COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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January 1, 2018

Virginia Medical Assistance Eligibility Manual

Transmittal #DMAS-7

The following acronyms are used in this cover letter:

- ABD – Aged, Blind, or Disabled
- ABLE – Achieving a Better Life Experience
- AC – Aid Category
- CNNMP – Categorically Needy No Money Payment
- CN – Categorically Needy
- COLA – Cost of Living Adjustment
- CPU – Central Processing Unit
- DBHDS – Department of Behavioral Health and Developmental Services
- DDS – Disability Determination Services
- DMAS – Department of Medical Assistance Services
- EEOICP – Energy Employee Occupational Illness Compensation
- ICF/ID - Intermediate Care Facilities for the Intellectually Disabled
- LTC – Long Term Care
- IMD - Individuals with Mental Diseases
- MA – Medical Assistance
- MSP – Medicare Savings Program
- RAU – Recipient Audit Unit
- SPARK – Services, Programs, Answers, Resources, Answers
- SSI – Supplemental Security Income
- TN - Transmittal
- VA – Veterans Administration
- WIA – Workforce Investment Act

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TN #DMAS-7 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 January 1, 2018.

The following changes are contained in TN #DMAS-7:

Changed Pages	Changes
Subchapter M0130 Pages 1, 9	On page 1, clarified a term. On page 9, clarified that all available systems must be used to search for and verify resources.
Subchapter M0310 Page 34 Appendix 2	On page 34, corrected the section numbers for a policy reference. In Appendix 2, page 1, updated the contact information for DDS Regional Office.
Subchapter M0320 Pages 2-4, 11, 26, 27	On pages 2 and 4, added additional SSI payment codes. On page 3, clarified the costs for partition suits. On page 11, updated the COLA calculation. On page 26, expanded the examples of excluded resources for Medicaid Works. On pages 26-27, updated the Medicaid Works income limit (no change for 2018).
Subchapter M0450 Pages 16-25	On pages 16-25, updated the income examples utilizing January 2017 income figures.
Subchapter M0810 Pages 1-2	On pages 1 and 2, updated the income limits that are based on the SSI amounts for 2018.
Subchapter M0815 Page 1	Expanded the definition of cash.
Subchapter M0820 Pages 11, 30-31, 32	On page 11, corrected the header. On pages 30 and 31, updated the ABD student earned income exclusion for 2018. On page 32, updated an example using 2018 amounts.
Subchapter M0830 Table of Contents, pages iii-iv Pages 7-8, 17-18, 20, 29, 48, 79a, 82, 124a-124b, 125	Updated the Table of Contents. On pages 7-8, updated the exclusion guide. On page 17, added policy instructions regarding verification. On page 18, updated the WIA program name. On page 20, corrected the page number. On page 29, input the end date of the weekly exclusion. On page 48, updated the VA Regional Office list. On page 79a, added policy on gift cards and gift certificates. On page 82, updated the WIA program name. On page 124a, added policy on EEOICP. On page 124b, added policy on the Ricky Ray Hemophilia Relief Payments. On page 125, modified the policy on Walker v. Bayer Settlement Payments.
Subchapter M1110 Page 2	Updated the resource limits for the MSPs for 2018.

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Changed Pages	Changes
Subchapter M1120 Table of Contents Pages 3, 22a, 30	Updated the Table of Contents. On page 3, clarified the explanation of a partition suit/action. On page 22a, clarified when income added to a special needs trust is excluded. On page 30, added policy on health and medical savings accounts.
Subchapter M1130 Pages 45, 78–79 Appendix 1, pages 3, 5	On page 45, clarified actions on irrevocable assignments. On pages 78-79, expanded the description and clarified policy for ABLE accounts. In Appendix 1, clarified when to use average versus actual partition costs.
Subchapter M1140 Page 30	Updated the term for intellectually disabled.
Subchapter M1340 Pages 18, 20, 22	On page 18, updated the list of state/local public programs. On pages 20 and 22, replaced the acronym and definition of program designation with aid category.
Subchapter M1350 Pages 11-12	On pages 11 and 12, updated the acronym CNNMP to CN.
Subchapter M1410 Page 7	Updated the term for intellectually disabled.
Subchapter M1420 Table of Contents, Pages 2, 5 Appendices 2 and 3	Updated the Table of Contents. On page 2, updated the term for intellectually disabled. On page 5, removed the reference to the Technology Assisted Waiver form. Appendix 2 was removed and Appendix 3 was renumbered to Appendix 2.
Subchapter M1430 Pages 1-2, 4 Appendix 1	On pages 1-2, updated term ICF/ID. On page 4, updated the term for intellectually disabled. In Appendix 1, updated the list of IMDs.
Subchapter M1440 Page 1 Appendix 1, page 4	On page 1, updated the term for intellectually disabled. In Appendix 1, corrected the header.
Subchapter M1450 Pages 4, 24, 36-36a, 37, 41-42 Appendix 1, page 1	On page 4, updated the term for intellectually disabled. On page 24, clarified the criteria for services contracts. On page 36, clarified the policy on an asset transfer penalty period from another state. Page 36a was added as runover page. On page 37, updated the partial month transfer example. On pages 41-42, clarified the policy on undue hardship claims. In Appendix 1, updated the list of private nursing facility costs.

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Changed Pages	Changes
Subchapter M1460 Pages 3, 7	On page 3, updated the home equity limit for 2018. On page 7, added additional SSI payment codes.
Subchapter M1470 Pages 19, 20, 43-44	On page 19, updated the personal maintenance allowance for 2018. On page 20, updated the special earnings allowances for 2018. On page 43, added a link for the DMAS-225 form for non-SPARK users. On pages 43-44, clarified when the DMAS-225 is to be used.
Subchapter M1480 Pages 18c, 66	On page 18c, updated the spousal resource standards for 2018. On page 66, updated the maximum monthly maintenance needs allowance for 2018.
Subchapter M1520 Pages 2, 3, 3a, 5, 6, 6a, 7, 7a.	On page 2, clarified how eligibility changes are handled. On page 3, corrected formatting. On page 5, provided the reference to policy on SSI payment codes. On page 6, corrected the header. On page 7, added a reference to other policy. Pages 3a, 6a, and 7a are runover pages.
Subchapter M1550 Page 1 Appendix 1	On page 1, updated the state training center locations. In Appendix 1, updated the contact information for the DBHDS facility medical technicians.
Subchapter M1700 Table of Contents, page i Appendices 2, 3, 4	Updated the Table of Contents. In Appendices 2 and 3, updated the RAU fax number, added the email address, and updated the form revision date. In Appendix 4, revised the form footer.
Subchapter M2100 Pages 1, 6, 7	On page 1, clarified which applications are processed at the CPU. On page 6, clarified the use of Appendix E to the application form. On page 7, clarified when FAMIS Select information is sent to an enrollee.

Please retain this TN cover letter for future reference. Should you have questions about information contained in this transmittal, please contact Cindy Olson, Director, Eligibility and Enrollment Services Division with DMAS, at cindy.olson@dmas.virignia.gov or (804) 225-4282.

Sincerely,

Linda Nablo
Chief Deputy Director

Attachment

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M0130 Changes

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

M0130.001 Medical Assistance Application Processing Principles

A. Introduction

Under the Affordable Care Act (ACA), the Medicaid and FAMIS medical assistance (MA) programs are part of a continuum of health insurance options available to Virginia residents. MA application processing is based on several principles that are prescribed by the ACA.

B. Principles

1. Single Application

Applications for affordable health insurance, including qualified health plans with Advance Premium Tax Credit (APTC) assistance and MA, are made on a single, streamlined application. The application gathers information needed to determine eligibility for both APTC and MA.

2. No Wrong Door

Individuals may apply for MA through their local department of social services (LDSS), through the Health Insurance Marketplace (HIM), through CommonHelp, or through the Cover Virginia Call Center. HIM applications and telephonic applications received by the Cover Virginia Central Processing Unit (CPU) are sent to the LDSS for either case management or LDSS processing.

3. Use of Electronic Data Source Verification

The eligibility determination process for MA is based on electronic data source verification (EDSV) to the fullest extent possible. The Federally-managed Data Services Hub (the Hub) provides verification of a number of elements related to eligibility for MA applications processed in the Virginia Case Management System (VaCMS). *Data from on-line sources including the* Virginia Employment Commission (VEC) *and the Work Number are also* acceptable for both initial applications and renewals.

Eligibility workers are to request information from the applicant *or authorized representative(s)* only when it is not available through an approved data source or the information is inconsistent with agency records.

Searches of online information systems, including but not limited to the Hub, State Online Query-Internet (SOLQ-I) and the State Verification Exchange System (SVES) 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.

4. Processing Time

Agencies are required by the State Plan to adhere to prescribed standards for the processing of MA applications, including applications processed using the self-directed functionality in VaCMS. The amount of time allowed to process an application is based on the availability of required information and verifications, as well as the covered group under which the application must be evaluated.

When all necessary information is available through EDSV, it is expected that the application be processed without delay.

When it is necessary to request information from the applicant and/or a disability determination is required, the processing standards in M0130.100 are applicable.

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. *All available resource verification system(s) must be searched prior to requesting information from the applicant.*

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.

M0310 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-7	1/1/18	Pages 34, Appendix 2, page 1
TN #DMAS-5	7/1/17	Pages 13, 37, 38
TN #DMAS-4	4/1/17	Pages 24, 30a Page 23 is a runover page. Page 24a was added as a runover page.
TN #DMAS-3	1/1/17	Pages 8, 13, 28b
TN #DMAS-2	10/1/16	Pages 4, 7, 29 Page 30 is a runover page. Appendix 2, page 1
TN #DMAS-1	6/1/16	Table of Contents, page ii Pages 13, 26, 28 Appendix 2, page 1

M0310 Changes

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

See sections *M0320.601 (QMB), M0320.602 (SLMB), and M0320.603 (QI)* for the procedures to use to determine if an individual meets an MSP covered group. See section *M0320.604* for the procedures to use to determine if an individual meets the QDWI covered group.

M0310.122 OASDI

A. Old Age, Survivors & Disability Insurance (OASDI)

Old Age, Survivors & Disability Insurance (OASDI) is the federal insurance benefit program under Title II of the Social Security Act that provides cash benefits to workers and their families when the workers retire, become disabled or die.

OASDI is sometimes called RSDI - Retirement, Survivors & Disability Insurance. Because Title II of the Social Security Act is still officially called “Old Age, Survivors & Disability Insurance”, the Medicaid manual uses the abbreviation “OASDI” interchangeably with “Title II” to refer to Title II Social Security benefits.

B. Entitlement

An individual is fully insured if he has at least 1 credit for each calendar year after 1950, or if later, after the year in which he attained age 21, and prior to the year in which he or she attains age 62 or dies or becomes disabled, whichever occurs earlier.

A worker is entitled to retirement insurance benefits if he is at least age 62, is fully insured and files an application for retirement insurance benefits.

A claimant who is the worker's spouse is entitled to spouse's benefits on the worker's record if the claimant is age 62 or over, has in care a child under age 16 or disabled who is entitled to benefits on the worker's record, and the claimant has been married to the worker for at least 1 year before filing the claim or the claimant is the natural mother or father of the worker's biological child.

A child is entitled to child's insurance benefits on a parent's work record if an application for child's benefits is filed, the child is or was dependent on the parent, the child is unmarried, the child is under age 18 or is age 18-19 and a full-time elementary or secondary school student or age 18 or over and under a disability which began before the child attained age 22; and the parent is entitled to retirement or disability insurance benefits, or died and was either fully or currently insured at the time of death.

When an insured worker dies, monthly cash benefits may be paid to eligible survivors as follows: widow(er)'s benefits, surviving child's benefits, mother's or father's benefits, and parent's benefits.

C. Procedures

Verify an individual’s entitlement to OASDI by inquiring the MMIS computer system or entering the required data into the State Verification Exchange System (SVES). The individual’s award letter from SSA is acceptable verification of OASDI entitlement.

Disability Determination Services (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
Central Regional Office Disability Determination Services 9960 Mayland Drive, Suite 200 Richmond, Virginia 23233 Phone: 800-523-5007 804-367-4700 General FAX: 804-527-4523 Expedited FAX: 804-527-4518 Professional Relations: Alvin Gritz Office Manager: Karry Rouse Regional Director: Brett Fielding	Amelia, Brunswick, Buckingham, Charles City, Charlotte, Chesterfield, Colonial Heights, Cumberland, Danville, Dinwiddie, Emporia, Essex, Goochland, Greensville, 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	Primary Contact (scheduler): Jacqueline Fitzgerald 804-367-4838 Backup: Lauren Decker 804-367-4755 Fax Number for Hearings: 804-527-4518
Tidewater Regional Office Disability Determination Services 5850 Lake Herbert Drive, Suite 200 Norfolk, Virginia 23502 Phone: 800-379-4403 757-466-4300 General FAX: 757-466-4300 Expedited FAX: 757-455-3829 Professional Relations: Sandy Bouldin Office Manager: Heidi Salas Regional Director: Cheryl McCall	Accomack, Chesapeake, Franklin, Gloucester, Hampton, Isle of Wight, James City, Mathews, Newport News, Norfolk, Northampton, Portsmouth, Poquoson, Southampton, Suffolk, Courtland, Virginia Beach, Williamsburg, York	Primary Contact: Bonnie Chatham 757-466-3311 Backup: (vacant at this time) Fax Number for Hearings: 757-455-3829
Northern Regional Office Disability Determination Services 11150 Fairfax Boulevard, Suite 200 Fairfax, Virginia 22030-*5066* Phone: 800-379-9548 703-934-7400 General FAX: 703-934-7410 Expedited FAX: 703-455-3829 Professional Relations: Vida Cyrus Office Manager: Rachel Cuervo Regional Director: Sharon Gottovi	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	Primary Contact: Tara Lassiter 703-934-0071 Backup: Vida Cyrus 703-934-7408 Fax Number for Hearings: 703-934-7410
Southwest Regional Office Disability Determination Services 612 S. Jefferson Street, Suite 300 Roanoke, Virginia 24011-2437 Phone: 800-627-1288 540-857-7748 General FAX: 540-857-7748 Expedited FAX: 540-983-4799 Professional Relations: *Melissa Phillips* Office Manager: Marcia Hubbard Regional Director: Betsy Stone	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	Primary Contact: Lesley Gears 540-857-6027 Backup: Brenda Ragland 540-857-6470 Fax Number for Hearings: 540-857-6374

M0320 Changes

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

- M0320.202 Conversion Cases
- M0320.203 Former SSI/AG Recipients
- M0320.206 Protected Adult Disabled Children
- M0320.207 Protected SSI Disabled Children
- M0320.300 ABD with Income ≤ 80% FPL
- M0320.400 MEDICAID WORKS
- M0320.501 ABD In Medical Institution, Income ≤ 300% SSI
- M0320.502 ABD Receiving CBC Services
- M0320.503 ABD Hospice
- M0320.601 Qualified Medicare Beneficiary (QMB)
- M0320.602 Special Low-income Medicare Beneficiary (SLMB)
- M0320.603 Qualified Individuals (QI)
- M0320.604 Qualified Disabled & Working Individual (QDWI))

M0320.100 ABD CASH ASSISTANCE COVERED GROUPS

A. Legal base

Medicaid eligibility for certain individuals is based on their receipt of cash assistance from another benefit program that has a cash assistance component.

B. Procedure

The policy and procedures for cash assistance recipients are found in the following sections:

- M0320.101 SSI Recipients
- M0320.102 AG Recipients

M0320.101 SSI RECIPIENTS

A. Introduction

42 CFR 435.121 - SSI recipients are a mandatory CN covered group. However, in Virginia, not all SSI recipients are eligible for Medicaid. Virginia has chosen to impose real property eligibility requirements that are more restrictive than the federal SSI real property eligibility requirements. Thus, Virginia SSI recipients must apply separately for Medicaid at their local departments of social services.

The SSI recipient is NOT conditionally or presumptively eligible for SSI, or is not presumptively disabled or blind. Conditionally eligible SSI recipients are being allowed time to dispose of excess resources. Presumptively blind or disabled SSI recipients are presumed to be blind or disabled; no final blindness or disability determination has been made.

SSI payments for eligible individuals are effective the first day of the month following the month in which the SSI application was filed. When the Medicaid application is filed in the same month as the SSI application, the applicant is not eligible for Medicaid as an SSI recipient until the month for which he receives his first SSI payment. Also refer to policy M0320.101.C. *When the SSA record indicates a payment code(s) of "C01" and no payment amount is shown, the individual is considered to be an SSI recipient for Medicaid purposes. If the SSA record indicates a code of EO1 or E02 and no SSI payment has been received in more than twelve months, the individual's SSI status must be confirmed.*

Eligibility for months prior to SSI entitlement must be evaluated in other covered groups.

