COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

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July 1, 2020

Virginia Medical Assistance Eligibility Manual
Transmittal #DMAS-17

The following acronyms are contained in this letter:

- CARES – Coronavirus Aid, Relief, and Economic Security
- DBHDS – Department of Behavioral Health and Developmental Services
- DMAS – Department of Medical Assistance Services
- F&C – Families and Children
- LIFC – Low Income Families with Children
- LPR – Lawful Permanent Resident
- LTC – Long-term Care
- LTSS – Long-term Services and Supports
- MN – Medically Needy
- TN – Transmittal

TN #DMAS-17 includes policy clarifications, updates and revisions. Unless otherwise noted in the Cover Letter and/or policy, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after July 1, 2020.

The following changes are contained in TN #DMAS-17:

Changed Pages	Changes
Chapter M01 Table of Contents, page ii	Table of Contents, page ii was added.
Subchapter M0110 Pages 1, 5, 6, 8 Page 4a is a runover page.	On pages 1 and 8, removed the policy on DBHDS staff. On pages 5 and 6, clarified how information can be released.

Changed Pages	Changes
Subchapter M0120 Pages 2, 2a, 5, 7, 8, 13, 16 Page 6 is a runover page. Page 14 was removed. Pages 15-20 were renumbered.	On pages 2, 2a, and 13, removed the policy on Medicaid Technicians and DBHDS staff. On pages 5 and 7, clarified the policy regarding a non-custodial parent applying for a child. On page 8, revised a paragraph number. On page 16, removed the phrase "do not receive a Commonwealth of Virginia (COV) Medicaid card."
Subchapter M0130 Pages 2, 6, 10 Page 6a was added as a runover page.	On page 2, revised the application processing time for pregnant women from 10 work days to seven (7) calendar days. On page 6, clarified the verification requirements when a non-custodial parent applies for a child. On page 10, clarified the policy on income verifications.
Subchapter M0220 Pages 21, 22, 23, 25 Appendices 3-7 were renumbered.	On pages 21, 21, 23 and 25, clarified the policy on dialysis patients and updated the Emergency Services Certification Form information.
Subchapter M0280 Pages 7, 9, 10 Page 11 was deleted.	On page 7, clarified the institutional status of an individual who is released from incarceration. On page 9, clarified the institutional status for an inmate released for medical reasons. On page 10, removed the policy on DBHDS facilities and Medicaid Technicians.
Subchapter M0310 Page 7 Pages 8 and 9 are runover pages.	Clarified how an individual's birthday impacts eligibility in covered groups with an age requirement.
Subchapter M0320 Pages 24. 25. 26, 27 Page 26a was added as a runover page.	On page 24, corrected formatting. On pages 25 and 27, clarified the treatment of Social Security benefit increases for Medicaid Works participants. On page 26, revised the limit for earnings held in the Work Incentive Account.
Chapter M04 Pages 15, 16, 16a, 19 Appendices 3, 5, and 8	On page 15, clarified when a child's income is countable and revised the tax filing threshold amounts for 2020. On pages 16, 16a, 19 in Appendix 8, added policy regarding Federal Pandemic Unemployment Compensation payments and Recovery Rebates paid under the CARES Act. In Appendix 3 revised the LIFC income limits, effective July 1, 2020. In Appendix 5, revised the Individuals Under Age 21 income limits, effective July 1, 2020.
Subchapter M0630 Page 5 Page 6 is a runover page.	Added policy regarding the treatment of Recovery Rebates paid under the CARES Act.
Chapter M07 Table of Contents, page i	Revised the Table of Contents

Changed Pages	Changes
Subchapter M0710 Appendices 2 and 3	In Appendix 2, revised the F&C MN income limits, effective July 1, 2020. In Appendix 3, revised the F&C 100% Standard of Assistance income limits, effective July 1, 2020.
Subchapter M0715 Table of Contents Page 2	Revised the Table of Contents. On page 2, added policy regarding the treatment of Recovery Rebates paid under the CARES Act.
Subchapter M0730 Page 7	Added policy regarding Federal Pandemic Unemployment Compensation payments
Subchapter M0810 Page 2	Revised the MN income limits, effective July 1, 2020.
Subchapter M0815 Table of Contents Pages 11, 12	Revised the Table of Contents. On pages 11 and 12, added policy regarding the treatment of Recovery Rebates paid under the CARES Act.
Subchapter M0830 Page 29	Added policy regarding Federal Pandemic Unemployment Compensation payments
Subchapter M1110 Page 1	Clarified the scope of time involved for a resource evaluation.
Subchapter M1130 Table of Contents, page ii Page 4 Page 5 is a runover page.	Revised the Table of Contents. On page 4, added policy regarding the treatment of Recovery Rebates paid under the CARES Act.
Subchapter M1410 Pages 1, 4, 8, 11-13 Pages 4a and 7 were removed. Pages 8-14 were renumbered 7-13.	On pages 1 and 8, removed the policy on DBHDS staff. On page 4, removed the bullets for incarcerated individuals. On pages 11 and 12, revised the name of the "Notice of Obligation for Long-term Care Costs" to the "Notice of Patient Pay Responsibility." On page 12, updated the address for the Office of Community Living at DMAS.
Subchapter M1420 Pages 1-6	Clarified the requirements and procedures for LTSS screenings.
Subchapter M1450 Page 45	Revised the name of the "LTC Communication Form" (DMAS-225) to "LTSS Communication Form."
Subchapter M1470 Table of Contents, page ii Pages 1, 14, 28a, 47, 48, 50, 55 Appendix 1, page 1	On all pages, revised the name of the "Notice of Obligation for Long-term Care Costs" to the "Notice of Patient Pay Responsibility."

Changed Pages	Changes
Subchapter M1480 Pages 8b, 9, 14, 66, 77, 92	On page 8b, removed the policy on DBHDS staff. On pages 9 and 14, clarified that only one home is excluded for the resource assessment. On page 66, revised the Monthly Maintenance Needs Allowance and Excess Shelter Standard, effective July 1, 2020. On pages 77 and 92, revised the names of the "Notice of Obligation for Long-term Care Costs" to the "Notice of Patient Pay Responsibility" and the "LTC Communication Form" (DMAS-225) to "LTSS Communication Form."
Subchapter M1510 Page 15	Revised the name of the "Notice of Obligation for Long-term Care Costs" to the "Notice of Patient Pay Responsibility."
Subchapter M1520 Pages 2, 4, 25, 30 Page 3 is a runover page.	On page 2, clarified verification requirements for reported changes in income. On page 4, clarified the enrollment process for ongoing members who report a pregnancy. On pages 25 and 30, removed the policy on Medicaid Technicians and DBHDS staff.
Subchapter M1550 Table of contents Pages 1, 2 Appendix 1, page 1 Pages 3-9 and Appendix 1, page 2 were deleted.	Revised the Table of Contents. On pages 1, 2, and Appendix 1, page 1, revised the policy on patients who are admitted to DBHDS facilities due to the suspension of operation of the Medicaid Technicians effective July 1, 2020.

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

Sincerely,

Rachel Pryor
Deputy Director of Administration

Attachment

M01 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-17	7/1/20	Table of Contents, page ii was added.
Transmittal (TN) #97	9/1/12	Table of Contents

SUBCHAPTER **Page**

M0110 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-17	7/1/20	Pages 1, 5, 6, 8 Page 4a is a runover page.
TN #DMAS-15	1/1/20	Pages 4, 8 Page 4a was added.
TN #DMAS-14	10/1/19	Page 15
TN #DMAS-12	4/1/19	Table of Contents Page 1, 2, 9 Page 2a is a runover page
TN #DMAS-4	4/1/17	Page 15
TN #DMAS-3	1/1/17	Page 15
TN #DMAS-2	10/1/16	Pages 3, 13
TN #100	5/1/15	Pages 2, 7 Page 1 is a runover page.
TN #98	10/1/13	Table of Contents Pages 1-15 Page 6a was removed. Page 16 was added.
TN #97	9/1/12	Table of Contents Page 13 Page 14 was added. Appendix 1 was added.
Update #7	7/1/12	Pages 3, 6a, 7, 8
TN #96	10/1/11	Table of Contents Pages 2-6a
TN #95	3/1/11	Pages 2-4a
TN #94	9/1/10	Pages 2, 3
TN #93	1/1/10	Pages 1, 6

M0110 General Information

M0110.100 Legal Base and Agency Responsibilities

A. Introduction

Virginia's two medical assistance programs are Medicaid and the Family Access to Medical Insurance Security Plan (FAMIS). Collectively, these programs are referred to as medical assistance (MA). The MA programs pay medical service providers for medical services rendered to eligible individuals. When an individual submits an application for MA, his eligibility is determined for Medicaid first. If he is not eligible for Medicaid due to excess income, his eligibility is determined for FAMIS.

The policies and procedures for determining Medicaid eligibility are contained in Chapters 1 through 18 of this manual; the policies and procedures for determining FAMIS eligibility for children and pregnant women (FAMIS MOMS) are contained in Chapters 21 and 22, respectively.

The MA eligibility determination consists of an evaluation of an individual's situation that compares each of the individual's circumstances to an established standard. Requests for Virginia MA must be made on an approved electronic or paper application form or telephonically through the Cover Virginia Call Center.

All activity of the agency in receiving and acting upon an application must be consistent with the objectives of the MA programs and be conducted in a manner which respects the personal dignity and privacy of the individual.

The local agency must provide timely, accurate, and fair service to all applicants and recipients. Each local agency must establish office procedures and operations that accommodate the needs of the populations it serves. The local agency must not establish any polices, regulations, or rules that create a barrier to accessing benefits. Populations with special needs include households with elderly or disabled members, homeless households, and households with members who work during normal office hours. The local agency must provide bilingual staff and interpreter services to households with limited English proficiency.

B. Legal Base

The Medicaid Program is established under Title XIX of the Federal Social Security Act and is financed by state and federal funds. The State Plan for Medical Assistance (State Plan) is the official body of regulations covering the operation of the Medicaid program in Virginia. The FAMIS program is established under Title XXI of the Social Security Act.

Virginia law provides that the MA programs be administered by the Department of Medical Assistance Services (DMAS). Determination of eligibility for medical assistance is the responsibility of local departments of social services under the supervision of the Virginia Department of Social Services (DSS).

Certified Application Counselors and Navigators are designated on the MA application and are deemed to have client consent to release information without an additional release of information form. The client may revoke his consent to the release of information at any time by notifying the LDSS verbally or in writing. The revocation of consent or statement is to be documented in the case record.

F. Safeguarding Client Information

All information associated with an applicant or recipient that could disclose the individual's identity is confidential and shall be safeguarded. Such information includes but is not limited to:

- name, address, and all types of identification numbers assigned to the client;
- medical services provided to the client;
- social and economic conditions or circumstances of the client;
- agency evaluation of the client's personal information;
- medical data about the client, including diagnoses and past histories of disease or disabilities;
- information received for verifying income, eligibility, and amount of medical assistance payments;
- information received in connection with identification of legally liable third party resources; and
- information received in connection with processing and rendering decisions of recipient appeals.

G. Ownership of Records

All client information contained in the agency records is the property of the agency, and employees of the agency shall protect and preserve such information from dissemination except as indicated.

Original client records are not to be removed from the premises by individuals other than authorized staff of the agency, except by court order. The agency may destroy records pursuant to records retention schedules.

H. Release of Client Information with Consent

As part of the application process for MA, the client shall be informed of the need to consent to the release of information necessary for verifying eligibility. Whenever a person, agency or organization that is not performing one or more of the functions described in M0110.110 B above requests client information, the agency must obtain written permission to release the information from the client or the personal legally responsible for the client whenever possible. A release for information obtained from the client by the requesting agency also satisfies this requirement.

Certified Application Counselors and Navigators are designated on the MA application and are deemed to have client consent to release information without an additional release of information. The client may revoke his consent to the release of information at any time by notifying the LDSS verbally or in writing. The revocation of consent is to be documented in the case record.

I. Release of Client Information without Consent

Information from the applicant/recipient's case record may not be released to other agencies, such as public housing agencies, legal services, private organizations, the U.S. Citizenship and Immigration Services (USCIS), Virginia Employment Commission (VEC), school lunch programs, health departments or elected officials *beyond what is specified in interagency agreements as described below* without the client's consent.

An exception applies to agencies with which there is an agreement for specific types of sharing of information, such as wage information from the VEC, Systematic Alien Verification for Entitlements (SAVE) with USCIS, the State Verification Exchange System (SVES) with the Social Security Administration, etc.

Client information may be disclosed without client consent in the following situations:

1. **Social Services Employees** — to employees of state and local departments of social services for the purpose of program administration;

2. **Program Staff in Other States** — to program staff in other states when a client moves or when there is a question of dual participation, or to verify the status of assistance in Virginia for applicants in another state;

3. **DMAS & LDSS Staff** — between state/local department of social services staff and DMAS for the purpose of supervision and reporting;

4. Auditors to federal, state and local employees for the purposes of auditing, monitoring, and evaluation; and

5. For Recovery Purposes for the purpose of recovery of monies for which third parties are liable for payment of claims.

6. Law Enforcement Agencies *when the request is made under a court order, such as a search warrant or subpoena, and the release of information is not prohibited under state or federal law, including the Health Insurance Portability and Accountability Act (HIPAA). Local departments of social services are advised to consult with the agency's legal counsel prior to releasing information requested by law enforcement agencies.*

J. Client's Right of Access to Information Any client has the right to obtain personal information held by the agency. Upon written or verbal request, the client shall be permitted to review or obtain a copy of the information in his record with the following exceptions:

- Information that the agency is required to keep confidential from the client pursuant to §2.2-3704 and §2.2-3705, Code of Virginia, Virginia Freedom of Information Act, Public Records to be open to Inspection; and
- Information that would breach another individual's right to confidentiality

1. Freedom of Information Act (FOIA) Consistent with the Virginia Freedom of Information Act, §2.2-3704 and §2.2-3705, Code of Virginia, the agency shall provide access within five working days after the receipt of the request. The agency shall make disclosures to applicants and recipients during normal business hours. Copies of the requested documents shall be provided to the client or a representative at reasonable standard charges for document search and duplication.

2. Client May Be Accompanied The client shall be permitted to be accompanied by a person or persons of the client's choice and may grant permission verbally or in writing to the agency to discuss the client's file in such person's presence. Upon request and proper identification of any client or agent of the client, the agency shall grant to the client or agent the right to review the following:

- All personal information about the client except as provided in §2.2-3704 and §2.2-3705,

The identity of all individuals and organizations not having regular access authority that request access to the client's personal information.

3. Client May Contest Information Pursuant to the Code of Virginia §2.2-3800, a client may contest the accuracy, completeness or relevancy of the information in his record. Correction of the contested information, but not the deletion of the original information if it is required to support receipt of state or federal financial participation, shall be inserted in the record when the agency concurs that such correction is justified.

C. Application for Medical Assistance means an official form prescribed by DMAS for requesting medical assistance that is used for initial eligibility determinations and redeterminations. An application for medical assistance is an application for the Medicaid, Family Access to Medical Insurance Security (FAMIS) and FAMIS MOMS programs.

D. Attorney-In-Fact (Named in a Power of Attorney Document) means a person authorized by a power of attorney document (also referred to as a "POA") to act on behalf of another individual, either for some particular purpose or for the transaction of business in general. **A power of attorney document does not necessarily authorize the attorney-in-fact to apply for MA on behalf of the applicant.** The eligibility worker must read the power of attorney document to determine (1) if the person has the power to act as the applicant in any of the applicant's business and (2) whether or not the document grants durable power of attorney. If the document is a general power of attorney or includes the power to conduct the applicant's financial business, the attorney-in-fact is considered the applicant's authorized representative as long as the person for whom the attorney-in-fact is authorized to act is not legally incapacitated.

If the individual on whose behalf the attorney-in-fact is acting is incapacitated and not able to act on his own behalf, the eligibility worker must examine the document to determine if it grants a durable power of attorney. The contents of the document must indicate that the power of attorney does not stop upon the incapacity of the person. **If the power of attorney is not durable, it is no longer valid when the individual on whose behalf it is executed becomes legally incapacitated.**

E. 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 authorized representative statement is valid until:

- the application is denied;
- medical assistance coverage is canceled; or
- the individual changes his authorized representative.

The authorized representative can file an appeal on behalf of an individual whose application was denied or canceled. The DMAS Appeals Division will determine whether or not the authorized representative can represent the individual during the appeal.

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. An individual's spouse is permitted to be an authorized representative for MA purposes as long as the spouse and applicant are living together, or lived together immediately before the applicant's institutionalization; no written designation is required.

M0120 Changes

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

- a change in the case name,
- a change in living arrangements, and
- a change in income.

