COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

JENNIFER S. LEE, M.D.
DIRECTOR

SUITE 1300
600 EAST BROAD
STREET RICHMOND,
VA 23219
804/786/7933
800/343-0634 (TDD)
www.dmas.virginia.gov

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Virginia Medical Assistance Eligibility Manual
Transmittal #DMAS-12

- BCCTA-Breast and Cervical Treatment Act
- CCC- Commonwealth Coordinated Care
- FPL – Federal Poverty Level
- GAP- Governor's Access Plan
- MAGI—Modified Adjusted Gross Income
- TN – Transmittal

TN #DMAS-12 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 April 1 2019.

The following changes are contained in TN #DMAS-12:

Changed Pages	Changes
Subchapter M0110 Table of Contents Pages 1, 2, 9 Page 2a is a runover page.	Updated the Table of Contents. On page1, added statement that local agency must establish office procedures and operations that accommodate the needs of the population it serves and provide bilingual staff and interpreter services to households with limited English proficiency. On page 2, added a reference to the Cover Virginia Incarcerated Unit and DSS/Cover Virginia processes. On page 9, added the definition of incarcerated individual.
Subchapter M0120 Pages 2, 12-13, 15, 20a	On page 2, clarified the mailing address for offender applications. On page 12, clarified where applications may be accepted. On page 13, clarified what physical address is used for an offender's application. On page 15 clarified the mailing address for offender's applications. Page 20a, explained that the GAP Program ends on March 31, 2019 .

Changed Pages	Changes
Subchapter M0220 Pages 20, 21, 23	On page 20, clarified the covered group requirement for emergency services only non-citizens. On pages 21 & 23, added verbiage regarding eligibility worker ability to process certain Emergency Services coverage.
Subchapter M0310 Pages 8, 9, 13	On pages 8, 9, and 13, clarified the requirements for a parent to be considered living in the home with a dependent child.
Subchapter M0320 Pages 21, 22, 25-27	On pages 21 and 22, clarified that the group of Protected SSI Disabled Children is no longer applicable as all affected children are over age 18; however, it remains in federal regulations. On page 25, revised text for clarity. On pages 26 and 27, updated the Medicaid Works resource limit for 2019.
Subchapter M0330 Pages 26, 28	On page 26, added website for BCCPTA screening locations. On page 28, clarified no limitations on the length of time person can be enrolled in BCCPTA covered group.
Chapter M04 Pages 3,5 - 8, 15-16, 19, 32-37 Page 16a was added as a runover page. Appendices 1, 2, 5, 7,	On page 2, added note regarding MAGI Adults LTC procedures in M14. On page 5, clarified the definition of a dependent child. On page 6, added the definition of a tax filing threshold. On page 8, clarified gap-filling rules. On pages 15- 16, clarified countable and non-countable income. On page 19, updated the list of excluded income. On pages 32-36, clarified gap-filling rules and revised the examples. In Appendices 1, 2, 5, and 7, updated the income limits based on the FPL.
Subchapter M0520 Pages 1, 2	Clarified the requirements for a parent to be considered living in the home with a dependent child.
Subchapter M0610 Page 1	Added reference of categorically needy to subchapter M0330.
Subchapter M0810 Page 2	Updated the income limits based on the FPL.
Subchapter M0820 Page 21	Corrected misspelling.
Subchapter M0830 Page 113	Corrected grammatical error
Subchapter M1110 Pages 10-10a	Clarified that the appraised value is valid up to six months prior to application and clarify when the appraised value differs from tax assessed value, the amount which is most beneficial to individual is used.
Subchapter M1130 Page 13	Clarified use of certified appraisal is valid up to six months prior to date of application.
Subchapter M1320 Page 3	Clarified that there is no time limit for when an applicant can submit medical expenses for a spenddown.
Subchapter M1340 Page 2	Added subchapter reference regarding health insurance expenses.
Subchapter M1360 Pages 4, 4a.	On page 4, clarified spend down procedure when individual is incarcerated. On Page 4a, updated example 3 and additional example is added.
Subchapter M1410 Pages 4, 10, 11 Page 4a is a runover page.	On page 4, add clarification an offender in a public institution is not eligible for LTSS while incarcerated. On page 10 & 11, update acronym of LTC to LTSS.
Subchapter M1420 Page 2	Clarified that individuals in non-hospital facilities will be screened by the community-based team in the locality in which the facility is located.

Changed Pages	Changes
Subchapter M1470 Pages 10, 12a, 14, 21, 28b	On page 10 clarified scope of services includes benefits or services provided by MCO. On page 12a, clarified that the majority of LTSS individuals are covered under CCC plus with enhanced benefits packages which may be submitted as patient pay adjustments. On pages 14 and 28b, clarified that the majority of LTSS individuals are covered under CCC plus with enhanced benefits packages which may be submitted as patient pay adjustments. If there are other coverage sources, a request for coverage must be submitted to sources and exhausted prior to DMAS approval of patient pay adjustment. On page 21, clarified that MCO services or benefits are deducted from patient pay.
Subchapter M1510 Pages 7, 9a Page 7a is a runover page.	On page 7, added description of an offender's new application. On page 9a, added bullet to the responsibilities of the DMAS Enrollment unit.
Subchapter M1520 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.	Updated the Table of Contents. On page 2, clarified the procedures for a partial review. On pages 5 and 6, added information about the GAP program ending and rearranged paragraphs for clarity. On Page 6a, inadvertently removed from the manual in a previous transmittal and was replaced in this transmittal with no changes. On pages 7, 8 and 8a, clarified the procedures when no income ($0) is reported at renewal and when it is appropriate to send a paper renewal form. On page 11, clarified the allowable format for a physician's statement. On page 12, clarified the renewal process for incarcerated individuals. On pages 15-18 and 20, clarified the policy and procedures for Extended Medicaid. On page 24a, clarified case transfer procedures. In Appendix 2, updated the income limits.
Chapter M16 Page 7	On page 7, updated the website address for the Agency Appeal Summary form.
Chapter M1800 Pages 3, 5	On page 3, removed Medallion 3.0 and updated the Medallion 4.0 exclusion list. On page 5, updated the list of enrollees excluded from enrollment in CCC Plus and updated list of additional services available to Medicaid Expansion (MAGI Adults) enrollees.
Chapter M21 Appendix 1	Updated the income limits.
Chapter M22 Appendix 1	Updated the income limits.

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,

Karen Kimsey
Chief Deputy Director

Attachment

M0110 Changes

Changed With	Effective Date	Pages Changed
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

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M0110 GENERAL INFORMATION

M0110.000 GENERAL INFORMATION

Appendices

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).

Exception: DSS carries direct responsibility for the determination of eligibility of certain patients in Virginia Department of Behavioral Health and Developmental Services (DBHDS) facilities and for their enrollment in the Medicaid program.

C. Agency Responsibilities

1. DMAS The administrative responsibilities of DMAS are:

- the development of the State Plan to cover eligibility criteria and scope of services, in conformity with federal law and regulation,
- the determination of medical care covered under the State Plan,
- oversight of the Cover Virginia Call Center, the Central Processing Uni (CPU), which handles telephonic applications for MA, *and the Cover Virginia Incarcerated Unit (CVIU).*
- the handling of appeals related to the MA programs,
- the approval of providers authorized to provide medical care and receive payments under the MA programs,
- the processing of claims and making payments to medical providers, and
- the recovery of MA expenditures in appropriate cases. Suspected applicant fraud is a combined responsibility of both DMAS and DSS.

2. DSS The responsibilities of DSS are:

- the determination of continuing eligibility for Medicaid and FAMIS,
- the referral of individuals with inappropriate MA payments to the DMAS Recipient Audit Unit, and
- the referral of certain individuals to the Health Insurance Marketplace.

2. DSS / Cover Virginia *Certain processes are handled at DSS or at Cover Virginia, with general responsibilities that may include:*

- the determination of initial eligibility for Medicaid and FAMIS, including applications referred from the Health Insurance Marketplace,
- the enrollment of eligible persons in the Medicaid or FAMIS programs,
- the maintenance of case records pertaining to the eligibility of MA enrollees for certain populations or aid categories.

M0110.110 Confidentiality

A. **Confidentiality**

MA applicants and recipients are protected by federal and state confidentiality regulations, 42 CFR 431.300 and 12VAC30-20-90. These regulations were established to protect the rights of clients to confidentiality of their information.

B. **Release of Client Information**

Except as otherwise indicated, no person shall obtain, disclose or use, authorize, or permit the use of any client information that is directly or indirectly derived from the records, files or communications of the agency, except for purposes directly connected with the administration of the MA programs, which include but is not limited to:

- establishing eligibility,
- determining the amount of medical assistance,
- providing services for recipients, and
- conducting or assisting in an investigation, prosecution or a civil or criminal proceeding related to the administration of the program.

F. Child means an individual under age 21 years.

G. Competent Individual means an individual who has **not** been judged by a court to be legally incapacitated.

H. Conservator means a person appointed by a court of competent jurisdiction to manage the estate and financial affairs of an incapacitated individual.

I. Family Substitute Representative means a spouse age 18 or older or designated relative age 18 or older who is willing and able to take responsibility for the individual's personal or financial affairs. Designated relatives other than the spouse who may be substitute representatives are, in this preferred order, the individual's child, parent, sibling, grandchild, niece or nephew, aunt or uncle.

J. Guardian means a person appointed by a court of competent jurisdiction to be responsible for the personal affairs of an incapacitated individual, including responsibility for making decisions regarding the person's support, care, health, safety, habilitation, education, and therapeutic treatment, and if not inconsistent with an order of commitment, residence.

K. Incapacitated Individual means an individual who, pursuant to an order of a court of competent jurisdiction, has been found to be incapable of receiving and evaluating information effectively or responding to people, events, or environments to such an extent that the individual lacks the capacity to (1) meet the essential requirements of his health, care, safety, or therapeutic needs without the assistance or protection of a guardian; or (2) manage property or financial affairs or provide for his or her support or the support of his legal dependents without the assistance or protection of a conservator.

L. Legal Emancipation of a Minor means a minor who has been declared emancipated by a court of competent jurisdiction. A married minor is not emancipated unless a court has declared the married minor emancipated from his parents.

M. Incarcerated Individual *means an inmate or offender in a Department of Corrections (DOC), local/regional jail, or Department of Juvenile Justice (DJJ) facility.*

***N*. Medical Assistance** means any program administered by DMAS jointly with the Department of Social Services (DSS) that helps individuals or families pay for medical, dental and related health services. These programs are Medicaid, FAMIS and FAMIS MOMS.

M0110.300 Availability of Information

A. Information Required to be Given to the Applicant

1. Explanation of the Medical Assistance Programs The local agency must furnish the following information in written form, and orally as appropriate, to all applicants and enrollees, and to other individuals upon request:

- the eligibility requirements,
- services covered under the MA programs,

M0120 Changes

Changed With	Effective Date	Pages Changed
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
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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. Individuals in State Facilities

Staff with certain Virginia state agencies may assist individuals who are in state residential facilities in applying *for* medical assistance.

1. Patients in DBHDS Facilities

Patients of any age in the Department of Behavioral Health and Developmental Services (DBHDS) facilities may have applications signed and submitted by DBHDS staff. The DBHDS facilities are listed in subchapter M1550.

2. Incarcerated Individuals

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:_____

____

2. BCCPTA Medicaid Application

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application, form #032-03-384, is used only by individuals screened under the Breast and Cervical Cancer Early Detection Program. **This form is not to be given to applicants by the local departments of social services** (M0120, Appendix 2 is provided for reference purposes only).

3. Replaced Application Forms

The following forms were replaced by the streamlined application forms effective October 1, 2013. While agencies should accept and process any of these forms if they are submitted, additional information, such as tax filing information, may need to be obtained (see M0120.300 B.4 below).

- Application for Benefits (#032-03-824)
- The Application/Redetermination for Medicaid for SSI Recipients (#032-03-091)
- The Medicaid Application/Redetermination for Medically Indigent Pregnant Women (#032-03-040)
- The Health Insurance for Children and Pregnant Women (#FAMIS-1)
- The Application for Adult Medical Assistance form (#032-03-0222)
- The Plan First Application (#DMAS-65E)

4. Renewal Forms Returned After Reconsideration Period

Renewal forms filed after the end of the 90-day reconsideration period are treated as reapplications. Accept the form and request any additional information needed to determine the individual's eligibility. See M1520.200 C for additional information.

5. If Additional Information is Required

Applicants may apply for MA on any valid application form. Regardless of which application form is used, if additional information is required to determine an applicant's eligibility, send the applicant the relevant page(s) of the Cover Virginia Application for Health Coverage & Help Paying Costs, and/or Appendices D or E, as appropriate, along with a checklist asking for the information. Give the applicant at least 10 business days to return the information and any required verifications to the agency.

M0120.400 Place of Application

A. Principle

The place of application *may be* the office of the local social services department serving the locality in which the applicant resides. Verification of locality residence is not required. MA applications are also *accepted online, telephonically through Cover Virginia, or* at designated hospitals and health clinics (Medicaid outstationed sites). If an applicant is homebound and needs assistance with completing the application, the agency, upon request, must arrange to have the application taken where he resides or is a patient.

1. Locality of Residence

Medical assistance applications that are *approved* are sent to the LDSS in the applicant's locality of residence or where the individual last lived outside of an institution.

2. Joint Custody Situations

A child whose residence is divided between two custodial parents living in different localities is considered to reside in the locality in which he attends school. If the child is not enrolled in school, the parents must decide which locality is the child's residence for application/ enrollment purposes.

