

CHAPTER M15

ENTITLEMENT POLICY & PROCEDURES

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TN #100	5/15	Table of Contents
TN #99	1/1/14	Table of Contents

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SUBCHAPTER 10

MEDICAID ENTITLEMENT

M1510 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-2	10/1/16	On pages 3-15, corrected the subchapter number in the headers. Neither the dates nor the policies were changed.
TN #DMAS-1	6/1/16	Pages 2 Pages 1 and 2a are runover pages.
TN #100	5/1/15	Table of Contents Pages 1-2a, 5-8b
UP #10	5/1/14	Table of Contents Pages 7-8a Page 8b was added.
TN #99	1/1/14	Table of Contents Pages 1, 2, 8, 8a, 9-11 Page 11a was added.
UP #9	4/1/13	Pages 2-7, 10-12, 14
UP #7	7/1/12	Pages 8, 9
TN #96	10/01/11	Pages 8a, 10
TN #95	3/1/11	Table of Contents Pages 8, 11-15
TN #94	9/1/10	Pages 2a, 8-8a
TN #93	1/1/10	Page 6
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M1510.000 ENTITLEMENT POLICY & PROCEDURES

M1510.100 MEDICAID ENTITLEMENT

A. Policy

If an individual meets all eligibility factors within a month covered by the application, eligibility exists for the entire month unless the individual became eligible by meeting a spenddown.

1. Spenddown Met

If the applicant had excess income and met the spenddown within the month, he remains responsible for his spenddown liability and his coverage begin date cannot be any earlier than the date he met the spenddown.

2. Individual is Deceased

If an application is filed on behalf of a deceased individual or the applicant dies during the application process, his eligibility is determined only for the days he was alive. He must have been eligible for Medicaid while he was alive in order to be entitled to enrollment in Medicaid. Any changes in the individual's resources or income after his death do not affect the eligibility determination.

Example: An individual applies on July 23 for retroactive and ongoing Medicaid. The worker determines that the individual had excess resources (cash value of life insurance) throughout the retroactive period and the application month. The individual dies on August 5. The family asserts that he no longer owned the life insurance policies on August 5 and meets the resource requirements for the month of August. The worker determines that the individual owned the policies on the date of his death, the countable value exceeded the resource limit and he was not eligible for medical assistance on or before the date of his death.

3. Applicant Has Open MA Coverage in Another State

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

B. SSI Entitlement Date Effect on Medicaid

SSI payments for eligible individuals are effective the first day of the month following the month in which the SSI application was filed. Medicaid coverage for eligible individuals is effective the first day of the month in which the Medicaid application is filed. When the Medicaid application is filed in the same month as the SSI application, the applicant is not eligible for Medicaid as an SSI recipient until the month in which his SSI entitlement began - the month following the application month. His eligibility for Medicaid in the application month must be determined in another covered group.

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C. Procedures

The procedures for determining an eligible individual's Medicaid coverage entitlement are contained in the following sections:

- M1510.101 Retroactive Eligibility & Entitlement
- M1510.102 Ongoing Entitlement
- M1510.103 Hospital Presumptive Eligibility
- M1510.104 Disability Denials
- M1451.105 Foster Care Children
- M1510.106 Delayed Claims

M1510.101 RETROACTIVE ELIGIBILITY & ENTITLEMENT

A. Definitions

1. Retroactive Period

The retroactive period is the three months immediately prior to the application month. Within this retroactive period, the individual may be Categorically Needy (CN) in one or two months and Medically Needy (MN) in the third month, or any other combination of classifications.

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

2. Retroactive Budget Period

The "budget period" is the period of time during which an individual's income is calculated to determine income eligibility. The retroactive budget period depends on the individual's covered group.

B. Policy

An application for Medicaid or Auxiliary Grants (AG) is also an application for retroactive Medicaid coverage whenever the applicant reports that he/she received a Medicaid-covered service *or had Medicare coverage* in retroactive period. Eligibility for retroactive coverage is determined at the same time as the ongoing eligibility is determined, using the same application.

When an applicant reports that he/she, or anyone for whom he/she is applying, received a Medicaid covered service in any one of the three retroactive months, determine the applicant's eligibility for all three retroactive months, regardless of the service date. Determine nonfinancial, resource and income eligibility for each month in the retroactive period.

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C. Budget Periods By Classification

1. CN

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

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

2. MN

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

D. Verification

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

For eligibility determinations completed for individuals subject to Modified Adjusted Gross Income (MAGI) methodology, income verification by the Federal Hub is acceptable for retroactive eligibility determinations provided that reasonable compatibility is met (see M0420.100 B.9). The applicant must provide verification of income received in the retroactive period, as well as for ongoing eligibility if his income is not verified by the Hub.

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

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

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

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**1. Excess Income
In One or More
Retroactive
Months**

When an applicant has excess income in one or more of the retroactive months, he must verify that he met the nonfinancial and resource requirements in the month(s). He must verify the income he received in **all 3** retroactive months in order to determine his MN income or spenddown eligibility in the retroactive month(s).

If he fails to verify income in all three months, he CANNOT be eligible as MN in the retroactive period. His application for the retroactive months in which excess income existed must be denied because of failure to provide income verification for that month(s). However, coverage for the retroactive month(s) in which he was eligible as CN must be approved.

EXAMPLE #2: (Using July 2006 figures)

A parent of a child under age 19 applies for Medicaid in April. She requests retroactive coverage for the child's medical bills incurred in January, February and March, including a hospital stay in February. She also has unpaid medical bills (old bills) from December. The retroactive period is January - March.

The eligibility worker determines that the child met all the Medicaid nonfinancial requirements in the retroactive period, and that the countable income of \$3,250 per month in January and February exceeded the F&C, CN and the MN income limits. The income of \$800 starting March 1 is within the F&C CN income limit. The parent verifies that the resources in January, February were within the MN resource limit, but does not verify the March resources because the income is within the CN income limits.

The application is approved for retroactive coverage as CN beginning March 1 and for ongoing coverage beginning April 1. The child's spenddown liability is calculated for January and February. The eligibility worker deducts the old bills and the incurred medical expenses, and a spenddown liability remains. The retroactive Medicaid coverage is denied for January and February because the spenddown was not met.

**2. Excess Income
In All 3
Retroactive
Months**

When excess income existed in all classifications in all 3 retroactive months, the applicant must verify that he met all eligibility requirements in all 3 months. If he fails to verify nonfinancial, resource or income eligibility in any of the retroactive months, the retroactive period cannot be shortened and he CANNOT be placed on a retroactive spenddown. His application for retroactive coverage must be denied because of excess income and failure to provide eligibility verification for the retroactive period.

EXAMPLE #3: (Using July 2006 figures)

A parent of a child under age 19 applies for Medicaid in April. She requests retroactive coverage for the child's medical bills incurred in January, February and March, including a hospital stay in March. The retroactive period is January – March.

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The worker verifies that the child met all the Medicaid nonfinancial requirements in the retroactive period, and that their countable income of \$3,250 in January, February and March exceeded the F&C CN and the MN income limits. The worker verifies that their resources in January and February were within the MN resource limits, but is unable to verify the resources for March.

The application is denied for retroactive coverage as CN Medicaid because of excess income and denied for MN spenddown because of failure to provide resource verification for all months in the retroactive period.

E. Disabled Applicants

If the applicant was not eligible for SS or SSI disability benefits during the retroactive period and the recipient alleges he/she was disabled during the retroactive period, follow the procedures in M0310.112 for obtaining an earlier disability onset date.

F. Excess Resources in Retroactive Period

If the applicant had excess resources during part of the retroactive period, retroactive resource eligibility exists only in the month(s) during which the resources were at or below the limit at any time within the month. The applicant's eligibility must be denied for the month(s) during which excess resources existed during the entire month.

EXAMPLE #4: (Using July 2006 figures)

Mr. A applied for Medicaid for himself on July 8. He reported receiving a Medicaid covered service in each retroactive month; no hospital service was received. The retroactive period is April 1 through June 30. He currently receives SS disability benefits of \$1500 per month and received SS disability of \$1500 monthly during the retroactive period. He is not eligible for Medicare Part A. His verified resources exceeded the MN limit in April and part of May; the resources were reduced to below the MN limit on May 20. He met the retroactive spenddown on April 5. His application was approved for retroactive MN coverage beginning May 1, and April coverage was denied because of excess resources.

G. Income Determination

Countable income for the applicant's unit is that income which was actually received in the three months prior to the application month.

1. Monthly Determination for CN

When an individual in the family unit meets a CN covered group, compare each month's countable income to the appropriate CN income limit for the month. When the countable income is within the CN income limit in the month, the CN individual meets the income eligibility requirement for that retroactive month. Enroll the eligible CN unit member(s) **for that month(s) only**, using the appropriate CN covered group program designation.

2. MN

When the family unit's countable income exceeds the CN income limit in one or more of the retroactive months, and all other

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Medicaid medically needy eligibility factors are met in that month(s), determine if the unit meets the MN income limit for the **3-month** retroactive budget period.

When the unit's countable income exceeds the MN limit for 3 months, place the unit on a spenddown for the month(s) in which excess income existed. See subchapter M1330 for retroactive spenddown eligibility determination policy and procedures.

H. Retroactive Entitlement

Retroactive coverage can begin the first day of the third month prior to application month if all eligibility requirements are met.

NOTE: A QMB is never eligible for retroactive coverage as a QMB-only.

The applicant is entitled to Medicaid coverage for only the month(s) in which all eligibility factors were met. If all factors except income were met in all the retroactive months, then the applicant is placed on spenddown for the retroactive period. **See subchapter M1330 to determine retroactive spenddown eligibility.**

1. Retroactive Coverage Begin Date

If the applicant is eligible for retroactive coverage, he is enrolled effective the first day of the month in which he met all eligibility factors. When excess income existed in a retroactive month(s), entitlement begins the date the retroactive spenddown was met.

2. Retroactive Coverage End Date

The Medicaid recipient's retroactive Medicaid coverage expires after the last day of the retroactive month(s) in which he was entitled to Medicaid.

3. Example

EXAMPLE #5: Mr. B applied for Medicaid for himself on July 8. He reported receiving a Medicaid covered service in each retroactive month. The retroactive period is April 1 through June 30. He met all eligibility requirements in the retroactive period. He is entitled to retroactive Medicaid coverage beginning April 1 and ending June 30.

M1510.102 ONGOING ENTITLEMENT

A. Coverage Begin Date

Ongoing Medicaid entitlement for all covered groups except the QMB group **begins the first day of the application month** when all eligibility factors are met at any time in the month of application. Exceptions:

- when an applicant has excess income;
- when the applicant is eligible only as a QMB;
- when the applicant is age 21-64 years and is admitted to an institution for mental diseases (IMD), or
- *when the individual is incarcerated.*

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1. **Applicant Has Excess Income** When all eligibility requirements are met except for income, entitlement begins the date the spenddown is met. Only medically needy applicants can be eligible after meeting a spenddown. See subchapter M1330 to determine retroactive spenddown eligibility.
2. **QMB Applicant** Entitlement to Medicaid for QMB begins the first day of the month **following** the month in which the individual's QMB eligibility is determined.
3. **SLMB and QDWI** Ongoing entitlement for the Special Low Income Medicare Beneficiary (SLMB) and the Qualified Disabled and Working Individuals (QDWI) covered groups is the first day of the application month when all eligibility factors are met at any time in the month of application.
4. **Applicant Age 21-64 Is Admitted To An IMD** An applicant who is age 21-64 years and who is admitted to an IMD is NOT eligible for Medicaid. If otherwise eligible for Medicaid in the application month, his entitlement to Medicaid begins the date he is discharged from the ineligible institution in the month.

EXAMPLE #6: Mr. A is a 50 year old man who applies for Medicaid at his local agency on October 1, 2006. He receives Social Security disability benefits. He was admitted to Central State Hospital (an IMD) on October 20, 2006, and was discharged on November 2, 2006, back to his home locality. The agency completes the Medicaid determination on November 5 and finds that he is eligible for Medicaid in October 2006 and ongoing, except for the period of time he was in Central State Hospital.

