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

October 1, 2024

Virginia Medical Assistance Eligibility Manual Transmittal
#DMAS-33

The following acronyms are contained in this letter:

- DACA – Deferred Action for Childhood Arrivals
- DMAS – Department of Medical Assistance Services
- HIM – Health Insurance Marketplace (Federal)
- FAMIS – Family Access to Medical Insurance Security
- NADA - National Automobile Dealers Association
- PRTF – Psychiatric Residential Treatment Facility
- TN – Transmittal
- VIM – Virginia Insurance Marketplace

TN #DMAS-33 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 October 1, 2024.

The following changes are contained in TN #DMAS-33:

Changed Sections	Changes
Subchapter M01302.200; M01302.400; M01302.500	Added information and a new section regarding returned mail requirements.
Subchapter M0220.314; M0220.500	Clarified individuals with DACA status should be evaluated for FAMIS Prenatal coverage, and that emergency services aliens can be evaluated for retroactive coverage (not just ongoing).
Subchapter M0310:112	Updated that Plan First is only evaluated if requested effective 11/1/2024, and updated HIM to VIM (Virginia Insurance Marketplace)
Subchapter M0320.102; M0320.503	Updated that Plan First is only evaluated if requested effective 11/1/2024, clarified eligibility can begin within a month when transitioning to and from LTSS or AG, and appropriate Hospice aid categories.
Subchapter M0330.001; M0330.600	Updated that Plan First is only evaluated if requested effective 11/1/2024.
Subchapter M0520.100	Corrected link to find out whether a PRTF is a Level C facility.

Subchapter M0610.400	Updated link to determine car values from J.D. Powers (bought NADA Used Car Division and now operates the car value website).
Subchapter M0720.260	Remove reference to Table 1, M0710 App 4 (removed prior to 2005)
Subchapter M1320.100	Clarified that Plan First is only evaluated if requested.
Subchapter M1370.100	Corrected header and clarified that Plan First is only evaluated if requested.
Subchapter M1410	LTSS Communication forms (DMAS-225) should be sent to the MCO, if any.
Subchapter M1420.100	PACE providers can complete LTSS Screenings.
Subchapter M1460.155	LTSS Communication forms (DMAS-225) should be sent to the MCO, if any.
Subchapter M1470.001; M1470.100	Clarified that eligibility can be determined with attested income, but actual income is needed to calculate patient pay.
Subchapter M1480.220	Updated Eligibility Policy and Outreach Division name (to send Undue Hardship requests); added email address.
Subchapter M1510.107	Enrollment and Medicare changes
Subchapter M1520.001; M1520.200	Clarified that Plan First is only evaluated if requested; added child continuous coverage information. Add page 5a and remove page 6a from M1520.100
Chapter 23	Added information about what consists of 12 months continuous eligibility for a child born to a mother in aid category 111.

Please retain this TN letter for future reference. Should you have questions about information contained in this transmittal, please contact Sara Cariano, Director, DMAS Eligibility Policy & Outreach Division, at sara.cariano@dmas.virginia.gov or (804) 229-1306.

Sincerely,

Sarah Hatton

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

Attachment

M0130 Changes
Page 1 of 2

Changed With	Effective Date	Pages Changed
TN #DMAS-33	10/1/24	TOC, Pages 6, 6a, 14 Page 15 is added.
TN #DMAS-32	7/1/24	Pages 9 and 10
TN #DMAS-29	10/1/23	Page 12
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

TABLE OF CONTENTS

M01 APPLICATION FOR MEDICAL ASSISTANCE

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

3. Copy or Scan Verification Documents

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

4. Non-custodial Parent Applying for Child

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

5. Information Not Provided

If information necessary to make an eligibility determination is requested but not provided by the applicant and cannot be obtained from any other source, the application must be denied (or the coverage cancelled) due to the inability to determine eligibility. Individuals whose applications are denied due to the inability to determine eligibility are not referred to the HIM. See M0130.300 D.2. *If the Verification Checklist or other mail is returned to the agency, follow the steps in M0130.500 Returned Mail prior to taking negative action.*

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

C. Verification of Nonfinancial Eligibility Requirements

1. Verification Not Required

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

- Virginia state residency;
- pregnancy.

2. Verification Required

The following information must be verified:

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

The worker must attempt to verify all information using Electronic Verification sources prior to requesting proof from the applicant.

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.

E. Notification for Retroactive Entitlement Only

There are instances when an applicant is not eligible for ongoing eligibility but is eligible for retroactive benefits or a change in the applicant's situation during the application process results in the applicant being eligible for only a limited period of time. Only one notice is sent to the applicant covering both actions. Statements of the exact dates of eligibility, the date of ineligibility, and the reason(s) for ineligibility must be included on this notice.

M0130.400 Applications Denied Under Special Circumstances

A. General Principle

When an application is withdrawn or the applicant cannot be located, the application is denied. The reason for the denial must be recorded in the case record, and a notice must be sent to the applicant's last known address.

B. Withdrawal

An applicant may withdraw his application at any time. The request can be verbal or written. An applicant may voluntarily withdraw only his application for retroactive coverage by signing a statement or by a verbal statement specifically indicating the wish to withdraw the retroactive coverage part of the application.

A written withdrawal request must be placed in the case record. A verbal request for withdrawal can be accepted only from the applicant or case head, or *the* 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* and title of the agency staff person who took the call.

When the applicant withdraws an application, the eligibility worker must send a notice of action on MA to the applicant.

C. Inability to Locate

If mail is returned, the worker must follow the returned mail policy in M0130.500. The agency must *attempt to contact the applicant by at least two methods in addition to* send*ing* a letter to the last known address informing the applicant of the agency's attempt to locate *them* and asking that *they* contact the office. For applicants who are documented as homeless *and do not provide a mailing address*, maintain all correspondence at the local agency. If the applicant does not respond *or contact the agency* within 45 days of the date of application, deny the application.

D. Duplicate Applications

The worker will review a duplicate application to verify there are no changes in circumstances, request(s) for coverage, or other actions that need to be acted on. Applications received requesting MA for individuals who already have an application recorded (i.e. pending) or who are currently active and receiving coverage will be denied due to duplication of request. *Document current coverage on the notice*.

For duplicate applications submitted by individuals currently enrolled in coverage, the denial notice must include the member's coverage status, as appropriate:

- the application has been approved for a new level or type of coverage; or
- the application has been denied for new services, but the member remains enrolled in their current level or type of coverage; or
- the requested coverage was denied and the member's existing coverage is being terminated.

*Do **NOT** deny an application for "overlapping coverage" without adding an explanation to the Notice of Action on Medicaid.*

M0130.500 Returned Mail

A. General Principle

Generally, there are three types of recipient mail that could be returned to the Medicaid agency:
(1) mail with an in-state forwarding address;
(2) mail with an out-of-state forwarding address; and
(3) mail that does not include a forwarding address.

Workers must confirm whether the address information on the piece of returned mail is complete and consistent with the address information the agency has on file. The front of the returned mail should be scanned into the case record and all actions to contact the client must be documented.

B. Returned Mail With Complete Information

Compare the address provided to existing records. If an error is discovered (i.e., missing or incorrect apartment number, etc.), make any necessary corrections and resend the information. If the subsequent mailing to the correct address is not returned, no additional contact is required. If the subsequent mailing is returned, proceed as indicated below based on whether the returned mail has a forwarding address.

C. Returned Mail with no Forwarding Address

The worker must attempt to contact the recipient through two other methods, including phone, email, or alternate addresses. If only one other method is available, a contact attempt must be made. If no other methods are available, the condition will be met if it has satisfied the up-to-date contact information.

D. Returned Mail with Forwarding Address

Sending the VCL or other mail to the new address will represent one method. One other method of contact, if available, is required to satisfy the returned mail condition. If mail is not returned from the forwarding address, the returned mail condition no longer applies because the original mailing has been completed and is no longer considered to be returned.

E. Lack of Alternative Contact Information

If after complying with the conditions described above, the only contact information available is the address in the individual's case record, and the LDSS does not have or cannot find a phone number, email address or other means to contact the individual, no further efforts to contact the individual are necessary.

F. Documentation

The case narrative must contain documentation of all methods used for contact attempts. To ensure applicants are able to complete the application process, the worker should ensure that if they successfully contact an individual after receiving returned mail, the recipient receives any necessary verification requests at their correct address and has sufficient time to return the information and complete the application process.

Changed With	Effective Date	Pages Changed
TN #DMAS-33	10/1/24	Pages 14e, 22
TN #DMAS-32	7/1/24	Pages 1, 4-5, 6a; Appendix 1, page 5 Appendix 4, page 2 Appendix 5, page 1
TN #DMAS-30	1/1/24	Page 3; Appendix 4, page 1
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.

M0220.314 LAWFULLY RESIDING NON-CITIZEN CHILDREN UNDER AGE 19 AND PREGNANT WOMEN

A. Policy

Section 214 of CHIPRA of 2009 gives states the option to provide Medicaid and FAMIS/FAMIS MOMS coverage to certain individuals who are lawfully residing in the United States and are otherwise eligible for assistance. Virginia has elected to cover children under the age of 19 and pregnant women who are lawfully residing in the U.S.

Noncitizens are lawfully residing in the U.S. if they have been admitted lawfully into the U.S. and have not overstayed the period for which they were admitted, or they have current permission to stay or live in the U.S.

This policy does **not** apply to individuals who receive temporary relief from removal under the Deferred Action for Childhood Arrivals (DACA) process announced by the U.S. Department of Homeland Security on June 15, 2012.

Children born in the U.S. to foreign diplomat parents (i.e. neither parent is a U.S. citizen) must have their own lawful status. They may apply for immediate LPR status.

Children under age 19 and pregnant women who are in one of the lawfully residing non-citizen alien groups described below must have their immigration status verified at the time of the initial eligibility determination and at each annual renewal of eligibility to ensure that they are lawfully residing in the U.S. and that their immigration status has not changed.

NOTE: All aliens who meet the alien status eligibility requirements for Medicaid and FAMIS/FAMIS MOMS must also meet the Virginia state residency requirements to be eligible for coverage under the programs.

For a pregnant woman who is not lawfully residing in the U.S., *or has the immigration status of DACA,* use Chapter M23 to evaluate her eligibility for FAMIS Prenatal Coverage. If she is not eligible for FAMIS Prenatal Coverage, evaluate her eligibility for the coverage of emergency services using M0220.500.