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

M0120.200 Who Can Sign the Application

A. Incarcerated Individuals

Offenders of any age who are being held in Department of Corrections (DOC) or Department of Juvenile Justice (DJJ) facilities may have applications submitted with the assistance of DOC or DJJ staff.

Offenders of local and regional jails may submit applications for themselves, authorize facility staff to assist, or designate an authorized representative to assist in applying.

For new applications, send all notices and correspondence to the mailing address listed on the application (normally the facility address). For re-entry and pre-release applications, send all notices and correspondence to the post-release mailing address of the individual.

B. Applicants Age 18 or Older

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

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

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

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

Witness's signature:_____

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.

2. Family Substitute Representative

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

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

NO: Does the applicant have at least one of the following who is age 18 or older:

- spouse,
- child,
- parent,
- sibling,
- grandchild, niece or nephew, or
- aunt or uncle?

YES: The authorized representative is the individual identified above who is willing and able to act on the applicant's behalf.

NO: Verify the inability of the applicant to sign the application because of a diagnosis or condition through a written statement from the applicant's doctor. Refer to APS. Pend the application. At the conclusion of the APS investigation, if APS concludes that guardianship proceedings will not be initiated, the applicant must sign or make a mark on the application or designate an authorized representative in writing. If the signed application form is not received by the specified date, deny MA.

C. Applicants Under Age 18

1. Child Applicant

A child under age 18 years is not legally able to sign his own *MA* application unless he is legally emancipated from his parents. If the child is not legally emancipated, one of the following individuals who is age 18 or older must sign the application:

- his parent *(custodial or non-custodial)*
- legal guardian,
- authorized representative, or
- an adult related by blood or marriage with whom the child lives (documentation of the relationship is not required).

If the child under 18 years of age is married and living with his spouse who is age 18 or older, the child's spouse may sign the application.

a. No Guardian or Legal Custody

If the child does not live with a parent or an adult relative and no adult is the child's guardian or has legal custody of the child, whomever the child is living with is responsible for seeking custody or guardianship of the child in the Juvenile and Domestic Relations court. Determine if the person submitting the application, or another person, has begun the process to obtain legal guardianship or custody of the child applicant.

b. Action Is Initiated To Appoint Guardian/Award Custody

If action has been initiated to appoint a guardian for or seek legal custody of the child, meaning a court guardianship or custody hearing is scheduled on the court docket, request verification that the action is on the court docket. Give 10 calendar days for this verification to be provided.

If the verification is provided within the 10-calendar-day period, continue to pend the application until a guardian is appointed or custody is awarded. If the application pends for 45 calendar days, send a notice to the applicant explaining that the application pending period will be extended.

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. Allow 10 calendar days for the signed application and guardianship or custody papers to be returned.

If the court refuses to appoint a guardian or custodian and there is no adult who is legally able to sign an application for the child, deny the application as invalid.

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. *Non-custodial Parent Applying for Child*

Eligibility for a child is based on the income of the parent with whom the child lives. If a non-custodial parent applies for his child, he must give written permission for the eligibility worker to contact the custodial parent. The eligibility worker must obtain the custodial parent's income information, written permission to verify income using available online data sources, and other information necessary to verify and calculate countable income, including Social Security Number and residence address. If either the non-custodial parent or the custodial parent fail to give the necessary permission, the child's eligibility cannot be determined using the application filed by the non-custodial parent.

3. **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.

4. **Foster Care Child**

a. IV-E

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

b. Non-IV-E

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

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

***5.* Adoption Assistance & Special Medical Needs Children**

a. IV-E

A separate MA application is not required for a child who has been determined eligible for Title IV-E Adoption Assistance, regardless of which state has the adoption assistance agreement with the adoptive parents. IV-E Adoption Assistance children who have been placed for adoption through the Interstate Compact for Adoption and Medical Assistance (ICAMA) should have an ICAMA form 6.01 which verifies their Title IV-E eligibility for Medicaid. The ICAMA form 6.01 serves as the MA application form.

b. Non-IV-E

Non-IV-E Adoption Assistance children include Non-IV-E Special Medical Needs children.

1) Placed by a Virginia agency

An MA application is required for all non-IV-E Adoption Assistance and Non-IV-E Special Medical Needs children whose parents have adoption assistance agreements with a Virginia public or private child-placing agency. The child's adoptive parent signs and files the application for the child.

B. Placed by another state

Non-IV-E Adoption Assistance children who have been placed for adoption through the Interstate Compact for Adoption and Medical Assistance (ICAMA) should have an ICAMA form 6.01 which verifies their adoption assistance status (IV-E or non-IV-E). The ICAMA form 6.01 serves as the MA application form and a separate application is not required when:

- the other state is an ICAMA member state, and
- the ICAMA member state **reciprocates** Medicaid coverage of Virginia Non-Title IV-E Adoption Assistance children.

All states and territories EXCEPT Vermont, Wyoming, Puerto Rico and Virgin Islands are members or associate members of ICAMA. A list of the ICAMA member states and whether they reciprocate Medicaid coverage for Non-IV-E Adoption Assistance children is in M0120, Appendix 3.

An MA application must be filed for Non-IV-E Adoption Assistance children from non-member states and ICAMA member or associate member states which do NOT reciprocate. The child's adoptive parent signs and files the MA application for the child.

D. Deceased Applicant

An application may be made on the behalf of a deceased person within a three-month period subsequent to the month of his death if both of the following conditions were met:

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 will be handled either centrally or by the LDSS in the locality in Virginia in which he last resided prior to going into the DJJ system. For a new applicant use the physical address where the person is located. For pre-release and re-entry individuals, use the address where the person will reside after release (post-release).

C. Institutionalized Individual (Not Incarcerated)

When an individual of any age is a resident or patient in a medical or residential institution, except *a* 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.

D. **Individuals In Virginia Veteran's Care Center**

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

E. **Incarcerated Individuals and DJJ Supervisees**

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

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

The physical address on the application should be the address where the individual is currently placed.

The mailing address will be the facility address where the individual is currently placed. For pre-release or re-entry individuals, use the address the person provides where they will be located after release. If the individual was homeless prior to being incarcerated, use the physical address of the local DSS or an address the person provides.

M0120.500 Receipt of Application

A. General Principle

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

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

B. Application Date

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

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

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

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

C. Hospital Presumptive Eligibility

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

1. HPE Determination and Enrollment

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

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

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

The HPE covered groups and the ACs are:

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

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

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

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

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

There are no appeal rights for an HPE determination.

2. Eligibility Procedures – Post HPE Enrollment

a) MA Application Not Submitted

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

b) MA Application Submitted

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

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

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

c) Applicant Determined Eligible for MA Coverage

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

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

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

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

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

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

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

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

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

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

e) Retroactive Coverage

An individual cannot receive retroactive HPE coverage.

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

f) Applicant Determined Not Eligible for ongoing MA coverage

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

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

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

M0130 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-17	7/1/20	Pages 2, 6, 10 Page 6a was added as a runover page.
TN #DMAS-15	1/1/20	Pages 9, 10
TN #DMAS-14	10/1/19	Pages 9, 10
TN #DMAS-11	1/1/19	Page 1
TN #DMAS-10	10/1/18	Table of Contents Pages 1, 2-2b, 9-12 Pages 2c-2e were added as runover pages.
TN #DMAS-9	7/1/18	Page 2b
TN #DMAS-8	4/1/18	Page 13
TN #DMAS-7	1/1/18	Pages 1, 9
TN #DMAS-5	7/1/17	Pages 1, 10
TN #DMAS-4	4/1/17	Page 6
TN #DMAS-3	1/1/17	Pages 5, 7, 11
TN #DMAS-2	10/1/16	Table of Contents Pages 2. 4, 5, 7-10, 12, 13 Page 2a is a runover page. Page 14 was added as a runover page.
TN #DMAS-1	6/1/16	Table of Contents Pages 4, 6, 10, 12 Page 11 is a runover page. Page 13 was added as a runover page.
TN #100	5/1/15	Pages 1, 2-2b, 5, 11 Pages 3, 6 and 2c are runover Pages.
UP #10	5/1/14	Table of Contents Pages 8-12 Page 13 was added.
TN #99	1/1/14	Pages 10-12 Page 13 was added.
TN #98	10/1/13	Table of Contents Pages 1-12
UP #9	4/1/13	Page 3, 5
UP #7	7/1/12	Pages 4, 5
TN #96	10/1/11	Pages 6-8
TN #95	3/1/11	Page 8
TN #94	9/1/10	Pages 2-6, 8
TN #93	1/1/10	Pages 4-6, 8
Update (UP) #2	8/24/09	Pages 8, 9

M0130.100 Processing Time Standards

A. Processing Time Standards

1. Expedited Application *Requirements*

2. Pregnant Women

Applications for pregnant women must be processed within ***seven (7) calendar* days** of the agency's receipt of the signed application.

If the pregnant woman also applies for other children or other persons in her family and the agency cannot determine the other persons' eligibility within *7 calendar* days, the agency must determine just the MA eligibility of the pregnant woman within the *7 calendar* days.

The agency must have all necessary verifications within the *7 calendar* days in order to determine eligibility. If the agency does not receive the verifications within the *7 calendar* days, the worker must send the applicant written notice on the *7th* day. The notice must state why action on the application was not taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 days by which to submit the documentation.

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

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

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

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

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

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

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.

3. 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.***

4. *Non-custodial Parent Applying for Child*

Eligibility for a child is based on the income of the parent with whom the child lives. If a non-custodial parent applies for his child, he must give written permission for the eligibility worker to contact the custodial parent. The eligibility worker must obtain the custodial parent's income information, written permission to verify income using available online data sources, and other information necessary to verify and calculate countable income, including Social Security Number and residence address. If the either the non-custodial parent or the custodial parent fails to give the necessary permission, the child's eligibility cannot be determined using the application filed by the non-custodial parent.

5. 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.

from these available sources, including the VEC, may be used if the information is less than 12 months old. The agency must include in each applicant's case record facts to support the agency's decision on the case.

1. Resources

The value of all countable, non-excluded resources must be verified. If an applicant's attested resources are over the resource limit, the applicant or authorized representative must be given the opportunity to provide verification of the resources. All available resource verification system(s) must be searched prior to requesting information from the applicant.

2. Use of Federal Income Tax Data

The Hub provides verification of income reported to the IRS. Income information reported to the IRS may be used for eligibility determinations for Families and Children (F&C), MAGI Adults, and ABD covered groups when IRS information is available. The income reported on the application is compared to the data obtained from the Hub for reasonable compatibility per M0420.100. When IRS verification is used for an ABD individual, reasonable compatibility is acceptable as verification of earned (i.e. taxable) income.

Note: Reasonable compatibility only applies to applications or reapplications; it does not apply to renewals.

3. SSA Data

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

4. Income

For all case actions effective October 26, 2019, the applicant's attested income, including when the applicant attests to having zero ($0.00) income, is considered the verified income if the income attested to by the applicant is within 10% of the income *reported by* electronic *data sources* OR both sources are below the applicable income limit.

If the attested income is under the income limit and the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return. If the applicant meets a MN covered group, verification of income **is required** to determine spenddown liability based on actual income received.

For individuals requesting long-term services and supports (LTSS), verification of income is required to calculate the patient pay. See M1470.

If the attested income is over the income limit and the individual does not meet a Medically Needy (MN) covered group, deny the application.

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

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

Changed With	Effective Date	Pages Changed
TN #DMAS-17	7/1/20	Pages 21, 22, 23, 25 .
TN #DMAS-14	10/1/19	Table of Contents Pages 3, 4, 23, 24 Page 25 was added as a runover page. Appendix 8 was added.
TN #DMAS-13	7/1/19	Page 21
TN #DMAS-12	4/1/19	Pages 20, 21, 23
TN #DMAS-10	10/1/18	Page 1
TN #DMAS-9	7/1/17	Page 1, 2, 14c
TN #DMAS-6	10/1/17	Page 15 Appendix 1, page 4
TN #DMAS-5	7/1/17	Pages 18, 19, 23, 24
TN #DMAS-3	1/1/17	Table of Contents Page 22a Appendix 1, page 1
TN #DMAS-2	10/1/16	Pages 13, 19-22, 23, 24
TN #DMAS-1	6/1/16	Pages 4, 4b, 5, 23
TN #100	5/1/15	Table of Contents Pages 4b, 12, 17, 18 Appendix 5, page 3 Page 4 was renumbered for clarity. Page 4a is a runover page.
TN #99	1/1/14	Table of Contents Pages19, 23, 24 Appendix 4 was removed.
TN #98	10/1/13	Pages 2-3b Appendix 1 Pages 1-5 Pages 6-18 were removed.
UP #9	4/1/13	Page 3 Appendix 1, pages 3, 17 Appendix 3, pages 3, 4
UP #8	10/1/12	Table of Contents Pages 4, 7-8, 12, 14d-20 Page 17a was deleted. Appendix 5 , page 3 Appendix 7 pages 1-5

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

7. Financial Eligibility

the asset transfer requirements (see subchapter M1450) apply.

Resources must be within the resource limit appropriate to the individual's covered group. (Chapter M06 for F&C covered groups; Chapter S11 for ABD covered groups).

Income must be within the income limit appropriate to the individual's covered group (Chapter M04 for Modified Adjusted Gross Income [MAGI] covered groups; Chapter M07 for F&C Medically Needy covered groups, and Chapter S08 for ABD covered groups). Spenddown provisions apply to individuals who meet a Medically Needy covered group. All medical expenses count toward meeting the spenddown, but once an entitlement date is determined after the individual meets the spenddown, only emergency services rendered on or after the entitlement date and which are within the period of coverage on the Emergency Medical Certification form are covered for emergency services aliens.

B. Emergency Services Certification--Not Applicable to Full Benefit Aliens

Certification with completion of an Emergency Services Certification form (*DMAS Form 2019NR - available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*) that the service provided was an emergency service is an additional eligibility requirement for emergency services aliens (not applicable to full benefit aliens). An eligibility worker can certify emergency services coverage for pregnancy-related labor and delivery services for limited, specified periods of time. DMAS must certify emergency services coverage for all other requests and determine the period of coverage.

1. Eligibility Worker Certification for Pregnancy-Related Labor and Delivery Services

An eligibility worker can certify emergency services payment for pregnancy-related labor and delivery services, including inpatient hospitalizations that did not exceed:

- 3 days for a vaginal delivery, or
- 5 days for a cesarean delivery.

To determine the length of stay, count the day of admission, but not the day of discharge. If the length of stay exceeded 3 days for a vaginal delivery or 5 days for a cesarean delivery, DMAS must approve the coverage following the procedures in M0220.500 B.2 below. Note that the enrollment period for the emergency service(s) includes the day of discharge even though it is not counted to determine the length of stay (see M0220.700).

For eligibility worker certifications, verification of the labor and delivery services must be obtained from the physician or hospital and include the following information:

- patient name, address and date of birth,
- facility name and address where the delivery took place
- type of delivery (vaginal or cesarean), and
- inpatient hospital admission and discharge dates.

The verification must be documented in the record.

NOTE: A child born to an emergency-services-only alien mother who was eligible for Medicaid on the date of the child's birth is entitled to Medicaid as a newborn child (see M320.301).

2. DMAS Certification for Emergency Services Required

When DMAS certification for emergency services is required, send a written request for the evidence of emergency treatment listed below to the applicant or authorized representative. Request that the applicant/authorized representative provide the following information from the hospital or treating physician, as applicable to the emergency service provided, **for each period of service**:

- On the Emergency Medical Certification Form, **specify the exact dates of service requested.** Ask for a phone number where the person can be reached .
- emergency room record, admission (admit) orders, history and physical, MD notes. discharge summary, operative notes;
- operative consent form;
- **pre operative evaluation;**
- labor and delivery notes, if pregnancy related; and
- dates of service – admission date/discharge date.
- *Dialysis patients - a dialysis certification, which must provide and include the Medicaid application date, requested date of dialysis coverage, and a dialysis letter signed and dated by a physician.*

  If a CMS ESRD Entitlement Form is submitted as the dialysis Plan of Care, all areas of the form must be completed; a physician must sign and date the form.

If the applicant/authorized representative is unlikely to be able to obtain the above information without assistance (e.g. due to a language barrier), obtain a signed release of information. If necessary, use the release to request evidence of emergency treatment from the hospital and/or treating physician

If the hospital or treating physician is unsure of the information that is needed, refer the hospital's staff, physician or physician's staff to the Virginia Medicaid Hospital Provider Manual, Chapter VI "Documentation Guidelines."

Using the Emergency Medical Certification, form #032-03-628 as a cover letter, send the medical evidence to:

Division of Program Operations
Department of Medical Assistance Services (DMAS)
600 E. Broad Street, Suite 1300
Richmond, VA 23219

for a determination of medical emergency and the duration of the emergency services certification period.

