



COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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October 1, 2019

Virginia Medical Assistance Eligibility Manual Transmittal #DMAS-14

The following acronyms are contained in this letter:

- DMAS – Department of Medical Assistance Services
- DDS – Disability Determination Services
- LDSS – Local Department of Social Services
- LTSS – Long-term Services and Supports
- PACE – Program of All-inclusive Care for the Elderly
- QMB – Qualified Medicare Beneficiaries
- SSI – Supplemental Security Income
- TN – Transmittal
- VCU – Virginia Commonwealth University

TN #DMAS-14 includes policy clarifications, updates and revisions. Unless otherwise noted in the Cover Letter and/or policy, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after October 1 2019.

The following changes are contained in TN #DMAS-14:

Changed Pages	Changes
Subchapter M0110 Page 15	Clarified the information that must be maintained in the case record.
Subchapter M0120 Pages 7, 10, 11, 18, Page 20a was deleted.	On pages 7, 10, and 18, revised the links to online forms. On page 11, removed an obsolete link.

Changed Pages	Changes
Subchapter M0130 Pages 9, 10	On pages 9 and 10, clarified that income must be verified or determined reasonably compatible.
Subchapter M0140 Pages 4, 5	On page 4, added a reference to M1350.850. On page 5, clarified that the treatment of split cases.
Subchapter M0220 Table of Contents Pages 3, 4, 23, 24 Page 25 was added as a runover page. Appendix 8 was added.	Revised the Table of Contents. On pages 3, 4, 23, and 24, revised the links to online forms. Appendix 8, Alien Status Reference Guide, was added.
Subchapter M0280 Pages 6, 7, 9, 11	On page 6, added a reference to M0280.300. On page 7, clarified the term “halfway house.” On page 9, clarified that inpatient treatment is not inpatient hospitalization. On page 11, clarified that the LDSS is not responsible for case maintenance of offenders in aid categories 108 or 109.
Subchapter M0310 Pages 24, 26, 27, 40	On page 24, clarified that children receiving SSI are not referred to DDS prior to turning 18. On pages 26 and 27, revised the links to online forms. On page 40, corrected the formatting.
Subchapter M0320 Page 40	Clarified that QMB coverage begins the month following the month in which the eligibility determination is made.
Subchapter M0330 Pages 1, 10a Page 2 is a runover page.	On page 1, clarified the covered group hierarchy for former foster care children under age 26, as well as children and adults who receive SSI. On page 10a, clarified the income limit for MAGI Adults.
Chapter M04 Pages 1, 3, 4, 5, 14, 16, 32, 33 Appendix 8	On pages 1, 4, 5, 14, and 33, clarified the definition of reasonable compatibility and procedures for verifying attested income using electronic data sources. On page 3, clarified that incarcerated individuals are not eligible for LTSS. On page 16, clarified the treatment of alimony received when the divorce occurred prior to January 1, 2019 and that census income is countable. On page 32, clarified that APTC methodology does not apply to non-filer households or married individuals filing separately in the same household. On page 32, also clarified that gap-filling methodology is applicable to the retroactive period. In Appendix 8, clarified the treatment of a child’s social security income and alimony.
Subchapter M0610 Table of Contents Pages 1, 2 Page 2a was added as a runover page.	Revised the Table of Contents. On pages 1 and 2, clarified the treatment of resources for institutionalized individuals.

Changed Pages	Changes
Subchapter M0710 Pages 1, 2, 7, 8 Page 2a was added as a runover page.	On page 1, added MAGI Adults to the list of covered groups subject to the policies in Chapter M04. On pages 2, 7, and 8, clarified that income must be verified or determined reasonably compatible.
Subchapter M0720 Page 2	Clarified that income must be verified or determined reasonably compatible.
Subchapter M0730 Page 1	Clarified that income must be verified or determined reasonably compatible.
Subchapter M0810 Pages 20, 25, 27 Page 28 is a runover page.	On pages 20, 25, and 27, clarified that income must be verified or determined reasonably compatible.
Subchapter M0820 Pages 10, 11, 13, 22, 24	On pages 10, 11, 13, 22, and 24, clarified that income must be verified or determined reasonably compatible.
Subchapter M1310 Page 1	Added a reference to M1350.850.
Subchapter M1320 Pages 3, 4	On page 3, clarified that a third party can submit a medical expense. On page 4, clarified that a notice is either generated from VaCMS or produced by the worker.
Subchapter M1340 Pages 2, 18	On page 2, changed “spenddown income” to “spenddown liability.” On page 18, expanded the definition of VCU and University of Virginia Health Systems.
Subchapter M1410 Pages 10, 12-14	On page 10, clarified that an LTSS screening must be completed for individuals seeking LTSS. On pages 12-14, revised the links to online forms and the DMAS address.
Subchapter M1450 Pages 19, 41, 42, 46	On pages 19, 42, and 46, revised the DMAS addresses. On page 41, revised the link to an online form.
Subchapter M1460 Pages 4, 29	On pages 4 and 29, revised the DMAS addresses.
Subchapter M1470 Table of Contents, page i Pages 1, 14, 28a, 31, 32, 43, 47, 48, 50 Appendix 1, page 2 Page 14a was added as a runover page.	Updated the Table of Contents. On pages 1, 28a, 43, 47, 48, and 50, revised the links to online forms. On page 14, clarified the treatment of certain medical expense deductions. On pages 31 and 31, revised the policy on the treatment of patient pay for PACE participants who are placed in nursing facilities through PACE. In the appendix, revised the DMAS address.

Changed Pages	Changes
Subchapter M1480 Pages 8a, 8b, 12, 15, 16, 18, 20, 21, 30, 32, 51	On pages 8a and 8b, clarified the resource assessment process for married institutionalized MAGI Adults who subsequently lost eligibility as MAGI Adults. On pages 12, 15, 16, 20, and 51, revised the DMAS addresses. On page 18, 30 and 32, revised the links to online forms. On page 21, removed an obsolete link. On page 66, updated the Utility Standard Deduction for 2019. Note that the amounts decreased from 2018.
Subchapter M1510 Pages 2b, 4, 5-7	On pages 2b and 4, clarified that income must be verified or determined reasonably compatible. On pages 5 and page 7, added a reference regarding incarcerated individual. On page 6, clarified entitlement for QMB coverage and added example.
Subchapter M1520 Pages 2, 3, 4, 6a, 8, 9, 10, 13 Page 4a is a runover page. Page 10a was added as a runover pages. Page 7a was deleted.	On pages 2, 6a, and 13, revised the links to online forms. On pages 3 and 8, clarified that income must be verified or determined reasonably compatible. On pages 4 and 9, clarified the entitlement for QMB coverage. On page 10, added policy regarding automatic changes in covered group for pregnant women who have reached the end of their postpartum period.
Subchapter M1550 Appendix 1, page 1 Appendix 1, page 2 was added	Revised the appendix.
Chapter M17 Table of Contents Pages 1, 2, 4, 6, 7 Appendix 1, pages 1 and 2 Appendix 2, pages 1 and 2 Appendix 4 was added.	Revised the Table of Contents. On pages 1, 2, 4, 6, and 7, revised the links to the online forms. On page 7 and in Appendix 4, added a new form, Public Assistance Reporting Information System (PARIS) Notice of Recipient Fraud/Non-Fraud Recovery (form # DMAS 754R). In Appendices 1 and 2, revised the forms.
Chapter M21 Pages 4-6	On pages 4-6, clarified that income must be verified or determined reasonably compatible.
Chapter M22 Page 5	Clarified that income must be verified or determined reasonably compatible.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Rachel Pryor", with a long horizontal flourish extending to the right.

Rachel Pryor
Deputy Director of Administration

Attachment

M0110 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/19	Page 15
TN #DMAS-12	4/1/19	Table of Contents Page 1, 2, 9 Page 2a is a runover page
TN #DMAS-4	4/1/17	Page 15
TN #DMAS-3	1/1/17	Page 15
TN #DMAS-2	10/1/16	Pages 3, 13
TN #100	5/1/15	Pages 2, 7 Page 1 is a runover page.
TN #98	10/1/13	Table of Contents Pages 1-15 Page 6a was removed. Page 16 was added.
TN #97	9/1/12	Table of Contents Page 13 Page 14 was added. Appendix 1 was added.
Update #7	7/1/12	Pages 3, 6a, 7, 8
TN #96	10/1/11	Table of Contents Pages 2-6a
TN #95	3/1/11	Pages 2-4a
TN #94	9/1/10	Pages 2, 3
TN #93	1/1/10	Pages 1, 6

Manual Title Virginia Medical Assistance Eligibility	Chapter M01	Page Revision Date October 2019
Subchapter Subject M0110.000 GENERAL INFORMATION	Page ending with M0110.400	Page 15

M0110.400 Retention of Case Information

A. Introduction

The agency must maintain case records that contain information necessary to support the facts essential to the determination of initial and continuing eligibility as well as any basis for discontinuing or denying assistance. The case record shall consist of a hard (i.e. paper) record, an electronic record, or a combination of the two. To be stored electronically in the individual's case record in the Virginia Case Management System (VaCMS), a document is scanned into VaCMS using the Document Management Imaging System (DMIS).

Records of active cases must be maintained for as long as the client receives benefits. Closed records must be maintained for a minimum of three years from the date of closure.

B. Policy

Case records must contain the following elements:

- the date of application,
- the date of and basis for the disposition of the application,
- facts essential to the determination of initial and continuing eligibility,
- the provision of medical assistance (i.e. enrollment),
- the basis for discontinuing medical assistance,
- the disposition of income and eligibility verification information, and
- the name of the agency representative taking action on the case and the date of the action.

The agency must include in each applicant's case record documentation to support the agency's decision *on his application and the fact that the agency gave recipients timely and adequate notice of proposed action to terminate, discontinue or suspend their eligibility or to reduce or discontinue services they may receive under the medical assistance programs*. Types of documentation that support the agency's decision include evaluations of eligibility, case narratives, and permanent verifications. Verifications of earned and unearned income, *documentation of reasonable compatibility* and the current value of resources *(if applicable)* must be maintained in the record. Notes by the eligibility worker that the verifications were viewed are not sufficient; *income reasonable compatibility and electronic verification of income should be documented in case comments*.

The case record must contain a duplicate, either electronically or in writing, of all notices sent to the client. Copies of the documents used for verification of citizenship and identity, such as birth certificates, must also be maintained within the case record.

Active cases may be purged with the exception of documentation that supports the information shown in the paragraphs above. Agencies may wish to retain other information used in future eligibility determinations, such as resource assessments and burial contracts. Closed cases are required to be retained by the agency for a period of no less than three years from the date of closure.

The case record shall be organized as to enable audit and program integrity entities to properly discharge their respective responsibilities for reviewing the manner in which the MA programs are being administered.

M0120 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/2019	Pages 7, 10, 11, 18 Page 20a was deleted.
TN #DMAS-12	4/1/19	Pages 2, 12-13,15, 20a
TN #DMAS-10	10/1/18	Pages 2, 4, 15, 17-20 Page 20a was added as a runover page.
TN #DMAS-8	4/1/18	Page 12
TN #DMAS-6	10/1/17	Page 1
TN #DMAS-5	7/1/17	Page 2a
TN #DMAS-4	4/1/17	Pages 2a, 7, 10, 13
TN #DMAS-3	1/1/17	Page 15
TN #DMAS-2	9/1/16	Pages 2, 15 Page 2a is a runover page.
TN #DMAS-1	6/1/16	Pages 7, 10, 11, 16-20
TN #100	5/1/15	Table of Contents Pages 1, 2, 15, 20 Page 2a and 16 are runover pages.
UP #10	5/1/14	Table of Contents Pages 11, 16-18 Pages 11a and 11b were deleted. Pages 19 and 20 were added.
TN #99	1/1/14	Page 11 Pages 11a and b were added.
TN #98	10/1/13	Table of Contents Pages 1-17
UP #9	4/1/13	Page 13, 15, 16
UP #7	7/1/12	Pages 1, 10-12
TN #96	10/1/11	Table of Contents Pages 6-18
TN #95	3/1/11	Pages 1, 8, 8a, 14
TN #94	9/1/10	Pages 8, 8a
TN #93	1/1/10	Pages 1, 7, 9-16
Update (UP) #1	7/1/09	Page 8
TN #91	5/15/09	Page 10

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Subchapter Subject M0120 MEDICAL ASSISTANCE APPLICATION	Page ending with M0120.200	Page 7

c. Action Not Initiated – Refer to Child Welfare Services

If guardianship or custody procedures have not begun or have not been verified as being on the court docket, refer the child to the appropriate Family Services worker.

Continue to pend the application until the service investigation is completed and any court proceedings are completed. Once the guardian has been appointed or custody awarded, request verification of the appointment or award and that the application be signed by the guardian or adult who was awarded custody. Retain a copy of the application and mail the original application to the guardian or custodian. Allow 10 calendar days for the signed application and guardian or custody papers to be returned.

If the child was emancipated by the court, request the child’s signature on the application. If the application is mailed to the child, allow 10 calendar days for the signed application form to be returned.

If the application form is not signed by the applicant, the guardian, the custodial adult, or the emancipated child and returned to the agency by the specified date, deny the application because it is invalid.

2. Minor Parent Applying for His Child

A parent under age 18 years may apply for MA for his own child because he is the parent of the child.

3. Foster Care Child

a. IV-E

The Title IV-E Foster Care & Medicaid Application form, available at <https://fusion.dss.virginia.gov/Portals/%5Bdfs%5D/Files/Copy%20of%20032-03-0636-06-eng.xlsx>, is used for the IV-E Foster Care eligibility determination. A separate MA application is **not** required for a child who has been determined eligible for Title IV-E Foster Care. However, if there is a non-custodial agreement for the IV-E eligible child, the parent or legal guardian must sign an MA application for the child.

b. Non-IV-E

The Cover Virginia Application for Health Coverage & Help Paying Costs is used for the MA eligibility determination of a **non-IV-E** Foster Care child. Applications for non-IV-E Foster Care children may also be filed online. The MA application for a non-IV-E child who is in foster care must be signed by an authorized employee of the public or private agency that has custody of the child. Exception: If the child has been placed with and is living with a parent or care-taker relative, the parent or care-taker relative can sign the application.

If there is a non-custodial agreement, an MA application form must be filed and the parent or legal guardian must sign the application.

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1. Title IV-E Foster Care & Medicaid Application

The Title IV-E Foster Care & Medicaid Application, available at <https://fusion.dss.virginia.gov/Portals/%5Bdfs%5D/Files/Copy%20of%20032-03-0636-06-eng.xlsx>, is used for foster care or adoption assistance children who are eligible under Title IV-E of the Social Security Act. If the child requires a resource evaluation for a medically needy spenddown, Appendix E can be used to collect the information. The Appendix must be signed by the applicant's guardian.

For a IV-E FC child whose custody is held by an LDSS or a private FC agency, or for a IV-E adoption assistance (AA) child, the Title IV-E Foster Care & Medicaid Application is used to determine if the child meets Medicaid IV-E eligibility requirements. This form is also used to determine Medicaid eligibility for IV-E AA children. This form is **not** used for children in non-custodial agreement cases or non-IV-E FC or AA.

For IV-E FC children in the custody of another state's social services agency and for IV-E AA children, a separate Medicaid application is not required. The worker must verify the IV-E maintenance payment (for FC) or the IV-E status (for AA). Virginia residency (by declaration) and current third party liability (TPL) information must be obtained. This information may be supplied by the foster/adoptive parent or obtained from the agency that entered into the FC or AA agreement.

For non-IV-E FC children, a separate Medicaid application must be submitted by either the custodial agency or a parent or caretaker relative with whom the child has been placed. When a child enters care through a non-custodial agreement, or when a child is a non-IV-E AA child, a separate Medicaid application must be submitted by the parent or guardian.

2. Auxiliary Grant (AG)

An application for AG is also an application for Medicaid. A separate MA application is not required.

3. Exception for Certain Newborns

A child born to a mother who was Medicaid or FAMIS eligible at the time of the child's birth (including a child born to an emergency-services-only alien mother) is deemed to have applied and been found eligible for Medicaid on the date of the child's birth (see M0320.301). An application for the child is not required. The child's coverage is subject to renewal when he turns 1 year old.

If the child was born to a mother who was covered by Medicaid or the Children's Health Insurance Program outside Virginia at the time of the child's birth, verification of the mother's coverage must be provided or else an application must be filed for the child's eligibility to be determined in another covered group.

4. Forms that Protect the Application Date

a. Low Income Subsidy (LIS) Medicaid Application

The Medicare Patient and Provider Improvement Act (MIPPA) requires LIS application data submitted by the Social Security Administration (SSA) to states to be treated as an application for Medicaid, if the LIS applicant agrees. LIS application data is sent to LDSS via the SSA Referral Inbox in VaCMS. The LDSS must generate an LIS Medicaid application and cover sheet and mail them to the individual. The individual must return the application or apply for Medicaid online or by telephone in order for his Medicaid eligibility to be determined. If the individual submits the application, the date of LIS application with the SSA is treated as the date of the Medicaid application.

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b. Model Application for Medicare Premium Assistance Form

The Model Application for Medicare Premium Assistance Form was developed by the federal Centers for Medicare & Medicaid Services (CMS) that states can choose to use for the Medicare Savings Program applicants. The model application is **NOT** a prescribed Virginia Medicaid application form at this time.

Should a local department of social services (LDSS) receive a model application form, the agency is to send a valid Virginia MA application to the applicant with a request that it be completed, signed, and returned to the agency within 30 calendar days. The date of application on the model Application for Medicare Premium Assistance is to be preserved as the application date for purposes of Medicaid entitlement.

The processing time for the LDSS begins when the agency receives the Virginia application form back from the applicant. If the Virginia application form is not returned within 30 days, no further action is necessary on that application. The agency does not send a Notice of Action because no Virginia application was received. The model application date is not preserved beyond 30 calendar days. Should the person later submit a valid Virginia application, the date the Virginia application is received by the LDSS is the application date.

The model application form may be viewed on the SSA web site at:
<https://www.ssa.gov/forms/ssa-1020b-ocr-sm-inst.pdf>.

B. Application Forms

Medical assistance must be requested using an application method or form approved by the Departments of Medical Assistance Services (DMAS) and Social Services (VDSS). Applications may be made electronically through CommonHelp or the Health Insurance Marketplace. When an individual applies for assistance through the Marketplace and is assessed as being Medicaid-eligible, his application data is electronically transmitted to the local DSS for a final determination of eligibility.

Applications may also be made telephonically through the Cover Virginia Call Center or with a paper application form.

The following paper forms have been prescribed as application forms for Medicaid and FAMIS:

1. Streamlined Applications

The following forms are used to apply for affordable health insurance, including qualified health plans with the Advance Premium Tax Credit (APTC), through the Health Insurance Marketplace or the local DSS:

- the Cover Virginia Application for Health Coverage & Help Paying Costs and all applicable appendices, including Appendix D for applications submitted for aged, blind or disabled and/or long-term care applicants, and Appendix E for when a Families and Children (F&C) Medically Needy determination is requested.
- the federal Application for Health Coverage & Help Paying Costs for multiple individuals and all applicable appendices and
- the federal Application for Health Coverage & Help Paying Costs (Short Form) for individuals and all applicable appendices.

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(AC 035) is limited to outpatient prenatal services; labor and delivery are not covered under HPE for AC 035. HPE coverage for Plan First enrollees AC084 is limited to family planning services only. Transportation to receive covered medical services is covered for all HPE enrollees.

Enrollment as HPE is limited to one HPE period per calendar year for all individuals other than pregnant women. For pregnant women, enrollment is limited to one HPE eligibility period per pregnancy.

There are no appeal rights for an HPE determination.

**1. Eligibility
Procedures –
Post HPE
Enrollment**

a) MA Application Not Submitted

If the person does not submit an MA application prior to the end of the HPE coverage period, no further worker action or additional notice not required because the enrollment was for a closed period of coverage.

b) MA Application Submitted

For MA coverage to continue beyond the initial HPE coverage period, the individual must submit a full MA application. MA applications submitted by HPE enrollees are subject to the standard eligibility and entitlement policies. The 10-working day processing standard applies to MA applications submitted by pregnant women and BCCPTA individuals enrolled in HPE.

While the LDSS does not determine eligibility for HPE, if an MA application is received and pended in VaCMS, the individual's coverage in the HPE AC may need to be extended or reinstated (if HPE coverage will end during the application processing period) while the application is processed. If HPE coverage needs to be extended/reinstated, alert a VDSS Regional Consultant or send an MMIS Coverage Correction Request form, available at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms>, to the DMAS Eligibility and Enrollment Unit at enrollment@dmass.virginia.gov.

Example 1: Mary Smith is enrolled in HPE coverage in AC 065 (LIFC) for the period of 3-5-18 through 4-30-18. On 4-20-18, she submits an MA application; however, the 45th processing day will fall after the HPE end date of 4-30-18. Therefore, the worker must have the HPE coverage reinstated in MMIS under the same aid category (AC 065), using the MA application date. The effective date of the reinstatement is 5-1-18, the day after the HPE coverage ends. Once the application has been processed, the worker must act to cancel the HPE coverage, and if the individual remains eligible reinstate coverage in the appropriate AC.

M0130 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/19	Pages 9, 10
TN #DMAS-11	1/1/19	Page 1
TN #DMAS-10	10/1/18	Table of Contents Pages 1, 2-2b, 9-12 Pages 2c-2e were added as runover pages.
TN #DMAS-9	7/1/18	Page 2b
TN #DMAS-8	4/1/18	Page 13
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

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

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

G. Health Insurance Premium Payment (HIPP) Program

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

The local DSS agency must give each applicant or enrollee who reports that he or someone in his family is employed more than 30 hours each week and is eligible for health insurance coverage under an employer’s group health plan must be given a HIPP Fact Sheet, which provides a brief description of the program and the contact information for the HIPP Unit at DMAS. The HIPP Fact Sheet is available at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms>. 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;
- asset transfer information for individuals in need of long-term care services, including the date of transfer, asset value, and compensation received.
- earned and unearned income (*for all case actions effective October 26, 2019, if the income attested to by the applicant is within 10% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required. If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return*).

The agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information, and information from SSA through SVES or SOLQ-I. Verification of income from these available sources, including the VEC, may be used if the information is less than 12 months old. The agency must include in each applicant’s case record facts to support the agency’s decision on the case.

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- 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 Families and Children (F&C), *MAGI Adults*, 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 (*i.e. taxable*) income.
- 3. SSA Data** Social Security and/or Supplemental Security Income must be verified through SSA. The Federal Hub links to SSA data. SOLQ-I may also be used. The State Data Exchange (SDX) system should only be used as an alternate method when the Hub or SOLQ-I is not available.
- 4. Income** *For all case actions effective October 26, 2019, countable earned and unearned income is only verified if reasonable compatibility does not exist or the applicant's attested income or information from electronic data sources is over the income limit for his covered group.*

If the applicant meets a Medically Needy covered group, verification of income is required to determine spenddown liability based on actual income received.
- 5. \$0 (Zero) Income Procedures – Applicable Only to MAGI Cases Processed in VaCMS** When an individual whose income must be counted for the eligibility determination reports \$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 the individual receives benefits through other benefit programs and/or childcare, income information in those records must also be reviewed.

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

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

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

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

M0140 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/19	Pages 4, 5

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M0140.300 CASE MAINTENANCE

- A. Ongoing Case Maintenance** Case maintenance may include updates such as when the inmate is moved to another facility, change of an authorized representative, updates to demographics, or other changes affecting Medicaid eligibility or coverage.
- Update to an offender's case are handled by the CVIU. Facilities will use a CVIU Communication Form to report changes. Local agencies will use the LDSS to Cover Virginia Communication Form #032-03-0458-00-eng to report changes.
- B. Partial Reviews** If a change occurs it may be necessary to re-evaluate the offender's Medicaid coverage. This may include release from incarceration, change of anticipated release date, death, an inmate turning age 65 years old, becoming eligible for Medicare, or end of a pregnancy (see M0140.001 G).
- The eligibility worker will handle such changes within 30 days and re-evaluate the offender for continued coverage.
- For an offender case which involves a spenddown, see M1350.850.*
- C. Redetermination** An offender with ongoing approved Medicaid coverage is subject to an annual (every 12 months) redetermination of coverage. The CVIU processes redeterminations of incarcerated individuals (see M1520.200 A).
- Do not initiate a renewal of eligibility of a pregnant woman during her pregnancy. Eligibility as a pregnant woman ends effective the last day of the month in which the 60th day following the end of the pregnancy occurs. When eligibility as a pregnant woman ends, prior to the cancellation of her coverage, determine if the woman meets the definition for another Medicaid covered group (see M0310.002). If the woman meets the definition of a full-benefit covered group, determine if an ex parte renewal can be completed or if a renewal form is required and take appropriate action.
- Follow Ex Parte Renewal procedure as found in M1520.200 B. 1 if applicable. If unable to process an Ex Parte renewal, see M1520.200 B. 2 and 3 for procedures.
- D. Pre-Release Review** An offender with active Medicaid coverage and a reported release date of 45 days or less requires a "Pre-Release" partial review. Eligibility will be evaluated for ongoing Medicaid coverage based on the anticipated living arrangement after release from incarceration.
- If the offender is approved and remains eligible for ongoing Medicaid coverage, the worker will cancel the existing aid category (AC108 or AC109) on the day prior to the actual release date and reinstate coverage in the new AC as of the date of release.