B. Eligible Alien Groups

Lawfully residing children under age 19 and pregnant women meet Medicaid and FAMIS/FAMIS MOMS alien requirements without regard to their date of arrival or length of time in the U.S. Children under 19 or pregnant women are lawfully residing aliens if they are:

1. a qualified alien as defined in section 431 of PRWORA (8 U.S.C § 1641). See M0220.310;

2. an alien in a nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission . This group includes individuals with valid visas;

3. an alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and nationality Act (INA) (8 U.S.C § 1182 (d)(5)) for less than I year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;

4. an alien who belongs to one of the following classes:
   a. aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C.§§ 1160 or 1255a, respectively),

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

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

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

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

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

D. Emergency Services Only Aliens

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

Effective July 1, 2022, an emergency services only alien who meets all other Medicaid eligibility requirements is enrolled in Medicaid with *retroactive and/or* ongoing coverage. Emergency services are no longer certified by the LDSS or DMAS, and the LDSS does not obtain an emergency services certification.

Applications received prior to July 1, 2022, are subject to the policies and procedures in M0220, Appendix 9. For an individual whose certification period begins prior to July 1, 2022 and expires on or after July 1, 2022, re-evaluate the individual's eligibility for ongoing coverage.

An emergency services alien will be assigned to one of the following Aid Categories (AC) by VaCMS:

- AC 112 for adults in Modified Adjusted Gross Income (MAGI) based covered groups
- AC 113 for children and adults in non-MAGI Families and Children's (F&C) and all Medically Needy (MN) covered groups.

For cases processed at Cover Virginia, the individual will be enrolled in the appropriate AC, and the case will be transferred to the local agency for ongoing case maintenance. For CVIU incarcerated individuals refer to Policy M0140.200.3 C.

Once an emergency services alien is found eligible in VaCMS, the enrollment will transfer into the Medicaid enrollment system. Any claims for emergency services will be sent by the provider or treating physician to DMAS for review and reimbursement. Medicaid coverage for emergency services only aliens will be restricted to emergency services (including dialysis).

Appropriate notice must be sent to the applicant of the status of his application and the duration of his eligibility. The notice must specify that their Medicaid coverage is limited to emergency services.

Changed With	Effective Date	Pages Changed
TN #DMAS-33	10/1/24	Page 28
TN #DMAS-29	10/1/23	Page 5
TN #DMAS-26	1/1/23	Pages 2, 28b Appendix 1
TN #DMAS-24	7/1/22	Page 36 Page 37 is a runover page.
TN #DMAS-23	4/1/22	Pages 2, 5, 6, 6a
TN #DMAS-22	1/1/22	Page 28
TN #DMAS-20	7/1/21	Page 6 Pages 5 and 5a are runover pages.
TN #DMAS-18	1/1/21	Table of Contents, page ii Pages 26, 27 Appendix 1 was removed. Appendix 2 was renumbered to Appendix 1.
TN #DMAS-17	7/1/20	Page 7 Pages 8 and 9 are runover pages.
TN #DMAS-15	1/1/20	Pages 29, 30
TN #DMAS-14	10/1/19	Pages 24, 26, 27, 40
TN #DMAS-13	7/1/19	Pages 24 Page 24a is a runover page.
TN #DMAS-12	4/1/19	Pages 8, 9, 13
TN #DMAS-10	10/1/18	Table of Contents, page ii Pages 1-4 Page 40 was added.
TN #DMAS-9	7/1/18	Page 35 Appendix 2, Page 1
TN #DMAS-8	4/1/18	Page 9
TN #DMAS-7	1/1/18	Pages 34, Appendix 2, page 1
TN #DMAS-5	7/1/17	Pages 13, 37, 38
TN #DMAS-4	4/1/17	Pages 24, 30a Page 23 is a runover page. Page 24a was added as a runover page.

application is pending for the disability determination. DDS does NOT stop the disability determination when the individual has excess income because of possible spenddown eligibility

4. LDSS Responsibilities for Communication with DDS

The LDSS must make every effort to provide DDS with complete and accurate information and shall report all changes in address, medical condition, and earnings to the DDS on pending applications.

5. Evaluation for Plan First and Referral to Health Insurance Marketplace

While an individual's application is pending during the non-expedited disability determination process, evaluate his eligibility in non-ABD covered groups (e.g. MAGI Adults, and Plan First *if requested*). If the individual is not eligible for full Medicaid coverage, refer the individual to the Health Insurance Marketplace (HIM) for evaluation for the Advance Premium Tax Credit (APTC).

H. Notification of DDS Decision to LDSS

1. Hospitalized Individuals

The DDS will advise the agency of the applicant's disability status as soon as it is determined by either SSA or the DDS. For hospitalized individuals who meet the requirements for an expedited disability determination, DDS will fax the outcome of the disability determination directly to the LDSS responsible for processing the application and enrolling the eligible individual.

2. Individuals Not Hospitalized

For all other disability determinations, DDS will notify the LDSS responsible for processing the application and enrolling the eligible individual by an alert in VaCMS. If the claim is denied, DDS will also include a personalized denial notice to be sent to the applicant explaining the outcome of his disability determination.

3. Disability Cannot Be Determined Timely

A disability determination cannot be completed within the allotted time when there is missing or incomplete medical information. DDS will notify the applicant about 75 days from the application date of the delay. DDS will notify the LDSS by an alert in VaCMS. The LDSS must send the applicant a Notice of Action to extend the pending application.

4. DDS Rescinds Disability Denial

DDS will notify the agency if it rescinds its denial of an applicant's disability to continue an evaluation of the individual's medical evidence. If the Medicaid application has been denied, the agency must reopen the application and notify the applicant of the action. The application continues to pend until notification is received from DDS of the disability determination. If an appeal has been filed with DMAS, the agency must notify the DMAS Appeals Division so that the appeal may be closed (see M1650.100).

I. LDSS Action & Notice to the Applicant

The eligibility worker must complete the Medicaid eligibility determination immediately after receiving notice of the applicant's disability status and send the applicant a Notice of Action regarding the disability determination and the agency's decision on the Medicaid application.

M0320 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-33	10/1/24	Page 1
TN #DMAS-32	7/1/24	Pages 24-26a, 29
TN #DMAS-29	10/1/23	Pages 1, 25, 26, 26a, 27, 28
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

M0320.000 AGED, BLIND & DISABLED (ABD) 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 ABD covered groups into categorically needy and medically needy (MN) groups.

B. Procedure

Determine an individual's eligibility first in a CN covered group. This includes eligibility in the Modified Adjusted Gross Income (MAGI) Adults covered group (see M0330.250). If the individual is not eligible in a full-benefit CN covered group, determine the individual's eligibility as MN (on a spenddown).

An evaluation of eligibility for an aged, blind or disabled individual should follow this hierarchy:

1. If the individual is a current SSI/AG recipient, evaluate in this covered group. Exception-- if the individual requests MEDICAID WORKS, go to *5* below.
2. If the individual is a former SSI or AG recipient, evaluate first in the protected covered groups Exception-- if the individual requests MEDICAID WORKS, go to *5* below.
3. If the individual does not meet the criteria for SSI/AG or protected, is between ages 19 and 64, and is not eligible for or enrolled in Medicare, evaluate next in the MAGI Adults covered group.
4. If the individual is aged and/or is eligible for or has Medicare, evaluate next in the ABD with income $\leq$ 80% FPL covered group.
5. If a disabled individual has income at or below *138%* FPL (including SSI recipients and 1619(b) individuals) and is going back to work, evaluate the individual in the MEDICAID WORKS covered group.
6. If the individual does not meet the requirements for MAGI Adults, 80% FPL group or MEDICAID WORKS, but meets the definition of an institutionalized individual, evaluate in the 300% of SSI covered groups.
7. If the individual is a Medicare beneficiary with income or resources in excess of the full-benefit Medicaid covered groups, evaluate in the Medicare Savings Programs (MSP) groups (QMB, SLMB, QI, QDWI).
8. If the individual is not eligible for Medicaid coverage in an MSP group *AND* a Plan First evaluation *is requested*, evaluate in the Plan First covered group.
9. If the individual meets all the requirements, other than income, for coverage in a full benefit Medicaid group, evaluate as MN.

C. Referral to Health Insurance Marketplace

Unless an individual is incarcerated, an ABD individual who does not have Medicare and is not for eligible for full Medicaid coverage must be referred to the Health Insurance Marketplace (HIM) so the applicant's eligibility for the APTC can be determined. Incarcerated individuals and those with Medicare are not referred to the HIM.

M0330 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-33	10/1/24	Pages 1a, 24
TN #DMAS-32	7/1/24	Page 1a, 4
TN #DMAS-31	4/1/24	Pages 8, 26-28
TN #DMAS-30	1/1/24	Pages 1, 2, 4, 6, 8, 10, 12, 17, 20, 23, 34, 35, 38, 40
TN #DMAS-26	1/1/23	Page 10
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.

1. 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 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.

4. 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.

5. 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.

6. 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, is between the ages of 19 and 64 *and opted in for Plan First*, 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.

M0330.600 PLAN FIRST - FAMILY PLANNING SERVICES

A. Policy

Plan First, Virginia's family planning services health program covers individuals who are not eligible for another full or limited-benefit Medicaid covered group or FAMIS. This optional covered group is available to individuals regardless of their age, gender, disability status, insured status or if they previously had a sterilization procedure. Plan First covers only family planning services, including transportation to receive family planning services.

The income limit for Plan First is 200% FPL. *Plan first is an "opt in" program effective 11/1/2024.* There are no specific age requirements for Plan First, *so* eligibility for Plan First is determined *for any individual including* children under 19 years or for individuals age 65 years and older *if* the child's parent or the individual requests an evaluation for Plan First.

Individuals who are eligible for Plan First must be referred to the Federal Health Insurance Marketplace for an evaluation for the APTC, because they are not eligible for full Medicaid coverage.

If the information contained in the application indicates **potential** eligibility in a full-benefit Medicaid covered group (e.g., the applicant has a child under 18 in the home or alleges disability), in another limited benefit covered group (e.g., the individual has Medicare) or in FAMIS, the worker must determine whether eligibility exists in another covered group before the individual(s) can be determined eligible for Plan First.

If additional information is needed to complete the eligibility determination in another Medicaid covered group**,** the applicant must be given the opportunity to provide the additional information needed. If the additional information is not provided by the deadline *and Plan First was requested*, determine the applicant's eligibility for Plan First only.

