Cheryl Roberts
DIRECTOR

Department of Medical Assistance Services

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

April 1, 2023

Virginia Medical Assistance Eligibility Manual
Transmittal #DMAS-27

The following acronyms are contained in this letter:

- COVID – Coronavirus Disease
- DHS – Department of Homeland Security
- DMAS – Department of Medical Assistance Services
- DOC – Department of Corrections
- FFC – Former Foster Care
- IMD – Institution for the Treatment of Mental Diseases
- LDSS – Local Department of Social Services
- LIFC – Low Income Families with Children
- LTSS – Long-term Services and Supports
- MAGI – Modified Adjusted Gross Income
- NABD – Non-Aged, Blind or Disabled
- PHE – Public Health Emergency
- TN – Transmittal

TN #DMAS-27 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, 2023.
Note: The Public Health Emergency has continued however The Consolidated Appropriations Act of 2023 has been implemented which has an effect on case redeterminations.

The following changes are contained in TN #DMAS-27:

Changed Pages	Changes
Subchapter M0130.200	Clarify that gender is not an eligibility factor. Note that to change gender need verification of change form SSA, driver's license or other official document.

Changed Pages	Changes
Subchapter M0220	Add DHS final rule regarding Public Charge Immigrants. Update status of Afghan immigrants paroled and extend coverage period.
Subchapter M0320	Update of Medicare Part B Premium amount, Medicaid Works limits.
Subchapter M0330	Update of hierarchy for Former Foster Care individuals.
Chapter M04	RecognizeB5 Initiative and Incentive payments are countable income.
Subchapter M0720	Correct Reasonable compatibility standard to 20%.
Subchapter M0730	Correct Reasonable compatibility standard to 20%.
Subchapter M0810	Update FPL income limits and correct Reasonable compatibility standard to 20%.
Subchapter M0830	Add section on Eugenics Sterilization Compensation (VESP) payments – exempt.
Subchapter M1110	PHE Retained assets exclusion.
Subchapter M1130	ABLE accounts are no longer subject to estate recovery.
Subchapter M1310	If the applicant fails to provide requested information for gap filling rules, deny (don't request additional information for Medically Needy evaluation). During the first renewal after the end of the Public Health Emergency there will be considered to be NO BREAK since the prior spenddown.
Subchapter M1450	Clarifies that LDSS responsible for all Recipient Audit Unit referrals.
Subchapter M1470	Remove reference to M1470.340 (no longer exits).
Subchapter M1520	Removes signature requirement for worker accepting member's verbal request to close. Notes that renewals suspended during the Public Health Emergency will commence as of April 1, 2023. Clarifies that members receiving Auxiliary Grant Supportive Housing payments transfer to locality where member resides.

Please retain this TN letter for future reference. Should you have questions about information contained in this transmittal, please contact Yolanda Chandler, Assistant Director, DMAS Eligibility and Enrollment Services Division, at yolanda.chandler@dmas.virginia.gov or (804) 588-4879.

Sincerely,

Sarah Hatton

Sarah Hatton, M.H.S.A.
Deputy of Administration

Attachment

M0130 Changes
Page 1 of 2

Changed With	Effective Date	Pages Changed
TN #DMAS-27	4/1/23	Page 6a
TN #DMAS-25	10/1/22	Pages 9,10
TN #DMAS-23	4/1/22	Pages 5, 12
TN #DMAS-21	10/1/21	Page 14
TN #DMAS-20	7/1/21	Page 2 Page 2a is a runover page.
TN #DMAS-18	1/1/21	Pages 4, 8, 13

C. Verification of Nonfinancial Eligibility Requirements

1. Verification Not Required

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

- Virginia state residency;
- pregnancy.

2. Verification Required

The following information must be verified:

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

3. *Verification Required for a Case Change of Gender*

An individual's gender is not a factor used to process a determination of Medicaid eligibility and does not have to be verified. The individual's request to a change the gender listed on the case cannot be accepted verbally and verification of a change is required. Acceptable verification could include a Social Security Administration record, a state driver license, state identification card, or other official document.

Changed With	Effective Date	Pages Changed
TN #DMAS-27	4/1/23	Page 17 Appendix 4, page 1 Appendix 5, page 1
TN #DMAS-25	10/1/22	Table of Contents, Page 14d. Page 22 Appendix 4 added page 2.
TN #DMAS-24	7/1/22	Table of Contents Pages 1, 4a, 4b, 5, 6a, 8, 14d, 14e, 15, 17, 18, 21, 22, 23 Page 6b was added as a runover page. Appendix 9 was added. Pages 22a and 24-25 were removed.

C. AFTER 7 Years of Residence in U.S.

1. Refugees — After 7 years of residence in the U.S., a refugee or Amerasian immigrant who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an "emergency services" alien.

2. Asylees — After 7 years have passed since asylum was granted, an asylee who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an "emergency services" alien.

3. Deportees — After 7 years have passed since deportation was withheld, a deportee who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an "emergency services" alien.

4. Cuban or Haitian Entrants — After 7 years of residence in the U.S., a Cuban or Haitian Entrant who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an "emergency services" alien.

5. Afghan and Iraqi Special Immigrants — Medicaid coverage for Afghan and Iraqi Special Immigrants who are eligible in a Medicaid covered group cannot begin earlier than December 26, 2007. After 7 years of residence in the U.S., Afghan and Iraqi Special Immigrants are no longer eligible for full Medicaid benefits and become "emergency services" aliens.

After the applicable limited time period expires, individuals become "emergency services" aliens unless the requirements in M0220.313 B or M0220.314 are met.

D. Services Available To Eligibles — An emergency services alien who meets all Medicaid eligibility requirements is eligible for Medicaid coverage of emergency services only.

E. Entitlement & Enrollment of Eligibles — The Medicaid entitlement policy and enrollment procedures for emergency services aliens are found in section *M0220.600 D* below.

F. Public Charge Immigrants — *Effective December 23, 2022, DHS implemented a final rule in regards to immigrants who may become a public charge. USCIS issued policy guidance under section 212(a)(4) of the Immigration and Nationality Act (INA).*

The eligibility worker will use results from a SAVE system inquiry which will indicate a status if the applicant is inadmissible under the public charge policy. Such an indication would define the individual as an unqualified alien (see M0220.441).

Afghan Special Immigrants

The United States Congress passed the Continuing Resolution on October 1, 2021, allowing individuals with a humanitarian parole status to receive full Medicaid (within certain parameters). Section 2502 of the Continuing Resolution provides that certain Afghan nationals who receive parole "shall be eligible for resettlement assistance, entitlement programs, and other benefits available to refugees" to include Medicaid, until March 1, 2023 (or until their parole expires). The majority of Afghan special immigrants entering into the U.S. fall into one of three groups:

1. Holders of a Special Immigrant Visa,

2. Special Immigrant Parolees (SIP), who are individuals granted Special Immigrant (SI/SQ) Parole (per section 602(B)(1) AAPA/Section 1059(a) NDAA 2006), and

3. Non Special Immigrant Parolees entering the United States without SI/SQ parole due to the urgent nature of their arrival (Humanitarian status).

On December 23, 2022 Congress passed the Consolidated Continuing Appropriations Act 2023 which expanded the groups and extended coverage until September 30, 2023. Eligible parolees *include:*

- *Citizens or nationals of Afghanistan* paroled into the United States between July 31, 2021, and September 30, *2023, including Unaccompanied Afghan Minors;*

- Qualifying relative of someone who received parole in that period (CR section 2502(a)(1)(B)), even if they receive parole after Sept 30, 2022. *These include a spouse, a child of any individual described above, or the parent or legal guardian determined to be of an unaccompanied child paroled into the United States after September 30, 2023..*

Individuals with (1) SIV status, (2) SIP status, and (3) Humanitarian Parolee Status issued between July 31, 2021, and September 30, 2021, are qualified for evaluation in Medicaid and FAMIS without a five-year residency bar (provided that all other eligibility requirements are met).

Exception: Humanitarian Parolees who arrived **before July 31, 2021**, are eligible only for Medicaid coverage of emergency medical services and Health Insurance Marketplace coverage. Many of these individuals have already been enrolled in subsidized Marketplace coverage or have been granted asylum and are therefore eligible for Medicaid or FAMIS without the 5-year bar.

Children under 19 years and pregnant women with SIV, SIP, or Humanitarian status meet the definition of lawfully residing aliens for Medicaid and FAMIS/FAMIS MOMS coverage.