B. Financial Eligibility

1. Resources

Determine if the SSI recipient has the following real property resource(s):

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) 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 *individual's (recipient/applicant)* attorneys' fees may be deducted as described in M1120.215;

3) ownership (equity value) of the individual's former residence when the SSI recipient is in an institution for longer than 6 months. Determine if the former residence is excluded under policy in section M1130.100 D;

4) equity value in property owned jointly by the SSI recipient with another person in 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 an SSI recipient has any of the real property listed in 1) through 5) above, ALL of the recipient's resources must be verified, evaluated, and counted together to determine if the SSI recipient meets the Medicaid resource requirements. Calculate resources 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 covered group; he may be eligible as MSP (which has more liberal resource methods and standards).

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. *When the SSA record indicates a payment code(s) of "C01" and no payment amount is shown, the individual is considered to be an SSI recipient for Medicaid purposes. If the SSA record indicates a code of EO1 or E02 and no SSI payment has been received in more than twelve months, the individual's SSI status must be confirmed.*

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 retroactiv period, the individual is not eligible for retroactive Medicaid in the SSI recipients 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 ≤ 80% FPL and the MSP covered groups.

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

***The* Cost-of-living calculation formula**
(The formula is Current Title II Benefit divided by the percentage increase to equal the Benefit Before COLA change):

a. Current Title II Benefit / *1.020 (1/1/18 Increase)* = Benefit Amount before *1/18* COLA

b. Benefit Before 1/18 COLA / 1.003 (1/17 Increase) = Benefit Before 1/17 COLA

c. Benefit Before 1/16 COLA / 1.017 (1/15 Increase) = Benefit Before 1/15 COLA

d. Benefit Before 1/15 COLA / 1.015 (1/14 Increase) = Benefit Before 1/14 COLA

5. Medicare Premiums

a. Medicare Part B premium amounts:

1-1-17 $109.00
1-1-16 $121.80
1-1-15 $104.90
1-1-14 $104.90

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

b. Medicare Part A premium amount:

1-1-17 $413.00
1-1-16 $411.00
1-1-15 $407.00
1-1-14 $426.00

Contact a Medical Assistance Program Consultant for amounts for years prior to *2013*.

6. Evaluation

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

D. Financial Eligibility

1. Assistance Unit

a. Initial eligibility determination

In order to qualify for MEDICAID WORKS, the individual must meet, the assistance unit policy and procedures in chapter M05 that apply to ABD individuals with income less than or equal to 80% FPL.

Resources from the individual's spouse with whom he lives or, if under age 21, the individual's parents with whom he lives, must be deemed available.

Spousal and parental income are **not** considered deemable income and are not counted for the initial eligibility determination for individuals requesting to participate in MEDICAID WORKS.

b. Ongoing eligibility

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

2. Resources

a. Initial eligibility determination

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

b. Ongoing eligibility

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

1) For **earnings** accumulated **after** enrollment in MEDICAID WORKS, up to the current 1619(b) income threshold amount will be disregarded if deposited and retained in the WIN Account. The *current* 1619(b) threshold amount *(last change* 2017*)* is $35,684.

2) Resources accumulated while in MEDICAID WORKS and held in Internal Revenue Service (IRS)-approved retirement accounts, medical *or health* savings accounts, medical reimbursement *(flex)* accounts, education accounts, independence accounts, and other similar State-approved accounts are excluded. Examples of these accounts include Archer Medical Savings Accounts, 401(k*)/403(b)/457(b)/503(b)* accounts, traditional Individual Retirement Accounts (IRAs), Roth IRAs, SEP-IRAs, SIMPLE IRAs, and Thrift Savings Plans. The account must be designated as a WIN Account in order to be excluded. **Resources accumulated while in MEDICAID WORKS and held in IRS-approved accounts that have been designated as WIN**

Accounts are also excluded.in all future Medicaid determinations for former MEDICAID WORKS enrollees. The account must be exclusively used to hold resources accumulated while in MEDICAID WORKS (including interest) in order for the exclusion to continue.

3) For **all** other resources, the resource requirements in chapter S11 and Appendix 2 to chapter S11 apply. All of the individual's countable, nonexempt resources must be verified and evaluated.

All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements. The resource limit for resources not excluded in 1) or 2) above is $2,000 for an individual.

3. Income

a. Initial eligibility determination

For the initial eligibility determination, the income limit is ≤ 80% of the FPL (see M0810.002). The income requirements in chapter S08 must be met. Individuals who receive SSI are considered to meet the income requirements and no evaluation of income is necessary for the initial eligibility determination (see M0320.101).

b. Ongoing eligibility

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

1) The income limit for earned income *(last change* 2017) is $6,250 per month ($75,000 per year) as long as the funds are deposited in a WIN Account. The policy for determining countable earned income is contained in subchapter S0820.

   If the individual is self-employed, net earnings from self-employment (NESE) must be demonstrated through documentation of Internal Revenue Service (IRS) filings, quarterly estimated taxes, business records, and/or business plans. The individual's signed allegation of self-employment is acceptable if no other evidence of NESE can be obtained. Follow the policy in S0820.220 for determining NESE.

2) The income limit for unearned income remains less than or equal to 80% of the FPL. The policy for determining countable unearned income is contained in subchapter S0830.

3) Any increase in an enrollee's Social Security Disability benefits resulting from employment as a MEDICAID WORKS participant OR as a result of a COLA adjustment to the Social Security Disability benefits will not be counted as long as it is regularly deposited upon receipt into the individual's WIN account.

4) Unemployment insurance benefits received due to loss of employment through no fault of the individual's own are not counted during the six-month safety net period (see M0320.400 G) as income as long as the payments are regularly deposited upon receipt into the individual's WIN account.

M04 Changes

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

M0450.200 INCOME EXAMPLES – TAX FILER HOUSEHOLDS

A. Example #1
Tax Filer Single Parent, Two Children

(Using *Jan. 1, 2017* figures)

Tom is a single parent living in Henrico County (Group II) with his two children, Jack and Betty, ages 6 and 10, whom he claims as tax dependents. Tom earns $3,000 per month, with projected annual income of $36,000.

The MAGI households are:

Person	# - Household Composition	Reason
Tom	3 – Tom, Jack, Betty	Tax-filer & 2 dependents
Jack	3 – Jack, Tom, Betty	Tax dependent, taxpayer & other tax dependent
Betty	3 – Betty, Tom, Jack	Tax dependent, taxpayer & other tax dependent

<u>Tom (parent) eligibility determination:</u>

<u>Potential covered groups:</u>
LIFC (full-coverage MA)
Plan First (limited coverage)

<u>Monthly Income limits:</u>
LIFC, Group II for HH of 3 = $577
Plan First 200% FPL for HH of 3 = $3,404
5% FPL Disregard for HH of 3 = $86

Tom's gross HH income of $3,000.00 exceeds the LIFC income limit of $577 for a HH of 3, so he is entitled to a 5% FPL disregard.

$3,000.00 gross household income
<u>- 86.00</u> 5% FPL Disregard for HH of 3
$2,914.00 countable income (after disregard)

His countable income of $2,914.00 is compared to the LIFC income limit for HH of 3 which is $577; however as it exceeds the LIFC limit Tom is not eligible for full-coverage MA.

Tom's gross HH income of $3,000.00 is then compared to the Plan First 200% FPL income limit for 3 which is $3,404. As his income is under the limit, no disregard is needed; Tom is eligible for Plan First.

Tom is also referred to the Health Insurance Marketplace (HIM).

Jack (child) eligibility determination:

Potential covered groups:
Child < Age 19
FAMIS

Monthly Income limits:
Child < 19 143% FPL for a HH of 3 = $2,434
FAMIS 200% FPL for HH of 3 = $3,404
5% FPL Disregard for HH of 3 = $86

The gross HH income for Jack of $3,000 (his father's earnings) exceeds the Medicaid Child < Age 19 143% FPL income limit for 3 ($2,434), so Jack is entitled to the 5% disregard.

$3,000.00 gross household income
- 86.00 5% FPL Disregard for HH of 3
$2,914.00 countable income (after 5% disregard)

The countable income of $2,914.00 still exceeds the Medicaid Child < Age 19 143% FPL limit ($2,434), Jack is not eligible for Medicaid.

The gross HH income for Jack of $3,000 is then compared to the FAMIS income limit for a HH of 3 which is $3,404. As the gross HH income is less than the FAMIS income limit ($3,404) Jack is eligible for FAMIS. If the gross HH income had been over the FAMIS income limit, the 5% disregard would have been used and compared to the FAMIS income limit.

Betty (child) eligibility determination:

Betty's (the other child) income eligibility determination is the same as Jack's; she is eligible for FAMIS too.

B. Example #2
Tax Filer / Three Generation Household

(Using *Jan. 1, 2017* figures)

Mary Lewis is a 52-year-old working grandmother living in Louisa County (Group I). Mary claims her daughter (Samantha), age 20 and a full-time student, and granddaughter Joy (Samantha's daughter), age 2, as tax dependents who both live in the household with her.

Mary earns $4,500/month ($54,000/year).
Samantha earns $300/month ($3,600/year)
Projected annual income for tax household = Mary's income (Samantha not required to file) = $54,000 per year

Tax household = Mary, Samantha, and Joy.
MAGI Households:

Person	# - Household Composition	Reason
Mary	3 – Mary, Samantha, Joy	Tax-filer & 2 tax dependents
Samantha	3 – Samantha, Mary, Joy	Tax dependent, tax filer, & other tax dependent
Joy	2 – Joy, Samantha	Non-filer child & child's parent with whom child lives

Mary's eligibility determination:

Potential covered groups:
Plan First

Monthly Income Limits:
Plan First 200% FPL income limit for HH of 3 = $3,490
5% FPL Disregard for HH of 3 = $86

HH gross monthly income:
$4,500 Mary's earnings
(Samantha's earnings are excluded because she is a child for tax purposes and is not required to file taxes).

The gross HH income of $4,500.00 is compared to the Plan First 200% FPL income limit for 3, $3,490. As the gross HH income exceeds the limit, she is entitled to the 5% FPL disregard.

$4,500.00 gross household income
- 86.00 5% FPL Disregard for HH of 3
$4,414.00 countable income (after 5% FPL disregard)

The countable income of $4,414.00 is then compared to the Plan First income limit of $3,436; but as her countable income exceeds the Plan First limit, Mary is not eligible for Plan First.

Mary is referred to the HIM.

Samantha's eligibility determination:

Potential covered groups:

LIFC
Plan First.

Monthly Income limits:

LIFC, Group I for HH of 3 = $474
Plan First 200% FPL for HH of 3 = $3,404
5% FPL Disregard for HH of 3 = $86

HH monthly income:

$4,500 Mary's earnings
(Samantha's income is not counted in this HH).

As $4,500 exceeds the LIFC limit for 3 ($474) she is entitled to the 5% FPL disregard. Her income eligibility is determined as follows:

$4,500.00	gross household income
- 86.00	5% FPL Disregard for HH of 3
$4,414.00	countable income

Samantha's countable income of $4,414 still exceeds the LIFC income limit for 3 of $457 so she is not eligible for LIFC (full-coverage) MA.

The gross HH income of $4,500.00 is compared to the Plan First 200% FPL income limit for 3 which is $3,404, and as Samantha exceeds this amount, the 5% FPL Disregard ($86) can be deducted. The countable income of $4,414 is greater than the Plan First income limit of $3,404. Samantha is not eligible for Plan First, and is referred to the HIM.

An alternate method, which accomplishes the same results, is to compare the Plan First 205% FPL (200% FPL + 5% FPL Disregard) for a HH of 3 which is $3,490. As the countable income amount of $4,500 is greater the income limit of $3,490, Samantha is not eligible for Plan First, and is referred to the HIM.

Joy's eligibility determination

C. Example # 3 Tax Filer with Dependent Outside of the Home (Using January 1, 2017 figures)

John applies for Medicaid for himself and his child Richard. John files taxes and claims Richard as well as his 17-year-old daughter, Bridget, who does not live with him. John works part time making $800 a month and Bridget works part time making $625 a month. They live in Fairfax County (Group III).

Person	*# - Household Composition*	*Reason*
John	*3 - John, Richard, Bridget*	*Tax filer and dependents*
Richard	*3 - Richard, John, Bridget*	*Tax dependent, tax filer, and other dependent*

Even though Bridget has income over the tax filing threshold ($6,300 in 2016) and is required to file taxes on her own, she is part of John's tax filing household as a dependent, so her income counts toward any HH in which she is included, in this case, the HH of her father John.

John's eligibility determination:

Potential covered groups:
LIFC
Plan First

Monthly income limits:
LIFC (Group III) HH of 3 = $791
Plan First 200% FPL for HH of 3 = $3,404
5% FPL Disregard for HH of 3 = $86

John's gross HH income of $1,425.00 exceeds the LIFC income limit for 3 of $791, and he is entitled to the 5% FPL disregard.

$1,425.00 gross household income
- 86.00 5% FPL Disregard for HH of 3
$1,339.00 countable income

His countable income of $1,339.00 is compared to the LIFC income of $791, which it exceeds, so John is not eligible for full-coverage LIFC MA.

His gross HH income of $1,425.00 is compared to the Plan First 200% FPL income limit for 3, $3,404. As the HH income is less than the limit, John is eligible for Plan First. John is also referred to the HIM.

Bridget's eligibility determination
Bridget was not applied for.

Richards's eligibility determination:

Potential covered groups:
Child < Age 19
FAMIS

Monthly Income limits:
Child < 19 - 143% FPL for a HH of 3 = $2,434
FAMIS 200% FPL for HH of 3 = $3,404
5% FPL Disregard for HH of 3 = $86

Richard's gross HH income of $1,425 (his father's and sibling's earnings) is less than the FAMIS 200% income limit of $3,404. And as the HH income does not exceed the Medicaid Child < Age 19 income of $2,434, the 5% disregard is not needed. Richard is eligible for full-coverage MA.

M0450.300 INCOME EXAMPLES – NON TAX FILER HOUSEHOLDS

A. Example #1

Robb lives in the City of Norfolk (Group II) with his sons, and does not file taxes. He receives of $2,500 per month disability income, with projected annual income of $24,000. His children receive monthly interest on trust accounts their grandparent's setup. Mike is 16 years old and receives $500 per month while Ike is 13 years old and receives $400 per month.

Non Tax Filer Single Parent, Two Children (Using Jan. 1, 2017 figures)

The MAGI households are:

Person	# - Household Composition	Reason
Robb	3 – Robb, Mike & Ike	Non tax filer & his 2 children < 19
Mike	3 – Mike, Robb & Ike	Non-filer child < 19, his parent & his sibling < 19
Ike	3 – Ike, Robb & Mike	Non-filer child < 19, his parent & his sibling < 19

HH income:

$2,500.00 Robb's disability benefit income
+ 500.00 Mike's trust income
+ 400.00 Ike's trust income
$3,400.00 gross household income

Robb's gross HH's of $3,400 monthly income exceeds the LIFC income limit for 3 of $577 per month, thus entitled to the 5% disregard. His income eligibility is determined as follows:

$3,400.00 gross household income
- 86.00 5% disregard
$3,314.00 countable income

As his countable income exceeds the LIFC income limit of $577, he is ineligible for full coverage MA.

His gross HH income of $3,400.00 is then compared to the Plan First 200% FPL income limit for 3 of $3,404. As the income is less than the Plan First income limit, he is eligible for Plan First. Robb is also referred to the HIM.

Mike's eligibility determination:

Potential covered groups:

Child < Age 19
FAMIS

Monthly Income limits:

Child < Age 19, 143% FPL for a HH of 3 = $2,434
FAMIS, 200% FPL for HH of 3 = $3,404
5% FPL for 3 = $86

HH income:

$2,500.00 Robb's disability benefit income
+ 500.00 Mike's trust income
+ 400.00 Ike's trust income
$3,400.00 gross household income

Mike's gross HH's $3,400 monthly income exceeds the Medicaid Child < Age 19 143% FPL income limit for 3, $2,434, so he is entitled to the 5% disregard. Mike's income eligibility is determined as follows:

$3,200.00 gross household income
- 86.00 5% FPL disregard
$3,114.00 countable income

Mike's countable income of $3,114.00 exceeds the Medicaid Child < Age 19 143% FPL income limit for 3, $2,434. Mike is not eligible for Medicaid.

His gross HH income of $3,400.00 is then compared to the FAMIS 200% FPL income limit for 3, $3,404. He is eligible for FAMIS because his gross HH income is less than the FAMIS income limit for the household size.