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The worker should confirm a new Commonwealth of Virginia Medicaid Card has been generated and copy of the Notice of Action sent to the post-release address.

If eligibility for ongoing Medicaid is denied, cancel existing Medicaid coverage the day prior to actual date of release.

1. Release to a Community Living Arrangement

An offender entering a household with existing benefits after incarceration may affect Medicaid eligibility for those in the household.

The CVIU will process Pre-Release Reviews if the offender will be residing in a household where no other members in the household have active Medicaid or other benefits (such as SNAP or TANF). If Medicaid is approved, the case will be assigned to the locality where the ex-offender plans to reside.

If the offender will be joining a household in which other members have active Medicaid or other benefits, the CVIU will assign the case to LDSS for processing since the household size change may impact existing benefits.

2. Release to an Institutional Placement, LTSS, or HCBS

When an offender needs to be placed in an institution or receive home and community-based services (HCBS), the CVIU will route such applications to LDSS in the locality where the individual will be residing for processing to ensure the eligible individual can receive necessary medical support/services when released.

E. Split Cases

For case maintenance, an offender with active Medicaid coverage in aid category 108 or 109 should be placed in his own case in VaCMS and assigned to the CVIU. If the incarcerated individual is the case name and other household members with active coverage are on the case, the local agency will be responsible for removing any other member(s), setting up a new case, and transferring the offender's case to the CVIU.

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Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/19	Table of Contents Pages 3, 4, 23, 24 Page 25 was added as a runover page. Appendix 8 was added.
TN #DMAS-13	7/1/19	Page 21
TN #DMAS-12	4/1/19	Pages 20, 21, 23
TN #DMAS-10	10/1/18	Page 1
TN #DMAS-9	7/1/17	Page 1, 2, 14c
TN #DMAS-6	10/1/17	Page 15 Appendix 1, page 4
TN #DMAS-5	7/1/17	Pages 18, 19, 23, 24
TN #DMAS-3	1/1/17	Table of Contents Page 22a Appendix 1, page 1
TN #DMAS-2	10/1/16	Pages 13, 19-22, 23, 24
TN #DMAS-1	6/1/16	Pages 4, 4b, 5, 23
TN #100	5/1/15	Table of Contents Pages 4b, 12, 17, 18 Appendix 5, page 3 Page 4 was renumbered for clarity. Page 4a is a runover page.
TN #99	1/1/14	Table of Contents Pages 19, 23, 24 Appendix 4 was removed.
TN #98	10/1/13	Pages 2-3b Appendix 1 Pages 1-5 Pages 6-18 were removed.
UP #9	4/1/13	Page 3 Appendix 1, pages 3, 17 Appendix 3, pages 3, 4
UP #8	10/1/12	Table of Contents Pages 4, 7-8, 12, 14d-20 Page 17a was deleted. Appendix 5, page 3 Appendix 7 pages 1-5

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Changed With	Effective Date	Pages Changed
UP #7	7/1/12	Table of Contents Pages 14d, 16-19 Appendix 5 , page 3
TN #96	10/1/11	Table of Contents Pages 2, 3, 7, 8, 14d, 18-22a, 23 Appendix 5, page 3
TN #95	3/1/11	Table of Contents Pages 3, 3a, 4-6a, 14a-14c, 17, 19, 20 Pages 22a, 23, 24 Appendices 1-2a removed. Appendix 3 and Appendices 5-8 reordered and renumbered.
TN #94	9/1/10	Pages 3-3b, 7-9, 14a-14d, 18, 21, 22a, 23 Appendix 1 Appendix 3, page 3
Update (UP) #3	3/1/10	Pages 1-3a
TN #93	1/1/10	Table of Contents Pages 7-8, 14a, 14c-14d, 15-20, 22a Appendix 1 Appendix 3, page 3 Appendix 4, pages 1 and 2 Appendix 6, page 2
TN #92	5/22/09	Table of Contents Pages 1-6a Appendix 8 (18 pages) Pages 4a-4t were removed and not replaced.
TN #91	5/15/09	Page 7 Pages 14a, 14b Page 18 Page 20 Appendix 3, page 3

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- a. All foster care children and IV-E Adoption Assistance children;
- b. Individuals born to mothers who were eligible for MA in any state on the date of the individuals' birth;
- c. Individuals entitled to or enrolled in Medicare, individuals receiving Social Security benefits on the basis of a disability and SSI recipients currently entitled to SSI payments. Former SSI recipients are not included in the exemption. The local department of social services (LDSS) must have verification from the Social Security Administration (such as a SVES response) of an individual's Medicare enrollment, benefits entitlement or current SSI recipient status.

When an individual loses an exception status and his C&I has not previously been verified, the individual must be given a reasonable opportunity to provide C&I.

NOTE: A parent or caretaker who is applying for a child, but who is NOT applying for MA for himself, is NOT required to verify his or her C&I.

**3. Verification
Required One
Time**

Once verification of C&I has been provided, it is not necessary to obtain verification again. Documentary evidence may be accepted without requiring the individual to appear in person. C&I documentation must be stored in the case record.

**4. Enroll Under
Good Faith
Effort**

If an individual meets all other eligibility requirements and declares that he is a citizen, he is to be enrolled under a good faith effort. **Do not request verification of C&I from the applicant, and do not delay or deny application processing for proof of C&I.**

If the applicant meets all other eligibility requirements:

- Approve the application and enroll the applicant in MA, AND
- Specify on the Notice that the individual may have to provide documentation of C&I if it cannot be obtained by other means, OR
- Include the Reasonable Opportunity Insert, available at https://fusion.dss.virginia.gov/Portals/1/bpl/Files/Medical%20Assistance%20Guidance/medicaid_reasonable_opportunity_insertrev_03-09-10.pdf?ver=2019-06-04-151050-230 with the Notice.

The individual remains eligible for MA while the agency attempts to verify C&I through the data matching process described in M0220.100 D below, or if necessary, requests verification from the individual. The same good faith effort requirements apply should an individual lose his exemption from providing C&I verification.

**D. Procedures for
Documenting C&I**

CHIPRA allows the option for verification of C&I for individuals newly enrolled in Medicaid or Family Access to Medical Insurance Security Plan (FAMIS) using a data match with SSA to confirm the consistency of a declaration of citizenship with SSA records in lieu of presentation of original documentation. This option, implemented in March 2010, allows for a monthly exchange of data between the Medicaid Management Information System

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(MMIS) and SSA for the documentation of C&I for individuals enrolled in the Medicaid and FAMIS programs. In order for this process to be used to verify citizenship and identity, the individual's SSN must be verified by SSA (see M0240).

For eligibility determinations processed through VaCMS, the Social Security data match takes place when the individual's information is sent through the Hub. For cases not processed in VaCMS, the SSA data match will take place after the individual has been enrolled in MMIS.

1. MMIS Data Matches SSA

If the information in the MMIS matches the information contained in the SSA files, the MMIS will be updated to reflect the verification of C&I. No further action is needed on the part of the eligibility worker, and the enrollee will not be required to provide any additional documentation, if the SSA match code in MMIS shows that SSA verified the individual's C&I.

2. MMIS Data Does Not Match SSA

If the information in the MMIS does not match the information in the SSA files, a discrepancy report will be generated monthly listing the inconsistent information. Eligibility staff is expected to review the report to see if the report lists any enrollees who were rejected because SSA could not verify the enrollee's citizenship and identity.

a. SSA Cannot Verify C&I

If the SSA data match result does not verify the individual's C&I, eligibility workers must review the information in the system to determine if a typographical or other clerical error occurred. If it is determined that the discrepancy was the result of an error, steps must be taken to correct the information in the system so that SSA can verify C&I when a new data match with SSA occurs in the future.

If the inconsistency is not the result of a typographical or other clerical error, the individual must be given a reasonable opportunity period of 90 days to either resolve the issue with SSA or provide verification of C&I. The eligibility worker must send a written notification to the enrollee that informs the enrollee of the discrepancy and gives him 90 calendar days from the date of the notice to either resolve the discrepancy with the SSA and to provide written verification of the correction, OR provide acceptable documentation of C&I to the LDSS.

The notice must specify the date of the 90th day, and must state that, if the requested information is not provided by the 90th day, the individual's Medicaid coverage will be canceled. Include with the notice the "Birth Certificates and Proof of Citizenship for Medicaid" Fact Sheet available on at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/References>. Acceptable forms of documentation for C&I are also included in Appendix 1 to this subchapter.

b. Individual Does Not Provide Verification in 90 Days

If the individual does not provide the information necessary to meet the C&I documentation requirements by the 90th day, his coverage must be canceled. Send an advance notice, and cancel coverage at the end of the month in which the 90th day occurs.

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

M0220.700 EMERGENCY SERVICES ALIENS ENTITLEMENT & ENROLLMENT

A. Policy Unqualified aliens, and qualified aliens eligible for emergency services only are eligible for Medicaid coverage of emergency medical care only. This care must be provided in a hospital emergency room or as an inpatient in a hospital.

B. Entitlement-Enrollment Period If the applicant is found eligible and is certified for emergency services, eligibility exists only for the period of coverage certified by *the eligibility worker* or DMAS staff on the Emergency Medical Certification form, available at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms>.

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

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

DMAS will certify dialysis patients for up to a one year period of services without the need for a new Medicaid application. However, due to edits in MMIS, only one six-month certification period at a time can be entered. The worker must manually enter the second certification period of up to six months (as certified by DMAS) after the first period expires.

The dialysis patient must reapply for Medicaid after his full certification period expires.

C. Enrollment Procedures Once an emergency services alien is found eligible for coverage of emergency services, enroll the individual in the eligibility and enrollment system using the following data:

- 1. Country** In this field, Country of Origin, enter the code of the alien's country of origin.

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2. Cit Status In this field, Citizenship Status code, enter :

A = Emergency services alien (Alien Chart codes B2, C2, C3, D2, D3, E2, E3, F3, G3, H3, I2, I3, codes J3 through V3, Z2) other than dialysis patient.

D = Emergency services alien who receives dialysis.

V = Visitor, non-immigrant alien (Alien Chart codes W1, W2, W3).

The Alien Codes Chart is found in Appendix 5 to this subchapter.

NOTE: Foreign visitors are not usually eligible for Medicaid because usually they do not meet the Virginia state residency requirement.

3. Entry date **THIS FIELD MUST BE ENTERED.** Enter the date on which the alien entered the U.S., except for asylees and deportees. For asylees, enter the date asylum was granted. For deportees, enter the date deportation withholding was granted.

4. App Dt In this field, application date, enter the date of the alien's Medicaid application upon which the eligibility coverage period is based.

5. Covered Dates Begin In this field, coverage begin date, enter the begin date of the emergency service(s).

6. Covered Dates End In this field, coverage end date, enter the date when the alien's emergency service(s) ends. When the emergency service(s) received was related to labor and delivery, the end date includes the day of discharge even though it is not counted to determine the length of stay for certification purposes.

7. AC Enter the code applicable to the alien's covered group.

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

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

[https://fusion.dss.virginia.gov/Portals/\[bp\]/Files/SAVE/Inform%20for%20Applicants%20Verification%20of%20Immigration%20Status.pdf?ver=2019-05-29-135745-363](https://fusion.dss.virginia.gov/Portals/[bp]/Files/SAVE/Inform%20for%20Applicants%20Verification%20of%20Immigration%20Status.pdf?ver=2019-05-29-135745-363).

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

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

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Alien Status Reference Guide

		Immigration Status	Eligible for Full Medicaid Benefits?	MMIS Code
Qualified Non-Citizen				
Arrived in U.S. before 8/22/1996	Exempt from 5 year waiting period and no time limit on eligibility	Lawful Permanent Resident	Yes	P
		Refugee under section 207	Yes	R
		Amerasian Immigrant	Yes	P
		Conditional Entrant Under Section 303(a)(7)	Yes	P
		Asylee Under Section 208	Yes	P
		Parolee under section 212(d)(5)	Yes	P
		Deportee whose deportation is withheld under section 243(h) or 241(b)(3)	Yes	P
		Cuban or Haitian Entrant	Yes	P
		Battered alien, alien parent of a battered child, and/or alien child of a battered parent	Yes	P
		Alien who arrived prior to 8/22/96 with unqualified status and who remained physically present in U.S. from date of entry to date of adjustment to a status listed above	Yes	See above
Arrived in U.S. on or after 8/22/1996	Has resided in the U.S. for 7 years or less; exempt from 5 year waiting period	Refugee	Yes	R
		Asylee	Yes	P
		Deportee	Yes	P
		Cuban or Haitian Entrant	Yes	P
		Victim of a severe form of trafficking	Yes	P
		Afghan or Iraqi immigrant admitted on a Special Immigrant Visa	Yes	P
Arrived in U.S. on or after 8/22/1996	Has resided in the U.S. for more than 7 years	Refugee	No—Eligible for Emergency Services Coverage Only	A
		Asylee		A
		Deportee		A
		Cuban or Haitian Entrant		A
		Victim of a severe form of trafficking		A
		Afghan or Iraqi immigrant admitted on a Special Immigrant Visa		A
Arrived in U.S. on or after 8/22/1996	Has resided in the U.S. for at least 5 years	Lawful Permanent Resident with 40 qualify quarters of work coverage on record with the Social Security Administration	Yes	P
		Lawful Permanent Resident without at least 40 qualify quarters of work coverage on record with the Social Security Administration	No—Eligible for Emergency Services Coverage Only	A

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	Immigration Status	Eligible for Full Medicaid Benefits?	MMIS Code
Lawfully Residing Non-Citizen Children Under Age 19 Years and Pregnant Women			
No limitation on date of arrival to the U.S. No time limitation on eligibility as long as covered group requirements are met	A qualified alien as defined in section 431 of PRWORA (8 U.S.C § 1641) (see M0220.310)	Yes	<19 I Pregnant P
	An alien in a nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission, including individuals with valid visas.	Yes	<19 I Pregnant P
	An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and nationality Act (INA) (8 U.S.C § 1182 (d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings	Yes	<19 I Pregnant P
	An alien who belongs to one of the following classes:	Yes	<19 I Pregnant P
	<ul style="list-style-type: none"> aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C.§§ 1160 or 1255a, respectively) 	Yes	<19 I Pregnant P
	<ul style="list-style-type: none"> aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. § 1254a), and pending applicants for TPS who have been granted employment authorization 	Yes	<19 I Pregnant P
	<ul style="list-style-type: none"> aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24) 	Yes	<19 I Pregnant P
	<ul style="list-style-type: none"> Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended 	Yes	<19 I Pregnant P
	<ul style="list-style-type: none"> aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President 	Yes	<19 I Pregnant P
	<ul style="list-style-type: none"> aliens currently in deferred action status, except for individuals receiving deferred status as a result of the Deferred Action for Childhood Arrivals (DACA) process, announced by the U.S. Department of Homeland Security on June 15, 2012 	Yes	<19 I Pregnant P
	<ul style="list-style-type: none"> aliens whose visa petition has been approved and who have a pending application for adjustment of status 	Yes	<19 I Pregnant P
	A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158), or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231), or under the Convention Against Torture who has been granted employment authorization, or such an applicant under the age of 19 who has had an application pending for at least 180 days	Yes	<19 I Pregnant P
	An alien who has been granted withholding of removal under the Convention Against Torture	Yes	<19 I Pregnant P
	A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J))	Yes	<19 I Pregnant P
An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806 (e)	Yes	<19 I Pregnant P	
An alien who is lawfully present in American Samoa under the immigration laws of American Samoa	Yes	<19 I Pregnant P	

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		Immigration Status	Eligible for Full Medicaid Benefits?	MMIS Code
Non-Citizen				
No limitation on date of arrival to the U.S.	No time limitation on eligibility as long as covered group requirements are met	a. A qualified alien and veteran who was discharged honorably not on account of alienage, and who fulfills the minimum active-duty service requirements of section 5303A(d) of title 38, United States Code	Yes	P
		b. A qualified alien on active duty (other than active duty for training) in the Armed Forces of the United States (not in the Armed Forces Reserves)	Yes	R
		The spouse or the unmarried dependent child (see M0220.311 A) of a living (not deceased) qualified alien who meets the conditions in a. or b. above	Yes	P
		The unremarried surviving spouse of an individual described in a. or b. above who is deceased, if the spouse was married to the veteran <ul style="list-style-type: none"> before the expiration of fifteen years after the termination of the period of service in which the injury or disease causing the death of the veteran was incurred or aggravated; or for one year or more; or for any period of time if a child was born of the marriage or was born to them before the marriage. 	Yes	P
		Recipients of Supplemental Security Income (SSI)	Yes	P
		An alien who is <ul style="list-style-type: none"> an American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (INA) apply, or a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)), 	Yes	P

Arrived in U.S. on or after 8/22/1996	Regardless of length of residency in U.S.	Individuals with no immigration documents (undocumented)	No—Eligible for Emergency Services Coverage Only	A
		Deferred Action Childhood Arrivals (DACA)	No—Eligible for Emergency Services Coverage Only	A
		Individuals whose immigration status has expired and who do not meet any other immigration status	No—Eligible for Emergency Services Coverage Only	A
		Lawful Permanent Resident who has resided in the U.S. for fewer than 5 years and/or without at least 40 qualify quarters of work coverage on record with the Social Security Administration	No—Eligible for Emergency Services Coverage Only	A

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TN #93	1/1/10	Page 13

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Subchapter Subject M0280 INSTITUTIONAL STATUS REQUIREMENTS	Page ending with M0280.300	Page 6

M0280.300 INMATE OF A PUBLIC INSTITUTION

A. Policy

Inmates of public institutions fall into three groups:

- individuals living in ineligible public institutions;
- incarcerated adults; and
- juveniles in detention.

An individual is an inmate of a public institution from the date of admission to the public institution until discharge, or from the date of actual incarceration in a prison, county or city jail or juvenile detention facility until permanent release, bail, probation or parole. An individual is considered incarcerated until permanent release, bail, probation or parole.

Incarcerated individuals (adults and juveniles) who are hospitalized can be eligible for Medicaid payment limited to services received during an inpatient hospitalization, provided they meet all other Medicaid eligibility requirements.

An individual released from jail under a court probation order due to a medical emergency is NOT an inmate of a public institution because he is no longer incarcerated.

B. Public Residential Facility Residents

An individual who lives in a public residential facility that serves more than 16 residents is NOT eligible for Medicaid.

A public residential facility that does not meet the definition of a “publicly operated community residence” in section M0280.100 above, is an “ineligible public institution.”

The following are ineligible public institutions:

- public residential institutions with more than 16 beds
- residential facilities located on the grounds of, or adjacent to, a public institution with more than 16 beds:

C. Incarcerated Adults

Offenders can be eligible for Medicaid payment limited to services received during an inpatient hospitalization of 24 hours or longer.

Offenders include:

- individuals under the authority of the Department of Corrections (DOC)
- individuals held in regional and local jails, including those on work release

Individuals are not eligible for full benefit Medicaid coverage while they are living in a correctional facility, regional or local jail *For a juvenile in a*

facility, refer to M0280.300.D below and Appendix 1.

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An *offender* who transfers temporarily to a halfway house, *residential re-entry center (RRC)*, or residential treatment facility prior to a formal probation release order is still an inmate of a public institution and can only be eligible for Medicaid payment limited to services received during an inpatient hospitalization. *Note: some drug or alcohol rehabilitation centers may be referred to as a “halfway house”; the eligibility worker should confirm the individual is not an inmate or incarcerated.*

Once an individual is released from the correctional facility, he can be *reviewed and* enrolled in full benefit Medicaid, provided all Medicaid eligibility requirements *are met*.

D. Juveniles in Detention

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

1. Held for Care, Protection or Best Interest

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

2. Held for Criminal Activity

a. Prior to Court Disposition

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

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

b. After Court Disposition

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

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

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G. Probation, Parole, or Conditional Release

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

- home arrest
- community services
- outpatient treatment
- inpatient treatment (*not inpatient hospitalization*)

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

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

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

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

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

I. Juvenile on Probation in Secure Treatment Center

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

J. Juvenile On Conditional Probation

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

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

K. Juvenile On Probation in Secure Treatment Center

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

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B. All Other Institutions

Local social services departments *are responsible* for the Medicaid eligibility determination and enrollment of individuals in institutions that are not operated by DBHDS, **EXCEPT for incarcerated individuals in aid category 108 or 109**. The local DSS agency in the Virginia locality where the individual last resided outside of an institution is the responsible DSS agency. If the individual resided outside of Virginia immediately before admission to the institution, the responsible local DSS is the DSS agency serving the locality where the institution is located.

When a local department carries responsibility for eligibility determination and enrollment of an individual living in an institution, the department is also responsible for:

- advising the institution of the individual's eligibility for Medicaid and enrollment in the program;
- submitting a DMAS-225 form to the institution to indicate the patient's eligibility and availability of current patient pay information in the Medicaid Management Information System (MMIS), if applicable; and
- seeing that the Medicaid card is forwarded to the institution for the enrollee's use.

The Cover Virginia Incarcerated Unit (CVIU) is responsible for case management of incarcerated individuals with active Medicaid coverage enrolled in aid categories 108 and 109, regardless of the facility where the offender resides. See M0140 for details.

M0310 Changes
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Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/19	Pages 24, 26, 27, 40
TN #DMAS-13	7/1/19	Pages 24 Page 24a is a runover page.
TN #DMAS-12	4/1/19	Pages 8, 9, 13
TN #DMAS-10	10/1/18	Table of Contents, page ii Pages 1-4 Page 40 was added.
TN #DMAS-9	7/1/18	Page 35 Appendix 2, Page 1
TN #DMAS-8	4/1/18	Page 9
TN #DMAS-7	1/1/18	Pages 34, Appendix 2, page 1
TN #DMAS-5	7/1/17	Pages 13, 37, 38
TN #DMAS-4	4/1/17	Pages 24, 30a Page 23 is a runover page. Page 24a was added as a runover page.
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

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Subchapter Subject M0310 GENERAL RULES & PROCEDURES	Page ending with M0310.112	Page 24

1. Individual Under Age 19 and Not Receiving Long-term Care

A child under age 19 who is not receiving LTC services and who is claiming to have a disabling condition must have his disability determined by DDS if:

- he is not eligible for FAMIS Plus or FAMIS, or
- it is 90 calendar days prior to his 19th birthday.

Do **NOT** refer a disabled child under age 19 to DDS for the sole purpose of participation in the Health Insurance Premium Payment (HIPP) program

2. Individual Under 21 in LTC

a. Facility-based Care

An individual under age 21 in a nursing facility or intermediate care facility for the intellectually disabled (ICF-ID) must have his disability determined if

- he is not eligible in the Individuals Under 21 covered group, or
- it is 90 calendar days prior to his **21st** birthday.

b. Home and Community-based Services (HCBS)

A child who is receiving HCBS waiver services and has not previously had a disability determination must have his disability determined prior to his **18th** birthday because he will no longer be eligible in the F&C 300% SSI covered group (*under which parental income is not counted*), once he turns 18. The child must be evaluated for coverage as a blind or disabled individual using the income and resource rules applicable to blind/disabled institutionalized individuals. For a child under 19 who is not disabled, MAGI income counting rules require that parental income be included in the eligibility determination.

Ninety days (90) prior to the child turning age 18, the eligibility worker must contact the parent or responsible party and send a verification checklist to request the required documents to start the DDS referral process. Follow the procedure in M0310.112 G below to make a referral to DDS.

Note: The local DSS is not responsible for initiating a DDS referral for a child turning 18 who receives SSI. The child will have a review of continuing disability and SSI eligibility completed by the SSA. The child remains disabled for Medicaid purposes unless and until his disability status is discontinued by SSA.

E. When an LDSS Referral to DDS is Required

1. Disability Determination Has Not Been Made

The DDS must make a determination of disability when the applicant alleges a disability and a disability determination has not been made by SSA or the RRB. The DDS must make a disability determination within a time frame that will allow the LDSS to process the application within 90 days, provided all medical information has been submitted.