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).*

B. Institutionalized Individual (Not Incarcerated)

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

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

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

c. Pending Discharge to the Community

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

d. Eligibility Determination and Enrollment

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

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

e. Coverage Begin Date

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

E. Individuals In Virginia Veteran's Care Center

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

F. Incarcerated Individuals and DJJ Supervisees

Inmates of state *(DOC)*, regional and local correctional facilities, and individuals under the age of 21 under the supervision of DJJ (placed in a facility or receiving services from any court services unit or DJJ contractor) may apply for Medicaid. 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.

E. Governor's Access Plan (GAP)

The GAP Program was ended effective March 31, 2019.

The GAP *program covered* uninsured, low-income adults ages 21-64 years with serious mental illness (SMI) who were not eligible for any existing full-benefit MA entitlement program. Eligibility determinations and ongoing case maintenance for eligible individuals *was* handled by dedicated staff in the Cover Virginia GAP unit.

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

The GAP income limit is 95% of the Federal Poverty Level (FPL) plus the 5% FPL disregard as appropriate~~.~~ The AC for GAP coverage is 087.

Changed With	Effective Date	Pages Changed
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
UP #7	7/1/12	Table of Contents Pages 14d, 16-19 Appendix 5 , page 3

Changed With	Effective Date	Pages Changed
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

3. **Assignment of Rights and Pursuit of Support from Absent Parents** — the assignment of rights to medical benefits requirements (M0250);

4. **Application for Other Benefits** — the requirements regarding application for other benefits (M0270);

5. **Institutional Status** — the institutional status requirements (M0280);

6. **Covered Group** — the covered group requirements (chapter M03). *Individuals who are eligible for Medicaid payment of emergency services only must meet a covered group that covers emergency medical services; emergency services are not covered for individuals in Plan First or the Medicare Savings Programs (Qualified Medicare Beneficiaries, Special Low Income Medicare Beneficiaries, Qualified Individuals).*

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)* 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. LDSS 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

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

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

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

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

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

M0220.700 EMERGENCY SERVICES ALIENS ENTITLEMENT & ENROLLMENT

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

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

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

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

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

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

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

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

M0310 Changes
Page 1 of 2

Changed With	Effective Date	Pages Changed
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

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

M0310.107 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.

5. *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.

6. *Child* Living in the Home

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

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

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

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

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

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

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

7. *Parent Living in the Home*

A parent who is absent from the home is considered living with his child in the household if the absence is temporary and the parent 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-12	4/1/19	Pages 21, 22, 25-27
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

ineligibility is excluded when determining the individual's countable income. Calculate income according to the assistance unit policy in chapter M05, including deeming of parent(s)' income when the individual is under age 21 and living with a parent(s). Exclude the amount of the increase which caused SSI ineligibility.

1) Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected individual is eligible for Medicaid in this protected covered group.

   In this situation, the adult disabled child received SSI and SSA concurrently, and lost SSI because of an increase in SSA disabled child's benefits. The amount of the increase that caused SSI ineligibility is excluded. No subsequent increases in the disabled child's benefit are excluded when reviewing the individual's eligibility as a protected adult disabled child. However, if the protected adult disabled child becomes ineligible for Medicaid, evaluate his/her Medicaid eligibility as a protected former SSI recipient using the policy and procedures in Section M0320.201 of this chapter.

2) If countable income exceeds the SSI limit, determine the individual's eligibility in another covered group. If the individual does not meet an F&C MI covered group, is not institutionalized, is not receiving CBC or does not have Medicare Part A, he/she must be evaluated in a medically needy covered group.

D. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

The ACs are:

- 021 for an aged individual;
- 041 for a blind individual;
- 061 for a disabled individual.

M0320.207 PROTECTED SSI DISABLED CHILDREN

A. Introduction

The Balanced Budget Act of 1997 (P.L. #105-33) created a new covered group which protects Medicaid eligibility for disabled children who received SSI, whose SSI is canceled solely because the children do not meet the SSI definition of childhood disability (revised per section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996), and who would be paid SSI but for the change in the childhood disability definition.

Note: The group of Protected SSI Disabled Children is no longer applicable as all affected children are over age 18; however, it remains in federal regulations.

B. Nonfinancial Eligibility Requirements

To be eligible in this protected covered group, the protected SSI disabled child must

- have had his/her SSI canceled solely because he/she does not meet the SSI definition of childhood disability (revised per section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996);
- continue to meet the SSI childhood disability definition and regulations that were in effect prior to the effective date of the change in the disability definition (August 22, 1996); and
- be under age 18 years.

Note: All affected children are now over age 18 years.

1. Disability Determination Referral to Disability Determination Services (DDS)

An SSI disabled child is presumed to meet the childhood disability definition
in effect prior to August 22, 1996, until he/she reaches age 18 years, unless there is an improvement in the child's condition. If the child's condition improves, complete

- DDS Referral Form, available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi
- the Disability Report Child (SSA-3820-BK), available at http://www.socialsecurity.gov/online/ssa-3820.pdf **and**
- a minimum of 3 signed, original Authorization to Disclose Information to the Social Security Administration forms (SSA-827), available at http://www.socialsecurity.gov/online/ssa-827.pdf **or** a form for each medical provider if more than 3. "General Authorization for Medical Information" (form #032-03-311) for each medical practitioner reported by the individual on the report.

Send the report(s) and authorization forms to the DDS.

2. DDS Decision

If the DDS decides that the child continues to meet the childhood disability definition in effect prior to August 22, 1996, the child continues eligible in the protected group of SSI disabled children, provided the child meets the financial eligibility requirements in item C. below.

If the DDS decides that the child no longer meets the childhood disability definition in effect prior to August 22, 1996, the child no longer meets the protected group of SSI disabled children. Determine the child's eligibility in another covered group. If the child is not eligible in any covered group, send an advance notice to the authorized representative and take action to cancel the child's Medicaid coverage.

C. Financial Eligibility Procedures

1. Assistance Unit

Follow the policy and procedures in M0530.

- 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)) 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 no other income but the wages earned while in MEDICAID WORKS. It cannot contain the individual's 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.

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

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

b. Ongoing eligibility

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

2. Resources

a. Initial eligibility determination

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

b. Ongoing eligibility

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

1) For **earnings** accumulated **after** enrollment in MEDICAID WORKS, up to the current 1619(b) income threshold amount will be disregarded if deposited and retained in the WIN Account. The 1619(b) threshold amount *for 2019* is *$36,548*.

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 income limit is ≤ 80% of the FPL (see M0810.002). The income requirements in chapter S08 must be met. Individuals who receive SSI 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 2019)* 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 it 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.

M0330 Changes

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

M0330 Changes

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

M0330.700 BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT (BCCPTA)

A. Policy

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000 (P.L. 106-354) provides for payment of medical services, including long-term care (LTC) (see Chapter M14) for certain women and men with breast cancer or women with cervical cancer

Individuals eligible for the BCCPTA program must be age 18 through 64. They must have been screened and certified as needing treatment for breast or cervical cancer (including pre-cancerous conditions) by a medical provider operating under the Center for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program (BCCEDP) and referred to LDSS for a Medicaid eligibility determination. These individuals must not have creditable health insurance coverage for treatment of breast or cervical cancer.

Virginia's BCCEDP program, Every Woman's Life, is administered by the Virginia Department of Health. *Screening locations can be found at http://www.vdh.virginia.gov/every-womans-life/clients / Information can also be obtained by calling 1-866-395-4968.*

Through an agreement between Virginia and the District of Columbia (D.C.), residents of northern Virginia (the cities of Alexandria, Fairfax, Falls Church, Manassas, Manassas Park and the counties of Arlington, Fairfax, Loudoun and Prince William) are allowed to be screened and diagnosed for breast or cervical cancer and pre-cancerous conditions through the DC Center for Disease Control and Prevention's "Project Wish" program. Individuals who are screened and certified as needing treatment for breast or cervical cancer through Project Wish may be eligible for Virginia Medicaid, provided they meet the requirements of the BCCPTA covered group. These individuals will receive a Virginia BCCPTA application form from the DC providers and will be instructed to submit the application directly to the local department of social services in their home locality.

Individuals diagnosed with cancer by a provider who is not operating under the BCCEDP are not eligible in this covered group.

B. Nonfinancial Eligibility

1. Required Nonfinancial Requirements

BCCPTA individuals must meet the Medicaid nonfinancial requirements in chapte M02.

In addition, BCCPTA individuals must not be eligible for Medicaid under the following mandatory categorically needy covered groups:

Pregnant Women, FAMIS Plus, or SSI recipients covered groups, then determine their eligibility in the BCCPTA covered group.

1. Application Form

This covered group has a special application, BCCPTA Medicaid Application (form #032-03-384), **that must be initiated by a BCCEDP provider**, including those affiliated with Project Wish operating in the District of Columbia. The application includes the BCCEDP certification of the individual's need for treatment and the information needed to determine the nonfinancial eligibility in the BCCPTA covered group. Appendix 7 to subchapter M0120 contains a sample of the BCCPTA Medicaid Application form.

If eligibility in another Medicaid covered group must first be determined, the applicant must be given the appropriate Medicaid application.

2. Application Processing Time Frames

BCCPTA Medicaid applications filed by individuals who do not meet the description of an individual in the LIFC, Pregnant Women, FAMIS Plus, 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, MI Pregnant Women, FAMIS Plus, or SSI recipients covered groups must be processed as soon as possible, but no later than 45 calendar days of the agency's receipt of the signed application.

3. Notices

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

If a decision cannot be made within 10 working days of receipt of the BCCPTA application, the worker must send a "Notice of Action on Medicaid", form #032-03-008, on the 10th day stating why action has not been taken, specifying what information is needed and a deadline for submitting the information.

E. Entitlement

1. Entitlement Begin Date

Eligibility under this covered group is met the beginning of the month the screening is completed if the individual later has a positive diagnosis as a result of the screening and is determined to be in need of treatment for breast and/or cervical cancer.

Eligible BCCPTA individuals are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. *Coverage is to be provided throughout the person's course of treatment, and no limit is placed upon the number of years an eligible person may be covered as long as physician certifies at renewal that treatment for the breast or cervical condition is still required.*

2. Retroactive Entitlement

Retroactive coverage is applicable to this covered group if the individual was screened by a medical provider operating under the BCCEDP and diagnosed as needing treatment for breast or cervical cancer in the retroactive month(s).

M04 Changes

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

- has no resource test (Exception: MAGI Adults requesting coverage of Long Term Care services are subject to certain asset/resource requirements)

1. MAGI Rules

- MAGI has an income disregard equal to 5% of the federal poverty level (FPL) for the Medicaid or FAMIS individual's household size. The disregard is only given if the individual is not eligible for coverage due to excess income. It is applicable to individuals in both full-benefit and limited-benefit covered groups.
- If the individual meets multiple Medicaid covered groups (and/or FAMIS) his gross income is compared first to the income limit of the group with the highest income limit under which the individual could be eligible.
- If the income exceeds the limit, the 5% FPL disregard can be allowed, and the income again is compared to the income limit.
- When considering tax dependents in the tax filer's household, the tax dependent may not necessarily live in the tax filer's home.
- Under MAGI counting rules, an individual may be counted in more than one household but is only evaluated for eligibility in his household.
- Use non-filer rules when the household does not file taxes.
- Use non-filer rules when the applicant is claimed as a tax dependent by someone outside the applicant's household.
- Non-filer rules may be used in multi-generational household.

2. Eligibility Based on MAGI

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

Children under 19

a. Parent/caretaker relatives of children under the age of 18 - Low Income Families With Children (LIFC)

b. Pregnant women

c. Individuals Under Age 21

d. Adults between the ages of 19 and 64 not eligible or enrolled in Medicare (effective January 1,2019)

e. Individuals in Plan First.

3. Eligibility NOT Based on MAGI

MAGI methodology is NOT used for eligibility determinations for:

a. individuals for whom the eligibility worker is not required to make an income determination:

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

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

- individuals eligible for or enrolled in Medicare;

- individuals evaluated as Medically Needy (MN);

5. Special Medical Needs Adoption Assistance Children

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

6. MAGI Adults

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

- Parents and caretaker- relatives with excess income for LIFC

- Disabled individuals not eligible for or entitled to Medicare or individuals alleging disability who have not been determined disabled

- Childless adults ages 19-64

- Incarcerated individuals ages 19-64

- Non-citizens eligible for emergency services only

- Individuals eligible for Long Term Care Services and Support (LTSS) ages 19-64
  Note: See Chapter M14 for LTSS screening requirements.

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

- Individuals pregnant at initial application or redetermination of eligibility

- Individuals under the age of 19 or 65 and over

- Individuals eligible for or enrolled in Medicare Part A or B

1. **Dependent Child** means a child under age 18, or age 18 and a full-time student in a secondary school is *expected is to graduate prior to his 19th birthday*, who lives with his parent or caretaker-relative.

2. **Family** means the tax filer (including married tax filers filing jointly) and all claimed tax dependents.

3. **Family Size** means the number of persons counted as an individual's household. The family size of a pregnant woman's household includes the pregnant woman plus the number of children she is expected to deliver. When determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted as just one person.

4. **Household** A household is determined by tax dependency. Parents, children and siblings are included in the same household. A child claimed by non-custodial parent is evaluated for eligibility in the household in which he is living and is also counted in the family size of the parent claiming him as a dependent. There can be multiple households living in the home.

   This definition is different from the use of the word household in other programs such as the Supplemental Nutrition Assistance Program (SNAP).

5. **MAGI Adult** is an individual between the ages of 19-64 who is not eligible for or enrolled in Medicare and who has income at or below 138% of FPL.

6. **Non-filer Household** means individuals who do not expect to file a Federal tax return and/or do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made. A non-filer household can also be a child who lives in the household with his custodial parent who is claimed on his non-custodial parent's taxes.

