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July 1, 2024

Virginia Medical Assistance Eligibility Manual Transmittal
#DMAS-32

The following acronyms are contained in this letter:

- DD Waivers – Developmental Disability Waivers
- DDS - Department of Disability Services
- DJJ – Department of Juvenile Justice
- DMAS – Department of Medical Assistance Services
- ROP – Reasonable Opportunity Period
- SSI – Supplemental Security Income
- SSN – Social Security Number
- TN – Transmittal
- WIN – Work Incentive Account

TN #DMAS-32 includes policy clarifications, updates and revisions. Unless otherwise noted in the Cover Letter and/or policy, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after July 1, 2024.

The following changes are contained in TN #DMAS-32:

Changed Sections	Changes
Subchapter M0130	Add information about resource reasonable compatibility
Subchapter M0210	Remove requirement to apply for other benefits per final rule eff 6/3/24
Subchapter M0220.001 Subchapter M0220.500	Remove limitation on reasonable opportunity periods (ROP) and extend timeframe for Ukrainian Humanitarian Parolees Remove requirement to apply for other benefits per final rule eff 6/3/24
Subchapter M230.204	Virginia residency continues when custody is held by the LDSS but the child is placed out of state in a trial home visit with parents.
Subchapter M0240.100 Subchapter M0240.200	Remove limitation on reasonable opportunity periods (ROP) and extend timeframe for Ukrainian Humanitarian Parolees Clarify deemed child can continue past one with no SSN if in a period of Continuous Eligibility
Subchapter M0270	The subchapter has been removed due to the removal of the requirement to apply for other benefits per final rule eff 6/3/24

Subchapter M0280	Correct broken link to DJJ facilities
Subchapter M0310.102 Subchapter M0310.112 Subchapter M0310 Appendix 1	Correct formatting for A.2 Update Department of Disability Services procedures Update DDS contact information
Subchapter M0320.400	Remove SSI and 1619(b) recipients from Medicaid Works automatic eligibility. Clarify they must meet income and resource limits to enter the program. Note that the WIN account cannot be a joint account and that children are not included in the assistance unit for Medicaid Works. Update 2024 1619(b) threshold. Clarify that transfer policy does not apply to Medicaid Works. Medicaid Works participants cannot be enrolled in a DD Waiver. If the person is already enrolled Medicaid, a new application is not required. Appendix D should be completed to gather additional information on resources. If the person is not currently enrolled in Medicaid, a new application is needed.
Subchapters M0330.001 B,M0330.109 Subchapter M0330.105 B	Update hierarchy so individuals go to Former Foster Care first as of January 2023 Correct sequence of subsections
Chapter M04	Add information about how to count lottery and gambling winnings
Subchapter M0610.001; M0640.001	Add information about resource reasonable compatibility
Subchapter M0710	Medically Needy income limit updates
Subchapter M0810	Medically Needy income limit updates
Subchapters M1110.001, M1110.600, M1140.010, S1140.020	Add information about resource reasonable compatibility
Subchapter M1460.160 B.	Correct references regarding LTSS insurance
Subchapter M1470.410	Updated Community Based Care Personal Maintenance Allowance
Subchapter M1480.225 Subchapter M1480.410	A claim of undue hardship cannot be made on a denied or closed Medicaid case or when the individual is deceased. If the applicant cannot complete the Resource Assessment due to a medical condition, a physician's statement must be provided documenting the medical condition. Maintenance Standards updated for July 1, 2024
Subchapter M1510.101D.	Update to 20%, still said 10% for income reasonable compatibility
Throughout	Remove references to "he", "she" and replace with "individual" or "child". Denote "calendar" or "work" day timeframes.

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-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

If the client is eligible for benefits to be used exclusively for the payment of medical expenses (i.e. an insurance settlement), but there is no TPL code for that benefit, the worker must email the information to the DMAS TPL Unit at TPLUnit@dmas.virginia.gov, or send the information to:

DMAS Third Party Liability Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

G. Health Insurance Premium Payment (HIPP) Program

The HIPP program is a cost-savings program for individuals enrolled in Medicaid which may reimburse some or all of the employee portion of the employer group health insurance premium. Eligibility for HIPP is determined by the HIPP Unit at DMAS. Participation in HIPP is voluntary.

The local DSS agency must give each applicant or enrollee who reports that he or someone in his family is employed more than 30 hours each week and is eligible for health insurance coverage under an employer's group health plan 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/Forms. Enrollees and other members of the public may contact the HIPP Unit for additional information at hippcustomerservice@dmas.virginia.gov.

If the health insurance policy holder lives outside of the home, a HIPP Consent Form must be completed by both the policy holder and the parent/authorized representative so the DMAS HIPP Unit can process the HIPP application. If the form is required, the DMAS HIPP Unit will send it to the applicant for completion.

H. Verification of Financial Eligibility Requirements

The eligibility worker must verify the following financial eligibility requirements:

- the value of all countable, non-excluded resources, *if the reported values of the resources are not both reasonably compatible with electronic sources AND below the resource limit. In all situations the sources of the resources do not have to match. If the member attests to having resources below the limit and values received from electronic sources are above the limit, additional verification should be requested. Reasonable compatibility for resource evaluation is effective for all case actions as of June 3, 2024.*
- asset transfer information for individuals in need of long-term care services, including the date of transfer, asset value, and compensation received.
- earned and unearned income. For all case actions effective August 26, 2022, if the income attested to by the applicant is within 20% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required.

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

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

The agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information, and information from SSA through SVES or SOLQ-I. Verification of income *and resources* from these available sources, including the VEC, may be used if the

information is less than 12 months old. The agency must include in each applicant's case record facts to support the agency's decision on the case.

1. Resources

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

2. Use of Federal Income Tax Data

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

3. SSA Data

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

4. Income

For all case actions effective August 26, 2022, the applicant's attested income, including when the applicant attests to having zero ($0.00) income, is considered the verified income if the income attested to by the applicant is within *2*0% of the income reported by electronic data sources OR both sources are below the applicable income limit.

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

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

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

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

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

M02 Table of Contents Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Page ii
TN #DMAS-24	7/1/22	Page i
TN #DMAS-15	1/1/20	Pages i, ii
TN #DMAS-10	10/1/18	Page ii
TN #95	3/1/11	Page i
Update (UP) #2	8/24/09	Page ii

M0250.000 ASSIGNMENT OF RIGHTS AND PURSUIT OF SUPPORT FROM THE ABSENT PARENT REQUIREMENTS

Section Page

M0260 RESERVED

NOTE: Policy references to M0260 that are still in effect have been moved to subchapter M0250.

M0270.000 APPLICATION FOR OTHER BENEFITS -*Subchapter Removed 07/2024*

M0280.000 INSTITUTIONAL STATUS REQUIREMENTS

M0290.000 HIPP REQUIREMENTS—Subchapter Removed 08/2009

M0210 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/23	Page 1
TN #DMAS-18	1/1/21	Page 4
TN #DMAS-2	10/1/16	Page 4
TN #98	10/1/13	Pages 1-3
TN #97	9/1/12	Page 3
Update (UP) #2	8/24/09	Pages 1, 2

M0210.000 GENERAL RULES & PROCEDURES

M0210.001 PRINCIPLES OF MEDICAID ELIGIBILITY DETERMINATION

A. Introduction

Medicaid is an assistance program which pays medical service providers for services rendered to eligible needy individuals. An individual's need for medical care, the state of his health, or his coverage by private health insurance, have no effect on his Medicaid eligibility.

The eligibility determination consists of an evaluation of an individual's situation which compares each of the individual's circumstances to an established standard or definition. The evaluation provides a structured decision-making process. An individual must be evaluated for eligibility in all covered groups for which he meets the definition, and the applicant/enrollee shall be informed of all known factors that affect eligibility.

