COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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Virginia Medical Assistance Eligibility Manual

Transmittal #DMAS-5

The following acronyms are used in this cover letter:

- ABD – Aged, Blind or Disabled
- ABLE – Achieving a Better Life Experience
- CCC – Commonwealth Coordinated Care
- CMV – Current Market Value
- DDS – Disability Determination Services
- DMAS – Department of Medical Assistance Services
- EDCD – Elderly and Disabled with Consumer Direction
- F&C – Families and Children
- LIFC – Low Income Families with Children
- MA – Medical Assistance
- MN – Medically Needy
- MAGI – Modified Adjusted Gross Income
- MSP – Medicare Savings Program
- PARIS – Public Assistance Reporting Information System
- QI – Qualified Individuals
- SSI – Supplemental Security Income
- TN – Transmittal
- VaCMS – Virginia Case Management System
- VEC – Virginia Employment Commission

TN #DMAS-5 includes policy clarification, updates and revisions to the MA Eligibility Manual. Unless otherwise noted, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after July 1, 2017.

The following changes are contained in TN #DMAS-5:

Changed Pages	Changes
Subchapter M0120 Page 2a	Clarified that a grandparent is included in the list of family substitute representatives.
Subchapter M0130 Pages 1, 10	On page 1, clarified that VEC data can be used for the initial eligibility determination. On page 10, corrected the formatting.
Subchapter M0220 Pages 18, 19, 23, 24	On pages 18 and 19, clarified the residency policy for non-immigrant visa holders. On pages 23 and 24, added enrollment information for emergency services only aliens.
Subchapter M0310 Pages 13, 37, 38	On page 13, clarified the definition of a dependent child. On pages 37 and 38, revised the resource information for the MSPs.
Subchapter M0330 Pages 9, 14	On page 9, clarified the alien status requirement for the Former Foster Care Child Under Age 26 covered group. On page 14, removed obsolete policy.
Chapter M04 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.	Updated the Table of Contents. On pages 5 and 6, clarified the rules for household composition. On pages 12, 13, and 14-14b, clarified how self-employment income and the income of a child are treated under MAGI methodology. Updated the LIFC and Individual Under 21 income limits effective July 1, 2017, in Appendices 3 and 5. In Appendix 4, added Salem and Poquoson to the list of locality groupings. These localities were inadvertently removed in a previous transmittal.
Subchapter M0710 Appendices 1, 2 and 3	In Appendix 1, added Salem and Poquoson to the list of locality groupings. These localities were inadvertently removed in a previous transmittal. Updated the F&C MN income limits and F&C deeming standards effective July 1, 2017, in Appendices 2 and 3.
Subchapter M0810 Page 2	Updated the ABD MN limits effective July 1, 2017.
Subchapter M0820 Pages 11, 13, 29, 30 Page 12 is a runover page.	On pages 11 and 13, clarified that online verifications are to be used to the extent possible. On pages 29 and 30, corrected the formatting.

Changed Pages	Changes
Subchapter M1120 Pages 15, 17, 18	On all pages, updated the policy on trusts to conform to SSI policy.
Subchapter M1130 Pages 13,15, 78, 79 Page 14 is a runover page.	On pages 13 and 15, clarified that certified appraisals may be used as the CMV of real property. On pages 78 and 79, revised the policy on ABLE accounts.
Subchapter M1140 Page 7	Clarified that certified appraisals may be used as the CMV of real property.
Subchapter M1370 Table of Contents, page i. Pages 1-3 Pages 4, 5 and 6 were removed.	Updated the Table of Contents. On all pages, removed the obsolete policy specific to the QI covered group and streamlined the spenddown policy for limited-benefit covered groups.
Subchapter M1410 Pages 4-7	On page 4, updated the policy on incarcerated individuals. On all other pages, revised the policy to reflect the implementation of the new CCC Plus Waiver, which consolidated the EDCD and Technology Assisted Individuals Waivers, and reformatted the pages.
Subchapter M1420 Pages 2-6	On all pages, revised the policy to reflect the implementation of the new CCC Plus Waiver and reformatted the pages.
Subchapter M1440 Table of Contents Pages 3-9, 11, 12	Updated the Table of Contents. On all other pages, revised the policy to reflect the implementation of the new CCC Plus Waiver and reformatted the pages.
Subchapter M1450 Table of Contents Pages 13, 35, 41-44 Page 43a was renumbered. Pages 45 and 46 were added as runover pages.	Updated the Table of Contents. On page 13, added policy on other asset transfers, which was inadvertently removed in a previous transmittal. On page 35, clarified the Medicaid coverage policies for individuals in a penalty period. On page 41, corrected the web link. On pages 42-44, clarified the local agency's procedures for following up when a subsequent claim of asset transfer undue hardship is approved by DMAS.
Subchapter M1470 Pages 1, 7-9, 11, 15, 19, 20, 28a, 43, 47-51, 53	On all pages, updated the policies to reflect VaCMS patient pay procedures, the implementation of the new CCC Plus Waiver, and clarified acronyms.
Subchapter M1480 Pages 66, 69, 70, 92	On page 66, updated the maintenance allowances effective July 1, 2017. On pages 69 and 70, revised the information on the personal maintenance allowance and special earnings allowances to reflect name changes in the waivers. On page 92, corrected the web link.

Changed Pages	Changes
Subchapter M1510 Page 1 Page 2 is a runover page.	Added policy on PARIS.
Subchapter M1520 Pages 1, 2, 6, 8 Pages 3, 7, 7a and 9 are runover pages.	On pages 1 and 2, clarified when changes need to be verified. On page 6, clarified that the DDS blindness/disability interface and PARIS report must be reviewed at each renewal. On page 8, clarified the procedures for completing a paper-based renewal.
Chapter M17 Table of Contents Pages 1, 2, 4 Appendix 2 Appendix 3 was added.	Updated the Table of Contents. On pages 1, 2 and 4, and in Appendix 2, revised the name of the Notice of Recipient Fraud/Nonfraud Recovery. The word "Recovery" was dropped from the title. In Appendix 3, a new form, the Notice of Recipient LTC Underpayment Notice, was added.

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

Sincerely,

Linda Nablo

Linda Nablo
Chief Deputy Director

Attachment

M0120 Changes

Changed With	Effective Date	Pages Changed
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

1. Authorized Representative

An authorized representative is a person age 18 years or older who is authorized to conduct business for an individual. A competent individual age 18 years or older must designate the authorized representative in a written statement (which defines the representative's responsibilities). The individual may change or his authorized representative at any time by submitting a new authorized representative statement.

The authorized representative statement is valid while the application is being processed and for as long as the individual is covered, as well as during an appeal related to the denial, reduction of or cancellation of the individual's coverage.

An individual who reapplies after a period of non-coverage must sign another authorized representative statement to designate an authorized representative.

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

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

2. Family Substitute Representative

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

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

M0130 Changes

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

M0130.001 Medical Assistance Application Processing Principles

A. Introduction

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

B. Principles

1. Single Application

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

2. No Wrong Door

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

3. Use of Electronic Data Source Verification

The eligibility determination process for MA is based on electronic data source verification (EDSV) to the fullest extent possible. *On-line data from the Virginia Employment Commission (VEC) is acceptable for both initial applications and renewals.* LDSS are to rely on EDSV as the first course of action and are to request information from the applicant only when it is not available through an approved data source or the information is inconsistent with agency records.

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).

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.

3. SSA Data

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

4. Income

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

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

5. $0 (Zero) Income Procedures – Applicable Only to F&C MAGI Cases Processed in VaCMS

When an individual whose income must be counted for the eligibility determination reports $0 income at application, search the 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 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.

M0220 Changes

Changed With	Effective Date	Pages Changed
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 Pages19, 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.

Changed With	Effective Date	Pages Changed
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

M0220.411 UNQUALIFIED ALIENS

A. Unqualified Aliens Aliens who do not meet the qualified alien definition M0220.310 above and who are **NOT** lawfully residing non-citizen children under age 19 or pregnant women per M0220.314 above are "unqualified" aliens and are eligible for emergency services only if they meet all other Medicaid eligibility requirements. Unqualified aliens include illegal and non-immigrant aliens.

B. Illegal aliens Illegal aliens were never legally admitted to the U.S. or were legally admitted for a limited period of time and did not leave when that period expired. If an alien remains in the U.S. after his visa expires, he becomes an illegal alien.

C. Non-immigrant Aliens Aliens who are lawfully admitted to the U.S. for a temporary or limited period of time, and the limited period has **not** expired, are non-immigrant aliens. *Regardless of the individual's immigration status, accept declaration of Virginia residency on the application as verification of residency unless the individual resides on the grounds of a foreign embassy. Do **NOT** require individuals who have been admitted into the U.S. on non-immigrant visas to sign a statement of intended residency.*

Non-immigrants have the following types of USCIS documentation:

- Form I-94 Arrival-Departure Record,
- Form I-185 Canadian Border Crossing Card,
- Form I-186 Mexican Border Crossing Card,
- Form SW-434 Mexican Border Visitor's Permit,
- Form I-95A Crewman's Landing Permit.

Note: If the alien remains in the U.S. after the limited time period (visa) is over, he becomes an illegal alien.

Non-immigrants include:

1. Visitors visitors for business or pleasure, including exchange visitors;

2. Foreign Government Representative foreign government representatives on official business and their families and servants. *Note: if the foreign government representative resides on the grounds of a foreign embassy, he does not meet the Virginia residency requirement;*

3. Travel Status aliens in travel status while traveling directly through the U.S.;

4. Crewmen Crewmen on shore leave;

5. Treaty Traders treaty traders and investors and their families;

6. Travel Status aliens in travel status while traveling directly through the U.S.;

7.	**Foreign Students**	foreign students;
8.	**International Organization**	international organization representatives and personnel, and their families and servants;
9.	**Temporary Workers**	temporary workers including some agricultural contract workers;
10.	**Foreign Press**	members of foreign press, radio, film, or other information media and their families.

M0220.500 ALIENS ELIGIBILITY REQUIREMENTS

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

1. Residency the Virginia residency requirements (M0230);

Regardless of the individual's immigration status *or whether or not his documentation (e.g. visa) has expired,* accept declaration of Virginia residency on the application as verification of residency. Do **NOT** require individuals who have been admitted into the U.S. on non-immigrant visas and other non-immigrants to sign a statement of intended residency.

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

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

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

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

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

5. Coverage Begin Date In this field, Coverage Begin Date, enter the date the alien's Medicaid entitlement begins.

6. Coverage End Date Enter data in this field only if eligibility is a closed period of eligibility in the past. Enter the date the alien's Medicaid entitlement ended.

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

M0220.700 EMERGENCY SERVICES ALIENS ENTITLEMENT & ENROLLMENT

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

B. Entitlement-Enrollment Period If the applicant is found eligible and is certified for emergency services, eligibility exists only for the period of coverage certified by the LDSS or DMAS staff on the Emergency Medical Certification form, available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi.

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

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

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

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

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

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

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

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

D = Emergency services alien who receives dialysis.

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

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

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

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

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

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

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

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

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

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

A Medicaid card will not be generated for an individual enrolled as an emergency services alien. The agency must contact the provider(s) and supply the eligibility dates and Medicaid number for billing purposes by sending a copy of the completed referral form #032-03-628, Emergency Medical Certification, to the provider(s).

M0310 Changes

Changed With	Effective Date	Pages Changed
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

M0310 Changes

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

2. **Living in the Home**

A child's presence in the home as declared on the application/ redetermination is used to determine if the child is living in the home with a parent or caretaker-relative. No verification is required unless the information contained in the application does not clearly establish whether or not the child is living with the parent or care-taker relative.

A dependent child is considered living with only one parent for Medicaid eligibility purposes When separated/divorced parents who claim to have equal physical custody of the child both apply for Medicaid and neither spouse has other children under age 18 in the home, obtain a copy of the custody agreement and verify the custody arrangements. If the custody is divided exactly equally between both parents, the parents must decide which parent the dependent child lives with for Medicaid purposes.

A child who is living away from the home is considered living with his parents in the household if:

- the child is not emancipated, and
- the absence is temporary and the child intends to return to the parent's home when the purpose of the absence (such as vacation, visit, education, rehabilitation, placement in a facility for less than 30 days) is complete.

  NOTE: If the stay in the medical facility has been or is expected to be 30 days or more, go to M1410.010 to determine if the child is institutionalized in long-term care.

Children living in foster homes or medical institutions are NOT temporarily absent from the home. They are indefinitely absent from home and are NOT living with their parents or siblings for Medicaid purpose.

Children placed in Level C psychiatric residential treatment facilities (PRTF) are considered absent from their home if their stay in the facility has been 30 days or more. A child who is placed in a Level C PRTF is considered NOT living with his parents for Medicaid eligibility purposes as of the first day of the month in which the 30th day of residential placement occurs. Modified Adjusted Gross Income (MAGI) methodology contained in Chapter M04 is applicable to children in PRTFs; long-term care rules do not apply to these children.

M0310.126 Qualified Individuals

A. Qualified Individuals (QI)

QI *is* the short name used to designate the Medicaid covered group of "Qualified Individuals." A qualified individual means a Medicare beneficiary

- who is entitled to Medicare Part A,
- *who has resources that are within the resource limits for the Medicare Savings Programs (MSPs). See chapter section M1110.003 for the current resource limits; and*
- whose income is equal to or more than 120% of the federal poverty level (FPL) and is less than 135% FPL.

B. Procedure

QI is a mandatory covered group that the State Plan must cover for the purpose of paying the Medicare Part B premium for the QI. See section *M0320.603* for the procedures used to determine if an individual meets the QI covered group.

M0310.127 QMB

A. Qualified Medicare Beneficiary (QMB)

QMB is the short name used to designate the Medicaid covered group of "Qualified Medicare Beneficiary." A qualified Medicare beneficiary means an individual

- who is entitled to enroll for Medicare Part A,
- *who has resources that are within the resource limits for the Medicare Savings Programs (MSPs). See chapter section M1110.003 for the current resource limits; and*
- whose income does not exceed *100%* of the FPL.

B. Procedure

QMB is a mandatory covered group that the state plan must cover for the purpose of paying the beneficiary's Medicare premiums and cost sharing expenses. See section *M0320.601* for the procedures to use to determine if an individual meets the QMB covered group.

M0310.128 RSDI

A. Retirement, Survivors & Disability Insurance (RSDI)

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

B. Procedure

RSDI Is not used in the Medicaid manual. Because Title II of the Social Security Act is still officially called "Old Age, Survivors & Disability Insurance", the Medicaid manual uses the abbreviation "OASDI" interchangeably with "Title II" to refer to Title II Social Security benefits.

M0310.129 SLMB

A. Special Low-income Medicare Beneficiary (SLMB)

SLMB is the short name used to designate the Medicaid covered group of "Special Low-income Medicare Beneficiary". A special low-income Medicare beneficiary means an individual

- who is entitled to enroll for Medicare Part A,
- *who has resources that are within the resource limits for the Medicare Savings Programs (MSPs). See chapter section M1110.003 for the current resource limits; and*
- whose income exceeds the QMB income limit (100% of the FPL) but does NOT exceed the higher SLMB income limit, which is 120% of the FPL.

B. Procedure

SLMB is a mandatory covered group that the state plan must cover for the purpose of paying the beneficiary's Medicare Part B premium. See section M0320.602 for the procedures to use to determine if an individual meets the SLMB covered group.

