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April 1, 2017

Virginia Medical Assistance Eligibility Manual

Transmittal #DMAS-4

The following acronyms are used in this cover letter:

- ABD – Aged, Blind or Disabled
- DMAS – Department of Medical Assistance Services
- F&C – Families and Children
- FAMIS – Family Access to Medical Insurance Security
- FPL – Federal Poverty Level
- MA – Medical Assistance
- MAGI – Modified Adjusted Gross Income
- RAU Recipient Audit Unit
- TN – Transmittal

TN #DMAS-4 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 April 1, 2017.

The changes below are contained in TN #DMAS-4. Items in italics were added to the final version of the transmittal.

Changed Pages	Changes
Subchapter M0110 Page 15	Clarified that copies of verifications of income and resources must be scanned into the case record or retained in the paper record.
Subchapter M0120 Pages 2a, 7, 10, 13	On page 2a, clarified that the authorized representative designation is valid through the appeal process. On pages 7, 10 and 13, clarified the application process for non-IV-E foster care children in the custody of another state, including those who have been placed with a parent or caretaker-relative in Virginia.
Subchapter M0130 Page 6	Clarified that copies of verifications of income and resources must be scanned into the case record or retained in the paper record.
Subchapter M0310 Pages 24, 30a Page 23 is a runover page. Page 24a was added as a runover page.	On page 24, clarified when a child needs a disability determination. On page 30a, clarified that non-IV-E foster care children whose custody is held by another state only meet the Virginia residency requirement if they have been placed with and are living with a parent or caretaker-relative in Virginia.
Subchapter M0320 Page 26	Revised the MEDICAID WORKS resource limit for 2017.
Subchapter M0330 Page 5	Revised the policy on household composition for Individuals Under 21. MAGI policy is applicable to this covered group, including during a trial visitation.
Chapter M04 Appendices 1, 2, 6	Revised the F&C income limits that are based on the FPL, effective January 31, 2017.
Subchapter M0730 Pages 7, 8	On pages 7 and 8, removed obsolete policy regarding Unemployment Compensation
Subchapter M0810 Page 2	Revised the ABD income limits that are based on the FPL, effective January 31, 2017.
Subchapter M0830 Table of Contents, page i Pages 24, 24c	In the Table of Contents and on pages 24 and 24c, removed the obsolete Medically Indigent covered group designation
M1110 Pages 10, 10a	On pages 10 and 10a, clarified the documentation requirements for licenses appraisers.

Changed Pages	Changes
Subchapter M1470 Page 19	Corrected the effective date for the 2016 personal maintenance allowance.
Subchapter M1510 Pages 2a, 10	On page 2a, clarified that copies of verifications of income and resources must be scanned into the case record or retained in the paper record. On page 10, clarified when a manual Notice of Action must be sent.
Subchapter M1520 Pages 25-27 Appendix 2, page 1 Pages *28-30* were added.	On pages 25-30, revised the policy on agency-to-agency case transfers *and added decision pathways.* In Appendix 2, revised the income limits, effective January 31, 2017.
Subchapter M1550 Appendix 1,page 1	Revised the Medicaid Technicians' contact information.
Chapter M16 Page 7 Pages 8-10 are runover pages.	On page 7, revised the procedures for completing the Local Agency Appeal Summary.
Chapter M17 Pages 4, 5 Pages 6 and 7 are runover pages.	On page 4, added policy on RAU post-eligibility investigations. On page 5, revised the formatting.
Chapter M21 Appendix 1, page 1	In Appendix 1, revised the income limits effective January 31, 2017.
Chapter M22 Appendix 1, page 1	In Appendix 1, revised the income limits effective January 31, 2017.

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

M0110 Changes

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

M0110.400 Retention of Case Information

A. Introduction

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

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

B. Policy

Case records must contain the following elements:

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

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

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

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

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

M0120 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-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,
- niece or nephew, or
- aunt or uncle.

c. Action Not Initiated – Refer to Child Welfare Services

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

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

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

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

2. Minor Parent Applying for His Child

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

3. Foster Care Child

a. IV-E

The Title IV-E Foster Care & Medicaid Application form, posted on SPARK at http://spark.dss.virginia.gov/divisions/dfs/iv_e/ is used for the IV-E Foster Care eligibility determination. A separate MA application is **not** required for a child who has been determined eligible for Title IV-E Foster Care. However, if there is a non-custodial agreement for the IV-E eligible child, the parent or legal guardian must sign an MA application for the child.

b. Non-IV-E

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

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

1. Title IV-E Foster Care & Medicaid Application

The Title IV-E Foster Care & Medicaid Application, form #032-03-636, available at: http://spark.dss.virginia.gov/divisions/dfs/iv_e/, is used for foster care or adoption assistance children who are eligible under Title IV-E of the Social Security Act. If the child requires a resource evaluation for a medically needy spenddown, Appendix E can be used to collect the information. The Appendix must be signed by the applicant's guardian.

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

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

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

2. Auxiliary Grant (AG)

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

3. Exception for Certain Newborns

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

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

4. Forms that Protect the Application Date

a. Low Income Subsidy (LIS) Medicaid Application

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

B. Foster Care, Adoption Assistance, Department of Juvenile Justice

1. Foster Care

Responsibility for taking applications and maintaining the case belongs as follows:

a. Title IV-E Foster Care

Children in the custody of a Virginia LDSS or private foster care agency who receive Title IV-E maintenance payments apply at the agency that holds custody. Title IV-E foster care children in the custody of another state's social services agency apply in the Virginia locality where they reside.

b. State/Local Foster Care

Non-Title IV-E (state/local) children in the custody of a Virginia LDSS or a private child placing agency apply at the LDSS that holds custody.

Children in the custody of another state's social services *agency who have been placed with and are living with a parent or caretaker-relative apply at the LDSS where the child is residing.* (see M0230).

2. Adoption Assistance

Children receiving adoption assistance through a Virginia local department of social services apply at the LDSS that made the adoption assistance agreement.

Children receiving adoption assistance through another state's social services agency apply at the LDSS where the child is residing.

3. Virginia Department of Juvenile Justice/Court (Corrections Children)

When a child is in the custody of the Virginia Department of Juvenile Justice (DJJ) or is the responsibility of a court (corrections children), responsibility for processing the application and determining eligibility rests with the LDSS in the locality in Virginia in which he last resided prior to going into the DJJ system.

B. Institutionalized Individual (Not Incarcerated)

When an individual of any age is a resident or patient in a medical or residential institution, except DBHDS facilities and the Virginia Veteran's Care Center, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in Virginia in which he last resided outside of an institution.

Exception: If the applicant is applying for or receives SNAP, responsibility for processing the MA application and determining MA eligibility rests with the LDSS in the locality in which the institution where he is receiving care is located.

If the individual did not reside in Virginia prior to entering an institution, responsibility for processing the application and determining eligibility rests with the LDSS in the locality in which the institution where he is receiving care is located.

M0130 Changes

Changed With	Effective Date	Pages Changed
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

The eligibility worker must allow at least 10 calendar days for receipt of the necessary verifications, but additional time may be allowed depending on the type of information requested. The specific information requested and the deadline for receipt of the verifications must be documented in the case record. If the applicant reports to the EW that he needs help to obtain certain verifications, the EW must attempt to assist the applicant. If the verification cannot be obtained, the application must be denied.

