



COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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October 1, 2018

Virginia Medical Assistance Eligibility Manual

Transmittal #DMAS-10

- ABD – Aged, Blind or Disabled
- CCC Plus – Commonwealth Coordinated Care Plus
- DMAS – Department of Medical Assistance Services
- DOC – Department of Corrections
- DJJ – Department of Juvenile Justice
- F&C – Families and Children
- FPL – Federal Poverty Level
- HPE – Hospital Presumptive Enrollment
- LIFC – Low Income Families with Children
- LTC – Long-term Care
- LTSS – Long-term Supportive Services
- MA – Medical Assistance
- MAGI – Modified Adjusted Gross Income
- MCO – Managed Care Organization
- QMB – Qualified Medicare Beneficiaries
- SLMB – Special Low-income Medicare Beneficiaries
- SSN – Social Security Number
- TN – Transmittal
- VaCMS – Virginia Case Management System

TN #DMAS-10 contains new policy that has been added to the MA Eligibility Manual based on the Medicaid expansion approved by the General Assembly. A new covered group called MAGI Adults is being implemented effective January 1, 2019. This covered group is for individuals aged 19-64 years who are not eligible for or receiving Medicare. VaCMS will be programmed to process applications for coverage under the new group prior to January 1, 2019; however, coverage in the MAGI Adults group can begin no earlier than January 1, 2019.

TN #DMAS-10 also 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, 2018.

The following changes are contained in TN #DMAS-8:

Changed Pages	Changes
Pages 2, 4, 15, 17-20 Page 20a was added as a runover page.	On page 2 clarified who may assist an incarcerated individual. On page 4, clarified where to locate telephonic application authorized representative information. On page 15, clarified that an application cannot be refused due to incarceration. On page 16, rearranged a paragraph. On pages 17-20, added details about the HPE process.
Subchapter M0130 Table of Contents Pages 1, 2, 2a-2e, 9, 10, 11, 12	Updated the Table of Contents. On page 1, updated where HIM applications may be processed. On page 2, updated who may assist an incarcerated individual with applying. On pages, 2a-2e, updated the policy on incarcerated individuals including screening for LTSS or CBC. On page 9, clarified the covered groups for which IRS data from the Federal Hub can be used. On page 10, removed "F&C" from "5. \$0 (Zero) Income Procedures – Applicable Only to MAGI Cases Processed in VaCMS." On page 11, clarified the file clearance process in VaCMS. On page 12, clarified a process.
Chapter M02 Table of Contents Page ii	Updated the name of the appendix in Subchapter M0280.
Subchapter M0220 Page 1	Corrected the page formatting.
Subchapter M0240 Pages 3, 4	Revised the pseudo-SSN prefix.
Subchapter M0310 Table of Contents, page ii Pages 1-4 Page 40 was added.	Updated the Table of Contents. On pages 1-4, added references to the MAGI Adults covered group, effective January 1, 2019. On page 40, added the definition of MAGI Adult.

Changed Pages	Changes
Subchapter M0320 Table of Contents Pages 1, 26, 29, 35, 37 Page 2 is a runover page. Page 2a was added as a runover page.	Updated the Table of Contents. On page 1, added references to the MAGI Adults covered group, effective January 1, 2019. On page 26, revised the Medicaid Works resource amount for 2018. On page 29, updated the fax number for sending Medicaid Works enrollment documents to DMAS. On pages 35 and 37, changed the reference to the CCC Plus waiver.
Subchapter M0330 Table of Contents, page i Pages 1, 2, 30 Pages 10a and 10b were added as runover pages.	Updated the Table of Contents. On pages 1 and 2, added MAGI Adults as a reference to a new aid category. On pages 10a and 10b, added MAGI Adults as an F&C group. On page 30, corrected the income limit for CN pregnant women.
Chapter M04 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	Updated the Table of Contents. On pages 1-5, 9, and 10, added policy on the MAGI Adults covered group. On pages 15, 16, and 19, revised the policy on several types of income due to changes in the tax code. On pages 22, 23, and 30-32, revised several examples. On page 32, also clarified that there must be a tax filing household for Gap-filling methodology to apply. Added Appendix 7, MAGI Adults Income Limits.
Subchapter M0520 Page 2	Updated the link to the list of Level C psychiatric residential treatment facilities.
Subchapter M0810 Page 2	Corrected the 7/1/2017 ABD Medically Needy amounts for Groups I & II.
Subchapter M1120 Pages 3, 26	Page 3 was inadvertently changed in a previous transmittal; the correct page was replaced. On page 26, clarified the treatment of partition costs.
Subchapter M1310 Page 1 Pages 2 and 3 are runover pages.	Clarified which groups of individuals do not fall into any Medically Needy covered group.
Subchapter M1410 Pages 8-14	Added policy on LTC eligibility for the MAGI Adults covered group. On page 13, also clarified that the DMAS-225 is sent to the CCC Plus MCO care coordinator for individuals in CCC Plus.
Subchapter M1430 Pages 3-5 Appendix 1	On pages 3 and 4, added policy on LTC eligibility for the MAGI Adults covered group. On page 5, updated the title Regional Consultant. Updated Appendix 1.

Changed Pages	Changes
Subchapter M1440 Pages 3, 5	On page 3, added policy on LTC eligibility for the MAGI Adults covered group. On page 5, corrected formatting.
Subchapter M1450 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.	On pages 1 and 2, added policy on asset the transfer requirement for MAGI Adults seeking LTC services. In Appendix 3, corrected formatting.
Subchapter M1460 Table of Contents, page i Pages 1-3, 4b, 5, 6, 9, 10, 13, 15, 17a, 18, 26, 27, 30a, 37, 38 Pages 8a, 11, 19, 30, 39 and 40 are runover pages.	On all pages, added policy on evaluating MAGI Adults for LTSS.
Subchapter M1470 Page 1	Noted that MAGI Adults have no responsibility for patient pay.
Subchapter M1480 Pages 1, 8a, 66	On pages 1 and 8a, clarified that Resource Assessment policy does not apply to individuals eligible in the MAGI Adult covered group. On page 66, updated the Utility Standard Deduction effective October 1, 2018.
Subchapter M1510 Pages 7, 8a, 9a, 14 Pages 8b and 8c are runover pages.	On page 7, added policy on entitlement for the MAGI Adults covered group. On page 8a, revised policy citations. On page 92, corrected formatting. On page 14, clarified the Medicare buy-in month for QMB and SLMB Plus individuals.
Subchapter M1520 Page 3	On page 3, clarified the treatment of a MAGI Adult who turns 65 years old.
Chapter M18 Pages 3-5	On page 3, updated the information on Medallion 3.0 and Medallion 4.0. On page 4, removed the policy on the CCC program. On page 5, reformatted the page.

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@dmass.virginia.gov or (804) 225-4282.

Sincerely,

A handwritten signature in blue ink that reads "Karen Kimsey". The signature is written in a cursive style with a large initial 'K'.

Karen Kimsey
Chief Deputy Director

Attachment

M0120 Changes

Changed With	Effective Date	Pages Changed
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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- a change in the case name,
- a change in living arrangements, and
- a change in income.

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

M0120.200 Who Can Sign the Application

- A. Individuals in State Facilities** Staff with certain Virginia state agencies may assist individuals who are in state residential facilities in applying *for* medical assistance.
- 1. Patients in DBHDS Facilities** Patients of any age in the Department of Behavioral Health and Developmental Services (DBHDS) facilities may have applications signed and submitted by DBHDS staff. The DBHDS facilities are listed in subchapter M1550.
 - 2. Incarcerated Individuals** Inmates of any age who are being held in Department of Corrections (DOC) or Department of Juvenile Justice (DJJ) facilities may have applications submitted by DOC or DJJ staff. *Send all notices and other correspondence to the DOC or DJJ mailing address as indicated on the application*

Inmates of local and regional jails may submit applications for themselves, authorize jail staff to assist, or designate an authorized representative to assist in applying. Send all notices and other correspondence to the correctional facility where he resides or the mailing address listed on the application.

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

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

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

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

Witness's signature: _____

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3. Procedure for Who Can Sign the Application

When preparing to determine the *MA* eligibility of an individual age 18 or older, examine the application to determine if the applicant can complete and sign the application form or if the applicant has an authorized representative. Ask the following questions:

Has the applicant been judged legally incapacitated by a court of law, as evidenced by a copy of the conservator or guardian certificate of appointment in the record?

YES: The authorized representative is the appointed conservator or guardian. STOP.

NO: The applicant is competent. Does the applicant have an attorney in fact who has the power of attorney to apply for *MA* for the applicant as evidenced by a copy of the power of attorney document in the record?

YES: The authorized representative is the attorney in fact. STOP.

NO: Has the applicant signed a written statement authorizing a person (or staff of an organization) to apply for *MA* on his behalf? (*Note: a completed authorized representative section on a telephonic application is acceptable*)

YES: The authorized representative is the person or organization authorized by the applicant to represent him. STOP.

NO: Is the applicant able to sign or make a mark on a Medicaid application form?

YES: Ask the applicant for his signature or mark on the application form or for a written statement authorizing someone to apply for *MA* on his behalf. Give the applicant 10 working days to return the completed and signed form(s). If the completed and correctly signed form(s) are not returned by the specified date, DENY *MA* because of an invalid application.

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c. Pending Discharge to the Community

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

d. Eligibility Determination and Enrollment

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

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

e. Coverage Begin Date

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

E. Individuals In Virginia Veteran's Care Center

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

F. Incarcerated Individuals and DJJ Supervisees

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

If the individual did not reside in Virginia prior to becoming incarcerated or committed to DJJ, responsibility for processing the application and determining eligibility *will be handled through a centralized process or by* the department of social services in the locality in which correctional facility is located.

The physical address on the application should be the address where the individual was living prior to incarceration or DJJ/court custody. This will facilitate the transfer of applications from Cover Virginia. If the individual was homeless or did not reside in Virginia prior to entering an institution, use the physical address where the institution is located.

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M0120.500 Receipt of Application

A. General Principle

An applicant or authorized representative may submit an application for medical assistance only or may apply for MA in addition to other programs.

An applicant may be assisted with completing the various aspects of the application by an individual(s) of his choice and may designate in writing (*or documented on a telephonic application*) that such individual(s) may represent him in subsequent contacts with the agency.

B. Application Date

The application date is the earliest date the signed application for medical assistance is received by the local agency, an out-stationed site, or an entity contracted with DMAS to accept applications. The application must be on a form prescribed by DMAS and signed by the applicant or person acting on his behalf.

The application may be received by mail, fax, hand delivery, electronically or telephonically. The date of receipt by the agency must be recorded. If an application is received after the agency's business hours, the date of the application is the next business day. Exception: For CommonHelp applications, if the application is received after business hours and the next business day is in the following month, the date of the application is the actual date it was submitted.

The date of application for foster care children in the custody of a local department of social services is the date the application is received by the eligibility worker.

If an application for a pregnant woman or child is denied due to excess income, the applicant must be given the opportunity to request a medically needy evaluation. If the evaluation is requested within 10 calendar days of the date the notice of denial was mailed, the application date is protected, and the date of application is the date the denied application was received.

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C. Hospital Presumptive Eligibility

The Affordable Care Act required states to allow approved hospitals to enroll patients who meet certain Families & Children covered groups in Medicaid for a limited time on the basis of their presumptive eligibility. The Department of Medical Assistance Services (DMAS) is responsible *for coordinating* the HPE Agreement with *approved* hospitals, *providing* training and technical assistance, and monitoring the appropriate use of the HPE enrollments. HPE is not available to individuals who are already *actively* enrolled in Medicaid or FAMIS. *Local eligibility staff do not determine eligibility for HPE.*

1. HPE Determination and Enrollment

To provide an individual HPE coverage, the hospital *staff* obtains basic demographic information about the individual, as well as the attestations from the individual *regarding* Virginia residency (including locality), U.S. citizenship or lawful presence, Social Security number, household size and income, and requirements related to a covered group. *As the information is self attested*, no verifications *or additional proof is required.*

Hospital staff determines eligibility and *enters the approved* individual's data into the HPE webpage located in the provider portal in the Medicaid Management Information System (MMIS). *This information is electronically transferred to the Cover Virginia Central Processing Unit (CPU) which is responsible for enrolling the individual in the appropriate aid category (AC) in MMIS. The HPE enrollment is not entered in the Virginia Case Management System (VaCMS). HPE recipients do not receive a Commonwealth of Virginia (COV) Medicaid card and are not entered into a managed care organization (MCO).*

The hospital is responsible *for providing immediate notification to the individual of his HPE coverage. They will request that he file a full MA application by the end of the following month so that continued eligibility for Medicaid can be evaluated without an interruption in coverage.*

The HPE covered groups and the ACs are:

- Pregnant Women (AC 035)
- Child Under Age 19 (AC 064)
- Low Income Families with Children (LIFC) (AC 065)
- Former Foster Care Children Under Age 26 (AC 077)
- Breast & Cervical Cancer Prevention & Treatment Act (BCCPTA) (AC 067)
- Plan First (AC 084)
- *MAGI Adults (AC 106) (effective January 1, 2019)*

Individuals enrolled on the basis of HPE receive a closed period of coverage beginning with the date of the HPE determination through the last day of the following month or the date MA eligibility is determined, whichever comes first. Enrollment in HPE is not based on the date of the hospital admission *nor* the first day of the month.

While enrolled as HPE, individuals in the Child Under Age 19 years, LIFC, Former Foster Care Children Under Age 26, BCCPTA, and *MAGI Adults* covered groups receive full Medicaid benefits. HPE pregnant women coverage

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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.

2. 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 on the VDSS intranet at <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi> 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.

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c) Applicant Determined Eligible for MA Coverage

If the individual is determined eligible for MA coverage, coverage under the appropriate MA aid category will includes any day(s) to which he is entitled and not covered by HPE.

*If the individual submits a MA application and it is approved in the **same month** HPE coverage began and HPE began *the first day of the month*, MA coverage begins the first day of that application month.*

If the MA application is approved and HPE began on any day other than the first day of the month, the worker will enroll MA coverage beginning with the first day of the month and end on the day before the HPE begin date. Ongoing coverage will then begin the day after the HPE coverage ends. An exception to this process will be for an approved pregnant woman or Plan First application.

Example 2: *Tony is an adult enrolled in HPE coverage (AC106) for the period of 9-6-18 through 10-31-18. He submits an MA application on 9-8-18 and is approved as a MAGI Adults AC103 on 9-28-18. He did not request retroactive coverage so the AC103 coverage will be for the period 9-1 thru 9-5 and ongoing AC103 coverage will begin on 11-1-18 (after the HPE coverage ended).*

If an individual submits an MA application in the month a full-benefit HPE coverage is to end, and is determined eligible for ongoing MA coverage, the ongoing coverage is entered in the appropriate MA AC beginning the first day of the month after the effective date of the HPE coverage cancellation. An exception to this process will be for an approved pregnant woman application.

Example 3: *Billy is a child enrolled in HPE coverage (AC 064) for the period of 2-14-18 through 3-31-18. His parent submits an MA application on 3-18-18 and there is no indication of any medical services in a retro period. Billy is determined eligible for Medicaid coverage in AC 092 on 3-26-18.*

The Medicaid entitlement begins after the HPE coverage ends. The worker enrolls the child into AC 092 with ongoing coverage beginning 4-1-18.

d) Applicant Determined Eligible as Pregnant Woman (PW) or for Plan First

The HPE process for a pregnant woman (AC 035) or Plan First (AC 084) follows the same policy as other HPE categories. The exception is for enrollment if an MA application is submitted and approved for a pregnant woman (AC 091 or AC 005) or for Plan First. In those cases, coverage will begin on the first day of the month the MA application was received. Request that HPE coverage be cancelled retroactively. Reinstate in full coverage for the ongoing coverage.

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Example 4: Jane was enrolled in HPE AC 035 (pregnant women) for the period of 4-13-18 through 5-30-18. She files an MA application on 4-28-18 and is approved for AC 091 coverage. Jane would have coverage as AC 091 for the period beginning 4-1-18. However, based on her expected delivery date found on the application, Jane was pregnant during the months prior to her HPE determination. The worker determines and approves retro coverage. The worker ensures Jane has coverage for AC 091 with a begin date of 1-1-18. In MMIS this transaction would be a retro cancel reinstate using Cancel Reason 024.

e) Retroactive Coverage

An individual cannot receive retroactive HPE coverage.

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

f) Applicant Determined Not Eligible for ongoing MA coverage

If the applicant is determined to not be eligible for ongoing MA coverage, his entitlement to HPE coverage ends. *Unless the HPE coverage was extended, no further action is required by the worker. If cancellation of HPE coverage is needed, request that the effective cancel date be the current date (i.e. day of the eligibility determination), using Cancel Reason 008.*

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

The individual's HPE coverage is valid regardless of whether or not the individual is eligible for ongoing coverage; do not refer the case to the DMAS Recipient Audit Unit.

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**E. Governor's
Access Plan
(GAP)**

GAP covers uninsured, low-income adults ages 21-64 years with serious mental illness (SMI) who are not eligible for any existing full-benefit MA entitlement program. Eligibility determinations and ongoing case maintenance for eligible individuals are handled by dedicated staff in the Cover Virginia GAP unit. GAP is not a medical assistance program for which LDSS staff have responsibility. However, LDSS staff is involved in the transfer process when individuals transition between GAP and Medicaid or FAMIS MOMS.

Eligibility for GAP is a two-step process. The individual must: 1) receive a GAP SMI screening and 2) meet non-financial and income eligibility requirements. SMI evaluations will be completed by community services boards, Federally Qualified Healthcare Centers, inpatient psychiatric hospitals, or general hospitals with inpatient psychiatric units. GAP uses Medicaid non-financial requirements and Modified Adjusted Gross Income for household composition and income eligibility.

The GAP income limit is 95% of the Federal Poverty Level (FPL) plus the 5% FPL disregard as appropriate. GAP eligibility can begin no earlier than January 12, 2015. For applications received on or after February 2015, eligibility will begin the first day of the month of application, provided all eligibility requirements are met that month. There is no retroactive coverage in GAP. The AC for GAP coverage is 087.

Additional information about GAP is available at:
<http://www.coverva.org/gap.cfm>.

M0130 Changes

Changed With	Effective Date	Pages Changed
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
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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
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M0130.001 Medical Assistance Application Processing Principles

A. Introduction

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

B. Principles

1. Single Application

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

2. No Wrong Door

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

3. Use of Electronic Data Source Verification

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

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

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

4. Processing Time

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

When all necessary information is available through EDSV, it is expected that the application be processed without delay. When it is necessary to request information from the applicant and/or a disability determination is required, the processing standards in M0130.100 are applicable.

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M0130.050 Incarcerated Individuals

A. Introduction

Virginia has developed guidelines for incarcerated individuals that cover:

- *application processing for an individual who meets a Medicaid aid category (e.g. MAGI Adults) but not enrolled due to incarceration,*
- *pre-release planning including MA application processing or review of MA eligibility for an individual transitioning from or leaving a facility,*
- *limited coverage for medical services received for an inpatient hospitalization during incarceration, and*
- *individuals with active coverage at the time of incarceration.*

Incarcerated individuals include those persons being held in a Virginia Department of Corrections (DOC) facility, regional or local jails, and youth placed in a Virginia Department of Juvenile Justice (DJJ) facility.

B. Existing Coverage

If an individual has active coverage when the agency becomes aware of his incarceration, a partial review must be completed to determine if he continues to meet the requirements for coverage in a full-benefit CN covered group. Refer to M1510.102.A.6

C. Application for Benefits

Incarcerated individuals may file their own application. A spouse, parent, or an authorized representative, (including facility staff if documented on the application) may also apply. The written authorized representative statement must indicate whether or not the authority to act on the applicant's behalf will continue after the applicant is no longer incarcerated, unless the authorization is changed by the individual.

Direct communication between the incarcerated individuals and the CPU or LDSS may be prohibited, depending on the facility. Facility staff assisting in the application process will be identified on the application or in a separate document on agency letterhead. Communication between the staff assisting the individual and the CPU or LDSS handling the application is permitted.

Staff employed by the facility or at a designated central point are responsible for coordinating the application process and communicating information to the incarcerated individuals and the CPU or LDSS.

D. Application Processing

Applications are not to be refused or denied because an applicant is incarcerated. Applications are to be processed in the same manner and within the same processing time standard as any other MA applications.

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Applications are processed centrally or the locality where the incarcerated individual resided prior to incarceration. If the individual lived outside of Virginia prior to incarceration, the application is be processed centrally or by locality where the facility is located.

Individuals who are actively enrolled in MA coverage at the time of incarceration are not required to file a new application but are subject to a partial review based on the change in their living situation (see M1520.100).

*Send all notices and other correspondence to the mailing address indicated on the application. If the applicant has designated a person or authorized representative to act on their behalf and receive notices, send all correspondence and notices to the individual. The Commonwealth of Virginia Medicaid Card **should be suppressed and not mailed** to the incarcerated individual.*

Denied applications are not transferred to localities, and incarcerated individuals are not referred to the Health Insurance Marketplace.

E. Covered Group and Aid Category

The individual is evaluated for eligibility in a CN covered group in which they would be otherwise eligible except for being incarcerated. The primary CN covered groups an incarcerated individual could meet include:

- *MAGI Adults (M0330.250)*
- *Pregnant Women (M0330.400)*
- *Aged, Blind or Disabled with Income than \leq 80% of the Federal Poverty Level (M0320.300)*
- *Former Foster Care Child Under Age 26 Years (M0330.109)*
- *Child Under Age 19 (M0330.300)*

Enroll eligible MAGI Adults in aid category AC 108 and all other individuals in aid category AC 109 regardless of their covered group.

F. Case Maintenance

The case will be enrolled under the locality where the individual lived prior to incarceration. If the individual was not residing in a Virginia locality (e.g. transferred from out of state), was homeless, or is unable to provide an exact address of where they resided prior to incarceration, the case will be assigned to the locality where the facility is located.

Ongoing case maintenance for enrolled individuals will be provided by the LDSS where the individual lived prior to incarceration or at a central site. If the individual was not residing in a locality (e.g. transferred from out of state), was homeless, or unable to provide an exact address of where residing prior to incarceration, the case will be maintained by the locality where the facility is located or by a central site.

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G. Pre-Release Planning

Pre-release planning permits individuals who are completing their term of incarceration to apply for MA and have eligibility determined prior to their release. Eligibility is to be determined based on the living arrangement anticipated upon release.

An individual who is completing their term of incarceration and has current enrollment in aid category AC 109 or AC 108 is not required to file a new application, but subject to a partial review of their case based on the change in the living situation (see M1520.100).

Individuals who are determined to meet all Medicaid eligibility requirements are to be enrolled in the appropriate MA coverage after release, beginning with the date of release. The DOC/DJJ staff or the individual can contact the CPU or LDSS to report the actual date of release. Enroll the individual in the appropriate MA coverage and provide the individual's enrollee identification number so services can be accessed without delay. Order a Commonwealth of Virginia Medicaid Card. Send notice of the eligibility determination to the individual at the address where he will be living. A copy of the notice must also be sent to DOC/DJJ staff if the individual was in one of their facilities.

