



COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

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October 1, 2016

Virginia Medical Assistance Eligibility Manual

Final Version of Transmittal #DMAS-2

The following acronyms are used in this cover letter:

- AVS – Asset Verification System
- DDS – Disability Determination Services
- DMAS – Department of Medical Assistance Services
- FAMIS – Family Access to Medical Insurance Security
- HIP – Health Insurance Premium Payment
- LIFC – Low Income Families with Children
- MA – Medical Assistance
- MAGI – Modified Adjusted Gross Income
- MN – Medically Needy
- RAU – Recipient Audit Unit
- SOLQ –I – State Online Query-Internet
- SSN – Social Security number
- TN – Transmittal
- VDSS – Virginia Department of Social Services

TN #DMAS-2 includes policy clarification, updates and revisions to the MA Eligibility Manual. Unless otherwise noted, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after October 1, 2016.

A draft of this transmittal was posted for review. All comments and suggestions were appreciated and reviewed. Changes made to the draft and included in the final version are noted in italics below.

The following changes are contained in TN #DMAS-2:

Changed Pages	Changes
Subchapter M0110 Pages 3, 13	On page 3, added the AVS to the list of verification systems. On page 13, updated the links to online forms.
<i>Subchapter M0120</i> Pages 2, 2a, 15	<i>On page 2, clarified where correspondence is sent for incarcerated applicants. Page 2a is a runover page. On page 15, clarified that incarcerated individuals include inmates in regional and local jails.</i>
Subchapter M0130 Table of Contents Pages 2, 2a 4, 5, 7-10, 12, 13 Page 14	Revised the Table of Contents. <i>On page 2, clarified where correspondence is sent for incarcerated applicants. Page 2a is a runover page.</i> On pages 4, 7 and 8, updated the links to online forms. On page 5, clarified that the verification checklist must be sent to the authorized representative when one has been designated. On page 9, clarified that when attested resources are over the resource limit, the applicant must be given the opportunity to provide verification of the resources. On page 10, clarified that income must be verified unless attested income is over the income limit. On pages 12 and 13, added policy on notification to the applicant. Page 14 was added as a runover page.
Subchapter M0210 Page 4	On page 4, updated the link to an online form.
Subchapter M0220 Pages 13, 19-24	On pages 13, 21, and 22, corrected the headers. <i>On page 19, revised the residency and SSN policies.</i> On pages 23 and 24, revised the procedures for enrolling an emergency services alien.
Subchapter M0230 Pages 1, 6	On page 1, revised the residency policy for non-immigrant aliens. On page 6, clarified that a non-IV-E foster care child in the custody of another state but living with a parent or care-taker relative in Virginia is considered a resident of Virginia.
Subchapter M0240 Pages 1, 2, 4	<i>On page 2, revised the SSN requirement for non-U.S. Citizens. Page 2 is a runover page.</i> On page 4, corrected the page number.
Subchapter M0280 Pages 7, 9	On page 7, updated the link to an online form. On page 9, removed redundant text.
Subchapter M0310 Pages 4, 7, 29, 30 Appendix 2, page 1	On page 4, removed redundant text. <i>On page 7, revised the procedures on verifying blindness.</i> On page 29, clarified that a child age 18 and over who is in an Independent Living arrangement or in the Fostering Futures Program with a local department of social services may be eligible in the Former Foster Care Child Under Age 26 covered group. Page 30 is a runover page. In Appendix 2, updated the DDS contact information.

Changed Pages	Changes
Subchapter M0320 Pages 4, 15, 16, 18, 20, 22, 30, 33, 39- 41, 43-45, 48, 51, 52, 55	On page 4, clarified that SOLQ-I can be used to verify Social Security income. <i>On page 48, moved the policy on spenddowns, which was incorrectly placed, to M0320.603 C.4.</i> On all other pages, corrected the headers.
Subchapter M0330 Pages 8 Page 9b	On page 8, clarified that a child age 18 and over who is in an Independent Living arrangement or in the Fostering Futures Program with a local department of social services may be eligible the Former Foster Care Child Under Age 26 covered group. Page 9b was renumbered to 9a.
Chapter M04 Appendix 2, pages 1, 2 Appendices 3, 5	In Appendix 2, corrected typographical errors. In Appendices 3 and 5, updated the tables of income limits effective July 1, 2016. There were no changes from 2015.
Subchapter M0530 Pages 23, 24	On page 23 corrected an error in the example. On pages 23 and 24, revised the examples for clarity.
Subchapter M0710 Appendices 2 and 3	In Appendices 2 and 3, updated the tables of income limits effective July 1, 2016. There were no changes from 2015
Subchapter M0720 Table of Contents, page i Pages 11, 13, 14 Appendix 1 Pages 15-18.	In the Table of Contents, on pages 11, 13, 14, and in Appendix 1, removed obsolete policy on LIFC earned income exclusions used prior to the implementation of MAGI methodology. Pages 15-18 were deleted.
<i>Subchapter M0810 Page 2</i>	<i>On page 2, updated the MN income limits, effective July 1, 2016.</i>
Subchapter M0830 Page 109	On page 109, updated the format of the header. Neither the date nor the policies were changed.
Subchapter M1120 Page 6	On page 6, updated the format of the header. Neither the date nor the policies were changed.
Subchapter M1310 Pages 1-6	On pages 1 and 4-6, corrected the subchapter number in the headers. Neither the dates nor the policies were changed. On page 2, added procedures for enrolling a MN child under 18 with \$0 spenddown liability. On Page 3, removed obsolete policy related to MN eligibility without a spenddown.
Subchapter M1320 Pages 2, 3	On page 2, revised the name of the form used for renewing coverage on individuals enrolled in limited coverage or who have \$0 spenddown liability. Page 3 is a runover page.

Changed Pages	Changes
Subchapter M1460 Page 35	On page 35, updated the blind or disabled student earned income exclusion.
Subchapter M1470 Pages 12, 12a, 27, 28, 28a	On pages 12 and 27, added a list of items and services that are neither medically necessary nor allowable as patient pay deductions. Pages 12a and 28a were added as runover pages.
Subchapter M1480 Pages 66, 72	On page 66, updated the spousal monthly maintenance needs allowance, the excess shelter standard, both effective July 1, 2016, and the utility standard deduction effective October 1, 2016. On page 72, clarified that the amount of spousal maintenance allowance deducted from patient pay is the actual amount the community spouse receives, if it is less than the calculated allowance.
Subchapter M1510 Pages 3-15	On pages 3-15, corrected the subchapter number in the headers. Neither the dates nor the policies were changed.
Subchapter M1520 Pages 1, 3, 6, 8, 12, 14, 15, 19-24	On page 1, 6, 8, 12, clarified that renewal forms and notices are sent to the authorized representative, if one has been designated. On page 3, revised the example for improved clarity. On page 6, also clarified that resources must be verified even if the attested amount is over the resource limit. On page 14, corrected number formatting. On pages 15, and 19-24, updated the procedures for managing an extended Medicaid case.
Chapter M16 Page 3	On page 3, updated the fax number for the DMAS Appeals Division.
Chapter M17 Table of Contents, page i Pages 1-8 Appendix 2	In the Table of Contents, on pages 1-7, streamlined the policies and procedures for making referrals to the RAU. Page 8 was deleted. In Appendix 2, the Notice of Recipient Fraud/Non-fraud Recovery has been added in place of the obsolete Managed Care Capitation Fees Recovery Form.
Chapter M21 Page 3	On page 3, clarified that enrollment in HIPP while covered by Medicaid does not impact a child's eligibility for FAMIS if the child subsequently has an increase in income.

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Please retain this TN letter for future reference. Should you have questions about information contained in this transmittal, please contact Cindy Olson, Eligibility Policy Manager with DMAS, at cindy.olson@dmass.virginia.gov or (804) 225-4282.

Sincerely,

A handwritten signature in cursive script that reads "Linda Nablo".

Linda Nablo
Chief Deputy Director

Attachment

M0110 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-2	10/1/16	Pages 3, 13
TN #100	5/1/15	Pages 2, 7 Page 1 is a runover page.
TN #98	10/1/13	Table of Contents Pages 1-15 Page 6a was removed. Page 16 was added.
TN #97	9/1/12	Table of Contents Page 13 Page 14 was added. Appendix 1 was added.
Update #7	7/1/12	Pages 3, 6a, 7, 8
TN #96	10/1/11	Table of Contents Pages 2-6a
TN #95	3/1/11	Pages 2-4a
TN #94	9/1/10	Pages 2, 3
TN #93	1/1/10	Pages 1, 6

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C. Use of System Searches

Searches of online information systems, including but not limited to the State Online Query-Internet (SOLQ-I), the State Verification Exchange System (SVES), and the Federal Data Hub, are permitted **only** for applicants and family members whose income and/or resource information is required to determine eligibility for the applicant or patient pay for an enrollee. This includes spouses of applicants and parents of child applicants. Searches of the *Asset Verification System (AVS) are permitted only for applicants with a resource test.*

The Federal Data Hub *and AVS are* to be accessed only for information necessary to determine eligibility for MA cases processed in the Virginia Case Management System (VaCMS). *They* may not be used for other public assistance programs.

D. Release of Information to Medical Providers

Although certain individuals are authorized to receive information about an applicant's/recipient's case, only the minimum data necessary to respond to the request is to be released. Federal regulations stipulate that the disclosure of information about an applicant or recipient can only be for purposes related to administration of the Medicaid State Plan.

Information in the case record related to an individual's medical treatment, or method of reimbursement for services may be released to Virginia MA providers by DMAS without the applicant's/enrollee's consent. Enrollee consent is not needed for the DSS agency to provide confirmation of an individual's eligibility, the dates of eligibility, and any patient pay responsibility if the medical provider is unable to obtain that information from the member verification system or from DMAS staff. The provider **is not** entitled to specific information about an applicant's/recipient's income or resources because the provider does not need that information for medical treatment or payment.

Provider contractors, such as application assistance companies, operate under the authority of the provider. A patient's consent is not required for the agency to provide the contractor with information related to reimbursement for services rendered or medical treatment. Providers and their contractors **are not** entitled to receive detailed financial or income information contained in an applicant's or recipient's case record. Information should not be provided from case records unless the release of such information is for purposes directly related to the administration of the MA programs.

Local agencies may release MA enrollee identification numbers to medical providers by telephone if the provider cannot contact the DMAS provider/recipient verification telephone number. This procedure does not conflict with federal or State confidentiality regulations, if the local agency is satisfied that the number is being released to an identifiable provider.

E. Release to Authorized Representatives and Other Application Assistants

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

f. Voter Registration Application Sites

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

B. Information Made Available to the Public in General

1. Availability of Manual

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

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

2. MA Handbooks and Fact Sheets

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

C. Inquiries

1. General Inquiries

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

M0120 Changes

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

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- a change in the case name,
- a change in living arrangements, and
- a change in income.

A change in living arrangements may require a partial review of the individual's eligibility when the change results in a change to the assistance unit. Whenever the change requires verifications that can be used to complete a renewal, the annual renewal should be completed at the time the change is reported.

M0120.200 Who Can Sign the Application

A. Individuals in State Facilities

Staff with certain Virginia state agencies may assist individuals who are in state residential facilities in applying medical assistance.

1. Patients in DBHDS Facilities

Patients of any age in the Department of Behavioral Health and Developmental Services (DBHDS) facilities may have applications signed and submitted by DBHDS staff. The DBHDS facilities are listed in subchapter M1550.

2. Incarcerated Individuals

Inmates of any age who are being held in Department of Corrections (DOC) or Department of Juvenile Justice (DJJ) facilities may have applications submitted by DOC or DJJ staff. ***Send all notices and other correspondence to the mailing address indicated on the application if it is different than the individual's physical address.***

Inmates of local and regional jails may submit applications for themselves or may authorize jail staff to apply on their behalf. If the inmate does not designate an authorized representative, send all notices and other correspondence to the inmate at the correctional facility in which he resides or, if one is designated, to the mailing address.

B. Applicants Age 18 or Older

The applicant must sign the application, even if the form is filled out by another person, unless the application is filed and signed by the applicant's legal guardian, conservator (known as the "committee" for persons declared incompetent prior to the 1997 changes in the guardianship section of the Code of Virginia), attorney in fact, or authorized representative. A spouse, aged 18 or older, may sign the application for his spouse when they are living together.

EXCEPTION: A parent can submit and sign an application for a child under age 21, when the child is living with the parent. The child does not need to authorize the parent to apply or conduct Medicaid business on his behalf.

If the applicant cannot sign his or her name on a paper application but can make a mark, the mark must be correctly designated (the individual's first and last name and the words "his mark" or "her mark" must be printed adjacent to the mark) and witnessed by one person as in the example below:

E.g.: (X) John Doe, his mark

Witness's signature: _____

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1. Authorized Representative

An authorized representative is a person age 18 years or older who is authorized to conduct business for an individual. A competent individual age 18 years or older must designate the authorized representative in a written statement (which defines the representative’s responsibilities). The authorized representative statement is valid until:

- the application is denied;
- medical assistance coverage is canceled; or
- the individual changes his authorized representative.

The authorized representative of an incompetent or incapacitated individual is the individual’s spouse, parent, attorney-in-fact (person who has the individual’s power-of-attorney), legally appointed guardian, legally appointed conservator (committee), or family substitute representative.

EXCEPTION: Patients in the DBHDS facilities may have applications submitted by DBHDS staff.

2. Family Substitute Representative

When it is reported that an applicant cannot sign the application and the applicant does not have a guardian, conservator, attorney in fact or designated authorized representative, one of the individuals listed below who is age 18 years or older and is willing to take responsibility for the applicant’s MA business will be the applicant’s “family substitute” representative. The family substitute representative will be, in this preferred order, the applicant’s:

- spouse,
- child,
- parent,
- sibling,
- grandchild,
- niece or nephew, or
- aunt or uncle.

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c. Pending Discharge to the Community

If a patient who was not Medicaid eligible in the DBHDS facility will live outside of an institution, the responsibility for processing the application and determining eligibility rests with the locality in which he will be living.

d. Eligibility Determination and Enrollment

The local agency determines the patient's MA eligibility BEFORE actual discharge, based on the type of living arrangement to which the patient will be discharged. If the patient is found eligible for MA in the locality, he is not enrolled in MA until the day he is discharged from the DBHDS institution.

When the individual is discharged, the DBHDS discharge planner, or the individual, may call the local agency worker on the discharge date. The worker can then enroll the patient in the MMIS and give the enrollee number to the discharge planner.

e. Coverage Begin Date

The eligible individual's coverage Begin Date cannot be earlier than the date of discharge from the DBHDS institution.

E. Individuals In Virginia Veteran's Care Center

MA applications for patients in the Virginia Veteran's Care Center in Roanoke may be filed, processed and maintained at the Roanoke City Department of Social Services.

F. Incarcerated Individuals and DJJ Supervisees

Inmates of state, *regional, and local* correctional facilities and individuals under the age of 21 under the supervision of DJJ (placed in a facility or receiving services from any court services unit or DJJ contractor) may apply for Medicaid, limited to inpatient hospitalization and as part of pre-release planning. Responsibility for processing the application and determining eligibility rests with the local department of social services in the locality where the individual was living prior to incarceration or DJJ/court custody. Applications are not to be refused because an applicant is an inmate of a public institution at the time of application.

If the individual did not reside in Virginia prior to becoming incarcerated or committed to DJJ, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in which correctional facility is located.

M0130 Changes

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

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M0130.050 Incarcerated Individuals

A. Introduction

Virginia has two MA initiatives for incarcerated individuals: 1) pre-release planning (application processing) for individuals transitioning from or leaving a correctional facility and 2) coverage limited to medical services received during an inpatient hospitalization. For the purpose of these initiatives, incarcerated individuals include those individuals being held in Virginia Department of Corrections (DOC) facilities, regional and local jails, and youth being held in Virginia Department of Juvenile Justice (DJJ) facilities. Incarcerated individuals must meet all MA eligibility requirements and can only be eligible for MA payment for medical services when they are not physically residing in the correctional facility.

Staff employed by DOC or DJJ are responsible for coordinating the application process and communicating information for individuals held in their facilities and the LDSS. DOC/DJJ staff assigned to assist in the application process will be identified on the application or in a separate document on agency letterhead. Communication between the staff assisting the individual and the LDSS handling the application is permitted. Direct communication between the incarcerated individuals and the LDSS may be prohibited, depending on the facility placement. ***Send all notices and other correspondence to the mailing address indicated on the application if it is different than the individual's physical address.***

Once an individual is released from a DOC facility, the individual will be responsible for all matters pertaining to his MA eligibility and involvement of the correctional facility staff will end. DJJ staff may continue to assist juveniles returning to the community as long as the juvenile continues to receive DJJ services.

Individuals in regional or local jails may file their own applications or may name an authorized representative, including facility staff, to assist with the application process and ongoing eligibility. The authorized representative statement must indicate if the authority to act on the applicant's behalf will continue after the applicant is no longer incarcerated.

Applications are to be processed in the same manner and within the same processing time standard as any other MA applications. *If the inmate does not designate an authorized representative, send all notices and other correspondence to the inmate at the correctional facility in which he resides or, if one is designated, to the mailing address.*

Individuals who are actively enrolled in MA programs at the time of incarceration are not required to file a new application, but are subject to partial reviews based on the change in their living situation (see M1520.100) and annual renewals (see M1520.200). Ongoing case maintenance for individuals enrolled for inpatient services will be provided by the LDSS where the individual lived prior to incarceration.

B. Pre-release Planning

Pre-release planning permits individuals who are completing their term of confinement to apply for MA and have their eligibility determined prior to

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release. Eligibility is to be determined based on the living arrangement anticipated upon release. Applications are not to be refused or denied because an applicant is an inmate of a public institution. Individuals who are determined to meet all Medicaid eligibility requirements are to be enrolled in the appropriate MA coverage after release and beginning with the date of release. The DOC/DJJ staff or the individual can contact the LDSS to report the actual date of release. Enroll the individual in the appropriate MA coverage and provide the individual's enrollee identification number so services can be accessed without delay. Send notice of the eligibility determination to the individual at the address where he will be living. A copy of the notice must also be sent to DOC/DJJ staff if the individual was in one of their facilities.

Pre-release planning for individuals being held by the DOC is coordinated by assigned staff and the Offender Release Services-Community Release Unit, 6900 Atmore Drive, Richmond, Virginia 23225.

Pre-release planning for juveniles being held by the DJJ is coordinated by assigned staff and the DJJ Re-entry Services Unit, 600 E. Main Street, Richmond, Virginia 23219.

Pre-release planning for individuals in regional and local jails is handled by the individual and/or his authorized representative.

1. Release to a Community Living Arrangement

Individuals returning to a community living arrangement (outside of an institution) will have their eligibility determined based on their anticipated living situation upon release. If it is anticipated that the individual will enter a community living arrangement in a different locality from the one he lived in prior to incarceration, the application will be processed by the locality of prior residence and if eligible, transferred to the new locality of residence. Application processing is not to be delayed based on the individual's change in locality. Denied applications are not transferred.

2. Release to an Institutional Placement or Long-term Care (LTC) Services

Applications for incarcerated individuals in need of placement in an institution or community-based care (CBC) services are processed by the locality where the individual lived prior to incarceration. If the individual lived outside of Virginia prior to incarceration and he plans to remain in Virginia, the application is processed in the locality where the correctional facility is located.

Correctional facility staff will notify the agency where the individual is housed if a pre-admission screening is needed for nursing facility or CBC services. The pre-admission screening is to be done by the LDSS in the locality where the correctional facility is located even if the application is being processed by another locality. Correctional facility staff will coordinate with the screening team, service provider and eligibility worker to ensure the eligible individual can receive necessary medical support/services when released.

C. Inpatient Hospitalization (Medicaid Only)

Incarcerated individuals (adults and juveniles) who meet **all** Medicaid eligibility requirements, including a categorically needy (CN) covered group (see M0310.108), are eligible for Medicaid coverage limited to inpatient hospitalization services. These individuals are not considered to be inmates of ineligible institutions while they are hospitalized.

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

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

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

B. Application for Retroactive Coverage

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

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

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

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

If the applicant is found eligible for retroactive coverage and a Medicaid-covered medical service was received over one year prior to the date the retroactive eligibility is determined, the applicant must be given an "Eligibility Delay" letter to give to the medical provider so that Medicaid will pay the claim (see the sample letter on the intranet at:

<http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi>). Once retroactive eligibility is established, Medicaid coverage begins the first day of the earliest retroactive month in which retroactive eligibility exists.

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M0130.200 Required Information and Verifications

A. Identifying Information

An application must contain basic identifying information about the applicant. Basic identifying information is the applicant's name, address, Social Security number (SSN) or proof that the individual applied for the SSN, and date of birth.