Ike's income eligibility determination:

Potential covered groups:

Child < Age 19
FAMIS

Monthly Income limits:

Child < Age 19, 143% FPL for a HH of 3 = $2,434
FAMIS, 200% FPL for HH of 3 = $3,404
5% FPL for 3 = $86

HH income:

$2,500.00	Robb's disability benefit income
+ 500.00	Mike's trust income
+ 400.00	Ike's trust income
$3,400.00	gross household income

Ike's countable income of $3,114.00 exceeds the Medicaid Child < Age 19 143% FPL income limit for 3, $2,434. Mike is not eligible for Medicaid.

As his gross monthly income exceeded the Medicaid Child < Age 19 143% income limit of $2,434, he is entitled to the 5% disregard. Ike's income eligibility is determined as follows:

$3,200.00	gross household income
- 86.00	5% FPL disregard
$3,114.00	countable income

As his countable income exceeds the income limit of $2,434, he is ineligible for Medicaid child <19, and move to the next step.

His gross HH income of $3,400.00 is compared to the FAMIS 200% FPL income limit for 3 of $3,404. He is eligible for FAMIS because his gross HH income is less than the FAMIS income limit for the household size of 3.

This example also illustrates as even though Mike and Ike had different trust account income, it made no difference in the results, and both eligible for FAMIS coverage.

B. Example #2 Non Tax Filer Three Generation Household (Using Jan. 1, 2017 figures)

Sally Green is age 64, a grandmother who does not expect to file taxes this year. She is neither blind or disabled. She lives with her daughter Jane, age 20 and a full-time student, and her granddaughter Dee (Jane's daughter), age 2. Sally takes care of Dee while Jane is attending school and working at her part-time job. Jane is pregnant with 1 unborn. They live in Hanover, a Group I locality.

Income:
Sally receives SSA widow's benefits of $1,500 per month, with projected annual income of $18,000.

Jane earns $300 per month or $3,600 annually and is not required to file taxes.

The MAGI non-filer households are:

Person	# - Household Composition	Reason
Sally	1 – Sally	Non-filer grandmother
Jane (PG)	3 – Jane, Jane's unborn child & Dee	Non-filer, her unborn child & non-filer's child < 19
Jane (LIFC)	2 – Jane, Dee	Non-filer & non-filer's child < 19
Dee	2 – Dee, Jane	Non-filer child < 19 & non-filer child's parent

Sally's eligibility determination:
Potential covered groups:
Plan First

Monthly Income limits:
Plan First 200% FPL income limit for HH of 1 = $2,010
5% FPL for 1 = $51

HH gross monthly income = $1,500 Sally's SSA benefits

Her gross HH income of $1,500.00 is compared to the Plan First 200% FPL income limit for 1, $2,010. As her countable income is less than the Plan First income limit, Sally is eligible for Plan First. She is also referred to the HIM.

Sally does not meet any other covered group, such as Aged, Blind, or Disabled (ABD).

Jane's eligibility determination:

Potential covered groups:
LIFC
Medicaid Pregnant Women

Monthly Income limits:
LIFC, Group I for HH of 2 = $373
Pregnant Women 143% FPL for a HH of 3 = $2,434
5% FPL for 3 = $86

HH monthly income = $300 Jane's income.

Jane is over age 19, not a child and not counted as a dependent for anyone else. Jane's earnings must be counted even though she is not required to file taxes. As her mother (Sally) is not in Jane's her tax filing HH, Sally's income is not counted when determining Jane's eligibility. The HH would consist of Jane and her daughter Dee.

$300 is less than the LIFC limit for 2 ($373) so the 5% disregard is not applied (it is not necessary). Jane is eligible for Medicaid in the LIFC covered group.

If Jane had been over income for the LIFC covered group, the step to apply the 5% disregard would have been used. If she was found over the LIFC income limit, a review as a Medicaid Pregnant Woman 143% income limit would have been used.

Dee's eligibility determination:
Potential covered groups:
Child < Age 19
FAMIS

Monthly Income limits:
Child < Age 19 143% FPL for a HH of 2 = $1,936
FAMIS, 200% FPL for HH of 2 = $2,585
5% FPL for 2 = $65

HH monthly income:
$300 (Jane's gross earnings)

As HH income $300 is less than the Medicaid Child < Age 19 143% FPL income limit for 2 ($1,849), Dee is eligible for Medicaid. The 5% disregard is not necessary since she qualified in this aid category.

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M0810 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-7	1/1/18	Page 1,2
TN #DMAS-5	7/1/17	Page 2
TN #DMAS-4	4/1/17	Page 2
TN #DMAS-3	1/1/17	Pages 1, 2
TN #DMAS-2	10/1/16	Page 2
TN #DMAS-1	6/1/16	Pages 1, 2
UP #11	7/1/15	Page 2
TN #100	5/1/15	Pages 1, 2
UP #10	5/1/14	Page 2
TN #99	1/1/14	Pages 1, 2
TN #98	10/1/13	Page 2
UP #9	4/1/13	Pages 1, 2
UP #7	7/1/12	Page 2
UP #6	4/1/12	Pages 1, 2
TN #95	3/1/11	Pages 1, 2
TN #93	1/1/10	Pages 1, 2
Update (UP) #1	7/1/09	Page 2

GENERAL

M0810.001 INCOME AND ELIGIBILITY

A. Introduction

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

B. Policy Principles

1. Who is Eligible

An individual is eligible for Medicaid if the person:

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

2. General Income Rules

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

M0810.002 INCOME LIMITS

A. Income Limits

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

1. Categorically Needy

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

2. Categorically Needy Protected Cases Only

Categorically-Needy Protected Covered Groups Which Use SSI Income Limits		
Family Unit Size	*2018 Monthly Amount*	2017 Monthly Amount
1	*$750*	$735
2	*1,125*	1,103
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size	*2018 Monthly Amount*	2017 Monthly Amount
1	*$500.00*	$490.00
2	*750.00*	735.34

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	*2018 Monthly Amount*	2017 Monthly Amount
1	*$2,250*	$2,205

4. ABD Medically Needy

a. Group I	7/1/2017		*7/1/2016 – 6/30/17*	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	*$1,867.21*	*$311.20*	$1,861.63	$310.27
2	*2,377.24*	*396.20*	2,370.20	395.03
b. Group II	7/1/2017		*7/1/2016 – 6/30/17*	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	*$2,154.48*	*$359.08*	$2,148.04	$358.00
2	*2,653.01*	*442.16*	2,645.09	440.84
c. Group III	7/1/2017		*7/1/2016 – 6/30/17*	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	*$2,800.83*	*$466.80*	$2,792.45	$465.40
2	*3,376.83*	*562.80*	3,366.75	561.12

5. ABD Categorically Needy

For:

ABD 80% FPL, QMB, SLMB, & QI <u>without</u> Social Security income; all QDWI; effective 1/31/17

ABD 80% FPL, QMB, SLMB, & QI <u>with</u> Social Security income; effective 3/1/17

All Localities	2017		2016	
ABD 80% FPL	Annual	Monthly	Annual	Monthly
1	$9,648	$804	$9,504	$792
2	12,992	1,083	12,816	1,068
QMB 100% FPL	Annual	Monthly	Annual	Monthly
1	$12,060	$1,005	$11,880	$990
2	16,240	1,354	16,020	1,335
SLMB 120% of FPL	Annual	Monthly	Annual	Monthly
1	$14,472	$1,206	$14,256	$1,188
2	19,488	1,624	19,224	1,602
QI 135% FPL	Annual	Monthly	Annual	Monthly
1	$16,281	$1,357	$16,038	$1,337
2	21,924	1,827	21,627	1,803
QDWI	Annual	Monthly	Annual	Monthly
200% of FPL	$24,120	$2,010	$23,760	$1,980.00
1	32,480	2,707	32,040	2,670.00
2				

M0815 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-7	1/1/18	Page 1

WHAT IS NOT INCOME

M0815.001 WHAT IS NOT INCOME-GENERAL

A. Introduction

Some items that an individual receives are not income because they do not meet the definition of income in S0810.005 A. Other items are income but are excluded by statute (see S0830.099). In making income determinations, the eligibility worker (EW) must distinguish between an income exclusion and an item which is not income by definition. Only those items specifically listed in the law and regulations can be excluded from income.

B. Policy

An item received is not **income** if it is not cash, or its equivalent, or listed in this chapter. Contributions of in-kind items are not income.

An item which is not income when received by an individual, if retained until the following month, is subject to evaluation as a resource as of the first of the month after the month of receipt. (See S1110.600.)

C. Procedure

1. Is the Item Income?

In evaluating whether an item meets the definition of income, determine if it is:

- cash, *or its equivalent*
- **not** listed in this subchapter

If the item is **neither** of the above, consider it as not income.

2. Need to Document

Do not document the receipt of those items listed in this subchapter which are not income unless:

- Documentation is required by specific operating instructions elsewhere (e.g., rebates and refunds in S0815.250); or
- It is material to an eligibility computation.

D. References

- Treatment of income which is subject to garnishment, S0810.025.
- Treatment of contributions made to and benefits received from a cafeteria plan, *M*0820.102.

S0820 Changes

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

S0820.130 EVIDENCE OF WAGES OR TERMINATION OF WAGES

A. Policy

1. Primary Evidence of Wages

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

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

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

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

d. Written statement from employer.

2. Secondary Evidence of Wages

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

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

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

3. Acceptable Evidence of Termination of Wages

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

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

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

c. Written statement from employer.

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

B. Procedure

1. Order of Priority

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

2. Pay Slips

a. Stress to the individual that he/she is responsible for providing proof of wages and is expected to retain all pay stubs and provide them as requested.

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

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

NOTE: Pay slips which do not contain all the required information may be used in conjunction with other evidence; however, any discrepancies must be resolved.

3. Employer Reports

If an employer returns a statement to the EW unsigned, do not re-contact the employer for a signature unless the EW questions the statement's validity (e.g., the income verification form was hand-carried to the LDSS by the applicant rather than mailed directly to the LDSS).

4. Evidence Reflects Only an Annual Wage Amount

If the evidence that can be obtained reflects only an **annual** wage amount, divide the annual amount by 12 to get monthly wage amounts.

C. References

- Military pay and allowances, *M*0830.540.

3. Other Earned Income

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

a. Federal earned income tax credit payments.

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

c. For 2018, up to *$1,820* per month, but not more than *$7,350* in a calendar year, of the earned income of a blind or disabled student child.

For 2017, up to $1,790 per month, but not more than $7,200 in a calendar year, of the earned income of a blind or disabled student child.

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

e. $65 of earned income in a month.

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

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

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

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

4. Unused Exclusion

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

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

5. Couples

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

B. References

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

- S0810.410 for infrequent/irregular income
- S0810.420 $20 general exclusion
- *M*0810.430 amount to fulfill a plan for achieving self-support

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

S0820.510 STUDENT CHILD EARNED INCOME EXCLUSION

A. Policy

1. General

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

For Months	Up to per month	But not more than in a calendar year
In calendar year 2018	*$1,820*	*$7,350*
In calendar year 2017	$1,790	$7,200

2. Qualifying for the Exclusion

The individual must be:

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

3. Earnings Received Prior to Month of Eligibility

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

4. Future Increases

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

B. Procedure

1. Application of the Exclusion

Apply the exclusion:

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

2. School Attendance and Earnings

Develop the following factors and record them:

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

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

C. References

- Grants, scholarships and fellowships, S0830.455.
- Educational assistance with Federal funds involved, S0830.460.

D. Example *(Using January 2018 Figures)*

Jim Thayer, a student child, starts working in June at a local hardware store. He had no prior earnings during the year, and he has no unearned income. Jim earns *$2,100* a month in June, July and August. In September, when he returns to school, Jim continues working part-time. He earns *$1,100* a month in September and October. Jim's countable income computation for June through October is as follows:

June, July and August
$2100.00 gross earnings
- 1820.00 student child exclusion
$ 280.00
- 20.00 general income exclusion
$ 260.00
- 65.00 earned income exclusion
$ 195.00
- 97.50 one-half remainder
$ 97.50 countable income

Jim has used *$5,460 ($1,820* in each of the three months) of his *$7,350* yearly student child earned income exclusion.

September
$1100.00 gross earnings
- 1100.00 student child exclusion
0 countable income

Jim has now used *$6,560 ($5460 +1100)* of his *$7,350* yearly student child earned income exclusion.

October
$1100.00 gross earnings
- 790.00 student child exclusion *remaining ($7,350-$6,560=$790)*
$310.00
- 20.00 general income exclusion
$290.00
- 65.00 earned income exclusion
$225.00
- 112.50 one-half remainder
$*112.50* countable income

Jim has exhausted his entire *$7,350* yearly student child earned income exclusion. The exclusion cannot be applied to any additional earnings during the calendar year.

S0830 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-7	1/1/18	Table of Contents, page iii, iv. Pages 7-8, 17-18, 20, 29, 48, 79a, 82, 124a-124b, 125.
TN #DMAS-4	4/1/17	Table of Contents, page i Pages 24, 24c
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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S0830.099 GUIDE TO EXCLUSIONS

A. Introduction

The following provides a list of those instructions which address a partial or total exclusion of unearned income. Those in **bold print** involve an exclusion under another Federal statute.

B. List of Instructions About Unearned Income Exclusions

Agent Programs **S0830.610**
Agent Orange Settlement Payments..... S0830.730

Austrian Social Insurance Payments S0830.715
BIA Student Assistance S0830.460
Capital Gains M0815.200
Child Support S0830.420

Disaster Assistance S0830.620

Educational Assistance S0830.450
Energy Assistance S0830.600
Energy Employees Occupational Illness Compensation Plan (EEOICP) *S0830.450*

Farmers Home Administration Housing Assistance (FMHA) S0830.630
Food/Meal Programs S0830.635
Food Stamps S0830.635
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General Assistance (General Relief) S0830.175
German Reparation Payments S0830.710
Gifts Occasioned by a Death S0830.545
Gifts of Domestic Travel Tickets S0830.521
Grants, Scholarships, and Fellowships S0830.455

HUD Subsidies S0830.630
Home Energy Assistance S0830.605
Home Produce S0830.700
Hostile Fire Pay from the Uniformed Services S0830.540
Housing Assistance S0830.630
Interest on Excluded Burial Funds S0830.501

Japanese-American and Aleutian Restitution Payments S0830.720

Low Income Energy Assistance S0830.600

Meals for Older Americans S0830.635
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National Defense Student Loans (NDSL)..... S0830.460

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Refunds of Taxes Paid on Real Property or Food S0830.705
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University Year for Action (UYA). S0830.610

Victim's Compensation Payments S0830.660
Volunteers in Service to America (VISTA) S0830.610

Walker v. Bayer Settlement Payments.....M0830.760
Women, Infants, and Children Program (WIC).....S0830.635

D. Procedure

1. Initial Applications

In initial applications, be alert for clues which may indicate a receipt of or potential eligibility for an annuity, pension, or similar payment; e.g., long employment with a particular industry or a government agency, military service, membership in a union.

2. Check Specific Instructions

Check for specific policy instructions pertaining to the payment involved. (See C. above.)

3. Overpayment Question

Ask if any benefits otherwise due are being withheld to recover an overpayment. If the answer is yes, see S0830.110.

4. Verification/ General

If there are no specific policy instructions for the payment, use award letters or other documentation in the individual's possession or contact the source to verify:

- the type, source, and amount of payment;
- *recipient of the payment;*
- if necessary, the frequency of payment.

5. Verification/ Frequency

It is not necessary to verify the frequency of the payment if you are familiar with the type of payment involved either through direct experience or a precedent.

6. Verification/ Use of Check

If the individual does not possess an award letter or other document, a **check** may be used to verify the payment amount if it is clear that the amount shown represents the gross amount.

7. Contact with the Source

If the individual has no evidence in his/her possession, contact the source of the payment.

E. References

Determining the amount of unearned income, S0830.100

Contributions by an employer into a retirement fund, S0815.600

Retirement funds as resources, S1120.210 E.

S0830.165 ASSISTANCE PROGRAMS WITH GOVERNMENTAL INVOLVEMENT -- GENERAL

A. Introduction

Federal, State, and local governments are involved in a number of programs which provide assistance (cash or in-kind goods and services) to Medicaid recipients. For Medicaid purposes, treatment of this assistance will vary depending on the nature of the program and the payment. Sections S0830.170, S0830.175 and S0830.180 provide guidelines for determining the nature of these programs and the income, if any, to count when program specific instructions do not exist elsewhere. A guide is provided in B. below.

B. Programs-Specific Instructions

Use this table to locate specific instructions pertaining to frequently encountered programs with governmental involvement.