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

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

Pre-release planning for individuals in regional and local jails is handled in coordination with the CPU and /or the local DSS office, and by the individual and/or his authorized representative.

When an individual is released from a facility, the individual is responsible for all matters pertaining to his MA eligibility and involvement with the facility staff ends. DJJ staff may continue to assist a juveniles returning to the community as long as the juvenile continues to receive DJJ services.

1. Release to a Community Living Arrangement

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

2. Release to an Institutional Placement or Long Term or HCBS

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

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Correctional facility staff will notify the LDSS in the locality where the individual is housed if a Long-term Services and Supports (LTSS) screening is needed. The LTSS screening is to be conducted by the LDSS and local health department in the locality where the correctional facility is located even if the eligibility application is being processed centrally or by another locality. Correctional facility staff will coordinate with the screening team, service provider or eligibility worker to ensure the eligible individual can receive necessary medical support/services when released.

**H. Inpatient
Hospitalization
(Medicaid Only)**

*Incarcerated individuals who meet **all** Medicaid eligibility requirements, including a CN covered group, are eligible for Medicaid coverage limited to inpatient hospitalization services. These individuals are not considered to be residents of ineligible institutions while they are hospitalized.*

Information about the individual's incarceration along with the verifications needed for the Medicaid application must be provided. Denied applications are not referred to the Health Insurance Marketplace

Medicaid coverage for inpatient hospitalization for incarcerated individuals is based on the month of application and can include up to three months prior to the month of application, provided all eligibility requirements were met. Enroll eligible MAGI Adults individuals in aid category AC 108 and all other individuals in aid category AC 109. AC 108 and AC 109 identify the individual as eligible for coverage limited to inpatient hospitalization and ensures claims will be paid correctly.

Eligibility in AC 108 or AC 109 may continue as long as the individual continues to meet all Medicaid eligibility requirements and remains incarcerated. Individuals, other than pregnant women, are subject to an annual renewal of coverage. The first 12-month period begins with the month of application for Medicaid.

If the individual is a pregnant woman, set the renewal date based on the expected delivery date and the post-partum period to determine if she will meet a full benefit covered group after the pregnancy ends.

Non-citizen incarcerated individuals who meet all Medicaid eligibility requirements other than alien status may be eligible for Medicaid payment limited to emergency services received during an inpatient hospitalization. Determine eligibility for emergency services using policy in M0220.500 B and enroll eligible individuals using the procedures in M0220.600.

All communication regarding individuals incarcerated in DOC facilities who have inpatient hospitalizations must be sent to the DOC Health Services Reimbursement Unit, 6900 Atmore Drive, Richmond, Virginia 23225.

Applications for juveniles in DJJ facilities will be coordinated through the DJJ Re-entry Services Unit, 600 E. Main Street, Richmond VA 23219

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Applications for individuals in regional or local jails may be coordinated with the jail or may be submitted by the individual or his authorized representative.

M0130.100 Processing Time Standards

A. Processing Time Standards

1. 10 Day Requirement (Expedited Application)

a. Pregnant Women

Applications for pregnant women must be processed within 10 working days of the agency's receipt of the signed application.

If the pregnant woman also applies for other children or other persons in her family and the agency cannot determine the other persons' eligibility within 10 working days, the agency must determine just the MA eligibility of the pregnant woman within the working 10 days.

The agency must have all necessary verifications within the 10 working days in order to determine eligibility. If the agency does not receive the verifications within the 10 working days, the worker must send the applicant written notice on the 10th day. The notice must state why action on the application was not taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 days by which to submit the documentation.

Once all necessary verifications for the pregnant woman are received, an eligibility decision must be made immediately and the applicant must be immediately notified of the decision. If the pregnant woman applied for other persons in the family, and the eligibility determination for those persons has not been completed, the written notice must state that the application is still pending.

If all necessary verifications are not received, the application continues to pend until the 45-day processing time limit is reached.

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b. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Applications

BCCPTA Medicaid applications filed by individuals who do not meet the description of an individual in the Low-income Families with Children (LIFC), Medicaid pregnant women, or SSI recipients covered groups must be processed within 10 working days of the agency's receipt of the signed application.

BCCPTA Medicaid applications filed by individuals who meet the description of an individual in the LIFC, pregnant women, or the SSI recipients covered groups must be processed as soon as possible, but no later than 45 days of the agency's receipt of the signed application.

If the BCCPTA Medicaid application is the only application required and no additional information is required, the eligibility decision must be made immediately and the applicant must be notified of the decision within 10 working days of the agency's receipt of the application.

If a decision cannot be made within 10 working days of receipt of the BCCPTA application, the worker must send a written notice on the 10th day stating why action has not been taken, specifying what information is needed, and a deadline for submitting the information.

If all necessary verifications are not received, the application continues to pend until the 45-calendar-day processing time limit is reached.

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

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

G. Health Insurance Premium Payment (HIPP) Program

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

The local DSS agency must give each applicant or enrollee who reports that he or someone in his family is employed more than 30 hours each week and is eligible for health insurance coverage under an employer's group health plan must be given a HIPP Fact Sheet, which provides a brief description of the program and the contact information for the HIPP Unit at DMAS. The HIPP Fact Sheet is available on-line at: <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>. Enrollees and other members of the public may contact the HIPP Unit for additional information at hippcustomerservice@dmas.virginia.gov.

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

H. Verification of Financial Eligibility Requirements

The eligibility worker must verify the following financial eligibility requirements:

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

1. Resources

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

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

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

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

5. \$0 (Zero) Income Procedures – Applicable Only to 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 ten calendar days for the return of the verifications.

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

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M0130.300 Eligibility Determination Process

A. Evaluation of Eligibility Requirements

When an MA application is received the *worker* must determine through a “file clearance” search of the eligibility and enrollment systems whether or not the individual already has Medicaid or FAMIS coverage.

With the exception of individuals enrolled on the basis of presumptive eligibility (PE), applications for MA submitted by individuals who already have an application recorded or who are currently active are denied as duplicate applications.

Applications submitted by individuals currently enrolled as *HPE* or as Newborn Children are not duplicate applications because they were initially enrolled without filing a full MA application. See M0120.300 A.5 for more information.

The eligibility determination process consists of an evaluation of an individual’s situation that compares each of the individual’s circumstances to an established standard or definition. The applicant must be informed of all known factors that affect eligibility.

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.

The evaluation of eligibility requirements must be documented in writing for cases not processed in VaCMS. The Evaluation of Eligibility (form #032-03-823) may be used. The form is available online at the DSS Fusion website.

Agency *or CPU* created evaluation forms are also acceptable as long as all information needed to determine eligibility is documented on the evaluation form.

Eligibility decisions are made following a prescribed sequence:

- The applicant must meet all non-financial requirements, including a covered group.
- If applicable to the covered group, resource limits must be met.
- The income limits appropriate to the covered group must be met.

Subchapter M0210 contains the Medicaid non-financial requirements.

B. Hierarchy of Covered Group

An applicant must be evaluated for eligibility in all potential covered groups and enrolled in the group that is the most beneficial to the applicant. First, evaluate under covered groups offering full coverage and if the applicant is not eligible, evaluate under groups offering limited coverage. Specific instructions regarding the determination of covered group are contained in chapter M03.

C. Applicant’s Choice of Covered Group

An individual who meets more than one covered group may choose the covered group under which he wishes his eligibility determined. Appropriate policy used is based on that individual's choice. If the choice is not clear on the application/redetermination form, the individual must state his covered group choice in writing. If the applicant does not make a choice, enroll him in the covered group that is the most beneficial.

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D. Application Disposition

1. General Principle

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

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

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

2. Entitlement and Enrollment

a. Entitlement

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

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

b. Enrollment

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

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

3. Notification to Applicant

Either a Notice of Action generated by the eligibility determination system or the equivalent form #032-03-006 (available at the *DSS Fusion website*) must be used to notify the applicant of the specific action taken on the application. The notice must be sent to the authorized representative, if one has been designated.

M02 Table of Contents Changes

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TN #DMAS-10	10/1/18	Page ii
TN #95	3/1/11	Page i
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**M0250.000 ASSIGNMENT OF RIGHTS AND PURSUIT OF SUPPORT
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M0260 RESERVED

NOTE: Policy references to M0260 that are still in effect have been moved to subchapter M0250.

M0270.000 APPLICATION FOR OTHER BENEFITS

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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
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.

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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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M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS

M0220.001 GENERAL PRINCIPLES

A. Introduction

This subchapter explains in detail how to determine if an individual is a citizen or alien eligible for full Medicaid benefits (referred to as “full benefit aliens”) or emergency services only (referred to as “emergency services aliens”). The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) made major changes to the Medicaid eligibility of non-citizens of the United States. These changes eliminated the “permanently residing under color of law” (PRUCOL) category of aliens. The Medicaid benefits for which an alien is eligible are based upon whether or not the alien is a “qualified” alien as well as the alien’s date of entry into the United States.

With some exceptions, the Deficit Reduction Act of 2005 (DRA) required applicants for Medicaid and Medicaid recipients to verify their United States citizenship and identity to be able to qualify for Medicaid benefits. The citizenship and identity (C&I) verification requirements became effective July 1, 2006. The Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) allows additional exemptions from the C&I verification requirements and provides states with the option to verify C&I through the use of an electronic data match with the Social Security Administration (SSA). It also requires states to enroll otherwise eligible individuals prior to providing C&I verification, and grant them a “reasonable opportunity” period after enrollment to provide documentation, if necessary.

The policy and procedures for determining whether an individual is a citizen or a “full-benefit” or “emergency services” alien are contained in the following sections:

- M0220.100 Citizenship & Naturalization;
- M0220.200 Alien Immigration Status
- M0220.300 Full Benefit Aliens
- M0220.400 Emergency Services Aliens
- M0220.500 Aliens Eligibility Requirements
- M0220.600 Full Benefit Aliens Entitlement & Enrollment
- M0220.700 Emergency Services Aliens Entitlement & Enrollment

B. Declaration of Citizenship/Alien Status

The Immigration Reform and Control Act (IRCA) requires as a condition of eligibility that the adult applicant who is head of the household (with exceptions below) declare in writing under penalty of perjury whether or not the individual(s) for whom he is applying is a citizen or national of the United States, and if not, that the individual is a lawfully admitted alien. For children under 18 years of age, the declaration is made by an adult family member. The declaration statement is on the application form.

EXCEPTION: An individual who is an “unqualified” alien (as defined in section M0220.410) does NOT complete the declaration.

Individuals who are required to sign the declaration and who fail or refuse to sign are NOT eligible for any Medicaid services.

M0240 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-10	10/1/18	Pages 3, 4
TN #DMAS-9	7/1/18	Table of Contents Page 6 Page 6a is a runover page
TN #DMAS-2	10/1/16	Pages 1, 4 Page 2 is a runover page.
TN #100	5/1/15	Page 2
TN #98	10/1/13	Table of Contents Pages 1-5 Page 6 was deleted.
TN #96	10/1/11	Pages 2-4
TN #94	9/1/10	Pages 1-6
TN #93	1/1/10	Pages 1-4
Update (UP) #1	7/1/09	Pages 1, 2
TN #91	5/15/09	Pages 1, 2

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- 1. Failure to Apply for SSN** Applicants who refuse to furnish an SSN or to show proof of application for a number are ineligible for Medicaid.
- 3. Retroactive Eligibility** 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.

M0240.200 FOLLOW-UP REQUIREMENTS FOR SSN APPLICATION

- A. Applicant Applied for SSN** When an applicant who has applied for an SSN is determined eligible for medical assistance, he is enrolled with a pseudo-SSN. The worker must obtain the enrollee's SSN when it is assigned and enter it into the enrollee's records.
- B. Follow-Up Procedures** The follow-up procedures below do not apply to individuals listed in M0240.100 B.
 - 1. Documentation** If the applicant does not have an SSN, the agency must document in the record the date he applied for an SSN.
 - 2. Entering Computer Systems** When entering the individual the eligibility/enrollment system, use the date the individual applied for an SSN, or the individual's date of birth, preceded by "000" as the individual's SSN.

For example, an individual applied for an SSN on October 13, 2006. Enter "000101306" as the individual's SSN in the eligibility/enrollment system.
 - 3. Follow-up**
 - a. Follow-up in 90 Days**

After enrollment of the eligible individual, the agency must follow-up within 90 days of the Social Security number application date or 120 days if application was made through hospital enumeration:
 - b. Check for Receipt of SSN**

Check the system records for the enrollee's SSN. If the SSN still has "000" the first 3 digits, contact the enrollee to obtain the enrollee's SSN verbally or by mail.
 - c. Verify SSN by a computer system inquiry of the SSA records.**
 - d. Enter Verified SSN in the eligibility/enrollment system.**

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4. Renewal Action

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

a. Check for Receipt of SSN

Before or at renewal, the SSN must be entered into the eligibility/enrollment system. Check the system records for the enrollee’s SSN. If the SSN has “000” as the first 3 digits, contact the enrollee to obtain the enrollee’s SSN verbally or by mail, or on the renewal form if a renewal form is required.

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

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

d. SSN Not Provided by Renewal Deadline

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

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

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

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

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

M0240.300 SSN Verification Requirements

A. SSN Provided By Individual

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

B. Procedures

1. Enter Verified SSN in Systems

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

M0310 Changes
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Changed With	Effective Date	Pages Changed
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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M0310.000 GENERAL RULES & PROCEDURES

M0310.001 GENERAL PRINCIPLES OF MEDICAID COVERED GROUPS

A. Introduction

An individual who meets all the non-financial eligibility requirements in Chapter M02 and who is not an ineligible person listed in M0210.100, must meet a Medicaid covered group in order to be eligible for Medicaid. Chapter M03 explains in detail each of the Medicaid covered groups and how to determine if an individual meets the covered group requirements.

The Medicaid covered groups are divided into two classifications: the categorically needy (CN) and the medically needy (MN). CN individuals meet all Medicaid non-financial requirements (see M02) and the definition for a covered group. MN individuals meet all Medicaid non-financial requirements and resource requirements, but have income in excess of the Medicaid limits. MN individuals may be placed on a spenddown (SD). The covered groups are also divided into Aged, Blind and Disabled (ABD) and Families & Children (F&C) covered groups. Within some covered groups are several definitions of eligible individuals. Some individuals may meet the requirements of more than one group. The agency must verify the individual meets a definition for a covered group and the group's financial requirements.

B. Refugees

If the Medicaid applicant is a refugee, first determine if the refugee meets the requirements in a Medicaid covered group using the policy and procedures in this chapter. If the refugee does not meet the requirements of a Medicaid covered group, the refugee is not eligible for Medicaid under a Medicaid covered group. Go to the Refugee Resettlement Program Manual Volume XVIII to determine the refugee's eligibility for assistance under the Refugee Resettlement Program.

The requirements for the Refugee Other (Cash Assistance) and Refugee Medicaid Other and Refugee Medicaid Unaccompanied Minors programs are found in another manual: the Refugee Resettlement Program Manual Volume XVIII.

C. Covered Group Information

This subchapter contains the general principles for determining if the individual meets a definition and covered group(s).

- M0310.002 contains the list of Covered Groups;
- M0310.100 - M0310.134 contains the Definitions;
- M0320 contains the detailed policy and covered group requirements for the Aged, Blind and Disabled Groups;
- M0330 contains the detailed policy and covered group requirements for the Families & Children Groups, *and includes the Modified Adjusted Gross Income (MAGI) Adults covered group, effective January 1, 2019.*

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M0310.002 LIST OF MEDICAID COVERED GROUPS

Group and Description <i>Mandatory = required under federal regulations</i> <i>Optional = State Plan Option</i>		Categorically Needy (CN)	Medically Needy(MN)
Aged, Blind, or Disabled (ABD)	SSI – <i>mandatory</i>	X	
	AG – <i>mandatory</i>	X	
	Protected – <i>mandatory</i>	X	
	≤ 80% FPL – <i>optional</i>	X	
	≤ 300% of SSI – <i>optional</i> (institutionalized only)	X	
	Medicaid Works – <i>optional</i>	X	
	Medicare Savings Programs (QMB, SLMB, QI, QDWI) -- <i>all mandatory</i>	X	
	Aged Blind Disabled -- <i>all optional</i>		X
Families & Children (F&C)	IV-E Foster Care or Adoption Assistance - <i>mandatory</i>	X	
	LIFC Parent/Caretaker Relatives - <i>mandatory</i>	X	
	Pregnant woman/newborn child – <i>mandatory</i>	X <i>mandatory</i>	X <i>optional</i>
	Child under age 19 – <i>mandatory</i>	X	
	BCCPTA – <i>optional</i>	X	
	Plan First – <i>optional</i>	X	
	Child under 18 – <i>optional</i>		X
	Individuals under age 21, Special Medical Needs Adoption Assistance	X <i>optional</i>	X <i>optional</i>
	Former Virginia Foster Care Children under age 26 – <i>mandatory</i> (effective January 1, 2014)	X	
	<i>MAGI Adults – optional</i> (effective January 1, 2019)	X	

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A. Categorically Needy (CN)

The ABD, and F&C (including the *MAGI Adults*) covered groups in the CN classification are listed below.

1. ABD Groups

- a. SSI cash assistance recipients who meet more restrictive Medicaid resource eligibility requirements.
- b. Auxiliary Grants (AG) cash assistance recipients.
- c. ABD individuals who are institutionalized in a medical institution, who meet all Medicaid eligibility requirements and have income before exclusions that is less than 300% of the SSI individual payment limit.
- d. ABD individuals who receive or are applying for Medicaid-approved community-based care services, who meet all Medicaid eligibility requirements and who have income before exclusions that is less than 300% of the SSI individual payment limit.
- e. ABD individuals who have a “protected” status:
 - 1) individuals who received OAA, AB, APTD, or ADC as of August 1972, and meet specified requirements.
 - 2) individuals who are former SSI/AG recipients and meet specified requirements.
 - 3) individuals who are widows(ers) and meet specified requirements.
 - 4) individuals who are classified as 1619(b) by Social Security and meet specified requirements.
 - 5) individuals who are adult disabled children and meet specified requirements
- f. Hospice--a hospice patient is a person who is terminally ill and has elected to receive hospice care; if the individual is not aged, presume that the individual is disabled.
- g. Qualified Medicare Beneficiaries (QMBs).
- h. Special Low-income Medicare Beneficiaries (SLMBs).
- i. Qualified Disabled and Working Individuals (QDWIs).
- j. Qualified Individuals (QIs).
- k. ABD With Income ≤ 80% Federal Poverty Limit (ABD 80% FPL).
- l. MEDICAID WORKS.

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**2. F&C Groups,
Including the
MAGI Adult
Group**

- a. foster care children receiving IV-E and adoption assistance children receiving IV-E.
- b. Low income families with children (LIFC) eligible children, parents, non-parent caretaker-relatives, and EWBs (*essential to the well-being* applications submitted prior to October 1, 2013).
- c. Children under age 1 born to mothers who were eligible for and receiving MA at the time of the child's birth.
- d. Individuals under age 21
 1. Title IV-E Eligible Foster Care children who do not receive a Title IV-E maintenance payment
 2. Non-IV-E Foster Care
 3. Juvenile Justice Department children
 4. Non-IV-E Adoption Assistance children
 4. Individuals in an ICF or ICF-MR
- e. Former foster care children under age 26 years (Effective January 1, 2014)
- f. Pregnant women
- g. Plan First; Family Planning Services
- h. Children under age 19 years
- i. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). Women and men screened and diagnosed with breast or cervical cancer under the Centers for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program (BCCEDP) and eligible to receive Medicaid under the BCCPTA.
- j. *MAGI Adults, 19 – 64 years of age (Effective January 1, 2019)*

**B. Medically Needy
(MN)**

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

1. ABD Groups

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

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M0310.136 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-10	10/1/18	Table of Contents Pages 1, 26, 29, 35, 37 Page 2 is a runover page. Page 2a was 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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M0320.000 AGED, BLIND & DISABLED (ABD) 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 ABD covered groups into categorically needy and medically needy (MN) groups.

B. Procedure

Determine an individual's eligibility first in a CN covered group. *This includes eligibility in the Modified Adjusted Gross Income (MAGI) Adults covered group (see M0330.250).* If the individual is not eligible in a full-benefit CN covered group, determine the individual's eligibility as MN (on a spenddown).

An evaluation of eligibility for an aged, blind or disabled individual should follow this hierarchy:

1. If the individual is a current SSI/AG recipient, evaluate in this covered group. Exception-- if the individual requests MEDICAID WORKS, go to 4 below.
2. If the individual is a former SSI or AG recipient, evaluate first in the protected covered groups Exception-- if the individual requests MEDICAID WORKS, go to 4 below.
3. *If the individual does not meet the criteria for SSI/AG or protected, is between ages 19 and 64, and is not eligible for or enrolled in Medicare, evaluate next in the MAGI Adults covered group.*
4. *If the individual is aged and/or is eligible for or has Medicare, evaluate next in the ABD with income \leq 80% FPL covered group.*
5. If a disabled individual has income at or below 80% FPL (including SSI recipients and 1619(b) individuals) and is going back to work, evaluate the individual in the MEDICAID WORKS covered group.
6. If the individual does not meet the requirements for *MAGI Adults*, 80% FPL group or MEDICAID WORKS, but meets the definition of an institutionalized individual, evaluate in the 300% of SSI covered groups.
7. If the individual is a Medicare beneficiary with income or resources in excess of the full-benefit Medicaid covered groups, evaluate in the Medicare Savings Programs (MSP) groups (QMB, SLMB, QI, QDWI).
8. If the individual is not eligible for Medicaid coverage in an MSP group AND he is at least age 19 years but under age 65 years or he requests a Plan First evaluation, evaluate in the Plan First covered group.
9. If the individual meets all the requirements, other than income, for coverage in a full benefit Medicaid group, evaluate as MN.

C. Referral to Health Insurance Marketplace

Unless an individual is incarcerated, an ABD individual who does not have Medicare and is not for eligible for full Medicaid coverage must be referred to the Health Insurance Marketplace (HIM) so the applicant's eligibility for the APTC can be determined. Incarcerated individuals and those with Medicare are not referred to the HIM.

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M0320.001 ABD CATEGORICALLY NEEDY

A. Introduction

To be eligible in an ABD covered group, the individual must meet all Medicaid non-financial requirements in chapter M02 and an “Aged,” “Blind” or “Disabled” definition in subchapter M0310. If he does not, then go to the Families & Children covered groups in subchapter M0330.

B. Procedures

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

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

M0320.100 ABD CASH ASSISTANCE COVERED GROUPS

A. Legal base

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

B. Procedure

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

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

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M0320.101 SSI RECIPIENTS

A. Introduction

42 CFR 435.121 - SSI recipients are a mandatory CN covered group. Many states automatically grant Medicaid when the individual is approved for SSI based on disability. However, in Virginia, not all SSI recipients are eligible for Medicaid. Virginia has chosen to impose real property eligibility requirements that are more restrictive than the federal SSI real property eligibility requirements. SSI recipients living in Virginia must apply separately for Medicaid at their local departments of social services because they are subject to a resource evaluation.