1. Name

The name entered in the official case record and computer enrollment systems for an applicant must match the applicant's name on his Social Security card or Social Security Administration (SSA) records verification. This is important because of the Medicare Buy-in and other computer matches the Medicaid Management Information System (MMIS) performs with SSA. At the time of the initial MA application, verify the SSA record of the individual's name.

The Federally managed Data Services Hub verifies the individual's name and SSN with the SSA for cases processed in VaCMS (see M0130.200 B.1 below). For an individual whose name and SSN cannot be verified in VaCMS and for all individuals whose cases are not processed in VaCMS, either SVES or the State Online Query-Internet system (SOLQ-I) SSA Title II and Title XVI results may be used.

If the individual says his name is different from the name on his Social Security card, he must first notify SSA and have his name changed on SSA records. When SSA changes his name and SSA verification of the name change is received, the worker can change his name in the case record and on the eligibility and MMIS computer systems.

For purposes of the case record only, the agency may choose to set up the case in the individual's alleged name before it is changed on the Social Security card.

2. SSN

The SSN of an individual for whom medical assistance is requested must be provided by the applicant and verified by the worker through SSA. The Hub or SOLQ-I may be used to verify the individual's SSN.

B. Required Verifications

1. The Federally-managed Data Services Hub

The Hub is a data center that links the following federal systems:

- Social Security Administration
- Internal Revenue Service (IRS)
- Systematic Alien Verification for Entitlements (SAVE).

Income verification by the Hub is acceptable for retroactive eligibility determinations provided that reasonable compatibility is met (see M0420.100 B.9).

Information from other sources, such as the Work Number, may become available via the Hub in the future.

2. Other Verification Sources

An individual must provide verifications of certain MA eligibility requirements when they cannot be verified through EDSV. Before taking action on the application, the applicant must be notified in writing of the required information. *The verification request (checklist) must be sent to the authorized representative, if one has been designated.*

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

D. Social Security Numbers

Applicants must provide the Social Security number (SSN) of any person for whom they request Medicaid. An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

1. SSN Verification

The Federal Hub, SVES or SOLQ-I may be used to verify the individual's SSN. However, to verify the SSA record of the individual's name at the initial Medicaid application, SSA data from the Hub or SVES must be used because it verifies the spelling, etc., of the individual's name in the SSA records.

2. Exceptions to SSN Requirements

Children under age one born to Medicaid-eligible mothers or born to mothers covered by FAMIS are deemed to have applied and been found eligible for Medicaid, whether or not eligibility requirements have actually been met. A child eligible in this covered group does not need to provide a Social Security number.

Illegal aliens who are eligible only for Medicaid payment of emergency services are not required to provide or apply for SSNs (see M0220).

3. SSN Not Yet Issued

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

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

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

E. Legal Presence (Effective January 1, 2006)

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

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

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

2. Documents That Demonstrate Legal Presence

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

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

3. Failure to Provide Proof of Legal Presence

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

- a period of 90 days or until it is determined that he is not legally present in the U.S., whichever is earlier; or
- indefinitely if the applicant provides a copy of a completed application for a birth certificate that has been filed and is pending and being actively pursued in accordance with federal or state law. Such extension shall terminate upon the applicant's receipt of a birth certificate or determination that a birth certificate does not exist because the applicant is not a U.S. citizen.

The affidavit form is on the intranet at:

<http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi>.

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

4. Relationship to Other Medicaid Requirements

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

F. Third Party Liability (TPL)

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

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If the client is eligible for benefits to be used exclusively for the payment of medical expenses (i.e. an insurance settlement), but there is no TPL code for that benefit, the worker must email the information to the DMAS TPL Unit at TPLUnit@dmas.virginia.gov, or send the information to:

DMAS Third Party Liability Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

G. Health Insurance Premium Payment (HIPP) Program

The HIPP program is a cost-savings program for individuals enrolled in Medicaid which may reimburse some or all of the employee portion of the employer group health insurance premium. Eligibility for HIPP is determined by the HIPP Unit at DMAS. Participation in HIPP is voluntary.

The local DSS agency must give each applicant or enrollee who reports that he or someone in his family is employed more than 30 hours each week and is eligible for health insurance coverage under an employer's group health plan 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>. Enrollees and other members of the public may contact the HIPP Unit for additional information at hippcustomerservice@dmas.virginia.gov.

If the health insurance policy holder lives outside of the home, a HIPP Consent Form must be completed by both the policy holder and the parent/authorized representative so the DMAS HIPP Unit can process the HIPP application. If the form is required, the DMAS HIPP Unit will send it to the applicant for completion.

H. Verification of Financial Eligibility Requirements

The eligibility worker must verify the following financial eligibility requirements:

- the value of all countable, non-excluded resources;
- earned and unearned income; and
- asset transfer information for individuals in need of long-term care services, including the date of transfer, asset value, and compensation received.

1. Resources

The value of all countable, non-excluded resources must be verified. If an applicant's attested resources are over the resource limit, the applicant or authorized representative must be given the opportunity to provide verification of the resources.

2. Use of Federal Income Tax Data

The Hub provides verification of income reported to the IRS. Income information reported to the IRS may be used for eligibility determinations *for both Families and Children (F&C) and ABD covered groups when IRS information is available*. The income reported on the application is compared to the data obtained from the Hub for reasonable compatibility per M0420.100. *When IRS verification is used for an ABD individual, reasonable compatibility is acceptable as verification of earned income.*

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3. **SSA Data** Social Security and/or Supplemental Security Income must be verified through SSA. The Federal Hub links to SSA data. SOLQ-I may also be used. The State Data Exchange (SDX) system should only be used as an alternate method when the Hub or SOLQ-I is not available.

4. **Income** *Countable earned and unearned income must be verified unless the applicant's attested income is over the income limit for his covered group.*

Verification of income is required to evaluate an applicant for a spenddown, if the applicant meets a Medically Needy covered group.

5. **\$0 (Zero) Income Procedures – Applicable Only to F&C MAGI Cases Processed in VaCMS** When an individual whose income must be counted for the eligibility determination reports \$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 the 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 individual 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.

If the inquiry indicates recent or current income that is countable for the MAGI determination, contact the individual and ask about the income (name of employer, amount of wages and period earned, date of unemployment payment, etc.). If it appears there is a mistake and the income belongs to someone other than the individual, discontinue further inquiry and document the finding in the record.

If the individual agrees that the discovered countable income was received, determine if the on-line information can be used to evaluate current/ongoing eligibility. If the discovered information is not sufficient to evaluate eligibility, send a written request for needed verifications and allow ten calendar days for the return of the verifications.

If the individual reports the income has stopped, ask when the income stopped to ensure all income needed to correctly determine prospective and retroactive eligibility (if appropriate) is evaluated. Note the date of termination of income (last pay received) in the record. If the income stopped during a month that is being evaluated for eligibility, the individual must provide verification of the termination of income.

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D. Application Disposition

1. General Principle

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

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

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

2. Entitlement and Enrollment

a. Entitlement

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

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

b. Enrollment

MA enrollees must be enrolled in the Medicaid Management Information System (MMIS), either through the system interface with the eligibility determination system or directly by the eligibility worker.

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

3. Notification to Applicant

Either a Notice of Action generated by the eligibility determination system or the equivalent form #032-03-006 (available at <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi>) must be used to notify the applicant of the specific action taken on the application. The notice must be sent to the authorized representative, if one has been designated.

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a. Approvals

As applicable, the notice must state that:

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

b. Denials

As applicable, the notice must state that:

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

c. Delays

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

d. Other Actions

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

E. Notification for Retroactive Entitlement Only

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

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M0130.400 Applications Denied Under Special Circumstances

A. General Principle

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

B. Withdrawal

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

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

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

C. Inability to Locate

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

D. Duplicate Applications

Applications received requesting MA for individuals who already have an application recorded or who are currently active will be denied due to duplication of request. A notice will be sent to the applicant when a duplicate application is denied.

M0210 Changes

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

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

C. Failure to Provide Proof of Legal Presence

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

- a period of 90 days or until it is determined that he is not legally present in the U.S., whichever is earlier; or
- indefinitely if the applicant provides a copy of a completed application for a birth certificate within the United States or its territories that has been filed and is pending. The affidavit's validity shall terminate upon the applicant's receipt of a birth certificate or determination that a birth certificate does not exist because the applicant is not a citizen of the United States.

The Affidavit Of United States Citizenship Or Legal Presence In The United States is available at:

<http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi>.

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

D. Relationship to Other Medicaid Requirements

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

M0210.200 COVERED GROUPS

A. Introduction

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

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

M0220 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-2	10/1/16	Pages 13, 19-24
TN #DMAS-1	6/1/16	Pages 4, 4b, 5, 23
TN #100	5/1/15	Table of Contents Pages 4b, 12, 17, 18 Appendix 5, page 3 Page 4 was renumbered for clarity. Page 4a is a runover page.
TN #99	1/1/14	Table of Contents Pages 19, 23, 24 Appendix 4 was removed.
TN #98	10/1/13	Pages 2-3b Appendix 1 Pages 1-5 Pages 6-18 were removed.
UP #9	4/1/13	Page 3 Appendix 1, pages 3, 17 Appendix 3, pages 3, 4
UP #8	10/1/12	Table of Contents Pages 4, 7-8, 12, 14d-20 Page 17a was deleted. Appendix 5, page 3 Appendix 7 pages 1-5
UP #7	7/1/12	Table of Contents Pages 14d, 16-19 Appendix 5, page 3
TN #96	10/1/11	Table of Contents Pages 2, 3, 7, 8, 14d, 18-22a, 23 Appendix 5, page 3
TN #95	3/1/11	Table of Contents Pages 3, 3a, 4-6a, 14a-14c, 17, 19, 20 Pages 22a, 23, 24 Appendices 1-2a removed. Appendix 3 and Appendices 5-8 reordered and renumbered.
TN #94	9/1/10	Pages 3-3b, 7-9, 14a-14d, 18, 21, 22a, 23 Appendix 1 Appendix 3, page 3
Update (UP) #3	3/1/10	Pages 1-3a
TN #93	1/1/10	Table of Contents Pages 7-8, 14a, 14c-14d, 15-20, 22a Appendix 1 Appendix 3, page 3 Appendix 4, pages 1 and 2 Appendix 6, page 2

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- b) the unmarried surviving spouse of an individual described in 1. or 2. above who is deceased, if the spouse was married to the veteran
- before the expiration of fifteen years after the termination of the period of service in which the injury or disease causing the death of the veteran was incurred or aggravated; or
 - for one year or more; or
 - for any period of time if a child was born of the marriage or was born to them before the marriage.

A divorced person is not a spouse.

A “dependent child” for this section’s purposes is one whom the Veterans Administration (VA) has determined to meet the VA definition of “dependent child.” According to the VA, a dependent child is an unmarried child under age 18, an unmarried child between ages 18 and 23 who is attending a VA-approved school, or a “helpless” child who became disabled before attaining age 18.

B. Verification

Acceptable verification of honorable discharge or active duty status include the following documents:

1. Discharge Status

For discharge status, an original or notarized copy of the veteran’s discharge papers (DD 214) issued by the branch of service in which the alien was a member verifies whether he/she was honorably discharged for a reason other than alien status.

Other documentation which is acceptable under the Department of Defense (DOD) or VA guidelines can be substituted for the DD 214 form.

A self declaration under penalty of perjury may be accepted pending receipt of acceptable documentation.

2. Active Duty Status

For active duty military status, an original or notarized copy of the alien’s current orders showing the individual is on full-time duty in the U.S. Army, Navy, Air Force, Marine Corps, or Coast Guard (full-time National Guard duty is NOT active military status), or a military identification card (DD Form 2 (active)) verifies whether the alien is in active duty military status.

Other documentation which is acceptable under the Department of Defense (DOD) or VA guidelines can be substituted for the current orders or military ID card.

A self declaration under penalty of perjury may be accepted pending receipt of acceptable documentation.

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- 8. Temporary Workers** temporary workers including some agricultural contract workers;
- 9. Foreign Press** members of foreign press, radio, film, or other information media and their families.

M0220.500 ALIENS ELIGIBILITY REQUIREMENTS

A. Policy An alien must meet all other Medicaid eligibility requirements to be eligible for any Medicaid services. The eligibility requirements are:

- 1. Residency** the Virginia residency requirements (M0230);

*Regardless of the individual's immigration status, accept declaration of Virginia residency on the application as verification of residency. Do **NOT** require individuals who have been admitted into the U.S. on non-immigrant visas and other non-immigrants to sign a statement of intended residency.*

- 2. Social Security Number (SSN)** the SSN provision/application requirements (M0240);

An alien eligible only for Medicaid payment of emergency services *is not required* to apply for or provide an SSN. This includes emergency-services-only aliens as defined in M0220.410 and unqualified aliens as defined in M0220. 411.

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

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- 3. Assignment of Rights and Pursuit of Support from Absent Parents** the assignment of rights to medical benefits requirements (M0250);
- 4. Application for Other Benefits** the requirements regarding application for other benefits (M0270);
- 5. Institutional Status** the institutional status requirements (M0280);
- 6. Covered Group** the covered group requirements (chapter M03);
- 7 Financial Eligibility** the asset transfer requirements (see subchapter M1450) apply.

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

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

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

- 1. LDSS Certification for Pregnancy-Related Labor and Delivery Services** LDSS can certify emergency services payment for pregnancy-related labor and delivery services, including inpatient hospitalizations that did not exceed:
 - 3 days for a vaginal delivery, or
 - 5 days for a cesarean delivery.

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

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

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

The verification must be documented in the record.

NOTE: A child born to an emergency-services-only alien mother who was eligible for Medicaid on the date of the child’s birth is entitled to Medicaid as a newborn child (see M320.301).

**2. DMAS
Certification for
Emergency
Services
Required**

When DMAS certification for emergency services is required, send a written request for the evidence of emergency treatment listed below to the applicant or authorized representative. Request that the applicant/authorized representative provide the following information from the hospital or treating physician, as applicable to the emergency service provided, **for each period of service:**

- On the Emergency Medical Certification Form, **specify the exact dates of service requested.** Ask for a phone number where the person can be reached .
- emergency room record, admission (admit) orders, history and physical, MD notes. discharge summary, operative notes;
- operative consent form;
- **pre operative evaluation;**
- labor and delivery notes, if pregnancy related; and
- dates of service – admission date/discharge date.

If the applicant/authorized representative is unlikely to be able to obtain the above information without assistance (e.g. due to a language barrier), obtain a signed release of information. If necessary, use the release to request evidence of emergency treatment from the hospital and/or treating physician

If the hospital or treating physician is unsure of the information that is needed, refer the hospital’s staff, physician or physician’s staff to the Virginia Medicaid Hospital Provider Manual, Chapter VI “Documentation Guidelines.”

Using the Emergency Medical Certification, form #032-03-628 (see M0220, Appendix 4) as a cover letter, send the medical evidence to:

Division of Program Operations
Department of Medical Assistance Services (DMAS)
600 E. Broad Street, Suite 1300
Richmond, VA 23219

for a determination of medical emergency and the duration of the emergency services certification period.

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- 3. Entry Date** THIS FIELD MUST BE ENTERED. Enter the date on which the alien entered the U.S., except for asylees and deportees. For asylees, enter the date asylum was granted. For deportees, enter the date deportation withholding was granted.
- 4. Appl Dt** In this field, Application Date, enter the date of the alien's Medicaid application upon which the eligibility coverage period is based.
- 5. Coverage Begin Date** In this field, Coverage Begin Date, enter the date the alien's Medicaid entitlement begins.
- 6. Coverage End Date** Enter data in this field only if eligibility is a closed period of eligibility in the past. Enter the date the alien's Medicaid entitlement ended.
- 7. AC** Enter the AC code applicable to the alien's covered group.

M0220.700 EMERGENCY SERVICES ALIENS ENTITLEMENT & ENROLLMENT

- A. Policy** Unqualified aliens, and qualified aliens eligible for emergency services only are eligible for Medicaid coverage of emergency medical care only. This care must be provided in a hospital emergency room or as an inpatient in a hospital.
- B. Entitlement-Enrollment Period** If the applicant is found eligible and is certified for emergency services, eligibility exists only for the period of coverage certified by the LDSS or DMAS staff on the Emergency Medical Certification form, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi>.

Once an eligibility period is established, additional requests for coverage of emergency services within 6 months will not require a new Medicaid application. However, each request for Medicaid coverage of an emergency service or treatment requires a new, separate certification and a review of the alien's income and resources and any change in situation that the alien reports.

With the exception of dialysis patients, an emergency services alien must file a new Medicaid application after the 6-month eligibility period is over if the individual receives an emergency service and wants Medicaid coverage for that service.

DMAS will certify dialysis patients for up to a one year period of services without the need for a new Medicaid application. The dialysis patient must reapply for Medicaid after their full certification period expires. Transportation to receive dialysis treatments is not covered for emergency services aliens.

- C. Enrollment** Once an emergency services alien is found eligible for coverage of emergency services, *enroll the individual in the eligibility and enrollment system.*

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D. Notices

Appropriate notice must be sent to the applicant of the status of his application and the duration of his eligibility.

The USCIS requires that all benefit applicants who are denied benefits based **solely or in part** on the SAVE response be provided with adequate written notice of the denial as well as the information necessary to contact USCIS, so that the individual may correct his records in a timely manner, if necessary. The fact sheet, “Information for Applicants: Verification of Immigration Status and How to Correct Your Record with USCIS” (Form # 032-03-0427-00) must be included with the Notice of Action when benefits are denied, **including the approval of emergency-services-only Medicaid coverage**, and with the Advance Notice of Proposed Action when benefits are subsequently cancelled based on the results of a SAVE inquiry. The fact sheet is available on SPARK at <http://www.localagency.dss.state.va.us/divisions/dgs/warehouse.cgi>.

A Medicaid card will not be generated for an individual enrolled as an emergency services alien.

The agency must contact the provider(s) and supply the eligibility dates and Medicaid number for billing purposes by sending a copy of the completed referral form #032-03-628, Emergency Medical Certification, to the provider(s).

M0230 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-2	10/1/16	Pages 1, 6
TN #100	5/1/15	Pages 3, 4
TN #98	10/1/13	Table of Contents pages 3-6 Page 7 was deleted.
TN #97	9/1/12	Page 4
TN #95	3/3/11	Pages 1, 2
TN #93	1/1/10	Page 2

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M0230.000 VIRGINIA RESIDENCY REQUIREMENTS

M0230.001 POLICY PRINCIPLES

A. Policy

An individual must be a Virginia resident in order to be eligible for Medicaid, but is not required to have a fixed address. This subchapter, M0230, explains in detail how to determine if an individual is a Virginia resident.

An individual placed by a Virginia government agency in an institution is considered a Virginia resident for Medicaid purposes even when the institution is in another state (section M0230.203 below).

For all other individuals, Virginia residency is dependent on whether the individual is under age 21 years or is age 21 or older (sections M0230.201 and 202 below).

B. Retention of Residency

Residence is retained until abandoned. Temporary absence from Virginia with subsequent return to the state, or intent to return when the purposes of the absence have been accomplished, does not interrupt continuity of Virginia residence.

C. Non-immigrant Aliens

Regardless of an individual's immigration status, accept declaration of Virginia residency on the application as verification of residency. Do NOT require individuals who have been admitted into the U.S. on non-immigrant visas and other non-immigrants to sign a statement of intended residency.

D. Cross-Reference to Intra-State Transfer

Procedures for handling cases where individuals who are Virginia residents move from one Virginia locality to another are described in subchapter M1520.

E. No Fixed Address

The agency cannot deny Medicaid to an eligible Virginia resident just because the resident has no fixed address. A Virginia resident is not required to have a fixed address in order to receive Medicaid.

For an eligible Virginia resident who does not have a fixed address, use the local social services department's address for the Medicaid card and inform the resident that he must come to the social services department to receive his card until he obtains a fixed address.

F. Length of Residency

The agency may not deny Medicaid eligibility because an individual has not resided in Virginia for a specified period of time.

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- 1. Lack Of Facilities** When a placement is initiated by a state because the state lacks a sufficient number of appropriate facilities to provide services to its residents, the state making the placement is the individual's state of residence for Medicaid purposes.
- 2. Individual Leaves Facility** When a competent individual leaves the facility in which he was placed by a state, that individual's state of residence for Medicaid purposes is the state where the individual is physically located.
- C. Individual Placed Out-of-State by Virginia Government** An individual can leave Virginia and retain Virginia residency if he is placed in an institution outside Virginia by a Virginia government agency. Out-of-state placement into a long-term care facility must be preauthorized by the Director of the Virginia Department of Medical Assistance Services for Virginia Medicaid to pay for the institutional care.