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1. LDSS Referrals to DDS for Non-expedited Cases

- a. Send the following forms to the applicant for completion immediately, giving the applicant 10 calendar days to return the completed forms:
 - a copy of the Frequently Asked Questions—Disability Determinations for Medicaid (form #032-03-0426), available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>, explaining the disability determination process and the individual’s obligations;
 - the Disability Report Adult (SSA-3368-BK), available at <http://www.socialsecurity.gov/online/ssa-3368.pdf>, or the Disability Report Child (SSA-3820-BK), available at <http://www.socialsecurity.gov/online/ssa-3820.pdf>,
 - an Authorization to Disclose Information to the Social Security Administration form (SSA-827), available at <http://www.socialsecurity.gov/online/ssa-827.pdf>.
- b. In most cases, the DDS referral is transmitted electronically to DDS through VaCMS. Form 3368-BK or 3830-BK and SSA-827 are uploaded to VaCMS for submission to DDS. No DDS Referral Form is used for electronic submissions. Follow the instructions in the Quick Reference Guide “Sending a DDS Referral in the VaCMS,” available in VaCMS.
- c. If the DDS referral cannot be completed in VaCMS, manually submit the referral. Complete the DDS Referral Form, available at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms>. Use the DDS Referral Form that corresponds with the DDS Regional Office to which the LDSS has been assigned (#032-03-0095, #032-03-0096, #032-03-0097, or #032-03-0098). To the form, attach the following:
 - the completed Disability Report
 - the signed Authorization to Disclose Information
 - copies of paystubs, if the applicant is currently working.

If the individual’s application was filed with the assistance of a hospital-based eligibility assistance organization, a copy of the consent to release information to the organization must be included with the referral so DDS staff can communicate with them, if necessary.

Mail the DDS Referral form and attachments to the appropriate DDS Regional Office. See Appendix 2 to this subchapter for the locality assignments and addresses for DDS Regional Offices. **Do not send referrals to DDS via the courier.**

2. Expedited Referrals for Hospitalized Individuals Awaiting Transfer to a Rehabilitation Facility

The 2004 Budget Bill mandated that DDS make a disability determination within seven (7) working days of the receipt of a referral from the LDSS when the Medicaid applicant is hospitalized, needs to be transferred directly to a rehabilitation facility AND the individual does not already have a disability application pending with DDS. To ensure that the DDS is able to make the disability determination within the mandated timeframe, the procedures below shall be followed:

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- a. Hospital staff shall simultaneously send:
 - the Medicaid application and a cover sheet (see Appendix 1 to this subchapter for an example of the cover sheet) to the LDSS or the hospital outstationed eligibility worker
 - the medical documentation (disability report, authorizations to release information and medical records) and cover sheet to the DDS.
- b. LDSS shall **immediately** upon receipt of the Medicaid application:
 - fax a completed DDS Referral Form (#032-03-0095, #032-03-0096, #032-03-0097, or #032-03-0098) available at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms> to the appropriate DDS region, to verify receipt of the Medicaid application unless it is known to the agency that the individual already has a pending disability claim with DDS. If the individual already has a pending disability claim with DDS, the claim cannot be treated as an expedited referral.
 - give priority to processing the applications and immediately request any verifications needed; and
 - process the application as soon as the DDS disability determination and all necessary verifications are received; and
 - notify the hospital contact identified on the cover sheet of the action on the application and provide the Medicaid enrollee number, if eligible.
- c. DDS shall make a disability determination within seven (7) working days and fax the result of the disability decision to the LDSS. DDS is not responsible for notifying either the applicant or the hospital of the outcome of the disability determination.

If DDS is unable to render a decision within 7 working days, DDS will send a communication to the LDSS advising that the disability determination has been delayed.

3. Application Processing When DDS Referral is Pending

If the completed forms are not returned by the applicant within 45 calendar days from the date of application, the applicant is considered not to meet the covered group and the application must be denied.

Individuals who require a disability determination must meet all non-financial requirements other than covered group, within 45 calendar days or the application must be denied. If these requirements are met, the application timeframe may be extended to 90 days while DDS is making the disability determination. If any non-financial requirement other than covered group is not met by the 45th calendar day, his application must be denied and DDS must be notified of the denial.

DDS does NOT stop the disability determination process when the individual meets all non-financial requirements, but has excess resources (see M0130.100 B.4) because he might reduce his resources while the

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M0310.136 MAGI ADULT

A. Definition

A MAGI Adult is a person who is not defined as a “child” (see M0310.110).

The 2018 Appropriations Act mandated that Medicaid in Virginia be expanded effective January 1, 2019. This new expanded coverage group is called MAGI Adults and covers individuals ages 19-64 who are not eligible for or enrolled in Medicare and who have income at or below 138% of FPL. Several new aid categories have been added for the MAGI Adults covered group.

- Childless adults, income less than 100% FPL;
- Childless adults, income less than 138% FPL (133% + 5% income disregard);
- Parent/Caretaker adult relatives, above current LIFC income limit and at or below 100% FPL;
- Parent/Caretaker adult relatives, above 100% FPL and at or below 138% FPL (133% + 5% income disregard);
- Presumptive eligible adult, income at or below 138% FPL (133% + 5% income disregard);
- Incarcerated adult who otherwise meet a Medicaid MAGI Adult aid category but not enrolled due to incarceration.

B. Procedure

The procedures used to determine if an individual meets the MAGI Adults covered group are contained in subchapters M0320 and M0330.

M0320 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/19	Page 40
TN #DMAS-13	7/1/19	Pages 1, 24-27
TN #DMAS-11	1/1/19	Pages 2a, 11, 35, 37
TN #DMAS-10	10/1/18	Page 1 1a added as a runover page
TN #DMAS-9	7/1/18	Page 2, 17
TN #DMAS-7	1/1/18	Page 2, 3, 4, 11, 26-27.
TN #DMAS-4	4/1/17	Page 26
TN #DMAS-3	1/1/17	Pages 11, 27, 29, 40, 41, 44, 45, 52
TN #DMAS-2	10/1/16	Pages 4, 15, 16, 18, 20, 22, 30, 33, Pages 39- 41, 43-45, 48, 51, 52, 55
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 1, 11, 25-27, 46-49 Page 50 is a runover page.
TN #100	5/1/15	Pages 6, 11, 24, 25-27, 29-30
TN #99	1/1/14	Page 11
TN #98	10/1/13	Pages 1, 54, 55.
UP #9	4/1/12	Pages 11, 26, 32, 34-37, 45, 46, 55
TN #97	9/1/12	Table of Contents Pages 1-56 (all pages)
UP #6	4/1/12	Pages 11, 12, 46a
TN #96	10/1/11	Table of Contents Pages 46f-50b Page 50c deleted
TN #95	3/1/10	Pages 11, 12, 42c, 42d, 50, 53, 69 Pages 70, 71 Page 72 added.
TN #94	9/1/10	Pages 49-50b
UP #3	3/1/10	Pages 34, 35, 38, 40, 42a, Pages 42b, 42f
TN #93	1/1/10	Pages 11-12, 18, 34-35, 38 Pages 40, 42a-42d, 42f-44, 49 Pages 50c, 69-71
UP #2	8/24/09	Pages 26, 28, 32, 61, 63, 66
Update (UP) #1	7/1/09	Pages 46f-48
TN #91	5/15/09	Pages 31-34 Pages 65-68

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Subchapter Subject M0320.000 AGED, BLIND & DISABLED GROUPS	Page ending with M0320.601	Page 40

3. Income

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

4. Income Exceeds QMB Limit

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

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

D. QMB Entitlement

Entitlement to Medicaid coverage for QMB only begins the first day of the month **following** the month in which Medicaid eligibility as a QMB is *determined and approved*, **not** the month of application. See M1520.102.A.2.

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

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

E. Enrollment

1. Aid Categories

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

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

2. Enrollee's Covered Group Changes To QMB

If a Medicaid enrollee becomes **ineligible** for full-coverage Medicaid because of an increase in income or resources, but is eligible as a QMB, the agency must send an advance notice of proposed action to the enrollee because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare premiums, deductibles and coinsurance amounts as a QMB.

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Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/19	Pages 1, 2, 10a
TN #DMAS-12	4/1/19	Pages 26, 28
TN #DMAS-11	1/1/19	Pages 1, 2, 12, 14-16, 24, 25
TN #DMAS-10	10/1/18	Table of Contents Page 1-2, 30 Page 10a-b were added as runover pages.

M0330 Changes

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TN #DMAS-8	4/1/18	Pages 1, 9, 10, 25
TN #DMAS-6	10/1/17	Pages 8, 14
TN #DMAS-5	7/1/17	Pages 9, 14
TN #DMAS-4	4/1/17	Page 5
TN #DMAS-3	1/1/17	Pages 9, 10 Page 9a was removed.
TN #DMAS-2	10/1/16	Pages 8 Page 9b was renumbered to 9a.
TN #DMAS-1	6/1/16	Pages 2, 8, 9, 15, 31, 32-35 Page 9b was added as a runover page.
TN #100	5/1/15	Table of Contents Pages 4-8, 15-22, 24,25 36-38
UP #10	5/1/14	Pages 5, 8, 9
TN #99	1/1/14	Pages 1, 8, 9, 13, 24
TN #98	10/1/13	Table of Contents Pages 1-3, 6-16, 19, 22, 24-29
UP #8	10/1/12	Pages 4, 6
TN #97	9/1/12	Table of Contents Pages 1-40 (all pages)
UP #2	8/24/09	Pages 3, 6, 8, 16, 22
Update (UP) #1	7/1/09	Pages 20, 21
TN #DMAS-4	4/1/17	Page 5
TN #DMAS-3	1/1/17	Pages 9, 10 Page 9a was removed.
TN #DMAS-2	10/1/16	Pages 8 Page 9b was renumbered to 9a.
TN #DMAS-1	6/1/16	Pages 2, 8, 9, 15, 31, 32-35 Page 9b was added as a runover page.
TN #100	5/1/15	Table of Contents Pages 4-8, 15-22, 24,25 36-38
UP #10	5/1/14	Pages 5, 8, 9
TN #99	1/1/14	Pages 1, 8, 9, 13, 24
TN #98	10/1/13	Table of Contents Pages 1-3, 6-16, 19, 22, 24-29
UP #8	10/1/12	Pages 4, 6
TN #97	9/1/12	Table of Contents Pages 1-40 (all pages)
UP #2	8/24/09	Pages 3, 6, 8, 16, 22
Update (UP) #1	7/1/09	Pages 20, 21

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Subchapter Subject M0330.000 FAMILIES & CHILDREN GROUPS	Page ending with M0330.001	Page 1

M0330.000 FAMILIES & CHILDREN GROUPS

M0330.001 GENERAL POLICY PRINCIPLES

A. Overview

A State Plan for Medicaid must include the mandatory federal categorically needy (CN) groups of individuals as well as the optional groups a state has elected to cover. This subchapter divides the Families & Children (F&C) covered groups into categorically needy and medically needy (MN) groups.

Enroll children and adults who receive Supplemental Security Income (SSI) in the SSI Medicaid covered group (see M0320.101). Evaluate other disabled children and adults for eligibility in the F&C CN covered groups first because they do not have a resource requirement. Individuals who are eligible for or entitled to Medicare cannot be eligible in the MAGI Adults covered group.

B. Procedure

Determine an individual's eligibility first in a CN covered group. If the individual is not eligible as CN or for the Family Access to Medical Insurance Security Plan (FAMIS), go to the MN groups.

A determination of eligibility for a F&C child should follow this hierarchy:

1. If the child meets the definition of a foster care child, adoption assistance child, special medical needs adoption assistance child or an individual under age 21, evaluate in these groups first.
2. If the child meets the definition of a newborn child, evaluate in the pregnant woman/newborn child group.
3. If the child is under age 18 or is an individual under age 21 who meets the adoption assistance or foster care definition or is under age 21 in an intermediate care facility (ICF) or facility for individuals with intellectual disabilities (ICF-ID), AND is in a medical institution or has been screened and approved for Home and Community Based Services (HCBS) or has elected hospice, evaluate in the appropriate F&C 300% of SSI covered group.
4. If a child is under the age of 19, evaluate in this group.
5. If a child is a former foster care child under age 26 years, evaluate for coverage in this group.
6. If a child has income in excess of limits individual, evaluate for the Family Access to Medical Insurance Security Plan (FAMIS) eligibility (chapter M21).
7. If the child is a child under age 1, child under age 18, an individual under age 21 or a special medical needs adoption assistance child, but has income in excess of the appropriate F&C CN income limit, evaluate as MN.

A determination of eligibility for a F&C adult should follow this hierarchy:

1. If the individual meets the definition of a parent/caretaker relative, evaluate in the LIFC covered group.
2. If the individual is not eligible as LIFC, but meets the definition of a pregnant woman, evaluate in the pregnant woman/newborn child group.
3. If the individual has been screened and diagnosed with breast or cervical cancer or pre-cancerous conditions by the Every Woman's Life program and does not meet the definition of for coverage as SSI, LIFC, Pregnant Woman or Child under 19, evaluate in the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) covered group.
4. If the individual is a former foster care child under 26 years, *and does not meet the definition of for coverage as SSI, LIFC, Pregnant Woman or Child under 19*, evaluate in this covered group.
5. If the individual is between the ages of 19 and 64 and is not eligible for or entitled to Medicare, evaluate in the MAGI Adults group.
6. If the individual is not eligible as a MAGI Adult, as LIFC or as a pregnant woman, is in medical institution, has been screened and approved for Home and Community Based Services or has elected hospice, evaluate in the appropriate F&C 300 % of SSI covered group.

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If the individual is a parent or caretaker-relative of a dependent child and in a medical institution, the stay must be temporary while receiving treatment, rehabilitation, etc. for him to meet the definition of living in the home with the dependent child. There are no time limits on the amount of time the parent can be in a medical institution as long as he intends to return home. Verify with the parent the reason he is in a medical facility and ask about the intent to return home.

7. If the individual has excess income for full coverage in a Medicaid covered group and is between the ages of 19 and 64, evaluate for Plan First coverage.
8. If the individual is a pregnant woman but has excess income for coverage in a CN group or FAMIS MOMS evaluate as MN.

M0330.100 FAMILIES & CHILDREN CATEGORICALLY NEEDY

A. Introduction

An F&C individual must be a child under age 19 or must meet the adoption assistance, dependent child, foster care, parent or caretaker-relative of a dependent child living in the home, pregnant woman, or BCCPTA definition, or must have applied for Plan First.

The F&C covered groups are divided into the categorically needy (CN) and medically needy (MN) classifications. Always evaluate eligibility in the categorically needy groups and FAMIS before moving to MN.

B. Procedure

The policy and procedures for determining whether an individual meets an F&C CN covered group are contained in the following sections:

M0330.100 Families & Children Categorically Needy Groups
M0330.105 IV-E Foster Care & IV-E Adoption Assistance;
M0330.107 Individuals Under Age 21;
M0330.108 Special Medical Needs Adoption Assistance;
M0330.109 Former Foster Care Children Under Age 26 Years
M0330.200 Low Income Families With Children;
M0330.250 MAGI Adults Group
M0330.300 Child Under Age 19 (FAMIS Plus);
M0330.400 Pregnant Women & Newborn Children;
M0330.500 300% of SSI Covered Groups
M0330.600 Plan First--Family Planning Services;
M0330.700 Breast and Cervical Cancer Prevention and Treatment Act

C. Eligibility Methodology Used

With the exception of the F&C 300% of SSI covered groups for institutionalized individuals, the F&C covered groups that require a financial eligibility determination use Modified Adjusted Gross Income (MAGI) methodology for evaluating countable income. The policies and procedures for MAGI methodology are contained in chapter M04 unless otherwise specified.

MAGI methodology is not applicable to the F&C 300% of SSI covered groups. See M0330.501 – M0330.503 for information regarding the applicable financial eligibility policies.

M0330.105 IV-E FOSTER CARE OR IV-E ADOPTION ASSISTANCE RECIPIENTS

A. Policy

42 CFR 435.145--The federal Medicaid law requires the State Plan to cover children who are eligible for foster care or adoption assistance payments under Title IV-E of the Social Security Act.

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Subchapter Subject M0330.000 FAMILIES & CHILDREN GROUPS	Page ending with M0330.250	Page 10a

M0330.250 MAGI ADULTS (EFFECTIVE JANUARY 1, 2019)

A. Policy

The Virginia 2018 Appropriations Act mandated that effective January 1, 2019, the State Plan for Medical Assistance be amended to add a new covered group for adults between the ages of 19 – 64. This mandate is titled “New Health Coverage Options for Virginia Adults” and the new covered group will be known as MAGI (Modified Adjusted Gross Income) Adults.

This new group may be designated in various reports, documentation, or publications of other agencies as New Enrolled Adults, Newly Enrolled Adults, or Medicaid Expansion Adults.

The MAGI Adults Group includes:

- MAGI Parent/Caretaker Relatives (AC 100, AC 101) who meet Medicaid requirements within a MAGI Adult group and must be responsible for a dependent child under age 18 (or less than age 19, still in school and expected to graduate by his 19th birthday);
- MAGI Childless Adults (AC 102, AC 103) who meet Medicaid requirements within a MAGI Adults group and are not responsible for a dependent child or claim such a child on his tax return;
- MAGI Presumptive Eligible Adults (AC 106) who meet Medicaid requirements within a MAGI Adults group and have had a determination made by an authorized PE Hospital; and
- MAGI Incarcerated Adults (AC 108) who would otherwise be eligible for Medicaid as a MAGI Adult except for being incarcerated in a Department of Corrections (DOC) facility or a local / regional jail.

Note: All HPE applications are processed by hospitals and enrolled at Cover Virginia. See M0120.500.D - Hospital Presumptive Eligibility.

B. Procedure

Eligible individuals in the MAGI Adults group must:

- be an individual between the ages of 19 and 64;
- have income at or below 138% *FPL* (133% *FPL* + 5% *FPL* disregard);
- not be entitled to or enrolled in Medicare Part A or B;
- not be eligible in a Medicaid mandatory covered group or the BCCPTA covered group.
- meet any other criteria as outlined in the particular aid categories.

A person in the MAGI Adults covered group may receive long term services and supports (LTSS) in either a facility or home and community based services (waiver) setting. The individual is still required to be assessed and approved for such care.

C. Non-Financial Eligibility

The individual must meet all the nonfinancial eligibility requirements in chapter M02. If the individual is not a U.S. citizen, he must meet the alien status requirements. These requirements differ depending on the age and pregnancy status of the individual. See subchapter M0220.

M04 Changes
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Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/19	Pages 1, 3, 4, 5, 14, 16, 32, 33 Appendix 8
TN #DMAS-13	7/1/19	Pages 32-34, 36 Appendices 3 and 5
TN #DMAS- 12	4/1/19	Pages 2, 3, 5-8, 15-16, 19, 32-37 Page 16a was added as a runover page. Page 37 was removed. Appendices 1, 2, 5, 7, 8
TN #DMAS-11	1/1/19	Pages 8, 15, 32-35 Pages 36 and 37 were added.
TN #DMAS-10	10/1/18	Table of Contents Pages 1-5, 9, 10, 15, 16, 19, 22, 23, 30-32 Appendix 7 Appendix 8 was renumbered. Pages 6-8, 11-14, 17, 18, 20, 21, 24-29, 33-35 are runover pages.

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M0410.000 MODIFIED ADJUSTED GROSS INCOME (MAGI)

M0410.100 MAGI GENERAL INFORMATION

A. Introduction

Beginning October 1, 2013, determinations of eligibility for most families and children (F&C) Medicaid covered groups and the Family Access to Medical Insurance Security Plan (FAMIS) will be done using the Modified Adjusted Gross Income (MAGI) methodology.

Effective January 1, 2019, determination of eligibility for adults age 19-64 without Medicare will be evaluated using MAGI income methodology. These newly eligible individuals are referred to as MAGI Adults.

MAGI methodology will also be used to determine eligibility for participation in the Federal Health Insurance Marketplace. Medicaid, FAMIS and the Federal Health Insurance Marketplace (HIM) are called insurance affordability programs. Medicaid and FAMIS are collectively referred to as medical assistance (MA) programs.

For all case actions effective October 26, 2019, verification of earned and unearned income will be evaluated using attested income and reasonable compatibility rules. Whenever possible, income reported on the application will be verified through electronic data sources.

The goal of using MAGI methodology for all insurance affordability programs is to align financial eligibility rules, provide a seamless and coordinated system of eligibility and enrollment, and maintain the eligibility of low-income populations, especially children.

B. Legal Base

The Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152) (collectively referred to as the Affordable Care Act [ACA]) is the legal base for the changes required to be made in the Medicaid and CHIP (FAMIS) eligibility determinations. The 2018 Appropriations Act provided funding for New Health Coverage Options for Virginia Adults. Effective January 1, 2019, determination of eligibility for adults between the ages of 19-64 without Medicare will be evaluated using MAGI income methodology. Adults eligible under the expansion of coverage will be referred to as Modified Adjusted Gross Income (MAGI) Adults. Individuals in the MAGI Adults covered group are not subject to a resource test unless the individual requests Medicaid payment for LTC/LTSS. The resource and home equity requirements for MAGI Adults are contained in M1460.

MAGI and household income are defined in section 36B(d)(2)(A) and (B) of the Internal Revenue Service Code (IRC). The MAGI-based methodology under the Medicaid statute includes certain unique income counting and household (HH) composition rules reflected in the Centers for Medicare and Medicaid Services (CMS) regulations at 42 CFR 435.603 and discussed in section III.B. of the preamble to the eligibility final rule published in the Federal Register on March 23, 2012.

C. Policy Principles

1. What is MAGI?

MAGI:

- is a methodology for how income is counted and how household composition and family size are determined,
- is based on federal tax rules for determining adjusted gross income (with some modification), and

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- Supplemental Security Income (SSI) recipients.
- IV-E foster care or adoption assistance recipients
- Deemed newborns
- BCCPTA (Breast and Cervical Cancer Prevention and Treatment Act) enrollees
- Auxiliary Grants.

b. individuals who are eligible on the basis of being aged (age 65 or older), blind or disabled;

- individuals eligible for or enrolled in Medicare;
- individuals evaluated as Medically Needy (MN);

5. Special Medical Needs Adoption Assistance Children

A Special Medical Needs Adoption Assistance (AA) child is subject to MAGI methodology for the child's initial Medicaid eligibility determination. These children are in their own household apart from parents and siblings. Parents' and siblings' income is not counted for these children.

6. MAGI Adults

a. MAGI methodology is used to determine eligibility for the following individuals with income at or below 138% (133% + 5% disregard) of the Federal Poverty Limit:

- Parents and caretaker- relatives with excess income for LIFC
- Disabled individuals not eligible for or entitled to Medicare or individuals alleging disability who have not been determined disabled
- Childless adults ages 19-64
- Incarcerated individuals ages 19-64. *Incarcerated individuals are eligible for inpatient hospital services only; no LTSS services are covered.*
- Non-citizens eligible for emergency services only
- Individuals eligible for Long Term Care Services and Support (LTSS) ages 19-64
Note: See Chapter M14 for LTSS screening requirements.

b. The following individuals are not eligible under the MAGI ADULTS group:

- Individuals pregnant at initial application or redetermination of eligibility
- Individuals under the age of 19 or 65 and over
- Individuals eligible for or enrolled in Medicare Part A or B

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- Individuals eligible in the following covered groups:
 - LIFC (parents and caretaker-relatives)
 - Pregnant Women
 - Adoption Assistance and Foster Care Children
 - Former Foster Care Children Under Age 26
 - BCCPTA
- Supplemental Security Income (SSI) recipients and protected individuals.

7. Children in Level C Psychiatric Residential Treatment Facilities (PRTFs)

Children placed in Level C PRTFs are considered absent from their home if their stay in the facility has been 30 consecutive days or more. A child who is placed in a Level C PRTF is considered NOT living with his parents for MAGI purposes as of the first day of the month in which the 30th day of psychiatric residential placement occurs. Long-term care rules do not apply. See M0520.100 B.3.

M0420.100 Definitions

A. Introduction

The definitions below are used in this chapter. Some of the definitions are also in subchapter M0310. Some of the definitions are from the IRC.

B. Definitions

1. Advance Premium Tax Credit (APTC)

is a tax credit that an individual or family with taxable income of at least 100% FPL but no more than 400% FPL can take in advance to lower their monthly health insurance premium. Eligibility for the APTC is determined by the federal HIM using MAGI rules for tax-filer households. Projected annual household income, rather than monthly income, is evaluated.

2. Attested Income

means the agency must review income information attested by the applicant and utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family. 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 other verified income in the eligibility record or system. Verification of income from available sources, including the VEC, may be used if it is dated within the previous 12 months.

3. Caretaker Relative

means a non-parent relative of a “dependent” child by blood, adoption, or marriage with whom the child lives, who assumes primary responsibility for the child’s care. When a parent is in the home, no adult relative other than a stepparent can be eligible for Medicaid in the LIFC covered group.

4. Child

means a natural, biological, adopted, or stepchild.