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

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

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

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

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

M0220.700 EMERGENCY SERVICES ALIENS ENTITLEMENT & ENROLLMENT

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

B. Entitlement-Enrollment Period If the applicant is found eligible and is certified for emergency services, eligibility exists only for the period of coverage certified by the eligibility worker or DMAS staff on the Emergency Medical Certification form *#DMAS Form 2019NR.*

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

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

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

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

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

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

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

The agency must contact the provider(s) and supply the eligibility dates and Medicaid number for billing purposes by sending a copy of the completed Emergency Medical Certification *#DMAS Form 2019NR*, to the provider(s).

M0280 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-17	7/1/20	Pages 7, 9, 10 Page 11 was deleted.
TN #DMAS-15	1/1/20	Page 9 Appendix 1
TN #DMAS-14	10/1/19	Pages 6, 7, 9, 11
TN #DMAS-2	10/1/16	Pages 7, 9
TN #100	5/1/15	Table of Contents Pages 1-11 Appendix 1 was added Pages 12 and 13 were deleted.
UP #9	4/1/13	Page 5
Update (UP) #7	7/1/12	Table of Contents Page 8 Appendix 1 was deleted.
TN #94	9/1/10	Page 1
TN #93	1/1/10	Page 13

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

Once an incarcerated individual who is enrolled in Medicaid is released from the correctional facility, he may be eligible for all benefits available under the Medicaid covered group he meets.

D. Juveniles in Detention

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

1. Held for Care, Protection or Best Interest

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

2. Held for Criminal Activity

a. Prior to Court Disposition

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

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

b. After Court Disposition

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

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

G. Probation, Parole, Conditional Release, *Furlough*

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

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

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

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

An individual released from a correctional facility on furlough, for example during a pregnancy, is not an inmate of a public institution while furloughed and may be eligible for Medicaid.

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

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

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

I. Juvenile on Probation in Secure Treatment Center

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

J. Juvenile On Conditional Probation

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

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

K. Juvenile On Probation in Secure Treatment Center

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

M0280.500 INDIVIDUALS MOVING TO OR FROM PUBLIC INSTITUTIONS

A. Moves To Public Institution

If a currently eligible individual enters a public institution, a partial review must be completed to determine if he continues to meet institutional status requirements for continued coverage, as well as all other Medicaid eligibility requirements.

Outstanding bills for covered medical services incurred prior to his admission and during his Medicaid coverage period will be paid.

B. Moving From Public Institution

Although a person may not be eligible for Medicaid while living in a specified public institution or part thereof, he may apply for such assistance as a part of prerelease planning. If he is found eligible (except for institutional status), do not enroll until he leaves the institution to live elsewhere.

C. Resident Admitted to Medical Facility

A resident of an ineligible public institution may be eligible for Medicaid coverage limited to inpatient hospitalization when admitted to a medical institution (general hospital or nursing facility) for inpatient care.

M0280.600 DEPARTMENTAL RESPONSIBILITY

A. Incarcerated Individuals

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

B. All Other Institutions

Local social services departments are responsible for the Medicaid eligibility determination and enrollment of individuals in institutions **EXCEPT** for incarcerated individuals in aid category 108 or 109. The local DSS agency in the Virginia locality where the individual last resided outside of an institution is the responsible DSS agency. If the individual resided outside of Virginia immediately before admission to the institution, the responsible local DSS is the DSS agency serving the locality where the institution is located.

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

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

M0310 Changes
Page 1 of 2

Changed With	Effective Date	Pages Changed
TN #DMAS-17	7/1/20	Page 7 Pages 8 and 9 are runover pages.
TN #DMAS-15	1/1/20	Pages 29, 30
TN #DMAS-14	10/1/19	Pages 24, 26, 27, 40
TN #DMAS-13	7/1/19	Pages 24 Page 24a is a runover page.
TN #DMAS-12	4/1/19	Pages 8, 9, 13
TN #DMAS-10	10/1/18	Table of Contents, page ii Pages 1-4 Page 40 was added.
TN #DMAS-9	7/1/18	Page 35 Appendix 2, Page 1
TN #DMAS-8	4/1/18	Page 9
TN #DMAS-7	1/1/18	Pages 34, Appendix 2, page 1
TN #DMAS-5	7/1/17	Pages 13, 37, 38
TN #DMAS-4	4/1/17	Pages 24, 30a Page 23 is a runover page. Page 24a was added as a runover page.
TN #DMAS-3	1/1/17	Pages 8, 13, 28b
TN #DMAS-2	10/1/16	Pages 4, 7, 29 Page 30 is a runover page. Appendix 2, page 1
TN #DMAS-1	6/1/16	Table of Contents, page ii Pages 13, 26, 28 Appendix 2, page 1

M0310 Changes
Page 2 of 2

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

M0310.105 AGE and AGED

A. Age

"Age" is the individual's age reached on the anniversary of birth. If the year but not the month and day of the individual's birth is known, July 1 is assigned for both eligibility determination and enrollment.

For covered groups with a maximum age requirement, an individual meets the age requirement for the month of his birthday unless his birthday falls on the first day of the month.

Examples:

Gracie has been enrolled in the Child Under 19 covered group. She turns 19 on August 15. She continues to be eligible in the Child Under 19 covered group through the month of August.

Oliver has been enrolled in the MAGI Adults covered group. He turns 65 on July 1. Therefore, he is no longer eligible for the MAGI Adults covered group for the month of July.

B. Aged

"Aged," means age 65 years or older.

C. Procedures

For individuals under age 21, accept the date of birth provided on the application/redetermination form. No verification is required.

For aged individuals, verify the individual's age by Social Security records or documents in the individual's possession. Acceptable documents include:

- birth certificate or notification of birth;
- hospital or physician's record;
- court record of adoption;
- baptismal record;
- midwife's record of birth;
- form VS95 from state Bureau of Vital Statistics; or
- marriage records.

M0310.106 BLIND

A. Definition

The Medicaid blindness definition is the same as that of the Supplemental Security Income (SSI) blindness definition.

Blindness is defined by using one of two criteria. The first criteria indicates that blindness is defined as having best corrected central visual acuity of 20/200 or less in the better eye. The second criteria indicates that blindness is defined as the contraction of the visual field in the better eye with the widest diameter subtending an angle around the point of fixation no greater than 20 degrees.

B. Procedures

An SSI recipient who receives SSI as blind meets the blindness definition for Medicaid. Verify the SSI recipient's SSI eligibility via SVES (State Verification Exchange System).

Virginia no longer maintains a central registry of individuals who have been certified as blind or visually impaired. For an individual who alleges blindness or a visual impairment but does not receive SSI or Social Security Disability Income benefits, refer to section M0310.112 B to establish whether or not the individual requires a referral to the Disability Determination Services (DDS). If the individual requires a determination of blindness, refer the individual to the DDS using the procedure in M0310.112 E. 1.

M0310.107 CARETAKER-RELATIVE

A. Definitions

1. Caretaker-relative

A "caretaker-relative" is an individual who is not a parent, but who

- is a relative, of a specified degree, of a dependent child (as defined in M0310.111) and
- is living with and assuming continuous responsibility for day to day care of the dependent child (as defined in M0310.111) in a place of residence maintained as his or their own home.

A caretaker-relative is also referred to as a "non-parent caretaker" to distinguish the caretaker-relative from the parent.

2. Specified Degree

A relative of specified degree of the dependent child is

- any blood relative, including those of half-blood and including first cousins, nephews or nieces and persons of preceding generations as denoted by prefixes of grand, great, or great-great;
- a stepfather, stepmother, stepbrother, and stepsister;
- a relative by adoption following entry of the interlocutory or final order, whichever is first; the same relatives by adoption as listed above: including first cousins, nephews or nieces and persons of preceding generations as denoted by prefixes of grand, great, or great-great, and stepfather, stepmother, stepbrother, and stepsister.
- spouses of any persons named in the above groups even after the marriage is terminated by death or divorce.

Neither severance of parental rights nor adoption terminates the relationship to biological relatives.

B. Procedures

1. Relationship

The relationship as declared on the application/redetermination form is used to determine the caretaker-relative's relationship to the child. No verification is required.

2. *Child* Living in the Home

A child's presence in the home as declared on the application/ redetermination form is used to determine if the child is living in the home with a parent or a caretaker-relative. No verification is required.

3. Parent and Stepparent in Home

The presence of a parent in the home does not impact a stepparent's eligibility in the Low Income Families with Children (LIFC) covered group. Both the parent and stepparent may be eligible in the LIFC covered group. See M0330.300.

4. Parent and Other Relative in Home

When a parent is in the home, no relative other than a stepparent can be eligible for Medicaid in the LIFC covered group. See M0330.300.

***2.* Caretaker-Relative Living in the Home**

A caretaker-relative who is absent from the home is considered living with a child in the household if the absence is temporary and the caretaker-relative intends to return home when the purpose of the absence (such as military service, vacation, education, medical care or rehabilitation) is complete.

M0320 Changes

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

B. Financial Eligibility

1. Assistance Unit

The assistance unit policy and procedures in chapter M05 apply to ABD individuals with income less than or equal to 80% FPL. If not institutionalized, deem or count any resources and income from the individual's spouse with whom he lives. If institutionalized with a community spouse, go to subchapter M1480.

2. Resources

The resource limit is $2,000 for an individual and $3,000 for a couple.

The resource requirements in chapter S11 and Appendix 2 to chapter S11 apply to this covered group.

All of the individual's resources must be verified and evaluated. All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements.

3. Income

The income limits are ≤ 80% of the FPL and are in section M0810.002. The income requirements in chapter S08 must be met.

4. Income Exceeds 80% FPL

Spenddown does not apply to this covered group. If the individual's income exceeds the 80% FPL limit, he is not eligible in this covered group. Determine the individual's eligibility in all other Medicaid covered groups.

D. Entitlement

If all eligibility factors are met in the application month, entitlement to full Medicaid coverage in this covered group begins the first day of the application month.

ABD individuals in this covered group are entitled to retroactive coverage if they meet all the requirements in the retroactive period.

E. Enrollment

The ABD 80% group AC is:

- 029 for an aged individual;
- 039 for a blind individual;
- 049 for a disabled individual; or
- 109 for all incarcerated individuals.

M0320.400 MEDICAID WORKS

A. Policy

The Appropriations Act of 2006 authorized an amendment to the Virginia State Plan for Medical Assistance that allows disabled (including blind) individuals to work and earn higher income while retaining Medicaid coverage. This program is called MEDICAID WORKS and includes individuals:

- at least age 16 and are under age 65, **and**
- who have countable income less than or equal to 80% of the FPL, (or who are SSI recipients and 1619(b) individuals) **and**
- who have countable resources less than or equal to $2,000 for an individual and $3,000 for a couple; **and**

- who are working or have a documented date for employment to begin in the future.

These individuals can retain Medicaid coverage by cost-sharing through the payment of a premium as long as they remain employed and their earned income is less than or equal to $6,250 per month. This type of cost-sharing arrangement is known as a **Medicaid** buy-in (MBI) program. MEDICAID WORKS is Virginia's MBI program.

B. Relationship Between MEDICAID WORKS and 1619(b) Status

An individual with SSI or eligible for Medicaid as a Qualified Severely Impaired Individual (QSII) (1619(b)) meet the income requirement for entry into MEDICAID WORKS and must not be discouraged from enrolling in MEDICAID WORKS. An individual who meets the criteria for 1619(b) status may choose to participate in MEDICAID WORKS because of the higher resource limit.

C. Nonfinancial Eligibility

The individual must also meet the following additional nonfinancial criteria:

- The individual must be competitively employed in an integrated setting. Work must occur in a work setting in the community or in a personal business alongside people who do not have disabilities. Work performed in a sheltered workshop or similar setting is **not** considered competitive employment in an integrated setting. Contact a Regional Medical Assistance Program Consultant if there is a question about whether the employment meets the criteria for MEDICAID WORKS.

- The individual must receive pay at the minimum wage or at the prevailing wage or "going rate" in the community, and the individual must provide documentation that payroll taxes are withheld. Self-employment must be documented according to the policy contained in S0820.210.

- The individual must establish a Work Incentive (WIN) Account at a bank or other financial institution, such as a checking or savings account. The individual must provide documentation for the case record designating the account(s) as a WIN Account. The account must either be a new account or an existing account with *only the wages earned while in MEDICAID WORKS deposited into it. Increases in an enrollee's Social Security Disability benefits resulting from employment as a MEDICAID WORKS participant OR as a result of a COLA adjustment to the Social Security Disability benefits may also be deposited into the WIN account and will be excluded as described in M0320.400 D.3.b.3) as long as the increase is regularly deposited upon receipt into the WIN account.* The WIN account cannot contain the individual's *other* Social Security benefits.

- All individuals requesting enrollment in MEDICAID WORKS must also sign a MEDICAID WORKS Agreement, available on SPARK at: http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi. The agreement outlines the individual's responsibilities as an enrollee in the program.

  The individual must participate in cost sharing through the payment of a monthly premium to the Department of Medical Assistance Services. Note: Monthly premiums are not being charged at this time.

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. Individuals receiving SSI or who have 1619(b) status also meet the income requirement for entry into MEDICAID WORKS.

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 and QSII/(1619(b) individuals, who wish to qualify for MEDICAID WORKS. The resource requirements in chapter S11 and Appendix 2 to chapter S11 apply for the initial eligibility determination. The individual's countable, nonexempt resources must be verified. All countable resources, must be added together to determine if the individual's countable resources are within the limit.

b. Ongoing eligibility

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

1) For **earnings** accumulated **after** enrollment in MEDICAID WORKS, up to the current 1619(b) income threshold amount will be disregarded if deposited and retained in the WIN Account. The current 1619(b) threshold amount is *$36,836*.

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

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

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

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

3. Income

a. Initial eligibility determination

For the initial eligibility determination, the limit *for total countable* income *(unearned and earned)* is ≤ 80% of the FPL (see M0810.002). The income requirements in chapter S08 must be met. Individuals who receive SSI or who have 1619(b) status are considered to meet the income requirements and no evaluation of income is necessary for the initial eligibility determination (see M0320.101).

b. Ongoing eligibility

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

1) The income limit for earned income is $6,250 per month ($75,000 per year) (no change for 2020) as long as the funds are deposited in a WIN Account. The policy for determining countable earned income is contained in subchapter S0820.

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

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

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

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

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

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

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

The reported income of a child must be verified regardless of whether or not the attested income is above or below the tax-filing threshold amount.

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

B. MAGI Income Rules

1. Income That is Counted

a. Gross earned income is counted. There are no earned income disregards.

b. Earnings and unearned income, including Social Security benefits, of everyone in the household are counted, except the income of

- a tax dependent who is claimed by his parent(s), or
- a child under 19 in a non-filer household who is living with a parent or parents

who is not required to file taxes because the tax filing threshold is not met.

For children and tax dependents, Social Security income only counts toward the total household income if the individual is required to file a federal tax return.

c. Income of a child under 19 in a non-filer household who is NOT living with a parent or parents and who is not required to file taxes because the tax filing threshold is not met. Any Social Security benefits the child may have do not count in determining whether or not the tax filing threshold is met.

When determining the total household *income* of a child who is NOT living with a parent (for example, living with a grandparent), the child's income is always counted in determining the child's eligibility, even if the child's income is below the tax filing threshold.

Effective, *January 1, 2020*, the Tax Filing Threshold for MAGI income counting purposes is *$1,100* in unearned income and *$12,200* in earned income.

d. Interest, including tax-exempt interest, is counted.

e. Foreign income is counted.

f. Stepparent income is counted.

g. Effective January 1, 2019, alimony received is not countable.

Alimony received prior to January 1, 2019, is countable. An individual whose divorce decree was finalized prior to January 1, 2019, has the option with the IRS to adopt the new IRS alimony rule by modifying the divorce agreement. If an individual whose divorce decree was finalized prior to January 1, 2019, does not want alimony received on or after January 1, 2019 to be countable for the MAGI income determination, the individual must provide a copy of the modified divorce agreement to the eligibility worker.

h. An amount received as a lump sum is counted only in the month received

i. Military pay based upon age or years of service (other types of military pay are also counted and excluded; see M0720.290)

j. Census income.

k. *Unemployment Compensation is counted as unearned income.*

Exception: Additional benefits of $600 per week paid under the under the Federal Pandemic Unemployment Compensation program are not counted. See M0440.100 B.2.n.