When an individual age 19 through 64 years is not eligible for Medicaid in any other covered group, evaluate his eligibility for Plan First *if* the individual has indicated on the application the desire to opt *in* to *be evaluated for Plan First.*

When a Medicaid enrollee no longer meets the requirements for his current covered group, prior to cancelling his coverage he must be evaluated in all covered groups for which he may meet the definition. If the individual is age 19 through 64 years and is not eligible for full-benefit Medicaid coverage or as a Medicare beneficiary, he must be evaluated for Plan First *if* the individual has indicated on the application the desire to opt *in* to *be evaluated for Plan First.*

M0520 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-33	10/1/24	Page 4
TN #DMAS-19	4/1/21	Page 2
TN #DMAS-12	4/1/19	Page 1, 2
TN #DMAS-10	10/1/18	Page 2
TN #DMAS-3	1/1/17	Table of Contents Pages 3, 5-35 Pages 36-38 were removed.
TN #100	5/1/15	Page 2
TN #98	10/1/13	Title Page Table of Contents Pages 1,2,9
UP #7	7/1/12	Table of Contents Pages 2-5
Update (UP) #4	7/1/10	Pages 2, 2a

Include a TANF recipient who is a responsible relative in the unit but **do not count the TANF grant as income**. Non-TANF income is counted as income to the unit.

The unit must also include all individuals in the household for whom each individual in the unit is legally responsible except

- excluded individuals;
- SSI recipients, and
- IV-E recipients.

For example, a child age 10 lives with his mother and his 5 year-old sister who receives SSI; all are included on the application. The family unit consists of the 10 year old child and his mother who is legally responsible for him, but not his SSI recipient sister even though the mother is also legally responsible for her.

3. Child Under 21 Living Away From Home

A child under age 21 who is living away from home is considered living with his/her parent(s) in the household for family unit composition purposes if:

- the child is not emancipated, and
- the absence is temporary and the child intends to return to the parent's home when the purpose of the absence (such as education, rehabilitation, medical care, vacation, visit) is completed.

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

Children placed in Level C PRTFs are considered absent from their home if their stay in the facility has been **30** days or more. A child who is placed in a Level C PRTF is considered NOT living with his parents for Medicaid eligibility purposes as of the first day of the month in which the 30th day of psychiatric residential placement occurs. Long-term care rules do not apply to these children.

If the child is placed in a PRTF, verify that it is a Level C facility on the Department of Medical Assistance Services web site at *arts-prtf-rates-web-file-sfy25_20240701.pdf (virginia.gov),* If the facility is not a Level C facility, the child is considered not to be living away from his parents.

M0610 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-33	10/1/24	Page 5
TN #DMAS-32	7/1/24	Page 1, Page 7a is added
TN #DMAS-14	10/1/19	Table of Contents Pages 1, 2 Page 2a was added as a runover page.
TN #DMAS-12	4/1/19	Page 1
TN #100	5/1/15	Pages 1, 2

B. Development and Documentation

The family/budget unit has the burden of proving that the members of the unit were unaware of and had no reason to be aware of the resource.

- Obtain a signed statement from the applicant/recipient or authorized representative.
- Obtain supporting documentation including (but not limited to) signed statements from other individuals who are familiar with the individual's situation.

M0610.400 WHAT VALUES TO APPLY TO RESOURCES

A. Introduction

The countable value of a resource is the owner's pro rata share of the equity value. The equity value is the fair market value minus encumbrances (legal debts) against the property. This section contains the procedures for determining the fair market values, equity values, and the countable values of resources.

B. Policy

The value of an asset as a resource to the individual or family is the client's equity in the real or personal property.

C. Establishing Fair Market Value

The fair market value of a resource is determined as follows:

1. Real Property

For real property other than the home, apply the local assessment rate to the tax assessed value

2. Personal Property

For personal property (other than motor vehicles) if it is taxed, use the tax assessed value. If not taxed, obtain one statement from a knowledgeable source such as a supplier or distributor.

3. Motor Vehicles

For countable motor vehicles:

a. *Online at Get New Car Prices & Used Car Values | Find Real-world Car Costs (jdpower.com) (J. D. Powers bought NADA and now provides this information).*

d. If the vehicle is not listed *on the J.D. Powers website*, the value which is assessed for tax purposes, or

e. If the methods listed above are not available:

- *a* statement from a licensed dealer, or
- the statement of the applicant/recipient.

M0720
Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-33	10/1/24	Page 7
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

2. Determine Profit

Deduct the amount of allowable business expense from the gross income to determine profit from self-employment.

a. Board

The profit from board is the monthly gross income from boarders less the food allowance for one person living in a group (at 100%) per boarder.

b. Room Rent

The profit from room rent is 65% of the monthly gross income received if heat is furnished, 75% of gross income if heat is not furnished.

c. Room and Board

The profit from room and board is determined by

- subtracting from the monthly gross income the food allowance for one person living in a group (at 100%) per boarder as in a. above, and
- multiplying the balance by 65% if heat is furnished, 75% if heat is not furnished.

M0720.270 INCOME FROM DAY CARE

A. Policy

Income from day care is earned income from self-employment. Income from day care is determined on a monthly basis.

B. Procedure

1. Day Care Provided in Applicant/ Recipient's Home

a. Day Care for Children Living in the Home

Verify gross monthly income by self-employment bookkeeping or tax records or a written statement from the person who pays the day care costs.

Do not deduct the cost of meals and snacks. Profit is sixty-five percent of the gross income from day care.

b. Day Care for Children Not Living in the Home

Verify gross monthly income by self-employment bookkeeping or tax records or a written statement from the person who pays the day care costs.

From the average monthly gross income received, deduct the cost of meals and snacks that are provided for the children. Sixty-five percent of the balance is profit from day care.

The cost of meals is determined using the following method:

- Determine the number of days in the month in which meals were provided for each child and the number of meals provided to each child per day;

M1320 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-33	10/1/24	Page 2
TN #DMAS-14	10/1/19	Pages 3, 4
TN #DMAS-12	4/1/19	Page 3
TN #DMAS-6	10/1/17	Page 2
TN #DMAS-2	10/1/16	Page 2 Page 3 is a run over page.
TN #95	3/1/11	Page 1

C. Incur Noncovered Expenses First

The worker must inform the applicant that it is to his advantage to use the spenddown liability (excess income) for medical and dental services not covered by the Medicaid program before he uses the spenddown liability for covered services. Medicaid will not pay for noncovered medical services even after the spenddown is met.

D. Estimate When Spenddown Liability Will Be Met

The worker can help the applicant estimate the approximate time when the spenddown liability will be met if:

- the individual has already spent or owes for medical services received prior to, on, or after the first day of the month of application, and
- the individual anticipates medical expenditures in the near future.

E. Reapplying at the End of the Spenddown Period

The worker must inform the individual of the spenddown period and the need to file a reapplication if additional coverage is needed. If the individual is enrolled in the QMB, SLMB, or QDWI covered groups; *opted in and* is enrolled in Plan First and also meets a Medically Needy (MN) covered group; or is an MN Child Under Age 18 with $0 spenddown liability (see M0330.803), the system-generated Medicaid/FAMIS Renewal form may be used to establish new spenddown budget periods.

An individual on a spenddown who is living with Medicaid and/or FAMIS enrollees can use their Medicaid/FAMIS Renewal form to reapply; the reapplication is entered into VaCMS as a new application.

For all others, the Application for Health Insurance & Help Paying Costs is required to establish additional spenddown budget periods.

M1320.200 PROCESSING TIME STANDARDS

A. Applications

1. Processing Standards

The time standards for Medicaid eligibility determination must be met when determining spenddown. The processing time standards are:

- 90 days for applicants whose disability must be determined and
- 45 days for all other applicants

from the date the signed Medicaid application is received by the local agency.

2. Third Party Payment Verifications

The standards shall also apply to receipt of third party payment or verification of third party intent to pay in order to determine allowable expenses deductible from the spenddown liability. Efforts to determine the third party liability shall continue through the last day of the processing standard period of time. If information regarding third party liability for an incurred expense is not received by this date, eligibility must be determined without deducting the expense.

B. Changes

The time standard for evaluating a reported change is 30 days from the date the worker receives notice of a change in circumstances or a medical or dental expense submitted by the individual.

M1370 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-33	10/1/24	Pages 1 and 3
TN #DMAS-5	7/1/17	Table of Contents, page i. Pages 1-3 Pages 4, 5 and 6 were removed.
TN #DMAS-3	1/1/17	Pages 3-5
TN #100	5/1/15	Title page
TN #99	1/1/14	Page 2
UP #9	4/1/13	Table of Contents Pages 1-5 Page 6 was added.
TN #94	9/1/10	Table of Contents Pages 1-5

M1370.100 SPENDDOWN – LIMITED BENEFIT ENROLLEES

A. Introduction

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

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

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

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

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

1. Placement on Spenddown

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

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

2. Spenddown Not Met

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

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

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

D. Continuing Eligibility and Enrollment After Spenddown Ends

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

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

Note *for* Plan First: Enrollees do not have a resource test, *so* it is necessary to obtain resource information for Plan First enrollees who meet an MN covered group at the time of renewal. *Prior to reopening Plan First after the spenddown period of eligibility is over, make sure the individual has opted in for Plan First coverage.*

E. Example--QMB Meets Spenddown

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

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

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

M1410 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-33	10/1/24	Pages 2-5
TN #DMAS-31	4/1/24	Page 12
TN #DMAS-30	1/1/24	Pages 2 and 9
TN #DMAS-29	10/1/23	Page 11
TN #DMAS-25	10/1/22	Page 2a
TN #DMAS-24	7/1/22	Pages 2, 9, 13
TN #DMAS-21	10/1/21	Page 9
TN #DMAS-18	1/1/21	Page 1
TN #DMAS-17	7/1/20	Table of Contents Pages 1, 4, 8, 11-13 Pages 4a and 7 were removed. Pages 8-14 were renumbered 7-13.
TN #DMAS-14	10/1/19	Pages 10, 12-14
TN #DMAS-12	4/1/19	Page 4, 10-11 Page 4a was added as a runover page.
TN #DMAS-11	1/1/19	Pages 6, 7
TN #DMAS-10	10/1/18	Pages 8-14
TN #DMAS-9	7/1/18	Page 1
TN #DMAS-8	4/1/18	Page 9
TN #DMAS-7	1/1/18	Page 7
TN #DMAS-5	7/1/17	Pages 4-7
TN #DMAS-3	1/1/17	Pages 6, 7, 12-14
TN #DMAS-1	6/1/16	Pages 12-14
TN #100	5/1/15	Page 2
TN #99	1/1/14	Page 10
Update #7	7/1/12	Pages 6, 7
TN #96	10/1/11	Page 11, 12
TN #95	3/1/11	Pages 13, 14 Page 15 was removed.
TN #94	9/1/10	Pages 6, 7, 13
TN #93	1/1/10	Pages 1, 7, 9, 12
TN #91	5/15/09	Pages 11-14

If documentation is not available when placement needs to be made, verbal assurance from a screener that the form approving LTSS will be mailed or electronically available is sufficient to determine Medicaid eligibility as an institutionalized individual. This information must be received prior to approval and enrollment in Medicaid as an institutionalized individual.

a. The Community Living Waiver, Building Independence Waiver, and Family and Individual Supports Waiver.