Afghan Special Immigrant visa holders will have either (1) a passport or I-94 form indicating category SI1, SI2, SI3, SQ1, SQ2, or SQ3 and bearing the Department of Homeland Security stamp or notation or an I-151 ("green card") indicating SI6, SI7, SI8, SQ6, SQ7, or SQ8. Special Immigrant Parolees will have an I-94 form noting SQ or SI Parole (per section 602(B)(1) AAPA/Sec 1059(a) NDAA 2006).

If an individual has attested to eligible immigration status and is found otherwise eligible for Medicaid, but verification of that status cannot be obtained, do not deny or delay coverage. Enroll the individual and *provide the* 90-day reasonable opportunity period.

Code	MEDICAID ALIEN CODE CHART QUALIFIED ALIEN GROUPS	Arrived Before August 22, 1996	Arrived On or After August 22, 1996	
			1st 5 years	After 5 years
A	Qualified aliens who are Veterans or Active Military (includes spouses/dependent children); certain American Indians [Form DD 214-veteran]	Full Benefit A1	Full Benefit A2	Full Benefit A3
B	Permanent Resident Aliens (Aliens lawfully admitted for permanent residence) who have worked 40 qtrs., except Amerasians [I-151; AR-3a; I-551; I-327; I-688B-274a.12(a)(1)]	Full Benefit B1	Emergency Only B2	Full Benefit B3
C	Permanent Resident Aliens (Aliens lawfully admitted for permanent residence) who have NOT worked 40 qtrs., except Amerasians and citizens of Micronesia, Marshall Islands, Palau [I-327; I-151; AR-3a; I-551; I688B-274 a.12(a)(1)]	Full Benefit C1	Emergency Only C2	Full Benefit effective 4-1-21 C1; Emergency Only for months prior to 4-21 C2
CC	Compact of Free Association (COFA) migrants who are citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau.	Full Benefit CC1	Full Benefits effective 12-27-20. CC1; Emergency Only for months prior to 12-20. CC2	Full Benefit effective 12-27-20. CC1; Emergency Only prior to 12-20. CC2
D	Conditional entrants-aliens admitted pursuant to 8 U.S.C. 1153(a)(7), section 203(a)(7) of the INA [I-94]	Full Benefit D1	Emergency Only D2	Full Benefit D3
E	Aliens, other than Cuban or Haitian Entrants, paroled in the US pursuant to 8 U.S.C. 1182(d)(5) section 212(d)(5) of INA [I-94; I-688B – 274a(12)(c)(11)] Afghan Special Immigrant Parolees paroled into the United States between July 31, 2021, and September 30, *2023* will have an I-94 form noting SQ or SI Parole (per section 602(B)(1) AAPA/Sec 1059(a) NDAA 2006). They are eligible for full coverage without a 5-year waiting period. See Appendix 4. Ukraine Humanitarian Parolees. See Appendix 4.	Full Benefit E1	Emergency Only E2	Full Benefit E3
I	Battered aliens, alien parents of battered children, alien children of battered parents [U.S. Attorney General]	Full Benefit I1	Emergency Only I2	Full Benefit I3
	QUALIFIED ALIEN GROUPS		1st 7 years	After 7 years
F	Aliens granted asylum pursuant to section 208 of the INA [I-94; I-688B – 274a.12(a)(5)]	Full Benefit F1	Full Benefit F2	Emergency Only F3
G	Aliens admitted as refugees pursuant to section 207 of the INA, or as Cuban or Haitian Entrants as defined in section 501(e) of Refugee Education Assistance Act of 1980 {including those under section 212(d)(5)}, or Amerasians [I-551; I-94; I-688B]	Full Benefit G1	Full Benefit G2	Emergency Only G3
H	Aliens whose deportation has been withheld pursuant to Section 243(h) or 241(b)(3) of the INA [I-688B – 274a.12(a)(10); Immigration Judge's Order]	Full Benefit H1	Full Benefit H2	Emergency Only H3

M0320 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-27	4/1/23	Pages 11, 24, 25, 27
TN #DMAS-26	1/1/23	Page 11
TN #DMAS-24	7/1/22	Pages 2, 30, 31, 33
TN #DMAS-23	4/1/22	Page 27
TN #DMAS-22	1/1/22	Pages 11, 26a, 27
TN #DMAS-20	7/1/21	Pages 24, 26-29
TN #DMAS-19	4/1/21	Pages 26a, 29
TN #DMAS-18	1/1/21	Pages 11, 22, 26, 27
TN #DMAS-17	7/1/20	Pages 24. 25. 26, 27 Page 26a was added as a runover page.
TN #DMAS-15	1/1/20	Pages 11, 26, 27, 29
TN #DMAS-14	10/1/19	Page 40
TN #DMAS-13	7/1/19	Pages 1, 24-27
TN #DMAS-11	1/1/19	Pages 2a, 11, 35, 37
TN #DMAS-10	10/1/18	Page 1 1a added as a runover page
TN #DMAS-9	7/1/18	Page 2, 17
TN #DMAS-7	1/1/18	Page 2, 3, 4, 11, 26-27.
TN #DMAS-4	4/1/17	Page 26
TN #DMAS-3	1/1/17	Pages 11, 27, 29, 40, 41, 44, 45, 52
TN #DMAS-2	10/1/16	Pages 4, 15, 16, 18, 20, 22, 30, 33, Pages 39- 41, 43-45, 48, 51, 52, 55
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 1, 11, 25-27, 46-49 Page 50 is a runover page.
TN #100	5/1/15	Pages 6, 11, 24, 25-27, 29-30
TN #99	1/1/14	Page 11
TN #98	10/1/13	Pages 1, 54, 55.
UP #9	4/1/12	Pages 11, 26, 32, 34-37, 45, 46, 55
TN #97	9/1/12	Table of Contents Pages 1-56 (all pages)
UP #6	4/1/12	Pages 11, 12, 46a
TN #96	10/1/11	Table of Contents Pages 46f-50b Page 50c deleted
TN #95	3/1/10	Pages 11, 12, 42c, 42d, 50, 53, 69 Pages 70, 71 Page 72 added.
TN #94	9/1/10	Pages 49-50b
UP #3	3/1/10	Pages 34, 35, 38, 40, 42a, Pages 42b, 42f
TN #93	1/1/10	Pages 11-12, 18, 34-35, 38 Pages 40, 42a-42d, 42f-44, 49 Pages 50c, 69-71
UP #2	8/24/09	Pages 26, 28, 32, 61, 63, 66
Update (UP) #1	7/1/09	Pages 46f-48
TN #91	5/15/09	Pages 31-34 Pages 65-68

Note: There was no COLA in 2010, 2011 or 2016.

The Cost-of-living calculation formula
(The formula is the current Title II Benefit divided by the percentage increase to equal the benefit amount before the COLA change):

a. Current Title II Benefit = Benefit Before 1/22 COLA
1.059 (1/22 Increase)

b. Benefit Before 1/22 COLA = Benefit Before 1/21 COLA
1.013 (1/21 Increase)

c. Benefit Before 1/21/ COLA = Benefit Before 1/20 COLA
1.016 (1/20 Increase)

d. Benefit Before 1/20 COLA = Benefit Before 1/19 COLA
1.028 (1/19 Increase)

5. Medicare Premiums

a. Medicare Part B premium amounts:

1-1-23 $164.90
1-1-22 $170.10
1-1-21 $148.50
1-1-20 $144.60
1-1-19 $135.50
1-1-18 $134.00

Note: These figures are based on the individual becoming entitled to Medicare during the year listed. The individual's actual Medicare Part B premium may differ depending on when he became entitled to Medicare. **Verify the individual's Medicare Part B premium in SVES or SOLQ-I if it is necessary to know the premium amount for Medicaid eligibility or post-eligibility purposes.**

b. Medicare Part A premium amount:

1-1-23 $506.00
1-1-22 $499.00
1-1-21 $471.00
1-1-20 $458.00
1-1-19 $437.00
1-1-18 $422.00

Contact a Medical Assistance Program Consultant for amounts for years prior to *2018.*

6. Evaluation

Individuals who are eligible when a cost-of-living increase is excluded are eligible.