M0310.130 SSI

A. Supplemental Security Income (SSI)

Supplemental Security Income (SSI) is the federal cash assistance benefit program under Title XVI of the Social Security Act that provides cash assistance to eligible aged, blind or disabled individuals to meet their shelter, food and clothing needs.

B. Procedures

Individuals who receive SSI (SSI recipients) are not "automatically" eligible for Medicaid in Virginia. SSI recipients must meet all of the Medicaid nonfinancial eligibility requirements and must meet the Medicaid resource eligibility requirements that are more restrictive than SSI's resource requirements. See section M0320.101 for the procedures to use to determine if an SSI recipient meets a covered group.

M0310.131 STATE PLAN

A. Definition

The State Plan for Medical Assistance is a comprehensive written statement submitted by the Department of Medical Assistance Services (DMAS) describing the nature and scope of Virginia's Medicaid program. It contains all the information necessary for the federal Centers for Medicare and Medicaid Services (CMS) to determine whether the state plan can be approved for federal financial participation (FFP) in the state's Medicaid program expenses.

M0330 Changes

Changed With	Effective Date	Pages Changed
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

B. Nonfinancial Eligibility Requirements

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.*

D. Entitlement

Entitlement as a former foster care child begins the first day of the month following the month the child was no longer in the custody of a local department of social services or the URM Program if the child was enrolled in Medicaid during the month foster care ended.

Accept the individual's declaration of enrollment in foster care or the URM Program and enrollment in Medicaid at the time turned at least 18.

If Medicaid coverage of a former foster care child was previously discontinued when the child turned 18, he may reapply for coverage and be eligible in this covered group if he meets the requirements in this section. The policies regarding entitlement in M1510 apply.

Individuals in this covered group receive full Medicaid coverage, including long-term care (LTC) services. Do not move enrollees in this covered group who need LTC to the 300% of SSI covered group.

E. Enrollment

The AC for former foster care children is "070."

M0330.200 LOW INCOME FAMILIES WITH CHILDREN (LIFC)

A. Policy

Section 1931 of the Act - The federal Medicaid law requires the State Plan to cover dependent children under age 18 and parents or caretaker-relatives of dependent children who meet the financial eligibility requirements of the July 16, 1996 AFDC state plan. This covered group is called "Low Income Families With Children" (LIFC).

Public Law 111-148 (The Affordable Care Act) requires that coverage for all children under the age of 19 be consolidated in the Child Under Age 19 (FAMIS Plus) covered group. Virginia has chosen to implement this coverage effective October 1, 2013. Children are not enrolled as LIFC except when the child is under age 18 and his parents are receiving LIFC Extended Medicaid coverage (see M1520.500). In these situations, if the child's household income exceeds the limit for coverage in the Child Under Age 19 group, the child must be evaluated for LIFC Extended Medicaid coverage with his family.

B. Nonfinancial Eligibility

The individual must meet all the nonfinancial eligibility requirements in chapter M02.

For an adult to be eligible in the LIFC covered group, the adult must be living in the home with his or her dependent child under the age of 18 or must meet the definition of a caretaker-relative of a dependent child in M0310.107. The presence of a parent in the home does not impact a stepparent's eligibility in the Low Income Families with Children (LIFC) covered group. Both the parent and stepparent may be eligible in the LIFC covered group.

2. Newborn Child

42 CFR 435.117 - A child born to a woman who was eligible for Medicaid or to an individual covered by FAMIS at the time the child was born (including a newborn child born to an alien eligible for Medicaid payment of emergency services only) is eligible as a newborn child under age 1 year.

a. Eligible To Age 1

A child no longer meets this covered group effective the end of the month in which the child reaches age 1, provided he was under age 1 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 1.

Any child born a Medicaid-eligible woman will continue to be eligible up to age 1. If the child's mother was covered by Medicaid as a categorically needy individual in a state other than Virginia at the time of the child's birth, verification of the mother's Medicaid coverage must be provided by the parent or authorized representative.

b. No Other Eligibility Requirements

No other nonfinancial or financial eligibility requirements need to be met by the newborn child.

C. Financial Eligibility

Eligibility for CN Pregnant Women and Newborn Children is based on the Modified Adjusted Gross Income (MAGI) methodology contained in Chapter M04.

1. Assistance Unit

The unborn child or children are included in the household size for a pregnant woman's eligibility determination. Refer to the procedures for determining the MAGI household in Chapter M04.

2. Resources

There is no resource test.

3. Income

Women enrolled as Pregnant Women are not subject to renewals during the pregnancy. The income limits for Pregnant Women are contained in M04, Appendix 2.

4. Income Changes After Eligibility Established

a. Pregnant Woman

Once eligibility is established as a pregnant woman, changes in income do not affect her eligibility as long as she meets the pregnant definition and the other nonfinancial eligibility requirements. This also includes situations where eligibility is established in the retroactive period.

M04 Changes

Changed With	Effective Date	Pages Changed
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

TABLE OF CONTENTS

M04 MODIFIED ADJUSTED GROSS INCOME (MAGI)

- 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.

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 tax dependent's household consists of the (1) tax dependent, (2) his parents and (3) his siblings living in the home *who are also claimed by the same tax filer.*

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,
- married couples and children of parents are not filing 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.
- Children under age 19 living with a relative other than a parent are included only in their own household.
- 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.
- 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.

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

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

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

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 dependent children
Jack	2 – Jack and Daria	Non filer and parent living in home
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,

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

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.

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

- a tax dependent who is claimed by his parent(s), or
- the income of 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. Foreign income and interest, including tax-exempt interest, are counted.

e. Stepparent income is counted.

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. Alimony **paid** to a separated or former spouse outside the home is deducted from countable income.

f. Interest paid on student loans is deducted from countable income.

g. Proceeds from life insurance are not counted.

i. A parsonage allowance is not counted.

3. Income From Self-employment

An individual reporting self-employment income must provide documentation of business expenses and income. Acceptable documentation includes IRS Form 1040 for the adjusted gross income, Schedule C (business expenses), Schedule E (expenses from rental income) and Schedule F (expenses from farming).

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 or 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,

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.

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.

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, the steps below are not followed: no MAGI calculation is required.

Adjusted Gross Income (AGI) Line 4 on Internal Revenue Service (IRS) Form 1040 EZ Line 21 on IRS Form 1040A Line 37 on IRS Form 1040	**Include:** • 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 • Alimony received • Rental real estate, royalties, partnerships • S corporations, trusts, etc. • Taxable refunds, credits, or offset of state and local income taxes • Other income	**Deduct:** • Certain self-employment expenses • Student loan interest deduction • Educator expenses • IRA deduction • Moving expenses • Penalty on early withdrawal of savings • Health savings account deduction • Alimony paid • Domestic production activities deduction • Certain business expenses of reservists, performing artists, and fee-basis government officials

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.

Add (+) back certain income	• 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)

Exclude (-)from 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. • 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 • Proceeds from life insurance • An amount received as a lump sum is counted only in the month received.

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

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.

LIFC INCOME LIMITS

EFFECTIVE *7/1/17*

Group I

Household Size	Income Limit
1	*$245*
2	*373*
3	*474*
4	*575*
5	*678*
6	*764*
7	*862*
8	*965*
Each additional person add	*101*

Group II

Household Size	
1	*$320*
2	*459*
3	*577*
4	*690*
5	*811*
6	*914*
7	*1,024*
8	*1,143*
Each additional person add	*114*

Group III

Household Size	
1	*$483*
2	*646*
3	*791*
4	*928*
5	*1,097*
6	*1,220*
7	*1,358*
8	*1,501*
Each additional person add	*139*

GROUPING OF LOCALITIES EFFECTIVE *7/01/17*

GROUP I		GROUP II	GROUP III
Counties	Louisa	Counties	Counties
Accomack	Lunenburg	Albemarle	Arlington
Alleghany	Madison	Augusta	Fairfax
Amelia	Mathews	Chesterfield	Montgomery
Amherst	Mecklenburg	Henrico	Prince William
Appomattox	Middlesex	Loudoun	
Bath	Nelson	Roanoke	Cities
Bedford	New Kent	Rockingham	Alexandria
Bland	Northampton	Warren	Charlottesville
Botetourt	Northumberland		Colonial Heights
Brunswick	Nottoway	Cities	Falls Church
Buchanan	Orange	Chesapeake	Fredericksburg
Buckingham	Page	Covington	Hampton
Campbell	Patrick	Harrisonburg	Manassas
Caroline	Pittsylvania	Hopewell	Manassas Park
Carroll	Powhatan	Lexington	Waynesboro
Charles City	Prince Edward	Lynchburg	
Charlotte	Prince George	Martinsville	
Clarke	Pulaski	Newport News	
Craig	Rappahannock	Norfolk	
Culpeper	Richmond County	Petersburg	
Cumberland	Rockbridge	Portsmouth	
Dickenson	Russell	*Poquoson*	
Dinwiddie	Scott	Radford	
Essex	Shenandoah	Richmond	
Fauquier	Smyth	Roanoke	
Floyd	Southampton	*Salem*	
Fluvanna	Spotsylvania	Staunton	
Franklin	Stafford	Virginia Beach	
Frederick	Surry	Williamsburg	
Giles	Sussex	Winchester	
Gloucester	Tazewell		
Goochland	Washington		
Grayson	Westmoreland		
Greene	Wise		
Greensville	Wythe		
Halifax	York		
Hanover			
Henry	Cities		
Highland	Bristol		
Isle of Wight	Buena Vista		
James City	Danville		
King George	Emporia		
King & Queen	Franklin		
King William	Galax		
Lancaster	Norton		
Lee	Suffolk		

INDIVIDUALS UNDER AGE 21 INCOME LIMITS

EFFECTIVE *7/01/17*

Group I

Household Size	Income Limit
1	*$234*
2	*363*
3	*465*
4	*564*
5	*664*
6	*745*
7	*843*
8	*946*
Each additional person add	*97*

Group II

Household Size	
1	*$317*
2	*460*
3	*576*
4	*691*
5	*815*
6	*1,005*
7	*1,024*
8	*1,142*
Each additional person add	*112*

Group III

Household Size	
1	*$422*
2	*566*
3	*686*
4	*802*
5	*948*
6	*1,047*
7	*1,160*
8	*1,277*
Each additional person add	*113*

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

GROUPING OF LOCALITIES EFFECTIVE 7/01/17

GROUP I		GROUP II	GROUP III
Counties	Louisa	Counties	Counties
	Lunenburg		
Accomack	Madison	Albemarle	Arlington
Alleghany	Mathews	Augusta	Fairfax
Amelia	Mecklenburg	Chesterfield	Montgomery
Amherst	Middlesex	Henrico	Prince William
Appomattox	Nelson	Loudoun	
Bath	New Kent	Roanoke	Cities
Bedford	Northampton	Rockingham	
Bland	Northumberland	Warren	Alexandria
Botetourt	Nottoway		Charlottesville
Brunswick	Orange	Cities	Colonial Heights
Buchanan	Page		Falls Church
Buckingham	Patrick	Chesapeake	Fredericksburg
Campbell	Pittsylvania	Covington	Hampton
Caroline	Powhatan	Harrisonburg	Manassas
Carroll	Prince Edward	Hopewell	Manassas Park
Charles City	Prince George	Lexington	Waynesboro
Charlotte	Pulaski	Lynchburg	
Clarke	Rappahannock	Martinsville	
Craig	Richmond County	Newport News	
Culpeper	Rockbridge	Norfolk	
Cumberland	Russell	Petersburg	
Dickenson	Scott	Portsmouth	
Dinwiddie	Shenandoah	*Poquoson*	
Essex	Smyth	Radford	
Fauquier	Southampton	Richmond	
Floyd	Spotsylvania	Roanoke	
Fluvanna	Stafford	*Salem*	
Franklin	Surry	Staunton	
Frederick	Sussex	Virginia Beach	
Giles	Tazewell	Williamsburg	
Gloucester	Washington	Winchester	
Goochland	Westmoreland		
Grayson	Wise		
Greene	Wythe		
Greensville	York		
Halifax			
Hanover	Cities		
Henry			
Highland	Bristol		
Isle of Wight	Buena Vista		
James City	Danville		
King George	Emporia		
King & Queen	Franklin		
King William	Galax		
Lancaster	Norton		
Lee	Suffolk		

F&C MEDICALLY NEEDY INCOME LIMITS EFFECTIVE *7-01-17*

GROUP 1			GROUP II		GROUP III	
# of Persons in Family/Budget Unit	Semi-Annual Income	Monthly Income	Semi-Annual Income	Monthly Income	Semi-Annual Income	Monthly Income
1	*1,867.21*	*311.20*	*2,154.48*	*359.08*	*2,800.83*	*466.80*
2	*2,377.24*	*396.20*	*2,653.01*	*442.16*	*3,376.83*	*562.80*
3	*2,800.83*	*466.80*	*3,088.08*	*514.68*	*3,806.27*	*634.37*
4	*3,159.92*	*526.65*	*3,447.20*	*574.53*	*4,165.39*	*694.23*
5	*3,519.01*	*586.50*	*3,806.27*	*634.37*	*4,524.45*	*754.07*
6	*3,878.09*	*646.34*	*4,165.36*	*694.22*	*4,883.53*	*813.92*
7	*4,237.17*	*706.19*	*4,524.45*	*754.07*	*5,242.62*	*873.77*
8	*4,668.08*	*778.01*	*4,955.35*	*825.89*	*5,601.71*	*933.61*
9	*5,098.98*	*849.83*	*5,438.00*	*906.33*	*6,122.01*	*1,020.33*
10	*5,601.71*	*933.61*	*5,888.98*	*981.49*	*6,535.34*	*1,089.22*
Each add'l person add	*482.57*	*80.42*	*482.57*	*80.42*	*482.57*	*80.42*

F&C 100% STANDARD OF ASSISTANCE
AMOUNTS EFFECTIVE *7/1/17*
(Used as the F&C Deeming Standard)

Group I

Household Size	Income Limit
1	*$240*
2	*366*
3	*466*
4	*565*
5	*665*
6	*751*
7	*847*
8	*948*
Each additional person add	*99*

Group II

Household Size	
1	*$314*
2	*451*
3	*567*
4	*678*
5	*797*
6	*898*
7	*1,006*
8	*1,123*
Each additional person add	*112*

Group III

Household Size	
1	*$474*
2	*635*
3	*777*
4	*912*
5	*1,078*
6	*1,199*
7	*1,334*
8	*1,476*
Each additional person add	*136*

M0810 Changes

Changed With	Effective Date	Pages Changed
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

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	2017 Monthly Amount	2016 Monthly Amount
1	$2,205	$2,199

4. ABD Medically Needy

a. Group I	7/1/2017		*7/1/2016 – 6/30/17*	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	*$1,867.21*	*$311.20*	$1,861.63	$310.27
2	*2,377.24*	*396.20*	2,370.20	395.03

b. Group II	7/1/2017		*7/1/2016 – 6/30/17*	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	*$2,154.48*	*$359.08*	$2,148.04	$358.00
2	*2,653.01*	*442.16*	2,645.09	440.84

c. Group III	7/1/2017		*7/1/2016 – 6/30/17*	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	*$2,800.83*	*$466.80*	$2,792.45	$465.40
2	*3,376.83*	*562.80*	3,366.75	561.12

5. ABD Categorically Needy

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

For:

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

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

S0820 Changes

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

S0820.130 EVIDENCE OF WAGES OR TERMINATION OF WAGES

A. Policy

1. Primary Evidence of Wages

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

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

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

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

d. Written statement from employer.