The Waiver Authorization System (WaMS) (see M1420, Appendix 3) or Intellectual Disability On-line System (IDOLS) are used to authorize services received under the Community Living (CL) Waiver, Building Independence (BI) Waiver, and Family and Individual Supports Waiver. Copies of the authorization screens or a *LTSS Communication form (DMAS*-225) stating services have started are acceptable.

3. Authorization Not Received

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

4. *Continuing* Authorization

Providers re-evaluate the individual's level of care periodically. The authorization for Medicaid payment of LTSS may be rescinded by the physician or by DMAS at any point that the individual is determined to no longer meet the required Medicaid level of care criteria via level of care review process.

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

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

Facilities document the level of care using the Minimum Data Survey (MDS). For an individual in a nursing facility who no longer meets the level of care but continues to reside in the facility, **continue to use the eligibility rules for institutional individuals** even though the individual no longer meets the level of care criteria. Medicaid will not make a payment to the facility for LTSS.

M1420.200 RESPONSIBILITY FOR THE LTSS AUTHORIZATION

A. Introduction

The process for completing the required assessment and authorizing services depends on the type of LTSS.

B. Nursing Facility

In order to qualify for nursing facility care, an individual must be determined to meet functional criteria, have a medical or nursing need and be at risk of nursing facility or hospital placement within 30 days without services. An assessment known as the LTSS Screening is completed by a designated screener. For individuals who apply for Medicaid after entering a nursing facility, medical staff at facilities document the level of care needed using the Minimum Data Survey (MDS). The Eligibility Worker does not need to see any screening authorization if the individual applying is already a resident of a nursing *(or PACE)* facility when the Medicaid application is filed.

The screener's approval for Medicaid LTSS for new admissions must be substantiated in the case record by a DMAS-96 or the equivalent information from the eMLS system, WaMS printout or the Minimum Data Survey (MDS). Medicaid payment for LTSS cannot begin prior to the date the DMAS-96 is signed by the physician and prior authorization of services for the individual has been given to the provider by DMAS or the managed care plan.

An overview of the screening requirements when an individual needs nursing home care is listed below:

- For hospital patients who are currently enrolled in Medicaid and will be admitted to a nursing facility with Medicaid as the payment source, the screening is completed by hospital staff.
- Nursing *(and PACE)* facilities are permitted to admit individuals who are discharged directly from a hospital to a nursing facility for skilled services without an LTSS screening if the skilled services are not covered in whole or partially by Virginia Medicaid. Once the individual is admitted to the facility, if the individual requests an LTSS screening or applies for Medicaid coverage for LTSS, facility staff will conduct a LTSS screening. The Eligibility Worker does not need to see the screening authorization if the individual applying is already a resident of a nursing facility *(or receiving PACE services)* when the Medicaid application is filed. DMAS will not pay for LTSS services unless the facility has documented that the applicant meets the nursing facility level of care.
- For individuals who are not inpatients in a hospital or are incarcerated prior to nursing facility admission, the screening is completed by local community-based teams (CBT) composed of agencies contracting with the Department of Medical Assistance Services (DMAS). The community-based teams usually consist of the local health department physician, a local health department nurse, and a local social services department service worker. Incarcerated individuals will be screened by the community-based team in the locality in which the facility is located.

C. CCC Plus Waiver

Effective July 1, 2017, the Elderly or Disabled with Consumer-Direction (EDCD) Waiver and the Technology Assisted (Tech) Waiver were combined and are known as the Commonwealth Coordinated Care Plus (CCC Plus) Waiver. Community-based teams, hospital screening teams, and nursing facility *or PACE* screening teams are authorized to screen individuals for the CCC Plus Waiver. See M1420.400 C for more information.

An individual screened and approved for the CCC Plus Waiver will have a DMAS-96 signed and dated by the screener and the physician (or the nurse practitioner or the physician's assistant working with the physician) or the equivalent information printed from the eMLS system.

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

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

D. Program for All Inclusive Care for the Elderly (PACE)

Community-based screening teams, hospital screening teams and nursing *or PACE* facility screening teams are authorized to screen individuals for PACE. If the individual is screened and approved for LTSS, the team will inform the individual about any PACE program that serves the individual's locality. Individuals approved for PACE will have a DMAS-96 signed and dated by the screener and the supervising physician (or the nurse practitioner or the physician's assistant working with the physician) or the equivalent information printed from the eMLS system.

E. Community Living Waiver

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

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

F. Family and Individual Supports Waiver

CSBs are authorized to screen individuals for the Family and Individual Supports Waiver. Final authorizations for waiver services are made by DBHDS staff.

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

G. Building Independence Waiver

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

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

M1420.300 COMMUNICATION PROCEDURES

A. Introduction

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

B. Procedures

1. LDSS Contact

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

2. Screeners

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

3. Eligibility Worker (EW) Action

The EW must inform the individual, the provider *and the MCO* once eligibility for Medicaid payment of LTSS has been determined. If the individual is found eligible for Medicaid and written assurance of approval by the screening team, DMAS, or the managed care plan has been received (DMAS-96, WaMS printout or the Minimum Data Survey [MDS]), the eligibility worker must give the LTSS provider the enrollee's Medicaid identification number.

M1420.400 LTSS SCREENING EXCLUSIONS (Special Circumstances)

A. Purpose

The screening certification authorizes the local DSS to determine financial eligibility using the more liberal rules for institutionalized individuals, including the 300% SSI covered group and the special rules for married institutionalized individuals with a community spouse. The Eligibility Worker does not need to see any screening authorization if the individual applying is already a resident of a nursing *(or PACE)* facility when the Medicaid application is filed.

B. Screening Special Circumstances

Screening for LTSS is NOT required when:

- the individual is a resident in a nursing facility, receiving CCC Plus Waiver services or in PACE at the time of application and was admitted to the service prior to July 1, 2019;
- the individual resides out of state (either in a community, hospital or nursing facility setting) and seeks direct admission to a nursing facility;
- the individual is an inpatient at an in-state owned/operated facility licensed by DBHDS, in-state or out of state Veterans hospital, military hospital or VA Medical Center, and seeks direct admission to a nursing facility;
- the individual enters a nursing facility directly from the CCC Plus Waiver or PACE services;
- the individual is being enrolled in Medicaid hospice.

M1420 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-33	10/1/24	Page 4
TN #DMAS-30	1/1/24	Page 1
TN #DMAS-26	1/1/23	Pages 1 and 2
TN #DMAS-25	10/1/22	Table of Contents Pages 1-5
TN #DMAS-24	7/1/22	Table of Contents Pages 1-5 Appendix 1 Page 6 was removed. Appendix 1 was removed and Appendix 2 was renumbered to Appendix 1.
TN #DMAS-19	4/1/21	Page 2
TN #DMAS-17	7/1/20	Pages 1-6
TN #DMAS-12	4/1/19	Page 2
TN #DMAS-11	1/1/19	Entire subchapter
TN #DMAS-7	1/1/18	Table of Contents Pages 2, 5. Appendix 2.
TN #DMAS-5	7/1/17	Pages 2-6
TN #DMAS-1	1/1/17	Table of Contents Pages 3-6 Appendix 3 Appendices 4 and 5 were removed.
TN #DMAS-1	6/1/16	Pages 3-5 Page 6 is a runover page. Appendix 3, page 1
TN #99	1/1/14	Page 4
UP#7	7/1/12	Pages 3, 4
TN #94	09/01/10	Table of Contents Pages 3-5 Appendix 3
TN #93	01/01/10	Pages 2, 3, 5 Appendix 3, page 1 Appendix 4, page 1

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

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

D. Program for All Inclusive Care for the Elderly (PACE)

Community-based screening teams, hospital screening teams, nursing facility screening teams *and PACE provider teams* are authorized to screen individuals for PACE. If the individual is screened and approved for LTSS, the team will inform the individual about any PACE program that serves the individual's locality. Individuals approved for PACE will have a DMAS-96 signed and dated by the screener and the supervising physician (or the nurse practitioner or the physician's assistant working with the physician) or the equivalent information printed from the eMLS system.

E. Community Living Waiver

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

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

F. Family and Individual Supports Waiver

CSBs are authorized to screen individuals for the Family and Individual Supports Waiver. Final authorizations for waiver services are made by DBHDS staff.

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

G. Building Independence Waiver

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

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

M1460 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-33	10/1/24	
TN #DMAS-32	7/1/24	Page 4a
TN #DMAS-31	4/1/24	Page 3, 35
TN #DMAS-30	1/1/24	Pages 11 and 19
TN #DMAS-26	1/1/23	Pages 3, 35
TN #DMAS-24	7/1/22	Pages 11, 47, 48
TN #DMAS-23	4/1/22	Pages 12, 23
TN #DMAS-22	1/1/22	Pages 3, 35
TN #DMAS-18	1/1/21	Pages 3, 35
TN #DMAS-15	1/1/20	Pages 3, 35
TN #DMAS-14	10/1/19	Pages 4, 29
TN #DMAS-13	7/1/19	Page 42
TN #DMAS-11	1/1/19	Pages 3-5, 10, 26, 31
TN #DMAS-10	10/1/18	Table of Contents, page i Pages 1-3, 4b, 5, 6, 9, 10, 13, 15, 17a, 18, 18a, 26, 27, 30a, 37, 38 Pages 8a, 11, 19, 30, 39 and 40 are runover pages.
TN #DMAS-8	4/1/18	Pages 18a, 32, 35
TN #DMAS-7	1/1/18	Pages 3, 7
TN #DMAS-3	1/1/17	Pages 3, 4, 4b, 24, 25, 29
TN #DMAS-2	10/1/16	Page 35
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 3, 8a, 17, 32
TN #100	5/1/15	Table of Contents, page i Pages 1, 2, 5, 6, 10, 15, 16-17a, 25,41-51
TN #99	1/1/14	Pages 3, 35
UP #9	4/1/13	Table of Contents Pages 3, 35, 38, 41, 42, 50, 51
TN #97	9/1/12	Table of Contents Pages 1, 4-7, 9-17 Page 8a was deleted. Pages 18a-20, 23-27, 29-31 Pages 37-40, 43-51 Pages 52 and 53 were deleted
UP #6	4/1/12	Pages 3, 35
TN #96	10/1/11	Pages 3, 20, 21
TN #95	3/1/11	Pages 3, 4, 35
TN #94	9/1/10	Page 4a
TN #93	1/1/10	Pages 28, 35
TN #91	5/15/09	Pages 23, 24

1. Reverse Mortgages

Reverse mortgages **do not** reduce equity value until payments are being received from the reverse mortgage.