A Virginia SSI recipient is NOT conditionally or presumptively eligible for SSI, which means presumptively blind or disabled SSI recipients may be presumed to be blind or disabled; though no final blindness or disability determination may have been made. As Virginia has chosen to impose real property eligibility requirements which are more restrictive than the federal SSI real property eligibility requirements, a conditionally eligible SSI recipients is allowed time to dispose of excess resources.

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

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

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D. Financial Eligibility

1. Assistance Unit

a. Initial eligibility determination

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

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

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

b. Ongoing eligibility

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

2. Resources

a. Initial eligibility determination

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

b. Ongoing eligibility

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

- 1) For **earnings** accumulated **after** enrollment in MEDICAID WORKS, up to the current 1619(b) income threshold amount will be disregarded if deposited and retained in the WIN Account. The *current* 1619(b) threshold amount *for 2018* is \$36,044.
- 2) Resources accumulated while in MEDICAID WORKS and held in Internal Revenue Service (IRS)-approved retirement accounts, medical or health savings accounts, medical reimbursement (flex) accounts, education accounts, independence accounts, and other similar State-approved accounts are excluded. Examples of these accounts include Archer Medical Savings Accounts, 401(k)/403(b)/457(b)/503(b) accounts, traditional Individual Retirement Accounts (IRAs), Roth IRAs, SEP-IRAs, SIMPLE IRAs, and Thrift Savings Plans. The account must be designated as a WIN Account in order to be excluded. **Resources accumulated while in MEDICAID WORKS and held in IRS-approved accounts that have been designated as WIN**

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Resources accumulated while in MEDICAID WORKS and retained in an IRS-approved account described in M0320.400 D. 2. b. 2) that has been designated as a WIN Account are excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees.

H. Benefit Package

Individuals enrolled in MEDICAID WORKS are entitled to the standard benefits available to full-benefit Medicaid enrollees (see Chapter M18), as well as Personal Assistance Services; MEDICAID WORKS enrollees do **not** have a patient pay. Intensive Behavioral Dietary Counseling is also covered for MEDICAID WORKS enrollees when a physician determines that the service is medically necessary.

I. Entitlement and Enrollment

Entitlement for MEDICAID WORKS is dependent upon meeting the requirements listed above.

There is no retroactive coverage under MEDICAID WORKS. The application date in the Virginia Case Management System (VaCMS) is the date the individual signed the MEDICAID WORKS Agreement. Coverage shall begin on the first day of the month following the month in which all requirements are met. If the applicant has a future start date for employment, the effective date of eligibility shall be no earlier than the first day of employment. However, unless employment begins on the first day of the month, MEDICAID WORKS enrollment will begin on the first of the following month.

The AC for MEDICAID WORKS is 059. Use the following procedures to enroll the individual in VaCMS:

New Application – Applicant Eligible as 80% FPL

1. For the month of application and any retroactive months in which the person is eligible in the 80% FPL covered group, enroll the individual in a closed period of coverage using AC 039 (blind) or 049 (disabled), beginning the first day of the month in which eligibility exists. The cancel date is the last day of the month in which the MEDICAID WORKS Agreement was signed. Use Cancel Code 042.
2. Reinstate the individual's coverage in MEDICAID WORKS using AC 059 beginning the first day of the following month (the first day of the month following the month in which the MEDICAID WORKS Agreement is signed). Use the same application date (the actual date of the initial application) that was used for the month of application.

Complete the MEDICAID WORKS fax cover sheet and fax it together with the following information to DMAS at 804-786-1680:

- the signed MEDICAID WORKS Agreement,
- the Work Incentive Account (WIN) information (a bank account statement or verification from the bank that the account was opened), and
- one of the following verifications of employment:
 - a pay stub showing current employment or
 - an employment letter with start date or
 - self-employment document(s).

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- 022 for an aged individual also QMB;
- 042 for a blind individual also QMB;
- 062 for a disabled individual also QMB;
- 025 for an aged individual also SLMB;
- 045 for a blind or disabled individual also SLMB.

2. Not QMB or SLMB

If the individual is NOT a QMB or SLMB - the individual does NOT have Medicare Part A, OR has countable income over the QMB and SLMB income limits - the AC is:

- 020 for an aged individual NOT also QMB or SLMB;
- 040 for a blind individual NOT also QMB or SLMB;
- 060 for a disabled individual NOT also QMB or SLMB.

D. Ineligible In This Covered Group

If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy spenddown. Determine the individual's eligibility as QMB, SLMB, QDWI or QI if he/she has Medicare Part A.

M0320.503 ABD HOSPICE

A. Policy

SMM 3580-3584 - The state plan includes the covered group of aged, blind or disabled individuals who are terminally ill and elect hospice benefits.

The ABD Hospice covered group is for individuals who have a signed a hospice election statement in effect for at least 30 consecutive days, and who are not eligible in any other full-benefit Medicaid covered group. Hospice care is a covered service for individuals in all full-benefit covered groups; individuals who need hospice services but who are eligible in another full-benefit covered group do not meet the Hospice covered group.

Individuals receiving hospice services in the ABD Hospice Covered group may also receive services under *Commonwealth Coordinated Care Plus (CCC Plus)* Waiver, if the services are authorized by the Department of Medical Assistance Services (DMAS) (see M1440.101).

The individual must elect hospice care. Election of hospice care is verified either verbally or in writing from the hospice. If the verification is verbal, document the case record. Eligibility in the Hospice covered group is ongoing as long as the individual continues to receive hospice care, subject to a renewal of eligibility at least once every 12 months. The eligibility worker must verify that the hospice agreement is current at the time of the annual Medicaid renewal.

The 30-day requirement begins on the day the hospice care election statement is signed. Once the hospice election has been in effect for 30 consecutive days, the 300% of SSI income limit is used to determine Medicaid eligibility. If the individual's income is within 300% of SSI, eligibility in the Hospice covered group may be determined beginning with the month in which the hospice election was signed.

Individuals who already meet the definition of institutionalization in M1410.010 B.2 at the time of hospice election meet the 30-day requirement, provided there is no break between institutionalization and hospice election.

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D. Enrollment

Eligible individuals must be enrolled in the appropriate AC. If the individual is aged, blind, or disabled as defined in M0310, he is enrolled under the AC. **AC (054) is used for “deemed-disabled” individuals only.** Use the appropriate Hospice AC when the individual is also authorized to receive *CCC Plus* waiver services.

For individuals who are ABD and entitled/enrolled in Medicare Part A, income must be recalculated (allowing appropriate disregards) to determine if the individual is dually eligible as a QMB or SLMB.

1. ABD Individual

a. Dual-eligible As QMB or SLMB

If the individual is also a Qualified Medicare Beneficiary (QMB) or Special Low Income Medicare Beneficiary (SLMB) - the individual has Medicare Part A and has countable income within the QMB or SLMB income limits - the AC is:

- 022 for an aged individual also QMB;
- 042 for a blind individual also QMB;
- 062 for a disabled individual also QMB
- 025 for an aged individual also SLMB;
- 045 for a blind or disabled individual also SLMB.

b. Not QMB or SLMB

If the individual is NOT a Qualified Medicare Beneficiary (QMB) the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit – the AC is:

- 020 for an aged individual NOT also QMB or SLMB;
- 040 for a blind individual NOT also QMB or SLMB;
- 060 for a disabled individual NOT also QMB or SLMB.

2. “Deemed” Disabled Individual

An individual who is “deemed” disabled based on the hospice election is enrolled using AC 054. Individuals in this AC who have also been approved to receive services under the EDCD Waiver do not need a disability determination.

E. Post-eligibility Requirements (Patient Pay)

A patient pay must be calculated for individuals who receive hospice services in a nursing facility (see subchapter M1470). Individuals who receive hospice services outside of a nursing facility do not have a patient pay.

Individuals who have elected hospice services and who also receive Medicaid Long-term Care services available under the *CCC Plus* Waiver must have a patient pay calculation for the *CCC Plus* services (see subchapter M1470).

F. Ineligible In This Covered Group

There is no corresponding medically needy hospice covered group. If the individual is aged or has been determined blind or disabled, the individual must be evaluated in a medically needy covered group for medically needy spenddown.

M0330 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-10	10/1/18	Table of Contents Page 1-2, 30 Page 10a-b were added as runover pages.
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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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.

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 income limit, evaluate as MN.

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

1. If the individual is a former foster care child under 26 years, evaluate in this covered group.
2. If the individual *is not a former foster care child under 26 years and* meets the definition of a parent/caretaker relative, evaluate in the LIFC covered group.
3. If the individual is not *eligible as* LIFC, but meets the definition of a pregnant woman, evaluate in the pregnant woman/newborn child group.
4. 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 BCCPTA 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.
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.

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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 (LIFC);
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 (FPS);
M0330.700 Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA).

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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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% (133% + 5% 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.

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D. Resources *Although no resource test is applicable for MAGI Adults coverage, the worker must evaluate certain resources for any individuals seeking Medicaid payment for LTSS. These include asset transfers, trusts, annuities, and the home equity limit. See M1410.050*

E. Financial Eligibility *MAGI methodology is applicable to the MAGI Adults covered group. The policies and procedures contained in Chapters M04 are used to determine eligibility for these individuals.*

1. Basis For Eligibility *The basis for financial eligibility is the individual's MAGI household. See M0430.100.*

2. Income *The income limits, policies and procedures used to determine eligibility in this covered group are contained in Chapter M04.*

3. Income Exceeds Limit *If the individual's income exceeds the MAGI Adults income limit, the individual must be evaluated for eligibility in any other full benefit Medicaid group. If not eligible in a full benefit category, the individual must be evaluated for any limited benefit coverage for which they may be eligible.*

4. Spenddown *Spenddown does not apply to any MAGI Adults covered group.*

F. Referral to Health Insurance Marketplace *If the individual is not eligible for any full benefit Medicaid coverage group due to income over the applicable limit, the individual must be referred to the HIM for evaluation for the APTC.*

G. Entitlement *Entitlement in Medicaid as a MAGI Adult begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period; however, retroactive coverage in the MAGI Adults group is not available for any month prior to January 1, 2019.*

H. Enrollment *The Medicaid aid categories for MAGI Adults are:*

AC	Meaning
100	Parent/caretaker relative; income above the LIFC limit and below 100% FPL (no 5% disregard)
101	Parent/caretaker relative; income greater than 100% FPL, but less than or equal to 138% FPL (133% + 5% disregard)
102	Childless adult; income at or below 100% FPL (no disregard)
103	Childless adult; income greater than 100% FPL, but less than or equal to 138% FPL (133% + 5% disregard)
106	Presumptively-eligible MAGI Adult; income at or below 138% FPL (133% + 5% disregard)
108	Incarcerated adult

I. Long Term Services and Supports *Once medical assessment and financial evaluation are approved, a MAGI Adult may receive facility based or home and community based LTSS.*

Patient pay does not apply to MAGI Adults.

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M0330.801 PREGNANT WOMEN

A. Nonfinancial Eligibility

42 CFR 435.301(b)(1)(i)--If the state chooses to cover the medically needy, the State Plan must provide medically needy coverage to all pregnant women during the course of their pregnancy who, except for income and resources, would be eligible for Medicaid as categorically needy.

A pregnant woman's Medicaid eligibility is first determined in the CN pregnant women covered group which has no resource limit and has an income limit that is higher than the medically needy income limit. If a pregnant woman is not eligible as a *CN Pregnant Woman* because her income is too high, evaluate as FAMIS MOMS. If the individual is not eligible for FAMIS MOMS, then evaluate as MN. She may spenddown to the lower MN income limit IF her resources are within the MN resource limit.

A pregnant woman is eligible in this MN covered group if she meets the pregnant woman definition in M0310.119 and meets the nonfinancial requirements in chapter M02.

B. Financial Eligibility

1. Assistance Unit

The assistance unit policy and procedures in chapter M05 apply to medically needy pregnant women. If the pregnant woman is not institutionalized, consider the resources and income of a pregnant woman's spouse with whom she lives and, if the pregnant woman is under age 21, the pregnant woman's parent(s) with whom she lives. If a pregnant woman also applies for other assistance unit members living with her who do not meet an F&C medically needy covered group, separate financial eligibility determinations are done for the unit. One is the F&C medically needy determination for the pregnant woman. The other financial eligibility determination is based on the other individual's(s) covered group(s).

M04 Changes

Changed With	Effective Date	Pages Changed
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.
TN #DMAS-9	7/1/18	Table of Contents. Pages 5, 6, 11, 14a, 25-27 Appendices 3 and 5 Page 6a is a runover page. Page 28 was added as a runover page.
TN #DMAS-8	4/1/18	Table of Contents Pages 2-6a, 12-14b, 25 Pages 26 and 27 were added. Pages 14c was added as a runover pages. Appendices 1, 2, 6 and 7 Appendix 1, page 2 was added.
TN #DMAS-6	10/1/17	Pages 12, 13, 14b
TN #DMAS-5	7/1/17	Table of Contents Pages 5, 6, 12, 13, 14-14b Appendices 3, 4 and 5 Page 6a was added as a runover page. Page 13a, 14, and 14a were renumbered to pages 14, 14a and 14b.
TN #DMAS-4	4/1/17	Appendices 1, 2 and 6
TN #DMAS-3	1/1/17	Table of Contents Pages 3 -5, 13a, 20 Appendix 6, page 1 Page 20a was added.
TN #DMAS-2	10/1/16	Appendix 2, pages 1, 2 Appendices 3, 5
TN #DMAS-1	6/1/16	Pages 3, 5, 6, 12, 13, 14a Appendices 1, 2, 6 and 7 Appendix 2, page 2 was added. Page 13a is a runover page.
UP #11	7/1/15	Appendices 3 and 5
TN #100	5/1/15	Pages 2, 11, 12, 13, 14 Appendices 1, 2, 3, 5, 6 and 7 Page 1 is a runover page.
Update (UP) #10	5/1/14	Table Contents pages 2, 3, 5, 6, 10-15 Appendices 1, 2 and 6 Appendix 7 was added.
TN #99	1/1/14	Pages 2, 5, 6, 8, 14, 15 Appendix 6

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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.

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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- has no resource test (*Exception: MAGI Adults requesting coverage of Long Term Care services are subject to certain asset/resource requirements*)
- 2. MAGI Rules**
- *MAGI has an income disregard equal to 5% of the federal poverty level (FPL) for the Medicaid or FAMIS individual's household size. The disregard is only given if the individual is not eligible for coverage due to excess income. It is applicable to individuals in both full-benefit and limited-benefit covered groups.*

If the individual meets multiple Medicaid covered groups (and/or FAMIS) his gross income is compared first to the income limit of the group with the highest income limit under which the individual could

- be eligible. If the income exceeds the limit, the 5% FPL disregard can be allowed, and the income again is compared to the income limit.
- When considering tax dependents in the tax filer's household, the tax dependent may not necessarily live in the tax filer's home.
- Under MAGI counting rules, an individual may be counted in more than one household but is only evaluated for eligibility in his household.
- Use non-filer rules when the household does not file taxes.
- Use non-filer rules when the applicant is claimed as a tax dependent by someone outside the applicant's household.
- Non-filer rules may be used in multi-generational household.

- 3. Eligibility Based on MAGI**
- MAGI methodology is used for eligibility determinations for insurance affordability programs including Medicaid, FAMIS, the Advance Premium Tax Credit (APTC) and cost sharing reductions through the Health Insurance Marketplace for the following individuals:

Children under 19

- Parent/caretaker relatives of children under the age of 18 - Low Income Families With Children (LIFC)
- Pregnant women
- Individuals Under Age 21
- *Adults between the ages of 19 and 64 not eligible or enrolled in Medicare (effective January 1,2019)*
- Individuals in Plan First.

- 4. Eligibility NOT Based on MAGI**
- MAGI methodology is NOT used for eligibility determinations for:
- individuals for whom the agency is not required to make an income determination:

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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.
- 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*
 - *Non-citizens eligible for emergency services only*
 - *Individuals eligible for Long Term Care Services and Support (LTSS) ages 19-64*
- 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. 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.

3. Child

means a natural, biological, adopted, or stepchild.

4. Childless Adult

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

5. 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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- 6. Dependent Child** means a child under age 18, or age 18 and a full-time student in a secondary school *and expected is to graduate prior to his 19th birthday*, who lives with his parent or caretaker-relative.
- 7. Family** means the tax filer (including married tax filers filing jointly) and all claimed tax dependents.
- 8. 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.
- 9. 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).**
- 10. 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.*
- 11. 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.
- 12. 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*.
- 13. Reasonable Compatibility** means the income attested to (declared) by the applicant is within 10% of income information obtained from electronic sources. If the income from both sources meets the 10% requirement, then the attestation is considered verified.
- The applicant's income reported on the application is verified through a match with income data in the federal Hub, if is available. 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 the Hub, the income will be labeled unverified. If the system indicates that the income is not verified and the attestation is below the medical assistance income level, documentation of income is required.

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- 14. Sibling** means a natural, biological, stepsibling or half-sibling.
- 15. Tax-Dependent** means an individual for whom another individual claims a deduction for a personal exemption under section 151 of the Internal Revenue Code of 1986 for a taxable year.
- 16. Tax-filer Household** means individuals who expect to file a Federal tax return and/or who expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made.

M0430.100 MAGI HOUSEHOLD COMPOSITION

A. Introduction

The household composition is the basis for the financial eligibility determination for each person in the home who applies for MA. Eligibility is based on the countable income of the household members.

. Included in the MAGI household composition are:

- stepparents and stepchildren,
- children/siblings with income,
- children ages 21 and older who are claimed as tax dependents, and
- adult tax dependents.

B. Household Composition Rules

Tax filers and tax dependents use the tax household rules with limited exceptions. In most cases, the household is determined by principles of tax dependency.

- Parents, children and siblings are included in the same household.
- Stepparents and parents are treated the same.
- Children and siblings with or without income are included in the same household as the rest of the family.
- Older children are included in the family if claimed as tax dependent by the parents.
- Married couples living together are **always** included in each other's household even if filing separately.
- Married couples that are separated and not living together but file jointly are not included in each other's household.
- Dependent parents may be included in the household if they are claimed for income tax purposes.

1. Tax Filer Household Composition

The tax filer household is determined based on the rules of tax dependency. Parents, children and siblings are included in the same household. The tax filer's household consists of the tax filer and all tax dependents who **are expected to be claimed for the current year**. This could include non-custodial children claimed by the tax filer, but living outside the tax filer's home and dependent parents claimed by the tax filer, but living outside the tax filer's home.

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The tax filer household is composed of the individual who expects to file a tax return this year and does not expect to be claimed as dependent by another tax filer. The household consists of the tax filer and all individuals the tax filer expects to claim as a tax dependent.

2. Tax Dependent Household Composition

means all dependents expected to be claimed by another tax filer for the taxable year. Except for Special Medical Needs AA children and children who have been in a Level C PRTF for at least 30 consecutive days, the household of a tax dependent who does not meet an exception in M0430.100 B.2 below is the same as the tax filer's household.

If the tax dependent is living with a tax filer other than a parent or spouse or is living separately from the parent claiming him as a dependent, the tax dependent is included in the tax filer household, but the tax filer is NOT included in the tax dependent's household.

A Special Medical Needs AA child or a child who has been in a Level C PRTF for at least 30 consecutive days is in his own household with no parents or siblings.

Exceptions to the tax household composition rules apply when:

- individuals other than biological, adopted or stepchildren are claimed as tax dependents,
- children are claimed by non-custodial parents,
- children live with both parents and expect to be claimed as a tax dependent by one parent, but parents (married or unmarried) do not expect to file jointly,
- the tax dependent is a Special Medical Needs AA child or a child who has been in a Level C PRTF for at least consecutive 30 days.

3. Non Filer Household Composition

The Non Tax Filer household rules mirror the tax filer rules to the maximum extent possible.

- The household consists of parents and children under age 19.
Exception: A Special Medical Needs AA child or a child who has been in a Level C PRTF for at least 30 consecutive days is in his own household with no parents or siblings.
- Non-filer rules are used when a child is claimed as a tax dependent of someone not living in the home.
- Non-filer rules are used in the case of a multi-generational household where the tax dependent is also the parent of a child.
- Spouses, parents, stepparents and children living together are included in the same household. Exception: A Special Medical Needs AA child or a child who has been in a Level C PRTF for at least 30 consecutive days is in his own household with no parents or siblings.
- Children under age 19 living with a relative other than a parent are included in a household only with siblings/stepsiblings under age 19 who also live in the home.

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- For non-filers, a “child” is defined as under age 19.

4. Married Couple

In the case of a married couple living together, the spouse is always included in the household of the other spouse, regardless of their tax filing status. This includes a tax dependent living with both a tax filer parent AND the dependent’s spouse. The tax dependent’s household includes his spouse, the tax filer, any other parent in the home, and any siblings in the home who are also claimed by the same tax filer.

5. Tax Filer is Under Age 19

If the tax filer is under age 19, lives in the home with his parent(s) AND is not expected to be claimed as a dependent by anyone, the parent(s) are included in the child’s household.

6. Gap-filling Rule

States are required to use household income, as calculated by the federal HIM for the APTC eligibility determination, to determine eligibility for Medicaid or FAMIS if **all** of the following conditions apply:

- The individual is claimed as a tax dependent (including those who meet a tax dependent household exception in M0430.100 B.2). APTC methodology does not apply to non-filer households.
- Current monthly household income, using Medicaid/FAMIS MAGI-based methods is over the applicable income limit (including the 5% FPL disregard).
- Income already received and 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

This requirement is referred to the gap-filling rule. See M0450.400 for gap-filling rule evaluation procedures and examples.

M0430.200 TAX FILER HOUSEHOLD EXAMPLES

A. Married Parents and Their Tax Dependent Children

Sam and Sally are a married couple. They file taxes jointly and claim their two children Susie and Sarah as tax dependents. All of them applied for MA.

The MAGI household is the same as their tax household because the tax filers are a married couple filing jointly and claiming their dependent children. No additional individuals live in the home.

Ask the following questions for each tax dependent to determine if exceptions exist:

- Is Susie the tax dependent of someone other than a spouse or a biological, adopted, or stepparent? No, also applies to Sarah
- Is Susie a child living with both parents, but the parents do not expect to file a joint tax return? No, also applies to Sarah
- Is Susie a child who expects to be claimed by a non-custodial parent? No, also applies to Sarah

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The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Sam	4 - Sam, Sally, Susie, Sarah	Tax-filer & dependents
Sally	4 - Sally, Sam, Susie, Sarah	Tax filer & dependents
Susie	4 - Susie, Sam, Sally, Sarah	Tax dependent, tax-filer parents and other tax dependent
Sarah	4 - Sarah, Sam, Sally, Susie	Tax dependent, tax-filer parents and other tax dependent

B. Parent, Stepparent, and Parent's Child (not child of stepparent)

John and Joan are a married couple. They file taxes jointly and claim Joan's son by a first marriage, JP age 17, as a tax dependent. All of them applied for MA.