2. Secondary Evidence of Wages

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

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

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

3. Acceptable Evidence of Termination of Wages

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

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

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

c. Written statement from employer.

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

B. Procedure

1. Order of Priority

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

2. Pay Slips

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

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

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

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

3. Employer Reports

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

4. Evidence Reflects Only an Annual Wage Amount

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

C. References

- Military pay and allowances, S0830.540.

S0820.135 WAGE VERIFICATION

A. Procedure

1. Chart

This chart describes the procedure for verifying wages per month *when wages cannot be verified through an online data source.*

STEP	ACTION
1	Does the individual have acceptable pay slips for some or all of the period being verified? (See s0820.130 A. 1. a.) • If yes, go to Step 2. • If no, go to Step 8.
2	Were any wages deferred during the period covered by the pay slips? • If yes, go to Step 3. • If no, go to Step 4.
3	• Count deferred wages per S0820.115 B.2. • Document the file. • Go to Step 5.
4	• Count wages when received. • Go to Step 5.
5	Do the pay slips cover earnings for the entire period being verified or, if not, can the wages attributable to the missing pay slip(s) be determined by other evidence (e.g., year-to-date totals)? • If yes, go to Step 6. • If no, go to Step 7.
6	• Document the file with a copy or certification of the pay slips, and signed allegation (if necessary per S0820.130 B.2.) • STOP

C. Procedure

1. Verification

a. Verify these payments by examining documents in the individual's possession which reflect:

- the amount of the payment,
- the date(s) received, and
- the frequency of payment, if appropriate.

b. If the individual has no such evidence in his possession, contact the source of the payment.

c. If verification cannot be obtained by the above means, accept any evidence permitted by either S0820.130 A. or S0820.220.

2. Assumption

Assume that any honorarium received is in consideration of services rendered, absent evidence to the contrary. Evidence to the contrary would include a statement or document indicating that part or all of the honorarium is for something other than services rendered (e.g., travel expenses or lodging).

3. Expenses of Obtaining Income

DO NOT DEDUCT any expenses of obtaining income from royalties or honoraria that are earned income. (Such expenses are deductible from royalties/honoraria that are unearned income.)

4. Documentation

Document the file by including copies of documents or indicating in the file information provided by the payment source concerning the amount and, if appropriate, frequency of payment.

D. References

- Royalties as unearned income, S0830.510.
- To determine deductible IRWE/BWE, see S0820.535 - .565.

EARNED INCOME EXCLUSIONS

M0820.500 GENERAL

A. Policy

1. General

The source and amount of all earned income must be determined, but not all earned income counts when determining Medicaid eligibility.

2. Other Federal Laws

First, income is excluded as authorized by other Federal laws.

3. **2010 Census Income**

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

4. **Other Earned Income**

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

a. Federal earned income tax credit payments.

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

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

For 2016, up to $1,780 per month, but not more than $7,180 in a calendar year, of the earned income of a blind or disabled student child

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

e. $65 of earned income in a month.

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

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

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

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

5. **Unused Exclusion**

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

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

6. **Couples**

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

B. References

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

- S0810.410 for infrequent/irregular income
- S0810.420 $20 general exclusion
- S0810.430 amount to fulfill a plan for achieving self-support

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

M1120 Changes

Changed With	Effective Date	Pages Changed
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

D. Policy - Trust as Resources

1. Trusts Which Are Resources

a. General

If an individual (applicant or recipient) has legal authority to revoke the trust and then use the funds to meet his food, clothing or shelter needs, or if the individual can direct the use of the trust principal for his/her support and maintenance under the terms of the trust, the trust principal is a resource for Medicaid purposes.

If the individual can sell his beneficial interest in a trust, that interest is a resource. For example, if the trust provides for payment of $100 per month to the beneficiary for spending money, absent a prohibition to the contrary, the beneficiary may be able to sell the right to future payments for a lump-sum payment.

- M1120.200, B, 11
- M1140.402, Medicaid Qualifying Trust

b. Authority to Revoke Trust or Use Assets

- Grantor

  In some cases, the authority to revoke a trust is held by the grantor. Even if the power to revoke a trust is not specifically retained, a trust may be revocable in certain situations. (See B.8. above and 3. below for information on grantor trusts.) Additionally, State law may contain presumptions as to the revocability of trusts. If the trust principal reverts to the grantor upon revocation and can be used for support and maintenance, then the principal is a resource.

- Beneficiary

  A beneficiary generally does not have the power to revoke a trust. However, the trust may be a resource to the beneficiary, in the rare instance, where he/she has the authority under the trust to direct the use of the trust principal. (The authority to control the trust principal may be either specific trust provisions allowing the beneficiary to act on his/her own or by ordering actions by the trustee.) In such a case, the beneficiary's equitable ownership in the trust principal and his/her ability to use it for support and maintenance means it is a resource.

  The beneficiary's right to mandatory periodic payments may be a resource equal to the present value of the anticipated string of payments unless a valid spendthrift clause or other language prohibits anticipation of payments.

  While a trustee may have discretion to use the trust principal for the benefit of the beneficiary, the trustee should be considered a third party and not an agent of the beneficiary, i.e., the actions of the trustee are not the actions of the beneficiary, unless the trust specifically so provides.

E. Policy – Disbursements from Trusts

1. When Trust Principal Is Not a Resource

If the trust principal is not a resource, disbursements from the trust may be income to the beneficiary, depending on the nature of the disbursements. Regular rules to determine when income is available apply.

a. Disbursements Which are Income

Cash paid directly from the trust to the individual is unearned income.

b. Disbursements Which Result in Receipt of In-kind Support and Maintenance

Food, clothing or shelter received as a result of disbursements from the trust by the trustee to a third party are income in the form of in-kind support and maintenance and are not counted for Medicaid purposes.

c. Disbursements Which Are Not Income

Disbursements from the trust by the trustee to a third party that result in the individual receiving items that are not food, clothing or shelter are not income. For example, if trust funds are paid to a provider of medical services for care rendered to the individual, the disbursements are not income for Medicaid purposes.

2. When Trust Principal Is a Resource – Trusts Created By Will or Prior to Aug. 11, 1993

If the trust principal is a resource to the individual, disbursements from the trust principal received by the individual are not income, but conversion of a resource. *However, trust earnings are income.* See S1110.100 for instructions pertaining to conversion of resources from one form to another and F.2. below for treatment of income when the trust principal is a resource.

3. When Trust Principle is a Resource – For Trust Created on or After August 11, 1993

Effective August 11, 1993:

- payments for the benefit of the individual are counted as unearned income;
- corpus is a resource, and
- payments to other individual(s) are evaluated as asset-transfer;
- trust earnings, e.g., interest, are income.

F. Policy Earnings/Additions to Trusts

1. Trust Principal Is Not a Resource

a. Trust Earnings

Trust earnings are not income to the trustee or grantor unless designated as belonging to the trustee or grantor under the terms of the trust; e.g., as fees payable to the trustee or interest payable to the grantor.

Trust earnings are not income to the Medicaid *applicant*/recipient who is a trust beneficiary unless the trust directs, or the trustee makes, payment to the beneficiary.

b. Additions to Principal

Additions to trust principal made directly to the trust are not income to the grantor, trustee or beneficiary. Exceptions to this rule are listed in c. and d. below.

c. Exceptions

Certain payments are non-assignable by law and, therefore, are income to the individual entitled to receive the payment under regular income rules. They may not be paid directly into a trust, but individuals may attempt to structure trusts so that it appears that they are so paid. Non-assignable payments included:

- *Temporary Assistance to Needy Families (TANF);*
- Railroad Retirement Board-administered pensions;
- Veterans pensions and assistance;
- Federal employee retirement payments (CSRS, FERS) administered by the Office of Personnel Management;
- Social Security title II and SSI payments; and
- Private pensions under the Employee Retirement Income Security Act (ERISA) (29 U.S.C.A. section 1056(d)).

d. Assignment of Income

A legally assignable payment (see c. above for what is not assignable), that is assigned to a trust, is income for Medicaid purposes unless the assignment is irrevocable. If the assignment is revocable, the payment is income to the individual legally entitled to receive it.

M1130 Changes

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

M1130.140 REAL PROPERTY FOLLOWING REASONABLE BUT UNSUCCESSFUL EFFORTS TO SELL

A. Policy Principles

1. Exclusion

Real property, including a life estate in real property created on or after August 28, 2008 but before February 24, 2009, that an individual has made reasonable but unsuccessful efforts to sell, will continue to be excluded for as long as:

- the individual continues to make reasonable efforts to sell it; and
- including the property as a countable resource would result in a determination of excess resources.

This exclusion is effective the first of the month in which the most recent application was filed or up to three months prior if retroactive coverage is required.

B. Operating Procedure

The "current market" value (CMV) of real property located in Virginia is the tax assessed value of the property ***or****, effective 10/4/16, the certified value as determined by an appraiser licensed in Virginia. The use of an appraisal is applicable only to non-commercial real property. See M1110.400.*

For property located outside of Virginia the CMV is determined by applying the tax assessed value of the property to the local assessment rate, if the rate is not 100%, ***or****, effective 10/4/16, the certified value as determined by an appraiser licensed in the state in which the real property is located. The use of an appraisal is applicable only to non-commercial real property.*

1. Initial Effort Established

The following criteria define reasonable efforts to sell. The listing price must not exceed 100% of CMV in order for the initial effort to sell to be met.

A reasonable effort to sell is considered to have been made:

a. As of the date the property becomes subject to a realtor's listing agreement (must be actively marketed) if it is listed at no more than current market value **AND** the listing realtor verifies that it is unlikely to sell within 90 days of listing given particular circumstances involved; for example

- owner's fractional interest;
- zoning restrictions;
- poor topography;
- absence of road frontage or access;
- absence of improvements;
- clouds on title;
- right of way or easement;
- local market conditions; or

b. When at least two realtors employed by different realty companies refuse to list the property. The reason for refusal must be that the property is unsalable at CMV (other reasons are not sufficient – documentation of the property's deficiencies must be provided); or

c. When the applicant has personally advertised his property at or below CMV for 90 days by use of a "Sale by Owner" sign located on the property and by other reasonable efforts, such as newspaper advertisements, reasonable inquiries with all adjoining land-owners, or other potential interested purchasers.

d. For property which is an interest in an undivided estate and for jointly owned property when a co-owner refuses to sell, an initial reasonable effort to sell shall have been made when all other co-owners have refused to purchase the applicant's or recipient's share, and at least one of the other co-owners has refused to agree to sell the property.

e. For property owned by an individual who is incompetent and has no one authorized to sell real property on his behalf, when court action is initiated for appointment of a guardian or conservator to secure the court's approval to dispose of the property, an initial effort to sell shall be deemed to have been made beginning the date the hearing for appointment of a guardian is placed on the court docket and continuing until the court authorizes sale of the property or through the sixth month after the initiation of the court action, whichever comes first. Any period of time in excess of six months to secure appointment of a guardian and authorization to sell by the court is not deemed reasonable and the property loses this exemption.

Upon authorization, and only upon authorization, the guardian must place the property on the market according to the criteria in M1130.140 B.1.a-d and make a continuing effort to sell the property as described in M1130.140 B.3.

2. Retroactive Exclusion

There will be applications received with property already listed for sale. Inform the applicant of Reasonable Efforts to Sell policy. If the real property was already listed for more than the CMV when the individual applied for Medicaid, a reasonable effort to sell was made for the retroactive period and the month of application if:

- the property was listed at no more than 100% CMV

or

- the property was listed at or below 150% of CMV and the initial effort to sell requirement described above is met except for the listing price.

If the list price was initially higher than100% of the CMV, the listed sales price must be reduced to no more than 100% of the CMV to meet the continuing efforts to sell requirement.

If property was not listed when the application was filed or was listed higher than 150% of CMV, a reasonable effort to sell exclusion cannot be established for the retroactive period.

3. Continuing Effort to Sell

Notwithstanding the fact that the recipient made a reasonable effort to sell the property and failed to sell it, and although the recipient has become eligible, the recipient must make a continuing reasonable effort to sell until the property is sold or Medicaid coverage is canceled. Depending on how the initial effort to sell was met, a continuing effort to sell is met as follows:

a. When the property was listed at no more than the CMV and the listing realtor verified that the property is unlikely to sell within 90 days of listing per M1130.140 B.1.a, the listing agreement must continually be renewed at no more than 100% of the taxed assessed value, until the property is sold. If the list price was initially higher than the tax-assessed value, the listed sales price must be reduced to no more than 100% of the tax-assessed value.

b. In the case where at least two realtors have refused to list the property per M1130.140 B.1.b, the recipient must personally try to sell the property by efforts described in B.1.c. above, for 12 months.

c. In the case of recipient who has personally advertised his property for a year without success per M1130.140 B.1.c, (the newspaper advertisements, "for sale" sign, do not have to be continuous; these efforts must be done for at least 90 days within a 12 month period), the recipient must then:

- subject his property to a realtor's listing agreement (must be actively marketed) priced at or below current market value; or
- meet the requirements of M1130.140 B.1.b. above, which are that the recipient must try to list the property and at least two realtors must refuse to list it because it is unsaleable at current market value; other reasons for refusal to list are not sufficient.

d. When there is jointly owned property which a co-owner has refused to sell or when the property is an interest in an undivided estate, and the initial effort to sell was met per M1130.140 B.1.d., a partition suit is necessary in order to liquidate the property A continuing reasonable effort to sell the property shall be demonstrated by filing suit with the court to partition the property within 60 days of proving the property is otherwise unsaleable (in accordance with section B.1.e.) and shall continue until the property is sold or 9 months, whichever is less. Any period of time in excess of 9 months to sell shall not be deemed reasonable and the property loses this exemption.

4. After Continuing Effort Has Been Established

Even when real property is excluded while reasonable efforts to sell it are met, the sale of real property for less than *its CMV* is subject to an asset transfer penalty for the Medicaid payment of long-term care services (see M1450). However, if the individual made a continuing effort to sell the property for 12 months, then the individual may sell the property between 75% and 100% of its *CMV* without a penalty.

If the individual sells his property at less than 75% of *its CMV*, he must submit documentation from the listing realtor, or knowledgeable source if the property was not listed with a realtor, that the sale price was the best price the recipient can expect to receive for the property at this time. In this situation a sale can take place for less than 75% of *its CMV* without penalty.

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

A. Policy

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

An ABLE program can be established and maintained by a State or a State agency directly or by contracting with a private company working with the State. In Virginia, the ABLE program is operated by the Virginia529 program.

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

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

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

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

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

B. Procedures

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

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

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

S1140 Changes

Updated With	Effective Date	Pages Changed
TN #DMAS-5	7/1/17	Page 7
UP #9	4/1/13	pages 2, 17
TN #97	9/1/12	Table of Contents, page i Table of Contents page ii was removed. pages 2, 16-19, 26, 26a
TN #96	10/1/11	pages 12-12a, 24
TN #93	1/1/10	pages 13-15 pages 24, 25
TN #91	5/15/09	pages 11-12a

D. Development and Documentation Current Market Value

1. Tax Assessment Notice

a. When to Use

Obtain a copy of the most recently issued tax assessment notice for the property . Base the CMV on this assessment.

b. How to Use

To determine CMV based on a tax assessment notice, divide the assessed value by the assessment ratio. For example, an assessed value of $2,000 divided by an assessment ratio of 50 percent equals a CMV of $4,000.