7. **Parent** for the purposes of MAGI methodology, means a natural, biological, adoptive, or stepparent. When both the child's parent and stepparent are living in the home with the dependent child, both may be eligible in the LIFC covered group.

8. **Reasonable Compatibility** means the income attested to (declared) by the applicant is within 10% of income information obtained from electronic sources. If the income from both sources meets the 10% requirement, then the attestation is considered verified.

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

   If reasonable compatibility does not exist or income data was not available through the Hub, the income will be labeled unverified. If the system indicates that the income is not verified and the attestation is below the medical assistance income level, verification of income is required.

9. Sibling means a natural, biological, stepsibling or half-sibling.

10. Tax-Dependent means an individual for whom another individual claims a deduction for a personal exemption under section 151 of the Internal Revenue Code of 1986 for a taxable year.

11. Tax-filer Household means individuals who expect to file a Federal tax return and/or who expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made.

12. Tax Filing Threshold *is the minimum amount of income an individual must earn in order to be required to file a federal income tax return. The amount varies depending on the individual's age, marital status and number of dependents. The amount generally changes annually.*

M0430.100 MAGI HOUSEHOLD COMPOSITION

A. Introduction

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

. Included in the MAGI household composition are:

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

B. Household Composition Rules

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

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

1. Tax Filer Household Composition

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

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

2. Tax Dependent Household Composition

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

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

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

Exceptions to the tax household composition rules apply when:

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

3. Non Filer Household Composition

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

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

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

4. Married Couple

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

5. Tax Filer is Under Age 19

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

6. Gap-filling Rule

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

a. *The individual is in a tax filer household* (including those who meet a tax dependent household exception in M0430.100 B.2). APTC methodology does not apply to non-filer households.

b. Current monthly household income, using Medicaid/FAMIS MAGI-based methods is over the applicable *monthly* income limit (including the 5% FPL disregard) for the individual's covered group.

c. The *total* income already received *plus* projected income for the **calendar** year in which eligibility is being determined, using MAGI methods applied by the HIM for the purposes of APTC eligibility, is below 100% FPL (i.e. the lower income threshold for APTC eligibility). See M04, Appendix 1.

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

M0430.200 TAX FILER HOUSEHOLD EXAMPLES

A. Married Parents and Their Tax Dependent Children

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

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

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

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

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.

A. 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 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, 2019, the Tax Filing Threshold for MAGI income counting purposes is $1,050 in unearned income and $12,000 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 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 rule by modifying the divorce agreement. A copy of the modified divorce agreement must be provided to the eligibility worker; otherwise, the alimony or spousal support continues to be countable*.

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)*

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. Effective January 1, 2019, no deduction is allowed for alimony paid. Prior to January 1, 2019, alimony **paid** to a separated or former spouse outside the home is deducted from countable income.

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

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

i. A parsonage allowance is not counted.

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

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

l. Difficulty of care 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 providers home.

m. 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)

3. 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.

B. 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*

Dee's eligibility determination:

Potential covered groups:

Child < Age 19
FAMIS

Monthly Income limits:

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

HH monthly income:

$300 (Jane's gross earnings)

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

M0450.400 GAP-FILLING RULE EVALUATION

A. When to Complete Gap- Filling Evaluation

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

The individual is in a tax filer household (regardless of whether or not a tax dependent exception in M0430.100 B.2 is met). APTC methodology does not apply to non-filer households

- Current monthly household income, using Medicaid/FAMIS MAGI-based methods is over the applicable *monthly* income limit (including the 5% FPL disregard) for the individual's covered group.

- The total of income already received plus projected income for the **calendar** year in which eligibility is being determined, using MAGI methods applied by the HIM for the purposes of APTC eligibility, is below 100% FPL (i.e. the lower income threshold for APTC eligibility). See M04, Appendix 1. *The individual's prior income for the calendar year, or lack of income, is included in the calculation of annual income when determining financial eligibility.*

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

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

B. Non-financial Requirements

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

C. Household Income Calculation

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

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

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

1. Verification of Income

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

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

2. Countable Income

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

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

3. Income Evaluation

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

- First, add together income already received for the year. Do not convert the income.
- Next, calculate the projected income for the remainder of the year based on the current monthly income, unless the individual's income is expected to change (e.g. current employment is terminating).
- Add income already received to projected income to obtain the ***annual*** projected income for the current calendar year.
- *Compare the **annual** projected income to the 100% FPL **annual** income limits for the MAGI household size in M04, Appendix 1.*
- *If the **annual** income is less than or equal to 100% FPL, compare the **annua**l income to the **annual** income limit for the individual's covered group.*
- For the individual to be eligible for Medicaid or FAMIS *as a result of applying the gap-filling rule*, the countable income must be no more than the **annual i**ncome limit for the individual's covered group. The 5% income disregard used for the Medicaid/FAMIS MAGI determination does not apply. See M04 Appendices 2-6 for income limits.

4. Renewals

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

5. Individual Not Eligible Using Gap-filling Methodology

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

D. Example Situation – Coverage Gap and Gap Filling Rule

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

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

Since the child's countable income is under the lower financial threshold for the APTC and he has excess income using non-filer rules, *the child's eligibility must be evaluated using gap-filling rules.*

E. Example – Gap Filling Evaluation *Unmarried Couple and Child in Common*

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

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

The eligibility worker notes that a potential gap-filling situation exists. The worker evaluates Anita's eligibility for Medicaid or FAMIS using the APTC rules. Under the APTC rules, Anita's household consists of Anita (tax dependent) and Maria (tax filer); Tony is not in Anita's household because he does not claim Anita on his taxes. Maria's income from her part time job is *under the APTC* 100% FPL annual income limit *and under the Medicaid annual income limit for a Child Under 19 (143% FPL). Therefore, Anita is eligible for Medicaid under the gap-filling rule.*

The following tables show the household formation and income used.

For the Medicaid/FAMIs evaluation:

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

For the gap-filling evaluation

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

F. *Example – Gap Filling Evaluation— (Using 2019 Income Limits)*

Application dated 7/4//18 by Tom (tax-filer) for his two children Tia (age 8) and Tony (age 10). Household size is 3 (Tom, Tia and Tony) Tom was unemployed from January –June and started a new job in July. Tom earns $1750 bi-weekly. Only one pay was received in July ($940.62). The income is calculated as $1,750 x 2.15 =$3,762.50. The 5% FPL disregard amount of $89 is deducted ($3,762.50- 89=$3,673.50) and income exceeds the monthly FPL limits for FAMIS ($3,555). The worker requests income already received during the current tax year and Tom's employer verifies the following:

January- June	*$0*
July 23	*$940.62*
August – December (projected)	*$18,812.50*
Total Projected Annual Income	*$19,753.12*

The total annual projected income is of $19,753.12 is under the 100% annual FPL for household size 3 ($21,330). The projected annual amount of $19,753.12 is compared to the 143% annual FPL limit for household size of 3 ($30,502) and both children are eligible for Medicaid.

G. Example – Gap Filling Evaluation— Childless Adult (Using 2019 Income Limits)

Lee, age 27, is a tax-filer and applies for Medicaid on June 1. He is attending graduate school and works part-time as a teaching assistant. His income for June is $1,625. The 5% FPL disregard amount of $53 is deducted ($1,625 - $53 =$1,572) and income exceeds the limit for the MAGI Adults covered group for a HH of 1 ($1,436). Lee is not eligible for Medicaid using MAGI methodology.

Lee calls the worker when he receives the denial notice and tells the worker that his income is higher in the summer and less during the remainder of the year. A potential gap-filling situation exists, so the worker requests verification of Lee's income from January through May. He provides his paystubs for January ($710), February ($720), March ($697), April ($752), and May ($715). -His total year to date income is $3,594.

Lee also provides a letter from his employer that states his teaching income for September thru December will be a guaranteed amount of $715 per month. The worker uses a projected amount for September – December of $715 per month, which totals $2,145 .

January - May	*$3594*
June- August	*$4875*
September- December (projected)	*$2145*
Total Projected Annual Income	*$10,614*

The total annual projected income is of $10,614 is under the 100% annual FPL of $12,490 for household size of 1. The projected annual amount of $10,614 is compared to the 133% annual FPL limit for household size of 1 ($16,612, and Lee is eligible for Medicaid.as a MAGI Adult.

5% FPL INCOME DISREGARD AMOUNTS ALL LOCALITIES

EFFECTIVE *1/11/19*

Household Size	Monthly Amount
1	*$53*
2	*71*
3	*89*
4	*108*
5	*126*
6	*145*
7	*163*
8	*181*
Each additional, add	*19*

GAP-FILLING RULE EVALUATION
100% FPL
INCOME LIMITS

EFFECTIVE *1/11/19*

Household size	***Annual (Use for Gap-filling Evaluation)***	**Monthly**
1	*$12,490*	*$1,041*
2	*16,910*	*1,410*
3	*21,330*	*1,778*
4	*25,750*	*2,146*
5	*30,170*	*2,515*
6	*34,590*	*2,883*
7	*39,010*	*3,251*
8	*43,430*	*3,620*
Each additional	*4,420*	*369*

PREGNANT WOMEN
143% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/11//19*

Household Size	***143% FPL Yearly Amount***	**143% FPL Monthly Amount**	**148% FPL (143% FPL + 5% FPL Disregard)**
2*	*$24,182*	*$2,016*	*$2,087*
3	*30,502*	*2,542*	*2,631*
4	*36,823*	*3,069*	*3,177*
5	*43,144*	*3,596*	*3,722*
6	*49,464*	*4,122*	*4,267*
7	*55,785*	*4,649*	*4,812*
8	*62,105*	*5,176*	*5,357*
Each additional, add	*6,321*	*527*	*546*

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

CHILD UNDER AGE 19
143% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/11/19*

# of Persons in House-hold	**109% FPL (for Determining Aid Category)**	**143% FPL**		**148% FPL (143% FPL + 5% FPL Disregard)**
	Monthly Limit	*Annual Limit*	Monthly Limit	Monthly Limit
1	*$1,135*	*$17,861*	*$1,489*	*$1,542*
2	*1,536*	*24,182*	*2,016*	*2,087*
3	*1,938*	*30,502*	*2,542*	*2,631*
4	*2,339*	*36,823*	*3,069*	*3,177*
5	*2,741*	*43,144*	*3,596*	*3,722*
6	*3,142*	*49,464*	*4,122*	*4,267*
7	*3,544*	*55,785*	*4,649*	*4,812*
8	*3,945*	*62,105*	*5,176*	*5,357*
Each add'l, add	*402*	*6,321*	*527*	*546*

PLAN FIRST
200% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/11/19*

Household Size	***200% FPL Yearly Amount***	**200% FPL Monthly Amount**	**205% FPL (200% FPL + 5% FPL Disregard)**
1	*$24,980*	*$2,082*	*$2,135*
2	*33,820*	*2,819*	*2,890*
3	*42,660*	*3,555*	*3,644*
4	*51,500*	*4,292*	*4,400*
5	*60,340*	*5,029*	*5,155*
6	*69,180*	*5,765*	*5,910*
7	*78,020*	*6,502*	*6,665*
8	*86,860*	*7,239*	*7,420*
Each additional, add	*8,840*	*737*	*756*

MAGI ADULTS
133% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE 1/1/19

Household Size	***133% FPL Yearly Amount***	**133% FPL Monthly Amount**	**138% FPL (133% FPL + 5% FPL Disregard)**
1	*$16,612*	*$1,385*	*$1,438*
2	*22,491*	*1,875*	*1,946*
3	*28,369*	*2,365*	*2,454*
4	*34,248*	*2,854*	*2,962*
5	*40,127*	*3,344*	*3,470*
6	*46,005*	*3,834*	*3,979*
7	*51,884*	*4,324*	*4,487*
8	*57,762*	*4,814*	*4,995*
Each additional, add	*5,879*	*$490*	*$509*

TREATMENT OF INCOME FOR FAMILIES & CHILDREN COVERED GROUPS

INCOME	MAGI COVERED GROUPS	MEDICALLY NEEDY; 300% SSI; F&C COVERED GROUPS
Earnings	Counted with no disregards	Counted with appropriate earned income disregards
Social Security Benefits Adult's MAGI household	Benefits received by a parent or stepparent are counted for his eligibility determination, as well as the eligibility determinations of his spouse and children in the home.	Counted if anyone in the Family Unit/Budget Unit receives
Social Security Benefits Child's MAGI household	Benefits received by a child with at least one parent/stepparent in household are not countable unless the child is required to file taxes. When the child is in his own household, benefits are always countable.	Counted if anyone in the Family Unit/Budget Unit receives
Child Support Received	Not counted	Counted – subject to $50 exclusion
Child Support Paid	Not deducted from income	Not deducted from income
Alimony Received	Counted *if received prior to January 1, 2019*	Counted – subject to $50 exclusion if comingled with child support
Alimony Paid	Deducted from income *if paid 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

M0520 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-12	4/1/19	Page 1, 2
TN #DMAS-10	10/1/18	Page 2
TN #DMAS-3	1/1/17	Table of Contents Pages 3, 5-35 Pages 36-38 were removed.
TN #100	5/1/15	Page 2
TN #98	10/1/13	Title Page Table of Contents Pages 1,2,9
UP #7	7/1/12	Table of Contents Pages 2-5
Update (UP) #4	7/1/10	Pages 2, 2a

M0520.000 FAMILIES & CHILDREN (F&C) MEDICALLY NEEDY FAMILY/BUDGET UNIT

M0520.001 OVERVIEW

A. Introduction

This subchapter contains the policy and procedures for determining the assistance unit for certain individual or families who meet an F&C MN covered group. Refer to M0510.001 for information and instructions on when to use the policies in M0520.