1. Copy *or Scan* Verification Documents

Legal documents and documents that may be needed for future eligibility determinations *or audits* must be copied *or scanned into VaCMS using the Document Management Imaging System (DMIS)* and preserved for the record. These include citizenship and identity documents, alien status documentation, verification of legal presence, trusts, annuities, contracts, wills, life insurance policies, **the current value of all other countable resources, and verifications of earned and unearned income**. ***Notes by the eligibility worker that the verifications were viewed are not sufficient.***

2. Information Not Provided

If information necessary to make an eligibility determination is requested but not provided by the applicant and cannot be obtained from any other source, the application must be denied (or the coverage cancelled) due to the inability to determine eligibility. Individuals whose applications are denied due to the inability to determine eligibility are not referred to the HIM. See M0130.300 D.2.

When the deadline date falls on a weekend or holiday, LDSS may choose to deny the application (or cancel coverage) before the deadline date. However, if the early denial or cancel action is taken, LDSS must re-open the application if the individual provides the necessary information on or before the original deadline date. If the individual's application is re-opened and he/she is determined eligible, the LDSS must send a notice to the individual notifying him of the changed action.

C. Verification of Nonfinancial Eligibility Requirements

1. Verification Not Required

The applicant's statements on the application may be accepted for the following identifying information and nonfinancial eligibility requirements unless the eligibility worker has reason to question the applicant's statements:

- Virginia state residency;
- pregnancy.

2. Verification Required

The following information must be verified:

- application for other benefits;
- citizenship and identity;
- Social Security number (see section D below);
- legal presence in the U.S. of applicants age 19 or older;
- age of applicants age 65 and older; and
- disability and blindness.

M0310 Changes

Changed With	Effective Date	Pages Changed
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

- individuals who received SSDI or SSI disability benefits or RR total disability benefits in one or more of the 12 months preceding the Medicaid application and whose benefits were terminated for a reason **other than no longer meeting the disability or blindness requirements**.
- individuals who have been determined disabled or blind by DDS for Medicaid or for SSA, without a subsequent decision by SSA reversing the disability determination, and
- individuals who have been determined "totally" disabled by the RRB.

C. Procedures for Verifying Disability Status

1. Receives SSDI/SSI Disability Benefits

Verify SSDI/SSI disability status through a SVES (State Verification Exchange System) or SOLQ (State Online Verification Query) request or through documentation provided to the applicant by the SSA.

2. Receives RRB Disability Benefits

Verify RRB disability by contacting the RRB National Telephone Service at 1-877-772-5772 or through documentation provided to the applicant by the RRB.

3. Determined Disabled by DDS

If disability status cannot be ascertained **after** reviewing SVES or SOLQ, contact your regional DDS office to verify disability status. Contact information for the regional DDS offices is contained in Appendix 2 of this subchapter.

4. Incarcerated Disabled Individual

Although benefits administered by the Social Security Administration are suspended while an individual is incarcerated, a disabled individual continues to meet the definition of a disabled individual while incarcerated.

D. When a DDS Disability Determination is Required

- The DDS makes a disability determination for Medicaid when the individual alleges a disabling condition and has never applied for disability benefits from SSA or has not been denied disability within the past 12 months; **or**
- the individual alleges a disabling condition and SSA has not yet made a determination on a pending SSDI/SSI claim; **or**
- the individual alleges a disabling condition which is different from that considered by SSA or is in addition to that considered by SSA.

1. Individual Age 19 Years or Older

An individual age 19 years or older must have his disability determined by DDS if he:

- is claiming to have a disabling condition but does not receive SS/SSI disability benefits or RR total disability benefits, **and**
- has not been denied SSDI or SSI disability benefits in the past 12 months.

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

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

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

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

3. Individual Under 21 in LTC

a. Facility-based Care

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

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

b. ***Community-based Care (CBC)***

*A child who is receiving CBC waiver services must have his disability determined 90 days prior to his **18th** birthday.*

E. When an LDSS Referral to DDS is Required

1. Disability Determination Has Not Been Made

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

2. SSA Denied Disability Within the Past 12 Months

SSA decisions made within the past 12 months are final decisions for Medicaid purposes unless:

a) The applicant alleges a condition that is **new** or **in addition** to the condition(s) already considered by SSA,

OR

b) The applicant alleges his condition has **changed** or **deteriorated** causing a new period of disability **AND** he requested SSA reopen or reconsider his claim **AND** SSA has refused to do so or denied it for non-medical reasons. Proof of the decision made by SSA is required.

If the applicant indicates that one of the above exceptions applies, the Medicaid referral should be documented appropriately and sent to the DDS. After reviewing the Medicaid referral and Social Security decision, the DDS

may determine that the SSA decision addressed all the conditions reported to Medicaid. In this situation, the DDS will determine that no exception applies and that the SSA decision is still binding. In this situation, the DDS will not make an independent disability determination for Medicaid. Instead, the DDS will document that an exception does not apply and that the SSA determination is still binding until the end of the 12-month period.

If the conditions in a or b above do not exist, the SSA denial of disability is final for Medicaid purposes. **DO NOT** make a referral to DDS for a disability determination.

3. SSA Denied Disability More Than 12 Months Ago

If the applicant alleges a disability and SSA denied the disability more than 12 months ago, follow the procedure in M0310.112 G below to make a referral to DDS. DDS will accept and fully develop the Medicaid referral if more than 12 months have passed since the most recent SSA medical determination, regardless of appeal status with SSA, and for any reason.

F. Decision Pathway for DDS Referrals

When determining whether or not a referral to DDS is required, the worker should ask the following questions:

A child who is eligible for IV-E Foster Care but who does not receive a IV-E Foster Care maintenance payment is considered a "Non-IV-E Foster Care" child for Medicaid eligibility purposes.

Children in the custody of another state's social services agency, who are eligible for and receive Title IV-E Foster Care maintenance payments and who now reside in Virginia, are IV-E Foster Care for Medicaid eligibility purposes. Verify the child's IV-E eligibility from the other state's department of social services which makes the IV-E payment.

2. Non IV-E Foster Care

Children who are eligible for but do not receive IV-E maintenance payments or who are eligible for Non-IV-E (state/local) Foster Care (whether or not they receive a Non-IV-E payment), and who reside in Virginia are Non-IV-E Foster Care for Medicaid eligibility purposes.

3. Non-IV-E Children in Another State's Custody

A child in the custody of another state's social services agency who *is* not receiving IV-E foster care maintenance or SSI payments, *does* NOT meet the Virginia residency requirement for Medicaid (M0230) and *is* not eligible for Virginia Medicaid UNLESS *the child has been placed with and is residing in Virginia with a parent or care-taker relative.*

4. Trial Home Visits

A foster care or DJJ child continues to meet the foster care definition (either IV-E or non-IV-E) when placed by the agency in the child's own home for a trial period of up to six months, if the child continues to be in the agency's custody or remains the financial responsibility of DJJ or the court. Do not redetermine Medicaid eligibility during the 6 month trial home visit.