2. Certified Real Property Assessment

a. When to Use

Effective 10/4/16, the certified value of real property as determined by an appraiser licensed in the state in which the real property is located, is accepted as the property's CMV.

b. How to Use

The use of an appraisal is applicable only to non-commercial real property. A certified appraisal documenting the value of the property must contain the name and license number of the individual conducting the appraisal. A copy of the appraisal must be scanned into the VaCMS case record or placed in the paper case record. See M0110.400.

3. Knowledge-able Source Estimate

a. **When to Use**

If an individual owns property which does not have a tax assessment, in order to establish CMV, have the individual obtain an estimate of the property's CMV from a knowledgeable source.

b. What The Estimate Must Show

The estimate must show, in addition to the estimate itself:

- the name of the person providing the estimate;
- the name, address and telephone number of the business or agency for whom the person providing the estimate works;
- the basis for the estimate, to include such things as a description of the property and its condition and, where appropriate, the value of similar property in the same area; and
- the period to which the estimate applies (which should correspond to the period for which it is being request).

M1370 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-3	1/1/17	Table of Contents, page i. Pages 1-3 Pages 4, 5 and 6 were removed.
TN #DMAS-3	1/1/17	Pages 3-5
TN #100	5/1/15	Title page
TN #99	1/1/14	Page 2
UP #9	4/1/13	Table of Contents Pages 1-5 Page 6 was added.
TN #94	9/1/10	Table of Contents Pages 1-5

TABLE OF CONTENTS

M13 SPENDDOWN

M1370 SPENDDOWN –LIMITED BENEFIT ENROLLEES

M1370.000 SPENDDOWN –*LIMITED BENEFIT ENROLLEES*

M1370.100 SPENDDOWN – *LIMITED BENEFIT ENROLLEES*

A. Introduction

This policy applies to individuals enrolled in one of the following limited benefit Medicaid covered groups:

- Qualified Medicare Beneficiaries (QMBs),
- Special Low-income Medicare Beneficiaries (SLMBs),
- Qualified Individuals (QIs),
- Qualified Disabled Working Individuals (QDWIs), and
- Plan First individuals *who meet a medically needy (MN) covered group.*

These enrollees are eligible for only a limited package of Medicaid services. They do not receive full Medicaid coverage, therefore they must be evaluated to determine if they could become eligible for full Medicaid coverage as medically needy (MN) by meeting a spenddown.

QMB, SLMB, QI, and QDWI individuals meet the ABD MN covered group. Individuals enrolled in the Plan First covered group do not necessarily meet an MN covered group. If a Plan First enrollee *also* meets a MN covered group listed in M0320 or M0330, he must be evaluated to determine if he could become eligible for full Medicaid coverage MN by meeting a spenddown.

This policy does not apply to individuals in full-benefit covered groups.

1. Placement on Spenddown

At application and redetermination, *limited benefit* enrollees who meet the MN covered group and resource requirements are placed on two six-month spenddown budget periods within the 12 month renewal certification period. They may also be eligible for retroactive MN spenddown eligibility.

When only one spouse of an aged, blind or disabled (ABD) couple is eligible for limited benefit Medicaid (i.e., one spouse has Medicare and the other does not), the couple is an assistance unit of two for spenddown purposes and placed on two six-month spenddowns.

2. Spenddown Not Met

If an individual who is enrolled in limited-benefit Medicaid coverage does not meet the spenddown, he continues to be eligible for limited benefits. He is subject to the eligibility review policies in M1520.

The spenddown budget period is based on the application date. At renewal, the new spenddown budget period begins the month following the end of the previous spenddown budget period if the renewal is filed in the last month of the spenddown budget period or the following month.

If the renewal is filed two or more months after the end of the last spenddown budget period, the new spenddown budget periods (retroactive or prospective) are based on the date the renewal form was received in the LDSS. Do not complete an early renewal on a spenddown case because the spenddown period must not be shortened by the completion of an early renewal.

M1370.200 ENROLLMENT PROCEDURES FOR LIMITED-BENEFIT ENROLLEES WHO MEET A SPENDDOWN

A. Policy

QMBs are eligible only for Medicaid coverage of their Medicare premiums, the Medicare deductible and coinsurance charges for Medicare covered services. Medicare does not cover all of the services that Medicaid covers. For example, Medicare does not cover non-emergency transportation.

SLMBs and QDWIs are eligible only for Medicaid coverage of certain Medicare premiums.

Plan First enrollees are eligible only for limited Medicaid coverage related to family planning services and transportation to access those services.

B. Entitlement After Meeting Spenddown

When an enrolled QMB, SLMB, QDWI or Plan First enrollee meets a medically needy spenddown, he is eligible for Medicaid as medically needy beginning the date the spenddown was met and ending the last day of the spenddown budget period.

C. Enrollment Procedures

The *enrollee's limited coverage* must be canceled and *full coverage* reinstated *in VaCMS* in order for the individual to receive the full scope of Medicaid services for the portion of the spenddown budget period in which he is eligible as medically needy. Take the following actions:

1. Cancel Limited Benefit Coverage

Cancel the enrollee's current coverage line that has the limited-benefit aid category (AC).

a. Cancel date is the date **before** the date the spenddown was met.

b. Cancel reason is "024".

2. Reinstate MN Coverage

Reinstate the enrollee in the appropriate medically needy aid category (AC).

- enter the eligibility begin date as the date the spenddown was met.
- enter the eligibility end date - the date the spenddown budget period ends.

Be sure that the application date is the first month in the spenddown budget period. Eligibility will be cancelled effective the end date entered.

D. Continuing Eligibility and Enrollment After Spenddown Ends

When the spenddown budget period ends, reinstate the enrollee's Medicaid eligibility as medically indigent beginning the day after the MN spenddown budget period eligibility cancel date. Use the original Medicaid application date. Limited-benefit Medicaid eligibility resumes the first day of the month following the end of the spenddown budget period. The month in which the spenddown budget period ends is considered the month in which the agency determines the enrollee's limited benefit eligibility.

Use the procedures in section M1520.200 for completing the annual *renewal* and establishing new spenddown budget periods. Eligibility for each spenddown budget period is evaluated.

Note: Because Plan First enrollees do not have a resource test, it is necessary to obtain resource information for Plan First enrollees who meet an MN covered group *at the time of renewal.*

E. Example--QMB Meets Spenddown

EXAMPLE #1: Mr. B is 69 years old. He has Medicare Parts A & B. He applied for Medicaid on July 14, 2005. Resources are within the medically needy limit. His income exceeds the medically needy limit, but is less than the QMB limit. His eligibility is determined on August 1, 2005. He is enrolled in Medicaid QMB coverage effective September 1, 2005, the month following the month the agency determined his QMB eligibility. He is placed on two consecutive 6-month spenddown budget periods, July 1, 2005 through December 31, 2005 and January 1 through June 30, 2006. The agency enrolls him with an eligibility begin date of September 1, 2005, AC 023.

On September 15, 2005, he brings in prescription drug bills. He meets the spenddown on September 13, 2005. On September 25, 2005, the agency cancels his QMB coverage (AC.023) effective September 12, 2005. He is reinstated with MN Medicaid eligibility as AC 028 (dual-eligible medically needy aged) with a begin date of September 13, 2005, an application date of July 14, 2005, and an end date of December 31, 2005.

His spenddown eligibility ends December 31, 2005. On January 1, 2006, the agency worker reinstates his QMB-only Medicaid coverage with a begin date of January 1, 2006, AC 023, application date July 14, 2005. He remains on a spenddown for the spenddown budget period January 1, 2006 through June 30, 2006.

M1410 Changes

Changed With	Effective Date	Pages Changed
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

B. Ineligible Individuals

The following individuals are not eligible for *full* Medicaid *coverage*:

- an inmate in a public institution; see section M1430.102 for the definition of an inmate in a public institution. *Incarcerated individuals (adults and juveniles) can be eligible for Medicaid payment limited to services received during an inpatient hospitalization, provided they meet all other Medicaid eligibility requirements. See M0280.300.*
- individuals under age 65 who are patients in an institution for mental diseases (IMD), unless they are under age 22 and receiving inpatient psychiatric services.

C. Types of Medical Institutions

The following are types of medical institutions in which Medicaid will cover part of the cost of care for eligible individuals:

1. Chronic Disease Hospitals

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

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

2. Hospitals and/or Training Centers for the Intellectually Disabled

Facilities (medical institutions) that specialize in the care of intellectually disabled individuals. Intermediate Care Facilities for the Intellectually Disabled (ICF/IDs) are certified by the Department of Health to provide care in a group home setting. Patients in these facilities may have income from participating in work programs.

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

3. Institutions for Mental Diseases (IMDs)

A hospital, nursing facility or other medical institution that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, of persons with mental diseases. An institution for the mentally retarded is not an IMD.

NOTE: Medically needy (MN) patients age 65 or older are not eligible for Medicaid payment of LTC in an IMD because these services are not covered for medically needy individuals age 65 or over.

4. Intermediate Care Facility (ICF)

A medical institution licensed by the state to provide, on a regular basis, health-related services to patients who do not require hospital or skilled nursing facility care, but whose mental or physical condition requires services in addition to room and board which can be made available only in an institutional setting.

5. Nursing Facility

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

6. Rehabilitation Hospitals

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

M1410.040 COMMUNITY-BASED CARE WAIVER SERVICES

A. Introduction

Medicaid covers long-term care in a community-based setting to individuals whose mental or physical condition requires nursing supervision and assistance with activities of daily living.

This section provides general information about the Community-based Care (CBC) Waiver Services covered by Medicaid. The detailed descriptions of the waivers and the policy and procedures specific to patients in CBC are contained in subchapter M1440.

B. Community-Based Care Waivered Services (CBC)

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

C. Virginia's Waivers

Virginia has approved Section 1915(c) home and community-based *care* waivers. These waivers contain services that are otherwise not available to the general Medicaid population. The target population and service configuration for each waiver is outlined in subchapter M1440. An individual cannot receive services under two or more waivers simultaneously; the individual can receive services under only one waiver at a time.

1. *Commonwealth Coordinated Care Plus Waiver*

Effective July 1, 2017, the Elderly or Disabled with Consumer-Direction (EDCD) Waiver and the Technology Assisted (Tech) Waiver were combined and are known as the Commonwealth Coordinated Care Plus (CCC Plus) Waiver. The CCC Plus Waiver serves aged individuals and disabled individuals who would otherwise require institutionalization in a nursing facility. The waiver also serves "technology-assisted" 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.

The individual may choose to receive 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 and/or the person directing the care for the recipient. If an individual is incapable of directing his own care, a spouse, parent, adult child, or guardian may direct the care on behalf of the recipient. Services available through this waiver include:

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

Services provided through CCC Plus Waiver for technology-assisted individuals are expected to prevent placement, or to shorten the length of stay, in a hospital or nursing facility and include:

- *private duty nursing*
- *nutritional supplements*
- *medical supplies and equipment not otherwise available under the Medicaid State Plan.*

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

As part of the My Life, My Community Developmental Disabilities Waiver Redesign, the Intellectual Disabilities (ID) Waiver was renamed the Community Living Waiver in 2016. The waiver is targeted to provide home and community-based services to individuals with developmental disabilities and individuals under the age of six years at developmental risk who have been determined to require the level of care provided in an ICF/ID, and to individuals with related conditions currently residing in nursing facilities who require specialized services. See M1440, Appendix 1 for a list of services available through this waiver.

3. **Family and Individual Supports Waiver (Formerly the Individual and Family Developmental Disabilities Support Waiver)**

As part of the My Life, My Community Waiver Developmental Disabilities Redesign, the Individual and Family Developmental Disabilities Support (DD) Waiver was renamed the Family and Individual Supports Waiver in 2016. The waiver provides home and community-based services to individuals with developmental disabilities. See M1440, Appendix 1 for a list of services available through this waiver.

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

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

5. **Alzheimer's Assisted Living Waiver**

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

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

The services provided under the AAL waiver include:

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

M1420 Changes

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

M1420.200 RESPONSIBILITY FOR PRE-ADMISSION SCREENING

A. Introduction

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

B. Nursing Facility Screening

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

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

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

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

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

C. CBC Screening

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

1. *Commonwealth Coordinated Care Plus Waiver*

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

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

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

3. **Family and Individual Supports Waiver (Formerly the Individual and Family Developmental Disabilities Support Waiver)**

DMAS and the Virginia Health Department child development clinics are authorized to screen individuals for the Family and Individual Supports Waiver.

4. **Alzheimer's Assisted Living (AAL)Waiver**

Local screening committees/teams and hospital screening committees/teams are authorized to screen individuals for the AAL waiver; however, a copy of the pre-admission screening is not required for the Medicaid eligibility record. Documentation of the verbal assurance by the screeners must be included in the case record.

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

Local CSB and DBHDS case managers are authorized to screen individuals for the Building Independence Waiver. Final authorizations for the waiver services are made by DBHDS staff.

D. PACE

Local screening committees/teams and hospital screening committees/teams are authorized to screen individuals for PACE. If the individual is screened and approved for LTC, the committee/team will inform the individual about any existing PACE program that serves the individual's locality.

M1420.300 COMMUNICATION PROCEDURES

A. Introduction

To ensure that nursing facility/PACE placement or receipt of Medicaid CBC services are be arranged as quickly as possible, there must be prompt communication between screeners and eligibility staff.

B. Procedures

1. LDSS Contact

The LDSS should designate an appropriate staff member for screeners to contact. Local social services staff, hospital staff and DARS staff should be given the name and contact information for that person to facilitate timely communication between screeners and eligibility staff.

2. Screeners

Screeners must inform the individual's eligibility worker when the screening process has been initiated and completed.

3. Eligibility Worker (EW) Action

The EW must inform both the individual and the provider once eligibility for Medicaid payment of LTC services has been determined. If the individual is found eligible for Medicaid and verbal or written assurance of approval by the screening committee has been received, the eligibility worker must give the LTC provider the enrollee's Medicaid identification number.

M1420.400 SCREENING CERTIFICATION

A. Purpose

The screening certification authorizes the local DSS to determine financial eligibility using the more liberal rules for institutionalized individuals, including the 300% SSI covered group and the special rules for married institutionalized individuals with a community spouse. The screening certification is valid for one year.

B. Exceptions to Screening

Pre-admission screening is NOT required when:

- the individual is a patient in a nursing facility at the time of application;
- the individual received Medicaid LTC in one or more of the preceding 12 months and LTC was terminated for a reason other than no longer meeting the level of care;
- the individual enters a nursing facility directly from the *CCC Plus* Waiver or PACE;
- the individual leaves a nursing facility and begins receiving *CCC Plus* Waiver services or enters PACE **and** a pre-admission screening was completed prior to the nursing facility admission;
- the individual enters a nursing facility from out-of-state;
- the individual is in a Veteran's Administration Medical Center (VAMC) at the time of the request for nursing facility or *CCC Plus*/PACE services (these individuals receive an equivalent VAMC screening);
- an individual with full Medicaid coverage was or is expected to be admitted to a nursing facility for less than 30 days; or.
- the individual is no longer in need of long-term care but is requesting assistance for a prior period of long term care.