5. Childless Adult

a childless adult is someone who does not meet the definition of an LIFC parent or caretaker-relative.

6. Coverage Gap and Gap-filling Rule

occurs when the difference in eligibility rules between the APTC and Medicaid/FAMIS creates a situation in which an applicant may appear to be financially ineligible for both the APTC (household income is too low) and Medicaid or FAMIS (household income is too high). The gap-filling rule is applied in such cases to help mitigate the coverage gap.

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- 7. Dependent Child** means a child under age 18, or age 18 and a full-time student in a secondary school is expected to graduate prior to his 19th birthday, and who lives with his parent or caretaker-relative.
- 8. Family** means the tax filer (including married tax filers filing jointly) and all claimed tax dependents.
- 9. Family Size** means the number of persons counted as an individual's household. The family size of a pregnant woman's household includes the pregnant woman plus the number of children she is expected to deliver. When determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted as just one person.
- 10. Household** A household is determined by tax dependency. Parents, children and siblings are included in the same household. A child claimed by non-custodial parent is evaluated for eligibility in the household in which he is living and is also counted in the family size of the parent claiming him as a dependent. There can be multiple households living in the home.
- This definition is different from the use of the word household in other programs such as the Supplemental Nutrition Assistance Program (SNAP).**
- 11. MAGI Adult** is an individual between the ages of 19-64 who is not eligible for or enrolled in Medicare and who has income at or below 138% of FPL.
- 12. Non-filer Household** means individuals who do not expect to file a Federal tax return and/or do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made. A non-filer household can also be a child who lives in the household with his custodial parent who is claimed on his non-custodial parent's taxes.
- 13. Parent** for the purposes of MAGI methodology, means a natural, biological, adoptive, or stepparent. When both the child's parent and stepparent are living in the home with the dependent child, both may be eligible in the LIFC covered group.
- 14. Reasonable Compatibility** means the income attested to (declared) by the applicant is within 10% of income information obtained from electronic sources *OR that both the attested income and any electronic income verification are below the applicable income limit*. If the income from both sources meets the 10% requirement *or the income from both sources is below the limit*, then the attestation is considered verified.

The applicant's income reported on the application is compared through a match with income verification available from electronic income sources. The eligibility/enrollment system will compare the reported income with the income from the data match and determine if reasonable compatibility exists. If reasonable compatibility exists, the income will be labeled verified, and no further verification of the income is necessary.

If reasonable compatibility does not exist or income data was not available through *available electronic sources and the attestation is below the medical assistance income level*, *additional verification of income is required.*

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G. Tax Filer, Her Son and Her Nephew

Daria lives with her son, Jack age 11, and her nephew Billy age 8. All applied for MA.

Daria is a tax filer who claims her son and nephew as dependents. Her MAGI household is the same as her tax household. Jack is a tax dependent and no exceptions exist; his MAGI household is the same as the tax household. Billy is a tax dependent claimed by a tax filer who is not his parent so an exception exists and non-filer rules are used. Billy's MAGI household consists of Billy only because he has no parents or siblings in the home. The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Daria	3 – Daria, Jack and Billy	Tax filer and dependents
Jack	3 – Daria, Jack and Billy	Tax filer and dependents
Billy	1 – Billy	Non filer rules; Daria is not his parent, Jack is not his sibling

H. Tax Filer, Spouse, Their Child, His Parent Not Living In the Home

Dave lives with his wife Jean and their child, Cathy age 8. Dave files taxes separately from his wife who files her own taxes each year. Dave claims their child Cathy and his mother, Becky, as his tax dependents. Dave, Jean and Cathy applied for MA.

Dave's MAGI household includes the individuals in his tax household and his wife, Jean because married spouses are always included in each other's MAGI household. Jean is also a tax filer with no additional dependents. Jean's MAGI household includes Dave because married spouses are always included in each other's MAGI household. Cathy is a tax dependent whose parents are not filing jointly so non-filer rules are used; her MAGI household includes herself and her parents. The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Dave	4 – Dave, Jean, Cathy and Becky	Tax filer, spouse, dependent child and dependent parent
Jean	2 – Dave, Jean,	Tax filer and spouse
Cathy	3 – Cathy, Dave, Jean	Non filer rules; child and parents in home

M0440.100 HOUSEHOLD INCOME

A. General Rule

The income counted under MAGI rules is the income counted for federal tax purposes with few exceptions. All taxable income sources and some non-taxable income sources are counted for the MA eligibility determinations.

Whenever possible, income reported on the application will be verified *through available electronic data sources. The agency must utilize online systems that are available to the agency without requiring verifications from the individual or family. If no data sources exist to verify the attestation, and the attestation is below the medical assistance income level, documentation of income is required. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information and information from SSA through SVES or SOLQ-I. Verification of income from available sources, including the VEC, may be used if it is dated within the previous 12 months. The agency must include in each applicant's case record facts to support the agency's decision on the case.*

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- g. Effective January 1, 2019, alimony *received* is not countable.
- Alimony received prior to January 1, 2019, is countable. An individual whose divorce decree was finalized prior to January 1, 2019, has the option with the IRS to adopt the new *IRS alimony* rule by modifying the divorce agreement. *If an individual whose divorce decree was finalized prior to January 1, 2019, does not want alimony received on or after January 1, 2019 to be countable for the MAGI income determination, the individual must provide a copy of the modified divorce agreement to the eligibility worker.*
- h. An amount received as a lump sum is counted only in the month received
- i. Military pay based upon age or years of service (other types of military pay are also counted and excluded; see M0720.290)
- j. *Census income.*
1. **Income That is Not Counted**
- a. Child support received is not counted as income (it is not taxable income).
- b. Workers Compensation is not counted.
- c. When a child is included in a parent or stepparent's household, the child's income is not countable as household income unless the child is required to file taxes because the tax-filing threshold is met. Any Social Security benefits the child may have do not count in determining whether or not the tax filing threshold is met.
- d. Veterans benefits which are **not** taxable in IRS Publication 525 are not counted:
- Education, training, and subsistence allowances,
 - Disability compensation and pension payments for disabilities paid either to veterans or their families,
 - Veterans' insurance proceeds and dividends paid either to veterans or their beneficiaries, including the proceeds of a veteran's endowment policy paid before death,
 - Grants for homes designed for wheelchair living and motor vehicles for veterans who lost their sight or the use of their limbs,
 - Interest on insurance dividends left on deposit with the VA,
 - Benefits under a dependent-care assistance program,
 - The death gratuity paid to a survivor of a member of the Armed Forces who died after September 10, 2001, or
 - Payments made under the VA's compensated work therapy program.
- e. For divorce agreements *finalized* on or after January 1, 2019, no deduction is allowed for alimony paid. *For divorce agreements finalized* prior to January 1, 2019, alimony **paid** to a separated or former spouse outside the home is deducted from countable income.
- f. Interest paid on student loans is deducted from countable income.
- g. Gifts, inheritances, and proceeds from life insurance are not counted.

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Dee's eligibility determination:

Potential covered groups:

Child < Age 19
FAMIS

Monthly Income limits:

Child < Age 19 143% FPL for a HH of 2 = \$1,962
FAMIS, 200% FPL for HH of 2 = \$2,585
5% FPL for 2 = \$65

HH monthly income:

\$300 (Jane's gross earnings)

\$300 is less than the Medicaid Child < Age 19 143% FPL income limit for 2 (\$1,962) so Dee is eligible for Medicaid in the Child < Age 19 covered group. The 5% disregard is not applied because it is not necessary; her gross HH income is within the Medicaid Child < Age 19 income limit.

M0450.400 GAP-FILLING RULE EVALUATION

A. When to Complete Gap-Filling Evaluation

Complete a gap-filling evaluation to determine eligibility for Medicaid or FAMIS whenever **all** of the following conditions apply:

- The individual is in a tax filer household (regardless of whether or not a tax dependent exception in M0430.100 B.2 is met). *APTC methodology does not apply to non-filer households or if married parents file separately and live in the same home.*
- Current monthly household income, using Medicaid/FAMIS MAGI-based methods is over the applicable *monthly* income limit (including the 5% FPL disregard) for the individual's covered group.
- The total of income already received plus projected income for the **calendar** year in which eligibility is being determined, using MAGI methods applied by the HIM for the purposes of APTC eligibility, is below 100% FPL (i.e. the lower income threshold for APTC eligibility). See M04, Appendix 1. The individual's prior income for the calendar year, or lack of income, is included in the calculation of annual income when determining financial eligibility.

Note: The individual does not need to apply for the APTC prior to applying for Medicaid or having the gap-filling evaluation completed.

The gap-filling evaluation is applicable to the eligibility determination for retroactive and ongoing coverage.

If the eligibility and enrollment system is unable to determine eligibility using the gap-filling evaluation, the evaluation must be completed outside the system and documented in the electronic record. If the individual is eligible, the coverage must be entered directly into MMIS, and the renewal date must be updated for January of the following year.

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B. Non-financial Requirements

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

A. Household Income Calculation

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

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

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

1. Verification of Income

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

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

2. Countable Income

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

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

3. Income Evaluation

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

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TREATMENT OF INCOME FOR FAMILIES & CHILDREN COVERED GROUPS

INCOME	MAGI COVERED GROUPS	MEDICALLY NEEDY; 300% SSI; F&C COVERED GROUPS
Earnings	Counted with no disregards	Counted with appropriate earned income disregards
Social Security Benefits Adult's MAGI household	Benefits received by a parent or stepparent are counted for his eligibility determination, as well as the eligibility determinations of his spouse and children in the home.	Counted if anyone in the Family Unit/Budget Unit receives
Social Security Benefits Child's MAGI household	<i>If the child lives with a parent, only counted if the child is required to file a federal tax return..</i>	Counted if anyone in the Family Unit/Budget Unit receives
Child Support Received	Not counted	Counted – subject to \$50 exclusion
Child Support Paid	Not deducted from income	Not deducted from income
Alimony Received	<i>Counted if divorce agreement was finalized prior to January 1, 2019, and the agreement has not been modified.</i>	Counted – subject to \$50 exclusion if comingled with child support
Alimony Paid	Deducted from income if <i>divorce agreement was finalized</i> prior to January 1, 2019	Not deducted from income
Worker's Compensation	Not counted	Counted
Veteran's Benefits	Not counted if they are not taxable in IRS Publication 525	Counted
Scholarships, fellowships, grants and awards used for educational purposes	Not counted	Not counted
Student Loan Debt	Effective January 1, 2019, student loan debt forgiven due to death or disability of student is not counted as income	Not applicable
Foreign Income (whether or not excluded from taxes)	Counted	Counted
Interest (whether or not excluded from taxes)	Counted	Counted
Lump Sums	Income in month of receipt	Income in month of receipt
Gifts, inheritances, life insurance proceeds	Not counted	Counted as lump sum in month of receipt
Parsonage allowance	Not counted	Counted

M0610 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/19	Table of Contents Pages 1, 2 Page 2a was added as a runover page.
TN #DMAS-12	4/1/19	Page 1
TN #100	5/1/15	Pages 1, 2

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M06 FAMILIES AND CHILDREN RESOURCES

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M0610.000 GENERAL RULES FOR FAMILIES AND CHILDREN RESOURCES

M0610.001 OVERVIEW

A. Introduction

Medicaid is a needs based program. Two financial criteria, income and resources, are used to determine if a person is in need and is financially eligible for Medicaid. Most F&C categorically needy (CN) covered groups (see subchapter M0330) do not have a resource requirement. Resource policy does not apply to the following categorically needy covered groups:

- CN Pregnant Women & Newborn Children;
- Plan First,
- CN Child Under Age 19 (FAMIS Plus);
- IV-E Foster Care or IV-E Adoption Assistance Recipients;
- Low Income Families With Children (LIFC);
- Individuals Under Age 21;
- Special Medical Needs Adoption Assistance;
- BCCPTA,
- MAGI Adults (see M1460 for resource requirements)
- Former Foster Care Children Under Age 26

This section addresses how to determine resource eligibility for the following *covered groups and individuals*:

- F&C in Medical Institution, Income \leq 300% SSI *age 18 years and older**;
- F&C Receiving Waiver(CBC) Services *age 18 years and older**;
- F&C Hospice *age 18 years and older**; and
- all F&C medically needy covered groups.

****Children under age 18 in the F&C 300% SSI covered group are not subject to a resource test.***

All real and personal property legally owned by each member of the family unit/budget unit (FU/BU) is evaluated and the countable value is considered in determining Medicaid eligibility for the FU/BU.

Resources of each member of a FU/BU are evaluated using the rules in this chapter. Resource eligibility is determined by comparing the countable resources to the appropriate limit based on the composition of FU/BU. The policy governing the formation of the FU/BU is contained in M05.

B. Policy Principles

1. Monthly Determinations

Eligibility with respect to resources is a determination made for each calendar month, beginning with the third month prior to the month in which the application is received.

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2. Countable Resources Any assets that are resources but are not specifically excluded by policy are countable resources. Only countable resources are used to determine resource eligibility. See:

- M0610.002 for the resource limits;
- M0610.100 for the distinction between assets and resources;
- M0630.100 for a listing of exclusions.

3. Whose Resources Must Count *For MN eligibility*, Medicaid law requires that resources are only considered available between spouses and from parents to their children under age 21 who live at home.

4. Whose Resources Do Not Count Medicaid law does not allow certain resources to be considered in determining eligibility. Do not count resources:

- from a step-parent to a step-child;
- from siblings to siblings;
- from child to parent;
- from parent *when the child is between 18 and 21 and meets the 300% SSI covered group*;
- from spouse *when the spouses are living apart and neither spouse meets the definition of an institutionalized individual with a community spouse in M1480*;
- from an alien sponsor.

For an individual between the ages of 18 and 21 who meets the F&C 300% SSI covered group, the resources of a parent are not counted. Children under age 18 in the F&C 300% SSI covered group are not subject to a resource test.

For married individuals who meet the F&C 300% SSI covered group, see subchapter M1480.

5. Total Countable Resources The total value of the countable resources owned or deemed available to all FU members are counted in determining the resource eligibility of each FU member.

The total value of the countable resources owned or deemed available to all BU members is counted in determining the resource eligibility of each BU member.

6. Resource Eligibility If the total countable value of the FU/BU's countable resources are at or below the resource limit at any point during the application month, retroactive month, or a month in which the case is pending, resource eligibility exists for that month.

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7. Excess Resources

After determining countable resources in accordance with B.2 through B.5 above, if the family unit has resources other than the excluded items listed in M0630 totaling more than the allowable resource limit, determine if budget units can be formed. See Budget Unit rules in M0520. If BUs cannot be formed, or the BU's countable resources exceed the resource limit, resource eligibility does not exist.

If the FU/BU has a real property resource, see M0630.105 and M0630.110 for reasonable effort to sell real property.

8. Income Not Resources

When determining the value of resources available to the family/budget unit, do not consider any income as a resource in the month in which it is received.

M0610.002 RESOURCE LIMITS

A. Introduction

A separate resource limit is set for each Medicaid classification. A resource limit is the maximum dollar amount of countable resources a FU or BU may own and the individuals within that unit be eligible for Medicaid.

M0710 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/19	Pages 1, 2, 7, 8 Page 2a was added as a runover page.
TN #DMAS-9	7/1/18	Appendices 2 and 3
TN #DMAS-5	7/1/17	Appendices 1, 2 and 3
TN #DMAS-2	10/1/16	Appendices 2 and 3
UP #11	7/1/15	Appendix 5
TN #100	5/1/15	Table of Contents pages 1-8 Pages 9-13 were deleted. Appendices 1, 2 and 3 Appendices 4-7 were removed.
TN #98	10/1/13	pages 1-4, 8, 9 Page 1a was added. Appendices 1, 3, 5
UP #9	4/1/13	Appendix 6, pages 1, 2 Appendix 7
UP #7	7/1/12	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1
UP #6	4/1/12	Appendix 6, pages 1, 2 Appendix 7
TN #96	10/01/11	Appendix 6, page 1
UP #5	7/1/11	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1
TN #95	3/1/11	Appendix 6, pages 1, 2 Appendix 7
Update (UP) #1	7/1/09	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1

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Subchapter Subject M0710.000 GENERAL - F & C INCOME RULES	Page ending with M0710.001	Page 1

M0710.000 GENERAL-- F&C INCOME RULES

M0710.001 OVERVIEW

A. Introduction

Medicaid is a needs based program. Two financial criteria, income and resources, are used to determine if a person is in need and is financially eligible for Medicaid. The income eligibility policies that are used for the eligibility determination depend on the individual's covered group, as well as the date of the determination.

1. Use Policies in Chapter M07

The policies in **chapter M07** apply for **all initial applications, reapplications and renewals** for the Families & Children (F&C) Medically Needy (MN) covered groups.

2. Use Policies in Chapter M04 and Chapter M07 as Directed

The income policies, procedures and income limits for Modified Adjusted Gross Income (MAGI) contained in **chapter M04** apply to the covered groups listed below.

- CN Pregnant Women & Newborn Children;
- Plan First;
- CN Child Under Age 19 (FAMIS Plus);
- Low Income Families With Children (LIFC);
- Individuals Under Age 21;
- Special Medical Needs Adoption Assistance;
- *MAGI Adults.*

The income types and verification procedures in chapter M07 are used with MAGI methodology as directed in chapter M04.

3. Use Other Policies

Income eligibility for Medicaid is not determined by the local DSS for the following F&C covered groups:

- IV-E Foster Care or IV-E Adoption Assistance Recipients;
- BCCPTA.

See subchapter M0330 for additional information about these covered groups.

B. Use of Family Units/Budget Units

Family Units (FUs) are formed to establish whose income and resources are counted in determining financial eligibility. If financial eligibility does not exist at the family unit level for one or more persons for whom Medicaid was requested and if budget unit (BU) rules permit, form BUs.

Financial eligibility is determined at the BU level for each person for whom Medicaid was requested and who was financially ineligible in the FU determination. Eligibility is not determined for an individual who was found eligible in the FU determination.

See M0520 for F&C Family Unit/Budget Unit (FU/BU) policy and procedures.

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C. Individual Income Eligibility

An individual's income eligibility is based on the total countable income available to his/her FU/BU.

Each source of income received by a member of the FU/BU is evaluated and the countable amount determined based on the policy in this chapter. The countable amount of each FU/BU member's income is added to the countable amount of the income of all other FU/BU members. That total is used to determine the income eligibility of each individual within that FU/BU. The FU/BU's total countable income is compared to the income limit that is applicable to the individual's classification and to the number of members in the FU/BU.

D. Policy Principles

1. Income

Everything an individual owns and all monies received are assets. Monies received are income in the month received when the monies are cash or its equivalent.

Income may be either earned or unearned. See M0720 for earned income and M0730 for unearned income.

2. Verification

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

For all case actions effective October 26, 2019, if the income attested to by the applicant is within 10% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required. If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return.

All income other than Workforce Investment Act and the earned income of a student under age 19 must be verified. When attempts to verify income are unsuccessful because the person or organization who is to provide the information cannot be located or refuses to provide the information to both the applicant/recipient and the eligibility worker, a third party statement, a collateral contact, or as a last resort, the applicant's/recipient's written statement can be used as verification and to determine the amount of income to be counted.

Failure of the applicant/enrollee to verify his income results in the agency's inability to determine Medicaid eligibility and the applicant/enrollee's Medicaid coverage must be denied or canceled.

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3. Converted Income

For the ongoing evaluation period, all income received more frequently than monthly must be converted to a monthly amount.

- Weekly income is multiplied by 4.3
- Bi-weekly income is multiplied by 2.15
- Semi-monthly income is multiplied by 2.

4. Available Income

Retroactive period –available income is the gross income actually received in each month in the retroactive period.

Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months. The applicant’s actual gross income received in the application month may be used to determine eligibility for that month if the application is processed after the month has passed and the person is eligible only when using the actual gross income for the month.

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b. Example #3

The client's bi-weekly pay for the prior month was:

\$185.40

\$209.50

\$394.90

To obtain a monthly amount, multiply the bi-weekly average by 2.15.
\$394.90 (total of the pay stubs) divided by 2 (number of pay stubs) equals
\$197.45 (average bi-weekly amount).

$\$197.45 \times 2.15 = \424.52 monthly income.

c. Example #4

The client's salary is \$100 weekly. The pay does not vary. The client is paid every Friday.

The client reports she quit her job and will receive a final weekly paycheck on September 3. Since the client was paid for a partial month, the exact amount of \$100 will be used.

d. Example #5

The client reports she quit her job on June 21. She will receive a final bi-weekly paycheck on July 5.

For the month of May, she received \$190 and \$220 for a total of \$410. This amount is divided by two (the number of pays) to determine the average bi-weekly pay of \$205. \$205 is used to calculate her July Medicaid eligibility.

B. Procedure

1. When a Change Occurs

An anticipated change in income occurs when you expect an individual's income to start, to stop, or to come in at a different rate in the future.

2. How to Develop a Change

When you anticipate an increase in income, use only that income which the individual is reasonably certain he will receive.

3. Handling Changes in Income

When a change in income occurs, redetermine Medicaid eligibility. Countable earned and unearned income is only verified if *reasonable compatibility does not exist* or the applicant's attested income or information from electronic data sources is over the income limit for his covered group.

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C. Documentation

1. What the File Must Contain

If income verification is requested and received, verify and document the case record regarding the rate and frequency of payment (i.e., weekly, biweekly, semi-monthly, monthly, etc.) and the payment cycle (i.e., on what day the client is paid).

The case record must be documented to reflect the method used to arrive at the anticipated income.

2. Who May Provide an Estimate

Estimates of income may come from the applicant/recipient, employer, or representative.

M0710.700 DETERMINING ELIGIBILITY BASED ON INCOME

A. Locality Grouping and Income Limits

The countable income, allowing income exclusions when appropriate, is compared to the MN income limits for the locality and the number of members in the FU/BU.

Refer to M0710, Appendix 2 for the grouping of localities and M0710, Appendix 5 for the MN income limits.

B. Gross Income

Total gross income includes all gross earned income, other than Workforce Investment Act income and/or other earned income of a child under age 19 who is a student. It also includes the unearned income of all FU/BU members and any income deemed available to the family/budget unit.

C. Excluded Income

The following income is excluded when income is compared to *MN* limits:

1. Unearned Income

All unearned income specifically excluded per M0730.099;

2. Earned Income

Earned income is excluded in the following order:

- standard work exclusion of the first \$90 of gross earned income for each employed member of the assistance unit whose income;
- is not otherwise exempt per M0720.520;
- child care/incapacitated adult care exclusion per M0720.540.

D. Income Eligibility

If the *verified* countable income (gross income minus above exclusions) is equal to or less than the appropriate MN limit for the locality and the number of members in the FU/BU, the FU/BU is income eligible as MN. If the countable income is in excess of the MN limit, the FU/BU must be placed on an MN spenddown following policy in chapter M13.

M0720 Changes

Changed With	Effective Date	Pages Changed
TN# DMAS -14	10/1/19	Page 2
TN# DMAS -11	01/01/19	Page 4
TN #DMAS-2	10/1/16	Table of Contents, page i Pages 11, 13, 14 Appendix 1 Pages 15-19 were deleted.
TN #DMAS-1	6/1/16	Page 2
TN #98	10/1/13	Pages 6, 10
TN #94	9/01/2010	Pages 5, 6
TN #91	5/15/2009	Page 11

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- pay for jury duty
- severance pay
- tips
- vacation pay
- sick pay from employer or employer-obtained insurance

2. When to Count

Wages are calculated on a monthly basis and counted at the earliest of the following points:

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

Absent evidence to the contrary, if FICA (*Federal Insurance Contributions Act*) taxes have been deducted from an item, assume it meets the definition of wages. Failure to deduct FICA taxes does not mean the income is not wages.

EXAMPLE #1:

Mrs. Green is employed by Mr. Brown who owns a small business. Mr. Brown does not deduct FICA taxes from Mrs. Green's income. Mrs. Green's income from Mr. Brown is wages.

C. Verification

For all case actions effective October 26, 2019, if the income attested to by the applicant is within 10% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required. If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return.

Verify wages, salaries, and commissions by pay stubs, pay envelopes, a written statement from the employer, or by the eligibility worker's verbal contact with the employer.

When attempts to verify income are unsuccessful because the person or organization who is to provide the information cannot be located or refuses to provide the information to both the applicant/enrollee and the eligibility worker, a third party statement, a collateral contact, or as a last resort, the applicant's/enrollee's written statement can be used as verification and to determine the amount of income to be counted.

Verify tips by a weekly record of the tips prepared by the employed individual.

M0720.105 INCOME FROM A CORPORATION

If a person has incorporated a self-employment enterprise either alone or with other persons and draws a salary from the business, the wages drawn are regular earned income, not self-employment income.