B. Eligibility Requirements

Although all the requirements that follow may not be applicable in a particular individual's situation, they must be looked at and evaluated.

1. Nonfinancial Eligibility Requirements

The Medicaid nonfinancial eligibility requirements are:

a. Legal presence in the U.S., effective January 1, 2006 (M0210.150).
b. Citizenship/alien status (M0220).
c. Virginia residency (M0230).
d. Social Security number (SSN) provision/application requirements (M0240).
e. Assignment of rights to medical benefits and pursuit of support from the absent parent requirements (M0250).
f. Institutional status requirements (M0280).
g. Covered group requirements (M03).

2. Financial Eligibility Requirements

The Medicaid financial eligibility requirements are:

a. Asset transfer for individuals who need long-term care (subchapter M1450).

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

c. Income within income limit appropriate to the individual's covered group. (Chapters M04 and M07 for F&C covered groups; Chapter S08 for ABD covered groups).

Changed With	Effective Date	Pages Changed
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.

M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS

M0220.001 GENERAL PRINCIPLES

A. Introduction

This subchapter explains in detail how to determine if an individual is a citizen or alien eligible for full Medicaid benefits (referred to as "full benefit aliens") or emergency services only (referred to as "emergency services aliens"). The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) made major changes to the Medicaid eligibility of non-citizens of the United States. These changes eliminated the "permanently residing under color of law" (PRUCOL) category of aliens. The Medicaid benefits for which an alien is eligible are based upon whether or not the alien is a "qualified" alien as well as the alien's date of entry into the United States.

With some exceptions, the Deficit Reduction Act of 2005 (DRA) required applicants for Medicaid and Medicaid recipients to verify their United States citizenship and identity to be able to qualify for Medicaid benefits. The citizenship and identity (C&I) verification requirements became effective July 1, 2006. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) allows additional exemptions from the C&I verification requirements and provides states with the option to verify C&I through the use of an electronic data match with the Social Security Administration (SSA). It also requires states to enroll otherwise eligible individuals prior to providing C&I verification or immigration status, and grant them *one or more* "reasonable opportunity" period*s* after enrollment to provide documentation, if necessary.

The policy and procedures for determining whether an individual is a citizen or a "full-benefit" or "emergency services" *noncitizens* are contained in the following sections:

M0220.100 Citizenship & Naturalization;
M0220.200 Alien Immigration Status
M0220.300 Full Benefit Aliens
M0220.400 Emergency Services Aliens
M0220.500 Aliens Eligibility Requirements
M0220.600 Aliens Entitlement & Enrollment
M0220, Appendix 9 Emergency Services Aliens Entitlement & Enrollment

B. Declaration of Citizenship/Alien Status

The Immigration Reform and Control Act (IRCA) requires as a condition of eligibility that the adult applicant who is head of the household (with exceptions below) declare in writing under penalty of perjury whether or not the individual(s) for whom he is applying is a citizen or national of the United States, and if not, that the individual is a lawfully admitted alien. For children under 18 years of age, the declaration is made by an adult family member. The declaration statement is on the application form.

EXCEPTION: An individual who is an "unqualified" alien (as defined in section M0220.410) does NOT complete the declaration.

Individuals who are required to sign the declaration and who fail or refuse to sign are NOT eligible for any Medicaid services.

(MMIS) and SSA for the documentation of C&I for individuals enrolled in the Medicaid and FAMIS programs. In order for this process to be used to verify citizenship and identity, the individual's SSN must be verified by SSA (see M0240).

For eligibility determinations processed through VaCMS, the Social Security data match takes place when the individual's information is sent through the Hub. For cases not processed in VaCMS, the SSA data match will take place after the individual has been enrolled in MMIS.

1. MMIS Data Matches SSA

If the information in the MMIS matches the information contained in the SSA files, the MMIS will be updated to reflect the verification of C&I. No further action is needed on the part of the eligibility worker, and the enrollee will not be required to provide any additional documentation, if the SSA match code in MMIS shows that SSA verified the individual's C&I.

2. MMIS Data Does Not Match SSA

If the information in the MMIS does not match the information in the SSA files, a discrepancy report will be generated monthly listing the inconsistent information. Eligibility staff is expected to review the report to see if the report lists any enrollees who were rejected because SSA could not verify the enrollee's citizenship and identity.

a. SSA Cannot Verify C&I

If the SSA data match result does not verify the individual's C&I, eligibility workers must review the information in the system to determine if a typographical or other clerical error occurred. If it is determined that the discrepancy was the result of an error, steps must be taken to correct the information in the system so that SSA can verify C&I when a new data match with SSA occurs in the future.

If the inconsistency is not the result of a typographical or other clerical error, the individual must be given a reasonable opportunity period of 90 days to either resolve the issue with SSA or provide verification of C&I. The eligibility worker must send a written notification to the enrollee that informs the enrollee of the discrepancy and gives him 90 calendar days from the date of the notice to either resolve the discrepancy with the SSA and to provide written verification of the correction, OR provide acceptable documentation of C&I to the LDSS.

The notice must specify the date of the 90th day, and must state that, if the requested information is not provided by the 90th day, the individual's Medicaid coverage will be canceled. Include with the notice the "Birth Certificates and Proof of Citizenship for Medicaid" Fact Sheet available on at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/References. Acceptable forms of documentation for C&I are also included in Appendix 1 to this subchapter.

b. Individual Does Not Provide Verification in 90 Days

If the individual does not *respond to the request and does not* provide the information necessary to meet the C&I documentation requirements by the 90th day, coverage *may* be canceled. Send an advance notice, and cancel coverage at the end of the month in which the 90th day occurs. *If the individual provides part of the information or is in the process of getting the information, a new reasonable opportunity period shall be provided.*

c. Discrepancy Resolved With SSA Within 90 Days

If written verification is received that corrects the SSA discrepancy within the 90 days, update the system accordingly so that the enrollee's information will be included in a future data match for C&I verification. The individual continues to remain enrolled pending the results of the subsequent data match.

If this subsequent data match with SSA results in verified C&I, MMIS will automatically enter code "CV" in the Cit Lvl and Identity fields in the individual's MMIS record. No further match will be done with the SSA files for C&I verification.

d. Verification of C&I Provided Within 90 Days

If the individual provides acceptable verification of his C&I within the 90 days, update the appropriate demographic fields in MMIS (and ADAPT, if the case is in ADAPT) with the appropriate codes. No further match will be done with the SSA files for C&I verification.

3. Subsequent Applications

If the individual who lost coverage for failure to provide C&I documentation files a subsequent application, a new reasonable opportunity period *should be* granted.

M0220.200 ALIEN IMMIGRATION STATUS

A. Introduction

An alien's immigration status is used to determine whether the alien meets the definition of a "full benefit" alien. All aliens who meet the state residency, covered group and all other nonfinancial eligibility requirements (except SSN for illegal aliens), and who meet all financial eligibility requirements are eligible for Medicaid coverage of emergency services. "Full benefit" aliens may be eligible for all Medicaid covered services. "Emergency services" aliens may be eligible for emergency services only.

B. Procedure

An alien's immigration status must be verified. Use the procedures in sections M0220.201 and 202 below to verify immigration status. After the alien's immigration status is verified, use the policy and procedures in section M0220.300 to determine if the alien is a full benefit alien. If the alien is a full benefit alien and is eligible for Medicaid, use the policy and procedures in section M0220.600 to enroll the alien in Medicaid.

If the alien is an emergency services alien who is eligible for Medicaid, use the policy and procedures in section M0220.600 D to enroll an eligible emergency services alien in Medicaid for emergency services only.