For F&C MN and Extended Medicaid, financial eligibility determination purposes, the assistance unit is called the "family" unit. A household is divided into one or more family units.

The family unit's financial eligibility is determined first for F&C MN eligibility determinations. If the family unit has resources or income that cannot be verified or that exceeds the limit for the individual's covered group, the family unit is divided into "budget" units if certain requirements are met.

B. Policy

Medicaid law prohibits the consideration of resources and income of any person other than a spouse or parent in the final Medicaid eligibility determination. Resources and income CANNOT be counted

- from a stepparent to a stepchild;
- from a sibling to a sibling;
- from a child to a parent;
- from a spouse or parent living apart from the individual, unless it is a voluntary or court-ordered or DCSE-ordered contribution (exception for individuals in long-term care);
- from an alien sponsor to the alien.

The family unit will include any child(ren) under age 21 living in the home for whom a unit member is legally responsible regardless of whether or not the child(ren) meet(s) a covered group, unless the child is specifically excluded.

1. Member In One Unit

An applicant/recipient can be a member of only one family unit or one budget unit at a time.

2. May Exclude A Child

The applicant can choose to exclude any child(ren) from the family unit for any reason. If the parent wants to exclude a child who has been listed on the application, the request for exclusion must be in writing. None of the excluded child's needs are considered, and none of his income or resources are counted or deemed available to the unit. The advantages and disadvantages of the choice must be explained to the applicant or recipient.

3. *Child* Living Away From Home

A parent, or a child under age 21 who has not been emancipated, is considered living in the household for family unit composition purposes if the absence is temporary and the parent or child intends to return to the home when the purpose of the absence (such as employment, military service, education, rehabilitation, medical care, vacation, visit) is completed.

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

4. Psychiatric Residential Treatment Facilities (PRTFs)

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

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

5. Medical Facilities

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

6. *Parent/ Caretaker-Relative Living in the Home*

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

C. Procedure

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

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

M0610 Changes

Changed With	Effective Date	Pages Changed
DMAS #12	4/1/19	Page 1
TN #100	5/1/15	Pages 1, 2

M0610.000 GENERAL RULES FOR FAMILIES AND CHILDREN RESOURCES

M0610.001 OVERVIEW

A. Introduction

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

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

This section addresses how to determine resource eligibility for the following:

- F&C in Medical Institution, Income ≤ 300% SSI;
- F&C Receiving Waiver(CBC) Services;
- F&C Hospice; and
- all F&C medically needy covered groups.

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

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

B. Policy Principles

1. Monthly Determinations

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

2. Countable Resources

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

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

M0810 Changes

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

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	2018 Monthly Amount	2019 Monthly Amount
1	$2,250	$2,313

4. ABD Medically Needy

a. Group I	7/1/2017 – 6/30/18		7/1/2018	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$1,867.21	$311.20	$ 1,904.55	$317.42
2	2,377.24	396.20	2,424.75	404.12

b. Group II	7/1/2017 – 6/30/18		7/1/2018	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$ 2,154.48	$359.08	$ 2,197.56	$366.26
2	2,653.01	442.16	2,706.04	451.00

c. Group III	7/1/2017 – 6/30/18		7/1/2018	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$ 2,800.83	$466.80	$ 2,856.84	$476.14
2	3,376.83	562.80	3,444.33	574.05

5. ABD Categorically Needy

For:

ABD 80% FPL, QMB, SLMB, & QI <u>without</u> Social Security income; all QDWI; effective *1/11/19*

ABD 80% FPL, QMB, SLMB, & QI <u>with</u> Social Security income; effective *3/1/19*

All Localities	2018		*2019*	
ABD 80% FPL	Annual	Annual	Annual	Monthly
1	$9,712	$9,712	*$9,992*	*$833*
2	13,168	13,168	*13,528*	*1,128*
QMB 100% FPL	Annual	Annual	Annual	Monthly
1	$12,140	$12,140	*$12,490*	*$1,041*
2	16,460	16,460	*16,910*	*1,410*
SLMB 120% of FPL	Annual	Annual	Annual	Monthly
1	$14,568	$14,568	*$14,988*	*$1,249*
2	19,752	19,752	*20,292*	*1,691*
QI 135% FPL	Annual	Annual	Annual	Monthly
1	$16,389	$16,389	*$16,862*	*$1,406*
2	22,221	22,221	*22,829*	*1,903*
QDWI 200% of FPL	Annual	Annual	Annual	Monthly
1	$24,280	$24,280	*$24,980*	*$2,082*
2	32,920	32,920	*33,820*	*2,819*

S0820 Changes

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

4. Withdrawals for Personal Use

When an individual alleges (or you discover) that cash or in-kind items are withdrawn from a business for personal use, proceed as follows:

a. Ask the individual whether the withdrawals were **properly accounted for** in determining NESE. That is, were they either deducted on the individual's Federal income tax return in determining the cost of goods sold or the cost of expenses incurred, or deducted on his business records?

b. Accept the individual's allegation of whether the withdrawals were properly accounted for.

IF THE WITHDRAWALS ARE…	THEN…
Properly accounted for	Do not count them again as income.
Not properly accounted for	• Ask the individual to estimate the value of the cash or in-kind withdrawals. Deduct that amount from the cost of goods sold or the cost of expenses incurred on the profit and loss statement to arrive at the proper NESE. • If the individual cannot or will not provide the profit and loss statement, but alleges an amount of NESE, add the value of the withdrawals to the individual's allegation of NESE.

C. References

- *Property* essential to self-support, S1130.500.

S0830 Changes

Changed With	Effective Date	Pages Changed
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

S0830.640 PROGRAMS FOR OLDER AMERICANS

A. Introduction

The Federal Government through the Administration on Aging is involved in a variety of programs for older Americans. The programs may be operated by State or local governments or community organizations. Some types of programs are:

- health services;
- nutrition services (see S0830.635);
- legal assistance; and
- community service employment.

B. Policy

1. Wage or Salary

A wage or salary paid under Chapter 35 *of* Title 42 of the U.S. Code, Programs for Older Americans, is earned income subject to the general Medicaid policies on earned income.

2. Not a Wage or Salary

Anything provided under Chapter 35 of Title 42 of the U.S. Code, Programs for Older Americans, other than a wage or salary is excluded from income.

C. Procedure

1. Verify Program

Use documents in the individual's possession, contact with the provider or a local council on aging, or a precedent to verify that the program is funded by the Federal Government under chapter 35 of "The Older Americans Act" and whether a wage or salary is paid.

2. Wage or Salary

See S0820.100.

3. Not a Wage or Salary-Accept Allegation

Accept the individual's allegation of receipt of anything other than a wage or salary and exclude it without further development unless you have reason to question the allegation.

D. References

ACTION programs (e.g., foster grandparents, retired senior volunteer program, senior companion program), S0830.610

Food programs with Federal involvement, S0830.635

M1110 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-12	4/1/19	Pages 10-10a
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

S1110.310 RESOURCES ASSUMED TO BE NONLIQUID

A. Introduction

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

B. Operating Policy

1. Assumption of Nonliquidity

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

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

2. Evidence to The Contrary

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

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

C. Operating Policy-- Life Insurance

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

VALUATION OF RESOURCES

M1110.400 WHAT VALUES APPLY TO RESOURCES

A. Policy Principles

1. Definitions

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

- Real property – 100% of the local tax assessed value **or** effective 10/4/16, the certified value as determined by an appraiser licensed in the state in which the real property is located. The use of an appraisal is applicable only to non-commercial real property. *A licensed appraiser's certified value can be used if the appraisal was completed no more than six months previous to the date of the application.*

The cost of the appraisal must be paid by either the applicant/recipient or the individual acting on the applicant or recipient's behalf. Certified appraisals documenting the value of the property must contain the name and license number of the individual conducting the appraisal. *A copy of the appraisal must be scanned into the VaCMS case record or placed in the hard case record.*

If tax assessment and appraisal are both provided, use the value that is most beneficial to the applicant.

License validity for appraisers *in Virginia*, if necessary, can be verified through the "License Lookup" tool on the Department of Professional and Occupational Regulation's website at www.dpor.virginia.gov or by calling the Real Estate Appraiser staff at 804-367-2039. *A copy of the appraisal must be scanned into the VaCMS case record or placed in the hard case record.*

If tax assessment and appraisal are both provided, use the value that is most beneficial to the applicant.

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

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

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

M1130 Changes

Changed With	Effective Date	Pages Changed
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

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

A. Policy Principles

1. Exclusion

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

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

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

B. Operating Procedure

The "current market" value (CMV) of real property located in Virginia is the tax assessed value of the property **or**, effective 10/4/16, the certified value as determined by an appraiser licensed in Virginia.

For property located outside of Virginia the CMV is determined by applying the tax assessed value of the property to the local assessment rate, if the rate is not 100%, ***or*** *the certified value as determined by an appraiser licensed in the state in which the real property is located*.

A licensed appraiser's certified value can be used if the appraisal was completed no more than six months previous to the date of the application. The use of an appraisal is applicable only to non-commercial real property. See M1110.400.

1. Initial Effort Established

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

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

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

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

M1320 Changes

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

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

M1320.300 ACTION ON APPLICATIONS

A. Case Action

When an applicant meets all the MN eligibility requirements except income, the application is denied and the applicant is placed on a spenddown.

B. Retroactive Period

When an applicant has old bills, the worker will determine the retroactive budget period and retroactive spenddown liability. Determination of the retroactive budget period is necessary in order to correctly deduct the old bills from the spenddown liability in the first prospective and consecutive budget periods. If there is no Medicaid-covered service in the retroactive budget period, do not evaluate retroactive Medicaid eligibility.

C. Notice to Applicant

A "Notice of Action on Medicaid..." (#032-03-008) is sent to the applicant. Check the block in the third section, which states "Denied full coverage because income exceeds the income level". Enter the spenddown liability and the spenddown budget period begin and end dates in the appropriate section. Send a copy of the "Medical Expense Record - Medicaid" (#032-03-023) to the applicant for recording his medical expenses. See Appendix 1 to subchapter M1340.

M1320.400 SPENDDOWN CASE REVIEW REQUIREMENTS

A. Introduction

The individual must notify the worker when medical or dental expenses are incurred. The individual does NOT have to formally request a re-evaluation of his spenddown.

The individual should submit the "Medical Expense Record - Medicaid" together with bills or receipts for medical services either paid or incurred. Evidence of third party payment or denial of payment must be provided, if applicable.

B. Individual Submits Expenses

When the individual submits medical expenses for re-evaluating the spenddown, a new application form is NOT completed.

Contact the individual and ask if his living situation, resources or income have changed since he signed the application form. If the individual reports any changes, request verification, evaluate accordingly, and record the changes in the case record.

There is no time limit for an individual to submit medical expenses for a spenddown; however, the worker will follow the processing time frame when the first medical bill for a spenddown is received.

C. Eligibility Worker Actions

When verification of incurred expenses is received, the worker must record the expenses in the record, determine how much of the spenddown liability

M1340 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-12	4/1/19	Page 2
TN #DMAS-9	7/1/18	Pages 6a
TN #DMAS-7	1/1/18	Pages 18, 20, 22
TN #100	5/1/15	Pages 4, 5
TN #95	3/1/11	Page 6
TN #94	9/1/10	Page 6
TN #93	1/1/10	Page 18

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

M1340.200 KINDS OF ALLOWABLE DEDUCTIONS

A. Policy — To determine the allowable incurred expenses that will be deducted from income, the agency must identify the kind of service.

B. Kinds of Service — In determining allowable incurred expenses, the medical or remedial care expenses listed below may be deducted from the spenddown liability.

1. Health Insurance Expenses — Medicare and other health insurance premiums are allowable health insurance expenses. *See M1340.300*

2. Noncovered Services Expenses — Noncovered services expenses are expenses incurred by the individual or family or financially responsible relative for necessary medical or remedial care services which are not covered by the Virginia Medicaid State Plan. Noncovered services include expenses for Medicaid-covered services that exceed the State Plan limits on the amount, duration and scope of services. Medicaid co-payments and deductibles on covered services are "noncovered services." Section M1340.400 lists noncovered services.

3. Covered Services Expenses — Covered services expenses are expenses incurred by the individual or family or financially responsible relative for necessary medical or remedial care services which are covered by the Virginia Medicaid State Plan.

M1340.300 HEALTH INSURANCE PREMIUMS, DEDUCTIBLES, COINSURANCE

A. Policy — Incurred expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, including deductibles and copayments imposed by Medicaid, are deducted from the spenddown liability.

B. Health Insurance Premiums — Health insurance premium payments include:

1. Private Health Insurance — Payments made from the applicant's own income for private medical insurance are allowed deductions. Income protection insurance **(**indemnity) policy premiums are not medical expenses and are not deducted from the spenddown liability.

2. Medicare Premiums — Medicare Part A, Part B and/or *Part D* premium payments are allowed deductions when the premiums are paid from the applicant's own income.

3. Amount Deducted — The amount deducted is the amount of the premium paid.

1360 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-12	4/1/19	Page 4, 4a
TN #DMAS-9	7/1/18	Page 4 Page 4a was added.

E. Income Increases

Recalculate the spenddown liability for the spenddown budget period based on the actual income received. If the new spenddown liability has not been met, cancel eligibility. Notify the recipient of the new spenddown liability and the balance of the spenddown liability which must be met by the last day of the spenddown budget period.

NOTE: **This subsection does not apply to medically needy pregnant women who apply for and are enrolled in Medicaid on or before the date the pregnancy terminates. Income increases are excluded for these MN pregnant women.**

F. Resource Changes

Redetermine the assistance unit's eligibility based on a change in resources.

1. Resources Within Limit

When resources are within the Medicaid limit, the unit remains eligible as medically needy for the remainder of the spenddown budget period.