M0720.110 HOW TO COUNT INCOME IN THE RETROACTIVE PERIOD

When evaluating eligibility for a retroactive period, income eligibility is based on income actually received each month in the retroactive period.

M0730 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/19	Page 1
TN #DMAS-9	7/1/18	Table of Contents Pages 11, 15
TN #DMAS-4	4/1/17	Pages 7, 8
TN #98	10/1/13	Pages 7, 8 Page 8a was removed.
TN #97	9/1/12	Page 10
TN #94	9/1/2010	Pages 7, 8
TN #93	1/1/2010	Page 2
TN #91	5/15/2009	Table of Contents pages 7-8a

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Subchapter Subject M0730.000 F&C UNEARNED INCOME	Page ending with M0730.150	Page 1

GENERAL

M0730.001 INTRODUCTION TO UNEARNED INCOME

- A. Policy - General** Unearned income is all income received by members of the family/budget unit that is not earned income. Unearned income consists of:
- benefits, including public assistance benefits received from another state
 - royalties
 - child/spousal support
 - dividends and interest
 - some rental income
 - gifts
 - some home energy assistance
 - contributions
 - lump sums
- B. Policy - When to Count Unearned Income** Unearned income is counted as income in the earliest month it is:
- received by the individual;
 - credited to the individual's account; or
 - set aside for the individual's use.
- C. Available Income** Retroactive period –available income is the gross income actually received in each month in the retroactive period.
- Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months. The applicant's actual gross income received in the application month may be used if the application is processed after the month has passed and the person is eligible only when using the actual gross income for the month. For all case actions as of *October 26, 2019*, *attested income may be used if the requirements specified in M0730.001 E. are met.*
- D. Policy - What Amount of Unearned Income is Counted** The amount of unearned income received is counted as income.
- EXCEPTION: When the Medicare Part B premium is deducted from the Social Security or Railroad Retirement benefits, that amount must be added to the actual benefit being received.
- E. Verifications** *The agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family. For all case actions effective October 26, 2019, if the income attested to by the applicant is within 10% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required.*
- If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return.*
- Verify the amount of the unearned income by an award letter or notice, a benefit payment check, or through contact with the source of the unearned income, unless the source of the unearned income is listed in M0730.099 B. Verification of unearned income that is totally excluded is not required.
- F. References** What is income, M0710.003
What is not income, M0715.050
When income is counted, M0710.030
How to estimate income, M0710.610

M0810 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/19	Pages 20, 25, 27 Page 28 is a runover page.
TN #DMAS-12	4/1/19	Page 2
TN #DMAS-11	1/1/19	Pages 1, 2
TN #DMAS-10	10/1/18	Page 2
TN #DMAS-9	7/1/18	Page 2
TN #DMAS-8	4/1/18	Page 2
TN #DMAS-7	1/1/18	Pages 1, 2
TN #DMAS-5	7/1/17	Page 2
TN #DMAS-4	4/1/17	Page 2
TN #DMAS-3	1/1/17	Pages 1, 2
TN #DMAS-2	10/1/16	Page 2
TN #DMAS-1	6/1/16	Pages 1, 2
UP #11	7/1/15	Page 2
TN #100	5/1/15	Pages 1, 2
UP #10	5/1/14	Page 2
TN #99	1/1/14	Pages 1, 2
TN #98	10/1/13	Page 2
UP #9	4/1/13	Pages 1, 2
UP #7	7/1/12	Page 2
UP #6	4/1/12	Pages 1, 2
TN #95	3/1/11	Pages 1, 2
TN #93	1/1/10	Pages 1, 2
Update (UP) #1	7/1/09	Page 2

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**E. Process --Applying
The Exclusion**

The following process is for any earned income but only for unearned income which is not subject to other exclusions (see F. below).

When someone receives infrequent or irregular...	and...	then this exclusion...
unearned income	the total in a month does not exceed \$20	applies.
unearned income	the total in a month exceeds \$20,	does not apply.
earned income	the total in a month exceeds \$10,	does not apply.
earned and unearned income	the monthly earned income total does not exceed \$10 and the monthly unearned income total does not exceed \$20,	applies to both earned and unearned income.
earned and unearned income	the monthly earned income total exceeds \$10 but the monthly unearned income total does not exceed \$20,	applies to the unearned income but not to the earned.
earned and unearned income	the monthly earned income total does not exceed \$10 but the monthly unearned income total exceeds \$20,	applies to the earned income but not to the unearned.
earned and unearned income	the monthly earned income total exceeds \$10 and the monthly unearned income total exceeds \$20,	does not apply.

F. Procedure

1. Initial Applications

- a. **Infrequent**--If income is regular but may qualify for exclusion as infrequent, evaluate its receipt for the three months prior to the month of application.
- b. **Irregular**--If income may qualify for exclusion as irregular, evaluate the predictability of its receipt beginning with the month of application.

2. All Situations

- a. **Individual's Attestation**
Obtain a statement over the individual's signature concerning the type, amount, frequency, or predictability of income. The statement or similar information on the application or redetermination form is sufficient documentation. Absent evidence to the contrary, accept the individual's *attestation*.
- b. **Evidence Disagrees with Attestation**
If there is evidence which disagrees with the individual's *attestations*, develop and document under the appropriate income rules.

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VERIFYING AND ESTIMATING INCOME

S0810.500 INCOME VERIFICATION

A. Policy Principles

1. Why Verification is Necessary

Although Medicaid does not determine Medicaid eligibility solely on the basis of statements concerning eligibility factors by applicants and recipients, for all case actions as of October 26, 2019, attestation of income will be accepted absent evidence to the contrary. We verify relevant information from independent or collateral sources, and obtain additional information as necessary to be sure that eligibility is determined correctly.

2. All Situations

a. Individual's Attestation

Obtain a statement over the individual's signature concerning the type, amount, frequency, or predictability of income. The statement or similar information on the application or redetermination form, is sufficient documentation. Absent evidence to the contrary, accept the individual's attestation.

b. Evidence Disagrees with Attestation

If there is evidence which disagrees with the individual's attestations, develop and document under the appropriate income rules.

2. Applicants/ Recipient's Responsibility

A person applying for or receiving Medicaid must give the local Department of Social Services (LDSS) any requested information and show necessary documents or other evidence to establish the amount of the individual's income.

B. Operating Policy

1. Burden of Proof

Applicants and recipients (or their representative payees) are responsible for providing LDSS with proof of income *if requested* and for reporting any changes in income.

2. Additional Verification Requirements

See the instructions for the particular type of income involved for additional verification requirements.

3. Initial Applications Versus Posteligibility Situations

Unless instructions dealing with particular types of income state otherwise, verification requirements for initial applications also apply in post eligibility situations.

C. References

- Estimating future wages, S0820.150.
- Verification Requirements:
 - Unearned income, S0830.005.
 - Wages, S0820.135.
 - Self-employment, S0820.220.
 - Sheltered workshop earnings, S0820.300.
 - Sick pay, S0820.005.

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M0810.610 HOW TO ESTIMATE INCOME

A. Operating Policy

1. **Monthly Estimates** Estimate future income monthly.
2. **Fluctuating Income** When income fluctuates, use previous months' actual receipts *or written attestation* to project future anticipated monthly income.
 - a. **Individual's Attestation**

Obtain a statement over the individual's signature concerning the type, amount, frequency, or predictability of income. The statement or similar information on the application or redetermination form, is sufficient documentation. Absent evidence to the contrary, accept the individual's attestation.
 - b. **Evidence Disagrees with Attestation**

If there is evidence which disagrees with the individual's attestations, develop and document under the appropriate income rules. The anticipated income should be an accurate indication of the individual's future income situation.
3. **Income Expected Less Than Once a Month** Determine the specific month(s) of receipt and use the amount(s) estimated for the appropriate month(s).
4. **Converting to Monthly Totals** To estimate income for Medically Needy Income evaluation convert to a monthly total, then multiply by number of months in the spenddown time frame.
 - Weekly income is multiplied by 4.3,
 - Biweekly income is multiplied by 2.15,
 - dividing biweekly wages by 2 and multiplying by 4.3., or
 - semi-monthly income multiplied by 2.

B. Operating Procedure

1. **When a Change Occurs** An anticipated change in income occurs when you expect an individual's income to start, to stop, or to come in at a different rate in the future.
2. **How to Develop a Change** When you anticipate an increase in income, use only that income which the individual is reasonably sure he will receive.

Except in self-employment situations (S0820.230), do not compute on the basis of an anticipated decrease in or termination of income unless that decrease or termination can be verified. Instead, tell the individual what income has been used in the computation and that he should report immediately when a decrease or termination can actually be verified so that appropriate adjustment can be made.

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3. Example

Anticipated Decrease in Income

Mr. Danny Kelp, a student child, receives support payments from an absent parent. These payments are \$160 a month. In March, Danny's father begins a new job which pays less money. Danny notifies his EW that, based on his father's decrease in salary, he expects his support payments to decrease to \$125 a month. The EW includes \$160 unearned income in Danny's countable income computation, and tells him to report immediately when it can be verified that the payments have decreased.

C. Documentation

1. What the File Must Contain

The file must contain the estimates used.

2. Who May Provide an Estimate

Estimates of income may come from the applicant/recipient, representative, worker, or deemor.

3. Resolve any Discrepancy

If information received from an employer concerning current or future rate of pay is discrepant with an estimate provided by the applicant/recipient, representative payee, worker, or deemor, you must resolve the discrepancy.

4. Additional Documentation Requirements

See the specific sections dealing with the type(s) of income involved to determine if there are additional documentation requirements.

S0820 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/19	Pages 10, 11, 13, 22, 24
TN #DMAS-12	4/1/19	Page 21
TN #DMAS-11	1/1/19	Pages 30, 31
TN #DMAS-7	1/1/18	Page 11, 30-32
TN #DMAS-5	7/1/17	Pages 11, 13, 29, 30 Page 12 is a runover page.
TN #DMAS-3	1/1/17	Pages 30, 31
TN #DMAS-1	6/1/16	Pages 30, 31, 47
TN #100	5/1/15	Pages 30, 31, 47 Page 48 is a runover page.
TN #99	1/1/14	Pages 30, 31
UP #9	4/1/13	Pages 30, 31
Update (UP) #6	4/1/12	Pages 30, 31
TN #95	3/1/11	Pages 3, 30, 31
TN #93	1/1/10	Pages 30, 31
TN #91	5/15/09	Table of Contents Pages 29, 30

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Subchapter Subject M0820 EARNED INCOME	Page ending with M0820.127	Page 10

M0820.125 WAGE VERIFICATION IS REQUIRED

A. Policy

1. When to Verify Wages

Verification of wage amounts and frequency of receipt is required whenever an individual alleges (or you believe) he received wages, sick pay, or temporary disability. *For all case actions effective October 26, 2019, a written attestation may be used to project future anticipated monthly income.*

a. Individual's Attestation

Obtain a statement over the individual's signature concerning the type, amount, frequency, or predictability of income. The statement or similar information on the application or redetermination form is sufficient documentation. Absent evidence to the contrary, accept the individual's attestation.

b. Evidence Disagrees with Attestation

If there is evidence which disagrees with the individual's attestations, develop and document under the appropriate income rules. The anticipated income should be an accurate indication of the individual's future income situation.

2. When Not to Verify Wages

Wage Verification Is Not Required When:

- *No available evidence disagrees with the individual's attestation, or*
- *The individual alleges he has not worked or received earnings (e.g., wage/sick pay) in any month from the first month of the retroactive period through the application month and you have no reason to question the allegation, or*
- *The individual is being denied Medicaid for reasons other than earnings/income.*

M0820.127 PERIOD FOR WAGE VERIFICATION

Procedure

If income reasonable compatibility cannot be verified using electronic data sources, including the Federal Data Hub, the Virginia Employment Commission, or the Work Number, verify:

At initial application

- wages received in all retroactive months, (if a medical expense exists),
- wages for the month of application, if the applicant alleges that wages have been paid.
- wages received in the month of application, and
- wages received after month of application but prior to processing the application **if** the applicant alleges that a change in wages has occurred.
- wages used to estimate anticipated income.

At redetermination or review of income

- all unverified wages through the month immediately preceding the month the redetermination or review of income is initiated, unless
- employment began in current month.

NOTE: Obtain employer statement regarding wages (i.e., hourly wage, number of work hours per pay period, receipt of pay).

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M0820.130 EVIDENCE OF WAGES OR TERMINATION OF WAGES

A. Policy

1. **Primary Evidence of Wages**
The following proofs, in order of priority, are acceptable evidence of wages:
 - a. Verifications of income *received from or reasonable compatibility* with electronic data sources, including the Virginia Employment Commission (VEC), *Federal Data HUB or The Work Number*.
 - b. Pay slips--Must contain the individual's name or Social Security number, gross wages, and period of time covered by the earnings.
 - c. Oral statement from employer, recorded in case record.
 - d. Written statement from employer.

2. **Secondary Evidence of Wages**
If primary evidence is not available, the following proofs, in order of priority, are acceptable evidence of wages:
 - a. W-2 forms, Federal or State income tax forms showing annual wage amounts.
 - b. Individual's signed allegation of amount and frequency of wages.

3. **Acceptable Evidence of Termination of Wages**
The following proofs, in order of priority, are acceptable evidence of termination of wages:
 - a. Verifications from electronic data sources, including the Virginia Employment Commission (VEC).
 - b. Oral statement from employer, recorded in case record.
 - c. Written statement from employer.
 - d. Individual's signed allegation of termination of wages (including termination date and date last paid).

B. Procedure

1. **Order of Priority**
Seek type "a" evidence before type "b," etc.

2. **Pay Slips**
 - a. Stress to the individual that he/she is responsible for providing proof of wages *if not available from an electronic source* and is expected to retain all pay stubs and provide them as requested.
 - b. Accept the individual's signed allegation of when earnings were received if it is not shown on the pay slip.

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

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M0820.135 WAGE VERIFICATION

A. Procedure

1. Chart

This chart describes the procedure for verifying wages per month *when wages cannot be verified through an online data source, or attested income is not reasonably compatible with information obtained through an electronic source.*

STEP	ACTION
1	<p>Does the individual have acceptable pay slips for some or all of the period being verified? (See s0820.130 A. 1. a.)</p> <ul style="list-style-type: none"> • If yes, go to Step 2. • If no, go to Step 8.
2	<p>Were any wages deferred during the period covered by the pay slips?</p> <ul style="list-style-type: none"> • If yes, go to Step 3. • If no, go to Step 4.
3	<ul style="list-style-type: none"> • Count deferred wages per S0820.115 B.2. • Document the file. • Go to Step 5.
4	<ul style="list-style-type: none"> • Count wages when received. • Go to Step 5.
5	<p>Do the pay slips cover earnings for the entire period being verified or, if not, can the wages attributable to the missing pay slip(s) be determined by other evidence (e.g., year-to-date totals)?</p> <ul style="list-style-type: none"> • If yes, go to Step 6. • If no, go to Step 7.
6	<ul style="list-style-type: none"> • Document the file with a copy or certification of the pay slips, and signed allegation (if necessary per S0820.130 B.2.) • STOP

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M0820.220 HOW TO VERIFY NET EARNINGS FROM SELF-EMPLOYMENT (NESE)

A. Introduction Acceptable evidence of NESE, in order of priority, is listed in B.1. through B.3. below. C.2. describes situations in which verification is not required.

B. Policy The Federal income tax return contains evidence of NESE in the following schedules:

1. Federal Income Tax Return

a. Schedule SE

- Net earnings--Section A, line 4 or Section B, line 4.C.

NOTE: If line 4 or 4.C. shows a positive amount of less than \$400, then line 3 is used, even if the amount on line 3 is greater than \$400. For example, line 3 shows \$410 and line 4/4.C. shows \$378. Line 3 should be used because no tax was due.

- Net loss--Section A, line 3 or Section B, line 4.C.

b. Schedule C--Line entitled "Net Profit or Loss."

c. Schedule C--EZ—Line entitled "Net Profit"

c. Schedule F--Line entitled "Net Profit or Loss."

2. Business Records

Business records are acceptable evidence of NESE.

3. Individual's Signed Allegation

The individual's signed allegation of NESE is acceptable evidence of NESE if no other evidence can be obtained.

C. Procedure

1. When to Verify

Verify NESE per 2. below whenever self-employment is alleged or otherwise indicated, unless the individual:

- *reports income that is reasonably compatible with an accepted electronic source;*
- alleges starting a new business, and that he/she was not self-employed in the prior taxable year; or
- is being denied Medicaid for reasons other than income.

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M0820.230 HOW TO ESTIMATE NESE FOR CURRENT TAXABLE YEAR

A. Procedure

1. **When an Estimate Is Needed**

Unless the reported income meets the reasonable compatibility standard, estimate NESE for the current taxable year for an initial application, redetermination, or review of income when an individual alleges (or you believe) he/she is (or has been) engaged in self-employment during the current taxable year.
2. **Inform the Individual**

Inform the individual:

 - how his/her estimated NESE was determined and its effect on eligibility.
 - to promptly contact the LDSS office if any change occurs which could affect the amount of his/her estimated NESE.
 - to maintain business records until a Federal income tax return is available, so he/she can report any changes promptly (when any method other than the first two in the chart in 4. below is used).
 - to provide a copy of his/her Federal income tax return when it becomes available.
3. **Net Loss**

Do not take into account an **estimated** net loss when estimating NESE for the current taxable year.

NOTE: A net loss can only be used to offset other earnings **after** it has been verified.
4. **How to Estimate NESE**

Use the first of the following methods in the sequence below, which is applicable.

When the estimate is obtained using business records or the individual's allegation, ask the individual if he/she plans to file a tax return.

 - If **yes** and the estimated net profit is \$400 or more after applying the multiplier, multiply the net profit by .9235 to determine the countable NESE estimate.
 - If **yes** and the estimated net profit is less than \$400 after applying the multiplier, do not apply the multiplier.
 - If **no**, count the net profit as the NESE estimate. Do **not** apply the multiplier.

M1310 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/19	Page 1
TN #DMAS-10	10/1/18	Page 1 Pages 2 and 3 are runover pages.
TN #DMAS-2	10/1/16	Pages 1-6 On pages 1 and 4-6, corrected the subchapter number in the headers. Neither the dates nor the policies were changed.
UP #9	4/1/13	Pages 1-3
UP #7	7/1/12	Table of Contents Pages 1-5 Page 6 was added.
TN #95	3/1/11	Page 4

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Subchapter Subject M1310 SPENDDOWN GENERAL PRINCIPLES & DEFINITIONS	Page ending with M1310.100	Page 1

M1310.000 SPENDDOWN GENERAL PRINCIPLES AND DEFINITIONS

M1310.100 GENERAL PRINCIPLES OF MEDICAID SPENDDOWN

A. Introduction

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

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

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

B. Applicability

Spenddown applies only to the medically needy (MN) covered groups listed in M0320 and M0330. There are no MN covered groups for Low-income Families with Children (LIFC) parents, Modified Adjusted Gross Income (MAGI) Adults, or children between age 18 and 19 years who do not meet the definition of an Individual Under Age 21 in M0330.804.

Individuals and families who meet a MN covered group must meet the MN nonfinancial and resource requirements in order to be placed on a spenddown.

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

For a spenddown which involves an incarcerated person, see M1350.850.

C. Opportunity to Receive Full Medicaid Coverage

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

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

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

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

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

M1320 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/19	Pages 3, 4
TN #DMAS-12	4/1/19	Page 3
TN #DMAS-6	10/1/17	Page 2
TN #DMAS-2	10/1/16	Page 2 Page 3 is a run over page.
TN #95	3/1/11	Page 1

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

M1320.300 ACTION ON APPLICATIONS

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

M1320.400 SPENDDOWN CASE REVIEW REQUIREMENTS

- A. Introduction** The individual must notify the worker when medical or dental expenses are incurred. The individual does NOT have to formally request a re-evaluation of his spenddown.
- The individual should submit the “Medical Expense Record - Medicaid” together with bills or receipts for medical services either paid or incurred. Evidence of third party payment or denial of payment must be provided, if applicable.
- B. Submission of Expenses** When the individual or a *third party* submits medical expenses for re-evaluating the spenddown, a new application form is NOT completed.
- Contact the individual and ask if his living situation, resources or income have changed since he signed the application form. If the individual reports any changes, request verification, evaluate accordingly, and record the changes in the case record.
- There is no time limit for an individual to submit medical expenses for a spenddown; however, the worker will follow the processing time frame when the first medical bill for a spenddown is received.

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**C. Eligibility Worker
Actions**

When verification of incurred expenses is received, the worker must record the expenses in the record, determine how much of the spenddown liability - evaluation at the end of the 30-day processing time frame for spenddown re-evaluations. The 30-day processing time frame begins the date the first medical bill for that spenddown is received in the agency.

**2. Send Notice of
Action**

After completing a re-evaluation of the individual's spenddown, A "Notice of Action on Medicaid..." (#032-03-008) is sent to the applicant. *Generate the notice from VaCMS, or print the form with the appropriate block checked. In the section marked "Other", tell the individual that he must complete a review or reapply in order to be evaluated for Medicaid after the spenddown period ends.*

M1340 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/19	Page 2, 18
TN #DMAS-12	4/1/19	Page 2
TN #DMAS-9	7/1/18	Pages 6a
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

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incurred expenses can be found in sections M1340.600, M1340.700 and M1340.800.

M1340.200 KINDS OF ALLOWABLE DEDUCTIONS

- A. Policy** To determine the allowable incurred expenses that will be deducted from *the spenddown liability*, the agency must identify the kind of service.
- B. Kinds of Service** In determining allowable incurred expenses, the medical or remedial care expenses listed below may be deducted from the spenddown liability.
- 1. Health Insurance Expenses** Medicare and other health insurance premiums are allowable health insurance expenses. *See M1340.300*
 - 2. Noncovered Services Expenses** Noncovered services expenses are expenses incurred by the individual or family or financially responsible relative for necessary medical or remedial care services which are not covered by the Virginia Medicaid State Plan. Noncovered services include expenses for Medicaid-covered services that exceed the State Plan limits on the amount, duration and scope of services. Medicaid co-payments and deductibles on covered services are “noncovered services.” Section M1340.400 lists noncovered services.
 - 3. Covered Services Expenses** Covered services expenses are expenses incurred by the individual or family or financially responsible relative for necessary medical or remedial care services which are covered by the Virginia Medicaid State Plan.

M1340.300 HEALTH INSURANCE PREMIUMS, DEDUCTIBLES, COINSURANCE

- A. Policy** Incurred expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, including deductibles and copayments imposed by Medicaid, are deducted from the spenddown liability.
- B. Health Insurance Premiums** Health insurance premium payments include:
- 1. Private Health Insurance** Payments made from the applicant’s own income for private medical insurance are allowed deductions. Income protection insurance (indemnity) policy premiums are not medical expenses and are not deducted from the spenddown liability.
 - 2. Medicare Premiums** Medicare Part A, Part B and/or *Part D* premium payments are allowed deductions when the premiums are paid from the applicant’s own income.
 - 3. Amount Deducted** The amount deducted is the amount of the premium paid.

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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. *Virginia Commonwealth University (VCU) Health System* and *University of Virginia (UVA) Health System* clinics, *care centers*, 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:

M1410 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/19	Pages 10, 12-14
TN #DMAS-12	4/1/19	Page 4, 10-11 Page 4a was added as a runover page.
TN #DMAS-11	1/1/19	Pages 6, 7
TN #DMAS-10	10/1/18	Pages 8-14
TN #DMAS-9	7/1/18	Page 1
TN #DMAS-8	4/1/18	Page 9
TN #DMAS-7	1/1/18	Page 7
TN #DMAS-5	7/1/17	Pages 4-7
TN #DMAS-3	1/1/17	Pages 6, 7, 12-14
TN #DMAS-1	6/1/16	Pages 12-14
TN #100	5/1/15	Page 2
TN #99	1/1/14	Page 10
Update #7	7/1/12	Pages 6, 7
TN #96	10/1/11	Page 11, 12
TN #95	3/1/11	Pages 13, 14 Page 15 was removed.
TN #94	9/1/10	Pages 6, 7, 13
TN #93	1/1/10	Pages 1, 7, 9, 12
TN #91	5/15/09	Pages 11-14

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Subchapter Subject M1410.000 GENERAL RULES FOR LONG-TERM CARE	Page ending with M1410.200	Page 10

3. Processing

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

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

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

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

4. Notices

See section M1410.300 for the required notices.

M1410.200 INITIATING LONG-TERM CARE FOR CURRENT RECIPIENTS

A. Introduction

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

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

B. LTSS Screening

An *LTSS* screening is used to determine if an individual meets the level of care for Medicaid payment for LTSS services. Medicaid enrollees must be screened and approved before Medicaid will authorize payment for LTSS services.

