown liability of $1,430 is less than the private monthly cost of care of $2,015, Ms. Day met her spenddown in December and is eligible for the full month of December. She is enrolled *for a* closed period of eligibility, beginning 12-01-99 and ending 12-31-99. On December 3, she made a payment of $75 on her July 1998 medical expense. Her patient pay for December is calculated as follows:

$1,700	CSA
+ 225	Seminole Indians payment (not excluded for patient pay)
1,925	gross income for patient pay
- 30	personal needs allowance
- 75	12/3/99 current payment on medical bill from July 1998
- 50	health insurance premium paid on the 21st
$1,770	remaining income for patient pay (December)

The eligibility worker compares the remaining income to the Medicaid rate ($1,240) for December. The facility can collect no more than the Medicaid rate. Because the Medicaid rate is less than the remaining income for patient pay, Ms. Day's patient pay for December is the Medicaid rate of $1,240. Since she paid the nursing facility the private rate of $2,015 for December, the facility will reimburse her after receiving the Medicaid payment for December. If she retains this money, it becomes a resource to her in the month in which she receives the reimbursement (January at the earliest). Her countable resources must be verified for January before determining if her January spenddown was met.

M1470.630 CBC PATIENTS WITH SPENDDOWN LIABILITY

A. Policy

This section is applicable ONLY to an unmarried individual, or a married individual without a community spouse. **DO NOT USE this section** for a married individual with a community spouse; go to subchapter M1480.

1. Retrospective Determination

Community Based Care (CBC) patients who have income over the 300% of SSI income limit are placed on a monthly spenddown as institutionalized individuals because they have been screened and approved for waiver services. The monthly CBC expenses are determined retrospectively; they cannot be projected for the spenddown budget period.

Retrospective spenddown eligibility determinations are made monthly after the month has passed and the expenses have actually been incurred. The CBC expenses, along with other allowable medical and dental expenses, are deducted

daily and chronologically as the expenses are incurred. The individual's resources and income must be verified each month before determining if the spenddown has been met.

2. Full Month's Coverage If Spenddown Met

When incurred medical expenses equal or exceed the monthly spenddown liability, the individual is eligible for the full month of Medicaid coverage beginning the first day of the month, and ending the last day of the month.

Patient pay for the month in which the spenddown was met is calculated after determining that the spenddown was met.

3. Patient Pay

Because the spenddown is completed after the month and expenses are not projected, the spenddown liability is NOT added to the available income for patient pay. Use the following procedures to calculate the patient pay for the month in which the spenddown was met.

B. Patient Pay Procedures

1. Patient Pay Gross Monthly Income

Determine the CBC recipient's patient pay gross monthly income according to section M1470.100 (including any amounts excluded in determining MN countable income and the spenddown liability).

2. Calculate Remaining Income for Patient Pay

Calculate remaining income for patient pay by deducting the following from gross patient pay income:

a. a personal needs allowance (M1470.410),

b. a dependent child allowance, if appropriate (M1470.420),

c. any allowable noncovered medical expenses (M1470.430) including any old bills, carry-over expenses and other noncovered expenses that were used to meet the spenddown, but NOT including the cost of CBC care.

The result is the individual's **remaining income** for patient pay.

3. Patient Pay

Compare the remaining income to the Medicaid rate (hours of CBC waiver services multiplied by the Medicaid hourly rate) for the month. The patient pay is the lesser of the two amounts.

4. Example--CBC Spenddown Met (Using January 2000 Figures)

Ms. G. lives in Group III and filed an initial application for Medicaid in January. She is approved by the screener for the EDCD Waiver in January. She has no community spouse or dependent child. Her monthly income of $1800 SSA and a $200 private pension and exceeds the CNNMP 300% SSI limit. Her monthly spenddown liability is determined:

$1,800 SSA
+ 200 private pension
$2,000 total monthly income
- 20 exclusion
$1,980 countable income
- 325 MNIL for Group III
$1,655 monthly spenddown liability

Her January application is denied and she is placed on a monthly spenddown during the 12-month certification period of January through December.

In February she submits bills to determine if her January spenddown has been met. Her spenddown eligibility is evaluated first by comparing the private cost of care to her spenddown liability. The private cost of care is $15 per hour, 4 hours per day, or $60 per day. She received care on 20 days in January at the private rate of $60 per day. The private cost of care for January was $1,200. Because the private cost of care was less than her spenddown liability, her spenddown eligibility must be determined on a daily basis. She has old bills of $600 incurred prior to the retroactive period, a health insurance premium of $100 paid on the first of the month, and prescription costs of $500 incurred January 2. Her spenddown eligibility is determined:

$1,655		spenddown liability
-	600	old medical bills incurred prior to retroactive period
-	100	medical insurance premium paid January 1
-	60	cost of care incurred January 1
	895	balance beginning January 2
-	500	prescription costs incurred January 2
-	60	cost of care incurred January 2
	335	balance beginning January 3
-	300	cost of care incurred January 3 -7 (5 days)
	35	spenddown liability balance at beginning of January 8
-	60	cost of care incurred on January 8
$	0	spenddown met on January 8

Because she met the spenddown on January 8, she is eligible for *full* Medicaid coverage beginning January 1 and ending January 31. Her patient pay for January is calculated as follows:

$1,800		SSA
+	200	private pension
-	512	personal maintenance allowance
-	600	old bill incurred prior to retroactive period
-	100	medical insurance premium paid January 1
$	788	remaining income for patient pay (January)

The worker compares the remaining income for patient pay to the Medicaid rate for Medicaid CBC waiver services. The Medicaid hourly rate of $10.50 is multiplied by the 80 hours of CBC waiver services received in January. Because her remaining income ($788) is less than the Medicaid rate ($840), Ms. G's patient pay for January is the remaining income of $788.

The following month, Mrs. G submits bills to determine if and when her February spenddown was met. Her February spenddown eligibility is evaluated as follows:

$1,655 spenddown liability
- 100 medical insurance premium paid February 1
- 60 cost of care incurred on February 1
1,495 spenddown balance beginning February 2
-1,140 cost of care for remainder of February (19 days)
$ 355 spenddown balance on February 29

Mrs. G does not meet her spenddown for the month of February, so she is not eligible for February and no patient pay is calculated. In March and subsequent months, Mrs. G might have additional medical expenses which could enable her to meet her spenddown liability and establish eligibility.

M1470.640 PACE RECIPIENTS WITH SPENDDOWN LIABILITY

A. Policy

This section is applicable ONLY to an unmarried individual, or a married individual without a community spouse. **DO NOT USE this section** for a married individual with a community spouse; go to subchapter M1480.

1. Monthly Spenddown Determination

PACE recipients who have income over the CNNMP 300% of SSI income limit are placed on a monthly spenddown as institutionalized individuals because they have been screened and approved for LTC services.

Unlike CBC, PACE has a capitated monthly rate that is due and payable on the first day of the month. The monthly PACE rate is available from the PACE provider. When an MN individual is in PACE, the amount of allowed PACE expenses is the rate that is due as of the first day of each month.

PACE recipients are not responsible for Medicare Part D premiums, which are included in the monthly PACE rate. **Therefore, the cost of the Medicare Part D premium cannot be used to meet a spenddown and must be subtracted from the monthly PACE rate when determining if the spenddown has been met.**

The individual's spenddown liability and the PACE monthly rate (minus the Medicare Part D premium) establish whether the spenddown eligibility determination can be projected or must be determined retrospectively.

2. Projected Spenddown Determination

If the MN individual's spenddown liability is less than or equal to the monthly PACE rate (minus the Medicare Part D premium), the individual is eligible for Medicaid. As long as the individual's spenddown liability and the PACE monthly rate do not change, the individual is enrolled in ongoing coverage effective the first day of the month in which the spenddown is initially met.

3. Retrospective Spenddown Determination

If the MN individual's spenddown liability exceeds the monthly PACE rate (minus the Medicare Part D premium), he is not eligible for Medicaid until he actually incurs medical expenses that meet the spenddown liability within the month. The monthly medical expenses are determined retrospectively; they cannot be projected for the spenddown budget period.

Retrospective spenddown eligibility determinations are made monthly after the month has passed and the expenses have actually been incurred. The PACE rate (minus the Medicare Part D premium) along with other allowable medical and dental expenses are deducted daily and chronologically as the expenses are incurred. The individual's income and resources must be verified each month before determining if the spenddown has been met. See M1470.520 for allowable medical deductions.

When incurred medical expenses equal or exceed the monthly spenddown liability, the individual is eligible for the full month of Medicaid coverage beginning the first day of the month and ending the last day of the month.

4. Patient Pay

a. Projected Spenddown Eligibility Determinations

Medicaid must assure that enough of the individual's income is allowed so that he can have a personal maintenance allowance. Therefore, the spenddown liability is NOT subtracted from his gross income nor added to the available income for patient pay.

Subtract the allowances listed in M1470.400 from gross monthly income, as applicable. 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.

b. Retrospective Spenddown Eligibility Determinations

Because the spenddown eligibility determination is completed after the month in which the PACE services were received and expenses are not projected, the spenddown liability is NOT added to the available income for patient pay. Follow the instructions in M1470.630 for calculating the spenddown and patient pay when the spenddown liability exceeds the monthly PACE rate (minus the Medicare Part D premium).

M1470.800 COMMUNICATION BETWEEN LOCAL DSS AND LTC PROVIDER

A. Introduction

Certain information related to the individual's eligibility for and receipt of Medicaid LTC services must be communicated between the local agency and the LTC provider. The Medicaid LTC Communication Form (form DMAS-225) is used by both the local agency & LTC providers to exchange information.

B. Purpose

Eligibility workers should generate the DMAS-225 through VaCMS. The DMAS-225 form is also *available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*.

The form is used to:

- notify the LTC provider of a patient's Medicaid eligibility status;
- notify a new provider that the patient pay is available through the verification systems;
- reflect changes in the patient's deductions, such as a medical expense allowance;
- document death of an individual;

- document admission or discharge of a patient to an institution or community-based care services;
- provide information on health insurance, LTC insurance or VA contract coverage, and
- provide other information unknown to the provider that might cause a change in eligibility status or patient pay amount.

Do not use the DMAS-225 to relay the patient pay amount. Providers are responsible for obtaining patient pay information from the ARS/MediCall verification systems.

C. When to Complete the DMAS-225

Complete the DMAS-225 at the time of eligibility determination and/or the recipient's entry into LTC. Complete a new DMAS-225 when the recipient's eligibility status changes, such as when the recipient's Medicaid coverage is canceled or changed to limited QMB or SLMB coverage, or when the LTC provider changes.

Additionally, complete a DMAS-225 for an ongoing enrollee whose patient pay has been initially transitioned into *MES* to notify the provider that the patient pay information is available through ARS/MediCall.

D. Where to Send the DMAS-225

Refer to M1410.300 B.3.b to determine where to send the form. The worker must complete, send, and return the form timely.

M1470.900 ADJUSTMENTS AND CHANGES

A. Policy

The Medicaid recipient or his authorized representative is responsible to report any changes in his or her situation within 10 days of the day the change is known. In situations where the patient pay amount is less than the Medicaid rate the patient pay must be adjusted within 30 days of notification or discovery of the change. This section contains the procedures for when and how to adjust patient pay.

There are situations when the EW **cannot increase** the patient pay, such as when the current patient pay amount equals the Medicaid rate for the month. In this situation, an adjustment that results in an increase in patient pay cannot be made and a referral to the DMAS Recipient Audit Unit (RAU) must be completed following the procedures in M1470.900 D.3.c.1) below.

B. Action When A Change Is Reported

Upon receipt of notice that a change in an enrollee's income or deductions has occurred, the EW must evaluate continued income eligibility (see subchapter M1460). If eligibility no longer exists, follow the procedures for LTC medically needy income and spenddown (see M1460.700). If eligibility continues to exist, the EW must:

1. Recalculate the patient pay.

2. If the patient pay remains the same, send written notification to the person handling the patient's income that the patient pay is unchanged.

3. If the patient pay decreases, follow the instructions found in Item C. below. If the patient pay increases, follow the instructions found in Item D. below.

C. Patient Pay Decreases

1. When to Adjust

Reflect a patient pay decrease using the *VaCMS* Patient Pay process effective the month following the month in which the change was reported when:

- the patient's income decreases;
- an allowable deduction is added or increased;
- the patient did not receive, or no longer receives, some or all of his income.

Adjust the patient pay for the month following the month in which the change was reported. DO NOT adjust patient pay retroactively, unless the patient meets a condition specified in section M1470.910 below.

2. Procedures

Using the *VaCMS* Patient Pay process, take the following steps to reflect a decrease in patient pay:

a. Verify the decrease.

b. Once the decrease is verified, *enter the correct information into VaCMS along with the correct effective begin dates. VaCMS will* calculate the new patient pay based on the change(s).

c. Subtract the "new" patient pay from the "old" patient pay amount; the result is the reduced amount.

d. Multiply the reduced amount by the number of months in which the reduced amount should have been effective; the result is the total reduction.

e. Subtract the total reduction from the next month's (the month following the month in which the worker is taking this action) patient pay. If the total reduction exceeds the patient pay, the patient pay amount will be zero until the total reduction has been subtracted from the patient pay.

3. Example-Patient Pay Decrease

Mr. F is an institutionalized individual who had been receiving a SSA payment of $1,000 and a workman's compensation payment of $400 each month. On June 30, he reported he received his final worker's compensation payment on June 15. The EW requested verification of the termination of the worker's compensation and received the verification on August 22. His patient pay had been $1,370 per month. His new patient pay is calculated to be $960 per month. The "new" patient pay of $960 is subtracted from the "old" patient pay of $1,370. The monthly amount is reduced by $410. Since Mr. F reported the change in June, the patient pay must be adjusted for July and subsequent months. The reduction of $410 is multiplied by 2 months (July and August) and totals $820. The EW adjusts Mr. F's September patient pay to reflect the decreased monthly income for July and August. *VaCMS* shows a September patient pay of $140 and also shows a patient pay of $960 for October and subsequent months.

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 10 day advance notice period ends.*

2) Do not calculate or enter any underpayment amounts.

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M1470.910 RETROACTIVE ADJUSTMENTS FOR PRIOR MONTHS

A. Retroactive Adjustment

If a change was reported timely 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 timely, 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.

B. Procedures

DMAS has implemented changes effective for dates of service on or after April 1, 2017, to simplify responsibility for collecting patient pay in the transition month. For any month that an individual is enrolled in a nursing facility on the DMAS eligibility file, patient pay will be deducted only from nursing facility claims and not from agency personal care, respite care, and/or adult day health care claims.

For patients in the CCC Plus Waiver with a patient pay, *MES* will deduct patient pay from the claims submitted by waiver providers for services following the transition month. It may take a short period of time for the local department of social services to revise the patient pay (reflecting a change in status from nursing facility to CCC Plus). This will result in *MES* initially using a higher patient pay that will be adjusted by DMAS after the patient pay is revised. During this time, waiver or nursing facility providers will still be responsible for collection of identified patient pay amounts owed and should work together to collect the appropriate patient pay.

Eligibility staff will continue to calculate monthly patient pay. **There is no need to divide or apportion the patient pay when a patient changes providers or moves from one type of provider/care to another (e.g. CBC to a nursing facility) nor any a need to inform the provider via a DMAS-225.** Changes in patient pay will be made prospectively, based on advance notice requirements. Changes not requiring advance notice can be processed up to the last day of the month. If an individual has moved from NF to CBC, adjust the patient pay effective the month after the change. Patient Pay underpayment corrections should follow the procedures contained in M1470.900.

C. PACE

Enrollment in PACE begins on the first day of a month and ends on the last day of a month. Patient pay for PACE participants is not adjusted due to provider changes within a month.

M1470.930 DEATH OR DISCHARGE FROM LTC

A. Policy

The LTC provider may not collect an amount of patient pay that is more than the Medicaid rate for the month. When a patient dies or is discharged from LTC to another living arrangement that does not include LTC services, do not recalculate patient pay for the month in which the patient died or was discharged. The provider is responsible for collecting an amount of patient pay for the month of death or discharge that does not exceed the Medicaid rate for the month.

B. Procedure

Refer to the VaCMS Help feature for procedures regarding death or discharge from LTC. Send a DMAS-225 to the provider regarding the eligibility status of the patient. Send a notice to the patient or the patient's representative that reflects the reduction or termination of services. If VaCMS is not able to process required transactions or additional correction is needed, 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. DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into *MES*.

M1470.1000 LUMP SUM PAYMENTS

A. Policy

Lump sum payments of income or accumulated benefits are counted as income in the month they are received. Patient pay must be adjusted to reflect this income change for the month following the month in which the 10-day advance notice period expires. Any amount retained becomes a resource in the following month.

B. Lump Sum Defined

Income such as interest, trust payments, royalties, etc., which is received regularly but is received less often than quarterly (i.e., once every four months or three times a year, once every five months, once every six months or twice a year, or once a year) is treated as a lump sum for patient pay purposes.

EXCEPTION: Income that has previously been identified as available for patient pay, but which was not actually received because the payment source was holding the payment(s) for some reason or had terminated the payment(s) by mistake, is **NOT** counted again when the corrective payment is received.

See section M1470.1030 below for instructions for determining patient pay when a lump sum is received.

M1470.1010 LUMP SUM REPORTED IN RECEIPT MONTH

A. Lump Sum Available

Lump sum payments reported in the month the payment was received are counted available for patient pay effective the first of the month following the month in which the 10-day advance notice period expires.

If the individual is no longer in the facility and is not receiving Medicaid CBC, adjust the patient pay for the lump sum receipt month if the money is still available.

B. Lump Sum Not Available

If the money is not available, complete and send a Notice of Recipient Fraud/Non-Fraud to the DMAS Recipient Audit Unit.

M1470.1020 LUMP SUM NOT REPORTED TIMELY

A. Effective Date

Lump sum payments reported AFTER the month in which the payment was received are not reported timely. Evaluate total resources including the lump sum. If the resources are within the limit, determine availability for patient pay. See B. & C. below. If they exceed the resource limit, go to section M1470.1100 below.

B. Lump Sum Not Available

If the money is not available, complete and send a Notice of Recipient Fraud/Non-Fraud to the DMAS Recipient Audit Unit.

C. Lump Sum Available

1. If the money is still available and the individual is no longer in the facility and is not receiving Medicaid CBC, complete and send a Notice of Recipient Fraud/Non-Fraud to the DMAS Recipient Audit Unit.

2. If the money is still available and the individual is still in the facility or is still receiving Medicaid CBC, adjust the patient pay according to procedures in section M1470.1030 below.

M1470.1030 PATIENT PAY DETERMINATION FOR LUMP SUMS

A. Policy

When a lump sum payment is received, the patient pay for the month *following the month* in which the 10-day advance notice period expires must be adjusted using the procedures in this section. ***The patient pay cannot be increased retroactively.***

B. CN Procedures

1. Total Income

Add the lump sum to the patient's regular monthly income; the result is total income for the month.

2. Less Than Or Equal To 300% of SSI

If the total gross income (including the lump sum) is equal to or less than the 300% of SSI income limit, adjust the patient pay. None of the lump sum remains to be evaluated.

3. Greater Than 300% of SSI

If the total gross income (including the lump sum) exceeds the 300% of SSI income limit, adjust the patient pay. Compare the income available for patient pay to the Medicaid rate for the month.

If the income available for patient pay is less than or equal to the Medicaid rate, the available income is the patient pay. If the income available for patient pay exceeds the Medicaid rate, adjust the patient pay to equal the Medicaid rate for the month.

Evaluate the difference between the Medicaid rate and the available income as a resource for the next month. If the patient's total countable resources exceeds the resource limit, take appropriate action to cancel the patient's Medicaid.

C. MN Procedures

1. Facility Patients--Spenddown Liability Less Than or Equal To Medicaid Rate

For facility patients who have a spenddown liability that is less than or equal to the facility Medicaid rate and who are enrolled in ongoing Medicaid coverage:

a. add the lump sum to the patient's regular monthly income; the result is total gross income for the month;

b. subtract the correct personal needs/maintenance allowance and any other allowable deductions; the remainder is the income available for patient pay for the month

c. compare the spenddown liability to the Medicaid rate for the month:

- if the available income for patient pay is less than or equal to the Medicaid rate, the available income is the patient pay.

- if the available income for patient pay is **greater than** the Medicaid rate, adjust the patient pay to the Medicaid rate for the month. Evaluate the difference between the Medicaid rate and the available income as a resource for the next month. If the patient's total countable resources, including the remainder of the available income, exceed the resource limit, take appropriate action to cancel the patient's Medicaid.

2. Facility Patients With Spenddown Liability Greater Than Medicaid Rate, & All Medicaid CBC Patients

For facility patients who have a spenddown liability that is greater than the facility Medicaid rate, and for ALL Medicaid CBC patients whose eligibility and patient pay are determined retrospectively:

a. Spenddown Eligibility & Patient Pay Previously Determined

If the individual's spenddown eligibility for the month has been determined without including the lump sum amount and the individual was enrolled for the month:

1) add the lump sum to the patient's regular monthly income in the month the lump sum was received; the result is total gross income for the month;

2) subtract the correct personal needs/maintenance allowance and any other allowable deductions; the remainder is the revised patient pay for the month;

3) compare the revised patient pay to the patient pay that was previously determined and sent to the provider:

- if the revised patient pay is **greater than** the previously determined patient pay, adjust the patient pay to the revised patient pay amount or the Medicaid rate, whichever is less. If the Medicaid rate is less, evaluate the difference between the Medicaid rate and the revised amount as a resource for the next month.

* if the revised patient pay is **less than or equal to** the previously determined patient pay, DO NOT adjust the patient pay.

Note: If the patient's total countable resources, including the remainder of the available income, exceed the resource limit, take appropriate action to cancel Medicaid eligibility the next month because of excess resources.

b. Spenddown Eligibility & Patient Pay NOT Previously Determined

If the individual's spenddown eligibility for the month has not yet been determined:

1) Recalculate the individual's spenddown liability by adding the lump sum to the patient's regular monthly income in the month the lump sum was received; determine spenddown eligibility by policy and procedures in section M1460.700.

2) If the individual meets the revised spenddown, determine patient pay by using the policy and procedures in section M1470.620 or M1460. 630.

M1470.1100 REDUCTION OF EXCESS RESOURCES

A. Policy

Medicaid policy allows for a full month of eligibility if the resource limit is met at any time during the month. LTC patients whose patient pay is less than the Medicaid rate can choose to reduce excess resources by expending the excess for the cost of LTC services. *This policy does not apply to individuals whose Medicaid application is pending.*

B. Resource Reduction Defined

A decrease in property value, such as an official reassessment or a lien placed against property, is not a reduction of resources. It is a decrease in the value of the resource.

In order to reduce resources, a resource must be transferred out of the patient's possession. Liquid resources such as bank accounts and prepaid burial accounts must actually be expended or encumbered. Non-liquid resources must be liquidated and the money expended.

A reduction of resources is an asset transfer and must be evaluated under asset transfer policy in subchapter M1450.

C. Procedures

1. Required Contact

When a Medicaid-enrolled LTC recipient is found to have excess resources, evaluate whether an adjustment to patient pay by using the excess toward the cost of care will allow continued eligibility in the month in which the 10-day advance notice period expires. Do not assume that the recipient or the recipient's representative will agree to use the excess resources to pay an increased patient pay.

Prior to initiating the following procedures, contact the individual or his authorized representative and tell him of the alternatives available. In the case record, document the conversation and the decision made. If unable to make contact by phone, send the Advance Notice of Proposed Action for cancellation due to excess resources.

2. Reduce Excess Resources

When the patient agrees to use the excess resources toward the cost of care, take the following steps for the month in which the 10-day advance notice period expires:

Step 1 Determine amount of excess resources (total resources minus the resource limit).

Step 2 Determine the monthly Medicaid rate:

* for a facility patient, the monthly rate is the *patient's daily RUG* rate multiplied by 31 days.

- for a CBC patient, the monthly rate is each CBC service provider's hourly rate multiplied by the number of hours of services provided to the patient in the month.

Step 3 Add the amount of excess resources to the current patient pay.

Step 4 If the result of Step 3 is less than the monthly Medicaid rate obtained in Step 2, adjust the patient pay for one month to allow the excess resources to be reduced.

Step 5 If the result of Step 3 is more than the monthly Medicaid rate obtained in Step 2, the patient is ineligible due to excess resources. Send an "Advance Notice of Proposed Action" to cancel Medicaid coverage due to excess resources.

D. Example--Recipient Reduces Resources

An institutionalized Medicaid recipient's resources accumulate to $2,200 in February. His monthly income is $500 from Social Security (SS) and $100 VA Compensation. His patient pay of $560 is less than the Medicaid rate. He pays the amount of his excess resources ($200) to the nursing facility as part of his March patient pay, so he remains eligible.

$ 500 SS
+ 100 VA Compensation
$ 600 total gross income
- 40 personal needs allowance
$ 560 current patient pay (prior to adding excess resources)

$ 560 current patient pay
+ 200 excess resources
$760 patient pay for March only

His patient pay for April and subsequent months is calculated:

$ 500 SS
+ 100 VA Compensation
$ 600 total gross income
- *40* personal needs allowance
$ 560 patient pay for April and subsequent months

M1470.1200 INCORRECT PAYMENTS TO PROVIDER

A. Introduction

There may be instances when the amount of patient pay collected by an LTC provider is less than the amount *determined* available for payment. This situation is most likely to occur when some other person is the payee for the patient's benefits.

B. Procedures

This section provides policy and procedures used to determine patient pay when the provider collects less than the patient pay *amount.* Patient pay can be adjusted *according to whether* certain criteria, specified in sections *M1470.1210 and M1470.1220* below, are met.

M1470.1210 ADJUSTMENTS NOT ALLOWED

A. Policy

The facility or CBC provider is responsible to collect the patient pay from the patient or the person handling the patient's funds. When the provider is not successful in collecting the patient pay, the EW **cannot** adjust the patient pay.

B. Do Not Adjust Patient Pay

The patient pay *reported in ARS/MediCall* is considered available by Medicaid. Do not adjust the patient pay when:

1. the patient directly receives his benefits and is considered to be competent but does not meet his patient pay responsibility; or

2. the amount of patient pay in question is from the patient's own funds which have been withheld by a payee or other individual receiving the patient's funds and have not been paid toward the cost of the patient's care, as specified by policy in this chapter and by the "Notice of Obligation for LTC Costs" sent to the individual.

Should the situation indicate that a change in payee is necessary, contact the program which is the source of the benefit payment and recommend a change. *Additionally,* be alert to situations that may require a referral to Adult Protective Services for an evaluation of exploitation.

C. Entitlement Benefits Adjustment

For an ongoing case, if benefits from entitlement programs (such as Social Security) are not received because the program is holding the check(s) for some reason, but the benefits will be paid some time in the future in a lump sum, do not adjust the patient pay for the months the benefits are not received.

When the lump sum payment is received, do **not** count the lump sum payment and do **not** follow instructions for lump sum payments as found in this subchapter because the patient must use the lump sum to pay the previous months' remaining patient pay amounts the patient still owes to the provider.

M1470.1220 ADJUSTMENTS ALLOWED

A. Adjust Patient Pay

Adjust the patient pay when:

* the income counted in the patient pay calculation was not actually received because the source did not pay; *and*
* the income will not be paid some time in the future; and
* documentation of the change in income is received by the worker.

See section M1470.900 for instructions on adjusting patient pay.

B. Adjustment Allowed Due To Income Changes

Some examples of when income is not received and will not be paid in the future are:

1. Rental Income

Rental income is no longer received because the property was not rented for a period of time, or the renter did not pay. Be aware that if property no longer produces income, the resource exclusion may be affected. Evaluate *the individual's* continued eligibility.

2. Contribution Not Received

A contribution from a responsible relative or other source is not received. Advise the responsible relative of his legal responsibility. If there is a legal responsibility to support the individual, advise the responsible relative that continued failure to meet that responsibility may result in a non-support petition being filed with the appropriate court.

3. Income Source Exhausted

Interest income is not received because the source of income was exhausted or is no longer available.

4. Trust Income

Income from a trust fund is not received because the trustee did not make it available and/or will no longer make it available.

5. Policy/Benefits Ran Out

Payment from an insurance company or organization is not paid because the policy is no longer in force, benefits ran out, the organization refuses to or cannot pay, etc.

Sample Notice of *Patient Pay Responsibility* from VaCMS

COMMONWEAL TH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

NOTICE OF PATIENT PAY RESPONSIBILITY

TO:

Recipient Name:

Recipient ID:

This form serves as your notice of patient pay, which is the amount of your income that must be paid to the provider every month for the cost of long-term care services you receive. The long-term care provider who is responsible for collection of any portion of your patient pay will directly bill you or your representative. A portion of patient pay may be paid to more than one provider when services are received from multiple providers. If you currently receive Medicaid long-term care services, this will serve as the 10-day advance notice when your patient pay amount is increased. Please contact your local worker if you have questions.

PATIENT PAYCALCULATIONS

Effective Date of Patient Pay (Month and Year):

Reason

Income
Social Security
Other Unearned Income
Total Earned Income
Total Gross Income
Minus Spenddown Liability (SDL)
Remaining Income

Allowances Deducted from Income Personal/Maintenance Needs Spousal
Child/Family Member
Non-covered Medical Expenses Home Maintenance
Income Remaining after Allowances

Spenddown Liability Contribution Income Medicaid Rate for Month
Patient Pay

DATE OF ACTION/NOTICE AGENCY REPRESENTATIVE TELEPHONE NUMBER

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Patient pay may be the lesser of the SDL amount, contributable income amount (income remaining after deductions plus the SDL), remaining income or the Medicaid Rate, whichever is applicable to the individual's circumstances.

Patient pay will not exceed the Medicaid Rate.

You must report any changes in income or resources to the local agency. Failing to report changes or providing false or misleading information may result in your prosecution for fraud.

Ifyou have Medicare Part A coverage, and were admitted to a nursing facility under "Skilled Care", the patient pay amount you owe for the first 100 days may be less than the amount shown on this notice. The nursing facility will determine how many days are covered by Medicare and will send you a bill. Once Medicare stops paying, you will be responsible for the full patient pay amount shown on this notice.

Appeal Information

If you disagree with this action, you have the right to file an appeal. You or your authorized representative must send a written appeal request within 30 days of receipt of this notification. If you file an appeal before the effective date of this action, the patient pay will remain unchanged during the appeal process. However, if the Appeals Division upholds this action, you may be required to reimburse the Medicaid Program for the excess cost of services paid on your behalf during the appeal period.

You may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, at your local department of social services, or by calling (804) 371-8488.

Please include a copy of this notification. Sign the appeal request and mail it to:

Department of Medical Assistance Services, Appeals Division
600 E Broad Street, Richmond,
Virginia 23219

Appeal requests may also be faxed to *(804) 452-5454*

CHAPTER M14
LONG-TERM CARE
SUBCHAPTER 70

PATIENT PAY — POST-ELIGIBILITY TREATMENT OF INCOME

M1470 Changes

Changed With	Effective Date	Pages Changed
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.

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

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M14 LONG-TERM CARE

M1470 PATIENT PAY--POST-ELIGIBILITY TREATMENT OF INCOME

APPENDIX

M1470.000 PATIENT PAY-POST-ELIGIBILITY TREATMENT OF INCOME

M1470.001 OVERVIEW

A. Introduction

"Patient pay" is the amount of the long-term care (LTC) patient's income which must be paid as his share of the LTC services cost. This subchapter provides basic rules regarding the post-eligibility determination of the amount of the LTC patient's income which must be paid toward the cost of his care. **MAGI Adults have no responsibility for patient pay.** If an individual receiving LTC, also called long-term supports and services (LTSS), loses eligibility in the MAGI Adults covered group and is eligible in another full coverage group, patient pay policy will apply.

B. Policy

The state's Medicaid program must reduce its payment to the LTC provider by the amount of the eligible patient's monthly income, after allowable deductions. Patient pay is calculated after an individual has been determined eligible for Medicaid and for Medicaid LTC services. A Medicaid recipient who is admitted to a nursing facility, facility for individuals with intellectual disability (ICF-ID) or Medicaid waiver services for less than 30 days must have a patient pay determined for the month(s) in which the recipient is in the facility or waiver services**.** The provider collects the patient pay from the patient or his authorized representative. Patient pay information is fed to the Automated Response System (ARS) and the MediCall Systems for provider verification of patient pay. These systems report the amount of patient pay and the date of service to the provider responsible for collecting patient pay.

C. VaCMS Patient Pay Process

The patient pay calculation is completed in VaCMS. Refer to the VaCMS Help feature for information regarding data entry. The patient pay must be updated in the system whenever the patient pay changes, but at least once every 12 months. If VaCMS is not able to process required transactions, a Patient Pay Correction form (DMAS 9PP), available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, should be submitted to patientpay@dmas.virginia.gov.

D. Patient Notification

The patient or the authorized representative is notified of the patient pay amount on the Notice of Patient Pay Responsibility. VaCMS will generate and send the Notice of Patient Pay Responsibility. M1470, Appendix 1 contains a sample Notice of Patient Pay Responsibility generated by VaCMS. DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into *the Medicaid Enterprise System (MES, formerly MMIS)*.

The provider is the only entity with the authority to take action when residents do not pay their patient pay amount. If a resident, or his authorized representative is negligent in paying his patient pay amount to the provider, the provider will provide written documentation regarding the requirement to pay the patient pay amount to the resident or authorized representative and follow the provider's collection procedures to collect the funds. The provider will report the resident's negligence in paying the patient pay amount to the LDSS.

The provider's failure to collect the patient pay, or the patient's failure to pay the patient pay, does not itself affect the patient's Medicaid eligibility. However, the

EW must review the patient's resources each month to determine if the resources are within the Medicaid limit.

If the individual resides in a nursing facility and the above attempts to collect the patient pay amount are unsuccessful, DMAS has advised that the facility may take one of the following options:

1. **Facility Option #1**

The facility will notify the LDSS no later than 120 days from the due date of the payment. The facility will include in this notification a copy of the third collection statement, a written notification of the situation, documentation of contacts made with the resident or authorized representative, and the reasons why payment has not been made.

The LDSS will take the following steps:

- Upon receipt of the written notice from the facility, the local DSS will review the case to determine if the individual's resources are within Medicaid eligibility limits or if a transfer of assets has occurred.

- If the individual alleges that he does not receive sufficient income to pay his patient pay, the eligibility worker will review the patient pay amount and make any necessary adjustments.

2. **Facility Option #2**

Discharge or transfer the resident, including transferring the resident within the facility, except as prohibited by the Virginia State Plan for Medical Assistance Services.

Prior to discharge or transfer, the facility must provide reasonable and appropriate notice of the required patient pay, and the resident or authorized representative must be given at least 30 days written notice prior to the discharge or transfer, which shall include appeal rights. If the resident or authorized representative does not agree with this action, he may submit an appeal request to DMAS. The individual will be allowed to continue residing in the facility during the appeal process.

M1470.100 AVAILABLE INCOME FOR PATIENT PAY

A. Gross Income

Gross monthly income is considered available for patient pay. Gross monthly income is the same income used to determine an individual's eligibility in the 300% SSI income group. It includes types and amounts of income which are excluded when determining medically needy eligibility.

1. 300% SSI Group

If the individual is eligible in the 300% SSI group, to determine patient pay start with the gross monthly income calculated for eligibility. Then add and deduct any amounts that are listed in subsection C. below.

2. Groups Other Than 300% SSI Group

If the individual is eligible in a covered group other than the 300% SSI group, determine the individual's patient pay income using subsections B. and C. below.

B. Income Counted For Patient Pay

All countable sources of income for the 300% SSI group listed in section M1460.611 are considered income in determining patient pay. Any other income NOT specified in C. below is counted as income for patient pay.

1. Aid & Attendance and VA Pension Payments

Count the total VA Aid & Attendance payments and/or VA pension payments in excess of $90.00 per month as income for patient pay when the patient is:

- a veteran who does not have a community spouse or dependent child,
- a deceased veteran's surviving spouse who does not have a dependent child, or
- *a veteran's dependent child.*

Do not count any VA Aid & Attendance payments and/or VA pension payments when the patient is:

- a veteran who has a community spouse or dependent child, or
- a deceased veteran's surviving spouse who has a dependent child.

NOTE: This applies to all LTC recipients, including patients who reside in a Veterans Care Center.

2. Non-Refundable Advance Payments To LTC Providers

Advance payments and pre-payments paid by a recipient to the LTC provider that will not be refunded are counted as income for patient pay. M1470.1100 contains instructions for calculating the patient pay when an advance payment has been made to reduce resources within a month.

C. Income Excluded For Patient Pay

Income from sources listed in subchapter M1460.610 "What is Not Income" is not counted when determining patient pay, **EXCEPT** for the VA Aid & Attendance and VA pension payments to veterans which are counted in the patient pay calculation (see B. above). Additional types of income excluded from patient pay are listed below.