C. Documentation

If the individual has not been institutionalized for at least 30 consecutive days and a screening is required, the screener's certification of approval for Medicaid long-term care must be substantiated in the case record by one of the following documents:

- Medicaid Funded Long-term Care Service Authorization Form (DMAS-96) for nursing facilities, PACE and *CCC Plus* Waivers (see Appendix 1) or the equivalent information printed from the Pre-admission Screening (PAS) system;

- Technology Assisted Waiver Level of Care Eligibility Form (see Appendix 2) *for individuals in the CCC Plus Waiver requiring technology-assisted services*;

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

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

1. Nursing Facility/PACE

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

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

2. *CCC Plus* Waiver

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

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

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

***3.* Community Living Waiver Authorization Screen Print**

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

***4.* Building Independence Waiver Level of Authorization Screen Print**

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

***5.* Family and Individual Supports Waiver Authorization Screen Print**

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

D. Authorization for LTC Services

If the screening approval document is not available when placement needs to be made, verbal assurance from a screener or DMAS that the form approving long-term care will be mailed or delivered is sufficient to determine Medicaid eligibility as an institutionalized individual. However, the appropriate form must be received prior to approval and enrollment in Medicaid as an institutionalized individual.

The appropriate authorization document (form or screen print) must be maintained in the individual's case record.

1. Authorization Not Received

If a pre-admission screening is required and the appropriate documentation is not received, Medicaid eligibility for an individual who is living in the community must be determined as a non-institutionalized individual.

2. Authorization Rescinded

The authorization for Medicaid payment of LTC services may be rescinded by the physician or by DMAS at any point that the individual is determined to no longer meet the required Medicaid level of care criteria.

When an individual is no longer eligible for a CBC Waiver service, the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

When an individual leaves the PACE program and no longer receives LTC services, the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

For an individual in a nursing facility who no longer meets the level of care but continues to reside in the facility, continue to use the eligibility rules for institutional individuals even though the individual no longer meets the level of care criteria. If the individual is eligible for Medicaid, Medicaid will not make a payment to the facility for LTC.

M1440 Changes

Changed With	Effective Date	Pages Changed
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

TABLE OF CONTENTS

M14 LONG-TERM CARE

M1440.000 COMMUNITY-BASED CARE WAIVER SERVICES

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, the resource and income eligibility criteria in subchapter M1460 is applicable.

For married individuals with community spouses, 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:

1. Developmental Disability

"Developmental disability," as defined in Virginia Code § 37.2-100, means a severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment, or a combination of mental and physical impairments, other than a sole diagnosis of mental illness; (ii) is manifested before the individual reaches 22 years of age; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, or economic self-sufficiency; (v) reflects the individual's need for a combination and sequence of special interdisciplinary or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated; and (vi) an individual from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability without meeting three or more of the criteria described in clauses (i) through (v), if the individual, without services and supports, has a high probability of meeting those criteria later in life.

2. Financial Eligibility Criteria

means the rules regarding asset transfers; what is a resource; when and how that resource counts; what is income; when and how that income is considered.

3. Non-financial Eligibility Criteria

means the Medicaid rules for non-financial eligibility. These are the rules for citizenship and alienage; state residence; social security number; assignment of rights and cooperation; application for other benefits; institutional status; cooperation DCSE; and covered group and category requirements.

4. Patient

an individual who has been approved by a pre-admission screener to receive Medicaid waiver services.

C. Developmental Disabilities Waivers

In 2016, as part of the My Life, My Community Waiver Redesign, the Intellectual Disabilities Waiver, Day Support Waiver and Individual and Family Developmental Disabilities Support Waiver (DD waiver) were renamed. They were renamed to the Community Living Waiver, Building Independence Waiver, and Family and Individual Supports Waivers, respectively. These waivers are referred to collectively as the Developmental Disabilities Waivers. The services offered under these waivers are contained in M1440, Appendix 1.

M1440.101 *COMMONWEALTH COORDINATED CARE PLUS WAIVER (FORMERLY THE EDCD AND TECHNOLOGY ASSISTED WAIVERS)*

A. General Description

Effective July 1, 2017, the Elderly or Disabled with Consumer-Direction (EDCD) Waiver and the Technology Assisted (Tech) Waiver were combined and are known as the Commonwealth Coordinated Care Plus (CCC Plus) Waiver. The CCC Plus Waiver is targeted to provide home and community-based services to individuals age 65 or older, or who are disabled, who have been determined to require the level of care provided in a medical institution and are at risk of facility placement. The waiver also serves "technology-assisted"

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 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. 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).

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).*

Services provided through CCC Plus Waiver for technology-assisted individuals include:

- *private duty nursing*
- *nutritional supplements*
- *medical supplies and equipment not otherwise available under the Medicaid State Plan.*

E. ***Assessment and Service Authorization*** — *The nursing home pre-admission screeners assess and authorize CCC Plus Waiver services based on a determination that the individual is at risk of nursing facility placement.*

M1440.102 COMMUNITY LIVING WAIVER

A. General Description — The Community Living Waiver program, formerly the Intellectual Disabilities (ID) Waiver, is targeted to provide home and community-based services to individuals with developmental disabilities and individuals under the age of six years at developmental risk who have been determined to require the level of care provided in an ICF/ID.

B. Eligibility Rules — All patients receiving waiver services must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid-eligible in a medical institution. The resource and income rules are applied to waiver eligible individuals as if the individual were residing in a medical institution.

The income limit used for this waiver is 300% of the current SSI payment standard for one person**. Medically Needy individuals are not eligible for this waiver.** If the individual's income exceeds 300% SSI, the individual is not eligible for services under this waiver.

C. Services Available — The services available under the Community Living Waiver are included in M1440, Appendix 1.

D. Assessment and Service Authorization — The individual's need for CBC is determined by the Community Services Board (CSB), Behavioral Health Authority (BHA) or Department for Aging and Rehabilitative Services (DARS) case manager after completion of a comprehensive assessment.

All recommendations are submitted to Department of Behavioral Health and Developmental Services (DBHDS) or DMAS staff for final authorization.

1. CSB — The CSB/BHA support coordinator/case manager may only recommend waiver services if:

- the individual is found Medicaid eligible; and
- the individual is intellectually disabled, or is under age 6 and at developmental risk; and
- the individual is not an inpatient of a nursing facility or hospital.

2. DARS The DARS case manager may only recommend waiver services if:

- the individual is found Medicaid eligible, and
  - the individual is in a nursing facility and has a related condition such as defined in the federal Medicaid regulations.

M1440.103 BUILDING INDEPENDENCE WAIVER

A. General Description

The Building Independence Waiver, formerly the Day Support (DS) Waiver, is targeted to provide home and community-based services to individuals with developmental disabilities who have been determined to require the level of care provided in an ICF/ID. These individuals may reside in an ICF/ID or may be in the community at the time of the assessment for Building Independence Waiver services.

B. Eligibility Rules

All patients receiving waiver services must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid-eligible in a medical institution. The resource and income rules are applied to waiver eligible individuals as if the individual were residing in a medical institution.

The income limit used for this waiver is 300% of the current SSI payment standard for one person. **Medically needy individuals are not eligible for this waiver**. If the individual's income exceeds 300% SSI, the individual is not eligible for services under this waiver.

C. Services Available

The services available under the Building Independence Waiver are included in M1440, Appendix 1.

D. Assessment and Service Authorization

The individual's need for CBC is determined by the CSB, BHA or DBHDS support coordinator/case manager after completion of a comprehensive assessment. All recommendations are submitted to DBHDS staff for final authorization.

M1440.104 ALZHEIMER'S ASSISTED LIVING WAIVER

A. General Description

The Alzheimer's Assisted Living (AAL) Waiver is available only to individuals who are Auxiliary Grants (AG) recipients. The AAL Waiver allows for the provision of services to individuals in approved assisted living facilities who, without the waiver, might require nursing home placement. **Individuals on this waiver do not have Medicaid eligibility determined as institutionalized individuals, and there are no post-eligibility requirements**.

The AAL waiver serves persons who are:

- Auxiliary Grants (AG) recipients,
- have a diagnosis of Alzheimer's or a related dementia and no diagnosis of mental illness or intellectual disability, and
- age 55 or older.

B. Eligibility Rules

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).

C. Services Available

Services available under the AAL waiver are**:**

- assistance with activities of daily living
- medication administration by licensed professionals
- nursing services for assessments and evaluations
- therapeutic social and recreational programming which provides daily activities for individuals with dementia.

D. Assessment and Service Authorization

Local and hospital screening committees or teams are authorized to screen individuals for the AAL waiver; however, a copy of the pre-admission screening is not required for the Medicaid eligibility record.

M1440.105 FAMILY AND INDIVIDUAL SUPPORTS WAIVER

A. General Description

The Family and Individual Supports Waiver, formerly the Individual and Family Developmental Disabilities Support Waiver (DD waiver), provides home and community-based services to individuals with developmental disabilities, who do not have a diagnosis of developmental disability. The objective of the waiver is to provide medically appropriate and cost-effective coverage of services necessary to maintain these individuals in the community and prevent placement in a medical institution.

B. Eligibility Rules

All patients receiving waiver services must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid eligible in a medical institution. The resource and income rules are applied to waiver eligible individuals as if the individuals were residing in a medical institution.

The income limit used for this waiver is 300% of the SSI limit (see M0810.002 A. 3.). **Medically Needy individuals are not eligible for this waive**r. If the individual's income exceeds 300% SSI, the individual is not eligible for services under this waiver.

C. Services Available

The services available under the Family and Individual Supports Waiver are included in M1440, Appendix 1.

D. Assessment and Service Authorization

The individual's need for CBC is determined by the CSB, BHA or DBHDS support coordinator/case manager after completion of a comprehensive assessment. All recommendations are submitted to DBHDS staff for final authorization.

M1440.106 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

A. General Description

PACE is NOT a CBC Waiver, but rather is the State's community model for the integration of acute and long-term care. PACE combines Medicaid and Medicare funding. PACE provides the entire spectrum of acute and long-term care services to enrollees without limitations on the duration of services or the dollars spent and is centered on an adult day health care model.

B. Targeted Population

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 their health care and long-term care medical needs. Individuals who meet the criteria for the *CCC Plus* Waiver may be enrolled in PACE in lieu of the *CCC Plus* Waiver.

C. Eligibility Rules

For Medicaid to cover PACE services, the individual must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid eligible in a medical institution. The resource and income rules are applied to PACE-eligible individuals as if the individuals were residing in a medical institution.

The income limit used for PACE is 300% of the SSI limit (see M0810.002 A. 3.) or the MN income limit and spenddown.

PACE is not available to individuals who reside in an assisted living facility (ALF) and receive Auxiliary Grant (AG) payments. Individuals who reside in an ALF may be enrolled in PACE if they meet the functional, medical/nursing, and financial requirements, but they will not be permitted to receive an AG payment.

D. Services Available

The following services are provided through PACE:

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

When an individual receives Hospice services, the hospice is required to provide the first 21 hours per week of personal care needed and a maximum of an additional 38.5 hours per week.

D. Who May Receive the Service

An individual must meet the criteria of the *CCC Plus* Waiver to qualify for Personal/Respite Care services.

M1440.202 ADULT DAY HEALTH CARE SERVICES

A. What Is Adult Day Health Care

Adult Day Health Care (ADHC) is a congregate service setting where individuals receive assistance with activities of daily living (e.g., ambulating, transfers, toileting, eating/feeding), oversight of medical conditions, administration of medications, a meal, care coordination including referrals to rehabilitation or other services if needed, and recreation/social activities. A person may attend half or whole days, and from one to seven days a week, depending on the patient's capability, preferences, and available support system.

B. Relationship to Other Services

ADHC centers may provide transportation and individuals may receive this service, if needed, to enable their attendance at the center. An individual may receive ADHC services in conjunction with Personal Care or Respite Care services as needed.

C. Who May Receive the Service

An individual must meet the criteria of the *CCC Plus* Waiver to qualify for ADHC services.

M1440.203 PRIVATE DUTY NURSING SERVICES

A. What is Private Duty Nursing

Private Duty Nursing services are called "nursing services" in the ID/MR waiver. These services are offered to medically fragile patients who require substantial skilled nursing care. Patients receive nursing services from Registered Nurses or Licensed Practical Nurses. Services are offered as needed by the patient, but always exceed what is available through the Home Health program.

For example, in the CCC Plus Waiver, most technology-assisted patients receive 8 hours or more of continuous nursing services at least four times per week.

B. Relationship to Other Services

There are no requirements that other waiver services be or not be received.

C. Who May Receive the Service

An individual must meet the *CCC Plus* Waiver technology-assisted criteria for nursing services. A Medicaid recipient who qualifies under EPSDT (Early & Periodic Screening, Diagnosis & Treatment) to receive private duty nursing services may also receive private duty nursing.

M1440.204 NUTRITIONAL SUPPLEMENTS

Nutritional Supplements (enteral nutrition products) are provided through DME (durable medical equipment) providers for patients who have an identified nutritional risk. Nutritional supplements are ordered by the individual's physician to cover a six-month period and Medicaid payment is authorized by the pre-admission screener or DMAS.

M1440.205 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

A. What is PERS

PERS is an electronic device that enables certain recipients who are at high risk of institutionalization to secure help in an emergency through the use of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the recipient's home telephone line. PERS may include medication monitoring to remind certain recipients at high risk of institutionalization to take their medications at the correct dosages and times.

B. Relationship to Other Services

An individual may receive PERS services in conjunction with agency-directed or consumer-directed Personal Care or Respite Care services.

C. Who May Receive the Service

PERS is available only to *CCC Plus* Waiver recipients who live alone or are alone for significant parts of the day, who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

M1450 Changes

Changed With	Effective Date	Pages Changed
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

TABLE OF CONTENTS

M14 LONG-TERM CARE

M1450.000 TRANSFER OF ASSETS

Appendices

However, the trust may provide for reasonable compensation for a trustee(s) to manage the trust, as well as for reasonable costs associated with investing or otherwise managing the funds or property in the trust. In defining what is reasonable compensation, consider the amount of time and effort involved in managing a trust of the size involved, as well as the prevailing rate of compensation, if any, for managing a trust of similar size and complexity.

2. Not for the Sole Benefit of Spouse, Blind/disabled Child, or Disabled Individual

A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is NOT the spouse, a blind or disabled child or a disabled individual, is NOT considered established for the sole benefit of one of these individuals. Thus, the establishment of such a trust is a transfer of assets that affects eligibility for Medicaid payment of LTC services.

3. Trusts for Disabled Individuals Under Which the State Is Beneficiary

Trusts established for disabled individuals, as described in M1120.202, do not have to provide for an actuarially sound spending of the trust funds for the benefit of the individual involved. However, under these trusts, the trust instrument must provide that any funds remaining in the trust upon the death of the individual must go to the state, up to the amount of Medicaid benefits paid on the individual's behalf.

The trust does not have to provide for an actuarially sound spending of the trust funds for the benefit of the individual involved when:

- the trust instrument designates the state as the recipient of funds from the trust, and
- the trust requirements in M1120.202 require that the trust be for the sole benefit of an individual.

The trust may also provide for disbursal of funds to other beneficiaries provided that the trust does not permit such disbursals until the state's claim is satisfied. "Pooled" trusts may provide that the trust can retain a certain percentage of the funds in the trust account upon the death of the beneficiary.