B. Financial Eligibility

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

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

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

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

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

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

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

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

E. Enrollment The ABD 80% group AC is:

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

M0320.400 MEDICAID WORKS

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

- at least age 16 and are under age 65, **and**
- who have countable income less than or equal to *138%* FPL.. **or**
- or who are SSI recipients or 1619(b) individuals), **and**
- who have countable resources less than or equal to $2,000 for an individual and *$*3,000 for a couple; **and**

- who are working or have a documented date for employment to begin in the future.
- *Current participation in the Social Security Administration (SSA) programs Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) will satisfy the condition for disability. Any applicant without SSA documentation of disability should be evaluated by the state's Disability Determination Services program before eligibility can be established.*

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

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

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

C. Nonfinancial Eligibility

The individual must also meet the following additional nonfinancial criteria:

- The individual must be competitively employed in an integrated setting. Work must occur in a work setting in the community or in a personal business alongside people who do not have disabilities. Work performed in a sheltered workshop or similar setting is **not** considered competitive employment in an integrated setting. Contact a Regional Medical Assistance Program Consultant if there is a question about whether the employment meets the criteria for MEDICAID WORKS.
- The individual must receive pay at the minimum wage or at the prevailing wage or "going rate" in the community, and the individual must provide documentation that payroll taxes are withheld. Self-employment must be documented according to the policy contained in S0820.210.
- The individual must establish a Work Incentive (WIN) Account at a bank or other financial institution, such as a checking or savings account. The individual must provide documentation for the case record designating the account(s) as a WIN Account. The account must either be a new account or an existing account with only the wages earned while in MEDICAID WORKS deposited into it. Increases in an enrollee's Social Security Disability benefits resulting from employment as a MEDICAID WORKS participant OR as a result of a COLA adjustment to the Social Security Disability benefits may also be deposited into the WIN account and will be excluded as described in M0320.400 D.3.b.3) as long as the increase is regularly deposited upon receipt into the WIN account. The WIN account cannot contain the individual's other Social Security benefits.

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 on or after July 1, 2021, the limit for total countable income (unearned and earned) is less than or equal to 138% of the FPL (*$1,677* per month for an individual or *$2,269* when the applicant has an ABD spouse who is also applying for or covered by Medicaid). The income requirements in chapter S08 must be met. Individuals who receive SSI or who have 1619(b) status are considered to meet the income requirements and no evaluation of income is necessary for the initial eligibility determination (see M0320.101).

b. Ongoing eligibility

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

1) The income limit for earned income is $6,250 per month ($75,000 per year) (no change for *2023*) 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 138% of the FPL. The policy for determining countable unearned income is contained in subchapter S0830.

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

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

M0330 Changes
Page 1 of 2

Changed With	Effective Date	Pages Changed
TN #DMAS-27	4/1/23	Pages 1, 2, 8
TN #DMAS-24	7/1/22	Pages 1, 2, 15, 18, 29, 31, 32 Page 2a was added as a runover page.
TN #DMAS-23	4/1/22	Table of Contents Pages 1, 2, 5, 7, 8, 29, 37, 39, 40
TN #DMAS-20	7/1/21	Pages 1, 13, 14
TN #DMAS-19	4/1/21	Pages 14, 26
TN #DMAS-14	10/1/19	Pages 1, 2, 10a
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.

M0330.000 FAMILIES & CHILDREN GROUPS

M0330.001 GENERAL POLICY PRINCIPLES

A. Overview

A State Plan for Medicaid must include the mandatory federal categorically needy (CN) groups of individuals as well as the optional groups a state has elected to cover. This subchapter divides the Families & Children (F&C) covered groups into categorically needy and medically needy (MN) groups.

Enroll children and adults who receive Supplemental Security Income (SSI) in the SSI Medicaid covered group (see M0320.101). Evaluate other disabled children and adults for eligibility in the F&C CN covered groups first because they do not have a resource requirement. Individuals who are eligible for or entitled to Medicare cannot be eligible in the MAGI Adults covered group.

B. Procedure

Determine an individual's eligibility first in a CN covered group. If the individual is not eligible as CN or for the Family Access to Medical Insurance Security Plan (FAMIS), go to the MN groups.

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

1. *If a child is a former foster care child under age 26 years, evaluate for coverage in this group.*
2. If the child meets the definition of a foster care child, adoption assistance child, adoption assistance child with special needs for medical or rehabilitative care, or an individual under age 21, evaluate in these groups first.
3. If the child meets the definition of a *pregnant woman or* newborn child, evaluate in the pregnant woman/newborn child group.
4. If the child is under age 18 or is an individual under age 21 who meets the adoption assistance or foster care definition or is under age 21 in an intermediate care facility (ICF) or facility for individuals with intellectual disabilities (ICF-ID), AND is in a medical institution or has been authorized for Home and Community Based Services (HCBS) or has elected hospice, evaluate in the appropriate F&C 300% of SSI covered group.
5. If a child is under the age of 19, evaluate in this group.
6. If a child has income in excess of limits individual, evaluate for the Family Access to Medical Insurance Security Plan (FAMIS) eligibility (chapter M21).
7. If the child is a child under age 1, child under age 18, an individual under age 21 or an adoption assistance child with special needs for medical or rehabilitative care but has income in excess of the appropriate F&C CN income limit, evaluate as MN.

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

1. *If the individual is a former foster care child under 26 years, evaluate in this covered group.*
2. If the individual meets the definition of a parent/caretaker relative, evaluate in the LIFC covered group.

3. If the individual is not eligible as *a former foster care child under 26 years,* but meets the definition of a pregnant woman, evaluate in the pregnant woman/newborn child group. If the pregnant women does not meet the definition of lawfully residing in M0220.314, evaluate for FAMIS Prenatal Coverage (see Chapter M23).

4. If the individual has been screened and diagnosed with breast or cervical cancer or pre-cancerous conditions by the Every Woman's Life program and does not meet the definition of for coverage as SSI, LIFC, Pregnant Woman or Child under 19, evaluate in the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) covered group.

5. If the individual is between the ages of 19 and 64 and is not eligible for or entitled to Medicare, evaluate in the MAGI Adults group.

6. If the individual is not eligible as a MAGI Adult, LIFC individual, or pregnant woman but is in a medical institution, has been authorized for Home and Community Based Services or has elected hospice, evaluate in the appropriate F&C 300 % of SSI covered group.

   If the individual is a parent or caretaker-relative of a dependent child and in a medical institution, the stay must be temporary while receiving treatment, rehabilitation, etc. for him to meet the definition of living in the home with the dependent child. There are no time limits on the amount of time the parent can be in a medical institution as long as he intends to return home. Verify with the parent the reason he is in a medical facility and ask about the intent to return home.

7. If the individual has excess income for full coverage in a Medicaid covered group and is between the ages of 19 and 64, evaluate for Plan First coverage.

8. If the individual is a pregnant woman but has excess income for coverage in a CN group or FAMIS MOMS evaluate as MN.

M0330.100 FAMILIES & CHILDREN CATEGORICALLY NEEDY

A. Introduction

An F&C individual must be a child under age 19 or must meet the adoption assistance, dependent child, foster care, parent or caretaker-relative of a dependent child living in the home, pregnant woman, or BCCPTA definition, or must have applied for Plan First.

The F&C covered groups are divided into the categorically needy (CN) and medically needy (MN) classifications. Always evaluate eligibility in the categorically needy groups and FAMIS before moving to MN.

B. Procedure

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

M0330.100 Families & Children Categorically Needy Groups
M0330.105 IV-E Foster Care & IV-E Adoption Assistance;
M0330.107 Individuals Under Age 21;
M0330.108 Adoption Assistance Children With Special Needs for Medical or Rehabilitative Care;
M0330.109 Former Foster Care Children Under Age 26 Years
M0330.200 Low Income Families With Children;

2. Resources

There is no resource test for the Adoption Assistance Children With Special Needs for Medical or Rehabilitative Care covered group.

3. Income

Adoption assistance children in residential facilities do not have a different income limit. The income limit for Individuals Under Age 21 for one person in the child's locality is used to determine eligibility in the Adoption Assistance Children With Special Needs for Medical or Rehabilitative Care covered group. See M04, Appendix 4.

For a Virginia adoption assistance child with special needs for medical or rehabilitative care living outside the State of Virginia, the income limit for the unit is the income limit for the Virginia locality that signed the adoption assistance agreement.

The adoption subsidy payment is excluded when determining the child's financial eligibility.

If the child's countable income exceeds the income limit for Individuals Under Age 21, evaluate the child in the Adoption Assistance Children With Special Needs for Medical or Rehabilitative Care MN covered group (see M0330.805). Ineligible individuals must be referred to the Health Insurance Marketplace for evaluation for the APTC.

D. Entitlement & Enrollment

Entitlement to Medicaid begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

The AC for individuals in the Adoption Assistance Children With Special Needs for Medical or Rehabilitative Care covered group is "072."

M0330.109 FORMER FOSTER CARE CHILDREN UNDER AGE 26 YEARS

A. Policy

P.L. 111-148 (The Affordable Care Act) - The federal Medicaid law requires the State Plan to cover individuals who were formerly in Title IV-E or non-IV-E foster care or the Unaccompanied Refugee Minors Program (URM) when the individual:

- was in the custody of a local department of social services in Virginia, another state, or a U.S. Territory, and receiving Medicaid until his discharge from foster care upon turning 18 years or older, or
- was in the URM program in Virginia or another state and receiving Medicaid until his discharge upon turning 18 years or older.
- is under age 26 years.