Adoption assistance S0830.415
Action Programs S0830.610
Aid to Families with Dependent Children (AFDC) S0830.400
Bureau of Indian Affairs General Assistance (BIAGA) S0830.800
Community Services Block Grant S0830.615
Community Work Experience Program (CWEP) S0830.185
Cuban/Haitian Entrant Cash Assistance S0830.645
Disaster Assistance S0830.620
Educational Assistance S0830.450
Emergency Assistance Under Title IV A S0830.405
Federal Emergency Management Agency (FEMA) S0830.625
Food Stamps S0830.635
Foster Care S0830.410
Foster Grandparents Program S0830.610
General Assistance, Home, Relief, etc. S0830.175
Housing Assistance S0830.630
Workforce Innovation and Opportunity Act
(Formerly Workforce Investment Act) S0830.535
Low Income Home Energy Assistance Program (LIHEAP) S0830.600
Older Americans Act S0830.640
Refugee Cash Assistance S0830.645
Refugee Reception and Placement Grants S0830.650
Refugee Matching Grants S0830.650
Rehabilitation Act of 1973 ..... S0815.050
Relocation Assistance S0830.655
School Lunches S0830.635
Social Service Block Grant (Title XX) S0815.050
State Assistance Based on Need S0830.175
VA Benefits S0830.300
Work Relied (Workfare) Programs S0830.185

S0830.175 ASSISTANCE BASED ON NEED (ABON)

A. Definitions

ABON is assistance:

1. Assistance Based on Need (ABON)

- provided under a program which uses income as a factor of **eligibility**; and
- funded **wholly** by a State (including the District of Columbia, Indian tribes and the Northern Mariana Islands), a political subdivision of a State, or a combination of such jurisdictions.

EXCEPTIONS: State supplementary payments, made to refugees are considered to be ABON even if the Federal government reimburses the State.

NOTE: If a program uses income to determine payment amount but not eligibility, it is not ABON (e.g., some crime victims compensation programs).

2. Federal Funds

For purposes of this section, Federal funds means monies supplied and directed by the Federal government for a specific use or specific type of program (e.g., community service block grants, Federal matching funds for AFDC). Monies not allocated for specific purposes are not considered Federal funds.

EXAMPLES: Nonspecific Funding

Revenue sharing funds are not "Federal funds" for purposes of this section and programs using these funds are considered wholly Sate funded.

B. Policy

Assistance based on need is excluded from income.

C. Procedure

1. Precedent Exists

If a precedent exists:

- **Accept** the claimant's **allegation** as to the type and source of assistance and exclude it without further development.

- **Document** the file to show that a precedent exists **only** if you use a local precedent.

2. No Precedent Exists

If a precedent does not exist:

- Use **documents** in the individual's possession or contact the administering agency to **determine** the program under which the assistance is provided.

- **Verify** with agency personnel and/or program descriptions that no

M0830.230 UNEMPLOYMENT COMPENSATION BENEFITS

A. Definition

Unemployment Compensation payments are received under a State or Federal unemployment law and additional amounts paid by unions or employers as unemployment benefits.

B. Procedures

1. General Procedures

Unemployment Compensation benefits are counted as unearned income

2. Special $25 Weekly Exclusion

The American Recovery and Reinvestment Act of 2009 (P.L. 111-5) authorized increased payments, called Federal Additional Compensation (FAC), of $25.00 per week to certain individuals receiving Unemployment Compensation payments. FAC increased payments are authorized for Unemployment Compensation payments made through December 4, 2010, provided that the initial claim for compensation was filed on or before May 23, 2010. Claims filed after May 23, 2010 are not subject to the increased payments.

The individual's entitlement to Unemployment Compensation is not affected—the individual will only receive the number of payments to which the individual would normally be entitled.

This special exclusion ended December 7, 2010.

S0830.235 WORKERS' COMPENSATION

A. Introduction

Workers' compensation (WC) payments are awarded to an injured employee or his/her survivor(s) under Federal and State WC laws, such as the Longshoremen and Harbor Workers' Compensation Act. The payments may be made by a Federal or State agency, an insurance company, or an employer.

B. Policy

1. Income

a. General

The WC payment less any expenses incurred in getting the payment is unearned income.

M0830.320 VA REGIONAL OFFICE

A. List of VA Regional Offices This list shows the VARO mailing address for each geographic area:

STATE	ADDRESS
Virginia	210 Franklin Road, SW Roanoke, VA 24011
Washington, D.C. VA-RO (Includes Fairfax County and cities of Alexandria, Fairfax, and Falls Church).	941 North Capitol Street, NE. Washington, DC 20421

S0830.522 GIFT CARDS and GIFT CERTIFICATES

A. Definition

Absent evidence to the contrary, presume a gift card/certificate can be resold. For example, evidence to the contrary may include a legally enforceable prohibition on resale or transfer of the card imposed by the card issuer/merchant printed on the card.

B. Policy

Gift Cards/Gift Certificates as Income

The value of a gift card/gift certificate is income in the month it is received if the gift card/certificate:

- *Can be used to purchase food or shelter;* ***or***
- *Can be resold.*

The value of the gift card/certificate is subject to the general rules pertaining to income and income exclusions. See S0810.410 for the infrequent or irregular income exclusion policy.

Any unspent balance remaining on a gift card/certificate is a resource beginning the month following the month the gift card/certificate was received. If personal property is obtained with the gift card/certificate, it must be evaluated under the resources policy

NOTE: *A gift card/certificate that is restricted on its use,* ***and*** *is legally prohibited from resale, must be evaluated (case by case) based on the restrictions and or prohibitions for determining as income.*

Gift Cards/Gift Certificates Not Income

The value of a gift card/gift certificate is not income in the month it is received if the gift card/certificate:

- *Cannot be used to purchase food or shelter;* ***and***
- *Cannot be resold.*

In addition, if the individual does not have the right, authority, or power to convert or sell the gift card/certificate for cash, and it cannot be used to purchase food or shelter, then the gift card/certificate would not meet the definition of a resource in M1110.100

The restriction on use of a gift card/certificate can be legal, (imposed by the card issuer), or practical, (the store where the card must be redeemed does not sell food or shelter items).

M0830.535 *WORKFORCE INNOVATION AND OPPORTUNITY ACT (FORMERLY WORKFORCE INVESTMENT ACT*)

A. Introduction

The purpose of the *Workforce Innovation and Opportunity Act (WIOA*, formerly the *Workforce Investments Act – WIA*) is to prepare individuals for entry into the labor force. *WIOA* funding is much like a block grant and programs will vary among areas within the State. *WIOA* payments may be called "needs-based" for *WIOA* purposes but are not "income based on need" or "assistance based on need" for Medicaid purposes. *WIOA* payments may be in cash or in kind, and participants in *WIOA* may receive supportive services in cash or in kind. Usually, adult participants receive **only** supportive services.

B. Policy

WIOA payments are **subject to the general rules** pertaining the income and income exclusions.

C. Procedure

1. Allegations

Accept an individual's allegation of participation in *WIOA* and receipt of supportive services unless there is reason to question the information.

2. Assumption

- **Assume** that supportive services such as child care, transportation, medical care, meals and other reasonable expenses, provided in cash or in kind, are **social services** and **not income**.

- Disregard the supportive services without further development or documentation.

NOTE: However, items such as salaries, stipends, incentive payments, etc., must be evaluated under the general rules of unearned and earned income. Any payments made directly to vendors by *WIOA* are not income.

D. References

Medical and Social Services S0815.050
Earned income, S0820.001.
Blind Work Expenses, S0820.535
IRW E, S0820.540
PASS, S0870.001.

S0830.741 ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PLAN (EEOICP)

A. Background

The EEOICP was established to pay claims for benefits under the Energy Employees Occupational Illness Compensation Program Act of 2000 (the EEOICP Act). The EEOICP Act authorizes lump sum payments and the reimbursement of medical expenses to employees of the Department of Energy (DOE) or of private companies under contract with DOE, who suffer from specified diseases as a result of their work in the nuclear weapons industry. The EEOICP Act also authorizes compensation to the survivors of these employees under certain circumstances. The Department of Labor (DOL) is responsible for the administration, adjudication and payment of claims under the EEOICP. DOL makes payments from the Energy Employees Occupational Illness Compensation Fund. Part B and Part E of the EEOICP have different effective dates, illness criteria and medical/compensation allowances.

B. Policy

1. EEOICP Payments

Lump sum payments made under the EEOICP, including reimbursement for medical expenses, are excluded from income for SSI purposes.

NOTE: *Individuals who are eligible under Section 5 of the Radiation Exposure Compensation Program (RECP) may also be eligible for compensation and paid medical expenses under the EEOICP.*

2. Interest on EEOICP Payments

C. Procedure

Effective July 1, 2004, interest earned on unspent EEOICP payments is excluded from income for SSI purposes.

Use documents the applicant provides to verify the payment is from EEOICP. Accept the individual's signed allegation of the amount and date of receipt if it is not evident from the documents.

If the individual has not documentation or there is reason to question the source of the payments, contact the Department of Labor (DOL). A list of the DOL district offices and telephone numbers can be found on the DOL website at: *http://www.dol.gov/esa/regs/compliance/owcp/eeoicp/main.htm*

S0830.755 RICKY RAY HEMOPHILIA RELIEF FUND PAYMENT

A. Background

On November 12, 1998, the President signed into law the Ricky Ray Hemophilia Relief Fund Act of 1998, P.L. 105-369.

This Act provides for a single payment of $100,000 from the Ricky Ray Hemophilia Relief Fund to:

- *Certain individuals with a blood-clotting disorder who may have contracted an HIV infection from a blood transfusion, and*
- *Certain current and former spouses of these individuals who also contracted an HIV infection, and*
- *Certain children of these individuals who also contracted an HIV infection, and*
- *Certain surviving spouses, children, and parents of the above persons.*

B. Policy

The Act provides for exclusion of payments from the Ricky Ray Hemophilia Relief Fund for Medicaid purposes.

C. Documents

Lump sum payments made under the EEOICP, including reimbursement for medical expenses, are excluded from income for SSI purposes.

NOTE: *Individuals who are eligible under Section 5 of the Radiation Exposure Compensation Program (RECP) may also be eligible for compensation and paid medical expenses under the EEOICP.*

Use documents an applicant provides to verify the payment is from EEOICP. Accept the individual's signed allegation of the amount and date of receipt if it is not evident from the documents.

If the individual has not documentation or there is reason to question the source of the payments, contact the Department of Labor (DOL). A list of the DOL district offices and telephone numbers can be found on the DOL website at: *http://www.dol.gov/esa/regs/compliance/owcp/eeoicp/main.htm*

M0830.760 WALKER V. BAYER SETTLEMENT PAYMENTS

A. Policy

Section 4735 of the Balanced Budget Act of 1997 (P.L. 105-33) states that payments described in this subsection from the settlement of the Susan Walker v. Bayer Corp., et.al., class action lawsuit are NOT counted as income in determining eligibility for Medicaid.

Refer to policy S0830.755.

SPECIAL CONSIDERATIONS FOR NATIVE AMERICANS

S0830.800 BUREAU OF INDIAN AFFAIRS GENERAL ASSISTANCE

A. Definition

Bureau of Indian Affairs General Assistance (BIA GA) is a federally funded program administered by the Bureau of Indian Affairs (BIA) through its local agency or a tribe. The program makes periodic payments to needy Indians.

B. Policy

BIA GA payments are federally funded income based on need and, therefore, count as income. The $20 per month general income exclusion does not apply.

C. Procedure

Develop BIA GA payments using the instructions and development guidelines for AFDC payments in S0830.400 D. except contact the local agency administering the BIA GA program.

M1110 Changes

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

M1110.003 RESOURCE LIMITS

A. Introduction

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

B. Policy Principles

1. Resource Ineligibility

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

2. Resource Limits

ABD Eligible Group	One Person	Two People
Categorically Needy Medically Needy	$2,000	$3,000
ABD with Income ≤ 80% FPL	$2,000	$3,000
QDWI	$4,000	$6,000
QMB SLMB QI	**Calendar Year** ***2018*** *$7,560* **2017** $7,390	**Calendar Year** ***2018*** *$12,840* **2017** $11,090

3. Change in Marital Status

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

4. Reduction of Excess Resources

Month of Application

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

M1120 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-7	1/1/18	Table of Contents i, pages 3, 22a, 30
TN #DMAS-5	7/1/17	Pages 15, 17, 18
TN #DMAS-2	10/1/16	On page 6, updated the format of the header. Neither the date nor the policy was changed.
TN #96	10/1/11	Table of Contents pages 24-26
TN #93	1/1/2010	page 22

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F. Example

1. Situation

Jeff Grant currently works 3 days a week for a company where he has been employed full-time for 20 years. Under his employer's pension plan, Mr. Grant has a $4,000 retirement fund. The EW confirms that Mr. Grant could withdraw the funds now, but there would be a penalty for early withdrawal and he would forfeit eligibility for an annuity when he stopped working.

2. Analysis

Since Mr. Grant can withdraw the retirement funds without terminating employment, they are a resource in the amount available after penalty deduction. This is true despite the fact Mr. Grant forfeits eligibility for periodic annuity payments in the future. All sources of available support (unless otherwise excluded) are considered in determining eligibility.

*M*1120.215 INHERITANCES AND UNPROBATED ESTATES

A. Introduction

Property in the form of an interest in an undivided estate is to be regarded as an asset when the value of the interest plus all other resources exceed the applicable resource limit, unless it is considered unsalable for reasons other than being an undivided estate. An heir can initiate a court action to partition. If a partition suit is necessary (because at least one other owner of or heir to the property will not agree to sell the property) in order for the individual to liquidate the interest, estimated partition costs plus *the individual's (applicant/recipient) attorney fees* may be deducted from the property's value. However, if such an action would result in the applicant/recipient securing title to property having *a* value less than the cost*(s)* of the *partition action,* the property would not be regarded as an asset.

An ownership interest in an unprobated estate may be a resource if an individual:

- is an heir or relative of the deceased; or
- receives any income from the property; or
- under State intestacy laws, has acquired rights in the property due to the death of the deceased.

The procedure for determining the countable value of an unprobated or undivided estate is found in Appendix 1 to subchapter S1130.

B. For QDWI, QMB, SLMB, QI and ABD 80%FPL

The policy for treatment of an unprobated or undivided estate for the QDWI covered group is in Appendix 1 to chapter S11. The policy for treatment of an unprobated or undivided estate for the QMB, SLMB, QI and ABD 80% FPL covered groups is in Appendix 2 to chapter S11.

***C.* Operating Policies**

1. When to Develop

We develop for this type of resource only if:

3. Qualified Income Trusts ("Miller Trusts")

A Qualified Income Trust, referred to as a "QIT, Miller, or Utah Gap" trust is a special irrevocable trust created for individuals with income which some states exempt from being considered as a countable resource for Medicaid eligibility. Virginia ***does not*** *recognize a Qualified Income Trust as an exempt resource for Medicaid eligibility.*

However, the treatment of income transferred to a special needs trust or pooled trust for eligibility purposes is dictated by federal rules for the treatment of such income, thus transfers into a Qualified Income Trust would follow the same conditions. Although this type of trust is not recognized in Virginia, the same rules as found in M1120.202.B.1 and M1120.202.B.2 are equally applicable to this type of trust.

M1120.235 HEALTH AND MEDICAL SAVINGS ACCOUNTS

A. Introduction

The Medicare Prescription Drug, Improvement, and Modernization Act, signed into law on December 8, 2003, created the Health Savings Accounts (HSAs) system. An HSA is a tax-exempt trust or custodial account used to pay for the qualified medical expenses listed in the Internal Revenue Service (IRS) publication 502, of the account beneficiary, spouse, or dependents. HSAs are set up with qualified trustees, which can be banks, insurance companies or any entity already approved by the IRS to be a trustee of individual retirement arrangements (IRAs) or Archer MSAs.

Medical Savings Accounts, also known as MSAs or Archer MSAs, are trust-like accounts set up solely as an IRS-related, tax-exempt financial instrument for medical expense purposes. HSAs superseded MSAs; however, some valid MSAs still exist based on previously existing law.

B. Policy Principles

Generally, HSAs and MSAs are countable resources for Medicaid purposes because individuals may use those funds to pay for expenses unrelated to their medical needs. However, there are some HSAs and MSAs that may not count towards the resource limit. For HSAs and MSAs that are not countable resources, see Medicaid Works M0320.400.D.2.

Unused account funds remain in the account, drawing interest on a tax-favored basis, until needed for future medical expenses or retirement. The resource value of an HSA or MSA is the balance in the account available for withdrawal.