2. Home Equity Credit Lines

A home equity line of credit **does not** reduce the equity value until credit line has been used or payments from the credit line have been received.

C. Verification Required

Verification of the equity value of the home is required.

D. Notice Requirement

If an individual is ineligible for Medicaid payment of LTSS because of substantial home equity exceeding the limit, the Notice of Action must state why he is ineligible for Medicaid payment of LTSS. The notice must also indicate whether the applicant is eligible for other Medicaid covered services.

If the individual is in a nursing facility *or receiving LTSS services in the community*, send the *service provider and the Managed Care Organization (MCO)* a DMAS-225 indicating that the individual is not eligible for the Medicaid payment of LTSS.

E. References

See section M1120.225 for more information about reverse mortgages.

M1460.155 THIRD PARTY & LONG-TERM CARE INSURANCE PAYMENTS

A. Payments Made by Another Individual

Payment of an individual's bills (including Medicare supplementary medical insurance or other medical insurance premiums) by a third party directly to the supplier is not income.

Payments made directly to the service provider by another person for the individual's private room or "sitter" in a medical facility are NOT income to the individual. Refer all cases of Medicaid eligible enrollees in nursing facilities who have a "sitter" to DMAS, Division of *High Needs Supports*, for DMAS review to assure that DMAS is not paying the facility for services provided by the sitter.

B. LTC Insurance Policy Payments

The LTC insurance policy must be entered into the recipient's TPL file. The insurance policy type is "H" and the coverage type is "N." When entered in the Virginia Case Management System (VaCMS) on the TPL screen, Medicaid will not pay the nursing facility's claim unless the claim shows how much the policy paid.

If the patient receives the payment from the insurance company, it is **not** counted as income. The patient should assign it to the provider. If the patient cannot do this, or the policy prohibits assignment, the payment should be given directly to the provider. The provider should report the payment as a third party payment on its claim form.

If the patient received the payment and cannot give it to the provider for some reason, then the patient should send the insurance payment to:

DMAS Fiscal Division, Cashiering Unit
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

b. F&C Covered Groups

1) Excluded Resources (section M0630.100).

2) Reasonable Effort To Sell (CN) (section M0630.105).

3) Reasonable Effort To Sell For the Medically Needy (section M0630.110).

F. Home No Longer Excluded

If the individual's home property is no longer excluded and the individual has excess resources, cancel Medicaid because of excess resources when the individual does not have Medicare Part A. If the individual has Medicare Part A, evaluate the individual's eligibility as ABD Medicare Savings Program (MSP) which has more liberal resource requirements and limits (see M0320.600).

1. Individual Has Medicare Part A

When the individual has Medicare Part A:

a. compare income with the ABD MSP limits; if the income is below one of the ABD MSP income limits, then

b. evaluate the resources using ABD MSP policy as found in Chapter S11, Appendix 2.

c. If eligible as ABD MSP only, Medicaid will not pay for nursing facility or CBC waiver services costs. Do the following:

- prepare and send an Advance Notice of Proposed Action to the recipient;
  - cancel the recipient’s coverage, then reinstate the recipient to ABD MSP limited coverage;
  - send a Medicaid LTC Communication Form (DMAS-225) to the provider *and the MCO*, stating that the recipient is no longer eligible for full Medicaid coverage because of excess resources, but is eligible for limited ABD MSP coverage; beginning (specify the date following the cancel date of the recipient’s full coverage), Medicaid will not pay for the individual's care.

d. If NOT eligible as ABD MSP because of resources and/or income, cancel the recipient's Medicaid. Do the following:

- prepare and send an “Advance Notice of Proposed Action” to the recipient;
- cancel the recipient's Medicaid coverage because of excess resources or income;

- send a DMAS-225 to the provider *and the MCO*, stating that the recipient's Medicaid will be canceled because of excess resources (and/or income) and the effective date of cancellation.

2. Individual Does Not Have Medicare Part A

When the individual DOES NOT have Medicare Part A:

a. cancel the recipient's Medicaid coverage because of excess resources;

b. prepare and send an Advance Notice of Proposed Action to the recipient;

c. send a DMAS-225 to the provider, stating that the recipient's Medicaid will be canceled because of excess resources, and the effective date of cancellation.

M1460.540 SUSPENSION PROCEDURES

A. Policy

This section applies ONLY to Medicaid recipients:

- who are enrolled in ongoing Medicaid coverage and
- whose patient pay exceeds the Medicaid rate.

B. Procedures

If a Medicaid recipient's patient pay exceeds the Medicaid rate and his resources go over the Medicaid resource limit, take the following actions:

1. For Recipients Who Have Medicare Part A

a. Resources Less Than or Equal to ABD MSP Resource Limit

If the recipient's resources are less than or equal to the higher ABD **MSP** resource limit, **determine** if the recipient's income is less than or equal to the QMB, SLMB, or QI income limit.

1) When the recipient's income is less than or equal to the QMB, SLMB, or QI income limit:

a) prepare and send an advance notice to reduce the recipient's Medicaid coverage from full benefits to limited benefits (specify the appropriate QMB, SLMB, or QI coverage). Write a note on the notice telling the recipient that:

- the limited (QMB, SLMB, or QI) benefits will NOT pay for long-term care services, and
- if he verifies that his resources are less than or equal to the $2,000 resource limit, he should request reinstatement of full Medicaid benefits.

M1470 Changes
Page 1 of 2

Changed With	Effective Date	Pages Changed
TN #DMAS-33	10/1/24	Pages 1, 2, 2a
TN #DMAS-32	7/1/24	Pages 1, 2, 5, 12, 15, 18-20, 28-30, 44, 54, and 55
TN #DMAS-31	4/1/24	Page 10, 12a, 14 and 14a
TN #DMAS-30	1/1/24	Page 20
TN #DMAS-29	10/1/23	Pages 46-48
TN #DMAS-28	7/1/23	Page 19, Appendix 1
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

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

M1470.001 OVERVIEW

A. Introduction

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

B. Policy

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

C. VaCMS Patient Pay Process

The patient pay calculation is completed in VaCMS. Refer to the VaCMS Help feature for information regarding data entry. The patient pay must be updated in the system whenever the patient pay changes, but at least once every 12 months. If VaCMS is not able to process required transactions, a Patient Pay Correction form (DMAS 9PP), available at https://fusion.dss.virginia.gov/bp/BP- Home/Medical-Assistance/Forms, should be submitted to patientpay@dmas.virginia.gov. *If attested income was used to determine eligibility, actual income must be verified to calculate patient pay. A checklist can be sent with the Notice of Action at approval if needed.*

D. Patient Notification

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

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

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

EW must review the patient's resources each month to determine if the resources are within the Medicaid limit.

If the individual resides in a nursing facility and the above attempts to collect the patient pay amount are unsuccessful, DMAS has advised that the facility may take one of the following options:

1. Facility Option #1

The facility will notify the LDSS no later than 120 *calendar* days from the due date of the payment. The facility will include in this notification a copy of the third collection statement, a written notification of the situation, documentation of contacts made with the resident or authorized representative, and the reasons why payment has not been made.

The LDSS will take the following steps:

- Upon receipt of the written notice from the facility, the local DSS will review the case to determine if the individual's resources are within Medicaid eligibility limits or if a transfer of assets has occurred.
- If the individual alleges that he does not receive sufficient income to pay his patient pay, the eligibility worker will review the patient pay amount and make any necessary adjustments.

2. Facility Option #2

Discharge or transfer the resident, including transferring the resident within the facility, except as prohibited by the Virginia State Plan for Medical Assistance Services.

Prior to discharge or transfer, the facility must provide reasonable and appropriate notice of the required patient pay, and the resident or authorized representative must be given at least 30 calendar days written notice prior to the discharge or transfer, which shall include appeal rights. If the resident or authorized representative does not agree with this action, *they* may submit an appeal request to DMAS. The individual will be allowed to continue residing in the facility during the appeal process.

M1470.100 AVAILABLE INCOME FOR PATIENT PAY

A. Gross Income

Eligibility can be determined using reasonable compatibility, but income must be verified to establish patient pay. Gross monthly income is considered available for patient pay. Gross monthly income *includes* the same income *sources* used to determine an individual's eligibility in the 300% SSI income group. It includes types and amounts of income which are excluded when determining medically needy eligibility. *Patient pay is a post-eligibility determination. If actual income was not obtained while determining eligibility the worker must request verification to calculate patient pay.*

1. 300% SSI Group

If the individual is eligible in the 300% SSI group, to determine patient pay start with the gross monthly income *from the sources used* for eligibility. Then add and deduct any amounts that are listed in subsection C. below.

2. Groups Other Than 300% SSI Group

If the individual is eligible in a covered group other than the 300% SSI group, determine the individual's patient pay income using subsections B. and C. below.

B. Income Counted For Patient Pay

All countable sources of income for the 300% SSI group listed in section M1460.611 are considered income in determining patient pay. Any other income NOT specified in C. below is counted as income for patient pay.

1. Aid & Attendance and VA Pension Payments

Count the total VA Aid & Attendance payments and/or VA pension payments in excess of $90.00 per month as income for patient pay when the patient is:

- a veteran who does not have a community spouse or dependent child,
- a deceased veteran's surviving spouse who does not have a dependent child, or
- a veteran's dependent child.

Do not count any VA Aid & Attendance payments and/or VA pension payments when the patient is:

- a veteran who has a community spouse or dependent child, or
- a deceased veteran's surviving spouse who has a dependent child.