2. Resources Exceed Limit

When the resources exceed the limit, cancel the unit's Medicaid eligibility after the advance notice is sent if the effective date of cancellation is prior to the end of the spenddown budget period. Do not change the spenddown liability or the spenddown budget period.

3. Example--Resource Change

EXAMPLE #3: Mr. and Mrs. Jones applied for Medicaid on July 10. They were put on a spenddown for the spenddown budget period July - December, which they met on August 3. They were enrolled effective August 3 through December 31. On September 2, they reported that they inherited some real property worth $20,000. It is not excluded since it is saleable. They are sent an advance notice on September 4 stating their Medicaid eligibility is canceled effective September 30 because of excess resources.

G. Change Due to Incarceration

Redetermine all persons in the assistance unit and their eligibility based on a change of household size due to incarceration of one of the persons.

1. Assistance Unit

For all individuals in the assistance unit (other than incarcerated person), see Policy M1360.100.B - Decrease of Assistance Unit.

2. Incarcerated Becomes Incarcerated

If the incarcerated individual (offender) has Medicaid coverage, the worker must review the case to determine if the change has affected eligibility for the offender or any household members (see M0130.050).

If the offender is on a spenddown when he becomes incarcerated and the offender is not eligible for full coverage Medicaid (e.g. his continues to receive the same amount of income as he did prior to incarceration), the spenddown period continues. The worker does not send an application form to the offender at the end of the spenddown period, and no new spenddown periods are determined for an offender while he remains incarcerated.

3. Example - Incarcerated Change

EXAMPLE #4:
Mr. Thomas applied in March and after determined was placed on a *MN* spenddown for the budget period March 1 – August 31. On May 10, he met the SD and is enrolled in *Medicaid* effective May 10 through August 31.

On June 3, Mr. Thomas is incarcerated. The worker reviews the case and determines him to *still* be eligible for Medicaid. The worker changes the aid category (AC) to AC 109, effective June 3 with an end date of August 31.

4. Example - Incarcerated with Spenddown period

EXAMPLE #5:
Ms. Kincaid applied in June. She receives $2,000 per month from a pension and was not eligible for full Medicaid coverage in the 80% FPL covered group. She was placed on an MN spenddown for the budget period June 1 – November 30.

On August 10, she becomes incarcerated. Because she continues to receive her pension while she is incarcerated, the eligibility worker determines that Ms. Kincaid is still not eligible for full Medicaid coverage, and her spenddown continues.

As of November 30 Ms. Kincaid is still incarcerated. Her spenddown period ends. The worker does not need to take further action on the spenddown.

M1410 Changes

Changed With	Effective Date	Pages Changed
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

B. Ineligible Individuals

The following individuals are not eligible for full Medicaid coverage:

- an inmate in a public institution; see section M1430.102 for the definition of an inmate in a public institution. Incarcerated individuals (adults and juveniles) can be eligible for Medicaid payment limited to services received during an inpatient hospitalization, provided they meet all other Medicaid eligibility requirements. See M0280.300.

- *An offender in a public institution is not eligible for LTSS while incarcerated. An inmate with an anticipated release date may apply for Medicaid LTSS, and the eligibility worker will follow case processing guidelines found in M0130.050.H.4.*

- individuals under age 65 who are patients in an institution for mental diseases (IMD), unless they are under age 22 and receiving inpatient psychiatric services.

C. Types of Medical Institutions

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

1. Chronic Disease Hospitals

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

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

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

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

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

3. Institutions for Mental Diseases (IMDs)

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

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

4. Intermediate Care Facility (ICF)

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

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

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 living outside of a nursing facility meets the level of care for Medicaid payment for LTSS services. Medicaid enrollees living outside a nursing facility must be screened and approved before Medicaid will authorize payment for LTSS services.

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).

M1420 Changes

Changed With	Effective Date	Pages Changed
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

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. Community Based LTSS Screening

Entities other than hospital or local community-based teams are authorized to screen individuals for HCBS. The following entities are authorized to screen patients for Medicaid HCBS:

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.

CHAPTER M14
LONG-TERM CARE
SUBCHAPTER 70

PATIENT PAY — POST-ELIGIBILITY TREATMENT OF INCOME

M1470 Changes

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

Notify the patient or the patient' authorized representative of the denial of the request using the Notice of Action.

If a noncovered service is already being deducted, leaving no patient pay, and a new deduction for another noncovered service has been approved, notify the patient or his authorized representative that the deduction for the new noncovered service will be made after the first noncovered service deductions are completed.

2. Allowable Non-covered Expenses

When a patient has income available for patient pay, the following can be deducted as noncovered expenses:

a. Old Bills

"Old bills" are deducted from patient pay as noncovered expenses. "Old bills" are unpaid medical, dental, or remedial care expenses which:

- were incurred prior to the Medicaid application's retroactive period, or during the retroactive period if the individual was not eligible for Medicaid in the retroactive period or the service was not a Medicaid-covered service;
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met; **and**
- remain a liability to the individual.
- **"Old bills" do not require approval from DMAS in order to be deducted in the patient pay calculation even when the amount of the "old bill" exceeds $500.**

b. Medically Necessary Covered Services Provided By A Non-participating Provider

Medically necessary medical and dental services that are covered by Medicaid, but that the enrollee received from a provider who does not participate in Virginia Medicaid, are deducted from patient pay as non-covered services.

c. Covered Services Outside of Medicaid's Scope

Medically necessary medical and dental services exceeding Medicaid's amount, duration, or scope can be deducted from patient pay. *Scope includes benefits or services provided by the enrollee's MCO (managed care organization).*

d. Other Allowable Noncovered Services

1) The following medically necessary medical and dental services that are NOT covered by Medicaid *or by benefits provided by the enrollee's MCO* can be deducted from patient pay by the local department of social services without DMAS approval when the cost does NOT exceed $500. **If the service is not identified in the list below and/or the cost of the service exceeds $500, send the request**

3a. 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 service and support (LTSS) 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.

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

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

4. Documentation Required

a. Requests For Adjustments From A Patient or Authorized Representative

Request the following documentation from the patient or his representative:

- a copy of the bill;
- if applicable, the amount owed that was not covered by the patient's insurance;
- proof that the service was medically necessary. Proof may be the prescription, doctor's referral**,** or a statement from the patient's doctor or dentist. Proof applies to a physician, doctor, or dentist's <u>current,</u> and not "standing", order(s).

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.

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

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

1. Example--Two Dependent Children In One Home (Using January 2009 Figures)

Mr. H is a single individual with gross monthly income of $920, living in the community in Group II and receiving Medicaid CBC. He is divorced and has two children under age 18 who live with his ex-wife in Group I. His two children each receive $75 SSA.

The allowance for his dependent children is calculated as follows:

$ 337.92	MN limit for 2 (Group I)
- 150.00	children's SSA income
$ 187.92	dependent children's allowance

2. Example--Three Dependent Children In Two Homes (Using January 2009 Figures)

Mrs. K is a married individual who lives at home in a Group II locality and receives Medicaid CBC. Her spouse is in a medical facility and is not a community spouse. One of their three dependent children lives with Mrs. K. The other two children live with her sister in a Group III locality. The children each receive $95.00 per month SSA.

The allowance for the dependent children is calculated as follows:

$ 306.23	MN limit for 1 (Group II)
- 95.00	child's SSA income
$ 211.23	child's allowance

$ 480.00	MN limit for 2 (Group III)
- 190.00	children's SSA income
$ 290.00	children’s allowance

$ 211.23	child's allowance
+ 290.00	children's allowance
$ 501.23	total dependent children’s allowance

NOTE: If Mrs. K’s institutionalized spouse is eligible for Medicaid, an allowance for their children may also be deducted from his income in determining his patient pay. However, the allowance the children receive from Mrs. K will be counted as part of their income when determining any allowance from Mr. K’s income.

M1470.430 MEDICAID CBC - NONCOVERED MEDICAL EXPENSES

A. Policy

Amounts for incurred medical and dental expenses not covered by Medicaid or another third party, *including services or benefits provided as part of an enrollee’s managed care organization,* are deducted from the patient’s gross monthly income when determining patient pay.

B. Health Insurance Premiums

Payments for medical/health insurance which meet the definition of a health benefit plan, *including dental insurance,* are deducted from patient pay when:

- the premium amount is deducted from the patient's benefit check;

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.

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

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

M1510 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-12	4/1/19	Page 7, 9a. Page 7a is a runover page.
TN #DMAS-11	1/1/19	Page 7
TN #DMAS-10	10/1/18	Pages 7, 8a, 9a, 14 Pages 8b and 8c are runover pages.
TN #DMAS-9	7/1/18	Table of Contents Page 5. Page 9a was added.
TN #DMAS-8	4/1/18	Pages 2, 8a, 8b Page 8c was added.
TN #DMAS-6	10/1/17	Table of Contents Pages 1, 2 Page 2a is a runover page. Page 2b was added as a runover page.
TN #DMAS-5	7/1/17	Page 1 Page 2 is a runover page.
TN #DMAS-4	4/1/17	Pages 2a, 10
TN #DMAS-2	1/1/17	Table of Contents Pages 1, 8, 8a, 12-15 Page 11a was deleted.
TN #DMAS-2	10/1/16	On pages 3-15, corrected the subchapter number in the headers. Neither the dates nor the policies were changed.
TN #DMAS-1	6/1/16	Pages 2 Pages 1 and 2a are runover pages.
TN #100	5/1/15	Table of Contents Pages 1-2a, 5-8b
UP #10	5/1/14	Table of Contents Pages 7-8a Page 8b was added.
TN #99	1/1/14	Table of Contents Pages 1, 2, 8, 8a, 9-11 Page 11a was added.
UP #9	4/1/13	Pages 2-7, 10-12, 14
UP #7	7/1/12	Pages 8, 9
TN #96	10/01/11	Pages 8a, 10
TN #95	3/1/11	Table of Contents Pages 8, 11-15
TN #94	9/1/10	Pages 2a, 8-8a
TN #93	1/1/10	Page 6
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his local agency a Medicaid application which is received on August 18. The facility's statement notes that he will be discharged on September 17 to ABC Nursing Home, a nursing facility. The agency completes the determination on August 27 and finds that he will be eligible once he is discharged to the nursing facility.

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

4. Offenders (Incarcerated Individuals)

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

a. ***New Applicant Coverage*** *– (See M0130.050.F.1)*

For offenders approved for Medicaid, coverage in AC 108 or AC 109 begins either the first day of the month of application or the first day of incarceration, whichever is later. Entitlement can also begin the first day of any month in the application's retroactive period, provided all eligibility requirements were met. *Enroll the individual in the appropriate AC for his covered group for any period prior to the date he became incarcerated.*

b. ***Active Medicaid at Time of Incarceration*** *– (See M0130.050.F.2)*

If the *offender* has active coverage when the agency becomes aware of his incarceration, a partial review must be completed to determine if he continues to meet the requirements for coverage in a full-benefit CN covered group. If he continues to be eligible, cancel the existing coverage *effective with the date of the incarceration* and reinstate in *AC 108* /AC 109 for ongoing coverage *beginning* the following day. If the individual no longer meets the requirements for a full benefit CN covered group, cancel the coverage effective the date the determination is made.

c. ***Re-Entry or Pre-Release Case Processing*** *– (See M0130.050.H). If the offender is anticipated to be released from incarceration, eligibility for Medicaid will be re-evaluated or determined. If the offender is approved for ongoing Medicaid, the effective date of new coverage will be on the date of release. If the individual no longer meets the requirements for a Medicaid, coverage will be cancelled effective the day prior to the release date.*

If the offenders's individual's change of coverage will impact a household which has active Medicaid members and where the offender resided prior to or upon release of incarceration, notify the agency handling the case to such a change.

5. MAGI Adult Turns 65 or Eligible for Medicare

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

M1510.107 Enrollment Changes

~~D~~. Enrollment Changes

VaCMS is the MA eligibility system of record, however some enrollment functions can only be handled by the DMAS Eligibility and Enrollment Unit. The VaCMS and MMIS systems **must** reflect correct coverage. Appropriate change requests include:

- Retroactive coverage that cannot be approved through VaCMS
- Duplicate linking
- Erroneous death cancellations
- Spenddown end-dates (if open-ended coverage was sent to MMIS)
- Missing newborn coverage
- Approved non-labor and delivery Emergency Services coverage
- Same day void
- *Coverage corrections unable to be handled through VaCMS.*

There may be instances when VaCMS should be able to successfully update the enrollment system but does not. When this occurs, the eligibility worker must follow the steps as listed below:

- First attempt to make the correction in VaCMS with the help of supervisors or other agency resources. If not successful;

- Contact the VDSS Regional Consultant (RC) for assistance. The RC will help the local worker make the correction in MMIS or VaCMS. If not successful;

- If either the agency resources or Regional Consultant is unable to correct the enrollment in MMIS, they can instruct the worker to submit a coverage correction to DMAS.

- The worker will complete a MMIS Coverage Correction Request Form (DMAS-09-1111-eng). The form can be found on the VDSS intranet. Follow the instructions as provided on the form.

- Once completed, the form is sent via email to: DMAS Eligibility and Enrollment Unit at: enrollment@dmas.virginia.gov. All requests should be documented in the VaCMS system.