C. Health Savings Accounts

HSAs require individuals to have coverage under a high deductible health plan (HDHP). Although individuals generally use HSAs to pay for qualified medical expenses listed in the IRS publication 502 (Medical and Dental Expenses), individuals may use HSA funds at any time for expenses unrelated to their medical needs.

D. Medical Savings Accounts

Individuals generally use MSAs to pay for qualified medical expenses, as. listed in the IRS publication 502 (Medical and Dental Expenses). Deposits made toward the savings plan may be tax-deductible, and can be used to pay for out-of-pocket medical expense, like paying a premium, satisfying a deductible, covering office visits, paying for prescription drugs, etc.

Distributions from an MSA is not income, however an MSA distribution would be counted as a conversion of a resource.

M1130 Changes

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

The life insurance policy's face value of $1,300 reduces the maximum $3,500 burial fund exclusion by that same amount. Ms. Fisher may have an additional $2,200 in excluded burial funds.

- If Ms. Fisher has another life insurance policy on her life and the total face value of the two policies exceeds $1,500 (the life insurance exclusion does not apply), then the CSV may be excludable under the burial funds exclusion. No burial space exclusion applies per a. above.

2. Irrevocable Assignments

The eligibility worker must review the policy. If it is found the life insurance policy permit*s the* irrevocable assignment of policy proceeds without requiring the irrevocable assignment of ownership, submit a copy of the policy to the Regional *Consultant for review.*

E. Policy--Life Insurance Policy Placed in a Trust

A life insurance company may provide an individual with the option of irrevocably transferring ownership of a revocable life insurance policy that funds a burial contract to a trust established by the company.

1. Treatment of Policy's CSV

If an individual assigns a life insurance policy to a trust the CSV (if any) will not continue to be a countable resource; if

- the individual neither owns nor has the legal right to direct the use of trust assets to meet his or her maintenance needs*;* and
- a *revocable* assigned life insurance policy funds a funeral contract and the policy is placed irrevocably in a trust then the policy’s CSV is not a resource for Medicaid purposes.

2. Treatment Of Dividends

If the policy's CSV is not a resource, assume, absent evidence to the contrary, that any dividends paid on the policy are also not a resource.

3. Individual Retains Right to Change Funeral Firm

Under an irrevocable trust arrangement, the life insurance policy's CSV is not a resource even if the individual retains the right to change the funeral firm that will provide the burial goods and services.

4. Burial Fund Exclusions Offset

A *revocable* assigned life insurance policy placed in an irrevocable life insurance trust is treated the same as a life insurance policy for which the ownership has been irrevocably assigned to fund a burial contract (see C.2 above). This means that the value of the burial funds portion of the contract (IF ANY) reduces the $3,500 burial funds exclusion.

This is the case because the burial funds portion of the contract represents an irrevocable arrangement that is available to meet the individual's burial expenses.

M1130.740 ACHIEVING A BETTER LIFE EXPERIENCE (ABLE) ACCOUNTS

A. Policy

The federal Stephen Beck, Jr. Achieving a Better Life Experience Act (ABLE Act), was enacted by Congress on December 19, 2014 and approved by the Virginia General Assembly and Governor in 2015. An ABLE account is a type of tax-advantaged account that an eligible individual can use to save funds for the disability related expenses of the account's designated beneficiary, who must be blind or disabled by a condition that began before the individual's 26th birthday. Funds retained in these accounts are not considered to be resources for Medicaid.

In Virginia, the *qualified* ABLE program is operated by the Virginia529 program *and can be contacted Toll-Free: 1-844-NOW-ABLE (1-844-669-2253.*

An eligible individual can be the designated beneficiary/account owner of only one ABLE savings trust account, which must be administered by a qualified ABLE program.

The designated beneficiary is the eligible individual who established and owns the ABLE account. To be an eligible individual, he or she must be:

- Eligible for Supplemental Security Income (SSI) based on disability or blindness that began before age 26;
- Entitled to disability insurance benefits, childhood disability benefits, or disabled widow's or widower's benefits based on disability or blindness that began before age 26; or
- Someone who has certified, or whose parent or guardian has certified, that he or she:
    - Has a medically determinable impairment meeting certain statutorily specified criteria; or is blind; and,
    - The disability or blindness occurred before age 26.

NOTE: A certification that someone meets disability requirements for the ABLE program does not replace a disability determination from either SSA or DDS in determining whether someone meets the Medicaid definition of a disabled individual.

Upon the death of the designated beneficiary, the State can seek to recover funds remaining in the ABLE account, after payment of any outstanding qualified disability expenses, to reimburse the State for Medicaid benefits that the designated beneficiary received.

B. Procedures

The *designated beneficiary*, or person acting on the individual's behalf, must provide a copy of the ABLE account documentation for the case record. The documentation should include the designated beneficiary's/account owner's name, address, and the date the ABLE account was established. *The eligibility worker must retain the information in the case record.*

A copy of the account documentation also must be sent to DMAS at the following address:

Department of Medical Assistance Services
Eligibility *& Enrollment Services Division*
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

C. Contributions to an ABLE Account

Third party contributions to an ABLE account are not counted as income or included in total resources of the beneficiary. This includes distributions from special needs or pooled trusts. Earnings on an ABLE account (e.g. interest) are part of the account and to be disregarded in determining Medicaid eligibility.

Income contributed into an ABLE account by the designated beneficiary is counted as available income, and not disregarded.

D. Distributions From an ABLE Account

Distributions from an ABLE account are not included in the designated beneficiary's taxable income or counted as income for eligibility determination as long as used for qualified disability expenses.

Example #1, Step 5:

$12,500.00 Contiguous property assessed value
- 11,037.60 Contiguous property lien amount
$ 1,462.40 Contiguous property equity value

Example #1, Step 6:

The property does not produce any income and is not used to produce goods or services that are essential to the operation of the home.

$ 1,462.40 contiguous property countable value

B. Procedure #2: Joint Ownership, Undivided Estate or Unprobated Estate, one owner subject to lien

Step 1 - Determine the whole property's assessed value, the assessed value of the excluded house and homesite, and determine the balance due on all liens against the property if the Medicaid applicant is subject to the lien(s).

Step 2 - **When a partition suit is necessary to liquidate the property** because at least one owner does not agree to sell the contiguous property**:** Determine the shared partition costs for liquidating the property. Use the average cost of partitioning in the locality where the property is located, based on the **assessed** (not equity) value of the whole property. *Use the average cost of partitioning on property not yet partitioned, otherwise use the actual shared cost to partition.*

If a partition suit is NOT necessary to liquidate the property (all the owners agree to sell it), **do not** subtract any partition costs or attorneys' fees; insert zeros in the formula in place of partition costs and attorney's fees.

Step 3 - Assessed value homesite property
+ $5,000 Exclusion
Excluded property value

Step 4 - Whole property assessed value
- Shared partition costs
Countable assessed value
- Excluded property value
Contiguous property assessed value

Step 5 - Contiguous property assessed value
÷ Whole property assessed value
Portion of whole property value represented by the contiguous property
x Balance due on the lien(s)
Contiguous property lien amount
÷ Number of owner's subject to lien
Applicant's share of contiguous property lien amount

Step 6 - Contiguous property assessed value
÷ Applicant's ownership share
Applicant's share of contiguous property assessed value
- Applicant's share of contiguous property lien amount
Applicant's share contiguous property equity value
- Applicant's attorney fees
Contiguous property countable value

Example #2, Step 6:

$ 53,000.00 Contiguous property assessed value
÷ 3 Applicant's ownership share
17,666.67 Applicant's share of contiguous property assessed value
- 5,300.00 Applicant's share of contiguous property lien amount
12,366.67 Applicant's share contiguous property equity value
- 1,000.00 Applicant's attorney fees
$11,366.67 Contiguous property equity value

Example #2, Step 7:

The property does not produce any income and is not used to produce goods or services that are essential to the operation of the home.
$11,366.67 contiguous property countable value

C. Procedure #3: Re-evaluated homesite, partition required, multiple owners subject to lien

Step 1 - Determine the whole property's assessed value, the assessed value of the excluded house and homesite, and determine the balance due on all liens against the property if the Medicaid applicant is subject to the lien(s). If another owner is subject to the lien, calculate the applicant's share of the lien balance by dividing the lien balance by the number of owner's subject to the lien. The formula will calculate the applicant's share of the lien balance that is against the contiguous property.

Step 2 - **When a partition suit is necessary to liquidate the property:** Determine the shared partition costs for liquidating the property. Use the average cost of partitioning in the locality where the property is located, based on the **assessed** (not equity) value of the whole property. *Use the average cost of partitioning on property not yet partitioned, otherwise use the actual shared cost to partition.*
If a partition suit is NOT necessary to liquidate the property (all the owners agree to sell it), do not subtract any partition costs or attorney's fees; insert zeros in the formula in place of partition costs and attorney's fees.

Step 3 - Assessed value house & homesite property
+ $5,000 exclusion
Excluded property value

Step 4 - Total property assessed value
- Shared partition costs
Countable assessed value
- Excluded property value
Contiguous property assessed value

Step 5 - Contiguous property assessed value
÷ Whole property assessed value
Portion of whole property value represented by the contiguous property
x Balance due on the lien(s)
Contiguous property lien amount
÷ Number of owner's subject to lien
Applicant's share of contiguous property lien amount

M1140 Changes

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TN #DMAS-7	1/1/18	Page 30
TN #DMAS-5	7/1/17	Table of Contents Pages 3-9, 11, 12

M1140.402 MEDICAID QUALIFYING TRUSTS (CREATED PRIOR TO AUGUST 11, 1993)

A. Introduction

A "Medicaid qualifying trust" is a trust, or similar legal device, established (other than by a will) by an individual or an individual's spouse prior to August 11, 1993. Under this trust the individual may be beneficiary to *all/or* part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.

EXCEPTION: A trust or initial trust decree established **prior** to April 7, 1986, solely for the benefit of an *intellectually disabled* individual who resides in an intermediate care facility for the *intellectually disabled* is not "Medicaid Qualifying Trust."

B. Trust Restrictions Not Recognized

The requirements of this section shall apply without regard to:

- whether or not the Medicaid qualifying trust is irrevocable or
- is established for purposes other than to enable a grantor to qualify for Medicaid; or
- whether or not the trustee(s) exercises his discretion to distribute any payments to the individual.

C. Development

1. Countable Value

The **maximum** amount of payments permitted under the terms of a "Medicaid Qualifying Trust" to be distributed to the grantor, **if** the trustee exercised his discretion to the **fullest** extent possible, shall be considered available in determining the grantor's eligibility for Medicaid.

D. Exception

A trust or initial trust decree established prior to April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded is not a "Medicaid Qualifying Trust."

E. References

M1120.200, Trust Property
M1120.201, Trusts Established on or after August 11, 1993.

1340 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-7	1/1/18	Pages 18, 20, 22
TN #100	5/1/15	Pages 4, 5
TN #95	3/1/11	Page 6
TN #94	9/1/10	Page 6
TN #93	1/1/10	Page 18

and which do not have any federal funding or administration. State or local public programs include, but are not limited to:

1. General Relief (GR)

2. Community Service Boards (CSB) services.

3. Department of Behavioral Health and Developmental Services (DBHDS) institutional services.

4. Medical College of Virginia (MCV) and University of Virginia (UVA) clinics and hospitals.

5. *Crime victims compensation* (*Virginia Workers Compensation Commission)*

6. Local "free" clinics funded and administered by local governments that do not charge any fee to any patient for any service.

7. Community Services or Neighborhood Assistance programs.

C. Procedures

1. Worker

a. Inform the applicant that expenses for medical services for which the applicant was legally liable and which were provided, covered, or paid for by a state or local public program will be deducted from the spenddown even though the applicant does not owe anything for the service.

b. The EW must take reasonable measures to determine the public program's payment or coverage of the medical or remedial care service. However, because of application processing time standards, do not delay a spenddown determination because the public program's payment is not verified. Complete the determination without deducting the expense, notify the applicant of the decision and that the public program expense(s) was not used in the determination because verification was not received.

2. Applicant

The applicant is responsible to submit:

- verification that the medical/remedial service was received and that a claim for the incurred expense was submitted, and

- evidence of the public program's amount of payment for the service.

M1340.1200 SPENDDOWN LIABILITY CALCULATION

A. Retroactive Spenddown Budget Period

The procedures for calculating a retroactive spenddown liability for a spenddown budget period follow:

eligibility begins the date the retroactive spenddown was met.

If the individual continues to meet the MN requirements, eligibility continues for the remainder of the retroactive spenddown budget period.

1. Begin Date The coverage begin date is the date the spenddown was met.

2. End Date The end date of Medicaid eligibility is the end date of the retroactive spenddown budget period, if the individual continued to meet the MN requirements throughout the period.

3. Coverage Type Enroll the individual in "Type 2" retroactive coverage. Coverage will automatically end after the coverage period end date.

4. *Aid Category* The *aid category* for the individual is the medically needy (MN) *aid category (AC*) of the individual's MN covered group.

5. Reference See Appendix 1 of this subchapter for further examples of retroactive spenddown budget periods.

B. Prospective Budget Period Enrollment in Medicaid begins the date the spenddown was met - the date withi the prospective budget period that the spenddown liability amount, after deducti incurred expenses, reached zero. When the spenddown is not met, eligibility do not exist.

- When the spenddown is met entirely by old bills or carry-over expenses, eligibility begins the first day of the prospective budget period.
- When the spenddown is met by current payments or by expenses incurred during the prospective budget period, eligibility begins the date the spenddown was met.

If the individual continues to meet the MN requirements, eligibility continues for the remainder of the prospective budget period.

1. Begin Date The coverage begin date is the date the spenddown was met.

2. End Date The end date of coverage is the end date of the prospective budget period, if the individual continues to meet the MN requirements throughout the prospective budget period.

3. Coverage Type Enroll the individual in the appropriate coverage type.

4. *Aid Category* The *aid category* for the individual is the medically needy (MN) *aid category (AC)* of the individual's MN covered group.

Her income is projected from her $550 per month June SSA disability check. The budget period is June 1 through November 30; the income limit is $1,300. Her spenddown liability is $1,880.

$ 550	SSA disability
- 20	general income exclusion
530	countable income
x 6	months
3,180	countable income for subsequent budget period
- 1,300	MNIL for subsequent budget period Group I *(using June 2000 figures)*
$ 1,880	spenddown liability June 1 - November 30

The current budget period based on her re-application abuts her previous spenddown budget period. It is a consecutive budget period because she established eligibility in the preceding budget period and, therefore, the $1,300 balance owed on the old bill and the carry-over September expenses are deducted from her current spenddown liability. She owes a total of $2,800 on these expenses as of June 1. Her eligibility is calculated:

$ 1,880	spenddown liability June 1 - November 30
- 1,300	old bill balance from August dental bill
580	spenddown liability after deducting dental bill
- 580	September carry-over expense; balance of $920 remains
$ 0	spenddown balance on June 1

NOTE: The non-covered dental expense and the physician's bill meet the definition of an old bill. The remaining balance of the carry-over expense can be used in a consecutive budget period if still owed.

Because the spenddown was met on June 1, Ms. Sub is enrolled in Medicaid for the period June 1 through November 30, eligibility *Aid Category 058.*

E. Reference

See Appendix 1 to this subchapter for further examples of spenddown budget periods.

M1350 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-7	1/1/18	Pages 11,12
TN #96	10/1/11	pages 7, 8

The worker recalculates the spenddown liability:

$1,455.00	monthly countable income
x 4	months
5,820.00	countable income for the spenddown budget period
- 866.68	1 person MNIL Group I for 4 months spenddown budget period
$4953.32	spenddown liability for spenddown budget period June 1 - September 30

The worker verified $500 incurred expenses on July 8 and $245 on August 4. The spenddown liability was not met. A liability balance of $4,208.32 remains for the prorated spenddown budget period.

The worker notifies Mr. H that he did not meet his spenddown for the spenddown budget period June 1 through September 30, of the MDU determination that he is no longer disabled and that he does not meet another Medicaid covered group. The notice states:

- You are not eligible for Medicaid for the months of June through September 30 because of excess income. Your spenddown liability is $4,953.32. You have incurred $745 in expenses, leaving a balance of $4,208.32. You have not met the spenddown.

- You are not eligible for Medicaid for the month of October 1999 because the MDU determined that you are no longer disabled. You do not meet another Medicaid covered group as of October 1. Should your condition worsen, it is necessary for you to reapply if you want your Medicaid eligibility determined again.

M1350.700 CHANGE OF COVERED GROUP

A. Policy

An individual is entitled to Medicaid in a new classification effective the first day of the month in which he meets that new classification.