2. Income That is Not Counted

a. Child support received is not counted as income (it is not taxable income).

b. Workers Compensation is not counted.

c. When a child is included in a parent or stepparent's household, the child's income is not countable as household income unless the child is required to file taxes because the tax-filing threshold is met. Any Social Security benefits the child may have do not count in determining whether or not the tax filing threshold is met.

d. Veterans benefits which are **not** taxable in IRS Publication 525 are not counted:

- Education, training, and subsistence allowances,
- Disability compensation and pension payments for disabilities paid either to veterans or their families,
- Veterans' insurance proceeds and dividends paid either to veterans or their beneficiaries, including the proceeds of a veteran's endowment policy paid before death,
- Grants for homes designed for wheelchair living and motor vehicles for veterans who lost their sight or the use of their limbs,
- Interest on insurance dividends left on deposit with the VA,
- Benefits under a dependent-care assistance program,
- The death gratuity paid to a survivor of a member of the Armed Forces who died after September 10, 2001, or
- Payments made under the VA's compensated work therapy program.

e. For divorce agreements finalized on or after January 1, 2019, no deduction is allowed for alimony paid. For divorce agreements finalized prior to January 1, 2019, alimony **paid** to a separated or former spouse outside the home is deducted from countable income.

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

g. Gifts, inheritances, and proceeds from life insurance are not counted.

h. A parsonage allowance is not counted.

i. Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are not counted.

j. Effective January 1, 2019, student loan debt forgiven due to death or disability of student is not counted as income.

k. Difficulty of Care Payments, which include (1) payments designated by the payer as compensation for providing additional care that is required for a physically, mentally or emotionally disabled qualified foster care individual living in the provider's home and (2) payments to care providers who provide care under a Medicaid home and-community-based Waiver to an individual in the care provider's home. The care provider's home is the residence in which the care provider resides and regularly performs the routines of the care provider's life. If the care provider moves into an individual's home to care for that individual and performs the routines of the care provider's life in that residence, it is considered the care provider's home.

l. General Welfare Payments for Indian Tribes are not countable To qualify under the general welfare exclusion, the payments must be made pursuant to a governmental program for the promotion of the general welfare based on need and not represent compensation for services (See https://www.irs.gov/pub/irs-drop/n-12-75.pdf)

m. Kinship Guardianship Payments are not income. These payments are a stipend paid to a relative caregiver who has assumed custody of a child as an alternative to that child remaining in foster care.

n. *Under the Federal Pandemic Unemployment Compensation Program, eligible individuals who are collecting certain Unemployment Compensation, including regular unemployment compensation, will receive an additional $600 in federal benefits per week for weeks of unemployment ending on or before July 31, 2020.* ***The $600 weekly Pandemic Unemployment Compensation payments (monthly equivalent of $2,580) are not counted as income.***

o. *Recovery Rebate payments provided under Section 2201 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Public Law No. 116-136) are not counted as income.*

h. **Income From Self-employment**

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

C. Steps for Calculating MAGI

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

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

Adjusted Gross Income (AGI) Line 4 on Internal Revenue Service (IRS) Form 1040 EZ Line 21 on IRS Form 1040A Line 37 on IRS Form 1040	**Include:** • Wages, salaries, tips, etc. • Taxable interest • Taxable amount of pension, annuity or Individual Retirement Account (IRA) distributions and Social Security benefits • Business Income, farm income, capital gain, other gains (or loss) • Unemployment Compensation • Ordinary dividends • Rental real estate, royalties, partnerships • S corporations, trusts, etc. • Taxable refunds, credits, or offset of state and local income taxes • Other income	**Deduct:** • Certain self-employment expenses • Student loan interest deduction • Educator expenses • IRA deduction • Moving expenses • Penalty on early withdrawal of savings • Health savings account deduction • Domestic production activities deduction • Certain business expenses of reservists, performing artists, and fee-basis government officials • Alimony paid prior to January 1, 2019 (but not child support paid)

Note: Check the IRS website for detailed requirements for the income and deduction categories above. Do not include Veteran's disability payments, Worker's Compensation or child support received. Pre-tax contributions, such as those for child care, commuting, employer-sponsored health insurance, flexible spending accounts and retirement plans such as 401(k) and 403(b), are not included in AGI but are not listed above because they are already subtracted out of W-2 wages and salaries.

Add (+) back certain income	• Non-taxable Social Security benefits (line 20a minus 20b on Form 1040) • Tax –exempt interest (Line 8b on Form 1040) • Foreign earned income and housing expenses for Americans living abroad (calculated in IRS Form 2555)

Exclude (-)from income	• Social Security benefits received by a child are not countable for his eligibility when a parent is in the household, unless the child is required to file taxes. • Scholarships, awards, or fellowship grants used for education purposes and not for living expenses • Certain American Indian and Alaska Native income derived from distributions, payments, ownership interests, real property usage rights and student financial assistance • Gifts, inheritances, and proceeds from life insurance • An amount received as a lump sum is counted only in the month received. • Parsonage allowance • Effective January 1, 2019, student loan debt forgiven due to death or disability of student is not counted as income. • Grants for homes designed for wheelchair living and motor vehicles for veterans who lost their sight or the use of their limbs • Difficulty of Care Payments • General Welfare Payments for Indian Tribes • Kinship Guardianship Payments • *Pandemic Unemployment Compensation payments paid under the Federal Pandemic Unemployment Compensation Program.* • *Recovery Rebates paid under the CARES Act.*

LIFC INCOME LIMITS

EFFECTIVE *7/1/20*

Group I

Household Size	Monthly Amount	Annual Amount
1	*$262*	*$3,144*
2	*399*	*4,788*
3	*506*	*6,072*
4	*614*	*7,368*
5	*724*	*8,688*
6	*815*	*9,780*
7	*920*	*11,040*
8	*1,030*	*12,360*
Each additional person add	*108*	*1,296*

Group II

Household Size	Monthly Amount	Annual Amount
1	*$343*	*$4,116*
2	*491*	*5,892*
3	*616*	*7,392*
4	*736*	*8,832*
5	*866*	*10,392*
6	*976*	*11,712*
7	*1,093*	*13,116*
8	*1,219*	*14,628*
Each additional person add	*123*	*1,476*

Group III

Household size	Monthly Amount	Annual Amount
1	*$516*	*$6,192*
2	*689*	*8,268*
3	*844*	*10,128*
4	*990*	*11,880*
5	*1,170*	*14,040*
6	*1,301*	*15,612*
7	*1,448*	*17,376*
8	*1,601*	*19,212*
Each additional person add	*149*	*1,788*

INDIVIDUALS UNDER AGE 21 INCOME LIMITS
EFFECTIVE *7/1/20*

Group I

Household Size	Monthly Income Limit	Annual Income Limit
1	*$250*	*$3,000*
2	*389*	*4,668*
3	*497*	*5,964*
4	*603*	*7,236*
5	*709*	*8,508*
6	*795*	*9,540*
7	*890*	*10,680*
8	*1,009*	*12,108*
Each additional person add	*104*	*1,248*

Group II

Household Size	Monthly Income Limit	Annual Income Limit
1	*$340*	*$4,080*
2	*492*	*5,904*
3	*615*	*7,380*
4	*737*	*8,844*
5	*870*	*10,440*
6	*1,072*	*12,864*
7	*1,093*	*13,116*
8	*1,218*	*14,616*
Each additional person add	*121*	*1,452*

Group III

Household Size	Monthly Income Limit	Annual Income Limit
1	*$452*	*$5,424*
2	*605*	*7,260*
3	*732*	*8.784*
4	*856*	*10,272*
5	*1,012*	*12,144*
6	*1,116*	*13,392*
7	*1,238*	*14,856*
8	*1,362*	*16,344*
Each additional person add	*122*	*1,464*

TREATMENT OF INCOME FOR FAMILIES & CHILDREN COVERED GROUPS

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

M0630 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-17	7/1/20	Page 5 Page 6 is a runover page.
Transmittal (TN) #93	1/1/10	Page 8

Any life, retirement, or other related types of insurance policies with face values totaling $1500 or less on any one person 21 years old and over are excluded. When the face values of such policies of any one person exceed $1500, the cash surrender value of the policies is counted as a resource.

E. Burial Plots

1. All Groups Other Than MN — For F&C covered groups other than MN, one burial plot per member of the family/budget unit is excluded.

2. MN — All burial plots are excluded for MN.

F. EITC Refunds or Advance Payments — For all classifications, Earned Income Tax Credit refunds and advance payments are excluded as resources in the month following the month of receipt. Any portion of the refund or advance payment retained after the month following the month of receipt is a countable resource.

G. Bona Fide Loans — For all classifications, all bona fide loans are excluded, regardless of the intended use. See M0640.800.

H. CARES Act Recovery Rebate Payments — *Recovery Rebate payments provided under Section 2201of the Coronavirus Aid, Relief, And Economic Security (Cares) Act (Public Law No. 116-136) are **not** counted as resources for **12 months following the month** of receipt. Interest earned on the payments is countable as income for individuals subject to a resource test per M0610.001.*

M0630.121 BURIAL ARRANGEMENTS

A. *All Groups Other Than MN*

1. Bona Fide Funeral Agreement — A bona fide funeral agreement covering a family/budget unit member with a maximum equity value of $1500 per individual is excluded. A bona fide funeral agreement is a formal agreement for funeral and burial expenses, such as a revocable burial contract, burial trust, or another funeral arrangement (generally with a licensed funeral director). Passbook bank accounts, or simple "set asides" of savings for funeral expenses, and cash surrender values of life insurance policies are not bona fide funeral agreements and **are not** excluded resources.

NOTE: Funds in excess of the $1500 burial limit per individual are counted against the resource limit. See section M0640.500.

2. Irrevocable Burial Contracts — Irrevocable burial contracts, regardless of value, are not counted as resources since they cannot be converted to cash by the individual.

B. MN — Burial funds are excluded from resources up to a maximum of $3,500 per individual. From August 1, 1994 on, in order for resources to be disregarded under the burial funds exclusion, they must be in the

following forms:

- irrevocable burial trusts established on or after August 11, 1993;
- revocable burial trusts;
- revocable burial contracts;other revocable burial arrangements (including the value of certain installment sales contracts for burial spaces);
- cash;
- financial accounts (e.g., savings or checking accounts);
- other financial instruments with a definite cash value (e.g., stocks, bonds, certificate of deposit, life insurance policies, etc.).

Use the ABD policy and procedures in M1130.410 and M1130.420 for MN F&C groups.

M0630.125 SAVINGS OR OTHER INVESTMENT ACCOUNT FOR THE PURPOSE OF SELF-SUFFICIENCY

A. Policy

For all covered groups that have resource requirements, up to $5,000 of principal and interest in one savings or other investment account for the purpose of self-sufficiency, is excluded. Investment accounts may include but are not limited to, mutual funds, money market accounts and stock ownership.

Any excess principal and/or interest over the $5,000 limit is a countable resource.

B. Requirements

1. Must Be Kept Separate

The funds on deposit in such an account cannot be commingled with funds intended for another use.

2. More Than One Account

If the family unit has more than one savings account established for self-sufficiency, the family unit must specify which account is the excluded resource.

3. Withdrawals

Self-sufficiency expenditures may include expenses related to securing and maintaining employment, education, home purchase, vehicle purchase, starting a business or other purposes reasonably determined to promote self-sufficiency. If any amount is withdrawn from the account for any purpose other than self-sufficiency, any portion of the amount determined to be misused will be treated as a countable resource in the month following the month withdrawn, if it is retained.

C. Notification

The eligibility worker must explain the policy in this section to the applicant/recipient who has one of these accounts.

D. Documentation

When a savings or investment account established for the purpose of self-sufficiency is first reported or discovered, the agency must verify the amount in the account and obtain a written statement from the applicant/recipient which includes the purpose of the account. The balance must be verified at application and redetermination.

M07 Table of Contents Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-17	7/1/20	Table of Contents, page i
Transmittal (TN) #DMAS-1	6/1/16	Table of Contents, pages i and ii

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M07 FAMILIES AND CHILDREN INCOME

M0710 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-17	7/1/20	Appendices 2 and 3
TN #DMAS-14	10/1/19	Pages 1, 2, 7, 8 Page 2a was added as a runover page.
TN #DMAS-13	7/1/19	Appendices 2 and 3
TN #DMAS-9	7/1/18	Appendices 2 and 3
TN #DMAS-5	7/1/17	Appendices 1, 2 and 3
TN #DMAS-2	10/1/16	Appendices 2 and 3
UP #11	7/1/15	Appendix 5
TN #100	5/1/15	Table of Contents pages 1-8 Pages 9-13 were deleted. Appendices 1, 2 and 3 Appendices 4-7 were removed.
TN #98	10/1/13	pages 1-4, 8, 9 Page 1a was added. Appendices 1, 3, 5
UP #9	4/1/13	Appendix 6, pages 1, 2 Appendix 7
UP #7	7/1/12	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1
UP #6	4/1/12	Appendix 6, pages 1, 2 Appendix 7
TN #96	10/01/11	Appendix 6, page 1
UP #5	7/1/11	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1
TN #95	3/1/11	Appendix 6, pages 1, 2 Appendix 7
Update (UP) #1	7/1/09	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1

F&C MEDICALLY NEEDY INCOME LIMITS
EFFECTIVE *7/1/20*

GROUP 1			GROUP II		GROUP III	
Number of Persons in Family/Budget Unit	Semi-Annual Income	Monthly Income	Semi-Annual Income	Monthly Income	Semi-Annual Income	Monthly Income
1	*$1,993.11*	*$332.18*	*$2,299.75*	*$383.29*	*$2,989.69*	*$498.28*
2	*2,537.36*	*422.89*	*2,831.85*	*471.97*	*3,604.37*	*600.72*
3	*2,989.69*	*498.28*	*3,296.31*	*549.38*	*4,062.94*	*677.15*
4	*3,373.00*	*562.16*	*3,679.65*	*613.27*	*4,446.27*	*741.04*
5	*3,756.30*	*626.05*	*4,062.77*	*677.12*	*4,809.18*	*801.53*
6	*4,139.60*	*689.93*	*4,446.24*	*741.04*	*5,212.84*	*868.80*
7	*4,522.89*	*753.81*	*4,809.18*	*801.53*	*5,596.14*	*932.69*
8	*4,982.86*	*830.47*	*5,289.50*	*881.58*	*5,979.45*	*996.57*
9	*5,442.82*	*907.13*	*5,804.70*	*967.45*	*6,534.83*	*1,089.13*
10	*5,979.45*	*996.57*	*6,286.08*	*1,047.68*	*6,976.03*	*1,162.67*
Each add'l person add	*515.11*	*85.85*	*515.11*	*85.85*	*515.11*	*85.85*

F&C 100% STANDARD OF ASSISTANCE EFFECTIVE *7/1/20*

(Used as the F&C Deeming Standard)

Group I

Household Size	Income Limit
1	*$257*
2	*392*
3	*498*
4	*604*
5	*711*
6	*802*
7	*904*
8	*1,011*
Each additional person add	*106*

Group II

Household Size	
1	*$336*
2	*482*
3	*606*
4	*724*
5	*850*
6	*958*
7	*1,073*
8	*1,198*
Each additional person add	*121*

Group III

Household Size	
1	*$506*
2	*716*
3	*830*
4	*974*
5	*1,150*
6	*1,279*
7	*1,423*
8	*1,574*
Each additional person add	*146*

M0715 Changes

Changed With	Effective Date	Pages Changed
Transmittal (TN) #DMAS-17	7/1/20	Table of Contents Page 2

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M07 FAMILIES AND CHILDREN INCOME

M0715.000 *F&C* WHAT IS NOT INCOME

Example 2:

Mrs. X and Mrs. Y live in the same house which is rented in Mrs. X's name. Mrs. Y gives Mrs. X an established portion of the rent each month. Mrs. X adds her portion to Mrs. Y's and pays the rent. Since this is a shared shelter arrangement, Mrs. Y's portion of the rent is not considered income to Mrs. X.

M0715.200 CONVERSION OR SALE OF A RESOURCE

A. Policy

Receipts from the sale, exchange, or replacement of a resource are not income, but are resources that have changed their form.-

This includes cash or in-kind items that are provided to replace or repair a resource that has been lost, damaged, or stolen.

B. Reference

Casualty Property Loss Payments, M0630.130

M0715.270 INCOME TAX REFUNDS *AND CREDITS*

A. Policy

Income tax refunds and Earned Income Tax Credit payments are not income.

Recovery Rebate payments provided under Section 2201 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Public Law No. 116-136) are considered tax credits and are not countable as income.

B. Tax Withheld Prior to Application Date

Income tax refunds are not income even if the income from which the tax was withheld or paid was received in a period prior to application for Medicaid.

M0715.350 PROCEEDS OF A LOAN

A. Introduction

Proceeds of a loan are not income to the borrower because of the borrower's obligation to repay the loan.

B. Policy

1. Loan Not Income

All bona fide loans, regardless of the intended use, are not income. This includes loans obtained for any purpose and may be from a private individual as well as from a commercial institution.