C. Changes in Immigration Status

If a "full benefit" alien who was admitted to the U.S with immigration status in one of the "seven-year" alien groups listed in M0220.313.A becomes a Lawful Permanent Resident, he is considered to have full benefit status for the purposes of Medicaid eligibility for the first seven years of residency in the U.S.

M0220.201 IMMIGRATION STATUS VERIFICATION

A. Verification Procedures

An alien's immigration status is verified by the official document issued by the United States Citizenship and Immigration Services (USCIS) and a comparison with the Systematic Alien Verification for Entitlements (SAVE) system. SAVE interfaces with the Federal Hub for applications processed in VaCMS. The EW does not need to obtain the alien status document when immigration status is verified through the Hub. If immigration status cannot be verified through the Hub, the EW must see the original document or a photocopy; submission of just an alien number is NOT sufficient verification.

If the alien has an alien number but no USCIS document, or has no alien number and no USCIS document, use the **secondary verification** SAVE procedure in M0220.202 below if the alien provides verification of his or her identity.

If the agency cannot promptly verify immigration status of an individual in the Hub/SAVE, the agency must provide a 90-calendar-day reasonable opportunity period for the individual's immigration status to be verified and may not delay, deny, reduce or terminate benefits for an individual whom the agency determines to be otherwise eligible for Medicaid during such reasonable the opportunity period.

If the individual does not *respond to the request and does not* provide the information necessary to meet the C&I documentation requirements by the 90th day, coverage *may* be canceled. Send an advance notice, and cancel coverage at the end of the month in which the 90th day occurs. *If the individual provides part of the information or is in the process of getting the information, a new reasonable opportunity period should be provided.*

NOTE: *If a noncitizen attests that they do not have a valid immigration status,* do not use the verification procedures in this section or the SAVE procedures. Go to section M0220.400 below to determine the *noncitizen*'s eligibility.

B. Documents That Verify Status

Appendix 7 to this subchapter contains a list of typical immigration documents used by lawfully present *noncitizens*.

Verify lawful permanent resident status by a Resident Alien Card or Permanent Resident Card (Form I-551), or for recent arrivals a temporary I-551 stamp in a foreign passport or on Form I-94.

Verify lawful admission by a Resident Alien Card (issued from August 1989 until December 1997) or Permanent Resident Card (Form I-551); a Re-entry Permit; or a Form I-688B with a provision of law section 274A.12(A)(1). Afghan and Iraqi immigrants admitted to the U.S. under a Special Immigrant Visa will have either (1) a Form I-551 or (2) a passport or I-94 form indicating categories SI1, SI2, SI3, SQ1, SQ2, or SQ3 and bearing the Department of Homeland Security stamp or notation.

Form I-151 (Alien Registration Receipt Card – the old aka "green card"), Form AR-3 and AR-3a are earlier versions of the Resident Alien Card (Form I-551). An alien with one of the older cards who does not have an I-551should be referred to USCIS to obtain the application forms for the I-551. The forms may be ordered by calling 1-800-375-5283. When an I-151 is presented, refer the alien to USCIS, but accept the document for further verification (see M0220.201.E below).

C. Letters that Verify Status

The USCIS and the Office of Refugee Resettlement (ORR) issue letters that are used in lieu of or in conjunction with USCIS forms to identify alien status. If the letter is the only document provided, it is necessary to verify the status of the alien. For USCIS letters, contact the USCIS at 1-800-375-5283 for assistance in identifying the alien's status. For ORR letters, contact the toll-free ORR Trafficking Verification Line at 866-401-5510 (see Appendix 2 of this subchapter). Do not verify ORR letters via the SAVE system.

D. Local USCIS Office Documents

Some USCIS offices have developed their own stamps. Therefore, it is possible that a locally produced stamp or legend will be on an USCIS form. If there is any question as to the veracity or status of the document, contact USCIS.

E. Expired or Absent Documentation

If an applicant presents an expired USCIS document or is unable to present any document showing his immigration status, refer the individual to the USCIS district office to obtain evidence of status **unless** he provides an alien registration number. Allow the individual a 90-calendar-day reasonable opportunity period to provide the documentation.

If the individual meets all other Medicaid eligibility requirements, do not delay, deny, reduce or terminate the individual's eligibility for Medicaid **on the basis of *immigration* status**. If the individual does not *respond to the request and does not* provide the information necessary to meet the C&I documentation requirements by the 90th day, coverage *may* be canceled. Send an advance notice, and cancel coverage at the end of the month in which the 90th day occurs. *If the individual provides part of the information or is in the process of getting the information, a new reasonable opportunity period should be provided.*

If the applicant provides an alien registration number with supporting verification of his identity, use the SAVE procedures in M0220.202 below to verify immigration status.

If an applicant presents an expired I-551 or I-151, follow procedures for initiating a primary verification. If the alien presents any expired document other than an expired I-551 or I-151, follow procedures for initiating a secondary verification.

If the alien does not provide verification of his identity, his immigration status cannot be determined, and he must be considered an unqualified alien.

M0220.202 SYSTEMATIC ALIEN VERIFICATION FOR ENTITLEMENTS (SAVE)

A. SAVE

Aliens must submit documentation of immigration status before eligibility for the full package of Medicaid benefits can be determined. SAVE interfaces with the Federal Hub for applications processed in VaCMS. The following procedures are applicable when immigration status cannot fully be verified by the Hub.

If the documentation provided appears valid and meets requirements, eligibility is determined based on the documentation provided AND a comparison of the documentation provided with immigration records maintained by the USCIS. The comparison is made by using the SAVE system established by Section 121 of the Immigration Reform and Control Act of 1986 (IRCA).

1. Primary Verification

Primary verification is the automated method of accessing the USCIS data bank. SAVE regulations require that automated access be attempted prior to initiating secondary verification. There are some specific instances, however, when the agency will forego the primary verification method and initiate secondary verification (see **Secondary Verification**).

A separate form must be completed for each alien. Completely legible copies (front and back) of the alien immigration documents must be stapled to the upper left corner of Form G-845. Copies of other documents used to make the initial alien status determination such as marriage records or court documents must also be attached.

Once the requirement to obtain secondary verification is determined, the agency must initiate the request within ten work days. The USCIS mailing address is subject to frequent changes. Obtain the current mailing address from the SAVE web site at http://www.uscis.gov. Click on "Direct Filing Addresses for Form G-845."

A photocopy of the completed G-845 form must be filed in the record as evidence that the form has been forwarded to USCIS.

The USCIS maintains a record of arrivals and departures from the United States for most legal entrants, and LDSS can obtain the required information from their USCIS office. The USCIS does not maintain an arrival and departure record for Canadian and Mexican border crossers. For these immigrants, as well as immigrants whose status was adjusted and whose original date of entry cannot be verified by USCIS, LDSS will need to verify continuance presence by requiring the immigrant to provide documentation showing proof of continuous presence.

Acceptable documentation includes:

- letter from employer
- school or medical records
- series of pay stubs
- shelter expense receipts, such as utility bills

in the immigrant's name that verify continuous presence for the period of time in question.

C. Agency Action

When the primary verification response requires the eligibility worker to initiate a secondary verification from USCIS, do not delay, deny, reduce or terminate the individual's eligibility for Medicaid **on the basis of alien status**. If the applicant meets all other Medicaid eligibility requirements, approve the application and enroll the applicant in Medicaid. Allow 90 calendar days for the secondary verification to be received. If the secondary verification or the individual do not provide the information necessary to meet the documentation requirements by the 90th day, coverage *may* be canceled. Send an advance notice and cancel coverage at the end of the month in which the 90th day occurs. *If the individual provides part of the information or is in the process of getting the information, a new reasonable opportunity period should be provided.*

Upon receipt of the G-845 or response to the on-line query, compare the information with the case record. Timely notice must be given to the individual when Medicaid benefits are denied or reduced.