The tax household includes John, Joan and JP. Since no one is claimed as a tax dependent by anyone else, the tax household and MAGI household are the same.

Ask the following questions for each tax dependent to determine if exceptions exist:

- Is JP the tax dependent of someone other than a spouse or a biological, adopted, or stepparent? No
- Is JP a child living with both parents, but the parents do not expect to file a joint tax return? No
- Is JP a child who expects to be claimed by a non-custodial parent? No

The following table shows each person's tax filer household:

Person	# - Household Composition	Reason
John	3 - John, Joan, JP	Tax-filer & dependents
Joan	3 - Joan, John, JP	Tax-filer & dependents
JP	3 - JP, Joan, John	Tax dependent and tax-filer parents

C. Husband and Wife (Childless Adults)

Regina and Tyrone, both age 33, are a married couple. Regina is unemployed. The couple file taxes together. Both applied for MA.

Person	#-Household Composition	Reason
<i>Regina</i>	<i>2-Regina, Tyrone</i>	<i>Tax-filers</i>
<i>Tyrone</i>	<i>2-Tyrone, Regina</i>	<i>Tax-filers</i>

D. Father and Child

Elyse, age 20, is single and lives with her father. Her father does not claim her on his taxes. Elyse applied for MA.

Person	# - Household Composition	Reason
<i>Elyse</i>	<i>1-Elyse</i>	<i>Tax-filer</i>

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M0430.300 NON TAX FILER HOUSEHOLD EXAMPLES

A. Example for non-filer HH with child over age 19

Jill lives with her daughter, Lea, age 24 and her son, Mike, age 15. Lea and Mike's father is deceased. Jill and Mike receive Social Security survivor's benefits. They do not file taxes. All applied for MA. The following table shows each person's MAGI household:

For individuals who neither file a tax return nor are claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, the household consists of the individual and, if living with the individual:

- the individual's spouse
- the individual's natural, adopted and stepchildren under the age 19
- the individual's natural, adopted and stepparents and natural, adoptive and step siblings under the age of 19.

Person	# - Household Composition	Reason
Jill	2 Jill, Mike	Non tax filer household-parent and child under age 19
Mike	2 Mike, Jill	Non tax filer household-child under age 19 and parent
<i>Lea</i>	<i>1-Lea</i>	<i>Non-filer over age 19 (MAGI Adults)</i>

B. Married Parents and Their Dependent Children

Josh and Penny are a married couple. They live with their children Daisy and Kate, both under age 18. They do not expect to file federal taxes this year so non-filer rules are used. All applied for MA. The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Josh	Josh, Penny, Daisy, Kate	Non -filer household-married parents living with 2 children in common
Penny (Spouse)	Josh, Penny, Daisy, Kate	Non- filer household-married parents living with 2 children in common
Daisy	Josh, Penny, Daisy, Kate	Non- filer household-married parents living with 2 children in common
Kate	Josh, Penny, Daisy, Kate	Non- filer household-married parents living with 2 children in common

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C. Parent, Stepparent, and Parent's Child (not child of stepparent)

Paul and Pattie are a married couple. They live with Pattie's son by a first marriage, Edgar age 17. They do not plan to file taxes this year. The household for the MAGI determination is the non-filer household which includes Paul (stepparent/spouse), Pattie (parent/spouse) and Edgar (child/stepchild). All of them applied for MA. The following table shows each person's tax filer household:

Person	# - Household Composition	Reason
Paul	3-Paul, Pattie, Edgar	Non filers – spouses, parent, stepparent and child/stepchild under age 19
Pattie	3-Pattie, Paul, Edgar	Non filers - spouses, parent, stepparent and child/stepchild under age 19
Edgar	3-Edgar, Paul, Pattie	Non filer lives with parents

M0430.400 TAX FILER AND NON TAX FILER HOUSEHOLD EXAMPLES

A. Parent and Child Claimed by Non-custodial Parent

Linda and her daughter, Liza (age 6), live in the home. Linda works and claims only herself as a tax dependent. Liza is claimed by her father who does not live in the home. Both applied for MA.

Linda is a tax filer claiming only herself. Her tax household and MAGI household are the same. Liza is a tax dependent claimed by a non-custodial parent so a tax dependent exception exists and non-filer rules must be used. The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Linda	1– Linda	Tax-filer with no tax dependent
Liza	2 – Liza, Linda	Non-filer child and parent living in the home

B. Three Generation Household – Grandmother is Tax Filer

Mary is a working grandmother who claims her daughter, Samantha, age 20 and a full-time student, and granddaughter, Joy, age 2 as tax dependents. Although Samantha has a part-time job, she is not required to file taxes. All applied for MA.

The tax household includes Mary (the tax filer), Samantha (Mary's dependent child), and Joy (Mary's tax dependent). Mary's MAGI household is the same as her tax household and includes Mary, Samantha and Joy. Samantha's MAGI household is the same as Mary's because Samantha is a tax dependent and no tax dependent exceptions exist. Joy's is also a tax dependent, but meets an exception because she is not the child of the tax filer. Her MAGI household is a non-filer household and includes just Samantha and Joy; parent and child living in the home.

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The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Mary	3 – Mary, Samantha, Joy	Tax-filer & dependents
Samantha	3 – Samantha, Mary, Joy	Tax-filer & dependents
Joy	2 – Joy, Samantha	Non-filer parent and child

C. Three Generation Household – Second Generation Tax Filer

Rose is a tax dependent of her daughter, Lee, age 18. Lee works and claims her son, Peter, and Rose as tax dependents. All applied for MA.

The tax household includes Lee (tax filer), Rose (tax dependent), and Peter (tax dependent). Rose is not the child of the tax filer so a tax dependent exception exists and non-filer rules are used for her MAGI household. Lee is a tax filer with dependents so her MAGI household is the same as her tax household. Peter is a tax dependent living with his tax filer parent so his MAGI household is the same as the tax household.

The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Rose	2– Rose and Lee	Non-filer, has child under age 19
Lee	3 – Lee, Rose and Peter	Tax-filer with dependents
Peter	3 – Peter, Lee and Rose	Tax dependent lives with tax-filer parent and parent's other tax dependent

D. Two Parents Not Married To Each Other, One Is Tax Filer With Children, One Is Child Of One Parent And Other Is Child-In-Common

Bob and Ann live together with Bob's son, John age 14, and their child-in-common, Jane age 12. Ann works and files taxes claiming both children as dependents. Bob does not file taxes. All applied for MA.

Bob is a non-filer and is not claimed as a tax dependent of anyone. His MAGI household uses non-filer rules and includes Bob and his children living in the home. Ann is a tax filer with tax dependents; her MAGI household is the same as her tax household. John is a tax dependent of someone other than his parent so non-filer rules are used. John's MAGI household includes John, his father Bob and his sibling Jane. Jane is a tax dependent of her tax filer mother, but her parents are not filing jointly so non-filer rules are used and her MAGI household includes her parents and siblings.

The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Bob	3 - Bob, John and Jane	Non-filer with children
Ann	3 – Ann, John and Jane	Tax filer and her dependents
John	3 - John, Bob, and Jane	Non-filer with parent and siblings-no direct relation to tax filer Ann
Jane	4 – Jane, Bob, Ann and John	Non-filer child with 2 parents and half-sibling

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E. Two Parents Not Married To Each Other, Both File Taxes; 1 Child-In-Common, One Child Not In Common; Mom Is Pregnant

Jill and Max are both tax filers. Also in the home are Max's son, Mark and their child-in-common, May. Jill is pregnant, expecting 1 baby. Max claims both children on his taxes. All applied for MA.

Jill is a tax filer who claims no additional dependents. Her MAGI household is the same as her tax household for Medicaid coverage in the LIFC covered group and includes her unborn child when determining her eligibility as a pregnant woman. Max is a tax filer with two dependent children; his MAGI household is the same as his tax household. Mark is a tax dependent living with his tax filer parent and no exceptions exist; his MAGI household is the same as the tax household. May is a tax dependent, but her parents are not filing jointly so an exception exists and non-filer rules are used for her MAGI household.

The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Jill	2 – Jill and 1 unborn	Tax-filer pregnant woman; no other dependents
Jill	1 – Jill	Tax filer household for determining eligibility as LIFC
Max	3 – Max, Mark and May	Tax filer and two dependent children
Mark	3 – Mark, Max and May	Tax filer rules, tax household rules for person filing for him
May	4 – May, Max, Jill and Mark	Non-filer rules child with parents not filing jointly, non-married parents and half sibling.

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

Gerry and Bree are married and file their taxes jointly. Also in the home is their son, Tad age 7, whom they claim as their dependent. They also claim Gerry's daughter, Tansy age 10, who does not live with them. Gerry, Bree and Tad applied for MA.

Gerry and Bree are tax filers who are married, filing jointly claiming two dependent children. Their MAGI household is the same as their tax household.

Tad is a tax dependent child and no tax dependent exceptions exist; Tad's MAGI household is the same as the tax household. The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Gerry	4 – Gerry, Bree, Tad and Tansy	Tax filers and dependent children
Bree	4 – Gerry, Bree, Tad and Tansy	Tax filers and dependent children
Tad	4 – Gerry, Bree, Tad, Tansy	Tax filer and dependents

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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 a data match with the federal Hub. If no data sources exists to verify the attestation,

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and the attestation is below the medical assistance income level, documentation of income is required.

The reported income of a child must be verified regardless of whether or not the attested income is above or below the tax-filing threshold amount. *Effective January 1, 2019, the tax filing threshold will change from \$10,400 to \$12,000.*

If an income calculation must be made, use the information in subchapter M0710 for estimating income, subchapter M0720 for sources of earned income, and subchapter M0730 for sources of unearned income with the exceptions in B. below. The sources of income listed in this section are organized in table form in M04, Appendix 7.

B. MAGI Income Rules

1. Income That is Counted

- a. Gross earned income is counted. There are no earned income disregards.
- b. Earnings and unearned income, including Social Security benefits, of everyone in the household are counted, except the income of
 - a tax dependent who is claimed by his parent(s), or
 - a child under 19 in a non-filer household who is living with a parent or parents

who is not required to file taxes because the tax filing threshold is not met.
- c. Income of a child under 19 in a non-filer household who is NOT living with a parent or parents and who is not required to file taxes because the tax filing threshold is not met. Any Social Security benefits the child may have do not count in determining whether or not the tax filing threshold is met.
- d. Interest, including tax-exempt interest, *is* counted.
- e. *Foreign income is counted.*
- f. Stepparent income is counted.
- g. *Effective January 1, 2019, alimony received will no longer be counted as income. Alimony **received prior to January 1, 2019** is counted. An individual whose divorce decree was finalized prior to that date has the option with the IRS to adopt this new rule. If the individual does not want alimony to be countable for Medicaid purposes, the individual must provide a copy of the modified agreement to the eligibility worker.*
- h. An amount received as a lump sum is counted only in the month received.

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2. 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 pub 907 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,
 - 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. *Effective January 1, 2019, no deduction is allowed for alimony paid. Prior to January 1, 2019, alimony **paid** to a separated or former spouse outside the home is deducted from countable income.*
- f. Child support paid is **not** deducted from income.
- g. Interest paid on student loans is deducted from countable income.
- h. Gifts, inheritances, and proceeds from life insurance are not counted.
- i. A parsonage allowance is not counted.
- j. Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are not counted.
- k. *Effective January 1, 2019, student loan debt forgiven due to death or disability of student is not counted as income.*

3. Income From Self-employment

An individual reporting self-employment income must documentation of business expenses and income, such as IRS Form 1040 for the adjusted gross income, Schedule C (business expenses), Schedule E (expenses from rental income) and Schedule F (expenses from farming). If the individual alleges that his current income is not accurately represented by tax records, obtain additional information (such as business records) that documents current income.

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Business expenses are expenses directly related to producing goods or services and without which the goods or services could not be produced. Allowable business expenses include, but are not limited to, the following:

- payments on the interest of the purchase price of, and loans for, capital assets such as real property, equipment, machinery and other goods of a durable nature;
- insurance premiums;
- legal fees;
- expenses for routine maintenance and repairs;
- advertising costs;
- bookkeeping costs.
- depreciation and capital losses. If the losses exceed income, the resulting negative dollar amount offsets other countable income.

Expenses that are not deducted for MAGI purposes include the following: payments on the principal of the purchase price of, and loans for, capital assets, such as real property, equipment, machinery and other goods of a durable nature; the principal and interest on loans for capital improvements of real property; net losses from previous periods; federal, state, and local taxes; personal expenses, entertainment expenses, and personal transportation; and money set aside for retirement purposes.

4. Private Accident/Health Plan Benefits

Private accident, health plan, and disability benefits are benefits paid from a plan provided by an employer or purchased by the individual. Social Security benefits and Supplemental Security Income (SSI) are not private benefits.

Benefits received for personal injury or sickness through an accident or health plan that is paid for by an employer are countable income.

If the individual pays the entire cost of the accident or health plan, benefits received from the plan are NOT income.

If both the employer and the individual pay for the plan, only the benefits received through the employer's payments are income.

5. American Indian-Alaska Native Payments

In addition, the following payments to American Indian/Alaska Natives are not counted as income:

- a. distributions received from the Alaska Native Corporations and Settlement Trusts (Public Law 100-241),
- b. distributions from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the Supervision of the Interior,

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- c. distribution and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extractions and harvest from:
 - rights of any lands held in trust located within the most recent boundaries of a prior Federal reservation or under the supervision of the Secretary of the Interior,
 - federally protected rights regarding off-reservation hunting, fishing, gathering or usage of natural resources,
 - distributions resulting from real property ownership interests related to natural resources and improvements,
 - located on or near a reservation of within the most recent boundaries of a prior Federal reservation, or
 - resulting from the exercise of federally-protected rights relating to such property ownership interests.
- d. payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or right or rights that support subsistence or a traditional lifestyles according to applicable Tribal Law or custom.
- e. Student financial assistance provided under the Bureau of Indian Affairs Education Program.

6. Income from Crowdsourcing

Crowdsourcing or crowdfunding is a practice to raise funds online for donations, fund a project, or underwrite a venture by requesting small amounts of money from a large number of people. Examples of crowdsourcing websites include GoFundME, YouCaring, Kickstarter, or IndieGoGo. The treatment of the funds as income depends on the reason the funds were solicited.

If the individual or someone on his behalf is raising donations to go toward medical costs or bills, money raised is considered a gift and is not countable under MAGI rules.

If there is an exchange of goods or services, money raised is considered earned income and is countable. Funds deposited into an account to which the individual has access and which the individual has control over the use of are countable in the month of receipt. Platform fees or costs, including the cost per transaction, percentage of donation to the online host site, and costs to a payment processor, are not counted as income.

C. Monthly Income Determinations

Medicaid and FAMIS income eligibility is determined using current monthly income. **Sources and amounts of income that are verified electronically and are reasonably compatible do not require additional verification.**

When income cannot be verified electronically **or** the information reported is not reasonably compatible (see M0420.100 for the definition), the individual must be asked to provide current verification of the household income so a point-in-time income eligibility determination can be made.

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- D. Steps for Calculating MAGI** For non-filers or any other individuals whose income cannot be verified by the Hub, use the following steps for calculating an individual's MAGI. Subtract any deductions listed below if they are reported by the individual.

For tax filers whose income is verified in the Hub as being reasonably compatible, no MAGI calculation is required.

<p>Adjusted Gross Income (AGI)</p> <p>Line 4 on Internal Revenue Service (IRS) Form 1040 EZ</p> <p>Line 21 on IRS Form 1040A</p> <p>Line 37 on IRS Form 1040</p>	<p>Include:</p> <ul style="list-style-type: none"> • Wages, salaries, tips, etc • Taxable interest • Taxable amount of pension, annuity or Individual Retirement Account (IRA) distributions and Social Security benefits • Business Income, farm income, capital gain, other gains (or loss) • Unemployment Compensation • Ordinary dividends • Rental real estate, royalties, partnerships • S corporations, trusts, etc. • Taxable refunds, credits, or offset of state and local income taxes • Other income 	<p>Deduct:</p> <ul style="list-style-type: none"> • Certain self-employment expenses • Student loan interest deduction • Educator expenses • IRA deduction • Moving expenses • Penalty on early withdrawal of savings • Health savings account deduction • Domestic production activities deduction • Certain business expenses of reservists, performing artists, and fee-basis government officials • Alimony paid <i>prior to January 1, 2019</i> (but not child support paid)
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Note: Check the IRS website for detailed requirements for the income and deduction categories above. Do not include Veteran's disability payments, Worker's Compensation or child support received. Pre-tax contributions, such as those for child care, commuting, employer-sponsored health insurance, flexible spending accounts and retirement plans such as 401(k) and 403(b), are not included in AGI but are not listed above because they are already subtracted out of W-2 wages and salaries.

<p>Add (+) back certain income</p>	<ul style="list-style-type: none"> • Non-taxable Social Security benefits (line 20a minus 20b on Form 1040) • Tax –exempt interest (Line 8b on Form 1040) • Foreign earned income and housing expenses for Americans living abroad (calculated in IRS Form 2555)
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<p>Exclude (-)from income</p>	<ul style="list-style-type: none"> • Social Security benefits received by a child are not countable for his eligibility when a parent is in the household, unless the child is required to file taxes. • Scholarships, awards, or fellowship grants used for education purposes and not for living expenses • Certain American Indian and Alaska Native income derived from distributions, payments, ownership interests, real property usage rights and student financial assistance • Gifts, inheritances, and proceeds from life insurance • An amount received as a lump sum is counted only in the month received. • <i>Parsonage allowance</i> • <i>Effective January 1, 2019, student loan debt forgiven due to death or disability of student is not counted as income.</i>
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M0450.100 STEPS FOR DETERMINING MAGI-BASED ELIGIBILITY

A. Determine Household Composition

1. **Does the individual expect to file taxes?**
 - a. If No - Continue to Step 2
 - b. If Yes - Does the individual expect to be claimed as a tax dependent by anyone else?
 - 1) If No - the household consists of the tax filer, a spouse living with the tax filer, and all persons whom the tax filer expects to claim as a tax dependent. For a tax filer under age 19, parents living in the home are also in the individual's household.
 - 2) If Yes - Continue to Step 2

2. **Does the Individual Expect to be Claimed As a Tax Dependent?**
 - a. If No - Continue to Step 3
 - b. If Yes - Does the individual meet any of the following exceptions?
 - 1) the individual expects to be claimed as a tax dependent of someone other than a spouse or a biological, adopted, or stepparent;
 - 2) the individual is a child (under age 19) living with both parents, but the parents do not expect to file a joint tax return; or
 - 3) the individual is a child who expects to be claimed by a non-custodial parent?
 - i. If no - the household is the household of the tax filer claiming her/him as a tax dependent.
 - ii. Is the individual married? If yes – does the household also include the individual's spouse?
 - iii. If yes - Continue to Step 3.
 - 4) the child is a Special Medical Needs AA child?

If yes, continue to Step 3 below.

3. **Individual Is Neither Tax Filer Nor Tax Dependent Or Meets An Exception In 2. b Above**

For individuals, other than Special Medical Needs AA children, who neither expect to file a tax return nor expect to be claimed as a tax dependent, as well as tax dependents who meet one of the exceptions in 2.b above, the household consists of the individual and, if living with the individual:

 - the individual's spouse;
 - the individual's natural, adopted and step children under the age 19; and
 - In the case of individuals under age 19, the individual's natural, adopted and stepparents and natural, adoptive and stepsiblings under age 19.

The household of a Special Medical Needs AA child consists only of the child.

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B. Determine the MA Income for Each Member of the Household

1. Is Any Household Member The Child Or Expected Tax Dependent Of Another Member Of The Household?

- a. If yes - is the individual expected to be required to file a tax return?
- 1) If yes, continue to Step 2 and include child's income in total household income.
 - 2) If no, continue to Step 2, but do not include child's income in total household income.
- b. If no, continue to Step 2.

2. Determine MAGI Income For Each Member

Determine MAGI-based income of each member of the individual's household, unless income of such member is flagged as not being counted in step 1. Recall that, for purposes of MA eligibility, the following rules apply:

- An amount received as a lump sum is counted as income only in the month received.
- Scholarships, awards or fellowship grants used for education purposes and not for living expenses are excluded from income.
- Certain distributions, payments and student financial assistance for American Indians/Alaska Natives are excluded from income.
- Child support is not countable income.
- Social Security benefits received by a child are not countable for his eligibility when a parent is in the household, unless the child is required to file taxes.
- Interest paid on student loans is deducted from income.
- Foreign income and interest, including tax-exempt interest, are counted.

3. Using the 5% of FPL Disregard

If the individual's household income is over the income limit for his covered group, subtract an amount equal to 5% of FPL for his household size (see M04, Appendix 1). Compare the countable income against the income limit for the individual's covered group to determine his income eligibility.

If the individual meets multiple Medicaid covered groups (and/or FAMIS) his gross income is compared first to the income limit of the full-benefit covered group with the highest income limit for which the individual could be eligible. If the income exceeds the limit, subtract 5% FPL based on his household size and compare the income again to the income limit. If he is still not eligible, the same process is followed for Plan First, if the individual is age 19 through 64 years.

C. Household Income

Household income is the sum of the MAGI-based income for every member of the individual's household as determined in step 2 above.

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M0450.200 INCOME EXAMPLES – TAX FILER HOUSEHOLDS

**A. Example #1
Tax Filer Single
Parent, Two Children
(Using Jan. 18, 2018
figures)**

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

The MAGI households are:

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

Tom (parent) eligibility determination:

Potential covered groups:

- LIFC (full-coverage MA)
- MAGI Adults (full-coverage-MA)
- Plan First (limited coverage)

Monthly Income limits:

- LIFC, Group II for HH of 3 = \$589
- MAGI Adults for HH of 3=\$2,391
- Plan First 200% FPL for HH of 3 = \$3,464
- 5% FPL Disregard for HH of 3 = \$86

Tom's gross HH income of \$3,000.00 exceeds the LIFC income limit of \$589 for a HH of 3, so he is entitled to a 5% FPL disregard.

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

His countable income of \$2,914.00 is compared to the LIFC income limit for HH of 3 which is \$589 ; income exceeds the LIFC limit. Tom is not eligible for full-coverage MA.

His countable income of \$2,914 is compared to the MAGI Adult income limit for household of 3 which is \$2,391. Toms income exceeds the MAGI Adult, therefore making him ineligible for full coverage MA

Tom's gross HH income of \$3,000.00 is then compared to the Plan First 200% FPL income limit for 3 which is \$3,464. As his income is under the limit, no disregard is needed; Tom is eligible for Plan First.

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

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Jack (child) eligibility determination:

Potential covered groups:

Child < Age 19
FAMIS

Monthly Income limits:

Child < 19 143% FPL for a HH of 3 = \$2,477
FAMIS 200% FPL for HH of 3 = \$3,464
5% FPL Disregard for HH of 3 = \$86

The gross HH income for Jack of \$3,000 (his father's earnings) exceeds the Medicaid Child < Age 19 143% FPL income limit for 3 (\$2,477), so Jack is entitled to the 5% disregard.