2. Documentation of Bona Fide

A simple statement signed by both parties indicating that the payment is a loan and must be repaid is sufficient to verify that a loan is bona fide.

3. Loan Not Bona Fide

If an individual indicates that money received was a loan but does not provide required verification, the money is to be treated as unearned income in the month received and a resource thereafter.

4. Interest on a Loan

Interest earned on the proceeds of a loan while held in a savings account, checking account, or other financial instrument will be counted as unearned income in the month received and as a resource thereafter.

M0730 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-17	7/1/20	Page 7
TN #DMAS-14	10/1/19	Page 1
TN #DMAS-9	7/1/18	Table of Contents Pages 11, 15
TN #DMAS-4	4/1/17	Pages 7, 8
TN #98	10/1/13	Pages 7, 8 Page 8a was removed.
TN #97	9/1/12	Page 10
TN #94	9/1/2010	Pages 7, 8
TN #93	1/1/2010	Page 2
TN #91	5/15/2009	Table of Contents pages 7-8a

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. *Federal Pandemic Unemployment Compensation Program* — *Section 2104 of the Coronavirus Aid, Relief, and Economic Security (Cares) Act (Public Law No. 116-136) provides that under the Federal Pandemic Unemployment Compensation Program, eligible individuals who are collecting certain Unemployment Compensation, including regular unemployment compensation, will receive an additional $600 in federal benefits per week for weeks of unemployment ending on or before July 31, 2020.*

The $600 weekly Pandemic Unemployment Compensation payments (monthly equivalent of $2,580) are disregarded as income.

M0810 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-17	7/1/20	Page 2
TN #DMAS-16	4/1/20	Page 2
TN #DMAS-15	1/1/20	Pages 1, 2
TN #DMAS-14	10/1/19	Pages 20, 25, 27 Page 28 is a runover page.
TN #DMAS-12	4/1/19	Page 2
TN #DMAS-11	1/1/19	Pages 1, 2
TN #DMAS-10	10/1/18	Page 2
TN #DMAS-9	7/1/18	Page 2
TN #DMAS-8	4/1/18	Page 2
TN #DMAS-7	1/1/18	Pages 1, 2
TN #DMAS-5	7/1/17	Page 2
TN #DMAS-4	4/1/17	Page 2
TN #DMAS-3	1/1/17	Pages 1, 2
TN #DMAS-2	10/1/16	Page 2
TN #DMAS-1	6/1/16	Pages 1, 2
UP #11	7/1/15	Page 2
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UP #10	5/1/14	Page 2
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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
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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	2019 Monthly Amount	2020 Monthly Amount
1	$2,313	$2,349

4. ABD Medically Needy

a. Group I	*7/1/19 – 6/30/20*		*7/1/20*	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$1,957.87	$326.31	*$1,9993.11*	*$332.18*
2	2,492.57	415.42	*2,537.36*	*422.89*

b. Group II	*7/1/19 – 6/30/20*		*7/1/20*	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,259.09	$376.51	*$2,299.75*	*$383.29*
2	2,781.69	463.61	*2,831.85*	*471.97*

c. Group III	*7/1/19 – 6/30/20*		*7/1/20*	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,936.83	$489.47	*$2,989.69*	*$498.28*
2	3,540.71	590.11	*3,604.37*	*600.72*

5. ABD Categorically Needy

For:

ABD 80% FPL, QMB, SLMB, & QI <u>without</u> Social Security income; all QDWI; effective 1/17/20

ABD 80% FPL, QMB, SLMB, & QI <u>with</u> Social Security income; effective 3/1/20

All Localities	2019		2020	
ABD 80% FPL	Annual	Annual	Annual	Monthly
1	$9,992	$9,992	$10,208	$851
2	13,528	13,528	13,792	1,150
QMB 100% FPL	Annual	Annual	Annual	Monthly
1	$12,490	$12,490	$12,760	$1,064
2	16,910	16,910	17,240	1,437
SLMB 120% of FPL	Annual	Annual	Annual	Monthly
1	$14,988	$14,988	$15,312	$1,276
2	20,292	20,292	20,688	1,724
QI 135% FPL	Annual	Annual	Annual	Monthly
1	$16,862	$16,862	$17,226	$1,436
2	22,829	22,829	23,274	1,940
QDWI 200% of FPL	Annual	Annual	Annual	Monthly
1	$24,980	$24,980	$25,520	$2,127
2	33,820	33,820	34,480	2,874

M0815 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-17	7/1/20	Table of Contents Pages 11, 12
Transmittal (TN) #DMAS-7	1/1/18	Page 1

TABLE OF CONTENTS

M0815.000 WHAT IS NOT INCOME

M0815.200 CONVERSION OR SALE OF A RESOURCE

A. Policy

Receipts from the sale, exchange, or replacement of a resource are **not income** but are resources that have changed their form.

This includes any cash or in-kind items that is provided to replace or repair a resource that has been lost, damaged, or stolen

Capital gains, which are profits made from the sale of capital assets (long-term assets such as land or buildings), are also not income. Any proceeds that remain the month after this type of sale must be evaluated as a resource.

B. Reference

See S1110.600 B.4. for a complete discussion of the policy.

C. Example

Jerry Wallace sells his 1974 Plymouth Satellite for $300. The money he receives is not income but a resource which has been converted from one form (a car) to another form (cash).

*M*0815.250 REBATES AND REFUNDS

A. Policy

When an individual receives a rebate, refund, or other return of money he or she has already paid, the money returned is **not income.**

CAUTION: The key idea is applying this policy is a return of an individual's own money. Some "rebates" do not fit that category. For example, if a cooperative operating as a jointly-owned business pays a "rebate" as a return on a member's investment, this money is unearned income similar to a dividend. Developmental guidelines for interest and dividends are in S0830.500.

See M0815.270 for the treatment of Recovery Rebate payments provided under Section 2201 of the Coronavirus Aid, Relief, and Economic Security (Cares) Act.

B. Procedure

1. General

Unless you have reason to question the situation, accept an individual's signed allegation that a rebate or refund of money is a return of money already paid and do not count it as income.

2. Questionable Situation

In questionable situations, make copies for the file of any documents in the individual's possession, and contact the source of the payment, etc. to verify that the payment is a return of money already paid.

C. Example

Rose Woods, an elderly recipient, pays property taxes on the home she lives in. Because of her low income, the city government returns part of Mrs. Woods' property taxes in the form of a check. This return of money already paid by Mrs. Woods is not income.

D. References

See S0830.705 for rules on the exclusion of certain taxes.

S0815.270 INCOME TAX REFUNDS *AND CREDITS*

A. Policy

1. General — Any amount refunded on income taxes already paid is **not income**.

2. Tax Withheld Prior to Application Date — Income tax refunds are not income even if the income from which the tax was withheld or paid was received in a period prior to application for Medicaid.

3. Tax Refunds and Blind Work Expenses — Income tax refunds are **not income** even if the income taxes were included as work expenses of the blind. (See S0820.535 B.3.)

4. CARES Act Recovery Rebate Payments — *Recovery Rebate payments provided under Section 2201 of the Coronavirus Aid, Relief, and Economic Security (CARES) Act (Public Law No. 116-136) are considered tax credits and are not countable as income, and are **not** counted as resources for **12 months following the month** of receipt. See M1130.675. Interest earned on the retained payments is countable as interest income.*

S0815.300 CREDIT LIFE OR CREDIT DISABILITY INSURANCE PAYMENTS

A. Definition of Credit Life/Disability Insurance — Credit life and credit disability insurance policies are issued to or on behalf of borrowers, to cover payments on loans, mortgages, etc. in the event of death or disability. These insurance payments are made directly to loan or mortgage companies, etc. and are not available to the individual.

B. Policy

- Payments made under a credit life or credit disability insurance policy on behalf of an individual are **not income.**
- Food, clothing, or shelter received as the result of a credit life or credit disability payment is **not income.**

C. Example — Frank Fritz, a Medicaid recipient, purchased credit disability insurance when he bought his home. Subsequently Mr. Fritz was in a car accident and became totally disabled. Because of his disability, the insurance company pays off the home mortgage. Neither the payment nor the increased equity in the home is income to Mr. Fritz.

S0830 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-17	7/1/20	Page 29
TN #DMAS-12	4/1/19	Page 113
TN #DMAS-7	1/1/18	Table of Contents, page iii, iv. Pages 7-8, 17-18, 20, 29, 48, 79a, 82, 124a-124b, 125.
TN #DMAS-4	4/1/17	Table of Contents, page i Pages 24, 24c
TN #DMAS-2	10/1/16	On page 109, updated the format of the header. Neither the date nor the policy was changed.
TN #DMAS-1	3/23/16	Table of Contents, page iii Pages 18, 82
Update #7	7/1/12	Page 24
TN #94	9/1/10	Page 29
TN #93	1/1/10	Table of Contents, page iv Pages 28, 67, 119-120 Pages 122-125
TN #91	5/15/09	Table of Contents, page i Page 29

M0830.230 UNEMPLOYMENT COMPENSATION BENEFITS

A. Definition

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

B. Procedures

1. General Procedures

Unemployment Compensation benefits are counted as unearned income

2. *Federal Pandemic Unemploy-ment Compensation Program*

Section 2104 of the Coronavirus Aid, Relief, and Economic Security (Cares) Act (Public Law No. 116-136) provides that under the Federal Pandemic Unemployment Compensation Program, eligible individuals who are collecting certain Unemployment Compensation, including regular unemployment compensation, will receive an additional $600 in federal benefits per week for weeks of unemployment ending on or before July 31, 2020.

The $600 weekly Pandemic Unemployment Compensation payments (monthly equivalent of $2,580) are disregarded as income.

S0830.235 WORKERS' COMPENSATION

A. Introduction

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

B. Policy

1. Income

a. General

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

M1110 Changes

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

OVERVIEW

M1110.001 ROLE OF RESOURCES

A. Introduction

As a program based on need, Medicaid uses the value of a person's countable resources as one of two financial criteria in determining eligibility. The other criterion is income.

B. Policy Principles

1. Monthly Determinations

Eligibility with respect to resources is a determination made for each calendar month, beginning with the *month of application or, if retroactive eligibility is being determined, the* third month prior to the month in which the application is *submitted*. Resource eligibility exists for the full month if countable resources were at or below the applicable resource limit for any part of the month.

2. Countable Resources

Not everything a person owns (i.e., not every asset) is a resource and not all resources count against the resource limit. The Social Security Act and other Federal statutes require the exclusion of certain types and amounts of resources. Any assets that are resources but not specifically excluded are "countable." See:

- M1110.003 B.2. for the resource limits;
- S1110.100 for the distinction between assets and resources; and
- S1110.210 for a listing of exclusions.

3. Whose Resources Can Count

Medicaid law specifies that resources are only considered available between spouses and from parents to their children under age *21*, and for certain blind and disabled children ages 18 to 21.

See M1110.530 for blind and disabled children age 18 to 21.

4. Whose Resources Can Not Count

Medicaid law will not allow certain resources to be considered in determining eligibility. Do not count resources:

- From a step-parent.
- From siblings.
- From spouse or parent living apart unless it is a voluntary financial contribution. (Exception for Long-term care)
- From an alien sponsor.

M1130 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-17	7/1/20	Table of Contents, page ii Page 4 Page 5 is a runover page.
TN #DMAS-12	4/1/19	Page 13
TN #DMAS-9	7/1/18	Pages 1, 3
TN #DMAS-7	1/1/18	Pages 45,78-79 Appendix 1, pages 3,5
TN #DMAS-5	7/1/17	Pages 13, 15, 78, 79 Page 14 is a runover page.
TN #DMAS-3	1/1/17	Table of Contents, page ii Page 76 Page 77 is a runover page. Pages 78 and 79 were added.
TN #DMAS-1	6/1/16	Pages 4, 14, 15
TN #100	5/1/15	Pages 13, 15, 21, 31, 33, 34 Pages 16 and 32 are runover pages.
UP #9	4/1/13	Table of Contents, page ii Pages 5, 62 Pages 62a was added.
TN#97	9/1/12	Page 14
Update #7	7/1/12	Page 24
TN #96	10/1/11	Table of Contents, page ii Pages 4, 73, 74 Appendix 1, pages 1-14 Appendix 2, page 1 Appendix 4, pages 1-8 added
TN #95	3/1/11	Pages 28, 29, 33
TN #94	9/1/10	Pages 20, 20a, 28-29a
TN #93	1/1/10	Pages 63-65 Pages 70, 74, 75
TN #91	5/15/09	Page 13

M1130.000 ABD RESOURCES EXCLUSIONS Section Page

RETAINED CASH AND IN-KIND PAYMENTS

OTHER EXCLUDED RESOURCES

Appendix

The six-month home exclusion allowed for an institutionalized individual's former home also applies to the home owned by an individual receiving Medicaid *home* and community-based services *(HCBS)* in another person's home, providing the individual resided in the home prior to receipt of Medicaid *HCBS*. See M1460.530 for additional information.

3. Extended Exclusion for Institutionalized Individual

An institutionalized individual's home property continues to be excluded if it is occupied by his:

- spouse;
- minor dependent child under age 18;
- dependent child, **under** age 19, **who attends** school or vocational training; or
- individual's parent or adult child who:
  - has been determined to be disabled according to the Medicaid disability definition, and
  - lived in the home with the individual for at least one year prior to the individual's institutionalization, and
  - is dependent upon the individual for his shelter needs.

E. Development and Documentation-- Initial Applications

1. Ownership

a. Verify Ownership

Verify an individual's allegation of home ownership. Have the individual submit one of the items of evidence listed in b.- d. below.

For manufactured (mobile) homes, *if a mobile home is assessed and taxed by the county/locality as real estate (not personal property), it is treated as real property. If the mobile home is registered and titled at the DMV and taxed as personal property, it is treated as personal property.*

b. Evidence of real property ownership;

- tax assessment notice;
- recent tax bill;
- current mortgage statement;
- deed;
- report of title search;
- evidence of heirship in an unprobated estate (e.g., receipt of income from the property, a will, or evidence of relationship recognizable under State intestate distribution laws in cases where the home is unprobated property).

c. Evidence of personal property ownership (e.g., a mobile home):

- title,
- current registration.

d. Evidence of life estate or similar property rights:

- a deed,
- a will,

other legal document.

e. Equitable Ownership

Virginia does not recognize equitable ownership of real property

2. Principal Place of Residence--Operating Assumption

If the individual does not own more than one residence and there is no evidence that raises a question about his principal place of residence, assume that the alleged home is the individual's principal place of residence.

3. Indication of More than One Residence

If an individual alleges or other evidence indicates ownership of more than one residence, obtain his signed statement concerning such points as:

- how much time is spent at each residence;
- where he is registered to vote;
- which address he uses as a mailing address or for tax purposes.

Determine the principal place of residence accordingly and document the determination in the case file.

4. Evidence Indicates Non-adjoining Property

a. Individual Agrees With Evidence

If evidence indicates that land the individual owns does not adjoin the home plot, and the individual agrees that it does not:

- **obtain** his statement to that effect; and
- **develop** the non-adjoining portion per S1140.100 (Non-home Real Property) or S1130.500 (Property Essential to Self-Support), as applicable.

b. Individual Disagrees With Evidence

If the individual maintains that all the land adjoins the home plot, document the file with:

- a sketch of the land showing the boundaries of the various plots and the location of the shelter used as the home; and
- evidence of how the land is treated for tax assessment purposes.

The sketch may be by the individual, from public records, or by EW (from direct observation).

C. Procedure -- Initial Applications and Posteligibility

1. When to Develop

When an individual would otherwise be ineligible due to excess resources, determine if applying this exclusion would permit eligibility. If the exclusion would permit eligibility, develop per 2. below.

NOTE: If the individual is resources-eligible even without the application of this exclusion, it is not necessary to develop under this section.

2. Development and Documentation

If an individual alleges that his/her resources include unspent relocation assistance payments:

- follow the procedures in S0830.655D.;
- document the date(s), type(s) and amount(s) of such payments(s); and
- obtain a statement as to the date(s) and amount(s) of any account deposits corresponding to the payments.

D. References

Commingled funds, S1130.700.

*M*1130.675 TAX ADVANCES, REFUNDS AND *REBATES* RELATED TO EARNED INCOME TAX CREDITS AND THE *CORONAVIRUS AID, RELIEF, AND ECONOMIC SECURITY (CARES) ACT*

A. Policy

1. EITC Related Refunds

Effective with resource determinations made for the month of January 1991, an unspent Federal tax refund or payment made by an employer related to Earned Income Tax Credits (EITC's) is excluded from resources **only for the month following the month** the refund or payment is received.

Interest earned on unspent tax refunds related to EITC's is **not** excluded from income or resources by this provision (S0830.500).