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

M0230.204 CASH ASSISTANCE PROGRAM RECIPIENTS

- A. Introduction** Certain individuals are considered residents of Virginia for Medicaid purposes if they live in Virginia and receive a cash assistance payment specified below in this section. Some recipients of cash assistance from a Virginia social services agency who do NOT reside in Virginia are considered residents of Virginia for Medicaid purposes, as specified below.
- B. Auxiliary Grants Recipients** An individual receiving an Auxiliary Grants (AG) payment from a locality in Virginia is considered a Virginia resident.
- An individual who receives a State Supplement of SSI payment from another state is considered a resident of the state making the State Supplement payment.
- C. IV-E Payment Recipients** For an individual of any age who receives federal foster care or adoption assistance payments under Title IV-E of the Social Security Act, the state of residence for Medicaid eligibility is the state where the child lives.
- D. Non-IV-E Foster Care Payment Recipients** *A child in foster care receiving a non-IV-E (state and local) payment whose custody is held by another state but who has been placed with and is residing in Virginia with a parent or care-taker relative is considered a resident of Virginia. If the child is not living with a parent or care-taker relative, the child is a resident of the state that is making the non IV-E payment.*
- E. Non-IV-E Adoption Assistance Payment Recipients** The non IV-E (state/local) Adoption Assistance recipient is a resident of the state in which the child's adoptive parent(s) resides, regardless of whether a final order of adoption has been entered in court.

M0240 Changes

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

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M0240.000 SOCIAL SECURITY NUMBER REQUIREMENTS

M0240.001 GENERAL PRINCIPLES

A. Policy

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

Exceptions – the SSN requirement does not apply to:

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

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

B. Failure to Meet SSN Requirement

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

1. Child Under Age 1

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

2. Emergency-Services Aliens and other Non-Citizens

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

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

C. Relationship to Other Medicaid Requirements

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

D. Verification

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

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

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

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

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

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

M0240.100 APPLICATION FOR SSN

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

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

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

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3. Renewal Action

If the enrollee’s SSN has not been assigned by the 90-day follow-up, the worker must follow-up no later than the enrollee’s annual renewal, by checking the systems for the enrollee’s SSN and by contacting the enrollee if necessary.

a. Check for Receipt of SSN

Before or at renewal, the SSN must be entered into the eligibility/enrollment system. Check the system records for the enrollee’s SSN. If the SSN has “999” as the first 3 digits, contact the enrollee to obtain the enrollee’s SSN verbally or by mail, or on the renewal form if a renewal form is required.

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

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

d. SSN Not Provided by Renewal Deadline

The worker must assist the enrollee in obtaining the applied-for SSN. The worker will ask the enrollee for the assigned SSN at the first renewal, and give a deadline date for the enrollee to provide the SSN.

If the enrollee does not provide the SSN by the deadline, the worker will ask the enrollee why it was not provided to the worker:

- Did the enrollee ever receive the SSN from SSA?
- If not, why not?

If the problem is an SSA administrative problem, such as a backlog of SSN applications causing the delay in issuing an SSN to the enrollee, the enrollee continues to meet the MA SSN eligibility requirement. The worker will assist the enrollee with obtaining the SSN and will periodically check with the computer systems and the enrollee.

If the problem is **not** an SSA administrative problem, the worker must cancel MA coverage for the enrollee whose SSN is not provided.

M0240.300 SSN Verification Requirements

A. SSN Provided By Individual

The individual’s SSN must be verified. When the individual provides his SSN, the worker may use the SOLQ-I or SVES to verify the individual’s SSN. The individual is not eligible for MA and cannot be enrolled in the eligibility/enrollment system if his SSN is not verified.

B. Procedures

1. Enter Verified SSN in Systems

Enter the eligible enrollee’s verified SSN in the eligibility/enrollment system.

M0280 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-2	10/1/16	Pages 7, 9
TN #100	5/1/15	Table of Contents Pages 1-11 Appendix 1 was added Pages 12 and 13 were deleted.
UP #9	4/1/13	Page 5
Update (UP) #7	7/1/12	Table of Contents Page 8 Appendix 1 was deleted.
TN #94	9/1/10	Page 1
TN #93	1/1/10	Page 13

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Subchapter Subject M0280 INSTITUTIONAL STATUS REQUIREMENTS	Page ending with M0280.300	Page 7

An individual in prison or jail who transfers temporarily to a halfway house or residential treatment facility prior to a formal probation release order is still an inmate of a public institution and can only be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

Once an individual is released from the correctional facility, he can be enrolled in full benefit Medicaid, provided he meets all Medicaid eligibility requirements.

D. Juveniles in Detention

In determining whether a juvenile (individual under age 21 years) is incarcerated, the federal Medicaid regulations distinguish between the nature of the detention, pre- and post- disposition situations, and types of facilities.

1. Held for Care, Protection or Best Interest

A juvenile who is in a detention center due to care, protection or in the best interest of the child can be eligible for full benefit Medicaid or Family Access to Medical Insurance Security (FAMIS) coverage.

2. Held for Criminal Activity

a. Prior to Court Disposition

The following juveniles can be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

- juvenile who is in a detention center due to criminal activity
- juvenile who has criminal charges pending (no court disposition has been made) who is ordered by the judge to go to a treatment facility, then come back to court for disposition when the treatment is completed

b. After Court Disposition

Juveniles who are on probation with a plan of release which includes residence in a detention center are inmates of a public institution. If they go to any of the secure juvenile correctional facilities, they are inmates of a public institution and can only be eligible for Medicaid payment limited to inpatient hospitalization. A list of secure detention facilities in Virginia is available on the Department of Juvenile Justice's web site at http://www.djj.virginia.gov/pdf/Residential/Detention_Home_Contacts.pdf. Because this list is subject to change, consult the list whenever eligibility must be evaluated for a juvenile who is reportedly in a detention center.

If *the juvenile goes* to a non-secure group home, *he* can be eligible for Medicaid or FAMIS because a non-secure group home is not a detention center.

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G. Probation, Parole, or Conditional Release

An individual released from prison or jail on probation, parole, or release order with a condition of:

- home arrest
- community services
- outpatient treatment
- inpatient treatment

is not an inmate of a public institution and may be eligible for Medicaid.

An individual released from prison or jail under a court probation order due to a medical emergency is NOT an inmate of a public institution and may be eligible for Medicaid.

H. Juvenile in Detention Center Due to Care, Protection, Best Interest

A minor in a juvenile detention center prior to disposition (judgment) due to care, protection or the best interest of the child (e.g., Child Protective Services [CPS]), if there is a specific plan for that child that makes the detention center stay temporary, is NOT an inmate of a public institution and may be eligible for Medicaid.

This could include a juvenile awaiting placement but who is still physically present in the juvenile detention center.

I. Juvenile on Probation in Secure Treatment Center

A minor placed on probation by a juvenile court and placed in a secure treatment facility is NOT an inmate of a public institution and may be eligible for Medicaid.

J. Juvenile On Conditional Probation

A minor placed on probation by a juvenile court with, as a condition of probation, treatment in a psychiatric hospital or a residential treatment center, or treatment as an outpatient may be eligible for Medicaid.

However, if the minor is NOT on probation but is ordered to the treatment facility, he remains an inmate of a public institution and not eligible for full benefit Medicaid. He may be eligible for Medicaid coverage limited to inpatient hospitalization.

K. Juvenile On Probation in Secure Treatment Center

A minor placed on probation by a juvenile court and placed in a secure treatment facility may be eligible for Medicaid.

M0310 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-1	10/1/16	Pages 4, 7, 29 Page 30 is a runover page. Appendix 2, page 1
TN #DMAS-1	6/1/16	Table of Contents, page ii Pages 13, 26, 28 Appendix 2, page 1
TN #100	5/1/15	Table of Contents, pages i, ii pages 11, 23, 28b, Pages 27a-27c were renumbered to 28-28a for clarity. Page 10 is a runover page. Appendix 2
UP #10	5/1/14	Pages 29, 30
TN #99	1/1/14	Pages 6, 7, 21, 24, 25, 27a, 39
TN #98	10/1/13	Pages 2, 4, 27a, 27b, 28, 35, 36, 39
UP #9	4/1/13	Pages 24-27 Appendix 2
TN #97	9/1/12	Table of Contents, page i Pages 1-5a, 10-13 Pages 23, 28, 29, 30a, 31 Pages 33, 36, 38, 39
UP #7	7/1/12	Table of Contents, page ii Pages 23, 26, 27 Appendices 1-3 were removed. Appendices 3 and 4 were renumbered and are now Appendices 1 and 2, respectively.
TN #96	10/1/11	Appendix 4
TN #95	3/1/11	Pages 30, 30a
TN #94	9/1/10	Pages 21-27c, 28
TN #93	1/1/10	Page 35 Appendix 5, page 1
Update (UP) #2	8/24/09	Table of Contents Page 39
TN #91	5/15/09	Pages 23-25 Appendix 4, page 1 Appendix 5, page 1

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2. F&C Groups

- a. foster care children receiving IV-E and adoption assistance children receiving IV-E.
- b. Low income families with children (LIFC) eligible children, parents, non-parent caretaker-relatives, and EWBs (for applications submitted prior to October 1, 2013).
- c. Children under age 1 born to mothers who were eligible for and receiving MA at the time of the child's birth.
- d. Individuals under age 21
 - 1. Title IV-E Eligible Foster Care children who do not receive a Title IV-E maintenance payment
 - 2. Non-IV-E Foster Care
 - 3. Juvenile Justice Department children
 - 4. Non-IV-E Adoption Assistance children
 - 4. Individuals in an ICF or ICF-MR
- e. Effective January 1, 2014, former foster care children under age 26 years
- f. Pregnant women
- g. Plan First; Family Planning Services
- h. Children under age 19 years
- i. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). Women and men screened and diagnosed with breast or cervical cancer under the Centers for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program (BCCEDP) and eligible to receive Medicaid under the BCCPTA.

B. Medically Needy (MN)

The ABD and the F&C covered groups in the MN classification are listed below.

1. ABD Groups

- a. Aged - age 65 years or older.
- b. Blind - meets the blind definition
- c. Disabled - meets the disability definition.
- d. Individuals who received Medicaid in December 1973 as AB/APTD-related MN and who continue to meet the December 1973 eligibility requirements.

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M0310.105 AGE and AGED

A. Age

“Age” is the individual's age reached on the anniversary of birth. If the year but not the month and day of the individual's birth is known, July 1 is assigned for both eligibility determination and enrollment.

Eligibility in a Medicaid covered group often depends on an individual’s age.

B. Aged

“Aged,” means age 65 years or older.

C. Procedures

For individuals under age 21, accept the date of birth provided on the application/redetermination form. No verification is required.

For aged individuals, verify the individual’s age by Social Security records or documents in the individual’s possession. Acceptable documents include:

- birth certificate or notification of birth;
- hospital or physician’s record;
- court record of adoption;
- baptismal record;
- midwife’s record of birth;
- form VS95 from state Bureau of Vital Statistics; or
- marriage records.

M0310.106 BLIND

A. Definition

The Medicaid blindness definition is the same as that of the Supplemental Security Income (SSI) blindness definition.

Blindness is defined by using one of two criteria. The first criteria indicates that blindness is defined as having best corrected central visual acuity of 20/200 or less in the better eye. The second criteria indicates that blindness is defined as the contraction of the visual field in the better eye with the widest diameter subtending an angle around the point of fixation no greater than 20 degrees.

B. Procedures

An SSI recipient who receives SSI as blind meets the blindness definition for Medicaid. Verify the SSI recipient’s SSI eligibility via SVES (State Verification Exchange System).

Virginia no longer maintains a central registry of individuals who have been certified as blind or visually impaired. For an individual who alleges blindness or a visual impairment but does not receive SSI or Social Security Disability Income benefits, refer to section M0310.112 B to establish whether or not the individual requires a referral to the Disability Determination Services (DDS). If the individual requires a determination of blindness, refer the individual to the DDS using the procedure in M0310.112 E. 1.

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M0310.115 FOSTER CARE

A. Definition

Foster Care provides maintenance and care for children whose custody is held by:

- a local board of social services;
- a licensed private, non-profit child placement agency;
- the Department of Juvenile Justice; or
- the child’s parent(s), under a non-custodial agreement.

Federal regulations define “foster care” as “24-hour substitute care for children placed away from their parents or guardians and for whom the State agency has placement and care responsibility” (45 C.F.R. §1355.20). Transfer of the legal custody of the child is not a component when determining if a child is considered to be in foster care. The federal definition is based upon the child being placed outside of the home and who has placement and care responsibility for the child. If a child is placed outside of the home and LDSS is the case manager with placement and care responsibility, then the federal government considers the child to be in foster care. For the federal government, the term “placement and care” means that LDSS is legally accountable for the day-to-day care and protection of the child through either a court order or a voluntary placement agreement.

1. Custody

Custody may be given to an agency by the court or may be retained by the parent(s) or guardian when a non-custodial agreement is involved. If custody is retained by the parent under a parental agreement with the Community Policy and Management Team (CPMT), the child is NOT in foster care.

2. Child Placing Agency

A child placing agency is an agency that is licensed by the State Department of Social Services for child placing services. Not all child placing agencies provide adoption services; some may provide foster home placement. The services offered must be identified in the description given for the license. The foster care service unit of the local department of social services should be familiar with the function of the child placing agency, and whether or not it is licensed.

3. Independent Living and Fostering Futures

A foster care child who is under age 18 who is in an Independent Living arrangement and receives full or partial support from a local social services agency, continues to meet the foster care definition and may be eligible in the covered group of Individuals Under Age 21. *A child age 18 and over who is in an Independent Living arrangement with a local department of social services or in the Fostering Futures Program is considered a former foster care child and may be eligible in the Former Foster Care Child Under Age 26 covered group.*

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4. Non-custodial and Parental Agreements

a. Non-custodial Agreement

A non-custodial agreement is an agreement between the child’s parent or guardian and the local Board of Social Services. The parent(s) or guardian retains legal custody of the child. The social services agency agrees to provide financial assistance and/or services to the child, such as placement in and payment for residential facility services.

Non-custodial agreements are used when LDSS serves as the case manager and has placement and care responsibilities to place a child outside of his home for treatment.

Children with non-custodial agreements are considered to be in foster care for Medicaid eligibility purposes.

b. Parental Agreement

A parental agreement is an agreement between the child’s parent or guardian and an agency **other than DSS** which is designated by the CPMT. The other agency designated by the CPMT has placement and care responsibility for the child and agrees to provide financial assistance and/or services to the child, such as placement in and payment for residential facility services.

Parental agreements are used when an agency other than LDSS is designated by the CPMT as case manager and the child is placed outside of the home for treatment.

Children with parental agreements ARE NOT considered to be in foster care for Medicaid eligibility purposes.

c. Placement

Federal Title IV-E funds can only be claimed if LDSS has placement and care responsibility for the child **and** the child is placed by LDSS outside the child’s home. If the LDSS has placement and care responsibility for the child and the child is placed in the child’s home, the child is not eligible for Title IV-E funds and is a Non-IV-E foster child for Medicaid eligibility purposes.

5. Department of Juvenile Justice

A child in the custody of the Virginia Department of Juvenile Justice or who is the responsibility of a court is a “Department of Juvenile Justice (DJJ) child.”

B. Procedures

1. IV-E Foster Care

Children who are eligible for and receive Title IV-E (AFDC-FC) foster care maintenance payments are IV-E Foster Care for Medicaid eligibility purposes. A child of a IV-E foster care child is also considered to be a IV-E foster care child when the mother’s IV-E payment includes an allocation for her child

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DDS Regional Offices

Send all expedited and non-expedited disability referrals to the DDS Regional Office to which the local DSS agency is assigned, as indicated in the table below.

DDS Regional Office	Local DSS Agency Assignments	Hearing Contacts
<p>Central Regional Office Disability Determination Services 9960 Mayland Drive, Suite 200 Richmond, Virginia 23233</p> <p>Phone: 800-523-5007 804-367-4700 <i>General FAX: 804-527-4523</i> Expedited FAX: 804-527-4518</p> <p>Professional Relations: Alvin Gritz Office Manager: Karry Rouse Regional Director: <i>Brett Fielding</i></p>	<p>Amelia, Brunswick, Buckingham, Charles City, Charlotte, Chesterfield, Colonial Heights, Cumberland, Danville, Dinwiddie, Emporia, Essex, Goochland, Greenville, Halifax, Hanover, Henrico, Hopewell, King and Queen, King William, Lancaster, Lunenburg, Mecklenburg, Middlesex, New Kent, Northumberland, Nottoway, Petersburg, Pittsylvania, Powhatan, Prince Edward, Prince George, Richmond County, Richmond City, South Boston, Surry, and Sussex</p>	<p>Primary Contact (scheduler): <i>Jacqueline Fitzgerald</i> 804-367-4838</p> <p>Backup: <i>Lauren Decker</i> 804-367-4755</p> <p>Fax Number for Hearings: 804-527-4518</p>
<p>Tidewater Regional Office Disability Determination Services 5850 Lake Herbert Drive, Suite 200 Norfolk, Virginia 23502</p> <p>Phone: 800-379-4403 757-466-4300 <i>General FAX: 757-466-4300</i> Expedited FAX: 757-455-3829</p> <p>Professional Relations: Sandy Bouldin Office Manager: Heidi Salas Regional Director: Cheryl McCall</p>	<p>Accomack, Chesapeake, Franklin, Gloucester, Hampton, Isle of Wight, James City, Mathews, Newport News, Norfolk, Northampton, Portsmouth, Poquoson, Southampton, Suffolk, Courtland, Virginia Beach, Williamsburg, York</p>	<p>Primary Contact: <i>Bonnie Chatham</i> 757-466-3311</p> <p>Backup: (vacant at this time)</p> <p>Fax Number for Hearings: 757-455-3829</p>
<p>Northern Regional Office Disability Determination Services 11150 Fairfax Boulevard, Suite 200 Fairfax, Virginia 22030</p> <p>Phone: 800-379-9548 703-934-7400 <i>General FAX: 703-934-7410</i> Expedited FAX: 703-455-3829</p> <p>Professional Relations: <i>Vida Cyrus</i> Office Manager: <i>Rachel Cuervo</i> Regional Director: Sharon Gottovi</p>	<p>Albemarle, Alexandria, Arlington, Augusta, Caroline, Charlottesville, Clarke, Culpepper, Fairfax City, Fairfax County, Falls Church, Fauquier, Fluvanna, Frederick, Fredericksburg, Greene, Harrisonburg, Highland, King George, Loudoun, Louisa, Madison, Manassas City, Orange, Page, Prince William, Rappahannock, Rockingham, Shenandoah, Spotsylvania, Stafford, Staunton, Warren, Waynesboro, Westmoreland, and Winchester</p>	<p>Primary Contact: Tara Lassiter 703-934-0071</p> <p>Backup: <i>Vida Cyrus</i> 703-934-7408</p> <p>Fax Number for Hearings: 703-934-7410</p>
<p>Southwest Regional Office Disability Determination Services 612 S. Jefferson Street, Suite 300 Roanoke, Virginia 24011-2437</p> <p>Phone: 800-627-1288 540-857-7748 <i>General FAX: 540-857-7748</i> Expedited FAX: 540-983-4799</p> <p>Professional Relations: Teresa Sizemore-Hernandez Office Manager: Marcia Hubbard Regional Director: Betsy Stone</p>	<p>Alleghany, Amherst, Appomattox, Bath, Bedford City, Bedford County, Bland, Botetourt, Bristol, Buchanan, Buena Vista, Campbell, Carroll, Covington, Craig, Dickenson, Floyd, Franklin, Galax, Giles, Grayson, Henry, Lee, Lexington, Lynchburg, Martinsville, Montgomery, Nelson, Patrick, Pulaski, Radford, Roanoke County, Roanoke City, Rockbridge, Russell, Salem, Scott, Smyth, Tazewell, Washington, Wise, and Wythe</p>	<p>Primary Contact: Lesley Gears 540-857-6027</p> <p>Backup: Brenda Ragland 540-857-6470</p> <p>Fax Number for Hearings: 540-857-6374</p>

M0320 Changes

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

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When an SSI recipient has no real property resource listed in 1) through 5) above, do NOT determine the SSI recipient's resources. The SSI recipient meets the Medicaid resource requirements because he receives SSI and does not have a real property resource listed above.

2. Income

Verify the SSI recipient's eligibility for SSI payments by an SSI awards notice and inquiring the *State On-line Query-Internet (SOLQ-I) system*, SDX (State Data Exchange) or SVES (State Verification Exchange System). If the recipient is eligible for SSI, he meets the Medicaid income eligibility requirement.

C. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month, including the receipt of, or entitlement to, an SSI payment in that month. An individual is considered to be an SSI recipient when the SSA record indicates a payment code of "C01" but shows no payment amount due to a recovery of an overpayment.

Retroactive coverage is applicable to this covered group. However, if the individual did not receive, or was not entitled to, an SSI payment in the retroactive period, the individual is not eligible for retroactive Medicaid in the SSI recipient's covered group. His retroactive eligibility must be evaluated in another Medicaid covered group.

The ACs are:

- 011 for an aged SSI recipient;
- 031 for a blind SSI recipient;
- 051 for a disabled SSI recipient.

D. Ineligible as SSI Recipient

If a non-institutionalized SSI recipient is ineligible for Medicaid because of resources, evaluate the individual's eligibility in all other Medicaid covered groups including, but not limited to, the ABD with Income \leq 80% FPL and the MSP covered groups.

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- 3) If the individual is not income-eligible, Medicaid eligibility may exist in another covered group. However, when determining eligibility in another covered group, count all current income including the current SSA benefit amount. If the individual does not meet an F&C covered group, is not institutionalized, is not receiving CBC or does not have Medicare Part A, he/she must be determined eligible in a medically needy covered group.

C. Protected Disabled Widow(er)

42 CFR § 435.138 specifies that categorically needy eligibility for Medicaid is protected for the group of disabled widow(er)s age 60 through 64 years who meet the criteria specified below. Under 42 USC § 1383c(d), Medicaid protected status was extended to the group of disabled widower(er)s age 50 through 59 years who meet the same criteria.

A protected disabled widow(er) is an individual who:

- is at least age 50 years (and has not attained age 65);
- is **not** eligible for Medicare Part A hospital insurance;
- becomes ineligible for SSI and/or AG because of mandatory application for and receipt of SSA Title II widow(er)'s disability benefits under section 202(e) or 202(f) of the Social Security Act (or any other provision of section 202 if they are also eligible for benefits under subsections (e) or (f) of the Act).
- would be eligible for SSI or AG if the SSA widow(er)'s benefit were excluded from income.

1. Nonfinancial Eligibility

The protected disabled widow(er) must:

- a. have received SSI and/or AG for the month before the month in which he/she began receiving SSA Title II disabled widow(er)'s benefits or widow(er)'s benefits;
- b. be eligible for SSI or AG if the SSA widow(er)s disability benefit were not counted as income.

2. Financial Eligibility

a. Assistance Unit

Determine whose resources and income will be counted or deemed available according to the assistance unit policy in chapter M05.

b. Resource Eligibility

Financial eligibility is determined by comparing the widow(er)'s resources to the current Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). If current resources are within the limit, go on to determine income eligibility.

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If current resources are NOT within the limit, the individual is NOT eligible in this protected group; he/she may be eligible in an MSP covered group (which has more liberal resource methods and standards).

c. Income Eligibility

When determining a protected widow(er)'s eligibility in this covered group, the agency must deduct from the individual's income all of the Social Security benefits that made him or her ineligible for SSI.

- 1) If the individual received SSI (or SSI and AG) and is not currently residing in an approved AG home, the individual's SSA benefit that made him/her ineligible for SSI must be excluded. Other current countable income must be within the current SSI individual limit, or couple limit if the individual is married and living with his/her spouse. Exclude the protected individual's current SSA widow(er)'s benefit amount.

Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected individual is eligible for Medicaid in this protected covered group.

- 2) If the individual received AG (or AG and SSI) and is currently residing in an approved AG home, the individual's countable income must be within the current AG limit (home's rate plus personal care allowance). Exclude the protected individual's current SSA widow(er)'s benefit amount.

Compare the total countable income to the current AG limit (home's rate plus personal care allowance). If countable income is within that limit, the protected individual is eligible for Medicaid in this protected group.

- 3) If the individual is not income eligible, the individual must be evaluated for Medicaid eligibility in other covered groups. However, when determining eligibility in another covered group, count all current income including the current SSA benefit amount.

D. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

The ACs are:

- 021 for an aged individual;
- 041 for a blind individual;
- 061 for a disabled individual.

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- 1) equity in non-exempt property contiguous to the individual's home which exceeds \$5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 are applicable to the property;
- 2) an interest in undivided heir property and the equity value of the individual's share that, when added to all other countable resources exceeds the appropriate Medicaid resource limit. (The interest in the estate must be legally available. If a partition suit is necessary to sell the interest, costs of partition and attorneys' fees may be deducted as described in M1120.215;
- 3) ownership (equity value) of an individual's former residence when the QSII recipient is in an institution for longer than 6 months. Determine if the former residence is excluded under policy in section M1130.100 D;
- 4) equity value in property owned jointly by the QSII recipient and another person who is not the individual's spouse as tenants in common or joint tenants with the right of survivorship at common law. Determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;
- 5) other real property; determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property.

When a QSII recipient has any of the real property listed in 1) through 5) previously, ALL of the recipient's resources must be verified, evaluated, and counted together to determine if the recipient meets the Medicaid resource requirements. Calculate resources according to the assistance unit policy in chapter M05. If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible for Medicare Savings Program (MSP) limited-benefit Medicaid (which has more liberal resource methods and standards).

When a QSII recipient has no real property resource listed in 1) through 5) previously, do NOT determine the recipient's resources. The QSII recipient meets the Medicaid resource requirements because his resource eligibility for QSII has been determined by SSA and he does not have a real property resource as listed previously.

a. Income Eligibility

There are no income eligibility requirements for QSII individuals once they have been determined eligible as 1619(b).

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- becomes ineligible for SSI on or after July 1, 1987 because of the receipt of, or increase in, Title II disabled child's benefits;
- has resources within the current Medicaid resource limit; and
- has income which, in the absence of the Title II disabled child's benefit, or in the absence of the increase in such benefit, is within the current SSI income limit.

C. Financial Eligibility

Determine whose resources and income will be counted or deemed available according to the assistance unit policy in chapter M05.

1. Resources

Financial eligibility is determined by comparing the protected individual's resources to the current Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). Calculate resources according to the assistance unit policy in chapter M05. If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this protected covered group; he/she may be eligible in an MSP covered group (which has more liberal resource methods and standards).

2. Income

a. Receipt of SSA Child's Benefits Causes SSI Ineligibility

If the individual began receiving adult disabled child's benefits and this receipt caused SSI ineligibility, then the entire adult disabled child's benefit amount and any subsequent increases in the benefit are excluded when determining the individual's countable income.

In determining whether the adult disabled child's income, in absence of the Title II adult disabled child's benefit is within the current SSI income limit, all of the adult disabled child's other current countable income must be within the current SSI individual limit, or couple limit if the individual is married and living with his/her spouse. Calculate income according to the assistance unit policy in chapter M05, including deeming of parent(s)' income when the individual is under age 21 and living with a parent(s). **Exclude all of the protected individual's current SSA adult disabled child's benefit amount.**

Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected individual is eligible for Medicaid in this protected covered group.

If countable income exceeds the SSI limit, determine the individual's eligibility in another Medicaid covered group.

b. Increase In SSA Child's Benefits Causes SSI Ineligibility

If the individual received an increase in disabled child's benefits and this increase caused SSI ineligibility, only the increase which caused SSI

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B. Nonfinancial Eligibility Requirements

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

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

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

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

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

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

2. DDS Decision

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

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

C. Financial Eligibility Procedures

1. Assistance Unit

Follow the policy and procedures in M0530.

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Current Enrollee

1. Cancel current coverage using Cancel Code 042.
2. Reinstate in AC 059 beginning the first day of the following month. **Use the date the MEDICAID WORKS Agreement was signed for the application date.**

Send a Notice of Action to the applicant/recipient advising him of his eligibility and acceptance into MEDICAID WORKS. Do not send the Advance Notice of Proposed Action when a recipient moves to MEDICAID WORKS, because his Medicaid coverage has not been reduced or terminated.

Eligibility for MEDICAID WORKS continues as long as the enrollee continues to:

- be employed,
- meet the definition of disability or blindness,
- meet the age limitation, and
- does not exceed the income and resource limits for MEDICAID WORKS.

The MEDICAID WORKS enrollee continues to meet the disability criteria as long as SSA has not completed a Continuing Disability Review and has not determined that the individual no longer has a disabling condition. The fact that the MEDICAID WORKS enrollee is earning over the SSA substantial gainful activity amount has no bearing on whether he meets the disability criteria. If the enrollee's disability status is unclear, contact a Regional Medical Assistance Program Consultant for assistance.

The individual's continuing eligibility must be determined at least every 12 months.

If the individual is no longer eligible for MEDICAID WORKS, the eligibility worker must determine whether the individual remains eligible in any other covered group. **The policy in M0320.400 G above must be reviewed to determine whether the resource exclusion safety net rules apply.** If the individual is not eligible for Medicaid in any other covered group, coverage shall be cancelled effective the first of the month following the expiration of the 10-day advance notice.

M0320.500 300% of SSI INCOME LIMIT GROUPS

A. Introductions

The 300% of SSI income limit groups are for individuals who meet the definition of an institutionalized individual or have been screened and approved for long-term care (LTC) services (see M1410. B. 2) and are not eligible in any other full-benefit Medicaid covered group.

B. Covered Groups

- M0320.501 ABD in a Medical Institution, Income \leq 300% of SSI
- M0320.502 ABD Receiving Medicaid Waiver Services (CBC)
- M0320.503 ABD Hospice

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M0320.502 ABD RECEIVING MEDICAID WAIVER SERVICES (CBC)

A. Policy

42 CFR 435.217 - The state plan includes the covered group of aged, blind or disabled individuals in the community who

- would be eligible for Medicaid if institutionalized;
- are screened and approved to receive Medicaid waiver services and have selected the option to receive Medicaid waiver services in lieu of nursing facility services;
- in the absence of the waiver services would require the level of care furnished in a hospital, nursing facility or ICF-MR; and
- have income that does not exceed 300% of the SSI individual payment limit (see M0810.002 A. 3).

Do not wait until the individual starts to receive the waiver services to determine eligibility in this covered group. Determine eligibility in this covered group if the individual is screened and approved (see subchapter M1420) to receive Medicaid waiver services and has selected the option to receive Medicaid waiver services in lieu of nursing facility services. Presume the individual will receive the services and go on to determine financial eligibility using the policy and procedures in C. below.

If the individual's eligibility was determined as an institutionalized individual prior to the receipt of waiver services, the EW must verify the receipt of Medicaid CBC services within 30 days of the date of the Notice of Action on Medicaid. If Medicaid CBC services did not start within 30 days of the date of the Notice of Action on Medicaid, the individual's continued eligibility must be re-evaluated as a non-institutionalized individual.

B. Financial Eligibility

1. Asset Transfer

The individual must meet the asset transfer policy in subchapter M1450.

2. Resources

a. Resource Eligibility - Unmarried Individual

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements in chapter S11 (ABD Resources). Pay close attention to:

- 1) equity in non-exempt property contiguous to the individual's home which exceeds \$5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property, and
- 2) ownership of his/her former residence when the individual has been away from his home property for longer than 6 months. Determine if the home property is excluded in M1130.100.

DO NOT DEEM any resources from a blind or disabled child's parent

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Medicaid as QMB.

If an individual appears to be eligible for Medicare but is not enrolled in Medicare, refer him to the SSA district office to apply for Medicare enrollment.

If an individual must pay a monthly premium for Medicare Part A, and cannot afford the premium, the SSA office will give the individual a bill for the premium when the individual is enrolled. The individual must present this bill and the Medicare Part A enrollment verification to the local DSS worker in order to be eligible for Medicaid as a QMB.

NOTE: A disabled working individual who is enrolled or is eligible to enroll in Medicare Part A under Section 1818A of the Social Security Act **cannot** be enrolled as a QMB; he may be eligible as a Qualified Disabled and Working Individual (QDWI). See M0320.604 below for information on the QDWI covered group.0

3. Verification Not Provided

If the applicant does not provide information documenting enrollment in Medicare Part A within the application processing time standard, he is not eligible for Medicaid as QMB, but may be eligible for Medicaid in another covered group.

C. Financial Eligibility

1. Assistance Unit

The assistance unit policy in chapter M05 applies to QMBs.

If the QMB individual is living with his spouse who is aged, blind, or disabled, but does not have Medicare Part A, and both apply for Medicaid, two different financial calculations must be completed for the unit because of the different income limits used in the eligibility determinations. One is the MSP QMB determination; the other is for the ABD spouse's CN or MN covered group.

2. Resources

The resource requirements in chapter S11 and Appendix 2 to chapter S11 must be met by the MSP Medicare beneficiary. Some of the real and personal property requirements are different for QMBs. The different requirements are identified in Appendix 2.

The resource limit for an individual is the resource limit for the MSPs. See section M1110.003 for the current resource limits.

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3. Income

The income requirements in chapter S08 must be met by QMBs. The income limits are in M0810.002. By law, for QMBs who have SSA benefits, the new QMB income limits are effective the first day of the second month following the month in which the federal poverty limit is updated. For QMBs who do NOT have SSA benefits, the new QMB income limits are effective the date the updated FPL is published. Local DSS are notified each year of the new FPL via the broadcast system. Check that system to ascertain when the SSA COLA must be counted in determining QMB income eligibility.

4. Income Exceeds QMB Limit

Spenddown does not apply to the MSP income limits. If the individual's income exceeds the QMB limit, he is not eligible as QMB and cannot spenddown to the QMB limit. Determine the individual's eligibility in the SLMB covered group below in M0320.602.

At application and renewal, if the eligible QMB individual's resources are within the medically needy limit and the individual meets a MN covered group, place the individual on two 6-month spenddown based on the MN income limit.

D. QMB Entitlement

Entitlement to Medicaid coverage for QMB only begins the first day of the month **following** the month in which Medicaid eligibility as a QMB is approved.

Because QMB coverage does not begin until the month following the month of approval, an applicant who is eligible for QMB coverage must apply for Extra Help in order to receive the subsidy for the month of QMB approval. See chapter M20 for more information on Extra Help.

Retroactive eligibility does **not** apply to the QMB covered group. To be eligible for Medicaid in the retroactive period, and in the application month, a QMB must meet the requirements of another Medicaid covered group.

E. Enrollment

1. Aid Categories

The following ACs are used to enroll individuals who are only eligible as QMBs; they do not meet the requirements of another covered group:

- 023 for an aged QMB only;
- 043 for a blind QMB only;
- 063 for a disabled or end-stage renal disease QMB only.

2. Recipient's AC Changes To QMB

An enrolled recipient's AC cannot be changed to the QMB-only AC using a "change" transaction in the MMIS. If a Medicaid recipient becomes **ineligible** for full-coverage Medicaid because of an increase in income or resources, but is eligible as a QMB, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare premiums, deductibles and coinsurance amounts as a QMB.

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Cancel the recipient's full coverage effective the last day of the month, using cancel reason "007". Reinstatement the recipient's coverage with the begin date as the first day of the month following the cancellation effective date. The AC is QMB-only.

3. QMB's AC Changes To Full Coverage AC

When an enrolled QMB-only becomes eligible in another covered group and covered group which has full Medicaid coverage, except when he/she meets a spenddown, e.g., a QMB-only individual's resources change to below the MN limits:

- cancel the QMB-only coverage effective the last day of the month immediately **prior** to the month in which he/she became eligible in the full coverage covered group, using cancel reason "024";
- reinstate the recipient's coverage with the begin date as the first day of the month in which he/she became eligible in the full coverage covered group, with the appropriate full coverage AC.

4. Spenddown Status

At application and redetermination, eligible QMBs who meet an MN covered group and who have resources that are within the lower MN resource limits are placed on two 6-month medically needy spenddowns. All spenddown periods are based on the application or renewal date, as appropriate. See M1370.

In order to be placed on spenddown, QMBs with end-stage renal disease must meet a medically needy covered group.

5. QMB Meets Spenddown

When an eligible QMB meets the spenddown, cancel the QMB-only coverage effective the day before the spenddown was met, using cancel reason "024". Reinstatement the recipient's coverage with the first date the spenddown was met as the begin date of coverage, and enter the end date of the spenddown period as the end date of coverage. The aid category is medically needy dual-eligible:

- 028 for an aged MN individual also eligible as QMB;
- 048 for a blind MN individual also eligible as QMB;
- 068 for a disabled MN individual also eligible as QMB.

6. Spenddown Period Ends

After the spenddown period ends, reinstate the QMB-only coverage using the appropriate QMB-only AC. The begin date of the reinstated coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial QMB eligibility.

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2. Individual Not Currently Enrolled In Medicare Part A

Individuals who are not currently enrolled in Medicare Part A must apply for and enroll in Medicare Part A at the local Social Security Administration (SSA) office, and must present verification of Medicare Part A enrollment to the local department of social services (DSS) in order to be eligible for Medicaid as SLMB.

If an individual appears to be eligible for Medicare but is not enrolled in Medicare, refer him/her to the SSA district office to apply for Medicare enrollment.

If an individual must pay a monthly premium for Medicare Part A, and cannot afford the premium, the SSA office will give the individual a bill for the premium when the individual is enrolled. The individual must present this bill and the Medicare Part A enrollment verification to the local DSS worker in order to be eligible for Medicaid as an SLMB.

NOTE: A disabled working individual who is enrolled or is eligible to enroll in Medicare Part A under Section 1818A of the Social Security Act **cannot** be enrolled as SLMB; he/she may be eligible as a Qualified Disabled and Working Individual (QDWI). See M0320.604 below for information on the QDWI covered group.

3. Verification Not Provided

If the applicant does not provide information documenting enrollment in Medicare Part A within the application processing time standard, he/she is not eligible for Medicaid as SLMB, but may be eligible in another covered group.

C. Financial Eligibility

1. Assistance Unit

The assistance unit policy in chapter M05 applies to SLMBs.

If the SLMB individual is living with his/her spouse who is aged, blind, or disabled, but does not have Medicare Part A, and both apply for Medicaid, two different financial calculations must be completed for the unit because of the different income limits used in the eligibility determinations. One is the MSP SLMB determination; the other is for the ABD spouse's CN or MN covered group.

2. Resources

The resource requirements in chapter S11 and Appendix 2 to Chapter S11 must be met by the SLMB. Some of the real and personal property requirements are different for SLMBs. The different requirements are identified in Appendix 2.

The resource limits are the resource limits for the Medicare Savings Programs (MSPs). See section M1110.003 for the current resource limits.

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3. Income

The income requirements in chapter S08 must be met by SLMBs. The income limits for SLMBs are in M0810.002. An SLMB's income must exceed the QMB limit and must be less than the SLMB limit.

By law, for SLMBs who have Title II benefits, the new SLMB income limits are effective the first day of the second month following the month in which the federal poverty limit is updated. For SLMBs who do NOT have Title II benefits, the new SLMB income limits are effective the date the updated federal poverty level is published.

Local DSS are notified each year of the new poverty limits via the broadcast system. Check that system to ascertain when the Title II COLA must be counted in determining SLMB income eligibility.

**4. Income
Equals or
Exceeds
SLMB Limit**

Spenddown does not apply to the MSP income limits. If the individual's income is equal to or exceeds the SLMB limit, he/she is not eligible as SLMB and cannot spenddown to the SLMB limit. At application and redetermination, if the individual's resources are within the medically needy limit and the individual meets a medically needy covered group, place the individual on two 6-month spenddowns based on the MN income limit.

**D. SLMB
Entitlement**

If all eligibility factors are met in the application month, entitlement to Medicaid as an SLMB begins the first day of the application month.

SLMBs are entitled to retroactive coverage if they meet all the SLMB requirements in the retroactive period. However, coverage under this group cannot begin earlier than January 1, 1993.

The eligible SLMB will only receive Medicaid payment of his/her Medicare Part B premium through the Medicaid Buy-In Agreement with SSA. **The SLMB will not receive a Medicaid card.**

E. Enrollment

1. Aid Category

The AC for all SLMBs is "053".

**2. Recipient's
AC Changes
To SLMB**

An enrolled recipient's AC cannot be changed to AC "053" using a "change" transaction in the MMIS. If a Medicaid recipient becomes ineligible for full-coverage Medicaid or QMB-only coverage because of an increase in income, but is eligible as an SLMB, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare Part B premiums as an SLMB.

Cancel the recipient's full coverage effective the last day of the month, using cancel reason "007." Reinstate the recipient's coverage with the begin date as the first day of the month following the cancellation effective date. The aid category (AC) is "053."

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3. SLMB's AC Changes To Full Coverage AC

When an enrolled SLMB becomes eligible in another covered group which has full Medicaid coverage, except when he/she meets a spenddown, e.g., an SLMB's resources change to below the MN limits:

- cancel the SLMB coverage effective the last day of the month immediately prior to the month in which he/she became eligible in the full coverage covered group, using cancel reason "024";
- reinstate the recipient's coverage with the begin date as the first day of the month in which he/she became eligible in the full coverage covered group, with the appropriate full coverage AC.