1. SSI & AG Payments

All SSI and Auxiliary Grants (AG) payments are excluded from income when determining patient pay.

2. Certain Interest Income

a. Interest or dividends accrued on excluded funds which are set aside for burial are not income for patient pay.

b. Interest income when the total interest accrued on all interest-bearing accounts is less than or equal to $10 monthly is not income for patient pay. Interest income that is not accrued monthly must be converted to a monthly amount to make the determination of whether it is excluded.

- Verify interest income at application and each scheduled redetermination.

- If average interest income per month exceeds $10.00 and is received less often than monthly, it must be treated as a lump sum payment for patient pay purposes. Refer to Section M1470.1000 of this subchapter for procedures and instructions.

3. Repayments

Amounts withheld from monthly benefit payments to repay prior overpayments ***are*** income for patient pay *unless the exception in S0830.110 is met*. The patient or his representative should be advised to appeal the withholding *with the benefit source.*

4. CBC Additional Care

Additional care purchased outside of a CBC recipient's plan of care is not counted as income available for patient pay if it is purchased by someone other than the recipient. This additional care may be purchased from any source including the agency providing the CBC.

5. Refundable Payments to LTC Facilities

The family of a prospective Medicaid patient or other interested party may make an advance payment on the cost of facility care prior to or during the Medicaid application process to assure the patient's admission and continued care. The individual may have been promised that the advance payment will be refunded if Medicaid eligibility is established.

Advance payments made by a person other than the patient and which are expected to be reimbursed once Medicaid is approved, as well as payments made by outside sources to hold the facility bed while the patient is hospitalized, are **not counted as income** in determining eligibility or patient pay.

The facility must reimburse any payment contributed toward the cost of patient care pending a Medicaid eligibility determination once Medicaid eligibility is established.

6. Survivor's Benefit Plan Deductions from Military Pensions

Any portion of a military retiree's pension that is withheld as a contribution to participate in the Survivor's Benefit Plan (SBP) is not income for patient pay. To participate in SBP in conjunction with their retirement, military members must elect to receive reduced retirement pay for their lifetime so that a percentage of their retirement pay can continue to be paid to their survivors following their death. Once SBP is elected, retirees cannot discontinue the deductions from their pensions.

M1470.200 FACILITY PATIENTS - ALLOWABLE DEDUCTIONS FROM INCOME

A. Introduction

Sections M1470.210 through 240 are the only allowable deductions from a facility patient's gross monthly income when calculating patient pay in the month of entry and subsequent months when the patient does not have a community spouse.

If the individual is married and his spouse is in a nursing facility, then there is no community spouse and each spouse is treated as an unmarried individual for patient pay purposes. When the patient is an institutionalized spouse with a community spouse, as defined in subchapter M1480, go to subchapter M1480 to determine the institutionalized spouse's patient pay.

B. Order of Patient Pay Deductions

Deductions from gross monthly income are subtracted in the order presented below. Deductions are made only to the extent that income remains after a prior deduction has been subtracted. Therefore, if the patient has no income remaining after a deduction, no additional deductions can be made.

1. Personal Needs

See section M1470.210 "Facility Personal Needs Allowance."

2. Dependent Child Allowance

See section M1470.220 "Dependent Child Allowance."

3. Noncovered Medical Expenses

See section M1470.230 "Facility - Noncovered Medical Expenses."

4. Home Maintenance Deduction

See section M1470.240 "Facility - Home Maintenance Deduction."

C. Appeal Rights

The patient or his representative has the right to appeal the patient pay determination, the amounts used in the calculation and denial of any request for adjustment. If a recipient or his representative appeals the patient pay, the EW or Medicaid Technician who made the decision prepares the appeal summary and attends the hearing.

M1470.210 FACILITY PERSONAL NEEDS ALLOWANCE

A. Policy

The personal needs allowance is calculated according to the instructions in this section for the month of entry and subsequent months. The amount of the personal needs allowance depends on whether or not:

- the patient has a guardian or conservator who charges a fee; or
- the patient has earnings from employment that is part of the treatment plan.

The personal needs allowance is the sum of the basic personal allowance plus the guardianship fee and/or special earnings allowance, if applicable.

1. Basic Personal Allowance

Deduct $40 per individual.

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

Working patients are allowed a higher personal needs allowance if they meet the following criteria. These patients will be identified by the facility. The patient must regularly participate in vocational activity which is a planned habilitation program and is carried out as a therapeutic work program, such as:

- sheltered workshops
- vocational training
- pre-vocational training.

Deduct a special earnings allowance if the patient participates in a work program as part of treatment. The special earnings allowance is deducted from earned income only. Subtract:

- the first $75 of gross monthly earnings, PLUS
- ½ the remaining gross earnings,
- up to a maximum of $190 per month.

The special earnings allowance cannot exceed $190 per month.

4.* Example - *Calculation of Personal Needs Allowance

A patient in the nursing facility is employed as a telephone salesperson as part of his plan of care in the facility. He has a legally appointed guardian who charges a 2% fee. His only income is gross earnings of $875 per month. *The patient receives deductions for the basic allowance, the guardianship fee, and the special earning allowance.*

His special earnings allowance is calculated first:

$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 computed as follows:

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

M1470.220 DEPENDENT CHILD ALLOWANCE

A. Unmarried Individual or Married Individual With No Community Spouse

An unmarried individual, or married individual without a community spouse, who has a minor dependent child(ren) under age 21 in the community, can have a dependent child allowance**.** When the individual verifies that he/she has a dependent child(ren) in the community:

- Calculate the difference between the appropriate monthly medically needy income limit (MNIL) for the child's locality for the number of minor dependent children in the home, and the child(ren)'s gross monthly income. If the child lives outside of Virginia, use the Group III MNIL.

- The result is the dependent child allowance. If the result is greater than $0, deduct it from the patient's monthly income as the dependent child allowance. If the result is $0 or less, there is NO dependent child allowance.

The dependent child allowance *cannot be given when* the dependent child(ren)'s gross monthly income exceeds the monthly MNIL for the number of children in the child(ren)'s locality, if money is not made available or he does not accept the monthly income allowance.

Do NOT deduct any allowance for other family member(s).

1. Example--One Dependent Child (Based on July 2008 figures)

Mrs. K is a married individual who is now residing in a nursing facility. Her spouse is in another medical facility. Their dependent child lives with her sister in a Group II locality. The child receives a $95.00 of Social Security income per month.

The allowance for the dependent child is calculated as follows:

$ 265.39 MN limit for 1 (Group II)
- 95.00 child's SSA income
$ 170.39 dependent child's allowance

NOTE: If Mrs. K's institutionalized spouse is eligible for Medicaid, an allowance for their child may also be deducted from his income in determining his patient pay. However, the income the child receives from Mrs. K will be counted in the child's gross income when determining any allowance from Mr. K.

2. Example--Two Dependent Children (Based on July 2008 figures)

Mr. H is a single individual with gross monthly income of $920, living in a nursing facility. He is divorced and has two children under age 21 who live with his ex-wife in Group I. His two children each receive $75 of monthly Social Security income.

The allowance for the dependent children is calculated as follows:

$ 337.92 MN limit for 2 (Group I)
- 150.00 children's total monthly SSA income
$ 187.92 dependent children's allowance

M1470.230 FACILITY - NONCOVERED MEDICAL EXPENSES

A. Policy

Amounts for incurred medical and dental expenses not covered by Medicaid or another third party are deducted from the patient's gross monthly income when determining patient pay.

B. Health Insurance Premiums

1. *Private or Commercial Insurance*

Payments for medical/health insurance, *including dental insurance*, which meet the definition of a health benefit plan are deducted from patient pay when:

- the premium amount is deducted from the patient's benefit check;
- the premium is paid from the patient's own funds; OR
- the premium is paid by a relative (other than a spouse or parent for minor child) when that relative receives a benefit payment (income) which includes a benefit amount for the patient.

The amount deducted is the amount of the **monthly** premium. If the patient pays the premium less often than monthly, such as quarterly, prorate the amount paid by the number of months covered by the payment to obtain the monthly amount to deduct in the patient pay calculation.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA (Multiple Employer Welfare Arrangement) or plan provided by another benefit arrangement.

Health benefit plan does not mean accident only, credit, or disability insurance; long-term care insurance; vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance (14VAC5-234-30).

Income protection insurance (indemnity) policy premiums are not medical expenses and are not deducted from the patient pay.

Membership fees for an organization that sponsors or provides the health insurance are not part of the premium and are not deductible.

2. Medicare Part A and/or B Premiums

Medicare Part B premiums and/or Medicare Part A premiums are paid by Medicaid for eligible individuals. The premiums are paid by Medicaid via the "buy-in" and are not usually deducted from patient pay. However, Medicaid does not start paying the premiums immediately for all eligible patients, so the Medicare premium(s) must be deducted from patient pay in those months for which Medicaid does not pay the premium.

For Categorically Needy (CN) individuals enrolled in the 300% SSI covered group in Aid Categories (ACs) 020, 040, and 060 and Medically Needy (MN)-*only individuals in ACs 018, 038, and 058*, the Medicare buy-in is effective **2 months after the begin date** of Medicaid coverage. If the begin date of coverage is other than the first day of a month, the buy-in is effective the first of the month in which the 60th day occurs. Part B premiums (and Part A premiums if the recipient must pay the Part A premium) must be deducted from patient pay in the month(s) in which the buy-in is not effective.

Deduct the Medicare premium(s) for the first two months of coverage for *individuals in the following ACs:*

- *CN 300% SSI and not dually eligible as a Qualified Medicare Beneficiary (QMB) or a Special Low-income Medicare Beneficiary (SLMB) Plus - ACs 020, 040, 060*
- *MN and not also QMB or SLMB - ACs 018, 038, 058.*

For individuals *in other ACs*, the buy-in is effective with the begin date of Medicaid coverage. Therefore, do NOT deduct Medicare premiums in the patient pay determination for months in the retroactive and ongoing coverage periods.

The Medicaid Medicare buy-in does NOT pay for Medicare premiums in closed periods of coverage for LTC patients who are on spenddown and whose eligibility is for a closed period. Deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from patient pay in the month(s) in which the buy-in is NOT effective.

The Medicaid Medicare buy-in pays for Medicare premiums in retroactive coverage and closed periods of coverage EXCEPT for LTC patients who are on spenddown. DO NOT deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from the patient pay in the month(s) in which the buy-in is effective for LTC patients who are NOT on spenddowns.

3. Example--Dual Eligible QMB

Mrs. Q has Medicare coverage and SSA income of $580 per month. Her Medicare premiums are deducted from her SSA check. She was admitted to the nursing facility on September 9. Her daughter filed a Medicaid application for her on September 10.

Mrs. Q is eligible in the *CN* 300% SSI group in September and is eligible as QMB. Her Medicare premiums are not deducted for September because they will be paid by Medicaid.

4. Example--Not Dual Eligible QMB

Mr. A was admitted to a nursing facility on March 5. He applied for Medicaid on June 2. His monthly income is $1,295, and his Medicare Part B premium is deducted from his SSA check. He is determined to be eligible in the *CN* 300% SSI covered group effective March 1.

His patient pay for March (the month of entry) includes a deduction for the Medicare premium. Because he is not QMB eligible, the buy-in is effective in May, the second month following the month in which his ongoing Medicaid coverage began. The cost of his Medicare Part B premium is deducted from his patient pay for the months of March and April, as his buy-in will be in effect beginning with the month of May.

If the buy-in is delayed for any reason, the individual will be reimbursed by SSA for premiums deducted after the second month.

5. Medicare Advantage (Part C) Premiums

Medicare Advantage plans, also referred to as Medicare Part C, are voluntary managed-care Medicare plans. In addition to Medicare Part B premiums, some individuals may pay an extra Medicare Advantage premium. The Medicaid Medicare buy-in is initiated for individuals with Medicare Advantage ; however, the buy-in covers only the allowable Medicare Part A and/or B premiums. The individual is responsible for any additional Medicare Advantage monthly premium. The Medicare Advantage monthly premium remains the individual's responsibility and is an allowable deduction from patient pay.

***6.* Medicare Part D Premiums**

An individual who is eligible for Medicare and Medicaid is entitled to enrollment in a basic Medicare Part D prescription drug plan (PDP) *at no cost*. However, the individual may elect enrollment in a plan with a premium.

When a full-benefit Medicaid enrollee is enrolled in *a Medicare Part D* PDP, *any* premium that is the individual's responsibility is an allowable deduction from patient pay.

7. LTC Insurance

a. Deduct LTC premium in admission month only

When an individual has an LTC insurance policy, the individual stops paying premiums beginning the month after he is admitted to LTC. The premium paid for the policy in the admission month can be deducted from the admission month's patient pay only. The LTC insurance premium is not deducted from patient pay for the months following the admission month.

b. LTC insurance benefits

LTC insurance benefits are treated as *Third Party Liability* (TPL). If the individual receives the payment from the insurance company, the payment is not income for patient pay or eligibility determinations. The individual should assign it to the nursing facility. If the individual cannot do this, or the policy prohibits assignment, the LTC insurance payment should be given directly to the nursing facility. The facility should report the payment as a third party payment on its claim form.

If the provider is unable to accept payment directly from the individual, the individual must send the insurance payment to:

DMAS Fiscal Division, Accounts Receivable
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

C. Non-covered Medical/Dental Services

Deductions for the cost of a patient's medically necessary medical or dental services not covered by Medicaid, other insurance (such as Medicare), or another person are subtracted from income to determine patient pay. Some deductions for noncovered services must be approved by DMAS before they can be subtracted from the patient's income.

Services that are covered by Medicaid in the facility's per diem rate cannot be deducted from patient pay as a noncovered service. See M1470.230 C.3 for examples of services that are included in the facility per diem rate.

1. Zero Patient Pay Procedures

If deductions from patient pay cannot be allowed because the recipient has no income remaining after deducting the personal needs allowance, dependent child allowance(s) and health insurance premiums, or the recipient has no income available for patient pay, deny the request.

Notify the patient or the patient' authorized representative of the denial of the request using the Notice of Action.

If a noncovered service is already being deducted, leaving no patient pay, and a new deduction for another noncovered service has been approved, notify the patient or his authorized representative that the deduction for the new noncovered service will be made after the first noncovered service deductions are completed.

2. Allowable Non-covered Expenses

When a patient has income available for patient pay, the following can be deducted as noncovered expenses:

a. Old Bills

"Old bills" are deducted from patient pay as noncovered expenses. "Old bills" are unpaid medical, dental, or remedial care expenses which:

- were incurred prior to the Medicaid application's retroactive period, or during the retroactive period if the individual was not eligible for Medicaid in the retroactive period or the service was not a Medicaid-covered service;
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met; **and**
- remain a liability to the individual.
- **"Old bills" do not require approval from DMAS in order to be deducted in the patient pay calculation even when the amount of the "old bill" exceeds $500.**

b. Medically Necessary Covered Services Provided By A Non-participating Provider

Medically necessary medical and dental services that are covered by Medicaid, but that the enrollee received from a provider who does not participate in Virginia Medicaid, are deducted from patient pay as non-covered services.

c. Covered Services Outside of Medicaid's Scope

Medically necessary medical and dental services exceeding Medicaid's amount, duration, or scope can be deducted from patient pay. *Scope includes benefits or services provided by the enrollee's MCO (managed care organization).*

d. Other Allowable Noncovered Services

1) The following medically necessary medical and dental services that are NOT covered by Medicaid *or by benefits provided by the enrollee's MCO* can be deducted from patient pay by the local department of social services without DMAS approval when the cost does NOT exceed $500. **If the service is not identified in the list below and/or the cost of the service exceeds $500, send the request**

and the documentation to DMAS for approval (see M1470.230 C.5). DMAS will advise the eligibility worker if the adjustment is allowable and the amount that is to be allowed.

- dental services ***not covered by Medicaid.*** *Effective July 1, 2021, Medicaid covers dental services for full-benefit adults, as well as children (see M1850.100.D).* **Pre-approval for dental services that exceed $500 must be obtained from DMAS prior to receipt of the service;**

- routine eye exams, eyeglasses and eyeglass repair;

- hearing aids (when medically necessary), hearing aid batteries and hearing aid repair;

- batteries for power wheelchairs or other power mobility items owned by the recipient, not to exceed four batteries in a 12-month period;

- chiropractor services, except for Medicare recipients (Medicare covers chiropractor services and Medicaid covers the Medicare deductible and coinsurance amounts);

- dipyridamole (Persantine) and other prescription medications not covered by Medicaid but ordered by the recipient's physician;

- **transportation to medical, dental or remedial services not covered by Medicaid.**

2) Services received by a Medicaid enrollee during a period of limited Medicaid eligibility (e.g., LTC services not covered because of a property transfer) can be deducted in the patient pay calculation by the local agency without DMAS approval even when the amount of the service exceeds $500.

e. Medicare Part D

Individuals who:

- qualify for Medicare Part D,
- are NOT enrolled in a Medicare Prescription Drug Plan (PDP), and
- are NOT Medicaid eligible at the time of admission to a nursing facility,

will be fully responsible for their drug costs until Medicaid eligibility is determined and the Medicare Part D PDP enrollment process is completed. The individual remains responsible for any drugs purchased prior to the effective date of the PDP enrollment; Medicaid cannot pay for these drugs. The cost of drugs purchased before the PDP begin date can be deducted from patient pay.

Medicaid-enrolled nursing facility patients who are enrolled in a Medicare Part D PDP are **not** responsible for the payment of deductibles or co-pays, nor will

they be subject to a coverage gap in their Part D benefits. Do NOT deduct from patient pay any Medicare PDP deductibles, co-pays or coverage gap costs beyond the month of admission into the nursing facility.

If a full-benefit Medicaid/Medicare recipient was subject to PDP co-pays prior to his admission to a nursing facility, he may continue to be assessed co-pays until the PDP is notified of his admission to the nursing facility. Deduct PDP co-pays incurred during the month of admission to the nursing facility only.

If an individual is enrolled in Part D and is in a nursing facility but was not eligible for Medicaid at the time of admission to the nursing facility, he may continue to be charged co-pays or deductibles until the PDP is notified of his eligibility as a full-benefit Medicaid enrollee. Deduct PDP co-pays incurred during first month of Medicaid eligibility in the nursing facility only.

3. Services NOT Allowed

Types of services that CANNOT be deducted from patient pay include:

a. medical supplies and equipment that are part of the routine facility care and are included in the Medicaid per diem, such as:

- diabetic and blood/urine testing strips,
- bandages and wound dressings,
- standard wheelchairs,
- air or egg-crate mattresses,
- IV treatment,
- splints,
- certain prescription drugs (placebos).

b. TED stockings (billed separately as durable medical supplies),
c. acupuncture treatment,
d. massage therapy,
e. personal care items, such as special soaps and shampoos,
f. ancillary services, such as physical therapy, speech therapy and occupational therapy provided by the facility or under arrangements made by the facility.

i. services that are NOT medical/remedial care services, even if ordered by a physician:

- *air conditioners or humidifiers,*
- *refrigerators, whole house generators and other non-medical equipment,*
- *assisted living facility (ALF) room & board and services,*
- *personal comfort items, such as reclining chairs or special pillows,*
- *health club memberships and costs,*
- *animal expenses such as for seeing eye dogs,*
- *cosmetic procedures.*

3a. Managed Care Organizations and CCC Plus (effective January. 1, 2018)

As of January 1, 2018, the majority of Medicaid-eligible individuals who receive long-term service and support (LTSS) are covered under the CCC Plus program through one of six (6) managed care organizations (MCO). As part of the CCC Plus program, each health plan offers enhanced benefits, such as adult dental services or hearing aids, outside of the required contracted Medicaid services. Some of these enhanced benefits are frequently submitted to the LDSS as patient pay adjustment.

If there are other coverage sources available for these services or items, Medicaid policy requires the request for coverage first be submitted to those sources and exhausted there, before the LDSS/DMAS may consider or approve a patient pay adjustment.

A process is in development to develop a procedure for distinguishing MCO enhanced benefit services from allowable patient pay deductions. Until further notice, providers and nursing facilities will continue sending all patient pay adjustment requests to the patient's LDSS eligibility worker.

Eligibility workers will review and process patient pay adjustment requests without requiring submission of the request to the individual's CCC Plus plan.

4. Documentation Required

a. Requests For Adjustments From A Patient or Authorized Representative

Request the following documentation from the patient or his representative:

- a copy of the bill;
- if applicable, the amount owed that was not covered by the patient's insurance;
- proof that the service was medically necessary. Proof may be the prescription, doctor's referral**,** or a statement from the patient's doctor or dentist. Proof applies to a physician, doctor, or dentist's current, and not "standing", order(s).

The local agency can make the adjustment for services identified in subsection C. 2. b. through d.1), above providing the cost of the service does not exceed $500. If the cost of the service is not identified in subsection C. 2. b. through d. 1), or exceeds $500, send the documentation to DMAS to obtain approval and the allowable amount of the adjustment (reimbursement is limited to the prevailing Medicaid or Medicare rate).

b. Requests For Adjustments From LTC Providers

If the request for an adjustment to patient pay to deduct one of the above expenses is made by a nursing facility, ICF-MR, long-stay hospital, or *Department of Behavioral Health and Developmental Services (DBHDS)* facility, the request must be accompanied by:

1) the recipient's correct Medicaid ID number;

2) the current physician's order for the non-covered service (not required for replacement of hearing aid batteries or eyeglass frames or for repair of hearing aids or eyeglasses);

3) actual cost information;

4) documentation that the recipient continues to need the equipment for which repair, replacement, or battery is requested; and

5) a statement of denial or non-coverage by other insurance. The denial may be from the insurance carrier or may be a written statement from the facility that the insurance company was contacted and the item/service is not covered.

If the request from a facility does not include all the above documentation, return the request to the facility asking for the required documentation.

When the cost of the service cannot be authorized by the local department of social services and/or exceeds $500, send the request and the documentation to DMAS to obtain approval for the adjustment and the allowable amount of the adjustment (reimbursement is limited to the prevailing Medicaid or Medicare rate). DMAS must be notified of the name and address of the recipient's spouse, POA or guardian so that proper notification of the decision can be given.

5. Procedures

a. DMAS Approval Required

Requests for adjustments to patient pay for services not included in subsection C.2. b. through d.1) above, or for any service which exceeds $500, must be submitted by the provider to the DSS worker. The DSS worker sends the request and documentation to:

Health Care Compliance Program Analyst
Division of Program Operations, Customer Service Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Do not send requests for adjustments to DMAS when the patient has no available income for patient pay. Refer to M1470.230 C.5.c for notification procedures to be followed by the local worker.

When a request for an adjustment is approved or denied by DMAS, the local DSS worker will receive a copy of the letter sent to the recipient by DMAS:

1) If approved, adjust the patient pay using the VaCMS Patient Pay process.

2) If the adjustment request is denied, DMAS prepares the notification.

b. DMAS Approval Not Required

Determine if the expense is deducted from patient pay using the following sequential steps:

1) Upon receipt of the requested documentation, determine the amount of the bill that is a valid deduction. Do not deduct more than the available income that remains after the personal needs, dependent child allowance(s), and health insurance premiums are deducted.

   If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service is requested, deduct the new noncovered services after the first noncovered service deductions have been completed.

2) Subtract the deduction for the month following the month the change is reported. If the deduction exceeds the available income, the remaining balance can be carried over to the following month(s).

c. Notice Procedures

Upon the final decision to allow the deduction, use the VaCMS Patient Pay process to adjust the patient pay. VaCMS will generate and send the Notice of *Patient Pay Responsibility*.

6. Managed Care Organizations and CCC Plus (effective January. 1, 2018)

As of January 1, 2018, the majority of Medicaid-eligible individuals who receive long-term care (LTC) services are covered under the CCC Plus program through one of six (6) managed care organizations (MCO). As part of the CCC Plus program, each health plan offers enhanced benefits, such as adult dental services or hearing aids, outside of the required contracted Medicaid services. Some of these enhanced benefits are frequently submitted to the LDSS as patient pay adjustment.

If there are other coverage sources available for these services or items, Medicaid policy requires the request for coverage first be submitted to those sources and exhausted there, before the LDSS/DMAS may consider or approve a patient pay adjustment.

A process is in development to develop a process for distinguishing MCO enhanced benefit services from allowable patient pay deductions. Until further notice, providers and nursing facilities will continue sending all patient pay adjustment requests to the patient's LDSS eligibility worker.

Eligibility workers will review and process patient pay adjustment requests without requiring submission of the request to the individual's CCC Plus plan.

M1470.240 FACILITY - HOME MAINTENANCE DEDUCTION

A. Policy

A single institutionalized individual can be allowed a deduction for the cost of maintaining a home for not more than six months, if a physician has certified he or she is likely to return home within that period.

Home maintenance means that the individual has the responsibility to pay shelter costs on his former place of residence in Virginia, such as rent, mortgage, utilities, taxes, room and board, or assisted living facility (ALF) payments, and that the home, apartment, room or bed is being held for the individual's return to his former residence in Virginia. Individuals who have no responsibility to pay shelter costs are not permitted a home maintenance deduction. If responsibility for shelter costs is questionable, documentation must be requested and provided.

EXCEPTION: For an individual admitted to a nursing facility from an ALF, deduct a home maintenance allowance for the month of entry even if the admission to the nursing facility is not temporary.

Only one spouse of an institutionalized married couple (both spouses are in a medical facility) is allowed the deduction to maintain a home for up to six months, if a physician certifies that he is likely to return home within that period.

B. Temporary Care

Temporary care is defined as not exceeding 6 months of institutionalization, beginning the **month** of admission to the medical facility. A physician's written statement or a DMAS 225 from the individuals managed care plan indicating that the individual is expected to return to his home within 6 months of admission is required to certify temporary care. If the individual is in the facility less than 6 months and returns to a community living arrangement, temporary care status is assumed and patient pay should be adjusted with the home maintenance allowance for the entire period of institutionalization. When the temporary care period ends, the home maintenance deduction must be discontinued.

The DMAS 96 no longer relays information about the expected length of stay. Assume that the stay is not temporary unless notified by the individual, authorized representative, or managed care plan. A written statement from a physician or a DMAS 225 notification from the managed care plan that the individual is expected to return home within 6 months is acceptable in lieu of a physician's statement.

C. Amount Deducted

The home maintenance deduction is the MNIL for one person in the individual's locality of residence. See Appendix 5 to subchapter M0710 or section M0810.002 A. 4 for the MN income limits.

M1470.300 FACILITY PATIENTS

A. Overview

This section provides policy and procedures for calculating patient pay for the facility patient.

B. Policy and Procedures

Policy and procedures for determining patient pay in the most common admission situations are contained in the following sections:

- Facility Admission From A Community Living Arrangement (M1470.310)
- *Patient pay for facility stay of less than 30 days* (M1470.320)

M1470.310 FACILITY ADMISSION FROM A COMMUNITY LIVING ARRANGEMENT

A. Policy

The policy in this section describes the procedures for calculating patient pay for the month of admission and ongoing months for all persons admitted to an LTC facility except:

- persons who received Medicaid CBC in the community during the admission month;
- persons who were admitted from another facility;
- persons admitted to a facility from a state institution.

B. Procedures

To determine patient pay for the admission month, use the procedures in this subsection.

1. All Covered Groups Except MN Spenddown

For an individual admitted to a facility (except an individual who meets a spenddown), take the following steps in the order presented, to the extent that income remains:

a. Count all income received in the admission month (M1470.100).

b. Deduct a personal needs allowance:

- $40.00 basic personal needs;
- additional amount for guardianship fees, if appropriate;
- additional amount for special earnings allowance, if working.

c. Deduct a dependent child allowance, if appropriate (M1470.220).

d. Deduct the Medicare premium withheld if the applicant is a Medicare recipient and was not receiving Medicaid prior to admission (see M1470.230).

e. Deduct other health insurance premiums, deductibles or co-insurance charges, if appropriate (M1470.230).

f. Deduct other allowable noncovered medical expenses, if appropriate (M1470.230).

g. Deduct the home maintenance (MNIL) deduction **if appropriate**, if a doctor has certified that the individual is likely to return home within a six-month period (see M1470.240). For recipients who are admitted for a stay that has been for less than 30 days, a physician certification of length of stay is NOT required.

h. Any remainder is the patient pay for the month(s).

2. MN Spenddown Individual in Facility for Less than 30 Days

For a medically needy individual on a spenddown who is in a facility for less than 30 days, see section M1470.320 B. for procedures.

3. MN Spenddown Individual In Facility For More Than 30 Days

For an institutionalized medically needy individual, see Section M1470.600 for procedures.

M1470.320 PATIENT PAY FOR FACILITY STAY OF LESS THAN 30 DAYS

A. All *Full Coverage* Groups Except MN Spenddown

To determine patient pay for a non-institutionalized individual *with full Medicaid coverage* admitted to a facility for less than 30 days (except an individual who meets a spenddown), use the procedures in subsection M1470.310 B.1 for the admission month and for the subsequent month when the facility stay continues into the month after admission. *Individuals with limited-coverage Medicaid do not have a patient pay since facility care is not covered.*

B. Non-Institutionalized Individuals on MN Spenddown

A non-institutionalized MN individual who is on a spenddown is not eligible for Medicaid until the spenddown is met. Non-institutionalized MN individuals are either on a three-month retroactive or six-month ongoing spenddown.

1. Individual Who Meets the Spenddown

For a non-institutionalized MN individual who meets the spenddown on a date that is within the dates of facility service, take the following steps to determine patient pay:

a. Add together the number of days in the facility stay that are NOT covered by Medicaid. Multiply the result by the facility's private pay daily rate.

b. Determine the remaining balance of the spenddown prior to applying the bill that caused the spenddown to be met.

c. Add the amount in a. above to the figure obtained in b. above. The total is the individual's patient pay for the part of the facility stay that occurs in the spenddown coverage period.

d. Enter patient pay *using* VaCMS.

2. Example – Spenddown Met

Mr. B, an unmarried 70 year-old individual living in a Group II locality, filed an initial application for Medicaid on October 5, 1999. He had excess income and was placed on a spenddown of $2000 for the period October 1, 1999 through March 31, 2000. On October 8, 1999, he was admitted to a nursing facility for temporary care that is expected to be less than 30 days.

On November 10, 1999, his authorized representative asks for his spenddown to be re-evaluated due to his admission to the nursing facility. The representative also submits medical bills incurred before October 8, 1999, that the worker determines leave a spenddown balance of $500 as of October 8, 1999. The nursing facility charges him $120 per day; the Medicaid per diem is $85. His spenddown is determined:

$2000	spenddown liability October 1, 1999-March 31, 2000
- 1500	old bills incurred prior to October 1, 1999
500	spenddown balance on October 1, 1999
- 50	doctor's charge on October 5, 1999 (after TPL pays)
- 120	private pay rate on October 8, 1999
330	spenddown balance beginning October 9, 1999
- 120	private pay rate on October 9,1999
210	spenddown balance beginning October 10, 1999
- 120	private pay rate on October 10, 1999
90	spenddown balance beginning October 11, 1999
- 120	private pay rate on October 11, 1999
$ 0	spenddown met on October 11, 1999

Mr. B met his spenddown on October 11, 1999. Medicaid coverage begins on October 11, 1999 and ends on March 31, 2000, the end of the six month spenddown budget period.

He is discharged from the nursing facility to his home without CBC on November 1, 1999. He was in the nursing facility for less than 30 days. His patient pay for the October 8, 1999 through November 1, 1999 stay is determined:

a) 3 number of days in the nursing facility that are NOT covered by the individual's Medicaid coverage period (October 8 through October 10)
x 120 facility private pay daily rate
$ 360 amount of the spenddown liability for which the individual is responsible.

b) $90 is the spenddown balance on the date the spenddown was met, therefore, the individual is responsible to pay the $90 to the nursing facility. Medicaid will pay the remainder of the cost.

c) $360 amount of the spenddown liability for which the individual is responsible (October 8 - October 10)
+ 90 spenddown balance on October 11; begin date of coverage
$450 individual's patient pay for October 11 through October 31

If his dates in the nursing facility include part of a second month, his patient pay for the second month would be $0.

3. Individual Who Does Not Meet Spenddown

An individual who meets the spenddown on a date after the date he left the facility has full responsibility for the days he was in the facility. Send the individual a Notice of Action showing the dates of Medicaid coverage and that the facility care was not covered by Medicaid. Send the provider a DMAS-225 regarding the individual's eligibility status.

M1470.400 MEDICAID CBC PATIENTS - ALLOWABLE DEDUCTIONS FROM INCOME

A. Introduction

Sections M1470.410 through 430 are the only *allowable* deductions from a Medicaid CBC patient's gross monthly income when calculating patient pay when the patient does not have a community spouse. *If* the patient has a community spouse, go to subchapter M1480 to determine patient pay.

Medicaid CBC patients are not allowed a home maintenance deduction because shelter costs are included in the personal maintenance allowance.

B. Procedure

Subtract the deduction(s) from gross monthly income in the order presented below:

1. Medicaid CBC Personal Maintenance Allowance (M1470.410)

2. Dependent Child Allowance (M1470.420)

3. Medicaid CBC - Incurred Medical Expenses (M1470.430)

C. Appeal Rights

The patient or his representative has the right to appeal the patient pay determination, the amounts used in the calculation and denial of any request for adjustment. If a recipient or his representative appeals the patient pay, the EW who made the decision prepares the appeal summary and attends the hearing.

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, 2021 through December 31, 2021: $1,311
- January 1, 2022 through December 31, 2022: $1,388
- *January 1, 2023 through December 31, 2023: $1,508*

Contact a Medical Assistance Program Consultant for the PMA in effect for years prior to *2021*.

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 (*$2,742* in *2023*) per month.

b. for individuals employed at least *8* but less than 20 hours per week, all earned income up to 200% of SSI (*$1,828* in *2023*) 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.

1. Example--Two Dependent Children In One Home (Using January 2009 Figures)

Mr. H is a single individual with gross monthly income of $920, living in the community in Group II and receiving Medicaid CBC. He is divorced and has two children under age 18 who live with his ex-wife in Group I. His two children each receive $75 SSA.

The allowance for his dependent children is calculated as follows:

$ 337.92	MN limit for 2 (Group I)
- 150.00	children's SSA income
$ 187.92	dependent children's allowance

2. Example--Three Dependent Children In Two Homes (Using January 2009 Figures)

Mrs. K is a married individual who lives at home in a Group II locality and receives Medicaid CBC. Her spouse is in a medical facility and is not a community spouse. One of their three dependent children lives with Mrs. K. The other two children live with her sister in a Group III locality. The children each receive $95.00 per month SSA.

The allowance for the dependent children is calculated as follows:

$ 306.23	MN limit for 1 (Group II)
- 95.00	child's SSA income
$ 211.23	child's allowance

$ 480.00	MN limit for 2 (Group III)
- 190.00	children's SSA income
$ 290.00	children’s allowance

$ 211.23	child's allowance
+ 290.00	children's allowance
$ 501.23	total dependent children’s allowance

NOTE: If Mrs. K’s institutionalized spouse is eligible for Medicaid, an allowance for their children may also be deducted from his income in determining his patient pay. However, the allowance the children receive from Mrs. K will be counted as part of their income when determining any allowance from Mr. K’s income.

M1470.430 MEDICAID CBC - NONCOVERED MEDICAL EXPENSES

A. Policy

Amounts for incurred medical and dental expenses not covered by Medicaid or another third party, *including services or benefits provided as part of an enrollee’s managed care organization,* are deducted from the patient’s gross monthly income when determining patient pay.

B. Health Insurance Premiums

Payments for medical/health insurance which meet the definition of a health benefit plan, *including dental insurance*, are deducted from patient pay when:

- the premium amount is deducted from the patient's benefit check;

- the premium is paid from the patient's own funds; OR

- the premium is paid by a relative (other than a spouse or parent for minor child) when that relative receives a benefit payment (income) which includes a benefit amount for the patient.

The amount deducted is the amount of the monthly premium. If the patient pays the premium less often than monthly, such as quarterly, prorate the amount paid by the number of months covered by the payment to obtain the monthly amount to deduct in the patient pay calculation.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA (Multiple Employer Welfare Arrangement) or plan provided by another benefit arrangement.

Health benefit plan does not mean accident only, credit, or disability insurance; long-term care insurance; vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance (14VAC5-234-30).

Income protection insurance (indemnity) policy premiums are not medical expenses and are not deducted from the patient pay.

Membership fees for an organization that sponsors or provides the health insurance are not part of the premium and are not deductible.