2. *CARES Act Recovery Rebate Payments*

*Recovery Rebate payments provided under Section 2201of the CARES Act (Public Law No. 116-136) are **not** counted as resources for **12 months following the month** of receipt.*

*Interest earned on unspent Recovery Rebates related to the CARES Act is **not** excluded from income or resources by this provision (S0830.500).*

B. Procedure--Initial Claims and Post-Eligibility

1. When to Develop

Develop *these* exclusion*s* only when an individual alleges the receipt of assistance excludable under this provision and the exclusion would permit eligibility.

2. Development and Documentation

If an individual alleges that his or her resources include unspent EITC and/or *CARES* Act-related refunds or payments:

- verify the source, date(s), and amount(s) of such refund(s) or payment(s) in accordance with S0820.400, and
- obtain a statement as to the date(s) and amount(s) of any account deposits corresponding to the EITC and/or *CARES* Act refunds or payments.

C. References

Commingled funds, S1130.700.

S1130.680 RADIATION EXPOSURE COMPENSATION TRUST FUND PAYMENTS

A. Background

Fallout emitted during the U.S. Government's atmospheric nuclear testing in Nevada during the 1950's and during a brief period in 1962 exposed some individuals to doses of radiation that put their health at risk. In addition, some individuals employed in uranium mines during the period January 1, 1947 to December 31, 1971 were exposed to large doses of radiation. Public Law 101-426 created the Radiation Exposure Compensation Trust Fund (RECTF) and authorizes the Department of Justice (DOJ) to make compensation payments to individuals (or their survivors) who were found to have contracted certain diseases after exposure. The payments will be made as a one-time lump sum. Generally, the exposure occurred in parts of Arizona, Colorado, Nevada, New Mexico, Utah, and Wyoming.

B. Policy

1. Resource Exclusion

Unspent payments received from the RECTF are excluded from resources.

2. Interest On Unspent RECTF Payments

Interest earned on unspent RECTF payments prior to July 1, 2004 is not excluded from income or resources. Interest earned on unspent RECTF payments on or after July 1, 2004 is excluded from income and resources.

C. Procedure

1. When to Develop

When an individual would otherwise be ineligible due to excess resources, determine if applying this exclusion would permit eligibility.

If the exclusion would permit eligibility, develop per 2. below.

NOTE: If the individual is resources-eligible even without the application of this exclusion, it is not necessary to develop under this section.

M1410 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-17	7/1/20	Pages 1, 4, 8, 11-13 Pages 4a and 7 were removed. Pages 8-14 were renumbered 7-13.
TN #DMAS-14	10/1/19	Pages 10, 12-14
TN #DMAS-12	4/1/19	Page 4, 10-11 Page 4a was added as a runover page.
TN #DMAS-11	1/1/19	Pages 6, 7
TN #DMAS-10	10/1/18	Pages 8-14
TN #DMAS-9	7/1/18	Page 1
TN #DMAS-8	4/1/18	Page 9
TN #DMAS-7	1/1/18	Page 7
TN #DMAS-5	7/1/17	Pages 4-7
TN #DMAS-3	1/1/17	Pages 6, 7, 12-14
TN #DMAS-1	6/1/16	Pages 12-14
TN #100	5/1/15	Page 2
TN #99	1/1/14	Page 10
Update #7	7/1/12	Pages 6, 7
TN #96	10/1/11	Page 11, 12
TN #95	3/1/11	Pages 13, 14 Page 15 was removed.
TN #94	9/1/10	Pages 6, 7, 13
TN #93	1/1/10	Pages 1, 7, 9, 12
TN #91	5/15/09	Pages 11-14

M1410.010 GENERAL--LONG-TERM CARE

A. Introduction

Chapter M1410 contains the rules that apply to individuals needing long-term services and support (LTSS). The rules are contained in the following subchapters:

- M1410 General Rules
- M1420 Pre-admission Screening
- M1430 Facility Care
- M1440 Community-based Care Waiver Services
- M1450 Transfer of Assets
- M1460 Financial Eligibility
- M1470 Patient Pay - Post-eligibility Treatment of Income
- M1480 Married Institutionalized Individuals' Financial Eligibility

The rules found within this Chapter apply to those individuals applying for or receiving Medicaid who meet the definition of institutionalization.

B. Definitions

The definitions found in this section are for terms used when policy is addressing types of long-term services and support (LTSS), institutionalization, and individuals who are receiving that care.

1. Authorized Representative

An **authorized representative** is a person who is authorized to conduct business for an individual. A competent individual must designate the authorized representative in a written statement, which is signed by the individual applicant. The authorized representative of an incompetent or incapacitated individual is the individual's

- spouse
- parent, if the individual is a child under age 18 years
- attorney-in fact (person who has the individual's power-of-attorney)
- legally appointed guardian
- legally appointed conservator (formerly known as the committee)
- trustee.

2. Institutionalization

Institutionalization means receipt of 30 consecutive days of

- care in a medical institution (such as a nursing facility), or
- Medicaid Home and Community-Based Services (HCBS), or
- a combination of the two.

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

The 30 days begins with the day of admission to the medical institution or receipt of Medicaid HCBS. The date of discharge into the community (not in LTSS) or death is **NOT** included in the 30 days.

The institutionalization provisions may be applied when the individual is already in a medical facility at the time of the application, or the

B. Ineligible Individuals

Individuals under age 65 who are patients in an institution for mental diseases (IMD) *are not eligible for Medicaid* unless they are under age 22 and receiving inpatient psychiatric services.

C. Types of Medical Institutions

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

1. Chronic Disease Hospitals

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

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

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

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

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

3. Institutions for Mental Diseases (IMDs)

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

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

4. Intermediate Care Facility (ICF)

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

5. Nursing Facility

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

- nursing services for assessments and evaluations
- therapeutic social and recreational programming which provides daily activities for individuals with dementia.

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

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

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

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

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

M1410.050 FINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

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

B. Asset Transfer

The asset transfer policy is found in subchapter M1450.

C. Resources

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

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

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

D. Income

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

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

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

A. Introduction

Most Medicaid-eligible individuals must pay a portion of their income to the LTSS provider; Medicaid pays the remainder of the cost of care. The portion of their income that must be paid to the provider is called "patient pay." Patient pay policy does NOT apply to MAGI Adults.

B. Patient Pay

The policies and procedures for patient pay determination are found in subchapter M1470 of this chapter for individuals who do not have community spouses and in subchapter M1480 for individuals who have community spouses.

M1410.100 LONG-TERM CARE APPLICATIONS

A. Introduction

The general application requirements applicable to all Medicaid applicants/ recipients found in chapter M01 also apply to applicants/recipients who need LTSS services. This section provides those additional or special application rules that apply only to persons who meet the institutionalization definition.

B. Responsible Local Agency

The local social services department in the Virginia locality where the institutionalized individual (patient) last resided outside an institution retains responsibility for receiving and processing the application.

If the patient did not reside in Virginia prior to admission to the institution, the local social services department in the county/city where the institution is located has responsibility for receiving and processing the application.

Home and Community-Based Services (HCBS) applicants apply in their locality of residence.

C. Procedures

1. Application Completion

A signed application is received. A face-to-face interview with the applicant or the person authorized to conduct his business is not required, but is strongly recommended, in order to correctly determine eligibility.

2. Pre-admission Screening

Notice from pre-admission screener is received by the local Department of Social Services (DSS).

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

3. Processing

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

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

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

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

4. Notices

See section M1410.300 for the required notices.

M1410.200 INITIATING LONG-TERM CARE FOR CURRENT RECIPIENTS

A. Introduction

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

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

B. LTSS Screening

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

C. Recipient Enters LTC

A re-evaluation of eligibility must be done when the EW learns that a Medicaid recipient has started receiving LTSS services. An LTSS screening **is required.**

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

- For an SSI recipient who has no community spouse and owns no countable real property, verify continued receipt of SSI through SOLQ-I or SVES, obtain information regarding asset transfer from the enrollee or authorized representative, and document the case record. See section M1430.104 for additional information regarding an SSI recipient who enters a nursing facility.

- Rules for married institutionalized recipients, with the exception of MAGI Adults, who have a community spouse are found in subchapter M1480.

D. Notification

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

M1410.300 NOTICE REQUIREMENTS

A. Introduction

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

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

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

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

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

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

B. Forms to Use

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

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

2. Notice of *Patient Pay Responsibility* (#032-03-0062)

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

3. Medicaid LTC Communication Form (DMAS-225)

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

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

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

a. When to Complete the DMAS-225

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

b. Where to Send the DMAS-225.

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

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

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

     Office for Community Living
     600 E. Broad St,
     Richmond, VA 23219

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

4. Advance Notices of Proposed Action

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

a. Advance Notice of Proposed Action

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

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

b. Notice of *Patient Pay Responsibility*

When a change in the patient pay amount is entered in VaCMS or MMIS, a "Notice of *Patient Pay Responsibility*" will be generated and sent as the advanced notice to the recipient or the authorized representative.

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

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

5. Administrative Renewal Form

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

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

M1420 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-17	7/1/20	Pages 1-6
TN #DMAS-12	4/1/19	Page 2
TN #DMAS-11	1/1/19	Entire subchapter
TN #DMAS-7	1/1/18	Table of Contents Pages 2, 5. Appendix 2.
TN #DMAS-5	7/1/17	Pages 2-6
TN #DMAS-1	1/1/17	Table of Contents Pages 3-6 Appendix 3 Appendices 4 and 5 were removed.
TN #DMAS-1	6/1/16	Pages 3-5 Page 6 is a runover page. Appendix 3, page 1
TN #99	1/1/14	Page 4
UP#7	7/1/12	Pages 3, 4
TN #94	09/01/10	Table of Contents Pages 3-5 Appendix 3
TN #93	01/01/10	Pages 2, 3, 5 Appendix 3, page 1 Appendix 4, page 1

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LONG-TERM SERVICES AND SUPPORTS

M1420.000 SCREENING FOR MEDICAID LTSS

M1420.000 SCREENING FOR MEDICAID LTSS

M1420.100 MEDICAID LTSS SCREENING PROCESS

A. Introduction

The Medicaid screening process for LTSS was implemented in 1977 to ensure that Medicaid eligible individuals entering nursing facilities met the required level of care for Medicaid payment of long-term services and supports (LTSS.). In 1982, the screening process for LTSS was expanded to require screening *and authorization* for individuals requesting Medicaid payment of LTSS through the Medicaid Home and Community-based Services Waivers (HCBS) or institutional long-term care. In 2007, the screening process was expanded to include individuals requesting Medicaid payment of LTSS services through the Program for the All-Inclusive Care of the Elderly (PACE).

This subchapter describes the LTSS screening process; the eligibility implications; the communication requirements; the inter-agency cooperation requirements; and eligibility worker responsibilities in the LTSS screening process.

B. Operating Policies

1. Payment Authorization

An LTSS screening provides authorization for Medicaid payment of facility (medical institution), *HCBS waiver* and PACE long-term care services for Medicaid recipients.

2. When an *LTSS* Screening is Required

A screening is used to determine if an individual entering *LTSS* care meets the level of care criteria for the form of care being requested. LTSS include nursing facility care, care in one of the HCBS waivers, and PACE services. A screening is not needed when an individual is already in a nursing facility or is currently authorized to receive Medicaid LTSS The exceptions to the screening requirement are listed in M1420.400 B. 1.

The approval by the screening team for receipt of Medicaid *LTSS* services allows the individual to be evaluated using the eligibility rules for institutionalized individuals. See M1420.100 B.3.

3. Eligibility Rules

The Medicaid LTSS Authorization Form, DMAS 96, is used to determine the appropriate rules used for the eligibility determination (which *LTSS* rules to use, or whether to use non-institutional Medicaid eligibility rules). An individual who is screened and approved for *LTSS* is treated as an institutionalized individual in the Medicaid eligibility determination. The Authorization form also certifies the type of *LTSS* service and provides information for the personal needs/maintenance allowance.

M1420.200 RESPONSIBILITY FOR LTSS SCREENING

A. Introduction

In order to qualify for Medicaid payment of LTSS an individual must be determined to meet functional criteria, have a medical or nursing need and be at risk of nursing facility or hospital placement within 30 days without services. The LTSS screening is completed by a designated screening team. The team that completes the screening depends on the type(s) of services chosen and needed by the individual. Below is a listing of the types of LTSS services an individual may receive and the teams responsible for completion of the screening for those services.

B. Nursing Facility Screening

This evaluation is completed by local community-based teams (CBT) composed of agencies contracting with the Department of Medical Assistance Services (DMAS) or by staff of hospitals for inpatients.

Individuals in non-hospital facilities (such as incarcerated individuals) will be screened by the community-based team in the locality in which the facility is located.

The community-based teams usually consist of the local health department physician, a local health department nurse, and a local social services department service worker.

C. *Screening for HCBS Waivers*

Screening and authorization for the Medicaid HCBS waivers are completed as follows:

1. Commonwealth Coordinated Care Plus Waiver

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

2. Community Living Waiver

Local Community Services Boards (CSBs) are authorized to screen individuals for the Community Living Waiver. Final authorizations for waiver services are made by DBHDS staff.

3. Family and Individual Supports Waiver

CSBs are authorized to screen individuals for the Family and Individual Supports Waiver.

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

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

D. PACE

Community-based screening teams and hospital screening teams are authorized to screen individuals for PACE. If the individual is screened and approved for LTSS, the team will inform the individual about any PACE program that serves the individual's locality.

M1420.300 COMMUNICATION PROCEDURES

A. Introduction

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

B. Procedures

1. LDSS Contact

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

2. Screeners

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

3. Eligibility Worker (EW) Action

The EW must inform both the individual and the provider once eligibility for Medicaid payment of *LTSS* has been determined. If the individual is found eligible for Medicaid and written assurance of approval by the screening team has been received (DMAS-96 or WaMS print out), the eligibility worker must give the LTSS provider the enrollee's Medicaid identification number.

M1420.400 LTSS SCREENING CERTIFICATION

A. Purpose

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

B. Exceptions to Screening

Screening *for LTSS* is NOT required when:

- the individual is a resident in a nursing facility at the time of application and a screening for LTSS was completed prior to the nursing facility admission;
- the individual is a resident in a nursing facility at the time of application and was a private pay resident at the time of nursing facility admission;
- the individual is a resident in a nursing facility at the time of application *and was admitted to the nursing facility prior to July 1, 2019;*
- the individual received Medicaid *LTSS* in one or more of the preceding 12 months and *LTSS* was terminated for a reason other than no longer meeting the level of care;
- the individual enters a nursing facility directly from the CCC Plus Waiver or PACE **and** an LTSS screening was completed prior to the CCC Plus Waiver or PACE services starting;
- the individual leaves a nursing facility and begins receiving CCC Plus Waiver services or enters PACE **and** an *LTSS* screening was completed prior to the nursing facility admission ***or*** *at the point of a change in nursing facility level of care or care status. For example, the individual did not receive a Medicaid LTSS Screening prior to nursing facility admission but wishes to leave the nursing facility and receives an LTSS Screening while in the nursing facility in order to be discharged to HCBS*;
- the individual resides out of state (either in a community or nursing facility setting) and seeks direct admission to a nursing facility;
- the individual is an inpatient at an in state owned/operated facility licensed by DBHDS, in-state or out of state Veterans hospital or in-state or out of state military hospital and seeks direct admission to a nursing facility;
- the individual will not become financially eligible within six months of admission;
- the individual is no longer in need of LTSS and is requesting assistance for a prior period of long term care;
- the individual is being enrolled in Medicaid hospice services or home health services.

C. Documentation

If a screening is required, the screener's approval for Medicaid LTSS must be substantiated in the case record by one of the following documents:

- Medicaid Funded Long-term Services and Supports Authorization Form (DMAS-96) for nursing facilities, PACE and CCC Plus Waiver (see Appendix 1) or the equivalent information printed from the *electronic* Pre-admission Screening (*e*PAS) system. *A copy of the assessment screen from MMIS is also acceptable for LTSS screenings conducted prior to December 1, 2019.*

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

Medicaid payment for LTSS cannot begin prior to the date the DMAS-96 is signed and prior authorization of services for the individual has been given to the provider by DMAS or its contractor.

1. Nursing Facility/PACE

Individuals who require care in a nursing facility or elect PACE will have a DMAS-96 signed and dated by the screener and the supervising physician or the equivalent information printed from the *e*PAS system. *A copy of the assessment screen from MMIS is also acceptable for LTSS screenings conducted prior to December 1, 2019.*

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

2. CCC Plus Waiver

Individuals screened and approved for the CCC Plus Waiver must have a DMAS-96 signed and dated by the screener and the physician or the equivalent information printed from the *e*PAS system. *A copy of the assessment screen from MMIS is also acceptable for LTSS screenings conducted prior to December 1, 2019.*

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

For individuals who qualify for Private Duty Nursing (PDN) under the CCC Plus Waiver, a Medicaid *LTSS* Communication form (DMAS-225) and a Commonwealth Coordinated Care Plus Waiver PDN Level of Care Eligibility form *(DMAS-108 for Adults or DMAS-109 for children) will be* completed and sent to the LDSS.