A child age 18 and over who is in an Independent Living arrangement or in the Fostering Futures Program with a local department of social services may be eligible in this covered group.

Changed With	Effective Date	Pages Changed
TN #DMAS-27	4/1/23	Pages 5, 6, 16 Definitions renumbered
TN #DMAS-26	1/1/23	Page 34
TN #DMAS-25	10/1/22	Pages 5, 15, 16
TN #DMAS-24	7/1/22	Appendix 3 Appendix 5
TN #DMAS-23	4/1/22	Pages 16b, 18, 32 Appendix 1, pages 1-2 Appendix 2, pages 1-2 Appendices 6 and 7
TN #DMAS-21	10/1/21	Pages 3, 15
TN #DMAS-20	7/1/21	Pages 2, 14, 15, 16a, 16b, 19 Appendix 3 Appendix 5 Appendix 8
TN #DMAS-19	4/1/21	Appendix 1, pages 1-2 Appendix 2, pages 1-2 Appendices 6 and 7
TN #DMAS-18	1/1/21	Pages 7, 16a, 18, 19 Page 16 b was added. Page 18a was added as a runover page.
TN #DMAS-17	7/1/20	Pages 15, 16, 16a, 19 Appendices 3, 5, and 8
TN #DMAS-16	4/1/20	Pages 16a, 20 Appendix 1, pages 1-2 Appendix 2, pages 1-2 Appendices 6 and 7
TN #DMAS-15	1/22/19	Pages 16, 16a, 19
TN #DMAS-14	10/1/19	Pages 1, 3, 4, 5, 14, 16, 32, 33 Appendix 8
TN #DMAS-13	7/1/19	Pages 32-34, 36 Appendices 3 and 5
TN #DMAS-12	4/1/19	Pages 2, 3, 5-8, 15-16, 19, 32-37 Page 16a was added as a runover page. Page 37 was removed. Appendices 1, 2, 6, 7, 8
TN #DMAS-11	1/1/19	Pages 8, 15, 32-35 Pages 36 and 37 were added.
TN #DMAS-10	10/1/18	Table of Contents Pages 1-5, 9, 10, 15, 16, 19, 22, 23, 30-32 Appendix 7 Appendix 8 was renumbered. Pages 6-8, 11-14, 17, 18, 20, 21, 24-29, 33-35 are runover pages.

7. **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, and who lives with his parent or caretaker-relative.

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

9. **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.

10. **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).

11. **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.

12. **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.

13. **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.

14. **Reasonable Compatibility** means the income attested to (declared) by the applicant is within 20% of income information obtained from electronic sources OR that both the attested income and any electronic income verification are below the applicable income limit. If the income from both sources meets the 20% requirement or the income from both sources is below the limit, then the attestation is considered verified.

    The applicant's income reported on the application is compared through a match with income verification available from electronic income sources. 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 available electronic sources and the attestation is below the medical assistance income level, additional verification of income is required.

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

16. 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.

17. 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.

18. 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.

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

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

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

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

j. Census income.

k. *RecognizeB5 Initiative and Incentive Payments issued to educators for their ongoing efforts to improve Virginia's early childcare and education structure are counted.*

l. Unemployment Compensation is counted as unearned income.

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

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

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

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

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

0720 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-27	4/1/23	Page 2
TN #DMAS-16	4/1/20	Page 11
TN# DMAS -14	10/1/19	Page 2
TN# DMAS -11	01/01/19	Page 4
TN #DMAS-2	10/1/16	Table of Contents, page i Pages 11, 13, 14 Appendix 1 Pages 15-19 were deleted.
TN #DMAS-1	6/1/16	Page 2
TN #98	10/1/13	Pages 6, 10
TN #94	9/01/10	Pages 5, 6
TN #91	5/15/09	Page 11

- pay for jury duty
- severance pay
- tips
- vacation pay
- sick pay from employer or employer-obtained insurance

2. When to Count Wages are calculated on a monthly basis and counted at the earliest of the following points:

- when they are received, or
- when they are credited to the individual's account, or
- when they are set aside for the individual's use.

Absent evidence to the contrary, if FICA (Federal Insurance Contributions Act) taxes have been deducted from an item, assume it meets the definition of wages. Failure to deduct FICA taxes does not mean the income is not wages.

EXAMPLE #1:
Mrs. Green is employed by Mr. Brown who owns a small business. Mr. Brown does not deduct FICA taxes from Mrs. Green's income. Mrs. Green's income from Mr. Brown is wages.

C. Verification For all case actions effective *August 26, 2022*, if the income attested to by the applicant is within *20%* of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required. If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return.

Verify wages, salaries, and commissions by pay stubs, pay envelopes, a written statement from the employer, or by the eligibility worker's verbal contact with the employer.

When attempts to verify income are unsuccessful because the person or organization who is to provide the information cannot be located or refuses to provide the information to both the applicant/*enrollee* and the eligibility worker, a third party statement, a collateral contact, or as a last resort, the applicant's/enrollee's written statement can be used as verification and to determine the amount of income to be counted.

Verify tips by a weekly record of the tips prepared by the employed individual.

M0720.105 INCOME FROM A CORPORATION

If a person has incorporated a self-employment enterprise either alone or with other persons and draws a salary from the business, the wages drawn are regular earned income, not self-employment income.

M0720.110 HOW TO COUNT INCOME IN THE RETROACTIVE PERIOD

When evaluating eligibility for a retroactive period, income eligibility is based on income actually received each month in the retroactive period.

M0730 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-27	4/1/23	Page 1
TN #DMAS-18	1/1/21	Page 3
TN #DMAS-17	7/1/20	Page 7
TN #DMAS-14	10/1/19	Page 1
TN #DMAS-9	7/1/18	Table of Contents Pages 11, 15
TN #DMAS-4	4/1/17	Pages 7, 8
TN #98	10/1/13	Pages 7, 8 Page 8a was removed.
TN #97	9/1/12	Page 10
TN #94	9/1/2010	Pages 7, 8
TN #93	1/1/2010	Page 2
TN #91	5/15/2009	Table of Contents pages 7-8a

M0730.000 GENERAL-- F&C UNEARNED INCOME
M0730.001 INTRODUCTION TO UNEARNED INCOME

A. Policy - General

Unearned income is all income received by members of the family/budget unit that is not earned income. Unearned income consists of:

- benefits, including public assistance benefits received from another state
- royalties
- child/spousal support
- dividends and interest
- some rental income
- gifts
- some home energy assistance
- contributions
- lump sums

B. Policy - When to Count Unearned Income

Unearned income is counted as income in the earliest month it is:

- received by the individual;
- credited to the individual's account; or
- set aside for the individual's use.

C. Available Income

Retroactive period –available income is the gross income actually received in each month in the retroactive period.

Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months. The applicant's actual gross income received in the application month may be used if the application is processed after the month has passed and the person is eligible only when using the actual gross income for the month. For all case actions a*s of August 26, 2022,* attested income may be used if the requirements specified in M0730.001 E. are met.

D. Policy - What Amount of Unearned Income is Counted

The amount of unearned income received is counted as income.

EXCEPTION: When the Medicare Part B premium is deducted from the Social Security or Railroad Retirement benefits, that amount must be added to the actual benefit being received.

E. Verifications

The agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family. For all case actions effective *August 26, 2022*, if the income attested to by the applicant is within *20%* of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required.

If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return.

Verify the amount of the unearned income by an award letter or notice, a benefit payment check, or through contact with the source of the unearned income, unless the source of the unearned income is listed in M0730.099 B. Verification of unearned income that is totally excluded is not required.