The worker enrolls him in Medicaid for a closed period of coverage beginning October 1, 2006, and ending October 20, 2006. The worker also enrolls him in an ongoing period of Medicaid coverage beginning November 2, 2006.

5. **Applications From CSBs For IMD Patients Ages 21-64 Years** A patient who is age 21 years or older but is less than 65 years and who is *in an IMD* is not eligible for Medicaid while in the IMD. Local agencies will take the **applications received from the CSBs** for Department of Behavioral Health and Developmental Services (DBHDS) IMD patients who will be discharged within 30 days and process the applications within the established time frames. Eligibility will be determined based on the type of living arrangement to which the patient will be discharged. If eligible, do not enroll the patient until the date the patient is discharged from the IMD.

If the patient is discharged from the facility and the patient meets all eligibility factors, the agency will enroll the patient effective the date of discharge.

EXAMPLE #6a: Mr. A is a 50 year old patient at Central State Hospital (an IMD). He receives Social Security disability benefits. The CSB sends

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

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

6. Incarcerated Individuals

a. Pre-release Planning

Incarcerated individuals, who are approved for Medicaid in advance of their release, are enrolled in the appropriate AC for the covered group beginning with the date of release. If the individual is already enrolled in AC 109 at the time of release, cancel the AC 109 coverage effective the day prior to the date of release and reinstate the ongoing coverage effective the following day.

b. Inpatient Hospitalization – Aid Category (AC) 109

Incarcerated individuals (see M0130.050) who meet all Medicaid eligibility requirements, including eligibility in a full benefit CN covered group are eligible for Medicaid coverage limited to inpatient hospitalization. Incarcerated individuals are enrolled in AC 109 regardless of the covered group to ensure Medicaid claims payment is limited to inpatient hospitalization.

Entitlement for newly eligible individuals begins the first day of the month of application/reapplication, provided all eligibility factors are met and the individual had an inpatient hospitalization. Entitlement can also begin the first day of any month in the application's retroactive period, provided all eligibility requirements were met and he had an inpatient hospitalization in the retroactive period.

If the individual has active coverage when the agency becomes aware of his incarceration, a partial review must be completed to determine if he continues to meet the requirements for coverage in a full-benefit CN covered group. If he continues to be eligible, cancel the existing coverage the date of the report and reinstate in AC 109 for ongoing coverage the following day. If the individual no longer meets the requirements for a full benefit CN covered group, cancel the coverage, effective the date the determination is made.

B. Coverage End Date

Medicaid entitlement ends the last day of the month in which the recipient fails to meet all of the Medicaid eligibility requirements, unless the recipient is a CN pregnant woman or is age 21-64 and admitted to an IMD or other ineligible institution.

Medicaid coverage is canceled on the last day of the month in which the agency determines that the recipient no longer meets the eligibility requirements IF the

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agency can send an advance notice to the recipient at least 11 days before the last day of the month. If the agency cannot send the notice at least 11 days before the end of the month, coverage is canceled effective the last day of the next month.

1. CN Pregnant Woman

After eligibility is established, a pregnant woman in any CN covered group continues to be eligible for Medicaid during the remainder of her pregnancy and the 60-day post-partum period regardless of any changes in family income, as long she continues to meet all non-financial criteria.

2. Individual Age 21-64 Admitted to Ineligible Institution

a. Entitlement - applicants

For a Medicaid enrollee age 21-64 years, entitlement to Medicaid begins on the first day of the application month and ends on the date following the date he is admitted to an IMD or other ineligible institution. When enrolling the individual in the MMIS, enter the begin date and the end date of coverage.

b. Cancel procedures for ongoing enrollees

Cancel coverage as soon as possible after learning of the enrollee's admission to an ineligible institution. **DO NOT cancel coverage retroactively.** Cancel coverage in the MMIS effective the current date (date the worker enters the cancel transaction in MMIS), using cancel reason code "008."

c. Notice

An Advance Notice of Proposed Action is not required. Send a Notice of Action to the enrollee or his authorized representative informing him of the cancel date and the reason.

3. Spenddown Enrollees

Medicaid entitlement ends on the last day of the last month in the spenddown budget period, unless the individual's or family's circumstances change before that date.

C. Ongoing Entitlement After Resources Are Reduced

When an applicant has excess resources throughout the application month, he is not eligible for Medicaid for the month of application. An applicant who reduces excess resources during the month of application or a subsequent month before action is taken on the application may become 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, the resources must actually be expended and the expenditure documented. (For example: a receipt, a canceled check, or a bank statement).

Reduction of resources is an asset transfer and must be evaluated under asset transfer policy (subchapter M1450).

When excess resources are reduced, entitlement to ongoing Medicaid may begin no earlier than the first day of the month in which the resources were reduced to the Medicaid limit. When retroactive coverage is requested, policy in M1510.101 above must be followed.

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M1510.103 HOSPITAL PRESUMPTIVE ELIGIBILITY

A. Policy

Individuals enrolled on the basis of Hospital Presumptive Eligibility (HPE) are covered by Medicaid beginning with the date of the HPE determination through the last day of the following month or the date MA eligibility is determined by an LDSS, whichever comes first. For their coverage to continue beyond the HPE enrollment period, they must submit a full MA application to the LDSS. If the individual does not submit an MA application, no further action is necessary on the part of the LDSS. See M0120.500 C. for additional information.

B. Procedures

When an HPE enrollee submits a full MA application and it is pended in VaCMS, the individual's coverage in the HPE AC is extended by the eligibility worker in MMIS, as necessary, while the application is processed. The MMIS User's Guide for DSS, available at http://dmasva.dmas.virginia.gov/Content/pgs/dss-elgb_enrl.aspx, contains procedures for completing the MA enrollment of an individual who was enrolled in HPE at the time of application.

The 10-working day processing standard applies to applications submitted by pregnant women and BCCPTA individuals enrolled in HPE.

1. Enrollment

When an individual is determined eligible for MA coverage, his MA coverage under the appropriate MA AC includes any days to which he is entitled that are not already covered by HPE. If the individual submitted the MA application in the same month HPE coverage began and HPE began on any day other than the first day of the month, his MA coverage begins the first day of that month and the eligibility worker enrolls him in a closed period of coverage in the appropriate MA AC beginning with the first day of the month and ending the day before the HPE begin date. The worker is to enroll the eligible individual in ongoing coverage in the appropriate MA AC beginning the first day of the month after the effective date of the HPE coverage cancellation.

2. Individuals Enrolled in HPE as Pregnant Women or in Plan First

If an individual who was enrolled in HPE with partial coverage as a pregnant woman or in Plan First is determined eligible for full MA coverage in the period covered by HPE, cancel HPE coverage retroactively and reinstate in full coverage for the retroactive months and ongoing, if eligible.

3. Retroactive Entitlement

An individual's eligibility for retroactive coverage for the three months prior to the month of the MA application is determined when the individual had a medical service within the three months prior to the month of the full MA application. If the individual had full coverage while enrolled as HPE, only enroll him for *the* portion of the retroactive period that he was not enrolled as HPE.

4. HPE Enrollee Not Eligible for Ongoing Coverage

If the applicant is determined to not be eligible for ongoing MA coverage, his entitlement to HPE coverage ends. Cancel the HPE coverage effective the current date (i.e. day of the eligibility determination), using Cancel Reason 008.

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Send a Notice of Action indicating that the individual's MA application was denied and that his HPE coverage was cancelled with the effective date. The individual receives notice of the HPE coverage period from the hospital at the time of the HPE enrollment; advance notice of the HPE cancellation is not required. There are no appeal rights for HPE.

M1510.104 DISABILITY DENIALS

A. Policy

When an individual concurrently applies for SSI or SS and Medicaid as disabled, and either the DDS or the Social Security Administration (SSA) denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.

When an individual applies for Medicaid as disabled or concurrently applies for SS/SSI and Medicaid as disabled, and DDS denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.

B. Procedures

1. Subsequent SSA/SSI Disability Decisions

The SSA disability decision takes precedence over a DDS decision (DDS will make a decision before SSA if SSA does not take action within the 90-day Medicaid application processing time). If SSA denies disability and the decision is appealed and subsequently reversed, reopen and re-evaluate the denied Medicaid application as long as the disability onset month is prior to the month of application or is no later than 90 days after the month of application.

2. Use Original Application

The original application is used as long as the application was denied because the individual was not disabled and the subsequent disability onset month is no later than 90 days from the month of application.

3. Entitlement

If the re-evaluation determines that the individual is eligible, the individual's Medicaid entitlement is based on the Medicaid application date including the retroactive period if all eligibility requirements were met during the retroactive period. However, eligibility as a disabled individual cannot begin prior to the disability onset date when the disability onset date falls after the application date.

4. Renewal Required When More Than 12 Months Have Passed

If, based upon the re-evaluation, the individual is determined to be eligible and more than 12 months have passed since the application was filed, complete a *renewal*/redetermination to determine whether or not the individual remains eligible.

5. Spenddown

If, based upon the re-evaluation, the individual is determined not eligible but met the requirements in Chapter M13 for placement on a spenddown, a first prospective and additional 6 month spenddown budget period(s) are established to cover the period of time between the date of application and the date action is taken on his case.

A new application is not required for each 6 month spenddown budget period leading up to the date of processing; however, verification of all income and resources for those time periods must be obtained.

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M1510.105 FOSTER CARE CHILDREN

A. Policy

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

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

B. Retroactive Entitlement

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

M1510.106 DELAYED CLAIMS

A. When Applicable

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

B. Eligibility Delay Letter Requirements

The letter must:

- be on the agency's letterhead stationery and include the date completed.
- be addressed to the "Department of Medical Assistance Services, Claims Processing Unit."
- state the enrollee's name and Medicaid recipient I.D. number.
- state that "the claim for the service was delayed for more than one year because eligibility determination and enrollment was delayed."

C. Procedures

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

A sample eligibility delay letter is available on the local agency intranet at: <http://spark.dss.virginia.gov/divisions/bp/me/forms/>.

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M1510.200 NOTICE REQUIREMENTS

A. Policy

Federal regulations in 42 CFR 431.206 through 431.214 require the agency to inform every applicant or enrollee in writing

- of his right to a hearing;
- of the method by which he may obtain a hearing; and
- that he may represent himself or use legal counsel, a relative, a friend or other spokesperson.

The agency must provide the information required above at the time of any action affecting his claim for Medicaid benefits.

B. Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs

A system-generated Notice of Action or the "Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs" (Form 032-03-008) must be used to notify the applicant:

- that his application has been approved and the effective date(s) of his Medicaid coverage.
- that retroactive Medicaid coverage was approved and the effective dates.
- that his application has been denied including the specific reason(s) for denial.
- that retroactive Medicaid coverage was denied, including the specific reason(s) for denial.
- of the reason for delay in processing his application.
- of the status of his request for reevaluation of his application in spenddown status.

When the application was filed by the applicant's authorized representative, a copy of the notification must be mailed to the applicant's authorized representative.

1. CN Children or Pregnant Women

When the application of a medically indigent child or pregnant woman is denied because of excess income, the denial notice must state the reason for denial. The notice must also include the resource question pages from *an MA application form* and must advise the applicant of the following:

- a. that he/she may complete and return the enclosed form for a Medicaid spenddown to be evaluated, and
- b. if the information is returned within 10 days of this notice, the medically indigent application date will be used as the Medicaid spenddown application date.

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2. Qualified Medicare Beneficiaries

a. Excess resources

When a Qualified Medicare Beneficiary's (QMB's) application for full benefit Medicaid coverage is denied because of excess resources, the denial notice must state that the applicant is not eligible for full Medicaid coverage because of excess resources.

b. Excess income

- 1) If the QMB's resources are within the Medicare Savings Program (MSP) limit but are over the MN limit, and the income exceeds the limit for full Medicaid coverage, the notice must state that the applicant is not eligible for QMB Medicaid because of excess income, and is not eligible for MN spenddown because of excess resources. The notice must specify the dollar amount of the appropriate MN resource limit.
- 2) If the QMB's resources are within the MN income limit, and income exceeds the limit for full Medicaid coverage, the notice must state that the applicant is not eligible for full-benefit Medicaid because of excess income, but that the applicant can become eligible by incurring medical or dental expenses that equal or exceed his excess income. The notice must specify the spenddown amount, the spenddown period begin and end dates, and include a copy of the Spenddown Fact Sheet.