M0310.116 HOSPICE

A. Definition

"Hospice" is a covered group of terminally ill individuals whose life expectancy is 6 months or less and who have voluntarily elected to receive hospice care. The term "hospice" is also used to refer to the covered service for a terminally ill Medicaid recipient, regardless of his covered group. Hospice services can be provided in the individual's home or in a medical facility, including a nursing facility.

1. Hospice Care

"Hospice care" means items and services are provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan of care for the individual that is established and periodically reviewed by the individual's attending physician and the hospice program's medical director:

2. Hospice Program

A "hospice program" is a public agency or private organization which

- is primarily engaged in providing hospice care, makes hospice care services available as needed on a 24-hour basis, and provides bereavement counseling for the terminally ill individual's immediate family;
- provides hospice care in individuals' homes or in medical facilities on a short-term inpatient basis;
- meets federal and state staffing, record-keeping and licensing requirements.

M0320 Changes

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

D. Financial Eligibility

1. Assistance Unit

a. Initial eligibility determination

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

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

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

b. Ongoing eligibility

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

2. Resources

a. Initial eligibility determination

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

b. Ongoing eligibility

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

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

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

M0330 Changes

Changed With	Effective Date	Pages Changed
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

1. Non IV-E Foster Care

Children who meet the foster care definition in M0310.115 but do not receive a IV-E maintenance payment are "individuals in foster homes, private institutions or independent living arrangements for whom a public or private nonprofit child-placing agency is assuming full or partial financial responsibility." This group also includes DJJ children.

a. Children Living In Public Institutions

Non-IV-E foster care recipients meet the Medicaid institutional status requirements when they live in a public child care institution if the facility has less than 25 beds, or if they live in a publicly operated community residence that has no more than 16 beds. See section M0280.100 for definitions of public institutions.

When these children are placed in public residential institutions, the facility must not have capacity for more than 16 children (see M0280).

b. Child in Independent Living Arrangement

A child under age 18 in an independent living arrangement is eligible for Medicaid in this covered group if the child is receiving services from the local social services agency.

A child age 18 and over who is in an Independent Living arrangement with a local department of social services no longer meets the definition of a foster care child and may be eligible for Medicaid in the covered group of Former Foster Care Children Under Age 26 Years group. See M0330.109

2. Non-IV-E Adoption Assistance

Children under age 21 who meet the adoption assistance definition in M0310.102 for whom a Non-IV-E adoption assistance agreement between the local department of social services (LDSS) and the adoptive parent(s) is in effect are "individuals in adoptions subsidized in full or in part by a public agency." If the child receives a Non-IV-E adoption assistance payment, or if the child was adopted under an adoption assistance agreement and is not eligible as a IV-E Adoption Assistance child, then the child meets the "Non-IV-E adoption assistance" definition.

Non IV-E adoption assistance children who have "special medical needs" have additional requirements. See section M0330.805 for the Special Medical Needs Adoption Assistance requirements.

3. In ICF or ICF-ID

Children under age 21 who are patients in either an ICF or ICF-ID meet the classification of "individuals in an ICF or ICF- ID" in the Individual Under Age 21 covered group.

C. Assistance Unit

1. Non-IV-E Foster Care Children (Includes DJJ)

The child is an assistance unit of one effective the date the child is removed from the home and placed in foster care. Each child in foster care is evaluated as a separate assistance unit, even if the child is living with his/her siblings in a foster care home.

The child continues to meet the Individuals Under Age 21 covered group as long as he is under the supervision of the LDSS or DJJ, including during a trial visit in the child's own home. The Modified Adjusted Gross Income (MAGI) household composition methodology contained in Chapter M04 is applicable.

M04 Changes

Changed With	Effective Date	Pages Changed
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

5% FPL DISREGARD **EFFECTIVE *1/31/17***	
Household Size	**Monthly Amount**
1	*$51*
2	*68*
3	*86*
4	*103*
5	*120*
6	*138*
7	*155*
8	*173*
Each additional, add	*18*

PREGNANT WOMEN
143% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/31/17*

Household Size	143% FPL Monthly Amount	149% FPL (143% FPL + 5% FPL Disregard as Displayed in VaCMS)
2*	*$1,936*	*$2,004*
3	*2,434*	*$2,520*
4	*2,932*	*$3,035*
5	*3,430*	*$3,550*
6	*3,928*	*$4,066*
7	*4,426*	*$4,581*
8	*4,924*	*$5,097*
Each additional, add	*499*	*$517*

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

CHILD UNDER AGE 19
143% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/31/17*

# of Persons in House-hold	**109% FPL (for Determining Aid Category)**	**143% FPL**	**149% FPL (143% FPL + 5% FPL Disregard as Displayed in VaCMS)**
	Monthly Limit	Monthly Limit	Monthly Limit
1	*$1,096*	*$1438*	*$1,489*
2	*1,476*	*1,936*	*$2,004*
3	*1,855*	*2,434*	*$2,520*
4	*2,235*	*2,932*	*$3,035*
5	*2,615*	*3,430*	*$3,550*
6	*2,994*	*3,928*	*$4,066*
7	*3,374*	*4,426*	*$4,581*
8	*3,754*	*4,924*	*$5,097*
Each add'l, add	*380*	*499*	*$517*

PLAN FIRST
200% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/31/17*

Household Size	200% FPL Monthly Amount	205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)
1	*$2,010*	*$2,061*
2	*2,707*	*$2,775*
3	*3,404*	*$3,490*
4	*4,100*	*$4,203*
5	*4,797*	*$4,917*
6	*5,494*	*$5,632*
7	*6,190*	*$6,345*
8	*6,887*	*$7,060*
Each additional, add	*697*	*$715*

M0730 Changes

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

B. Definitions

1. Annuity — An annuity is a sum paid yearly or at other specific times in return for the payment of a fixed sum. Annuities may be purchased by an individual or by an employer.

2. Pensions and Retirement Benefits — Pensions and retirement benefits are payments to a worker following his retirement from employment. These payments may be paid directly by a former employer, by a trust fund, an insurance company, or other entity.

3. Disability Benefits — Disability benefits are payments made because of injury or other disability.

C. List of Benefits — The following are examples of benefits:

- Social Security Benefits
- VA Payments – certain types not counted under MAGI methodology (see Chapter M04)
- Worker's Compensation – not counted under MAGI methodology (see Chapter M04)
- Railroad Retirement
- Black Lung Benefits
- Civil Service Payments
- Military Pensions
- VIEW Transitional Payments

D. Procedure — Verify entitlement amount and amount being received by documents in the applicant/enrollee's possession, such as an award letter or benefit payment check, or by contact with the entitlement source.

M0730.200 UNEMPLOYMENT COMPENSATION

A. Policy — Unemployment Compensation received by an individual is counted as unearned income. The amount counted is the gross benefit before any taxes or deductions.

B. Procedures

1. General Procedures — Count Unemployment Compensation as unearned income for all covered groups.

2. Special $25 Weekly Exclusion — The American Recovery and Reinvestment Act of 2009 (P.L. 111-5) authorized increased payments, called Federal Additional Compensation (FAC), of $25.00 per week to certain individuals receiving Unemployment Compensation payments. FAC increased payments *were* authorized for Unemployment Compensation payments made through December 4, 2010, provided that the initial claim for compensation was filed on or before May 23, 2010. Claims filed after May 23, 2010 are not subject to the increased payments.