Changed With	Effective Date	Pages Changed
TN #DMAS-12	4/1/2019	Table of Contents Pages 2, 5, 6, 6a, 7, 8, 8a, 11, 12, 15-18, 20 Appendix 2 Page 24a was added. Pages, 19, 21-24, 25 are runover pages.
TN #DMAS-11	1/1/2019	Pages 2, 5, 6, 7, 9
TN #DMAS-8	4/1/18	Pages 2, 18 Appendix 2
TN #DMAS-7	1/1/18	Pages 2, 3, 3a, 5, 6, 7 Pages 6a and 7a are runover pages.
TN #DMAS-5	7/1/17	Pages 1, 2, 6, 8 Pages 3, 7, 7a and 9 are runover pages.
TN #DMAS-4	4/1/17	Pages 25-27 Appendix 2, page 1 Pages 28-30 were added.
TN #DMAS-3	1/1/17	Pages 1, 2, 4, 6, 7, 8, 14, 26
TN #DMAS-2	10/1/16	Pages 1, 3, 6, 8, 12, 14, 15 Pages 19-24
TN #DMAS-1	6/1/16	Pages 3, 6, 7, 9, 11-14, 17 Appendix 2, page 1 Pages 3a and 7a were added. Page 8 is a runover page.

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
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M1520.000 MEDICAL ASSISTANCE (MA) ELIGIBILITY REVIEW

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M1520.100 PARTIAL REVIEW

A. Enrollee's Responsibility

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

B. Eligibility Worker's Responsibility

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

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

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

1. Changes That Require Partial Review of Eligibility

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

A reported decrease in income or termination of employment must be verified. *If a reported change is not compatible with information obtained from online system searches, obtain verification from enrollee or authorized representative.*

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

2. Changes That Do Not Require Partial Review

Document changes in an enrollee's situation, such as the enrollee's Social Security number (SSN) and card have been received, 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 on-line at: http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi. The eligibility worker must report to the HIPP Unit at DMAS any changes in an enrollee's situation.

If an annual renewal has been done within the past 6 months, a partial review to address factors pertinent to receipt of LTC, such as asset transfer, spousal resource assessment, etc., must be completed. If an annual renewal has not been done within the past 6 months, a complete renewal must be completed (see M1520.200). When the re-evaluation is completed, send all required notices to the enrollee/authorized representative, and send a DMAS-225 to the provider (see M1410.300).

If the individual is already enrolled in a full benefit Medicaid covered group, do not change the AC. If the individual is enrolled *in a limited-benefit covered group*, the individual must be evaluated for eligibility in one of the covered groups for institutionalized individuals (i.e. income $\leq$ 300% of SSI) (see M1460).

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. As long as the individual continues to receive SSI, do not change the AC. If the individual loses SSI, evaluate his Medicaid eligibility in other covered groups. See M1430.103 for additional information regarding an SSI recipient who enters a nursing facility.

When an individual on a spenddown enters LTC, his Medicaid eligibility must be determined using the procedures in subchapter M1460. An individual on a spenddown in an assistance unit with a spouse and/or children becomes a separate assistance unit when he enters LTC. The spouse's and/or children's spenddown liability is recalculated to reflect a decrease in assistance unit size. See M1350.220 for additional information.

F. Governor's Access Plan (GAP)

Effective October 31, 2018, GAP applications are no longer being be accepted. The GAP Unit at Cover Virginia will handle GAP case management activity until March 31, 2019. Eligibility workers will follow the procedures found in M1510.107 for enrollment changes.

When an individual enrolled in GAP *was* eligible for *benefit coverage* prior to *January 1, 2019, and* enrollment in *MMIS* is *required*, the eligibility worker will follow the procedures found in M1510.107. The eligibility worker will complete the MA enrollment *in VaCMS* and send notice of eligibility to the enrollee~~.~~

M1520.200 RENEWAL REQUIREMENTS

A. Policy

The agency must evaluate the eligibility of all MA enrollees, with respect to circumstances that may change, at least every 12 months. Each renewal must be authorized by an eligibility worker or supervisor, although administrative staff may assist in the gathering of information.

The scope of renewals is limited to information that is necessary to determine ongoing eligibility and that relates to circumstances that are subject to change, such as income and resources. Verification of information that is not subject to change, such as date of birth and SSN, is not required at renewal, unless it has not been verified previously.

If an annual renewal has been done within the past 6 months, a partial review to address factors pertinent to receipt of LTC, such as asset transfer, spousal resource assessment, etc., must be completed. If an annual renewal has not been done within the past 6 months, a complete renewal must be completed (see M1520.200). When the re-evaluation is completed, send all required notices to the enrollee/authorized representative, and send a DMAS-225 to the provider (see M1410.300).

If the individual is already enrolled in a full benefit Medicaid covered group, do not change the AC. If the individual is enrolled in a limited-benefit covered group, the individual must be evaluated for eligibility in one of the covered groups for institutionalized individuals (i.e. income $\leq$ 300% of SSI) (see M1460).

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. As long as the individual continues to receive SSI, do not change the AC (s*ee M0320.101.C).* If the individual loses SSI, evaluate his Medicaid eligibility in other covered groups. See M1430.103 for additional information regarding an SSI recipient who enters a nursing facility.

When an individual on a spenddown enters LTC, his Medicaid eligibility must be determined using the procedures in subchapter M1460. An individual on a spenddown in an assistance unit with a spouse and/or children becomes a separate assistance unit when he enters LTC. The spouse's and/or children's spenddown liability is recalculated to reflect a decrease in assistance unit size. See M1350.220 for additional information.

1. Required Verifications

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

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

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

Continuing blindness and disability must be verified at the time of each annual renewal. For individuals receiving Supplemental Security Income (SSI) and Social Security Disability Insurance, the State Online Query-Internet (SOLQ-I) or the State Verification and Exchange System (SVES) may be used. The printout must be scanned into the case record. For individuals determined blind or disabled for Medicaid by the Disability Determination Services (DDS) interface with VaCMS, blindness and disability are considered continuing unless DDS has notified the LDSS that the individual is no longer blind or disabled.

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

2. SSN Follow Up

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

3. Evaluation and Documentation

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

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

4. Renewal Period

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

B. Renewal Procedures *Renewals may be completed in one of the following ways:*

- *ex parte,*
- *using a paper form,*
- *online,*
- *telephonically by calling the Cover Virginia Call Center.*

1. Ex Parte Renewals

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

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

a. MAGI-based Cases

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

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

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

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

b. $0 Income Reported

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

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

No statement regarding income is necessary from the individual.

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

c. SSI Medicaid Enrollees

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

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

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

d. Continuing Eligibility Not Established Through Ex Parte Process

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

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

2. Paper Renewals

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

The form needs to be sent to the enrollee in time to allow for the return and processing periods prior to the system cut-off in the 12th month of eligibility. The enrollee must be allowed 30 days to return the renewal form and any necessary verifications; Administrative Renewal forms are pre-filled with the return date. The specific information requested and the deadline for receipt of the verification must be documented in the case record.

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

New or revised information provided by the enrollee must be entered into the system. The enrollee is responsible for reporting any changes. If the enrollee does not check either "yes" or "no" in response to a particular question, there is considered to be no change with regard to that question.

Verifications must be copied or scanned into VaCMS using the Document Management Imaging System (DMIS) and preserved for the record. Notes by the eligibility worker that the verifications were viewed are not sufficient. *If the enrollee reports having no income ($0 income), follow the procedures in M1520.200 B.1.b).*

Renewals must be completed prior to cut-off in the 12th month of eligibility or within 30 calendar days from the receipt of the renewal, whichever is later.

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

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

3. Online and Telephonic Renewals

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

Renewals completed through CommonHelp are electronically signed by the enrollee or authorized representative. For cases in VaCMS, renewals completed through CommonHelp will automatically be entered into VaCMS for the worker to complete processing. For non-VaCMS cases, the renewal must be completed manually. It is not necessary to print a renewal completed through CommonHelp for the case record because it will be maintained electronically; however, the evaluation of eligibility and verifications must documented in the VaCMS case record. *If the enrollee reports having no income ($0 income), follow the procedures in M1520.200 B.1.b).*

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

C. Disposition of Renewal

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

If the child does not meet the definition for another covered group, determine the child's eligibility in Plan First using the eligibility requirements in M0320.302. If the child is eligible for Plan First, reinstate coverage in Plan First and send the Advance Notice of Proposed Action indicating that he has been enrolled in Plan First. On the notice, state that if he does not wish to remain covered by Plan First, to contact the eligibility worker and request that the coverage be cancelled. Include a Plan First Fact Sheet, available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi, with the Advance Notice of Proposed Action.

6. IV-E FC & AA Children and Special Medical Needs Children

The renewal of Medicaid coverage for Title IV-E foster care or adoption assistance children and non-IV-E special medical needs adoption assistance children requires only the following information:

- verification of continued IV-E eligibility status or non-IV-E special medical needs status,
- the current address, and
- any changes regarding third-party liability (TPL).

7. Child Under 21 Turns Age 21

When an individual who is enrolled in the Child Under Age 21 covered group turns 21, redetermine his continuing Medicaid eligibility in other covered groups, including Plan First.

This information can be obtained from agency records, the parent or the Interstate Compact office from another state, when the child's foster care or adoption assistance agreement is held by another state. A renewal form is not required. The information must be documented in the case record.

***8.* Foster Care Child in an Independent Living Arrangement Turns Age 18**

A foster care child who is in an Independent Living arrangement with a local department of social services *(LDSS)* no longer meets the definition of a foster care child when he turns 18. Determine the child's eligibility in the Former Foster Care Children Under Age 26 Years covered group.

***9.* Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)**

The BCCPTA Redetermination Form (#032-03-653) is used to redetermine eligibility for the BCCPTA covered group. The form is available on SPARK at: http://spark.dss.virginia.gov/divisions/bp/me/forms/index.html. The enrollee must provide a statement from *his or* her medical provider *on the renewal form or else a separate written statement* verifying continued treatment for breast or cervical cancer. There are no Medicaid financial requirements for the BCCPTA covered group.

10. Hospice Covered Group

At the annual renewal for an individual enrolled in the Hospice covered group (AC 054), the worker must verify the enrollee's continued election and receipt of hospice services, in addition to determining continued Medicaid eligibility.

11. Qualified Individuals

Funding for the QI covered group became permanent in 2015; the QI covered group is subject to the same policies regarding renewals as other ABD covered groups.

12. FAMIS Renewal Period Extension For Declared Disaster Areas

Effective January 1, 2017, if the Governor or the Federal Emergency Management Agency (FEMA) declares Virginia or any area in Virginia to be a disaster area, children enrolled in FAMIS who reside in the declared disaster area may be granted a 90-day extension of the continuous coverage period before their next renewal is due. The next 12-month continuous eligibility period begins the month after the renewal completion date.

The extension of the renewal period applies only to children in a declared disaster area (1) for whom an ex parte renewal cannot be completed and (2) who do not return a renewal form or complete an online or telephonic renewal prior to the renewal due date. The three-month reconsideration period outlined in M1520.200 C.4 also applies to these children if their coverage is cancelled upon not completing a renewal at the end of the 90-day extension period.

E. LTC

The ex parte renewal process is used for institutionalized individuals who receive SSI and have no countable real property. It can also be used for F&C enrollees subject to MAGI methodology when the local agency has access to on-line information for verifications necessary to determine ongoing eligibility and/or income verifications obtained for other benefit programs.

ABD, as well as F&C individuals over age 18, in the 300% of SSI covered group LTC must complete a contact-based renewal due to the resource requirement.

The patient pay must be updated in MMIS at least every 12 months, even if there is no change in patient pay. Send the provider a DMAS-225 when there has been a change in circumstances resulting in a change in eligibility. If there has been no change in circumstances, do not send a DMAS-225 to the provider.

F. Incarcerated Individuals

Incarcerated individuals who have active Medicaid are subject to annual renewals. Renewals for individuals in Department of Corrections and Department of Juvenile Justice facilities will be handled *with assistance* through the designated *facility staff* liaison.

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- For individuals incarcerated in DOC facilities, send the renewal form and related correspondence to the DOC Health Services Reimbursement Unit, 6900 Atmore Driver, Richmond, Virginia 23225.

- For individuals in DJJ facilities, send the renewal form and related correspondence to the DJJ Re-entry Services Unit, 600 E. Main Street, Richmond VA 23219.

- For individuals in regional or local jails, send the renewal form and related correspondence to the individual or his authorized representative.

7. Enrollee Requests Cancellation

An enrollee may request cancellation of his and/or his children's medical assistance coverage at any time. The request can be verbal or written. A written withdrawal request must be placed in the case record. A verbal request for withdrawal can be accepted only from the enrollee or case head, or his authorized representative. A verbal request must be documented in the case record with the date and time the withdrawal request was received, the name of the person who made the withdrawal request, and the signature and title of the agency staff person who took the call.

When the enrollee requests cancellation of Medicaid, the local department must send adequate notice using the Notice of Action to the enrollee no later than the effective date of cancellation.

On the notice:

- check the "other" block and list the reason as "Medicaid coverage cancelled at the enrollee's request,"
- include the effective date of cancellation and instruct the enrollee to discontinue using the card after that date, and
- instruct the enrollee to retain the Medicaid card for future use in case coverage is reinstated within the next 12 months (the system will generate a new card after 12 months).

M1520.400 EXTENSIONS OF MEDICAID COVERAGE

A. Policy

Medicaid families may be eligible for an extended period of Medicaid coverage when the family meets all the requirements for the Low Income Families with Children (LIFC) covered group except income.

LIFC families who received Medicaid in three of the last six months and who became ineligible for Medicaid due to increased income from spousal support may be eligible for a four-month extension.

LIFC families who received Medicaid in three of the last six months and who became ineligible for Medicaid due to an increase in earnings may be eligible for a twelve-month extension. Earnings could increase because of a new job, a raise in the rate of pay or more hours are being worked.

Prior to evaluating a child for the Medicaid extensions, review the child's eligibility in the Child Under Age 19 (FAMIS Plus) covered group. If he is eligible, update his renewal date. If the child is ineligible as a Child Under Age 19, evaluate his eligibility for the Medicaid extensions.