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B. Forms to Use

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

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

2. Notice of Obligation for Long-Term Care Costs (#032-03-0062)

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

3. Medicaid LTC Communication Form (DMAS-225)

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

- a change in the LTC provider, including when an individual moves from CBC to a nursing facility or the reverse;
- the enrollee's physical residence, if different than the LDSS locality;
- changes in the patient's deductions (e.g. a medical expense allowance);
- admission, death or discharge to an institution or community-based care service;
- changes in eligibility status; and
- changes in third-party liability.

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

a. When to Complete the DMAS-225

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

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b. Where to Send the DMAS-225.

If the individual is enrolled in a Commonwealth Coordinated Care (CCC) Plus Managed Care Organization (MCO), send the DMAS-225 to the individual's MCO. If known, send it to the individual's care coordinator. Contact information for the CCC Plus MCOs is available at <https://cccplusva.com/contacts-and-links>.

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

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

Department of Medical Assistance Services
Division of *Aging and Disability Services*
600 E. Broad St,
Richmond, VA 23219

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

4. Advance Notices of Proposed Action

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

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a. Advance Notice of Proposed Action

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

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

b. Notice of Obligation for Long-Term Care Costs

When a change in the patient pay amount is entered in VaCMS or MMIS, a “Notice of Obligation for Long-term Care Costs” will be generated and sent as the advanced notice to the recipient or the authorized representative.

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

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

5. Administrative Renewal Form

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

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

M1450 Changes

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

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Subchapter Subject M1450.000 TRANSFER OF ASSETS	Page ending with M1450.540	Page 19

EXAMPLE #2:

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

EXAMPLE #3:

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

1. Send Copy to DMAS

A copy of the annuity agreement must be sent to:

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

2. Maintain Copy of Annuity

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

M1450.530 RESERVED

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

A. Introduction

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

B. Policy

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

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

C. Uncompensated Amount

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

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

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

a. Undue Hardship Claimed - Required Documentation

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

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

b. 10 Days to Return Undue Hardship Claim

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

c. Documentation for DMAS

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

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

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- 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, *Eligibility & 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.

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C. Send DMAS Notice

The agency worker must send a copy of the DMAS-225 to:

Eligibility and Enrollment Services Division
Department of Medical Assistance Services
600 E. Broad St., Suite 1300
Richmond, VA 23219.

The copy of the DMAS-225 must be signed and dated by the worker, and must show the worker number and the local agency's FIPS code.

Any information the agency receives about the individual's subsequent receipt of compensation which shortens the penalty period must be sent to the *Eligibility and Enrollment Services Division* at the above address.

M1460 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/2019	Pages 4, 29
TN #DMAS-13	7/1/19	Page 42
TN #DMAS-11	1/1/19	Pages 3-5, 10, 26, 31
TN #DMAS-10	10/1/18	Table of Contents, page i Pages 1-3, 4b, 5, 6, 9, 10, 13, 15, 17a, 18, 18a, 26, 27, 30a, 37, 38 Pages 8a, 11, 19, 30, 39 and 40 are runover pages.
TN #DMAS-8	4/1/18	Pages 18a, 32, 35
TN #DMAS-7	1/1/18	Pages 3, 7
TN #DMAS-3	1/1/17	Pages 3, 4, 4b, 24, 25, 29
TN #DMAS-2	10/1/16	Page 35
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 3, 8a, 17, 32
TN #100	5/1/15	Table of Contents, page i Pages 1, 2, 5, 6, 10, 15, 16-17a, 25, 41-51
TN #99	1/1/14	Pages 3, 35
UP #9	4/1/13	Table of Contents Pages 3, 35, 38, 41, 42, 50, 51
TN #97	9/1/12	Table of Contents Pages 1, 4-7, 9-17 Page 8a was deleted. Pages 18a-20, 23-27, 29-31 Pages 37-40, 43-51 Pages 52 and 53 were deleted
UP #6	4/1/12	Pages 3, 35
TN #96	10/1/11	Pages 3, 20, 21
TN #95	3/1/11	Pages 3, 4, 35
TN #94	9/1/10	Page 4a
TN #93	1/1/10	Pages 28, 35
TN #91	5/15/09	Pages 23, 24

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

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

C. Verification Required Verification of the equity value of the home is required.

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

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

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

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

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

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

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

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

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

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

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7. **Credit Life/Disability Payments** (S0815.300) Payments made under a credit life or credit disability insurance policy on behalf of an individual are not income.
8. **Loan Proceeds** (S0815.350) Proceeds of a bona fide loan are not income to the borrower because of the borrower's obligation to repay.
9. **Third Party Payments**
- a. Payments made by another individual
- (S0815.400) Payment of an individual's bills (including Medicare supplementary medical insurance or other medical insurance premiums) by a third party directly to the supplier is not income.
- Payments made directly to the service provider by another person for the individual's private room or "sitter" in a medical facility are **not** income to the individual. Refer all cases of Medicaid eligible recipients who have a "sitter" to DMAS, Division of *Aging and Disability Services*, for DMAS review to assure that DMAS is not paying the facility for services provided by the sitter.
- EXCEPTION:** For F&C covered groups **except** the 300% SSI group: If the person paying the bill(s) is the child's absent father and the Division of Child Support Enforcement (DCSE) has not established an obligation for the absent parent, the amount(s) paid by the absent parent for the child is counted as income.
- b. Long-term care (LTC) insurance payments
- Institutionalized individuals who have LTC insurance coverage must have the LTC insurance coverage information entered into the recipient's TPL file in VaCMS. The insurance policy type is "H" and the coverage type is "N."
- If the patient receives the payment from the insurance company, it is not counted as income. The patient should assign it to the provider. If the patient cannot do this, or the policy prohibits assignment, the payment should be given directly to the provider. The provider should report the payment as a third party payment on its claim form. If the patient received the payment and cannot give it to the provider for some reason, then the patient should send the insurance payment to the DMAS Fiscal Division, *Cashiering Unit*, 600 E. Broad Street, Suite 1300, Richmond, Virginia 23219.
10. **Replacement Income** (S0815.450) If an individual's income is lost, stolen, or destroyed and the individual receives a replacement, the replacement is not income if the original payment was counted in determining the individual's Medicaid eligibility.
11. **Erroneous Payments** (S0815.460) A payment is not income when the individual is aware that he is not due the money and returns the check uncashed or otherwise refunds all of the erroneously received money.

M1470 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/19	Table of Contents, page i Pages 1, 14, 28a, 31, 32, 43, 47, 48, 50 Appendix 1, page 2 Page 14a was added as a runover page.
TN #DMAS-12	4/1/19	Pages 10, 12a, 14, 21, 28b
TN #DMAS-10	10/1/18	Page 10, 12a, 14, 21
TN #DMAS-8	4/1/18	Page 2a
TN #DMAS-7	1/1/18	Pages 19, 20, 43, 44.
TN #DMAS-5	7/1/17	Pages 1, 7-9, 11, 15, 19, 20, 28a, 43, 47-51, 53
TN #DMAS-4	4/1/17	Page 19
TN #DMAS-3	1/1/17	Table of Contents, page ii Pages 1, 14, 17, 19, 20, 28a, 45-47, 50 Appendix 1, pages 1 and 2
TN #DMAS-2	10/1/16	Pages 12, 27, 28 Pages 12a and 28a were added as runover pages.
UP #11	7/1/15	Pages 43-46 Page 46a was deleted.
TN #100	5/1/15	Pages 2a, 4, 29, 31, 32, 34, 43, 44, 45, 53, 54 Pages 1a, 2, 3a and 4 were renumbered for clarity. Pages 3, 4a, 46 and 46a are runover pages. Pages 1 and 3 are reprinted.
TN #99	1/1/14	Pages 9, 19, 20, 23, 24, 40
TN #98	10/1/13	Pages 9, 24
UP #9	4/1/13	Pages 9, 16, 19, 20, 24, 43
UP #7	7/1/12	Pages 19, 46-48
UP #6	4/1/12	Pages 4, 9, 19, 20, 24, 26
TN #96	10/1/11	Pages 3, 4, 7-9, 19, 22-24, 43
TN #95	3/1/11	Pages 9, 19, 20, 23
TN #94	9/1/10	Table of Contents pages 1, 1a, 3, 3a, 11, 12, pages 19, 20, 24, 28, 31
TN #93	1/1/10	Pages 9, 13, 19-20, 23, 43, 44
TN #91	5/15/09	Table of Contents Pages 1-56 Appendix 1

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M1470.000 PATIENT PAY-POST-ELIGIBILITY TREATMENT OF INCOME

M1470.001 OVERVIEW

- A. Introduction** “Patient pay” is the amount of the long-term care (LTC) patient’s income which must be paid as his share of the LTC services cost. This subchapter provides basic rules regarding the post-eligibility determination of the amount of the LTC patient's income which must be paid toward the cost of his care. **MAGI Adults have no responsibility for patient pay.** If an individual receiving LTC, also called long-term supports and services (LTSS, loses eligibility in the MAGI Adults covered group and is eligible in another full coverage group, patient pay will policy will apply.
- B. Policy** The state’s Medicaid program must reduce its payment to the LTC provider by the amount of the eligible patient's monthly income, after allowable deductions. Patient pay is calculated after an individual has been determined eligible for Medicaid and for Medicaid LTC services. A Medicaid recipient who is admitted to a nursing facility, facility for individuals with intellectual disability (ICF-ID) or Medicaid waiver services for less than 30 days must have a patient pay determined for the month(s) in which the recipient is in the facility or waiver services. The provider collects the patient pay from the patient or his authorized representative. Patient pay information is fed to the Automated Response System (ARS) and the MediCall Systems for provider verification of patient pay. These systems report the amount of patient pay and the date of service to the provider responsible for collecting patient pay.
- C. VaCMS Patient Pay Process** The patient pay calculation is completed in VaCMS. Refer to the VaCMS Help feature for information regarding data entry. The patient pay must be updated in the system whenever the patient pay changes, but at least once every 12 months. If VaCMS is not able to process required transactions, a Patient Pay Correction form (DMAS 9PP), available at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms>, should be submitted to patientpay@dmas.virginia.gov.
- D. Patient Notification** The patient or the authorized representative is notified of the patient pay amount on the Notice of Obligation for Long-term Care Costs. VaCMS will generate and send the Notice of Obligation for LTC Costs. M1470, Appendix 1 contains a sample Notice of Obligation for LTC Costs generated by VaCMS. DMAS will generate and mail a Notice of Obligation for any changes input directly into MMIS.
- The provider is the only entity with the authority to take action when residents do not pay their patient pay amount. If a resident, or his authorized representative is negligent in paying his patient pay amount to the provider, the provider will provide written documentation regarding the requirement to pay the patient pay amount to the resident or authorized representative and follow the provider’s collection procedures to collect the funds. The provider will report the resident’s negligence in paying the patient pay amount to the LDSS.
- The provider's failure to collect the patient pay, or the patient's failure to pay the patient pay, does not itself affect the patient's Medicaid eligibility. However, the

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Do not send requests for adjustments to DMAS when the patient has no available income for patient pay. Refer to M1470.230 C.5.c for notification procedures to be followed by the local worker.

When a request for an adjustment is approved or denied by DMAS, the local DSS worker will receive a copy of the letter sent to the recipient by DMAS:

- 1) If approved, adjust the patient pay using the VaCMS Patient Pay process.
- 2) If the adjustment request is denied, DMAS prepares the notification.

b. DMAS Approval Not Required

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

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

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

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

c. Notice Procedures

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

6. Managed Care Organizations and CCC Plus (effective January 1, 2018)

As of January 1, 2018, the majority of Medicaid-eligible individuals who receive long-term care (LTC) services are covered under the CCC Plus program through one of six (6) managed care organizations (MCO). As part of the CCC Plus program, each health plan offers enhanced benefits, such as adult dental services or hearing aids, outside of the required contracted Medicaid services. Some of these enhanced benefits are frequently submitted to the LDSS as patient pay adjustment.

If there are other coverage sources available for these services or items, Medicaid policy requires the request for coverage first be submitted to those sources and exhausted there, before the LDSS/DMAS may consider or approve a patient pay adjustment.

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A process is in development to develop a process for distinguishing MCO enhanced benefit services from allowable patient pay deductions. Until further notice, providers and nursing facilities will continue sending all patient pay adjustment requests to the patient's LDSS eligibility worker.

Eligibility workers will review and process patient pay adjustment requests without requiring submission of the request to the individual's CCC Plus plan.

M1470.240 FACILITY - HOME MAINTENANCE DEDUCTION

A. Policy

A single institutionalized individual can be allowed a deduction for the cost of maintaining a home for not more than six months, if a physician has certified he or she is likely to return home within that period.

Home maintenance means that the individual has the responsibility to pay shelter costs on his former place of residence in Virginia, such as rent, mortgage, utilities, taxes, room and board, or assisted living facility (ALF) payments, and that the home, apartment, room or bed is being held for the individual's return to his former residence in Virginia. Individuals who have no responsibility to pay shelter costs are not permitted a home maintenance deduction. If responsibility for shelter costs is questionable, documentation must be requested and provided.

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

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

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

b. Notice Procedures

Upon the final decision to allow the deduction, use the VaCMS Patient Pay process to adjust the patient pay. VaCMS will generate and send the Notice of Obligation for LTC Costs. *If VaCMS is not able to process required transactions, a Patient Pay Correction form (DMAS 9PP), available at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms>, should be submitted to patientpay@dmass.virginia.gov. DMAS will generate and mail a Notice of Obligation for any changes input directly into MMIS.*

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M1470.520 PACE

A. Policy

The Program of All-inclusive Care for the Elderly (PACE) serves individuals aged 55 and older who (1) meet the nursing facility level of care criteria and (2) reside in their own communities. PACE provides all of an individual's health care and long-term care medical needs. PACE is not a CBC Waiver; individuals who meet the criteria for the EDCD Waiver may be enrolled in PACE in lieu of the EDCD Waiver. Individuals who are enrolled in Medicaid as AG recipients (Aid Categories 012, 032, and 052) are not eligible for PACE. See M1440.108 for additional information about PACE.

Individuals enrolled in PACE have a patient pay obligation.

B. Procedures

The patient pay for an individual enrolled in PACE who is not Medically Needy is calculated using the procedures in M1470.400 through M1470.520 for an individual in CBC, with the exceptions listed below.

1. Medicare Part D Premiums

PACE recipients are not responsible for Medicare Part D premiums because their prescriptions are provided through PACE and they are eligible for the full Medicare Part D subsidy. Therefore, the cost of the Medicare Part D premium is not allowable as a deduction from patient pay.

2. Covered Medical Expenses

Because PACE includes most medically-necessary services the individual needs, the allowable medical expense deductions differ from the allowable medical expense deductions for CBC.

The following services are provided through PACE:

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

Any medical expenses incurred by the individual for the services listed above are not allowable patient pay deductions. With the exception of the services listed above, the noncovered expenses listed in M1470.430 C.2 are allowable for PACE recipients. DMAS approval **is not required** for deductions of noncovered services from patient pay for PACE recipients, regardless of the amount of the deduction.

3. PACE Recipient Enters a Nursing Facility

Because PACE is a program of all-inclusive care, nursing facility services are part of the benefit package for PACE recipients who can no longer reside in the community. *PACE recipients may be placed in a nursing facility while still enrolled in PACE.* When a PACE recipient *is placed in* a nursing facility, the PACE provider has 60 days from the date of *placement* to notify the eligibility worker of the individual's placement in the nursing facility and the need for a recalculation of the patient pay.

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Do not change the personal needs allowance to the facility amount unless notification is received from PACE. After notification from PACE of the individual's placement in a nursing facility, the eligibility worker will take action to recalculate the individual's patient pay prospectively for the month following the month the 10 day advance notice period ends. There is NO retroactive calculation of patient pay back to the date the individual entered the facility. Do not refer to the Recipient Audit Unit. When the change is made, the individual is entitled to a personal needs allowance of \$40 per month.

M1470.600 MN PATIENTS - SPENDDOWN LIABILITY

A. Policy

This section is for unmarried individuals or married individuals who have no community spouse. **DO NOT USE this section** for a married individual with a community spouse, go to subchapter M1480.

MN individuals have a spenddown liability that must be met before they are eligible for Medicaid because their monthly income exceeds 300% of SSI, which exceeds the MN income limits. When an MN individual meets the spenddown, he is eligible for Medicaid (see section M1460.700 for spenddown determination policy and procedures). Patient pay for **each** month in which the individual meets the spenddown must be determined.

A patient under 22 years of age receiving inpatient psychiatric services in an IMD (Institution for Treatment of Mental Diseases) whose income exceeds 300% of SSI may be eligible for Medicaid as MN if he meets the spenddown liability.

Coverage in an IMD is not part of the Medicaid benefit package for any other MN individuals who are eligible for Medicaid while in an IMD, including individuals age 65 years or older. Individuals under age 22 years who are not receiving inpatient psychiatric services and all individuals over age 22 years but under age 64 years are not eligible for Medicaid while in an IMD (see M0280.201).

B. Definitions

The following definitions are used in this section and subsequent sections of this subchapter:

1. Medicaid Rate

The Medicaid rate for facility patients is the patient's daily Resource Utilization Group (RUG) code amount multiplied by the number of days in the month. A patient's RUG code amount is based on his room and board and ancillary services. The RUG code amount may differ from facility to facility and from patient to patient within the same facility. Confirmation of the individual's RUG code amount must be obtained by contacting the facility. For the month of entry, use the actual number of days that care was received or is projected to be received. For ongoing months, multiply the daily RUG code amount by 31 days.

The Medicaid rate for CBC patients is the number of hours per month actually provided by the CBC provider multiplied by the Medicaid hourly rate.

PACE has a capitated monthly rate that is due and payable on the first day of the month. The monthly PACE rate is available from the PACE provider.

2. Remaining Income

Remaining income is the amount of the patient's total monthly countable income for patient pay minus all allowable patient pay deductions.

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

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

4. Patient Pay

a. Projected Spenddown Eligibility Determinations

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

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

b. Retrospective Spenddown Eligibility Determinations

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

M1470.800 COMMUNICATION BETWEEN LOCAL DSS AND LTC PROVIDER

A. Introduction

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

B. Purpose

Eligibility workers should generate the DMAS-225 through VaCMS. The DMAS-225 form is also available at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms>.

The form is used to:

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

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- b) If the total patient pay obligation exceeds the provider's Medicaid rate, determine the difference between the ongoing patient pay and the provider's Medicaid rate. The difference is the amount of the underpayment that can be collected the first month. The patient pay for the first month (current patient pay and a portion of the underpayment) will equal the Medicaid rate. The balance of the underpayment must be collected in subsequent months. Repeat these procedures for subsequent months until the total amount of the underpayment has been reduced to zero.

c. Total underpayment of \$1,500 or more

- 1) Underpayment amounts totaling \$1,500 or more must be referred to the DMAS Recipient Audit Unit for collection.
- a) Complete and send a Notice of Recipient Fraud/Non-Fraud (see M17, Appendix 2) to:
- Recipient Audit Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
- b) Send a Notice of Action, *available at* <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms>, informing the patient of the referral to DMAS for collection of the underpayment.
- 2) Prospective months' patient pay

VaCMS will automatically generate and send a "Notice of Obligation for LTC Costs" to the patient or the patient's representative for the month following the month in which the 10-day advance notice period ends.

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**5. Example--
Patient Pay
Increase -Total
Underpayment
\$1,500 or More**

Mr. M is an institutionalized individual. On February 25, he reports his pension increased \$600 per month in February. On March 22 the EW recalculated the patient pay based on the current income. His new monthly patient pay is \$1,800. His "old" monthly patient pay was \$1200.

Because of the 10-day advance notice requirement the change could not be made for April and must be made for May 1. His "old" patient pay is subtracted from his "new" patient pay for February, March and April to determine his underpayment for those months. The \$600 underpayment for three months totals \$1,800. Since the total underpayment exceeds \$1,500, a patient pay adjustment *cannot* be made. A referral must be made to the DMAS Recipient Audit Unit for collection and the recipient must be notified of the referral (see M1470.900 D. 3. c).

M1470.910 RETROACTIVE ADJUSTMENTS FOR PRIOR MONTHS

**A. Retroactive
Adjustment**

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

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

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

**B. Notification
Requirements**

VaCMS automatically generates and sends the Notice of Obligation for LTC Costs. DMAS will generate and mail a Notice of Obligation for any changes input directly into MMIS.

M1470.920 LTC PROVIDER CHANGE WITHIN A MONTH

A. Policy

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

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M1470.930 DEATH OR DISCHARGE FROM LTC

- A. Policy** The LTC provider may not collect an amount of patient pay that is more than the Medicaid rate for the month. When a patient dies or is discharged from LTC to another living arrangement that does not include LTC services, do not recalculate patient pay for the month in which the patient died or was discharged. The provider is responsible for collecting an amount of patient pay for the month of death or discharge that does not exceed the Medicaid rate for the month.
- B. Procedure** Refer to the VaCMS Help feature for procedures regarding death or discharge from LTC. Send a DMAS-225 to the provider regarding the eligibility status of the patient. Send a notice to the patient or the patient's representative that reflects the reduction or termination of services. If VaCMS is not able to process required transactions or additional correction is needed, submit a Patient Pay Correction form (DMAS 9PP), available at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms>, to patientpay@dmas.virginia.gov. DMAS will generate and mail a Notice of Obligation for any changes input directly into MMIS.

M1470.1000 LUMP SUM PAYMENTS

- A. Policy** Lump sum payments of income or accumulated benefits are counted as income in the month they are received. Patient pay must be adjusted to reflect this income change for the month following the month in which the 10-day advance notice period expires. Any amount retained becomes a resource in the following month.
- B. Lump Sum Defined** Income such as interest, trust payments, royalties, etc., which is received regularly but is received less often than quarterly (i.e., once every four months or three times a year, once every five months, once every six months or twice a year, or once a year) is treated as a lump sum for patient pay purposes.
- EXCEPTION:** Income that has previously been identified as available for patient pay, but which was not actually received because the payment source was holding the payment(s) for some reason or had terminated the payment(s) by mistake, is **NOT** counted again when the corrective payment is received.
- See section M1470.1030 below for instructions for determining patient pay when a lump sum is received.

M1470.1010 LUMP SUM REPORTED IN RECEIPT MONTH

- A. Lump Sum Available** Lump sum payments reported in the month the payment was received are counted available for patient pay effective the first of the month following the month in which the 10-day advance notice period expires.
- If the individual is no longer in the facility and is not receiving Medicaid CBC, adjust the patient pay for the lump sum receipt month if the money is still available.
- B. Lump Sum Not Available** If the money is not available, complete and send a Notice of Recipient Fraud/Non-Fraud to the DMAS, Recipient Audit Unit.

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COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Patient pay may be the lesser of the SDL amount, contributable income amount (income remaining after deductions plus the SDL), remaining income or the Medicaid Rate, whichever is applicable to the individual's circumstances.

Patient pay will not exceed the Medicaid Rate.

You must report any changes in income or resources to the local agency. Failing to report changes or providing false or misleading information may result in your prosecution for fraud.

If you have Medicare Part A coverage, and were admitted to a nursing facility under "Skilled Care", the patient pay amount you owe for the first 100 days may be less than the amount shown on this notice. The nursing facility will determine how many days are covered by Medicare and will send you a bill. Once Medicare stops paying, you will be responsible for the full patient pay amount shown on this notice.

Appeal Information

If you disagree with this action, you have the right to file an appeal. You or your authorized representative must send a written appeal request within 30 days of receipt of this notification. If you file an appeal before the effective date of this action, the patient pay will remain unchanged during the appeal process. However, if the Appeals Division upholds this action, you may be required to reimburse the Medicaid Program for the excess cost of services paid on your behalf during the appeal period.

You may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, at your local department of social services, or by calling (804) 371-8488.

Please include a copy of this notification. Sign the appeal request and mail it to:

Department of Medical Assistance Services, Appeals Division
600 E Broad Street, Richmond,
Virginia 23219

Appeal requests may also be faxed to (804) 452-5454

M1480 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/19	Pages 8a, 8b, 12, 15, 16, 18, 20, 21, 30, 32, 51
TN #DMAS-13	7/1/19	Page 66
TN #DMAS-11	1/1/19	Pages 2, 7, 8, 18c, 66, 69, 70
TN #DMAS-7	1/1/18	Pages 18c, 66
TN #DMAS-11	1/1/19	Page 2
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, 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, 69, 70, 93 Appendix 4 was removed.
Update (UP) #1	7/1/09	Page 66
TN # 91	5/15/09	Pages 67, 68 Pages 76-93

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M1480.200 RESOURCE ASSESSMENT RULES

A. Introduction

A resource assessment must be completed when an institutionalized spouse with a community spouse applies for Medicaid coverage of long term care services and may be requested without a Medicaid application.