4. Cross-reference

If the trust is not for the sole benefit of the individual's spouse, blind or disabled child or a disabled individual, and it does not meet the criteria in item M1450.400 D.3 above, go to M1450.*550* to determine if the transfer of assets into the trust affects Medicaid payment for LTC services.

NOTE: Evaluate the trust to determine if it is a resource. See M1120.200, M1120.201 and M1120.202.

E. Other Asset Transfers

For asset transfers other than those described in sections M1450.400 B and C, the transfer does not affect eligibility for Medicaid payment of LTC services if the individual shows that he intended to receive or received adequate compensation for the asset. To show intent to receive adequate compensation, the individual must provide objective evidence according to items 1 through 3 below, and provide evidence that the transfer was made for reasons exclusive of becoming or remaining eligible for Medicaid payment of LTC services.

M1450.630 PENALTY PERIOD CALCULATION

A. Policy

When a transfer of assets affects eligibility, the penalty period begins when the individual would otherwise be eligible for Medicaid payment for LTC services if not for the penalty period. The penalty period includes the fractional portion of the month, rounded down to a day. Penalty periods for multiple transfers cannot overlap.

As long as an individual in a penalty period meets a full or limited-benefit Medicaid covered group and all nonfinancial and financial requirements for that covered group, he is eligible for all services covered under that group EXCEPT the Medicaid payment of LTC services. Individuals in nursing and other medical facilities meet the 300% SSI covered group during a penalty period because they meet the definition of an institutionalized person. An individual with a penalty period who is not in a medical facility does not meet the 300% SSI covered group but may meet other covered groups. See M1450.630 B.5.

B. Penalty Begin Date

For individuals not receiving LTC services at the time of transfer, the penalty period begins the first day of the month in which the individual would otherwise be eligible for Medicaid payment for LTC services, except for the imposition of a penalty period. This includes the application retroactive period for nursing facility patients who have been in the facility during the retroactive period.

For individuals who are receiving Medicaid payment for LTC services at the time of transfer, the penalty period begins the month following the month of transfer.

1. Medicaid LTC Not Received at Time of Transfer

If the individual is not receiving Medicaid-covered LTC services at the time of the asset transfer, the penalty period begins the first day of the month in which the individual would otherwise be eligible for Medicaid payment for LTC services but for the application of the penalty period, as long as the date does not fall into another period of ineligibility imposed for any reason.

2. Receiving Medicaid LTC Services at Time of Transfer

If the individual is receiving Medicaid LTC services at the time of the asset transfer, the penalty period begins the first day of the month following the month in which the asset transfer occurred as long as the individual would otherwise be eligible for Medicaid payment for LTC services but for the application of the penalty period.

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

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

a. Undue Hardship Claimed - Required Documentation

When requesting an undue hardship, the individual must provide the following documentation:

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

b. 10 Days to Return Undue Hardship Claim

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

c. Documentation for DMAS

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

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

- the penalty period(s)
- a brief summary of the applicant/recipient's current eligibility status and living arrangements (nursing facility or community), and
- other documentation provided by the applicant/recipient

Send the documentation to DMAS at the following address:

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

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

d. When Applicant/Recipient Was Victim

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

e. Undue Hardship Not Claimed or Not Granted by DMAS

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

2. DMAS

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

3. Subsequent Claims

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

If the individual/authorized representative alleges a change in circumstances while still in the penalty period, follow the procedures in M1450.700 B.1.

a. Penalty period has begun

If DMAS approves the subsequent claim of undue hardship, the penalty period ends effective with the date of the discharge notice or other documentation of undue hardship. The effective date is indicated in the approval letter from DMAS. Medicaid cannot pay for LTC received prior to the end of the penalty period.

b. Penalty period has not begun

If the individual was screened and approved for Medicaid CBC, PACE, or hospice services but his penalty period could not be imposed per M1450.630 B.5, and DMAS approves the subsequent claim of undue hardship, the penalty period is waived. However, Medicaid cannot pay for LTC received prior to the date of the documentation of undue hardship, as designated by DMAS.

M1450.800 AGENCY ACTION

A. Policy If an individual's asset transfer is not allowable by policy, the individual is not eligible for Medicaid payment of long-term care services. The individual, the service provider, and the Department of Medical Assistance Services (DMAS) must be notified of his/her ineligibility for the Medicaid payment of long-term care services, as well as his eligibility or ineligibility for Medicaid per M1450.810 below.

B. Procedures The procedures used for notifying the recipient, the provider and DMAS are in sections M1450.810, 820, and 830 below.

M1450.810 APPLICANT/RECIPIENT NOTICE

A. Policy Whenever an institutionalized individual is not eligible for Medicaid payment of long-term care services because of an asset transfer, the notice to the individual must contain the following:

1. Notice Includes Penalty Period The form which notifies him/her of Medicaid eligibility must include the penalty period during which Medicaid will not cover LTC services for the individual.

2. Individual In Facility - Eligible An individual in a nursing or other medical facility continues to meet the definition of an institutionalized person. If the individual meets all other Medicaid eligibility requirements, he is eligible for Medicaid in the 300% SSI covered group, except for payment for LTC services.

3. Individual Not in Facility - Not Eligible An individual outside a medical facility (i.e. living in the community) **does not** meet the definition of an institutionalized person if he is not receiving Medicaid covered CBC services, PACE or hospice services. Therefore, an individual for whom a penalty period is imposed cannot be eligible for Medicaid unless the individual is eligible for Medicaid outside the 300% SSI covered group.

4. Referral to DMAS Recipient Audit Unit (RAU)

If the individual already received Medicaid long-term care services during a penalty period or made a claim of an undue hardship for imposition of a penalty period and the claim was approved, a referral to the DMAS RAU must be made. The DMAS Eligibility Section will make the referral to RAU for approved claims of an asset transfer undue hardship. The LDSS must make all other referrals for recovery.

B. Notice Contents

The Notice of Action on Medicaid sent to the individual must specify that:

- Medicaid will not pay for nursing facility or CBC waiver services for the months (state the begin and end dates of the penalty period) because of the uncompensated asset transfer(s) that occurred on (date/dates);
- the penalty period may be shortened if compensation is received.

The notice must also specify that either:

- the individual is eligible for Medicaid coverage of services other than nursing facility or waiver services beginning (the appropriate date); **or**
- the individual is ineligible for Medicaid in any covered group, citing M1450.810 A.3, above.

If an asset transfer undue hardship claim was approved and the amount of the uncompensated transfer was $25,000 or more and was made within 30 months of the individual becoming eligible for or receiving Medicaid LTC services, the notice must also include the following statement:

"Section 20-88.02 of the Code of Virginia allows DMAS to seek recovery from the transferee (recipient of the transfer) when a Medicaid enrollee transfer assets with an uncompensated value of $25,000 or more within 30 months of receiving or becoming eligible for Medicaid."

C. Advance Notice

When an institutionalized Medicaid recipient is found no longer eligible for Medicaid payment of long-term care services because of an asset transfer, the Advance Notice of Proposed Action must be sent to the individual at least 10 days before cancelling coverage of LTC services, and must specify that either:

- The individual is eligible for Medicaid coverage of services other than nursing facility or waiver services beginning (the appropriate date), **or**
- The individual is ineligible for Medicaid in any covered group, citing M1450.810 A.3, above, **and**
- Medicaid will not pay for long-term care services for the months (state the penalty period begin and end dates) because of the asset transfer(s) that occurred (date/dates), **and**
- The penalty period may be shortened if compensation is received.

M1450.820 PROVIDER NOTICE

A. Introduction

Use the Medicaid LTC Communication Form (DMAS-225) to notify the provider of the individual's Medicaid eligibility and ineligibility for Medicaid payment of long-term care services.

B. Medicaid LTC Communication Form (DMAS-225)

The DMAS-225 should include:

- the individual's full name, Medicaid and Social Security numbers;
- the individual's birth date;
- the patient's Medicaid coverage begin date; and
- that the patient is not eligible for Medicaid payment of nursing facility/CBC waiver services for the months (state the penalty period begin and end dates) because of an asset transfer(s).

If the individual reports a change in circumstances to the local DSS, he or his authorized representative must be offered the chance to submit an additional claim of undue hardship. Follow the procedures in M1450.700 B above.

If DMAS grants the claim of undue hardship, the portion of the asset transfer penalty remaining **as of the date of the undue hardship request** is nullified. **Medicaid cannot pay for long-term care services received during the penalty period prior to the undue hardship request.** Nursing facility charges incurred during a penalty period may be evaluated as a patient pay deduction using the policy and procedures in M1470.230.

Once the penalty period has expired, no additional claims of undue hardship may be made.

M1450.830 DMAS NOTICE

A. Introduction

The worker must notify DMAS that the recipient is not eligible for LTC services payment because of an asset transfer. DMAS must input the code in the Virginia Case Management System (VaCMS) that will deny payment of LTC services claims.

The worker notifies DMAS via a copy of the DMAS-225 sent to the provider.

B. Copy of DMAS-225

The copy of the DMAS-225 that is sent to DMAS must contain the following information, in addition to the information on the provider's copy of the DMAS-225:

- date(s) the asset transfer(s) occurred;
- the uncompensated value(s); and
- penalty period(s) (begin and end dates) and computation of that period(s).

C. Send DMAS Notice

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

Program Delivery Systems
Long-Term Care Unit
Department of Medical Assistance Services
600 E. Broad St., Suite 1300
Richmond, VA 23219.

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

Any information the agency receives about the individual's subsequent receipt of compensation which shortens the penalty period must be sent to the Long-Term Care Unit at the above address.

M1470 Changes

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

M1470.000 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.

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@dmas.virginia.gov.*

D. Patient Notification

The patient or the authorized representative is notified of the patient pay amount on the Notice of Obligation for Long-term Care Costs. VaCMS will generate and send the Notice of Obligation for LTC Costs. M1470, Appendix 1 contains a sample Notice of Obligation for LTC Costs generated by VaCMS. *DMAS will generate and mail a Notice of Obligation for any changes input directly into MMIS.*

The provider is the only entity with the authority to take action when residents do not pay their patient pay amount. If a resident, or his authorized representative is negligent in paying his patient pay amount to the provider, the provider will provide written documentation regarding the requirement to pay the patient pay amount to the resident or authorized representative and follow the provider's collection procedures to collect the funds. The provider will report the resident's negligence in paying the patient pay amount to the LDSS.

The provider's failure to collect the patient pay, or the patient's failure to pay the patient pay, does not itself affect the patient's Medicaid eligibility. However, the

The amount deducted is the amount of the **monthly** premium. If the patient pays the premium less often than monthly, such as quarterly, prorate the amount paid by the number of months covered by the payment to obtain the monthly amount to deduct in the patient pay calculation.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA (Multiple Employer Welfare Arrangement) or plan provided by another benefit arrangement.

Health benefit plan does not mean accident only, credit, or disability insurance; long-term care insurance; vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance (14VAC5-234-30).

Income protection insurance (indemnity) policy premiums are not medical expenses and are not deducted from the patient pay.

Membership fees for an organization that sponsors or provides the health insurance are not part of the premium and are not deductible.

2. Medicare Part A and/or B Premiums

Medicare Part B premiums and/or Medicare Part A premiums are paid by Medicaid for eligible individuals. The premiums are paid by Medicaid via the "buy-in" and are not usually deducted from patient pay. However, Medicaid does not start paying the premiums immediately for all eligible patients, so the Medicare premium(s) must be deducted from patient pay in those months for which Medicaid does not pay the premium.

For *Categorically Needy (CN) and Medically Needy (MN) enrollees*, the Medicare buy-in is effective **2 months after the begin date** of Medicaid coverage. If the begin date of coverage is other than the first day of a month, the buy-in is effective the first of the month in which the 60th day occurs. Part B premiums (and Part A premiums if the recipient must pay the Part A premium) must be deducted from patient pay in the month(s) in which the buy-in is not effective.

Deduct the Medicare premium(s) for the first two months of coverage for the following recipients:

- *CN* individuals who are not dually eligible QMB,
- MN recipients who are not dually eligible QMB.

The Medicaid Medicare buy-in does NOT pay for Medicare premiums in closed periods of coverage for LTC patients who are on spenddown and whose eligibility is for a closed period. Deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from patient pay in the month(s) in which the buy-in is NOT effective.

For cash assistance and QMB (either just QMB or dually-eligible) enrollees, the buy-in is effective with the begin date of Medicaid coverage. Therefore, do NOT deduct Medicare premiums in the patient pay determination for months in the retroactive and ongoing coverage periods.

Do not deduct Medicare premiums in retroactive and ongoing coverage periods for the following recipients:

- SSI recipients,
- AG recipients,
- ABD 80% FPL recipients,
- IV-E cash assistance recipients,
- QMB eligible recipients (either dually-eligible or just QMB).

The Medicaid Medicare buy-in pays for Medicare premiums in retroactive coverage and closed periods of coverage EXCEPT for LTC patients who are on spenddown. DO NOT deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from the patient pay in the month(s) in which the buy-in is effective for LTC patients who are NOT on spenddowns.

3. Example--Dual Eligible QMB

Mrs. Q has Medicare coverage and SSA income of $580 per month. Her Medicare premiums are deducted from her SSA check. She was admitted to the nursing facility on September 9. Her daughter filed a Medicaid application for her on September 10.

Mrs. Q is eligible in the *CN* 300% SSI group in September and is eligible as QMB. Her Medicare premiums are not deducted for September because they will be paid by Medicaid.

4. Example--Not Dual Eligible QMB

Mr. A was admitted to a nursing facility on March 5. He applied for Medicaid on June 2. His monthly income is $1,295, and his Medicare Part B premium is deducted from his SSA check. He is determined to be eligible in the *CN* 300% SSI covered group effective March 1.

His patient pay for March (the month of entry) includes a deduction for the Medicare premium. Because he is not QMB eligible, the buy-in is effective in May, the second month following the month in which his ongoing Medicaid coverage began. The cost of his Medicare Part B premium is deducted from his patient pay for the months of March and April, as his buy-in will be in effect beginning with the month of May.

If the buy-in is delayed for any reason, the individual will be reimbursed by SSA for premiums deducted after the second month.

5. Medicare Advantage (Part C) Premiums

Medicare Advantage plans, also referred to as Medicare Part C, are voluntary managed-care Medicare plans. In addition to Medicare Part B premiums, some individuals may pay an extra Medicare Advantage premium. The Medicaid Medicare buy-in is initiated for individuals with Medicare Advantage ; however, the buy-in covers only the allowable Medicare Part A and/or B premiums. The individual is responsible for any additional Medicare Advantage monthly premium. The Medicare Advantage monthly premium remains the individual's responsibility and is an allowable deduction from patient pay.

6. **Medicare Part D Premiums**

An individual who is eligible for Medicare and Medicaid is entitled to enrollment in a basic Medicare Part D prescription drug plan (PDP) *at no cost*. However, the individual may elect enrollment in a plan with a premium.

When a full-benefit Medicaid enrollee is enrolled in *a Medicare Part D* PDP, *any* premium that is the individual's responsibility is an allowable deduction from patient pay.

7. LTC Insurance

a. Deduct LTC premium in admission month only

When an individual has an LTC insurance policy, the individual stops paying premiums beginning the month after he is admitted to LTC. The premium paid for the policy in the admission month can be deducted from the admission month's patient pay only. The LTC insurance premium is not deducted from patient pay for the months following the admission month.

b. LTC insurance benefits

LTC insurance benefits are treated as *Third Party Liability* (TPL). If the individual receives the payment from the insurance company, the payment is not income for patient pay or eligibility determinations. The individual should assign it to the nursing facility. If the individual cannot do this, or the policy prohibits assignment, the LTC insurance payment should be given directly to the nursing facility. The facility should report the payment as a third party payment on its claim form.