3. Failure to Provide Requested Verifications

Failure to provide satisfactory evidence of citizenship and identity, after being provided a reasonable opportunity to present such documentation, *may* result in the termination of MA.

An enrollee who fails to cooperate with the agency in presenting documentary evidence of citizenship may be denied or terminated. Failure to cooperate consists of failure by a recipient or that individual's representative, after being notified, to take a required action within the reasonable opportunity time period. *If the individual provides part of the information or is in the process of getting the information, a new reasonable opportunity period should be provided.*

4. Notification Requirements

Prior to the termination of benefits, the enrollee must be sent written notice at least 10 calendar days (plus one day for mailing) prior to the effective date of the closure.

A Notice of Action and appeal rights must be sent to an individual whose application is denied because of failure to provide citizenship and/or identity verification.

5. Maintain Documents in Case Record

The agency must maintain copies of the documents used to verify citizenship and identity in the individual's case record or data base and must make the documents available for state and federal audits.

6. No Reporting Requirements

There are no monthly reporting requirements. However, the Medical Assistance Program Consultants may conduct reviews of cases where eligibility was denied or terminated because of lack of citizenship and/or identity verification.

7. Refer Cases of Suspected Fraud to DMAS

If documents are determined to be inconsistent with pre-existing information, are counterfeit, or are altered, refer the individual to DMAS for investigation into potential fraud and abuse. See section M1700.200 for fraud referral procedures.

Ukraine Humanitarian Parolees

The U.S. Department of Homeland Security (DHS) is providing support and humanitarian relief to Ukrainians who have been displaced by Russia's February 24, 2022 invasion and fled Ukraine. The United States Congress passed the Additional Ukraine Supplemental Appropriations Act (AUSAA) and was signed on May 21, 2022 by President Biden. *It was extended by the Ukraine Security Supplemental Appropriations Act, 2024.* This measure confers eligibility for all Ukrainian Humanitarian Parolees for mainstream federal benefits as well as resettlement services funded by the Office Refugee Resettlement (ORR).

Certain Ukraine nationals entering the U.S. may be eligible for health coverage through Medicaid, the Children's Health Insurance Program (CHIP), the Health Insurance Marketplace, or Refugee Medical Assistance (RMA). These individuals may be granted a range of lawful non-citizen statuses, including parole, temporary protected status (TPS), immigrant and nonimmigrant visas, and refugee or asylees. The primary non-citizen immigrant statuses include:

1. Parolees: Ukrainian nationals who enter the United States as parolees on or **between February 24, 2022 and September 30, *2024*** are eligible for Medicaid or CHIP to the same extent as refugees, without a five-year waiting period, if they meet other eligibility requirements. These Ukrainian parolees are considered "qualified non-citizens" for purposes of Medicaid and CHIP eligibility since they are eligible for the same benefits as refugees.

   Ukrainian nationals who are paroled into the U.S. **after September 30, 2023** and are the spouse or child of a parolee described above, or who is the parent, legal guardian, or primary caregiver of a parolee described above who is determined to be an unaccompanied child will also be eligible for Medicaid and CHIP to the same extent as refugees.

   For eligible Ukrainian parolees who entered the United States with parole between February 24, 2022 – Sept 30, 2023, their date of eligibility is May 21, 2022, or their date of parole, whichever is later.
   For eligible Ukrainian parolees who enter the United States with parole between October 1, 2023 – Sept 30, 2024, their date of eligibility is April 24, 2024, or their date of parole, whichever is later.

2. Temporary Protected Status (TPS): Ukrainian nationals (and individuals having no nationality who last habitually resided in Ukraine) are eligible to apply for TPS. This includes Ukrainians granted TPS or have pending applications for TPS and who have been granted employment authorization. The TPS designation is effective **April 19, 2022 and will remain in effect through October 19, 2023**.

3. Refugees: Some Ukrainian nationals may be granted refugee status and resettled into the U.S. are eligible for full Medicaid or CHIP benefits, without application of the five-year waiting period, if they otherwise meet all other Medicaid eligibility requirements.

4. Lawfully Residing individual: Children under age 19 and pregnant women who are in one of the lawfully residing non-citizen alien groups (see M0220.314) and meet the definition of a lawfully residing alien for Medicaid and FAMIS/FAMIS MOMS coverage may be eligible for assistance.

5. Emergency Services: Ukrainian non-citizens who do not qualify for full Medicaid benefits based on their immigration status may be eligible for "emergency services Medicaid" if they meet all other eligibility requirements. An individual eligible only for emergency Medicaid is permitted to enroll in Marketplace coverage if they meet all Marketplace eligibility requirements.

Ukrainian parolees will generally have foreign passports with a DHS stamp admitting them with a PAR, DT, or UHP Class of Admission (COA). DHS will be using the existing COA code DT and PAR for some Ukrainians who were paroled into the U.S. Additional COA code(s) will be programmed into Hub logic in early fall of 2022.

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

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

M0230 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Page 3
TN #DMAS-2	10/1/16	Pages 1, 6
TN #100	5/1/15	Pages 3, 4
TN #98	10/1/13	Table of Contents pages 3-6 Page 7 was deleted.
TN #97	9/1/12	Page 4
TN #95	3/3/11	Pages 1, 2
TN #93	1/1/10	Page 2

M0230.200 RESIDENCY REQUIREMENTS

M0230.201 INDIVIDUALS UNDER AGE 21

A. Under Age 21 NOT In An Institution

An individual under age 21 is considered a resident of Virginia if he:

a. is married or emancipated from his parents, is capable of indicating intent and is residing in Virginia with the intent to reside Virginia.

b. is not emancipated but is not living with a parent or caretaker and is presently residing in Virginia with the intent to reside in Virginia;

c. lives with a parent or caretaker who is presently residing in Virginia with the intent to reside in Virginia;

d. is a non-IV-E (state/local) foster care child whose custody is held by Virginia (see M230.204 C. and D.);

e. is a non-IV-E foster care child whose custody is held by another state but who has been placed with and is residing in Virginia with a parent or caretaker relative;

f. is a non-IV-E child adopted under an adoption assistance agreement with Virginia (see M230.204 C. and D.);

g. is a non-IV-E foster care child whose custody is held by a licensed, private foster care agency in Virginia, regardless of the state in which the child physically resides;

h. is under age 21 and is residing in another state for temporary period (for reasons such as medical care, education or training, vacation, (or visit) but is still in the custody of his/her parent(s) who reside in Virginia.

i. is living with a parent(s) who is a non-immigrant alien (admitted to the U.S. for a temporary or limited time) when the parent has declared his intent to reside in Virginia permanently or for an indefinite period of time, and no other information is contrary to the stated intent.

j. Is placed out of state for a trial home visit with parents (while custody is retained by Virginia).

B. Under Age 21 In An Institution

If the individual was placed in the institution by a state government agent, go to section M0230.203 below.

An institutionalized individual (who was not placed in the institution by a state government) who is under age 21 and is not married or emancipated, is a resident of Virginia if:

1. the individual's parent or legal guardian was a Virginia resident at the time of the individual's institutional placement;

2. the individual's parent or legal guardian who applies for Medicaid is a Virginia resident and the individual is institutionalized in Virginia; or

3. the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, and the individual is institutionalized in Virginia.