3. Community Living Waiver Authorization Screen Print

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

4. Building Independence Waiver Level of Authorization Screen Print

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

5. Family and Individual Supports Waiver Authorization Screen Print

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

D. Authorization for LTSS

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

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

1. Authorization Not Received

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

2. Authorization Rescinded

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

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

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

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

M1450 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-17	7/1/20	Page 45
TN #DMAS-15	1/1/20	Page 46
TN #DMAS-14	10/1/19	Pages 19, 41, 42, 46
TN #DMAS-10	10/1/18	Pages 1, 2 Appendix 3, page 2 Page 24a was added back; it was inadvertently removed in a previous transmittal. Page 2a was added as a runover page.
TN #DMAS-9	7/1/18	Page 35-36a, 37-38, 43
TN #DMAS-7	1/1/18	Page 4, 24, 36, 36a, 37, 41, 42 Appendix 1, Page 1.
TN #DMAS-5	7/1/17	Table of Contents Pages 13, 35, 41-44 Page 43a was renumbered. Pages 45 and 46 were added as runover pages.
TN #DMAS-3	1/1/17	Pages 30, 40-42, 44
TN #DMAS-1	6/1/16	Pages 13, 15, 35 Pages 14 and 16 are runover pages.
TN #100	5/1/15	Table of Contents Pages 17-19, 36, 37 Page 35 is a runover page.
TN #99	1/1/14	Page 7, 10, 21
UP #7	6/1/12	Table of Contents Pages 37-43 Page 43a was added.
TN #96	10/1/11	Table of Contents Pages 4-8 Pages 15, 16, 25, 26 Pages 31-38 Page 31a removed.
TN #95	3/1/11	Pages 4, 24, 32, 36, 37, 37a, Pages 39, 42, 43
TN #94	9/1/10	Table of Contents Pages 36-37a, 39-44
TN #93	1/1/10	Table of Contents Pages 3, 17-18, 29 Appendix 2, page 1
TN #91	5/15/09	Pages 41, 42

M1450.820 PROVIDER NOTICE

A. Introduction

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

B. Medicaid LTC Communication Form (DMAS-225)

The DMAS-225 should include:

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

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

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

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

M1450.830 DMAS NOTICE

A. Introduction

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

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

B. Copy of DMAS-225

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

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

M1470 Changes
Page 1 of 2

Changed With	Effective Date	Pages Changed
TN #DMAS-17	7/1/20	Table of Contents, page ii Pages 1, 14, 28a, 47, 48, 50, 55 Appendix 1, page 1
TN #DMAS-15	1/1/20	Pages 19, 20
TN #DMAS-14	10/1/19	Table of Contents, page i Pages 1, 14, 28a, 31, 32, 43, 47, 48, 50 Appendix 1, page 2 Page 14a was added as a runover page.

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

APPENDIX

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

M1470.001 OVERVIEW

A. Introduction

"Patient pay" is the amount of the long-term care (LTC) patient's income which must be paid as his share of the LTC services cost. This subchapter provides basic rules regarding the post-eligibility determination of the amount of the LTC patient's income which must be paid toward the cost of his care. **MAGI Adults have no responsibility for patient pay.** If an individual receiving LTC, also called long-term supports and services (LTSS), loses eligibility in the MAGI Adults covered group and is eligible in another full coverage group, patient pay policy will apply.

B. Policy

The state's Medicaid program must reduce its payment to the LTC provider by the amount of the eligible patient's monthly income, after allowable deductions. Patient pay is calculated after an individual has been determined eligible for Medicaid and for Medicaid LTC services. A Medicaid recipient who is admitted to a nursing facility, facility for individuals with intellectual disability (ICF-ID) or Medicaid waiver services for less than 30 days must have a patient pay determined for the month(s) in which the recipient is in the facility or waiver services**.** The provider collects the patient pay from the patient or his authorized representative. Patient pay information is fed to the Automated Response System (ARS) and the MediCall Systems for provider verification of patient pay. These systems report the amount of patient pay and the date of service to the provider responsible for collecting patient pay.

C. VaCMS Patient Pay Process

The patient pay calculation is completed in VaCMS. Refer to the VaCMS Help feature for information regarding data entry. The patient pay must be updated in the system whenever the patient pay changes, but at least once every 12 months. If VaCMS is not able to process required transactions, a Patient Pay Correction form (DMAS 9PP), available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, should be submitted to patientpay@dmas.virginia.gov.

D. Patient Notification

The patient or the authorized representative is notified of the patient pay amount on the Notice of *Patient Pay Responsibility*. VaCMS will generate and send the Notice of *Patient Pay Responsibility*. M1470, Appendix 1 contains a sample Notice of *Patient Pay Responsibility* generated by VaCMS. DMAS will generate and mail a Notice of *Patient Pay Responsibility* for any changes input directly into MMIS.

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

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

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

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

1) If approved, adjust the patient pay using the VaCMS Patient Pay process.

2) If the adjustment request is denied, DMAS prepares the notification.

b. DMAS Approval Not Required

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

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

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

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

c. Notice Procedures

Upon the final decision to allow the deduction, use the VaCMS Patient Pay process to adjust the patient pay. VaCMS will generate and send the Notice of *Patient Pay Responsibility*.

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

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

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

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

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

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

b. Notice Procedures

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

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

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

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

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

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

b) Send a Notice of Action, available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, informing the patient of the referral to DMAS for collection of the underpayment.

2) Prospective months' patient pay

VaCMS will automatically generate and send a Notice of *Patient Pay Responsibility* to the patient or the patient's representative for the month following the month in which the 10-day advance notice period ends.

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

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

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

M1470.910 RETROACTIVE ADJUSTMENTS FOR PRIOR MONTHS

A. Retroactive Adjustment

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

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

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

B. Notification Requirements

VaCMS automatically generates and sends the Notice of *Patient Pay Responsibility*. DMAS will generate and mail a Notice of *Patient Pay Responsibility* for any changes input directly into MMIS.

M1470.920 LTC PROVIDER CHANGE WITHIN A MONTH

A. Policy

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

M1470.930 DEATH OR DISCHARGE FROM LTC

A. Policy

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

B. Procedure

Refer to the VaCMS Help feature for procedures regarding death or discharge from LTC. Send a DMAS-225 to the provider regarding the eligibility status of the patient. Send a notice to the patient or the patient's representative that reflects the reduction or termination of services. If VaCMS is not able to process required transactions or additional correction is needed, submit a Patient Pay Correction form (DMAS 9PP), available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, to patientpay@dmas.virginia.gov. DMAS will generate and mail a Notice of *Patient Pay Responsibility* for any changes input directly into MMIS.

M1470.1000 LUMP SUM PAYMENTS

A. Policy

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

B. Lump Sum Defined

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

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

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

M1470.1010 LUMP SUM REPORTED IN RECEIPT MONTH

A. Lump Sum Available

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

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

B. Lump Sum Not Available

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

His patient pay for April and subsequent months is calculated:

$500	SS
+ 100	VA Compensation
$600	total gross income
- 40	personal needs allowance
$560	patient pay for April and subsequent months

M1470.1200 INCORRECT PAYMENTS TO PROVIDER

A. Introduction

There may be instances when the amount of patient pay collected by an LTC provider is less than the amount determined available for payment. This situation is most likely to occur when some other person is the payee for the patient's benefits.

B. Procedures

This section provides policy and procedures used to determine patient pay when the provider collects less than the patient pay amount. Patient pay can be adjusted according to whether certain criteria, specified in sections M1470.1210 and M1470.1220 below, are met.

M1470.1210 ADJUSTMENTS NOT ALLOWED

A. Policy

The facility or CBC provider is responsible to collect the patient pay from the patient or the person handling the patient's funds. When the provider is not successful in collecting the patient pay, the EW **cannot** adjust the patient pay.

B. Do Not Adjust Patient Pay

The patient pay reported in ARS/MediCall is considered available by Medicaid. Do not adjust the patient pay when:

1. the patient directly receives his benefits and is considered to be competent but does not meet his patient pay responsibility; or

2. the amount of patient pay in question is from the patient's own funds which have been withheld by a payee or other individual receiving the patient's funds and have not been paid toward the cost of the patient's care, as specified by policy in this chapter and by the Notice of *Patient Pay Responsibility* sent to the individual.

Should the situation indicate that a change in payee is necessary, contact the program which is the source of the benefit payment and recommend a change. Additionally, be alert to situations that may require a referral to Adult Protective Services for an evaluation of exploitation.

C. Entitlement Benefits Adjustment

For an ongoing case, if benefits from entitlement programs (such as Social Security) are not received because the program is holding the check(s) for some reason, but the benefits will be paid some time in the future in a lump sum, do not adjust the patient pay for the months the benefits are not received.

When the lump sum payment is received, do **not** count the lump sum payment and do **not** follow instructions for lump sum payments as found in this subchapter because the patient must use the lump sum to pay the previous months' remaining patient pay amounts the patient still owes to the provider.

Sample Notice of *Patient Pay Responsibility* from VaCMS

COMMONWEAL TH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

NOTICE OF PATIENT PAY RESPONSIBILITY

TO:

Recipient Name:

Recipient ID:

This form serves as your notice of patient pay, which is the amount of your income that must be paid to the provider every month for the cost of long-term care services you receive. The long-term care provider who is responsible for collection of any portion of your patient pay will directly bill you or your representative. A portion of patient pay may be paid to more than one provider when services are received from multiple providers. If you currently receive Medicaid long-term care services, this will serve as the 10-day advance notice when your patient pay amount is increased. Please contact your local worker if you have questions.

PATIENT PAY CALCULATIONS

Effective Date of Patient Pay (Month and Year):

Reason

Income
Social Security
Other Unearned Income
Total Earned Income
Total Gross Income
Minus Spenddown Liability (SDL)
Remaining Income

Allowances Deducted from Income Personal/Maintenance Needs Spousal
Child/Family Member
Non-covered Medical Expenses Home Maintenance
Income Remaining after Allowances

Spenddown Liability Contribution Income Medicaid Rate for Month
Patient Pay

DATE OF ACTION/NOTICE AGENCY REPRESENTATIVE TELEPHONE NUMBER

M1480 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-17	7/1/20	Pages 8b, 9, 14, 66, 77, 92
TN #DMAS-15	1/1/20	Pages 1, 7, 18c, 66, 69, 70 Page 2 is a runover page.
TN #DMAS-14	10/1/19	Pages 8a, 8b, 12, 15, 16, 18, 20, 21, 30, 32, 51
TN #DMAS-13	7/1/19	Page 66
TN #DMAS-11	1/1/19	Pages 2, 7, 8, 18c, 66, 69, 70
TN #DMAS-7	1/1/18	Pages 18c, 66
TN #DMAS-11	1/1/19	Page 2
TN #DMAS-6	10/1/17	Table of Contents, page i Pages 2, 50, 50a, 52, 52a, 55, 57, 59, 63, 66, 76, 79, 80, 82, 84, 86, 88, 89
TN #DMAS-5	7/1/17	Pages 66, 69, 70, 92
TN #DMAS-3	1/1/17	Pages 7, 9, 18, 18b, 18c, 20 Pages 47, 51, 66, 67, 77
TN #DMAS-2	10/1/16	Pages 66, 72
TN #DMAS-1	6/1/16	Pages 7, 11, 14, 18, 18c, 30, 66, 69, 70, 92, 93
UP #11	7/1/15	Page 18c
TN #100	5/1/15	Pages 7, 16, 18, 18a, 18c, 65, 66 Pages 8, 15, 17 and 18b are reprinted.
TN #99	1/1/14	Pages 7, 18c, 66, 69, 70
TN #98	10/1/13	Page 66
UP #9	4/1/13	Pages 7, 18c, 66, 69, 70
UP #8	10/1/12	Page 66
TN #97	9/1/12	Pages 3, 6, 8b, 16 Pages 20-25 Page 20a was deleted.
UP #7	7/1/12	Pages 11, 14, 18c, 21 Pages 32, 66, 67, 69
UP #6	4/1/12	Pages 7, 18c, 66, 68, 69, 70
TN #96	10/1/11	Pages 7, 14, 66, 71
UP #5	7/1/11	Page 66
TN #95	3/1/11	Pages 7-9, 13, 18a, 18c, 66, Pages 69, 70
TN #94	9/1/10	Pages 64, 66, 69, 70
TN #93	1/1/10	Table of Contents, page ii Pages 3, 8b, 18, 18c, 20a Pages 21, 50, 51, 66, Pages 69, 70, 93 Appendix 4 was removed.
Update (UP) #1	7/1/09	Page 66
TN # 91	5/15/09	Pages 67, 68 Pages 76-93

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

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

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

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

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

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

c. Both Spouses Request Medicaid CBC

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

C. Responsible Local Agency

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

M1480.210 RESOURCE ASSESSMENT WITHOUT A MEDICAID APPLICATION

A. Introduction

This section applies only to married individuals with community spouses who are inpatients in medical institutions or nursing facilities and who have NOT applied for Medicaid.

B. Policy

1. Resource Evaluation

For the purposes of the resource assessment and spousal share calculation, countable and excluded resources are determined for all covered groups using the ABD resource policy found in Chapter S11 **regardless of the individual's covered group and regardless of community property laws or division of marital property laws**, except for the following resources which are excluded as indicated below when completing the resource assessment and spousal share [1924(c)(5)]:

- the home and all contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SS & SSI payments received on or after 11/01/05 for nine (9) calendar months following the month in which the individual receives the benefits; and
- up to **$1,500** of burial funds for each spouse (NOT $3,500), if there are designated burial funds.

Resources owned in the name of one or both spouses are considered available regardless of whether either spouse agrees to sell or liquidate the resource and regardless of whether either spouse refuses to make the resource available.

If either or both spouses own more than one home, the home in which the institutionalized spouse last resided prior to institutionalization is excluded. Any other home(s) owned by either or both spouse is counted.

The resource assessment is not affected by the amount disregarded in the eligibility determination as a result of an LTC Partnership Policy (Partnership Policy).

2. No Appeal Rights

When a resource assessment is requested and completed **without** a concurrent Medicaid application, it cannot be appealed pursuant to the existing Virginia Client Appeals regulations (VR 460-04-8.7). The spousal share determination may be appealed when a Medicaid application is filed.

Resources owned in the name of one or both spouses are considered available regardless of whether either spouse agrees to sell or liquidate the resource, and regardless of whether either spouse refuses to make the resource available.

If either or both spouses own more than one home, the home in which the institutionalized spouse resides or last resided prior to institutionalization is excluded. Any other home(s) owned by either or both spouse are counted.

The resource assessment is not affected by the amount disregarded in the eligibility determination as a result of a Partnership Policy.

C. Appeal Rights

When the resource assessment is completed as part of a Medicaid application and eligibility determination, the spousal share calculation can be appealed pursuant to the existing Client Appeals regulations (VR 460-04-8.7).

D. Eligibility Worker Responsibility

Each application for Medicaid for a person receiving *LTSS* services who has a community spouse requires the completion of a resource assessment to determine the spousal share used in determining eligibility.

The EW must provide the applicant with a written request for verification of:

- all reported countable resources owned by the couple **on the first moment of the first day of the first month (FOM)** of the first continuous period of institutionalization. Request this information using the Medicaid Resource Assessment form (#032-03-816) when the FOM is prior to the application's retroactive period.
- all reported countable resources owned by the couple on the first moment of the first day of the month of application, and
- all reported countable resources owned by the couple as of the first moment of the first day of each retroactive month for which eligibility is being determined.

To expedite the application processing, the EW may include a copy of the "Intent to Transfer Assets to A Community Spouse" form, available on *the VDSS intranet* with the request for verifications.

The same verification requirements as for all Medicaid applications apply to the resource assessment.

If the applicant reports to the EW that he cannot obtain certain verifications, the EW must determine why he cannot obtain them and what the EW can do to assist the applicant.

E. Procedures

The resource assessment is only a part of the eligibility determination process. The spousal share is calculated as a result of the resource assessment. The spousal share is used in the calculation of the spousal protected resource amount (PRA) and the institutionalized spouse's countable resources.

1. Forms

The applicant or his representative does not complete a Medicaid Resource Assessment Request form. The Medicaid application is the resource assessment request. The resource assessment will be calculated in VaCMS as part of the eligibility determination process.