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

The countable income of \$2,914.00 still exceeds the Medicaid Child < Age 19 143% FPL limit (\$2,477), Jack is not eligible for Medicaid.

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

Betty (child) eligibility determination:

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

**B. Example #2
Tax Filer/Three
Generation Household**

**(Using Jan. 18, 2018
figures)**

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

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

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

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

Mary’s eligibility determination:

Potential covered groups:

Plan First
MAGI Adult

Monthly Income Limits:

Plan First income limit for HH of 3 = \$3,464
MAGI Adult income limit for HH of 3=\$2,391
5% FPL Disregard for HH of 3 = \$86

HH gross monthly income:

\$4,500 Mary’s earnings
(Samantha’s earnings are excluded because she is a child for tax purposes and is not required to file taxes).

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

Her gross income of \$4,500 is compared to the MAGI Adult income limit for household of 3 which is \$2,391. Mary’s income exceeds the MAGI Adult limit.

After subtracting the 5% FPL disregard, the countable income of \$4,414.00 is then compared to the MAGI Adult income limit of \$2,391 and her countable income exceeds the MAGI Adult limit, Mary is not eligible for full coverage MA.

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

The countable income of \$4,414.00 is then compared to the Plan First income limit of \$3,464; but as her countable income exceeds the Plan First limit, Mary is not eligible for Plan First.

Mary is referred to the HIM

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Samantha's eligibility determination:

Potential covered groups:

LIFC
MAGI Adult
Plan First.

Monthly Income limits:

LIFC, Group I for HH of 3 = \$484
MAGI Adult income limit for HH of 3=\$2,391
Plan First for HH of 3 = \$3,464
5% FPL Disregard for HH of 3 = \$86

HH monthly income:

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

As \$4,500 exceeds the LIFC limit for 3 (\$484) she is entitled to the 5% FPL disregard. Her income eligibility is determined as follows:

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

Samantha's countable income of \$4,414 still exceeds the LIFC income limit for 3 of \$484 so she is not eligible for LIFC (full-coverage) MA.

Her countable income of \$4,414 is compared to the MAGI Adult income limit for household of 3 which is \$2,391. Mary's income exceeds the MAGI Adult limit, therefore, making her ineligible for full coverage MA

The gross HH income of \$4,500.00 is compared to the Plan First 200% FPL income limit for 3 which is \$3,464, and as Samantha exceeds this amount, the 5% FPL Disregard (\$86) can be deducted. The countable income of \$4,414 is greater than the Plan First income limit of \$3,464. Samantha is not eligible for Plan First, and is referred to the HIM.

An alternate method, which accomplishes the same results, is to compare the Plan First 205% FPL (200% FPL + 5% FPL Disregard) for a HH of 3 which is \$3,551. As the countable income amount of \$4,500 is greater the income limit of \$3,551, Samantha is not eligible for Plan First, and is referred to the HIM.

Joy's eligibility determination

HH gross monthly income:

\$300 Samantha's earnings (Mary's income is not counted in this HH).

Potential covered group:

Child < Age 19

The HH income is \$300 which is less than the Medicaid Child < Age 19 limit for 2 (\$1,936). Joy is eligible for Medicaid in the Child < Age 19 covered group.

The 5% disregard is not necessary since the gross household income is within the Medicaid Child < Age 19 income limit.

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**C. Example # 3
Tax Filer with
Dependent Outside of
the Home (Using
January 18, 2018
figures)**

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

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

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

John's eligibility determination:

Potential covered groups:

LIFC
MAGI Adult
Plan First

Monthly income limits:

LIFC (Group III) HH of 3 = \$807
MAGI Adult income limit for HH of 3=\$2,391
Plan First HH of 3 = \$3,464
5% FPL Disregard for HH of 3 = \$86

John's gross HH income of \$1,425.00 exceeds the LIFC income limit for 3 of \$807, and he is entitled to the 5% FPL disregard.

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

His countable income of \$1,339 is less than the MAGI Adult limit of \$2,304 for 3. John is eligible for full coverage in the MAGI Adult coverage group.

Bridget's eligibility determination

Bridget was not applied for.

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Richards's eligibility determination:

Potential covered groups:

Child < Age 19
FAMIS

Monthly Income limits:

Child < 19 - 143% FPL for a HH of 3 = \$2,477
FAMIS 200% FPL for HH of 3 = \$3,464
5% FPL Disregard for HH of 3 = \$86

Richard's gross HH income of \$1,425 (his father's and sibling's earnings) is less than the FAMIS 200% income limit of \$3,464. And as the HH income does not exceed the Medicaid Child < Age 19 income of \$2,477, the 5% disregard is not needed. Richard is eligible for full-coverage MA.

M0450.300 INCOME EXAMPLES – NON TAX FILER HOUSEHOLDS

A. Example #1

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

**Non Tax Filer Single
Parent, Two Children
(Using Jan. 18, 2018
figures)**

The MAGI households are:

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

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HH income:

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

Robb's gross HH's of \$3,400 monthly income exceeds the LIFC income limit for 3 of \$589 per month, thus entitled to the 5% disregard. His income eligibility is determined as follows:

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

As his countable income exceeds the LIFC income limit of \$589, he is ineligible for full coverage MA.

His gross income of \$3,400.00 is compared to the MAGI Adults income limit for household of 3 which is \$2,391. After applying the 5% disregard, Robb's income exceeds the MAGI Adults limit. Robb is ineligible for full coverage MA.

His gross HH income of \$3,400.00 is then compared to the Plan First 200% FPL income limit for 3 of \$3,464. As the income is less than the Plan First income limit, he is eligible for Plan First. Robb is also referred to the HIM.

Mike's eligibility determination:

Potential covered groups:

Child < Age 19
FAMIS

Monthly Income limits:

Child < Age 19, 143% FPL for a HH of 3 = \$2,477
FAMIS, 200% FPL for HH of 3 = \$3,464
5% FPL for 3 = \$86

HH income:

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

Mike's gross HH's \$3,400 monthly income exceeds the Medicaid Child < Age 19 143% FPL income limit for 3, \$2,477, so he is entitled to the 5% disregard. Mike's income eligibility is determined as follows:

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

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Mike's countable income of \$3,314.00 exceeds the Medicaid Child < Age 19 143% FPL income limit for 3, \$2,477. Mike is not eligible for Medicaid.

His gross HH income of \$3,400.00 is then compared to the FAMIS 200% FPL income limit for 3, \$3,464. He is eligible for FAMIS because his gross HH income is less than the FAMIS income limit for the household size.

Ike's income eligibility determination:

Potential covered groups:

Child < Age 19
FAMIS

Monthly Income limits:

Child < Age 19, 143% FPL for a HH of 3 = \$2,477
FAMIS, 200% FPL for HH of 3 = \$3,464
5% FPL for 3 = \$86

HH income:

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

Ike's countable income of \$3,314.00 exceeds the Medicaid Child < Age 19 143% FPL income limit for 3, \$2,477. Mike is not eligible for Medicaid.

As his gross monthly income exceeded the Medicaid Child < Age 19 143% income limit of \$2,477, he is entitled to the 5% disregard. Ike's income eligibility is determined as follows:

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

As his countable income exceeds the income limit of \$2,477, he is ineligible for Medicaid child <19, and move to the next step.

His gross HH income of \$3,400.00 is compared to the FAMIS 200% FPL income limit for 3 of \$3,464. He is eligible for FAMIS because his gross HH income is less than the FAMIS income limit for the household size of 3.

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

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**B. Example #2
Non Tax Filer Three
Generation Household
(Using Jan. 18, 2018
figures)**

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

Income:

Sally receives SSA widow's benefits of \$1,000 per month.

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

The MAGI non-filer households are:

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

Sally's eligibility determination:

Potential covered groups:

Plan First

MAGI Adult

Monthly Income limits:

MAGI Adult income limit for HH of 1=\$1,346

Plan First 200% FPL income limit for HH of 1 = \$2,024

5% FPL for 1 = \$51

HH gross monthly income = \$1,000 Sally's SSA benefits

Her gross income of \$1,000 is less than the MAGI Adult limit of \$1,346 for 1. Sally is eligible for full coverage in the MAGI Adult coverage group.

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Jane's eligibility determination:

Potential covered groups:

LIFC
MAGI Adult
Medicaid Pregnant Women

Monthly Income limits:

LIFC, Group I for HH of 2 = \$381
Pregnant Women 143% FPL for a HH of 3 = \$2,477
MAGI Adult income limit for HH of 3 = \$2,391
5% FPL for 3 = \$86

HH monthly income = \$300 Jane's income.

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

\$300 is less than the LIFC limit for 2 (\$381) so the 5% disregard is not applied (it is not necessary). Jane is eligible for Medicaid in the LIFC covered group.

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

Dee's eligibility determination:

Potential covered groups:

Child < Age 19
FAMIS

Monthly Income limits:

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

HH monthly income:

\$300 (Jane's gross earnings)

As HH income \$300 is less than the Medicaid Child < Age 19 143% FPL income limit for 2 (\$1,962), Dee is eligible for Medicaid. The 5% disregard is not necessary since she qualified in this aid category.

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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 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.
- Current monthly household income, using Medicaid/FAMIS MAGI-based methods is over the applicable 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*

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

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.

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.

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C. Household Income Calculation

Under the gap-filling rule, financial eligibility for Medicaid and FAMIS is determined using household income as calculated by the federal HIM for APTC purposes.

Tax-filer rules for determining household composition are used. 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.

- Virginia Employment Commission (VEC) income data may be used to the extent that the verified income was earned in the calendar year in which benefits are sought.
- Income cannot be verified by a match with IRS data contained in the federal HUB since IRS data is based on income received for the previous year.

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:

- Payments made to American Indian/Alaska Natives as described in M0440.100 B.5.
- Scholarship 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.

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3. Income Evaluation

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

- First, add together income already received for the year. Do not convert the income.
- Next, calculate the projected income for the remainder of the year based on the current monthly income, unless the individual's income is expected to change (e.g. current employment is terminating).
- Add income already received to projected income to obtain the income for the calendar year.
- For the individual to be eligible for Medicaid or FAMIS, the countable income must be no more than the income limit for the individual's covered group. The 5% income disregard used for the Medicaid/FAMIS MAGI determination does not apply. See M04 Appendices 2-6 for income limits.

4. Renewals

A renewal of eligibility must be completed in January of the following year and annually thereafter. Evaluate the individual's eligibility using Medicaid/FAMIS MAGI methodology before applying gap-filling methodology. A gap-filling evaluation may not be necessary for future eligibility determinations/renewals since tax dependency status and/or income may have changed.

5. Individual Not Eligible Using Gap-filling Methodology

If the individual's household income is determined to be over the Medicaid and FAMIS income limits after the gap-filling rule evaluation or the individual does not provide the necessary verifications for the gap-filling evaluation **and** he meets a MN covered group, he must be offered the opportunity to be placed on a MN spenddown.

D. Example Situation – Coverage Gap and Gap Filling Rule

A 10-year-old child lives with both parents, who are not married, and the child is expected to be claimed as a tax dependent by one parent. His parents apply for the APTC through the federal HIM. The HIM only processes applications for tax filers because the APTC only applies to tax filing households. The child is determined to not be eligible for the APTC because his countable income is below the lower income threshold (it is too low) for APTC eligibility

The HIM makes an application referral to Virginia for a Medicaid/FAMIS eligibility determination. The child meets a tax dependent exception in M0430.100 B.2 (he lives with both parents, is claimed as a tax dependent by one parent, and the parents do not expect to file jointly). The child's eligibility for Medicaid or FAMIS is determined using non-filer methodology. Because he is under 19 and both parents are in his household, the income of both parents is counted. His household income with the 5% FPL disregard is over the limit for both Medicaid and FAMIS.

Since the child does not qualify for the APTC because his countable income is under the lower financial threshold for the APTC AND he has excess income using non-filer rules household composition/ income rules, the gap-filling rule must be applied.

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E. Example – Gap Filling Evaluation

Maria and Tony are an unmarried couple who live with their 12-year-old daughter, Anita. Maria and Tony are both employed. Anita is claimed as a tax dependent by Maria, who works part time. Maria applies for Medicaid only for Anita. Because Anita lives with both parents, but the parent’s file taxes separately and only one parent claims her as a tax dependent, Anita meets a tax dependent exemption. Her eligibility must be evaluated using non-filer rules.

Because she is under age 19, Anita’s MAGI household consists of Anita and both parents. Both Maria’s and Tony’s income is counted for Anita’s eligibility. Her countable income, including with the 5% FPL disregard, is over the limits for both Medicaid and FAMIS.

The eligibility worker notes that a potential gap-filling situation exists. The worker evaluates Anita’s eligibility for Medicaid or FAMIS using the APTC rules. Under the APTC rules, Anita’s household consists of Anita (tax dependent) and Maria (tax filer); Tony is not in Anita’s household because he does not claim Anita on his taxes. Maria’s income from her part time job is under 100% FPL. Therefore, Anita is eligible for Medicaid under the gap-filling rule. The eligibility worker enrolls Anita in Medicaid.

The following tables show the household formation and income used.

For the Medicaid/FAMIs evaluation:

Person	# - MAGI Household Composition Non-filer rules	Income to count for Medicaid/FAMIS eligibility
Anita	3 – Anita, Maria, Tony	Maria, Tony

For the gap-filling evaluation

Person	# - APTC Household Composition	Income to count for Medicaid/FAMIS eligibility
Anita	2 – Maria, Anita	Maria, and (non-excluded) income from Anita

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PREGNANT WOMEN 143% FPL INCOME LIMITS ALL LOCALITIES EFFECTIVE 1/18/18		
Household Size	143% FPL Monthly Amount	148% FPL (143% + 5% disregard)
2*	\$1,962	\$2,031
3	2,477	2,564
4	2,992	3,027
5	3,506	3,629
6	4,021	4,162
7	4,536	4,695
8	5,051	5,228
Each additional, add	515	533

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

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Subchapter Subject M04 MODIFIED ADJUSTED GROSS INCOME (MAGI)	Page ending with Appendix 7	Page 1

MAGI Adults Covered Group 133% FPL (+ 5% disregard If Over Limit) ALL LOCALITIES EFFECTIVE 1/1/19		
Household Size	133% FPL Monthly Amount	138% FPL (133%FPL + 5% disregard)
1	\$1,346	\$1,397
2	1,825	\$1894
3	2,304	\$2391
4	2,782	\$2887
5	3,261	\$3384
6	3,740	\$3881
7	4,219	\$4378
8	4,698	\$4875
<u>Each additional, add</u>	\$479	\$497

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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	Benefits received by a child with at least one parent/stepparent in household are not countable unless the child is required to file taxes. When the child is in his own household, benefits are always countable.	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	Counted <i>if received prior to January 1, 2019.</i>	Counted – subject to \$50 exclusion if comingled with child support
Alimony Paid	Deducted from income <i>if paid prior to January 1, 2019</i>	Not deducted from income
Worker's Compensation	Not counted	Counted
Veteran's Benefits	Not counted if they are not taxable in IRS pub 907	Counted
Scholarships, fellowships, grants and awards used for educational purposes	Not counted	Not counted
Student Loan Debt	<i>Effective January 1, 2019, student loan debt forgiven due to death or disability of student is not counted as income</i>	<i>Not applicable</i>
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

M0520 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-10	10/1/18	Page 2
TN #DMAS-3	1/1/17	Table of Contents Pages 3, 5-35 Pages 36-38 were removed.
TN #100	5/1/15	Page 2
TN #98	10/1/13	Title Page Table of Contents Pages 1,2,9
UP #7	7/1/12	Table of Contents Pages 2-5
Update (UP) #4	7/1/10	Pages 2, 2a

Manual Title Virginia Medical Assistance Eligibility	Chapter M05	Page Revision Date October 2018
Subchapter Subject M0520.000 F&C MN FAMILY/BUDGET UNIT	Page ending with M0520.001	Page 2

4. Psychiatric Residential Treatment Facilities (PRTFs)

Children residing in Level C PRTFs are not temporarily absent from home. They are indefinitely absent from home and are not living with their parents or siblings for Medicaid purposes, if their stay in the facility has been 30 calendar days or longer. Long-term care rules do not apply to these children.

If the child is placed in a PRTF, verify that it is a Level C facility *on the Magellan website at <https://www.magellanofvirginia.com/providers/residential-program-process>. Click on **Medicaid Contracted Residential Treatments Service Providers**. If the facility is not a Level C facility, the child is NOT considered living away from his parents.*

5. Medical Facilities

Children in medical institutions (facilities) are temporarily absent from home if their stay in the medical facility is less than 30 consecutive days. If the stay has been, or is expected to be, 30 or more consecutive days, go to section M1410.010 to determine if the child is institutionalized in long-term care. A child who is institutionalized in a medical facility or Medicaid waiver services is NOT considered living with his or her parents for Medicaid eligibility purposes.

C. Procedure

This section contains an overview of the F&C family unit and budget unit rules. The detailed policy and procedures are contained in the following sections:

- M0520.010 Definitions;
- M0520.100 Family Unit Rules;
- M0520.200 Budget Unit Rules;
- M0520.300 Deeming From Spouse;
- M0520.400 Deeming From Parent;
- M0520.500 Changes In Status;
- M0520.600 Pregnant Woman Budget Unit;
- M0520.700 Individual Under Age 21 Family Unit.

M0810 Changes

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

Manual Title Virginia Medical Assistance Eligibility	Chapter M08	Page Revision Date October 2018
Subchapter Subject M0810 GENERAL - ABD INCOME RULES	Page ending with M0810.002	Page 2

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

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

Family Size Unit 1	2018 Monthly Amount \$2,250	2017 Monthly Amount \$2,205
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**4. ABD Medically
Needy**

a. Group I	7/1/2018		7/1/2017 – 6/30/18	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	\$ 1,904.55	\$317.42	\$1,867.21	\$311.20
2	2,424.75	404.12	2,377.24	396.20
b. Group II	7/1/2018		7/1/2017 – 6/30/18	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	\$ 2,197.56	\$366.26	\$ 2,154.48	\$359.08
2	2,706.04	451.00	2,653.01	442.16
c. Group III	7/1/2018		7/1/2017 – 6/30/18	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	\$ 2,856.84	\$476.14	\$ 2,800.83	\$466.80
2	3,444.33	574.05	3,376.83	562.80

**5. ABD
Categorically
Needy**

All Localities	2018	2017
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For:

**ABD 80% FPL,
QMB, SLMB, &
QI without Social
Security income;
all QDWI;
effective 1/18/18**

**ABD 80% FPL,
QMB, SLMB, &
QI with Social
Security income;
effective 3/1/18**

ABD 80% FPL	Annual	Monthly	Annual	Monthly
1	\$9,712	\$810	\$9,648	\$804
2	13,168	1,098	12,992	1,083
QMB 100% FPL	Annual	Monthly	Annual	Monthly
1	\$12,140	\$1,012	\$12,060	\$1,005
2	16,460	1,372	16,240	1,354
SLMB 120% of FPL	Annual	Monthly	Annual	Monthly
1	\$14,568	\$1,214	\$14,472	\$1,206
2	19,752	1,646	19,488	1,624
QI 135% FPL	Annual	Monthly	Annual	Monthly
1	\$16,389	\$1,366	\$16,281	\$1,357
2	22,221	1,852	21,924	1,827
QDWI 200% of FPL	Annual	Monthly	Annual	Monthly
1	\$24,280	\$2,024	\$24,120	\$2,010
2	32,920	2,744	32,480	2,707

M1120 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-10	10/1/18	Pages 3, 26
TN #DMAS-8	4/1/18	Page 22a
TN #DMAS-7	1/1/18	Table of Contents i, pages 3, 22a, 30
TN #DMAS-5	7/1/17	Pages 15, 17, 18
TN #DMAS-2	10/1/16	On page 6, updated the format of the header. Neither the date nor the policy was changed.
TN #96	10/1/11	Table of Contents pages 24-26
TN #93	1/1/2010	page 22

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Subchapter Subject IDENTIFYING RESOURCES	Page ending with S1120.010	Page 3

C. Policy – Access to Resources

1. **Access via an Agent**
We consider that an individual has free access to, and unrestricted use of, property even when he/she can take those actions only through an agent; e.g., a representative payee, guardian, etc. (S1120.020). **For real property where reasonable but unsuccessful efforts to sell must be established, see M1130.140.**

2. **Access Only via Litigation**
When there is a legal bar to sale of property (e.g., if a co-owner legally blocks sale of jointly-owned property), we do not require an individual to undertake litigation in order to accomplish sale or access. The property is not a resource under such circumstances in a month if a legal bar exists anytime during that month.

An individual's interest in an unprobated estate is a countable resource. An heir can initiate a court action to partition. If a partition suit is necessary (because at least one other owner or heir to the property will not agree to sell the property) in order for the individual to liquidate the interest, estimated partition costs may be deducted from the property's value.

An applicant or recipient's proportional share of the value of property owned jointly with another person to whom the applicant or recipient is not married as tenants in common or joint tenants with the right of survivorship at common law is counted as a resource unless it is exempt property or is unsalable.

3. **Access via Petition - Conservatorship Accounts**
If State law requires that funds in a conservatorship account be made available for the care and maintenance of an individual, we assume, absent evidence to the contrary, that funds in such an account are available for the individual's support and maintenance and are, therefore, that individual's resource. This is true despite the fact that the individual or his/her agent is required to petition the court to withdraw funds for the individual's support and maintenance. See S1140.215 for instructions concerning conservatorship accounts.

D. Examples

1. **Lack of Ownership**
 - a. **Situation** - In response to unstated income development, Mr. John Hart, explains that his brother, Ted, who lives in an adjacent State, allows him (John) access to his bank account in emergencies. John Hart says he withdraws funds to pay an overdue utility bill to avoid shutoff.

The EW confirms that the account is titled "Ted Hart by Ted Hart or John Hart." John Hart states that he uses the funds solely for his own benefit and not as an agent for his brother.
 - b. **Analysis** - Even though John Hart has unrestricted access to the account and can use the funds at his own discretion, the funds are not his resources because he has no ownership interest in them. The title of the account clearly designates Ted Hart as sole owner. However, whatever funds John withdraws from Ted's account are John's income in the month of the withdrawal.

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Subchapter Subject IDENTIFYING RESOURCES	Page ending with S1120.215	Page 26

F. Example

1. **Situation** Jeff Grant currently works 3 days a week for a company where he has been employed full-time for 20 years. Under his employer's pension plan, Mr. Grant has a \$4,000 retirement fund. The EW confirms that Mr. Grant could withdraw the funds now, but there would be a penalty for early withdrawal and he would forfeit eligibility for an annuity when he stopped working.
2. **Analysis** Since Mr. Grant can withdraw the retirement funds without terminating employment, they are a resource in the amount available after penalty deduction. This is true despite the fact Mr. Grant forfeits eligibility for periodic annuity payments in the future. All sources of available support (unless otherwise excluded) are considered in determining eligibility.