3. Retroactive Entitlement Only or Limited Period of Entitlement

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

4. Example #7 Limited Period of Entitlement

A Medicaid application was filed on December 30. The client inherited real property on January 30. The agency processed the application on February 5 and determined the client was eligible for Medicaid for the months of December and January, but was ineligible for additional coverage beginning February because the countable value of the inheritance caused excess resources. One notice is sent to the applicant stating that his Medicaid application was approved beginning December 1 and ending January 31, and that he was denied coverage after January 31 because of excess resources (real property).

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M1510.300 FOLLOW-UP RESPONSIBILITIES

M1510.301 THIRD PARTY LIABILITY (TPL)

A. Introduction

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

B. Private Health Insurance

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

Health insurance policy or coverage changes must be updated in the eligibility record and the MMIS TPL file.

1. Verification Required - Policy or Coverage Termination

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

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

2. HIPP

If an applicant or enrollee reports that he or a family member is employed more than 30 hours each week and is eligible for health insurance coverage under an employer's group health plan, he or she must be given a HIPP Fact Sheet which provides a brief description of the program and the contact information for the HIPP Unit at DMAS. The HIPP Fact Sheet is available on-line at: <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>.

Changes to TPL coverage in MMIS for HIPP participants can only be made by the HIPP Unit at DMAS. Call the HIPP Unit at 1-800-432-5924 when changes to the TPL information in MMIS are needed.

C. Medicare

For persons age 65 or over, for persons under age 65 who have received SSA or Railroad Retirement benefits because of disability for 24 consecutive months, and for persons with chronic end-stage renal disease, the Department of Medical Assistance Services has a buy-in agreement with Medicare to provide to those eligible individuals who are also eligible for Medicare the medical services available under Medicare, Part B (Title XVIII of the Social Security Act) through payment of the Part B premium.

When the recipient has to pay a Medicare Part A premium, Medicaid will pay the Part A premium for

- all QMBs; the "dually-eligible" (those who are eligible in a CN or MN covered group and also are QMB), and the QMB-only (those QMBs who are not eligible for Medicaid in another covered group);
- Qualified Disabled and Working Individuals (QDWI).

1. Buy-In Procedure

The Centers for Medicare and Medicaid Services(CMS) maintains a current list of individuals for whom the State is paying the Part B premiums. The list is updated on a monthly basis by adding newly enrolled individuals and deleting those no longer eligible. Before CMS will admit an individual to the buy-in list for Part B coverage, the individual must have established his eligibility for Medicare. His name and claim number, if one has been assigned, must be identical to the information in the SSA files. A difference between the name and number on the MMIS and in the SSA files results in a mismatch and rejection of Part B premium coverage.

2. Medicare Claim Numbers

Only two types of claim numbers correctly identify an individual's entitlement to Medicare coverage: a Social Security claim number or a Railroad Retirement claim number.

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- a. SSA claim numbers consist of a nine-digit number followed by a letter, or a letter and numerical symbol. The most common symbols are T, M, A, B, J1, K1, D, W, and E.
- b. RR annuity-claim numbers have a letter (alpha) prefix followed by a six or nine digit number. The most common prefixes are A, M, H, WCD, NCA, CA, WD, WCH, and PD.
- c. Certain letters following nine digit numbers identify an individual as an SSI recipient and are not acceptable as a Medicare claim number. These claim symbols are AI, AS, BC, BI, BS, DC, DI, and DS.

3. Procedures for Obtaining Claim Numbers

a. Requesting Medicare Card

Each Medicaid applicant who appears to qualify for Medicare must be asked if he has applied for Medicare. Those that have applied and are eligible have received a white card with a red and a blue stripe at the top, with his name as it appears in the SSA files and the assigned claim number on the card. The name as it appears and the claim number must be included in the TPL section of the MMIS eligibility file maintained by the Department of Medical Assistance Services.

b. Applicants Who Cannot Produce a Claim Number

In the event the applicant either does not have a Medicare card or does not know his claim number, inquire SSA via the SVES (State Verification Exchange System) using the applicant's own SSN.

If the applicant has never applied for Medicare, complete the Referral to Social Security Administration Form DSS/SSA-1 (form #032-03-099) and write in, "Buy-In" on the upper margin. Mail the form to the Social Security Office serving the locality in which the applicant resides. The SSA office will provide the correct claim number if the individual is on their records. Should the (local/area) SSA office have no record of an application for Medicare, a representative will contact the applicant to secure an application.

Should the applicant be uncooperative (not wish to apply) or be deceased, the Social Security Office will contact the local social services department and ask that agency to file the Medicare application in his behalf. A local department of social services must also submit an application for Medicare on behalf of an individual who is unable or unwilling to apply. When the local department must file a Medicare application, the local Social Security office will advise the local department of the procedure to follow.

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4. Buy-in Begin Date

Some individuals have a delay in Buy-in coverage:

Classifications	Buy-in Begin Date
<i>SSI and AG recipients</i> (includes dually-eligible)	1st month of eligibility
CN and MN who are dually-eligible (countable income < 100% FPL and Medicare Part A)	1st month of eligibility
CN and MN who are not dually-eligible (countable income > 100% FPL or no Medicare Part A)	3 rd month of eligibility

If the medically needy coverage begin date is other than the first day of a month, Buy-in is effective the first day of the month in which the 60th day after the begin date occurs.

D. Other Third Party Liability

When the agency identifies another third party which has responsibility to pay for a recipient's medical bill, the agency must report the third party to:

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

Examples of other third parties include liability insurance settlements, trust funds established for the recipient's medical care, awards resulting from liability lawsuits, and persons ordered by the court to pay for the recipient's medical care.

E. Pursuing Third Party Liability and Medical Support

In order to continue to be eligible for Medicaid, an individual who is required to assign rights to, and cooperate in, pursuing medical support and third party liability must continue to cooperate with the local agency and DMAS. See subchapter M0250 for details.

M1510.302 SOCIAL SECURITY NUMBERS

A. Policy

Applicants must provide the Social Security number (SSN) of any person for whom they request Medicaid, or must apply for a Social Security number if he/she does not have one. An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

When an individual has applied for an SSN and is determined eligible for medical assistance, the worker must take follow-up action to obtain the individual's SSN.

B. Procedures

See subchapter M0240 for the SSN application follow-up procedures required after enrolling an eligible individual who has applied for an SSN.

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M1510.303 PATIENT PAY INFORMATION

A. Policy

After an individual in long-term care is found eligible for Medicaid, the recipient's patient pay must be determined. When the patient pay amount is initially established or when it is changed, the worker enters the information in MMIS. MMIS sends the "Notice of Obligation for Long-Term Care Costs" to the enrollee or the enrollee's authorized representative.

B. Procedure

When patient pay increases, the MMIS "Notice of Obligation for Long-Term Care Costs" is sent in advance of the date the new amount is effective.

CHAPTER M15
ENTITLEMENT POLICY & PROCEDURES
SUBCHAPTER 20

MEDICAL ASSISTANCE ELIGIBILITY REVIEW

M1520 Changes

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

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M1520.000 MEDICAL ASSISTANCE ELIGIBILITY REVIEW

M1520.001 GENERAL PRINCIPLE

A. Policy

A MA recipient's eligibility must be partially reviewed whenever the agency becomes aware of any change in the enrollee's circumstances that might affect the enrollee's continued eligibility.

An annual review of all of the enrollee's eligibility requirements is called a "renewal." A renewal of the enrollee's eligibility must be completed at least once every 12 months. The renewal should be initiated in the 11th month to ensure timely completion of the renewal. The timeframe for acting on a change or renewal is 30 calendar days from the report of the change or upon receipt of the completed renewal form. When a telephone interview is conducted for a renewal, the 30 day period begins upon completion of the telephone interview.

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

When an enrollee no longer meets the requirements for his current covered group, prior to cancelling his coverage, he must be evaluated in all covered groups for which he may meet the definition. If the individual is not eligible for full benefit Medicaid coverage and is not eligible as a Medicare beneficiary, he must be evaluated for Plan First, unless he has declined that coverage.

1. Negative Action Requires Notice

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

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

2. Renewal Approval Requires Notice

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

3. Voter Registration

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

B. Procedures For Partial Review and Renewals

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

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

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M1520.100 PARTIAL REVIEW

A. Enrollee's Responsibility Enrollees must report changes in circumstances which may affect eligibility and/or patient pay within 10 days from the day the change is known. For enrollees participating in the Health Insurance Premium Payment (HIPP) Program, changes that may affect participation in HIPP must also be reported to the DMAS HIPP Unit within the 10 day timeframe.

B. Eligibility Worker's Responsibility The eligibility worker has a responsibility for keeping a record of changes that may be anticipated or scheduled, and for taking appropriate action on those changes.

Appropriate agency action on a reported change must be taken within 30 days of the report. If the enrollee reports any changes requiring verifications, such as changes in income or resources, or an asset transfer for enrollees receiving long-term-care (LTC) services, send the enrollee a checklist requesting the necessary verifications, and allow at least 10 calendar days for the information to be returned. Document the information and evaluation in the case record.

1. Changes That Require Partial Review of Eligibility When changes in an enrollee's situation are reported by the enrollee or when the agency receives information indicating a change in an enrollee's circumstances (i.e. *Supplemental Security Income* [SSI] purge list, reported transfer of assets), the worker must take action to partially review the enrollee's continued eligibility.

A reported increase in income and/or resources can be acted on without requiring verification, unless a reported change causes the individual to move from a limited-benefit covered group to a full-benefit covered group. The reported change must be verified when it causes the individual to move from a limited-benefit covered group to a full-benefit covered group.

2. Changes That Do Not Require Partial Review When changes in an enrollee's situation are reported or discovered, such as the enrollee's *Social Security number* (SSN) and card have been received, the worker must document the change in the case record and take action appropriate to the reported change in the appropriate computer system(s).

Example: The MA enrollee who did not have an SSN, but applied for one when he applied for MA, reports by calling the worker that he received his SSN. The worker records the telephone call and the enrollee's newly assigned SSN in the case record, verifies the SSN via SPIDeR and enters the enrollee's verified SSN in the eligibility determination/enrollment systems.

3. HIPP The eligibility worker must provide the enrollee with a copy of the HIPP FACT Sheet when it is reported that he or a family member is employed more than 30 hours per week and is eligible for coverage under an employer's group health plan. The HIPP Fact Sheet is available on-line at: <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>. The eligibility worker must report to the HIPP Unit at DMAS any changes in an enrollee's situation that may affect the premium payment. The worker may report changes by e-mail to [happ@dmass.virginia.gov](mailto:hipp@dmass.virginia.gov). This e-mail address is for use by the local agency staff only. See M0130.200 G for additional information about HIPP requirements.

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4. Program Integrity

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

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

C. Covered Group and Aid Category Changes

1. Enrollee's Situation Changes

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

- a pregnant woman reaches the end of her post-partum period (the month in which the 60th day after the end of the pregnancy occurs),
- a newborn child reaches age one year,
- a families & children's (F&C) enrollee becomes entitled to SSI, and
- an SSI Medicaid enrollee becomes a Qualified Severely Impaired Individual (QSII) (1619(b)).

5. Enrollee in Limited Coverage Becomes Entitled to Full Coverage

When an individual who has been enrolled in limited coverage, such as Plan First, experiences a change, such as pregnancy, that results in eligibility for full coverage, the individual's entitlement to full coverage begins the month the individual is first eligible for full coverage, regardless of when or how the agency learns of the change. The enrollee must provide verification of income or other information necessary to establish eligibility for full coverage.

Example: In June 2016, a woman enrolled in Plan First reports that she became pregnant in December 2015. She provides verification of her income for December 2015. Her coverage in AC 080 (Plan First) is cancelled retroactively using cancel code 024, and she is reinstated in AC 091 effective December 1, 2015, the earliest month her entitlement to full coverage began.