1. Medicare Part A and/or Part B Premiums

Medicare Part B premiums and/or Medicare Part A premiums are paid by Medicaid for eligible individuals. The premiums are paid by Medicaid via the "buy-in" and are not usually deducted from patient pay. However, Medicaid does not start paying the premiums immediately for all eligible patients, so the Medicare premium(s) must be deducted from patient pay in those months for which Medicaid does not pay the premium.

For CN individuals enrolled in the 300% SSI covered group in ACs 020, 040, and 060 and MN-*only individuals in ACs 018, 038, and 058*, the Medicare buy-in is effective **2 months after the begin date** of Medicaid coverage. If the begin date of coverage is other than the first day of a month, the buy-in is effective the first of the month in which the 60th day occurs. Part B premiums (and Part A premiums if the recipient must pay the Part A premium) must be deducted from patient pay in the month(s) in which the buy-in is not effective.

Deduct the Medicare premium(s) for the first two months of coverage for *individuals in the following ACs:*

- *CN 300% SSI and not dually eligible as QMB or SLMB Plus - ACs 020, 040, 060*

- *MN and not also QMB or SLMB - ACs 018, 038, 058.*

For individuals *in other ACs*, the buy-in is effective with the begin date of Medicaid coverage. Therefore, do NOT deduct Medicare premiums in the patient pay determination for months in the retroactive and ongoing coverage periods.

The Medicaid Medicare buy-in does NOT pay for Medicare premiums in closed periods of coverage for LTC patients who are on spenddown and whose eligibility is for a closed period. Deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from patient pay in the month(s) in which the buy-in is NOT effective.

The Medicaid Medicare buy-in pays for Medicare premiums in retroactive coverage and closed periods of coverage EXCEPT for LTC patients who are on spenddown. DO NOT deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from the patient pay in the month(s) in which the buy-in is effective for LTC patients who are NOT on spenddowns.

2. Example - Medicare Buy-in (Using January 2009 Figures)

Mr. A is 80 years old and started receiving CBC on February 15. He applied for Medicaid on February 2. His only income is $1500 per month. He has no Medicare Part A premium. His Part B premium is withheld from his SSA benefit. Therefore, his gross SSA entitlement is actually $1596.40. He is CN eligible, but he is not dually-eligible as QMB.

Mr. A submitted bills for January and met a retroactive spenddown in January. Ongoing Medicaid began in February because he began receiving Medicaid CBC in February and became CN. The Medicare Buy-in begins on April 1.

His Medicare Part B premium is deducted in February's and March's patient pay. April and subsequent months will not include a deduction for the Medicare premium.

3. Medicare Advantage (Part C) Premiums

Medicare Advantage plans, also referred to as Medicare Part C, are voluntary managed-care Medicare plans. In addition to Medicare Part B premiums, some individuals may pay an extra Medicare Advantage premium. The Medicaid Medicare buy-in is initiated for individuals with Medicare Advantage; however, the buy-in covers only the allowable Medicare Part A and/or B premiums. The individual is responsible for any additional Medicare Advantage monthly premium. The Medicare Advantage monthly premium remains the individual's responsibility and is an allowable deduction from patient pay.

4. Medicare Part D Premiums

An individual who is eligible for Medicare and Medicaid is entitled to enrollment in a basic Medicare Part D prescription drug plan (PDP) at no cost. However, the individual may elect enrollment in a plan with a premium.

When a full-benefit Medicaid enrollee is enrolled in a Medicare Part D PDP, *any* premium that is the individual's responsibility is an allowable deduction from patient pay.

***5.* LTC Insurance**

a. Deduct LTC premium in admission month only

When an individual has an LTC insurance policy that covers long-term care services received in the home, the individual stops paying premiums beginning the month after he is admitted to the home-based LTC. The premium paid for the policy in the LTC admission month can be deducted from the admission month's patient pay only. The LTC insurance premium is not deducted from patient pay for the months following the admission month.

b. LTC insurance benefits

LTC insurance benefits are treated as TPL. If the individual receives the payment from the insurance company, the payment is not income for patient pay or eligibility determinations. The individual should assign it to the waiver services provider. If the individual cannot do this, or the policy prohibits assignment, the LTC insurance payment should be given directly to the provider. The provider should report the payment as a third party payment on its claim form.

If the provider is unable to accept payment directly from the individual, the individual must send the insurance payment to:

DMAS Fiscal Division, Accounts Receivable
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

C. Noncovered Medical/Dental Services

Deductions for the cost of a patient's medically necessary medical or dental services not covered by Medicaid, other insurance (such as Medicare), or another person are subtracted from income to determine patient pay.

See M1470.430 B.3 for the procedures used to deduct Medicare Part D prescription drug co-pays for patients who have Medicare.

DMAS approval **is not** required for deductions of noncovered services from patient pay when the individual receives CBC services, regardless of the amount of the deduction.

1. Zero Patient Pay Procedures

If deductions from patient pay cannot be allowed because the recipient has no income remaining after deducting the personal maintenance allowance, dependent child allowance(s) and health insurance premiums, or the recipient has no income available for patient pay, deny the request.

Notify the patient or the patient's representative using the Notice of Action.

If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service has been approved, notify the patient or his authorized representative that the deduction for the new non-covered service will be made after the first noncovered service deductions are completed.

2. Allowable Non-covered Expenses

When a patient has income available for patient pay, the following can be deducted as noncovered expenses:

a. Old Bills

Old bills are deducted from patient pay as non-covered expenses. Old Bills are unpaid medical, dental or remedial care expenses which:

- were incurred prior to the Medicaid application's retroactive period, or during the retroactive period if the individual was not eligible for Medicaid in the retroactive period or the service was not a Medicaid-covered service;
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and
- remain a liability to the individual.

b. Medically Necessary Covered Services Provided By A Non-participating Provider

Medically necessary medical and dental services that are covered by Medicaid, but that the recipient received from a provider who does not participate in Virginia Medicaid, are deducted from patient pay as non-covered services.

c. Covered Services Outside of Medicaid's Scope

Medically necessary medical and dental services that can be deducted from patient pay are:

- services exceeding Medicaid's amount, duration, or scope;
- services rendered during a prior period of Medicaid eligibility (i.e., LTC services not covered because of a property transfer).

d. Other Allowable Non-covered Services

Medically necessary medical and dental services that are NOT covered by Medicaid and can be deducted from patient pay include:

1) medical supplies, such as antiseptic solutions, incontinent supplies (adult diapers, pads, etc.), dressings, EXCEPT for patients under the Technology-assisted Individuals Waiver (Medicaid covers these services for Technology-assisted Individuals Waiver patients). For Medicaid CBC recipients who have Medicare Part B, do not deduct the cost of supplies/equipment obtained from a Medicare/Medicaid supplier since the supplier receives direct payment from Medicare and Medicaid.

2) dental services ***not covered by Medicaid.*** *Effective July 1, 2021, Medicaid covers dental services for full-benefit adults, as well as children (see M1850.100.D)*;

3) routine eye exams, eyeglasses and eyeglass repair;

4) hearing aids (when medically necessary), hearing aid batteries and hearing aid repair;

5) batteries for power wheelchairs or other power mobility items owned by the recipient, not to exceed four batteries in a 12-month period;

6) chiropractor services, except for Medicare recipients (Medicare covers chiropractor services and Medicaid covers the Medicare deductible and coinsurance amounts);

7) dipyridamole (Persantine) and other prescription medications not covered by Medicaid but ordered by the recipient's physician;

8) copayments for prescription drugs obtained under Medicare Part D.

e. Medicare Part D copays

Individuals who:

- qualify for Medicare Part D,
- are NOT enrolled in a Medicare PDP, and
- are NOT Medicaid eligible at the time of admission to CBC

will be fully responsible for their drug costs until Medicaid eligibility is determined and the Medicare Part D PDP enrollment process is completed. The individual remains responsible for any drugs purchased prior to the effective date of the PDP enrollment; Medicaid cannot pay for these drugs. The cost of drugs purchased before the PDP begin date can be deducted from patient pay.

Full benefit Medicaid enrollees who have Medicare, are receiving Medicaid CBC services, and are enrolled in a Medicare Part D PDP were responsible for the payment of co-pays for prescriptions filled prior to January 1, 2012. Effective January 1, 2012, individuals receiving Medicaid CBC services are not responsible for co-pays for prescriptions covered under their Medicare Part D PDP. CBC recipients are not subject to payment of deductibles or a coverage gap in their Part D benefits.

1) Monthly Statements

PDPs must issue a periodic (at least monthly) statement to the beneficiary explaining all benefits paid and denied. Part D drugs that are not covered by the PDP may not be covered by Medicaid and, absent other drug coverage, remain the responsibility of the individual. When a PDP denies coverage of a prescription, the beneficiary has the right to request an exception for coverage of the drug. The beneficiary is notified in writing of the decision on any exception requested.

2) Verifying Allowable Co-pays

To determine whether or not prescription expenses can be deducted from patient pay, apply the following rules:

- *If the drug expense appears on the statement as a denial, and no exception was requested, **do not** allow the expense.*
- *If the drug expense appears on the statement as a denial, and an exception was requested and denied, allow the expense.*

Enrollees should be advised to maintain these monthly statements if they wish to request patient pay adjustments for Medicare Part D co-pays and for drugs for which the PDP denied coverage.

3. Services NOT Allowed

a. medical supplies covered by Medicaid, or Medicare when the recipient has Medicare, such as:

- diabetic and blood/urine testing strips,
- bandages and wound dressings,
- standard wheelchairs,
- air or egg-crate mattresses,
- IV treatment,
- splints,
- certain prescription drugs (placebos).

b. TED stockings (billed separately as durable medical supplies),
c. acupuncture treatment,
d. massage therapy,
e. personal care items, such as special soaps and shampoos,
f. physical therapy,
g. speech therapy,
h. occupational therapy.

ii. services that are NOT medical/remedial care services, even if ordered by a physician:

- *air conditioners or humidifiers,*
- *refrigerators, whole house generators and other non-medical equipment,*
- *assisted living facility (ALF) room & board and services,*
- *personal comfort items, such as reclining chairs or special pillows,*
- *health club memberships and costs,*
- *animal expenses such as for seeing eye dogs,*
- *cosmetic procedures.*

j. personal care or other waiver services in excess of the number of hours authorized by DMAS (i.e. private pay).

4. Documentation Required

a. Requests For Adjustments From A Patient or An Authorized Representative

Request the following documentation from the patient or his representative:

- a copy of the bill;
- the amount still owed by the patient;
- if applicable, the amount owed that was not covered by the patient's insurance;
- proof that the service was medically necessary. Proof may be the prescription, doctor's referral or a statement from the patient's doctor or dentist. *Proof applies to a physician, doctor, or dentist's current, and not "standing", order(s).*

b. Requests For Adjustments From CBC Providers

If the request for an adjustment to patient pay to deduct a noncovered expense is made by a Medicaid CBC waiver service provider or case manager, the request must be accompanied by:

1) the recipient's correct Medicaid ID number;

2) the current physician's order for the non-covered service (not required for replacement of hearing aid batteries or eyeglass frames or for repair of hearing aids or eyeglasses);

3) actual cost information;

4) documentation that the recipient continues to need the equipment for which repair, replacement, or battery is requested; and

5) a statement of denial or non-coverage by other insurance. The denial may be from the insurance carrier or may be a written statement from the facility that the insurance company was contacted and the item/service is not covered.

If the request from a provider or case manager does not include all the above documentation, return the request to the provider or case manager asking for the required documentation.

5. Procedures

a. Determine Deduction

When the individual receives CBC services, DMAS approval **is not required** for deductions of noncovered services from patient pay, regardless of the amount of the deduction.

Determine if the expense is deducted from patient pay using the following sequential steps:

1) Upon receipt of the requested documentation, determine the amount of the bill that is a valid deduction. Do not deduct more than the available income that remains after the personal needs, dependent child allowance(s), and health insurance premiums are deducted.

   If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service is requested, deduct the new noncovered services after the first noncovered service deductions have been completed.

2) Subtract the deduction for the current month. If the deduction exceeds the available income, the remaining balance can be carried over to the following month(s).

b. Notice Procedures

Upon the final decision to allow the deduction, use the VaCMS Patient Pay process to adjust the patient pay. VaCMS will generate and send the Notice of Patient Pay Responsibility If VaCMS is not able to process required transactions, a Patient Pay Correction form (DMAS 9PP), available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, should be submitted to patientpay@dmas.virginia.gov. DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into *MES*.

6. ***Managed Care Organizations and CCC Plus (effective January. 1, 2018)***

As of January 1, 2018, the majority of Medicaid-eligible individuals who receive long-term care (LTC) services are covered under the CCC Plus program through one of six (6) managed care organizations (MCO). As part of the CCC Plus program, each health plan offers enhanced benefits, such as adult dental services or hearing aids, outside of the required contracted Medicaid services. Some of these enhanced benefits are frequently submitted to the LDSS as patient pay adjustment.

If there are other coverage sources available for these services or items, Medicaid policy requires the request for coverage first be submitted to those sources and exhausted there, before the LDSS/DMAS may consider or approve a patient pay adjustment.

A process is in development to develop a process for distinguishing MCO enhanced benefit services from allowable patient pay deductions. Until further notice, providers and nursing facilities will continue sending all patient pay adjustment requests to the patient's LDSS eligibility worker.

Eligibility workers will review and process patient pay adjustment requests without requiring submission of the request to the individual's CCC Plus plan.

D. Example--CBC Deduction of Noncovered Services (Using January *2009* Figures)

An aged, single individual, with no dependent child and no guardian or conservator, who lives in Group II, applied for Medicaid for the first time in June. He is approved by the screener for long-term care under the *EDCD* waiver. His gross income is $950 Civil Service Annuity (CSA) and $500 SSA. His resources are within the Medicaid limit. He has Medicare and federal employee's health insurance (Medicare is withheld from his SSA check at the rate of *$96.40* per month and $80 is withheld from his CSA for the Health Insurance). Because his income is less than 300% of the SSI income limit, he meets the 300% SSI group.

He is denied retroactive eligibility because he had no Medicaid covered service in the retroactive period. He owes $1,500 on a hospital bill he incurred the prior September *and is making payments*. His patient pay for June is determined in the following steps:

Step 1. gross income:

$ 950	CSA
+ 500	SSA
$1,450	total gross income

Step 2. deduct the correct personal maintenance allowance:

$ 1,450	total gross income
- *1,112*	personal maintenance allowance
$ *338*	remaining income

Step 3. deduct the appropriate medical expense deductions in the correct sequential order:

$ *338.00*	remaining income
- *176.40*	*96.40* Medicare + 80.00 health insurance premium
161.60	remaining income
- *161.60*	non-covered medical expenses ($1,500-*161.60=$1,338.40*)
$ 0	patient pay for June

The *$1,338.40* balance remaining from the $1,500 hospital bill that was not deducted from the June patient pay can be deducted in subsequent month(s) as long as it remains a liability.

M1470.500 MEDICAID CBC PATIENTS

A. Overview

This section is only for unmarried individuals and or married individuals who have no community spouse. For married patients who have a community spouse, go to subchapter M1480 for patient pay determination.

This section provides policy and procedures for calculating Medicaid CBC recipients' patient pay.

B. Policy and Procedures

Policy and procedures for determining Medicaid CBC admission month patient pay in the most common admission situations are contained in the following sections:

- Community Living Arrangement Admission to Medicaid CBC (M1470.510)
- *PACE (M1470.520)*

M1470.510 COMMUNITY LIVING ARRANGEMENT ADMISSION TO MEDICAID CBC WAIVER SERVICES

A. Policy

The policy in this section describes the procedures for calculating patient pay for the month of admission and ongoing months for **all** persons residing in the community who are screened and approved for Medicaid CBC waiver services.

B. Procedures

1. All Covered Groups Except MN Spenddown

For an individual admitted to Medicaid CBC waiver services (EXCEPT an individual who meets a spenddown**),** use these procedures:

a. Count all income received in the admission month (M1470.100).

b. Deduct a personal needs allowance (M1470.410):

- basic maintenance allowance based on the waiver;
- guardianship fees, if *any*;
- special earnings allowance, if *any*.

c. Deduct a dependent child allowance, if *any* (M1470.420).

d. Deduct the Medicare premium withheld if the individual is a Medicare recipient and was not receiving Medicaid prior to admission, if *any* (see M1470.430).

e. Deduct other health insurance premiums, deductibles or co-insurance charges, if *any* (M1470.430).

f. Deduct other allowable noncovered medical expenses, if *any* (M1470.430).

g. Any remainder is the patient pay for the month(s).

2. MN Individual Who Meets Spenddown

An MN individual who is on a spenddown is not eligible for Medicaid until the spenddown is met. If an individual is screened and approved for Medicaid waiver services, he is considered "institutionalized" and his eligibility for Medicaid is determined as an institutionalized individual. If the individual's income exceeds the 300% SSI income limit, he must meet an MN institutionalized individual monthly spenddown.

Go to section M1470.600 below to determine patient pay for a CBC patient who is on a spenddown.

M1470.520 PACE

A. Policy

The Program of All-inclusive Care for the Elderly (PACE) serves individuals aged 55 and older who (1) meet the nursing facility level of care criteria and (2) reside in their own communities. PACE provides all of an individual's health care and long-term care medical needs. PACE is not a CBC Waiver; individuals who meet the criteria for the EDCD Waiver may be enrolled in PACE in lieu of the EDCD Waiver. Individuals who are enrolled in Medicaid as *AG* recipients (Aid Categories 012, 032, and 052) are not eligible for PACE. See M1440.108 for additional information about PACE.

Individuals enrolled in PACE have a patient pay obligation.

B. Procedures

The patient pay for an individual enrolled in PACE who is not Medically Needy is calculated using the procedures in M1470.400 through M1470.520 for an individual in CBC, with the exceptions listed below.

1. Medicare Part D Premiums

PACE recipients are not responsible for Medicare Part D premiums because their prescriptions are provided through PACE and they are eligible for the full Medicare Part D subsidy. Therefore, the cost of the Medicare Part D premium is not allowable as a deduction from patient pay.

2. Covered Medical Expenses

Because PACE includes most medically-necessary services the individual needs, the allowable medical expense deductions differ from the allowable medical expense deductions for CBC.

The following services are provided through PACE:

- adult day care that offers nursing, physical, occupational, speech and recreational therapies;
- meals and nutritional counseling; social services;
- medical care provided by a PACE physician; personal care and home health care;
- all necessary prescription drugs;
- access to medical specialists such as dentists, optometrists and podiatrists;
- respite care;
- hospital and nursing facility care when necessary; and
- transportation.

Any medical expenses incurred by the individual for the services listed above are not allowable patient pay deductions. With the exception of the services listed above, the noncovered expenses listed in M1470.430 C.2 are allowable for PACE recipients. DMAS approval **is not required** for deductions of noncovered services from patient pay for PACE recipients, regardless of the amount of the deduction.

3. PACE Recipient Enters a Nursing Facility

Because PACE is a program of all-inclusive care, nursing facility services are part of the benefit package for PACE recipients who can no longer reside in the community. *PACE recipients may be placed in a nursing facility while still enrolled in PACE.* When a PACE recipient *is placed in* a nursing facility, the PACE provider has 60 days from the date of *placement* to notify the eligibility worker of the individual's placement in the nursing facility and the need for a recalculation of the patient pay.

Do not change the personal needs allowance to the facility amount unless notification is received from PACE. After notification *from PACE* of the individual's *placement in* a nursing facility, the eligibility worker will take action to recalculate the individual's patient pay prospectively for the month following the month the 10 day advance notice period ends. There is NO retroactive calculation of patient pay back to the date the individual entered the facility. *Do not refer to the Recipient Audit Unit.* When the change is made, the individual is entitled to a personal needs allowance of $40 per month.

M1470.600 MN PATIENTS - SPENDDOWN LIABILITY

A. Policy

This section is for unmarried individuals or married individuals who have no community spouse. **DO NOT USE this section** for a married individual with a community spouse, go to subchapter M1480.

MN individuals have a spenddown liability that must be met before they are eligible for Medicaid because their monthly income exceeds 300% of SSI, which exceeds the MN income limits. When an MN individual meets the spenddown, he is eligible for Medicaid (see section M1460.700 for spenddown determination policy and procedures). Patient pay for **each** month in which the individual meets the spenddown must be determined.

A patient under 22 years of age receiving inpatient psychiatric services in an IMD (Institution for Treatment of Mental Diseases) whose income exceeds 300% of SSI may be eligible for Medicaid as MN if he meets the spenddown liability.

Coverage in an IMD is not part of the Medicaid benefit package for any other MN individuals who are eligible for Medicaid while in an IMD, including individuals age 65 years or older. Individuals under age 22 years who are not receiving inpatient psychiatric services and all individuals over age 22 years but under age 64 years are not eligible for Medicaid while in an IMD (see M0280.201).

B. Definitions

The following definitions are used in this section and subsequent sections of this subchapter:

1. Medicaid Rate

The Medicaid rate for facility patients is the patient's daily Resource Utilization Group (RUG) code amount multiplied by the number of days in the month. A patient's RUG code amount is based on his room and board and ancillary services. The RUG code amount may differ from facility to facility and from patient to patient within the same facility. Confirmation of the individual's RUG code amount must be obtained by contacting the facility. For the month of entry, use the actual number of days that care was received or is projected to be received. For ongoing months, multiply the daily RUG code amount by 31 days.

The Medicaid rate for CBC patients is the number of hours per month actually provided by the CBC provider multiplied by the Medicaid hourly rate.

PACE has a capitated monthly rate that is due and payable on the first day of the month. The monthly PACE rate is available from the PACE provider.

2. Remaining Income

Remaining income is the amount of the patient's total monthly countable income for patient pay minus all allowable patient pay deductions.

3. Spenddown Liability The spenddown liability is the amount by which the individual's countable income exceeds the medically needy income limit.

C. Procedures The subsections identified below contain the procedures for determining patient pay when an LTC patient meets a spenddown liability and is determined eligible for Medicaid.

1. Facility Patients Patient pay determination procedures are different for medically needy facility patients, depending on whether the spenddown liability is less than or equal to or greater than the Medicaid rate. To determine patient pay for MN facility patients:

a. Determine the individual's spenddown liability using the policy and procedures in subchapter M1460.

b. Compare the spenddown liability to the Medicaid rate.

c. If the spenddown liability is less than or equal to the Medicaid rate, go to section M1470.610 below to determine patient pay.

d. If the spenddown liability is greater than the Medicaid rate, go to section M1470.620 to determine patient pay.

2. Medicaid CBC Patients Medicaid CBC patient pay determination procedures are different from facility procedures. For CBC patients with a spenddown liability, go to section M1470.630.

3. PACE Recipients For PACE recipients with a spenddown liability, go to section M1470.640.

M1470.610 FACILITY PATIENTS--SPENDDOWN LIABILITY LESS THAN OR EQUAL TO MEDICAID RATE

A. Policy This section is applicable ONLY to an unmarried individual, or a married individual without a community spouse. **DO NOT USE this section** for a married individual with a community spouse; go to subchapter M1480.

An MN facility patient whose spenddown liability is less than or equal to the Medicaid rate is eligible for Medicaid effective the first day of the month, based on the projected Medicaid rate for the month.
Medicaid must NOT pay any of the recipient's spenddown liability to the provider. In order to prevent any Medicaid payment of the spenddown liability, the spenddown liability is added to available income for patient pay.

B. Procedures Determine patient pay for the month using the procedures below.

1. Patient Pay Gross Monthly Income Determine the recipient's patient pay gross monthly income according to M1470.100 (including any amounts excluded in determining MN countable income and the spenddown liability).

2. Subtract Spenddown Liability

From the individual's gross monthly income for the month, subtract the spenddown liability. The result is the remaining income.

3. Subtract Allowable Deductions

Deduct the following from the remaining income:

a. a personal needs allowance (M1470.210),

b. a dependent child allowance, if appropriate (M1470.220),

c. any allowable noncovered medical expenses (M1470.230), not including the facility cost of care,

d. a home maintenance deduction, if appropriate (M1470.240).

The result is the **remaining income**.

4. Add Spenddown Liability

Add the spenddown liability to the remaining income (**because the individual is responsible to pay his spenddown liability to the facility**). The result is the **contributable income** for patient pay.

5. Patient Pay

Compare the contributable income to the Medicaid rate for the month. The patient pay is the lesser of the two amounts.

C. Examples

1. Facility--MN And Patient Pay Income Are The Same (Using April 2000 Figures)

Mr. Cay first applied for Medicaid in April. He was admitted to the facility a year earlier. He has a monthly Civil Service Annuity (CSA) benefit of $1,600. He last lived outside the facility in a Group III locality. His income exceeds the CNNMP 300% SSI income limit. He has no old bills, but he has a health insurance premium of $50 monthly plus a $25 noncovered medical expense he incurred on April 2, and a guardian who charges a guardian fee of 5% of Mr. Cay's income. His MN eligibility is being determined for April. The MN determination results in a spenddown liability of $1,255:

$1,600		monthly MN income
-	20	exclusion
1,580		countable MN income
-	325	MN limit for 1 (Group III)
$1,255		spenddown liability for month

The Medicaid rate is $45 per day, or $1,395 for a projected 31-day month. By projecting the month's cost of facility care, he meets his spenddown because his spenddown liability is less than the Medicaid rate. He is eligible effective the first day of the month and for the whole month of April. Because his spenddown liability is less than the Medicaid rate, Mr. Cay will have ongoing Medicaid eligibility. His patient pay for April is determined:

$1,600 total patient pay gross income
- 1,255 spenddown liability
345
- 110 personal needs allowance (basic plus guardian fee)
- 50 health insurance premium
- 25 noncovered medical expense incurred April 2
160 remaining income
+1,255 spenddown liability (his responsibility to pay)
$1,415 contributable income for patient pay (April)

Compare the contributable income for patient pay ($1,415) to the facility's Medicaid rate for April, $1,395. The facility can collect no more that the Medicaid rate. Because the Medicaid rate is less than the contributable income for patient pay, Mr. Cay's patient pay for April is the Medicaid rate of $1,395. Any income retained by Mr. Cay is a resource in May.

2. Facility--MN And Patient Pay Income Are Different (Using July 1999 Figures)

Mr. Day is a disabled individual who applied for Medicaid in July 1999. He was admitted to the facility in November 1998. He has a monthly CSA benefit of $1,500 and a monthly Seminole Indian payment of $235. He last lived outside the facility in a Group III locality. His income of $1,735 exceeds the CNNMP 300% of SSI income limit. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His MN eligibility is determined for July 1999. The MN determination results in a spenddown liability of $1,155:

$1,500 monthly MN income (Seminole Indian payment excluded)
- 20 exclusion
1,480 countable MN income
- 325 MN limit for 1 (Group III)
$1,155 spenddown liability for month

He has an old bill of $250 incurred in December 1998, which was not used to meet a spenddown, and a health insurance premium of $50 monthly plus a noncovered medical expense of $25 that he incurred on July 2. The facility's Medicaid rate is $40 per day, or $1,240 for a projected 31-day month. By projecting the month's cost of facility care, he meets his spenddown because his spenddown liability is less than the Medicaid rate. He is eligible for full month's coverage. His patient pay for July is determined:

$1,500 CSA
+ 235 Seminole Indian payment (not excluded for patient pay)
1,735 patient pay gross income
- 1,155 spenddown liability
580
- 30 personal needs allowance
- 50 health insurance
- 250 old bill from December 1998
- 25 non-covered medical expense incurred July 2
$ 225 remaining income
+1,155 spenddown liability (his responsibility to pay)
$1,380 contributable income for patient pay (July)

Compare the contributable income for patient pay to the facility's Medicaid rate for July. The facility can collect no more than the Medicaid rate. Because the Medicaid rate is less than the contributable income for patient pay for July, Mr. Day's patient pay for July is the Medicaid rate of $1,240. Any income that is retained becomes a resource the following month.

3. Facility-Not Eligible in Admission Month, Eligible in Following Month (Using April 2000 Figures)

Mr. C first applied for Medicaid on April 25. He was admitted to the facility on April 22. He last lived outside the facility in a Group III locality. He is a 40-year-old disabled individual with one dependent child age 10 years; the child lives with his sister in a Group II locality. He has a monthly CSA benefit of $1,700; the child has a CSA benefit of $150 per month. Mr. C has a guardian who charges a 5% guardian fee. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period.

Mr. C's income exceeds the CNNMP 300% of SSI income limit, so he is not eligible as CNNMP. He has a carry-over expense of $200 incurred in the retroactive period. He has a monthly health insurance premium of $50 paid on the 15th of the month plus a $25 noncovered medical expense he incurred on April 2. His MN eligibility is determined for April. The MN determination results in a spenddown liability of $1,355:

$1,700	monthly MN income
- 20	exclusion
1,680	countable MN income
- 325	MN limit for 1 (Group III)
$1,355	spenddown liability for month

The facility's Medicaid rate is $45 per day, or $405 for April 22 - 30 (9 days), the admission month. He does not meet his spenddown by projecting the cost of care at the Medicaid rate for the admission month because his spenddown liability ($1,355) exceeds the Medicaid rate of $405 for the admission month. Therefore, his spenddown cannot be met by projecting the nursing facility costs at the Medicaid rate. His spenddown eligibility must be determined retrospectively using the private pay rate for the number of days of facility care to reduce his spenddown liability. The private pay rate is $50 per day, or $450 for the days April 22 - 30. After subtracting all allowable expenses, he does not meet his spenddown in April and is not eligible for Medicaid in April.

His eligibility for May is determined. His April facility expenses are not deducted because he paid them in April. His $200 January bill is not deducted as a carry-over expense, but any current payments on that bill can be deducted. He incurred a noncovered medical expense on May 2, and paid $65 on his January medical bill.

The facility's Medicaid rate is $45 per day, or $1,395 for a projected 31-day month. By projecting the cost of care at the Medicaid rate, he meets his spenddown on the first of the month (May) because his spenddown liability of $1,355 is less than the Medicaid rate ($1,395). His patient pay for May is determined:

$1,700 total patient pay gross income
- 1,355 spenddown liability
345
- 105 personal needs allowance (basic plus guardian fee)
- 100 dependent child allowance ($250-150=100)
- 50 health insurance premium
- 25 noncovered medical expense incurred May 2
65
- 65 current payment on January medical bill
0 remaining income
+1,355 spenddown liability (his responsibility)
$1,355 contributable income for patient pay (May)

Compare the contributable income for patient pay to the facility's Medicaid rate for May. The facility can collect no more than the Medicaid rate. Because the contributable income for patient pay is less than the Medicaid rate, Mr. C's patient pay for May is his contributable income of $1,355.

M1470.620 FACILITY PATIENTS--SPENDDOWN LIABILITY GREATER THAN THE MEDICAID RATE

A. Policy

This section is applicable ONLY to an unmarried individual, or a married individual without a community spouse. **DO NOT USE this section** for a married individual with a community spouse; go to subchapter M1480.

1. Retrospective Determination

An MN facility patient whose spenddown liability exceeds the Medicaid rate is not eligible for Medicaid until he actually incurs medical expenses that meet the spenddown liability within the month. ALL of these determinations are made monthly, retrospectively, **after** the month has passed and the expenses have actually been incurred. The individual's resources and income must be verified each month before determining if the spenddown has been met.

2. Full Month's Coverage If Spenddown Met

When incurred expenses equal or exceed the spenddown liability, the individual is eligible for the full month of Medicaid coverage beginning the first day of the month in which the spenddown was met, and ending the last day of the month in which the spenddown was met. See subchapter M1460 for procedures to determine spenddown eligibility for these individuals. Patient pay for the month in which the spenddown was met is calculated after determining that the spenddown was met.

3. Patient Pay

Medicaid must not pay any of the recipient's spenddown liability to the provider. Because the spenddown determination is completed after the month and expenses are not projected, the spenddown liability is NOT added to remaining income for patient pay. Use the following procedures to calculate the patient pay for the month in which the spenddown was met.

B. Patient Pay Procedures

1. Patient Pay Gross Monthly Income

Determine the recipient's patient pay gross monthly income according to section M1470.100 (including any amounts excluded in determining MN countable income and the spenddown liability).

2. Calculate Remaining Income For Patient Pay

Calculate remaining income for patient pay by deducting the following from gross patient pay income:

a. a personal needs allowance (M1470.210),

b. a dependent child allowance, if appropriate (M1470.220),

c. any allowable noncovered medical expenses (M1470.230) **NOT** including the facility cost of care, and

d. a home maintenance deduction, if appropriate (M1470.240).

The result is individual's **remaining income**.

4. Patient Pay

Compare the remaining income to the facility's Medicaid rate for the month. The patient pay is the lesser of the two amounts.

C. Example—In a Facility, Spenddown Liability Exceeds Medicaid Rate; No Dependent *(Using July 1999 Figures)*

Ms. Day is an institutionalized individual with no dependents who filed an initial application for Medicaid on November 13, 1999. She was admitted to the facility on November 12, 1999. She has a monthly CSA benefit of $1,700 and a monthly payment of $225 from the Seminole Indians Land Trust. She has a $75 old bill incurred in July 1998, and she has a health insurance premium payment of $50 per month paid on the 20th of the month. She does not have Medicare. She last lived outside the facility in a Group II locality. Her income exceeds the 300% SSI income limit. Her MN eligibility is determined for November 1999. The MN determination results in a spenddown liability:

$1,700	monthly MN income (Seminole Indians payment excluded)
- 20	exclusion
1,680	countable MN income
- 250	MN limit for 1 (Group II)
$1,430	spenddown liability for November

The facility's Medicaid rate is $40 per day, or $760 for the 19 days in November, the admission month. Because her spenddown liability of $1,430 exceeds the $760 Medicaid rate for the admission month of November, Ms. Day is not eligible until she actually incurs medical expenses, including the private facility rate, on or before November 30 that equal or exceed the spenddown liability of $1,430. The private rate is $65 per day. The old bill of $75 is deducted on November 1. She incurs $1,235 for 19 days of care and the $50 insurance premium on November 21; she incurs no other expenses. She does not meet the spenddown in the admission month of November. She paid her all of her November medical expenses in November.

Her eligibility for December (the month following the admission month) is determined. The Medicaid rate of $40 per diem is projected for a 31-day month and equals $1,240. The spenddown liability for the month is compared to the Medicaid rate before deducting any incurred medical expenses. Because the monthly spenddown liability of $1,430 exceeds the Medicaid rate, eligibility must be determined, retrospectively, after the actual facility care costs have been incurred.

In January, to determine if the spenddown was met in December, the worker compares the spenddown liability to the private cost of care for December. The private daily rate of $65 per day is multiplied by 31 days in December to determine the private monthly cost of care. Because the monthly spenddown liability of $1,430 is less than the private monthly cost of care of $2,015, Ms. Day met her spenddown in December and is eligible for the full month of December. She is enrolled *for a* closed period of eligibility, beginning 12-01-99 and ending 12-31-99. On December 3, she made a payment of $75 on her July 1998 medical expense. Her patient pay for December is calculated as follows:

$1,700	CSA
+ 225	Seminole Indians payment (not excluded for patient pay)
1,925	gross income for patient pay
- 30	personal needs allowance
- 75	12/3/99 current payment on medical bill from July 1998
- 50	health insurance premium paid on the 21st
$1,770	remaining income for patient pay (December)

The eligibility worker compares the remaining income to the Medicaid rate ($1,240) for December. The facility can collect no more than the Medicaid rate. Because the Medicaid rate is less than the remaining income for patient pay, Ms. Day's patient pay for December is the Medicaid rate of $1,240. Since she paid the nursing facility the private rate of $2,015 for December, the facility will reimburse her after receiving the Medicaid payment for December. If she retains this money, it becomes a resource to her in the month in which she receives the reimbursement (January at the earliest). Her countable resources must be verified for January before determining if her January spenddown was met.

M1470.630 CBC PATIENTS WITH SPENDDOWN LIABILITY

A. Policy

This section is applicable ONLY to an unmarried individual, or a married individual without a community spouse. **DO NOT USE this section** for a married individual with a community spouse; go to subchapter M1480.

1. Retrospective Determination

Community Based Care (CBC) patients who have income over the 300% of SSI income limit are placed on a monthly spenddown as institutionalized individuals because they have been screened and approved for waiver services. The monthly CBC expenses are determined retrospectively; they cannot be projected for the spenddown budget period.

Retrospective spenddown eligibility determinations are made monthly after the month has passed and the expenses have actually been incurred. The CBC expenses, along with other allowable medical and dental expenses, are deducted

daily and chronologically as the expenses are incurred. The individual's resources and income must be verified each month before determining if the spenddown has been met.

2. Full Month's Coverage If Spenddown Met

When incurred medical expenses equal or exceed the monthly spenddown liability, the individual is eligible for the full month of Medicaid coverage beginning the first day of the month, and ending the last day of the month.

Patient pay for the month in which the spenddown was met is calculated after determining that the spenddown was met.