M0730.210 TRADE ADJUSTMENT ASSISTANCE ACT INCOME

A. Policy

The Trade Adjustment Assistance Act is administered by the Virginia Employment Commission. The Act allows qualified unemployed individuals to receive additional weeks of Unemployment Compensation (UC). UC benefits are counted as unearned income. The amount counted is the gross benefit before any taxes or deductions.

B. Procedure

See M0730.200, above, for procedures to use in counting UC benefits.

M0730.400 CHILD/SPOUSAL SUPPORT

A. Policy

For covered groups subject to Modified Adjusted Gross Income (MAGI) methodology, child support income is **NOT** counted (see chapter M04). However, spousal support (alimony) **is** counted as unearned income.

For covered groups that are not subject to MAGI methodology, support received by an individual, whether it comes directly from the provider or is redirected to the individual by DCSE, **is** unearned income. The support received by the individual is subject to the $50 Support Exclusion. Use the policies and procedures below.

B. Procedures

1. Child Living in Home

Child support payments received for a child who is living in the home is counted as income to the child for a non-MAGI determination.

2. Child Not Living in Home

Child support payments received for a child who is not living in the home are counted a income to the person receiving it for a non-MAGI determination if the money is not given to the child.

M0810 Changes

Changed With	Effective Date	Pages Changed
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	7/1/2016 (no change)		7/1/2015 – 6/30/16	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$1,861.63	$310.27	$1,861.63	$310.27
2	2,370.20	395.03	2,370.20	395.03
b. Group II	7/1/2016 (no change)		7/1/2015 – 6/30/16	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,148.04	$358.00	$2,148.04	$358.00
2	2,645.09	440.84	2,645.09	440.84
c. Group III	7/1/2016 (no change)		7/1/2015 – 6/30/16	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,792.45	$465.40	$2,792.45	$465.40
2	3,366.75	561.12	3,366.75	561.12

5. ABD Categorically Needy

All Localities	*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*

S0830 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-4	4/1/17	Table of Contents, page i Pages 24, 24c
TN #DMAS-2	10/1/16	On page 109, updated the format of the header. Neither the date nor the policy was changed.
TN #DMAS-1	3/23/16	Table of Contents, page iii Pages 18, 82
Update #7	7/1/12	Page 24
TN #94	9/1/10	Page 29
TN #93	1/1/10	Table of Contents, page iv Pages 28, 67, 119-120 Pages 122-125
TN #91	5/15/09	Table of Contents, page i Page 29

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M0830 UNEARNED INCOME

SMI premiums for January - March 1987, April - June 1987, and July - September 1987. A Title II check sent in July 1987 includes full benefits for January - June 1987 and refunds SMI premiums for August - September 1987, which will be withheld from future checks. For Medicaid purposes, the part of the check which represents full benefits for January - June 1987 is unearned income in July 1987 and the refunded SMI premiums for August - September 1987 are not income.

4. Retroactive State Buy-In

When a State "buys-in" for Medicare on behalf of an individual, a different amount of Title II income may be posted because of the Title II rounding provisions.

5. Underpay-ments

Title II benefits can be received in regular monthly checks (or by direct deposit) or in retroactive payments. If an individual receives a check because of an underpayment, charge the amount of the check (plus any SMI premiums withheld) as unearned income in the month received; do no look back and allocate an underpayment being made in the current month to prior months. See S0830.010 B. on counting retroactive RSDI benefits for an offset period. See S1120.022 for the treatment of reissued Title II monies in change-of-payee situations.

6. Facility of Payment Provisions

When a Title II auxiliary or survivor beneficiary who is subject to work deductions receives Title II benefits in his name because of the facility (something that makes an operation or action easier) of payment provisions but the benefits are those of other beneficiaries, the amount of Title II benefits of each of the involved beneficiaries must be determined separately. Count the benefits as income to the appropriate beneficiaries.

M0830.211 SPECIAL EXCLUSION OF TITLE II COLA *FOR CERTAIN* ABD *COVERED GROUPS*

A. Policy

The cost-of-living adjustment (COLA) in the individual's Social Security Title II benefit is excluded through the month following the month in which the new federal poverty limits (FPLs) are published when determining the income eligibility of an individual in the following ABD covered groups:

- Qualified Medicare Beneficiary (QMB
- Special Low-income Medicare Beneficiary (SLMB),
- Qualified Individuals (QI), and
- ABD with Income ≤ 80% FPL (ABD 80% FPL).

B. Procedure

Exclude the COLA in the individual's SSA Title II benefit until the first day of the second month following the publication month of the new FPL. Local agency staff are notified of the FPL publication *via a broadcast on the VDSS intranet site, SPARK.*

C. Example

A QMB-only Medicaid recipient *with* SSA Title II benefits receives a COLA in the benefit *payment for* January. The worker does not take any action on this change in income until the *FPL broadcast has been posted on SPARK. The FPL change is published on January 31, and LDSS are notified by the FPL broadcast posted on February 3.* The worker recalculates the *enrollee's* income for *March 1*, based on the recipient's increased Title II benefit and the new QMB income limit which was effective *January 31*.

S0830.215 BLACK LUNG BENEFITS

A. Introduction

1. Types of Black Lung Benefits

Black Lung (BL) benefits are paid to miners and their survivors under the provisions of the Federal Mine Safety and Health Act (FMSHA).

Benefits under **Part B** of the FMSHA are paid by the **Social Security Administration** (SSA) and benefits under **Part C** of the FMSHA are paid by the **Department of Labor** (DOL).

2. Payment Dates

In general, Part B benefits are paid on the third of the month while Part C benefits are paid on the fifteenth of the month.

M1110 Changes

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

S1110.310 RESOURCES ASSUMED TO BE NONLIQUID

A. Introduction

Certain non-cash resources, though they may occasionally be liquid, are nearly always non-liquid.

B. Operating Policy

1. Assumption of Nonliquidity

Absent evidence to the contrary, we assume that the following type of resources are non-liquid.

- automobile, trucks, tractors, and other vehicles;
- machinery and livestock;
- buildings, land and other real property rights; and
- non-cash business property.

2. Evidence to The Contrary

a. If there is no apparent evidence to the contrary of the assumptions in 1. above, we do not seek out any evidence to the contrary. There is no need to document a lack of evidence to the contrary.

b. In very rare situations an individual may volunteer firm evidence that one of the above types of resources is liquid (i.e., its sale has been accomplished or arranged within 20 workdays). Document the file *in the VaCMS case record* and proceed accordingly only if the distinction is material.

C. Operating Policy-- Life Insurance

This subchapter provides no categorical assumption regarding the liquidity or non-liquidity of life insurance policies.

VALUATION OF RESOURCES

M1110.400 WHAT VALUES APPLY TO RESOURCES

A. Policy Principles

1. Definitions

a. The current market value (CMV) or fair market value (FMV) of a resource is:

- Real property – 100% of the local tax assessed value **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.