6. Enrollee Turns Age 6

When an enrolled child turns six years old, MMIS automatically changes the child's AC from 090 or 091 to AC 092 (ages 6-19, insured or uninsured with income less than or equal to 109% FPL OR **insured** with income greater than 109% FPL and less than or equal to 143% FPL).

If the child is **uninsured** with income greater than 109% FPL and less than or equal to 143% FPL, manually change the child's AC to AC 094 no later than at the next renewal.

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D. Child Moves From Parental Home

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

1. Case Management

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

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

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

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

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

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2. MMIS Enrollment

a. MMIS Case Number

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

b. MMIS Demographics Comment Screen

On the child's MMIS Demographics screen, enter a Comment that will inform staff that the person with whom the child lives cannot be given information from the child's MMIS records. Type a message in the Comment screen that says "information from the case cannot be shared with (the name of the person with whom the child lives) because he/she is NOT authorized to receive the information."

c. Renewal Date

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

d. Medicaid Card

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

3. Obtain Authorization from Parent Prior to Renewal

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

4. Renewal

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

E. Recipient Enters LTC

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

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

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

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

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

F. Changes Between Coverage Under MA and the Governor's Access Plan (GAP)

If an individual enrolled in Plan First subsequently applies and is eligible for GAP, staff at the GAP Unit with the Cover Virginia Call Center will cancel the Plan First coverage and reinstate GAP coverage. The GAP Unit will send a Communication Form to the local agency to report the GAP enrollment. The worker will close Plan First coverage in VaCMS using the override function and notify the individual of the Plan First cancellation.

When an individual enrolled in GAP coverage becomes eligible for MA, prior to enrollment in Medicaid, the local eligibility worker will send a Communication form to the GAP Unit to report eligibility for Medicaid/FAMIS and the effective date of coverage. GAP Unit staff will cancel GAP coverage within two work days. Once GAP coverage is cancelled, the local eligibility worker will complete the MA enrollment and send notice of eligibility to the enrollee. The GAP Unit will send separate notice of the GAP cancellation.

M1520.200 RENEWAL REQUIREMENTS

A. Policy

The agency must evaluate the eligibility of all MA enrollees, with respect to circumstances that may change, at least every 12 months. Each renewal must be authorized by an eligibility worker or supervisor, although administrative staff may assist in the gathering of information.

The scope of renewals is limited to information that is necessary to determine ongoing eligibility and that relates to circumstances that are subject to change, such as income and resources. Verification of information that is not subject to change, such as date of birth and SSN, is not required at renewal, unless it has not been verified previously.

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1. Required Verifications

An individual's continued eligibility for MA requires verification of income for all covered groups and resources for covered groups with resource requirements.

Whenever the necessary renewal information is available to the worker through data verification sources and policy permits, the client is not to be contacted and the renewal is to be completed ex parte (see M1520.200 B.1). Verification of income obtained through available verification sources may be used if it is dated within the previous 12 months.

When it is necessary to obtain information and/or verifications from the enrollee, a contact-based renewal must be completed. *If an enrollee's attested resources are over the resource limit, the applicant or authorized representative must be given the opportunity to provide verification of the resources. The renewal must be signed by the enrollee or authorized representative.*

Blindness and disability are considered continuing unless it is reported that the individual is no longer blind or disabled.

2. SSN Follow Up

If the enrollee's SSN has not been assigned by the renewal date, the worker must obtain the enrollee's assigned SSN at renewal in order for coverage to continue. See subchapter M0240 for detailed procedures for obtaining the SSN.

3. Evaluation and Documentation

An evaluation of the information used to determine continued eligibility must be completed and included in the case record. For SSI Medicaid ex parte renewals, the Record of Ex Parte Medicaid Renewal (#032-03-0740) is recommended.

For other renewals of cases outside of VACMS, the Evaluation of Eligibility (#032-03-0823), available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi>, is recommended to document the case record.

4. Renewal Period

Renewals must be completed prior to cut-off in the 12th month of eligibility. The first 12-month period begins with the month of application for Medicaid.

B. Renewal Procedures

Renewals may be completed in the following ways:

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

1. Ex Parte Renewals

An ex parte renewal is an internal review of eligibility based on information available to the agency. Conduct renewals of ongoing Medicaid eligibility through the ex parte renewal process when:

- the local agency has access to on-line systems information for verifications necessary to determine ongoing eligibility and/or income verifications obtained for other benefit programs, and
- the enrollee's covered group is not subject to a resource test.

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

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

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

The eligibility worker must document the date and method used to obtain the verification information (viewed pay stub dated xx/xx/xxxx, telephone call on xx/xx/xxxx date, etc.), the type of verification, the source and a description of the information. It is not necessary to retain a copy of income verifications in the case record. If the renewal is not processed and documented electronically, the documentation must be in the case record.

- b. \$0 Income Reported** *When the household members all reported \$0 income at application, search the Virginia Employment Commission (VEC) online quarterly wage data and unemployment records and other agency records to verify the absence of income. If an individual receives benefits through other benefit programs and/or childcare, income information in those records must also be reviewed.*

If the VEC inquiry and review of other agency records confirms that the household has not received wages, unemployment compensation, or other unearned income within the most recent reporting period, document the absence of verifiable income and determine or redetermine income eligibility. No statement regarding income is necessary from the individual.

If the inquiry indicates recent or current income that is countable for the MAGI determination, follow the steps in M1520.200 B.2 below for completing a paper-based renewal.

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

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

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

- d. Continuing Eligibility Not Established Through Ex Parte Process*** *If the ex parte renewal results in the individual no longer being eligible for coverage, the individual must be given the opportunity to submit current income information and verifications. Follow the steps in M1520.200 B.2 below for completing a paper-based renewal.*

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2. Paper Renewals

When an ex parte renewal cannot be completed, send the enrollee a pre-filled paper Administrative Renewal form to sign and return. *Send the form to the authorized representative if one has been designated.*

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

The enrollee must be allowed 30 days to return the renewal form and the necessary verifications. The form needs to be sent to the enrollee no later than the beginning of the 11th month of the eligibility cycle to allow for the 30 day return period and processing prior to the MMIS cutoff on the 16th of the month. The specific information requested and the deadline for receipt of the verification must be documented in the case record.

New or revised information provided by the enrollee must be entered into the system. Local agencies are to accept the Application for Health Coverage & Help Paying Costs if it is submitted in lieu of a renewal form.

When an individual does not return the renewal form and action is taken to cancel coverage, a three-month reconsideration period applies (see M1520.200 C.4).

Note: Follow Auxiliary Grants (GR) policy regarding the appropriate renewal form to use for AG/Medicaid enrollees.

3. Online and Telephonic Renewals

Enrollees may opt to complete a renewal online using CommonHelp or by telephone through the Cover Virginia Call Center.

Renewals completed through CommonHelp are electronically signed by the enrollee or authorized representative. For cases in VaCMS, renewals completed through CommonHelp will automatically be entered into VaCMS for the worker to complete processing. For non-VaCMS cases, the renewal must be completed manually. It is not necessary to print a renewal completed through CommonHelp for the case record because it will be maintained electronically; however, the evaluation of eligibility and verifications must be documented in the case record.

Telephonic renewals may be taken only by the Cover Virginia Call Center. Telephonic renewals cannot be taken directly by the local agency because a telephonic signature is required.

C. Disposition of Renewal

The enrollee must be informed in writing of the findings of the renewal and the action taken using the Notice of Action when continued eligibility exists. Advance written notice must be used when there is a reduction of benefits or termination of eligibility (see M1520.300).

1. Renewal Completed

Notify the enrollee in writing of the findings of the renewal and the action taken. When eligibility continues, use the Notice of Action, and include the month and year of the next scheduled renewal. When the individual is no longer eligible, use the Advance Notice of Proposed Action and include spenddown information, if applicable. When there is a reduction of benefits, use the Advance Notice of Proposed Action and include the month and year of the next scheduled renewal.

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2. Renewal Not Completed

If information necessary to redetermine eligibility is not available through online information systems that are available to the agency and the enrollee has been asked but has failed to provide the information, the renewal must be denied and the coverage cancelled using cancel reason “005” due to the inability to determine continued eligibility. Action cannot be taken to cancel coverage until after the deadline for the receipt of verifications has passed, except for situations when the deadline falls on a weekend or holiday.

3. Referral to Health Insurance Marketplace (HIM)

Unless the individual has Medicare, a referral to the HIM—also known as the Federally Facilitated Marketplace (FFM)—must be made when an individual’s coverage is cancelled so that the individual’s eligibility for the Advance Premium Tax Credit (APTC) in conjunction with a Qualified Health Plan (QHP) can be determined. If the individual’s renewal was not processed in VaCMS, his case must be entered in VaCMS in order for the HIM referral to be made.

4. Renewal Filed During the Three-month Reconsideration Period

If the individual’s coverage is cancelled because the individual did not return the renewal form (or complete an online or telephonic renewal) or requested verifications, the Affordable Care Act (ACA) requires a reconsideration period of 90 days be allowed for an individual to file a renewal or submit verifications. For MA purposes, the 90 days is counted as three calendar months. *The individual must be given the entire reconsideration period to submit the renewal form and any required documentation.* The reconsideration period applies to all renewals, including renewals for the Qualified Medicare Beneficiary (QMB) and Qualified Individuals (QI) covered groups.

If the individual files a renewal or returns verifications *at any time* during the reconsideration period and is determined to be eligible, reinstate the individual’s coverage back to the date of cancellation. Send a Notice of Action informing him of the reinstatement, his continued coverage and the next renewal month and year. See M1520, Appendix 1 for the Renewal Process Reference Guide.

If the individual is not eligible, send a Notice of Action indicating the correct reason for the cancellation (e.g. countable income exceeds the limit). Renewal forms filed after the end of the reconsideration period are treated as reapplications. Accept the form and request any additional information needed to determine the individual’s eligibility.

D. Special Requirements for Certain Covered Groups

1. Pregnant Woman

Do not initiate a renewal of eligibility of an MI pregnant woman, or a pregnant woman in any other covered group, during her pregnancy. Eligibility in a

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pregnant woman covered group ends effective the last day of the month in which the 60th day following the end of the pregnancy occurs.

When eligibility in a pregnant woman covered group ends, prior to the cancellation of her coverage, determine if the woman meets the definition for another Medicaid covered group (see M0310.002). If the woman meets the definition of a full-benefit covered group, or for limited coverage under Plan First, determine if an ex parte renewal can be completed or if a renewal form is required and take appropriate action.

If the woman does not meet the definition and/or the income requirements for another full-benefit covered group, determine her eligibility in the limited benefit Plan First covered group using the eligibility requirements in M0320.302.

2. Newborn Child Turns Age 1

A *renewal* must be completed for a child enrolled as a Newborn Child Under Age 1 before MMIS cut-off in the last month in which the child meets the Newborn Child Under Age 1 covered group and must include:

- SSN or proof of application
- verification of income
- verification of resources for the MN child.

The ex parte process may be used if appropriate.

3. Child Under Age 19—Income Exceeds FAMIS Plus Limit

When an enrolled FAMIS Plus child no longer meets the *FAMIS Plus* income limits *and there is not an LIFC parent on the case*, evaluate the child for the FAMIS, using the eligibility requirements in chapter M21. If the child is eligible for FAMIS, send the family an Advance Notice of Proposed Action that Medicaid will be cancelled effective the last day of the month in which the 10-day advance notice expires and the FAMIS coverage will begin the first day of the month following the Medicaid cancellation. Use cancel reason “042” when the child loses eligibility in Medicaid and is reinstated in FAMIS and there is no break in coverage.

Do not use change transactions to move a child between Medicaid and FAMIS. If the child is not eligible for FAMIS, the worker must provide an opportunity for the child to be evaluated as medically needy (MN) **prior** to sending an advance notice and canceling the child’s Medicaid coverage.