NOTE: This applies to all LTC recipients, including patients who reside in a Veterans Care Center.

2. Non-Refundable Advance Payments To *LTSS* Providers

Advance payments and pre-payments paid by a recipient to the *LTSS* provider that will not be refunded are counted as income for patient pay. M1470.1100 contains instructions for calculating the patient pay when an advance payment has been made to reduce resources within a month.

C. Income Excluded For Patient Pay

Income from sources listed in subchapter M1460.610 "What is Not Income" is not counted when determining patient pay, **EXCEPT** for the VA Aid & Attendance and VA pension payments to veterans which are counted in the patient pay calculation (see B. above). Additional types of income excluded from patient pay are listed below.

1. SSI & AG Payments

All SSI and Auxiliary Grants (AG) payments are excluded from income when determining patient pay.

2. Certain Interest Income

a. Interest or dividends accrued on excluded funds which are set aside for burial are not income for patient pay.

b. Interest income when the total interest accrued on all interest-bearing accounts is less than or equal to $10 monthly is not income for patient pay. Interest income that is not accrued monthly must be converted to a monthly amount to make the determination of whether it is excluded.

- Verify interest income at application and each scheduled redetermination.

M1480 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-33	10/1/24	Page 16
TN #DMAS-32	7/1/24	Pages 6, 8a, 8b, 15, 17, 18, 18a, 18c, 21, 30, 31, 47, 52, 52a, 55, 56, 60, 65, 66, 68, 73, 74, 77, 78, 82, 86, 87, 91
TN #DMAS-31	4/1/24	Page 8a, 17
TN #DMAS-30	1/1/24	Pages 3, 7, 18c, 66, 69, 70
TN #DMAS-29	10/1/23	Page 66
TN #DMAS-26	1/1/23	Pages 7, 18c, 66, 69, 70
TN #DMAS-25	10/1/22	Page 66
TN #DMAS-24	7/1/22	Pages 8a, 8b, 13, 50b, 51, 55, 57, 66, 87, 89, 91
TN #DMAS-22	1/1/22	Pages 7, 18c, 66, 69, 70
TN #DMAS-21	10/1/21	Page 66
TN #DMAS-20	7/1/21	Pages 66, 70
TN #DMAS-18	1/1/21	Page 7, 18c, 66, 69, 70, 92
TN #DMAS-17	7/1/20	Pages 8b, 9, 14, 66, 77, 92
TN #DMAS-15	1/1/20	Pages 1, 7, 18c, 66, 69, 70
TN #DMAS-14	10/1/19	Pages 8a, 8b, 12, 15, 16, 18, 20, 21, 30, 32, 51

requested data, the worker is unable to complete the resource assessment and eligibility as a married institutionalized individual cannot be determined. The application must be processed using rules for non-institutionalized individuals and payment for LTC services must be denied for failure to verify resources held at the beginning of institutionalization.

b. Applicant Notifies Agency of Difficulty Securing Verifications

If the applicant is unable to provide verification of the value of the couple's resources held at the beginning of the first continuous period of institutionalization and notifies the EW of difficulty in securing the requested data, the applicant may claim undue hardship.

Undue hardship can be claimed when both spouses have exhausted all avenues to verify the value of the resources owned on the first day of the first month of the first continuous period of institutionalization. When undue hardship is claimed, the applicant must provide documentation of the attempts made to obtain the verification. **Claims of undue hardship must be evaluated and can only be granted by DMAS.** The EW must send a summary of the needed verifications and documentation of the attempts to secure the verifications, along with the applicant's name and case number to:

DMAS, Eligibility *Policy and Outreach* Division
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

Or email DMASEvaluation@dmas.virginia.gov.

If DMAS determines undue hardship does not exist, the resource assessment cannot be completed and the application must be denied due to failure to verify resources held at the beginning of institutionalization. If DMAS determines undue hardship exists, the completion of a resource assessment is waived, and the spousal resource standard is to be substituted for the spousal share in determining the individual's resource eligibility. Go to section M1480.230 below.

5. Completing the Medicaid Resource Assessment

When verification is provided, completion of the resource assessment establishes the spousal share which is equal to ½ of a couple's total countable resources as of **the first moment of the first day of** the first month of the first continuous period of institutionalization that began on or after September 30, 1989. The spousal share is one factor in determining the spousal protected resource amount (PRA) in section M1480.230 below.

Changed With	Effective Date	Pages Changed
TN #DMAS-33	10/1/24	Pages 9a, 10, 12-15
TN #DMAS-32	7/1/24	Page 2b
TN #DMAS-31	4/1/24	Pages 7 and 8
TN #DMAS-30	1/1/24	Page 1, 2a, 8a,
TN #DMAS-24	7/1/22	Pages 8, 9a, 12-14
TN #DMAS-22	1/1/22	Page 8a Page 8 is a runover page.
TN #DMAS-21	10/1/21	Page 9a
TN #DMAS-19	4/1/21	Pages 6, 8
TN #DMAS-18	1/1/21	Pages 2b, 9, 12
TN #DMAS-17	7/1/20	Page 15
TN #DMAS-16	4/1/20	Pages 5, 6, 12, 13 Pages 14 and 15 are runover pages.
TN #DMAS-14	10/1/19	Pages 2b, 4, 5-7
TN #DMAS-12	4/1/19	Pages 7, 9a. Page 7a is a runover page.
TN #DMAS-11	1/1/19	Page 7

M1510.107 Enrollment Changes

~~D~~. Enrollment Changes

VaCMS is the MA eligibility system of record, however some enrollment functions can only be handled by the DMAS Eligibility and Enrollment Unit. The VaCMS and MES [Medicaid Enterprise System (formerly MMIS)] systems **must** reflect correct coverage. Appropriate change requests include (*but are not limited to)*:

- Coverage corrections unable to be handled through VaCMS
- Duplicate linking
- Erroneous death cancellations
- Same day void.

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

- First attempt to make the correction in VaCMS with the help of supervisors or other agency resources. If not successful;
    - Contact the VDSS Regional Practice Consultant (RC) for assistance. The RC will help the local worker make the correction in VaCMS.
    - If either the agency resources or RC is unable to correct the enrollment in VaCMS, they can instruct the worker to submit a coverage correction to DMAS.
- The worker will complete a Coverage Correction Request Form (DMAS-09-1111-eng). The form can be found on the VDSS intranet. Follow the instructions as provided on the form.

M1510.200 NOTICE REQUIREMENTS

A. Policy

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

* of *their* right to a hearing;
* of the method by which *a* hearing *may be requested and obtained*; and
* that *the person* may represent *themself* or use legal counsel, a relative, a friend or other spokesperson.

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

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

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

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

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

When *an* authorized representative *is documented in the case or on the application*, a copy of the notification must be mailed to the applicant's authorized representative.

The notice must be generated in the applicant's preferred language designated on the application.

1. CN Children or Pregnant Women

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

a. that *they* may complete and return the enclosed form for a Medicaid spenddown to be evaluated, and

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

M1510.300 FOLLOW-UP RESPONSIBILITIES

M1510.301 THIRD PARTY LIABILITY (TPL)

A. Introduction

Medicaid is a "last pay" program and cannot pay any claim for service until the service provider has filed a claim with the recipient's liable third parties such as health insurance companies or legally liable person. The procedures depend on the type of third party liability (TPL) the recipient has.

B. Private Health Insurance

Information on an eligible individual's private health insurance coverage must be obtained and recorded in the case record and in VaCMS. This must include the company name (code number for the TPL file), the policy number, and the begin date of coverage. This information does NOT require verification.

Health insurance policy or coverage changes must be updated in VaCMS.

1. Verification Required - Policy or Coverage Termination

Verification of the date the health insurance policy and/or a coverage type terminated is required. The verification of the termination date can be a written letter from, or verbal statement by, the insurance company that states the termination date. If verification is obtained, the worker is to **end-date** the TPL coverage in VaCMS (note: do not delete the TPL from VaCMS).

Absent receipt of documentation showing that the TPL coverage has ended, it must be left open in VaCMS and MES and cannot be ended by the worker. If the worker is unable to obtain verification of the coverage termination date from the insurance company or the enrollee/authorized representative, the worker is to notify DMAS that the enrollee's TPL coverage was terminated, but verification cannot be obtained. The notification should be sent via e-mail to: tplunit@dmas.virginia.gov. If it is determined that TPL coverage no longer exists, the coverage will be closed in MES by DMAS staff. The worker must then close the coverage in VaCMS.

2. Health Insurance Premium Payment (HIPP)Program

If an applicant or enrollee reports that he or a family member is employed more than 30 hours each week and is eligible for health insurance coverage under an employer's group health plan, he or she must be given a HIPP Fact Sheet which provides a brief description of the program and the contact information for the HIPP Unit at DMAS. The HIPP Fact Sheet is available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/References.

If the enrollee opts to enroll in HIPP, update **VaCMS** with the TPL information when it is provided by the enrollee. Call the HIPP Unit at 1-800-432-5924 *or email* *HIPPcustomerservice@dmas.virginia.gov* when an enrollee reports changes to the TPL information so that MES can be updated.

C. Medicare

Individuals are *not* required to apply for coverage under Medicare A, B or D, or any combination of Medicaid A, B, and D, *even* if it is likely that the individual would meet the eligibility criteria for any or all of those programs. The state *will* pay any applicable premiums and cost-sharing (except those applicable under Part D) for *Medicaid-eligible* individuals *who* apply for Medicare.

Application for Medicare is *not* a condition of eligibility *for Medicaid.*

For persons age 65 or over, for persons under age 65 who have received SSA or Railroad Retirement benefits because of disability for 24 consecutive months, and for persons with chronic end-stage renal disease, the Department of Medical Assistance Services has a buy-in agreement with Medicare to provide to those eligible individuals who are also eligible for Medicare the medical services available under Medicare, Part B (Title XVIII of the Social Security Act) through payment of the Part B premium.

When the recipient has to pay a Medicare Part A premium, Medicaid will pay the Part A premium for

- all QMBs; the "dually-eligible" (those who are eligible in a CN or MN covered group and also are QMB), and the QMB-only (those QMBs who are not eligible for Medicaid in another covered group);

- Qualified Disabled and Working Individuals (QDWI).