The cost of the appraisal must be paid by either the applicant/recipient or the individual acting on the applicant or recipient's behalf. Certified appraisals 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 hard case record.*

License validity for appraisers *in Virginia*, if necessary, can be verified through the "License Lookup" tool on the Department of Professional and Occupational Regulation's website at www.dpor.virginia.gov or by calling the Real Estate Appraiser staff at 804-367-2039. *If the appraiser is located in another state, contact the state's department of Professional and Occupational Regulation or its equivalent department.*

- Countable vehicles – the **average trade-in value** listed in the National Automobile Dealers Official Used Car Guide (NADA) Guide, **or** the value assessed by the locality for tax purposes may be used, if vehicle is not listed in N.A.D.A. Guide.

b. Equity value (EV) is the CMV of a resource minus any encumbrance on it.

c. An encumbrance is a legally binding debt against a specific property. Such a debt reduces the value of the encumbered property but does not have to prevent the property owner from transferring ownership (selling) to a third party. However, if the owner of encumbered property does sell it, the creditor will nearly always require a debt satisfaction from the proceeds of sale.

M1470 Changes

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

M1470.410 MEDICAID CBC - PERSONAL MAINTENANCE ALLOWANCE

A. Individuals

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

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

1. Basic Maintenance Allowance

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

- Elderly or Disabled with Consumer-Direction (EDCD) Waiver,
- Community Living Waiver (formerly Intellectual Disabilities (ID) Waiver),
- Technology-Assisted Individuals Waiver,
- Family and Individual Supports Waiver (formerly Individual and Family Developmental Disabilities Support (DD) Waiver , and
- Building Independence Waiver (formerly Day Support (DS) Waiver).

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.

M1510 Changes

Changed With	Effective Date	Pages Changed
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

C. Budget Periods By Classification

1. CN

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

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

2. MN

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

D. Verification

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

Income verification by the Federal Hub is acceptable for retroactive eligibility determinations provided that reasonable compatibility is met (see M0420.100 B.9). The applicant must provide verification of income received in the retroactive period, as well as for ongoing eligibility, if his income is not verified by the Hub. *An applicant with a resource test must provide verification of resources held in the retroactive period.*

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

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

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

M1510.200 NOTICE REQUIREMENTS

A. Policy

Federal regulations in 42 CFR 431.206 through 431.214 require the agency to inform every applicant or enrollee in writing

- of his right to a hearing;
- of the method by which he may obtain a hearing; and
- that he may represent himself or use legal counsel, a relative, a friend or other spokesperson.

The agency must provide the information required above at the time of any action affecting his claim for Medicaid benefits.

B. Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs

A system-generated Notice of Action or the "Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs" (Form 032-03-008) must be used to notify the applicant:

- that his application has been approved and the effective date(s) of his Medicaid coverage.
- that retroactive Medicaid coverage was approved and the effective dates.
- that his application has been denied including the specific reason(s) for denial.
- that retroactive Medicaid coverage was denied, including the specific reason(s) for denial.
- of the reason for delay in processing his application.
- of the status of his request for reevaluation of his application in spenddown status.

When additional information is necessary to clearly explain the case action, suppress the system-generated notice and send a manual notice containing the necessary information.

When the application was filed by the applicant's authorized representative, a copy of the notification must be mailed to the applicant's authorized representative.

1. CN Children or Pregnant Women

When the application of a medically indigent child or pregnant woman is denied because of excess income, the denial notice must state the reason for denial. The notice must also include the resource question pages from an MA application form the and must advise the applicant of the following:

a. that he/she may complete and return the enclosed form for a Medicaid spenddown to be evaluated, and

b. if the information is returned within 10 days of this notice, the medically indigent application date will be used as the Medicaid spenddown application date.

M1520 Changes

Changed With	Effective Date	Pages Changed
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

When an applicant/recipient is discharged from a nursing facility or ALF to a community living arrangement not in the Virginia locality that had responsibility for the individual's case while he was in the nursing facility or ALF, the case is transferred to the new locality.

C. DBHDS Facilities

The procedures for transfer of Medicaid cases of ABD patients admitted to or discharged from Department of Behavioral Health and Developmental Services (DBHDS) facilities are in subchapter M1550. F&C cases are not transferred to the DBHDS facilities.

D. Cases From Outstationed Workers

Medicaid applications taken and Medicaid cases approved by outstationed workers, such as the workers stationed at the University of Virginia (UVA) and Virginia Commonwealth University-Medical College of Virginia (VCU-MCV) hospitals, must be transferred to the LDSS where the applicant/enrollee lives. Medicaid cases and applications are **not** transferred from LDSS **to** outstationed workers.

1. Confirm Receipt

The receiving LDSS must confirm receipt of the case by completing the Case Record Transfer Form and returning the copy to the outstationed worker.

2. Review Eligibility

LDSS workers must review (partial review) the Medicaid eligibility determination in approved cases transferred from an outstationed worker, and must take any necessary corrective action.

3. Corrective Action

If an eligibility error(s) is found, do not send the case back. Correct the error(s), send the notice to the case head if required, and refer the case to the LDSS supervisor for possible contact with the outstationed worker's supervisor.

E. Local Agency to Local Agency

When a Medicaid applicant/enrollee (including a Medicaid CBC waiver services enrollee) moves from one locality to live in a community living arrangement (not a medical facility, an ALF, or group home with 4 or more beds) in another locality within the state of Virginia, the following procedures apply:

1. Sending Locality Responsibilities

a. Medical Assistance Case with No Other Benefit Programs Attached

The sending locality must ensure that the ongoing case is current and complete before transferring the case. If the annual renewal has been completed within the past 10 months, a partial review based on known information, as to whether or not the enrollee will meet a covered group and the income and resource limits in the new locality, must be completed before transferring the case.

If the case is in a current case action in VaCMS, the agency must complete the case action before transferring the case. If the individual applies for other benefits programs in another locality, the sending LDSS has 7 calendar days from the time they receive information indicating the individual has moved to complete the case action and transfer the case to the new locality.

If the annual renewal is due in the month the LDSS plans to transfer the case, the following month, or is overdue, the renewal must be completed before transferring the case. If the enrollee applies for other benefit programs in another locality, the sending LDSS must transfer the case to the new locality by the end of the next business day after they receive information indicating the enrollee has moved, provided the agency has not started the redetermination case action in VaCMS

If the individual applies for other benefits in the new locality and the case is in the redetermination case action in VaCMS, the sending LDSS has 7 calendar days from the time they receive information indicating the individual has moved to complete the case action and transfer the case to the new locality. The worker will update VaCMS immediately with the new address so the information transfers over to MMIS to assure managed care continuity but will maintain ownership of the case in their FIPS until the renewal is completed.

The sending LDSS must process the renewal if a renewal or application is submitted during the reconsideration period and the enrollee indicates he has moved on the application or renewal form.

If the case is closed and in the reconsideration period, and the individual applies for other benefits programs in another locality, the case will be transferred to the new locality automatically when the new locality associates the application for other benefits with the closed case. The new locality will be responsible for processing the renewal if it is submitting within the reconsideration period.

b. Medical Assistance Case with Other Benefit Programs Attached

The sending locality must ensure that the MA program attached to the ongoing case is current and complete before transferring the case. If the annual renewal has been completed within the past 10 months, a partial review based on known information, as to whether or not the recipient will meet a covered group and the income and resource limits in the new locality, must be completed before transferring the case. If the case is in a current case action the agency must complete the case action before transferring the case.