3. Patient Pay

Because the spenddown is completed after the month and expenses are not projected, the spenddown liability is NOT added to the available income for patient pay. Use the following procedures to calculate the patient pay for the month in which the spenddown was met.

B. Patient Pay Procedures

1. Patient Pay Gross Monthly Income

Determine the CBC recipient's patient pay gross monthly income according to section M1470.100 (including any amounts excluded in determining MN countable income and the spenddown liability).

2. Calculate Remaining Income for Patient Pay

Calculate remaining income for patient pay by deducting the following from gross patient pay income:

a. a personal needs allowance (M1470.410),

b. a dependent child allowance, if appropriate (M1470.420),

c. any allowable noncovered medical expenses (M1470.430) including any old bills, carry-over expenses and other noncovered expenses that were used to meet the spenddown, but NOT including the cost of CBC care.

The result is the individual's **remaining income** for patient pay.

3. Patient Pay

Compare the remaining income to the Medicaid rate (hours of CBC waiver services multiplied by the Medicaid hourly rate) for the month. The patient pay is the lesser of the two amounts.

4. Example--CBC Spenddown Met (Using January 2000 Figures)

Ms. G. lives in Group III and filed an initial application for Medicaid in January. She is approved by the screener for the EDCD Waiver in January. She has no community spouse or dependent child. Her monthly income of $1800 SSA and a $200 private pension and exceeds the CNNMP 300% SSI limit. Her monthly spenddown liability is determined:

$1,800 SSA
+ 200 private pension
$2,000 total monthly income
- 20 exclusion
$1,980 countable income
- 325 MNIL for Group III
$1,655 monthly spenddown liability

Her January application is denied and she is placed on a monthly spenddown during the 12-month certification period of January through December.

In February she submits bills to determine if her January spenddown has been met. Her spenddown eligibility is evaluated first by comparing the private cost of care to her spenddown liability. The private cost of care is $15 per hour, 4 hours per day, or $60 per day. She received care on 20 days in January at the private rate of $60 per day. The private cost of care for January was $1,200. Because the private cost of care was less than her spenddown liability, her spenddown eligibility must be determined on a daily basis. She has old bills of $600 incurred prior to the retroactive period, a health insurance premium of $100 paid on the first of the month, and prescription costs of $500 incurred January 2. Her spenddown eligibility is determined:

$1,655		spenddown liability
-	600	old medical bills incurred prior to retroactive period
-	100	medical insurance premium paid January 1
-	60	cost of care incurred January 1
	895	balance beginning January 2
-	500	prescription costs incurred January 2
-	60	cost of care incurred January 2
	335	balance beginning January 3
-	300	cost of care incurred January 3 -7 (5 days)
	35	spenddown liability balance at beginning of January 8
-	60	cost of care incurred on January 8
$	0	spenddown met on January 8

Because she met the spenddown on January 8, she is eligible for *full* Medicaid coverage beginning January 1 and ending January 31. Her patient pay for January is calculated as follows:

$1,800		SSA
+	200	private pension
-	512	personal maintenance allowance
-	600	old bill incurred prior to retroactive period
-	100	medical insurance premium paid January 1
$	788	remaining income for patient pay (January)

The worker compares the remaining income for patient pay to the Medicaid rate for Medicaid CBC waiver services. The Medicaid hourly rate of $10.50 is multiplied by the 80 hours of CBC waiver services received in January. Because her remaining income ($788) is less than the Medicaid rate ($840), Ms. G's patient pay for January is the remaining income of $788.

The following month, Mrs. G submits bills to determine if and when her February spenddown was met. Her February spenddown eligibility is evaluated as follows:

$1,655 spenddown liability
- 100 medical insurance premium paid February 1
- 60 cost of care incurred on February 1
1,495 spenddown balance beginning February 2
-1,140 cost of care for remainder of February (19 days)
$ 355 spenddown balance on February 29

Mrs. G does not meet her spenddown for the month of February, so she is not eligible for February and no patient pay is calculated. In March and subsequent months, Mrs. G might have additional medical expenses which could enable her to meet her spenddown liability and establish eligibility.

M1470.640 PACE RECIPIENTS WITH SPENDDOWN LIABILITY

A. Policy

This section is applicable ONLY to an unmarried individual, or a married individual without a community spouse. **DO NOT USE this section** for a married individual with a community spouse; go to subchapter M1480.

1. Monthly Spenddown Determination

PACE recipients who have income over the CNNMP 300% of SSI income limit are placed on a monthly spenddown as institutionalized individuals because they have been screened and approved for LTC services.

Unlike CBC, PACE has a capitated monthly rate that is due and payable on the first day of the month. The monthly PACE rate is available from the PACE provider. When an MN individual is in PACE, the amount of allowed PACE expenses is the rate that is due as of the first day of each month.

PACE recipients are not responsible for Medicare Part D premiums, which are included in the monthly PACE rate. **Therefore, the cost of the Medicare Part D premium cannot be used to meet a spenddown and must be subtracted from the monthly PACE rate when determining if the spenddown has been met.**

The individual's spenddown liability and the PACE monthly rate (minus the Medicare Part D premium) establish whether the spenddown eligibility determination can be projected or must be determined retrospectively.

2. Projected Spenddown Determination

If the MN individual's spenddown liability is less than or equal to the monthly PACE rate (minus the Medicare Part D premium), the individual is eligible for Medicaid. As long as the individual's spenddown liability and the PACE monthly rate do not change, the individual is enrolled in ongoing coverage effective the first day of the month in which the spenddown is initially met.

3. Retrospective Spenddown Determination

If the MN individual's spenddown liability exceeds the monthly PACE rate (minus the Medicare Part D premium), he is not eligible for Medicaid until he actually incurs medical expenses that meet the spenddown liability within the month. The monthly medical expenses are determined retrospectively; they cannot be projected for the spenddown budget period.

Retrospective spenddown eligibility determinations are made monthly after the month has passed and the expenses have actually been incurred. The PACE rate (minus the Medicare Part D premium) along with other allowable medical and dental expenses are deducted daily and chronologically as the expenses are incurred. The individual's income and resources must be verified each month before determining if the spenddown has been met. See M1470.520 for allowable medical deductions.

When incurred medical expenses equal or exceed the monthly spenddown liability, the individual is eligible for the full month of Medicaid coverage beginning the first day of the month and ending the last day of the month.

4. Patient Pay

a. Projected Spenddown Eligibility Determinations

Medicaid must assure that enough of the individual's income is allowed so that he can have a personal maintenance allowance. Therefore, the spenddown liability is NOT subtracted from his gross income nor added to the available income for patient pay.

Subtract the allowances listed in M1470.400 from gross monthly income, as applicable. 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.

b. Retrospective Spenddown Eligibility Determinations

Because the spenddown eligibility determination is completed after the month in which the PACE services were received and expenses are not projected, the spenddown liability is NOT added to the available income for patient pay. Follow the instructions in M1470.630 for calculating the spenddown and patient pay when the spenddown liability exceeds the monthly PACE rate (minus the Medicare Part D premium).

M1470.800 COMMUNICATION BETWEEN LOCAL DSS AND LTC PROVIDER

A. Introduction

Certain information related to the individual's eligibility for and receipt of Medicaid LTC services must be communicated between the local agency and the LTC provider. The Medicaid LTC Communication Form (form DMAS-225) is used by both the local agency & LTC providers to exchange information.

B. Purpose

Eligibility workers should generate the DMAS-225 through VaCMS. The DMAS-225 form is also *available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*.

The form is used to:

- notify the LTC provider of a patient's Medicaid eligibility status;
- notify a new provider that the patient pay is available through the verification systems;
- reflect changes in the patient's deductions, such as a medical expense allowance;
- document death of an individual;

- document admission or discharge of a patient to an institution or community-based care services;
- provide information on health insurance, LTC insurance or VA contract coverage, and
- provide other information unknown to the provider that might cause a change in eligibility status or patient pay amount.

Do not use the DMAS-225 to relay the patient pay amount. Providers are responsible for obtaining patient pay information from the ARS/MediCall verification systems.

C. When to Complete the DMAS-225

Complete the DMAS-225 at the time of eligibility determination and/or the recipient's entry into LTC. Complete a new DMAS-225 when the recipient's eligibility status changes, such as when the recipient's Medicaid coverage is canceled or changed to limited QMB or SLMB coverage, or when the LTC provider changes.

Additionally, complete a DMAS-225 for an ongoing enrollee whose patient pay has been initially transitioned into *MES* to notify the provider that the patient pay information is available through ARS/MediCall.

D. Where to Send the DMAS-225

Refer to M1410.300 B.3.b to determine where to send the form. The worker must complete, send, and return the form timely.

M1470.900 ADJUSTMENTS AND CHANGES

A. Policy

The Medicaid recipient or his authorized representative is responsible to report any changes in his or her situation within 10 days of the day the change is known. In situations where the patient pay amount is less than the Medicaid rate the patient pay must be adjusted within 30 days of notification or discovery of the change. This section contains the procedures for when and how to adjust patient pay.

There are situations when the EW **cannot increase** the patient pay, such as when the current patient pay amount equals the Medicaid rate for the month. In this situation, an adjustment that results in an increase in patient pay cannot be made and a referral to the DMAS Recipient Audit Unit (RAU) must be completed following the procedures in M1470.900 D.3.c.1) below.

B. Action When A Change Is Reported

Upon receipt of notice that a change in an enrollee's income or deductions has occurred, the EW must evaluate continued income eligibility (see subchapter M1460). If eligibility no longer exists, follow the procedures for LTC medically needy income and spenddown (see M1460.700). If eligibility continues to exist, the EW must:

1. Recalculate the patient pay.

2. If the patient pay remains the same, send written notification to the person handling the patient's income that the patient pay is unchanged.

3. If the patient pay decreases, follow the instructions found in Item C. below. If the patient pay increases, follow the instructions found in Item D. below.

C. Patient Pay Decreases

1. When to Adjust

Reflect a patient pay decrease using the *VaCMS* Patient Pay process effective the month following the month in which the change was reported when:

- the patient's income decreases;
- an allowable deduction is added or increased;
- the patient did not receive, or no longer receives, some or all of his income.

Adjust the patient pay for the month following the month in which the change was reported. DO NOT adjust patient pay retroactively, unless the patient meets a condition specified in section M1470.910 below.

2. Procedures

Using the *VaCMS* Patient Pay process, take the following steps to reflect a decrease in patient pay:

a. Verify the decrease.

b. Once the decrease is verified, *enter the correct information into VaCMS along with the correct effective begin dates. VaCMS will* calculate the new patient pay based on the change(s).

c. Subtract the "new" patient pay from the "old" patient pay amount; the result is the reduced amount.

d. Multiply the reduced amount by the number of months in which the reduced amount should have been effective; the result is the total reduction.

e. Subtract the total reduction from the next month's (the month following the month in which the worker is taking this action) patient pay. If the total reduction exceeds the patient pay, the patient pay amount will be zero until the total reduction has been subtracted from the patient pay.

3. Example-Patient Pay Decrease

Mr. F is an institutionalized individual who had been receiving a SSA payment of $1,000 and a workman's compensation payment of $400 each month. On June 30, he reported he received his final worker's compensation payment on June 15. The EW requested verification of the termination of the worker's compensation and received the verification on August 22. His patient pay had been $1,370 per month. His new patient pay is calculated to be $960 per month. The "new" patient pay of $960 is subtracted from the "old" patient pay of $1,370. The monthly amount is reduced by $410. Since Mr. F reported the change in June, the patient pay must be adjusted for July and subsequent months. The reduction of $410 is multiplied by 2 months (July and August) and totals $820. The EW adjusts Mr. F's September patient pay to reflect the decreased monthly income for July and August. *VaCMS* shows a September patient pay of $140 and also shows a patient pay of $960 for October and subsequent months.

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. *When the underpayment is more than $1,500, VaCMS will not make an adjustment to the patient pay. Follow the instructions in M1700.300 for making a referral 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)

Determine the amount of the recipient underpayment when:

- the income counted was less than the income actually received; or
- an allowable deduction stopped or decreased.

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 amount of the underpayment(s):

1) Calculate the new monthly patient pay based on the change(s), beginning with the month in which the change occurred.

2) Subtract the "old" monthly patient pay from the "new" monthly patient pay amount. The result is the amount of the recipient's underpayment for that month.

3) Add the monthly underpayment(s) together to determine the total amount of the recipient's underpayment. If the underpayment is less than $1,500, follow the procedures in "b" below. If the underpayment is $1,500 or more, follow the procedures in "c" below.

b. Total underpayment of less than $1,500

To adjust the patient pay obligation for the month following the month in which the 10-day advance notice period ends, take the following steps:

1) Add the total underpayment to the new ongoing patient pay. This is the total patient pay obligation.

2) Compare the total patient pay obligation to the provider's Medicaid rate.

a) If the total patient pay obligation is less than the provider's Medicaid rate, the total amount of the patient's underpayment can be collected in one month. The total patient pay obligation is the patient pay for the month following the month in which the 10-day advance notice period ends.

b) If the total patient pay obligation exceeds the provider's Medicaid rate, determine the difference between the ongoing patient pay and the provider's Medicaid rate. The difference is the amount of the underpayment that can be collected the first month. The patient pay for the first month (current patient pay and a portion of the underpayment) will equal the Medicaid rate. The balance of the underpayment must be collected in subsequent months. Repeat these procedures for subsequent months until the total amount of the underpayment has been reduced to zero.

c. **Total underpayment of $1,500 or more**

1) Underpayment amounts totaling **$**1,500 or more must be referred to the DMAS Recipient Audit Unit for collection.

a) Complete and send a Notice of Recipient Fraud/Non-Fraud (see M17, Appendix 2) to:

Recipient Audit Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

b) Send a Notice of Action, available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, informing the patient of the referral to DMAS for collection of the underpayment.

2) Prospective months' patient pay

VaCMS will automatically generate and send a Notice of *Patient Pay Responsibility* to the patient or the patient's representative for the month following the month in which the 10-day advance notice period ends.

5. Example--Patient Pay Increase -Total Underpayment $1,500 or More

Mr. M is an institutionalized individual. On February 25, he reports his pension increased $600 per month in February. On March 22 the EW recalculated the patient pay based on the current income. His new monthly patient pay is $1,800. His "old" monthly patient pay was $1200.

Because of the 10-day advance notice requirement the change could not be made for April and must be made for May 1. His "old" patient pay is subtracted from his "new" patient pay for February, March and April to determine his underpayment for those months. The $600 underpayment for three months totals $1,800. Since the total underpayment exceeds $1,500, a patient pay adjustment cannot be made. A referral must be made to the DMAS Recipient Audit Unit for collection and the recipient must be notified of the referral (see M1470.900 D. 3. c).

M1470.910 RETROACTIVE ADJUSTMENTS FOR PRIOR MONTHS

A. Retroactive Adjustment

If a change was reported timely 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 timely, 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.

B. Procedures

DMAS has implemented changes effective for dates of service on or after April 1, 2017, to simplify responsibility for collecting patient pay in the transition month. For any month that an individual is enrolled in a nursing facility on the DMAS eligibility file, patient pay will be deducted only from nursing facility claims and not from agency personal care, respite care, and/or adult day health care claims.

For patients in the CCC Plus Waiver with a patient pay, *MES* will deduct patient pay from the claims submitted by waiver providers for services following the transition month. It may take a short period of time for the local department of social services to revise the patient pay (reflecting a change in status from nursing facility to CCC Plus). This will result in *MES* initially using a higher patient pay that will be adjusted by DMAS after the patient pay is revised. During this time, waiver or nursing facility providers will still be responsible for collection of identified patient pay amounts owed and should work together to collect the appropriate patient pay.

Eligibility staff will continue to calculate monthly patient pay. **There is no need to divide or apportion the patient pay when a patient changes providers or moves from one type of provider/care to another (e.g. CBC to a nursing facility) nor any a need to inform the provider via a DMAS-225.** Changes in patient pay will be made prospectively, based on advance notice requirements. Changes not requiring advance notice can be processed up to the last day of the month. If an individual has moved from NF to CBC, adjust the patient pay effective the month after the change. Patient Pay underpayment corrections should follow the procedures contained in M1470.900.

C. PACE

Enrollment in PACE begins on the first day of a month and ends on the last day of a month. Patient pay for PACE participants is not adjusted due to provider changes within a month.

M1470.930 DEATH OR DISCHARGE FROM LTC

A. Policy

The LTC provider may not collect an amount of patient pay that is more than the Medicaid rate for the month. When a patient dies or is discharged from LTC to another living arrangement that does not include LTC services, do not recalculate patient pay for the month in which the patient died or was discharged. The provider is responsible for collecting an amount of patient pay for the month of death or discharge that does not exceed the Medicaid rate for the month.

B. Procedure

Refer to the VaCMS Help feature for procedures regarding death or discharge from LTC. Send a DMAS-225 to the provider regarding the eligibility status of the patient. Send a notice to the patient or the patient's representative that reflects the reduction or termination of services. If VaCMS is not able to process required transactions or additional correction is needed, 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. DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into *MES*.

M1470.1000 LUMP SUM PAYMENTS

A. Policy

Lump sum payments of income or accumulated benefits are counted as income in the month they are received. Patient pay must be adjusted to reflect this income change for the month following the month in which the 10-day advance notice period expires. Any amount retained becomes a resource in the following month.

B. Lump Sum Defined

Income such as interest, trust payments, royalties, etc., which is received regularly but is received less often than quarterly (i.e., once every four months or three times a year, once every five months, once every six months or twice a year, or once a year) is treated as a lump sum for patient pay purposes.

EXCEPTION: Income that has previously been identified as available for patient pay, but which was not actually received because the payment source was holding the payment(s) for some reason or had terminated the payment(s) by mistake, is **NOT** counted again when the corrective payment is received.

See section M1470.1030 below for instructions for determining patient pay when a lump sum is received.

M1470.1010 LUMP SUM REPORTED IN RECEIPT MONTH

A. Lump Sum Available

Lump sum payments reported in the month the payment was received are counted available for patient pay effective the first of the month following the month in which the 10-day advance notice period expires.

If the individual is no longer in the facility and is not receiving Medicaid CBC, adjust the patient pay for the lump sum receipt month if the money is still available.

B. Lump Sum Not Available

If the money is not available, complete and send a Notice of Recipient Fraud/Non-Fraud to the DMAS Recipient Audit Unit.

M1470.1020 LUMP SUM NOT REPORTED TIMELY

A. Effective Date

Lump sum payments reported AFTER the month in which the payment was received are not reported timely. Evaluate total resources including the lump sum. If the resources are within the limit, determine availability for patient pay. See B. & C. below. If they exceed the resource limit, go to section M1470.1100 below.

B. Lump Sum Not Available

If the money is not available, complete and send a Notice of Recipient Fraud/Non-Fraud to the DMAS Recipient Audit Unit.

C. Lump Sum Available

1. If the money is still available and the individual is no longer in the facility and is not receiving Medicaid CBC, complete and send a Notice of Recipient Fraud/Non-Fraud to the DMAS Recipient Audit Unit.

2. If the money is still available and the individual is still in the facility or is still receiving Medicaid CBC, adjust the patient pay according to procedures in section M1470.1030 below.

M1470.1030 PATIENT PAY DETERMINATION FOR LUMP SUMS

A. Policy

When a lump sum payment is received, the patient pay for the month *following the month* in which the 10-day advance notice period expires must be adjusted using the procedures in this section. ***The patient pay cannot be increased retroactively.***

B. CN Procedures

1. Total Income

Add the lump sum to the patient's regular monthly income; the result is total income for the month.

2. Less Than Or Equal To 300% of SSI

If the total gross income (including the lump sum) is equal to or less than the 300% of SSI income limit, adjust the patient pay. None of the lump sum remains to be evaluated.

3. Greater Than 300% of SSI

If the total gross income (including the lump sum) exceeds the 300% of SSI income limit, adjust the patient pay. Compare the income available for patient pay to the Medicaid rate for the month.

If the income available for patient pay is less than or equal to the Medicaid rate, the available income is the patient pay. If the income available for patient pay exceeds the Medicaid rate, adjust the patient pay to equal the Medicaid rate for the month.

Evaluate the difference between the Medicaid rate and the available income as a resource for the next month. If the patient's total countable resources exceeds the resource limit, take appropriate action to cancel the patient's Medicaid.

C. MN Procedures

1. Facility Patients--Spenddown Liability Less Than or Equal To Medicaid Rate

For facility patients who have a spenddown liability that is less than or equal to the facility Medicaid rate and who are enrolled in ongoing Medicaid coverage:

a. add the lump sum to the patient's regular monthly income; the result is total gross income for the month;

b. subtract the correct personal needs/maintenance allowance and any other allowable deductions; the remainder is the income available for patient pay for the month

c. compare the spenddown liability to the Medicaid rate for the month:

- if the available income for patient pay is less than or equal to the Medicaid rate, the available income is the patient pay.

- if the available income for patient pay is **greater than** the Medicaid rate, adjust the patient pay to the Medicaid rate for the month. Evaluate the difference between the Medicaid rate and the available income as a resource for the next month. If the patient's total countable resources, including the remainder of the available income, exceed the resource limit, take appropriate action to cancel the patient's Medicaid.

2. Facility Patients With Spenddown Liability Greater Than Medicaid Rate, & All Medicaid CBC Patients

For facility patients who have a spenddown liability that is greater than the facility Medicaid rate, and for ALL Medicaid CBC patients whose eligibility and patient pay are determined retrospectively:

a. Spenddown Eligibility & Patient Pay Previously Determined

If the individual's spenddown eligibility for the month has been determined without including the lump sum amount and the individual was enrolled for the month:

1) add the lump sum to the patient's regular monthly income in the month the lump sum was received; the result is total gross income for the month;

2) subtract the correct personal needs/maintenance allowance and any other allowable deductions; the remainder is the revised patient pay for the month;

3) compare the revised patient pay to the patient pay that was previously determined and sent to the provider:

- if the revised patient pay is **greater than** the previously determined patient pay, adjust the patient pay to the revised patient pay amount or the Medicaid rate, whichever is less. If the Medicaid rate is less, evaluate the difference between the Medicaid rate and the revised amount as a resource for the next month.

* if the revised patient pay is **less than or equal to** the previously determined patient pay, DO NOT adjust the patient pay.

Note: If the patient's total countable resources, including the remainder of the available income, exceed the resource limit, take appropriate action to cancel Medicaid eligibility the next month because of excess resources.

b. Spenddown Eligibility & Patient Pay NOT Previously Determined

If the individual's spenddown eligibility for the month has not yet been determined:

1) Recalculate the individual's spenddown liability by adding the lump sum to the patient's regular monthly income in the month the lump sum was received; determine spenddown eligibility by policy and procedures in section M1460.700.

2) If the individual meets the revised spenddown, determine patient pay by using the policy and procedures in section M1470.620 or M1460. 630.

M1470.1100 REDUCTION OF EXCESS RESOURCES

A. Policy

Medicaid policy allows for a full month of eligibility if the resource limit is met at any time during the month. LTC patients whose patient pay is less than the Medicaid rate can choose to reduce excess resources by expending the excess for the cost of LTC services. *This policy does not apply to individuals whose Medicaid application is pending.*

B. Resource Reduction Defined

A decrease in property value, such as an official reassessment or a lien placed against property, is not a reduction of resources. It is a decrease in the value of the resource.

In order to reduce resources, a resource must be transferred out of the patient's possession. Liquid resources such as bank accounts and prepaid burial accounts must actually be expended or encumbered. Non-liquid resources must be liquidated and the money expended.

A reduction of resources is an asset transfer and must be evaluated under asset transfer policy in subchapter M1450.

C. Procedures

1. Required Contact

When a Medicaid-enrolled LTC recipient is found to have excess resources, evaluate whether an adjustment to patient pay by using the excess toward the cost of care will allow continued eligibility in the month in which the 10-day advance notice period expires. Do not assume that the recipient or the recipient's representative will agree to use the excess resources to pay an increased patient pay.

Prior to initiating the following procedures, contact the individual or his authorized representative and tell him of the alternatives available. In the case record, document the conversation and the decision made. If unable to make contact by phone, send the Advance Notice of Proposed Action for cancellation due to excess resources.

2. Reduce Excess Resources

When the patient agrees to use the excess resources toward the cost of care, take the following steps for the month in which the 10-day advance notice period expires:

Step 1 Determine amount of excess resources (total resources minus the resource limit).

Step 2 Determine the monthly Medicaid rate:

* for a facility patient, the monthly rate is the *patient's daily RUG* rate multiplied by 31 days.

- for a CBC patient, the monthly rate is each CBC service provider's hourly rate multiplied by the number of hours of services provided to the patient in the month.

Step 3 Add the amount of excess resources to the current patient pay.

Step 4 If the result of Step 3 is less than the monthly Medicaid rate obtained in Step 2, adjust the patient pay for one month to allow the excess resources to be reduced.

Step 5 If the result of Step 3 is more than the monthly Medicaid rate obtained in Step 2, the patient is ineligible due to excess resources. Send an "Advance Notice of Proposed Action" to cancel Medicaid coverage due to excess resources.

D. Example--Recipient Reduces Resources

An institutionalized Medicaid recipient's resources accumulate to $2,200 in February. His monthly income is $500 from Social Security (SS) and $100 VA Compensation. His patient pay of $560 is less than the Medicaid rate. He pays the amount of his excess resources ($200) to the nursing facility as part of his March patient pay, so he remains eligible.

$ 500 SS
+ 100 VA Compensation
$ 600 total gross income
- 40 personal needs allowance
$ 560 current patient pay (prior to adding excess resources)

$ 560 current patient pay
+ 200 excess resources
$760 patient pay for March only

His patient pay for April and subsequent months is calculated:

$ 500 SS
+ 100 VA Compensation
$ 600 total gross income
- *40* personal needs allowance
$ 560 patient pay for April and subsequent months

M1470.1200 INCORRECT PAYMENTS TO PROVIDER

A. Introduction

There may be instances when the amount of patient pay collected by an LTC provider is less than the amount *determined* available for payment. This situation is most likely to occur when some other person is the payee for the patient's benefits.

B. Procedures

This section provides policy and procedures used to determine patient pay when the provider collects less than the patient pay *amount.* Patient pay can be adjusted *according to whether* certain criteria, specified in sections *M1470.1210 and M1470.1220* below, are met.

M1470.1210 ADJUSTMENTS NOT ALLOWED

A. Policy

The facility or CBC provider is responsible to collect the patient pay from the patient or the person handling the patient's funds. When the provider is not successful in collecting the patient pay, the EW **cannot** adjust the patient pay.

B. Do Not Adjust Patient Pay

The patient pay *reported in ARS/MediCall* is considered available by Medicaid. Do not adjust the patient pay when:

1. the patient directly receives his benefits and is considered to be competent but does not meet his patient pay responsibility; or

2. the amount of patient pay in question is from the patient's own funds which have been withheld by a payee or other individual receiving the patient's funds and have not been paid toward the cost of the patient's care, as specified by policy in this chapter and by the "Notice of Obligation for LTC Costs" sent to the individual.

Should the situation indicate that a change in payee is necessary, contact the program which is the source of the benefit payment and recommend a change. *Additionally,* be alert to situations that may require a referral to Adult Protective Services for an evaluation of exploitation.

C. Entitlement Benefits Adjustment

For an ongoing case, if benefits from entitlement programs (such as Social Security) are not received because the program is holding the check(s) for some reason, but the benefits will be paid some time in the future in a lump sum, do not adjust the patient pay for the months the benefits are not received.

When the lump sum payment is received, do **not** count the lump sum payment and do **not** follow instructions for lump sum payments as found in this subchapter because the patient must use the lump sum to pay the previous months' remaining patient pay amounts the patient still owes to the provider.

M1470.1220 ADJUSTMENTS ALLOWED

A. Adjust Patient Pay

Adjust the patient pay when:

* the income counted in the patient pay calculation was not actually received because the source did not pay; *and*
* the income will not be paid some time in the future; and
* documentation of the change in income is received by the worker.

See section M1470.900 for instructions on adjusting patient pay.

B. Adjustment Allowed Due To Income Changes

Some examples of when income is not received and will not be paid in the future are:

1. Rental Income

Rental income is no longer received because the property was not rented for a period of time, or the renter did not pay. Be aware that if property no longer produces income, the resource exclusion may be affected. Evaluate *the individual's* continued eligibility.

2. Contribution Not Received

A contribution from a responsible relative or other source is not received. Advise the responsible relative of his legal responsibility. If there is a legal responsibility to support the individual, advise the responsible relative that continued failure to meet that responsibility may result in a non-support petition being filed with the appropriate court.

3. Income Source Exhausted

Interest income is not received because the source of income was exhausted or is no longer available.

4. Trust Income

Income from a trust fund is not received because the trustee did not make it available and/or will no longer make it available.

5. Policy/Benefits Ran Out

Payment from an insurance company or organization is not paid because the policy is no longer in force, benefits ran out, the organization refuses to or cannot pay, etc.

Sample Notice of *Patient Pay Responsibility* from VaCMS

COMMONWEAL TH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

NOTICE OF PATIENT PAY RESPONSIBILITY

TO:

Recipient Name:

Recipient ID:

This form serves as your notice of patient pay, which is the amount of your income that must be paid to the provider every month for the cost of long-term care services you receive. The long-term care provider who is responsible for collection of any portion of your patient pay will directly bill you or your representative. A portion of patient pay may be paid to more than one provider when services are received from multiple providers. If you currently receive Medicaid long-term care services, this will serve as the 10-day advance notice when your patient pay amount is increased. Please contact your local worker if you have questions.

PATIENT PAYCALCULATIONS

Effective Date of Patient Pay (Month and Year):

Reason

Income
Social Security
Other Unearned Income
Total Earned Income
Total Gross Income
Minus Spenddown Liability (SDL)
Remaining Income

Allowances Deducted from Income Personal/Maintenance Needs Spousal
Child/Family Member
Non-covered Medical Expenses Home Maintenance
Income Remaining after Allowances

Spenddown Liability Contribution Income Medicaid Rate for Month
Patient Pay

DATE OF ACTION/NOTICE AGENCY REPRESENTATIVE TELEPHONE NUMBER

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Patient pay may be the lesser of the SDL amount, contributable income amount (income remaining after deductions plus the SDL), remaining income or the Medicaid Rate, whichever is applicable to the individual's circumstances.

Patient pay will not exceed the Medicaid Rate.

You must report any changes in income or resources to the local agency. Failing to report changes or providing false or misleading information may result in your prosecution for fraud.

If you have Medicare Part A coverage, and were admitted to a nursing facility under "Skilled Care", the patient pay amount you owe for the first 100 days may be less than the amount shown on this notice. The nursing facility will determine how many days are covered by Medicare and will send you a bill. Once Medicare stops paying, you will be responsible for the full patient pay amount shown on this notice.

Appeal Information

If you disagree with this action, you have the right to file an appeal. You or your authorized representative must send a written appeal request within 35 days of receipt of this notification. If you file an appeal before the effective date of this action, the patient pay will remain unchanged during the appeal process. However, if the Appeals Division upholds this action, you may be required to reimburse the Medicaid Program for the excess cost of services paid on your behalf during the appeal period.

Applicant/enrollees are encouraged to file an appeal request through the DMAS appeals portal at https://www.dmas.virginia.gov/appeals/. It is also acceptable to file an appeal by other means, using the "Virginia Medicaid/FAMIS Appeal Request Form," which is available from DMAS at https://www.dmas.virginia.gov/appeals/.

The appeal request should identify the action under appeal, the reason for the appeal, and include a copy of the notice of action. The submission should also include acceptable proof of authorization to act on behalf of an applicant or enrollee if an authorized representative is filing on their behalf. Appeals filed more than 35 days after the date on the notice of action should include a good cause statement explaining the reason for filing an untimely appeal. Finally, appellants and their representatives may include any other documentation that they wish the hearing officer to consider.

How to File an Appeal Request
1. Electronically. Via the Appeals Information Management System (AIMS) portal at https://www.dmas.virginia.gov/appeals/ or email an appeal request to appeals@dmas.virginia.gov
2. By fax. Fax an appeal request to DMAS at (804) 452-5454
3. By mail or in person. Send or bring an appeal request to:

Department of Medical Assistance Services
Appeals Division
600 East Broad Street
Richmond, Virginia 23219

4. By phone. Call the Appeals Division at (804) 371-8488 (TTY: 1-800-828-1120).

CHAPTER M14
LONG-TERM CARE
SUBCHAPTER 80

MARRIED INSTITUTIONALIZED INDIVIDUALS' ELIGIBILITY & PATIENT PAY

M1480 Changes
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Changed With	Effective Date	Pages Changed
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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
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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

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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
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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
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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.
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M1480 MARRIED INSTITUTIONALIZED INDIVIDUALS' ELIGIBILITY & PATIENT PAY

M1480.000 GENERAL

A. Introduction

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

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

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

B. Applicability

1. MAGI Adult

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

2. Admitted Before 9-30-89

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

3. Admitted On/ After 9-30-89

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

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

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

The rules in this subchapter apply only to the institutionalized spouse's financial eligibility. If the community spouse applies for Medicaid, use the financial eligibility rules for non-institutionalized persons in the community spouse's covered group to determine the community spouse's Medicaid eligibility.

M1480.010 DEFINITIONS

A. Introduction

This section provides definitions for those words and terms used in this subchapter.

B. Definitions

1. Beginning of a Continuous Period of Institutionaliz-ation

means the first calendar month of a continuous period of institutionalization (in a medical institution or receipt of a Medicaid Community-based Care (CBC) waiver service). See section M1410.010 for definition of a medical institution.

2. Community Spouse

means a person who:

- is married to an institutionalized spouse and
- is not an inpatient in a medical institution or nursing facility.

The community spouse can be living in the home with the institutionalized spouse who is a Medicaid CBC patient, can be living in a residential institution such as an assisted living facility (ALF), or can be living in the institutionalized spouse's former home.

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

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

3. Community Spouse Monthly Income Allowance

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

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

4. Community Spouse Resource Allowance (CSRA)

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

- the spousal share;
- the spousal resource standard;

- an amount designated by a DMAS Hearing Officer, or

- an amount actually transferred to the community spouse by the institutionalized spouse following a court spousal support order issued as the result of an appeal of a DMAS Hearing Officer's decision

exceeds the amount of resources otherwise available to the community spouse.

5. Continuous Period of Institutionalization means 30 consecutive days of institutional care in a medical institution, or 30 consecutive days of receipt of Medicaid waiver services (CBC), or 30 consecutive days of a combination of institutional and waiver services. Continuity is broken only by *180* or more days absence from a medical institution or *180* or more days of non-receipt of waiver services.

6. Couple's Countable Resources means all of the couple's non-excluded resources, regardless of state laws relating to community property or division of marital property. For purposes of determining the combined and separate resources of the institutionalized and community spouses when determining the institutionalized spouse's eligibility, the couple's home, contiguous property, household goods, and one automobile are excluded.

7. Dependent Child **means a child 21 years old or older**, of either spouse, who lives with the community spouse and who may be claimed as a dependent by either member of the couple for tax purposes pursuant to the Internal Revenue Code. Tax dependency is verified by a verbal or a written statement of either spouse.

8. Dependent Family Member means a dependent parent, minor child, dependent child, or dependent sibling (including half brothers/sisters and adopted siblings) of either member of a couple who resides with the community spouse and who may be claimed as a dependent by either member of the couple for tax purposes under the Internal Revenue Code. Tax dependency is verified by a verbal or a written statement of either spouse.

9. Excess Shelter Allowance means the actual monthly expense of maintaining the community spouse's residence that exceeds the excess shelter standard (30% of the monthly maintenance needs standard). Actual monthly expenses are the total of:

- rent or mortgage including interest and principal;

- taxes and insurance;

- any maintenance charge for a condominium or cooperative; and

- the utility standard deduction under the Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps) that would be appropriate to the number of persons living in the community spouse's household, if utilities are not included in the rent or maintenance charge [Section 1924(d)(4) of the Social Security Act].

10. Excess Shelter Standard means 30% of the monthly maintenance needs standard. See section M1480.410 below for the current excess shelter standard.

11. Family Member's Income Allowance means an allowance for each dependent family member residing with the community spouse. The family member's income allowance is equal to 1/3 of the amount by which the monthly maintenance needs standard exceeds the family member's income. The family member's income allowance is deducted from the institutionalized spouse's income for the family member's needs.

Family member allowance = (monthly maintenance needs standard - family member income) ÷ 3

EXAMPLE #1:

$1,383 monthly maintenance needs standard
- 300 family member's income
1,083 amount by which monthly maintenance needs standard exceeds the family member's income
÷ 3
$ 361 family member's monthly income allowance.

12. First Continuous Period of Institutionalization means the first day of the month of the first continuous period of institutionalization which began on or after September 30, 1989. For example, a person was institutionalized from September 8, 1989 through March 12, 1991, then readmitted on May 28, 1991. His first continuous period of institutionalization that began on/after September 30, 1989 began on May 1, 1991.