F. References

What is income, M0710.003
What is not income, M0715.050
When income is counted, M0710.030
How to estimate income, M0710.610

M0810 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-27	4/1/23	Page 2, 25, 27, 28 Page 25a is a runover page
TN #DMAS-25	1/1/23	Pages 1, 2
TN #DMAS-24	7/1/22	Page 2
TN #DMAS-23	4/1/22	Page 2
TN #DMAS-22	1/1/22	Pages 1, 2, 3
TN #DMAS-20	7/1/21	Page 2
TN #DMAS-19	4/1/21	Page 2
TN #DMAS-18	1/1/21	Pages 1, 2
TN #DMAS-17	7/1/20	Page 2
TN #DMAS-16	4/1/20	Page 2
TN #DMAS-15	1/1/20	Pages 1, 2
TN #DMAS-14	10/1/19	Pages 20, 25, 27 Page 28 is a runover page.
TN #DMAS-12	4/1/19	Page 2
TN #DMAS-11	1/1/19	Pages 1, 2
TN #DMAS-10	10/1/18	Page 2
TN #DMAS-9	7/1/18	Page 2
TN #DMAS-8	4/1/18	Page 2
TN #DMAS-7	1/1/18	Pages 1, 2
TN #DMAS-5	7/1/17	Page 2
TN #DMAS-4	4/1/17	Page 2
TN #DMAS-3	1/1/17	Pages 1, 2
TN #DMAS-2	10/1/16	Page 2
TN #DMAS-1	6/1/16	Pages 1, 2
UP #11	7/1/15	Page 2
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	2022 Monthly Amount	2023 Monthly Amount
1	$2,523	$2,742

4. ABD Medically Needy

a. Group I	7/1/21 – 6/30/22		7/1/22	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,019.02	$336.50	$2,138.14	$356.35
2	2,570.31	428.38	2,721.95	453.65

b. Group II	7/1/21 – 6/30/22		7/1/22	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,329.65	$388.27	$2,467.09	$411.18
2	2,868.64	478.40	3,037.88	506.31

c. Group III	7/1/21 – 6/30/22		7/1/22	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$3,028.56	$504.76	$3,207.24	$534.54
2	3,651.15	608.52	3,866.55	644.42

5. ABD Categorically Needy

For:

ABD 80% FPL, QMB, SLMB, & QI <u>without</u> Social Security income; all QDWI; effective 1/18/22

ABD 80% FPL, QMB, SLMB, & QI <u>with</u> Social Security income; effective 3/1/22

All Localities	2022		*2023*	
ABD 80% FPL	Annual	Annual	Annual	Monthly
1	$10,872	$10,872	*$11,664*	*$972*
2	14,648	14,648	*15,776*	*1,315*
QMB 100% FPL	Annual	Annual	Annual	Monthly
1	$13,590	$13,590	*$14,580*	*$1,215*
2	18,310	18,310	*19,720*	*1,644*
SLMB 120% of FPL	Annual	Annual	Annual	Monthly
1	$16,308	$16,308	*$17,496*	*$1,458*
2	21,972	21,972	*23,664*	*1,972*
QI 135% FPL	Annual	Annual	Annual	Monthly
1	$18,347	$18,347	*$19,683*	*$1,738*
2	24,719	24,719	*28,200*	*2,350*
QDWI 200% of FPL	Annual	Annual	Annual	Monthly
1	$27,180	$27,180	*$29,160*	*$2,430*
2	36,620	36,620	*39,440*	*3,287*

VERIFYING AND ESTIMATING INCOME

S0810.500 INCOME VERIFICATION

A. Policy Principles

1. Why Verification is Necessary

Although Medicaid does not determine Medicaid eligibility solely on the basis of statements concerning eligibility factors by applicants and recipients, for all case actions as of October 26, 2019, attestation of income will be accepted absent evidence to the contrary. We verify relevant information from independent or collateral sources and obtain additional information as necessary to be sure that eligibility is determined correctly. *The agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information, and information from SSA through SVES or SOLQ-I. 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.*

For all case actions effective August 26, 2022, if the income attested to by the applicant is within 20% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required. If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return.

2. All Situations

a. **Individual's Attestation**
Obtain a statement over the individual's signature concerning the type, amount, frequency, or predictability of income. The statement or similar information on the application or redetermination form, is sufficient documentation. Absent evidence to the contrary, accept the individual's attestation.

b. **Evidence Disagrees with Attestation**
If there is evidence which disagrees with the individual's attestations, develop and document under the appropriate income rules.

2. Applicants/ Recipient's Responsibility

A person applying for or receiving Medicaid must give the local Department of Social Services (LDSS) any requested information and show necessary documents or other evidence to establish the amount of the individual's income.

B. Operating Policy

1. Burden of Proof

Applicants and recipients (or their representative payees) are responsible for providing LDSS with proof of income *if requested* and for reporting any changes in income.

2. Additional Verification Requirements

See the instructions for the particular type of income involved for additional verification requirements.

3. Initial Applications Versus Post eligibility Situations

Unless instructions dealing with particular types of income state otherwise, verification requirements for initial applications also apply in post eligibility situations.

C. References

- Estimating future wages, S0820.150.
- Verification Requirements:
  Unearned income, S0830.005.
  Wages, S0820.135.
  Self-employment, S0820.220.
  Sheltered workshop earnings, S0820.300.
  Sick pay, S0820.005.

M0810.610 HOW TO ESTIMATE INCOME

A. Operating Policy

1. Monthly Estimates

Estimate future income monthly.

2. Fluctuating Income

When income fluctuates, use previous months' actual receipts or written attestation to project future anticipated monthly income.

a. Individual's Attestation

Obtain a statement over the individual's signature concerning the type, amount, frequency, or predictability of income. The statement or similar information on the application or redetermination form, is sufficient documentation. Absent evidence to the contrary, accept the individual's attestation.

b. Evidence Disagrees with Attestation

If there is evidence which disagrees with the individual's attestations, develop and document under the appropriate income rules. The anticipated income should be an accurate indication of the individual's future income situation.

3. Income Expected Less Than Once a Month

Determine the specific month(s) of receipt and use the amount(s) estimated for the appropriate month(s).

4. Converting to Monthly Totals

To estimate income for Medically Needy Income evaluation convert to a monthly total, then multiply by number of months in the spenddown time frame.

- Weekly income is multiplied by 4.3,
- Biweekly income is multiplied by 2.15,
- dividing biweekly wages by 2 and multiplying by 4.3., or
- semi-monthly income multiplied by 2.

B. Operating Procedure

1. When a Change Occurs

An anticipated change in income occurs when you expect an individual's income to start, to stop, or to come in at a different rate in the future.

2. How to Develop a Change

When you anticipate an increase in income, use only that income which the individual is reasonably sure he will receive. *When a change in income occurs, redetermine Medicaid eligibility. Countable earned and unearned income is only verified if reasonable compatibility does not exist or the applicant's attested income or information from electronic data sources is over the income limit for his covered group.*

3. Example

Anticipated Decrease in Income

Mr. Danny Kelp, a student child, receives support payments from an absent parent. These payments are $160 a month. In March, Danny's father begins a new job which pays less money. Danny notifies his EW that, based on his father's decrease in salary, he expects his support payments to decrease to $125 a month. The EW includes $125 unearned income in Danny's countable income computation.

C. Documentation

1. What the File Must Contain

If income verification is requested and received, verify and document the case record regarding the rate and frequency of payment (i.e., weekly, biweekly, semi-monthly, monthly, etc.) and the payment cycle (i.e., on what day the client is paid). The file must contain the estimates used.

2. Who May Provide an Estimate

Estimates of income may come from the applicant/recipient, representative, worker, or deemor.

3. Resolve any Discrepancy

If information received from an employer concerning current or future rate of pay is discrepant with an estimate provided by the applicant/recipient, representative payee, worker, or deemor, you must resolve the discrepancy.

4. Additional Documentation Requirements

See the specific sections dealing with the type(s) of income involved to determine if there are additional documentation requirements.

S0830 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-27	4/1/23	Pages 7,
TN #DMAS-25	1/1/23	Pages 24, 24a, 50
TN #DMAS-24	7/1/22	Page 114
TN #DMAS-23	4/1/22	Page 78
TN #DMAS-17	7/1/20	Page 29
TN #DMAS-12	4/1/19	Page 113
TN #DMAS-7	1/1/18	Table of Contents, page iii, iv. Pages 7-8, 17-18, 20, 29, 48, 79a, 82, 124a-124b, 125.
TN #DMAS-4	4/1/17	Table of Contents, page i Pages 24, 24c
TN #DMAS-2	10/1/16	On page 109, updated the format of the header. Neither the date nor the policy was changed.
TN #DMAS-1	3/23/16	Table of Contents, page iii Pages 18, 82
Update #7	7/1/12	Page 24
TN #94	9/1/10	Page 29
TN #93	1/1/10	Table of Contents, page iv Pages 28, 67, 119-120 Pages 122-125
TN #91	5/15/09	Table of Contents, page i Page 29

S0830.099 GUIDE TO EXCLUSIONS

A. Introduction

The following provides a list of those instructions which address a partial or total exclusion of unearned income. Those in **bold print** involve an exclusion under another Federal statute.