M0240 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Pages 3 and 5
TN #DMAS-24	7/1/22	Pages 3-6
TN #DMAS-21	10/1/21	Pages 1, 3, 5
TN #DMAS-20	7/1/21	Table of Contents Pages 1, 3, 5 Page 6a was renumbered to Page 7. Pages 2, 4, 6 and 7 are runover pages.
TN #DMAS-13	7/1/19	Page 1 Pages 2 and 3 are runover pages.
TN #DMAS-10	10/1/18	Pages 3, 4
TN #DMAS-9	7/1/18	Table of Contents Page 6 Page 6a is a runover page
TN #DMAS-2	10/1/16	Pages 1, 4 Page 2 is a runover page.
TN #100	5/1/15	Page 2
TN #98	10/1/13	Table of Contents Pages 1-5 Page 6 was deleted.
TN #96	10/1/11	Pages 2-4
TN #94	9/1/10	Pages 1-6
TN #93	1/1/10	Pages 1-4
Update (UP) #1	7/1/09	Pages 1, 2
TN #91	5/15/09	Pages 1, 2

M0240.100 APPLICATION FOR SSN

A. Policy

If an SSN has not been issued for the individual or the individual's child(ren), the applicant must cooperate in applying for a number with the local Social Security Administration Office (SSA). Instruct the applicant to submit form SS-5, the Application for Social Security Number, to the SSA and to obtain a receipt from SSA verifying that the application was submitted. The SS-5 is available online at: http://www.socialsecurity.gov/ssnumber/ss5.htm.

The agency must provide *at least one* 90-calendar-day reasonable opportunity period for the individual to obtain and provide an SSN and may not delay, deny, reduce or terminate benefits for an individual whom the agency determines to be otherwise eligible for Medicaid during such reasonable the opportunity period. If the application for an SSN was made through hospital enumeration, the agency must allow 120 calendar days for the SSN to be obtained and provided.

The applicant must provide the SSN to the local social services department as soon as it is received and the number must be verified and entered in the eligibility/enrollment system.

1. Newborns

In the case of a newborn child, the applicant/recipient may satisfy this requirement by requesting that an SSN be applied for by hospital staff in conjunction with the filing of the birth record at the time of the child's birth. Form SSA-2853 will be given to the mother by hospital staff as verification of application for the child's SSN.

For an infant born to a mother in FAMIS Prenatal Coverage who is assigned to AC 110 and who is in managed care OR who is enrolled in AC 111, see M0240.200 C.

2. Failure to Apply for SSN

Applicants who refuse to furnish an SSN or to show proof of application for a number are ineligible for Medicaid.

3. Retroactive Eligibility

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

M0240.200 FOLLOW-UP REQUIREMENTS FOR SSN APPLICATION

A. Applicant Applied for SSN

When an applicant who has applied for an SSN is determined eligible for medical assistance, he is enrolled with a pseudo-SSN. The worker must obtain the enrollee's SSN when it is assigned and enter it into the enrollee's records.

For an infant born to a mother in FAMIS Prenatal Coverage who is assigned to AC 110 and who is in managed care OR who is assigned to AC 111, see M0240.200 C.

d. SSN Not Provided by Renewal Deadline

The worker must assist the enrollee in obtaining the applied-for SSN. The worker will ask the enrollee for the assigned SSN at the first renewal, and give a deadline date for the enrollee to provide the SSN.

If the enrollee does not provide the SSN by the deadline, the worker will ask the enrollee why it was not provided to the worker:

- Did the enrollee ever receive the SSN from SSA?
- If not, why not?

If the problem is **not** an SSA administrative problem, the worker must cancel MA coverage for the enrollee whose SSN is not provided.

C. Follow-Up Procedures For an Infant Born to a Woman Enrolled in FAMIS Prenatal Coverage

An infants born to a mother enrolled in FAMIS Prenatal Coverage assigned to Aid Category (AC) 110 and who is NOT in managed care is a deemed newborn. Follow up on the SSN is not required until the time of the newborn's first renewal *during the month or after turning one.*

An infant born to a mother in FAMIS Prenatal Coverage who is assigned to AC 110 and who IS in managed care OR who is assigned to AC 111 is not a deemed newborn; however, 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 above 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 *during the month or after turning one.*

M0240.300 SSN Verification Requirements

A. SSN Provided By Individual

The individual's SSN must be verified. When the individual provides his SSN, the worker may use the SOLQ-I or SVES to verify the individual's SSN. The individual is not eligible for MA and cannot be enrolled in the eligibility/enrollment system if his SSN is not verified.

B. Procedures

1. Enter Verified SSN in Systems

Enter the eligible enrollee's verified SSN in the eligibility/enrollment system.

2. Resolving Unverified SSN Discrepancies

a. Data Entry Error Caused Discrepancy

If it is determined that the discrepancy was the result of an error made while entering the SSN in the system, steps must be taken to correct the information in the eligibility/enrollment system so that a new data match with SSA can occur in the next month.

M0280 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Page 7
TN #DMAS-20	7/1/21	Table of Contents Page 1 Appendix 2 was added.
TN #DMAS-19	4/1/21	Pages 3, 4 Appendix 1 Page 4a was added.
TN #DMAS-17	7/1/20	Pages 7, 9, 10 Page 11 was deleted.
TN #DMAS-15	1/1/20	Page 9 Appendix 1
TN #DMAS-14	10/1/19	Pages 6, 7, 9, 11
TN #DMAS-2	10/1/16	Pages 7, 9
TN #100	5/1/15	Table of Contents Pages 1-11 Appendix 1 was added Pages 12 and 13 were deleted.
UP #9	4/1/13	Page 5
Update (UP) #7	7/1/12	Table of Contents Page 8 Appendix 1 was deleted.
TN #94	9/1/10	Page 1
TN #93	1/1/10	Page 13

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

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

D. Juveniles in Detention

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

1. Held for Care, Protection or Best Interest

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

2. Held for Criminal Activity

a. Prior to Court Disposition

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

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

b. After Court Disposition

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

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

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Pages 6 and 28 ; Appendix 1
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.

2. Special Medical Needs

Children with special needs for medical or rehabilitative care adopted under a Non IV-E Adoption Assistance agreement with a Virginia local department of social services or a Virginia private, non-profit child placement agency in conjunction with a local department of social services, in accordance with policies established by the State Board of Social Services *are considered to be residing in Virginia*.

a. Documentation must indicate that the child has special needs for medical or rehabilitative care

One of the following documents must indicate the child's special needs for medical or rehabilitative care:

- an adoption assistance agreement specifying that the child has a special need for medical or rehabilitative care; the agreement does NOT need to specify a particular diagnosis or condition.
- an amendment to the adoption assistance agreement specifying that the child has a special need for medical or rehabilitative care.
- a signed letter on official letterhead from the state that facilitated the adoption assistance agreement confirming that the child has a special need for medical or rehabilitative care.

b. Virginia Medicaid coverage for children with special needs for medical or rehabilitative care

Medicaid coverage is to be provided to any child who has been determined to be a Non-IV-E Adoption Assistance Child with special needs for medical or rehabilitative care for whom there is in effect an adoption assistance agreement between a local Virginia department of social services (LDSS) or a Virginia child-placing agency and an adoptive parent(s).

Virginia Medicaid coverage MAY be provided to a child with special needs for medical or rehabilitative care for whom there is in effect an adoption assistance agreement between another state's child-placing agency and an adoptive parent(s) IF the other state reciprocates with Virginia per the Interstate Compact on Adoption and Medical Assistance (ICAMA).

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 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.

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 may decide to rescind a disability denial when a determination or decision, which appeared to be correct based on the available evidence at the time it was made, is later discovered to have been incorrect. Applicants or Appellants cannot request that the DDS rescind a denial. If an applicant or appellant would like the claim re-evaluated, the individual must appeal the Medicaid decision with DMAS or file a new Medicaid application with DSS. 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.

Disability Determination Services (DDS) Contact Information

Send ALL expedited and non-expedited disability referrals to the DDS Central Regional Office.