S1120.215 INHERITANCES AND UNPROBATED ESTATES

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

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

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

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

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

C. Operating Policies

1. **When to Develop** We develop for this type of resource only if:
 - the property in question is not excludable under any of the provisions in S1110.210 B.; and
 - counting the property's value would result in excess resources.

M1310 Changes

Changed With	Effective Date	Pages Changed
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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M1310.000 SPENDDOWN GENERAL PRINCIPLES AND DEFINITIONS

M1310.100 GENERAL PRINCIPLES OF MEDICAID SPENDDOWN

A. Introduction

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

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

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

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

B. Applicability

Spenddown applies only to 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.

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.

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

3. MN Children Under Age 18 With \$0 Spenddown Liability Due to differences in income counting methodology applicable to Categorically Needy (CN) and MN covered groups, a child under age 18 may be ineligible for coverage in a CN covered group but have countable income under the income limit for MN coverage. The child's spenddown liability is \$0.00 (zero dollars); therefore, his spenddown is met on the first day of the spenddown period. Enroll the child in two back-to-back six-month periods of coverage, without the need for a new application, and complete an annual renewal. Continue to enroll the child in two consecutive six-month periods of coverage per year as long as he continues to be eligible as MN at renewal. See M0330.803.

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

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

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

M1310.300 SPENDDOWN DEFINITIONS

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

B. Definitions

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

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

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

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- 4. Break in Spenddown Eligibility** A break in spenddown eligibility only occurs after an individual has, at least once, established eligibility by meeting a spenddown in a prior budget period. A break in spenddown eligibility occurs when:
- there is a break between spenddown budget periods;
 - the individual establishes Medicaid eligibility in the ABD 80% FPL covered group or a CN F&C covered group; or
 - the individual does not meet the spenddown liability in a spenddown budget period.
- 5. Budget Period** Budget period means a period of time during which an individual's income is calculated to determine Medicaid eligibility.
- 6. Carry-over Expenses** Carry-over expenses are the balance due on medical, dental, and remedial care expenses incurred in the retroactive or prospective budget periods prior to the current budget period which were not used in establishing eligibility and which may be deducted in consecutive budget periods when there has been no break in spenddown eligibility.
- 7. Consecutive Budget Period** A consecutive budget period is any spenddown budget period that immediately follows a spenddown budget period in which eligibility was established.
- 8. Countable Income** Countable income means, for the medically needy, the amount of the individual's gross income after deducting allowable exclusions that is measured against the medically needy income limit (MNIL).
- 9. Covered Expenses** Covered expenses means expenses for services that are included in the State Plan for Medical Assistance (Medicaid State Plan).
- 10. Current Payments** Current payments are payments made in the current spenddown budget period on expenses incurred before the current spenddown budget period, which were not used in establishing eligibility in a previous spenddown budget period and when there has been a break in spenddown eligibility. The payment amount allowed is the actual payment amount paid to the provider and is deducted from the spenddown liability on the date the payment is actually made.
- 11. First Prospective Budget Period** The first prospective budget period is the spenddown budget period that begins:
- the first day of the month the individual first applied for Medicaid and is placed on spenddown, or
 - the first day of the month after the cancellation of Medicaid coverage due to excess income, or
 - when a new Medicaid application is filed after a break in spenddown eligibility.

M1410 Changes

Changed With	Effective Date	Pages Changed
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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- nursing services for assessments and evaluations
- therapeutic social and recreational programming which provides daily activities for individuals with dementia.

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

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

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

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

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

M1410.050 FINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

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

B. Asset Transfer

The asset transfer policy is found in subchapter M1450.

C. Resources

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

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

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

D. Income

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

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

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

- A. Introduction** *Most Medicaid-eligible individuals must pay a portion of their income to the LTSS provider; Medicaid pays the remainder of the cost of care. The portion of their income that must be paid to the provider is called “patient pay.” Patient pay policy does NOT apply to MAGI Adults.*
- B. Patient Pay** The policies and procedures for patient pay determination are found in subchapter M1470 of this chapter for individuals who do not have community spouses and in subchapter M1480 for individuals who have community spouses.

M1410.100 LONG-TERM CARE APPLICATIONS

- A. Introduction** The general application requirements applicable to all Medicaid applicants/recipients found in chapter M01 also apply to applicants/recipients who need LTSS services. This section provides those additional or special application rules that apply only to persons who meet the institutionalization definition.
- B. Responsible Local Agency** The local social services department in the Virginia locality where the institutionalized individual (patient) last resided outside an institution retains responsibility for receiving and processing the application.
- If the patient did not reside in Virginia prior to admission to the institution, the local social services department in the county/city where the institution is located has responsibility for receiving and processing the application.
- Home and Community-Based Services (HCBS)* applicants apply in their locality of residence.
- ABD patients in state Department of Behavioral Health and Developmental Services (DBHDS) facilities for more than 30 days have eligibility determined by Medicaid technicians located in the state DBHDS facilities. When an enrolled ABD Medicaid recipient is admitted to a state DBHDS facility, the local department of social services transfers the case to the Medicaid technician after the recipient has been in the facility for 30 days or more. See section M1520.500 for case transfer policy.

C. Procedures

- 1. Application Completion** A signed application is received. A face-to-face interview with the applicant or the person authorized to conduct his business is not required, but is strongly recommended, in order to correctly determine eligibility.
- 2. Pre-admission Screening** Notice from pre-admission screener is received by the local Department of Social Services (DSS).

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

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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. Pre-admission Screening

A pre-admission screening is used to determine if an individual living outside of a nursing facility meets the level of care for Medicaid payment for *LTSS* services. Medicaid enrollees living outside a nursing facility must be screened and approved before Medicaid will authorize payment for *LTSS* services.

A pre-admission screening is not required for a full-benefit enrollee if the nursing facility stay was or is expected to be less than 30 days.

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C. Recipient Enters LTC

A re-evaluation of eligibility must be done when the EW learns that a Medicaid recipient has started receiving *LTSS* services. If the recipient has been in a nursing facility for at least 30 consecutive days, a pre-admission screening is not required (See M1420.400). If an individual is receiving private-pay home health services, a pre-admission screening **is required** (see M1410.200 B. above).

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

- For an SSI recipient who has no community spouse and owns no countable real property, verify continued receipt of SSI through SOLQ-I or SVES, obtain information regarding asset transfer from the enrollee or authorized representative, and document the case record. See section M1430.104 for additional information regarding an SSI recipient who enters a nursing facility.
- Rules for married institutionalized recipients, *with the exception of MAGI Adults*, who have a community spouse are found in subchapter M1480.

D. Notification

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

M1410.300 NOTICE REQUIREMENTS

A. Introduction

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

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

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

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

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

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

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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 on *the VDSS intranet* at: <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi>, 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 <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi>. 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 LTC, Waiver Unit,
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 on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi> 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.

M1430 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-10	10/1/18	Pages 3-5 Appendix 1
TN #DMAS-7	1/1/18	Pages 1, 2, 4 Appendix 1
TN #93	1/1/10	Appendix 1, page 1
Update (UP) #1	7/1/09	Appendix 1, page 1

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M1430.100 BASIC ELIGIBILITY REQUIREMENTS

- A. Overview** To be eligible for Medicaid payment of long-term care, an individual must be eligible for Medicaid. The Medicaid non-financial eligibility requirements in Chapter M02 apply to all individuals in long-term care. The eligibility requirements and the location of the manual policy are listed below in this section.
- B. Citizenship/
Alienage** The citizenship and alien status policy is found in subchapter M220.
- C. Virginia Residency** The Virginia state resident policy specific to facility patient is found in subchapter M0230 and section M1430.101 below.
- D. Social Security
Number** The social security number policy is found in subchapter M0240.
- E. Assignment of
Rights** The assignment of rights is found in subchapter M0250.
- F. Application for
Other Benefits** The application for other benefits policy is found in subchapter M0270.
- G. Institutional
Status** The institutional status requirements specific to long-term care in a facility are in subchapter M0280.
- H. Covered Group
(Category)** The Medicaid covered groups eligible for LTC services, *also called long-term services and supports (LTSS)*, are listed in M1460. The requirements for the covered groups are found in chapter M03.
- I. Financial
Eligibility** An individual who has been a patient in a medical institution (such as a nursing facility) for at least 30 consecutive days of care or who has been screened and approved for LTC services is treated as an institutionalized individual for the Medicaid eligibility determination. Financial eligibility for institutionalized individuals is determined as a one-person assistance unit separated from his/her legally responsible relative(s).
- The 30-consecutive-days requirement is expected to be met if the pre-admission screening committee provides verbal or written confirmation of its approval for the individual's receipt of *LTSS*. If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has 30 days from the date on the Notice of Action to begin services.
- For unmarried individuals, and for married individuals without community spouses *other than MAGI Adults*, the resource and income eligibility criteria in subchapter M1460 is applicable.
- MAGI Adults in LTC are evaluated using the resource policy in M1460 and the MAGI income policy in M04. Only certain resource eligibility requirements are applicable to individuals in the Modified Adjusted Gross Income (MAGI) Adult covered group who are institutionalized.*

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

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

M1430.101 VIRGINIA RESIDENCE

A. Policy

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

B. Individual Age 21 or Older

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

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

1. Determining Incapacity to Declare Intent

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

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

2. Became Incapable Before Age 21

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

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

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- C. Individual Under Age 21** An institutionalized individual under age 21 years who is not emancipated is a resident of Virginia if:
- the individual’s legal guardian or parent was a Virginia resident at the time of the individual’s institutional placement;
 - the individual’s legal guardian or parent who applies for Medicaid for the individual resides in Virginia and the individual is institutionalized in Virginia; or
 - the individual’s parent(s) has abandoned the individual, no legal guardian has been appointed, the individual is institutionalized in Virginia, and the person who files the individual’s Medicaid application resides in Virginia.
 - if a legal guardian has been appointed for the individual and parental rights have been terminated, the guardian’s state of residence is used to determine residency instead of the parent’s.
- D. Placed by Another State’s Government** When an individual is placed in a facility by another (not Virginia) state or local government agency, the placing state retains responsibility for the individual’s Medicaid. Placement by a government agency is any action taken by the agency beyond providing general information to the individual and the individual’s family to arrange the individual’s admission to an institution. A government agency includes any entity recognized by State law as being under contract with the state government.
- E. Individual Placed Out-of-state by Virginia** An individual retains Virginia residency for Medicaid if he/she is placed by a Virginia government agency in an institution outside Virginia. Placement into an out-of-state LTC medical facility must be pre-authorized by DMAS.
- When a competent individual voluntarily leaves the facility in which Virginia placed him/her, he/she becomes a resident of the state where he/she is physically located.
- F. Disputed or Unclear Residency** If the individual’s state residency is unclear or is disputed, contact your Regional *Consultant* for help. When two states cannot resolve the residency dispute, the state where the individual is physically located becomes his/her state of residency for Medicaid purposes.

M1430.102 ADVANCE PAYMENTS

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

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List of Institutions for Mental Diseases (IMDs) in Virginia

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

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

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

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

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

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

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

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

Virginia Center for Behavioral Rehabilitation
P.O. Box 548
Burkeville, VA 23922-0548

Western State Hospital
P.O. Box 2500
Staunton, VA 24402-2500

1440 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-10	10/1/18	Pages 3, 5
TN #DMAS-7	1/1/18	Page 1. Appendix 1, Page 4.
TN #DMAS-5	7/1/17	Table of Contents Pages 3-9, 11, 12
TN #DMAS-3	1/1/17	Table of Contents Pages 3-12 Appendix 1 was added. Page 2 is a runover page. Pages 13-23 were deleted.
UP #9	4/1/13	Page 5
Update (UP) #7	7/1/12	Table of Contents Pages 2, 14, 15, 18a-18c Pages 19, 20
TN #94	9/1/2010	Table of Contents Pages 13, 16, 18b, 19-22
TN #93	1/1/2010	Pages 14, 16
TN #91	5/15/2009	Table of Contents Page 12 Pages 17-18c

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

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

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

If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has 30 days from the date on the Notice of Action to begin receiving CBC services.

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

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

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

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

M1440.100 CBC WAIVER DESCRIPTIONS

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

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

B. Definitions Term definitions used in this section are:

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

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

B. Targeted Population

This waiver serves persons who are:

- a. age 65 and over, or
- b. disabled; disability may be established either by SSA, DDS, or a pre-admission screener (provided the individual meets a Medicaid covered group and another category).

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

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

C. Eligibility Rules

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

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

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

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

D. Services Available

LTC services available through this waiver include:

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

M1450 Changes

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

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M1450.000 TRANSFER OF ASSETS

M1450.001 OVERVIEW

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

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

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

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

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

M1450.002 LEGAL BASE

A. Public Law 96-611 This federal law established a transfer of property eligibility rule for the SSI program and also permitted states to adopt a transfer eligibility rule for their Medicaid programs which could be, in certain respects, more restrictive than in SSI or the money payment programs. The rule adopted by Virginia was more restrictive than the SSI rule.

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

C. Public Law 103-66 (OBRA) Section 13611 of this federal law, enacted on August 10, 1993, revised transfer provisions for the Medicaid Program. It amended section 1917 of the Social Security Act by incorporating in section 1917 new requirements for asset transfers and for trusts.

D. Public Law 109-171 (DRA) The Deficit Reduction Act (DRA) of 2005, enacted on February 8, 2006, further revised asset transfer provisions for the Medicaid program.

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

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

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

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

M1450.003 DEFINITION OF TERMS

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

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

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

The term “asset” may also include:

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

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C. Asset Transfer

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

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

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- 6. Payments Prior To Contract Date** Any payment(s) made prior to the date the contract was signed (if contract is written) or date the contract was agreed upon (if contract is a legally binding oral contract) by all parties is considered an uncompensated transfer.
- 7. Advance Lump Sum Payments Made To Contractor** Certain contracts for services provide an advance lump sum payment to the person who is to perform the duties outlined in the contract. Any payment of funds for services that have not been performed is considered an uncompensated transfer of assets. The Medicaid applicant/recipient has not received adequate compensation, as he has yet to receive valuable consideration.
- 8. Determine Penalty Period** If it is determined that an uncompensated transfer of assets occurred, follow policy in this subchapter to determine the penalty period.

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A. Settlement Statement

U.S. Department of Housing and Urban Development

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

B. Type of Loan

1. FHA 2. FmHA 3. Conv. Unins. 4. VA 5. Conv. Ins. 6. File Number: 7. Loan Number: 8. Mortgage Insurance Case Number:

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

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

Buyer

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

J. Summary of Borrower's Transaction

100. Gross Amount Due From Borrower
101. Contract sales price
102. Personal property
103. Settlement charges to borrower (line 1400)
104.
105.
Adjustments for items paid by seller in advance
106. City/town taxes to
107. County taxes to
108. Assessments to
109.
110.
111.
112.

K. Summary of Seller's Transaction

400. Gross Amount Due To Seller
401. Contract sales price
402. Personal property
403.
404.
405.
Adjustments for items paid by seller in advance
406. City/town taxes to
407. County taxes to
408. Assessments to
409.
410.
411.
412.

120. Gross Amount Due From Borrower

200. Amounts Paid By Or In Behalf Of Borrower
201. Deposit or earnest money
202. Principal amount of new loan(s)
203. Existing loan(s) taken subject to
204.
205.
206.
207.
208.
209.
Adjustments for items unpaid by seller
210. City/town taxes to
211. County taxes to
212. Assessments to
213.
214.

420. Gross Amount Due To Seller

500. Reductions In Amount Due To Seller
501. Excess deposit (see instructions)
502. Settlement charges to seller (line 1400)
503. Existing loan(s) taken subject to
504. Payoff of first mortgage loan
505. Payoff of second mortgage loan
506.
507.
508.
509.
Adjustments for items unpaid by seller
510. City/town taxes to
511. County taxes to
512. Assessments to
513.
514.
515.
516.
517.
518.
519.

Gross Amount Due to Seller

Liens paid for by the seller

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

220. Total Paid For Borrower

300. Cash At Settlement From/To Borrower
301. Gross Amount due from borrower (line 120)
302. Less amounts paid by/for borrower (line 220) ()
303. Cash <input type="checkbox"/> From <input type="checkbox"/> To Borrower

520. Total Reduction Amount Due Seller

600. Cash At Settlement To/From Seller
601. Gross amount due to seller (line 420)
602. Less reductions in amt. due seller (line 520) ()
603. Cash <input type="checkbox"/> To <input type="checkbox"/> From Seller

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

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

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

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

M1460 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-10	10/1/18	Table of Contents, page i Pages 1-3, 4b, 5, 6, 9, 10, 13, 15, 17a, 18, 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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M1460.000 LTC FINANCIAL ELIGIBILITY

M1460.001 OVERVIEW

A. Introduction

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

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

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

B. Related Policies

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

M1460.100 DEFINITIONS

A. Purpose

This section provides definitions for terms used in this subchapter.

B. Definitions

1. 300% SSI Group

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

2. Budget Period

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

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- 3. Carry-over Expenses** Carry-over expenses are the balance due on medical, dental, and remedial care expenses incurred in the retroactive or prospective budget period prior to the current budget period which were not used in establishing eligibility and which may be deducted in a consecutive budget period(s) when there has been no break in spenddown eligibility.
- 4. Certification Period** The certification period is the period of time over which an application or redetermination is valid.
- 5. Current Payments** Current payments are payments made in the current spenddown budget period on expenses incurred before the current spenddown budget period which were not used in establishing eligibility in a previous spenddown budget period and when there has been a break in spenddown eligibility. The payment amount allowed is the actual payment amount paid to the provider and is deducted from the spenddown liability on the date the payment is actually made.
- 6. Income Determination Period** The income determination period is the budget period; for all LTC cases, the budget period is one month.
- 7. LTC Case** A case in which the Medicaid applicant or recipient is an institutionalized individual receiving long-term care services is an LTC case.
- 8. Lump Sum Payment** Income received on a "non-recurring basis" and/or income that is received once a year is a lump sum payment. All lump sum payments are income in the month of receipt and a resource in the following month(s), if retained.
- Different types of lump sum payments must be treated differently. Refer to the ABD Income chapter S08 (for both ABD and F&C individuals) for policy specific to the type of lump sum payment that is being evaluated.
- 9. MAGI Adults** *Effective January 1, 2019, MAGI Adults is the CN covered group of individuals between the ages of 19 and 64 with household income at or below 138% of the Federal Poverty Level (FPL) and who are not entitled to or receiving Medicare.*
- 10. Medicaid Rate** The Medicaid rate is a monthly rate which is calculated:
- for a facility, by multiplying the individual's daily Resource Utilization Group (RUG) code amount by the number of days in the month. A patient's RUG code amount is based on his room and board and ancillary services. The RUG code amount may differ from facility to facility and from patient to patient within the same facility. Confirmation of the individual's RUG code amount must be obtained by contacting the facility;
- NOTE: When projecting the facility's monthly Medicaid rate, the daily RUG code amount is multiplied by 31 days.
- for Medicaid CBC waiver services, by multiplying the provider's Medicaid hourly rate by the number of hours of service received by the patient in the month. Confirm the provider's hourly Medicaid rate and number of service hours by contacting the provider.

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11. Old Bills

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

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

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

12. Projected Expenses

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

13. Spenddown Liability

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

M1460.150 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LTC

A. Applicability

The policy in this section applies to nursing facility and CBC/PACE patients, *including MAGI Adults effective January 1, 2019*, who meet the requirements for LTC on or after January 1, 2006. This includes individuals who filed reapplications after a break in Medicaid eligibility. It does **not apply** to Medicaid recipients who were approved for LTC prior to January 1, 2006, and who maintain continuous Medicaid eligibility.

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

B. Policy

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

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

If substantial home equity exists, the individual is not eligible for the Medicaid payment of LTC. No evaluation of asset transfer is needed.

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

1. Home Equity Limit

The home equity limit applied is based on the date of the application or request for LTC coverage. The home equity limit is:

- Effective January 1, 2016: \$552,000
- Effective January 1, 2017: \$560,000
- Effective January 1, 2018: \$572,000

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M1460.200 DETERMINATION OF COVERED GROUP

A. Overview

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

1. Covered Groups Eligible for LTC Services

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

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

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

All medically needy (MN) covered groups

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

Medicaid will not pay for the following for MN individuals:

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

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2. Applicants Who Do Not Receive Cash Assistance

a. Child Under Age 18

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

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

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

b. Individual Age 19

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

c. Individual Age 19 or Older

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

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

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

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

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

B. Relation to Income Limits

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

1. ABD 80% FPL

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

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

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

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

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

C. Ongoing Recipient Enters LTC

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

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

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

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

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

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- b. If the recipient is temporarily in the nursing facility, the SSI check is not reduced or canceled. Temporary institutionalization for SSI purposes means 90 days or less. The SSI payment is **NOT** counted as income when determining eligibility or patient pay.

C. Development

A partial review of the SSI recipient's Medicaid eligibility is required when the recipient is admitted to facility care or Medicaid CBC waiver services. The EW must determine that asset transfer and resource requirements are met, and that the recipient's SSI continues.

If eligible, determine patient pay; see subchapter M1470. If the individual is eligible but is in an asset transfer penalty period, follow the notification instructions in M1450. If not eligible, follow the eligibility notice requirements in M1410.300.

M1460.205 OTHER CATEGORICALLY NEEDY (CN) COVERED GROUPS

A. Description

Categorically needy (CN) individuals receive or are deemed to be receiving public assistance cash benefits.

B. ABD Groups

1. QSII (1619(b))

Qualified Severely Impaired Individuals (QSII) are former SSI recipients who are working but are still disabled, and are eligible under 1619(b) of the Social Security Act. To be eligible for Medicaid, they must have met the more restrictive resource requirements for Medicaid in the month before the month they qualified under 1619(b). See section M0320.105 for details about this covered group.

2. AG Recipients

An Auxiliary Grants (AG) recipient is eligible for Medicaid if he meets the assignment of rights to medical support and third party payments requirements and the asset transfer policy. See section M0320.202 for details about this covered group.

C. F&C Groups

1. Individuals Under 21

a. IV- E Foster Care Recipients

Children who are eligible for foster care payments under Title IV-E of the Social Security Act are eligible for Medicaid. See section M0320.305 for details about this covered group.

b. IV-E Adoption Assistance Recipients

Children who are eligible for adoption assistance under Title IV-E of the Social Security Act are eligible for Medicaid. See section M0320.305 for details about this covered group.

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- b. If the recipient is temporarily in the nursing facility, the SSI check is not reduced or canceled. Temporary institutionalization for SSI purposes means 90 days or less. The SSI payment is **NOT** counted as income when determining eligibility or patient pay.

C. Development

A partial review of the SSI recipient's Medicaid eligibility is required when the recipient is admitted to facility care or Medicaid CBC waiver services. The EW must determine that asset transfer and resource requirements are met, and that the recipient's SSI continues.

If eligible, determine patient pay; see subchapter M1470. If the individual is eligible but is in an asset transfer penalty period, follow the notification instructions in M1450. If not eligible, follow the eligibility notice requirements in M1410.300.