MAGI methodology for the formation of households does not apply to individuals in Extended Medicaid. The family unit policies in M0520 apply to Extended Medicaid.

If ineligible for the Medicaid extensions, *individuals must be must be evaluated for eligibility other covered groups or for* FAMIS, if applicable. If *a* child *under 18* is ineligible for FAMIS, the child must be

given an opportunity for a medically needy determination prior to the worker taking action to cancel the Medicaid coverage and unless the child has Medicare, a referral to the HIM must be made.

B. Procedure

The policy and procedures for the four-month extension are in section M1520.401 below.

The policy and procedures for the twelve-month extension are in section M1520.402 below.

M1520.401 FOUR-MONTH EXTENSION

A. Policy

An LIFC Medicaid family is entitled to four additional months of Medicaid coverage after the family loses Medicaid LIFC eligibility when the following conditions are met:

- The parent or caretaker-relative received Medicaid as LIFC in at least three of the six months immediately preceding the month in which they became ineligible for LIFC;
- The parent or caretaker-relative lost eligibility solely or partly due to receipt of or increased ***countable*** spousal support income; and
- All other Medicaid eligibility factors except income are met.

Effective January 1, 2019, alimony or spousal support is not countable as income. 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 rule by modifying the divorce agreement. A copy of the modified divorce agreement must be provided to the eligibility worker; otherwise, the alimony or spousal support continues to be countable.

B. Procedures

1. Received in Error

For purposes of this subsection, "received Medicaid as LIFC" does not include received Medicaid erroneously. Therefore, a family who received Medicaid erroneously during three or more of the six months before the month of ineligibility does **not** qualify for the Medicaid extension *and must be evaluated for eligibility in other covered groups.*

2. New Family Member

A new member of the family, other than a newborn, is eligible for Medicaid under this provision if he/she was a member of the family in the month the unit became ineligible for LIFC Medicaid. A newborn born to an eligible member of the family at any time during the 4-month extension is eligible under this provision because the baby meets the CN newborn child under age 1 covered group.

3. Moves Out of State

Eligibility does not continue for any member of the family who moves to another state.

4. Coverage Period and AC

Medicaid coverage will continue for a period of four months beginning with the month in which the family became ineligible for LIFC Medicaid because of the receipt of or increase in spousal support. The AC for the enrollees in the family receiving the four-month extension is "081" for an LIFC family with one parent or caretaker-relative or "083" for a two-parent family.

5. Case Handling

Prior to the end of the fourth month of the extension, evaluate the individuals in the family for continuing Medicaid eligibility. Cancel coverage for any individuals in the family who are no longer eligible and send advance notice of the cancellation. Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made so that the individual's eligibility for the APTC in conjunction with a QHP can be determined.

M1520.402 TWELVE-MONTHS EXTENSION

A. Policy

An LIFC Medicaid family is entitled to six additional months, with possible extension to twelve months, of Medicaid coverage after they lose Medicaid LIFC eligibility when the following conditions are met:

- The parent or caretaker-relative received Medicaid as LIFC in at least three of the six months immediately preceding the month in which they became ineligible for LIFC;
- The parent or caretaker-relative lost eligibility solely or partly due to receipt of or increased income from earnings; and
- All other Medicaid eligibility factors except income are met.

The family consists of those individuals included in *the **non-MAGI F&C*** **family unit** as defined in M0520.100 at the time that the LIFC Medicaid eligibility terminated. It *includes non-married parents with a child in common. Because non-married parents have different MAGI LIFC households, it is possible that one parent will remain eligible in the LIFC covered group even through the other is no longer eligible as LIFC and must be evaluated for Extended Medicaid. The LIFC parent's income is counted in the Extended Medicaid family unit per M0520.100.*

The family unit also includes individuals born, adopted into, or returning to the family after extended benefits begin who would have been considered a member of the family at the time the LIFC Medicaid eligibility terminated.

The earned income received by a member of the family unit added after the loss of LIFC eligibility must be counted in determining the family's gross income.

B. Eligibility Conditions

The following conditions must be met:

1. Received LIFC Medicaid in Three of Six Months

The family received LIFC Medicaid in at least three of the six months immediately before the month in which the family became ineligible for LIFC. A family who received Medicaid erroneously during three or more of the six months before the month of ineligibility does **not** qualify for the Medicaid extension. Months during which the family received Extended Medicaid are not considered months in which the family received LIFC Medicaid, *and the family must be evaluated for eligibility in other covered groups.*

2. Cancel Reason

LIFC Medicaid was canceled solely because of:

- the parent's or caretaker/relative's new employment,
- the parent's or caretaker/relative's increased hours of employment, or

the parent's or caretaker/relative's increased wages of employment.

3. Has A Child Living in Home

There continues to be at least one child under age 18 or if in school, a child who is expected to graduate before or in the month he turns 19, living in the home with the parent or caretaker/relative.

4. No Fraud

The family has not been determined to be ineligible for LIFC Medicaid at any time during the last six months in which the family received LIFC Medicaid because of fraud.

C. Entitlement & Enrollment

The AC for enrollees in the family receiving the twelve-month extension is "081" for an LIFC family with one parent or caretaker-relative or "083" for a two-parent family.

Entitlement does not continue for any member of the family who moves to another state.

1. **Determining Extension Period**

a. Establishing Initial Month of Eligibility

Medicaid coverage will continue for six months beginning with the first month following the month in which the family is no longer eligible for LIFC Medicaid because of excess income due to the increased earnings of the parent or caretaker/relative.

If the new/increased earnings are not reported timely, or the agency does not take action timely, the extension period still begins the same month it would have begun had the new/increased earnings been reported or acted on timely.

Extension for an additional six-month period is possible if the reporting and financial requirements below are met.

For example, if the increased earnings were received in April, but were not reported or discovered until a review of eligibility in June, the 12-month extension period still begins with May. The screening period to determine if the family received LIFC Medicaid in at least three of the six months immediately preceding the month in which the family became ineligible for LIFC Medicaid is November through April.

b. Simultaneous Income Changes

In situations where a case has simultaneous income changes which cause LIFC Medicaid ineligibility, such as new or increased earned income plus an increase in spousal support, the eligibility worker must determine if the case would have been ineligible due to new or increased earnings. This requires that the eligibility worker recalculate the LIFC income eligibility only considering the increased earned income.

1) If the family would have been ineligible solely due to the increase in earned income, it will be considered the reason for LIFC Medicaid ineligibility and the family is eligible for the twelve-month Medicaid extension.

2) If, however, the family would have continued to be eligible for LIFC Medicaid if the only change had been increased earnings, the other changes which occurred simultaneously will be the reason for LIFC Medicaid ineligibility. The family is **not** eligible for the twelve-month Medicaid extension. If the reason for LIFC Medicaid ineligibility was due to the receipt of or increase in spousal support, evaluate the family's eligibility for the four-month extension in M1520.401.

2. Extension Ends

Entitlement to Medicaid under this extension terminates at the end of the first month in which there is no longer a child under 18 (or if in school, a child who is expected to graduate before or in the month he turns 19), living in the home, the family fails to comply with the reporting requirements in 1520.402 D below, or at the end of the extension period.

The individuals must be evaluated for continuing Medicaid eligibility prior to cancellation. Cancel coverage for any individuals in the family who are no longer eligible and send advance notice of the cancellation. Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.

D. Notice and Reporting Requirements

The Virginia Case Management System (VaCMS) generates the appropriate report forms and notices when the worker has approved extended Medicaid in the system. Instructions for managing an extended Medicaid case are contained in the "Extended Medicaid in the VaCMS" Quick Reference Guide (QRG) available in VaCMS.

1. LIFC Medicaid Cancellation Month

When LIFC Medicaid is canceled, the family must be notified of its entitlement to extended Medicaid coverage for six months, and that Medicaid coverage will terminate if the child(ren) in the home turns age 18, or turns age 19 if the child is in school and is expected to graduate before or in the month he turns 19. Use the VaCMS-generated Notice of Extended Medicaid Coverage form.

a. Notice and Instructions

The family must be instructed to retain verifications of all earnings received during each month of the extension and attach verifications of the first three-month period's earnings to the agency by the 21st day of the fourth month in the extension period. The instructions are on the Notice of Extended Medicaid Coverage and on the second page of the notice, which is the Medicaid Extension Earnings Report.

2. Third Month of Extension

In the third month of extension, the unit must be notified again that it must return the Medicaid Extension Earnings Report, with the earnings verifications attached, to the agency by the 21st of the following month (the fourth month).

This notice will be generated by VaCMS if the correct Follow-up Code and effective date of the 12-month extension are entered.

The notice will state that if the earnings report and verifications are not received by the 21st day of the fourth month, Medicaid coverage will be canceled effective the last day of the sixth month, and that the family will not be eligible for any additional Medicaid extension.

3. Fourth Month of Extension

a. Report Received Timely

If the first three-month period's report is received by the 21st day of the fourth month, and the family continues to include a child, entitlement to Extended Medicaid continues. The worker must update VaCMS when the report is received in order for Extended Medicaid to continue. No action is taken on the first three-month period's earnings.

*VaCMS will cancel coverage at **cut-off** of the sixth extension month. If the worker receives the report prior to cutoff and the family continues to include a child, reinstate the Extended coverage. If the report is not received,* the agency must reopen coverage for any individuals who remain eligible in another Medicaid covered group or in FAMIS and must notify the individual of the reopened coverage.

b. Notice Requirements

VaCMS will generate the advance notice and cancel coverage at the end of the sixth month if the initial Follow-up Code and Date were entered correctly, and the code is **not** updated because the report was not received on time. If the code was not entered correctly, the agency must manually send the Advance Notice of Proposed Action and must cancel the ineligible individual's coverage after the Medicaid cut-off date in the fifth month. The effective date of cancellation will be the last day of the sixth month in the extension period.

c. Report Not Received Timely

If the first three-month period's report is not received by the 21st day of the fourth month, the family is not eligible for the additional six-month extension. Medicaid must be canceled effective the last day of the sixth month in the extension period for any individuals who are not eligible for coverage in another Medicaid covered group or for FAMIS. Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.

4. Sixth Month of Extension

In the sixth month of extension, the family must be notified that it must return the "Medicaid Extension Earnings Report" for the previous three-month period (the fourth through the sixth month), with the earnings verifications for those three months attached, to the agency by the 21st day of the seventh month of extension.

The notice must state that if this three-month period's report and verifications are not returned by the 21st day of the seventh month, Medicaid coverage will be canceled effective the last day of the eighth month of extension.

VaCMS will generate this notice if the Follow-up Code in the base case information is correct. If it is not correct, the agency must manually send this notice.

5. Seventh Month of Extension

a. Report Received Timely

If the second three-month period's report is received by the 21st of the seventh month, update VaCMS immediately upon receipt of the report and verifications. The family will continue to be eligible for extended Medicaid coverage unless:

1) no child under age 18, or if in school, a child who is expected to graduate before or in the month he turns 19, lives with the family;

2) the parent or caretaker/relative had no earnings in one or more of the previous three months, unless the lack of earnings was due to:
   - the parent's or caretaker/relative's involuntary lay-off,
   - the business closed,
   - the parent's or caretaker/relative's illness or injury,
   - other good cause (such as serious illness of child in the home which required the parent's or caretaker/relative's absence from work);

3) the family's average gross monthly **earned** income (earned income only; unearned income is not counted) less costs for child care that was necessary for the employment of the caretaker/relative, during the preceding three-month period exceeds the 185% Federal Poverty Level (FPL) appropriate to the family unit size. See M1520, Appendix 2, for the 185% FPL income limits.

b. Calculate Family's Gross Earned Income

1) The family's gross earned income means the earned income of all family members who worked in the preceding three-month period. "Gross" earned income is total earned income before any deductions or disregards and profit from self-employment. All earned income must be counted, including students' earned income, Workforce Investment Act (WIA) earned income, children's earned income, etc. No exclusions or disregards are allowed. Use policy in M0720.200 for determining profit from self-employment.

2) child care costs that are "necessary for the caretaker/relative's employment" are expenses that are the responsibility of the caretaker/relative for child care that if not provided would prevent the caretaker/relative from being employed.

2) To calculate average gross monthly income:

- add each month's cost of child care necessary for the caretaker/relative's employment; the result is the three-month period's cost of child care necessary for the caretaker/relative's employment.
- add the family unit's total gross earned income received in each of the 3 months; the result is the family's total gross earned income.
- subtract the three-month period's cost of child care necessary for the caretaker/relative's employment from the family's total gross earned income.
- divide the remainder by 3; the result is the average monthly earned income.
- compare the average monthly earned income to the monthly 185% FPL for the appropriate number of family unit members (see M1520, Appendix 2).

c. Family No Longer Entitled To Extended Medicaid

If the family is not entitled to further Medicaid coverage because of one of the reasons in item M1520.402 D.5.a above, each individual's eligibility for Medicaid in another covered group or for FAMIS must be determined before canceling coverage. Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.

d. Family Remains Entitled To Extended Medicaid

If the family remains eligible for Extended Medicaid, no action is required until the ninth month of extension, except to be sure that the extended Medicaid information in VaCMS is up to date.

e. **Report Not Received Timely**

If the second three-month period's report and verifications are not received by the 21st day of the seventh month, the family's Medicaid coverage must be canceled for individuals who are not eligible for Medicaid in another covered group or for FAMIS unless the family establishes good cause for failure to report on a timely basis. Examples of good cause for failure to report timely are:

- illness or injury of family member(s) who is capable of obtaining and sending the material;
- agency failure to send the report notice to the family in the proper month of the extension.

Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.

VaCMS will generate the advance notice and cancel coverage if the report is not received on time and the code is not changed. Cancellation is effective the last of the eighth month of extension.