4. Spenddown Status

At application and redetermination, eligible SLMBs who meet an MN covered group and who have resources that are within the lower MN resource limits are also placed on two 6-month MN spenddowns.

All spenddown periods are based on the application or renewal date, as appropriate. See M1370.

SLMBs who are not determined disabled must be determined disabled or blind, or must be pregnant, under age 18 or under age 21 if in foster care or adoption assistance in order to meet a medically needy covered group for spenddown.

5. SLMB Meets Spenddown

When an SLMB meets a spenddown, cancel his AC "053" coverage effective the date before the spenddown was met, using cancel reason "024". Reinstate the recipient's coverage with the first date the spenddown was met as the begin date of coverage, and enter the end date of the spenddown period as the end date of coverage. The AC is medically needy dual-eligible as SLMB Plus:

- 024 for an aged MN individual also eligible as SLMB;
- 044 for a blind or disabled MN individual also eligible as SLMB.

6. Spenddown Period Ends

After the spenddown period ends, reinstate the SLMB-only coverage using the AC 053.

The begin date of the reinstated AC 053 coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial SLMB eligibility.

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By law, for QIs who have Title II benefits, the new income limits are effective the first day of the **second** month following the month in which the federal poverty limit is updated. For QIs who do NOT have Title II benefits, the new income limits are effective the date the updated federal poverty limit is published. Local DSS are notified each year of the new poverty limits via the broadcast system. Check that system to ascertain when the Title II COLA must be counted in determining QI income eligibility.

4. Income Within QI Limit

When the individual's countable income is equal to or more than 120% of the FPL and is less than 135% of FPL (the QI limit), the individual is eligible for Medicaid as a QI. Go to subsection D below. If the individual's resources are within the MN limit and the individual meets a MN covered group, place the individual on two (2) 6-month spenddowns based on the MN income limit for his locality. See M0320.603 E.5 below.

5. Income Equals or Exceeds QI Limit

If the individual's income is equal to or exceeds the QI limit (135% of FPL), he/she is not eligible as QI.

D. QI Entitlement

If all eligibility factors are met in the application month, entitlement to Medicaid as a QI begins the first day of the application month. QIs are entitled to retroactive coverage if they meet all the QI requirements in the retroactive period.

D. Enrollment

1. Aid Category

The AC for all QIs is 056.

2. Enrollee's Covered Group Changes To QI

If Medicaid recipient becomes ineligible for full-coverage Medicaid but is eligible as a QI, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare Part B premiums as a QI.

Cancel the recipient's full coverage effective the last day of the month, using cancel reason 007. Reinstate the recipient's coverage with the begin date as the first day of the month following the cancellation effective date. Specify the appropriate QI AC.

2. Spenddown Status

At application and redetermination, eligible QIs who meet an MN covered group and who have resources that are within the lower MN resource limits are placed on two 6-month MN spenddowns. All spenddown periods are based on the application or renewal date, as appropriate. See M1370.

QIs who have not been determined disabled must be determined disabled or blind, or must be pregnant, under age 18 or under age 21 if in foster care or adoption assistance in order to meet a medically needy covered group for spenddown.

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C. Financial Eligibility

The assistance unit policy in chapter M05 applies to QDWIs.

1. Assistance Unit

If the QDWI individual is living with his/her spouse who is aged, blind, or disabled, but does not have Medicare Part A, and both apply for Medicaid, two different financial calculations must be completed for the unit because of the different income limits used in the eligibility determinations. One is the QDWI determination; the other is for the ABD spouse's covered group.

2. Resources

The resource requirements in chapter S11 and Appendix 1 to Chapter S11 must be met by the QDWI Medicare beneficiary. Some of the real and personal property requirements are different for QDWIs. The different requirements are identified in Chapter S11, Appendix 1.

The resource limit for an individual is \$4,000 (twice the SSI resource limit for an individual); the resource limit for a couple is \$6,000 (twice the SSI resource limit for a couple).

3. Income

QDWIs must meet the income requirements in chapter S08. The income limits are in M0810.002. QDWIs do not receive Title II benefits.

4. Income Exceeds QDWI Limit

Spenddown does not apply to the MSP income limits. If the individual's income exceeds the QDWI limit, he/she is not eligible as QDWI and cannot spenddown to the QDWI limit. At application and redetermination, if the individual's resources are within the medically needy limit and the individual meets a medically needy covered group, place the individual on two 6-month spenddowns based on the MN income limit.

D. Entitlement

Entitlement to Medicaid as a QDWI begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month, including enrollment in Medicare Part A under Section 1818A of the Social Security Act. Retroactive entitlement, up to three months prior to application, is applicable if all QDWI eligibility criteria were met during the period.

If the individual is not enrolled in Medicare Part A under Section 1818A as of the month he/she meets the Medicaid eligibility requirements, the individual's entitlement to Medicaid cannot begin until the first day of the month in which his Medicare Part A enrollment under Section 1818A is effective.

The eligible QDWI will only receive Medicaid payment of his/her Medicare Part A premium through the Medicaid Buy-In Agreement with SSA. **The QDWI will not receive a Medicaid card.**

E. Enrollment

1. Aid Category

The AC for all QDWIs is "055."

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2. Recipient's AC Changes To QDWI

An enrolled recipient's AC cannot be changed to AC "055" using a "change" transaction in the MMIS. If a Medicaid recipient becomes ineligible for full-coverage Medicaid, but is eligible as a QDWI, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare Part A premiums as a QDWI.

Cancel the recipient's full coverage effective the last day of the month, using cancel reason "007." Reinstatement the recipient's coverage as QDWI with the begin date as the first day of the month following the cancellation effective date. AC is "055."

3. QDWI's AC Changes To Full Coverage AC

When an enrolled QDWI becomes eligible in another covered group which has full Medicaid coverage (except when he/she meets a spenddown); e.g., he/she is no longer able to work and starts to receive SSA and SSI disability benefits:

- cancel the QDWI coverage effective the last day of the month immediately prior to the month in which he/she became eligible in the full coverage covered group, using cancel reason "024;"
- reinstate the recipient's coverage with the begin date as the first day of the month in which he/she became eligible in the full coverage covered group, with the appropriate full coverage AC.

4. Spenddown Status

Eligible QDWIs who meet an MN covered group and who have resources that are within the lower MN resource limits are also placed on two 6-month medically needy spenddowns.

5. QDWI Meets Spenddown

When a QDWI meets a spenddown, cancel his AC "055" coverage effective the date before spenddown was met using cancel reason "024." Reinstatement coverage as medically needy beginning the day the spenddown was met and ending the last day of the spenddown budget period.

The AC is NOT dual-eligible:

- 018 for an aged MN individual NOT eligible as QMB;
- 038 for a blind MN individual NOT eligible as QMB;
- 058 for a disabled MN individual NOT eligible as QMB.

6. Spenddown Period Ends

After the spenddown period ends, reinstate the QDWI-only coverage using the AC "055."

The begin date of the reinstated AC "055" coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial QDWI eligibility.

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D. Enrollment

Eligible individuals in this group are classified as medically needy (MN). If the individual has Medicare Part A, compare the individual’s countable income to the QMB and SLMB limits.

The following ACs are used when the individual is ABD MN and QMB or SLMB:

- 028 for an aged individual also QMB;
- 048 for a blind individual also QMB;
- 068 for a disabled individual also QMB;
- 024 for an aged MN individual also SLMB;
- 044 for a blind or disabled MN individual also SLMB.

The following ACs are used when the individual is ABD MN and not QMB or SLMB:

- 018 for an aged individual NOT QMB or SLMB;
- 038 for a blind individual NOT QMB or SLMB;
- 058 for a disabled individual NOT QMB or SLMB.

D. Referral to Health Insurance Marketplace

When an ABD who does not have Medicare is placed on a spenddown, the individual must be referred to the Health Insurance Marketplace (HIM) so that the applicant’s eligibility for the APTC can be determined. Individuals with Medicare are not referred to the HIM.

M0320.702 DECEMBER 1973 ELIGIBLES

A. Policy

42 CFR 435.340 - If the State Plan covers the medically needy, the Plan must provide protected medically needy coverage for blind and disabled individuals eligible in December 1973.

B. Blind or Disabled in December 1973

This is an MN covered group of blind and disabled individuals who:

- were eligible as medically needy under the state plan in December 1973 on the basis of the blindness or disability criteria of the AB or APTD plan;
- for each consecutive month after December 1973 continue to meet the December 1973 blindness or disability criteria and the December 1973 financial eligibility requirements; and
- meet the **current** medically needy eligibility requirements except the blindness or disability criteria.

Continuing eligibility is determined on the basis of eligibility requirements in effect as of December, 1973 and current medically needy requirements.

Contact your Regional Medical Assistance Program Consultant if you have an applicant you believe meets this covered group.

M0330 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-2	10/1/16	Pages 8 Page 9b was renumbered to 9a.
TN #DMAS-1	6/1/16	Pages 2, 8, 9, 15, 31, 32-35 Page 9b was added as a runover page.
TN #100	5/1/15	Table of Contents Pages 4-8, 15-22, 24,25 36-38
UP #10	5/1/14	Pages 5, 8, 9
TN #99	1/1/14	Pages 1, 8, 9, 13, 24
TN #98	10/1/13	Table of Contents Pages 1-3, 6-16, 19, 22, 24-29
UP #8	10/1/12	Pages 4, 6
TN #97	9/1/12	Table of Contents Pages 1-40 (all pages)
UP #2	8/24/09	Pages 3, 6, 8, 16, 22
Update (UP) #1	7/1/09	Pages 20, 21

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Subchapter Subject M0330.000 FAMILIES & CHILDREN GROUPS	Page ending with M0330.109	Page 8

2. Resources

There is no resource test for the Special Medical Needs Adoption Assistance Children covered group.

3. Income

Adoption assistance children in residential facilities do not have a different income limit. The income limit for Individuals Under Age 21 for one person in the child’s locality is used to determine eligibility in the Special Medical Needs covered group. See M04, Appendix 4.

For a Virginia Special Medical Needs adoption assistance child living outside the State of Virginia, the income limit for the unit is the income limit for the Virginia locality that signed the adoption assistance agreement.

The adoption subsidy payment is excluded when determining the child’s financial eligibility.

If the child’s countable income exceeds the income limit for Individuals Under Age 21, evaluate the child in the Special Medical Needs Adoption Assistance MN covered group (see M0330.805). Ineligible individuals must be referred to the Health Insurance Marketplace for evaluation for the APTC.

D. Entitlement & Enrollment

Entitlement to Medicaid begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

The AC for individuals in the covered group of Special Medical Needs Adoption Assistance children is “072.”

M0330.109 FORMER FOSTER CARE CHILDREN UNDER AGE 26 YEARS

A. Policy

P.L. 111-148 (The Affordable Care Act) - The federal Medicaid law requires the State Plan to cover individuals who were formerly in Title IV-E or non-IV-E foster care or the Unaccompanied Refugee Minors Program (URM) when the individual:

- was in the custody of a local department of social services in Virginia or another state and receiving Medicaid until his discharge from foster care upon turning 18 years or older, or
- was in the URM program in Virginia or another state and receiving Medicaid until his discharge upon turning 18 years or older.
- is not eligible for Medicaid in another mandatory Medicaid covered group (LIFC parent, Pregnant Woman, Child Under age 19 or SSI), and
- is under age 26 years.

A child age 18 and over who is in an Independent Living arrangement *or in the Fostering Futures Program* with a local department of social services may be eligible in this covered group.

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Subchapter Subject M0330.000 FAMILIES & CHILDREN GROUPS	Page ending with M0330.200	Page 9a

The child(ren) must meet the definition of a dependent child in M0310.111. The adult with whom the child lives must be the child's parent or must meet the definition of a caretaker-relative of a dependent child in M0310.107. For applications submitted prior to October 1, 2013, a child or adult who lives in the household but who is not the dependent child's parent or caretaker-relative may be eligible as LIFC if he/she meets the definition of an EWB in M0310.113. Effective October 1, 2013, EWB is not included in the definition of LIFC.

C. Financial Eligibility

The financial eligibility policy used for this covered group depends on when the application is submitted or renewal is processed. Refer to Chapters M05 and M07 for applications submitted before October 1, 2013 and renewals completed before April 1, 2014. Refer to Chapter M04 for eligibility determinations completed on applications submitted on or after October 1, 2013, and renewals completed on or after April 1, 2014.

M04 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-2	10/1/16	Appendix 2, pages 1, 2 Appendices 3, 5
TN #DMAS-1	6/1/16	Pages 3, 5, 6, 12, 13, 14a Appendices 1, 2, 6 and 7 Appendix 2, page 2 was added. Page 13a is a runover page.
UP #11	7/1/15	Appendices 3 and 5
TN #100	5/1/15	pages 2, 11, 12, 13, 14 Appendices 1, 2, 3, 5, 6 and 7 Page 1 is a runover page.
Update (UP) #10	5/1/14	Table Contents pages 2, 3, 5, 6, 10-15 Appendices 1, 2 and 6 Appendix 7 was added.
TN #99	1/1/14	pages 2, 5, 6, 8, 14, 15 Appendix 6

Manual Title Virginia Medical Assistance Eligibility	Chapter M04	Page Revision Date October 2016
Subchapter Subject M04 MODIFIED ADJUSTED GROSS INCOME (MAGI)	Page ending with Appendix 2	Page 1

PREGNANT WOMEN 143% FPL INCOME LIMITS ALL LOCALITIES EFFECTIVE 1/25/16		
Household Size	143% FPL Monthly Amount	148% FPL (143% FPL + 5% FPL Disregard as Displayed in VaCMS)
2*	1,910	1,977
3	2,403	2,487
4	2,896	2,998
5	3,390	3,509
6	3,883	4,019
7	4,377**	4,531
8	4,873**	5,044
Each additional, add	496**	18

*A pregnant woman's household is at least two individuals when evaluated in the Pregnant Women covered group.

**No change for 2016.

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Subchapter Subject M04 MODIFIED ADJUSTED GROSS INCOME (MAGI)	Page ending with Appendix 2	Page 2

CHILD UNDER AGE 19 143% FPL INCOME LIMITS ALL LOCALITIES EFFECTIVE 1/25/16			
# of Persons in House- hold	109% FPL (for Determining Aid Category)	143% FPL	<i>148% FPL</i> (143% FPL + 5% FPL Disregard as Displayed in VaCMS)
	Monthly Limit	Monthly Limit	Monthly Limit
1	\$1,080	\$ 1,416	\$1,466
2	1,465	1,910	1,977
3	1,832	2,403	2,487
4	2,208	2,896	2,998
5	2,584	3,390	3,509
6	2,960	3,883	4,019
7	3,337*	4,377*	5,531
8	3,715*	4,873*	5,044
Each add'l, add	378*	496*	18

*No change for 2016.

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Subchapter Subject M04 MODIFIED ADJUSTED GROSS INCOME (MAGI)	Page ending with Appendix 3	Page 1

LIFC INCOME LIMITS

EFFECTIVE 7/1/15
(No Change for 2016)

Group I

Household Size	Income Limit
1	
2	\$244
3	371
4	472
5	573
6	675
7	761
8	859
	962
Each additional person add	100

Group II

Household Size	Income Limit
1	\$319
2	457
3	575
4	687
5	808
6	911
7	1,020
8	1,139
Each additional person add	113

Group III

Household Size	Income Limit
1	481
2	644
3	788
4	925
5	1,093
6	1,216
7	1,353
8	1,496

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Subchapter Subject M04 MODIFIED ADJUSTED GROSS INCOME (MAGI)	Page ending with Appendix 5	Page 1

INDIVIDUALS UNDER AGE 21 INCOME LIMITS

EFFECTIVE 7/01/15
(No Change for 2016)

Group I

Household Size	Income Limit
1	\$233
2	361
3	463
4	562
5	662
6	742
7	840
8	943
Each additional person add	96

Group II

Household Size	Income Limit
1	\$316
2	458
3	574
4	688
5	812
6	1,002
7	1,020
8	1,138
Each additional person add	111

Group III

Household Size	Income Limit
1	\$420
2	564
3	683
4	799
5	945
6	1,043
7	1,156
8	1,273
Each additional person add	112

M0530 Changes

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

Manual Title Virginia Medical Assistance Eligibility	Chapter M05	Page Revision Date October 2016
Subchapter Subject M0530.000 ABD ASSISTANCE UNIT	Page ending with M0530.203	Page 23

\$ 80 Mr. Wilson's unearned income
- 237 NBD child allocation
 - 157 remainder NBD child allocation
+ 0 Mr. Wilson's earned income
 \$ 0 NBD spouse's total income after allocation

Since Mr. Wilson has no remaining income, and \$0 is less than the \$257 deeming standard, no income is deemed to Mrs. Wilson. Instead, only her own countable income is compared to the income limits *for the ABD covered groups* for one person to determine whether she is eligible. Mrs. Wilson's own countable income is \$780, which exceeds the QMB income limit for one person. However, it is within the SLMB income limit. She is eligible for SLMB coverage beginning January 1, 2000. She is also placed on a two spenddowns for the periods of January 1 through June 30 and July 1 through December 31.

2. Spouse Has Earned and Unearned Income After Allocation

EXAMPLE #8: (Using January 25, 2016 figures)

Mr. Jack Ingalls, a disabled individual, applies for Medicaid. He lives with his NABD spouse and NBD 19 year old child, Cathy, in a Group I locality. Mr. And Mrs. Ingalls' resources are within the resource limit. Mr. Ingalls receives \$300 unearned income monthly; he does not have Medicare Part A. Cathy has no income. Mrs. Ingalls has earned income of \$450 a month and unearned income of \$1,165 a month. The deeming calculation *for Mrs. Ingalls* is:

\$1165 Mrs. Ingalls' unearned income
-367 NBD child allocation
 798 remainder unearned income
+450 Mrs. Ingalls' earned income
 \$1248 NBD spouse's total income after allocation

Mrs. Ingalls' total income is more than the \$367 deeming standard. Therefore, Mrs. Ingalls' income is deemed to Mr. Ingalls by combining Mrs. Ingalls' income after allocation with Mr. Ingalls' income to determine his eligibility:

\$1165 Mrs. Ingalls' unearned income
-367 NBD child allocation
 798 remainder unearned income
+ 300 Mr. Ingalls' unearned income
 1098 combined unearned income
- 20 general income exclusion
 1078 couple's countable unearned income

 450 Mrs. Ingalls' earned income
+ 0 Mr. Ingalls' earned income
 450 couple's earned income
- 65 earned income exclusion
 385

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Subchapter Subject M0530.000 ABD ASSISTANCE UNIT	Page ending with M0530.204	Page 24

385	
$\div \underline{2}$	1/2 remainder earned income exclusion
192.50	couple's countable earned income
$+ \underline{1078.00}$	couple's countable unearned income
<u>1270.50</u>	couple's total countable monthly income

$\$1270.50 > \1085.00 (80% of the Federal Poverty Level (FPL) for 2 people).

The couple's countable monthly income exceeds 80% FPL income limit for a couple. Mr. Ingalls is placed on a spenddown

3. Both ABD Individual and NABD Spouse Have Income-- Individual Is Eligible

EXAMPLE #9: (Using January 25, 2016 figures)

Harold Bergman, a disabled individual, applies for Medicaid. He lives in Group III with his NABD spouse, who earns \$459 per month. They have no children. Mr. Bergman receives a pension (unearned income) of \$165 a month and earns \$100 gross per month. He does not have Medicare Part A. The couple's resources are within the Medicaid limit. Because Mrs. Bergman's income exceeds the deeming standard of \$367, Mrs. Bergman's income is deemed to Mr. Bergman by combining Mrs. Bergman's income with Mr. Bergman's income to calculate his eligibility:

\$165.00	Mr. Bergman's unearned income
$+ \underline{0}$	Mrs. Bergman's unearned income
\$165.00	couple's unearned income
$- \underline{20.00}$	general income exclusion
\$145.00	couple's countable unearned income
\$459.00	Mrs. Bergman's earned income
$+ \underline{100.00}$	Mr. Bergman's earned income
559.00	couple's earned income
$- \underline{65.00}$	earned income exclusion
494.00	
$\div \underline{2}$	1/2 remainder earned income exclusion
247.00	couple's countable earned income
$+ \underline{145.00}$	couple's countable unearned income
\$392.00	couple's total countable monthly income

$\$392 < \1085.00 (80% of the FPL) for 2 people).

The couple's countable income is within the 80% FPL income limit for 2 persons, so Mr. Bergman is eligible for Medicaid.