1. Buy-In Procedure

The Centers for Medicare and Medicaid Services(CMS) maintains a current list of individuals for whom the State is paying the Part B premiums. The list is updated on a monthly basis by adding newly enrolled individuals and deleting those no longer eligible. Before CMS will admit an individual to the buy-in list for Part B coverage, the individual must have established eligibility for Medicare. *The* name and claim number, if one has been assigned, must be identical to the information in the SSA files. A difference between the name and number in MES and in the SSA files results in a mismatch and rejection of Part B premium coverage.

2. Medicare Claim Numbers

Only two types of claim numbers correctly identify an individual's entitlement to Medicare coverage: a *Medicare* claim number or a Railroad Retirement claim number. *The Medicare claim number contains 11 numbers and letters and is used to identify the services and goods that Medicare is billed on a recipient's behalf. The Medicare claim number is the same as the Medicare card number (the 11-character series of numbers and letters on the front of the red, white and blue Medicare card). Medicare uses this number to file and process claims, using the number to identify an individual as the beneficiary. The claim number is also known as a Medicare Beneficiary Identifier (MBI). The Centers for Medicare & Medicaid Services (CMS) sent new Medicare cards to all beneficiaries in 2018. On the new cards, the Social Security number was replaced by the Medicare claim number to help better protect the identity of each beneficiary and make it harder for someone to commit fraud.*

a. RR annuity-claim numbers have a letter (alpha) prefix followed by a six or nine digit number. The most common prefixes are A, M, H, WCD, NCA, CA, WD, WCH, and PD.

b. Certain letters following nine digit numbers identify an individual as an SSI recipient and are not acceptable as a Medicare claim number. These claim symbols are AI, AS, BC, BI, BS, DC, DI, and DS.

3. Procedures for Obtaining Claim Numbers

a. Requesting Medicare Card

Each Medicaid applicant who appears to qualify for Medicare must be asked if he has applied for Medicare. Those that have applied and are eligible have received a white card with a red and a blue stripe at the top, with *their* name as it appears in the SSA files and the assigned claim number on the card. The name as it appears and the claim number must be included in the TPL section of the MES eligibility file maintained by DMAS.

b. Applicants Who Cannot Produce a Claim Number

Prior to requesting a *copy of the* Medicare card, inquire SSA via the SVES (State Verification Exchange System) *or SOLQ* using the applicant's own SSN.

If the applicant has never applied for Medicare *and requests help with doing so*, complete the Referral to Social Security Administration Form DSS/SSA-1 (form #032-03-099) and write in, "Buy-In" on the upper margin. Mail the form to the Social Security Office serving the locality in which the applicant resides. The SSA office will provide the correct claim number if the individual is on their records. Should the (local/area) SSA office have no record of an application for Medicare, a representative will contact the applicant to secure an application.

4. Buy-in Begin Date

Some individuals have a delay in Buy-in coverage:

Classifications	Buy-in Begin Date
SSI and AG recipients (includes dually-eligible)	1st month of eligibility
CN and MN with Medicare Part A who are dually-eligible as either Qualified Medicare Beneficiaries (QMB) or Special Low Income Medicare Beneficiaries (SLMB Plus)	1st month of eligibility
CN and MN with no Medicare Part A or who are not dually-eligible as either QMB or SLMB Plus	3rd month of eligibility

If the medically needy coverage begin date is other than the first day of a month, Buy-in is effective the first day of the month in which the 60th day after the begin date occurs.

D. Other Third Party Liability

When the agency identifies another third party which has responsibility to pay for a recipient's medical bill, the agency must report the third party to:

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

Or email tplunit@dmas.virginia.gov.

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

E. Pursuing Third Party Liability and Medical Support

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

M1510.302 SOCIAL SECURITY NUMBERS

A. Policy

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

Exceptions – the SSN requirement does not apply to:

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

Individuals who *are* applying only for others and *are* not applying for *coverage are* not required to provide *their personal* SSN*(s)*.

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

B. Procedures

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

M1510.303 PATIENT PAY INFORMATION

A. Policy

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

B. Procedure

When patient pay increases, the Notice of *Patient Pay Responsibility* is sent in advance of the date the new amount is effective. *Patient pay cannot be increased in the past.*

Changed With	Effective Date	Pages Changed
TN #DMAS-33	10/1/24	Change List

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Appendix 2
TN #DMAS-31	4/1/24	Pages 15 and 16
TN #DMAS-30	1/1/24	Pages 3, 10, 10a, 13, 14, 18
TN #DMAS-29	10/1/23	Pages 3, 4, 7, 8, 12, 14, 15
TN #DMAS-28	7/1/23	Pages 1, 2, 2a, 4, 7, 8, 8a, 12, 13, 14 ; Appendix 2
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-11	1/1/19	Pages 2, 5, 6, 7, 9
TN #DMAS-8	4/1/18	Pages 2, 18 Appendix 2
TN #DMAS-7	1/1/18	Pages 2, 3, 3a, 5, 6, 7 Pages 6a and 7a are runover pages.
TN #DMAS-5	7/1/17	Pages 1, 2, 6, 8 Pages 3, 7, 7a and 9 are runover pages.
TN #DMAS-4	4/1/17	Pages 25-27 Appendix 2, page 1 Pages 28-30 were added.
TN #DMAS-3	1/1/17	Pages 1, 2, 4, 6, 7, 8, 14, 26
TN #DMAS-2	10/1/16	Pages 1, 3, 6, 8, 12, 14, 15 Pages 19-24
TN #DMAS-1	6/1/16	Pages 3, 6, 7, 9, 11-14, 17 Appendix 2, page 1 Pages 3a and 7a were added. Page 8 is a runover page.
TN #100	5/1/15	Table of Contents Pages 1-27 (entire subchapter –pages 28-34 were deleted) Appendices 1 and 2 were added.
TN #99	1/1/14	Table of Contents Pages 1-34 (entire subchapter)
UP #9	4/1/13	Pages 7b and 10a
TN #97	9/1/12	Page 1
UP #7	7/1/12	Pages 1, 7, 7c, 7g
TN #96	10/1/11	Table of Contents Pages 1-7g Pages 11-13 Pages 21-24
TN #95	3/1/11	Pages 6a, 7, 21, 22
TN #94	9/1/10	Table of Contents Pages 3, 4b, 5, 6-6a, 10 Appendix 1 was removed.
UP #4	7/1/10	Page 4
TN #93	1/1/10	Pages 3, 4b, 5-6, 10, 15 Pages 21, 22
Update (UP) #2	8/24/09	Pages 1, 2, 13, 14, 17, 18
Update (UP) #1	7/01/09	Page 3

M1520.000 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 *if the individual has opted to be considered for* that coverage.

B. Procedures For Partial Review and Renewals

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

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

C. Public Health Emergency (COVID)

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 *did* not take action to cancel or reduce medical assistance coverage for enrolled individuals, regardless of eligibility changes, unless the individual die*d*, move*d* out of the state, or request*ed* cancelation of coverage. This was referred to as Medicaid continuous coverage. On May 11, 2023 Congress ended the federal COVID-19 public health emergency.

The Consolidated Appropriations Act of 2023 was enacted on 12/29/2022. This policy took effect on April 1, 2023 and affected Medicaid continuous coverage. This outlined *that* case closures or cancellations for those enrollees no longer eligible for Medicaid coverage would be effective as of April 30, 2023.

CMS provided post-pandemic guidance known as "Unwinding" and procedures were developed and implemented for agencies to begin the redetermination process of the majority of Medicaid enrollees.

If a reported change is not compatible with information obtained from online system searches, obtain verification from enrollee or authorized representative. The agency may not deny an increase in benefits, terminate coverage, or reduce benefits for any individual unless the agency has sought additional information from the individual and provided proper notification.

Children under age 19 are eligible for 12 months of continuous eligibility unless

- *they are no longer Virginia residents;*
- *the child or child's representative requests eligibility be closed;*
- *the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or*
- *the child is deceased.*

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.

1. Asset Transfers during the PHE

When an enrollee reports an uncompensated asset transfer that took place during the COVID-19 Continuous Eligibility Period (sometimes termed the PHE- Public Health Emergency) before April 1, 2023, the transfer should be evaluated and a penalty period calculated. The option to claim undue hardship must be given to the member. **If Undue Hardship is denied or not requested, apply the FULL penalty period going forward (after the 10 day advance notice period)**, send notice to the client and a 225 (LTSS Communication form) to the provider.

2. Negative Action requires a Notice

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. *See M0130.500 Returned Mail.*

3. Changes That Do Not Require Partial Review

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

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

No partial review is required for a change in income (earned, unearned or self-employment) if the eligible individual's coverage remains within the equivalent coverage group (and there is no patient pay associated with the EDG).

Example: The individual is enrolled in a full coverage aid category prior to the reported change and remains in full coverage after the change. No verification is required as coverage remains within the equivalent coverage group after income change.

c. Renewal Date

If establishing a new case for the child, enter the child's existing renewal date from his former case. *If enough information is available, re-evaluate the child's eligibility and give them another 12 months of eligibility.* If moving the child to the adult relative's already established case, *and enough information is not available to re-evaluate coverage,* the child's renewal date *can* be the adult relative's case renewal date if this action does not extend the child's renewal date past one year.

d. Medicaid Card

A new ID card is only generated when the enrollee's name, SSN or gender changes, or when a worker requests a replacement ID card. Changing the child's address or case number does not generate a new card. The worker must request a replacement card if one is needed. The existing card will be voided when the replacement is issued.

3. Obtain Authorization from Parent Prior to Renewal

Prior to the next scheduled renewal, the agency should try to obtain an authorization from the parent to allow the agency to communicate with the adult. However, as long as the parent has not formally lost custody of the child, the parent is still the responsible party and can transact the Medicaid business if he is capable and willing, or until there is a guardian/custodian established. If the parent cannot or will not designate an authorized representative, refer the case to the agency's Family Services Unit is so that guardianship can be established per M0120.200 C.

4. Renewal

Follow the rules in M0120.200, which apply to both applications and renewals. If the adult is a relative, the adult can complete the renewal for the child. If the adult is a non-relative and not an authorized representative, then the adult cannot complete the child's renewal. If the child's parent cannot or will not complete the renewal, a referral to the agency's Family Services Unit is needed to pursue guardianship.

E. Recipient Enters LTC

An evaluation of continued eligibility must be completed using the rules in chapter M14 when a Medicaid enrollee begins receiving Medicaid-covered LTC services or has been screened and approved for LTC services. Rules for determining Medicaid eligibility for married institutionalized recipients who have a community spouse are found in subchapter M1480.