B. List of Instructions About Unearned Income Exclusions

S0830.741 ENERGY EMPLOYEES OCCUPATIONAL ILLNESS COMPENSATION PLAN (EEOICP)

A. Background

The EEOICP was established to pay claims for benefits under the Energy Employees Occupational Illness Compensation Program Act of 2000 (the EEOICP Act). The EEOICP Act authorizes lump sum payments and the reimbursement of medical expenses to employees of the Department of Energy (DOE) or of private companies under contract with DOE, who suffer from specified diseases as a result of their work in the nuclear weapons industry. The EEOICP Act also authorizes compensation to the survivors of these employees under certain circumstances. The Department of Labor (DOL) is responsible for the administration, adjudication and payment of claims under the EEOICP. DOL makes payments from the Energy Employees Occupational Illness Compensation Fund. Part B and Part E of the EEOICP have different effective dates, illness criteria and medical/compensation allowances.

B. Policy

Lump sum payments made under the EEOICP, including reimbursement for medical expenses, are excluded from income for Medicaid purposes.

1. EEOICP Payments

NOTE: Individuals who are eligible under Section 5 of the Radiation Exposure Compensation Program (RECP) may also be eligible for compensation and paid medical expenses under the EEOICP.

2. Interest on EEOICP Payments

Effective July 1, 2004, interest earned on unspent EEOICP payments is excluded from income for SSI purposes.

C. Procedure

Use documents the applicant provides to verify the payment is from EEOICP. Accept the individual's signed allegation of the amount and date of receipt if it is not evident from the documents.

If the individual has not documentation or there is reason to question the source of the payments, contact the Department of Labor (DOL). A list of the DOL district offices and telephone numbers can be found on the DOL website at: http://www.dol.gov/esa/regs/compliance/owcp/eeoicp/main.htm

M0830.745 EUGENICS STERILIZATION COMPENSATION (VESC)

C. Background

In 2015, the legislature authorized compensation of up to $25,000 per claim to provide compensation for individuals sterilized "pursuant to the Virginia Eugenical Sterilization Act and who were living as of February 1, 2015." If the person died on or after February 1, 2015, a claim may be submitted by the estate or personal representative of the person who died. Federal law provides that payments made under a state eugenics compensation program shall not be considered as income or resources for purposes of determining the eligibility of a recipient of such compensation for, or the amount of, any federal public benefit.

D. Policy

Use documents the applicant provides to verify the payment is from this source. Accept the individual's signed allegation of the amount and date of receipt if it is not evident from the documents.

M1110 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-27	4/1/23	Pages 6, 7
TN #DMAS-26	1/1/23	Page 2
TN #DMAS-22	1/1/22	Pages 1, 2
TN #DMAS-20	7/1/21	Page 16
TN #DMAS-19	4/1/21	Page 16
TN #DMAS-18	1/1/21	Page 2
TN #DMAS-17	7/1/20	Page 1
TN #DMAS-15	1/1/20	Page 2
TN #DMAS-12	4/1/19	Pages 10-10a
TN #DMAS-11	1/1/19	Page 2
TN #DMAS-3	1/1/18	Page 2
TN #DMAS-4	4/1/17	Pages 10, 10a
TN #DMAS-3	1/1/17	Pages 2, 7, 10, 11 Page 10a was added as a runover page.
TN #100	5/1/15	Page 2
TN #99	1/1/14	Page 2
UP #9	4/1/13	Page 2
UP #6	4/1/12	Page 2
TN #96	10/1/11	Page 2
TN #95	3/1/11	Page 2
Update (UP) #3	3/2/10	Table of Contents page 2
TN #93	1/1/10	Page 2
TN #91	5/15/09	Pages 14-16

C. Example (cont.)

2. While in the hospital, the recipient received a check for $25 as a "get-well" gift from her neighbors. She was unaware of the gift. At the time, her affairs were being managed by her daughter, who put the check in a desk drawer and failed to tell the recipient anything about it.

   In the month the recipient learns of the existence of the check, the check is counted as her **income**. In the following month, the $25 is counted as her **resource.**

COUNTABLE VS. EXCLUDED RESOURCES

S1110.200 COUNTABLE RESOURCES

Policy

The value of any asset that meets the definition of a resource counts against the applicable resource limit to the extent that the instructions in S1130.100 do not provide for its exclusion.

M1110.210 EXCLUDED RESOURCES

A. Introduction

Once you have determined that an asset meets the definition of a resource, it is necessary to determine that resource's effect on eligibility. Certain resources do not count against the resource limit; i.e., they are excluded.

B. List of Resource Exclusions

Exclusion	Reference	No Limit on Value and/or Length of Time	Limit on Value and/or Length of Time
Home serving as the principal place of residence, including the land on which the home stands (*contiguous property exempt for QDWI, QMB, SLMB, QI and ABD 80% FPL).	M1130.100	* X	X
Funds from sale of a home if reinvested timely in a replacement home	S1130.110		X
Jointly-owned real property which cannot be sold without undue hardship (due to loss of housing) to the other owner(s)-For QMB, QDWI, SLMB, QI and ABD 80% FPL only	S1130.130 Appendix 1 Appendix 2	X	
Real property for as long as the owner's reasonable efforts to sell it are unsuccessful	M1130.140	X	
Restricted, allotted Indian land if the Indian/owner cannot dispose of the land without the permission of other individuals, his/her tribe, or an agency of the Federal Government	S1130.150	X	

Exclusion	Reference	No Limit on Value and/or Length of Time	Limit on Value and/or Length of Time
Life insurance, depending on its face value	S1130.300		X
Burial space or plot held for an eligible individual, his/her spouse, or member of his/her immediate family	M1130.400	X	
Burial funds for an individual and/or his/her spouse	M1130.410		X
Certain prepaid burial contracts	M1130.420		X
Household Goods and Personal Effects	M1130.430	X	
Property essential to self-support	S1130.500-.504		X
Resources of a blind or disabled person which are necessary to fulfill an approved plan for achieving self-support	M0810.430 S1130.510		X
Retained retroactive SSI or RSDI benefits	S1130.600		X
Radiation Exposure Compensation Trust Fund payments	S1130.680	X	
German reparations payments made to World War II Holocaust survivors	S0830.710 S1130.610	X	
Austrian social insurance payments	S0830.715 S1130.615	X	
Japanese-American and Aleutian restitution payments	S0830.720	X	
Federal disaster assistance received because of a Presidentially declared major disaster, including accumulated interest	S0830.620 S1130.620	X	
Cash (including accrued interest) and in-kind replacement received from any source at any time to replace or repair lost, damaged, or stolen excluded resources	S0815.200 S1130.630		X
Certain items excluded from both income and resources by other Federal statutes	S0830.055 S1130.640	Varies	
Agent Orange settlement payments to qualifying veterans and survivors	S0830.730 S1130.660	X	
Victim's compensation payments	S0830.660 S1130.665		X
Tax refunds related to Earned Income Tax Credits	S0820.570 S1130.675		X
Achieving a Better Life Experience (ABLE) accounts	M1130.740		X
Post-PHE Excluded Resources	*M1130.720*		*X*

C. References

- Identifying excluded funds that have been commingled with non-excluded funds, S1130.700

M1130 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-27	4/1/23	Table of Contents, page ii Pages 77, 78 Page 77b added
TN #DMAS-23	4/1/22	Table of Contents, pages i, ii Pages 47, 48, 79 Page 48a was added. Page 48b was added as a runover page Page 78 is a runover page.
TN #DMAS-20	7/1/21	Table of Contents, page ii Pages 5, 73, 74 Page 74a was added as a runover page.
TN #DMAS-18	1/1/21	Pages 31, 33, 34
TN #DMAS-17	7/1/20	Table of Contents, page ii Pages 73, 74 Page 5 is a runover page.
TN #DMAS-12	4/1/19	Page 13
TN #DMAS-9	7/1/18	Pages 1, 3
TN #DMAS-7	1/1/18	Pages 45,78-79 Appendix 1, pages 3,5
TN #DMAS-5	7/1/17	Pages 13, 15, 78, 79 Page 14 is a runover page.
TN #DMAS-3	1/1/17	Table of Contents, page ii Page 76 Page 77 is a runover page. Pages 78 and 79 were added.
TN #DMAS-1	6/1/16	Pages 4, 14, 15
TN #100	5/1/15	Pages 13, 15, 21, 31, 33, 34 Pages 16 and 32 are runover pages.
UP #9	4/1/13	Table of Contents, page ii Pages 5, 62 Pages 62a was added.
TN#97	9/1/12	Page 14
Update #7	7/1/12	Page 24
TN #96	10/1/11	Table of Contents, page ii Pages 4, 73, 74 Appendix 1, pages 1-14 Appendix 2, page 1 Appendix 4, pages 1-8 added
TN #95	3/1/11	Pages 28, 29, 33
TN #94	9/1/10	Pages 20, 20a, 28-29a
TN #93	1/1/10	Pages 63-65 Pages 70, 74, 75
TN #91	5/15/09	Page 13

M1130.000 ABD RESOURCES EXCLUSIONS Section Page

RETAINED CASH AND IN-KIND PAYMENTS

OTHER EXCLUDED RESOURCES

Appendix

2. Determination

a. Accept the individual's allegation as to the date and amount of a deposit of excluded funds if it agrees with the evidence in file on the receipt of the funds.

b. Record in case record:

- each deposit of excluded funds;
- each withdrawal that reduces the amount of excluded funds;
- each computation of excluded interest and its addition to the excluded funds.