13. Initial Eligibility Determination means:

a. An eligibility determination made in conjunction with a Medicaid application filed during an individual's most recent continuous period of institutionalization; or

b. The initial redetermination of eligibility for a Medicaid-eligible institutionalized spouse after being admitted to a medical institution or Medicaid CBC waiver services.

The initial eligibility determination period includes the application month and any subsequent month(s) up to the date on which the agency takes action to approve the application.

14. Initial Redetermination means the first redetermination of eligibility for a Medicaid-eligible institutionalized spouse which is regularly scheduled or which is made necessary by a change in the individual's circumstances.

15. Institutionalized Spouse means an individual who:

- is in a medical institution, or who is receiving Medicaid waiver services, or who has elected hospice services;
- is likely to remain in the facility, or to receive waiver or hospice services for at least 30 consecutive days; and
- who is married to a spouse who is NOT in a medical institution or nursing facility.

NOTE: An institutionalized spouse receiving Medicaid CBC Waiver services can also be a community spouse if his spouse is in a medical facility or is receiving Medicaid CBC Waiver services.

16. Likely to Remain in an Institution means a reasonable expectation based on acceptable medical evidence that an individual will receive *LTC services* for 30 consecutive days, *unless it is known prior to processing the application that the 30-day requirement has not been met or will not be met. If it is known at the time the application is processed that the individual did not or will not meet the 30 consecutive day requirement, the individual is not to be treated as an institutionalized individual.*

17. Maximum Spousal Resource Standard means the maximum amount of the couple's combined countable resources established for a community spouse to maintain himself in the community ($60,000 in 1989). This amount increases annually by the same percentage as the percentage increase in the Consumer Price Index (CPI) for all urban consumers between September 1988 and the September before the calendar year involved. [1924(f)(2)(A)(ii)].

See section M1480.231 for the current maximum spousal resource standard.

18. Minimum Monthly Maintenance Needs Allowance (MMMNA) The minimum monthly maintenance needs allowance [1924(d)(3)(A)] is the monthly maintenance needs standard, plus an excess shelter allowance if applicable, up to a maximum [1924(d)(3)(C)]. The minimum monthly maintenance needs allowance is the amount to which a community spouse's income is compared in order to determine the community spouse's monthly income allowance.

The monthly maintenance needs standard and monthly maintenance needs allowance maximum change each year. See section M1480.410 below for the current standard and maximum.

19. Minor Child means a child under age 21 years, of either spouse, who lives with the community spouse and who may be claimed as a dependent by either member of the couple for tax purposes pursuant to the Internal Revenue Service Tax Code. Tax dependency is verified by a verbal or written statement from either spouse.

20. Monthly Maintenance Needs Standard

The monthly maintenance needs standard is 150% of 1/12 of the federal poverty level for a family of two in effect on July 1 of each year [Section 1924(d)(3)(A)(i)].

See section M1480.410 below for the current monthly maintenance needs standard.

21. Otherwise Available Income or Resources

means income and resources which are legally available to the community spouse and to which the community spouse has access and control.

22. Promptly Assess Resources

means within 45 days of the request for resource assessment, unless the delay due to non-receipt of documentation or verification, if required, from the applicant or from a third party.

23. Protected Period

means a period of time, not to exceed 90 days after an initial determination of Medicaid eligibility. During the protected period, the amount of the community spouse resource allowance (CSRA) will be excluded from the institutionalized spouse's countable resources IF the institutionalized spouse expressly indicates his intention to transfer resources to the community spouse.

24. Resource Assessment

means a calculation, completed by request or upon Medicaid application, of a couple's combined countable resources at the beginning of the **first** continuous period of institutionalization of the institutionalized spouse beginning on or after September 30, 1989.

25. Spousal Protected Resource Amount (PRA)

means at the time of Medicaid application as an institutionalized spouse, the greater of:

- the spousal resource standard in effect at the time of application;
- the spousal share, not to exceed the maximum spousal resource standard in effect at the time of application;
- the amount of resources designated by a DMAS Hearing Officer, or
    - an amount *actually* transferred to the community spouse by the institutionalized spouse pursuant to a court spousal support order *issued as the result of an appeal of the DMAS Hearing Officer's decision.*

26. Spousal Resource Standard

means the <u>minimum</u> amount of the couple's combined countable resources ($12,000 in 1989) necessary for a community spouse to maintain himself in the community. This amount increases each calendar year after 1989 by the same percentage increase as in the Consumer Price Index (CPI). [1924(f)(2)(A)(i)].

See section M1480.231 for the current spousal resource standard.

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

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

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

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

A. Applicability

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

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

B. Policy

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

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

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

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

***1.* Home Equity Limit**

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

- Effective January 1, 2022: $636,000
- Effective January 1, 2023: $688,000
- *Effective January 1, 2024: $713,000*

2. Reverse Mortgages

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

3. Home Equity Lines of Credit

A home equity line of credit **does not** reduce the equity value until credit line has been used or payments from the credit line have been received

B. Verification Required

Do not assume that the community spouse is living in the home. Obtain a statement from the applicant indicating who lives in the home. If there is no spouse, dependent child under age 21, or blind or disabled child living in the home, verification of the equity value of the home is required.

C. Notice Requirement

If an individual is ineligible for Medicaid payment of *LTSS* because of substantial home equity exceeding the limit, the Notice of Action must state why he is ineligible for Medicaid payment of *LTSS*. The notice must also indicate whether the applicant is eligible for other Medicaid covered services.

If the individual is in a nursing facility, send the facility a DMAS-225 indicating that the individual is not eligible for the Medicaid payment of LTSS.

D. References

See section M1120.225 for more information about reverse mortgages.

M1480.200 RESOURCE ASSESSMENT RULES

A. Introduction

A resource assessment must be completed when an institutionalized spouse with a community spouse applies for Medicaid coverage of long term care services and may be requested without a Medicaid application.

A resource assessment is strictly a:

- compilation of a couple's reported resources that exist(ed) at the first moment of the first day of the month in which the first continuous period of institutionalization began on or after September 30, 1989.
- calculation of the couple's total countable resources at that point, and
- calculation of the spousal share of those total countable resources.

A resource assessment does not determine resource eligibility but is the first step in a multi-step process. A resource assessment determines the spousal share of the couple's combined countable resources.

B. Policy Principles

1. Applicability

The resource assessment and resource eligibility rules apply to individuals who began a continuous period of institutionalization on or after September 30, 1989 and who are likely to remain in the medical institution for a continuous period of at least 30 consecutive days, or have been *authorized* for Medicaid CBC waiver services, or have elected hospice services.

The resource assessment and resource eligibility rules do **NOT** apply to individuals who were institutionalized before September 30, 1989, **unless** they leave the institution (or Medicaid CBC waiver services) for at least 30 consecutive days and are then re-institutionalized for a new continuous period that began on or after September 30, 1989.

Resource Assessment policy does not apply to individuals eligible in the MAGI Adult covered group. However, a resource assessment may be needed when a married individual FORMERLY received LTSS as a MAGI Adult, and needs to be re-evaluated for LTSS in a non-MAGI group. If the individual is currently married but was not married on the first day of the first continuous period of institutionalization, no resource assessment is needed.

2. Who Can Request

A resource assessment without a Medicaid application can be requested by the institutionalized individual in a medical institution, his community spouse, or an authorized representative. See section M1410.100.

3. When to Do A Resource Assessment

a. Without A Medicaid Application

A resource assessment without a Medicaid application may be requested when a spouse is admitted to a **medical institution**. Do not do a resource assessment **without** a Medicaid application unless the individual is in a medical institution.

b. With A Medicaid Application

The spousal share is used in determining the institutionalized individual's resource eligibility. A resource assessment must be completed when a married institutionalized individual *has* a community spouse *and*

- is in a nursing facility, or
  is *authorized* to receive nursing facility or Medicaid CBC waiver services, or
- has elected hospice services

applies for Medicaid. The resource assessment is completed when the applicant is *authorized* to receive nursing facility or Medicaid CBC services or within the month of application for Medicaid, whichever is later.

NOTE: Once an institutionalized spouse has established Medicaid eligibility as a Non-MAGI institutionalized spouse, count only the institutionalized spouse's resources when redetermining 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 in his name (including his share of jointly owned resources) for the eligibility determination.

The following table contains examples that indicate when an individual is treated as an institutionalized individual for the purposes of the resource assessment:

LTSS Authorized in:	In a Facility?	Application Month	Resource Assessment Month	Processing Month	Month of Application/ ongoing as Institutionalized	Retroactive Determination as Institutionalized (in a medical facility)
January	no	January	January	January	yes	no
January	no	February	February	February	yes	no
N/A	yes	January	first continuous period of institution-alization	February	yes	yes
January	no	March	March	April	yes	no
April	no	March	April	Whenever	no, but yes for April	no

c. Both Spouses Request Medicaid CBC

When both spouses request Medicaid CBC, one resource assessment is completed. The $2,000 Medicaid resource limit applies to each spouse.

C. Responsible Local Agency

The local department of social services (DSS) in the Virginia locality where the individual last resided outside of an institution (including an ACR) is responsible for processing a request for a resource assessment without a Medicaid application, and for processing the individual's Medicaid application. If the individual never resided in Virginia outside of an institution, the local DSS responsible for processing the request or application is the local DSS serving the Virginia locality in which the institution is located.

M1480.210 RESOURCE ASSESSMENT WITHOUT A MEDICAID APPLICATION

A. Introduction

This section applies only to married individuals with community spouses who are inpatients in medical institutions or nursing facilities and who have NOT applied for Medicaid.

B. Policy

1. Resource Evaluation

For the purposes of the resource assessment and spousal share calculation, countable and excluded resources are determined for all covered groups using the ABD resource policy found in Chapter S11 **regardless of the individual's covered group and regardless of community property laws or division of marital property laws**, except for the following resources which are excluded as indicated below when completing the resource assessment and spousal share [1924(c)(5)]:

- the home and all contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SS & SSI payments received on or after 11/01/05 for nine (9) calendar months following the month in which the individual receives the benefits; and
- up to **$1,500** of burial funds for each spouse (NOT $3,500), if there are designated burial funds.

Resources owned in the name of one or both spouses are considered available regardless of whether either spouse agrees to sell or liquidate the resource and regardless of whether either spouse refuses to make the resource available.

If either or both spouses own more than one home, the home in which the institutionalized spouse last resided prior to institutionalization is excluded. Any other home(s) owned by either or both spouse is counted.

The resource assessment is not affected by the amount disregarded in the eligibility determination as a result of an LTC Partnership Policy (Partnership Policy).

2. No Appeal Rights

When a resource assessment is requested and completed **without** a concurrent Medicaid application, it cannot be appealed pursuant to the existing Virginia Client Appeals regulations (VR 460-04-8.7). The spousal share determination may be appealed when a Medicaid application is filed.

C. Procedures

The Medicaid Resource Assessment Request form (#032-03-815) is completed by the person requesting the resource assessment when the assessment is not part of a Medicaid application.

Nursing facilities are required to advise new admissions and their families that Medicaid resource assessments are available for married individuals from their local department of social services.

1. Case Record Number

If the institutionalized individual does not already have a case record, assign a case number and establish a case record in the institutionalized individual's name. If there is an existing case record for the institutionalized individual, use the established case number and record for the resource assessment.

2. Determining the First Continuous Period of Institutionaliz-ation

The resource assessment is based on the couple's resources owned **on the first moment of the first day of the first month** of the first continuous period of institutionalization that began on or after September 30, 1989. This may be different from the current period of institutionalization. Use the information below to determine exactly when the individual's first continuous period of institutionalization began.

Inquire if the individual was ever institutionalized prior to the current institutionalization but not earlier than September 30, 1989. If yes, ascertain the first date on or after September 30, 1989, on which the individual was admitted to a medical institution.

Ask the following:

- From where was he admitted?

  If admitted from a home in the community that is not an institution as defined in section M1410.010, determine if Medicaid CBC waiver services were received and covered by Medicaid while the individual was in the home. If so, the days of Medicaid CBC receipt are “institutionalization” days.

  If admitted from another institution, ascertain the admission and discharge dates, institution’s name and type of institution. The days he was in a medical institution are institutionalization days if there was less than a 30-day break between institutionalizations.

- What was the last date the individual resided outside a medical institution (in the community, at home, or in a non-medical institution)?

3. Verification

The EW must advise the requesting party of the verification necessary to complete the assessment. Ownership interest and value of resources held **on the first moment of the first day of** the first month of the first continuous period of institutionalization must be verified.

Verify all non-excluded resources. Acceptable verification, for example, is a copy of the couple's bank statement(s) for the period. Do not send bank clearances; the requesting party is responsible to obtain verification of resources.

The EW is not required to assist the requesting party in obtaining any required verification for the resource assessment.

4. Failure To Provide Verification

If the applicant refuses to or fails to provide requested verification of resources held at the beginning of the first continuous period of institutionalization and does not notify the EW of difficulty in securing the requested data, the worker is unable to complete the resource assessment and is unable to determine the spousal share of resources. Go to item 8 below, "Notification Requirements."

5. Processing Time Standard

A resource assessment must be processed within 45 days of the date on which the agency receives the written and signed Medicaid Resource Assessment Request form.

If the requestor fails to provide requested verification within 45 days of receipt of notification, notify the applicant that the assessment cannot be completed, and of the reason(s) why. Use the Notice of Medicaid Resource Assessment (#032-03-817).

6. Completing the Medicaid Resource Assessment

When verification is provided, completion of the resource assessment establishes the spousal share which is equal to ½ of a couple's total countable resources as of **the first moment of the first day of** the first month of the first continuous period of institutionalization that began on or after September 30, 1989.

a. Compile the Couple's Resources

The value of non-excluded resources must be verified *and entered into VaCMS. Enter* all resources in which the couple has an ownership interest, including resources in their joint names, those in the institutionalized spouse's name and those in the community spouse's name, including those resources owned jointly with others. List each resource separately.

VaCMS will calculate the spousal share. The process used to calculate the spousal share is found in M1480.210 6.b below.

b. Calculate the Spousal Share

Calculate the total value of the couple's countable resources. Divide this total by 2 to obtain the spousal share. The spousal share is ½ of the couple's combined countable resources as of **the first moment of the first day of the first month** of the first continuous period of institutionalization that began on or after September 30, 1989.

Calculate the spousal share only once; it remains a constant amount for any Medicaid application filed after the resource assessment.

EXAMPLE #2: A Medicaid Resource Assessment Request is received on October 20, 1996 for Mrs. H who was admitted to the nursing facility on October 18, 1996. Her first continuous period of institutionalization began on December 21, 1995, and ended with her discharge on May 30, 1996. Mr. H provides verification which proves that the couple's total countable resources as of December 1, 1995 (the first day of the first month of the first continuous period of institutionalization) were $131,000. The spousal share is ½ of $131,000, or $65,500.

On the Medicaid Resource Assessment form the worker lists the couple's resources as of December 1, 1995 as follows:

Resource	Owner	Countable	Countable Value
Home	Mr & Mrs	No	0
Savings	Mr & Mrs	Yes	$100,000
CD	Mr	Yes	$ 31,000

$131,000	Total Value of Couple's Countable Resources
$ 65,500	Spousal Share

If in the future, Mrs. H applies for Medicaid and she is still married to Mr. H, the worker must use the spousal share of $65,500 determined by the October 1996 resource assessment.

7. Send Loans and/or Judgments to DMAS

When the resource assessment identifies a loan or a judgment against resources, send the documents pertaining to the loan and/or judgment to DMAS for review before taking action on the resource assessment. Send the documents, along with case identifying information (institutionalized spouse's and community spouse's names, address, SSN, case number) to:

DMAS, *Eligibility & Enrollment Services Division*
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

8. Notification Requirements

a. When the Assessment Is Not Completed

Both spouses and the guardian, conservator or authorized representative must be notified in writing that the assessment was not completed; note the specific reason on the form. Use the form Notice of Medicaid Resource Assessment (#032-03-817).

b. When the Assessment Is Completed

Both spouses and the guardian, conservator, or authorized representative must be notified in writing of the assessment results and the spousal share calculated. Use the form Notice of Medicaid Resource Assessment (#032-03-817). Attach a copy of the Medicaid Resource Assessment form (#032-03-816) to each Notice. A copy of all forms and documents used must be kept in the agency's case record.

M1480.220 RESOURCE ASSESSMENT WITH MEDICAID APPLICATION

A. Introduction

This section applies to married individuals with community spouses who are inpatients in medical institutions or nursing facilities, who have been *authorized* to receive Medicaid CBC waiver services, or who have elected hospice services. If a married individual with a community spouse is receiving private-pay home-based services, he **cannot** have a resource assessment done without also filing a concurrent Medicaid application.

B. Policy

1. Resource Assessment

If a resource assessment was **not completed** before the Medicaid application was filed, the spousal share of the couple's total countable resources that existed **on the first moment of the first day of** the first month of the first continuous period of institutionalization that began on or after September 30, 1989, is calculated when processing a Medicaid application for a married institutionalized individual with a community spouse.

If a resource assessment was completed before the Medicaid application was filed, use the spousal share calculated at that time in determining the institutionalized spouse's eligibility.

2. Use ABD Resource Policy

For the purposes of the resource assessment and spousal share calculation, countable and excluded resources are determined for all covered groups using the ABD resource policy in Chapter S11, **regardless of the individual's covered group and regardless of community property laws or division of marital property laws,** except for the following resources which are excluded as indicated below when completing the resource assessment and spousal share:

- the home and **all** contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SS & SSI payments for nine (9) calendar months following the month in which the individual receives the benefits; and
- up to **$1,500** of burial funds for each spouse (NOT $3,500), if there are designated burial funds.

Resources owned in the name of one or both spouses are considered available regardless of whether either spouse agrees to sell or liquidate the resource, and regardless of whether either spouse refuses to make the resource available.

If either or both spouses own more than one home, the home in which the institutionalized spouse resides or last resided prior to institutionalization is excluded. Any other home(s) owned by either or both spouse are counted.

The resource assessment is not affected by the amount disregarded in the eligibility determination as a result of a Partnership Policy.

C. Appeal Rights

When the resource assessment is completed as part of a Medicaid application and eligibility determination, the spousal share calculation can be appealed pursuant to the existing Client Appeals regulations (VR 460-04-8.7).

D. Eligibility Worker Responsibility

Each application for Medicaid for a person receiving *LTSS* services who has a community spouse requires the completion of a resource assessment to determine the spousal share used in determining eligibility.

The EW must provide the applicant with a written request for verification of:

- all reported countable resources owned by the couple **on the first moment of the first day of the first month (FOM)** of the first continuous period of institutionalization. Request this information using the Medicaid Resource Assessment form (#032-03-816) when the FOM is prior to the application's retroactive period.
- all reported countable resources owned by the couple on the first moment of the first day of the month of application, and
- all reported countable resources owned by the couple as of the first moment of the first day of each retroactive month for which eligibility is being determined.

To expedite the application processing, the EW may include a copy of the "Intent to Transfer Assets to A Community Spouse" form, available on *the VDSS intranet* with the request for verifications.

The same verification requirements as for all Medicaid applications apply to the resource assessment.

If the applicant reports to the EW that he cannot obtain certain verifications, the EW must determine why he cannot obtain them and what the EW can do to assist the applicant.

E. Procedures

The resource assessment is only a part of the eligibility determination process. The spousal share is calculated as a result of the resource assessment. The spousal share is used in the calculation of the spousal protected resource amount (PRA) and the institutionalized spouse's countable resources.

1. Forms

The applicant or his representative does not complete a Medicaid Resource Assessment Request form. The Medicaid application is the resource assessment request. The resource assessment will be calculated in VaCMS as part of the eligibility determination process.

2. Send Judgments to DMAS

When the resource assessment or eligibility determination identifies a judgment against resources, send the documents pertaining to the judgment to DMAS for review and how it relates to the resource before taking action on the application. Send the documents, along with case identifying information (institutionalized spouse's and community spouse's names, address, SSN, case number) to:

DMAS, *Eligibility & Enrollment Services Division*
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

3. Determining the First Continuous Period of Institutionaliz-ation

The spousal share is based on the couple's resources owned **on the first moment of the first day of** the first month of the first continuous period of institutionalization which occurred on or after September 30, 1989. This may be different from the current period of institutionalization. Use the information below to determine exactly when the individual's first continuous period of institutionalization began.

Inquire if the individual was ever institutionalized prior to current institutionalization but not earlier than September 30, 1989. If yes, ascertain the first date on or after September 30, 1989, on which the individual was admitted to a medical institution or the first date Medicaid CBC waiver services began.

Ask the following:

- From where was he admitted?

  If admitted from a home in the community which is not an institution as defined in section M1410.010, determine if Medicaid CBC waiver services were received and covered by Medicaid while the individual was in the home. If so, the days of Medicaid CBC receipt are "institutionalization" days.

  If admitted from another institution, ascertain the admission and discharge dates, institution's name and type of institution. The days he was in a medical institution are institutionalization days if there was less than a 30-day break between institutionalizations.

- What was the last date the individual resided outside a medical institution (in the community, at home, or in a non-medical institution)?

4. Failure to Provide Verification

a. Applicant Does Not Notify Agency of Difficulty Securing Verifications

If the applicant fails to provide requested verification of the value of the couple's resources held at the beginning of the first continuous period of institutionalization and does not notify the EW of difficulty in securing the

requested data, the worker is unable to complete the resource assessment and eligibility as a married institutionalized individual cannot be determined. The application must be processed using rules for non-institutionalized individuals and payment for LTC services must be denied for failure to verify resources held at the beginning of institutionalization.

b. Applicant Notifies Agency of Difficulty Securing Verifications

If the applicant is unable to provide verification of the value of the couple's resources held at the beginning of the first continuous period of institutionalization and notifies the EW of difficulty in securing the requested data, the applicant may claim undue hardship.

Undue hardship can be claimed when both spouses have exhausted all avenues to verify the value of the resources owned on the first day of the first month of the first continuous period of institutionalization. When undue hardship is claimed, the applicant must provide documentation of the attempts made to obtain the verification. **Claims of undue hardship must be evaluated and can only be granted by DMAS.** The EW must send a summary of the needed verifications and documentation of the attempts to secure the verifications, along with the applicant's name and case number to:

DMAS, *Eligibility & Enrollment Services Division*
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

If DMAS determines undue hardship does not exist, the resource assessment cannot be completed and the application must be denied due to failure to verify resources held at the beginning of institutionalization. If DMAS determines undue hardship exists, the completion of a resource assessment is waived, and the spousal resource standard is to be substituted for the spousal share in determining the individual's resource eligibility. Go to section M1480.230 below.

5. Completing the Medicaid Resource Assessment

When verification is provided, completion of the resource assessment establishes the spousal share which is equal to ½ of a couple's total countable resources as of **the first moment of the first day of** the first month of the first continuous period of institutionalization that began on or after September 30, 1989. The spousal share is one factor in determining the spousal protected resource amount (PRA) in section M1480.230 below.

a. Compile the Couple's Resources

The value of countable resources must be verified and recorded on the Medicaid Resource Assessment form (#032-03-816). Excluded resources must be listed separately on the form, but their value does not need to be noted or verified.

On the assessment form, list all resources in which the couple has an ownership interest - resources in their joint names, those in the institutionalized spouse's name and those in the community spouse's name, including those resources owned jointly with others. List each resource separately.

b. Calculate the Spousal Share

Calculate the total value of the couple's countable resources. Divide this total by 2 to obtain the spousal share. The spousal share is ½ of the couple's total countable resources as of the first moment of the first day of the first month of the first continuous period of institutionalization that began on or after September 30, 1989.

Calculate the spousal share only once; it remains a constant amount for the current Medicaid application and all subsequent Medicaid applications filed.

EXAMPLE #3: A Medicaid application is received on October 20, 1996 for Mrs. H who was admitted to the nursing facility on October 18, 1996. Her first continuous period of institutionalization began on December 21, 1995, and ended with her discharge on May 30, 1996. Neither she nor her spouse requested a resource assessment before applying for Medicaid.

To determine Mrs. H's eligibility and the amount of the couple's current resources that can be "protected" for Mr. H, Mr. H provides verification which proves that the couple's total countable resources as of December 1, 1995 (the first day of the beginning of the first continuous period of institutionalization) were $131,000. The spousal share is ½ of $131,000, or $65,500.

On the Medicaid Resource Assessment form the worker lists the couple's resources as of December 1, 1995 as follows:

Resource	Owner	Countable	Countable Value
Home	Mr & Mrs	No	0
Savings	Mr & Mrs	Yes	$100,000
CD	Mr	Yes	$31,000

$131,000 Total Value of Couple's Countable Resources
$ 65,500 Spousal Share

In the eligibility evaluation, the worker uses the spousal share amount ($65,500) as one factor to determine the spousal protected resource amount (PRA) that is subtracted from the couple's current resources to determine the institutionalized spouse's resource eligibility.

F. Notice Requirements

Do not send the Notice of Medicaid Resource Assessment when a resource assessment is completed as a part of a Medicaid application.

Include a copy of the Medicaid Resource Assessment form with the Notice of Action on Medicaid that is sent when the eligibility determination is completed.

M1480.225 INABILITY TO COMPLETE THE RESOURCE ASSESSMENT-UNDUE HARDSHIP

A. Policy

Federal law states that a resource assessment must be completed on all Medicaid applications for institutionalized individuals who have a community spouse. On occasion, however, it is difficult to comply with this requirement because the applicant is unable to establish his marital status or locate a separated spouse, or the community spouse refuses or fails to provide information necessary to complete the resource assessment. In situations where the applicant is unable to provide information necessary to complete the resource assessment, undue hardship can be claimed if each of the following criteria is met:

1. The applicant establishes by affidavit specific facts sufficient to demonstrate (a) that he has taken all steps reasonable under the circumstances to locate the spouse, to obtain relevant information about the resources of the spouse, and to obtain financial support from the spouse *(including information about any legal proceedings initiated, protective orders in effect, etc.)*; and (b) that he has been unsuccessful in doing so;

   Absent extraordinary circumstances, determined by DMAS, the requirements of A.1 (a) cannot be met unless the applicant and spouse have lived separate and apart without cohabitation and without interruption for at least 36 months.

2. Upon such investigation as DMAS may undertake, no *relevant* facts are revealed that refute the statement contained in the applicant's affidavit, as required by paragraph A.1.

3. The applicant has assigned to DMAS, to the full extent allowed by law, all claims he or she may have to financial support from the spouse; and
4. The applicant cooperates with DMAS in any effort undertaken or requested by DMAS to locate the spouse, to obtain information about the spouse's resources and/or to obtain financial support from the spouse.

B. Procedures

1. Assisting the Applicant

The EW must advise the applicant of the information needed to complete the resource assessment and assist the applicant in contacting the separated spouse to obtain resource and income information.

If the applicant cannot locate the separated spouse, document the VaCMS case record. Refer to M1480.225 B.2.b below.

If the applicant locates the separated spouse, the EW must contact the separated spouse to explain the resource assessment requirements for the determination of spousal eligibility for long-term care services.

If the separated spouse refuses to cooperate in providing information necessary to complete the resource assessment, document the VaCMS case record. Refer to M1480.225 B.2.b below.

EXCEPTION: If the separated spouse is institutionalized and is a Medicaid applicant/recipient, the definition of "community spouse" is not met, and a resource assessment is not needed.

2. Undue Hardship

If the applicant is unable to provide the necessary information to complete the resource assessment, he/she must be advised of the hardship policy and the right to claim undue hardship.

a. **Undue hardship not claimed**

If the applicant does not wish to claim undue hardship, the EW must document the VaCMS case record, and the application must be processed using rules for non-institutionalized individuals. Payment for LTC services must be denied for failure to verify resources held at the beginning of institutionalization.

b. **Undue hardship claimed**

If the applicant claims an undue hardship, he must provide a written statement requesting an undue hardship evaluation. A Resource Assessment Undue Hardship Request Form, including affidavit and assignment forms, may be given to the applicant to be used instead of an original statement but is **not required**. The forms are available at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*.

1) Applicant or Authorized Representative

The applicant or his authorized representative must provide a letter *or the Resource Assessment Undue Hardship Request Form – DMAS-E10* indicating the following:

- The applicant is requesting an undue hardship evaluation;
- The name of the applicant's attorney-in-fact (i.e. who has the power of attorney) or authorized representative *(if applicable*);
- The length of time the couple has been separated;
- The name of the estranged spouse and his
  - Last known address,
  - Last known employer,
  - The types (i.e. telephone, in-person visit) and number of attempts made to contact the spouse:
    - Who made the attempt
    - Date(s) the attempt(s) were made,
    - The name of the individual contacted and relationship to estranged spouse; and
- Any legal proceeding initiated, protective orders in effect, etc.

If not included with the request, the applicant or authorized representative may also be asked to provide:

- *A completed, signed, and notarized Affidavit Form (DMAS-E11);*
- *A signed and dated Assignment Form (DMAS-E12)*

A completed Resource Assessment Undue Hardship Request Form (including the affidavit and assignment forms) may be used instead of a letter from the worker but is ***not required****.*

2) Eligibility Worker

A cover sheet is to be prepared that includes the following information:

- The applicant's name and case number;
- Documentation of any actions the EW took to locate or contact the estranged spouse; *and*
- *Include any documentation provided by the applicant or authorized representative.*

The cover sheet and all information supporting the claim must be sent to:

Eligibility and Enrollment Services Division – Policy Unit
DMAS
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If DMAS determines that undue hardship does not exist, and the resource assessment cannot be completed, the EW must deny the application due to failure to verify resources held at the beginning of institutionalization.

If DMAS determines an undue hardship does exist, the EW will be sent instructions for continued processing of the case.

M1480.230 RESOURCE ELIGIBILITY OF INSTITUTIONALIZED SPOUSE

A. Introduction

This section contains the resource rules that apply to the institutionalized spouse's eligibility.

If the community spouse applies for Medicaid, do not use the rules in this subchapter to determine the community spouse's eligibility. Use the financial eligibility rules for a non institutionalized person in the community spouse's covered group.

B. Policy

An institutionalized spouse meets the resource eligibility requirements for Medicaid if the difference between the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined and the spousal protected resource amount (PRA) is equal to or less than $2,000.

In initial eligibility determinations for the institutionalized spouse, the spousal share of resources owned by the couple **at the first moment of the first day of the first month of the first continuous period of institutionalization** that began on or after September 30, 1989, remains a constant factor in determining the spousal PRA.

For the purposes of determining eligibility of an institutionalized spouse with excess resources, an institutionalized spouse **cannot** establish resource eligibility by reducing resources within the month. The institutionalized spouse may become eligible for Medicaid payment of LTC services when the institutionalized spouse's resources are equal to or below the $2,000 resource limit as of the first moment of the first day of a calendar month.

1. Use ABD Resource Policy

For the purposes of eligibility determination, countable and excluded resources are determined for all covered groups using the ABD resource policy in Chapter S11, **regardless of the individual's covered group and regardless of community property laws or division of marital property laws,** except for the following resources which are excluded as indicated below when determining eligibility of the institutionalized spouse:

- the home and all contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SS & SSI payments received on or after 11/01/05 for nine (9) calendar months following the month in which the individual receives the benefits; and
- up to $3,500 of burial funds for each spouse.

Resources owned in the name of one or both spouses are considered available in the initial month for which eligibility is being determined regardless of whether either spouse agrees to sell or liquidate the resource, and regardless of whether either spouse refuses to make the resource available.

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

$30,828	*1-1-24*
$29,724	1-1-23
$27,480	1-1-22

C. Maximum Spousal Resource Standard

$154,140	*1-1-24*
$148,620	1-1-23
$137,400	1-1-22

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.

If the applicant is not eligible in the month of application, the initial eligibility determination period continues until the first month in which the institutionalized spouse is eligible. NOTE: Established application processing procedures and timeframes apply.

An institutionalized spouse meets the resource eligibility requirements for Medicaid if the difference between the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined, the community spouse's protected resource amount (PRA) and the institutionalized spouse's partnership policy disregard amount (see M1460.160) is equal to or less than $2,000.

1. First Application

Use the procedures in item B below for the initial resource eligibility determination for an institutionalized spouse's first application for Medicaid in a continuous period of institutionalization that began on or after 9-30-89.

2. Subsequent Applications

a. Medicaid Eligibility For LTC Services Achieved Previously

If an individual achieved Medicaid eligibility as an institutionalized spouse during a period of institutionalization that began on/after 9-30-89, regardless of whether the period of institutionalization is the same continuous period covered by the previous application(s), **do not consider the couple's resources. Use only the institutionalized spouse's resources**. Use the policy and procedures in section M1480.*230 B.2* to determine the institutionalized individual's financial eligibility.

b. Medicaid Eligibility For LTC Services Not Previously Achieved

If an individual has never achieved Medicaid eligibility as an institutionalized spouse, **treat the application** as an "initial eligibility" determination.

- Determine countable resources for the application month (see item B below);
- Deduct the spousal PRA from the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined.
- Deduct a dollar amount equal to the Partnership Policy disregard, if any.

B. Procedures

Use the following criteria to determine Medicaid eligibility for any month in the initial eligibility determination period.

NOTE: The initial eligibility determination period begins with the month of application. If the institutionalized spouse is not eligible in that month, the initial eligibility determination period continues until the first month in which the institutionalized spouse is eligible.

1. Couple's Total Resources

Verify the amount of the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined.

NOTE: When a loan or a judgment against resources is identified, send the documents pertaining to the loan and/or judgment to DMAS for review before taking action on the application. Send the documents, along with case identifying information (institutionalized spouse's and community spouse's names, address, SSN, case number) to:

DMAS, *Eligibility & Enrollment Services Division*
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

2. Deduct Spousal Protected Resource Amount (PRA)

Deduct the spousal protected resource amount (PRA) from the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined.

If no spousal share was determined because the couple failed to verify resources held at the beginning of the first continuous period of institutionalization, the application must be processed using rules for non-institutionalized individuals and payment for LTC services must be denied for failure to verify resources held at the beginning of institutionalization.

The PRA is the greatest of the following:

- the **spousal share** of resources as determined by the resource assessment, provided it does not exceed the maximum spousal resource standard in effect at the time of application. **If the spousal share exceeds the maximum spousal resource standard, use the maximum spousal resource standard.** The spousal share does not change; if a spousal share was previously established and verified as correct, use it;
- the **spousal resource standard** in effect at the time of application;
- an amount designated by a DMAS Hearing Officer;
- an amount **actually transferred** to the community spouse from the institutionalized spouse under a **court spousal support order** issued as the result of an appeal of the DMAS Hearing Officer's decision**.**

The EW cannot accept a court order for a greater PRA unless the individual has exhausted the Medicaid administrative appeals process, the individual appealed the DMAS Hearing Officer's decision to the circuit court and the circuit court ordered a higher amount.

If the individual does not agree with the PRA, see subsection F. below.

Once the PRA is determined, it remains a constant amount for the current Medicaid application (including retroactive months). If the application is denied and the individual reapplies, the spousal share remains the same but a new PRA must be determined.

3. Deduct Partnership Policy Disregard Amount

When the institutionalized spouse is entitled to a Partnership Policy disregard, deduct a dollar amount equal to the benefits paid as of the month of application.

4. Compare Remainder

Compare the remaining amount of the couple's resources to the appropriate Medicaid resource limit for one person.

a. Remainder Exceeds Limit

When the remaining resources exceed the limit and the institutionalized spouse does not have Medicare Part A, the institutionalized spouse is not eligible for Medicaid coverage because of excess resources.

If the institutionalized spouse has Medicare Part A, he may be eligible for limited coverage QMB, SLMB or QI Medicaid (which will not cover the cost of the LTC services) because the resource requirements and limits are different. **The resource policies in subchapter M1480 do not apply to limited-coverage Medicaid eligibility determinations**. Follow the procedures for determining resource eligibility for an individual in Chapter S11. More information about the QMB, SLMB, and QI covered groups is contained in subchapter M0320.

Note: The institutionalized spouse cannot be eligible for QDWI Medicaid.

b. Remainder Less Than or Equal to Limit

When the remaining resources are equal to or less than the Medicaid limit, the institutionalized spouse is resource eligible in the month for which eligibility is being determined:

- determine the community spouse resource allowance (CSRA). To calculate the CSRA, see sections M1480.240 and 241 below;
- determine a protected period of eligibility for the institutionalized spouse, if the institutionalized spouse expressly states his intent to transfer resources that are in his name to the community spouse; see section M1480.240 below.

C. Example--Calculating the PRA

EXAMPLE #4:

Mr. A is married to a community spouse. He applied for Medicaid on December 2, 1997. The beginning of his first continuous period of institutionalization which began on or after 9-30-89 was October 12, 1993, when he was admitted to a nursing facility. He was discharged from the facility on February 5, 1995, then readmitted to the nursing facility on December 5, 1997 and remains there to date. Eligibility is being determined for December 1997.