M0530.204 CHANGES IN STATUS--MARRIED COUPLES

A. Introduction

There are several events which can change deeming status. All such changes affect deeming the month after the month in which the change

M0710 Changes

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

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F&C MEDICALLY NEEDY INCOME LIMITS EFFECTIVE 7-01-15
(No Change for 2016)

# of Persons in Family/Budget Unit	GROUP I		GROUP II		GROUP III	
	Semi-Annual Income	Monthly Income	Semi-Annual Income	Monthly Income	Semi-Annual Income	Monthly Income
1	1,861.63	310.27	2,148.04	358.00	2,792.45	465.40
2	2,370.20	395.03	2,645.09	440.84	3,366.75	561.12
3	2,792.45	465.40	3,078.88	513.14	3,794.89	632.48
4	3,150.47	525.07	3,436.89	572.81	4,152.90	692.15
5	3,508.48	584.74	3,794.89	632.48	4,510.92	751.82
6	3,866.49	644.41	4,152.90	692.15	4,868.93	811.48
7	4,224.50	704.08	4,510.92	751.82	5,226.94	871.15
8	4,654.12	775.68	4,940.53	823.42	5,584.96	930.82
9	5,083.73	847.28	5,421.74	903.62	6,103.70	1,017.28
10	5,584.96	930.82	5,871.37	978.56	6,515.79	1,085.96
Each add'l person add	481.13	80.18	481.13	80.18	481.13	80.18

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**F&C 100% STANDARD OF ASSISTANCE
AMOUNTS EFFECTIVE 7/1/15
(No Change for 2016)**

(Used as the F&C Deeming Standard)

Group I

Household Size	Monthly Amount
1	\$239
2	364
3	464
4	563
5	663
6	748
7	844
8	945
Each additional person add	98

Group II

Household Size	Monthly Amount
1	\$313
2	449
3	565
4	675
5	794
6	895
7	1,002
8	1,119
Each additional person add	111

Group III

Household Size	Monthly Amount
1	\$472
2	633
3	774
4	909
5	1,074
6	1,195
7	1,330
8	1,471
Each additional person add	135

M0720 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-2	10/1/16	Table of Contents, page i Pages 11, 13, 14 Appendix 1 Pages 15-18 were deleted.
TN #DMAS-1	6/1/16	Page 2
TN #98	10/1/13	Pages 6, 10
TN #94	9/01/2010	Pages 5, 6
TN #91	5/15/2009	Page 11

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B. Earned Income Exclusions

Income exclusions are applied, in the following order, to earned income for family unit/budget unit (FU/BU) members as appropriate to the covered group.

See Families and Children (F&C) Earned Income Exclusions chart in Appendix 1 to this subchapter.

1. Workforce Investment Act Income

Earned income of an eligible child (less than 18, or 18 and expected to graduate prior to 19) derived from employment in a program under the Workforce Investment Act is excluded. Do not request verification of income from employment under the Workforce Investment Act.

2. Student Income

Earned income of an individual under age 19 who is a student is excluded. Do not request verification of student income.

For this exclusion, a student is any individual under age 19 who is attending any type or level of school, part-time or full-time. Do not verify school attendance; declaration of school attendance is sufficient.

3. 2010 Census Income

Income paid by the U.S. Census Bureau to temporary employees specifically hired for the 2010 census is NOT counted when determining eligibility for medical assistance.

4. Standard Work Exclusion

A standard work exclusion of the first \$90 of gross monthly earned income is excluded for each employed member of the FU/BU whose income is not otherwise exempt. See M0720.520.

5. Child Care/Incapacitated Adult Care Exclusion

Monthly anticipated child care expenses or incapacitated adult care expenses, up to the appropriate maximums, which are paid for by the caretaker-relative must be excluded. See M0720.540.

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Subchapter Subject M0720.000 F & C EARNED INCOME	Page ending with M0720.540	Page 13

M0720.520 STANDARD WORK EXCLUSION

- A. Policy** The first \$90 of gross earned income is excluded for each employed individual in the FU/BU whose income is not otherwise exempt regardless of when it is reported.
- B. Procedure** Apply this exclusion to the amount of earned income

M0720.540 CHILD CARE/INCAPACITATED ADULT CARE EXCLUSION

- A. Policy** Anticipated child or incapacitated adult care expenses paid or anticipated to be paid by the family/budget unit for children or incapacitated adults in the family unit, up to the appropriate maximums, must be excluded from earned income in determining Medicaid eligibility when the expenses are necessary because of employment or seeking employment.

When both parents are in the household, both parents must be employed or seeking employment to receive the child care/incapacitated adult care exclusion. The child care/incapacitated adult care exclusion is based on a parent's employment status.

When only one parent is employed and the other parent is not employed or seeking employment and is not able to care for the child(ren) or incapacitated adult, the dependent/incapacitated adult care expense exclusion may be granted when:

- 1) the paid child or incapacitated adult care is necessary, **and**
- 2) a physician provides a statement that the parent is disabled and unable to care for the child(ren) or incapacitated adult in question. The doctor's statement must also indicate the anticipated length of time that the parent will be unable to care for the child(ren) or incapacitated adult.

B. Definitions

- 1. Full-time Employment** Full-time employment means employed to work 30 hours or more per week on an on-going basis; or working, or expected to work 120 hours or more per month (for an individual working on a fluctuating basis).
- 2. Part-time Employment** Part-time employment means employed to work less than 30 hours per week on an on-going basis; or working or expected to work less than 120 hours per month (for an individual working on a fluctuating basis).
- 3. Not Employed Throughout a Month** Not employed throughout a month means an individual began or terminated employment within the month.

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C. Operating Principle

1. Verification

a. Incapacity

Incapacity of the adult who requires care must be supported by a professional determination. The medical examination for Medicaid and GR is used for this purpose, unless incapacity is established by receipt of Social Security Disability benefits.

b. Employment Status

An individual's employment status is verified by either an employer's statement of the number of hours employed to work, or actually worked or by pay stubs. For self-employed individuals, the agency is required to accept the client's statement concerning the number of hours worked, unless the agency has reason to question the validity of the statement.

c. Expenses

Verification of child/incapacitated adult care expenses is not required. Accept the parent/caretaker's declaration of the amount of the child/incapacitated adult care expense.

2. Amount of Exclusion

a. Full-time Employment

For full-time employment, deduct an amount equal to the anticipated cost, not to exceed \$175 per month, for care of each child, age 2 and older and/or incapacitated adult in the family unit. In the case of child care for a child under 2 years old, deduct the anticipated cost not to exceed \$200 per month.

b. Part-time Employment

For part-time employment, deduct an amount equal to the anticipated cost, not to exceed \$120 per month, for care of each child and/or incapacitated adult in the family unit.

c. Not Employed Throughout a Month

- 1) If an individual has worked, or is expected to work, 120 hours or more in that month, deduct an amount not to exceed the full-time exclusion.
- 2) If an individual has worked, or is expected to work, less than 120 hours in that month, deduct an amount not to exceed the part-time exclusion.

3. Conversion to Monthly Amount

If child care/incapacitated adult care is payable on a weekly or bi-weekly basis, the amount of the monthly expense may be calculated using the 4.3 (weekly), or 2.15 (bi-weekly), or 2 (semi-monthly) conversion factors.

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FAMILIES & CHILDREN EARNED INCOME EXCLUSIONS

EXCLUSION	CRITERIA	LIMITATIONS
Workforce Investment Act M720.505	Child < age 19	None
Student Earnings M720.510	Child < age 19 in school	None
\$90 Standard Work M720.520	Available for EACH person in the FU/BU whose earnings are being counted	None
Child Care/ Incapacitated Adult Care M720.540	Allowed for child or adult in FU/BU Amount based on employment status of applicant/recipient and age of child or adult = or >30 hours/week or 120 hours/month <2 years= \$200 maximum per child >2 years= \$175 maximum per child or adult < 30 hours/week or 120 hours/month \$120 per child or adult	Allowed as long as child or adult is in FU/BU For child care, if both parents are in home, both must be employed

M0810 Changes

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

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Subchapter Subject M0810 GENERAL - ABD INCOME RULES	Page ending with M0810.002	Page 2

**3. Categorically
Needy 300% of
SSI**

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

Family Size Unit	2016 Monthly Amount	2015 Monthly Amount
1	\$2,199 (no change)	\$2,199

**4. ABD Medically
Needy**

a. Group I	7/1/2016 (no change)		7/1/2015 – 6/30/16	
Family Unit Size	<i>Semi-annual</i>	<i>Monthly</i>	<i>Semi-annual</i>	<i>Monthly</i>
1	\$1,861.63	\$310.27	\$1,861.63	\$310.27
2	2,370.20	395.03	2,370.20	395.03
b. Group II	7/1/2016 (no change)		7/1/2015 – 6/30/16	
Family Unit Size	<i>Semi-annual</i>	<i>Monthly</i>	<i>Semi-annual</i>	<i>Monthly</i>
1	\$2,148.04	\$358.00	\$2,148.04	\$358.00
2	2,645.09	440.84	2,645.09	440.84
c. Group III	7/1/2016 (no change)		7/1/2015 – 6/30/16	
Family Unit Size	<i>Semi-annual</i>	<i>Monthly</i>	<i>Semi-annual</i>	<i>Monthly</i>
1	\$2,792.45	\$465.40	\$2,792.45	\$465.40
2	3,366.75	561.12	3,366.75	561.12

**5. ABD
Categorically
Needy**

All Localities	2016	2015
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For:

**ABD 80% FPL,
QMB, SLMB, &
QI without Social
Security income;
all QDWI;
effective 1/25/16**

**ABD 80% FPL,
QMB, SLMB, &
QI with Social
Security income;
effective 3/1/16**

	Annual	Monthly	Annual	Monthly
ABD 80% FPL				
1	\$9,504	\$792	\$9,416	\$785
2	12,816	1,068	12,744	1,062
QMB 100% FPL				
1	\$11,880	\$990	\$11,770	\$981
2	16,020	1,335	15,930	1,328
SLMB 120% of FPL				
1	\$14,256	\$1,188	\$14,124	\$1,177
2	19,224	1,602	19,116	1,593
QI 135% FPL				
1	\$16,038	\$1,337	\$15,890	\$1,325
2	21,627	1,803	21,506	1,793
QDWI				
200% of FPL				
1	\$23,760	\$1,980.00	\$23,540	\$1,962.00
2	32,040	2,670.00	31,860	2,655.00

S0830 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-2	10/1/16	On page 109, updated the format of the header. Neither the date nor the policy was changed.
TN #DMAS-1	3/23/16	Table of Contents, page iii Pages 18, 82
Update #7	7/1/12	Page 24
TN #94	9/1/10	Page 29
TN #93	1/1/10	Table of Contents, page iv Pages 28, 67, 119-120 Pages 122-125
TN #91	5/15/09	Table of Contents, page i Page 29

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Subchapter Subject M0830 UNEARNED INCOME	Page ending with M0830.620	Page 109

D. Procedure

1. Presidential Declaration - Documentation

When a residentially-declared disaster has been verified, document the following:

- a. that it is declared to be a major disaster by the President in accordance with the Robert T. Stafford Disaster Relief and Emergency Assistance Act;
- b. the geographic areas included in the declared disaster area;
- c. the fact that the Medicaid applicant/recipient lived in the declared disaster area and was affected by the disaster; and
- d. the exact date(s) on which the disaster occurred.

NOTE: If a precedent has been established, only document the fact that the Medicaid applicant/recipient lived in the disaster area and was affected by the disaster.

2. Support and Maintenance

- a. Absent evidence to the contrary:
 - **Accept** an individual's allegation that he was affected by the disaster and that he is receiving support and maintenance on a temporary basis as a result.
 - **Assume** that a living arrangement change due to a disaster is temporary.
- b. **Be alert** to situations where an individual reports a change in circumstances (living arrangements, receipt of household items, cash receipts, etc.) which has been brought about by a disaster, but the individual has not reported involvement in the disaster.

3. Verification of Assistance Other Than Support and Maintenance

Use documents in the individual's possession, or contact with the source to verify that assistance, other than support and maintenance subject to the exclusion in B.1. above, is provided under a Federal statute and because of the disaster.

E. Reference

Disaster assistance (exclusion from resources), S1130.620.

M1120 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-2	10/1/16	On page 6, updated the format of the header. Neither the date nor the policy was changed.
TN #96	10/1/11	Table of Contents pages 24-26
TN #93	1/1/2010	page 22

Manual Title Virginia Medical Assistance Eligibility	Chapter M11	Page Revision Date July 1995
Subchapter Subject IDENTIFYING RESOURCES	Page ending with S1120.020	Page 6

- 2. Status of Assets Held for Ward** Unless there is a legal restriction on the agent's access to assets held for a ward or against their use for the ward's support and maintenance, the assets are the ward's resources. They are not the agent's resources since the agent has no ownership interest in them and often is not legally free to use them for his/her own support and maintenance.
- 3. Property Title Must Show Ownership** An agent holding property of any kind for a ward must keep it in a form that clearly shows ownership by the ward.
- D. Operating Policies- Improperly Titled Financial Account** The most common type of improperly titled account is the savings account designated as held "in trust for" a ward. This form of holding is not a formal trust (M1120.200) and is misleading as to ownership of the funds. If State law does not recognize the funds as the ward's property, see E.3. below. If evaluating an improperly titled account, consult your Regional Coordinator.
- 1. Singly Owned Account; EI/Deemor Is Ward**
- a. Agent Agrees Funds Belong to Ward - If there is an agency relationship so that deposits to the account are income to the ward, not the agent (S0810.120): we
- assume the funds are the ward's property; and
 - request that the agent change the account designation.
- b. Agent Does Not Agree Funds Belong to Ward - If the agent does not agree that the funds belong to the ward and refuses to correct the account title, we do not treat the funds as the ward's resources. See E.4. if the agent is a representative payee. See E.3. b. if the agent is not a representative payee.
- 2. Singly Owned Account; EI/Deemor Is Agent** Although deposits to the account are not the agent's income per S0810.120.D 2, we treat the account as the agent's resource. The account is the resource of the person shown as owner on the account title.
- 3. Jointly Owned Account** Regardless of whether the EI/deemor is ward or agent, an agent can rebut ownership of the funds and establish that they are the ward's property (S1140.205).
- E. Development and Documentation**
- 1. Verify Agency Relationship** Verify any allegation of an agency relationship per S0810.120 F.
- 2. Determine Resources** Document your decisions concerning the form and value of resources belonging to the EI/deemor. Follow the guidelines in C. and D. above, as well as in sections dealing with the specific type of property involved.
- 3. Improperly Titled Financial Account; EI/Deemor Has Agent**
- a. Agent Acknowledges Funds as Ward's
- Document the file with the agent's signed statement as to the ward's ownership.
 - Ask the agent to have the account retitled.
 - Treat the funds as the ward's property.
- b. Agent Is Not Representative Payee and Does Not Acknowledge Funds as Ward's
If an agent (other than a representative payee) has set up an account incorrectly, will not change the account designation, and will not acknowledge the funds as the ward's:
- document the file with the agent's refusal;
 - do not treat the funds as the ward's property; and
 - see S0820.120 E. for the income rules that apply when the EI/deemor has an agent.

M1310 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-2	10/1/16	Pages 1-6 On pages 1 and 4-6, corrected the subchapter number in the headers. Neither the dates nor the policies were changed.
UP #9	4/1/13	Pages 1-3
UP #7	7/1/12	Table of Contents Pages 1-5 Page 6 was added.
TN #95	3/1/11	Page 4

Manual Title Virginia Medical Assistance Eligibility	Chapter M13	Page Revision Date April 2013
Subchapter Subject M1310 SPENDDOWN GENERAL PRINCIPLES & DEFINITIONS	Page ending with M1310.100	Page 1

M1310.000 SPENDDOWN GENERAL PRINCIPLES AND DEFINITIONS

M1310.100 GENERAL PRINCIPLES OF MEDICAID SPENDDOWN

A. Introduction

Individuals and families who otherwise meet the medically needy non-financial and resource eligibility requirements, but whose countable income exceeds the medically needy income limits, are not eligible for Medicaid unless:

- the excess income is insufficient to meet the cost of needed medical care, and
- the cost of incurred medical or remedial care recognized under state law has been deducted from excess income.

This section contains the policy and procedures for determining a family's or a non-institutionalized individual's medically needy income eligibility when their income exceeds the medically needy income limit.

Contact your *Regional Medical Assistance Program* Consultant for the policy and procedures for Medicaid spenddowns established prior to July 1, 1999.

B. Applicability

Spenddown applies only to medically needy (MN) covered groups. Individuals and families must meet the MN nonfinancial and resource requirements in order to be placed on a spenddown.

An individual or family is income eligible when countable income after deducting specified medical or remedial care expenses is equal to or less than the medically needy income limit (MNIL) for the budget period.

C. Opportunity to Receive Full Medicaid Coverage

Individuals who are eligible for only a limited package of Medicaid services must be evaluated to determine if they could become eligible for full Medicaid coverage as medically needy (MN) by meeting a spenddown. To be evaluated for a spenddown, the individual must meet a MN covered group listed in M0330.001 and meet all of the requirements for the MN covered group.

1. Aged, Blind or Disabled (ABD) Medically Indigent (MI) Enrollees

Individuals in the following limited-benefit ABD covered groups also meet a MN covered group:

- Qualified Medicare Beneficiaries (QMBs),
- Special Low-income Medicare Beneficiaries (SLMBs),
- Qualified Individuals (QIs), and
- Qualified Disabled Working Individuals (QDWIs).

Information specific to processing spenddown for these individuals is contained in M1370.

2. Plan First Enrollees

Individuals enrolled in Plan First do not necessarily meet a MN covered group. Plan First enrollees who meet a MN covered group and its requirements in M0330 are placed on two six-month spenddown budget periods within the 12 month renewal period. They may also be eligible for a retroactive MN spenddown determination.

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Subchapter Subject M1310 SPENDDOWN GENERAL PRINCIPLES & DEFINITIONS	Page ending with M1310.300	Page 2

3. MN Children Under Age 18 With \$0 Spenddown Liability

Due to differences in income counting methodology applicable to Categorically Needy (CN) and MN covered groups, a child under age 18 may be ineligible for coverage in a CN covered group but have countable income under the income limit for MN coverage. The child's spenddown liability is \$0.00 (zero dollars); therefore, his spenddown is met on the first day of the spenddown period. Enroll the child in two back-to-back six-month periods of coverage, without the need for a new application, and complete an annual renewal. Continue to enroll the child in two consecutive six-month periods of coverage per year as long as he continues to be eligible as MN at renewal. See M0330.803.

M1310.200 INSTITUTIONALIZED INDIVIDUALS IN MEDICAL FACILITIES OR RECEIVING MEDICAID CBC

A. General Principle

Do not use this subchapter for institutionalized Medically Needy individuals in long-term care [medical facilities or Medicaid Community-based Care (CBC)] who have income over the MNIL.

Go to subchapter M1460 when the individual is institutionalized in a medical facility or when the individual receives Medicaid Community-based Care (CBC) waiver services. Subchapter M1460 contains the policy and procedures for determining the eligibility and spenddown liability for individuals in long-term care.

M1310.300 SPENDDOWN DEFINITIONS

A. Introduction

This section contains the definitions of terms used in the spenddown chapter, Chapter M13.

B.

C. Definitions

1. Applicable Exclusions

Applicable exclusions are the amounts that are deducted from income in determining an individual's income eligibility as identified under the July 16, 1996, AFDC State Plan for Families & Children covered groups, and under the SSI program for aged, blind or disabled individuals.

2. Assistance Unit

The Medicaid assistance unit is the individual or family who applies for Medicaid and whose financial eligibility is determined. The assistance unit for the Families & Children (F&C) covered groups is called the "family unit" or the "budget unit." The assistance unit for an ABD individual is just the individual, unless the individual is married, living with his/her spouse and the spouse is also ABD or the spouse is NABD and has deemable income. In this situation, the assistance unit is the married ABD couple.

3. Available Income

Available income means the earned and unearned income before exclusions used in determining the income eligibility of a medically needy individual.

4. Break in Spenddown Eligibility

A break in spenddown eligibility only occurs after an individual has, at least once, established eligibility by meeting a spenddown in a prior budget period. A break in spenddown eligibility occurs when:

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Subchapter Subject M1310 SPENDDOWN GENERAL PRINCIPLES & DEFINITIONS	Page ending with M1310.300	Page 3

- there is a break between spenddown budget periods;
- the individual establishes Medicaid eligibility in the ABD 80% FPL covered group or a CN F&C covered group; or
- the individual does not meet the spenddown liability in a spenddown budget period.