M1460.207 MAGI ADULTS COVERED GROUP (EFFECTIVE JANUARY 1, 2019)

A. Description

The MAGI Adults covered group includes individuals between 19 and 64 years old who are not eligible for or receiving Medicare.

B. Policy

1. Nonfinancial

Evaluate the non-financial Medicaid eligibility rules in Chapter M02.

2. Asset Transfer

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

3. Resources

Although no resource test is applicable for MAGI Adults coverage, the worker must evaluate certain resources for any individuals seeking Medicaid payment for LTSS. These include asset transfers, trusts, annuities, and the home equity limit.

4. Income

Income is determined using the policy in Chapter M04, and countable income must not exceed 138% FPL. Spenddown does not apply to this covered group.

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M1460.210 ABD 80% FPL COVERED GROUP

A. Description

The ABD 80% FPL covered group includes aged, blind and disabled individuals who have income less than or equal to 80% FPL and countable resources that do not exceed the SSI resource limits. See M0320.300 for details about this covered group.

B. Policy

1. Nonfinancial

Evaluate the non-financial Medicaid eligibility rules in Chapter M02.

2. Asset Transfer

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

3. Resources

Determine countable resources using the policy in chapter S11 and Appendix 2 to chapter S11. The resource limit is \$2,000.

The home property resource exclusion for individuals in the ABD 80% FPL covered group includes the home and ALL contiguous property as long as the individual lives in the home or, if absent, intends to return to the home (see Appendix 2 to chapter S11). When the ABD 80% FPL individual leaves his home property, obtain a signed statement from the individual as to:

- when and why he left the home;
- whether he intends to return; and
- if he does not intend to return, when that decision was made.

The *limited* 6-month home property resource exclusion for institutionalized individuals does NOT apply to this covered group.

4. Income

Income is determined using the policy in chapter S08, and countable income must not exceed 80% FPL. Spenddown does not apply to this covered group.

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M1460.220 300% of SSI PAYMENT LIMIT GROUP

A. Description

These are ABD or F&C individuals in medical facilities or who receive Medicaid CBC waiver services, who meet the appropriate CN resource requirements and resource limit and whose income is less than or equal to 300% of the SSI payment limit for an individual.

Individuals who have been screened and approved for Medicaid LTC services may be evaluated in this covered group. If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has 30 days from the date on the Notice of Action to begin services.

B. ABD Groups

Aged, blind or disabled individuals institutionalized in medical facilities, or who require institutionalization and are approved to receive Medicaid CBC waiver services are those who:

- meet the Medicaid ABD resource requirements; and
- have gross income, determined according to the ABD income requirements, that does not exceed 300% of the SSI individual payment limit.

See sections M0320.501 and M0320.502 for details about these covered groups.

C. F&C Groups

Individuals who meet an F&C definition (foster care or adoption assistance children under age 21, parents or caretaker-relatives of dependent children, and pregnant women) in medical facilities, or who require institutionalization and who are approved to receive Medicaid home and community-based care (CBC) waiver services, are those who:

- meet the F&C CN resource requirements if unmarried, (married individuals over age 18 must meet the ABD resource requirement); and
- have gross income, determined according to the ABD income requirements, that does not exceed 300% of the SSI individual payment limit.

Children under age 18 in the 300% of SSI covered group have no resource requirement.

See sections M0330.501 and M0330.502 for details about these covered groups.

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Yes: eligible as CN; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay. (Remember to review asset transfer to evaluate whether Medicaid payment may be made for LTC services).

No: Go to B below.

B. Covered Group

Is person already enrolled in Medicaid in a covered group eligible for LTC services?

Yes: Go to E “Resources” below, *unless the person is a MAGI Adult.*

No: Is person F&C *or an adult 19-64 years old and not receiving Medicare?*

Yes: Determine if he meets F&C *or MAGI Adult group* first (section M0330), go to D “Income” below.

No: Go to C below.

C. Is person ABD?

Yes: Go to D “Income” below.

No: Is person in Hospice?

Yes: Determine as Hospice; see section M0320.503.

No: ineligible for Medicaid, does not meet a covered group; STOP. Go to section M1460.660 for notice procedures.

D. Income

(See M1460.600)

**1. Person is F&C
or MAGI Adult**

Determine countable income using chapters M04 and M07.

Compare income to appropriate M04 income limit.

Is income within limit?

Yes: eligible as F&C/MAGI Adult, STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay *for F&C (MAGI Adults do not have a patent pay).*

No: not eligible as F&C, go to item 2 below.

**2. Person Is Not
F&C**

a. Is person ABD and does he meet the definition of institutionalization in M1410.010?

Yes: Determine if gross income is less than or equal to the 80% FPL income limit using chapter S08 and section M1460.600 below to determine gross income.

Is gross income less than or equal to 80% FPL income limit?

Yes: Go to section E "Resources" below.

No: Go to item 3 “Determine 300% SSI income” below.

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2) Married Individual with Community Spouse

Determine ABD countable resources using chapter S11 and subchapter M1480.

Compare to ABD CN resource limit = \$2000 for 1 person

b. F&C groups

1) *MAGI Adult*

- *There is no resource test.*
- *Evaluate substantial home equity and asset transfer, including annuities and trusts.*

2) Unmarried Individual age 18 or over or Married Individual age 18 or over with no Community Spouse

- Determine F&C CN countable resources using chapter M06 for the unmarried institutionalized individual.
- Compare to F&C CN resource limit = \$1,000.

3) Married Individual age 18 or over with Community Spouse

- Determine ABD countable resources, Chapter S11, M1480.
- Compare to ABD CN resource limit = \$2000 for 1 person.

2. Are resources within CN limit?

Yes: eligible in the covered group whose income limit is met; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

No: go to item 3 below.

3. Does person meet an MN covered group?

Yes: go to section M1460.410 “Steps for Determining MN Eligibility,” below.

No: person is not eligible for Medicaid because of excess resources; STOP. Go to section M1460.660 for notice procedures.

(Note: There is no MN covered group for MAGI Adults.)

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If the spenddown is met on any date within the month, the patient is eligible effective the first day of the month in which the spenddown was met. Eligibility ends the last day of the month.

Each month must be evaluated separately. These patients will always be enrolled after the month being evaluated has passed.

**5. Spenddown--
CBC Patients**

Do not project CBC waiver services costs. Eligibility is evaluated on a monthly basis. Determine spenddown eligibility AFTER the month has passed, by deducting old bills and carry-over expenses first, then (on a daily basis) chronologically deducting the daily CBC cost at the **private** daily rate and other medical expenses **as they are incurred**. If the spenddown balance is met on a date within the month, the patient is eligible effective the first day of the month in which the spenddown was met. Eligibility ends the last day of the month.

Each month must be evaluated separately. These patients will always be enrolled after the month being evaluated has passed.

M1460.500 RESOURCE DETERMINATION

A. Introduction

The following sections describe the resource eligibility rules that are applicable to individuals in long-term care.

B. Resource Limits

1. ABD Groups

ALL aged, blind and disabled (ABD) covered groups = \$2,000 per individual.

2. F&C Groups

F&C 300% SSI and Hospice groups = \$1,000 for individuals age 18 and over, regardless of the number of individuals in the assistance unit. Children under age 18 do not have a resource requirement.

There are no resource *limits* for any other F&C covered group. *All LTSS evaluations require evaluation of substantial home equity and asset transfers, including annuities and trusts.*

3. MN Groups

MN groups = \$2,000 for an individual and \$3,000 for 2 persons (pregnant woman with 1 unborn child; add \$100 for each additional unborn child).

C. Budget Period

The budget period for determining long-term care resource eligibility is always one month.

M1460.510 DETERMINING COUNTABLE RESOURCES

**A. Married
Individual**

**1. Married MAGI
Adult**

MAGI Adults do not have a resource assessment or resource limit. Evaluate substantial home equity and asset transfers, including annuities and trusts, made by the MAGI Adult and/or the spouse.

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2. With A Community Spouse

See **subchapter M1480** for the rules to determine the **institutionalized individual's resource eligibility** when he is married and his spouse is a community spouse (the spouse is not in a medical institution or nursing facility).

a. Community Spouse Not Receiving Medicaid CBC Waiver Services

When both husband and wife have applied for Medicaid and one is institutionalized, and the community spouse does NOT receive Medicaid CBC waiver services, the community spouse's eligibility is processed as a noninstitutionalized individual.

NOTE: Follow resource determination rules found in chapter S11 for ABD covered groups, and in chapter M06 for F&C covered groups. The community spouse's resource eligibility is determined as a couple in the month the other spouse becomes institutionalized, and as an unmarried individual for the following months.

b. Community Spouse Receives Medicaid CBC Waiver Services

When both husband and wife have applied for Medicaid and one is institutionalized in a medical facility, and the community spouse receives Medicaid CBC waiver services, the community spouse's eligibility is processed as a married institutionalized Medicaid CBC recipient in the initial month of Medicaid CBC and afterwards, using the policy and procedures in subchapter M1480.

2. Both Spouses In A Medical Facility (No Community Spouse)

When the institutionalized individual's spouse is NOT a community spouse (the spouse is in a medical institution or nursing facility), the policy and procedures in subchapter M1460 that apply to an **unmarried individual** apply to the institutionalized individual effective the month of institutionalization and apply to the individual's spouse if the spouse also applies for Medicaid. Do not use subchapter M1480 because the individual is not an "institutionalized spouse" as defined in M1480.

When both husband and wife are institutionalized in a facility, the policy and procedures in subchapter M1460 that apply to **unmarried** individuals apply to each spouse in the initial month of institutionalization and afterwards.

3. Both Spouses Receive Medicaid CBC

When both spouses have applied for Medicaid and both receive Medicaid CBC waiver services, each spouse must be evaluated using policy and procedures in subchapter M1480.

B. Unmarried Individual

1. MAGI Adult Group

MAGI Adults do not have a resource assessment or resource limit. Evaluate substantial home equity and asset transfers, including annuities and trusts.

2. ABD Covered Groups

An institutionalized individual is an assistance unit of 1 person, considered living separately from his family. No resources are deemed available from the individual's spouse. To determine the ABD resource eligibility of an unmarried individual, or married individual with no community spouse, use the ABD Resource policy and procedures found in chapter S11 and in section M1460.500.

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For the ABD 80% FPL covered group, use the ABD resource policy and procedures in chapter S11 and Appendix 2 to chapter S11.

The maximum allowable resource limit for an ABD individual is \$2,000.

NOTE: If the individual's resources exceed the resource limit, and the individual has Medicare Part A, evaluate for eligibility as QMB, SLMB, or QI (limited coverage) which have a higher resource limit.

3. F&C Covered Groups

An institutionalized individual is an assistance unit of 1 person, considered living separately from his family. No resources are deemed available from a child's parent(s).

NOTE: A pregnant woman's assistance unit includes the number of unborn children with which she is pregnant.

Use the resource policy and procedures in chapter M06 for the resource determination.

M1460.520 RETROACTIVE RESOURCE DETERMINATION

A. Policy

When an applicant reports that he received a medical service within the retroactive period, evaluate Medicaid eligibility for that period.

Evaluate resource eligibility for each month using resources available during that month.

B. Reduction of Resources

An individual cannot retroactively reduce resources. If countable resources exceeded the resource limit **throughout** a retroactive month, the individual is **not** eligible for that month. However, if an applicant reduces excess resources **within** a retroactive month, he may be eligible in the month in which the value of his resources is reduced to or below the Medicaid resource limit.

In order to reduce resources, liquid resources such as bank accounts and prepaid burial accounts must actually have been expended. Non-liquid resources must have been liquidated and the money expended.

M1460.530 HOME OWNERSHIP (NOT APPLICABLE TO ABD 80% FPL GROUP OR MAGI ADULTS)

A. Policy

The policy in this section does not apply to the ABD 80% FPL group. See Appendix 2 to chapter S11 for home ownership resource policy for the ABD 80% FPL group.

The policy in this section does not apply to MAGI Adults. However, the substantial home equity policy in M1460.160 DOES apply to MAGI Adults.

The institutionalized individual's former home in which he has an ownership interest, and which he occupied as his residence before becoming institutionalized, is not a countable resource for the first six months **following** admission to a medical facility or nursing facility. The former home is excluded indefinitely when it is occupied by a spouse, minor child, disabled adult child, or disabled parent.

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B. Definitions for This Section

1. Dependent

A dependent child or parent is one who may be claimed as a dependent for tax purposes under the Internal Revenue Service's Code by either the institutionalized individual or his spouse.

2. Institutionalization

a. Definition

Institutionalization means receipt of 30 consecutive days of :

- care in a medical facility (such as a nursing facility), or
- Medicaid waiver services (such as community-based care); or
- a combination of the two.

The definition of institutionalization is also met when an individual has a signed hospice election that has been in effect for 30 consecutive days.

The 30 consecutive days requirement is expected to be met if the pre-admission screening committee provides verbal or written confirmation of its approval for the individual's receipt of long-term care (LTC) services (see M1410.010).

NOTE: For purposes of this definition, continuity is broken by 30 or more consecutive days of:

- absence from a medical institution, or
- non-receipt of Medicaid waiver services.

EXCEPTION: When an individual is readmitted in less than 30 days due to a different diagnosis or a change in condition unforeseen at the time of discharge, a new 6-month home exclusion will begin if it was medically documented that the discharge occurred because facility services were no longer required and a physician documents that the change in circumstances could not be anticipated.

b. When Institutionalization Begins

Institutionalization begins the date of admission to a nursing facility or Medicaid waiver services when the pre-admission screening committee provides verbal or written confirmation of its approval for the individual's receipt of long-term care (LTC) services, or when the individual has been in the nursing facility for at least 30 consecutive days.

Institutionalization begins the date of admission to a hospital (acute care) when the individual has actually been a patient in the hospital for 30 consecutive days or more. For example, an individual was admitted to the general hospital on March 5. He applied for Medicaid on March 6. On April 3, he was still a patient in the general hospital. He was in the hospital for 30 consecutive days on April 3; his institutionalization began on the date he was admitted to the hospital, March 5. His eligibility for March is determined as an institutionalized individual.

The date of discharge from a medical institution into the community (and not receiving CBC waiver services) or death is **NOT** included in the 30 days.

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M1460.600 INCOME DETERMINATION

- A. Introduction** This section provides the income requirements specific to determinations of eligibility for Medicaid participation in payment of long-term care services.
- B. F&C CN** If an institutionalized individual meets an F&C *CN* covered group, determine if his income is within the appropriate F&C income limit. The institutionalized individual is an assistance unit of one person; no income is deemed from responsible relatives. Use the policy and procedures in chapters *M04* and *M07* to determine countable income.
- C. MAGI Adult Group** *If an individual is between the ages of 19 and 64 and is not entitled to or receiving Medicare, determine if his MAGI household income is less than or equal to 138% of the Federal Poverty Level (FPL). Use the policy in Chapter M04 to determine countable income.*
- D. ABD 80% FPL Group** If an individual is aged, blind or disabled, determine if his income is less than or equal to 80% of the FPL. See M0810.002 A.5 for the ABD 80% FPL income limits. Use the policy in chapter S08 to determine countable income.
- E. 300% SSI Income Limit Group** For purposes of this section, we refer to the ABD covered group and the F&C covered group of “individuals in medical facilities who have income less than or equal to 300% of the SSI individual payment limit” and “individuals receiving Medicaid waiver services who have income less than or equal to 300% of the SSI individual payment limit” as one covered group. We refer to this one group as “institutionalized individuals who have income within 300% of SSI” or the “300% SSI group.”
- 1. Assistance Unit** The institutionalized individual is an assistance unit of one person; no income is deemed from responsible relatives.
 - 2. Income Limit** The income limit for ABD and F&C individuals in the 300% SSI group is 300% of the SSI individual payment limit (see M0810.002 A. 3).
 - 3. Countable Income**

Income sources listed in section M1460.610 are NOT considered income.

Income sources listed in section M1460.611 ARE counted as income.

All other income is counted. The individual’s gross income is counted; no exclusions are deducted.

To determine an income type or source and to determine how to count the income, use the policy and procedures in chapter S08 for all individuals (both ABD and F&C) in this covered group.

Income is projected for the month for which eligibility for LTC is being determined. This calculation is based upon the income received in the past month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount expected to be received.

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E. MN Income - All MN Covered Groups The medically needy (MN) individual income limits are listed in Appendix 5 to subchapter M0710 and in section M0810.002 A.4.

1. ABD MN Covered Groups Evaluate MN resource and income eligibility for ABD individuals who have income over the 300% SSI income limit.

The income sources listed in sections M1460.610 “What is Not Income” and M1460.611 “Countable Income for the 300% SSI Group” are NOT counted. Countable income is determined by the income policy in chapter S08; applicable exclusions are deducted from gross income to calculate the individual’s countable income.

The income actually received in the retroactive period is considered for retroactive eligibility. The income expected to be received within the application month is considered when determining eligibility in that month. The income expected to be received within a month is counted in that month for ongoing eligibility.

2. F&C MN Covered Groups Evaluate MN resource and income eligibility for F&C individuals who have income over the 300% SSI income limit.

Countable income is determined by the income policy in chapter M07, using a monthly budget period; applicable exclusions are deducted from gross income to calculate the individual’s countable income. In addition, the income sources listed in sections M1460.610 B and M1460.611 are NOT counted.

Anticipated income is projected for the month for which eligibility is being determined. This calculation is based upon the income received in the prior month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount to be received.

M1460.610 WHAT IS NOT INCOME

A. Introduction This section contains a list of items that are not considered as income when determining income eligibility for institutionalized individuals in medical facilities or Medicaid CBC waiver services.

NOTE: The income items in C. below ARE COUNTED as income only when determining F&C medically needy eligibility.

B. What Is Not Income - All Covered Groups Do not consider the types of items in this subsection as income **when determining eligibility or patient pay for all covered groups.**

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- 12. Weatheriza-tion Assistance** (S0815.500) Weatherization assistance (e.g., insulation, storm doors, and windows, etc.) is not income.
- 13. Certain Employer Payments** (S0815.600) The following payments by an employer are not income UNLESS the funds for them are deducted from the employee's salary:
- funds the employer uses to purchase qualified benefits under a "cafeteria" plan;
 - employer contribution to a health insurance or retirement plan;
 - the employer's share of FICA taxes or unemployment compensation taxes in all cases;
 - the employer's share of FICA taxes or unemployment compensation taxes paid by the employer on wages for domestic service in the private home of the employer or for agricultural labor only, to the extent that the employee does not reimburse the employer.
- 14. Payments to Victims of Nazi Persecution** Any payments made to individuals because of their status as victims of Nazi persecution are not income [P.L.103-286 and 1902(r)(1)].
- 15. Advance Payments That will Be Reimbursed** Advance payments made by a person other than the patient which are expected to be reimbursed once Medicaid is approved, and payments made by outside sources to hold the facility bed while the patient is hospitalized, are **not counted as income** in determining eligibility or patient pay.
- There are instances when the family of a prospective Medicaid patient, or other interested party(ies), makes an advance payment on the cost of facility care prior to or during the Medicaid application process to assure the Patient's admission and continued care. The individual may have been promised that the advance payment will be refunded if Medicaid eligibility is established. Any monies contributed toward the cost of patient care pending a Medicaid eligibility determination must be reimbursed to the patient or the contributing party by the facility once Medicaid eligibility is established.
- 16. Medical Expense Reimbursement** Medical expense reimbursement from either VA or an insurance policy is not income. Medical expense reimbursements are resources.

The income in items 17 through 23 below are not income by other federal statutes or law:

- 17. Energy Assistance** Energy Assistance through Block Grants (Virginia's Fuel Assistance payments) is excluded [P.L. 93-644].
- 18. Radiation Exposure Trust Fund** Radiation Exposure Compensation Trust Fund payments are excluded [P.L. 101-426].

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19. Agent Orange Agent Orange Payments are excluded [P. L. 101-239].

20. Native American Funds The following funds for Native Americans are excluded *for all covered groups:*

- a. Alaska Native Claims Settlement Act (cash payments not to exceed \$2,000) [P.L. 100-241]
- b. Maine Claims Settlement Act [P.L. 96-420]
- c. Blackfeet and Gros Ventre [P.L. 92-254]
- d. Grand River Band of Ottawa [P.L. 94-540]
- e. Red Lake Band of Chippewa [P.L. 98-123]

For MAGI Adults, the following payments to American Indian/Alaska Natives are also not counted as income:

- a. *distributions received from the Alaska Native Corporations and Settlement Trusts (Public Law 100-241),*
- b. *distributions from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the Supervision of the Interior,*
- c. *distribution and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extractions and harvest from:*
 - *rights of any lands held in trust located within the most recent boundaries of a prior Federal reservation or under the supervision of the Secretary of the Interior,*
 - *federally protected rights regarding off-reservation hunting, fishing, gathering or usage of natural resources,*
 - *distributions resulting from real property ownership interests related to natural resources and improvements,*
 - *located on or near a reservation of within the most recent boundaries of a prior Federal reservation, or*
 - *resulting from the exercise of federally-protected rights relating to such property ownership interests.*
- d. *payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or right or rights that support subsistence or a traditional lifestyles according to applicable Tribal Law or custom.*
- e. *Student financial assistance provided under the Bureau of Indian Affairs Education Program.*

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M1460.650 RETROACTIVE INCOME DETERMINATION

A. Policy

The retroactive period is the three months immediately prior to the Application month. The three-month retroactive period cannot include a portion of a prior Medicaid medically needy spenddown budget period in which eligibility was established.

1. Institutional-ized Individual

For the retroactive months in which the individual was institutionalized in a medical facility, determine income eligibility on a monthly basis using the policy and procedures in this subchapter (M1460). An individual who lived outside of a medical institution during the retroactive period must have retroactive Medicaid eligibility determined as a non-institutionalized individual.

A spenddown must be established for any month(s) during which excess income existed. Go to M1460.700 for spenddown policies and procedures for medically needy institutionalized individuals.

2. Individual Not Institutional-ized

For the retroactive months in which the individual was NOT institutionalized, determine income eligibility for the ABD groups using the ABD policy and procedures in chapter S08. Determine income eligibility for the F&C groups using policy and procedures in chapters *M04* and *M07*. *Determine income eligibility for MAGI Adults using the policy and procedures in chapter M04.*

If the individual meets a MN covered group, a spenddown must be established for any month(s) during which excess income existed. See Chapter M13 for spenddown policies and procedures. There is no MN covered group for MAGI Adults.

3. Retroactive Entitlement

If an applicant meets all eligibility requirements, he is entitled to Medicaid coverage for the month(s) in which all eligibility factors were met.

B. Countable Income

Countable income is that income which was actually received in the retroactive month(s). Count the income received in the months in which the individual meets all other Medicaid eligibility requirements.