If the annual MA renewal is due in the month the LDSS plans to transfer the case, the following month, or is overdue, the renewal must be completed before transferring the case. If the individual submits his interim or renewal for other benefit programs in another locality, the sending LDSS must transfer the case to the new locality by the end of the next business day after they receive information indicating the individual has moved, provided the agency has not started the redetermination case action in VaCMS.

If the individual submits his renewal for other benefits in the new locality and the case is in the redetermination case action, the sending LDSS has 7 calendar days from the time they receive information indicating the individual has moved to complete the case action and transfer the case to the new locality. The worker will update VaCMS immediately with the new address so the information transfers over to MMIS to assure managed care continuity but will maintain ownership of the case in their FIPS until the renewal is completed.

The sending LDSS must process the renewal if a renewal or application is submitted during the reconsideration period and the individual indicates he has moved on the application or renewal form.

If the MA is closed and in the reconsideration period, and the individual submits a renewal for other benefit programs in another locality, the sending LDSS will transfer the case to the new locality and the new locality will be responsible for processing the renewal if it is submitted within the reconsideration period.

c. Transfer Pending Medical Assistance Applications

Pending applications or cases in Intake/Screening in VaCMS must be transferred to the new locality for an eligibility determination.

d. Foster Care & Adoption Assistance

Foster care and adoption assistance Medicaid cases are not transferred unless custody or responsibility for services and/or payment is transferred.

e. Sending Transferred Cases

If the renewal or the partial review indicates that the enrollee(s) will continue to be eligible for Medical Assistance in the new locality, the sending locality must update the enrollment system. Transfer the electronic case, and if applicable, send the additional case record materials to the enrollee's locality of residence with a completed Case Record Transfer Form.

Required Document Management Imaging System (DMIS) items must be uploaded to VaCMS before case transfer. Document within VaCMS to indicate if there are documents uploaded to DMIS and/or additional case record materials outside of VaCMS. If additional case record materials exist, the materials and a completed Case Record Transfer Form must be sent by certified mail, delivered personally and a receipt obtained or, at the agency's discretion, the case may be sent via the courier pouch.

If the annual renewal or the partial review finds that eligibility no longer exists for one or all enrollees in the case, the agency must take the necessary action, including advance notice to the individuals, to cancel the ineligible individuals' coverage.

2. Receiving Locality Responsibilities

a. Confirm Receipt

The receiving agency must confirm receipt of the additional case record materials by completing the Case Record Transfer Form and returning the copy to the sending agency. If VaCMS indicates no additional case record materials, no follow up action is required.

b. Process Pending Applications

When a pending application is transferred, the receiving agency makes the eligibility determination and takes all necessary action, including sending the notice and enrolling eligible individuals.

c. Review Eligibility

LDSS workers must review (partial review) the Medicaid eligibility determination for cases transferred from other LDSS and must take any necessary corrective action.

d. Corrective Action

If an eligibility error(s) is found or the case is overdue for renewal, do not send the case back. Correct the error(s), and/or complete the renewal, send the notice to the case head if required, and refer the case to the LDSS supervisor for possible contact with the sending agency's supervisor.

3. Decision Pathway for Case Transfers

When an enrollee reports a change of address, use the steps below as guidance. ***If a case is held before transfer to complete an action, immediately update the address to ensure managed care continuity.***

a. Enrollee Reports Change of Address

Step 1:
Is the case current and complete? This means the case is not in any case action and the renewal has been completed within the last 10 months.
-If Yes, go to Step 2.
-If No, go to Step 4.

Step 2:
Has the person applied for other programs?
-If yes, the worker has 7 calendar days to complete a partial review and transfer the case.
-If no, go to Step 3.

Step 3:
Has the person submitted an interim or renewal for other programs?
-If yes, the worker has by the end of the next business day to transfer the case.
-If no, the worker has 30 days to transfer the case per change policy.

Step 4:
What is incomplete?
-If the case is in a case action, go to Step 5.
-If the case is coming due, due or overdue for a renewal, go to Step 6.

Step 5:
Has the person applied for other programs?
-If yes, the worker has 7 calendar days to complete the action, a partial review, and transfer the case.
-If no, the worker has 30 days to transfer the case per change policy.

Step 6:
Has the person submitted an application, interim or renewal for other programs?
-If yes, go to step 7.
-If no, the worker must complete the renewal before transferring the case.

Step 7:
Is the case in redetermination action?
-If yes, the worker has 7 calendar days to complete the action, a partial review, and transfer the case.
-If no, the worker has by the end of the next business day to complete the action and transfer the case.

b. Enrollee Submits Renewal During Reconsideration Period That Includes a Change of Address:

Step 1:
Are there other benefit programs other than MA active on the case?
-If yes, go to Step 2.
-If no, go to Step 4.

Step 2:
Has the person submitted an interim or renewal for other programs?
-If yes, go to Step 3.
-If no, the worker must complete the renewal before transferring the case.

Step 3:
Is the case in any action?
-If yes, the worker has 7 calendar days to complete the action, a partial review, and transfer the case.
-If no, the worker has by the end of the next business day to complete the action and transfer the case.

Step 4:
Has the person submitted an application for other programs?
-If yes, the worker has 7 calendar days to complete a partial review and transfer the case.
-If no, the worker must complete the renewal before transferring the case.

F. Spenddown Cases

Cases in spenddown status (denied or canceled and placed on a spenddown) must be transferred when the applicant notifies the agency that he/she has moved to a new Virginia locality.

1. Sending Locality Responsibilities

Within 10 working days of notification that the applicant has moved, the case must be transferred to the new locality, *following the policies in M1520.500 E.1.e.* The sending agency must:

- inform the applicant of the receiving agency's name, address, and telephone number;
- deduct all known spenddown items from the spenddown balance on the worksheet before sending the case record.

2. Receiving Locality Responsibilities

The receiving locality *must review the case following the policies in M1520.500 E.2.*

G. Receiving LDSS Case Management Procedure

To identify and manage transferred Medicaid cases, use the report titled "Caseworker Alpha Case/Enrollee Listing." This report is posted in the Data Warehouse, MMIS Reporting, Medicaid Management Reports. It is updated on or about the 22nd of each month. *The LDSS can also use the Case Assignment function in VaCMS to view current caseloads.*

TWELVE MONTH EXTENDED MEDICAID INCOME LIMITS 185% of FEDERAL POVERTY LIMITS EFFECTIVE *1-31-17* ALL LOCALITIES

# of Persons in Family Unit/Budget Unit	185% FPL Monthly Limit
1	*$1,860*
2	*2,504*
3	*3,149*
4	*3,793*
5	*4,437*
6	*5,082*
7	*5,726*
8	*6,371*
Each additional person add	*645*

M1550 Transmittal Changes

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

DBHDS Facilities

Medicaid Technicians

NAME	LOCATION	WORK TELEPHONE	CASELOAD
Mary Lou Spiggle Medicaid Field Supervisor mls846 (T003)	**Central Virginia Training Center Medicaid Office Madison Heights, VA <u>Mail To</u>: PO Box 1098 Lynchburg, VA 24505**	**434-947-6256 FAX 434-947-2114**	**PGH-caseload-all NVMHI-caseload-all SVMHI-caseload-all WSH-caseload-all**
Carrie Richardson cer900 (T002)	**Central Virginia Training Center Medicaid Office Madison Heights, VA <u>Mail To</u>: PO Box 1098 Lynchburg, VA 24505**	**434-947-2754 FAX 434-947-2114**	**CVTC-caseload-all VCBR-caseload-all**
Frances Jones fwj900 (T004)	**Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354**	**276-783-0841 FAX 276-782-9732**	**ESH-caseload-all SWVMHI-caseload-all SWVTC-caseload-all**
***Alishia Fuller amf900 *(T005)**	**Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354**	**276-783-0842 FAX 276-782-9732**	**Catawba-caseload-all Hiram-Davis-caseload-all SEVTC-caseload-all**

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

DBHDS State Hospital facilities:

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

M16 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-4	4/1/17	Page 7 Pages 8-10 are runover pages.
TN #DMAS-2	10/1/16	Page 3
TN #DMAS-1	6/1/16	Page 1
TN #100	5/1/15	Page 3
Update #9	4/1/13	Page 8

The schedule letter contains information about summary due dates and other pertinent information.