If an individual's continuing eligibility is not reviewed by the **cut-off date** of the eighth extension month and coverage is cancelled, the agency must then reopen coverage and notify the recipient if he is subsequently found eligible. If an individual remains eligible, change the individual's enrollment to the appropriate aid category before the **cut-off date** of the eighth extension month.

6. Ninth Month of Extension

In the ninth month of extension, the family must be notified that it must return the "Medicaid Extension Earnings Report" with earnings verifications attached, for the previous three-month period (seventh through ninth month) to the agency by the 21st day of the tenth month of the extension.

The notice must state that if the report and verifications are not returned by 21st day of the tenth month, Medicaid coverage will be canceled effective the last day of the eleventh month of extension.

VaCMS will generate this notice if the correct Follow-up Code is in the base case information.

7. Tenth Month of Extension

a. Report Received Timely

If the third three-month period's report is received by the 21st of the tenth month, update VaCMS immediately upon receipt of the report and verifications. The family continues to be eligible for Medicaid unless one of the items in M1520.402 D.5 above applies. Calculate the family's income using the procedures in M1520.402 D.5 above.

b. Family No Longer Entitled To Extended Medicaid

If the family is not entitled to **extended** Medicaid coverage, review each individual's eligibility for Medicaid in another category or for FAMIS. If the individual is not eligible, cancel Medicaid after sending the **Advance Notice of Proposed Action**. Cancellation is effective the last day of the eleventh month of extension. Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.

c. Family Remains Entitled To Extended Medicaid

If the family remains entitled to Extended Medicaid coverage, a redetermination of the family's Medicaid eligibility must be completed by the Medicaid cut-off in the twelfth month.

d. Report Not Received Timely

If the third three-month period's report and verifications are not received by the 21st of the tenth month, Medicaid coverage must be canceled for individuals who are not eligible for Medicaid in another covered group or for FAMIS unless the family establishes good cause for failure to report timely (see M1520.402 D.5 above for good cause). Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.

VaCMS will cancel coverage and generate the advance notice if the report is not received on time and the Follow-up Code is not changed. Cancellation is effective the last day of the eleventh month of extension.

8. Twelfth Month of Extension

Before Medicaid cut-off in the twelfth month, complete the family's redetermination. VaCMS will cancel coverage and generate the advance notice after cut-off of the twelfth month, if the Follow-up Code was updated correctly. Therefore, for any of the family members that remain eligible for Medicaid or FAMIS, the AC and the Follow-up Code must be changed before cut-off of the twelfth month.

Individuals who meet a MN covered group must be given an opportunity for an MN determination prior to the worker taking action to cancel the Medicaid coverage and unless the individual has Medicare, a referral to the HIM must be made.

M1520.500 CASE TRANSFERS

A. Introduction

Applications and ongoing cases are transferred only when the individual retains residence in Virginia.

B. Nursing Facility and Assisted Living Facility (ALF)

When an individual is admitted to a nursing facility or an ALF from a community living arrangement, the case is not transferred, but remains with the Virginia locality in which the individual last lived outside of an institution. Community living arrangements do not include medical facilities, ALFs or group homes with four or more beds.

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

If the local agencies involved agree the case should remain with the original agency, then the case would not be transferred.

C. DBHDS Facilities

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

D. Cases From Outstationed Workers

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

1. Confirm Receipt

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

2. Review Eligibility

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

3. Corrective Action

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

E. Local Agency to Local Agency

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

1. Sending Locality Responsibilities

a. Medical Assistance Case with No Other Benefit Programs Attached

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

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

TWELVE MONTH EXTENDED MEDICAID INCOME LIMITS 185% of FEDERAL POVERTY LIMITS EFFECTIVE *1-18-19* ALL LOCALITIES

# of Persons in Family Unit/Budget Unit	185% FPL Monthly Limit
1	*$1,926*
2	*2,607*
3	*3,289*
4	*3,970*
5	*4,652*
6	*5,333*
7	*6,015*
8	*6,696*
Each additional person add	*682*

M16 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-12	4/1/19	Page 7
TN #DMAS-8	4/1/18	Page 7
TN #DMAS-4	4/1/17	Page 7 Pages 8-10 are runover pages.
TN #DMAS-2	10/1/16	Page 3
TN #DMAS-1	6/1/16	Page 1
TN #100	5/1/15	Page 3
Update #9	4/1/13	Page 8

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

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

M1670.100 LOCAL AGENCY APPEAL SUMMARY

A. Agency Appeal Summary Form

Upon notification that a fair hearing has been requested, the agency must *complete an Agency Appeal Summary (form #032-03-805) available on DMAS Website at http://www.dmas.virginia.gov/#/appealsresources*

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

B. Send to Appeals Division and Appellant

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

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

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

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

M1680.100 THE HEARING PROCEDURE

A. Hearing Procedure

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

1. **Record**

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

2. **Appellant**

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

M18 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-12	04/01/2019	Page 3,5
TN #11 DMAS -11	01/01/2019	Page 3
TN #DMAS-10	10/1/18	Pages 3-5
TN #DMAS-6	10/1/17	Table of Contents Pages 3-5 Page 6 is a runover page. Page 6a was added.
TN #100	5/1/15	Table of Contents Pages 1-9 Pages 10-17 were deleted. Appendix 1 was removed.
UP #9	4/1/13	Page 3
UP #7	7/1/12	Page 12
TN #96	10/01/11	Pages 3, 4, 16
TN #95	3/1/11	Page 9
TN #94	9/1/10	Page 12
TN #93	1/1/10	Pages 4, 5
TN #91	5/15/09	Page 2 Pages 5, 6 Page 8

M1830.100 MANAGED CARE

A. General Information

DMAS provides Medicaid coverage to enrollees primarily through two delivery systems: fee-for-service (FFS) and managed care. FFS benefits are administered by DMAS through participating providers within the traditional Medicaid program rules. Most Virginia Medicaid enrollees *including individuals with other forms of health insurance (TPL)* are required to receive medical care through a managed care organization.

B. *Medallion Programs*

The Medallion 4.0 managed care program is administered through DMAS' contracted managed care organizations (MCO).

Individuals eligible for Medallion *4.0* include non-institutionalized enrollees in both Families & Children (F&C) and Aged, Blind or Disabled (ABD) covered groups. Some enrollees in the groups below are not Medallion *4.0* eligible because they meet exclusionary criteria. The following is a **partial** list of enrollees excluded from managed care enrollment:

- Enrollees who are inpatients in state mental hospitals,
- Enrollees who are in long-stay hospitals, nursing facilities, or intermediate care facilities for the intellectually disabled,
- Enrollees who meet a spenddown and are enrolled for a closed period of coverage,
- Enrollees who are participating in Plan First,
- Enrollees under age 21 in Level C residential facilities,
- Enrollees who have an eligibility period that is less than three months or who have an eligibility period that is only retroactive.

All Medallion 4.0 health plans offer enhanced benefits to members including, but not limited to:

- Adult Dental
- Vision for adults
- Cell phone
- Centering pregnancy program
- GED for Foster Care
- Sports physical at no cost (under age 21)
- Swimming lessons for members six (6) years and younger
- Boys and Girls Club membership (6-18 olds)
- Free meal delivery after inpatient hospital stays

Note: Not all health plans will offer all of the same enhanced benefits

Enrollees excluded from mandatory managed care enrollment shall receive Medicaid services under the current fee-for-service system. When enrollees no longer meet the criteria for exclusion, they shall be required to enroll in the appropriate managed care program.

Enrollees and their families may contact the Medallion 4.0 Helpline at 1-800-643-2273 for information and assistance.

E. Commonwealth Coordinated Care (CCC) Plus

Effective August 1, 2017, the CCC Plus Medicaid managed care program was implemented. CCC Plus operates statewide through a network of managed care plans across six regions as a mandatory program serving adults and children with disabilities and complex care needs. Individuals in nursing facilities and the home and community based waivers, as well as dually-eligible individuals (those with both Medicare and Medicaid) receive Medicaid through CCC Plus. Individuals receiving services through the Developmental Disabilities waivers are currently enrolled in CCC Plus only for their non-waiver services.

*The following is a **partial** list of enrollees excluded from enrollment in CCC Plus:*

- *Limited covered groups – Plan First, Qualified Medicare Beneficiaries (QMB) only, Special Low income Medicare Beneficiaries (SLMB), and Qualified Individuals (QI);*
- *Enrollees in specialized settings – intermediate care facilities for individuals with intellectual disability (ICF-ID), Veterans' nursing facilities, psychiatric residential treatment facilities (PRTF), the Virginia Home, and the Piedmont, Catawba and Hancock state facilities;*
- *Enrollees in hospice care (CCC Plus who elect hospice will remain in CCC Plus);*
- *Enrollees in other programs – Medicaid or FAMIS Medallion 4.0 managed care, and the Program for All-inclusive Care for the Elderly (PACE).*

Medicaid Expansion enrollees receive the same amount, duration and scope of services as other CCC Plus Program Members, with the following four (4) additional federally-required essential health benefits.

- *Annual adult wellness exams;*
- *Individual and group smoking cessation counseling;*
- *Nutritional counseling for individuals with obesity or chronic medical diseases;*
- *Recommended adult vaccines or immunizations.*

Enrollees and their families may contact the CCC Plus Helpline at 1-844-374-9159 for information and assistance.

G. Enrollment Corrections/ Changes

DMAS pays a capitation rate for every month an individual is enrolled in managed care regardless of whether the individual receives medical services during the month. If an individual is incorrectly enrolled in a Medicaid managed care program, the eligibility worker must refer the case to DMAS at the following address for possible recovery of expenditures (see chapter M1700):

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

M21 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-12	4/1/19	Appendix 1, page 1
TN #DMAS-9	7/1/18	Page 5
TN #DMAS-8	4/1/18	Appendix 1, page 1
TN #DMAS-4	4/1/17	Appendix 1, page 1
TN #DMAS-2	1/1/17	Appendix 1, page 1
TN #DMAS-2	10/1/16	Page 3
TN #DMAS-1	6/1/16	Appendix 1, page 1
TN #100	5/1/15	Table of Contents Pages 1-7 Appendices 1 Pages 8-10 and Appendices 2 and 3 were deleted.
UP #10	5/1/14	Pages 1-3 Appendix 1
TN #99	1/1/14	Pages 1-3 Appendix 1
TN # 98	10/1/13	Table of Contents Pages 1-10 Pages 10a and 11-16 were deleted.
UP #9	4/1/13	Pages 3, 4
UP #8	10/1/12	Table of Contents Pages 2-4 Appendix 3 deleted
TN #97	9/1/12	Pages 3, 4
UP #7	7/1/12	Pages 3, 4 Appendix 2, pages 1 Appendix 3, pages 1 and 2
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	Pages 3, 8
TN #95	3/1/11	Table of Contents Pages 5, 6, 14, 15, Page 16 added Appendix 1
TN #94	9/1/10	Page3 Appendix 3, pages 1 and 2
UP #3	3/1/10	Pages 2-5
TN #93	1/1/10	Page 2-4, 8
Update (UP) #2	8/24/09	Page 4

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

EFFECTIVE *1/11/19*

# of Persons in FAMIS House-hold	**FAMIS 150% FPL**		**FAMIS 200% FPL**		
	Annual Limit	Monthly Limit	Annual Limit	Monthly Limit	205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)
1	*$18,735*	*$1,562*	*$24,980*	*$2,082*	*$2,135*
2	*25,365*	*2,114*	*33,820*	*2,819*	*2,890*
3	*31,995*	*2,667*	*42,660*	*3,555*	*3,644*
4	*38,625*	*3,219*	*51,500*	*4,292*	*4,400*
5	*45,255*	*3,772*	*60,340*	*5,029*	*5,155*
6	*51,885*	*4,324*	*69,180*	*5,765*	*5,910*
7	*58,515*	*4,877*	*78,020*	*6,502*	*6,665*
8	*65,145*	*5,429*	*86,860*	*7,239*	*7,420*
Each add'l, add	*6,630*	*553*	*8,840*	*737*	*756*

M22 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-12	4/1/19	Appendix 1, page 1
TN #DMAS-8	4/1/18	Appendix 1, page 1
TN #DMAS-6	10/1/17	Page 7 Appendix 1, page 1
TN #DMAS-4	4/1/17	Appendix 1, page 1
TN #DMAS-1	6/1/16	Page 4 Appendix 1, page 1
TN #100	5/1/15	Table of Contents Pages 1, 2, 5, 6, 7 Appendix 1 Pages 3 and 4 are runover Pages.
TN #98	10/1/13	Table of Contents Pages 1-7 Appendix 1 Pages 8-10 were deleted.
UP #9	4/1/13	Appendix 1
UP #8	10/1/12	Pages 2, 3 Page 3a deleted
UP #7	7/1/12	Pages 2, 3
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	Pages 3, 3a
TN #95	3/1/11	Pages 4-6 Appendix 1
UP #4	7/1/10	Page 10
TN #94	9/1/10	Page 3
UP #3	3/01/10	Page 2
TN #93	1/1/10	Pages 2-10
UP #2	8/24/09	Page 3
Update (UP) #1	7/1/09	Pages 1, 2, 7 Appendix 1, page 1

FAMIS MOMS
200% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/11/19*

Household Size	200% FPL Yearly Amount	200% FPL Monthly Amount	205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)
2	*$33,820*	*$2,819*	*$2,890*
3	*42,660*	*3,555*	*3,644*
4	*51,500*	*4,292*	*4,400*
5	*60,340*	*5,029*	*5,155*
6	*69,180*	*5,765*	*5,910*
7	*78,020*	*6,502*	*6,665*
8	*86,860*	*7,239*	*7,420*
Each additional, add	*8,840*	*737*	*756*