DDS Regional Office	Hearing Contacts
Central Regional Office Disability Determination Services 9960 Mayland Drive. Suite 200 Richmond, Virginia 23233 Phone: 800-523-5007 or 804-367-4700 FAX: 804-527-452*4* *Operations Manager: Talya Brown* *Professional Relations Officer: Shareen Young-Chavez* *District Director: Elliot Duncan*	Primary Contact *for Scheduling*: *Clint Barrett* *(804) 367-1570* Backup: Patrice Harris 804-367-4714

M0320 Changes

Changed With	Effective Date	Pages Changed
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

B. Financial Eligibility

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

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

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

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

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

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

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

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

E. Enrollment The ABD 80% group AC is:

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

M0320.400 MEDICAID WORKS

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

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

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

These individuals can retain Medicaid coverage as long as they remain employed and their *countable* earned income is less than or equal to $6,250 per month. MEDICAID WORKS is Virginia's Medicaid Buy-In (MBI) program.

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

An individual with SSI or eligible for Medicaid as a Qualified Severely Impaired Individual (QSII) (1619(b)) *must* meet the *138% FPL* income requirement for entry into MEDICAID WORKS and *should* not be discouraged from enrolling in MEDICAID WORKS. An individual who meets the criteria for 1619(b) status may choose to participate in MEDICAID WORKS because of the higher resource limit. ***SSI or eligible for Medicaid as a Qualified Severely Impaired Individual (QSII) (1619(b)) individuals are not automatically enrolled in Medicaid Works. They must be evaluated according to the non-financial and financial requirements used for all MEDICAID WORKS applicants and enrollees.***

C. Nonfinancial Eligibility

The individual must also meet the following additional nonfinancial criteria:

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

The WIN account cannot contain the individual's other Social Security benefits. The individual must provide statements from the institution where the account is held at application and renewal.

- *The WIN Account cannot be a jointly owned account; only funds of the MEDICAID WORKS enrollee can deposit into the designated account. A previously established ABLE account can be used as a WIN account.*

- All individuals requesting enrollment in MEDICAID WORKS must also sign a MEDICAID WORKS Agreement, available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms. The agreement outlines the individual's responsibilities as an enrollee in the program.

D. Financial Eligibility

1. Assistance Unit

Initial eligibility determination

In order to qualify for MEDICAID WORKS, the individual must meet the assistance unit policy and procedures in chapter M05 that apply to ABD non-institutionalized individuals. Individuals receiving SSI or who have 1619(b) status *must* also meet the income requirement for entry into MEDICAID WORKS.

Income from a non-ABD spouse, non-applicant/member ABD spouse, or parents is **not** considered deemable income and is not counted for the initial eligibility determination for individuals requesting to participate in MEDICAID WORKS.

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

b. Ongoing eligibility

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

Note: *Children and non-spouse dependents are not included in the assistance unit when determining eligibility for MEDICAID WORKS.*

2. Resources

a. Initial eligibility determination

For the initial eligibility determination, the resource limit is $2,000 for an individual and $3,000 for a couple. Resources must be evaluated for all individuals, including SSI recipients and QSII/(1619(b) individuals, who wish to qualify for MEDICAID WORKS. The resource requirements in chapter S11 and Appendix 2 to chapter S11 apply for the initial eligibility determination. The individual's countable, nonexempt resources must be verified. All countable resources, must be added together to determine if the individual's countable resources are within the limit. *WIN accounts and other non-countable resources are excluded from the resource determination.*

b. Ongoing eligibility

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

1) For **earnings** accumulated **after** enrollment in MEDICAID WORKS, up to the current 1619(b) income threshold amount will be disregarded if deposited and retained in the WIN Account. The *2024* 1619(b) threshold amount is *$45,976 (decreased from the 2023 amount)*.

2) Resources accumulated while in MEDICAID WORKS and held in Internal Revenue Service (IRS)-approved retirement accounts, medical or health savings accounts, medical reimbursement (flex) accounts, education accounts, independence accounts, and other similar State-approved accounts are excluded. Examples of these accounts include Archer Medical Savings Accounts, 401(k)/403(b)/457(b)/503(b) accounts, traditional Individual Retirement Accounts (IRAs), Roth IRAs, SEP-IRAs, SIMPLE IRAs, and Thrift Savings Plans. The account must be designated as a WIN Account to be excluded. **Resources accumulated while in MEDICAID WORKS and held in IRS-approved accounts that have been designated as WIN Accounts are also excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees**. The account must be exclusively used to hold resources accumulated while in MEDICAID WORKS (including interest) for the exclusion to continue. Resources can be spent however the individual chooses. Transfers will be evaluated if the individual applies for LTSS.

3) *Resources can be spent however the individual chooses. Transfers will be evaluated to determine if a penalty should be calculated if the individual applies for (or is receiving) LTSS.*

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

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

Resources accumulated while in MEDICAID WORKS and retained in an IRS-approved account described in M0320.400 D. 2. b. 2) that has been designated as a WIN Account are excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees.

H. Benefit Package

Individuals enrolled in MEDICAID WORKS are entitled to the standard benefits available to full-benefit Medicaid enrollees (see Chapter M18). *Medicaid Works members cannot be enrolled in* Developmental Disabilities (*DD) waivers, but the waiver slot will be held for up to six months if a DD Waiver recipient wants to try transitioning to Medicaid Works. Participants can receive personal care services as a service provided by the assigned MCO plan, however,* MEDICAID WORKS enrollees do **not** have a patient pay *responsibility*. Intensive Behavioral Dietary Counseling is also covered for MEDICAID WORKS enrollees when a physician determines that the service is medically necessary.

I. Entitlement and Enrollment

Entitlement for MEDICAID WORKS is dependent upon meeting the requirements listed above.

There is no retroactive coverage under MEDICAID WORKS. The application date in the Virginia Case Management System (VaCMS) is the date the individual signed the MEDICAID WORKS Agreement. Coverage shall begin on the first day of the month following the month in which all requirements are met. If the applicant has a future start date for employment, the effective date of eligibility shall be no earlier than the first day of employment. However, unless employment begins on the first day of the month, MEDICAID WORKS enrollment will begin on the first of the following month. *If the person is already enrolled Medicaid, a new application is not required. Appendix D should be completed to gather additional information on resources. If the person is not currently enrolled in Medicaid, a new application is necessary*.

The *Aid Category* for MEDICAID WORKS is 059. Use the following procedures to enroll the individual in VaCMS:

<u>New Application – Applicant is Disabled and enrolled in Medicaid</u>

1. For the month of application and any retroactive months in which the person is eligible, enroll the individual in the appropriate AC in a closed period of coverage, beginning the first day of the month in which eligibility exists. The cancel date is the last day of the month in which the MEDICAID WORKS Agreement was signed. Use Cancel Code 042.
2. Reinstate the individual's coverage in MEDICAID WORKS using AC 059 beginning the first day of the following month (the first day of the month following the month in which the MEDICAID WORKS Agreement is signed). Use the same application date (the actual date of the initial application) that was used for the month of application.

DMAS approval is not required for participation in MEDICAID WORKS; however, information must be sent to DMAS after the individual is enrolled for tracking purposes. Use the MEDICAID WORKS Email Cover Sheet available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, and **email** it together with the following information to DMAS at ***MedicaidWorks@*dmas.virginia.gov**:

- the signed MEDICAID WORKS Agreement,
- the Work Incentive Account (WIN) information (a bank account statement or verification from the bank that the account was opened), and
- a pay stub showing current employment or an employment letter with start date or self-employment document(s) *to verify employment.*

Changed With	Effective Date	Pages Changed
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 and is between the ages of 19 and 64, evaluate for Plan First coverage.

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

***G*. Entitlement**

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 because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.

1. IV-E Foster Care Child

Entitlement to Medicaid as a IV-E Foster Care child begins the first day of the month of commitment or entrustment if a Medicaid application is filed within 4 months of commitment or entrustment. Retroactive entitlement prior to the month of commitment or entrustment is not allowed.