Step 1:

The couple's total countable resources on October 1, 1993 (the first moment of the first day of the first continuous period of institutionalization) were $130,000.

Step 2: $130,000 ÷ 2 = 65,000. The spousal share is $65,000.

Step 3: The couple's total countable resources as of December 1, 1997 (the first moment of the first day of the month for which eligibility is being determined), are $67,000.

Step 4: Determine the spousal protected resource amount (PRA). The spousal PRA is the greatest of:

- $65,000 (the spousal share, which is less than the maximum spousal resource standard of $79,020 in December 1997, the time of application).
- $15,804 (the spousal resource standard in December 1997, the time of the application).
- *$0* (DMAS hearing decision amount or court-ordered spousal support resource amount;(there is neither in this case).

Since $65,000 is the greatest, $65,000 is the PRA.

Step 5: Deduct the PRA from the couple's combined countable resources as of December 1, 1997 (the first moment of the first day of the month for which eligibility is being determined.

$67,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined (December 1, 1997)
- 65,000	Step 4 PRA
$2,000	countable resources in month for which eligibility is being determined (December 1, 1997).

The remaining $2,000 is the countable resource *amount* available to the institutionalized spouse on December 1, 1997 (the first moment of the first month for which eligibility is being determined).

Step 6: Compare the $2,000 countable resources to the resource limit of $2,000. The countable resources of the institutionalized spouse are equal to the limit and he is resource eligible in December (the month for which eligibility is being determined). A CSRA and protected period of eligibility are determined in section M1480.240 and 241 below.

D. Example--DMAS Hearing Officer Revised PRA

EXAMPLE #5: Mr. C applied for Medicaid on November 21, 1996. He was admitted to a nursing facility on December 20, 1994. This is his first application for Medicaid as an institutionalized spouse. He is married to Mrs. C who lives in their community home. The first moment of the first day of the first month of the first continuous period of institutionalization is December 1, 1994. Mr. C is not resource eligible in the retroactive period. Eligibility is being determined for November 1996. The couple's total countable resources as of December 1, 1994 (the first moment of the first day of the first continuous period of institutionalization) were $150,000.

Step 2: $150,000 ÷ 2 = $75,000. The spousal share is $75,000.

Step 3: The couple's total countable resources on November 1, 1996 (first moment of the first day of the month for which eligibility is being determined) are $80,000.

Step 4: Determine the spousal protected resource amount (PRA). The spousal PRA is the greatest of:

$75,000 (the spousal share, which is less than the maximum spousal resource standard of $76,740 in November 1996);

$16,152 (the spousal resource standard at the time of the application);

$0 DMAS hearing decision amount (there is none in this case).

$0 amount actually transferred to community spouse pursuant to court-ordered spousal support (there is none in case).

Since $75,000 is the greatest, $75,000 is the PRA.

Step 5: Deduct the PRA from the couple's combined countable resources as of November 1, 1996 (the first moment of the first day of the month for which eligibility is being determined.

$80,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
- 75,000	Step 4 PRA
$ 5,000	countable resources in month for which eligibility is being determined.

$5,000 is the countable resources available to the institutionalized spouse in the month for which eligibility is being determined.

Steps 6 & 7: Compare the $5,000 countable resources to the resource limit of $2,000. The countable resources of the institutionalized spouse exceed the limit, so he is not eligible for *full-benefit* Medicaid in November 1996 (the month for which eligibility is being determined).

Mrs. C appealed the denial because she believes that she needs more resources protected so that her income will be sufficient to meet her needs. After a hearing in March 1997, and evidence gathered of Mrs. C's extraordinary shelter and medical expenses, the DMAS Hearing Officer decided that more of the couple's resources should be protected in order to raise Mrs. C's income to the minimum monthly maintenance needs allowance (MMMNA). The Hearing Officer decided that the spousal resource maximum of $76,740 should be the PRA. Mr. C's eligibility was recalculated using the $76,740 PRA.

Step 5 again: The revised PRA was deducted from the couple's total combined countable resources in November 1996 (the initial month for which eligibility is being determined):

$80,000 Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
- 76,740 Step 4 PRA
$3,260 countable resources in month for which eligibility is being determined.

$3,260 is the countable resources available to Mr. C in November 1996 (the month for which eligibility is being determined). He is not eligible for full-benefit Medicaid and the denial was sustained.

***E*. Example--PRA Is Amount Transferred Per Court-Ordered Spousal Support**

EXAMPLE #6: Mrs. C in Example #5 above is not satisfied with the Hearing Officer's decision to increase the PRA to $76,740 and files an appeal in circuit court. The hearing is held and the court orders Mr. C to transfer $79,000 of his resources to Mrs. C. He immediately completes the transfers, provides the documentation to his eligibility worker, and requests his eligibility be re-evaluated.

Step 1: The couple's total countable resources as of December 1, 1994 (the first moment of the first day of the first continuous period of institutionalization) were $150,000..

Step 2: $150,000 ÷ 2 = $75,000. The spousal share is $75,000.

Step 3: The couple's total countable resources as of November 1, 1996 (the first moment of the first day of the month for which eligibility is being determined) are $80,000.

Step 4: *Determine the spousal protected resource amount (PRA)*. The spousal PRA is the greatest of:

- $75,000 (the spousal share, which is less than the maximum spousal resource standard of $80,760 in the application month);
- $16,152 (the spousal resource standard at the time of the application);
- $76,740 DMAS hearing decision amount
- $79,000 amount actually transferred to community spouse pursuant to court-ordered spousal support.

Since $79,000 is the greatest, $79,000 is the PRA.

F. PRA Revisions Policy

Revisions to the community spouse's calculated protected resource amount (PRA) can be made when:

1. A DMAS Hearing Officer determines that the income generated from the resources is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance (MMMNA). Substitute the amount the DMAS Hearing Officer determines for the PRA calculated in section M1480.232 above.

2. A DMAS Hearing Officer confirms that the initial PRA determination was incorrect.

3. A court orders spousal support in an amount that is greater than the PRA established in subsection B above ***after*** *the applicant completes the administrative appeals process.*

M1480.233 INITIAL ELIGIBILITY - RETROACTIVE MONTHS

A. First Application

Use the procedures for the initial resource eligibility determination (section M1480.232 above) for each of the three (3) months preceding an institutionalized spouse's first application for Medicaid in a continuous period of institutionalization that began on or after 9-30-89.

To determine the institutionalized spouse's countable resources in each retroactive month, subtract the spousal PRA from the couple's total countable resources held **on the first moment of the first day of each retroactive month.** Use the procedures in C below.

B. Subsequent Applications

1. Medicaid Eligibility Established Previously

If an individual established Medicaid eligibility as an institutionalized spouse during a period of institutionalization that began on/after 9-30-89, regardless of whether the period of institutionalization is the same continuous period covered by the previous application(s), **do not consider the couple's resources. Use only the institutionalized spouse's resources**. Use the policy and procedures in section M1480.*230 B.2* to determine the institutionalized individual's financial eligibility.

For the application's retroactive month(s), determine resources using only the institutionalized spouse's resources in each retroactive month. If the institutionalized spouse's countable resources exceed the Medicaid resource limit in a retroactive month, the institutionalized spouse is NOT eligible for that month.

2. Medicaid Eligibility Not Previously Established

If an individual has never established Medicaid eligibility as an institutionalized spouse, **treat the application** as an "initial eligibility" determination (section M1480.232 above).

- Determine countable resources for the application month (see section M1480.232 above).
    - Deduct the spousal PRA from the couple's total countable resources held **on the first moment of the first day of each retroactive month.**
    - Deduct a dollar amount equal to the Partnership Policy disregard as of **the month of application** (Note: this amount is also used when determining eligibility for a retroactive month).

For the application's retroactive month(s), determine resources using the procedures in subsection C below.

C. Procedures

The procedures in this subsection are used for the retroactive determination based on a

- first application; or
- subsequent application when Medicaid eligibility as an institutionalized spouse was NOT previously established.

1. Couple's Resources — Determine the couple's total countable resources as of the **first moment of the first day of each retroactive month.**

2. Subtract PRA — Subtract the spousal PRA (M1480.232 above) from the couple's total resources in each retroactive month. Each result is the countable resources available to the institutionalized spouse in each retroactive month.

3. *Subtract Partnership Policy Disregard* — *When the institutionalized spouse is entitled to a Partnership Policy disregard, deduct the dollar amount equal to the benefits paid as of the month of application.*

4. **Countable Resources Within Limit** — If the countable resources in a *retroactive* month are less than or equal to the resource limit, the institutionalized spouse is eligible in that month.

5. **Countable Resources Exceed Limit** — If the countable resources exceed the Medicaid resource limit in a retroactive month, the institutionalized spouse is NOT eligible for that month.

D. Retroactive Example — **EXAMPLE #8:** Mr B's first continuous period of institutionalization began on 9-20-92. He **first applied for Medicaid on February 3, 1998** and requested retroactive coverage for December 1997 and January 1998. Mrs. B is his community spouse.

Retroactive Month — December 1997

Step 1: — The couple's total resources as of September 1, 1992 (the first moment of the first day of the first continuous period of institutionalization) were $200,000.

Step 2: — $200,000 ÷ 2 = $100,000. The spousal share is $100,000.

Step 3: — The couple's total countable resources as of December 1, 1997 (the retroactive month for which eligibility is being determined) are $96,000.

Step 4: — Determine the spousal protected resource amount (PRA). The spousal PRA is the greatest of:

- $80,760(the maximum spousal resource standard in effect at the time of application (February 20, 1998) is less than the spousal share of $100,000);
- $16,152(the spousal resource standard in effect at the time of application (February 20, 1998),
- $0(no amount designated by DMAS Hearing Officer),
- $0(no amount transferred pursuant to court support order).

The PRA is $80,760 (the lesser of the maximum resource standard and the spousal resource standard, because there was no amount designated by DMAS Hearing Officer or transferred per court order).

NOTE: Once the PRA is determined, it remains the same for all retroactive months and for months in the initial eligibility determination period.

Step 5: *Deduct the PRA from the couple's combined countable resources on as of December 1, 1997 (the first moment of the first day of the month for which eligibility is being determined)*

$96,000	Step 3 couple's total *resources owned as of first moment of the first day of the month for which eligibility is being determined*
- 80,760	Step 4 PRA
$15,240	countable resources *in month for which eligibility is being determined.*

$15,240 countable to Mr. B.

Step 6: Since $15,240 exceeds the $2,000 limit, Mr. B is not eligible for Medicaid for December 1997 (the retroactive month for which eligibility is being determined.

Complete a retroactive determination for January 1998.

Retroactive Month *January 1998*

Step 1: *The couple's total resources as of September 1, 1992 (the first moment of the first day of the first continuous period of institutionalization) were $200,000.*

Step 2: *$200,000 ÷ 2 = $100,000. The spousal share is $100,000.*

Step 3: *The couple's total countable resources as of January 1, 1998 (the retroactive month for which eligibility is being determined) are $93,000.*

Step 4: *Determine the PRA: Once the PRA is determined, it remains the same for all retroactive months and for months in the initial eligibility determination period.*

The PRA is $80,760 (See Step 4 in the retroactive determination for December 1997 above).

Step 5: *Deduct the PRA from the couple's combined countable resources as of January 1, 1998 (the first moment of the first day of the month for which eligibility is being determined):*

$93,000	*Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined*
- 80,760	*Step 4 PRA*
$ 12,240	*countable resources in month for which eligibility is being determined.*

$12,240 countable resources for Mr. B.

Step 6: *Since $12,240 exceeds the $2,000 limit, Mr. B is not eligible for Medicaid in for January 1998 (the retroactive month for which eligibility is being determined. Proceed to determine eligibility for the initial eligibility determination period that begins with February 1998 (month of application).*

Initial Eligibility Determination *Month* February 1998

Step 1: The couple's total resources as of September 1, 1992 (the first moment of the first day of the first continuous period of institutionalization) were $200,000.

Step 2: $200,000 x 2 = $100,000. The spousal share is $100,000.

Step 3: The couple's total countable resources as of February 1, 1998 (the month for which eligibility is being determined) are $90,000.

Step 4: Determine the PRA: Once the PRA is determined, it remains the same for all retroactive months and for months in the initial eligibility determination period.

The PRA is $80,760 (See Step 4 in the retroactive determine for December 1997 above).

Step 5: Deduct the PRA from the couple's combined countable resources on February 1, 1998 (the first moment of the first day of the month for which eligibility is being determined):

$90,000 Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
- 80,760 Step 4 PRA
$9,240 countable resources in month for which eligibility is being determined.

$ 9,240 countable resources for Mr. B.

Step 6: Since $9,240 exceeds the $2,000 limit, Mr. B is not eligible for Medicaid in February 1998 (the month for which eligibility is being determined).

Note: The initial eligibility determination period continues until the individual is found eligible. If Mr. B reapplies, he will still be in the initial eligibility determination period.

M1480.240 *INTENT TO TRANSFER - PROTECTED PERIOD*

A. Policy

After the initial eligibility determination, an institutionalized spouse who has resources in his name which exceed the Medicaid resource limit may have his Medicaid resource eligibility "protected" for a period of time if all of the following criteria are met:

- *resources in the community spouse's name are less than the PRA at the time of application,*

- the amount of resources that may be transferred to bring the community spouse up to the PRA will reduce the resources in the institutionalized spouse's name to no more than $2,000, and

- the institutionalized spouse has expressly indicated in writing his intent to transfer resources to the community spouse.

The protected period is designed to allow the institutionalized spouse time to legally transfer some or all of his resources to the community spouse. Resources in the institutionalized spouse's name are excluded only for one 90-day period.

If the institutionalized spouse does not transfer resources to the community spouse within the 90-day period, all of the institutionalized spouse's resources will be counted available to the institutionalized spouse when the protected period ends. If the institutionalized spouse loses eligibility after the 90-day protected period is over, and then reapplies for Medicaid, he CANNOT have resource eligibility protected again and a PRA is NOT subtracted from his resources.

B. Protected Period Is Not Applicable

A protected period of eligibility is not applicable to an institutionalized spouse when:

- the institutionalized spouse is not eligible for Medicaid;

- the institutionalized spouse previously established Medicaid eligibility as an institutionalized spouse, had a protected period of eligibility, became ineligible, and reapplies for Medicaid; or

- at the time of application, a community spouse has title to resources equal to or exceeding the PRA.

C. Intent to Transfer Resources To Community Spouse

The institutionalized spouse or authorized representative must expressly indicate in writing his intention to transfer resources to the community spouse. If not previously obtained, send an "Intent to Transfer Assets to A Community Spouse" form, available at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*, to the institutionalized spouse or authorized representative, allowing 10 days from the date of mailing for return of the form.

If the completed Intent to Transfer Assets form is not returned by the time the application is processed, no protected period of eligibility may be established. All resources in the institutionalized spouse's name must be counted in his eligibility determination beginning with the month following the initial eligibility determination period. If eligible, enroll the institutionalized spouse for a closed period of coverage beginning with the retroactive period and ending with the last day of the month of the initial eligibility period.

If the institutionalized spouse submits a new application for Medicaid payment of long-term care services, the process starts again and a new Intent to Transfer form must be mailed.

When the community spouse is a Medicaid recipient, the eligibility worker must inform the couple that the transfer of resources to the community spouse could impact the community spouse's Medicaid eligibility.

D. How to Determine the Protected Period

The 90-day protected period begins with the date the local agency takes action to approve the institutionalized spouse's initial eligibility for Medicaid LTC services, if the institutionalized spouse or his authorized representative *has signed the Intent to Transfer Assets form.*

E. Protected Period Ends

Set a special review for the month in which the 90-day period ends. When the protected period of eligibility is over, all resources owned in the institutionalized spouse's name are counted available to the institutionalized spouse. Extension of the protected period is NOT allowed.

F. Institutionalized Spouse Acquires Resources During the Protected Period of Eligibility

If the institutionalized spouse obtains additional resources during the protected period of eligibility, the additional resources shall be excluded during the protected period if:

- the new resources combined with other resources that the institutionalized spouse intends to retain do not exceed the appropriate Medicaid resource limit for one person, OR
- the institutionalized spouse intends to transfer the new resources to the community spouse during the protected period of eligibility and the total resources to be transferred do not exceed the balance remaining (if any) of the *PRA.*

NOTE: Some assets, such as inheritances, are income in the month of receipt. Be careful to count only those assets that are resources in the month of receipt, and to count assets that are income as a resource if retained in the month following receipt.

M1480.241 COMMUNITY SPOUSE RESOURCE ALLOWANCE (CSRA)

A. Policy

When the Intent to Transfer form has been completed, the institutionalized spouse's eligibility is protected for 90 days to allow time for resources in the institutionalized spouse's name to be transferred to the community spouse for the community spouse's support.

The community spouse resource allowance (CSRA) is the amount of the resources in the institutionalized spouse's name (including his share of jointly owned resources) which can be transferred to the community spouse to bring the resources in the community spouse's name up to the PRA. This amount is disregarded in the institutionalized spouse's Medicaid eligibility determination during the protected period.

B. CSRA Calculation Procedures

Use the following procedures for calculating the CSRA. The "Institutionalized Spouse Resource Eligibility Worksheet," available at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*, should be used to determine countable resources and the CSRA.

1. Determine Community Spouse's Resources

Determine the amounts of the couple's total resources which are in the community spouse's name only and the community spouse's share of jointly owned resources owned as of the first moment of the first day of the initial month for which eligibility was established.

2. Determine Institutionalize Spouse's Resources

Determine the amounts of the couple's total resources which are in the institutionalized spouse's name only and the institutionalized spouse's share of jointly owned resources owned as of the first moment of the first day of the initial month for which eligibility was established. If the institutionalized spouse's resources changed during initial month (after the first moment of the first day of the initial month which eligibility was established) verify the institutionalized spouse's resources owned as of the first moment of the first d of the month following the initial month.

3. Calculate CSR

To calculate the Community Spouse Resource Allowance (CSRA):

a. Determine PRA

Find the spousal PRA (determined in section M1480.232 above).

***b.* Subtract CS Resources from the PRA**

Subtract from the PRA an amount equal to the resources in the community spouse's name only and the community spouse's share of jointly owned resources as of the first moment of the first day of the initial month in which eligibility was established.

***c.* Remainder**

The remainder, if greater than zero, is the CSRA and the amount to be disregarded in the institutionalized spouse's Medicaid eligibility determination during the protected period. This is the amount to be transferred to the community spouse during the protected period.

If the remainder is $0 or a negative number, the CSRA = $0. The community spouse does not have a CSRA.

C. Example CSRA Calculation

EXAMPLE #9*: (Using January 2008 figures)*

Mrs. Tea applied for Medicaid on *May 21, 2008*. She was admitted to the nursing facility on *January 20, 2008*. She is married to Mr. Tea who lives in their community home. This is her first application for Medicaid as an institutionalized spouse. The first day of the first month of the first continuous period of institutionalization is *January 1, 2008*. Eligibility is being determined for May 2008. *Mrs. Tea signs the Intent to Transfer from June 1, 2008.*

Step 1:

Determine the PRA

The couple's total countable resources as of *January 1, 2008* (the first moment of the first day of the first continuous period of institutionalization) were $50,000.

$25,000spousal share ($50,000 ÷ 2), *not to exceed the maximum spousal resource standard of $104,400, eff. 01-01-2008*

$20,880spousal resource standard in effect on January 1, 2008

$0 (amount actually transferred as court-ordered spousal support); or
$0 (DMAS hearing decision amount).

Since $25,000 is the greatest of the above, $25,000 is the PRA.

Steps 2. and 3:

Subtract CS Resources from the PRA to Determine CSRA

The couple's total *resources owned as of first moment of the first day of the month for which eligibility is being determined are $26,500. The community spouse has $7,000 in his name. The institutionalized spouse has $19,500 in her name. From the PRA of $25,000, deduct the community spouse resource amount of $7000. The remaining $18,000 is the CSRA that can be transferred to the community spouse and disregarded in the institutionalized spouse' Medicaid eligibility determination during the protected period.*

$25,000PRA
- 7,000 Resources in the CS name
$18,000 CSRA (amount that can be transferred to CS)

***D.* Community Spouse Acquires Additiona Resources During Protected Period**

If the **community spouse** obtains additional resources during the protected period of eligibility, the institutionalized spouse's eligibility is NOT affected. The community spouse's new resources are not counted when determining the institutionalized spouse's eligibility during or after the protected period of eligibility. **Do NOT recalculate the CSRA.**

***E.* Reviewing Resourc Eligibility**

When reviewing the institutionalized spouse's resource eligibility at the end of the protected period and at scheduled redeterminations, the community spouse's resources are NOT counted available.

***F.* Asset Transfers**

Instructions for treatment of asset transfers are found in subchapter M1450.

Pages 35 through 46 have been deleted.

M1480.260 SUSPENSION PROCEDURES

A. Policy

This section applies to institutionalized individuals who:

are enrolled in ongoing Medicaid coverage,
have Medicare Part A,
have a patient pay that exceeds the Medicaid rate, and
have resources between $2,000 and $4,000.

B. Procedures

If the conditions above are met, take the following actions:

1. Prepare and Send Advance Notice

Prepare and send an advance notice to reduce the recipient's full Medicaid coverage to the appropriate ABD covered group. Specify the effective date, which is the last day of the month in which the 10-day advance notice period expires. Write a note on the notice telling the recipient that if he verifies that his resources are less than or equal to the $2,000 resource limit before the specified date (specify the date which is 3 months from the cancel effective date), he should request reinstatement of Medicaid coverage.

2. Suspend Case Administratively

Suspend the case administratively for a maximum of 3 months; do not close the case statistically. The suspension effective date is the effective date of the Medicaid cancellation in the *Virginia Case Management System* (*VaCMS)*. The case is counted as a "case under care" while suspended. While suspended, the case remains open for a maximum of 3 months.

If, by the end of 3 months from the suspension effective date, the individual provides verification that his resources have been reduced to or below the resource limit, update the latest application or redetermination form in the individual's case record. Reinstate his Medicaid coverage effective the first day of the month in which his resources are less than or equal to the resource limit.

If the individual does NOT provide verification within 3 months of the suspension effective date that his resources have been reduced to or below the resource limit, close the case administratively and statistically. Do not take any action on his enrollment in the *VaCMS* because his coverage has already been canceled. The individual will have to file a new Medicaid application.

M1480.300 INCOME ELIGIBILITY OF INSTITUTIONALIZED SPOUSE

A. Introduction

The income rules in this section apply only to the institutionalized spouse's eligibility.

The rules in this section supersede all other manual chapters and sections wherever those chapters or sections conflict with these rules. The ABD income policy rules in Virginia DSS Volume XIII, Chapter S08 are used to determine income eligibility for married institutionalized individuals.

1. When Applicable

The income rules apply to an institutionalized spouse regardless of when the continuous period of institutionalization began.

2. When Not Applicable

If the institutionalized spouse no longer meets the definition of an institutionalized spouse in section M1480.010, the income rules in this subchapter do not apply effective the first day of the first full calendar month following the month in which he no longer meets the definition of an institutionalized spouse.

These rules NEVER apply when determining the eligibility of the community spouse. The income rules applicable to non-institutionalized individuals, found in other sections and chapters of the manual, apply to the community spouse.

B. Policy

An institutionalized spouse's income shall be determined as follows without regard to state laws governing community property or division of marital property:

1. Income From Non-trust Property

Unless a DMAS Hearing Officer determines that the institutionalized spouse has proven to the contrary (by a preponderance of the evidence):

a. income paid to one spouse belongs to that spouse;

b. each spouse owns one-half of all income paid to both spouses jointly;

c. each spouse owns one-half of any income which has no instrument establishing ownership [1924(b)(2)(C)];

d. income paid in the name of either spouse, or both spouses and at least one other party, shall be considered available to each spouse in proportion to the spouse's interest. When income is paid to both spouses and each spouse's individual interest is not specified, consider one-half of their joint interest in the income as available to each spouse.

2. Income From Trust Property

Ownership of income from trust property shall be determined pursuant to regular income policy, except as follows:

a. Income is considered available to each spouse as provided in the trust.

b. If a trust instrument is not specific as to the ownership interest in the trust income, ownership shall be determined as follows:

1) Income paid to one spouse belongs to that spouse.

2) One-half income paid to both spouses shall be considered available to each spouse.

3) Income from a trust paid in the name of either spouse or both spouses, and at least one other party, shall be considered available to each spouse in proportion to the spouse's interest in the trust principal. When income from a trust is paid to both spouses and each spouse's individual interest in the trust principal is not specified, consider one-half of their joint interest in the income as available to each spouse.

3. Income Deeming

Do not deem a community spouse's income available to an institutionalized spouse for purposes of determining the institutionalized spouse's Medicaid eligibility for any month of institutionalization (including partial months). For the month of entry into institutionalization and subsequent months, only the institutionalized individual's income is counted for eligibility and patient pay purposes.

The community spouse's income is used only to determine the community spouse monthly income allowance, if any.

4. Income Determination

For purposes of the income eligibility determination of a married institutionalized spouse, regardless of the individual's covered group, income is determined using the income eligibility instructions in section M1480.310 below and chapter S08.

For individuals who are within a spenddown budget period prior to the month in which they become institutionalized, prorate and shorten the spenddown budget period to include months **prior to admission** to long-term care services. A separate monthly budget period is established for each month of receipt of long-term care services.

5. Post-eligibility Treatment of Income

After an institutionalized spouse is determined eligible for Medicaid, his or her patient pay must be determined. See the married institutionalized individuals' patient pay policy and procedures in section M1480.400 below.

M1480.310 ABD 80% FPL AND 300% SSI AND INCOME ELIGIBILITY DETERMINATION

A. Introduction

This section provides those income requirements specific to determinations of eligibility for Medicaid participation in payment of long-term care services.

For ABD individuals, first determine the individual's eligibility in the ABD 80% FPL covered group. If the individual is ineligible in the ABD 80% FPL covered group, determine the individual's eligibility in the 300% SSI covered group.

For purposes of this section, we refer to the ABD and F&C covered groups of "individuals in medical facilities who have income less than or equal to 300% of the SSI individual payment limit" and *the ABD and F&C covered groups of*" individuals receiving Medicaid waiver services who have income less than or equal to 300% of the SSI individual payment limit" as one *comprehensive* covered group. We refer to this comprehensive group as "institutionalized individuals who have income within 300% of SSI" or the "300% SSI group."

B. 300% SSI Group

The income limit for ABD and F&C individuals in the 300% SSI group is 300% of the SSI individual payment limit (see M0810.002.A.3).

1. Gross Income

Income sources listed in section M1460.610 are not considered as income.

Income sources listed in section M1460.611 ARE counted as income.

All other income is counted. The institutionalized spouse's gross income is counted; no exclusions are subtracted.

To determine an income type or source and to determine how to count the income, use the policy and procedures in chapter S08 for all individuals (ABD and F&C) in the 300% SSI group.

Income is projected for the month for which eligibility for LTC is being determined. This calculation is based upon the income received in the past month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount expected to be received.

2. Income Less Than or Equal to 300% SSI Limit

If the individual's gross income is less than or equal to the 300% SSI income limit, enroll the individual in the appropriate CN *aid category (AC)* and determine patient pay according to the policy and procedures found in section M1480.400.

a. Individual Has Medicare Part A

If the individual has Medicare Part A, determine if his income is within the QMB income limit. Calculate the individual's countable income for QMB according to chapter S08, and compare to the QMB limit. If the individual's gross income is less than or equal to the QMB limit, enroll the recipient with the appropriate dual-eligible QMB AC:

- Aged = 022
- Blind = 042
- Disabled = 062

If the income is over the QMB limit, enroll the recipient with the appropriate CN non-QMB AC:

- Aged = 020
- Blind = 040
- Disabled = 060

b. Individual Does Not Have Medicare Part A

If the individual does NOT have Medicare Part A, enroll the ABD recipient with the appropriate CN AC:

- Aged = 020
- Blind = 040
- Disabled= 060

Enroll the F&C recipient with the appropriate CN AC:

- Institutionalized child under age 21= 082
- Institutionalized F&C individual age 21 or older = 060.

3. Income Exceeds 300% SSI Limit

If income exceeds the 300% SSI limit, evaluate the institutionalized spouse as MN. Go to section M1480.330 below.

C. ABD 80% FPL

The income limit for the ABD 80% FPL covered group is 80% of the federal poverty level (see M0810.002.A.5). See section M0320.210 for details about this covered group.

The ABD income policy in chapter S08 is used to determine countable income for the ABD 80% FPL covered group. Income is projected for the month for which eligibility for LTC is being determined. This calculation is based upon the income received in the past month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount expected to be received.

If the individual's countable income is less than or equal to the 80% FPL income limit, enroll the individual with the appropriate ABD 80% FPL Aid Category (AC) and determine patient pay according to the policy and procedures found in section M1480.400. The ABD 80% FPL ACs are:

- Aged = 029
- Blind = 039
- Disabled = 049

M1480.315 THIRD PARTY & LONG-TERM CARE INSURANCE PAYMENTS

A. Payments Made by Another Individual

Payment of an individual's bills (including Medicare supplementary medical insurance or other medical insurance premiums) by a third party directly to the supplier is not income.

Payments made directly to the service provider by another person for the individual's private room or "sitter" in a medical facility are NOT income to the individual. Refer all cases of Medicaid eligible enrollees in nursing facilities who have a "sitter" to DMAS, Division of Aging and Disability Services, for DMAS review to assure that DMAS is not paying the facility for services provided by the sitter.

B. LTC Insurance Policy Payments

The LTC insurance policy must be entered into the recipient's TPL file. The insurance policy type is "H" and the coverage type is "N." *Medicaid* will not pay the nursing facility's claim unless the claim shows how much the policy paid.

If the patient receives the payment from the insurance company, it is **not** counted as income. The patient should assign it to the provider. If the patient cannot do this, or the policy prohibits assignment, the payment should be given directly to the provider. The provider should report the payment as a third party payment on its claim form.

If the patient received the payment and cannot give it to the facility for some reason, then the patient should send the insurance payment to:

DMAS Fiscal Division, Accounts Receivable
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

M1480.320 RETROACTIVE MN INCOME DETERMINATION

A. Policy

The retroactive spenddown budget period is the three months immediately prior to the application month, when none of the months overlap (was included in) a previous MN spenddown budget period in which spenddown eligibility was established. When some of the months overlap a previous MN spenddown budget period in which spenddown eligibility was established, the retroactive spenddown budget period is shortened (prorated) to include only the month (s) which were not included in the previous MN spenddown budget period.

1. Institutionalized

For the retroactive months in which the individual was institutionalized, determine income eligibility on a **monthly basis** using the policy and procedures in this subchapter. A spenddown must be established for a month during which excess income existed.

2. Individual Not Institutionalized

For the retroactive months in which the individual was NOT institutionalized, determine income eligibility for ABD groups using the ABD policy and procedures in chapter S08. Determine income eligibility for F&C groups using policy and procedures in chapter M07. A spenddown must be established for a month(s) during which excess income existed.

3. Retroactive Entitlement

If the applicant meets all eligibility requirements, he is entitled to Medicaid coverage for the month(s) in which all eligibility factors were met.

B. Countable Income

Countable income is that which was actually received in the retroactive month(s). Count the income received in the months in which the individual meets all other Medicaid eligibility requirements.

The countable income is compared to the appropriate income limit for the retroactive month, if the individual was CN in the month. **For the institutionalized MN individual, Medicaid income eligibility is determined monthly.**

C. Entitlement

Retroactive coverage cannot begin earlier than the first day of the third month prior to the application month. When an applicant reports that he received a medical service within the retroactive period, entitlement for Medicaid will begin with the first day of the third month prior to the application month, provided all eligibility factors were met in all three months. If the applicant had excess income in the retroactive period and met his spenddown, he is enrolled beginning the first day of the month in which his retroactive spenddown was met. For additional information refer to section M1510.101.

D. Retroactive Example

EXAMPLE #15: A disabled institutionalized spouse applies for Medicaid on June 5 and requests retroactive coverage for unpaid medical bills that he incurred in March, April, and May. His disability onset date was April 10. He was institutionalized on April 10. The retroactive period is March, April and May. He is not eligible for March because he did not meet a covered group in March. His countable resources are less than $2,000 in April, May and June. The income he received in April and May is counted monthly because he was institutionalized in each month.

His April income is calculated and compared to the monthly 300% SSI income limit. It exceeds that limit. His May income is calculated and compared to the monthly 300% SSI income limit; it is within the limit. Therefore, he is placed on a one-month retroactive spenddown for April, and is enrolled in retroactive Medicaid in the 300% SSI covered group for May.

M1480.330 MEDICALLY NEEDY INCOME & SPENDDOWN

A. Policy

An institutionalized spouse whose income exceeds the 300% SSI income limit must be placed on a monthly MN spenddown if he meets a medically needy MN covered group and has countable resources that are less than or equal to the MN resource limit. His income is over the MN income limit because 300% of SSI is higher than the highest MN income limit for one person for one month.

MN countable income must be calculated to exclude income and portions of income that were counted in the 300% SSI income limit group calculation. Income is determined on a monthly basis and an institutionalized individual's spenddown budget period is one month. The certification period for all long term care cases is 12 months from the last application or redetermination month. This includes MN cases placed on spenddown.

B. Recalculate Income

Evaluate income eligibility for an institutionalized spouse who has income over the 300% SSI income limit using a one-month budget period and the following procedures:

1. ABD MN Covered Groups

The income sources listed in both sections M1460.610 "What is Not Income" and M1460.611 "Countable Income for 300% SSI Group" are NOT counted when determining income eligibility for the ABD MN covered groups. Countable income is determined by the income policy in chapter S08; applicable exclusions are deducted from gross income to calculate the individual's countable income.

The income actually received in the retroactive period is considered for retroactive eligibility. The income expected to be received within the application month is considered when determining eligibility in that month.

The income expected to be received within a month is counted in that month for ongoing eligibility.

a. Start with the gross monthly income figure countable for the ABD MN income determination.

b. Subtract the $20 general income exclusion. If the institutionalized spouse has earned income, subtract the ABD earned income exclusions found in section S0820.500. Subtract any appropriate unearned income exclusions in subchapter S0830.

c. The remainder is the monthly countable ABD MN income.

2. F&C MN Covered Groups

The income sources listed in both sections M1460.610 "What is Not Income" and M1460.611 "Countable Income for 300% SSI Group" are NOT counted when determining income eligibility for the F&C MN covered groups. Countable income is determined by the income policy in chapter M07; applicable exclusions are deducted from gross income to calculate the individual's countable income

Anticipated income is projected for the month for which eligibility is being determined. This calculation is based upon the income received in the prior month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount to be received

a. Start with the gross monthly income figure countable for the F&C MN income determination.

b. If the unit has earned income, subtract the F&C earned income exclusions in section M0720.500 **except** for the $30 + 1/3 exclusion which is not applicable to MN F&C covered groups.

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

d. The remainder is the monthly countable F&C MN income.

D. MN Income Limits

The monthly medically needy (MN) individual income limits are *listed in Appendix 5 to subchapter M0710 and in section M0810.002 A. 4.*

E. Determine Spenddown Liability

Compare monthly countable income to the **monthly** MN individual income limit in the institutionalized spouse's locality.

The amount by which the institutionalized spouse's countable MN income exceeds the MN income limit is the **spenddown liability.**

F. Spenddown Eligibility Procedures

To be eligible for Medicaid coverage, the institutionalized spouse must incur medical expenses in the month in an amount that equals or exceeds the spenddown liability. The policy and procedures for determining if an institutionalized spouse has met the spenddown are the "spenddown eligibility" policy and procedures.

The spenddown eligibility procedures for facility patients differ from the spenddown procedures for Medicaid CBC waiver patients. The expected monthly cost of the facility care (at the Medicaid rate) is projected at the beginning of the month. The cost of CBC is NOT projected.

1. Facility Patients

Facility patients in the MN classification fall into two distinct subgroups for the purpose of spenddown eligibility determination. These subgroups are:

* individuals with a spenddown liability less than or equal to the monthly Medicaid rate for the facility; and

* individuals with a spenddown liability greater than the monthly Medicaid rate for the facility.

a. Determine the Facility's Medicaid Rate

The facility's projected Medicaid rate is the Medicaid per diem multiplied by 31 days.

b. Compare Spenddown Liability

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

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

If the spenddown liability is **less than or equal to** the facility's projected Medicaid rate, the institutionalized spouse is income eligible as medically needy because he meets the spenddown based on the projected Medicaid rate alone.

1) Medicaid eligibility begins the first day of the month. Enroll as eligibility Type 1.