If the provider is unable to accept payment directly from the individual, the individual must send the insurance payment to:

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

C. Non-covered Medical/Dental Services

Deductions for the cost of a patient's medically necessary medical or dental services not covered by Medicaid, other insurance (such as Medicare), or another person are subtracted from income to determine patient pay. Some deductions for noncovered services must be approved by DMAS before they can be subtracted from the patient's income.

Services that are covered by Medicaid in the facility's per diem rate cannot be deducted from patient pay as a noncovered service. See M1470.230 C.3 for examples of services that are included in the facility per diem rate.

1. Zero Patient Pay Procedures

If deductions from patient pay cannot be allowed because the recipient has no income remaining after deducting the personal needs allowance, dependent child allowance(s) and health insurance premiums, or the recipient has no income available for patient pay, deny the request.

and the documentation to DMAS for approval (see M1470.230 C.5). DMAS will advise the eligibility worker if the adjustment is allowable and the amount that is to be allowed.

- routine dental care, necessary dentures and denture repair for recipients 21 years of age and older. **Pre-approval for dental services that exceed $500 must be obtained from DMAS prior to receipt of the service;**
- routine eye exams, eyeglasses and eyeglass repair;
- hearing aids (when medically necessary), hearing aid batteries and hearing aid repair;
- batteries for power wheelchairs or other power mobility items owned by the recipient, not to exceed four batteries in a 12-month period;
- chiropractor services, except for Medicare recipients (Medicare covers chiropractor services and Medicaid covers the Medicare deductible and coinsurance amounts);
- dipyridamole (Persantine) and other prescription medications not covered by Medicaid but ordered by the recipient's physician;
- **transportation to medical, dental or remedial services not covered by Medicaid.**

2) Services received by a Medicaid enrollee during a period of limited Medicaid eligibility (e.g., LTC services not covered because of a property transfer) can be deducted in the patient pay calculation by the local agency without DMAS approval even when the amount of the service exceeds $500.

e. Medicare Part D

Individuals who:

- qualify for Medicare Part D,
- are NOT enrolled in a Medicare *Prescription Drug Plan* (PDP), and
- are NOT Medicaid eligible at the time of admission to a nursing facility,

will be fully responsible for their drug costs until Medicaid eligibility is determined and the Medicare Part D PDP enrollment process is completed. The individual remains responsible for any drugs purchased prior to the effective date of the PDP enrollment; Medicaid cannot pay for these drugs. The cost of drugs purchased before the PDP begin date can be deducted from patient pay.

Medicaid-enrolled nursing facility patients who are enrolled in a Medicare Part D PDP are **not** responsible for the payment of deductibles or co-pays, nor will

EXCEPTION: For an individual admitted to a nursing facility from an ALF, deduct a home maintenance allowance for the month of entry even if the admission to the nursing facility is not temporary.

Only one spouse of an institutionalized married couple (both spouses are in a medical facility) is allowed the deduction to maintain a home for up to six months, if a physician certifies that he is likely to return home within that period.

B. Temporary Care

Temporary care is defined as not exceeding 6 months of institutionalization, beginning the **month** of admission to the medical facility. A physician's written statement, including a DMAS-96, that the individual is expected to return to his home within 6 months of admission is required to certify temporary care. *If the individual is in the facility less than 6 months and returns to a community living arrangement, temporary care status is assumed and patient pay should be adjusted with the home maintenance allowance for the entire period of institutionalization.* When the temporary care period ends, the home maintenance deduction must be discontinued.

C. Amount Deducted

The home maintenance deduction is the MNIL for one person in the individual's locality of residence. See Appendix 5 to subchapter M0710 or section M0810.002 A. 4 for the MN income limits.

M1470.300 FACILITY PATIENTS

A. Overview

This section provides policy and procedures for calculating patient pay for the facility patient.

B. Policy and Procedures

Policy and procedures for determining patient pay in the most common admission situations are contained in the following sections:

- Facility Admission From A Community Living Arrangement (M1470.310)
- Medicaid CBC Recipient Entering A Facility (M1470.320)
- Facility Admission From Another Facility (M1470.340)

M1470.310 FACILITY ADMISSION FROM A COMMUNITY LIVING ARRANGEMENT

A. Policy

The policy in this section describes the procedures for calculating patient pay for the month of admission and ongoing months for all persons admitted to an LTC facility except:

- persons who received Medicaid CBC in the community during the admission month;
- persons who were admitted from another facility;
- persons admitted to a facility from a state institution.

B. Procedures

To determine patient pay for the admission month, use the procedures in this subsection.

M1470.410 MEDICAID CBC - PERSONAL MAINTENANCE ALLOWANCE

A. Individuals

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

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

1. Basic Maintenance Allowance

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

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

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

The PMA is:

- January 1, 2017 through December 31, 2017: $1,213
- January 1, 2016 through December 31, 2016: $1,210

Contact a Medical Assistance Program Consultant for the PMA in effect for years prior to 2009.

2. Guardianship Fee

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

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

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

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

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

a. for individuals employed 20 hours or more per week, all earned income up to 300% of SSI ($2,205 in 2017) per month.

b. for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI ($1,470 in 2017) per month.

4. Example – Special Earnings Allowance (Using January 2009 figures)

A working patient receiving *CCC Plus Waiver* services is employed 18 hours per week. His income is gross earnings of $928.80 per month and SSA of $300 monthly. His special earnings allowance is calculated by comparing his gross earned income ($928.80) to the 200% of SSI maximum ($1,348.00). His gross earned income is less than 200% of SSI; therefore, he is entitled to a special earnings allowance. His personal maintenance allowance is computed as follows:

$ 1,112.00 CBC basic maintenance allowance
+ 928.80 special earnings allowance
$ 2,040.80 PMA

Because the PMA may not exceed 300% of SSI, the PMA for the patient in this example must be reduced to $2,022.00.

B. Couples

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

M1470.420 DEPENDENT CHILD ALLOWANCE

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

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

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

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

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

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

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

b. Notice Procedures

Upon the final decision to allow the deduction, use the VaCMS Patient Pay process to adjust the patient pay. VaCMS will generate and send the Notice of Obligation for LTC Costs. *If VaCMS is not able to process required transactions, a Patient Pay Correction form (DMAS 9PP) should be submitted to patientpay@dmas.virginia.gov. DMAS will generate and mail a Notice of Obligation for any changes input directly into MMIS.*

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

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

4. Patient Pay

a. Projected Spenddown Eligibility Determinations

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

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

b. Retrospective Spenddown Eligibility Determinations

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

M1470.800 COMMUNICATION BETWEEN LOCAL DSS AND LTC PROVIDER

A. Introduction

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

B. Purpose

The DMAS-225 is available on SPARK at: *http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi* The form is used to:

- notify the LTC provider of a patient's Medicaid eligibility status;
- notify a new provider that the patient pay is available through the verification systems;
- reflect changes in the patient's deductions, such as a medical expense allowance;
- document admission, death or discharge of a patient to an institution or community-based care services;

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

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

1) Underpayment amounts totaling **$**1,500 or more must be referred to the DMAS Recipient Audit Unit for collection.

a) Complete and send a Notice of Recipient Fraud/Non-Fraud (see Appendix *2* to chapter M17) to:

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

b) Complete and send a "Notice of Action on Medicaid" (available at *http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi*) informing the patient of the referral to DMAS for collection of the underpayment.

2) Prospective months' patient pay

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

4. **Example-- Patient Pay Increase -Total Underpayment Less than $1,500**

Mr. S is an aged individual who has received Medicaid covered CBC services for two years. His "old" monthly patient pay was $300. On February 25, he reports his pension increased $50 per month in February. On March 22 the EW recalculated the patient pay based on the current income. His new monthly patient pay is $350. Because of the 10-day advance notice requirement the change could not be made for April and must be made for May 1.

His "old" patient pay is subtracted from his "new" patient pay for February, March and April to determine his underpayment for those months. The $50 underpayment for three months ($150) is added to his "new" ongoing patient pay ($350) and the total patient pay obligation ($500) is compared to the Medicaid rate of $1,700. Since the total patient pay obligation of $500 is less than the Medicaid rate of $1,700, the patient pay for May is $500. The ongoing patient pay starting in June is $350.

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

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

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

M1470.910 RETROACTIVE ADJUSTMENTS FOR PRIOR MONTHS

A. Retroactive Adjustment

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

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

In these situations, adjust the patient pay retroactively using *the VaCMS* Patient Pay process for the prior months in which the patient pay was incorrect. **In all other situations when a change is reported timely, do not adjust the patient pay retroactively.** *If VaCMS is not able to process required transactions, a Patient Pay Correction form (DMAS 9PP) ahould be submitted to patientpay@dmas.virginia.gov.*

B. Notification Requirements

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

M1470.920 LTC PROVIDER CHANGE WITHIN A MONTH

A. Policy

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

B. Procedures

DMAS has implemented changes effective for dates of service on or after April 1, 2017, to simplify responsibility for collecting patient pay in the transition month. For any month that an individual is enrolled in a nursing facility on the DMAS eligibility file, patient pay will be deducted only from nursing facility claims and not from agency personal care, respite care, and/or adult day health care claims.

For patients in the CCC Plus Waiver with a patient pay, the MMIS will deduct patient pay from the claims submitted by waiver providers for services following the transition month. It may take a short period of time for the local department of social services to revise the patient pay (reflecting a change in status from nursing facility to CCC Plus). This will result in the MMIS initially using a higher patient pay that will be adjusted by DMAS after the patient pay is revised. During this time, waiver or nursing facility providers will still be responsible for collection of identified patient pay amounts owed and should work together to collect the appropriate patient pay.

Eligibility staff will continue to calculate monthly patient pay. **There is no need to divide or apportion the patient pay when a patient changes providers or moves from one type of provider/care to another (e.g. CBC to a nursing facility) nor any a need to inform the provider via a DMAS-225.** Changes in patient pay will be made prospectively, based on advance notice requirements. *Changes not requiring advance notice can be processed up to the last day of the month. If an individual has moved from NF to CBC, adjust the patient pay effective the month after the change.* Patient Pay underpayment corrections should follow the procedures contained in M1470.900.

C. PACE

Enrollment in PACE begins on the first day of a month and ends on the last day of a month. Patient pay for PACE participants is not adjusted due to provider changes within a month.

M1470.930 DEATH OR DISCHARGE FROM LTC

A. Policy

The LTC provider may not collect an amount of patient pay that is more than the Medicaid rate for the month. When a patient dies or is discharged from LTC to another living arrangement that does not include LTC services, do not recalculate patient pay for the month in which the patient died or was discharged. The provider is responsible for collecting an amount of patient pay for the month of death or discharge that does not exceed the Medicaid rate for the month.

B. Procedure

Refer to the VaCMS Help feature for procedures regarding death or discharge from LTC. Send a DMAS-225 to the provider regarding the eligibility status of the patient. Send a notice to the patient or the patient's representative that reflects the reduction or termination of services. *If VaCMS is not able to process required transactions or additional correction is needed, a Patient Pay Correction form (DMAS 9PP) should be submitted to patientpay@dmas.virginia.gov. DMAS will generate and mail a Notice of Obligation for any changes input directly into MMIS.*

M1470.1000 LUMP SUM PAYMENTS

A. Policy

Lump sum payments of income or accumulated benefits are counted as income in the month they are received. Patient pay must be adjusted to reflect this income change for the month following the month in which the 10-day advance notice period expires. Any amount retained becomes a resource in the following month.

B. Lump Sum Defined

Income such as interest, trust payments, royalties, etc., which is received regularly but is received less often than quarterly (i.e., once every four months or three times a year, once every five months, once every six months or twice a year, or once a year) is treated as a lump sum for patient pay purposes.

EXCEPTION: Income that has previously been identified as available for patient pay, but which was not actually received because the payment source was holding the payment(s) for some reason or had terminated the payment(s) by mistake, is **NOT** counted again when the corrective payment is received.

See section M1470.1030 below for instructions for determining patient pay when a lump sum is received.

M1470.1010 LUMP SUM REPORTED IN RECEIPT MONTH

A. Lump Sum Available

Lump sum payments reported in the month the payment was received are counted available for patient pay effective the first of the month following the month in which the 10-day advance notice period expires.

If the individual is no longer in the facility and is not receiving Medicaid CBC, adjust the patient pay for the lump sum receipt month if the money is still available.

B. Lump Sum Not Available

If the money is not available, complete and send a Notice of Recipient Fraud/Non-Fraud to the DMAS, Recipient Audit Unit.

M1470.1020 LUMP SUM NOT REPORTED TIMELY

A. Effective Date

Lump sum payments reported AFTER the month in which the payment was received are not reported timely. Evaluate total resources including the lump sum. If the resources are within the limit, determine availability for patient pay. See B. & C. below. If they exceed the resource limit, go to section M1470.1100 below.

B. Lump Sum Not Available

If the money is not available, complete and send a Notice of Recipient Fraud/Non-Fraud to the DMAS, Recipient Audit Unit.

C. Lump Sum Available

1. If the money is still available and the individual is no longer in the facility and is not receiving Medicaid CBC, complete and send a Notice of Recipient Fraud/Non-Fraud to the DMAS, Recipient Audit Unit.

2. If the money is still available and the individual is still in the facility or is still receiving Medicaid CBC, adjust the patient pay according to procedures in section M1470.1030 below.

M1470.1030 PATIENT PAY DETERMINATION FOR LUMP SUMS

A. Policy

When a lump sum payment is received, the patient pay for the month in which the 10-day advance notice period expires must be adjusted using the procedures in this section.

B. CN Procedures

1. Total Income

Add the lump sum to the patient's regular monthly income; the result is total income for the month.

2. Less Than Or Equal To 300% of SSI

If the total gross income (including the lump sum) is equal to or less than the 300% of SSI income limit, adjust the patient pay. None of the lump sum remains to be evaluated.

3. Greater Than 300% of SSI

If the total gross income (including the lump sum) exceeds the 300% of SSI income limit, adjust the patient pay. Compare the income available for patient pay to the Medicaid rate for the month.

If the income available for patient pay is less than or equal to the Medicaid rate, the available income is the patient pay. If the income available for patient pay exceeds the Medicaid rate, adjust the patient pay to equal the Medicaid rate for the month.

Evaluate the difference between the Medicaid rate and the available income as a resource for the next month. If the patient's total countable resources exceeds the resource limit, take appropriate action to cancel the patient's Medicaid.

* if the revised patient pay is **less than or equal to** the previously determined patient pay, DO NOT adjust the patient pay.

Note: If the patient's total countable resources, including the remainder of the available income, exceed the resource limit, take appropriate action to cancel Medicaid eligibility the next month because of excess resources.

b. Spenddown Eligibility & Patient Pay NOT Previously Determined

If the individual's spenddown eligibility for the month has not yet been determined:

1) Recalculate the individual's spenddown liability by adding the lump sum to the patient's regular monthly income in the month the lump sum was received; determine spenddown eligibility by policy and procedures in section M1460.700.

2) If the individual meets the revised spenddown, determine patient pay by using the policy and procedures in section M1470.620 or M1460. 630.