1. Assistance Unit of One

The spenddown budget period changes and the spenddown is recalculated when an individual who is an assistance unit of one person becomes eligible for Medicaid in a non-medically needy covered group.

The individual remains on a spenddown for the month(s) before the change in classification.

When an individual is institutionalized, his covered group classification changes to CN *(Categorically Needy)* if his gross income is within the 300% SSI income limit. If his gross income exceeds the 300% SSI limit, he remains medically needy and his classification does not change. However, his spenddown budget period and spenddown liability must be changed. See section M1350.800 below.

EXAMPLE #7 (Using June 2000 figures): A disabled, single man living in Group I receives worker's compensation of $600 per month. He applies for Medicaid on June 10. The Medicaid Disability Unit determines him disabled. Disability onset was prior to March 1 of that year. His total monthly countable income was and is $600. The MNIL is $1,300. He did not incur any medical bills during the retroactive period. He does not have any old bills. The first prospective budget period is June through November. His spenddown liability is $2,180.

$ 600	income per month
- 20	general income exclusion
580	monthly countable income
x 6	months
3,480	countable income for the spenddown budget period
-1,300	1person MNIL Group I for spenddown budget period
$2,180	spenddown liability for spenddown budget period June 1 - November 30

His application is denied. He is placed on a spenddown for the first prospective budget period. On September 20, he requests re-evaluation of his spenddown due to his receipt of $512 per month SSI effective September. His worker's compensation income ended August 31. He incurred $1,000 in medical bills during July. He is eligible for Medicaid as categorically needy beginning September 1.

His spenddown budget period is prorated to June - August (3 months). His spenddown liability for the prorated spenddown budget period is recalculated:

$ 580	countable income for June - August
x 3	months
1,740	countable income for prorated spenddown budget period June - August
- 650	1 person MNIL Group I for 3 months
$1,090	spenddown liability for spenddown budget period June 1 - August 31

He incurred $1,100 worth of medical bills on July 15. He met his spenddown on that date. He is eligible effective July 15 - August 31 as medically needy, *Aid Category 0*58. Effective September 1, he is eligible as categorically needy, *Aid Category 0*51.

2. Assistance Unit of Two or More

When the entire assistance unit's classification changes, the spenddown budget period changes and the spenddown liability is recalculated. Eligible family members are entitled to Medicaid in the new classification effective the first day of the month in which they meet that new classification. They

M1410 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-7	1/1/18	Page 7
TN #DMAS-5	7/1/17	Pages 4-7
TN #DMAS-3	1/1/17	Pages 6, 7, 12-14
TN #DMAS-1	6/1/16	Pages 12-14
TN #100	5/1/15	Page 2
TN #99	1/1/14	Page 10
Update #7	7/1/12	Pages 6, 7
TN #96	10/1/11	Page 11, 12
TN #95	3/1/11	Pages 13, 14 Page 15 was removed.
TN #94	9/1/10	Pages 6, 7, 13
TN #93	1/1/10	Pages 1, 7, 9, 12
TN #91	5/15/09	Pages 11-14

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

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

7. Alzheimer's Assisted Living Waiver

The Alzheimer's Assisted Living (AAL) Waiver is available only to individuals who are Auxiliary Grants (AG) recipients, have a diagnosis of Alzheimer's Disease or a related dementia, no diagnosis of mental illness or i*ntellectual disabilities*, and who are age 55 or older. The AAL Waiver allows for the provision of services to individuals in approved assisted living facilities who, without the waiver, might require nursing home placement.

Individuals in this waiver do not have Medicaid eligibility determined as institutionalized individuals, and there are no post-eligibility requirements.

The services provided under the AAL waiver include:

- assistance with activities of daily living
- medication administration by licensed professionals.

M1420 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-7	1/1/18	Table of Contents Pages 2, 5. Appendix 2.
TN #DMAS-5	7/1/17	Pages 2-6
TN #DMAS-1	1/1/17	Table of Contents Pages 3-6 Appendix 3 Appendices 4 and 5 were removed.
TN #DMAS-1	6/1/16	Pages 3-5 Page 6 is a runover page. Appendix 3, page 1
TN #99	1/1/14	Page 4
UP#7	7/1/12	Pages 3, 4
TN #94	09/01/10	Table of Contents Pages 3-5 Appendix 3
TN #93	01/01/10	Pages 2, 3, 5 Appendix 3, page 1 Appendix 4, page 1

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LONG-TERM CARE

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Forms

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M1420.200 RESPONSIBILITY FOR PRE-ADMISSION SCREENING

A. Introduction

In order to qualify for Medicaid payment of LTC services, an individual must be determined to meet both functional and medical components of the level of care criteria through the pre-admission screening process. The pre-admission screening is completed by a designated screening team or committee. The screening team or committee that completes the pre-admission screening depends on the type(s) of services needed by the individual. Below is a listing of the types of LTC services an individual may receive and the committees/teams responsible for completion of the pre-admission screening certification for those services.

B. Nursing Facility Screening

This evaluation is completed by local teams composed of agencies contracting with the Department of Medical Assistance Services (DMAS) or by staff of acute care hospitals.

The local committees usually consist of the local health department director, a local health department nurse, and a local social services department service worker.

Patients placed directly from acute care hospitals are usually screened by hospital screening teams.

A state level committee is used for patients being discharged from State Department of Behavioral Health and Developmental Services (DBHDS) institutions for the treatment of mental illness and *intellectual disability.*

Patients in a Veterans Administration Medical Center (VAMC) who are applying to enter a nursing facility are assessed by VAMC staff. VAMC discharge planning staff use their own Veterans' Administration assessment form, which serves as the pre-admission screening certification.

C. CBC Screening

Entities other than hospital or local health committees are authorized to screen individuals for CBC. The following entities are authorized to screen patients for Medicaid CBC:

1. Commonwealth Coordinated Care Plus Waiver

Effective July 1, 2017, the Elderly or Disabled with Consumer-Direction (EDCD) Waiver and the Technology Assisted (Tech) Waiver were combined and are known as the Commonwealth Coordinated Care Plus (CCC Plus) Waiver. Local and hospital screening committees or teams are authorized to screen individuals for the CCC Plus Waiver. The screening and authorization processes were not changed. See M1420.400 C.

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

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

- Copy of the authorization screen from the Waiver Authorization System (WaMS) (see Appendix 3). A Copy of the authorization screen from the Intellectual Disability On-line System (IDOLS) is also acceptable.

Medicaid payment for CBC services cannot begin prior to the date the screener's certification form is signed and prior authorization of services for the individual has been given to the provider by DMAS or its contractor.

1. Nursing Facility/PACE

Individuals who require care in a nursing facility or elect PACE will have a DMAS-96 signed and dated by the screener and the supervising physician or the equivalent information printed from the PAS system.

The "Medicaid Authorization" section will have a number in the box that matches one of the numbers listed under the "Pre-admission Screening" section. These numbers indicate which of these programs was authorized. Medicaid payment of PACE services cannot begin prior to the date the DMAS-96 is signed and dated by the supervising physician and prior-authorization of services for the individual has been given to the provider by DMAS.

2. CCC Plus Waiver

Individuals screened and approved for the CCC Plus Waiver must have a DMAS-96 signed and dated by the screener and the physician or the equivalent information printed from the PAS system.

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

Individuals screened and approved for technology-assisted services will have either a DMAS-96 signed and dated by the screener and physician or the equivalent information printed from the PAS system; or a Technology Assisted Waiver Level of Care Eligibility Form signed and dated by a DMAS representative.

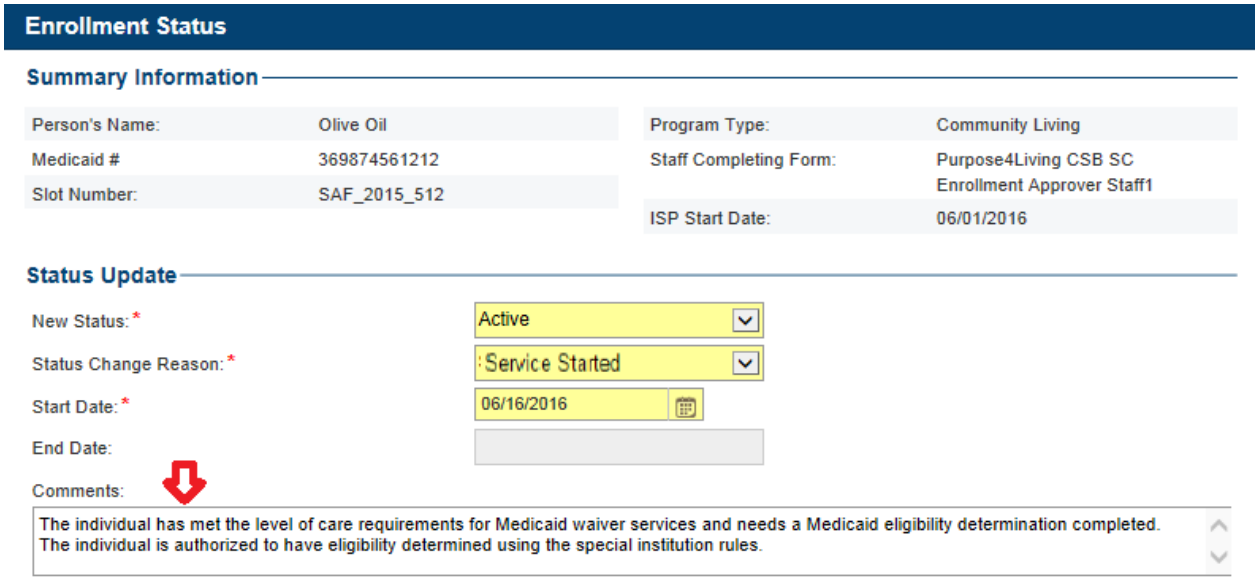
3. Community Living Waiver Authorization Screen Print

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

4. Building Independence Waiver Level of Authorization Screen Print

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

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



Enrollment Status

Summary Information

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

Status Update

New Status:*	Active
Status Change Reason:*	Service Started
Start Date:*	06/16/2016
End Date:	

Comments:

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

Note: Continue to accept the existing IDOLS screen print until DBHDS/CSB staff transitions to using WaMS.

M1430 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-7	1/1/18	Pages 1-2,4, Appendix 1.
TN #93	1/1/10	Appendix 1, page 1
Update (UP) #1	7/1/09	Appendix 1, page 1

M1430.000 FACILITY CARE

A. Introduction

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

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

B. Definitions

Definitions for terms used when policy is addressing types of long-term care (LTC), institutionalization, and individuals who are receiving that care are found in Subchapter M1410.

M1430.010 TYPES OF FACILITIES & CARE

A. Introduction

This section contains descriptions of the types of medical facilities in which Medicaid provides payment for services received by eligible patients.

B. Medical Facility Defined

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

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

C. Types of Medical Facilities

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

1. Chronic Disease Hospitals

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

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

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

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

- is primarily for the diagnosis, treatment or rehabilitation of individuals with *intellectual disabilities* or related conditions, and

- provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or rehabilitative services to help each individual function at his greatest ability.

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

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

3. Institutions for Treatment of Mental Diseases (IMDs)

An **IMD** is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, of persons with mental diseases. An institution *for those intellectually disabled* is NOT an IMD.

NOTE: Medically needy (MN) patients over 65 years of age are not eligible for Medicaid payment of LTC services in an IMD because these services are not covered for medically needy individuals age 65 or over. For a list of IMDs in Virginia, see Appendix 1 to this subchapter.

NOTE: Any individual over age 21 but under age 65 who is in an IMD is not eligible for Medicaid while residing in the IMD.

4. Nursing Facility

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

5. Rehabilitation Hospitals

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

M1430.101 VIRGINIA RESIDENCE

A. Policy

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

B. Individual Age 21 or Older

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

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

1. Determining Incapacity to Declare Intent

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

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

2. Became Incapable Before Age 21

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

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

List of *Institutions for Treatment of Mental Diseases* (IMDs*) i*n Virginia

Catawba Hospital
5525 Catawba Hospital Drive
Catawba, VA 24070-2006

Central State Hospital
P.O. Box 4030
Petersburg, VA 23803-*0030*
(NOTE: Hiram Davis Medical Center is not an IMD)

Commonwealth Center for Children and Adolescents
P.O. Box 4000
Staunton, VA 24402-4000

Eastern State Hospital
4601 Ironbound Road
Williamsburg, VA 23188-2652

Northern Virginia Mental Health Institute
3302 Gallows Road
Falls Church, VA 22042-3398

Piedmont Geriatric Hospital
P.O. Box 427
Burkeville, VA 23922-0427

Southern Virginia Mental Health Institute
382 Taylor Drive
Danville, VA 24541-4023

Southwestern VA Mental Health Institute
340 Bagley Circle
Marion, VA 24354-3126

Western State Hospital
P.O. Box 2500
Staunton, VA 2440*2-2500*

1440 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-7	1/1/18	Page 1. Appendix 1, Page 4.
TN #DMAS-5	7/1/17	Table of Contents Pages 3-9, 11, 12
TN #DMAS-3	1/1/17	Table of Contents Pages 3-12 Appendix 1 was added. Page 2 is a runover page. Pages 13-23 were deleted.
UP #9	4/1/13	Page 5
Update (UP) #7	7/1/12	Table of Contents Pages 2, 14, 15, 18a-18c Pages 19, 20
TN #94	9/1/2010	Table of Contents Pages 13, 16, 18b, 19-22
TN #93	1/1/2010	Pages 14, 16
TN #91	5/15/2009	Table of Contents Page 12 Pages 17-18c

M1440.000 COMMUNITY-BASED CARE WAIVER SERVICES

M1440.001 GOVERNING LAWS

A. Introduction

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

B. Community-Based Care Waiver Services (CBC)

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

C. Federal Law

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

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

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

D. Virginia's Waivers

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

	BI	FI	CL	Description
Additional Options				
Assistive Technology	✓	✓	✓	Assistive technology is specialized medical equipment, supplies, devices, controls, and appliances, not available under the State Plan for Medical Assistance, which enable individuals to increase their abilities to perform activities of daily living (ADLs), or to perceive, control, or communicate with the environment in which they live, or which are necessary for life support, including the ancillary supplies and equipment necessary to the proper functioning of such technology.
Electronic Home-Based Services	✓	✓	✓	Electronic Home-Based Services are goods and services based on Smart Home© technology. This includes purchases of electronic devices, software, services, and supplies not otherwise provided through this waiver or through the State Plan, that would allow individuals to access technology that can be used in the individual's residence to support greater independence and self-determination.).
Environmental Modifications	✓	✓	✓	Environmental modifications physical adaptations to the individual's primary home, primary vehicle, or work site that are necessary to ensure the health and welfare of the individual, or that enable the individual to function with greater independence.
Individual and Family/Caregiver Training		✓		Training and counseling to individuals, families and caregivers to improve supports or educate the individual to gain a better understanding of his/her disability or increase his/her self-determination/self-advocacy abilities.
Transition Services	✓	✓	✓	Transition services are nonrecurring set-up expenses for individuals who are transitioning from an institution or licensed or certified provider- operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

M1450 Changes

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

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

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

H. Legally Binding Contract

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

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

***1.* Parties Legally Competent**

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

***2.* Valuable Consideration**

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

***3.* Definite Contract Terms**

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

***4.* Mutual Assent**

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

I. Look-Back Date

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

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

M1450.570 SERVICES CONTRACTS

A. Policy

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

B. Procedures

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

***1.* Determine Institutionalization**

Determine when the individual met the requirement for institutionalization.

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

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

***3.* Contract Services**

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

***4.* Physician Statement Required**

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

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

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

***1.* Penalty Periods Cannot Overlap**

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

***2.* Nursing Facility**

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

***3.* CBC, PACE, Hospice**

a. Transfer Reported at Application

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

b. Transfer Reported After Eligibility is Established

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

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

4. Penalty Period imposed by another state

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

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

C. Penalty Period Calculation

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

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

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

Average Monthly Private Nursing Facility Cost

Application Date	Northern Virginia*	All Other Localities
1-1-15 and after	$8,367	$5,933 (no change)
1-1-11 to 12-31-14	$7,734	$5,933

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

See M1450, Appendix 1 for amounts prior to January 1, 2011.

E. Partial Month Transfer

The following example shows how to compute a penalty period for an uncompensated transfer that occurred on or after February 8, 2014 and involving a partial month.