2) The institutionalized spouse has ongoing eligibility for the 12-month application certification period. The individual must file a redetermination after the 12-month certification period ends.

3) If the institutionalized spouse does **NOT** have Medicare Part A, enroll with the appropriate MN PD that follows:

* Aged = **18**
  - Blind = **38**

- Disabled = **058**
- Child Under 21 in ICF/ICF-MR = **098**
- Child Under Age 18 = **088**
- Juvenile Justice Child = **085**
- Foster Care/Adoption Assistance Child = **086**
- Pregnant Woman = **097**.

4) If the institutionalized spouse has Medicare Part A, compare the individual's monthly MN countable income to the QMB monthly income limit for 1 person (see section M0810.002 for the current QMB limit):

   a) When income is less than or equal to the QMB limit, enroll using the appropriate AC that follows:

      - Aged = **028**
      - Blind = **048**
      - Disabled = **068**

   b) When income is greater than the QMB limit, enroll using the appropriate AC that follows:

      - Aged = **018**
      - Blind = **038**
      - Disabled = **058**

5) Patient Pay: Determine patient pay according to section M1480.400 below.

d. SD Liability Is Greater Than Medicaid Rate

If the spenddown liability is **greater than** the facility's Medicaid rate, the institutionalized spouse is NOT eligible unless he incurs medical expenses which meet the spenddown liability in the month. To determine if the spenddown is met, go to section M1480.335 below.

2. Medicaid CBC Waiver Patients

The institutionalized spouse meets the definition of "institutionalized" when he is *authorized* for Medicaid waiver services and the services are being provided. An institutionalized spouse who has been *authorized* for Medicaid waiver services and whose income exceeds the 300% SSI income limit is not eligible for Medicaid until he meets the monthly spenddown liability.

To determine if the spenddown is met, go to section M1480.335 below.

3. PACE Recipients

The individual's spenddown liability and the PACE monthly rate (minus the Medicare Part D premium) establish whether the spenddown eligibility determination can be projected or must be determined retrospectively.

To determine if the spenddown is met, go to section M1480.340 below.

M1480.*335* FACILITY PATIENTS WITH SPENDDOWN LIABILITY GREATER THAN MEDICAID RATE & ALL MN CBC PATIENTS

A. Facility Patients – SD Liability Is Greater Than Medicaid Rate

An MN institutionalized spouse whose spenddown liability is greater than the facility's Medicaid rate is not eligible for Medicaid until he incurs medical expenses that meet the spenddown liability within the month. These determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred. The institutionalized spouse's resources and income must be verified each month before determining if the spenddown was met.

To determine if the institutionalized spouse met the spenddown, use the following procedures:

1. Calculate Private Cost of Care

Multiply the facility's **private** per diem rate by the number of days the institutionalized spouse was actually in the facility in the month. Do not count any days the institutionalized spouse was in a hospital during the month.

The result is the private cost of care for the month.

2. Compare to Spenddown Liability

Compare the private cost of care to the institutionalized spouse's spenddown liability for the month.

3. Cost of Care Greater Than Spenddown Liability

When the private cost of care is **greater than** the institutionalized spouse's spenddown liability, the institutionalized spouse meets the spenddown in the month because of the private cost of care. He is entitled to **full-month coverage** for the month in which the spenddown was met.

Enroll the institutionalized spouse in Medicaid with the begin date of the first of the month, the end date the last day of the month. Go to section M1480.350 below for enrollment procedures. Determine patient pay according to section M1480.440 below.

4. Cost of Care Less Than or Equal To Spenddown Liability

When the private cost of care is less than or equal to the institutionalized spouse's spenddown liability, **determine spenddown on a day-by-day basis** in the month by deducting allowable incurred expenses from the spenddown liability.

To determine spenddown eligibility:

- Go to section M1480.341 below if the institutionalized spouse was NOT previously on a spenddown.
- Go to section M1480.342 below if the institutionalized spouse was previously on a spenddown.

B. All MN CBC Patients

An MN institutionalized spouse who has been *authorized* for Medicaid CBC waiver services is not eligible for Medicaid until he actually incurs medical expenses that meet the spenddown liability within the month. These determinations are made monthly, retrospectively, **after** the month has passed and the expenses have actually been incurred. The private cost of his home-based medical care is deducted on a day-by-day basis as a noncovered medical expense, along with any other incurred medical expenses.

The institutionalized spouse's resources and income must be verified each month before determining if the spenddown was met. To determine if the institutionalized spouse met the spenddown:

* Go to section M1480.341 below if the institutionalized spouse was NOT previously on a spenddown.
* Go to section M1480.342 below if the institutionalized spouse was previously on a spenddown.

M1480.340 MN PACE RECIPENTS

A. Policy

1. Monthly Spenddown Determination

PACE recipients who have income over the 300% of SSI income limit are placed on a monthly spenddown as institutionalized individuals because they have been *authorized* for LTC services.

Unlike CBC, PACE has a capitated monthly rate that is due and payable on the first day of the month. The monthly PACE rate is available from the PACE provider. When a MN individual is in PACE, the amount of allowed PACE expenses is the rate that is due as of the first day of each month.

PACE recipients are not responsible for Medicare Part D premiums, which are included in the monthly PACE rate. **Therefore, the cost of the Medicare Part D premium cannot be used to meet a spenddown and must be subtracted from the monthly PACE rate when determining if the spenddown has been met.**

The individual's spenddown liability and the PACE monthly rate (minus the Medicare Part D premium) establish whether the spenddown eligibility determination can be projected or must be determined retrospectively.

2. Projected Spenddown Determination

If the MN individual's spenddown liability is less than or equal to the monthly PACE rate (minus the Medicare Part D premium), the individual is eligible for Medicaid effective the first day of the month in which the spenddown is met. As long as the individual's spenddown liability and the PACE monthly rate do not change, the individual is enrolled in ongoing coverage.

3. Retrospective Spenddown Determination

If the MN individual's spenddown liability exceeds the monthly PACE rate (minus the Medicare Part D premium), he is not eligible for Medicaid until he actually incurs medical expenses that meet the spenddown liability within the month. The monthly medical expenses are determined retrospectively; they cannot be projected for the spenddown budget period.

Retrospective spenddown eligibility determinations are made monthly after the month has passed and the expenses have actually been incurred. The PACE

rate(minus the Medicare Part D premium) along with other allowable medical and dental expenses are deducted daily and chronologically as the expenses are incurred. The individual's income and resources must be verified each month before determining if the spenddown has been met. See M1470.530 for allowable medical deductions.

When incurred medical expenses equal or exceed the monthly spenddown liability, the individual is eligible for the full month of Medicaid coverage beginning the first day of the month and ending the last day of the month.

M1480.341 NOT PREVIOUSLY ON SPENDDOWN

A. Procedure

To determine eligibility in the one-month budget period for an institutionalized spouse who has NOT previously been on a spenddown, take the following actions:

* deduct old bills,
* deduct carryover expenses from the retroactive period,
* deduct medical/remedial care expenses incurred within the budget period (month).

Use the "Medical Expense Record-Medicaid" found in Appendix 1 to subchapter M1340 to document expenses and file it in the case record.

If the institutionalized spouse was on a spenddown in the retroactive period, whether or not the retroactive spenddown was met, go to section M1480.342 below.

B. Old Bills

Old bills for medical, dental, or remedial care services received prior to the retroactive period based on the initial application that can be deducted are:

1. Paid by Public Program

Expenses for medical services for which the applicant was legally liable received on or after December 22, 1987, which were provided, covered, or paid for by a public state or local government program, can be deducted. The amount deducted is the amount that the applicant would have been liable for if the service had not been covered by a public program, up to the spenddown liability amount.

2. Legally Liable

Expenses incurred for medical services that the applicant is legally liable to pay are deducted. For the expense to be deducted:

* the applicant must still owe the service provider a specific amount for the service and present current verification of the debt;

* the expense (or remainder of the expense) must not have been forgiven or written-off by the provider; and

  a claim for the expense must have been submitted to the liable third party and the applicant must provide evidence of the third party's payment denial or the amount paid for the expense.

3. Amount Deducted

The amount deducted is the balance of the old bills owed by the applicant as of the first day of the first prospective budget period, less any portion of the amount that was used to meet the retroactive spenddown.

4. When Deducted

Allowable old bills are deducted on the first day of the budget period.

C. Carry-over Expenses from Retroactive Period

Paid or unpaid expenses incurred during the retroactive period of an initial application can be deducted IF:

* the individual established eligibility in the retroactive budget period **without having to meet a spenddown**, AND

* the expenses are allowable by kind of service.

1. Amount Deducted

The amount deducted is the amount of the expense owed as of the beginning of the budget period, up to the spenddown liability amount.

2. When Deducted

Allowable expenses carried over from the retroactive period are deducted on the first day of the one-month budget period.

D. Expenses Incurred Within the Budget Period

Allowable expenses incurred on or after the beginning of the one-month budget period that can be deducted are:

1. Paid By Public Program

Allowable incurred expenses for medical or remedial care which the applicant received after the beginning of the budget period which were provided, covered, or paid for by a public state or local government program can be deducted. The incurred expense amount that can be deducted is the amount that the applicant would have been liable for if the service had not been covered by a public program, up to the spenddown liability amount.

2. Legally Liable

Allowable expenses (paid or unpaid) incurred during the budget period for which the applicant is legally liable are deducted. To be deducted, the claim for the expense must have been submitted to the liable third party. The applicant must provide evidence of the third party's payment denial or the February spenddown eligibility evaluated.

amount paid for the expense.

3. Amount Deducted

The amount that is deducted is the amount that was not or will not be paid by a third party, up to the spenddown liability amount. When determining the amount of long-term care expense incurred, use the daily private rate.

4. When Deducted

The incurred expenses are deducted in chronological order on the date the expense is incurred. The incurred expenses are deducted even if they have been paid.

EXAMPLE #16: Mr. Not lives in Group III and applied for Medicaid on November 21, 1999, as a disabled institutionalized spouse. He is in a nursing facility and was admitted on November 1, 1999. The MDU determined that he is disabled. He has not been on spenddown before. He has a $8,400 hospital bill and a $1,500 physician's bill for July 10 to July 20, 1998 (total $9,900) on which he still owes a total of $9,000. He has a $578 outpatient hospital bill for October 3, 1998. He has no health insurance. His income is $1,800 per month disability benefit from a private company. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His resources are within the Medicaid limit in November 1999 (application month).

He is not eligible as CN because his $1,800 gross income exceeds the 300% SSI income limit. The facility's Medicaid rate is $45 per day. His MN income eligibility is calculated:

$1,800	disability benefit
- 20	general income exclusion
1,780	MN countable income.
- 325	MNIL for 1 month for 1 person in Group III
$1,455	spenddown liability

The facility rate for the admission month is calculated as follows:

$ 45	Medicaid per diem
x 30	days
$1,350	facility Medicaid rate admission month

The $1,455 spenddown liability is greater than the Medicaid rate of $1,350.

Because he was not previously on spenddown, his verified old bills for July 1999 are deducted first from the spenddown liability. He owes the hospital $8,000 and the physician $1,000, total $9,000, as of November 1, 1999 (the first day of the budget period). His eligibility is calculated:

$1,455	spenddown liability
- 9,000	old bills owed 11-01-99
$ 0	spenddown balance on 11-1-99

Because the spenddown was met on November 1, Mr. Not is entitled to medically needy Medicaid for the budget period 11-1-99 through 11-30-99.

The old bills balance, or $7,545 ($9,000- 1,455 = $7,545) not used to achieve eligibility can be deducted in the subsequent month(s) from the subsequent spenddown liability if he continues to establish spenddown eligibility.

M1480.342 PREVIOUSLY ON SPENDDOWN

A. Procedure

To determine spenddown eligibility for the budget period for an institutionalized spouse who has previously been on spenddown, take the following actions:

B. Prorate Spenddown Prior To Institutionalization

If the institutionalized spouse is in a spenddown budget period when he becomes institutionalized, prorate the spenddown period and recalculate the spenddown liability for the months prior to the month in which he became institutionalized.

C. Old Bills

Deduct the remaining balance on old bills incurred prior to the retroactive period if there has been no break between spenddown budget periods and no break in spenddown eligibility (each spenddown was met in all prior budget periods). Only the amount NOT deducted in a previous spenddown, and which remains the liability of the individual, can be deducted.

D. Current Payments on Bills Incurred Prior to Retroactive Period

Deduct only the amount of the current payment(s) actually made on expenses incurred prior to the retroactive period, and which were not used previously to achieve eligibility, when there has been a break between spenddown budget periods or a break in spenddown eligibility (spenddown eligibility was NOT established in a prior spenddown budget period).

1. Legally Liable

Current payments for expenses that the applicant is legally liable to pay are deducted. For the expense to be deducted:

* the applicant must still owe the service provider a specific amount for the service and present current verification of the payment amount and date(s) paid.

* a claim for the expense must have been submitted to the liable third party and the applicant must provide evidence of the third party's payment denial or the amount paid for the expense.

2. Amount Deducted

The amount deducted is the amount of the payment.

3. When Deducted

Allowable current payments are deducted on the date the payments are made.

E. Expenses from Retroactive Spenddown Budget Period

Expenses from the retroactive spenddown budget period that were not used to achieve eligibility can be deducted from the spenddown liability balance.

1. Retroactive Spenddown Eligibility Achieved

Deduct expenses incurred during the retroactive period which were not previously used to establish eligibility, IF:

a. the individual established eligibility in the retroactive spenddown budget period AND

b. the expenses are:

* paid or unpaid;

* allowable by kind of service; and

* carried over from the retroactive spenddown budget period because the individual had a spenddown liability in the retroactive period that was met without deducting all such paid or unpaid expenses incurred in the retroactive spenddown budget period.

c. The amount deducted is the amount of the expense owed to the provider as of the beginning of the spenddown budget period, less the amount used to meet the retroactive spenddown, up to the spenddown liability amount.

d. Allowable expenses from the retroactive spenddown budget period are deducted on the first day of the prospective spenddown budget period.

2. Retroactive Spenddown Eligibility NOT Achieved

Deduct only **current payments** made on expenses incurred during the retroactive spenddown budget period. When there has been a break in spenddown eligibility, only current payments made on old bills based on a prior Medicaid application can be deducted from the current spenddown liability. For the current payment to be deducted:

a. the applicant must still owe the service provider a specific amount for the service and present current verification of the payment amount and date(s) paid,

b. a claim for the expense must have been submitted to the liable third party and the applicant must provide evidence of the third party's payment denial or the amount paid for the expense.

The amount deducted is the amount of the current payment made.

Current payments on expenses from the retroactive spenddown budget period are deducted on the date the payment is made.

F. Expenses Incurred Within Spenddown Budget Period

Allowable expenses incurred within the spenddown budget period that can be deducted are:

1. Paid By Public Program

Allowable incurred expenses for medical or remedial care which the applicant received after the beginning of the spenddown budget period which were provided, covered, or paid for by a public state or local government program.

The incurred expense amount that can be deducted is the amount that the applicant would have been liable for if the service had not been covered by a public program, up to the spenddown liability amount.

2. Legally Liable

Allowable expenses (paid or unpaid) incurred after the beginning of the spenddown budget period for which the applicant is legally liable are deducted. See subsection M1340.100 B.1. for a description of legal liability. To be deducted, the claim for the expense must have been submitted to any liable third party. The applicant must provide evidence of the third party's payment denial or the amount paid for the expense.

3. Amount Deducted

The amount that is deducted is the amount that was not or will not be paid by a third party, up to the spenddown liability amount.

4. When Deducted

The incurred expenses are deducted in chronological order on the date the expense is incurred. The incurred expenses are deducted even if they have been paid.

G. When Spenddown Is Met

When the institutionalized spouse incurs medical expenses which meet the spenddown on any day in the month, he is entitled to **full-month coverage** for the month in which the spenddown was met.

Enroll the institutionalized spouse in Medicaid with the begin date of the first of the month, the end date the last day of the month, eligibility Type 4. Go to section M1480.350 below for enrollment procedures. Determine patient pay according to section M1480.440 below.

H. Example--Retroactive Spenddown, Institutionalized Spenddown In Admission Month

EXAMPLE #17: Ms. Was lives in Group I and applied for Medicaid on January 6, 2000, as disabled. She is in a nursing facility and was admitted on January 5, 2000. Mr. Was is her community spouse; he lives in their Group I locality home. Her countable resources are less than the Medicaid resource limit in January, and were less than the Medicaid resource limit in all months in the retroactive period. She applied for Medicaid in December 1998 and was on a spenddown from December 1, 1998 through May 31, 1999, which she met on December 1, 1998.

She verifies that she has unpaid balances of $2,300 on a hospital bill and $1,500 on a physician's bill (total = $3,800) for services received August 10 to August 12, 1998 (prior to the retroactive period based on the December 1998 application) on which she pays $50 a month. These balances were not used to meet her December 1998 through May 1999 spenddown. She also has a $678 outpatient hospital bill for services dated November 13, 1999, in the retroactive period. She has no health insurance and is not eligible for Medicare. She has no old bills based on her January 2000 re-application (no unpaid medical expenses incurred in June, July, August or September 1999).

She was not institutionalized in the retroactive period. Her income in the retroactive budget period was $400 per month SSA disability. The retroactive budget period based on her January 2000 re-application is October, November and December 1999; the income limit is $650.

Her retroactive spenddown liability is $490.

$400	SSA disability
- 20	general income exclusion
380	countable income
x 3	months
$1,140	countable income for retroactive budget period
- 650	MNIL for retroactive budget period Group I
$ 490	retroactive spenddown liability

Since there was a break in her spenddown eligibility (the period June, July, August and September 1999 were not covered by a Medicaid application), only the current payments she is making on the August 1998 bills can be deducted from her retroactive spenddown liability. She paid the hospital and the physician $50 each ($100 total) on October 5, November 4 and December 5, 1999. Her retroactive eligibility is calculated:

$ 490	retroactive spenddown liability
- 100	current payment 10-5-99 (Aug.1998 hospital & physician bills)
390	spenddown balance on 10-5-99
- 100	current payment 11-4-99 (Aug.1998 hospital & physician bills)
290	spenddown balance on 11-3-99
- 678	outpatient expense 11-13-99 ($388 of expense carried over)
$ 0	spenddown balance on 11-13-99

The retroactive spenddown was met on November 13, 1999. Ms. Was' retroactive Medicaid entitlement was November 13, 1999 through December 31, 1999.

Her income starting January 1, 2000 increased. Her SSA is $620 per month and she began receiving a Civil Service Annuity of $1,300 per month; total income is $1,920 per month. Because this exceeds the 300% SSI income limit, her medically needy income eligibility is calculated as follows:

$1,920.00 total monthly income
- 20.00 general income exclusion
1,900.00 countable income
- 216.67 MNIL for 1 month for 1 person in Group I
$1,683.33 spenddown liability

The facility's private rate is $58 per day; the Medicaid rate is $45 per day. The facility Medicaid rate for the admission month is calculated as follows:

$ 45 Medicaid per diem
x 27 days
$1,215 Medicaid rate admission month

Her spenddown liability of $1,683.33 is greater than the Medicaid rate of $1,215. Therefore, she is not eligible until she has actually incurred medical bills that equal or exceed her spenddown liability in January. The worker is processing the application on February 2. Mrs. Was was in the facility from January 5 through January 31. The facility's private cost is calculated:

$ 58 private per diem
x 27 days in facility in January
$1,566 private cost of care in January

The private cost of care for January, $1,566, is less than Mrs. Was's spenddown liability of $1,683.33. Therefore, her spenddown eligibility for January must be determined on a daily basis. The prospective budget period is January 1 through January 31, 2000. Since she had a break in spenddown eligibility, only the current payments she is making on the August 1998 bills can be deducted from her spenddown liability. She paid the hospital $50 and the physician $50 each ($100 total) on January 5, 2000. Her spenddown eligibility is determined:

$1,683.33 prospective spenddown liability
- 388.00 carry-over expense (balance of 11-13-99 outpatient expense)
- 100.00 current payment Aug,1998 hospital & physician bills 1-1-00
1,195.33 spenddown balance on 1-1-00
- 812.00 14 days private rate @ $58 per day (1-5 through 1-18)
383.33 spenddown balance on 1-19-00
- 348.00 6 days private rate @ $58 per day (1-19 through 1-23)
35.33 spenddown balance on 1-23-00
- 58.00 private cost of care for 1-24-00
$ 0 spenddown balance on 1-24-00

Mrs. Was met her spenddown on January 24, 2000. On February 3, the worker enrolls Mrs. Was in Medicaid as medically needy with eligibility begin date 1-1-2000 and end date 1-31-2000. The worker sends her a "Notice of Action on Medicaid" stating her Medicaid coverage dates and asking her to bring or send in her medical bills for February if she wants her *February spenddown eligibility evaluated.*

M1480.350 SPENDDOWN ENTITLEMENT

A. Entitlement After Spenddown Met

When an institutionalized spouse meets a spenddown within a month, the begin date of eligibility will be the first day of the month in which the spenddown was met. Eligibility will end on the last day of the month in which the spenddown was met.

B. Procedures

1. Coverage Dates

Coverage begin date is the first day of the month; the coverage end date is the last day of the month.

2. *AC*

Enroll the institutionalized spouse in one of the following ACs:

- Aged = 018
- Blind = 038
- Disabled = 058
- Child Under 21 in ICF/ICF-MR = 098
- Child Under Age 18 = 088
- Juvenile Justice Child = 085
- Foster Care/Adoption Assistance Child = 086
- Pregnant Woman = 097

3. Patient Pay

Determine patient pay according to section M1480.400 below.

4. Notices & Re-applications

The institutionalized spouse on a spenddown must have his eligibility re-evaluated monthly, unless he is in a facility and the spenddown liability is less than or equal to the Medicaid rate. The institutionalized spouse must complete an annual redetermination.

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	\$2,177.50	7-1-21
	\$2,288.75	7-1-22
	$2,465	*7-1-23*
C. Maximum Monthly Maintenance Needs Allowance	\$3,435.00	1-1-22
	\$3,715.50	1-1-23
	$3,853.50	*1-1-24*
D. Excess Shelter Standard	\$653.25	7-1-21
	\$686.63	7-1-22
	$739.50	*7-1-23*

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	*10-1-23*
	\$*524.00*	4 or more household members	*10-1-23*

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).

B. What Is Patient Pay

The institutionalized spouse's gross monthly income, less all appropriate deductions according to this section, constitutes the patient pay - the amount of income the institutionalized spouse will be responsible to pay to the LTC facility or waiver services provider. The community spouse's and family member's monthly income allowances rules for patient pay apply to all institutionalized spouses with community spouses, regardless of when institutionalization began.

C. Dependent Allowances

A major difference in the institutionalized spouse patient pay policy is the allowance for a dependent child and for a dependent family member. If the institutionalized spouse has a dependent child, but the dependent child does NOT live with the community spouse, then **NO** allowance is deducted for the child. Additionally, an allowance may be deducted for other dependent family members living with the community spouse.

D. Home Maintenance Deduction

A major difference in the institutionalized spouse patient pay policy is the home maintenance deduction policy. A married institutionalized individual with a community spouse living in the home is **NOT allowed** the home maintenance deduction because the community spouse allowance provides for the home maintenance, **UNLESS**:

- the community spouse is not living in the home (e.g., the community spouse is in an ACR), and
- the institutionalized spouse still needs to maintain their former home.

***E. VaCMS* Patient Pay Process**

The patient pay is calculated in *VaCMS*. The patient pay must be updated in *in the system* whenever the patient pay changes, but at least once every 12 months. Refer to the *VaCMS Help feature* for information regarding data entry.

The Automated Response System (ARS) and the MediCall System convey the necessary patient pay information to the provider.

M1480.430 ABD 80% FPL and 300% SSI PATIENT PAY CALCULATION

A. Patient Pay Gross Monthly Income

Determine the institutionalized spouse's patient pay gross monthly income for patient pay. Use the gross income policy in section M1480.310 B.1 for both covered groups.

B. Subtract Allowable Deductions

If the patient has no patient pay income, he has no patient pay deductions.

When the patient has patient pay income, **deduct the following amounts in the following order** from the institutionalized spouse's gross monthly patient pay income. Subtract each subsequent deduction as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.

- personal needs or maintenance allowance,
- community spouse monthly income allowance,
- family member's income allowance,
- non-covered medical expenses,
- home maintenance deduction, if applicable.

C. Personal Needs or Maintenance Allowance

The personal needs allowance for an institutionalized spouse in a facility is different from the personal maintenance allowance of an institutionalized spouse in a Medicaid CBC waiver or PACE. The amount of the personal needs or maintenance allowance also depends on whether or not the patient has a guardian or conservator who charges a fee, and whether or not the patient has earnings from employment that is part of the treatment plan.

1. Facility Care

a. Basic Allowance

Deduct the $40 basic allowance, effective July 1, 2007. For prior months, the personal needs allowance is $30.

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 income) for guardianship fees, IF:

* the patient has a legally appointed guardian and/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.

. Special Earnings Allowance

Deduct a special earnings allowance if the patient participates in a work program as part of treatment. The special earnings allowance is deducted from earned income only. Deduct:

* the first $75 of gross monthly earnings, PLUS
  * ½ the remaining gross earnings,
  * up to a maximum of $190 per month.

The special earnings allowance cannot exceed $190 per month.

d. Example - Facility Care Personal Needs Allowance

EXAMPLE #18: A patient in the nursing facility is employed as a telephone salesperson as part of his plan of care in the facility. He has a legally appointed conservator who charges a 2% fee. His only income is gross earnings of $875 per month. His special earnings allowance is calculated first:

$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, 2021 through December 31, 2021: $1,311
- January 1, 2022 through December 31, 2022: $1,388
- January 1, 2023 through December 31, 2023: $1,509
- *January 1, 2024 through December 31, 2024: $1,556*

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:

- for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (*$2,829* in 2024) per month.

- for individuals employed at least 4 but less than 20 hours per week, all earned income up to 200% of SSI (*$1,886* in *2024*) 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

D. Community Spouse Monthly Income Allowance

The community spouse monthly income allowance is the difference between the community spouse's gross monthly income and the minimum monthly maintenance needs allowance determined below.

1. Determine Minimum Monthly Maintenance Needs Allowance (MMMNA)

Calculate the minimum monthly maintenance needs allowance using the following procedures **(do NOT round any cents to a dollar)**:

a. the monthly maintenance needs standard, plus

b. an excess shelter allowance for the community spouse's principal place of residence, if applicable. The excess shelter allowance is the amount by which the total of verified allowable expenses in 1) through 5) below **exceeds** the excess shelter standard.

Allowable expenses are:

1) rent,
2) mortgage (including interest and principal),
3) taxes and insurance,
4) any maintenance charge for a condominium or cooperative, and
5) the utility standard deduction, unless utilities are included in the community spouse's rent or maintenance charges.

The utility standard deduction for a household of 1-3 members is different than the deduction for households of 4 or more members.

2. Maximum Allowance

The minimum monthly maintenance needs allowance calculated above cannot exceed the maximum.

3. DMAS Hearing Officer or Court Ordered Amount

The Eligibility Worker has no flexibility to calculate a minimum monthly maintenance needs allowance greater than the one calculated using the steps listed above. If the individual states there is a need for a greater amount, he has the right to file an appeal using the procedures in chapter M16. A Hearing Officer may increase the community spouse income allowance if it is determined that exceptional circumstances resulting in extreme financial duress exist. If the individual disagrees with the outcome of the appeal, he may then appeal the decision through his local circuit court.

The EW cannot accept a court order for a greater community spouse allowance unless the individual has exhausted the Medicaid administrative appeals process.

4. Calculate Community Spouse Monthly Income Allowance

If no court order or DMAS Hearing Officer determination of the monthly maintenance needs allowance exists, use the following procedures to calculate the community spouse monthly income allowance:

a. Determine Gross Monthly Income

Determine the community spouse's gross monthly income using the income policy in section M1480.310. Do not count any payment that is made to the community spouse by the institutionalized spouse, such as the community spouse's portion of an augmented VA benefit which is included in the institutionalized spouse's VA check. This amount will be counted in the institutionalized spouse's income.

b. Subtract From MMMNA

Subtract the community spouse's gross income from the minimum monthly maintenance needs allowance from D.1. above. **Do NOT round any cents to a dollar.** The remainder is the community spouse monthly income allowance (a negative number equals $0).

c. Remainder Greater Than $0

If the remainder is greater than $0, the remainder is the amount of the community spouse monthly income allowance that is deducted from the institutionalized spouse’s patient pay.

d. Remainder Less Than or Equal To $0

If the remainder is $0 or less, the community spouse monthly income allowance is $0.

5. Deduct From Patient Pay

Deduct the community spouse monthly income allowance determined above from the institutionalized spouse's patient pay income UNLESS the institutionalized spouse or his authorized representative does not actually make it available to the community spouse or to another person for the benefit of the community spouse. *Should the community spouse opt to take a lesser amount than the amount to which the community spouse is entitled; deduct only the amount that the community spouse actually takes as an allowance. If the community spouse is a Medicaid applicant or enrollee, the income allowance is countable income to the community spouse.*

6. Example--Allowance Not Deducted

EXAMPLE #21: (Using January 2000 figures)

A community spouse has $800 per month gross income; $600 from Civil Service and $200 VA pension. The community spouse's shelter expenses are: mortgage, taxes, and insurance of $439 per month, plus the standard utility allowance of $168 for a household of one person, totaling $607. Total shelter costs of $607 exceed the excess shelter standard of $415 by $192. The excess shelter allowance is $192.

The minimum monthly maintenance needs allowance (MMMNA) is determined as follows:

$1,383.00	monthly maintenance needs standard
+ 192.00	excess shelter allowance
$ 1,575.00	MMMNA (less than maximum)

The community spouse monthly income allowance is calculated:

$1,575.00	MMMNA
- 800.00	community spouse's monthly gross income
$ 775.00	community spouse monthly income allowance

The institutionalized spouse has monthly income of $1,100. However, he refuses to give the monthly income allowance to his spouse at home; therefore, the community spouse monthly income allowance cannot be deducted. His patient pay is calculated:

$1,100	gross income
- 30	personal needs allowance
$1,070	patient pay

7. Example--Allowance Deducted

EXAMPLE #22: (Using January 2000 figures)

A community spouse has $900 per month gross income from Social Security. The community spouse's shelter expenses are: mortgage, taxes, and insurance of $502 per month, plus the standard utility allowance of $168 for a household of one person, totaling $670. Total shelter costs of $670 exceed $415 by $255. The excess shelter allowance is $255.

The minimum monthly maintenance needs allowance (MMMNA) is determined as follows:

$1,383	monthly maintenance needs standard
+ 255	excess shelter allowance
$1,638	MMMNA

The community spouse monthly income allowance is calculated:

$1,638 MMMNA
- 900 community spouse's gross income
$ 738 community spouse monthly income allowance

The institutionalized spouse has monthly income of $700. He agrees to give the monthly income allowance to his spouse at home; therefore, the community spouse monthly income allowance is deducted. His patient pay is calculated:

$700 gross patient pay income
- 30 personal needs allowance
$670 remainder
- 670 community spouse income allowance
$ 0 patient pay

NOTE: The community spouse monthly income allowance of $738 is greater than the income remaining after the personal needs allowance is deducted, so only $670 is deducted from patient pay for the community spouse monthly income allowance.

E. Family Member's Income Allowance

To be eligible for a family member's income allowance, the family member (as defined in section M1480.010) must live with the community spouse.

1. Minor Child NOT Living With Community Spouse

If an institutionalized spouse has a minor child who is **not** living with the community spouse, **no allowance** is calculated for that child and no deduction from the institutionalized spouse's income is made for that child.

2. Family Member Income Allowance Deductions

The family member income allowance is an amount equal to 1/3 of the amount by which the monthly maintenance needs standard exceeds the amount of the family member's gross monthly income: (maintenance needs standard - family member's income) ÷ 3 = family member's income allowance.

First, deduct the allowance(s) for minor child(ren) living with the community spouse in the home. Deduct other family members' allowances from patient pay after deducting the minor child(ren)'s allowance(s).

3. Calculate Family Member's Allowance

Calculate each family member's allowance as follows:

a. Subtract the family member's gross monthly income from the monthly maintenance needs standard. If the remainder is $0 or less, STOP. The family member is not entitled to an allowance.

b. Divide the remainder by 3.

c. The result is the family member's monthly income allowance. Do NOT round any cents to a dollar.

4. Deduct Family Member's Allowance

Deduct the family member(s)' monthly income allowance(s) from the institutionalized spouse's patient pay income. Do NOT deduct the family member's allowance if the family member does not accept the allowance.

5. Example-- Family Member's Allowance

EXAMPLE #23: (Using July 2000 figures)
The couple's minor child lives with the community spouse. The child has no income. The child's family member maintenance allowance is 1/3 of $1,406.25 which is *$468.75.*

The community spouse's father lives with the community spouse and receives $300 per month SSA, which is his only income. The monthly family member allowance for the father is calculated as follows:

$1,406.25	monthly maintenance needs standard
- 300.00	father's income
$1,106.25	remainder
÷ 3	(divide by 3)
$ 368.75	family member maintenance allowance for father

The institutionalized spouse's income is $1,200. The community spouse has no community spouse monthly income allowance in this example, so the institutionalized spouse's patient pay is calculated as follows:

$1,200.00	institutionalized spouse's patient pay income
- 30.00	personal needs allowance
1,170.00	
- 468.75	child's family member's income allowance
701.25	
- 368.75	father's family member's income allowance
$ 332.50	patient pay

F. Noncovered Medical Expenses

Incurred medical and remedial care expenses recognized under State law, but not covered under the Medicaid State Plan and not subject to third party payment are deducted from patient pay after all allowances are deducted.

See section M1470.230 for facility patients, section M1470.430 for Medicaid CBC waiver patients *or section M1470.530 for PACE recipients* for specific instructions in determining allowable noncovered medical expense deductions from patient pay.

G. Home Maintenance Deduction

A married institutionalized individual with a community spouse living in the home is **NOT allowed** the home maintenance deduction, because the community spouse allowance provides for the home maintenance, **UNLESS**:

- the community spouse is not living in the home (e.g., the community spouse is in an ACR), AND
- the institutionalized spouse still needs to maintain their former home.

H. Patient Pay

Compare the **remaining income** (patient pay gross monthly income minus allowable deductions) to the Medicaid rate for the month. The patient pay is the lesser of the two amounts.

I. Example--300% SSI Group Patient Pay

EXAMPLE #25: (Using July 2000 figures)

Mrs. Bay is a disabled institutionalized spouse who first applied for Medicaid for long term care services in July. She was admitted to the facility in June, but she is not eligible for Medicaid in the retroactive months because of excess resources. She has a monthly SSA benefit of $1,000 and a monthly private pension payment of $400. She has Medicare Parts A & B and private Medicare supplement health insurance which costs $75 per month. Her spouse, Mr. Bay, still lives in their Group II home with their dependent son, age 19 years. Mr. Bay has income of $1,500 per month from CSA. Their son has no income. Mrs. Bay's income is less than the 300% SSI income limit, so she is eligible for ongoing Medicaid coverage beginning July 1. She is enrolled in Medicaid in AC 060.

Her patient pay for July and subsequent months is determined. The community spouse monthly income allowance is calculated first:

$1,406.25	monthly maintenance needs standard
+ 200.00	excess shelter allowance
1,606.25	MMMNA (minimum monthly maintenance needs allowance)
-1,500.00	community spouse's gross income
$ 106.25	community spouse monthly income allowance

The family member monthly income allowance for their son is calculated:

$1,406.25	monthly maintenance needs standard
- 0	son's income
1,406.25	amount by which the standard exceeds the son's income
÷ 3	
$ 468.75	family member's monthly income allowance

Mrs. Bay has old bills totaling $200, dated the prior January. She has no noncovered expenses from the retroactive period because she paid the nursing facility in full through June. She is eligible in the 300% SSI group and is not a QMB; therefore, her Medicare premium is deducted from her patient pay for the first two months of Medicaid coverage (July and August). Her patient pay for July is calculated as follows:

$1,000.00	SSA
+ 400.00	private pension
1,400.00	total gross income

1,400.00	total gross income
- 30.00	PNA (personal needs allowance)
-106.25	community spouse monthly income allowance
-468.75	family member's monthly income allowance
795.00	
-120.50	Medicare premium & health insurance premium
-200.00	old bills
$474.50	remaining income for patient pay (July)

Her patient pay for August is calculated as follows:

$1,000.00	SS
+ 400.00	private pension
1,400.00	total gross income
- 30.00	PNA (personal needs allowance)
- 106.25	community spouse monthly income allowance
- 468.75	family member's monthly income allowance
795.00	
- 120.50	Medicare premium & health insurance premium
$ 674.50	remaining income for patient pay (August)

Mrs. Bay's patient pay for September is calculated as follows:

$1,000.00	SS
+ 400.00	private pension
1,400.00	total gross income
- 30.00	PNA (personal needs allowance)
- 106.25	community spouse monthly income allowance
- 468.75	family member's monthly income allowance
795.00	
- 75.00	health insurance premium
$ 720.00	remaining income for patient pay (September)

The worker completes the VaCMS Patient Pay process for July, August and September. VaCMS generates and sends a "Notice of *Patient Pay Responsibility*" to Mr. Bay showing Mrs. Bay's patient pay for July, August and September and each month's patient pay calculation.