4. Child Receiving LTC Services Turns 18

A child enrolled in the F&C 300% of SSI covered group no longer meets the covered group upon turning 18, unless he meets another F&C definition (e.g. pregnant woman or parent of a dependent child). A referral to Disability Determination Services (DDS) must be made at least 90 calendar days prior to the child’s 18th birthday to allow the disability determination to be made prior to the child’s 18th birthday.

5. FAMIS Plus Child Turns Age 19

When a FAMIS Plus child turns age 19, redetermine the child’s continuing Medicaid eligibility in other covered groups.

If information in the case record indicates that the child is disabled or may be disabled, verify the child’s SSI benefits through SVES or SOLQ-I. If the child does not receive SSI, complete a referral to DDS following the procedures in M0310.112. The referral to DDS must be made at least 90 calendar days prior to the child’s 19th birthday to allow the disability determination to be made prior to the child’s 19th birthday.

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If the child does not meet the definition for another covered group, determine the child's eligibility in Plan First using the eligibility requirements in M0320.302. If the child is eligible for Plan First, reinstate coverage in Plan First and send the Advance Notice of Proposed Action indicating that he has been enrolled in Plan First. On the notice, state that if he does not wish to remain covered by Plan First, to contact the eligibility worker and request that the coverage be cancelled. Include a Plan First Fact Sheet, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>, with the Advance Notice of Proposed Action.

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

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

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

7. Child Under 21 Turns Age 21

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

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

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

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

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

The BCCPTA Redetermination Form (#032-03-653), is used to redetermine eligibility for the BCCPTA covered group. The form is available on SPARK at: <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.html>. The enrollee must provide a statement from her medical provider verifying continued treatment for breast or cervical cancer. There are no Medicaid financial requirements for the BCCPTA covered group.

10. Hospice Covered Group

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

11. Qualified Individuals

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

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E. LTC

The ex parte renewal process is used for institutionalized individuals who receive SSI and have no countable real property. It can also be used for F&C enrollees subject to MAGI methodology when the local agency has access to on-line information for verifications necessary to determine ongoing eligibility and/or income verifications obtained for other benefit programs.

ABD, as well as F&C individuals over age 18, in the 300% of SSI covered group LTC must complete a contact-based renewal due to the resource requirement.

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

F. Incarcerated Individuals

Incarcerated individuals who have active Medicaid are subject to annual renewals. Renewals for individuals in Department of Corrections and Department of Juvenile Justice facilities will be handled through the designated liaison.

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

Although benefits administered by the Social Security Administration are suspended while an individual is incarcerated, a disabled individual continues to meet the definition of a disabled individual while incarcerated.

M1520.300 MA CANCELLATION OR SERVICES REDUCTION

A. Policy

At the time of any action affecting an individual's MA coverage, federal regulations in 42 CFR 431.206 through 431.214 require the agency to inform every applicant or enrollee in writing

- of his right to a hearing;
- of the method by which he may obtain a hearing; and
- that he may represent himself or use legal counsel, a relative, a friend or other spokesperson.

Send any notices and other correspondence to the authorized representative, if one has been designated.

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B. Procedures

1. Change Results in Adverse Action

Following a determination that eligibility no longer exists or that the enrollee's Medicaid services must be reduced, the Advance Notice of Proposed Action, available on SPARK at:

<http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi> or system-generated advance notice must be sent to the enrollee at least 10 days plus one day for mail, before action is taken to cancel or reduce Medicaid coverage.

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

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

2. Enrollee Appeals Action

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

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

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

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

3. Death of Enrollee

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

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

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

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

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

4. Enrollee Enters Ineligible Institution

When an enrollee who is not incarcerated enters an institution and is no longer eligible (e.g. an individual between the ages of 22 and 65 enters an institution for the treatment of mental diseases), cancel coverage as soon as possible after learning of the enrollee's admission to an ineligible institution. **DO NOT cancel coverage retroactively.** Cancel coverage in the MMIS effective the current date (date the worker enters the cancel transaction in MMIS), using cancel reason code "008."

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

5. End of Spenddown Period

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

6. Reason "012" Cancellations

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

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

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

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7. Enrollee Requests Cancellation

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

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

On the notice:

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

M1520.400 EXTENSIONS OF MEDICAID COVERAGE

A. Policy

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

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

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

Prior to evaluating a child for the Medicaid extensions, review the child's eligibility in the Child Under Age 19 (FAMIS Plus) covered group. If he is eligible, update his renewal date. If the child is ineligible as a Child Under Age 19, evaluate his eligibility for the Medicaid extensions.

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

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If ineligible for the Medicaid extensions, the child must be evaluated for FAMIS. If ineligible for FAMIS, the *child* must be given an opportunity for a medically needy determination prior to the worker taking action to cancel the Medicaid coverage *and* unless *the child* has Medicare, a referral to the HIM must be made.

B. Procedure

The policy and procedures for the four-month extension are in section M1520.401 below.

The policy and procedures for the twelve-month extension are in section M1520.402 below.

M1520.401 FOUR-MONTH EXTENSION

A. Policy

An LIFC Medicaid family is entitled to four additional months of Medicaid coverage after the family loses Medicaid LIFC eligibility when the following conditions are met:

- The *parent or caretaker-relative* received Medicaid as LIFC in at least three of the six months immediately preceding the month in which they became ineligible for LIFC;
- The *parent or caretaker-relative* lost eligibility solely or partly due to receipt of or increased spousal support income; and
- All other Medicaid eligibility factors except income are met.

B. Procedures

1. Received in Error

For purposes of this subsection, "received Medicaid as LIFC" does not include received Medicaid erroneously. Therefore, a family who received Medicaid erroneously during three or more of the six months before the month of ineligibility does **not** qualify for the Medicaid extension.

2. New Family Member

A new member of the family, other than a newborn, is eligible for Medicaid under this provision if he/she was a member of the family in the month the unit became ineligible for LIFC Medicaid. A newborn born to an eligible member of the family at any time during the 4-month extension is eligible under this provision because the baby meets the CN newborn child under age 1 covered group.

3. Moves Out of State

Eligibility does not continue for any member of the family who moves to another state.

4. Coverage Period and AC

Medicaid coverage will continue for a period of four months beginning with the month in which the family became ineligible for LIFC Medicaid because *of the receipt of or increase in spousal support*. The AC for the enrollees in the family *receiving the four-month extension is "081"* for an LIFC family with one parent or caretaker-relative or "083" for a two-parent family.

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5. Case Handling

Prior to the end of the fourth month of the extension, evaluate the individuals in the family for continuing Medicaid eligibility. Cancel coverage for any individuals in the family who are no longer eligible and send advance notice of the cancellation. Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made so that the individual's eligibility for the APTC in conjunction with a QHP can be determined.

M1520.402 TWELVE-MONTHS EXTENSION

A. Policy

An LIFC Medicaid family is entitled to six additional months, with possible extension to twelve months, of Medicaid coverage after they lose Medicaid LIFC eligibility when the following conditions are met:

- The parent or caretaker-relative received Medicaid as LIFC in at least three of the six months immediately preceding the month in which they became ineligible for LIFC;
- The parent or caretaker-relative lost eligibility solely or partly due to receipt of or increased income from earnings; and
- All other Medicaid eligibility factors except income are met.

The family consists of those individuals included in the family unit as defined in M0520.100 at the time that the LIFC Medicaid eligibility terminated. It also includes individuals born, adopted into, or returning to the family after extended benefits begin who would have been considered a member of the family at the time the LIFC Medicaid eligibility terminated. The earned income received by a member of the family unit added after the loss of LIFC eligibility must be counted in determining the family's gross income.

B. Eligibility Conditions

The following conditions must be met:

1. Received LIFC Medicaid in Three of Six Months

The family received LIFC Medicaid in at least three of the six months immediately before the month in which the family became ineligible for LIFC. *A family who received Medicaid erroneously during three or more of the six months before the month of ineligibility does **not** qualify for the Medicaid extension.* Months during which the family received Extended Medicaid are not considered months in which the family received LIFC Medicaid.

2. Cancel Reason

LIFC Medicaid was canceled solely because of:

- the parent's or caretaker/relative's new employment,
- the parent's or caretaker/relative's increased hours of employment, or
- the parent's or caretaker/relative's increased wages of employment.

3. Has A Child Living in Home

There continues to be at least one child under age 18 or if in school, a child who is expected to graduate before or in the month he turns 19, living in the home with the parent or caretaker/relative.

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4. No Fraud

The family has not been determined to be ineligible for LIFC Medicaid because of fraud any time during the last six months in which the family received LIFC Medicaid.

C. Entitlement & Enrollment

The AC for enrollees in the family receiving the twelve-month extension is "081" for an LIFC family with one parent or caretaker-relative or "083" for a two-parent family.

Entitlement does not continue for any member of the *family* who moves to another state.

1. Determining Extension Period

Medicaid coverage will continue for six months beginning with the first month the family is not eligible for LIFC Medicaid because of excess income due to the increased earnings of the parent or caretaker/relative. Extension for an additional six-month period is possible if the reporting and financial requirements below are met.

a. New/increased Earnings Not Reported Timely

When the new/increased earnings were not reported so that action to cancel LIFC Medicaid could be taken in a timely manner, the extension period begins the month following the month the family would have last received LIFC Medicaid if reported timely.

For example, if the increased earnings were received in April, but were not reported or discovered until a review of eligibility in June, the 12-month period begins with May, the first month LIFC Medicaid should not have been received. The screening period to determine if the family received LIFC Medicaid in at least three of the six months immediately preceding the month in which the family became ineligible for LIFC Medicaid will be November to April.

b. Simultaneous Income Changes

In situations where a case has simultaneous income changes which cause LIFC Medicaid ineligibility, such as new or increased earned income plus an increase in *spousal* support, the eligibility worker must determine if the case would have been ineligible due to new or increased earnings. This requires that the eligibility worker recalculate the LIFC income eligibility only considering the increased earned income.

- 1) If the family would have been ineligible solely *due to the increase in earned income*, it will be considered the reason for LIFC Medicaid ineligibility and the family is eligible for the twelve-month Medicaid extension.
- 2) If, however, the family would have continued to be eligible for LIFC Medicaid if the only change had been increased earnings, the other changes which occurred simultaneously will be the reason for LIFC Medicaid ineligibility. The *family* is **not** eligible for the twelve-month Medicaid extension. *If the reason for LIFC Medicaid ineligibility was due to the receipt of or increase in spousal support, evaluate the family's eligibility for the four-month extension in M1520.401.*

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2. Extension Ends

Entitlement to Medicaid under this extension terminates at the end of the first month in which there is no longer a child under 18 (or if in school, a child who is expected to graduate before or in the month he turns 19), living in the home, the family fails to comply with the reporting requirements in 1520.402 D below, or at the end of the extension period.

The individuals must be evaluated for continuing Medicaid eligibility prior to cancellation. Cancel coverage for any individuals in the family who are no longer eligible and send advance notice of the cancellation. Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.

D. Notice and Reporting Requirements

The Virginia Case Management System (VaCMS) generates the appropriate report forms and notices when the worker has approved extended Medicaid in the system. Instructions for managing an extended Medicaid case are contained in the "Extended Medicaid in the VaCMS" Quick Reference Guide (QRG) available in VaCMS.

1. LIFC Medicaid Cancellation Month

When LIFC Medicaid is canceled, the family must be notified of its entitlement to extended Medicaid coverage for six months, and that Medicaid coverage will terminate if the child(ren) in the home turns age 18, or turns age 19 if the child is in school and is expected to graduate before or in the month he turns 19. *Use the VaCMS-generated Notice of Extended Medicaid Coverage form.*

a. Notice and Instructions

The family must be instructed to retain verifications of all earnings received during each month of the extension and attach verifications of the first three-month period's earnings to the agency by the 21st day of the fourth month in the extension period. The instructions are on the Notice of Extended Medicaid Coverage and on the second page of the notice, which is the Medicaid Extension Earnings Report.

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2. Third Month of Extension

In the third month of extension, the unit must be notified again that it must return the Medicaid Extension Earnings Report, with the earnings verifications attached, to the agency by the 21st of the following month (the fourth month).

This notice will be *generated by VaCMS* if the correct Follow-up Code and effective date of the 12-month extension are entered.