Example #19: *An individual from Norfolk (located outside of Northern Virginia) makes an uncompensated asset transfer of $44,534 in April 2016, the same month he applies for Medicaid. The uncompensated value of $44,534 is divided by the average monthly rate of $5,933 and equals 7.51 months. The full 7-month penalty period runs from April 2016, the month of the transfer, through October 2016, with a partial penalty calculated for November 2016. The partial month penalty is calculated by dividing the partial month penalty remaining amount ($3,003) by the daily rate. The calculations are as follows:*

Step #1	*$ 44,534.00*	*uncompensated value of transferred asset*
	÷ 5,933.00	*avg. monthly nursing facility rate (at time of application*
	= 7.51	*penalty period (7 full months, plus a partial month)*
Step #2	*$ 5,933.00*	*avg. monthly nursing facility rate (at time of application)*
	X 7	*seven (full) month penalty period*
	$ 41,531.00	*penalty amount for seven full months*
Step #3	*$ 44,534.00*	*uncompensated value*
	- $ 41,531.00	*penalty amount for seven full months*
	$ 3,003.00	*remainder = partial month penalty amount*
Step #4	*$3,003.00*	*partial penalty amount*
	÷ 191.30	*daily rate ($5,933 ÷ 31)*
	= 15.69	*number of days for partial month penalty*

The eligibility worker must send a letter to the individual informing him of each asset transfer and the corresponding penalty period, as well as the right to claim an undue hardship. An Asset Transfer Undue Hardship Claim form, available on the VDSS local agency intranet at *http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi* must be included with the letter. The Asset Transfer Undue Hardship Claim Form serves as the request for an undue hardship evaluation.

a. Undue Hardship Claimed - Required Documentation

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

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

b. 10 Days to Return Undue Hardship Claim

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

c. Documentation for DMAS

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

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

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

Send the documentation to DMAS at the following address:

DMAS, Division of Policy and Research
Eligibility and Enrollment Services Division
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

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

d. When Applicant/Recipient Was Victim

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

e. Undue Hardship Not Claimed or Not Granted by DMAS

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

2. DMAS

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

3. Subsequent Claims

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

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

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

Application Date	*Average Monthly Cost*	
	*Northern Virginia**	*All Other Localities*
10-1-97 to 12-31-99	*$3,315*	*$2,585*
1-1-00 to 12-31-00	*$3,275*	*$2,596*
1-1-01 to 12-31-01	*$4,502*	*$3,376*
1-1-02 to 12-31-03	*$4,684*	*$3,517*
1-1-04 to 9-30-07	*$5,403*	*$4,060*
10-1-07 to 12-31-10	*$6,654*	*$4,954*

(Figures Provided by Virginia Health Information)

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

M1460 Changes

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

10. Old Bills

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

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

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

11. Projected Expenses

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

12. Spenddown Liability

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

M1460.150 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LTC

A. Applicability

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

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

B. Policy

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

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

Individuals with substantial home equity may be eligible for Medicaid payment of other covered services if they meet all the other Medicaid eligibility requirements.

***1.* Home Equity Limit**

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

- Effective January 1, 2012: $525,000.
- Effective January 1, 2013: $536,000
- Effective January 1, 2014: $543,000
- Effective January 1, 2016: $552,000
- Effective January 1, 2017: $560,000
- *Effective January 1, 2018: $572,000*

M1460.201 SSI RECIPIENTS

A. Introduction

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

1. Medicaid CBC

An SSI recipient who receives Medicaid CBC waiver services in his community residence usually continues to receive SSI with no change. If a recipient moves to another person's home to receive Medicaid CBC, his SSI payment may be affected. When a Medicaid SSI recipient begins receiving Medicaid CBC waiver services, asset transfer and resource eligibility must be evaluated. As long as the individual receives SSI, he is categorically needy if he meets the Medicaid nonfinancial and resource eligibility rules.

2. Facility

SSI recipients in nursing facilities are subject to the reduced SSI benefit rate of $30 for their personal needs. If they have other countable income that exceeds $30, their SSI will be canceled. SSI recipients may continue to receive their regular monthly SSI benefit for 3 months if they are considered temporarily institutionalized. Individuals who receive SSI after admission to a facility are categorically needy if they meet the Medicaid nonfinancial and resource eligibility rules.

B. Policy

1. Nonfinancial

Evaluate the non-financial Medicaid eligibility rules in section M1410.020. An SSI recipient meets an ABD covered group.

2. Asset Transfer

Determine if the recipient meets the asset transfer policy in subchapter M1450.

3. Resources

a. Determine Countable Resources

Determine if the SSI recipient has the following real property resource(s):

1) equity in non-exempt property contiguous to his home which exceeds $5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;

2) interest in undivided heir property and the equity value of the individual's share that, when added to all other countable resources, exceeds the appropriate Medicaid resource limit. (The interest in the

M1470 Changes

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

M1470.410 MEDICAID CBC - PERSONAL MAINTENANCE ALLOWANCE

A. Individuals

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

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

1. Basic Maintenance Allowance

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

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

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

The PMA is:

- *January 1, 2018 through December 31, 2018: $1,238*
- January 1, 2017 through December 31, 2017: $1,213

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

2. Guardianship Fee

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

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

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

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

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

a. for individuals employed 20 hours or more per week, all earned income up to 300% of SSI ($*2,250* in *2018*) per month.

b. for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI ($*1,500* in *2018*) per month.

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

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

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

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

B. Couples

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

M1470.420 DEPENDENT CHILD ALLOWANCE

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

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

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

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

Retrospective spenddown eligibility determinations are made monthly after the month has passed and the expenses have actually been incurred. The PACE rate (minus the Medicare Part D premium) along with other allowable medical and dental expenses are deducted daily and chronologically as the expenses are incurred. The individual's income and resources must be verified each month before determining if the spenddown has been met. See M1470.520 for allowable medical deductions.

When incurred medical expenses equal or exceed the monthly spenddown liability, the individual is eligible for the full month of Medicaid coverage beginning the first day of the month and ending the last day of the month.

4. Patient Pay

a. Projected Spenddown Eligibility Determinations

Medicaid must assure that enough of the individual's income is allowed so that he can have a personal maintenance allowance. Therefore, the spenddown liability is NOT subtracted from his gross income nor added to the available income for patient pay.

Subtract the allowances listed in M1470.400 from gross monthly income, as applicable. Compare the remaining income for patient pay to the monthly PACE rate (minus the Medicare Part D premium) for the month. The patient pay is the lesser of the two amounts.

b. Retrospective Spenddown Eligibility Determinations

Because the spenddown eligibility determination is completed after the month in which the PACE services were received and expenses are not projected, the spenddown liability is NOT added to the available income for patient pay. Follow the instructions in M1470.630 for calculating the spenddown and patient pay when the spenddown liability exceeds the monthly PACE rate (minus the Medicare Part D premium).

M1470.800 COMMUNICATION BETWEEN LOCAL DSS AND LTC PROVIDER

A. Introduction

Certain information related to the individual's eligibility for and receipt of Medicaid LTC services must be communicated between the local agency and the LTC provider. The Medicaid LTC Communication Form (form DMAS-225) is used by both the local agency & LTC providers to exchange information.

B. Purpose

Eligibility workers should generate the DMAS-225 through VaCMS. If unable to generate the DMAS-225 form, it is available at: *https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderFormsSearch*.

The form is used to:

- notify the LTC provider of a patient's Medicaid eligibility status;
- notify a new provider that the patient pay is available through the verification systems;
- reflect changes in the patient's deductions, such as a medical expense allowance;
- *document death of an individual;*

- *document admission or discharge of a patient to an institution or community-based care services;*
- provide information on health insurance, LTC insurance or VA contract coverage, and
- provide other information unknown to the provider that might cause a change in eligibility status or patient pay amount.

Do not use the DMAS-225 to relay the patient pay amount. Providers are responsible for obtaining patient pay information from the ARS/MediCall verification systems.

C. When to Complete the DMAS-225

Complete the DMAS-225 at the time of eligibility determination and/or the recipient's entry into LTC. Complete a new DMAS-225 when the recipient's eligibility status changes, such as when the recipient's Medicaid coverage is canceled or changed to limited QMB or SLMB coverage, or when the LTC provider changes.

Additionally, complete a DMAS-225 for an ongoing enrollee whose patient pay has been initially transitioned into MMIS to notify the provider that the patient pay information is available through ARS/MediCall.

D. Where to Send the DMAS-225

Refer to M1410.300 B.3.b to determine where to send the form. *The worker must complete, send, and <u>return the form timely</u>.*

M1470.900 ADJUSTMENTS AND CHANGES

A. Policy

The Medicaid recipient or his authorized representative is responsible to report any changes in his or her situation within 10 days of the day the change is known. In situations where the patient pay amount is less than the Medicaid rate the patient pay must be adjusted within 30 days of notification or discovery of the change. This section contains the procedures for when and how to adjust patient pay.

There are situations when the EW **cannot increase** the patient pay, such as when the current patient pay amount equals the Medicaid rate for the month. In this situation, an adjustment that results in an increase in patient pay cannot be made and a referral to the DMAS Recipient Audit Unit (RAU) must be completed following the procedures in M1470.900 D.3.c.1) below.

B. Action When A Change Is Reported

Upon receipt of notice that a change in an enrollee's income or deductions has occurred, the EW must evaluate continued income eligibility (see subchapter M1460). If eligibility no longer exists, follow the procedures for LTC medically needy income and spenddown (see M1460.700). If eligibility continues to exist, the EW must:

1. Recalculate the patient pay.

2. If the patient pay remains the same, send written notification to the person handling the patient's income that the patient pay is unchanged.

3. If the patient pay decreases, follow the instructions found in Item C. below. If the patient pay increases, follow the instructions found in Item D. below.

M1480 Changes

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

2. After Eligibility is Established

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

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

M1480.231 SPOUSAL RESOURCE STANDARDS

A. Introduction

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

B. Spousal Resource Standard	*$24,720*	*1-1-18*
	$24,180	1-1-17
C. Maximum Spousal Resource Standard	*$123,600*	*1-1-18*
	$120,900	1-1-17

M1480.232 INITIAL ELIGIBILITY DETERMINATION PERIOD

A. Policy

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

After eligibility is established, the usual reporting and notification processes apply. Send written notice for the month(s) during which the individual establishes Medicaid eligibility. VaCMS will generate the "Notice of 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	$2030.00	7-1-17	
	$2002.50	7-1-16	
C. Maximum Monthly Maintenance Needs Allowance	*$3,090.00*	*1-1-18*	
	$3,022.00	1-1-17	
D. Excess Shelter Standard	$609.00	7-1-17	
	$600.75	7-1-16	
E. Utility Standard Deduction (SNAP)	*$306.00*	1 - 3 household members	*10-1-17*
	$381.00	4 or more household members	*10-1-17*
	$287.00	1 - 3 household members	10-1-16
	$357.00	4 or more household members	10-1-16

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).

M1520 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-7	1/1/18	Pages 2, 3, 3a, 5, 6, 7 Pages 6a and 7a are runover pages.
TN #DMAS-5	7/1/17	Pages 1, 2, 6, 8 Pages 3, 7, 7a and 9 are runover pages.
TN #DMAS-4	4/1/17	Pages 25-27 Appendix 2, page 1 Pages 28-30 were added.
TN #DMAS-3	1/1/17	Pages 1, 2, 4, 6, 7, 8, 14, 26
TN #DMAS-2	10/1/16	Pages 1, 3, 6, 8, 12, 14, 15 Pages 19-24
TN #DMAS-1	6/1/16	Pages 3, 6, 7, 9, 11-14, 17 Appendix 2, page 1 Pages 3a and 7a were added. Page 8 is a runover page.
TN #100	5/1/15	Table of Contents Pages 1-27 (entire subchapter –pages 28-34 were deleted) Appendices 1 and 2 were added.
TN #99	1/1/14	Table of Contents Pages 1-34 (entire subchapter)
UP #9	4/1/13	Pages 7b and 10a
TN #97	9/1/12	Page 1
UP #7	7/1/12	Pages 1, 7, 7c, 7g
TN #96	10/1/11	Table of Contents Pages 1-7g Pages 11-13 Pages 21-24
TN #95	3/1/11	Pages 6a, 7, 21, 22
TN #94	9/1/10	Table of Contents Pages 3, 4b, 5, 6-6a, 10 Appendix 1 was removed.
UP #4	7/1/10	Page 4
TN #93	1/1/10	Pages 3, 4b, 5-6, 10, 15 Pages 21, 22
Update (UP) #2	8/24/09	Pages 1, 2, 13, 14, 17, 18
Update (UP) #1	7/01/09	Page 3

M1520.100 PARTIAL REVIEW

A. Enrollee's Responsibility

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

B. Eligibility Worker's Responsibility

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

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

1. Changes That Require Partial Review of Eligibility

When changes in an enrollee's situation are reported by the enrollee or when the agency receives information indicating a change in an enrollee's circumstances (i.e. Supplemental Security Income [SSI] purge list, reported transfer of assets), the worker must take action to partially review the enrollee's continued eligibility. *A* reported change must be verified when it causes the individual to move from a limited-benefit covered group to a full-benefit covered group *or causes an adverse action to eligibility.*

A reported decrease in income or termination of employment must be verified when the change in income causes the individual to move from a limited-benefit covered group *to another limited-benefit covered group, or to a* full-benefit covered group. For terminated employment, verify the date of termination and the date the last paycheck was received.

A reported increase in income and/or resources can be acted on without requiring verification, unless the *increase* causes the individual from Medicaid to FAMIS.

2. Changes That Do Not Require Partial Review

When changes in an enrollee's situation are reported or discovered, such as the enrollee's Social Security number (SSN) and card have been received, the worker must document the change in the case record and take action appropriate to the reported change in the appropriate computer system(s).

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

3. HIPP

The eligibility worker must provide the enrollee with a copy of the HIPP FACT Sheet when it is reported that he or a family member is employed more than 30 hours per week and is eligible for coverage under an employer's group health plan. The HIPP Fact Sheet is available on-line at: http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi. The eligibility worker must report to the HIPP Unit at DMAS any changes in an enrollee's situation

that may affect the premium payment. The worker may report changes by e-mail to hipp@dmas.virginia.gov. This e-mail address is for use by the local agency staff only. See M0130.200 G for additional information about HIPP requirements.

4. Program Integrity

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

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

C. Covered Group and Aid Category Changes

1. Enrollee's Situation Changes

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

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

***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, the child's AC *must* change to AC 094 no later than at the next renewal.

D. Child Moves From Parental Home

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

1. Case Management

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

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

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

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

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

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

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

For an SSI recipient who has no community spouse and owns no countable real property, verify continued receipt of SSI through SOLQ-I or SVES, obtain information regarding asset transfer from the enrollee or authorized representative, and document the case record. As long as the individual continues to receive SSI, do not change the AC. (*See M0320.101.C)* . If the individual loses SSI, evaluate his Medicaid eligibility in other covered groups. See M1430.103 for additional information regarding an SSI recipient who enters a nursing facility.

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

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

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

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

M1520.200 RENEWAL REQUIREMENTS

A. Policy

The agency must evaluate the eligibility of all MA enrollees, with respect to circumstances that may change, at least every 12 months. Each renewal must be authorized by an eligibility worker or supervisor, although administrative staff may assist in the gathering of information such as date of birth and SSN, is not required at renewal, unless it has not been verified previously.

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, including the Virginia Employment Commission (VEC), 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. T**he renewal must be signed by the enrollee or authorized representative.**

Continuing blindness and disability must be verified at the time of each annual renewal. For individuals receiving Supplemental Security Income (SSI) and Social Security Disability Insurance, the State Online Query-Internet (SOLQ-I) or the State Verification and Exchange System (SVES) may be used. The printout must be scanned into the case record. For individuals determined blind or disabled for Medicaid by the Disability Determination Services (DDS) interface with VaCMS, blindness and disability are considered continuing unless DDS has notified the LDSS that the individual is no longer blind or disabled.

At the time of each renewal, the most recent report from the Public Assistance Reporting Information System (PARIS) must be reviewed and the search documented in the case record to determine if the enrollee is receiving Medicaid in another state. Reference M1510.100.

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. It is crucial that individuals reviewing a case, including auditors, be able to follow the eligibility determination process in VaCMS. Changes and any questionable information must be appropriately documented as comments in the VaCMS case record.

For 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 or within 30 calendar days from the receipt of the renewal, whichever is later. The first 12-month period begins with the month of application for Medicaid.

B. Renewal Procedures Renewals may be completed in *one of* the following ways:

- ex parte,
- using a paper form,
- online,
- telephonically by calling 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.

a. MAGI-based Cases

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

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

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

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

b. $0 Income Reported

When the household members reported $0 income at application, search the VEC online quarterly wage data and unemployment records and other agency records to verify the absence of income. If an individual receives benefits through other benefit programs and/ or childcare, income information in those records must also be reviewed.