If the individual was CN in the retroactive month, the countable income is compared to the appropriate income limit for the retroactive month. **Medicaid income eligibility is determined on a monthly basis for the MN institutionalized individual.**

C. Entitlement

Retroactive coverage cannot begin earlier than the first day of the third month prior to the application month. When an applicant reports that he received a medical service within the retroactive period, entitlement for Medicaid will begin with the first day of the third month prior to the application month, provided all eligibility factors were met in all three months. If the institutionalized applicant had excess income in the retroactive period, entitlement may begin the first day of the month in which the retroactive spenddown was met.

For additional information, refer to section M1510.101.

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**D. Retroactive
Income
Determination
Example**

EXAMPLE #3: A disabled institutionalized individual applies for Medicaid on June 5 and requests retroactive coverage for unpaid medical bills that he incurred in March, April, and May. His disability onset date was April 10. He was institutionalized on April 10.

The retroactive period is March, April and May. He is not eligible for March because he did not meet a covered group in March. The income he received in April and May is counted monthly because he was institutionalized in each month. He is resource eligible for all three months.

His April income is calculated and compared to the monthly 300% SSI income limit. It exceeds that limit. His May income is calculated and compared to the monthly 300% SSI income limit; it is within the limit. Therefore, he is placed on a one-month retroactive spenddown for April, and is enrolled in the 300% SSI covered group for May.

**M1460.660 NOTICES & ENROLLMENT PROCEDURES FOR
CATEGORICALLY NEEDY**

**A. CN Eligible
Enrollment**

Enroll the recipient with the appropriate CN aid category (AC) as follows:

- | | |
|--|--|
| 1. SSI | 011 Aged
031 Blind
051 Disabled |
| 2. "Protected"
ABD Covered
Groups | 021 Aged
041 Blind
061 Disabled |
| 3. MAGI Adults | <i>100 Parent/Caretaker-relative; income at or below 100% FPL</i>
<i>101 Parent/Caretaker-relative; income greater than 100% FPL, but less than or equal to 138% FPL (133% + 5% disregard)</i>
<i>102 Childless Adult; income at or below 100% FPL (no disregard)</i>
<i>103 Childless Adult; income greater than 100% FPL, but less than or equal to 138% FPL (133% + 5% disregard)</i>
<i>106 Presumptive Eligible MAGI Adult; income at or below 138% FPL (133% + 5% disregard)</i> |
| 4. ABD 80% FPL | 029 Aged
039 Blind
049 Disabled |
| 5. MEDICAID
WORKS | 059 |

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6. 300% SSI

a. ABD

Not dually eligible as a Qualified Medicare Beneficiary (QMB) or Special Low Income Medicare Beneficiary (SLMB); individual does not have Medicare Part A and/or income equal to or greater than 120% FPL:

- 020** Aged
- 040** Blind
- 060** Disabled

Dually eligible; individual has Medicare Part A and income within 100% FPL

- 022** Aged also QMB
- 042** Blind also QMB
- 062** Disabled also QMB

Dually eligible; individual has Medicare Part A and income greater than 100% FPL but less than 120% FPL

- **025** aged individual also SLMB
- **045** blind or disabled also SLMB

b. F&C

060 F&C who does not meet “Individuals Under Age 21 in an ICF or ICF/MR covered group, not blind or disabled

082 Institutionalized child under age 21 in an ICF or ICF/MR, not blind or disabled

NOTE: Children who are eligible in the Child Under Age 19, FAMIS Plus, covered group should be enrolled in the appropriate AC for their age and income (see *M1460.660 A.10* below)

7. All Foster Care and Adoption Assistance

072 Adoption Assistance
076 Foster Care

8. Individuals Under age 21

075 child under supervision of Juvenile Justice Department
082 Child in an ICF or ICF/MR

9. LIFC

081 Parent/caretaker of a dependent child
083 Unemployed parent of a dependent child; 2 parent household

10. Child Under Age 19 FAMIS Plus

091 Child under age 6 w/income less than or equal to the **100% FPL**
090 Child under age 6, income greater than the **100% FPL** but less than or equal to the **133% FPL**
092 Child age 6 to 19 **insured or uninsured** w/income less than or equal to the **100% FPL**; or **insured** w/income greater than 100% and less than or equal to the **133% FPL**
094 **Uninsured** child age 6 to 19 w/income greater than 100% FPL and less than or equal to the **133% FPL**

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11. Pregnant Women 091

12. BCCPTA 066

B. CN Eligible Complete & Send Notice Complete a “Notice of Action on Medicaid and FAMIS to notify the individual of his Medicaid eligibility and coverage begin date. Go to subchapter M1470 to determine the individual’s patient pay.

C. Income Exceeds CN Covered Groups Limits If income exceeds the 300% SSI limit, evaluate as MN. If the individual meets an MN covered group, re-calculate countable income for MN.

Subtract the income exclusions listed in sections M1460.610 and 611 that apply to the individual’s MN covered group. Go to section M1460.700 below.

If the individual does NOT meet an MN covered group, he is not eligible for Medicaid; go to subsection D. below.

D. Ineligible--Notice Complete and send a “Notice of Action on Medicaid and FAMIS” to the individual notifying him that he is not eligible for Medicaid and of his appeal rights.

M1460.700 MEDICALLY NEEDY INCOME & SPENDDOWN

A. Policy Institutionalized individuals whose income exceeds the 300% SSI income limit must be placed on a monthly medically needy (MN) spenddown if they meet a MN covered group and have countable resources that are less than or equal to the MN resource limit. Countable income for the MN is different than countable income for the 300% SSI covered group. Recalculate income using medically needy income principles.

For individuals who were within a spenddown budget period prior to the month in which they become institutionalized, prorate and shorten the spenddown budget period for the months prior to admission to long-term care services.

M1470 Changes

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

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Subchapter Subject M1470 PATIENT PAY	Page ending with M1470.001	Page 1

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) should be submitted to patientpay@dmass.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

M1480 Changes

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

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Subchapter Subject M1480 MARRIED INSTITUTIONALIZED INDIVIDUALS	Page ending with M1480.000	Page 1

M1480 MARRIED INSTITUTIONALIZED INDIVIDUALS' ELIGIBILITY & PATIENT PAY

M1480.000 GENERAL

A. Introduction

Section 1924 of the Social Security Act contains special eligibility rules that apply **ONLY** to married institutionalized individuals whose first continuous period of institutionalization began on or after September 30, 1989. These rules are intended to prevent the impoverishment of a spouse living in the community when the other spouse enters long-term care. **For resource assessment and eligibility determination, the resource value is its value as of the first moment of the first day of a calendar month.**

Section 1924 supersedes all other sections of Medicaid law when determining countable resources and income of a married institutionalized individual who has a community spouse. Therefore, the usual Medicaid eligibility rules do not apply to an institutionalized individual with a community spouse whenever the usual Medicaid rules conflict with the law in section 1924.

An institutionalized spouse is an individual who is in a medical institution, who is receiving Medicaid waiver services or who has elected hospice services, and who is married to a spouse who is not in a medical institution or nursing facility. The term "community spouse" means the spouse of an institutionalized spouse. The community spouse can be living outside an institution or in a residential institution such as an adult care residence.

B. Applicability

1. MAGI Adult *DO NOT use this subchapter to determine the individual's financial eligibility for Medicaid if the individual is eligible in the MAGI Adult covered group.*

2. Admitted Before 9-30-89 **DO NOT use this subchapter** to determine the individual's financial eligibility for Medicaid when the married institutionalized individual was admitted to long-term care **prior to** September 30, 1989 and has been continuously institutionalized since admission. Use subchapters M1410 - M1460 to determine the individual's financial eligibility for Medicaid.

3. Admitted On/ After 9-30-89 Use this subchapter in determining Medicaid eligibility for an institutionalized spouse who

- was admitted to long-term care **on or after** September 30, 1989 and has been continuously institutionalized since admission, and
- has a community spouse.

Do NOT use this subchapter to determine the eligibility of a married institutionalized individual whose spouse is NOT a "community spouse" as defined in this subchapter. Use subchapters M1410 - M1470 to determine the individual's eligibility and patient pay.

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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.

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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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	\$2057.50	7-1-18	
	\$2030.00	7-1-17	
C. Maximum Monthly Maintenance Needs Allowance	\$3,090.00	1-1-18	
	\$3,022.00	1-1-17	
D. Excess Shelter Standard	\$617.25	7-1-18	
	\$609.00	7-1-17	
E. Utility Standard Deduction (SNAP)	\$311.00	1 - 3 household members	10-1-18
	\$387.00	4 or more household members	10-1-18
	\$306.00	1 - 3 household members	10-1-17
	\$381.00	4 or more household members	10-1-17

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-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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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.

4. Incarcerated Individuals

a. Pre-release Planning

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

b. Inpatient Hospitalization – Aid Category (AC) 109

Incarcerated individuals (see M0130.050) who meet all Medicaid eligibility requirements, including eligibility in a full benefit CN covered group are eligible for Medicaid coverage limited to inpatient hospitalization. *Enroll eligible MAGI Adults in aid category AC 108 and all other individuals in aid category AC 109 regardless of their covered group. See M0130.050*

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

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

5. MAGI Adult Turns 65 or Begins Receiving Medicare

When an individual enrolled in the Modified Adjusted Gross Income (MAGI) Adults covered group turns 65 years old or begins receiving 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.

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B. Coverage End Date

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

Medicaid coverage is canceled on the last day of the month in which the agency determines that the recipient no longer meets the eligibility requirements IF the agency can send an advance notice to the recipient at least 11 days before the last day of the month. If the agency cannot send the notice at least 11 days before the end of the month, coverage is canceled effective the last day of the next month.

1. CN Pregnant Woman

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

2. Individual Age 21-64 Admitted to Ineligible Institution

a. Entitlement - applicants

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

b. Cancel procedures for ongoing enrollees

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

c. Notice

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

3. Spenddown Enrollees

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

C. Ongoing Entitlement After Resources Are Reduced

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

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

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

M1510.103 HOSPITAL PRESUMPTIVE ELIGIBILITY

A. Policy

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

B. Procedures

When an HPE enrollee submits a full MA application and it is pended in VaCMS, the individual's coverage in the HPE AC is extended by the eligibility worker, as necessary, while the application is processed.

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

1. Enrollment

When an individual is determined eligible for MA coverage, his MA coverage under the appropriate MA AC includes any days to which he is entitled that are not already covered by HPE. If the individual submitted the MA application in the same month HPE coverage began and HPE began on any day other than the first day of the month, his MA coverage begins the first day of that month and the eligibility worker enrolls him in a closed period of coverage in the appropriate MA AC beginning with the first day of the month and ending the day before the HPE begin date. The worker is to enroll the eligible individual in ongoing coverage in the appropriate MA AC beginning the first day of the month after the effective date of the HPE coverage cancellation.
See M0120.500 C.2

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

If an individual who was enrolled in HPE with partial coverage as a pregnant woman or in Plan First is determined eligible for full MA coverage in the period covered by HPE, cancel HPE coverage retroactively and reinstate in full coverage for the retroactive months and ongoing, if eligible.
See M0120.500 C.2d

3. Retroactive Entitlement

An individual's eligibility for retroactive coverage for the three months prior to the month of the MA application is determined when the individual had a medical service within the three months prior to the month of the full MA application. If the individual had full coverage while enrolled as HPE, only enroll him for the portion of the retroactive period that he was not enrolled as HPE. *See M0120.500 C.2e*

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- 4. HPE Enrollee Not Eligible for Ongoing Coverage** If the applicant is determined to not be eligible for ongoing MA coverage, his entitlement to HPE coverage ends. Cancel the HPE coverage effective the current date (i.e. day of the eligibility determination). See *M0120.500 C.2f*

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

M1510.104 DISABILITY DENIALS

A. Policy

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

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

B. Procedures

- 1. Subsequent SSA/SSI Disability Decisions** The SSA disability decision takes precedence over a DDS decision (DDS will make a decision before SSA if SSA does not take action within the 90-day Medicaid application processing time). If SSA denies disability and the decision is appealed and subsequently reversed, reopen and re-evaluate the denied Medicaid application as long as the disability onset month is prior to the month of application or is no later than 90 days after the month of application.
- 2. Use Original Application** The original application is used as long as the application was denied because the individual was not disabled and the subsequent disability onset month is no later than 90 days from the month of application.
- 3. Entitlement** If the re-evaluation determines that the individual is eligible, the individual's Medicaid entitlement is based on the Medicaid application date including the retroactive period if *available documentation verifies that* all eligibility requirements were met during the retroactive period. However, eligibility as a disabled individual cannot begin prior to the disability onset date when the disability onset date falls after the application date.
- 4. Renewal** If, based upon the re-evaluation, the individual is determined to be eligible and more than 12 months have passed since the application was filed, complete a *renewal* to determine whether or not the individual remains eligible.
- 5. Original Application Was Purged** Closed cases may be purged after at least three years from the application date have passed (see M0130.400). If the case record was purged, in the absence of agency knowledge regarding the original application date (e.g. an application log), accept the individual's attestation of the application date.

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Send the individual two application forms. Instruct the individual to complete one application according to his circumstances at the time of the attested original application date and the other application according to his current circumstances. Request verifications for the attested original application month and retroactive period, as well as the current application according to the renewal policy in M1520.200 A, in order to evaluate ongoing eligibility

If verifications from the attested application month and retroactive period cannot be obtained, eligibility cannot begin until the earliest month that the individual was both disabled and his eligibility can be verified.

6. Spenddown

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

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

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M1510.107 Enrollment Changes

D. Enrollment Changes

VaCMS is the MA eligibility system of record, however some enrollment functions can only be handled by the DMAS Eligibility and Enrollment Unit. The VaCMS and MMIS systems **must** reflect correct coverage. Appropriate change requests include:

- Retroactive coverage that cannot be approved through VaCMS
- Duplicate linking
- Erroneous death cancellations
- Spenddown end-dates (if open-ended coverage was sent to MMIS)
- Missing newborn coverage
- Approved non-labor and delivery Emergency Services coverage
- Same day void

There may be instances when VaCMS should be able to successfully update the enrollment system but does not. When this occurs, the eligibility worker must follow the steps as listed below:

- First attempt to make the correction in VaCMS with the help of supervisors or other agency resources. If not successful;
- Contact the VDSS Regional Consultant (RC) for assistance. The RC will help the local worker make the correction in MMIS or VaCMS. If not successful;
- If either the agency resources or Regional Consultant is unable to correct the enrollment in MMIS, they can instruct the worker to submit a coverage correction to DMAS.
- The worker will complete a MMIS Coverage Correction Request Form (DMAS-09-1111-eng). The form can be found on the VDSS intranet. Follow the instructions as provided on the form.
- Once completed, the form is sent via email to: DMAS Eligibility and Enrollment Unit at: enrollment@dmass.virginia.gov. All requests should be documented in the VaCMS system.

For GAP enrollment or changes see M1520.200.F

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b. Applicants Who Cannot Produce a Claim Number

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

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

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

4. Buy-in Begin Date

Some individuals have a delay in Buy-in coverage:

Classifications	Buy-in Begin Date
SSI and AG recipients (includes dually-eligible)	1st month of eligibility
CN and MN with Medicare Part A who are dually-eligible <i>as either Qualified Medicare Beneficiaries (QMB) or Special Low Income Medicare Beneficiaries (SLMB Plus)</i>	1st month of eligibility
CN and MN with no Medicare Part A or who are not dually-eligible <i>as either QMB or SLMB Plus</i>	3 rd month of eligibility

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

D. Other Third Party Liability

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

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

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

M1520 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-10	10/1/18	Page 3
TN #DMAS-9	7/1/18	Pages 5, 21 Page 5a was added.
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.
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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that may affect the premium payment. The worker may report changes by e-mail to hipp@dmas.virginia.gov. This e-mail address is for use by the local agency staff only. See M0130.200 G for additional information about HIPP requirements.

1. Program Integrity

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

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

C. Covered Group and Aid Category Changes

1. Enrollee's Situation Changes

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

- a pregnant woman reaches the end of her post-partum period (the month in which the 60th day after the end of the pregnancy occurs),
- 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 and 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. The enrollee must provide verification of income or other information necessary to establish eligibility for full coverage.

M18 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-10	10/1/18	Pages 3-5
TN #DMAS-6	10/1/17	Table of Contents Pages 3-5 Page 6 is a runover page. Page 6a was added.
TN #100	5/1/15	Table of Contents Pages 1-9 Pages 10-17 were deleted. Appendix 1 was removed.
UP #9	4/1/13	Page 3
UP #7	7/1/12	Page 12
TN #96	10/01/11	Pages 3, 4, 16
TN #95	3/1/11	Page 9
TN #94	9/1/10	Page 12
TN #93	1/1/10	Pages 4, 5
TN #91	5/15/09	Page 2 Pages 5, 6 Page 8

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M1830.100 MANAGED CARE

A. General Information

DMAS provides Medicaid coverage to enrollees primarily through two delivery systems: fee-for-service (FFS) and managed care. FFS benefits are administered by DMAS through participating providers within the traditional Medicaid program rules. Most Virginia Medicaid enrollees are required to receive medical care through a managed care organization.

B. Medallion Programs

DMAS currently operates two programs, Medallion 3.0 and Medallion 4.0. Both Medallion programs are administered through DMAS' contracted managed care organizations (MCO). Recipients currently in Medallion 3.0 will be transitioned to Medallion 4.0 by December 31, 2018.

Individuals eligible for Medallion 3.0 and 4.0 include non-institutionalized enrollees in both Families & Children (F&C) and Aged, Blind or Disabled (ABD) covered groups. Some enrollees in the groups below are not Medallion 3.0 or 4.0 eligible because they meet exclusionary criteria. The following is a **partial** list of enrollees excluded from managed care enrollment:

- Enrollees who are inpatients in state mental hospitals,
- Enrollees who are in long-stay hospitals, nursing facilities, or intermediate care facilities for the intellectually disabled,
- Enrollees who meet a spenddown and are enrolled for a closed period of coverage,
- Enrollees who are participating in Plan First,
- Enrollees under age 21 in Level C residential facilities,
- Enrollees with other comprehensive group or member health insurance coverage, and
- Enrollees who have an eligibility period that is less than three months or who have an eligibility period that is only retroactive.

All Medallion 4.0 health plans offer enhanced benefits to members including, but not limited to:

- *Adult Dental*
- *Vision for adults*
- *Cell phone*
- *Centering pregnancy program*
- *GED for Foster Care*
- *Sports physical at no cost (under age 21)*
- *Swimming lessons for members six (6) years and younger*
- *Boys and Girls Club membership (6-18 olds)*
- *Free meal delivery after inpatient hospital stays*

Note: Not all health plans will offer all of the same enhanced benefits

Enrollees excluded from mandatory managed care enrollment shall receive Medicaid services under the current fee-for-service system. When enrollees no longer meet the criteria for exclusion, they shall be required to enroll in the appropriate managed care program.

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C. Managed Care HelpLine

Eligible individuals can enroll in an MCO or obtain additional information, as well as assistance with coverage issues, by calling the Managed Care HelpLine at 1-800-643-2273 (TTY/TDD 1-800-817-6608). The Helpline is available Monday through Friday from 8:30 a.m. until 6:00 p.m. Information is available online at www.viriniamanagedcare.com.

D. Family Access to Medical Insurance Security Plan (FAMIS) Managed Care

FAMIS benefits are administered through DMAS contracted MCOs or through FAMIS fee-for-service. The DMAS contracted MCOs for FAMIS are the same as those contracted with DMAS for Medallion 3.0.

In all areas of the Commonwealth, FAMIS enrollees have the choice between 2 or more MCOs. When a child is first enrolled in FAMIS, he or she is able to access health care through the FAMIS fee-for-service program. Within 1 or 2 months after FAMIS enrollment, the child will be enrolled with a FAMIS MCO.

FAMIS benefits are slightly different than the benefits that children enrolled in Medicaid receive. There are benefit limitations and small co-payments similar to those associated with commercial group health insurance. The following is a partial list of services (while covered under Medicaid) are **NOT** covered under FAMIS.

- Early and Period Screening Diagnosis and Treatment (EPSDT) services are not covered for FAMIS MCO members. Many of the services that are covered as EPSDT services by Medicaid are covered under FAMIS MCO's well child and immunization benefits. EPSDT services **are** covered for FAMIS FFS members because they receive the Medicaid benefit package.
- Psychiatric treatment in free standing facilities is not covered under FAMIS. However, psychiatric treatment is covered when provided in a psychiatric unit of an acute hospital.
- Routine transportation to and from medical appointments is not covered for FAMIS MCO enrollees. Children enrolled in FAMIS FFS may receive non-emergency transportation services. Emergency transportation is covered for both FAMIS MCO and FAMIS FFS enrollees.
- Intensive in-home, therapeutic day treatment, mental health crisis intervention, and case management for children at risk of or experiencing a serious emotional disturbance are covered under FAMIS. Other community mental health rehabilitation services are not covered.

Eligible FAMIS individuals can enroll in an MCO or obtain additional information, as well as assistance with coverage issues, by calling Cover Virginia at 1-855-242-8282, Monday through Friday from 8:00 a.m. until 7:00 p.m. and Saturdays from 9:00am – noon. Information is also available online at www.covervirginia.org.

A summary of FAMIS covered services can be found online at: <http://coverva.org/mat/FAMIS%20Covered%20Services.pdf>.

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E. CCC Plus

Effective August 1, 2017, the CCC Plus Medicaid managed care program was implemented. CCC Plus operates statewide through a network of managed care plans across six regions as a mandatory program serving adults and children with disabilities and complex care needs. Individuals in nursing facilities and the home and community based waivers, as well as dually-eligible individuals (those with both Medicare and Medicaid) receive Medicaid through CCC Plus. Individuals receiving services through the Developmental Disabilities waivers are currently enrolled in CCC Plus only for their non-waiver services.

The following is a **partial** list of enrollees excluded from enrollment in CCC Plus:

- Limited covered groups – Plan First, Qualified Medicare Beneficiaries (QMB) only, Special Low income Medicare Beneficiaries (SLMB), Qualified Individuals (QI), and individuals enrolled in the Governor’s Access Plan (GAP).
- Enrollees in specialized settings – intermediate care facilities for individuals with intellectual disability (ICF-ID), Veterans’ nursing facilities, Level C psychiatric residential treatment facilities (PRTF), the Virginia Home, and the Piedmont, Catawba and Hancock state facilities.
- Enrollees with special medical conditions – end stage renal disease or in hospice care (CCC Plus who develop end state renal disease or elect hospice will remain in CCC Plus).
- Enrollees in other programs – Medicaid Medallion and FAMIS managed care, the Program for All-inclusive Care for the Elderly (PACE), Money Follows the Person (MFP), and the Alzheimer’s Assisted Living Waiver (AAL)

Enrollees and their families may contact the CCC Plus Helpline at 1-844-374-9159 for information and assistance.

G. Enrollment Corrections/Changes

DMAS pays a capitation rate for every month an individual is enrolled in managed care regardless of whether the individual receives medical services during the month. If an individual is incorrectly enrolled in a Medicaid managed care program, the eligibility worker must refer the case to DMAS at the following address for possible recovery of expenditures (see chapter M1700):

Recipient Audit Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219