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

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

For an SSI recipient who has no community spouse and owns no countable real property, verify continued receipt of SSI through SOLQ-I or SVES, obtain information regarding asset transfer from the enrollee or authorized representative, and document the case record. As long as the individual continues to receive SSI, do not change the AC. If the individual loses SSI, evaluate his Medicaid eligibility in other covered groups. See M1430.103 for additional information regarding an SSI recipient who enters a nursing facility.

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

F. Woman Enrolled in FAMIS Prenatal Coverage Delivers Her Infant

For women enrolled in AC 110 under a fee for service (FFS) arrangement, labor and delivery services are paid as emergency services, and the newborn is considered a deemed-eligible newborn. When the birth of the child born to a women enrolled in FAMIS Prenatal Coverage is reported, review the available systems to determine if the mother is enrolled in AC110 under FFS. If so, the child is enrolled as a deemed newborn in AC 093. See M0330.400. *The child receives a 12 month certification period starting with the month of birth.*

An infant born to a woman enrolled in AC 111 and/or enrolled in managed care must be evaluated for ongoing coverage. The enrollment is treated as a change in circumstances. The infant is not considered a deemed-eligible newborn but has rather been enrolled prenatally through the mother's enrollment in FAMIS Prenatal Coverage. The infant's birth is treated as an "add a person" case change in the enrollment system *given a 12 month certification period starting with the mother's first month of enrollment.*

1. Note re: SSN

The infant is not required to provide an SSN or proof of application for an SSN in order to be enrolled. Follow the procedures in M0240.200 B.3 90 days following the infant's enrollment to determine if an SSN has been assigned. If the

- SSN number has not yet been issued at 90 days, obtain the SSN or proof of application for an SSN at the first renewal of the infant's coverage *that occurs after the child turns one*.

Unless the agency has information about the infant's father living in the home (i.e. for another program), use only the mother's reported income to enroll the infant. Do not request information about the father or the father's income unless the agency has information about the father living in the home and his income.

2. Required Information

To enroll the infant, the worker must have the information below. Use existing case data if possible. If additional information is needed, send a request for verification.

- Name, date of birth, sex (gender)

- Information about the infant's MAGI household and income.

Unless the agency has information about the infant's father living in the home (i.e. for another program), use only the mother's reported income to enroll the infant. Do not request information about the father or the father's income unless the agency has information about the father living in the home and his income.

3. Enrollment and Aid Category

Update the case with the new infant's information, enrolling the child as a Medicaid child under 19 or in FAMIS, as appropriate based on the mother's countable income at the time of application. Use the appropriate AC below to enroll the infant:

- Medicaid AC 090 for income > 109% FPL < 143% FPL
- Medicaid AC 091 for income < 109% FPL
- FAMIS AC 006 for income > 150% FPL and < 200% FPL
- FAMIS AC 008 for income > 143% FPL and < 150% FPL

The infant's first renewal is due 12 months from the month of the infant's enrollment.

M1520.200 RENEWAL REQUIREMENTS

A. Policy

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

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

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

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

For an SSI recipient who has no community spouse and owns no countable real property, verify continued receipt of SSI through SOLQ-I or SVES, obtain information regarding asset transfer from the enrollee or authorized representative, and document the case record. As long as the individual continues to receive SSI, do not change the AC (see M0320.101.C). If the individual loses SSI, evaluate his Medicaid eligibility in other covered groups. See M1430.103 for additional information regarding an SSI recipient who enters a nursing facility.

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

D. Special Requirements for Certain Covered Groups

1. Pregnant Woman

Do not initiate a renewal of eligibility of a pregnant woman in other covered group during her pregnancy. Eligibility ends effective the last day of the 12th month following the month in which her pregnancy ends.

The renewal for a woman who has been enrolled in post-partum coverage will be due the 12th month following the month in which the pregnancy ended. The partial review "batch process" will attempt to re-evaluate the coverage at the end of the 12 month of postpartum coverage.

If the woman does not meet the definition and/or the income requirements for another full-benefit covered group, determine her eligibility in the limited benefit Plan First covered group using the eligibility requirements in M0320.302.

2. Newborn Child Turns Age 1

A renewal must be completed for a child enrolled as a Newborn Child Under Age 1 before Medicaid Enterprise System (MES—formerly the Medicaid Management Information System [MMIS]) cut-off in the last month in which the child meets the Newborn Child Under Age 1 covered group and must include:

- SSN or proof of application
- verification of income
- verification of resources for the MN

child. The ex parte process may be used if appropriate.

3. Child Under Age 19

Children under 19 receive 12 months of continuous eligibility unless

- they reach age 19;
- are no longer Virginia residents;
- the child or child's representative requests eligibility be closed;
- the agency determines that eligibility was incorrectly approved *with the information known to the agency at the time* because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or
- the child is deceased.

4. Child Under Age 19 - Income Exceeds FAMIS Plus Limit

At renewal if an enrolled FAMIS Plus child no longer meets the FAMIS Plus income limits and there is not an LIFC parent on the case, evaluate the child for the FAMIS, using the eligibility requirements in chapter M21. If the child is eligible for FAMIS, send the family an Advance Notice of Proposed Action that Medicaid will be cancelled effective the last day of the month in which the 10-day advance notice expires and the FAMIS coverage will begin the first day of the month following the Medicaid cancellation. Use cancel reason "042" when the child loses eligibility in Medicaid and is reinstated in FAMIS and there is no break in coverage.

Do not use change transactions to move a child between Medicaid and FAMIS. If the child is not eligible for FAMIS, the worker must provide an opportunity for the child to be evaluated as medically needy (MN) **prior** to sending an advance notice and canceling the child's Medicaid coverage

If the child does not meet the definition for another covered group *and the applicant opted in to be evaluated for Plan First*, determine the child's eligibility in Plan First using the eligibility requirements in M0320.302. If the child is eligible for Plan First, reinstate coverage in Plan First and send the Advance Notice of Proposed Action indicating that *they have* been enrolled in Plan First. On the notice, state that if *the individual* does not wish to remain covered by Plan First, to contact the eligibility worker and request that the coverage be cancelled. Include a Plan First Fact Sheet, available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/References, with the Advance Notice of Proposed Action.

6. IV-E FC & AA Children and AA Children With Special Needs for Medical or Rehabilitative Care

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

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

7. Child Under 21 Turns Age 21

When an individual who is enrolled in the Child Under Age 21 covered group turns 21, redetermine his continuing Medicaid eligibility in other covered groups, including Plan First *if the applicant opted in to be evaluated for Plan First*.

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

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

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

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

The BCCPTA Redetermination Form (#032-03-653) is used to redetermine eligibility for the BCCPTA covered group. The form is available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms. The enrollee must provide a statement from *the* medical provider on the renewal form or else a separate written statement verifying continued treatment for breast or cervical cancer. There are no Medicaid financial requirements for the BCCPTA covered group.

10. Hospice Covered Group

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

11. Qualified Individuals

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

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

M1520.300 MA CANCELLATION OR SERVICES REDUCTION

A. Policy

At the time of any action affecting an individual's MA coverage, federal regulations in 42 CFR 431.206 through 431.214 require the agency to inform every applicant or enrollee in writing

- of *the* right to a hearing;
- of the method by which a hearing *may be obtained*; and
- that *individuals* may represent *themselves* or use legal counsel, a relative, a friend or other spokesperson.

All notices and other correspondence *must be sent* to the authorized representative if one has been designated.

M23 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-33	10/1/24	Page 7
TN #DMAS-31	4/1/24	Appendix 1
TN #DMAS-30	1/1/24	Pages 1, 6, 7, 8
TN #DMAS-28	7/1/23	Appendix 1
TN #DMAS-25	10/1/22	Pages 5 & 6. Adjust pages 7-8.
TN #DMAS-24	7/1/22	Page 6
TN #DMAS-23	4/1/22	Page 6 Appendix 1, page 1
TN #DMAS-21	10/1/21	Pages 6, 7

An infant born to a woman in FAMIS Prenatal Coverage who is assigned to AC 111 and/or enrolled in managed care must be evaluated for ongoing coverage. The enrollment is treated as a change in circumstances. The infant is not considered a deemed-eligible newborn but has rather been enrolled prenatally through the mother's enrollment in FAMIS Prenatal Coverage. The infant's birth is treated as an "add a person" case change in the enrollment system *and given a 12 month certification period starting with the mother's first month of enrollment.*

To enroll the infant, the worker must have the information below. Use existing case data if possible. If additional information is needed, send a request for verification.

1. Required Information

- Name, date of birth, sex (gender)
- Information about the infant's MAGI household and income, if not available in the case record

Unless the agency has information about the infant's father living in the home (i.e. for another program), use only the mother's reported income to enroll the infant. Do not request information about the father or the father's income unless the agency has information about the father living in the home and his income.

Note: The infant is not required to provide an SSN or proof of application for an SSN in order to be enrolled. Follow the procedures in M0240.200 B.3 90 days following the infant's enrollment to determine if an SSN has been assigned. If the SSN number has not yet been issued at 90 days, obtain the SSN or proof of application for an SSN at the first renewal of the infant's coverage.

2. Enrollment and Aid Category

Update the case with the new infant's information, enrolling the child as a Medicaid child under 19 or in FAMIS, as appropriate based on the mother's countable income at the time of application. Use the appropriate AC below to enroll the infant:

- Medicaid AC 090 for income > 109% FPL ≤ 143% FPL
- Medicaid AC 091 for income ≤ 109% FPL
- FAMIS AC 006 for income > 150% FPL and ≤ 200% FPL
- FAMIS AC 008 for income > 143% FPL and ≤ 150% FPL

3. Renewal

The infant's first renewal is due 12 months from the month of the *child*'s enrollment.

G. Examples

Example 1

Rose is pregnant and is carrying one unborn child. She was born outside the U.S. She applies for Medicaid on October 27, 2021. She reported on the application that she visited the emergency room in August 2021. The retroactive period for her application is July – September 2021.

Rose is unable to verify that she is lawfully residing in the U.S.; therefore, she cannot be eligible for full-benefit Medicaid or FAMIS Moms and is evaluated for FAMIS Prenatal Coverage. Her verified countable monthly income is $1,756 per month, which is under the income limit for FAMIS Prenatal Coverage for her MAGI household size of two. She is approved for FAMIS Prenatal coverage and enrolled effective October 1, 2021, in AC 110, based on her countable income of under 143% FPL (see M23, Appendix 1). She is enrolled in Managed Care, so her infant will not be considered a deemed-eligible newborn.