M1480.440 MEDICALLY NEEDY PATIENT PAY

A. Policy

When an institutionalized spouse has income exceeding 300% of the SSI payment level for one person, he is classified as medically needy (MN) for income eligibility determination. Because the 300% SSI income limit is higher than the MN income limits, an institutionalized spouse whose income exceeds the 300% SSI limit will be on a spenddown. He must meet the spenddown liability to be eligible for Medicaid as MN. See sections M1480.330, 340 and 350 above to determine countable income, the spenddown liability, and to determine when an institutionalized spouse's spenddown is met.

Section 1924 (d) of the Social Security Act contains rules which protect portions of an institutionalized spouse's income from being used to pay for the cost of institutional care. Protection of this income is intended to avoid the impoverishment of a community spouse. In order to insure that an institutionalized spouse will have enough income for his personal needs or maintenance allowance, the community spouse income allowance and the family members' income allowance, an institutionalized spouse who meets a spenddown is granted a full month's eligibility. The spenddown

determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred. An institutionalized spouse's resources and income must be verified each month before determining if the spenddown has been met. When the spenddown is met, an institutionalized spouse's patient pay for the month is calculated.

1. Patient Pay Deductions

Medicaid must assure that enough of an institutionalized spouse's income is "protected" for his personal needs, the community spouse and family member's income allowances, and noncovered medical expenses, NOT including the facility, CBC or PACE cost of care.

2. When Patient Pay Is Not Required

Intermediate Care Facility for the Mentally Retarded (ICF-MR) and Institution for Mental Diseases (IMD) services are not covered for medically needy (MN) eligible recipients. Therefore, a patient pay determination is not required when a MN enrolled recipient resides in an IMD or ICF-MR.

B. Patient Pay Procedures

Determine an MN institutionalized spouse's patient pay using the policy and procedures in the sections below:

* Facility Patient Pay - Spenddown Liability Less Than or Equal to Medicaid Rate (section M1480.450)

* Facility Patient Pay - Spenddown Liability Greater Than Medicaid Rate (section M1480.460)

- CBC - MN Institutionalized Spouse Patient Pay (section M1480.470)

- PACE - MN Institutionalized Spouse Patient Pay (section M1480.480).

M1480.450 FACILITY PATIENT PAY - SPENDDOWN LIABILITY LESS THAN OR EQUAL TO MEDICAID RATE

A. Policy

An MN institutionalized spouse in a facility whose spenddown liability is less than or equal to the Medicaid rate is eligible for a full month's Medicaid coverage effective the first day of the month, based on the projected Medicaid rate for the month. Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay his community spouse and family member allowances, and his personal needs and noncovered expenses not used to meet the spenddown. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability to the provider.

B. Procedures

Determine patient pay for the month in which the spenddown is met using the procedures below.

1. Patient Pay Gross Monthly Income

Determine the institutionalized spouse's patient pay gross monthly income according to section M1480.330 (including any amounts excluded in determining MN countable income and the spenddown liability).

2. Subtract Patient Pay Deductions

Subtract the following from the patient pay gross monthly income in the following order as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.

a. a personal needs allowance (per section M1480.430 C.),

b. a community spouse monthly income allowance, if appropriate (per section M1480.430 D.),

c. a family member's income allowance, if appropriate (per section M1480.430 E.),

d. any allowable noncovered medical expenses (per section M1470.230) **including** any old bills and carry-over expenses,

e. a home maintenance deduction, if appropriate (per section M1480.430 G.).

The result is the **remaining income** for patient pay.

3. Patient Pay

Compare the remaining income for patient pay to the Medicaid rate for the month. The patient pay is the lesser of the two amounts.

C. Example—Facility Spenddown Liability Less Than Medicaid Rate, Community Spouse Allowance

EXAMPLE #24: (Using July 2000 figures)
Mr. Hay is an institutionalized spouse who applied for Medicaid in July. He was admitted to the facility the prior November. He has a monthly CSA benefit of $1,700 and a monthly Seminole Indian payment of $235. He has Medicare Parts A & B and Federal Employees Health Insurance which costs $75 per month. He last lived outside the facility in a Group III locality. His wife, Mrs. Hay, still lives in their home; she has income of $500 per month from CSA. They have no dependent family members living with Mrs. Hay. Mr. Hay's total income exceeds the 300% of SSI income limit. His MN eligibility is determined for July. The MN determination results in a monthly spenddown liability of $1,355:

$1,700	monthly MN income (Seminole Indian payment excluded)
- 20	exclusion
1,680	countable MN income
- 325	MN limit for 1 (Group III)
$1,355	spenddown liability for month

The facility's Medicaid rate is $45 per day, or $1,395 for a 31-day month. By projecting the month's cost of facility care, Mr. Hay meets his spenddown effective the first day of the month and is eligible for Medicaid effective July 1. He is enrolled in Medicaid effective July 1 in AC 018.

The community spouse monthly income allowance is calculated:

$1,406.25	monthly maintenance needs standard
+ 0	no excess shelter allowance
1,406.25	MMMNA (minimum monthly maintenance needs allowance)
- 500.00	community spouse's gross income
$ 906.25	community spouse monthly income allowance

His patient pay is calculated as follows:

$1,700.00	CSA
+ 235.00	Seminole Indian payment (counted for patient pay)
1,935.00	total patient pay gross income
- 30.00	PNA (personal needs allowance)
- 906.25	community spouse monthly income allowance
998.75	
- 45.50	Medicare premium (not paid by Medicaid)
- 75.00	health insurance premium
$ 878.25	remaining income for patient pay (July)

The facility's Medicaid rate for July is $1,395. Because Mr. Hay's remaining income for patient pay is less than the Medicaid rate for July, his patient pay for July is $878.25. From his July income of $1,935, Mr. Hay must pay $878.25 patient pay to the facility, leaving him $1,056.75 from which he can pay the community spouse income allowance of $906.25, his personal needs allowance of $30 and his Medicare and health insurance premiums of $120.50 (total of $1,056.75). Medicaid will pay $476.75 of his spenddown liability ($1,355 spenddown liability - 878.25 patient pay = $476.75). **This is allowed under section 1924 of the Social Security Act (Special Treatment For Married Institutionalized Spouses).**

D. Example-Facility Spenddown Liability Less Than Facility Rate, Community Spouse & Family Member Allowance

EXAMPLE #25: (Using July 2000 figures)

Mrs. Zee is a disabled institutionalized spouse who applied for Medicaid for long term care services in July. She was admitted to the facility in June, but she is not eligible for Medicaid in the retroactive month because of excess resources. She has a monthly SSA benefit of $1,200 and a monthly private pension payment of $600. She has Medicare Parts A & B and private Medicare supplement health insurance which costs $75 per month. Her spouse, Mr. Zee, still lives in their Group II home with their dependent son, age 19 years. Mr. Zee has income of $1,500 per month from CSA. Their son has no income. Mrs. Zee's income exceeds the 300% SSI income limit. Her MN eligibility is determined for July. She has old bills totaling $300 dated the prior January. The MN determination results in a spenddown liability of $1,530:

$1,200.00	SSA
+ 600.00	monthly private pension
1,800.00	total monthly income
- 20.00	exclusion
1,780.00	countable MN income
- 250.00	MN limit for 1 (Group II)
$1,530.00	spenddown liability for July

The facility's Medicaid rate is $55 per day, or $1,705 for the month. By projecting the month's cost of facility care, she meets the spenddown effective the first day of the month. Mrs. Zee is eligible for Medicaid, effective July 1. She is enrolled in Medicaid in AC 058.

The community spouse monthly income allowance is calculated:

$1,406.25	monthly maintenance needs standard
+ 200.00	excess shelter allowance
1,606.25	MMMNA (minimum monthly maintenance needs allowance)
- 1,500.00	community spouse's gross income
106.25	community spouse monthly income allowance

The family member monthly income allowance for their son is calculated:

$1,406.25	monthly maintenance needs standard
- 0	son's income
1,406.25	amount by which the standard exceeds the son's income
÷ 3	
468.75	family member's monthly income allowance

Her patient pay for July is calculated as follows:

$1,200.00	SSA
+ 600.00	private pension
1,800.00	total gross income
- 30.00	PNA (personal needs allowance)
- 106.25	community spouse monthly income allowance
- 468.75	family member's monthly income allowance
1,195.00	
- 120.50	Medicare premium & health insurance premium
- 300.00	old bills
$ 774.50	remaining income for patient pay (July)

The facility's Medicaid rate for July is $1,705. Because Mrs. Zee's remaining income for patient pay is less than the Medicaid rate, her patient pay for July is $774.50. From her July income of $1,800, she must pay $774.50 to the facility, leaving her $1025.50 left to pay her personal needs, community spouse and family member's monthly income allowances, the old

bills and her medical insurance premiums, totaling $1025.50. Medicaid will pay $755.50 of her spenddown liability ($1,530 spenddown liability - 774.50 patient pay = $755.50). This is allowed under section 1924 of the Social Security Act (Special Treatment For Married Institutionalized Spouses).

M1480.460 FACILITY PATIENT PAY - SPENDDOWN LIABILITY GREATER THAN MEDICAID RATE

A. Policy

An MN facility institutionalized spouse whose spenddown liability is greater than the Medicaid rate is not eligible for Medicaid unless he incurs additional medical expenses that meet the spenddown liability within the month. If he meets the spenddown liability, his Medicaid coverage begins the first day of the month in which the spenddown is met, and ends on the last day of that month. A patient pay for the month is calculated.

Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay his personal needs, community spouse and family member allowances, and noncovered expenses. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability. Payment of part or all of the spenddown liability is permitted under Section 1924 (d) of the Social Security Act.

B. Procedures

The institutionalized spouse's spenddown eligibility was determined in section M1480.340 above. Because he met the spenddown in the month, he is enrolled in a closed period of coverage for the full month. His patient pay for the month must be determined using the procedures below.

1. Calculate Remaining Income for Patient Pay

a. Determine Gross Monthly Patient Pay Income

Determine the institutionalized spouse's patient pay gross monthly income according to section M1480.330 (including any amounts excluded in determining MN countable income and the spenddown liability).

b. Subtract Allowable Deductions

Deduct the following from the patient pay gross monthly income, in the following order as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.

1) a personal needs allowance (per section M1480.430 C.),

2) a community spouse monthly income allowance, if appropriate (per section M1480.430 D.),

3) a family member's monthly income allowance, if appropriate (per section M1480.430 E.),

4) allowable noncovered medical expenses (per section M1470.230) 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 facility care, and

5) a home maintenance deduction, if appropriate (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 Medicaid rate for the month. The patient pay is the lesser of the two amounts.

C. Example--Facility Spenddown Liability Greater Than Medicaid Rate, Less Than Private Cost of Care

EXAMPLE #26: (Using July 2000 figures)
Mr. L is an institutionalized spouse who applied for Medicaid in July. He was admitted to the facility the prior December. He has a monthly CSA benefit of $1,900 and a monthly Seminole Indian payment of $200. He has Medicare Parts A & B and Federal Employees Health Insurance which costs him $75 per month. He last lived outside the facility in a Group III locality.

His wife, Mrs. L, still lives in their home with their dependent child age 20 years. Mrs. L has income of $500 per month from CSA. Their child has no income. Mr. L's income exceeds the CNNMP 300% SSI income limit. His MN eligibility is determined for July. The MN determination results in a spenddown liability of $1,555:

$1,900	monthly MN income (Seminole Indian payment excluded)
- 20	exclusion
1,880	countable MN income
- 325	MN limit for 1 (Group III)
$1,555	spenddown liability for month

The facility's Medicaid rate is $45 per day, or $1,395 for a month. The private pay rate is $80 per day. By projecting the month's Medicaid rate, he does not meet his spenddown in July. He has no old bills. He is placed on a monthly spenddown of $1,555 for each month in the 12-month certification period beginning July 1.

On July 31, he submits expenses for July. The worker verifies that his resources were below the limit in July. His spenddown liability of $1,555 is compared to $2,480, the private rate for July ($80 per diem x 31 days). Because the private cost of care for July is greater than his spenddown liability for July, he met his spenddown in July. He is eligible for the full month of July. On August 1, the worker enrolls him in Medicaid with coverage beginning July 1 and ending July 31.

His patient pay is determined. The community spouse and family member allowances are calculated first:

$1,406.25	monthly maintenance needs standard
+ 0	no excess shelter allowance
1,406.25	MMMNA (minimum monthly maintenance needs allowance)
- 500.00	community spouse's gross income
$ 906.25	community spouse monthly income allowance

$1,406.25	monthly maintenance needs standard
- 0	child's income
1,406.25	amount by which standard exceeds child's income
÷ 3	
$ 468.75	child's family member monthly income allowance

$1,900.00	CSA income
+ 200.00	Seminole Indian payment (not excluded for patient pay)
2,100.00	total patient pay gross income
- 30.00	personal needs allowance
- 906.25	community spouse monthly income allowance
- 468.75	family member allowance
695.00	
- 45.50	noncovered Medicare Part B premium
- 75.00	noncovered health insurance premium
$ 574.50	remaining income (July)

The facility's Medicaid rate for July is $1,395. Because Mr. L's remaining income for patient pay is less than the Medicaid rate for July, his patient pay for July is $574.50.

From his July income of $2,100, he must pay the patient pay of $574.50. He has $1,525.50 left with which to meet his personal needs ($30), pay the community spouse and family member allowances, and pay his Medicare and health insurance premiums, a total of $1,525.50. In accordance with Section 1924 of the Social Security Act, Medicaid will assume responsibility for $980.50 of his spenddown liability ($1,555 - 574.50 patient pay = $980.50).

D. Example—Facility Spenddown Liability Greater Than Medicaid Rate and Private Cost of Care

EXAMPLE #27: (Using July 2000 figures)

Mrs. Bee is an institutionalized individual who files an initial application for Medicaid on July 6. She has a monthly SSA benefit of $2,000 and a monthly private pension payment of $500. She has Medicare Parts A & B and private Medicare supplement health insurance which costs her $100 per month. Mrs. Bee last resided outside the facility in a Group II locality. Her spouse, Mr. Bee, still lives in their home. He has income of $1,800 per month from CSA. Mrs. Bee's income exceeds the 300% SSI income limit.

Her MN eligibility is determined for July. The MN determination results in a spenddown liability of $2,230:

$2,000.00	SSA
+ 500.00	monthly private pension
2,500.00	total monthly income
- 20.00	exclusion
2,480.00	countable MN income
- 250.00	MN limit for 1 (Group II)
$2,230.00	spenddown liability for month

The facility's Medicaid rate is $55 per day, or $1,705 for a month. By projecting the month's Medicaid rate, she does not meet her spenddown. She is placed on a monthly spenddown for each month in the 12-month certification period beginning July 1. On August 2, she submits expenses for July. The private facility rate is $70 per day, or $2,170 for July (31 days). The private cost of care, $2,170, is less than her spenddown liability of $2,230. Therefore, the worker must complete a day by day calculation to determine Mrs. Bee's spenddown eligibility for July:

$2,230.00	spenddown liability 7-1
- 140.00	private pay rate for 7-1 & 7-2 @ $70 per day.
2,090.00	spenddown balance on 7-3
- 145.50	45.50 Medicare + 100.00 health ins. premium paid 7-3
- 1,890.00	private pay for 27 days @ $70 per day 7-3 through 7-29
54.50	spenddown liability balance at beginning of 7-30
- 70.00	private pay for 7-30
$ 0	spenddown met on 7-30

Mrs. Bee met her spenddown on July 30. On August 3, the worker enrolls her in Medicaid with a begin date of July 1 and end date of July 31. To determine her patient pay, the community spouse monthly income allowance is calculated:

$1,406.25	monthly maintenance needs standard
+ 525.00	excess shelter allowance
1,931.25	MMMNA (minimum monthly maintenance needs allowance
- 1,800.00	community spouse's gross income
$ 131.25	community spouse allowance

Mrs. Bee's patient pay for July is calculated as follows:

$2,000.00	SSA
+ 500.00	private pension
2,500.00	gross patient pay income
- 30.00	personal needs allowance
- 131.25	community spouse allowance
2,338.75	
- 145.50	noncovered Medicare & health ins. premium
$2,193.25	remaining income (July)

Mrs. Bee's remaining income for patient pay in July is $2,193.25, which is greater than the Medicaid rate for of July $1,705. The facility can only collect the Medicaid rate; therefore, her patient pay for July is the Medicaid rate of $1,705.

From her July income of $2,500, she must pay the Medicaid rate of $1,705. Medicaid will not pay for any of her facility care in July because she is responsible for the whole Medicaid rate; Medicaid will cover all other medical services except her Medicare & health insurance premiums. She has $795 left with which to meet her personal needs ($30), pay the community spouse allowance, and pay her Medicare and health insurance premiums, a total of $306.75. She has $488.25 left from her July income. Medicaid will assume responsibility for $525 of her spenddown liability ($2,230 - 1,705 Medicaid rate = $525).

Since Mrs. Bee paid the private rate of $2,170 to the facility in July, the facility is responsible to reimburse her for the difference between the private rate and the Medicaid rate ($465). On August 25, she requests evaluation of her spenddown for August. She was reimbursed $465 on August 20, which was deposited into her patient fund account. The worker verifies that her resources exceed the Medicaid resource limit in August. The worker sends her a notice denying Medicaid for August because of excess resources, and stating that she must reapply for Medicaid if she reduces her resources and wants to be placed on spenddown again.

M1480.470 CBC - MN INSTITUTIONALIZED SPOUSE PATIENT PAY

A. Policy

When the Medicaid community-based care (CBC) institutionalized spouse has been *authorized* for waiver services and has **income less than or equal to 300% of the SSI income limit** for one person, he is eligible for Medicaid as CNNMP and entitled to Medicaid for full-month, ongoing Medicaid coverage.

An institutionalized spouse who is *authorized* for waiver services, and whose income **exceeds the 300% SSI income limit**, is placed on a monthly spenddown. **The monthly CBC costs cannot be projected** for the spenddown budget period. The CBC costs, along with any other spenddown deductions, are deducted daily and chronologically as the costs are incurred. If the spenddown is met any day in the month, Medicaid coverage begins the first day of the month in which the spenddown is met, and ends on the last day of that month. A patient pay for the month is calculated.

Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay his personal needs, community spouse and family member allowances, and noncovered expenses. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability. Payment of part or all of the spenddown liability is permitted under Section 1924 (d) of the Social Security Act.

B. Procedures

The institutionalized spouse's spenddown eligibility was determined in section M1480.340 above. Because he met the spenddown in the month, he is enrolled in a closed period of coverage for the full month. His patient pay for the month must be determined for the month using the procedures below.

1. Calculate Available Income for Patient Pay

a. Determine Gross Monthly Patient Pay Income

Determine the institutionalized spouse's patient pay gross monthly income according to section M1480.330 (including any amounts excluded in determining MN countable income and the spenddown liability).

b. Subtract Allowable Deductions

Deduct the following from the patient pay gross monthly income, in the following order as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.

1) a personal maintenance allowance (per section M1480.430 C.),

2) a community spouse monthly income allowance, if any (per section M1480.430 D.),

3) a family member's monthly income allowance, if any (per section M1480.430 E.),

4) any allowable noncovered medical expenses (per section M1470.430) 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 Medicaid rate for the month. The patient pay is the lesser of the two amounts.

C. Example--CBC Institutionalized Spouse on Spenddown

EXAMPLE #28: (Using July 2000 figures)
Mr. T is an institutionalized spouse who applied for Medicaid in July. He was *authorized* for Medicaid E & D waiver services on July 1, and began receiving those services on that date. He has a monthly CSA benefit of $1,900 and a monthly Japanese-American Restitution payment of $200. He has Medicare Parts A & B and Federal Employees Health Insurance which costs him $75 per month. He last lived outside the facility in a Group III locality.

His wife, Mrs. T, lives in their home with Mr. T and their dependent child age 18 years. Mrs. T has income of $500 per month from CSA. Their child has no income. Mr. T's income exceeds the 300% of SSI income limit. His MN eligibility is determined for July. The MN determination results in a spenddown liability of $1,555:

$1,900	monthly MN income (Japanese-American Restitution payment excluded)
- 20	exclusion
1,880	countable MN income
- 325	MN limit for 1 (Group III)
$ 1,555	spenddown liability for month

He has no old bills. He is placed on a monthly spenddown of $1,555 for each month in the 12-month certification period beginning July 1.

On July 31, he submits expenses for July. The worker verifies that his resources were below the limit in July. His spenddown liability of $1,555 is compared to $2,400, the total private rate for July ($16 per hour private rate x 5 hours per day x 31 days = $2,480). Because the private cost of CBC care for July is greater than his spenddown liability for July, he met his spenddown in July. He is eligible for the full month of July. On August 1, the worker enrolls him in Medicaid beginning July 1 and ending July 31.

His patient pay is then calculated. The community spouse and family member allowances are calculated first:

$1,406.25	monthly maintenance needs standard
+ 0	no excess shelter allowance
1,406.25	MMMNA (minimum monthly maintenance needs allowance)
- 500.00	community spouse's gross income
906.25	community spouse monthly income allowance

$1,406.25	monthly maintenance needs standard
- 0	child's income
1,406.25	amount by which standard exceeds child's income
÷ 3	
$ 468.75	family member monthly income allowance

$1,900.00	CSA income
+ 200.00	Japanese-American Restitution payment (not excluded for patient pay)
2,100.00	total patient pay gross income
- 512.00	personal maintenance allowance
- 906.25	community spouse monthly income allowance
- 468.75	family member allowance
213.00	
- 45.50	noncovered Medicare Part B premium
- 75.00	noncovered health insurance premium
$ 92.50	remaining income for patient pay

The CBC provider's Medicaid rate is $9.50 per hour, 5 hours per day or $47.50 per day, a total of $1,472.50 for July (31 days). Because Mr. T's remaining income is less than the Medicaid rate, his patient pay for July is $92.50.

From his July income of $2,100, Mr. T must pay the patient pay of $92.50. He has $2,007.50 left with which to meet his maintenance needs ($512), pay the community spouse and family member allowances, and pay his Medicare and health insurance premiums, a total of $2,007.50. In accordance with Section 1924 of the Social Security Act, Medicaid will assume responsibility for $1,462.50 of his spenddown liability ($1,555 - 92.50 patient pay = $1,462.50). Because he paid all of his income to the CBC provider in July, his resources are within the limit in August.

D. Example-CBC Institutionalized Spouse on Spenddown

EXAMPLE #29: (Using July 2000 figures)

Mrs. Bly is an aged individual who files an initial application for Medicaid on July 1. She was *authorized* for Medicaid E & D waiver services on July 1, and began receiving those services on July 1. She has a monthly SSA benefit of $2,000 and a monthly private pension payment of $500. She has Medicare Parts A & B and private Medicare supplement health insurance which costs her $100 per month. Mrs. Bly resides in a Group II locality. Her spouse, Mr. Bly, lives with her in their home. He has income of $1,800 per month from CSA. Mrs. Bly's income exceeds the 300% of SSI income limit.

Her MN eligibility is determined for July. The MN determination results in a spenddown liability of $2,230:

$2,000.00	SSA
+ 500.00	monthly private pension
2,500.00	total monthly income
- 20.00	exclusion
2,480.00	countable MN income
- 250.00	MN limit for 1 (Group II)
$2,230.00	spenddown liability for month

She is placed on a monthly spenddown for each month in the 12-month certification period beginning July 1. On August 2, she submits expenses for July. The private CBC rate is $14 per hour, 5 hours per day or $70 per day, for a total of $2,170 for July (31 days). The private cost of care, $2,170, is less than her spenddown liability of $2,230. Therefore, the worker must complete a day-by-day calculation to determine Mrs. Bly's eligibility for July:

$2,230.00	spenddown liability 7-1
- 140.00	CBC private pay rate for 7-1 & 7-2 @ $70 per day.
2,090.00	spenddown balance on 7-3
- 145.50	45.50 Medicare + 100.00 health ins. premium paid 7-3
- 1,890.00	private pay for 27 days @ $70 per day 7-3 through 7-29
54.50	spenddown balance at beginning of 7-30
- 70.00	CBC private pay for 7-30
$ 0	spenddown met on 7-30

Mrs. Bly met her spenddown on July 30. On August 3, the worker enrolls her in Medicaid with the begin date of July 1 and end date July 31, application date July 1. To determine her patient pay, the community spouse monthly income allowance is calculated:

$1,406.25	monthly maintenance needs standard
+ 525.00	excess shelter allowance
1,931.25	MMMNA (minimum monthly maintenance needs allowance)
- 1,800.00	community spouse's gross income
$ 131.25	community spouse allowance

Mrs. Bly's patient pay for July is calculated as follows:

$2,000.00	SSA
+ 500.00	private pension
2,500.00	gross patient pay income
- 512.00	maintenance allowance
- 131.25	community spouse allowance
1,856.75	
- 145.50	noncovered 45.50 Medicare + 100.00 health ins. premium
$1,711.25	remaining income

Mrs. Bly's remaining income of $1,711.25 is greater than the Medicaid rate for July of $1,705, so her patient pay for July is the Medicaid rate of $1,705.

From her July income of $2,500, Mrs. Bly must pay the Medicaid rate of $1,705 to the CBC provider. Medicaid will not pay for any of her CBC care in July because she is responsible for the whole Medicaid rate; Medicaid will cover all other medical services except her Medicare & health insurance premiums. She has $795 left with which to meet her maintenance needs ($512), pay the community spouse allowance, and pay her Medicare and health insurance premiums, a total of $788.75. She has $6.25 left from her July income. Medicaid will assume responsibility for $525 of her spenddown liability ($2,230 - 1,705 patient pay = $525).

On August 25, she requests evaluation of her spenddown for August. She was reimbursed $465 on August 22 by the CBC provider, which was deposited into her bank account. The worker verifies that her resources exceed the Medicaid resource limit in August. The worker sends her a notice denying Medicaid for August because of excess resources, and stating that she must reapply for Medicaid if she reduces her resources and wants to be placed on spenddown again.

M1480.480 PACE – MN INSTITUTIONALIZED SPOUSE PATIENT PAY

A. Policy

An institutionalized spouse who is *authorize*d for PACE services, and whose income exceeds the 300% SSI income limit, is placed on a monthly spenddown. The individual's spenddown liability and the PACE monthly rate (minus the Medicare Part D premium) establish whether the spenddown eligibility determination can be projected or must be determined retrospectively. The instructions for determining spenddown eligibility for MN institutionalized spouse PACE recipients are in M1480.340.

If the spenddown is met, Medicaid coverage begins the first day of the month in which the spenddown is met and a patient pay for the month is calculated. If spenddown eligibility is projected, the patient pay is not calculated monthly as long as the monthly PACE rate (minus the Medicare Part D premium), income and allowances remain the same. If spenddown eligibility is determined retrospectively, the patient pay is calculated month-by-month.

Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay his personal needs, community spouse and family member allowances, and noncovered expenses. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability. Payment of part or all of the spenddown liability is permitted under Section 1924 (d) of the Social Security Act.

B. Procedures

The institutionalized spouse's spenddown eligibility was determined in section M1480.340 above. His patient pay must be determined using the procedures below.

1. Calculate Available Income for Patient Pay

a. Determine Gross Monthly Patient Pay Income

Determine the institutionalized spouse's patient pay gross monthly income according to section M1480.330 (including any amounts excluded in determining MN countable income and the spenddown liability).

b. Subtract Allowable Deductions

Deduct the following from the patient pay gross monthly income, in the following order as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.

1) a personal maintenance allowance (per section M1480.430 C.),

2) a community spouse monthly income allowance, if any (per section M1480.430 D.),

3) a family member's monthly income allowance, if *any* (per section M1480.430 E.),

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*.

The DMAS-225:

- notifies the LTC provider of a patient's Medicaid eligibility status;
- reflects changes in the patient's level of care or LTC provider;
- documents admission or discharge of a patient to an institution or community-based care services, or death of a patient;
- provides other information known to the provider that might cause a change in eligibility status or patient pay amount.

Do not use the DMAS-225 to relay the patient pay amount. Providers will be able to access the patient pay amount via the verification systems available to providers.

a. When to Complete the DMAS-225

Complete the DMAS-225 at the time of eligibility determination and/or the recipient's entry into LTC. Complete a new DMAS-225 when the enrollee's eligibility status changes, such as when the recipient's Medicaid coverage is canceled or changed to limited coverage (e.g. QMB coverage).

When a change in LTC providers occurs, complete a new DMAS-225 advising the new provider of the enrollee's eligibility status and that patient pay information is available through the verification systems.

b. Where To Send the DMAS-225

Refer to M1410.300 B.3.b to determine where the form is to be sent.

4. Resource Assessment Forms

The forms used for a resource assessment when no Medicaid application is filed are described in section M1480.210 (above). The resource assessment form that is used with a Medicaid application is described in section M1480.220. *The forms are generated by VaCMS when the resource assessment is completed in VaCMS*. Copies of the forms are included in Appendix 1 and Appendix 2 to this subchapter.

M1480.520 APPEALS

A. Client Appeals

The institutionalized spouse, the community spouse, or the authorized representative for either, has the right to appeal any action taken on a Medicaid application. The Medicaid client appeals process applies.

B. Appealable Issues

Any action taken on the individual's Medicaid **application** and receipt of Medicaid services may be appealed, including:

- spousal share determination,
- initial resource eligibility determination,
- spousal protected resource amount (PRA),
- resource redetermination,
- community spouse resource allowance (CSRA),
- income eligibility determination,
- patient pay and/or allowances calculations.

MEDICAID RESOURCE ASSESSMENT REQUEST

AGENCY USE ONLY	
COUNTY/CITY	DATE RECEIVED
CASE NUMBER	WORKER
CASE NAME	

Mr. and Mrs. _____ request that an assessment be completed to determine the spousal share of countable resources using the resources listed below.

INSTITUTIONALIZED SPOUSE

Name: _____
SS#: _____

Address: _____
_____
_____

COMMUNITY SPOUSE

Name: _____
SS#: _____

Address: _____
_____
_____

Date first admitted to a medical institution: _____
Admitted from where? _____

Provide the requested information on all resources owned, partially owned, or being bought on the first day of the month the institutionalized spouse was admitted to the institution or to Medicaid-covered community-based care. Include real estate (home, land, buildings), life insurance, cash on hand, stocks or bonds, savings and checking accounts, certificates of deposits, trusts, IRA or Keogh Plans, machinery, farming equipment, cemetery plots, burial funds, prearranged funerals, cars, mobile homes, and other real personal properties. If more room is needed, please attach another sheet of paper.

Description (Type of Resource)	Owned by Whom	Where Located	Value
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Signature: _____ Date: _____
(Spouse or Authorized Representative)

032-03-815

MEDICAID RESOURCE ASSESSMENT REQUEST

FORM NUMBER - 032-03-815

PURPOSE OF FORM - To provide information on resources that will enable the department of social services to assess the countable resources of a couple and to determine the spousal share.

USE OF FORM - To be completed when an assessment of resources available to an institutionalized spouse (spousal share) is requested, and a Medicaid application is not filed or requested.

NUMBER OF COPIES - Three.

DISPOSITION OF FORMS - The original is filed in the case record with the Medicaid Resource Evaluation and the Notice of Medicaid Resource Assessment. The first copy is sent to the community spouse with the Notice of Medicaid Resource Assessment. The second copy is sent to the institutionalized spouse with the Notice of Medicaid Resource Assessment. If an individual other than one of the spouses requested the assessment, a photocopy of the request is sent to the individual making the request along with a photocopy of the Notice of Medicaid Resource Assessment.

INSTRUCTIONS FOR PREPARATION OF FORM - The information in the right-hand corner will be completed by the worker when the form is received in the agency. The remainder of the form will be completed by the couple making the request or by the authorized representative acting on their behalf.

MEDICAID RESOURCE ASSESSMENT

COUNTY/CITY	CASE NUMBER
CASE NAME	
DATE INSTITUTIONALIZATION BEGAN	APPLICATION DATE

A. COUPLE'S RESOURCES AS OF _____ (Date)

RESOURCE (Description)	Owner	Countable YES	Countable NO	Countable Value	Documentation
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

B. COMPUTATION OF SPOUSAL SHARE

θ Documentation of resources not supplied. Spousal share not determined.

θ Documentation of resources supplied.

$_____ Total Value of Couple's Countable Resources

$_____ Spousal Share

Worker's Signature: _____ Date: _____

MEDICAID RESOURCE ASSESSMENT

FORM NUMBER - 032-03-816

PURPOSE OF FORM - To document the resources owned by a couple, to specify which resources are exempted, which resources are counted and their countable values, and to determine the spousal share of resources.

USE OF FORM - To be completed by the local agency eligibility worker when a Medicaid Resource Assessment Request is received by the local department of social services, or when a Medicaid application is filed by an institutionalized individual who has a community spouse.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The original is filed in the case record with the Medicaid Resource Assessment and the Notice of Medicaid Resource Assessment for assessments that are not parts of applications. The first copy is sent to the community spouse with the Notice of Medicaid Resource Assessment. The second copy is sent to the institutionalized spouse with the Notice of Medicaid Resource Assessment. If an individual other than one of the spouses requested the assessment, a photocopy of the evaluation is sent to the individual making the request, along with a photocopy of the Notice of Medicaid Resource Assessment.

For assessments that are part of Medicaid applications, the evaluation form is filed in the case record with the application evaluation. A copy of the Resource Evaluation is sent to the institutionalized spouse, the community spouse, and the individual making the request if applicable, along with the Notice of Medicaid Resource Assessment and the Notification of Action on Medicaid.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the identifying information in the upper right-hand corner of the form.

A. RESOURCES

From the resources identified on the Medicaid Resource Assessment Request, list the excluded resources first; the countable value(s) can be "N/A". Provide a description of the resource, list the owner(s), check whether the resource is countable, enter the countable value when it is a countable resource, and provide appropriate documentation information. If information was not provided, and owners or countable value, etc., cannot be documented, enter "not provided" in the appropriate columns.

B. COMPUTATION OF SPOUSAL SHARE

Check the appropriate box to indicate whether documentation was or was not supplied. If documentation was supplied, enter in the first line the value of countable resources, divide that figure by two and enter on the second line the spousal share.

C. The worker must sign the form and enter the date the form was completed.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

NOTICE OF MEDICAID RESOURCE ASSESSMENT

AGENCY USE ONLY
CASE NAME
CASE NUMBER
COUNTY/CITY

ϒ The resource assessment you or your authorized representative requested was completed.

The spousal share is $ _____.

Enclosed are copies of the Medicaid Resource Assessment Request you submitted and the Medicaid Resource Assessment completed by the worker.

ϒ The resource assessment you or your authorized representative requested was not completed because you or your authorized representative did not provide the necessary verifications of your resources. The spousal share of your resources cannot be determined.

ϒ The resource assessment you or your authorized representative requested was not completed because the institutionalization began prior to September 30, 1989.

Worker's Name	Agency Name and Address	Date Mailed

032-03-817/2

NOTICE OF MEDICAID RESOURCE ASSESSMENT

FORM NUMBER - 032-03-817

PURPOSE OF FORM - To provide notice that a resource assessment of a couple's countable resources, and the spousal share, was or was not completed.

USE OF FORM - To be prepared when the resource assessment is denied, evaluation is completed, or evaluation could not be completed.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The original is filed in the case record with the original Medicaid Resource Assessment Request and the original Medicaid Resource Evaluation. The first copy is sent to the community spouse with the first copy of the Medicaid Resource Assessment and the first copy of the Medicaid Resource Evaluation. The second copy is sent to the institutionalized spouse with the second copy of the Medicaid Resource Assessment and the second copy of the Medicaid Resource Evaluation.

If an individual other than one of the spouses requested the assessment, a photocopy of the notice is sent to the individual making the request along with a photocopy of the Medicaid Resource Assessment.

INSTRUCTIONS FOR PREPARATION OF THE FORM - Complete the identifying information in the upper right-hand corner. Enter the name and mailing address of the individual who will receive the form.

Check the appropriate box to show if the assessment was not completed because institutionalization began before 9-30-89, or if it was not completed because documentation was not provided, or if documentation of resources was provided and the assessment was completed. If documentation was provided, enter the spousal share of the countable resources.

Enter the worker's name, address, and the date the notice is or will be mailed.