A resource assessment is strictly a:

- compilation of a couple's reported resources that exist(ed) at the first moment of the first day of the month in which the first continuous period of institutionalization began on or after September 30, 1989.
- calculation of the couple's total countable resources at that point, and
- calculation of the spousal share of those total countable resources.

A resource assessment does not determine resource eligibility but is the first step in a multi-step process. A resource assessment determines the spousal share of the couple's combined countable resources.

B. Policy Principles

1. Applicability

The resource assessment and resource eligibility rules apply to individuals who began a continuous period of institutionalization on or after September 30, 1989 and who are likely to remain in the medical institution for a continuous period of at least 30 consecutive days, or have been screened and approved for Medicaid CBC waiver services, or have elected hospice services.

The resource assessment and resource eligibility rules do **NOT** apply to individuals who were institutionalized before September 30, 1989, **unless** they leave the institution (or Medicaid CBC waiver services) for at least 30 consecutive days and are then re-institutionalized for a new continuous period that began on or after September 30, 1989.

Resource Assessment policy *does not* apply to individuals eligible in the MAGI Adult covered group. *However, a resource assessment may be needed when a married individual FORMERLY received LTSS as a MAGI Adult, and needs to be re-evaluated for LTSS in a non-MAGI group. If the individual is currently married but was not married on the first day of the first continuous period of institutionalization, no resource assessment is needed.*

2. Who Can Request

A resource assessment without a Medicaid application can be requested by the institutionalized individual in a medical institution, his community spouse, or an authorized representative. See section M1410.100.

3. When to Do A Resource Assessment

a. Without A Medicaid Application

A resource assessment without a Medicaid application may be requested when a spouse is admitted to a **medical institution**. Do not do a resource assessment **without** a Medicaid application unless the individual is in a medical institution.

b. With A Medicaid Application

The spousal share is used in determining the institutionalized individual's resource eligibility. A resource assessment must be completed when a married institutionalized individual with a community spouse who

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- is in a nursing facility, or
is screened and approved to receive nursing facility or Medicaid CBC waiver services, or
- has elected hospice services

applies for Medicaid. The resource assessment is completed when the applicant is screened and approved to receive nursing facility or Medicaid CBC services or within the month of application for Medicaid, whichever is later.

NOTE: Once an institutionalized spouse has established Medicaid eligibility as a *Non-MAGI* institutionalized spouse, count only the institutionalized spouse's resources when redetermining the institutionalized spouse's Medicaid eligibility. Do not count or deem the community spouse's resources available to the institutionalized spouse.

If an institutionalized spouse's Medicaid coverage was cancelled and he reapplies as an institutionalized individual, use only the resources in his name (including his share of jointly owned resources) for the eligibility determination.

The following table contains examples that indicate when an individual is treated as an institutionalized individual for the purposes of the resource assessment:

Screened and Approved in:	In a Facility?	Application Month	Resource Assessment Month	Processing Month	Month of Application/ongoing as Institutionalized	Retroactive Determination as Institutionalized (in a medical facility)
January	no	January	January	January	yes	no
January	no	February	February	February	yes	no
N/A	yes	January	first continuous period of institutionalization	February	yes	yes
January	no	March	March	April	yes	no
April	no	March	April	Whenever	no, but yes for April	no

c. Both Spouses Request Medicaid CBC

When both spouses request Medicaid CBC, one resource assessment is completed. The \$2,000 Medicaid resource limit applies to each spouse.

C. Responsible Local Agency

The local department of social services (DSS) in the Virginia locality where the individual last resided outside of an institution (including an ACR) is responsible for processing a request for a resource assessment without a Medicaid application, and for processing the individual's Medicaid application. If the individual never resided in Virginia outside of an institution, the local DSS responsible for processing the request or application is the local DSS serving the Virginia locality in which the institution is located.

The Medicaid Technicians in the Department of Behavioral Health and Developmental Services (DBHDS) facilities are responsible for processing a married patient's request for a resource assessment without a Medicaid application, and for processing the patient's Medicaid application.

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b. Calculate the Spousal Share

Calculate the total value of the couple's countable resources. Divide this total by 2 to obtain the spousal share. The spousal share is ½ of the couple's combined countable resources as of **the first moment of the first day of the first month** of the first continuous period of institutionalization that began on or after September 30, 1989.

Calculate the spousal share only once; it remains a constant amount for any Medicaid application filed after the resource assessment.

EXAMPLE #2: A Medicaid Resource Assessment Request is received on October 20, 1996 for Mrs. H who was admitted to the nursing facility on October 18, 1996. Her first continuous period of institutionalization began on December 21, 1995, and ended with her discharge on May 30, 1996. Mr. H provides verification which proves that the couple's total countable resources as of December 1, 1995 (the first day of the first month of the first continuous period of institutionalization) were \$131,000. The spousal share is ½ of \$131,000, or \$65,500.

On the Medicaid Resource Assessment form the worker lists the couple's resources as of December 1, 1995 as follows:

<u>Resource</u>	<u>Owner</u>	<u>Countable</u>	<u>Countable Value</u>
Home	Mr & Mrs	No	0
Savings	Mr & Mrs	Yes	\$100,000
CD	Mr	Yes	\$ 31,000
<u>\$131,000</u>	Total Value of Couple's Countable Resources		
<u>\$ 65,500</u>	Spousal Share		

If in the future, Mrs. H applies for Medicaid and she is still married to Mr. H, the worker must use the spousal share of \$65,500 determined by the October 1996 resource assessment.

7. Send Loans and/or Judgments to DMAS

When the resource assessment identifies a loan or a judgment against resources, send the documents pertaining to the loan and/or judgment to DMAS for review before taking action on the resource assessment. Send the documents, along with case identifying information (institutionalized spouse's and community spouse's names, address, SSN, case number) to:

DMAS, Eligibility & Enrollment Services Division
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

8. Notification Requirements

a. When the Assessment Is Not Completed

Both spouses and the guardian, conservator or authorized representative must be notified in writing that the assessment was not completed; note the specific reason on the form. Use the form Notice of Medicaid Resource Assessment (#032-03-817).

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2. Send Judgments to DMAS

When the resource assessment or eligibility determination identifies a judgment against resources, send the documents pertaining to the judgment to DMAS for review and how it relates to the resource before taking action on the application. Send the documents, along with case identifying information (institutionalized spouse's and community spouse's names, address, SSN, case number) to:

DMAS, Eligibility & Enrollment Services Division
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

3. Determining the First Continuous Period of Institutionalization

The spousal share is based on the couple's resources owned **on the first moment of the first day of** the first month of the first continuous period of institutionalization which occurred on or after September 30, 1989. This may be different from the current period of institutionalization. Use the information below to determine exactly when the individual's first continuous period of institutionalization began.

Inquire if the individual was ever institutionalized prior to current institutionalization but not earlier than September 30, 1989. If yes, ascertain the first date on or after September 30, 1989, on which the individual was admitted to a medical institution or the first date Medicaid CBC waiver services began.

Ask the following:

- From where was he admitted?

If admitted from a home in the community which is not an institution as defined in section M1410.010, determine if Medicaid CBC waiver services were received and covered by Medicaid while the individual was in the home. If so, the days of Medicaid CBC receipt are “institutionalization” days.

If admitted from another institution, ascertain the admission and discharge dates, institution’s name and type of institution. The days he was in a medical institution are institutionalization days if there was less than a 30-day break between institutionalizations.

- What was the last date the individual resided outside a medical institution (in the community, at home, or in a non-medical institution)?

4. Failure to Provide Verification

a. Applicant Does Not Notify Agency of Difficulty Securing Verifications

If the applicant fails to provide requested verification of the value of the couple's resources held at the beginning of the first continuous period of institutionalization and does not notify the EW of difficulty in securing the

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requested data, the worker is unable to complete the resource assessment and eligibility as a married institutionalized individual cannot be determined. The application must be processed using rules for non-institutionalized individuals and payment for LTC services must be denied for failure to verify resources held at the beginning of institutionalization.

b. Applicant Notifies Agency of Difficulty Securing Verifications

If the applicant is unable to provide verification of the value of the couple's resources held at the beginning of the first continuous period of institutionalization and notifies the EW of difficulty in securing the requested data, the applicant may claim undue hardship.

Undue hardship can be claimed when both spouses have exhausted all avenues to verify the value of the resources owned on the first day of the first month of the first continuous period of institutionalization. When undue hardship is claimed, the applicant must provide documentation of the attempts made to obtain the verification. **Claims of undue hardship must be evaluated and can only be granted by DMAS.** The EW must send a summary of the needed verifications and documentation of the attempts to secure the verifications, along with the applicant's name and case number to:

DMAS, Eligibility & Enrollment Services Division
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

If DMAS determines undue hardship does not exist, the resource assessment cannot be completed and the application must be denied due to failure to verify resources held at the beginning of institutionalization. If DMAS determines undue hardship exists, the completion of a resource assessment is waived, and the spousal resource standard is to be substituted for the spousal share in determining the individual's resource eligibility. Go to section M1480.230 below.

5. Completing the Medicaid Resource Assessment

When verification is provided, completion of the resource assessment establishes the spousal share which is equal to ½ of a couple's total countable resources as of **the first moment of the first day of** the first month of the first continuous period of institutionalization that began on or after September 30, 1989. The spousal share is one factor in determining the spousal protected resource amount (PRA) in section M1480.230 below.

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3. The applicant has assigned to DMAS, to the full extent allowed by law, all claims he or she may have to financial support from the spouse; and
4. The applicant cooperates with DMAS in any effort undertaken or requested by DMAS to locate the spouse, to obtain information about the spouse's resources and/or to obtain financial support from the spouse.

B. Procedures

1. Assisting the Applicant

The EW must advise the applicant of the information needed to complete the resource assessment and assist the applicant in contacting the separated spouse to obtain resource and income information.

If the applicant cannot locate the separated spouse, document the VaCMS case record. Refer to M1480.225 B.2.b below.

If the applicant locates the separated spouse, the EW must contact the separated spouse to explain the resource assessment requirements for the determination of spousal eligibility for long-term care services.

If the separated spouse refuses to cooperate in providing information necessary to complete the resource assessment, document the VaCMS case record. Refer to M1480.225 B.2.b below.

EXCEPTION: If the separated spouse is institutionalized and is a Medicaid applicant/recipient, the definition of "community spouse" is not met, and a resource assessment is not needed.

2. Undue Hardship

If the applicant is unable to provide the necessary information to complete the resource assessment, he/she must be advised of the hardship policy and the right to claim undue hardship.

a. Undue hardship not claimed

If the applicant does not wish to claim undue hardship, the EW must document the VaCMS case record, and the application must be processed using rules for non-institutionalized individuals. Payment for LTC services must be denied for failure to verify resources held at the beginning of institutionalization.

b. Undue hardship claimed

If the applicant claims an undue hardship, he must provide a written statement requesting an undue hardship evaluation. A Resource Assessment Undue Hardship Request Form, including affidavit and assignment forms, may be given to the applicant to be used instead of an original statement but is **not required**. The forms are available at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms>.

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NOTE: When a loan or a judgment against resources is identified, send the documents pertaining to the loan and/or judgment to DMAS for review before taking action on the application. Send the documents, along with case identifying information (institutionalized spouse's and community spouse's names, address, SSN, case number) to:

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

2. Deduct Spousal Protected Resource Amount (PRA)

Deduct the spousal protected resource amount (PRA) from the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined.

If no spousal share was determined because the couple failed to verify resources held at the beginning of the first continuous period of institutionalization, the application must be processed using rules for non-institutionalized individuals and payment for LTC services must be denied for failure to verify resources held at the beginning of institutionalization.

The PRA is the greatest of the following:

- the **spousal share** of resources as determined by the resource assessment, provided it does not exceed the maximum spousal resource standard in effect at the time of application. **If the spousal share exceeds the maximum spousal resource standard, use the maximum spousal resource standard.** The spousal share does not change; if a spousal share was previously established and verified as correct, use it;
- the **spousal resource standard** in effect at the time of application;
- an amount designated by a DMAS Hearing Officer;
- an amount **actually transferred** to the community spouse from the institutionalized spouse under a **court spousal support order** issued as the result of an appeal of the DMAS Hearing Officer's decision.

The EW cannot accept a court order for a greater PRA unless the individual has exhausted the Medicaid administrative appeals process, the individual appealed the DMAS Hearing Officer's decision to the circuit court and the circuit court ordered a higher amount.

If the individual does not agree with the PRA, see subsection F. below.

Once the PRA is determined, it remains a constant amount for the current Medicaid application (including retroactive months). If the application is denied and the individual reapplies, the spousal share remains the same but a new PRA must be determined.

3. Deduct Partnership Policy Disregard Amount

When the institutionalized spouse is entitled to a Partnership Policy disregard, deduct a dollar amount equal to the benefits paid as of the month of application.

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**4. Compare
Remainder**

Compare the remaining amount of the couple's resources to the appropriate Medicaid resource limit for one person.

a. Remainder Exceeds Limit

When the remaining resources exceed the limit and the institutionalized spouse does not have Medicare Part A, the institutionalized spouse is not eligible for Medicaid coverage because of excess resources.

If the institutionalized spouse has Medicare Part A, he may be eligible for limited coverage QMB, SLMB or QI Medicaid (which will not cover the cost of the LTC services) because the resource requirements and limits are different. **The resource policies in subchapter M1480 do not apply to limited-coverage Medicaid eligibility determinations.** Follow the procedures for determining resource eligibility for an individual in Chapter S11. More information about the QMB, SLMB, and QI covered groups is contained in subchapter M0320.

Note: The institutionalized spouse cannot be eligible for QDWI Medicaid.

b. Remainder Less Than or Equal to Limit

When the remaining resources are equal to or less than the Medicaid limit, the institutionalized spouse is resource eligible in the month for which eligibility is being determined:

- determine the community spouse resource allowance (CSRA). To calculate the CSRA, see sections M1480.240 and 241 below;
- determine a protected period of eligibility for the institutionalized spouse, if the institutionalized spouse expressly states his intent to transfer resources that are in his name to the community spouse; see section M1480.240 below.

**C. Example--
Calculating the
PRA**

EXAMPLE #4:

Mr. A is married to a community spouse. He applied for Medicaid on December 2, 1997. The beginning of his first continuous period of institutionalization which began on or after 9-30-89 was October 12, 1993, when he was admitted to a nursing facility. He was discharged from the facility on February 5, 1995, then readmitted to the nursing facility on December 5, 1997 and remains there to date. Eligibility is being determined for December 1997.

Step 1:

The couple's total countable resources on October 1, 1993 (the first moment of the first day of the first continuous period of institutionalization) were \$130,000.

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- the amount of resources that may be transferred to bring the community spouse up to the PRA will reduce the resources in the institutionalized spouse's name to no more than \$2,000, and
- the institutionalized spouse has expressly indicated in writing his intent to transfer resources to the community spouse.

The protected period is designed to allow the institutionalized spouse time to legally transfer some or all of his resources to the community spouse. Resources in the institutionalized spouse's name are excluded only for one 90-day period.

If the institutionalized spouse does not transfer resources to the community spouse within the 90-day period, all of the institutionalized spouse's resources will be counted available to the institutionalized spouse when the protected period ends. If the institutionalized spouse loses eligibility after the 90-day protected period is over, and then reapplies for Medicaid, he CANNOT have resource eligibility protected again and a PRA is NOT subtracted from his resources.

B. Protected Period Is Not Applicable

A protected period of eligibility is not applicable to an institutionalized spouse when:

- the institutionalized spouse is not eligible for Medicaid;
- the institutionalized spouse previously established Medicaid eligibility as an institutionalized spouse, had a protected period of eligibility, became ineligible, and reapplies for Medicaid; or
- at the time of application, a community spouse has title to resources equal to or exceeding the PRA.

C. Intent to Transfer Resources To Community Spouse

The institutionalized spouse or authorized representative must expressly indicate in writing his intention to transfer resources to the community spouse. If not previously obtained, send an "Intent to Transfer Assets to A Community Spouse" form, available at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms>, to the institutionalized spouse or authorized representative, allowing 10 days from the date of mailing for return of the form.

If the completed Intent to Transfer Assets form is not returned by the time the application is processed, no protected period of eligibility may be established. All resources in the institutionalized spouse's name must be counted in his eligibility determination beginning with the month following the initial eligibility determination period. If eligible, enroll the institutionalized spouse for a closed period of coverage beginning with the retroactive period and ending with the last day of the month of the initial eligibility period.

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B. CSRA Calculation Procedures

Use the following procedures for calculating the CSRA. The “Institutionalized Spouse Resource Eligibility Worksheet,” available at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms>, should be used to determine countable resources and the CSRA.

1. Determine Community Spouse's Resources

Determine the amounts of the couple's total resources which are in the community spouse's name only and the community spouse's share of jointly owned resources owned as of the first moment of the first day of the initial month for which eligibility was established.

2. Determine Institutionalized Spouse's Resources

Determine the amounts of the couple's total resources which are in the institutionalized spouse's name only and the institutionalized spouse's share of jointly owned resources owned as of the first moment of the first day of the initial month for which eligibility was established. If the institutionalized spouse's resources changed during initial month (after the first moment of the first day of the initial month which eligibility was established) verify the institutionalized spouse's resources owned as of the first moment of the first day of the month following the initial month.

3. Calculate CSRA

To calculate the Community Spouse Resource Allowance (CSRA):

a. Determine PRA

Find the spousal PRA (determined in section M1480.232 above).

b. Subtract CS Resources from the PRA

Subtract from the PRA an amount equal to the resources in the community spouse's name only and the community spouse's share of jointly owned resources as of the first moment of the first day of the initial month in which eligibility was established.

c. Remainder

The remainder, if greater than zero, is the CSRA and the amount to be disregarded in the institutionalized spouse's Medicaid eligibility determination during the protected period. This is the amount to be transferred to the community spouse during the protected period.

If the remainder is \$0 or a negative number, the CSRA = \$0. The community spouse does not have a CSRA.

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M1480.315 THIRD PARTY & LONG-TERM CARE INSURANCE PAYMENTS

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

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

B. LTC Insurance Policy Payments The LTC insurance policy must be entered into the recipient's TPL file. The insurance policy type is "H" and the coverage type is "N." When entered in MMIS on the TPL screen, MMIS will not pay the nursing facility's claim unless the claim shows how much the policy paid.

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

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

DMAS Fiscal Division, Accounts Receivable
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

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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

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

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

- Introduction** This subsection contains the standards and their effective dates that are used to determine the community spouse’s and other family members’ income allowances. The income allowances are deducted from the institutionalized spouse’s gross monthly income when determining the monthly patient pay amount. Definitions of these terms are in section M1480.010 above.
- | | | | |
|---|------------|-----------------------------|---------|
| B. Monthly Maintenance Needs Allowance | \$2,057.50 | 7-1-18 | |
| | \$2,113.75 | 7-1-19 | |
| C. Maximum Monthly Maintenance Needs Allowance | \$3,090.00 | 1-1-18 | |
| | \$3,160.50 | 1-1-19 | |
| D. Excess Shelter Standard | \$617.25 | 7-1-18 | |
| | \$634.13 | 7-1-19 | |
| E. Utility Standard Deduction (SNAP) | \$311.00 | 1 - 3 household members | 10-1-18 |
| | \$387.00 | 4 or more household members | 10-1-18 |
| | \$303.00 | 1 - 3 household members | 10-1-19 |
| | \$379.00 | 4 or more household members | 10-1-19 |

Note: the amounts decreased effective 10-1-19.

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).

M1510 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/19	Pages 2b, 4, 5-7
TN #DMAS-12	4/1/19	Page 7, 9a. Page 7a is a runover page.
TN #DMAS-11	1/1/19	Page 7
TN #DMAS-10	10/1/18	Pages 7, 8a, 9a, 14 Pages 8b and 8c are runover pages.
TN #DMAS-9	7/1/18	Table of Contents Page 5. Page 9a was added.
TN #DMAS-8	4/1/18	Pages 2, 8a, 8b Page 8c was added.
TN #DMAS-6	10/1/17	Table of Contents Pages 1, 2 Page 2a is a runover page. Page 2b was added as a runover page.
TN #DMAS-5	7/1/17	Page 1 Page 2 is a runover page.
TN #DMAS-4	4/1/17	Pages 2a, 10
TN #DMAS-2	1/1/17	Table of Contents Pages 1, 8, 8a, 12-15 Page 11a was deleted.
TN #DMAS-2	10/1/16	On pages 3-15, corrected the subchapter number in the headers. Neither the dates nor the policies were changed.
TN #DMAS-1	6/1/16	Pages 2 Pages 1 and 2a are runover pages.
TN #100	5/1/15	Table of Contents Pages 1-2a, 5-8b
UP #10	5/1/14	Table of Contents Pages 7-8a Page 8b was added.
TN #99	1/1/14	Table of Contents Pages 1, 2, 8, 8a, 9-11 Page 11a was added.
UP #9	4/1/13	Pages 2-7, 10-12, 14
UP #7	7/1/12	Pages 8, 9
TN #96	10/01/11	Pages 8a, 10
TN #95	3/1/11	Table of Contents Pages 8, 11-15
TN #94	9/1/10	Pages 2a, 8-8a
TN #93	1/1/10	Page 6
Update (UP) #2	8/24/09	Page 11
TN #91	5/15/09	Page 14

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C. Budget Periods By Classification

1. CN

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

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

2. MN

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

D. Verification

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

Income verification *from available electronic sources* is acceptable for retroactive eligibility determinations provided that reasonable compatibility is met (see M0420.100 B.9). *For all case actions effective October 26, 2019, if the income attested to by the applicant is within 10% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required. If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return.* The applicant must provide verification of income received in the retroactive period, as well as for ongoing eligibility, if his income is not verified by *electronic sources*.

An applicant with a resource test must provide verification of resources held in the retroactive period.

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

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

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

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

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

E. Disabled Applicants

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

F. Excess Resources in Retroactive Period

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

EXAMPLE #4: (Using July 2006 figures)

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

G. Income Determination

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

1. Monthly Determination for CN

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

2. MN

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

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

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

H. Retroactive Entitlement

Retroactive coverage can begin the first day of the third month prior to application month if all eligibility requirements are met. An exception is eligibility for a newborn; coverage will be effective on the child's date of birth.

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

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

1. Retroactive Coverage Begin Date

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

2. Retroactive Coverage End Date

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

3. Example

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

M1510.102 ONGOING ENTITLEMENT

A. Coverage Begin Date

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

- when an applicant has excess income;
- when the applicant is eligible only as a QMB;
- when the applicant is age 21-64 years and is admitted to an institution for mental diseases (IMD);
- when the individual is incarcerated (*see M0140.200.C.1 and M0140.300.D*);
- for a newborn, coverage will begin on the child's date of birth.

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- 1. Applicant Has Excess Income**

When all eligibility requirements are met except for income, entitlement begins the date the spenddown is met. Only medically needy applicants can be eligible after meeting a spenddown. See subchapter M1330 to determine retroactive spenddown eligibility.

- 2. QMB Applicant**

Entitlement to Medicaid for QMB coverage begins the first day of the month **following** the month in which the individual's QMB eligibility is determined *and approved, not the month of application.*

***EXAMPLE #6:** Ms. C is 55 years old and is disabled. She applied for Medicaid on May 8, 2019, and requested retroactive coverage. She began receiving Medicare in May 2019. She is approved for QMB coverage on June 9; therefore, her QMB coverage will begin on July 1. She is eligible to receive coverage in the MAGI Adults covered group for the retroactive months of February, March, and April. However, she is not eligible for MAGI Adults coverage in May or June due to her Medicare enrollment. QMB eligibility cannot extend to the retroactive period (see M1510.101.H). If she did not opt out of Plan First, she should be enrolled in Plan First coverage for May and June, 2019.*

- 3. SLMB and QDWI**

Ongoing entitlement for the Special Low Income Medicare Beneficiary (SLMB) and the Qualified Disabled and Working Individuals (QDWI) covered groups is the first day of the application month when all eligibility factors are met at any time in the month of application.

- 4. Applicant Age 21-64 Is Admitted To An IMD**

An applicant who is age 21-64 years and who is admitted to an IMD is NOT eligible for Medicaid. If otherwise eligible for Medicaid in the application month, his entitlement to Medicaid begins the date he is discharged from the ineligible institution in the month.

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

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

- 5. Applications From CSBs For IMD Patients Ages 21-64 Years**

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

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

EXAMPLE #6b: Mr. A is a 50 year old patient at Central State Hospital (an IMD). He receives Social Security disability benefits. The CSB sends his local agency a Medicaid application which is received on August 18. The facility's statement notes that he will be discharged on September 17 to ABC Nursing Home, a nursing facility. The agency completes the determination on August 27 and finds that he will be eligible once he is discharged to the nursing facility.