The notice will state that if the earnings report and verifications are not received by the 21st day of the fourth month, Medicaid coverage will be canceled effective the last day of the sixth month, and that the family will not be eligible for any additional Medicaid extension.

3. Fourth Month of Extension

a. Report Received Timely

If the first three-month period's report is received by the 21st day of the fourth month, and the family continues to include a child, entitlement to extended Medicaid continues. *The worker must update VaCMS* when the report is received in order for Extended Medicaid to continue. No action is taken on the first three-month period's earnings.

If eligibility is not reviewed by the **cut-off date** of the sixth extension month, *VaCMS* will cancel coverage. The agency must reopen coverage for any individuals who remain eligible in another Medicaid covered group or in FAMIS and must notify the individual of the reopened coverage.

b. Notice Requirements

VaCMS will *generate* the advance notice and cancel coverage at the end of the sixth month if the initial Follow-up Code and Date were entered correctly, and the code is **not** updated because the report was not received on time. If the code was not entered correctly, the agency must manually send the Advance Notice of Proposed Action and must cancel the ineligible individual's coverage after the Medicaid cut-off date in the fifth month. The effective date of cancellation will be the last day of the sixth month in the extension period.

c. Report Not Received Timely

If the first three-month period's report is not received by the 21st day of the fourth month, the family is not eligible for the additional six-month extension. Medicaid must be canceled effective the last day of the sixth month in the extension period for any individuals who are not eligible for coverage in another Medicaid covered group or for FAMIS. Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.

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4. Sixth Month of Extension

In the sixth month of extension, the family must be notified that it must return the "Medicaid Extension Earnings Report" for the previous three-month period (the fourth through the sixth month), with the earnings verifications for those three months attached, to the agency by the 21st day of the seventh month of extension.

The notice must state that if this three-month period's report and verifications are not returned by the 21st day of the seventh month, Medicaid coverage will be canceled effective the last day of the eighth month of extension.

VaCMS will generate this notice if the Follow-up Code in the base case information is correct. If it is not correct, the agency must manually send this notice.

5. Seventh Month of Extension

a. Report Received Timely

If the second three-month period's report is received by the 21st of the seventh month, *update VaCMS* immediately upon receipt of the report and verifications. The family will continue to be eligible for extended Medicaid coverage unless:

- 1) no child under age 18, or if in school, a child who is expected to graduate before or in the month he turns 19, lives with the family;
- 2) the parent or caretaker/relative had no earnings in one or more of the previous three months, unless the lack of earnings was due to:
 - the parent's or caretaker/relative's involuntary lay-off,
 - the business closed,
 - the parent's or caretaker/relative's illness or injury,
 - other good cause (such as serious illness of child in the home which required the parent's or caretaker/relative's absence from work);
- 3) the family's average gross monthly **earned** income (earned income only; unearned income is not counted) less costs for child care that was necessary for the employment of the caretaker/relative, during the preceding three-month period exceeds the 185% Federal Poverty Level (FPL) appropriate to the family unit size. See M1520, Appendix 2, for the 185% FPL income limits.

b. Calculate Family's Gross Earned Income

- 1) The family's gross earned income means the earned income of all family members who worked in the preceding three-month period. "Gross" earned income is total earned income before any deductions or disregards and profit from self-employment. All earned income must be counted, including students' earned income, Workforce Investment Act (WIA) earned income, children's earned income, etc. No exclusions or disregards are allowed. Use policy in M0720.200 for determining profit from self-employment.
- 2) Child care costs that are "necessary for the caretaker/relative's employment" are expenses that are the responsibility of the

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caretaker/relative for child care that if not provided would prevent the caretaker/relative from being employed.

3) To calculate average gross monthly income:

- add each month's cost of child care necessary for the caretaker/relative's employment; the result is the three-month period's cost of child care necessary for the caretaker/relative's employment.
- add the family unit's total gross earned income received in each of the 3 months; the result is the family's total gross earned income.
- subtract the three-month period's cost of child care necessary for the caretaker/relative's employment from the family's total gross earned income.
- divide the remainder by 3; the result is the average monthly earned income.
- compare the average monthly earned income to the monthly 185% FPL for the appropriate number of family unit members (see M1520, Appendix 2).

c. Family No Longer Entitled To Extended Medicaid

If the family is not entitled to further Medicaid coverage because of one of the reasons in item M1520.402 D.5.a above, each individual's eligibility for Medicaid in another covered group or for FAMIS must be determined before canceling coverage. Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.

d. Family Remains Entitled To Extended Medicaid

If the family remains eligible for Extended Medicaid, no action is required until the ninth month of extension, except to be sure that *the extended Medicaid information in VaCMS is up to date.*

e. Report Not Received Timely

If the second three-month period's report and verifications are not received by the 21st day of the seventh month, the family's Medicaid coverage must be canceled for individuals who are not eligible for Medicaid in another covered group or for FAMIS unless the family establishes good cause for failure to report on a timely basis. Examples of good cause for failure to report timely are:

- illness or injury of family member(s) who is capable of obtaining and sending the material;
- agency failure to send the report notice to the family in the proper month of the extension.

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Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.

VaCMS will generate the advance notice and cancel coverage if the report is not received on time and the code is not changed. Cancellation is effective the last of the eighth month of extension.

If an individual's continuing eligibility is not reviewed by the **cut-off date** of the eighth extension month and coverage is cancelled, the agency must then reopen coverage and notify the recipient if he is subsequently found eligible. If an individual remains eligible, change the individual's enrollment to the appropriate aid category before the **cut-off date** of the eighth extension month.

6. Ninth Month of Extension

In the ninth month of extension, the family must be notified that it must return the "Medicaid Extension Earnings Report" with earnings verifications attached, for the previous three-month period (seventh through ninth month) to the agency by the 21st day of the tenth month of the extension.

The notice must state that if the report and verifications are not returned by 21st day of the tenth month, Medicaid coverage will be canceled effective the last day of the eleventh month of extension.

VaCMS will generate this notice if the correct Follow-up Code is in the base case information.

7. Tenth Month of Extension

a. Report Received Timely

If the third three-month period's report is received by the 21st of the tenth month, *update VaCMS* immediately upon receipt of the report and verifications. The family continues to be eligible for Medicaid unless one of the items in M1520.402 D.5 above applies. Calculate the family's income using the procedures in M1520.402 D.5 above.

b. Family No Longer Entitled To Extended Medicaid

If the family is not entitled to **extended** Medicaid coverage, review each individual's eligibility for Medicaid in another category or for FAMIS. If the individual is not eligible, cancel Medicaid after sending the **Advance Notice of Proposed Action**. Cancellation is effective the last day of the eleventh month of extension. Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.

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c. Family Remains Entitled To Extended Medicaid

If the family remains entitled to Extended Medicaid coverage, a redetermination of the family's Medicaid eligibility must be completed by the Medicaid cut-off in the twelfth month.

d. Report Not Received Timely

If the third three-month period's report and verifications are not received by the 21st of the tenth month, Medicaid coverage must be canceled for individuals who are not eligible for Medicaid in another covered group or for FAMIS unless the family establishes good cause for failure to report timely (see M1520.402 D.5 above for good cause). Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.

VaCMS will cancel coverage and *generate* the advance notice if the report is not received on time and the Follow-up Code is not changed. Cancellation is effective the last day of the eleventh month of extension.

8. Twelfth Month of Extension

Before Medicaid cut-off in the twelfth month, complete the family's redetermination. *VaCMS* will cancel coverage and *generate* the advance notice after cut-off of the twelfth month, if the Follow-up Code was updated correctly. Therefore, for any of the family members that remain eligible for Medicaid or FAMIS, the AC and the Follow-up Code must be changed before cut-off of the twelfth month.

Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.

M1520.500 CASE TRANSFERS

A. Introduction

Applications and ongoing cases are transferred only when the individual retains residence in Virginia.

B. Nursing Facility and Assisted Living Facility (ALF)

When an individual is admitted to a nursing facility or an ALF from a community living arrangement, the case is not transferred, but remains with the Virginia locality in which the individual last lived outside of an institution. Community living arrangements do not include medical facilities, ALFs or group homes with four or more beds.

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When an applicant/recipient is discharged from a nursing facility or ALF to a community living arrangement not in the Virginia locality that had responsibility for the individual's case while he was in the nursing facility or ALF, the case is transferred to the new locality.

C. DBHDS Facilities

The procedures for transfer of Medicaid cases of ABD patients admitted to or discharged from Department of Behavioral Health and Developmental Services (DBHDS) facilities are in subchapter M1550. F&C cases are not transferred to the DBHDS facilities.

D. Cases From Outstationed Workers

Medicaid applications taken and Medicaid cases approved by outstationed workers, such as the workers stationed at the University of Virginia (UVA) and Virginia Commonwealth University-Medical College of Virginia (VCU-MCV) hospitals, must be transferred to the LDSS where the applicant/enrollee lives. Medicaid cases and applications are **not** transferred from LDSS to outstationed workers.

1. Confirm Receipt

The receiving LDSS must confirm receipt of the case by completing the Case Record Transfer Form and returning the copy to the outstationed worker.

2. Review Eligibility

LDSS workers must review (partial review) the Medicaid eligibility determination in approved cases transferred from an outstationed worker, and must take any necessary corrective action.

3. Corrective Action

If an eligibility error(s) is found, do not send the case back. Correct the error(s), send the notice to the case head if required, and refer the case to the LDSS supervisor for possible contact with the outstationed worker's supervisor.

E. Local Agency to Local Agency

When a Medicaid applicant/enrollee (including a Medicaid CBC waiver services enrollee) moves from one locality to live in a community living arrangement (not a medical facility, an ALF, or group home with 4 or more beds) in another locality within the state of Virginia, the following procedures apply:

1. Sending Locality Responsibilities

a. Case Renewal Cannot Be Overdue

The sending locality must make certain the case is current and complete before transferring the case. If the annual renewal has been completed within the past 10 months, a partial review based on known information, as to whether or not the recipient will meet a covered group and the income and resource limits in the new locality, must be completed before transferring the case.

If the annual renewal is due in the month the LDSS plans to transfer the case or the following month, the renewal must be completed before transferring the case.

b. When Renewal Must Be Completed Before Transferring

If the sending LDSS must complete the renewal before transferring the case, the sending LDSS must keep the case record to complete the renewal. *The*

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sending LDSS must complete the renewal process if the case is currently due for a renewal or overdue for a renewal. The sending LDSS must process the renewal if a renewal or application is submitted during the reconsideration period.

The sending locality must update the enrollee's VaCMS/MMIS records as follows to assure managed care continuity:

- 1) Case Data screen - change the case address to the case's new address. Do not change the Case FIPS or Caseworker number because the sending LDSS worker retains responsibility for the case until the renewal is completed.
- 2) Enrollee Demographics screen, Enrollee FIPS – change each enrollee's Enrollee FIPS to the new address's FIPS code.

When the renewal is completed and the enrollee remains eligible, transfer the electronic case, if applicable, or update the enrollee's MMIS Case FIPS to the enrollee's locality of residence and update the Caseworker number to M0000. Send the paper case record to the enrollee's locality of residence with a completed Case Record Transfer Form.

c. Do Not Transfer Ineligible Cases

If the annual renewal or the partial review finds that eligibility no longer exists for one or all enrollees in the case, the agency must take the necessary action, including advance notice to the individuals, to cancel the ineligible individuals' coverage. Only eligible enrollees' cases are transferred.

d. Transfer Eligible Enrollees/Cases

If the renewal or the partial review indicates that the enrollee(s) will continue to be eligible for Medicaid in the new locality, the sending locality must update the enrollment system. The sending locality must prepare the "Case Record Transfer Form" and forward it with the case record to the LDSS in the new locality of residence.

e. Transfer Pending Medicaid Applications

Pending applications must be transferred to the new locality for an eligibility determination.

f. Foster Care & Adoption Assistance

Foster care and adoption assistance Medicaid cases are not transferred unless custody or responsibility for services and/or payment is transferred.

g. Sending Transferred Cases

The eligibility record must be sent by certified mail, delivered personally and a receipt obtained or, at the agency's discretion, the case may be sent via the courier pouch.