- 5. Budget Period** Budget period means a period of time during which an individual's income is calculated to determine Medicaid eligibility.
- 6. Carry-over Expenses** Carry-over expenses are the balance due on medical, dental, and remedial care expenses incurred in the retroactive or prospective budget periods prior to the current budget period which were not used in establishing eligibility and which may be deducted in consecutive budget periods when there has been no break in spenddown eligibility.
- 7. Consecutive Budget Period** A consecutive budget period is any spenddown budget period that immediately follows a spenddown budget period in which eligibility was established.
- 8. Countable Income** Countable income means, for the medically needy, the amount of the individual's gross income after deducting allowable exclusions that is measured against the medically needy income limit (MNIL).
- 9. Covered Expenses** Covered expenses means expenses for services that are included in the State Plan for Medical Assistance (Medicaid State Plan).
- 10. Current Payments** Current payments are payments made in the current spenddown budget period on expenses incurred before the current spenddown budget period, which were not used in establishing eligibility in a previous spenddown budget period and when there has been a break in spenddown eligibility. The payment amount allowed is the actual payment amount paid to the provider and is deducted from the spenddown liability on the date the payment is actually made.
- 11. First Prospective Budget Period** The first prospective budget period is the spenddown budget period that begins:
- the first day of the month the individual first applied for Medicaid and is placed on spenddown, or
 - the first day of the month after the cancellation of Medicaid coverage due to excess income, or
 - when a new Medicaid application is filed after a break in spenddown eligibility.

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Subchapter Subject M1310 SPENDDOWN GENERAL PRINCIPLES & DEFINITIONS	Page ending with M1310.300	Page 4

12. Incurred Expenses

Incurred expenses means expenses for medical, dental, or remedial care services:

- which are recognized under state law;
- which are rendered to an individual, family, or legally responsible relative;
- which the individual is liable for in the current budget period or was liable for in the three-month retroactive period; and
- which are not subject to payment by any liable third party.

An expense for a medical or remedial service is an incurred expense from the date the liability arises until the end of the budget period in which the expense is fully used to meet a spenddown.

13. Initial Application

An initial application is the individual's first Medicaid MN spenddown application. There are two ways an individual can have an initial application:

- this is the individual's first application for Virginia Medicaid, or
- this is the first time the individual has been placed on a spenddown.

14. Legally Responsible Relative

A legally responsible relative is the individual's spouse and/or, when the individual is under age 21, a parent who is responsible by law to support the individual. The legally responsible relative's resources and income may be used in determining the individual's Medicaid eligibility.

15. Liable Third Party

Liable third party means any individual, entity or program that is or may be liable to pay all or part of the cost of medical or remedial treatment for injury, disease or disability of a Medicaid applicant or recipient.

16. Medical Expense Record Form

The "Medical Expense Record-Medicaid" (#032-03-023) is a form provided to the client for keeping a chronological record of his medical expenses. It is used by the eligibility worker to determine if the spenddown has been met.

17. Medically Needy Income Limit (MNIL)

MNIL means the medically needy income limit. This is the income standard established to determine the financial eligibility of medically needy individuals and families.

18. Noncovered Expenses

Noncovered expenses are expenses for necessary medical and remedial services recognized under state law but not covered under the Medicaid State Plan, including those that exceed the Medicaid limitation on amount, duration, or scope of the service covered under the State Plan.

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Subchapter Subject M1310 SPENDDOWN GENERAL PRINCIPLES & DEFINITIONS	Page ending with M1310.300	Page 5

19. Old Bills

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

- were incurred prior to the Medicaid application’s retroactive period or
- were incurred during the retroactive period if the individual either did not meet the retroactive spenddown or was not eligible for Medicaid in the retroactive period (for example, due to excess resources), and
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and
- remain a liability to the individual.

Old bills that are based on previous applications do not meet the definition of “old bills” when there has been a break in spenddown eligibility.

EXCEPTION: Bills paid by a state or local program are treated as old bills even though they are not the individual’s liability.

20. Prospective Budget Period

A prospective budget period is the prospective period of time during which income is projected for the purpose of determining spenddown eligibility.

21. Re-application

Re-application means any Medicaid medically needy spenddown application which is filed after the initial application.

22. Retroactive Spenddown Budget Period

The retroactive spenddown budget period is the retroactive period in which the individual is on a spenddown. The retroactive spenddown budget period is the 3 months immediately prior to the application month, when none of the months overlap (was included in) a previous MN spenddown budget period in which spenddown eligibility was established.

When some of the months overlap a previous MN spenddown budget period in which spenddown eligibility was established, the retroactive spenddown budget period is shortened (prorated) to include only the month(s) which were not included in the previous MN spenddown budget period in which spenddown eligibility was established.

23. Spenddown

Spenddown is the process through which countable income is compared to the MNIL for the budget period and incurred expenses are deducted from excess countable income.

24. Spenddown Budget Period

A spenddown budget period is the budget period during which the individual’s or family’s countable income exceeds the MNIL for the budget period and during which the individual or family is placed on a spenddown.

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Subchapter Subject M1310 SPENDDOWN GENERAL PRINCIPLES & DEFINITIONS	Page ending with M1310.300	Page 6

- 25. Spenddown Eligibility** Spenddown eligibility means the individual established eligibility by meeting a spenddown within a spenddown budget period.
- 26. Spenddown Liability** The spenddown liability is the amount by which the individual's or family's countable income exceeds the MNIL for the budget period.
- 27. State or Territorial Public Program** A state or territorial public program is a public health program that is wholly or partially funded and administered by a state or territory, including a political subdivision thereof (i.e., SLH, GR, AG and CSB services).
- 28. State or Territorially-Financed Program** A state or territorially-financed program is a state or territorial public program whose funding, except for deductibles and coinsurance amounts required from program beneficiaries, is either:
- appropriated by the state or territory directly to the administering agency, or
 - transferred from another state or territorial public agency to the administering agency.

M1320 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-2	10/1/16	Page 2 Page 3 is a runover page.
TN #95	3/1/11	Page 1

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Subchapter Subject M1320 SPENDDOWN INFORMATION	Page ending with M1320.200	Page 2

- C. Incur Noncovered Expenses First** The worker must inform the applicant that it is to his advantage to use the spenddown liability (excess income) for medical and dental services not covered by the Medicaid program before he uses the spenddown liability for covered services. Medicaid will not pay for noncovered medical services even after the spenddown is met.
- D. Estimate When Spenddown Liability Will Be Met** The worker can help the applicant estimate the approximate time when the spenddown liability will be met if:
- * the individual has already spent or owes for medical services received prior to, on, or after the first day of the month of application, and
 - * the individual anticipates medical expenditures in the near future.
- E. Reapplying at the End of the Spenddown Period** The worker must inform the individual of the spenddown period and the need to file a re-application if additional coverage is needed. *If the individual is enrolled in the QMB, SLMB, or QDWI covered groups; is enrolled in Plan First and also meets a Medically Needy (MN) covered group; or is an MN Child Under Age 18 with \$0 spenddown liability (see M0330.803), the system-generated Medicaid Renewal form or the equivalent ABD Renewal Form #032-03-0186 may be used to establish new spenddown budget periods.*
- For all others, the *Application for Health Insurance & Help Paying Costs* is required to establish additional spenddown budget periods.

M1320.200 PROCESSING TIME STANDARDS

A. Applications

- 1. Processing Standards** The time standards for Medicaid eligibility determination must be met when determining spenddown. The processing time standards are:
- * 90 days for applicants whose disability must be determined and
 - * 45 days for all other applicants
- from the date the signed Medicaid application is received by the local agency.
- 2. Third Party Payment Verifications** The standards shall also apply to receipt of third party payment or verification of third party intent to pay in order to determine allowable expenses deductible from the spenddown liability. Efforts to determine the third party liability shall continue through the last day of the processing standard period of time. If information regarding third party liability for an incurred expense is not received by this date, eligibility must be determined without deducting the expense.

- B. Changes** The time standard for evaluating a reported change is 30 days from the date the worker receives notice of a change in circumstances or a medical or dental expense submitted by the individual.

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Efforts to determine the third party liability shall continue through the last day of the processing time standard. If information regarding third party liability for an incurred expense is not received by this date, eligibility must be determined without deducting the expense.

M1320.300 ACTION ON APPLICATIONS

- A. Case Action** When an applicant meets all the MN eligibility requirements except income, the application is denied and the applicant is placed on a spenddown.
- B. Retroactive Period** When an applicant has old bills, the worker will determine the retroactive budget period and retroactive spenddown liability. Determination of the retroactive budget period is necessary in order to correctly deduct the old bills from the spenddown liability in the first prospective and consecutive budget periods. If there is no Medicaid-covered service in the retroactive budget period, do not evaluate retroactive Medicaid eligibility.
- C. Notice to Applicant** A “Notice of Action on Medicaid...” (#032-03-008) is sent to the applicant. Check the block in the third section which states “Denied full coverage because income exceeds the income level”. Enter the spenddown liability and the spenddown budget period begin and end dates in the appropriate section. Send a copy of the “Medical Expense Record - Medicaid” (#032-03-023) to the applicant for recording his medical expenses. See Appendix 1 to subchapter M1340.

M1320.400 SPENDDOWN CASE REVIEW REQUIREMENTS

- A. Introduction** The individual must notify the worker when medical or dental expenses are incurred. The individual does NOT have to formally request a re-evaluation of his spenddown.
- The individual should submit the “Medical Expense Record - Medicaid” together with bills or receipts for medical services either paid or incurred. Evidence of third party payment or denial of payment must be provided, if applicable.
- B. Individual Submits Expenses** When the individual submits medical expenses for re-evaluating the spenddown, a new application form is NOT completed.
- Contact the individual and ask if his living situation, resources or income have changed since he signed the application form. If the individual reports any changes, request verification, evaluate accordingly, and record the changes in the case record.
- C. Eligibility Worker Actions** When verification of incurred expenses is received, the worker must record the expenses in the record, determine how much of the spenddown liability remains and notify the applicant of the re-evaluation decision.
- 1. Complete One Evaluation** If incurred medical expenses are submitted to the worker at various times within a month, the worker may accumulate the expenses and complete one

M1460 Changes

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

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Subchapter Subject M1460.000 LTC FINANCIAL ELIGIBILITY	Page ending with M1460.611	Page 35

- 6. Domestic Travel Tickets** Gifts of domestic travel tickets [1612(b)(15)].
- 7. Victim's Compensation** Victim's compensation provided by a state.
- 8. Tech-related Assistance** Tech-Related Assistance for Individuals with Disabilities [ref. P.L. 100-407].
- 9. \$20 General Exclusion** \$20 a month general income exclusion for the unit.
- EXCEPTION:** Certain veterans (VA) benefits are not subject to the \$20 income exclusion. Refer to subchapter S0830 for complete explanation of which VA payments are entitled to the \$20 general exclusion.
- 10. PASS Income** Any unearned income used to fulfill an SSI approved plan to achieve self-support (PASS). See item 12 below for earned income used to fulfill a PASS [1612(b) (4)(A) & (B)].
- 11. Earned Income Exclusions** The following earned income exclusions are not deducted for the 300% SSI group:
- a. For *2016*, up to \$1,780 per month, but not more than \$7,180 in a calendar year, of the earned income of a blind or disabled student *child (no change)*.

For *2015*, up to \$1,780 per month, but not more than \$7,180 in a calendar year, of the earned income of a blind or disabled student child.

 - b. Any portion of the \$20 monthly general income exclusion which has not been excluded from unearned income in that same month [1612(b) (2)(A)].
 - c. \$65 of earned income in a month [1612(b) (4)(C)].
 - d. IRWE - earned income of disabled individuals used to pay impairment-related work expenses [1612(b) (4)(B)].
 - e. One-half of remaining earned income in a month [1612(b) (4)(C)].
 - f. BWE - Earned income of blind individuals used to meet work expenses [1612(b) (4)(A)].
 - g. Earned income used to fulfill an SSI approved plan to achieve self-support (PASS) [1612(b) (4)(A) & (B)].
- 12. Child Support** Child support payments received from an absent parent for a blind or Disabled child [1612(b) (9)].

M1470 Changes

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

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they be subject to a coverage gap in their Part D benefits. Do NOT deduct from patient pay any Medicare PDP deductibles, co-pays or coverage gap costs beyond the month of admission into the nursing facility.

If a full-benefit Medicaid/Medicare recipient was subject to PDP co-pays prior to his admission to a nursing facility, he may continue to be assessed co-pays until the PDP is notified of his admission to the nursing facility. Deduct PDP co-pays incurred during the month of admission to the nursing facility only.

If an individual is enrolled in Part D and is in a nursing facility but was not eligible for Medicaid at the time of admission to the nursing facility, he may continue to be charged co-pays or deductibles until the PDP is notified of his eligibility as a full-benefit Medicaid enrollee. Deduct PDP co-pays incurred during first month of Medicaid eligibility in the nursing facility only.

3. Services NOT Allowed

Types of services that CANNOT be deducted from patient pay include:

a. medical supplies and equipment that are part of the routine facility care and are included in the Medicaid per diem, such as:

- diabetic and blood/urine testing strips,
- bandages and wound dressings,
- standard wheelchairs,
- air or egg-crate mattresses,
- IV treatment,
- splints,
- certain prescription drugs (placebos).

b. TED stockings (billed separately as durable medical supplies),

c. acupuncture treatment,

d. massage therapy,

e. personal care items, such as special soaps and shampoos,

f. ancillary services, such as physical therapy, speech therapy and occupational therapy provided by the facility or under arrangements made by the facility.

i. *services that are NOT medical/remedial care services, even if ordered by a physician:*

- *air conditioners or humidifiers,*
- *refrigerators, whole house generators and other non-medical equipment,*
- *assisted living facility (ALF) room & board and services,*
- *personal comfort items, such as reclining chairs or special pillows,*
- *health club memberships and costs,*
- *animal expenses such as for seeing eye dogs,*
- *cosmetic procedures.*

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Subchapter Subject M1470 PATIENT PAY	Page ending with M1470.230	Page 12a

**4. Documentation
Required**

**a. Requests For Adjustments From A Patient or Authorized
Representative**

Request the following documentation from the patient or his representative:

- a copy of the bill;
- if applicable, the amount owed that was not covered by the patient's insurance;
- proof that the service was medically necessary. Proof may be the prescription, doctor's referral or a statement from the patient's doctor or dentist.

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Subchapter Subject M1470 PATIENT PAY	Page ending with M1470.430	Page 27

2) *Verifying Allowable Co-pays*

To determine whether or not prescription expenses can be deducted from patient pay, apply the following rules:

- *If the drug expense appears on the statement as a denial, and no exception was requested, **do not** allow the expense.*
- *If the drug expense appears on the statement as a denial, and an exception was requested and denied, allow the expense.*

Enrollees should be advised to maintain these monthly statements if they wish to request patient pay adjustments for Medicare Part D co-pays and for drugs for which the PDP denied coverage.

3. **Services NOT Allowed**

Types of services that CANNOT be deducted from patient pay include:

- a. medical supplies covered by Medicaid, or Medicare when the recipient has Medicare, such as:
 - diabetic and blood/urine testing strips,
 - bandages and wound dressings,
 - standard wheelchairs,
 - air or egg-crate mattresses,
 - IV treatment,
 - splints,
 - certain prescription drugs (placebos).
 - b. TED stockings (billed separately as durable medical supplies),
 - c. acupuncture treatment,
 - d. massage therapy,
 - e. personal care items, such as special soaps and shampoos,
 - f. physical therapy,
 - g. speech therapy,
 - h. occupational therapy.
- ii. *services that are NOT medical/remedial care services, even if ordered by a physician:*
- *air conditioners or humidifiers,*
 - *refrigerators, whole house generators and other non-medical equipment,*
 - *assisted living facility (ALF) room & board and services,*
 - *personal comfort items, such as reclining chairs or special pillows,*
 - *health club memberships and costs,*
 - *animal expenses such as for seeing eye dogs,*
 - *cosmetic procedures.*
- j. *personal care or other waiver services in excess of the number of hours authorized by DMAS (i.e. private pay).*

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Subchapter Subject M1470 PATIENT PAY	Page ending with M1470.430	Page 28

**4. Document-
ation
Required**

a. Requests For Adjustments From A Patient or An Authorized Representative

Request the following documentation from the patient or his representative:

- a copy of the bill;
- the amount still owed by the patient;
- if applicable, the amount owed that was not covered by the patient's insurance;
- proof that the service was medically necessary. Proof may be the prescription, doctor's referral or a statement from the patient's doctor or dentist.

b. Requests For Adjustments From CBC Providers

If the request for an adjustment to patient pay to deduct a noncovered expense is made by a Medicaid CBC waiver service provider or case manager, the request must be accompanied by:

- 1) the recipient's correct Medicaid ID number;
- 2) the current physician's order for the non-covered service (not required for replacement of hearing aid batteries or eyeglass frames or for repair of hearing aids or eyeglasses);
- 3) actual cost information;
- 4) documentation that the recipient continues to need the equipment for which repair, replacement, or battery is requested; and
- 5) a statement of denial or non-coverage by other insurance. The denial may be from the insurance carrier or may be a written statement from the facility that the insurance company was contacted and the item/service is not covered.

If the request from a provider or case manager does not include all the above documentation, return the request to the provider or case manager asking for the required documentation.

5. Procedures

a. Determine Deduction

When the individual receives CBC services, DMAS approval **is not required** for deductions of noncovered services from patient pay, regardless of the amount of the deduction.

Determine if the expense is deducted from patient pay using the following sequential steps:

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- 1) Upon receipt of the requested documentation, determine the amount of the bill that is a valid deduction. Do not deduct more than the available income that remains after the personal needs, dependent child allowance(s), and health insurance premiums are deducted.

If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service is requested, deduct the new noncovered services after the first noncovered service deductions have been completed.

- 2) Subtract the deduction for the current month. If the deduction exceeds the available income, the remaining balance can be carried over to the following month(s).

b. Notice Procedures

Upon the final decision to allow the deduction, use the MMIS Patient Pay process to adjust the patient pay. MMIS will generate and send the Notice of Obligation for LTC Costs.

M1480 Changes

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

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Subchapter Subject M1480 MARRIED INSTITUTIONALIZED INDIVIDUALS	Page ending with M1480.420	Page 66

After eligibility is established, the usual reporting and notification processes apply. Send written notice for the month(s) during which the individual establishes Medicaid eligibility. MMIS will generate the “Notice of Obligation for LTC Costs” and it will be sent to the individual or his authorized representative.

M1480.400 PATIENT PAY

- A. Introduction** This section contains the policy and procedures for determining an institutionalized spouse’s (as defined in section M1480.010 above) patient pay in all covered groups.
- B. Married With Institutionalized Spouse in a Facility** For a married LTC patient with an institutionalized spouse in a facility, **NO** amount of the patient’s income is deducted for the spouse’s needs in the patient pay calculation.

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

- A. Introduction** This subsection contains the standards and their effective dates that are used to determine the community spouse’s and other family members’ income allowances. The income allowances are deducted from the institutionalized spouse’s gross monthly income when determining the monthly patient pay amount. Definitions of these terms are in section M1480.010 above.
- | | | | |
|---|-------------------|------------------------------------|----------------|
| B. Monthly Maintenance Needs Allowance | <i>\$2002.50</i> | <i>7-1-16</i> | |
| | <i>\$1,991.25</i> | <i>7-1-15</i> | |
| C. Maximum Monthly Maintenance Needs Allowance | <i>\$2,980.50</i> | <i>1-1-16 (no change)</i> | |
| | <i>\$2,980.50</i> | <i>1-1-15</i> | |
| D. Excess Shelter Standard | <i>\$600.75</i> | <i>7-1-16</i> | |
| | <i>\$597.38</i> | <i>7-1-15</i> | |
| E. Utility Standard Deduction (SNAP) | <i>\$287.00</i> | <i>1 - 3 household members</i> | <i>10-1-16</i> |
| | <i>\$357.00</i> | <i>4 or more household members</i> | <i>10-1-16</i> |
| | <i>\$294.00</i> | <i>1 - 3 household members</i> | <i>10-1-15</i> |
| | <i>\$369.00</i> | <i>4 or more household members</i> | <i>10-1-15</i> |

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

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

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Subchapter Subject M1480 MARRIED INSTITUTIONALIZED INDIVIDUALS	Page ending with M1480.430	Page 72

**4. Calculate
Community
Spouse
Monthly
Income
Allowance**

If no court order or DMAS Hearing Officer determination of the monthly maintenance needs allowance exists, use the following procedures to calculate the community spouse monthly income allowance:

a. Determine Gross Monthly Income

Determine the community spouse's gross monthly income using the income policy in section M1480.310. Do not count any payment that is made to the community spouse by the institutionalized spouse, such as the community spouse's portion of an augmented VA benefit which is included in the institutionalized spouse's VA check. This amount will be counted in the institutionalized spouse's income.

b. Subtract From MMMNA

Subtract the community spouse's gross income from the minimum monthly maintenance needs allowance from D.1. above. **Do NOT round any cents to a dollar.** The remainder is the community spouse monthly income allowance (a negative number equals \$0).

c. Remainder Greater Than \$0

If the remainder is greater than \$0, the remainder is the amount of the community spouse monthly income allowance that is deducted from the institutionalized spouse's patient pay.

c. Remainder Less Than or Equal To \$0

If the remainder is \$0 or less, the community spouse monthly income allowance is \$0.