If the agency representative cannot be available on the date and time selected by the Hearing Officer, he/she must notify the DMAS as soon as possible and request an alternate date and time for the hearing.

M1670.100 LOCAL AGENCY APPEAL SUMMARY

A. Agency Appeal Summary Form

Upon notification that a fair hearing has been requested, the agency must complete an "Agency Appeal Summary," form #032-03-805 available at: http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi.

The Agency Appeal Summary must address the issue(s) on the Notice of Action that the appellant has appealed. The Agency Appeal Summary must also include all relevant information that describes and supports the agency's action. The agency must submit all documents relevant to the agency's determination with the Agency Appeal Summary.

B. Send to Appeals Division and Appellant

The agency must send one copy of the Agency Appeal Summary form and all relevant documentation to the following parties by the due date specified by the Appeals Division at the time of the notification:

- Department of Medical Assistance Services
  Appeals Division, *6th Floor*
  600 East Broad Street
  Richmond, Virginia 23219

- The appellant or his authorized representative, *if the appellant has designated a representative for the appeal.*

The agency must keep a copy of the *Agency Appeal Summary* and all relevant documentation, including applications, notices, *and DMAS appeal decisions* for its records.

M1680.100 THE HEARING PROCEDURE

A. Hearing Procedure

The hearing will be conducted in an informal manner. Formal rules of evidence do not apply in these proceedings. The appellant is entitled to guarantees of fair hearings established in Goldberg v. Kelly, 397 US 245 (1970). The proceedings will be governed by the following rules:

1. Record

The Hearing Officer will swear-in all hearing participants who will be presenting evidence or facts and will record the hearing proceedings.

2. Appellant

The appellant will present his own case or have it presented by an authorized representative. He will be allowed to bring witnesses, establish all pertinent facts and circumstances, advance any testimony or evidence, and question witnesses.

3. Agency Representatives

The local DSS agency worker who took the action being appealed and/or the worker's supervisor should be present at the hearing. The local agency may be represented by its county or city attorney. The agency has the authority to ask its county or city attorney to attend the hearing.

When the action being appealed is a disability decision made by the DDS, a representative from DDS must be present at the hearing. When the action being appealed is a denial of a medical or dental covered service, a representative from DMAS or its contractor who made the decision must be present at the hearing.

4. Opportunity to Examine Documents

The appellant or his representative must be given the opportunity to examine all documents and records to be used at the hearing, at a time before the hearing or during the hearing. Copies of case record information must be made available free of charge to the appellant at his request.

B. Hearing Officer Evaluation and Decision

1. Evaluation

Following the hearing, the Hearing Officer prepares a decision taking into account the summary prepared by the agency or medical provider involved, evidence provided by the appellant or his representative, and additional information provided by the agency. The Hearing Officer evaluates all evidence, researches laws, regulations and policy, and decides on the accuracy of the agency's action.

2. Hearing Officer Decision

Examples of the Hearing Officer's decisions include, but are not limited to:

a. Sustain

When the Hearing Officer's decision upholds the agency's action, the decision is "sustained."

b. Reverse

When the Hearing Officer's decision overturns the agency's action, the decision is "reversed."

c. Remand

When The Hearing Officer sends the case back to the agency for additional evaluation, the decision is "remanded." The Hearing Officer's decision will include instructions that must be followed when completing the remand evaluation.

3. Failure to Provide Requested Information

If the local department of social services denies an application or terminates coverage because of failure to provide requested information, the hearing officer can hold the hearing open for a period of time to allow the appellant to submit additional information. The hearing will address:

- whether or not the applicant was given appropriate notification of what was needed for the eligibility determination; and
- whether or not the applicant was given sufficient time to submit the information requested.

a. Sustained

If the local department of social services followed correct procedures (see M0130.200) and the applicant brings the requested information to the hearing, the action of the local department of social services will be sustained and the applicant will be required to file a new application.

b. Remanded

If the Hearing Officer determines that the local department of social services did not follow appropriate procedures, the case may be remanded for appropriate action.

If the Hearing Officer determines that the local department of social services did not follow correct procedures, and the applicant brings the relevant information to the hearing, the case may be remanded for an eligibility determination using the original application date.

C. Local Agency Action

The decision of the Hearing Officer is the final administrative action taken on the appeal. The local agency must comply with the Hearing Officer's decision.

1. Agency Action - Sustained Cases

If the Hearing Officer's decision is to sustain the agency's action, and coverage was continued during the appeal process, the case must be closed without an additional notice to the enrollee from the local agency. The Hearing Officer's decision letter to the appellant is the appropriate official notice of cancellation.

The local agency must take action to close the case in the Medicaid computer using cancel reason "015"effective the date the agency receives the decision.

2. Agency Action - Remanded Cases

a. Do Not Send Documents to Hearing Officer

If the Hearing Officer's decision is to remand the case to the local agency, the local agency must not send documentation of the evaluation or a copy of the remand notice to the Hearing Officer.

b. Enrollment Actions

If the Hearing Officer's decision is to remand the case for further evaluation and coverage was continued during the appeal process, coverage must be continued until the local agency completes the evaluation and makes a new decision.

If the remand evaluation results in the appellant's continuous eligibility, the local agency must notify the appellant of his/her continuing eligibility for coverage.

If the remand evaluation results in the appellant's continuous eligibility and coverage was NOT continued during the appeal process, the local agency must reinstate coverage back to the original termination date (no break in coverage) and notify the appellant of his continued eligibility.

If the remand evaluation results in the appellant's ineligibility and coverage was continued during the appeal process, the enrollee's coverage must be canceled at the completion of the evaluation, and the appellant must be notified.

c. Take Action in 30-45 Days

The agency must complete the remand evaluation within 30 days or 45 days as applicable.

3. Agency Action-Reversed Cases

Following a Hearing Officer's decision to reverse an agency's action to deny, reduce, or terminate coverage, the agency must reinstate coverage retroactive to the date of closure or month of application (including retroactive coverage months, if applicable).

M1690.100 RECOVERY OF BENEFITS PAID DURING APPEAL

A. Applicable Circumstances

The Medicaid Program may recover expenses paid on behalf of appellants whose Medicaid coverage was continued during the appeal process, when the agency's proposed action is upheld by the Hearing Officer.