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**2. Receiving
Locality
Responsibilities**

a. Confirm Receipt

The receiving agency must confirm receipt of the case by completing the Case Record Transfer Form and returning the copy to the sending agency.

b. Process Pending Applications

When a pending application is transferred, the receiving agency makes the eligibility determination and takes all necessary action, including sending the notice and enrolling eligible individuals in MMIS.

c. Review Eligibility

LDSS workers must review (partial review) the Medicaid eligibility determination for cases transferred from other LDSS and must take any necessary corrective action.

d. Corrective Action

If an eligibility error(s) is found or the case is overdue for renewal, do not send the case back. Correct the error(s), and/or complete the renewal, send the notice to the case head if required, and refer the case to the LDSS supervisor for possible contact with the sending agency's supervisor.

F. Spenddown Cases

Cases in spenddown status (denied or canceled and placed on a spenddown) must be transferred when the applicant notifies the agency that he/she has moved to a new Virginia locality.

**1. Sending Locality
Responsibilities**

Within 10 working days of notification that the applicant has moved, the case must be transferred to the new locality, using the "Case Record Transfer Form." The sending agency must:

- inform the applicant of the receiving agency's name, address, and telephone number;
- deduct all known spenddown items from the spenddown balance on the worksheet before sending the case record;
- note the spenddown period and balance on the case transfer form.

**2. Receiving
Locality
Responsibilities**

The receiving locality logs the case record on file, but does not open it statistically. The receiving locality must review the spenddown to determine if a recalculation based on a different income limit is required.

If the spenddown is met, the application is recorded statistically as taken, approved, and added to the caseload at that time.

**G. Receiving LDSS Case
Management
Procedure**

To identify and manage transferred Medicaid cases, use the report titled "Caseworker Alpha Case/Enrollee Listing." This report is posted in the Data Warehouse, MMIS Reporting, Medicaid Management Reports. It is updated on or about the 22nd of each month.

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Renewal Process Reference Guide

Renewal Due	Renewal Grace Period	Renewal Completed & Individual Remains Eligible	Next Renewal Period	Next Renewal Due
November 2013 (overdue renewal)	N/A	May 2014	June 2014-May 2015	May 2015
May 2014	N/A	May 9 th (before cutoff)	June 2014-May 2015	May 2015
May 2014	N/A	May 19 th (after cutoff)	June 2014-May 2015	May 2015
June 2014	N/A	In May (any day)	July 2014-June 2015	June 2015
July 2014	N/A	In May (any day)	August 2014-July 2015	July 2015
April 2014 Client does not return renewal form and coverage is cancelled effective April 30, 2014.	May, June, July Renewal form returned in May 2014	In May (any day) Coverage is reinstated back to May 1	May 2014-April 2015	April 2015
April 2014 Client does not return renewal form and coverage is cancelled effective April 30, 2014.	May, June, July Renewal form returned in June 2014	In June (any day) Coverage is reinstated back to May 1.	July 2014-June 2015 (May is treated as retro month)	June 2015
April 2014 Client does not return renewal form and coverage is cancelled effective April 30, 2014.	May, June, July Renewal form returned in July 2014	July (any day) Coverage is reinstated back to May 1.	August 2014-July 2015 (May and June treated as retro months)	July 2015
April 2014 Client does not return renewal form and coverage is cancelled effective April 30, 2014.	May, June, July Renewal form returned in August 2014	Treat as new application since grace period expired (a new application form is not required). Application date is date of receipt, retroactive period is May-July.	August 2014-July 2015	July 2015

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TWELVE MONTH EXTENDED MEDICAID INCOME LIMITS 185% of FEDERAL POVERTY LIMITS EFFECTIVE 1-25-16 ALL LOCALITIES	
# of Persons in Family Unit/Budget Unit	185% FPL Monthly Limit
1	\$1,832
2	2,470
3	3,108
4	3,747
5	4,385
6	5,023
7	5,663*
8	6,304*
Each additional person add	642*

**No change for 2016*

CHAPTER M15

ENTITLEMENT POLICY & PROCEDURES

SUBCHAPTER 50

***DEPARTMENT OF BEHAVIORAL HEALTH AND
DEVELOPMENTAL SERVICES (DBHDS) FACILITIES***

M1550 Transmittal Changes

Changed With	Effective Date	Pages Changed
TN #100	5/1/15	Appendix 1,page 1
UP #9	4/1/13	Appendix 1, page 1
Update (UP) #7	7/1/12	Appendix 1, page 1
TN #96	10/1/11	Appendix 1, page 1
TN #93	1/1/10	Title page Table of Contents pages 1-9 Appendix 1, page 1
TN #91	5/15/09	Appendix 1

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M1550.000 DBHDS FACILITIES

M1550.100 GENERAL PRINCIPLES

- A. Introduction** The Department of Social Services' Division of Benefit Programs has five eligibility workers, called Medicaid Technicians, located in four *Department of Behavioral Health and Developmental Services (DBHDS)* facilities to determine the patients' eligibility for Medicaid. The Medicaid Technicians function like a local department of social services (LDSS) agency. Medicaid cases may be transferred to and from the Medicaid Technicians.
- B. Procedures** This subchapter contains a list and a brief description of the *DBHDS* facilities (M1550.200), a directory of the Medicaid Technicians (M1550.300, and procedures for handling cases of Medicaid applicants/recipients admitted to or discharged from a *DBHDS* facility (M1550.400).

M1550.200 DBHDS FACILITIES

- A. Introduction** Three types of medical facilities are administered by *DBHDS*: training centers, psychiatric hospitals, and a general hospital with nursing facility beds. Below is a brief description of each type of facility.
- 1. Training Centers** Training centers are medical facilities for patients diagnosed as mentally retarded (institutions for the mentally retarded). Training centers provide either or both intermediate and skilled nursing care. Some patients receiving intermediate care may be employed and have earned income.
- Normally, patients in the training centers are disabled, but some are children who have not been determined disabled. Patients of any age in a training center may be Medicaid eligible if they meet all nonfinancial and financial Medicaid eligibility requirements.
- The State training centers and locations are:
- Central Virginia Training Center (CVTC) – Madison Heights
 - Southside Virginia Training Center (SSVTC) – Petersburg
 - Northern Virginia Training Center (NVTC)– Fairfax
 - Southeastern Virginia Training Center (SEVTC) – Chesapeake
 - Southwestern Virginia Training Center (SWVTC) – Hillsville
- 2. Psychiatric Hospitals** Psychiatric hospitals are medical facilities – institutions for the treatment of mental diseases – which provide care and services to mentally ill patients. There are two types of psychiatric hospitals: intensive psychiatric and psychiatric/chronically mentally ill. These hospitals may have patients of any age, although two of them are dedicated to geriatric patients and one serves only adolescents.

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Patients in psychiatric hospitals may be Medicaid eligible only if they are

- under age 21 years (if treatment began before age 21 and continues, they may be eligible up to age 22), or
- age 65 years or older,

and they meet all non-financial and financial Medicaid eligibility requirements.

The following are psychiatric hospitals, offering differing levels of care:

- a. Eastern State Hospital – Williamsburg
- b. Central State Hospital – Petersburg
- c. Western State Hospital – Staunton
- d. Northern Virginia Mental Health Institute – Falls Church
- e. Southern Virginia Mental Health Institute – Danville
- f. Southwestern Virginia Mental Health Institute – Marion
- g. Piedmont Geriatric Hospital – Burkeville
- h. Catawba Hospital – Catawba
- i. Commonwealth Center for Children and Adolescents (CCCA) – Staunton (formerly DeJarnette Center)

CCCA is a psychiatric hospital for adolescents between the ages of 4 and 18. Children are provided schooling, counseling and medication. Most children have not been determined disabled. A child in CCCA can be Medicaid-eligible if the child meets all nonfinancial and financial Medicaid eligibility requirements.

2. General Hospital

General hospitals are medical facilities which provide care and services to acutely physically ill patients in the *DBHDS* facilities. The general hospitals may have patients of any age. There are general hospital acute care units within Eastern State and Western State Hospitals, and the Hiram Davis Medical Center general hospital located on the campus of Central State Hospital in Petersburg. Hiram Davis provides medical and surgical treatment for patients from any *DBHDS* facility. Hiram Davis also has some beds certified for nursing facility level of care.

Patients in the general hospitals may be Medicaid eligible if they meet all non-financial and financial Medicaid eligibility requirements.

M1550.300 MEDICAID TECHNICIANS

The Medicaid Technicians share responsibilities for the *DBHDS* facilities assigned to their caseloads. See M1550, Appendix 1, for the chart listing the Medicaid Technicians, their supervisor, addresses, telephone numbers and caseload assignment.

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M1550.400 CASE HANDLING PROCEDURES

A. Introduction

Effective July, 1994, the Aged, Blind or Disabled (ABD) Medicaid cases handled by local departments of social services and cases of patients in *DBHDS* facilities will be transferred between the facility and the local DSS agency when the individual leaves a community to enter a *DBHDS* facility or leaves the *DBHDS* facility to live in a community. Case transfer policy in M1520.600 is applicable.

NOTE: Transfer procedures are applicable only to individuals who are eligible in an ABD covered group. The Medicaid case of a child eligible in a Families and Children (F&C) covered group who is a patient in a *DBHDS* facility is the responsibility of the local department of social services (LDSS) in which the child last resided. If the child is not currently a Medicaid recipient, an application for Medicaid may be made with the LDSS in the locality in which the child last resided.

Persons between the ages of 21 (or 22 if treatment began before age 21) and 65 are not eligible for Medicaid while they are patients in an institution for treatment of mental diseases (IMD) or tuberculosis.

B. Procedures

Use the policy and procedures contained in the subchapters below when an individual is:

- admitted to a *DBHDS* facility (M1550.401),
- discharged from a *DBHDS* facility to a community living arrangement (M1550.402),
- discharged from a *DBHDS* facility to an assisted living facility (ALF) (M1550.403), and
- discharged from a *DBHDS* facility to a nursing facility or Medicaid Community-based Care (CBC) waiver services (M1550.404).

M1550.401 ADMISSION TO *DBHDS* FACILITIES

A. Introduction

When a Medicaid recipient is admitted to a *DBHDS* facility from a community living arrangement, follow the procedures in this section. The procedures for an ABD recipient differ from those for an F&C recipient

B. Local Social Services

1. ABD Recipient

When an ABD recipient has been admitted to a *DBHDS* facility, the eligibility worker must determine if it is appropriate to transfer the case. Do not transfer the Medicaid case of an individual between the ages of 21 and 65 if the individual is admitted to an IMD since he or she cannot be Medicaid eligible while in the institution. The Medicaid case of such an individual must be closed.

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If the recipient is not in the *DBHDS* facility for 30 days, the local EW must complete the DMAS-225 for the patient's stay in the facility, and must send it to the facility's Reimbursement office.

After the ABD recipient has been in the facility for 30 days, transfer the Case to the appropriate Medicaid Technician in the appropriate *DBHDS* facility. **Do not close the case.**

2. F&C Recipient

IF the patient being admitted is an individual eligible in a Families and Children (F&C) category, the case will NOT be transferred to the *DBHDS* facility, but will be retained by the LDSS. The individual will be considered temporarily absent from the home and will continue to be eligible in the F&C category as long as all non-financial and financial requirements are met.

C. DBHDS Reimbursement Office

Send a DMAS-225 to the Medicaid Technician to advise of name of the patient, date of admission, facility, etc. The technician will take the following steps.

1. Inquire MEDPEND

The Technician will inquire through MEDPEND and Medicaid Management and Information System (MMIS) to see if the patient has a pending Medicaid application or is enrolled in Medicaid. If a pending case is found in MEDPEND and the Medicaid Technician has not received the case, the Medicaid Technician will contact the eligibility worker (EW) in the LDSS which holds the patient's case and advise the EW that the recipient has been admitted to the facility. Pending applications must have eligibility determined with 45-90 days as per policy. The Medicaid Technician will request that the case be transferred immediately.