M1470.1100 REDUCTION OF EXCESS RESOURCES

A. Policy

Medicaid policy allows for a full month of eligibility if the resource limit is met at any time during the month. LTC patients whose patient pay is less than the Medicaid rate can choose to reduce excess resources by expending the excess for the cost of LTC services. *This policy does not apply to individuals whose Medicaid application is pending.*

B. Resource Reduction Defined

A decrease in property value, such as an official reassessment or a lien placed against property, is not a reduction of resources. It is a decrease in the value of the resource.

In order to reduce resources, a resource must be transferred out of the patient's possession. Liquid resources such as bank accounts and prepaid burial accounts must actually be expended or encumbered. Non-liquid resources must be liquidated and the money expended.

A reduction of resources is an asset transfer and must be evaluated under asset transfer policy in subchapter M1450.

C. Procedures

1. Required Contact

When a Medicaid-enrolled LTC recipient is found to have excess resources, evaluate whether an adjustment to patient pay by using the excess toward the cost of care will allow continued eligibility in the month in which the 10-day advance notice period expires. Do not assume that the recipient or the recipient's representative will agree to use the excess resources to pay an increased patient pay.

M1480 Changes

Changed With	Effective Date	Pages Changed
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

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

M1480.400 PATIENT PAY

A. Introduction

This section contains the policy and procedures for determining an institutionalized spouse's (as defined in section M1480.010 above) patient pay in all covered groups.

B. Married With Institutionalized Spouse in a Facility

For a married LTC patient with an institutionalized spouse in a facility, **NO** amount of the patient's income is deducted for the spouse's needs in the patient pay calculation.

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

A. Introduction

This subsection contains the standards and their effective dates that are used to determine the community spouse's and other family members' income allowances. The income allowances are deducted from the institutionalized spouse's gross monthly income when determining the monthly patient pay amount. Definitions of these terms are in section M1480.010 above.

B. Monthly Maintenance Needs Allowance	*$2030.00*	*7-1-17*		
	$2002.50	7-1-16		
C. Maximum Monthly Maintenance Needs Allowance	$3,022.50	1-1-17		
	$2,980.50	1-1-16		
D. Excess Shelter Standard	*$609.00*	*7-1-17*		
	$600.75	7-1-16		
E. Utility Standard Deduction (SNAP)	$287.00	1 - 3 household members	10-1-16	
	$357.00	4 or more household members	10-1-16	
	$294.00	1 - 3 household members	10-1-15	
	$369.00	4 or more household members	10-1-15	

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).

$875 gross earned income
- 75 first $75 per month
800 remainder
÷ 2
400 ½ remainder
+ 75 first $75 per month
$475 which is > $190

His personal needs allowance is calculated as follows:

$ 40.00 basic personal needs allowance
+190.00 special earnings allowance
+ 17.50 guardianship fee (2% of $875)
$247.50 personal needs allowance

2. Medicaid CBC Waiver Services and PACE

a. Basic Maintenance Allowance

For the Commonwealth Coordinated Care Plus (CC Plus) Waiver (formerly the Elderly or Disabled with Consumer Direction Waiver and the Technology-Assisted Individuals Waiver), Community Living (CL) Waiver (formerly Intellectual Disabilities Waiver), Family and Individual Supports (IS) Waiver (formerly Individual and Family Developmental Disabilities Support Waiver), Building Independence (BI) Waiver (formerly Day Support Waiver), or PACE, deduct the appropriate maintenance allowance for one person as follows:

- *January 1, 2017 through December 31, 2017: $1,213*
- January 1, 2016 through December 31, 2016: $1,210 (no change)
- January 1, 2015 through December 31, 2015: $1,210

Contact a Medical Assistance Program Consultant for the amount in effect for years prior to 2013.

b. Guardian Fee

Deduct the actual fee a guardian or conservator charges, up to a maximum of 5% of the patient's actual gross income (including amounts not counted as income and excluded amounts) for guardianship fees, IF:

* the patient has a legally appointed guardian or conservator AND
* the guardian or conservator charges a fee.

Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

NOTES: No deduction is allowed for representative payee or "power of attorney" fees or expenses. No deduction is allowed if the patient's guardian receives a payment for providing guardianship services from a public agency or organization that receives funding for guardianship services. The guardianship filing fees CANNOT be deducted from the individual's income.

c. Special Earnings Allowance For CCC Plus, CL, IS, and BI Waivers

[EXAMPLE #19 was deleted]

For the *CCC Plus, CL, IS, and BI waivers*, deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

1) for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (*$2,205* in *2017*) per month.

1) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI (*$1,470* in *2017*) per month.

The total of the basic maintenance allowance, the guardianship fee and the special earnings allowance cannot exceed 300% SSI.

EXAMPLE #20: (Using January 2000 figures)

A working patient in the *CL* Waiver is employed 18 hours per week. He has gross earnings of $928.80 per month and SS of $300 monthly. His special earnings allowance is calculated first:

$ 928.80	gross earned income
- 1,024.00	200% SSI maximum
$ 0	remainder

$928.80 = special earnings allowance

His personal maintenance allowance is calculated as follows:

$ 512.00	maintenance allowance
+ 928.80	special earnings allowance
$1,440.80	personal maintenance allowance

4) any allowable noncovered medical expenses (per section M1470.530) including any old bills, carry-over expenses and other noncovered expenses that were used to meet the spenddown, but NOT including the cost of the community-based care.

5) a home maintenance deduction, if any (per section M1480.430 G.).

The result is the remaining income for patient pay.

2. Patient Pay

Compare the remaining income for patient pay to the monthly PACE rate (minus the Medicare Part D premium) for the month. The patient pay is the lesser of the two amounts.

M1480.500 NOTICES AND APPEALS

M1480.510 NOTIFICATION

A. Notification

Send written notices to the institutionalized spouse, the authorized representative and the community spouse advising them of:

- the action taken on the institutionalized spouse's Medicaid application and the reason(s) for the action;
- the resource determination, the income eligibility determination, and the patient pay income, spousal and family member allowances and other deductions used to calculate patient pay;
- the right to appeal the actions taken and the amounts calculated.

B. Forms to Use

1. Notice of Action on Medicaid

The EW must send the "Notice of Action on Medicaid (Title XIX) and Children's Medical Security Insurance Plan (Title XXI Program)" or system-generated equivalent to the applicant/recipient and the person who is authorized to conduct business for the applicant to notify him of the Agency's decision on the initial Medicaid application, and on a redetermination of eligibility when a recipient starts Medicaid-covered LTC services.

2. Notice of Obligation for Long-Term Care Costs

The "Notice of Obligation for Long-term Care Costs" notifies the patient of the amount of patient pay responsibility. The form is generated and sent by the enrollment system when the patient pay is used entered or changed.

3. Medicaid LTC Communi-cation Form (DMAS-225)

The Medicaid Long-term Care (LTC) Communication Form (DMAS-225) is used to facilitate communication between the local agency and the LTC services provider. The form may be initiated by the local agency or the provider. The form is available on SPARK at: *http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi*.

M1510 Changes

Changed With	Effective Date	Pages Changed
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

M1510.000 ENTITLEMENT POLICY & PROCEDURES

M1510.100 MEDICAID ENTITLEMENT

A. Policy

An individual's entitlement to Medicaid coverage is based on the individual meeting all nonfinancial and financial eligibility requirements for the individual's covered group during a month covered by the application, as well as any additional entitlement policies that are applicable to the covered group.

1. Spenddown Met

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

2. Individual is Deceased

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

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

3. Applicant Has Open MA Coverage in Another State

If an applicant indicates that he has been receiving Medical Assistance (MA--Medicaid or Children's Health Insurance Program) coverage in another state prior to moving to Virginia, instruct him to contact his eligibility worker there and request that his coverage be cancelled, if he has not already done so. He is no longer considered a resident of the other state once he has moved and intends to reside in Virginia, and he is *no longer* 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.

4. *PARIS Data Match*

The Virginia Department of Social Services (VDSS) forwards, on a quarterly basis, an electronic file of Medicaid enrollees to the Public Assistance Reporting Information System (PARIS) maintained by the U.S. Department of Health and Human Services. Virginia Medicaid enrollees are matched against the Medicaid records of other states to identify individuals also enrolled in Medicaid in other states. If a match is found, steps are conducted to research further and report findings to the DMAS Program Integrity Unit, and if necessary, take further action. The PARIS User Guide, available at http://spark.dss.virginia.gov/divisions/bp/fm/files/intro_page/guidance_procedures/PARIS_User_Guide_5-2017.pdf, contains the procedures for researching and reporting PARIS-matched individuals

B. SSI Entitlement Date Effect on Medicaid

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

C. Procedures

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

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

M1510.101 RETROACTIVE ELIGIBILITY & ENTITLEMENT

A. Definitions

1. Retroactive Period

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

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

2. Retroactive Budget Period

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

B. Policy

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

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

M1520 Changes

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

M1520.000 MEDICAL ASSISTANCE ELIGIBILITY REVIEW

M1520.001 GENERAL PRINCIPLE

A. Policy

A MA recipient's eligibility must be partially reviewed whenever the agency becomes aware of any change in the enrollee's circumstances that might affect the enrollee's continued eligibility. The timeframe for acting on a change is 30 calendar days from the date the change is reported *or the agency becomes aware of the change.*

Exception: Children meeting the definition of a newborn in M0330.802 *or M2240.100.F* are to be enrolled as soon as possible upon report of the birth.

An annual review of all of the enrollee's eligibility requirements is called a *"redetermination" or* "renewal." A renewal of the enrollee's eligibility must be completed at least once every 12 months. The renewal *can* be initiated in the *10th* month to ensure timely completion of the renewal.

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

1. Negative Action Requires Notice

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

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

2. Renewal Approval Requires Notice

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

3. Voter Registration

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

B. Procedures For Partial Review and Renewals

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

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

M1520.100 PARTIAL REVIEW

A. Enrollee's Responsibility

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

B. Eligibility Worker's Responsibility

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

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

1. Changes That Require Partial Review of Eligibility

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

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

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

2. Changes That Do Not Require Partial Review

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

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

3. HIPP

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

e-mail to hipp@dmas.virginia.gov. This e-mail address is for use by the local agency staff only. See M0130.200 G for additional information about HIPP requirements.

4. Program Integrity

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

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

C. Covered Group and Aid Category Changes

1. Enrollee's Situation Changes

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

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

5. Enrollee in Limited Coverage Becomes Entitled to Full Coverage

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

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

6. Enrollee Turns Age 6

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

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

1. Required Verifications

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

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

When it is necessary to obtain information and/or verifications from the enrollee, a contact-based renewal must be completed. If an enrollee's attested resources are over the resource limit, the applicant or authorized representative must be given the opportunity to provide verification of the resources. T**he renewal must be signed by the enrollee or authorized representative.**

Blindness and disability must be verified through the Disability Determination Services (DDS) interface with VaCMS. Blindness and disability are considered continuing unless *the DDS interface search indicates* that the individual is no longer blind or disabled.

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

2. SSN Follow Up

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

3. Evaluation and Documentation

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

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

4. Renewal Period

Renewals must be completed prior to cut-off in the 12th month of eligibility *or within 30 calendar days from the receipt of the renewal, whichever is later*. The first 12-month period begins with the month of application for Medicaid.

B. Renewal Procedures

Renewals may be completed in the following ways:

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

1. Ex Parte Renewals

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

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

a. MAGI-based Cases

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

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

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

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

b. $0 Income Reported

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

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

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

c. SSI Medicaid Enrollees

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

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

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

d. Continuing Eligibility Not Established Through Ex Parte Process

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

2. Paper Renewals

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

The form needs to be sent to the enrollee in time to allow for the return and processing periods prior to the system cut-off in the 12th month of eligibility. The enrollee must be allowed 30 days to return the renewal form and any necessary verifications. *Administrative Renewal forms are pre-filled with the return date.*

The specific information requested and the deadline for receipt of the verification must be documented in the case record.

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

New or revised information provided by the enrollee must be entered into the system. *The enrollee is responsible for reporting any changes. If the enrollee does not check either "yes" or "no" in response to a particular question, there is considered to be no change with regard to that question. Renewals must be completed prior to cut-off in the 12th month of eligibility or within 30 calendar days from the receipt of the renewal, whichever is later.*

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

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

3. Online and Telephonic Renewals

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

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

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

C. Disposition of Renewal

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

1. Renewal Completed

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

2. Renewal Not Completed

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

3. Referral to Health Insurance Marketplace (HIM)

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

4. Renewal Filed During the Three-month Reconsideration Period

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

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

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

D. Special Requirements for Certain Covered Groups

1. Pregnant Woman

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

M17 Changes

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

TABLE OF CONTENTS

M17 MEDICAID FRAUD AND NON-FRAUD RECOVERY

M1700.000 MEDICAID FRAUD NON-FRAUD RECOVERY

Appendix 1

M1700 MEDICAID FRAUD AND NON-FRAUD RECOVERY

M1700.100 INTRODUCTION

A. Administering Agency

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

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

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

B. Utilization Review

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

M1700.200 FRAUD

A. Definitions

Fraud is defined as follows:

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

Abuse is defined as follows:

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

B. DMAS Authority

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

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

1. Amount of Loss

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

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

2. Recipient Fraud

a. Medical Assistance Only

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

2. Family Unit

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

M1700.300 NON-FRAUD RECOVERY

A. Authority

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

B. Recovery of Erroneous Payments

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

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

Complete and send the *Notice of Recipient LTC Patient Pay Underpayment (form #DMAS752R)* located at http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi to

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

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

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

C. Post-eligibility Investigations

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

RAU investigations are based on projected income consistent with the eligibility polices for counting ongoing income referenced in Chapters M04, M07, and M08. Post-eligibility determinations are made using a point-to-point method in which the income estimation period begins with an event that would have triggered a partial review under M1450.100. The end point is the next scheduled renewal that the LDSS actually completed.

***D.* Uncompensated Asset Transfers**

Individuals receiving long-term care services (LTC) who transfer assets and do not receive adequate compensation are subject to the imposition of a penalty period during which Medicaid cannot pay for long-term care services. When an uncompensated

NOTICE OF MEDICAID RECIPIENT FRAUD/NON-FRAUD

Date: / /

To: **Recipient Audit Unit (RAU)**
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
Fax Number: (804) 371-8891

Case Name: _____

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

Case Address: _____

_____

_____

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

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

☐ **Fraud** ☐ **Agency Error** ☐ **Other**
☐ **Uncompensated Transfer** ☐ **Non-Entitled Receipt of Medicaid**

☐ **Ineligible for Medicaid** **Dates:** ____

Ineligible person(s): _____

_____

_____

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

DMAS 751R

NOTICE OF MEDICAID RECIPIENT FRAUD/NON-FRAUD

ATTACH THE FOLLOWING INFORMATION IF AVAILABLE:

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

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

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

Address:
_____ **Name of Supervisor:**

_____

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

DMAS 751R

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

Date: / /

To: **Recipient Audit Unit**
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
Fax Number: (804) 371-8891

Case Name: _____

Case Name SSN: ___ - ___ - ____ **Medicaid ID Number:** ___ - ___ - ___

Case Address: _____

_____

_____

LTC Patient Pay Underpayment Breakdown

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

Explanation for the Underpayment:

NOTICE OF RECIPIENT LTC PATIENT PAY UNDERPAYMENT

THINGS TO REMEMBER:

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

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

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

Address:

_____

_____

Name of Supervisor:_____

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