DMAS will be responsible for recovering these expenses from the appellant, not the service provider. The appellant will be notified, after the hearing decision is made, of how much money if any is owed to the Medicaid Program.

B. Recovery Period

Medicaid expenditures for services received from the original effective date of the proposed adverse action (as stated on the notice) until the actual cancellation of Medicaid coverage or payment will be recovered.

M17 Changes

Changed With	Effective Date	Pages Changed
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

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

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

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

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

C. *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

transfer resulted in a penalty period during which LTC services were received, a referral must be made to the RAU to recover the misspent dollars. RAU staff will contact the recipient or the recipient's authorized representative to pursue recovery.

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

E. Recovery of Correctly Paid Funds

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

1. Deceased Recipient's Estate

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

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

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

2. Insurance Settlements and Similar Recoveries

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

3. Trusts

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

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

4. Notification to DMAS

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

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

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

M1700.400 RECOVERY RESPONSIBILITIES: LDSS AND DMAS

A. VDSS/LDSS Responsibilities in Loss Prevention Efforts

VDSS Medicaid operates under an interagency agreement with DMAS which lists specific responsibilities of VDSS and, by extension, the LDSS, for active participation in loss prevention efforts. The responsibilities of the LDSS fall under the interagency agreement and are neither optional nor discretionary for the LDSS. VDSS shall supervise the programmatic activities of the LDSS to ensure compliance.

B. LDSS Requirements

LDSS must participate in the identification, tracking, and correction of eligibility errors. LDSS must also determine and review ongoing or current recipient eligibility. **The DMAS RAU does not determine ongoing recipient eligibility, but rather reviews recipient eligibility in relation to allegations of fraud**. LDSS shall:

1. Report Individuals

Report to DMAS RAU every known instance relating to a non-entitled individual's use of Medicaid services, regardless of the reason for non-entitlement such as:

- instances where evidence of fraud may exist;
- errors involving eligibility discovered by the LDSS in which it appears there has been deliberate misrepresentation by an applicant/recipient with intent to defraud;
- eligibility errors discovered by the LDSS, independent of other audit or quality control functions, including cases in which the individual was enrolled incorrectly, added in error, not cancelled timely, allowed to remain on Medicaid during the conviction sanction period or when information known to the agency would render ineligibility;
- cases in which the LDSS discovers that the enrollee failed to report information that impacts eligibility; and
- LTC patient pay underpayments resulting from any cause totaling $1,500 or more.

2. Corrective Action

Report to the DMAS RAU corrective action taken on all discovered eligibility errors. Corrective action is a function of the loss prevention process. All corrected errors shall be reported to DMAS.

3. Cancel Coverage

Cancel the eligibility of all persons convicted of public assistance fraud or medical assistance fraud to the extent allowable under federal and state regulations, using the cancel code for fraud convictions (Cancel Code 014).

C. DMAS Response

The RAU shall send a referral acknowledgement letter to the LDSS worker making the referral. RAU may send out additional communication to the LDSS should additional verifications/documentation be required to complete the investigation.

D. Recipient Audit Reporting

The RAU has two prevention efforts for reporting fraud and abuse of Medicaid Services by individuals within the community. Both referral methods should be given to the individual by the LDSS. The individual may remain anonymous.

- the web address, recipientfraud@dmas.virginia.gov.
- the Recipient Audit fraud and abuse hotline. Both a local and a toll free number are available 24 hours daily for reporting suspected fraud and abuse: local (804) 786-1066; and toll free (866) 486-1971.

E. Statute of Limitations

There is no "statute of limitations" for Medicaid fraud; cases that are referred for fraud shall be flagged to ensure that the information is not purged.

M21 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-4	4/1/17	Appendix 1, page 1
TN #DMAS-2	1/1/17	Appendix 1, page 1
TN #DMAS-2	10/1/16	Page 3
TN #DMAS-1	6/1/16	Appendix 1, page 1
TN #100	5/1/15	Table of Contents Pages 1-7 Appendices 1 Pages 8-10 and Appendices 2 and 3 were deleted.
UP #10	5/1/14	Pages 1-3 Appendix 1
TN #99	1/1/14	Pages 1-3 Appendix 1
TN # 98	10/1/13	Table of Contents Pages 1-10 Pages 10a and 11-16 were deleted.
UP #9	4/1/13	Pages 3, 4
UP #8	10/1/12	Table of Contents Pages 2-4 Appendix 3 deleted
TN #97	9/1/12	Pages 3, 4
UP #7	7/1/12	Pages 3, 4 Appendix 2, pages 1 Appendix 3, pages 1 and 2
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	Pages 3, 8
TN #95	3/1/11	Table of Contents Pages 5, 6, 14, 15, Page 16 added Appendix 1
TN #94	9/1/10	Page3 Appendix 3, pages 1 and 2
UP #3	3/1/10	Pages 2-5
TN #93	1/1/10	Page 2-4, 8
Update (UP) #2	8/24/09	Page 4

FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS)
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/31/17*

# of Persons in FAMIS House-hold	**FAMIS 150% FPL**		**FAMIS 200% FPL**		
	Annual Limit	Monthly Limit	Annual Limit	Monthly Limit	205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)
1	*$18,090*	*$1,508*	*$24,120*	*$2,010*	*$2,061*
2	*24,360*	*2,030*	*32,480*	*2,707*	*2,775*
3	*30,630*	*2,553*	*40,840*	*3,404*	*3,490*
4	*36,900*	*3,075*	*49,200*	*4,100*	*4,203*
5	*43,170*	*3,598*	*57,560*	*4,797*	*4,917*
6	*49,440*	*4,120*	*65,920*	*5,494*	*5,632*
7	*55,710*	*4,643*	*74,280*	*6,190*	*6,345*
8	*61,980*	*5,165*	*82,640*	*6,887*	*7,060*
Each add'l, add	*6,270*	*523*	*8,360*	*697*	*715*

M22 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-4	4/1/17	Appendix 1, page 1
TN #DMAS-1	6/1/16	Page 4 Appendix 1, page 1
TN #100	5/1/15	Table of Contents Pages 1, 2, 5, 6, 7 Appendix 1 Pages 3 and 4 are runover Pages.
TN #98	10/1/13	Table of Contents Pages 1-7 Appendix 1 Pages 8-10 were deleted.
UP #9	4/1/13	Appendix 1
UP #8	10/1/12	Pages 2, 3 Page 3a deleted
UP #7	7/1/12	Pages 2, 3
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	Pages 3, 3a
TN #95	3/1/11	Pages 4-6 Appendix 1
UP #4	7/1/10	Page 10
TN #94	9/1/10	Page 3
UP #3	3/01/10	Page 2
TN #93	1/1/10	Pages 2-10
UP #2	8/24/09	Page 3
Update (UP) #1	7/1/09	Pages 1, 2, 7 Appendix 1, page 1

FAMIS MOMS
200% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/31/17*

Household Size	200% FPL Monthly Amount	205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)
2	*$2,707*	*$2,775*
3	*3,404*	*3,490*
4	*4,100*	*4,203*
5	*4,797*	*4,917*
6	*5,494*	*5,632*
7	*6,190*	*6,345*
8	*6,887*	*7,060*
Each additional, add	*697*	*715*