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

M1480.400 PATIENT PAY

Introduction

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

B. Married With Institutionalized Spouse in a Facility

For a married long-term services and support (LTSS) patient with an institutionalized spouse in a facility, **NO** amount of the patient's income is deducted for the spouse's needs in the patient pay calculation.

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

Introduction

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

B. Monthly Maintenance Needs Allowance	\$2,113.75	7-1-19	
	$2,155.00	*7-1-20*	
C. Maximum Monthly Maintenance Needs Allowance	\$3,160.50	1-1-19	
	\$3,216.00	1-1-20	
D. Excess Shelter Standard	\$634.13	7-1-19	
	$646.50	*7-1-20*	
E. Utility Standard Deduction (SNAP)	\$311.00	1 - 3 household members	10-1-18
	\$387.00	4 or more household members	10-1-18
	\$303.00	1 - 3 household members	10-1-19
	\$379.00	4 or more household members	10-1-19

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

M1480.420 PATIENT PAY FOR ABD 80% FPL AND 300% SSI INSTITUTIONALIZED SPOUSE

A. Policy

After a 300% SSI or ABD 80% FPL institutionalized spouse has been found eligible for Medicaid, determine his patient pay (post-eligibility treatment of income).

Her patient pay for August is calculated as follows:

$1,000.00	SS
+ 400.00	private pension
1,400.00	total gross income
- 30.00	PNA (personal needs allowance)
- 106.25	community spouse monthly income allowance
- 468.75	family member's monthly income allowance
795.00	
- 120.50	Medicare premium & health insurance premium
$ 674.50	remaining income for patient pay (August)

Mrs. Bay's patient pay for September is calculated as follows:

$1,000.00	SS
+ 400.00	private pension
1,400.00	total gross income
- 30.00	PNA (personal needs allowance)
- 106.25	community spouse monthly income allowance
- 468.75	family member's monthly income allowance
795.00	
- 75.00	health insurance premium
$ 720.00	remaining income for patient pay (September)

The worker completes the VaCMS Patient Pay process for July, August and September. VaCMS generates and sends a "Notice of *Patient Pay Responsibility*" to Mr. Bay showing Mrs. Bay's patient pay for July, August and September and each month's patient pay calculation.

M1480.440 MEDICALLY NEEDY PATIENT PAY

A. Policy

When an institutionalized spouse has income exceeding 300% of the SSI payment level for one person, he is classified as medically needy (MN) for income eligibility determination. Because the 300% SSI income limit is higher than the MN income limits, an institutionalized spouse whose income exceeds the 300% SSI limit will be on a spenddown. He must meet the spenddown liability to be eligible for Medicaid as MN. See sections M1480.330, 340 and 350 above to determine countable income, the spenddown liability, and to determine when an institutionalized spouse's spenddown is met.

Section 1924 (d) of the Social Security Act contains rules which protect portions of an institutionalized spouse's income from being used to pay for the cost of institutional care. Protection of this income is intended to avoid the impoverishment of a community spouse. In order to insure that an institutionalized spouse will have enough income for his personal needs or maintenance allowance, the community spouse income allowance and the family members' income allowance, an institutionalized spouse who meets a spenddown is granted a full month's eligibility. The spenddown

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

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

The result is the remaining income for patient pay.

2. Patient Pay

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

M1480.500 NOTICES AND APPEALS

M1480.510 NOTIFICATION

A. Notification

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

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

B. Forms to Use

1. Notice of Action on Medicaid

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

2. Notice of *Patient Pay Responsibility*

The "Notice of *Patient Pay Responsibility*" notifies the patient of the amount of patient pay responsibility. The form is generated and sent by the enrollment system when the patient pay is used entered or changed.

3. Medicaid *LTSS* Communi-cation Form (DMAS-225)

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

M1510 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-17	7/1/20	Page 15
TN #DMAS-16	4/1/20	Pages 5, 6, 12, 13 Pages 14 and 15 are runover pages.
TN #DMAS-14	10/1/19	Pages 2b, 4, 5-7
TN #DMAS-12	4/1/19	Pages 7, 9a. Page 7a is a runover page.
TN #DMAS-11	1/1/19	Page 7
TN #DMAS-10	10/1/18	Pages 7, 8a, 9a, 14 Pages 8b and 8c are runover pages.
TN #DMAS-9	7/1/18	Table of Contents Page 5. Page 9a was added.
TN #DMAS-8	4/1/18	Pages 2, 8a, 8b Page 8c was added.
TN #DMAS-6	10/1/17	Table of Contents Pages 1, 2 Page 2a is a runover page. Page 2b was added as a runover page.
TN #DMAS-5	7/1/17	Page 1 Page 2 is a runover page.
TN #DMAS-4	4/1/17	Pages 2a, 10
TN #DMAS-2	1/1/17	Table of Contents Pages 1, 8, 8a, 12-15 Page 11a was deleted.
TN #DMAS-2	10/1/16	On pages 3-15, corrected the subchapter number in the headers. Neither the dates nor the policies were changed.
TN #DMAS-1	6/1/16	Pages 2 Pages 1 and 2a are runover pages.
TN #100	5/1/15	Table of Contents Pages 1-2a, 5-8b
UP #10	5/1/14	Table of Contents Pages 7-8a Page 8b was added.
TN #99	1/1/14	Table of Contents Pages 1, 2, 8, 8a, 9-11 Page 11a was added.
UP #9	4/1/13	Pages 2-7, 10-12, 14
UP #7	7/1/12	Pages 8, 9
TN #96	10/01/11	Pages 8a, 10
TN #95	3/1/11	Table of Contents Pages 8, 11-15
TN #94	9/1/10	Pages 2a, 8-8a
TN #93	1/1/10	Page 6
Update (UP) #2	8/24/09	Page 11
TN #91	5/15/09	Page 14

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

Examples of other third parties include liability insurance settlements, trust funds established for the recipient's medical care, awards resulting from liability lawsuits, and persons ordered by the court to pay for the recipient's medical care.

E. Pursuing Third Party Liability and Medical Support

In order to continue to be eligible for Medicaid, an individual who is required to assign rights to, and cooperate in, pursuing medical support and third party liability must continue to cooperate with the local agency and DMAS. See subchapter M0250 for details.

M1510.302 SOCIAL SECURITY NUMBERS

A. Policy

Applicants must provide the Social Security number (SSN) of any person for whom they request Medicaid, or must apply for a Social Security number if he/she does not have one.

Exceptions – the SSN requirement does not apply to:

- an alien who is eligible only for Medicaid payment of emergency services, as defined in subchapter M0220, or
- a non-citizen who is only eligible to receive an SSN for a valid non-work reason, or
- a child under age one born to a Medicaid-eligible or FAMIS-covered mother (see M0330.301 B. 2 and M2220.100).

An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

When an individual has applied for an SSN and is determined eligible for medical assistance, the worker must take follow-up action to obtain the individual's SSN.

B. Procedures

See subchapter M0240 for the SSN application follow-up procedures required after enrolling an eligible individual who has applied for an SSN.

M1510.303 PATIENT PAY INFORMATION

A. Policy

After an individual in long-term care is found eligible for Medicaid, the recipient's patient pay must be determined. When the patient pay amount is initially established or when it is changed, the worker enters the information in VaCMS. VaCMS sends the Notice of *Patient Pay Responsibility* to the enrollee or the enrollee's authorized representative.

B. Procedure

When patient pay increases, the Notice of *Patient Pay Responsibility* is sent in advance of the date the new amount is effective.

Changed With	Effective Date	Pages Changed
TN #DMAS-17	7/1/20	Pages 2, 4, 25, 30 Page 3 is a runover page.
TN #DMAS-16	4/1/20	Pages 3, 4, 7, 9 Appendix 2 Pages 3a and 4 were renumbered to pages 4 and 4a. Page 4a is a runover page.
TN #DMAS-15	1/1/20	Pages 8, 8a
TN #DMAS-14	10/1/19	Pages 2, 3, 4, 6a, 8, 9, 10, 13 Page 4a is a runover page. Page 10a was added as a runover page. Page 7a was deleted.
TN #DMAS-13	7/1/19	Page 14
TN #DMAS-12	4/1/19	Table of Contents Pages 2, 5, 6, 6a, 7, 8, 8a, 11, 12, 15-18, 20 Appendix 2 Page 24a was added. Pages, 19, 21-24, 25 are runover pages.
TN #DMAS-11	1/1/19	Pages 2, 5, 6, 7, 9
TN #DMAS-8	4/1/18	Pages 2, 18 Appendix 2
TN #DMAS-7	1/1/18	Pages 2, 3, 3a, 5, 6, 7 Pages 6a and 7a are runover pages.
TN #DMAS-5	7/1/17	Pages 1, 2, 6, 8 Pages 3, 7, 7a and 9 are runover pages.
TN #DMAS-4	4/1/17	Pages 25-27 Appendix 2, page 1 Pages 28-30 were added.
TN #DMAS-3	1/1/17	Pages 1, 2, 4, 6, 7, 8, 14, 26
TN #DMAS-2	10/1/16	Pages 1, 3, 6, 8, 12, 14, 15 Pages 19-24
TN #DMAS-1	6/1/16	Pages 3, 6, 7, 9, 11-14, 17 Appendix 2, page 1 Pages 3a and 7a were added. Page 8 is a runover page.

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

M1520.100 PARTIAL REVIEW

A. Enrollee's Responsibility

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

B. Eligibility Worker's Responsibility

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

Appropriate agency action on a reported change must be taken within 30 days of the report. If the enrollee reports any changes requiring verifications, such as changes in income or resources, or an asset transfer for enrollees receiving long-term services and supports (LTSS), if possible, use available online systems information to verify the reported change. If the online-information is compatible with the reported *change*, determine eligibility based upon the information available.

If verifications must be obtained from the enrollee, send him a verification checklist, and allow at least 10 calendar days for the information to be returned. If information is not provided by the deadline and continued eligibility cannot be determined, send advance notice to the enrollee/ authorized representative informing him of the cancellation date and the reason. Document the information and evaluation in the VaCMS case record.

1. Changes That Require Partial Review of Eligibility

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

The following changes must be verified:

- A decrease in income or termination of employment *that causes the individual to move from limited Medicaid coverage to full Medicaid coverage,*
- *An increase in income that causes the individual to move from Medicaid to FAMIS, or to need a Medically Needy spenddown calculation.*

If a reported change is not compatible with information obtained from online system searches, obtain verification from enrollee or authorized representative.

The agency may not deny *an increase in benefits*, terminate *coverage*, or reduce benefits for any individual unless the agency has sought additional information from the individual and provided proper notification.

2. Changes That Do Not Require Partial Review

Document changes in an enrollee's situation, *such as the receipt of the* enrollee's Social Security number (SSN), that do not require a partial review in the case record and take action any necessary action on the enrollee's coverage.

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

3. HIPP

The eligibility worker must provide the enrollee with a copy of the HIPP FACT Sheet when it is reported that he or a family member is employed more than 30 hours per week and is eligible for coverage under an employer's group health plan. The HIPP Fact Sheet is available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/References.

The eligibility worker must report to the HIPP Unit at DMAS any changes in an enrollee's situation that may affect the premium payment. The worker may report changes by e-mail to hipp@dmas.virginia.gov. This e-mail address is for use by the local agency staff only. See M0130.200 G for additional information about HIPP requirements.

3. Program Integrity

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

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

C. Covered Group and Aid Category Changes

1. Enrollee's Situation Changes

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

- a pregnant woman reaches the end of her post-partum period (the month in which the 60th day after the end of the pregnancy occurs),
- an infant who has been enrolled as a Newborn Child reaches age one year,
- a Families & Children (F&C) enrollee becomes entitled to SSI,
- an SSI Medicaid enrollee becomes a Qualified Severely Impaired Individual (QSII) (1619(b),
- an individual enrolled in a Modified Adjusted Gross Income (MAGI) Adults aid category turns 65 years old, or becomes entitled for/begins receiving Medicare.

***2.* Enrollee in Limited Coverage Becomes Entitled to Full Coverage**

When an individual who has been enrolled in limited coverage, such as Plan First, experiences a change, such as pregnancy, that results in eligibility for full coverage, the individual's entitlement to full coverage begins the month the individual is first eligible for full coverage, regardless of when or how the agency learns of the change. If change in income is reported, the agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family.

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

3. **Enrollee Turns Age 6**

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

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

4. **MAGI Adult Becomes Entitled to Medicare**

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

Example: Ms. C is a 48 year old disabled adult enrolled as a MAGI Adult. She reports to the agency being approved for Medicare beginning June 2019. The worker sends advance notice to cancel the MAGI Adults coverage effective June 30. QMB coverage begins effective July 1, 2019. Ms. C also has resources under the Medically Needy resource limit and is therefore placed on a spenddown per M1370.100.

5. ***Enrollee Reports Pregnancy***

Dental services are covered for pregnant women. *If a woman enrolled in a full benefit covered group reports a pregnancy, complete a pregnancy screen to document her estimated delivery date in VaCMS and confirm that the information transmitted to MMIS.*

If a woman enrolled in a limited benefit covered group reports a pregnancy, follow the procedures in M1520.100 C.2 above.

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.

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.

M1550 Transmittal Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-17	7/1/20	Table of contents Pages 1, 2 Appendix 1, page 1 Pages 3-9 and Appendix 1, page 2 were deleted.
TN #DMAS-16	4/1/20	Page 2 Appendix 1, page 1
TN #DMAS-14	10/1/19	Appendix 1, page 1 Appendix 1, page 2 was added.
TN #DMAS-8	4/1/18	Page 3
TN #DMAS-7	1/1/18	Page 1 Appendix 1, page 1
TN #DMAS-4	4/1/17	Appendix 1,page 1
TN #DMAS-3	1/1/17	Pages 4-6, 8, 9
TN #100	5/1/15	Appendix 1,page 1
UP #9	4/1/13	Appendix 1, page 1
Update (UP) #7	7/1/12	Appendix 1, page 1
TN #96	10/1/11	Appendix 1, page 1
TN #93	1/1/10	Title page Table of Contents Pages 1-9 Appendix 1, page 1
TN #91	5/15/09	Appendix 1

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M1550.000 DBHDS FACILITIES

M1550.100 GENERAL PRINCIPLES

A. ***Introduction***

This subchapter contains a list and a brief description of the DBHDS facilities (M1550.200).

Prior to July 1, 2020, the Virginia Department of Social Services (VDSS) *had* eligibility workers, called Medicaid Technicians, located in Department of Behavioral Health and Developmental Services (DBHDS) facilities to determine the patients' eligibility for Medicaid. *On July 1, 2020, VDSS suspended operations of the Medicaid Technicians.*

Effective July 1, 2020, local DSS will process applications submitted by patients of DBHDS facilities and maintain cases for enrolled individuals who reside in DBHDS facilities.

M1550.200 DBHDS FACILITIES

A. Introduction

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

1. Training Centers

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

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

The State training centers and locations are:

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

2. Psychiatric Hospitals

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

Patients in psychiatric hospitals may be Medicaid eligible only if they are

- under age 21 years (if treatment began before age 21 and continues, they may be eligible up to age 22), or
- age 65 years or older,

and they meet all non-financial and financial Medicaid eligibility requirements.

The following are psychiatric hospitals, offering differing levels of care:

a. Eastern State Hospital – Williamsburg
b. Central State Hospital – Petersburg
c. Western State Hospital – Staunton
d. Northern Virginia Mental Health Institute – Falls Church
e. Southern Virginia Mental Health Institute – Danville
f. Southwestern Virginia Mental Health Institute – Marion
g. Piedmont Geriatric Hospital – Burkeville
h. Catawba Hospital – Catawba
i. Commonwealth Center for Children and Adolescents (CCCA) – Staunton (formerly Dejarnette Center)

   CCCA is a psychiatric hospital for adolescents between the ages of 4 and 18. Children are provided schooling, counseling and medication. Most children have not been determined disabled. A child in CCCA can be Medicaid-eligible if the child meets all nonfinancial and financial Medicaid eligibility requirements.

2. General Hospital

General hospitals are medical facilities which provide care and services to acutely physically ill patients in the DBHDS facilities. The general hospitals may have patients of any age. There are general hospital acute care units within Eastern State and Western State Hospitals, and the Hiram Davis Medical Center general hospital located on the campus of Central State Hospital in Petersburg. Hiram Davis provides medical and surgical treatment for patients from any DBHDS facility. Hiram Davis also has some beds certified for nursing facility level of care.

Patients in the general hospitals may be Medicaid eligible if they meet all non-financial and financial Medicaid eligibility requirements.

DBHDS FACILITIES

STATE HOSPITAL FACILITIES

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

*****These facilities no longer have Medicaid patients.

DBHDS FACILITIES
PSYCHIATRIC HOSPITALS

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

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