D. Examples

1. One Time Receipt and Deposit of Excluded Funds

An individual deposits a $1,000 SSA check ($800 for the preceding 4 months and $200 for the current month) in a checking account. The account already contains $300 in nonexcluded funds.

- Of the new $1,300 balance, $800 is excluded as retroactive SSI benefits.
- The individual withdraws $300. The remaining $1,000 balance still contains the excluded $800.
- The individual withdraws another $300, leaving a balance of $700. All $700 is excluded.
- The individual deposits $500, creating a new balance of $1,200. Only $700 of the new balance is excluded.

2. Periodic Receipt and Deposit of Excluded Funds

An individual deposits $200 in excluded funds in a non-interest bearing checking account that already contains $300 in nonexcluded funds.

- The individual withdraws $400. The remaining $100 is excluded.
- The individual then deposits $100 in nonexcluded funds. Of the
- resulting $200 balance, $100 is excluded.
- The individual next deposits $100 in excludable funds. Of the new $300 balance, $200 is excluded.

3. Interest

A $1,000 savings account includes $800 in excluded disaster assistance when a $10 interest payment is posted. Since 80 percent of the account balance is excluded at the time the interest is posted, 80 percent of the interest ($8) is excluded. The amount of excluded funds now in the account is $808.

M1130.720 Post-PHE Excluded Resources

A. Policy Principle

LTSS recipients with resources accumulated from March of 2020 through the first renewal after the end of the continuous coverage requirements due to the inability to increase patient pay may be exempted for one certification period. This exclusion applies to LTSS recipients at renewal only, not new applications.

B. Operating Policy

1. Identified vs. Segregated

Identifiability does not require that excluded funds be kept physically apart from other funds (e.g., in a separate bank account).

2. Operating Assumption

Always assume, *when withdrawals are made from an account with commingled funds in it, that* ***nonexcludable funds are withdrawn first,*** *leaving as much of the excluded funds in the account as possible.*

3. Effect of Account Transactions *If excluded funds are withdrawn, the excluded funds left in the account can be added to only by excluded interest (see 4. below).*

4. Interest *Interest on the excluded funds is excluded, and the percent of an interest payment to be excluded is the same as the percent of funds in the account that is excluded at the time the interest is posted.*

C. Development and Documentation - Post eligibility

1. Evidence *Bank statements, Patient Fund account statements or other financial documentation.*

2. Determination *If a member who receives LTSS is found to have excess resources at renewal, the state will review the patient pay history,* ***If that history indicates that the member's excess resources are solely due to the state having been unable to increase the patient pay during the pandemic, the amount of the would-be increase will be deducted from the member's excess resources.*** *If the member is under the resource limit after this deduction, and is otherwise eligible, coverage will continue. Record the amount of the excluded resources on the VaCMS screen.*

D. Example

1. Periodic Receipt and Deposit of Excluded Funds *An individual was receiving LTSS in a nursing facility in September 2020. An adjustment was made for a motorized wheelchair (with DMAS approval). Due to PHE provisions the patient pay could not be increased after the cost of the wheelchair was deducted. He or she has accumulated $20,000 in a checking account that would have been owed to a facility as part of the patient pay. The account already contains $300 in nonexcluded funds.*

- *Of the new $20,300 balance, $20,000 is excluded.*
- *The individual withdraws $1000 and spends it on a new wardrobe. The remaining $19,300 balance remains excluded.*
- *The individual withdraws another $300, leaving a balance of $19,000. All $19,000 remains excluded until the next renewal.*

An individual was receiving CBC, then entered a nursing facility in June 2022. Due to PHE provisions the patient pay could not be increased. When the renewal comes due in May 2023, he or she has accumulated $5000 in a checking account that would have been owed to a facility as part of the patient pay. The money has been deposited in a non-interest bearing checking account that already contained $500 in nonexcluded funds.

- *The individual withdraws $500. The remaining $5000 is excluded until the May 2024 renewal.*
- *When the May 2024 renewal comes due, the full amount of the account will be countable.*

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

A. Policy

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

In Virginia, the qualified ABLE program is operated by the Virginia529 program and can be contacted Toll-Free: 1-844-NOW-ABLE (1-844-669-2253).

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

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

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

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

ABLE accounts are not subject to estate recovery.

M1310 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-27	4/1/23	Pages 1, 3
TN #DMAS-14	10/1/19	Page 1
TN #DMAS-10	10/1/18	Page 1 Pages 2 and 3 are runover pages.
TN #DMAS-2	10/1/16	Pages 1-6 On pages 1 and 4-6, corrected the subchapter number in the headers. Neither the dates nor the policies were changed.
UP #9	4/1/13	Pages 1-3
UP #7	7/1/12	Table of Contents Pages 1-5 Page 6 was added.
TN #95	3/1/11	Page 4

M1310.000 SPENDDOWN GENERAL PRINCIPLES AND DEFINITIONS

M1310.100 GENERAL PRINCIPLES OF MEDICAID SPENDDOWN

A. Introduction

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

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

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

B. Applicability

Spenddown applies only to the medically needy (MN) covered groups listed in M0320 and M0330. There are no MN covered groups for Low-income Families with Children (LIFC) parents, Modified Adjusted Gross Income (MAGI) Adults, or children between age 18 and 19 years who do not meet the definition of an Individual Under Age 21 in M0330.804.

Individuals and families who meet a MN covered group must meet the MN nonfinancial and resource requirements in order to be placed on a spenddown. *If information requested for the Categorically Needy evaluation has not been returned, information for the MN evaluation should not be requested and a spenddown cannot be calculated.*

An individual or family is income eligible when countable income after deducting specified medical or remedial care expenses is equal to or less than the medically needy income limit (MNIL) for the budget period.

For a spenddown which involves an incarcerated person, see M1350.850.

C. Opportunity to Receive Full Medicaid Coverage

Individuals who are eligible for only a limited package of Medicaid services must be evaluated to determine if they could become eligible for full Medicaid coverage as medically needy (MN) by meeting a spenddown. To be evaluated for a spenddown, the individual must meet a MN covered group listed in M0330.001 and meet all of the requirements for the MN covered group.

1. Aged, Blind or Disabled (ABD) Medically Indigent (MI) Enrollees

Individuals in the following limited-benefit ABD covered groups also meet a MN covered group:

- Qualified Medicare Beneficiaries (QMBs),
- Special Low-income Medicare Beneficiaries (SLMBs),
- Qualified Individuals (QIs), and
- Qualified Disabled Working Individuals (QDWIs).

Information specific to processing spenddown for these individuals is contained in M1370.

4. Break in Spenddown Eligibility

A break in spenddown eligibility only occurs after an individual has, at least once, established eligibility by meeting a spenddown in a prior budget period. A break in spenddown eligibility occurs when:

- there is a break between spenddown budget periods;
- the individual establishes Medicaid eligibility in the ABD 80% F
- PL covered group or a CN F&C covered group; or
  the individual does not meet the spenddown liability in a spenddown budget period.

Note: during the first renewal after the end of the Public Health Emergency there will be considered to be NO BREAK since the prior spenddown.

5. Budget Period

Budget period means a period of time during which an individual's income is calculated to determine Medicaid eligibility.

6. Carry-over Expenses

Carry-over expenses are the balance due on medical, dental, and remedial care expenses incurred in the retroactive or prospective budget periods prior to the current budget period which were not used in establishing eligibility and which may be deducted in consecutive budget periods when there has been no break in spenddown eligibility.

7. Consecutive Budget Period

A consecutive budget period is any spenddown budget period that immediately follows a spenddown budget period in which eligibility was established.

8. Countable Income

Countable income means, for the medically needy, the amount of the individual's gross income after deducting allowable exclusions that is measured against the medically needy income limit (MNIL).

9. Covered Expenses

Covered expenses means expenses for services that are included in the State Plan for Medical Assistance (Medicaid State Plan).