If the VEC inquiry and review of other agency records confirms that the household has not received wages, unemployment compensation, or other unearned income within the most recent reporting period, document the absence of verifiable income and determine (or redetermine) income eligibility.

No statement regarding income is necessary from the individual.

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

c. SSI Medicaid Enrollees

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

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

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

d. Continuing Eligibility Not Established Through Ex Parte Process

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

M1550 Transmittal Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-7	1/1/18	Page 1 Appendix 1, page 1.
TN #DMAS-4	4/1/17	Appendix 1,page 1
TN #DMAS-3	1/1/17	Pages 4-6, 8, 9
TN #100	5/1/15	Appendix 1,page 1
UP #9	4/1/13	Appendix 1, page 1
Update (UP) #7	7/1/12	Appendix 1, page 1
TN #96	10/1/11	Appendix 1, page 1
TN #93	1/1/10	Title page Table of Contents Pages 1-9 Appendix 1, page 1
TN #91	5/15/09	Appendix 1

M1550.000 DBHDS FACILITIES

M1550.100 GENERAL PRINCIPLES

A. Introduction

The Department of Social Services' Division of Benefit Programs has eligibility workers, called Medicaid Technicians, located in Department of Behavioral Health and Developmental Services (DBHDS) facilities to determine the patients' eligibility for Medicaid. The Medicaid Technicians function like a local department of social services (LDSS) agency. Medicaid cases may be transferred to and from the Medicaid Technicians.

B. Procedures

This subchapter contains a list and a brief description of the DBHDS facilities (M1550.200), a directory of the Medicaid Technicians (M1550.300, and procedures for handling cases of Medicaid applicants/recipients admitted to or discharged from a DBHDS facility (M1550.400).

M1550.200 DBHDS FACILITIES

A. Introduction

Three types of medical facilities are administered by DBHDS: training centers, psychiatric hospitals, and a general hospital with nursing facility beds. Below is a brief description of each type of facility.

1. Training Centers

Training centers are medical facilities for patients diagnosed as mentally retarded (institutions for the mentally retarded). Training centers provide either or both intermediate and skilled nursing care. Some patients receiving intermediate care may be employed and have earned income.

Normally, patients in the training centers are disabled, but some are children who have not been determined disabled. Patients of any age in a training center may be Medicaid eligible if they meet all nonfinancial and financial Medicaid eligibility requirements.

The State training centers and locations are:

- Central Virginia Training Center (CVTC) – Madison Heights
- Southeastern Virginia Training Center (SEVTC) – Chesapeake
- Southwestern Virginia Training Center (SWVTC) – Hillsville

2. Psychiatric Hospitals

Psychiatric hospitals are medical facilities – institutions for the treatment of mental diseases – which provide care and services to mentally ill patients. There are two types of psychiatric hospitals: intensive psychiatric and psychiatric/chronically mentally ill. These hospitals may have patients of any age, although two of them are dedicated to geriatric patients and one serves only adolescents.

DBHDS Facilities
Medicaid Technicians

NAME	LOCATION	WORK TELEPHONE	CASELOAD
Mary Lou Spiggle Medicaid Field Supervisor mls846 (T003)	Central Virginia Training Center Medicaid Office Madison Heights, VA Mail To: PO Box 1098 Lynchburg, VA 24505	434-947-6256 FAX 434-947-2114	PGH-caseload-all NVMHI-caseload-all SVMHI-caseload-all WSH-caseload-all
Carrie Richardson cer900 (T002)	Central Virginia Training Center Medicaid Office Madison Heights, VA Mail To: PO Box 1098 Lynchburg, VA 24505	434-947-2754 FAX 434-947-2114	CVTC-caseload-all VCBR-caseload-all
Frances Jones fwj900 (T004)	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0841 FAX 276-782-9732	ESH-caseload-all SWVMHI-caseload-all SWVTC-caseload-all
Unassigned; contact Mary Lou Spiggle (above)	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0842 FAX 276-782-9732	Catawba-caseload-all HDMC-caseload-all SEVTC-caseload-all

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

DBHDS State Hospital facilities:

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

M17 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-7	1/1/18	Table of Contents, i, updated. Appendix 2, Pages 1 and 2. Appendix 3, Pages 1 and 2. Appendix 4 was added
TN #DMAS-6	10/1/17	Table of Contents Pages 4. Appendix 1 was deleted Appendices 2 and 3 were renumbered Appendices 1 and 2, respectively.
TN #DMAS-5	7/1/17	Table of Contents Pages 1, 2, 4 Appendix 2 Appendix 3 was added.
TN #DMAS-4	4/1/17	Pages 4, 5 Pages 6 and 7 are runover pages.
TN #DMAS-2	10/1/16	Table of Contents, page i Pages 1-7 Appendix 2 Page 8 was deleted.
TN #97	9/1/12	page 3 Appendix 1, page 1
UP #7	7/1/12	Table of Contents Pages 1-8 Appendix 1 Appendices 3 and 4 were removed.
TN #94	9/1/10	Title Page Table of Contents pages 1-7 Appendix 1 Appendix 2
TN #93	1/1/10	page 3

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M17 MEDICAID FRAUD AND NON-FRAUD RECOVERY

M1700.000 MEDICAID FRAUD NON-FRAUD RECOVERY

	Section	Page
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Fraud Recovery	**M1700.200**	**1**
Non-Fraud Recovery	**M1700.300**	**4**
Responsibility of the Local DSS	**M1700.400**	**6**

Appendices

Medicaid Fraud/Non-Fraud Referrals Form Matrix	**Appendix 1**	**1**
Notice of Recipient Fraud/Non-Fraud	**Appendix 2**	**1**
Notice of Recipient LTC Patient Pay Underpayment	**Appendix 3**	**1**
Notice to DMAS of Estate Recovery/TPL/Trusts	***Appendix 4***	***1***

NOTICE OF MEDICAID RECIPIENT FRAUD/NON-FRAUD

Date: / /

To: **Recipient Audit Unit (RAU)**
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
Fax Number: (804) 452-5472
Email: RecipientFraud@dmas.virginia.gov

Case Name: _____

Case Name SSN: ___-__-____ **Medicaid Case Number:** ___-_____-__-__

Case Address: _____
_____
_____

Has the Case Head been informed a referral is being sent to RAU? ☐ **Yes** ☐ **No**

Check the appropriate box below and give an explanation in the summary section.

☐ **Fraud** ☐ **Agency Error** ☐ **Other**
☐ **Uncompensated Transfer** ☐ **Non-Entitled Receipt of Medicaid**
☐ **Ineligible for Medicaid** **Dates:** _____

Ineligible person(s): _____
_____
_____

PARIS Match

☐ **Interstate Match** ☐ **Veteran Match**

Ineligible person(s): _____
_____
_____

Explanation summary of referral/PARIS match and any corrective action taken by the agency:

NOTICE OF MEDICAID RECIPIENT FRAUD/NON-FRAUD

ATTACH THE FOLLOWING INFORMATION IF AVAILABLE:

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

Name of Eligibility Worker: _____ **Telephone Number:** (___)____-_____

Agency Name: _____ **FIPS Code:** _____

Address: _____ **Name of Supervisor:** _____

RAU will send acknowledgment of receipt to the referring agency. RAU will contact the agency if any further action is required.

NOTICE OF RECIPIENT LONG TERM CARE (LTC) PATIENT PAY UNDERPAYMENT

Date: / /

To: **Recipient Audit Unit**
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
Fax Number: (804) 452-5472
Email: RecipientFraud@dmas.virginia.gov

Case Name: _____

Case Name SSN:___-__-____ **Medicaid ID Number:** ___-_____-__-_

Case Address: _____
_____
_____

LTC Patient Pay Underpayment Breakdown

Month/Year	Underpayment Amount
Total Time Frame:	**Total Amount:**

Explanation for the Underpayment:

NOTICE OF RECIPIENT LTC PATIENT PAY UNDERPAYMENT

THINGS TO REMEMBER:

- **All LTC patient pay underpayments totaling $1,500 or more should be referred to the Recipient Audit Unit (RAU). For Underpayments less than $1,500, reference M1470.900 for patient pay adjustments.**
- **Provide a monthly break down of the underpayment calculation along with the total underpayment amount. If additional space is needed please attach your calculations to this form.**

Name of Eligibility Worker: _____ **Telephone Number:** (___)____-_____

Agency Name: _____ **FIPS Code:** _____

Address:

_____

_____

Name of Supervisor:_____

RAU will send acknowledgment of receipt to the referring agency. RAU will contact the agency if any further action is required.

NOTICE to DMAS of ESTATE RECOVERY/TPL/TRUSTS

DATE: __/__/____

TO:

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
TPL UNIT
600 EAST BROAD STREET, SUITE 1300
RICHMOND, VA 23219
FAX NUMBER: (804) 786-0729

Case Name: _____

Case Address: _____
_____
_____

Case Name's Social Security Number: ___-__-____

Medicaid Case Number: ___-_____-__-

☐ **Estate Recovery** **Refer when deceased member is over 55 and has no surviving spouse, child under 21 or a disabled or blind child of any age.**

☐ **TPL Recovery** **Member has received funds from a settlement. DSS has received information concerning member being in an accident. DSS has information where member has other third party payers.**

☐ **Trust** **Refer all: Irrevocable, Discretionary, Pooled, and Special Needs Trusts**

Explanation Summary of referral:

_____
_____
_____
_____

Describe any corrective action taken by the agency:

_____
_____
_____
_____

NOTICE to DMAS of ESTATE RECOVERY/TPL/TRUSTS

ATTACH THE FOLLOWING INFORMATION IN THE ORDER LISTED BELOW:

- **Confirmation that ongoing eligibility has been reviewed in relation to allegation and results:**
- **Please attach the required decision from your Regional Specialist on all trust referrals;**
- **Member'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;**
- **When reporting health insurance information please include a copy of the insurance card or write in the "Explanation Summary of referral" as much information you can obtain. The policy number, insurance carrier name is most important.**
- **When reporting accident information concerning a Medicaid member, please include date of accident, the name of the attorney representing the member or the liable insurance carrier's name and address.**
- **For Estate recovery please include the address of any property owned by the Medicaid member.**
- **Relevant covered group, income, resource, and/or asset transfer documentation;**
- **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 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:
_____

NOTICE to DMAS of ESTATE RECOVERY/TPL/TRUSTS

PURPOSE:
To report information regarding estate recovery, trusts, property ownership and other health insurances to the DMAS TPL Unit. Please include LDSS Regional Specialists trust evaluations (as required by Virginia Medicaid policy).

USE OF FORM:
Complete for all cases referred to the DMAS for Estate, TPL and/or Trust recovery.

NUMBER AND DISTRIBUTION OF COPIES:
Prepare original. Make a copy for the agency record before sending to the DMAS TPL unit.

INSTRUCTIONS FOR PREPARATION OF FORM:
The form should contain the member(s) name, current mailing address (no P.O. Box should be used), member Medicaid ID, case name and/or responsible party and their address if different than the Medicaid member.

All referrals to TPL mailed to should be forwarded to:

DMAS
TPL Unit
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Referrals may also be faxed to (804) 786-0729.

The referring agency will be contacted if the DMAS TPL unit needs additional information.

M21 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-7	1/1/18	Pages 1, 6, 7.
TN #DMAS-4	4/1/17	Appendix 1, page 1
TN #DMAS-2	1/1/17	Appendix 1, page 1
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

M2100.000 FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS)

M2110.100 FAMIS GENERAL INFORMATION

A. Introduction

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program, enacted as Title XXI of the Social Security Act, to provide funds to States to enable them to initiate the provision of child health insurance to **uninsured low-income children**.

FAMIS is not an entitlement program, which means that if funds for this program are exhausted, no additional individuals will receive benefits under the program. The Department of Medical Assistance Services (DMAS) will notify the Department of Social Services (DSS) Central Office if funds for this program run out.

Children found eligible for FAMIS receive benefits described in the State's Title XXI Child Health Insurance Program. Eligible children are enrolled for benefits effective the first day of the child's application month if all eligibility requirements are met in that month, but no earlier than the date of the child's birth.

Retroactive coverage is only available to an eligible child who was born within the 3 months prior to the FAMIS application month. Eligibility for FAMIS coverage will be effective retroactive to the child's date of birth if the child would have met all eligibility criteria during that time.

Eligibility for FAMIS is determined by either the local DSS, including a DSS outstationed site, or the Cover Virginia Central Processing Unit (CPU). *Approved* applications processed by the Cover Virginia CPU will be transferred to the appropriate local DSS for case maintenance.

B. Legal Basis

The 1998 Acts of Assembly, Chapter 464, authorized Virginia's Children's Health Insurance Program by creating the Children's Medical Security Insurance Plan for uninsured children under 19 years of age. In August 2001, the program was revised and renamed the Family Access to Medical Insurance Security Plan (FAMIS).

C. Policy

FAMIS covers uninsured low-income children under age 19 who are not eligible for Medicaid (children's Medicaid) and whose gross family income is less than or equal to 200% of the federal poverty level (FPL) for the individual's household size (see M2130.100 for the definition of the FAMIS household and Appendix 1 for the income limits).

1. Retroactive Coverage For Newborns Only

Retroactive coverage is available ONLY to an eligible child who was born within the 3 months prior to the FAMIS application month. Eligibility for FAMIS coverage will be effective retroactive to the child's date of birth if the child was born within the retroactive period and would have met all eligibility criteria during the retroactive period.

The following eligibility requirements must be met in order for a newborn child to be enrolled in FAMIS for retroactive FAMIS coverage:

a. Retroactive coverage must be requested on the application form or in a later contact.

b. The child's date of birth must be within the three months immediately preceding the application month (month in which the agency receives the signed application form for the child).

c. The child must meet all the FAMIS eligibility requirements during the retroactive period.

2. FAMIS Aid Categories

The aid categories (ACs) for FAMIS are:

AC	Meaning
006	child under age 6 with income > 150% FPL and ≤ 200% FPL
007	child 6 – 19 with income > 150% FPL and ≤ 200% FPL
008	child under age 6 with income > 143% FPL and ≤ 150% FPL
009	child 6 – 19 with income > 143% FPL and ≤ 150% FPL
010	*FAMIS deemed newborn <1 year old*
014	*FAMIS deemed newborn above 150% FPL*

D. Notification Requirements

The eligibility worker must send a Notice of Action on Medicaid and FAMIS to the family informing them of the action taken the application. The notice must include the eligibility determination for both Medicaid and FAMIS.

If the child is ineligible for both Medicaid and FAMIS, the family must be sent a notice that the child is not eligible for either program. A referral to the Health Insurance Marketplace must be made, and the child must be given the opportunity to have a Medicaid medically needy evaluation if he is under 18 years. Along with the notice, *request verification of resources using Appendix E which can be found at: http://www.coverva.org/mat/APPENDIX%20E%20Medically%20Needy%20application.pdf (Application for Health Insurance and Help Paying Costs (Medical Needy Spenddown).* Advise *the family* that if the signed application is returned within 10 calendar days, the original application date will be honored.

E. Transitions Between Medicaid And FAMIS (Changes and Renewals)

When excess income for Medicaid causes the child's eligibility to change from Medicaid to FAMIS, the new income must be verified using an electronic data source such as the federal Hub or another reliable data source prior to requesting paystubs or employer statements.

***F.* FAMIS Select**

Under the FAMIS program, a family, whose child(ren) are determined eligible for FAMIS and who has access to health insurance through an employer or wishes to purchase a private policy, has the option of enrolling the family in that health plan. "FAMIS Select" allows the choice of the private or employer's insurance instead of FAMIS. Children enrolled in FAMIS whose families have access to private or employer sponsored health insurance coverage may qualify to have the State pay part of the family's share of the health insurance premium.

If a child is enrolled in FAMIS *and* the family is interested in more information about FAMIS Select *(and* has access to health insurance*), they may contact* DMAS about the benefits of enrolling in the FAMIS Select component of FAMIS and information about how to participate in the program. Participation in the FAMIS Select component is voluntary.

***G.* 12-Month Continuous Coverage**

Children under age 19 who are enrolled in FAMIS are entitled to 12 months of continuous coverage provided the family continues to reside in Virginia and the family income is less than or equal to 200% of the FPL.

Children enrolled in FAMIS who subsequently apply for Medicaid and are found eligible must have their FAMIS coverage cancelled so they can be reinstated in Medicaid.

M2150.100 REVIEW OF ADVERSE ACTIONS

A. Case Reviews

An applicant for FAMIS may request a review of an adverse determination regarding eligibility for FAMIS. FAMIS reviews follow the procedures established by Medicaid for client appeals (see chapter M16).

The payment of medical services on the part of any child or any right to participate in the program is not subject to review if funds for FAMIS are exhausted.