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

**6. Offenders
(Incarcerated
Individuals)**

Individuals who meet all Medicaid eligibility requirements, including eligibility in a **full benefit** CN covered group, are eligible for Medicaid coverage limited to inpatient hospitalization while incarcerated. Enroll eligible MAGI Adults in aid category AC 108 and all other offenders in aid category AC 109 regardless of their covered group.

See M0140.000 regarding incarcerated individuals *and M1520.102 for ongoing entitlement.*

**7. MAGI Adult
Turns 65 or
Eligible for
Medicare**

When an individual enrolled in the Modified Adjusted Gross Income MAGI Adults covered group turns 65 years old, begins to receive Medicare or is eligible to receive Medicare, he is no longer eligible in the MAGI Adults covered group. Evaluate the individual for eligibility in an Aged, Blind or Disabled covered group. If the individual is not eligible in any other covered group, cancel his coverage following the policy in M1510.102 B below.

M1520 Changes
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Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/2019	Pages 2, 3, 4, 6a, 8, 9, 10, 13 Page 4a is a runover page. Page 10a was added as a runover page. Page 7a was deleted.
TN #DMAS-13	7/1/2019	Page 14
TN #DMAS-12	4/1/2019	Table of Contents Pages 2, 5, 6, 6a, 7, 8, 8a, 11, 12, 15-18, 20 Appendix 2 Page 24a was added. Pages, 19, 21-24, 25 are runover pages.
TN #DMAS-11	1/1/2019	Pages 2, 5, 6, 7, 9
TN #DMAS-8	4/1/18	Pages 2, 18 Appendix 2
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.

M1520 Changes**Page 2 of 2**

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

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M1520.100 PARTIAL REVIEW

- A. Enrollee's Responsibility** Enrollees must report changes in circumstances that 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 be reported to the DMAS HIPP Unit within the 10-day timeframe.
- B. Eligibility Worker's Responsibility** The eligibility worker is responsible 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 services and supports (LTSS), if possible, use available online systems information to verify the reported change. If the online-information is compatible with the reported *change*, determine eligibility based upon the information available.
- If verifications must be obtained from the enrollee, send him a verification checklist, and allow at least 10 calendar days for the information to be returned. If information is not provided by the deadline and continued eligibility cannot be determined, send advance notice to the enrollee/ authorized representative informing him of the cancellation date and the reason. Document the information and evaluation in the VaCMS case record.
- 1. Changes That Require Partial Review of Eligibility** When an enrollee reports a change or the agency receives information indicating a change in the 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 decrease in income or termination of employment must be verified. If a reported change is not compatible with information obtained from online system searches, obtain verification from enrollee or authorized representative.
- The agency may not deny, terminate or reduce benefits for any individual unless the agency has sought additional information from the individual and provided proper notification.
- 2. Changes That Do Not Require Partial Review** Document changes in an enrollee's situation, *such as the receipt of the* enrollee's Social Security number (SSN), that do not require a partial review in the case record and take action any necessary action on the enrollee's coverage.
- Example: An 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 at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/References>. The eligibility worker must report to the HIPP Unit at DMAS any changes in an enrollee's situation

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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),
- an infant who has been enrolled as a Newborn Child reaches age one year,
- a Families & Children (F&C) enrollee becomes entitled to SSI,
- an SSI Medicaid enrollee becomes a Qualified Severely Impaired Individual (QSII) (1619(b)),
- an individual enrolled in a Modified Adjusted Gross Income (MAGI) Adults aid category turns 65 years old, or becomes entitled for/begins receiving Medicare.

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. *If change in income is reported, the agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family.*

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

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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.

3. MAGI Adult Becomes Entitled to Medicare/QMB Coverage

When an individual enrolled as a MAGI Adult becomes entitled to Medicare, he is no longer eligible for coverage in the MAGI Adults covered group effective the month in which his Medicare begins. Evaluate his eligibility in other covered groups. If he is income eligible for the QMB covered group, entitlement to QMB coverage begins the month following the month of entitlement to Medicare.

Example: Ms. C is a 48 year old disabled adult enrolled as a MAGI Adult. She reports to the agency being approved for Medicare beginning June 2019. The worker sends advance notice to cancel the MAGI Adults coverage effective June 30. QMB coverage begins effective July, the month following the month in which Medicare entitlement began. Ms. C also has resources under the Medically Needy income limit and is therefore placed on a spenddown per M1370.100.

D. Child Moves From Parental Home

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

1. Case Management

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

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

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

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

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

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2. Enrollment

a. Case Number

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

b. Demographics Comment Screen

In VaCMS, enter a comment that will inform staff that information from the case cannot be shared with (the name of the person with whom the child lives) because he/she is NOT authorized to receive the information.

c. Renewal Date

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

d. Medicaid Card

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

3. Obtain Authorization from Parent Prior to Renewal

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

4. Renewal

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

E. Recipient Enters LTC

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

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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. **The 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 documented in the case record to determine if the enrollee is receiving Medicaid in another state. See 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 at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms>, 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.

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a. \$0 Income Reported

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

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 *OR when there is inadequate information (such as no Social Security Number) to allow for a systems search on an individual in the household whose income must be verified*, 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. *If evaluating income, the agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family. For all case actions effective October 26, 2019, if the income attested to by the applicant is within 10% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required. If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return.*

Follow the steps in M1520.200 B.2 below for completing a paper-based renewal.

2. Paper Renewals

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

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1. **Renewal Completed** Notify the enrollee in writing of the findings of the renewal and the action taken. When eligibility continues, use the Notice of Action, and include the month and year of the next scheduled renewal. When the individual is no longer eligible, use the Advance Notice of Proposed Action and include spenddown information, if applicable. When there is a reduction of benefits, use the Advance Notice of Proposed Action and include the month and year of the next scheduled renewal.
2. **Renewal Not Completed** If information necessary to redetermine eligibility is not available through online information systems that are available to the agency and the enrollee has been asked but has failed to provide the information, the renewal must be denied and the coverage cancelled due to the inability to determine continued eligibility. Action cannot be taken to cancel coverage until after the deadline for the receipt of verifications has passed, except for situations when the deadline falls on a weekend or holiday.
3. **Referral to Health Insurance Marketplace (HIM)** Unless the individual has Medicare, a referral to the HIM—also known as the Federally Facilitated Marketplace (FFM)—must be made when an individual’s coverage is cancelled so that the individual’s eligibility for the Advance Premium Tax Credit (APTC) in conjunction with a Qualified Health Plan (QHP) can be determined. If the individual’s renewal was not processed in VaCMS, his case must be entered in VaCMS in order for the HIM referral to be made.
4. **Renewal Filed During the Three-month Reconsideration Period** If the individual’s coverage is cancelled because the individual did not return the renewal form (or complete an online or telephonic renewal) or requested verifications, the Affordable Care Act (ACA) requires a reconsideration period of 90 days be allowed for an individual to file a renewal or submit verifications. For MA purposes, the 90 days is counted as three calendar months. The individual must be given the entire reconsideration period to submit the renewal form and any required documentation. When the renewal or verifications are provided within the 90 day reconsideration period, process the renewal as soon as possible but at least within 30 calendar days from receipt.

The reconsideration period applies to renewals for all covered groups.

If the individual files a renewal or returns verifications at any time during the reconsideration period and is determined to be eligible, reinstate the individual’s coverage back to the date of cancellation.

For individuals who were enrolled as Qualified Medicare Beneficiaries (QMB) at the time of cancellation, reinstate coverage back to the date of cancellation.

If an individual began receiving Medicare during the reconsideration period and is eligible as QMB, the QMB coverage is effective the month after the month in which Medicare began. Evaluate eligibility for the other months of the reconsideration period in other possible covered groups, including Medically Needy.

Send a Notice of Action informing him of the reinstatement, his continued coverage and the next renewal month and year. See M1520, Appendix 1 for the Renewal Process Reference Guide.

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

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D. Special Requirements for Certain Covered Groups

1. Pregnant Woman

Do not initiate a renewal of eligibility of a pregnant woman in other covered group during her pregnancy. Eligibility in a pregnant woman covered group ends effective the last day of the month in which the 60th day following the end of the pregnancy (*60th postpartum day*) occurs.

Coverage for pregnant women who have reached the end of the month in which the 60th postpartum day occurs may be automatically reinstated in the MAGI Adults covered group. The next renewal will continue to be due in the month that was set during the enrollment into coverage as a pregnant woman. The impacted cases will be listed in the “MA-PG Summary Report.”

For women whose coverage cannot be automatically reinstated, prior to the cancellation of coverage, determine if the woman meets the definition for another Medicaid covered group (see M0310.002). If the woman meets the definition of a full-benefit covered group, or for limited coverage under Plan First, determine if an ex parte renewal can be completed or if a renewal form is required and take appropriate action.

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

2. Newborn Child Turns Age 1

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

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

The ex parte process may be used if appropriate.

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

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

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

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- 4. Child Receiving LTC Services Turns 18**

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

- 5. FAMIS Plus Child Turns Age 19**

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

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

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B. Procedures

1. Change Results in Adverse Action

Following a determination that eligibility no longer exists or that the enrollee's Medicaid services must be reduced, the Advance Notice of Proposed Action, available at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms>, or system-generated advance notice must be sent to the enrollee at least 10 days plus one day for mail, before action is taken to cancel or reduce Medicaid coverage.

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

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

2. Enrollee Appeals Action

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

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

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

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

3. Death of Enrollee

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

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

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

M1550 Transmittal Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/19	Appendix 1, page 1 Appendix 1, page 2 was added.
TN #DMAS-8	4/1/18	Page 3
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

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DBHDS FACILITIES MEDICAID TECHNICIANS

NAME	LOCATION	PHONE #	HOSPITALS
Carrie Richardson cer900 c.richardson@dss.virginia.gov	Central Virginia Training Center Medicaid Office Madison Heights, VA Mail To: PO Box 1098 Lynchburg, VA 24505	434-947-2754 FAX: 434-947- 2620 Pouch Mail FIPS 990	CVTC- VCBR- PGH-
Frances Jones fwj900 frances.jones@dss.virginia.gov	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0841 FAX: 276-782- 9732 Pouch Mail FIPS 992	ESH- SWVMHI-
Kim Bartleson kba900 kim.bartleson1@dss.virginia.gov	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0842 FAX: 276-782- 9732 Pouch Mail FIPS 992	Catawba- HDMC- SEVTC-

DBHDS STATE HOSPITAL FACILITIES

FIPS	FACILITY INITIALS and FULL NAME
161	Catawba – Catawba Hospital
009	CVTC – Central Virginia Training Center
830	ESH – Eastern State Hospital
730	HDMC – Hiram Davis Medical Center
	NVMHI – Northern Virginia Mental Health Institute*
135	PGH – Piedmont Geriatric Hospital
550	SEVTC – Southeastern Virginia Training Center
	SVMHI – Southern Virginia Mental Health Institute*
173	SWVMHI – Southwestern Virginia Mental Health Institute
135	VCBR – Virginia Center for Behavioral Rehabilitation
	WSH – Western State Hospital *

**These facilities no longer have Medicaid patients.*

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**DBHDS FACILITIES
PSYCHIATRIC HOSPITALS**

Medicaid can only cover patients under 21 years or 65 years and older in these facilities.

Central State Hospital – Petersburg
Western State Hospital – Staunton
Northern Virginia Mental Health Institute – Falls Church
Southern Virginia Mental Health Institute – Danville
Southwestern Virginia Mental Health Institute – Marion
Piedmont Geriatric Hospital – Burkeville
Catawba Hospital – Catawba
Commonwealth Center for Children and Adolescents (CCCA) –Staunton (formerly DeJarnette Center)

M17 Changes

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

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M1700 MEDICAID FRAUD AND NON-FRAUD RECOVERY

M1700.100 INTRODUCTION

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

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

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

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

M1700.200 FRAUD

A. Definitions Fraud is defined as follows:

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

Abuse is defined as follows:

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

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

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

1. Amount of Loss

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

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

2. Recipient Fraud

a. Medical Assistance Only

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

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2. Family Unit

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

M1700.300 NON-FRAUD RECOVERY

A. Authority

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

B. Recovery of Erroneous Payments

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

- eligibility errors due to recipient misunderstanding,
- agency errors,
- medical services received during the appeal process, if the agency's cancellation action is upheld.
- long-term care (LTC) patient pay underpayments totaling \$1,500 or more.

Complete and send the Notice of Recipient LTC Patient Pay Underpayment (form #DMAS752R) located at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms>, to:

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

The form can be faxed to 804-452-5472 or emailed to recipientfraud@dmass.virginia.gov.

Underpayments less than \$1,500 can be collected by adjusting the ongoing patient pay (see M1470.900 for patient pay adjustments).

C. Post-eligibility Investigations

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

RAU investigations are based on projected income consistent with the eligibility policies for counting ongoing income referenced in Chapters M04, M07, and M08. Post-eligibility determinations are made using a point-to-point method in which the income estimation period begins with an event that would have triggered a partial review under M1450.100. The end point is the next scheduled renewal that the LDSS actually completed.

D. Uncompensated Asset Transfers

Individuals receiving long-term care services (LTC) who transfer assets and do not receive adequate compensation are subject to the imposition of a penalty period during which Medicaid cannot pay for long-term care services. When an uncompensated

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4. Notification to DMAS

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

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

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

M1700.400 RECOVERY RESPONSIBILITIES: LDSS AND DMAS

A. VDSS/LDSS Responsibilities in Loss Prevention Efforts

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

B. LDSS Requirements

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

1. Report Individuals

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

- instances where evidence of fraud may exist;
- errors involving eligibility discovered by the LDSS in which it appears there has been deliberate misrepresentation by an applicant/recipient with intent to defraud;
- eligibility errors discovered by the LDSS, independent of other audit or quality control functions, including cases in which the individual was enrolled incorrectly, added in error, not cancelled timely, allowed to remain on Medicaid during the conviction sanction period or when information known to the agency would render ineligibility;
- cases in which the LDSS discovers that the enrollee failed to report information that impacts eligibility; and
- LTC patient pay underpayments resulting from any cause totaling \$1,500 or more.

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**2. PARIS
Match Data**

The Public Assistance Reporting Information System (PARIS) is a Federal computer matching initiative that the Virginia Department of Social Services (VDSS) participates in quarterly. VDSS participates in the data exchange with all active Medicaid enrollees and they are matched for the receipt of Veteran benefits and enrollment in multiple state's Medicaid programs. Each public assistance report is matched by social security number.

The worker must evaluate all matches for current and ongoing eligibility and take appropriate case action within 30 days. Multiple matches must be assessed as a whole for the entire case. Workers must document findings in VaCMS under Case Comments. Once the evaluation of the match is completed and the case comments are documented, send the *Public Assistance Reporting Information System (PARIS) Notice of Recipient Fraud/Non-Fraud Recovery, (form #DMAS 754R)* to the DMAS Program Integrity Division where steps will be conducted to complete the match and Benefit Impact Screen (BIS). Procedures for researching and reporting PARIS matched individuals are found in the PARIS User Guide at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms>.

Complete and send the *Public Assistance Reporting Information System (PARIS) Notice of Recipient Fraud/Non-Fraud Recovery (form #DMAS 754R)* located at <https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms>, to

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

The form may be faxed to 804-452-5472 or emailed to recipientfraud@dmass.virginia.gov

**3. Corrective
Action**

Report to the DMAS RAU corrective action taken on all discovered eligibility errors. Corrective action is a function of the loss prevention process. All corrected errors shall be reported to DMAS.

**4. Cancel
Coverage**

Cancel the eligibility of all persons convicted of public assistance fraud or medical assistance fraud to the extent allowable under federal and state regulations, using the cancel code for fraud convictions (Cancel Code 014).

C. DMAS Response

The RAU shall send a referral acknowledgement letter to the LDSS worker making the referral. RAU may send out additional communication to the LDSS should additional verifications/documentation be required to complete the investigation.

**D. Recipient Audit
Reporting**

The RAU has two prevention efforts for reporting fraud and abuse of Medicaid Services by individuals within the community. Both referral methods should be given to the individual by the LDSS. The individual may remain anonymous.

- The individual may send an e-mail to recipientfraud@dmass.virginia.gov.
- The individual can call the Recipient Audit fraud and abuse hotline. Both a local and a toll free number are available 24 hours daily for reporting suspected fraud and abuse: local (804) 786-1066; and toll free (866) 486-1971.

**E. Statute of
Limitations**

There is no "statute of limitations" for Medicaid fraud; cases that are referred for fraud shall be flagged to ensure that the information is not purged.

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NOTICE OF 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:

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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.

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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: _____

Are funds available to pay the underpayment back? **Yes** **No**

Have payments been made directly to the nursing facility? **Yes** **No**

LTC Patient Pay Underpayment Breakdown

Month/Year	“Old” Patient Pay Amount	“New” Patient Pay Amount	Underpayment Amount
Total Time Frame:		Total Amount:	

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NOTICE OF RECIPIENT LTC PATIENT PAY UNDERPAYMENT

Explanation for the 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 breakdown of the underpayment calculation along with the total underpayment amount. If additional space is needed, please attach your calculations to this form.
- Provide verification of the change that occurred that affected the patient pay. For example, income verification, cancelation of insurance premium.
- Provide pertinent case notes regarding the patient pay and underpayment.

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.

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**PARIS (PUBLIC ASSISTANCE REPORTING INFORMATION SYSTEM)
NOTICE OF MEDICAID RECIPIENT FRAUD/NON-FRAUD**

Date:

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

If you fax or email, you do not need to
mail a copy of the referral

Case Name:

Case Name SSN:

Medicaid Case Number:

Case Address:

City:
State: Zip:

PARIS Interstate PARIS Veterans PARIS Federal

Match Person(s):

Date of the PARIS match:	<input type="text"/>
Date of contact with the other state government agency:	<input type="text"/>
Individual(s) receiving Medicaid in the other state:	<input type="text"/>
Individual(s) receiving Veterans or federal benefits:	<input type="text"/>
Start date and end date of Medicaid from other state:	Start Date: <input type="text"/> End Date: <input type="text"/>
Veterans or Federal benefit information:	<input type="text"/>
Impact on Medicaid eligibility in this state:	<input type="text"/>

Name of Eligibility Worker:

Telephone Number:

Agency Name:

FIPS Code:

Address:

City:
State: Zip:

Name of Supervisor:

M21 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/19	Pages 4-6
TN #DMAS-12	4/1/19	Appendix 1, page 1
TN #DMAS-9	7/1/18	Page 5
TN #DMAS-8	4/1/18	Appendix 1, page 1
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

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Subchapter Subject FAMIS	Page ending with M2130.100	Page 4

Health benefit plan does not mean:

- Medicaid, FAMIS Plus, or State/Local Hospitalization;
- accident only;
- credit or disability insurance;
- long-term care insurance;
- dental only or vision only insurance;
- specified disease insurance;
- hospital confinement indemnity coverage;
- limited benefit health coverage;
- coverage issued as a supplement to liability insurance;
- insurance arising out of workers' compensation or similar law;
- automobile medical payment insurance; or
- insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

3. Insured means having creditable health insurance coverage or coverage under a health benefit plan.

4. Uninsured means having no insurance; having insurance that is not creditable; having coverage which is not defined as a health benefit plan, or having a health insurance plan that does not have a network of providers in the area where the child resides.

C. Policy A nonfinancial requirement of FAMIS is that the child be uninsured. A child **cannot:**

- have creditable health insurance coverage;
- have coverage under a group health plan (TRICARE, federal employee benefit plan, private group insurance such as Anthem, etc.) or Medicare;

M2130.100 FINANCIAL ELIGIBILITY

A. Financial Eligibility

1. Asset Transfer Asset transfer rules do not apply to FAMIS.

2. Resources Resources are not evaluated for FAMIS.

3. Income **a. Countable Income**

FAMIS uses the MAGI methodology for counting income contained in chapter M04.

To the maximum extent possible, *attested* income must be verified by information obtained from electronic data sources, such as the federal hub or another reliable data source, prior to requesting paystubs or employer statements.

FAMIS uses MAGI methodology for estimating income (see chapter M04).

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b. Household Size

FAMIS uses MAGI methodology for determining household size (see Chapter M04).

c. Available Gross Income

Retroactive period (for newborns only) – available income is the gross income actually received in each month in the retroactive period.

Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months.

d. Income Limits

The FAMIS income limit is 200% of the FPL (see Appendix 1 to this subchapter) for the number of individuals in the FAMIS assistance unit. Per MAGI policy in chapter M04, a 5% FPL income disregard is applicable.

5. Spenddown

Spenddown does not apply to FAMIS. If the household’s gross income exceeds the FAMIS income limits, the child is not eligible for the FAMIS program regardless of medical expenses.

M2140.100 APPLICATION and CASE PROCEDURES

A. Application Requirements

The policies in subchapters M0120 and M0130 apply.

B. Eligibility Determination

When an application is received and the child is not eligible for Medicaid due to excess income, determine eligibility for FAMIS. In order to complete an eligibility determination, both the FAMIS nonfinancial requirements in M2120.100 and the financial requirements in M2130.100 must be met

The applicant/enrollee must be notified in writing of the required information and the deadline by which the information must be received. Applications must be acted on as soon as possible, but no later than 45 days from the date the signed application was received.

C. Entitlement and Enrollment

1. Begin Date

Children determined eligible for FAMIS 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.**

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Subchapter Subject FAMIS	Page ending with M2140.100	Page 6

2. 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.

3. 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 *or determined reasonably compatible* using an electronic data source such as the federal Hub or another reliable data source prior to requesting paystubs or employer statements. *For all case actions effective October 26, 2019, if the income attested to by the applicant is within 10% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required. If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return.*

M22 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-14	10/1/19	Page 5
TN #DMAS-12	4/1/19	Appendix 1, page 1
TN #DMAS-8	4/1/18	Appendix 1, page 1
TN #DMAS-6	10/1/17	Page 7 Appendix 1, page 1
TN #DMAS-4	4/1/17	Appendix 1, page 1
TN #DMAS-1	6/1/16	Page 4 Appendix 1, page 1
TN #100	5/1/15	Table of Contents Pages 1, 2, 5, 6, 7 Appendix 1 Pages 3 and 4 are runover Pages.
TN #98	10/1/13	Table of Contents Pages 1-7 Appendix 1 Pages 8-10 were deleted.
UP #9	4/1/13	Appendix 1
UP #8	10/1/12	Pages 2, 3 Page 3a deleted
UP #7	7/1/12	Pages 2, 3
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	Pages 3, 3a
TN #95	3/1/11	Pages 4-6 Appendix 1
UP #4	7/1/10	Page 10
TN #94	9/1/10	Page 3
UP #3	3/01/10	Page 2
TN #93	1/1/10	Pages 2-10
UP #2	8/24/09	Page 3
Update (UP) #1	7/1/09	Pages 1, 2, 7 Appendix 1, page 1

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Subchapter Subject FAMIS MOMS	Page ending with M2240.100	Page 5

M2230.100 FINANCIAL ELIGIBILITY

A. Financial Eligibility

1. Income

Modified Adjusted Gross Income (MAGI) methodology *contained in Chapter M04* is used for the FAMIS MOMS income evaluation. *To the maximum extent possible, attested income must be verified by information obtained from electronic data sources, such as the federal hub or another reliable data source, prior to requesting paystubs or employer statements. For all case actions effective October 26, 2019, if the income attested to by the applicant is within 10% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required. If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return.*

The FAMIS MOMS income limit is 200% of the FPL (see Appendix 1 to this chapter) for the number of individuals in the pregnant woman's MAGI household composition as defined in M04. The pregnant woman is counted as herself plus the number of children she is expected to deliver. Per MAGI policy in chapter M04, a 5% FPL income disregard is applicable.

2. Resources

Resources are not evaluated for FAMIS MOMS.

3. No Spenddown

Spenddown does not apply to FAMIS MOMS. If countable income exceeds the FAMIS MOMS income limit, the pregnant woman is not eligible for the FAMIS MOMS program. She must be referred to the Health Insurance Marketplace and be given the opportunity to have a MN Medicaid evaluation.

M2240.100 APPLICATION and CASE PROCEDURES

A. Application Requirements

The policies in subchapters M0120 and M0130 apply.

B. Eligibility Determination

1. Pregnant Teenager Under Age 19

Process an application by a pregnant teenager under age 19 in the following order:

- a. Determine eligibility for Medicaid as a child under age 19; if not eligible because of excess income, go to item b.
- b. Determine eligibility for Medicaid as a pregnant woman; if not eligible because of excess income, go to item c.
- c. Determine eligibility for FAMIS; if not eligible because of excess income, go to item d.
- d. Determine eligibility for FAMIS MOMS. To complete the eligibility determination, the FAMIS MOMS nonfinancial requirements in M2220.100 and the financial requirements in M2230.100 must be met. If she is not eligible for FAMIS MOMS because of excess income, she must be referred to the Health Insurance Marketplace and given the opportunity to have a Medically Needy evaluation completed.