10. Current Payments

Current payments are payments made in the current spenddown budget period on expenses incurred before the current spenddown budget period, which were not used in establishing eligibility in a previous spenddown budget period and when there has been a break in spenddown eligibility. The payment amount allowed is the actual payment amount paid to the provider and is deducted from the spenddown liability on the date the payment is actually made.

11. First Prospective Budget Period

The first prospective budget period is the spenddown budget period that begins:

- the first day of the month the individual first applied for Medicaid and is placed on spenddown, or
- the first day of the month after the cancellation of Medicaid coverage due to excess income, or
- when a new Medicaid application is filed after a break in spenddown eligibility.

M1450 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-27	4/1/23	Page 44
TN #DMAS-26	1/1/23	Page 46
TN #DMAS-25	10/1/22	Page 36
TN #DMAS-17	7/1/20	Page 45
TN #DMAS-15	1/1/20	Page 46
TN #DMAS-14	10/1/19	Pages 19, 41, 42, 46
TN #DMAS-10	10/1/18	Pages 1, 2 Appendix 3, page 2 Page 24a was added back; it was inadvertently removed in a previous transmittal. Page 2a was added as a runover page.
TN #DMAS-9	7/1/18	Page 35-36a, 37-38, 43
TN #DMAS-7	1/1/18	Page 4, 24, 36, 36a, 37, 41, 42 Appendix 1, Page 1.
TN #DMAS-5	7/1/17	Table of Contents Pages 13, 35, 41-44 Page 43a was renumbered. Pages 45 and 46 were added as runover pages.
TN #DMAS-3	1/1/17	Pages 30, 40-42, 44
TN #DMAS-1	6/1/16	Pages 13, 15, 35 Pages 14 and 16 are runover pages.
TN #100	5/1/15	Table of Contents Pages 17-19, 36, 37 Page 35 is a runover page.
TN #99	1/1/14	Page 7, 10, 21
UP #7	6/1/12	Table of Contents Pages 37-43 Page 43a was added.
TN #96	10/1/11	Table of Contents Pages 4-8 Pages 15, 16, 25, 26 Pages 31-38 Page 31a removed.
TN #95	3/1/11	Pages 4, 24, 32, 36, 37, 37a, Pages 39, 42, 43
TN #94	9/1/10	Table of Contents Pages 36-37a, 39-44
TN #93	1/1/10	Table of Contents Pages 3, 17-18, 29 Appendix 2, page 1
TN #91	5/15/09	Pages 41, 42

1. Referral to DMAS Recipient Audit Unit (RAU)

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

B. Notice Contents

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

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

The notice must also specify that either:

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

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

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

C. Advance Notice

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

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

M1470 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-27	4/1/23	Page 15
TN #DMAS-26	1/1/23	Pages 19, 20
TN #DMAS-25	10/1/22	Page 20
TN #DMAS-24	7/1/22	Pages 1, 15, 28a, 44, 48-50 Page 14a is a runover page.
TN #DMAS-22	1/1/22	Pages 19, 20
TN #DMAS-21	10/1/21	Page 17
TN #DMAS-20	7/1/21	Pages 11, 20, 26
TN #DMAS-19	4/1/21	Pages 7, 8, 22, 23
TN #DMAS-18	1/1/21	Pages 19, 20
TN #DMAS-17	7/1/20	Table of Contents, page ii Pages 1, 14, 28a, 47, 48, 50, 55 Appendix 1, page 1
TN #DMAS-15	1/1/20	Pages 19, 20
TN #DMAS-14	10/1/19	Table of Contents, page i Pages 1, 14, 28a, 31, 32, 43, 47, 48, 50 Appendix 1, page 2 Page 14a was added as a runover page.

B. Temporary Care

Temporary care is defined as not exceeding 6 months of institutionalization, beginning the **month** of admission to the medical facility. A physician's written statement or a DMAS 225 from the individuals managed care plan indicating that the individual is expected to return to his home within 6 months of admission is required to certify temporary care. If the individual is in the facility less than 6 months and returns to a community living arrangement, temporary care status is assumed and patient pay should be adjusted with the home maintenance allowance for the entire period of institutionalization. When the temporary care period ends, the home maintenance deduction must be discontinued.

The DMAS 96 no longer relays information about the expected length of stay. Assume that the stay is not temporary unless notified by the individual, authorized representative, or managed care plan. A written statement from a physician or a DMAS 225 notification from the managed care plan that the individual is expected to return home within 6 months is acceptable in lieu of a physician's statement.

C. Amount Deducted

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

M1470.300 FACILITY PATIENTS

A. Overview

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

B. Policy and Procedures

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

- Facility Admission From A Community Living Arrangement (M1470.310)
- *Patient pay for facility stay of less than 30 days* (M1470.320)

M1470.310 FACILITY ADMISSION FROM A COMMUNITY LIVING ARRANGEMENT

A. Policy

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

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

B. Procedures

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

Changed With	Effective Date	Pages Changed
TN #DMAS-27	4/1/23	Page 1, 15, 24a
TN #DMAS-26	1/1/23	Pages 15 and 24a
TN #DMAS-24	7/1/22	Pages 1, 3, 10 Pages 2 and 11 are a runover pages.
TN #DMAS-23	4/1/22	Pages 10, 11, 12, 13, 26, 27, 30 Appendix 2, page 1
TN #DMAS-22	1/1/22	Page 14
TN #DMAS-21	10/1/21	Pages 6, 12
TN #DMAS-20	7/1/21	Pages 2, 3. 5. 6, 13, 14 Page 2a is a runover page. Page 6a was added as a runover page
TN #DMAS-19	4/1/21	Appendix 2
TN #DMAS-18	10/1/19	Pages 1, 4, 4a, 5, 11, 13 Content that was inadvertedly deleted in a previous transmittal was restored. No policy was revised.
TN #DMAS-17	7/1/20	Pages 2, 4, 25, 30 Page 3 is a runover page.
TN #DMAS-16	4/1/20	Pages 3, 4, 7, 9 Appendix 2 Pages 3a and 4 were renumbered to pages 4 and 4a. Page 4a is a runover page.
TN #DMAS-15	1/1/20	Pages 8, 8a
TN #DMAS-14	10/1/19	Pages 2, 3, 4, 6a, 8, 9, 10, 13 Page 4a is a runover page. Page 10a was added as a runover page. Page 7a was deleted.
TN #DMAS-13	7/1/19	Page 14
TN #DMAS-12	4/1/19	Table of Contents Pages 2, 5, 6, 6a, 7, 8, 8a, 11, 12, 15-18, 20 Appendix 2 Page 24a was added. Pages, 19, 21-24, 25 are runover pages.

M1520.000 MEDICAL ASSISTANCE ELIGIBILITY REVIEW

M1520.001 GENERAL PRINCIPLE

A. Policy

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

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

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

When an enrollee no longer meets the requirements for his current covered group, prior to cancelling his coverage, evaluate the enrollee in all covered groups for which he may meet the definition. If the enrollee is not eligible for full benefit Medicaid coverage and is not eligible in any other limited-benefit covered group (i.e. the Medicare Savings Programs), evaluate the enrollee for Plan First, unless he has declined that coverage.

1. Public Health Emergency

On January 31, 2020, a public health emergency (PHE) was declared by the U.S. Department of Health and Human Services as a result of the continued consequences of the Coronavirus Disease 2019 (COVID-19) pandemic. Under the direction of the Centers for Medicare and Medicaid Services (CMS), state Medicaid agencies have not taken action to cancel or reduce medical assistance coverage for enrolled individuals, regardless of eligibility changes, unless the individual dies, moves out of the state, or requests cancelation of coverage.

The Consolidated Appropriations Act of 2023 enacted on 12/29/2022 will take effect on 4/1/2023 and outlines Medicaid continuous coverage will end on 3/31/2023. Redetermination procedures began in March 2023 with the guidance that no case closures or cancellations would take place prior to April 30, 2023 for those affected.

Information was shared with the agencies that are involved with the processing of eligibility and redeterminations. Future updates will be provided as available.

2. Negative Action Requires Notice

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

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

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. *Documentation of* 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 *name* 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 the case for the Medicaid extensions, review the household's eligibility in the MAGI covered groups. If eligible, update the renewal date. If anyone in the household is ineligible in a MAGI group, evaluate 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

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.

A. Auxiliary Grant (AG)

See M0320.102 regarding a recipient receiving an Auxiliary Grant (AG) and eligible for Medicaid. The approved member's case should be retained by the agency (locality) which is issuing the grant. Eligibility workers should refer to processing guidelines provided by VDSS and DARS.

Exception: If the individual is receiving AG Supportive Housing (AGSH) payments (clients live in the community and still receive AG payments) the case should transfer to the locality in Virginia based on where the client currently resides (like LTSS CBC cases).