2. Active Case Found

If inquiry into MMIS indicates an active Medicaid case and the Medicaid Technician has not received the case, the Medicaid Technician will contact Medical Records at the end of 30 days to determine if the patient is still in the facility.

- If the patient is still in the facility, the Medicaid Technician will request that the case be transferred.
- If the patient has left the facility before the end of the 30 day period, the Medicaid Technician will advise the EW in the local agency that the individual has left the facility. Reimbursement will send the DMAS-225 to the local EW for completion.

3. No Active Case Found

If the patient has neither a pending application nor an active Medicaid case and Medicaid eligibility needs to be pursued, Reimbursement must submit a completed Application For Benefits on behalf of the patient, providing as much information as possible. Attach any verifications available and send to the Medicaid Technician.

D. Medicaid Technician

When a DMAS-225 is received from Reimbursement, search MEDPEND and MMIS systems. NOTE: If the patient is between the ages of 21 and 65 and in an IMD, he or she cannot be Medicaid eligible while in the IMD. For other patients admitted, including those admitted as respite or emergency admissions, use the following procedures:

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- 1. Pending Case in MEDPEND**

If a pending case is found in MEDPEND, contact the local agency shown holding the case. Advise them that the recipient is now a patient in the facility and request that the pending case be transferred immediately, since an eligibility determination must be made within 45/90 days. When a determination is completed, notify the agency according to policy. Send the Notice of Action on Medicaid to the Reimbursement office and a copy of the notice to the patient's authorized representative.

- 2. Active Case in MMIS**

If an active case is found in MMIS, follow-up 30 days from the date the patient entered the facility. Contact Medical Records to determine if the patient is still in the facility.

 - a. If so, ask the EW in the LDSS holding the case to transfer the case.
 - b. If the patient has left the facility at the time of the 30 day follow-up, advise the EW of that information; return the DMAS-225 to Reimbursement indicating that patient's eligibility must be determined by the local agency because the patient was not in the facility for 30 days.

- 3. Transfer Case Received**

When an active case is received in transfer, a full redetermination must be done in order to determine if the patient continues to be eligible for Medicaid based on his or her current status using policy for institutionalized ABD individuals. After the redetermination is completed, update the MMIS and send appropriate notification according to policy. Send appropriate notice to Reimbursement office and a copy to the patient's authorized representative.

- 4. No Pending or Active Case**

If neither a pending application nor an active Medicaid case is found, open a case using a completed Application for Benefits submitted by the Reimbursement Office on behalf of the patient.

 - a. If a case number is found in MEDPEND or MMIS, use that case number to establish the hospital case.
 - b. If no case number is found in MEDPEND or MMIS, but there is an inactive case in the facility, use the facility case number.
 - c. Send all notification required by policy to Reimbursement with a copy to the authorized representative for the patient.

- 5. Patient Discharged**

If the patient is discharged before spending 30 days in the facility and the application is received after discharge, immediately forward the case to the appropriate local DSS agency for processing.

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M1550.402 PATIENTS DISCHARGED FROM *DBHDS* FACILITIES

A. Introduction

When a Medicaid recipient in a *DBHDS* facility will be discharged from the facility, follow the procedures in the following sections:

- for patients discharged to a community living arrangement, see this section M1550.402;
- for patients discharged to an assisted living facility (ALF), see section M1550.403;
- for patients discharged to a nursing facility, see section M1550.404.

B. *DBHDS* Discharge Planner/Social Worker/Reimbursement

For Medicaid patients who do not receive SSI, contact the Social Security Administration (SSA) within 15 days of discharge to apply for SSI. If a patient's SSI has been decreased while in the institution, advise SSI of the patient's discharge so that, if appropriate, his or her SSI may be increased.

Medicaid cases of patients discharged to a living arrangement which is not an assisted living facility (ALF) or nursing facility will be transferred to the LDSS in which he or she will be living.

C. Reimbursement Office

Send the DMAS-225 to the Medicaid Technician and DMAS to advise of the date the patient will leave the facility.

D. Medicaid Technician

The Medicaid case of a Medicaid enrollee discharged to a living arrangement which is not an ALF or nursing facility will be transferred to the LDSS in the locality where he or she will be living.

Do a desk review of all cases to be transferred to an LDSS, **but do NOT determine if the recipient will be eligible in the locality.**

Update the MMIS. Enter the new city/county code on the case, new address, and change worker number to M0000.

Forward the case containing all original Medicaid information, any verification provided by discharge planner and/or Reimbursement office, and the DMAS-225, via certified mail to the appropriate LDSS.

E. Eligibility Worker in LDSS

When the case is received, do a full redetermination to determine the recipient's continued eligibility for Medicaid in his or her new circumstances.

Send the Case Record Transfer Form to the Medicaid Technician to notify the Technician of disposition of the transfer.

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M1550.403 PATIENTS DISCHARGED TO ALF

A. Introduction

When a patient in a *DBHDS* facility will be discharged to an assisted living facility (*ALF*), follow the procedures in this section.

B. *DBHDS* Discharge Planner/Social Worker/Reimbursement

The Medicaid case of a patient who will be discharged to enter an *ALF* will be transferred to the *LDSS* in the Virginia locality in which the Medicaid recipient last resided outside of an institution.

1. Medicaid Patient Discharge to *ALF*

For patients being discharged to an *ALF* who are Medicaid eligible in the *DBHDS* facility, complete an Application For Benefits to apply for Auxiliary Grants (*AG*) and a Uniform Assessment Instrument. Attach copies of any verifications, a copy of the Community Placement Plan, the *DMAS-225* and the *DMAS-96*. Send the completed forms to the *LDSS* immediately.

The Discharge Planner should not request information from the Medicaid case, but should complete the Application For Benefits providing the latest information available on the patient. The Medicaid Technician should also be given a copy of the Community Placement Plan and the *DMAS-225* for the Medicaid case.

The Medicaid Technician will transfer the Medicaid case to the *LDSS*. However, the *AG* application form should be sent immediately to the appropriate *LDSS* in order to expedite processing, with a note that the patient's Medicaid case is being transferred to them. **The application must be received by the *LDSS* in the month of the patient's entry to the *ALF* in order for an *AG* payment to be made for that month, if eligible; no retroactive payments are made for *AG*.**

2. Patient Not On Medicaid, Discharged to *ALF*

For patients being discharged to an *ALF* who are not Medicaid eligible in the *DBHDS* facility, but for whom a *AG*/*Medicaid* application needs to be pursued, complete an Application For Benefits providing the latest known information on the patient, and a *UAI*. Attach copies of any verifications available, a copy of the Community Placement Plan, the *DMAS-225* and the *DMAS-96*.

Applications for patients being discharged to an *ALF* must be sent to the *LDSS* in the locality in which the patient last resided prior to entering the *DBHDS* facility. If admission to the *DBHDS* facility was from the out of state but the patient intends to remain in Virginia, the application must be sent to the *LDSS* in the Virginia locality in which the *ALF* is located. **Do not send any information to the Medicaid Technician located in the *DBHDS* facility.**

The application must be received by the *LDSS* in the month of the patient's entry to the *ALF* in order for payment to be made for that month, if eligible; there are no retroactive payments made for *AG*.

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C. Medicaid Technician

Do a desk review of all cases to be transferred to a LDSS, **but do NOT determine if case will be eligible in the locality.** Update the MMIS. Enter new city/county code, new address, and change worker number to M0000.

Forward the case containing all original Medicaid information, any verifications provided by discharge planner/Reimbursement office, and DMAS-225, via certified mail to the appropriate LDSS.

D. Eligibility Worker in LDSS

When the case is received, do a full redetermination to determine the recipient's continued eligibility for Medicaid and, if appropriate, eligibility for Auxiliary Grants, in his or her new circumstances. Send the Case Record Transfer Form to the Medicaid Technician to notify the Technician that the case was received by the agency.

M1550.404 PATIENTS DISCHARGED TO NURSING FACILITY/CBC

A. Introduction

When a patient in a *DBHDS* facility will be discharged to a nursing facility or to a community living arrangement with Medicaid CBC waiver services, follow the procedures in this section.

B. DBHDS Discharge Planner/ Social Worker/ Reimbursement

1. Patient Not On Medicaid

If the patient was not Medicaid-eligible in the *DBHDS* facility but Medicaid eligibility in the patient's new circumstances needs to be determined, the Discharge Planner, Social Worker, Reimbursement, patient or the patient's authorized representative may complete an Application For Benefits and send it to the appropriate LDSS.

Applications for patients being discharged to a nursing facility must be sent to the LDSS in the locality in which the patient last resided prior to entering the *DBHDS* facility. If admission to the *DBHDS* facility was from out of state but the patient intends to remain in Virginia, the application form must be sent to the Virginia locality in which the nursing facility is located.

Applications for patients being discharged to a community living arrangement with Medicaid CBC waiver services must be sent to the locality in which the patient will reside.

2. Medicaid Patient

If the patient was Medicaid eligible in the facility, provide the Medicaid Technician a copy of the Community Placement Plan, the DMAS-225 and any other information necessary to transfer the Medicaid case record.

C. Reimbursement Office

Send the DMAS-225 to the Medicaid Technician and DMAS to advise them of the date the patient will leave the facility.

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D. Medicaid Technician

The Medicaid case of an eligible individual discharged to a nursing facility or CBC will be transferred to the LDSS in the locality in which he or she last resided outside of an institution.

Do a desk review of the case to be transferred to the LDSS. Update the MMIS with the new city/county code, new address, and change the worker number to M0000.

Forward the case containing all original Medicaid information, any verification provided by the discharge planner and/or Reimbursement office, and the DMAS-225, via certified mail to the appropriate LDSS. Note on the Case Transfer Form that this case is a nursing facility or CBC waiver case so that the receiving agency will be alerted to take immediate action.

E. Eligibility Worker in LDSS

When the case is received, do a full redetermination to determine the recipient's continued eligibility for Medicaid in his or her new circumstances.

Send the Case Record Transfer Form copy to the Medicaid Technician to notify the Technician that the case was received by the agency.

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DBHDS Facilities Medicaid Technicians

NAME	LOCATION	WORK TELEPHONE	CASELOAD
Mary Lou Spiggle Medicaid Field Supervisor (T003)	Central Virginia Training Center Medicaid Office Madison Heights, VA <u>Mail To:</u> PO Box 1098 Lynchburg, VA 24505	434-947-6256 Cell 434-660-8259 FAX 434-947-2114	PGH-caseload-all NVMHI-caseload-all SVMHI-caseload-all WSH-caseload-all
Carrie Richardson (T002)	Central Virginia Training Center Medicaid Office Madison Heights, VA <u>Mail To:</u> PO Box 1098 Lynchburg, VA 24505	434-947-6255 FAX 434-947-2114	CVTC-caseload-all VCBR-caseload-all
Frances Jones (T004)	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0841 FAX 276-782-9732	ESH-caseload-all NVTC-caseload-all SWVTC-caseload-all
Vickie C. Simmons (T005)	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0842 FAX 276-782-9732	Catawba-caseload-all Hiram-Davis-caseload-all SEVTC-caseload-all SWVMHI-caseload-all

NOTE: Because the Medicaid Technicians handle various hospitals in their caseloads, LDSS staff should send transferred case records directly to the Medicaid Technician who requested the case record. In the case record transfer request, the Medicaid Technician will give specific instructions about where to send the case record.

DBHDS State Hospital facilities:

FIPS	FACILITY INITIALS and FULL NAME
997	Catawba – Catawba Hospital
990	CVTC – Central Virginia Training Center
994	ESH – Eastern State Hospital
996	HDMC – Hiram Davis Medical Center
988	NVMHI – Northern Virginia Mental Health Institute
986	NVTC – Northern Virginia Training Center
993	PGH – Piedmont Geriatric Hospital
985	SEVTC – Southeastern Virginia Training Center
983	SVMHI – Southern Virginia Mental Health Institute
992	SWVMHI – Southwestern Virginia Mental Health Institute
984	SWVTC – Southwestern Virginia Training Center
993	VCBR – Virginia Center for Behavioral Rehabilitation
991	WSH – Western State Hospital