**5. Deduct From
Patient Pay**

Deduct the community spouse monthly income allowance determined above from the institutionalized spouse's patient pay income UNLESS the institutionalized spouse or his authorized representative does not actually make it available to the community spouse or to another person for the benefit of the community spouse. *Should the community spouse opt to take a lesser amount than the amount to which the community spouse is entitled; deduct only the amount that the community spouse actually takes as an allowance. If the community spouse is a Medicaid applicant or enrollee, the income allowance is countable income to the community spouse.*

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
Update (UP) #2	8/24/09	Page 11
TN #91	5/15/09	Page 14

Manual Title Virginia Medical Assistance Eligibility	Chapter M15	Page Revision Date April 2013
Subchapter Subject M1510 MEDICAID ENTITLEMENT	Page ending with M1510.101	Page 3

**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. **Spendedown**

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* the 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@dmass.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.

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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1. 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)).

2. 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.

3. 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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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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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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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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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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1. 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.

M16 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-2	10/1/16	Page 3
TN #DMAS-1	6/1/16	Page 1
TN #100	5/1/15	Page 3
Update #9	4/1/13	Page 8

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- F. Conference Decision** If the applicant/enrollee is not satisfied with the agency action following the conference and wants to request a fair hearing, he must be given that opportunity. See M1630.100 C. below. The applicant/enrollee may request an appeal before or after the conference. Participation in a conference does not extend the 30 day time limit for requesting an appeal.

M1630.100 APPEAL REQUEST PROCEDURES

- A. Appeal Definition** An appeal is a request for a fair hearing. The request must be a clear, written expression by an applicant or enrollee, his legal representative (such as a guardian, conservator, or person having power of attorney), or his authorized representative acting at his request, of a desire to present his case to a higher authority. It may be a letter or a completed "Medicaid/SLH/FAMIS Appeal Request Form."

- B. Where to File an Appeal** Appeals must be sent to the:
- Department of Medical Assistance Services
Appeals Division
600 East Broad Street
Richmond, Virginia 23219

Appeals may also be faxed to (804) 452-5454.

- C. Assuring the Right to Appeal** The right to appeal must not be limited or interfered with in any way. When requested to do so, the agency must assist the applicant/enrollee in preparing and submitting his request for a fair hearing.

- D. Appeal Time Standards** A request for an appeal must be made within 30 days of receipt of notification that Medicaid coverage or medical services has been denied, terminated, reduced, adversely affected, or that it has not been acted upon with reasonable promptness.

Notification is presumed received by the applicant/enrollee within three days of the date the notice was mailed, unless the applicant/enrollee substantiates that the notice was not received in the three-day period through no fault of his/her own.

An appeal request shall be deemed to be filed timely if it is mailed, faxed, or otherwise delivered to the DMAS Appeals Division before the end of last day of filing (30 days plus 3 mail days after the date the agency mailed the notice of adverse action). The date of filing will be determined by:

- the postmark date,
- the date of an internal DMAS receipt date-stamp, or
- the date the request was faxed or hand-delivered.

M17 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-2	10/1/16	Table of Contents, page i Pages 1-7 Appendix 2 Page 8 was deleted.
TN #97	9/1/12	page 3 Appendix 1, page 1
UP #7	7/1/12	Table of Contents Pages 1-8 Appendix 1 Appendices 3 and 4 were removed.
TN #94	9/1/10	Title Page Table of Contents pages 1-7 Appendix 1 Appendix 2
TN #93	1/1/10	page 3

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M1700 MEDICAID FRAUD AND NON-FRAUD RECOVERY

M1700.100 INTRODUCTION

A. Administering Agency The Department of Medical Assistance Services (DMAS) investigates and accepts referrals regarding fraudulent and non-fraudulent payments made by the Medicaid Program. DMAS has the authority to recover any payment incorrectly made for services received by a Medicaid recipient or former Medicaid recipient. DMAS will attempt to recover these payments from the recipient or the recipient's income, assets, or estate, unless such property is otherwise exempt from collection efforts by State or Federal law or regulation.

The DMAS Recipient Audit Unit (RAU) is responsible for the investigation of allegations of acts of fraud or abuse committed by recipients of the Medicaid and the *Family Access to Medical Insurance Security Plan* (FAMIS) programs. The RAU recovers overpayments due to recipient fraud, abuse, and overpaid benefits through voluntary repayments and criminal prosecution of recipient fraud.

The Third Party Liability Unit (TPL) at DMAS is responsible for investigating and recovering funds paid by DMAS from recipients' estates, trust accounts, annuities and/or other health insurance policies. This unit performs investigations to find "third party resources" that result when Medicaid pays medical costs that a third party should have paid. Medicaid is always the payer of last resort.

B. Utilization Review *The DMAS Recipient Monitoring Unit is responsible for reviewing all Medicaid and FAMIS covered services of recipients who utilize services at a frequency or an amount that is not medically necessary in accordance with utilization guidelines established by the state. Only recipients who are excluded, pursuant to 12VAC30-120-370 B, from receiving care from a managed care organization are reviewed and evaluated.*

M1700.200 FRAUD

A. Definitions Fraud is defined as follows:

An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law. (42 CFR 455.2)

Abuse is defined as follows:

Beneficiary practices that result in unnecessary cost to the Medicaid program. (42 CFR 455.2)

B. DMAS Authority DMAS has sole authority over cases of suspected Medicaid fraud when eligibility for a public assistance payment is not involved (Medicaid only cases). The local department of social services (LDSS) must refer all Medicaid cases involving suspected fraud to the DMAS Recipient Audit Unit, 600 E. Broad Street, Suite 1300, Richmond, Virginia 23219, using the Notice of Recipient Fraud/Non-Fraud Recovery (form #DMAS 751R) available at <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi>. The following information must be provided when making a referral:

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- confirmation that ongoing eligibility has been reviewed (in relation to the allegation) with evaluation results attached;
- reason(s) for and estimated period of ineligibility for Medicaid;
- the recipient's name and Medicaid enrollee identification number;
- the recipient's Social Security number;
- applicable Medicaid applications or review forms for the referral/ineligibility period;
- address and telephone number of any attorney-in fact, authorized representative, or other individual who assisted in the application process;
- relevant covered group, income, resource, and/or asset transfer documentation for the time period in question;
- any record of communication between the agency and the client or representative, such as case narratives, letters, and notices; and
- information obtained from the agency's fraud investigation, including names and addresses of knowledgeable individuals for testimony and/or interviews.

1. Amount of Loss

There is no fiscal threshold for any case for fraudulent and non-fraudulent erroneous payments made by the Medicaid Program.

In order to determine the amount of the loss of Medicaid funds related to the enrollee's eligibility when LDSS has jurisdiction because of participation in another public assistance program, a Medicaid Claims Request (form #DMAS 750R, available at <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi>.) must be sent to DMAS to obtain the amount of the loss. The local agency should allow a three-week turnaround for the documents. There may be exceptional circumstances when claims can be provided within a shorter time, i.e., expedited trial dates. Once the information is received and the agency determines that it will not make a joint criminal prosecution referral, the LDSS must send DMAS the Notice of Recipient Fraud/Non-Fraud Recovery. DMAS will determine if administrative non-fraud recovery is appropriate.

2. Recipient Fraud

a. Medical Assistance Only

The LDSS must refer cases of suspected fraud involving only medical assistance to the RAU for investigation using the DMAS 751R form. The LDSS must provide the RAU with the recipient's identifying information, address, and information regarding the circumstances of the suspected fraud. The LDSS is also responsible for reviewing and taking appropriate action for ongoing eligibility or termination of coverage, as appropriate. The RAU will determine the amount of the misspent funds and pursue recovery and/or legal action as appropriate.

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b. Cases in which Medicaid is received with TANF, AG, and other money payment public assistance programs.

The LDSS is responsible for the investigation of suspected fraud involving cases with combined Medicaid and Auxiliary Grant (AG); Medicaid and TANF; and other money payment public assistance programs. The final disposition on all money payment fraud cases shall be communicated to the RAU no later than 5 business days after disposition.

c. Cases in which Medicaid is received with Supplemental Nutrition Assistance Program (SNAP), Energy Assistance, and other non money payment public assistance programs

The LDSS must refer suspected fraud involving Medicaid cases combined with SNAP, Energy Assistance or other non money payment public assistance programs to the RAU using the DMAS 751R form. The local agency shall coordinate cases pending referral for prosecution with the RAU so that Medicaid may take concurrent action.

3. Provider Fraud

Cases of suspected fraud involving enrolled providers of medical services to Medicaid recipients shall be referred to the Medicaid Fraud Control Unit in the Office of the Attorney General, and a copy of the referral correspondence shall be sent to the Provider Review Unit at the Department of Medical Assistance Services.

C. Medicaid Ineligibility Following Fraud Conviction

1. Period of Eligibility

An individual who has been convicted of Medicaid fraud is ineligible for Medicaid for a period of 12 months beginning with the month of fraud conviction. Action to cancel the individual's Medicaid coverage shall be taken in the month of conviction or in the month the agency learns of the conviction, using cancel reason 014 (42 United States Code §1320a-7b.(a)(6)(ii); 12 Virginia Administrative Code 30-10-70).

2. Who is Ineligible

a. TANF or Families and Children (F&C) Cases

Only the parent/caretaker of a TANF/Medicaid or F&C Medicaid case is ineligible for Medicaid when the parent/caretaker has been convicted of Medicaid fraud. The TANF payment made to the caretaker on a child's behalf shall not be affected.

b. Aged, Blind, Disabled (ABD) or Pregnant Women Cases

In an ABD or pregnant woman case, only the individual found guilty of Medicaid fraud will be ineligible. If only one spouse of a married couple is convicted, the eligibility of the innocent spouse is not affected.

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3. Family Unit

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

M1700.300 NON-FRAUD RECOVERY

A. Authority

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

B. Recovery of Erroneous Payments

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

- eligibility errors due to recipient misunderstanding,
- agency errors,
- medical services received during the appeal process, if the agency's cancellation action is upheld.
- long-term care (LTC) patient pay underpayments totaling \$1,500 or more; underpayments less than \$1,500 can be collected by adjusting the ongoing patient pay (see M1470.900 for patient pay adjustments),

Complete and send the Notice of Recipient Fraud/Non-Fraud Recovery (form #DMAS 751R) located at <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi> to

Department of Medical Assistance Services
 Recipient Audit Unit,
 600 E. Broad Street, Suite 1300,
 Richmond, Virginia 23219

The form may be faxed to 804-371-8891.

C. Uncompensated Asset Transfers

Individuals receiving long-term care services (LTC) who transfer assets and do not receive adequate compensation are subject to the imposition of a penalty period during which Medicaid cannot pay for long-term care services. When an uncompensated transfer resulted in a penalty period during which LTC services were received, a referral must be made to the RAU to recover the misspent dollars. RAU staff will contact the recipient or the recipient's authorized representative to pursue recovery.

Section §20-88.02 of the Code of Virginia also allows DMAS to seek recovery from the **transferee** (recipient of the transfer) if the amount of the uncompensated transfer is \$25,000 or more and occurred within 30 months of the individual becoming eligible for or receiving Medicaid LTC services. The transferees may be liable to reimburse Medicaid for expenditures up to the amount of funds spent on the enrollee or the amount of the uncompensated transfer, whichever is less.

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D. Recovery of Correctly Paid Funds

Within specific restrictions, DMAS may recover funds correctly paid for medical services received by eligible recipients.

1. Deceased Recipient's Estate

Under federal regulations and state law, DMAS may make a claim against a deceased enrollee's estate when the recipient was age 55 or over. The recovery may include any Medicaid payments made on his/her behalf. This claim may be waived if there are surviving dependents. **(42 CFR §433.36; Va. Code §32.1-326.1 and 32.1-327).**

Section 1917(b)(1)(C)(ii) of the Social Security Act was amended by the Deficit Reduction Act of 2005 to exempt assets disregarded under a "qualified" Long-term Care (LTC) Partnership Policy from estate recovery, as defined in clause (iii) of 1917(b)(1)(C). The same amount of assets that was disregarded in the Medicaid eligibility determination for an individual under an LTC Partnership Policy will be protected during estate recovery.

Referrals should be made to DMAS for estate recovery when the deceased recipient is over 55, has no surviving spouse, no children under 21 or a disabled/blind child of any age.

2. Insurance Settlements and Similar Recoveries

Settlements related to personal injuries are a form of third party liability (TPL). When a Medicaid enrollee has received an insurance settlement or similar settlement from a law suit related to a medical condition or injury, DMAS may seek recovery of any amount of medical assistance expended on the enrollee prior to the receipt of the settlement. Generally, the insurance company notifies DMAS of the settlement; however, if an agency discovers that an enrollee received a settlement, the agency shall report it to DMAS. An insurance settlement that is sent directly to a recipient, in his name only, should be reviewed for its impact on the recipient's eligibility.

3. Trusts

Refer trust documents, including irrevocable, discretionary, pooled, and special needs trusts, to DMAS TPL for potential recovery at the time of recipient's (beneficiary's) death. Refer trust documents in all instances in which a Medicaid recipient is a beneficiary of a trust and the trustee refuses to make the assets available for the medical expenses of the recipient. Include a copy of the Medical Assistance Program Consultant's evaluation of the trust with the referral form, if available.

Include in the referral any corrective action that has been or will be taken by the LDSS, as well as the name of the supervisor of the person submitting the form. The supervisor's signature is not required.

4. Notification to DMAS

Referrals must be made to the Third Party Liability Unit when: a recipient has received funds from a settlement; DSS has received information concerning a recipient being in an accident; DSS has information where a recipient has other third party payers; or the recipient is the beneficiary of a trust. The cases should be referred to DMAS using the Notice to DMAS of Estate Recovery/TPL/Trust Form (DMAS 753R) located at <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi>, to make referrals to the TPL unit. The form should be completed and sent to:

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

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

M1700.400 RECOVERY RESPONSIBILITIES: LDSS AND DMAS

- A. VDSS/LDSS Responsibilities in Loss Prevention Efforts** VDSS Medicaid operates under an interagency agreement with DMAS which lists specific responsibilities of VDSS and, by extension, the LDSS, for active participation in loss prevention efforts. The responsibilities of the LDSS fall under the interagency agreement and are neither optional nor discretionary for the LDSS. VDSS shall supervise the programmatic activities of the LDSS to ensure compliance.
- B. LDSS Requirements** LDSS must participate in the identification, tracking, and correction of eligibility errors. LDSS must also determine and review ongoing or current recipient eligibility. **The DMAS RAU does not determine ongoing recipient eligibility, but rather reviews recipient eligibility in relation to allegations of fraud.** LDSS shall:
- 1. Report Individuals** Report to DMAS RAU every known instance relating to a non-entitled individual's use of Medicaid services, regardless of the reason for non-entitlement such as:
 - instances where evidence of fraud may exist;
 - errors involving eligibility discovered by the LDSS in which it appears there has been deliberate misrepresentation by an applicant/recipient with intent to defraud;
 - eligibility errors discovered by the LDSS, independent of other audit or quality control functions, including cases in which the individual was enrolled incorrectly, added in error, not cancelled timely, allowed to remain on Medicaid during the conviction sanction period or when information known to the agency would render ineligibility;
 - cases in which the LDSS discovers that the enrollee failed to report information that impacts eligibility; and
 - LTC patient pay underpayments resulting from any cause totaling \$1,500 or more.
 - 2. Corrective Action** Report to the DMAS RAU corrective action taken on all discovered eligibility errors. Corrective action is a function of the loss prevention process. All corrected errors shall be reported to DMAS.
 - 3. Cancel Coverage** Cancel the eligibility of all persons convicted of public assistance fraud or medical assistance fraud to the extent allowable under federal and state regulations, using the cancel code for fraud convictions (Cancel Code 014).

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- C. DMAS Response** The RAU shall send a *referral acknowledgement letter to the LDSS worker making the referral. RAU may send out additional communication to the LDSS should additional verifications/documentation be required to complete the investigation.*
- D. Recipient Audit Reporting** The RAU has two prevention efforts for reporting fraud and abuse of Medicaid Services by individuals within the community. Both referral methods should be given to the individual by the LDSS. *The individual may remain anonymous.*
- the web address, recipientfraud@dm.virginia.gov.
 - the Recipient Audit fraud and abuse hotline. Both a local and a toll free number are available 24 hours daily for reporting suspected fraud and abuse: local (804) 786-1066; and toll free (866) 486-1971.
- E. Statute of Limitations** There is no "statute of limitations" for Medicaid fraud; cases that are referred for fraud shall be flagged to ensure that the information is not purged.

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NOTICE of RECIPIENT FRAUD/NON-FRAUD RECOVERY

ATTACH THE FOLLOWING INFORMATION IN THE ORDER LISTED BELOW:

- *Confirmation that ongoing eligibility has been reviewed in relation to allegation and results;*
- *Reasons for and estimated period of ineligibility for Medicaid;*
- *Recipient's Social Security number;*
- *Applicable Medicaid applications or review forms for the referral/ineligibility*
- *Address and telephone number of any attorney-in fact, authorized representative, or other individual who assisted in the application process;*
- *Relevant covered group, income, resource, and/or asset transfer documentation;*
- *A copy of any Regional Specialist's decision regarding trusts that affect eligibility;*
- *Any record of communication between the agency and the client or representative, such as case narratives, letters, and notices; and*
- *Information obtained from the agency's fraud investigation, including names and addresses of knowledgeable individuals for testimony and/or interviews.*

Name of Eligibility Worker/Medicaid Technician: _____ *Telephone Number:*
() -

Agency Name: _____ *FIPS Code:* _____

Address: _____ *Name of Supervisor:*

You will receive acknowledgment of receipt of the referral from RAU. You will also be notified if any further action is required of the agency.

M21 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-2	10/1/16	Page 3
TN #DMAS-1	6/1/16	Appendix 1, page 1
TN #100	5/1/15	Table of Contents Pages 1-7 Appendices 1 Pages 8-10 and Appendices 2 and 3 were deleted.
UP #10	5/1/14	Pages 1-3 Appendix 1
TN #99	1/1/14	Pages 1-3 Appendix 1
TN # 98	10/1/13	Table of Contents Pages 1-10 Pages 10a and 11-16 were deleted.
UP #9	4/1/13	Pages 3, 4
UP #8	10/1/12	Table of Contents Pages 2-4 Appendix 3 deleted
TN #97	9/1/12	Pages 3, 4
UP #7	7/1/12	Pages 3, 4 Appendix 2, pages 1 Appendix 3, pages 1 and 2
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	Pages 3, 8
TN #95	3/1/11	Table of Contents Pages 5, 6, 14, 15, Page 16 added Appendix 1
TN #94	9/1/10	Page3 Appendix 3, pages 1 and 2
UP #3	3/1/10	Pages 2-5
TN #93	1/1/10	Page 2-4, 8
Update (UP) #2	8/24/09	Page 4

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M2120.200 HEALTH INSURANCE COVERAGE

A. Introduction

The intent of FAMIS is to provide health coverage to low-income uninsured children. Eligibility for this program is prohibited when a child has creditable health insurance coverage, *except for a child who was enrolled in the Health Insurance Premium Payment (HIPP) Program while covered by Medicaid and who subsequently becomes income eligible for FAMIS.*

B. Definitions

1. Creditable Coverage

For the purposes of FAMIS, creditable coverage means coverage of the individual under any of the following:

- church plans and governmental plans;
- health insurance coverage, either group or individual insurance;
- military-sponsored health care;
- a state health benefits risk pool;
- the federal Employees Health Benefits Plan;
- Medicare
- a public health plan; and
- any other health benefit plan under section 5(e) of the Peace Corps Act.

The definition of creditable coverage includes short-term limited coverage.

2. Health Benefit Plan

“Health benefit plan” is defined in the Virginia Bureau of Insurance Regulations (14VAC5-234-30) and means:

- “any accident and health insurance policy or certificate,
- health services plan contract,
- health maintenance organization subscriber contract,
- plan provided by a Multiple Employer Welfare Arrangement (MEWA)”.