If the Medicaid application is filed more than 4 months after entrustment or commitment, entitlement may be retroactive up to 3 months prior to application if the child met all Medicaid eligibility requirements in the retroactive months. However, Medicaid entitlement cannot go back to the month of entrustment or commitment when the application is filed more than 4 months after entrustment or commitment.

2. IV-E Adoption Assistance Child

Entitlement to Medicaid as a IV-E Adoption Assistance child begins the first day of the application month if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

***H*. Enrollment**

The aid category (AC) for IV-E foster care children is "076." The AC for IV-E Adoption Assistance children is "072".

M0330.107 INDIVIDUALS UNDER AGE 21

A. Policy

42 CFR 435.222 – The federal Medicaid law allows the State Plan to cover reasonable classifications of individuals under age 21 years who do not receive cash assistance but who meet the income requirements of the state's July 16, 1996 AFDC State Plan. Children under age 19 should be evaluated in the FAMIS Plus covered group if not eligible as individuals under age 21.

Individuals ages 19 and 20 should be evaluated in the Individuals Under Age 21 covered group when they are not eligible for Medicaid in any other full-benefit covered group.

The reasonable classifications of individuals under age 21 are:

- IV-E eligible foster care children who do NOT receive a IV-E maintenance payment,
- Non-IV-E foster care children,
- Department of Juvenile Justice (DJJ) children,
- Non-IV-E Adoption Assistance children,
- Children in intermediate care nursing facilities (ICF), and
- Children in intermediate care facilities for the intellectually disabled (ICF-ID).

B. Nonfinancial Eligibility Requirements

The individual must be under age 21 and meet the nonfinancial requirements in chapter M02.

C. Reasonable Classifications

The individual under age 21 must meet one of the following classifications:

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Pages 2, 4, 5, 8, 16, 16b2, 21, 33, 34, 34a Appendices 3, 5 and 8
TN #DMAS-31	4/1/24	Pages 15 and 16a; Appendices 1, 2, 6 and 7
TN #DMAS-30	1/1/24	Pages 1, 34 Page 34a is a runover page
TN #DMAS-28	7/1/23	Page 37 Appendices 1,2,3,5,6 and 7

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

2. MAGI Rules

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

3. Eligibility Based on MAGI

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

a. Children under 19

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

c. Pregnant *individuals*, including FAMIS MOMS and FAMIS Prenatal Coverage

d. Individuals Under Age 21

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

f. Individuals in Plan First.

4. Eligibility NOT Based on MAGI

MAGI methodology is NOT used for eligibility determinations for:

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

- Individuals eligible in the following covered groups:
  - LIFC (parents and caretaker-relatives)
  - Pregnant *Individuals*
  - Adoption Assistance and Foster Care Children
  - Former Foster Care Children Under Age 26
  - BCCPTA

- Supplemental Security Income (SSI) recipients and protected individuals.

7. Children in Level C Psychiatric Residential Treatment Facilities (PRTFs)

Children placed in Level C PRTFs are considered absent from their home if their stay in the facility has been 30 consecutive days or more. A child who is placed in a Level C PRTF is considered NOT living with his parents for MAGI 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. See M0520.100 B.3.

M0420.100 Definitions

A. Introduction

The definitions below are used in this chapter. Some of the definitions are also in subchapter M0310. Some of the definitions are from the IRC.

B. Definitions

1.* Advance Premium Tax Credit (APTC*)

is a tax credit that an individual or family with taxable income of at least 100% FPL but no more than 400% FPL can take in advance to lower their monthly health insurance premium. Eligibility for the APTC is determined by the federal HIM using MAGI rules for tax-filer households. Projected annual household income, rather than monthly income, is evaluated.

2. Attested Income

means the agency must review income information attested by the applicant and utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information, information from SSA through SVES or SOLQ-I and other verified income in the eligibility record or system. Verification of income from available sources, including the VEC, may be used if it is dated within the previous 12 months.

3. Caretaker Relative

means a non-parent relative of a "dependent" child by blood, adoption, or marriage with whom the child lives, who assumes primary responsibility for the child's care. When a parent is in the home, no adult relative other than a stepparent can be eligible for Medicaid in the LIFC covered group.

4. Child

means a natural, biological, adopted, or stepchild.

5. Childless Adult

a childless adult is someone who does not meet the definition of an LIFC parent or caretaker-relative.

6. Coverage Gap and Gap-filling Rule

occurs when the difference in eligibility rules between the APTC and Medicaid/FAMIS creates a situation in which an applicant may appear to be financially ineligible for both the APTC (household income is too low) and Medicaid or FAMIS (household income is too high). The gap-filling rule is applied in such cases to help mitigate the coverage gap.

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

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

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

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

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

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

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

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

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

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

If reasonable compatibility does not exist or income data was not available through available electronic sources and the attestation is below the medical assistance income level, additional verification of income is required.

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

4. Married Couple

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

5. Tax Filer is Under Age 19

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

6. Gap-filling Rule

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

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

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

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

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

M0430.200 TAX FILER HOUSEHOLD EXAMPLES

A. Married Parents and Their Tax Dependent Children

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

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

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

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

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

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

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

i. *Lottery and gambling winnings of $80,000 or greater, which are received in a single payout, are counted not only in the month received, but over a period of up to 120 months. Lottery winnings paid out in installments would be treated the same as other types of recurring income. Winnings less than $80,000 are counted in the month received;*

• Winnings of $80,000 but less than $90,000 are counted as income over two months, with an equal amount counted in each month; and

• For every additional $10,000 one month is added to the period over which total winnings are divided, in equal installments, and counted as income.

The maximum period of time over which winnings may be counted is 120 months, which would apply for winnings of $1,260,000 and above. The requirement to count qualified lottery and gambling winnings in household income over multiple months applies only to the individuals receiving the winnings. The determination of household income for other members of the individual's household are not affected. Thus, for example, the total amount of qualified lottery or gambling winnings of a spouse or parent continues to count only in the month received in determining the eligibility of the other spouse and children. If the winner wishes to claim an"undue medical or financial hardship" exemption to counting the income after the first month, send the request to DMASEvaluation@dmas.virginia.gov.

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

k. Census income.

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

m. Unemployment Compensation is counted as unearned income.

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

2. Income That is not Counted

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

b. Workers Compensation is not counted.

p. Tax filers who do not itemize their deductions are permitted to deduct from their MAGI up to $300 in charitable contributions made by an eligible individual in tax years beginning in 2020.

3. Income From Self-employment

The agency must utilize online systems that are available to the agency to attempt to verify self-employment income. If the income cannot be verified through online data sources, an *individual* reporting self-employment income must provide verification of business expenses, income, and applicable adjustments with forms or schedules including but not limited to IRS Form 1040, Schedule 1, Schedule C (business expenses), Schedule E (expenses from rental income) and Schedule F (expenses from farming). If the individual alleges that current income is not accurately represented by tax records, obtain additional information (such as business records) that documents current income.

B. Determine the MA Income for Each Member of the Household

1. Is Any Household Member The Child Or Expected Tax Dependent Of Another Member Of The Household?

a. If yes - is the individual expected to be required to file a tax return?

1) If yes, continue to Step 2 and include child's income in total household income.

2) If no, continue to Step 2, but do not include child's income in total household income.

b. If no, continue to Step 2.

2. Determine MAGI Income For Each Member

Determine MAGI-based income of each member of the individual's household, unless income of such member is flagged as not being counted in step 1. Recall that, for purposes of MA eligibility, the following rules apply:

- An amount received as a lump sum is counted as income only in the month received.
- Scholarships, awards or fellowship grants used for education purposes and not for living expenses are excluded from income.
- Certain distributions, payments and student financial assistance for American Indians/Alaska Natives are excluded from income.
- Child support is not countable income.
- Social Security benefits received by a child are not countable for his eligibility when a parent is in the household, unless the child is required to file taxes.
- Interest paid on student loans is deducted from income.
- Foreign income and interest, including tax-exempt interest, are counted.

3. Using the 5% of FPL Disregard

If the individual's household income is over the income limit for his covered group, subtract an amount equal to 5% of FPL for his household size (see M04, Appendix 1). Compare the countable income against the income limit for the individual's covered group to determine his income eligibility.

If the individual meets multiple Medicaid covered groups (and/or FAMIS) his gross income is compared first to the income limit of the full-benefit covered group with the highest income limit for which the individual could be eligible. If the income exceeds the limit, subtract 5% FPL based on his household size and compare the income again to the income limit. If still not eligible, the same process is followed for Plan First, if the individual is age 19 through 64 years.

C. Household Income

Household income is the sum of the MAGI-based income for every member of the individual's household as determined in step 2 above.

B. Non-financial Requirements

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

C. Household Income Calculation

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

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

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

1. Verification of Income

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

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

2. Countable Income

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

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

3. Income Evaluation

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

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

3. Renewals

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

For a pregnant *individual* determined eligible based on gap-filling methodology, coverage ends the last day of the 12th month after the end of the month in which the pregnancy ends. Complete a renewal 30 days prior to the end of coverage.

For a child with 12 months continuous eligibility, coverage ends the last day of the 12th month after the first month of eligibility (not including retroactive coverage). Complete a renewal 30 days prior to the end of coverage.

4. Individual Not eligible using Gap-Filling Methodology

If the individual's household income is determined to be over the Medicaid and FAMIS income limits after the gap-filling rule evaluation **and** he meets a MN covered group, he must be offered the opportunity to be placed on a MN spenddown. If the individual does not provide the necessary verifications for the gap-filling evaluation the application should be denied if the information provided is reasonably compatible with information obtained by the worker from electronic sources such as the VEC, or documentation is available from other social services program, such as TANF or SNAP, and the systems information is dated within the past 12 months, the agency must determine eligibility based upon the information available. If there is a discrepancy between what is stated on the application and the information obtained from online systems/agency knowledge, contact the enrollee to obtain clarification of reported income.

A.Example Situation – Covearge Gap and Gap Filling Countable Income

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

Virginia's Health Insurance Marketplace refers the application to Virginia for a Medicaid/FAMIS eligibility determination. The child meets a tax dependent exception in M0430.100 B.2 (lives with both parents, is claimed as a tax dependent by one parent, and the parents do not expect to file jointly). The child's eligibility for Medicaid or FAMIS is determined using non-filer methodology.

Because is under 19 and both parents are in *the* household, the income of both parents is counted. Household income with the 5% FPL disregard is over the limit for both Medicaid and FAMIS.

LIFC Income Limits Effective *7/1/2024*

Group I

Household Size	Monthly Amount	Annual Amount
1	*$319*	*$3,828*
2	*481*	*5,772*
3	*614*	*7,368*
4	*742*	*8,904*
5	*870*	*10,440*
6	*981*	*11,772*
7	*1109*	*13,308*
8	*1240*	*14,880*
Additional	*135*	*1,620*

Group II

Household Size	Monthly Amount	Annual Amount
1	*$416*	*$4,992*
2	*591*	*7,092*
3	*745*	*8,940*
4	*887*	*10,644*
5	*1,044*	*12,528*
6	*1,174*	*14,088*
7	*1,316*	*15,792*
8	*1,467*	*17,604*
Additional	*150*	*1,800*

Group III

Household size	Monthly Amount	Annual Amount
1	*$623*	*$7,476*
2	*834*	*10,008*
3	*1,018*	*12,216*
4	*1,191*	*14,292*
5	*1,411*	*16,932*
6	*1,567*	*18,804*
7	*1,742*	*20,904*
8	*1,927*	*23,124*
Additional	*182*	*2,184*

INDIVIDUALS UNDER AGE 21 INCOME LIMITS

EFFECTIVE *7/1/24*

Group I

Household Size	Monthly Income Limit	Annual Income Limit
1	*$306*	*$3,672*
2	*467*	*5,604*
3	*600*	*7,200*
4	*725*	*8,700*
5	*855*	*10,260*
6	*958*	*11,496*
7	*1,082*	*12,984*
8	*1,217*	*14,604*
Each additional person add	*131*	*1,572*

Group II

Household Size	Monthly Income Limit	Annual Income Limit
1	*$412*	*$4,944*
2	*593*	*7,116*
3	*743*	*8,916*
4	*888*	*10,656*
5	*1,048*	*12,576*
6	*1,174*	*14,088*
7	*1,316*	*15,792*
8	*1,466*	*17,592*
Each additional person add	*148*	*1,776*

Group III

Household Size	Monthly Income Limit	Annual Income Limit
1	*$544*	*$6,528*
2	*730*	*8,760*
3	*881*	*10,572*
4	*1,032*	*12,384*
5	*1,220*	*14,640*
6	*1,344*	*16,128*
7	*1,490*	*17,880*
8	*1,641*	*19,692*
Each additional person add	*149*	*1,788*

TREATMENT OF INCOME FOR FAMILIES & CHILDREN COVERED GROUPS

INCOME	MAGI COVERED GROUPS	MEDICALLY NEEDY; 300% SSI; F&C COVERED GROUPS
Earnings	Counted with no disregards	Counted with appropriate earned income disregards
Social Security Benefits Adult's MAGI household	Benefits received by a parent or stepparent are counted for his eligibility determination, as well as the eligibility determinations of his spouse and children in the home.	Counted if anyone in the Family Unit/Budget Unit receives
Social Security Benefits Child's MAGI household	If the child lives with a parent, only counted if the child is required to file a federal tax return..	Counted if anyone in the Family Unit/Budget Unit receives
Child Support Received	Not counted	Counted – subject to $50 exclusion
Child Support Paid	Not deducted from income	Not deducted from income
Alimony Received	Counted if divorce agreement was finalized prior to January 1, 2019, and the agreement has not been modified.	Counted – subject to $50 exclusion if comingled with child support
Alimony Paid	Deducted from income if divorce agreement was finalized prior to January 1, 2019	Not deducted from income
Worker's Compensation	Not counted	Counted
Veteran's Benefits	Not counted if they are **not** taxable in IRS Publication 525	Counted
Scholarships, fellowships, grants and awards used for educational purposes	Not counted	Not counted
Student Loan Debt	Effective January 1, 2019, student loan debt forgiven due to death or disability of student is not counted as income	Not applicable
Foreign Income (whether or not excluded from taxes)	Counted	Counted
Interest	Counted	Counted
Lump Sums	Income in month of receipt	Income in month of receipt
Lottery & Gambling Winnings	*Lottery and gambling winnings of $80,000 or greater, received in a single payout, are counted in the month received and over a period of up to 120 months. Income in month of receipt for other HH members.*	*Income in month of receipt*
Gifts, inheritances, life insurance proceeds	Not counted	Counted as lump sum in month of receipt
Parsonage allowance	Not counted	Counted
Pandemic Unemployment Compensation Payments	Not counted (regular Unemployment Compensation is counted.)	Not counted (regular Unemployment Compensation is counted.)
***Federal* COVID-19 relief payments**	Not counted	Not counted

M0610 Changes

Changed With	Effective Date	Pages Changed
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

M0610.000 GENERAL RULES FOR FAMILIES AND CHILDREN RESOURCES

M0610.001 OVERVIEW

A. Introduction

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

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

This section addresses how to determine resource eligibility for the following covered groups and individuals:

- F&C in Medical Institution, Income ≤ 300% SSI age 18 years and older*;
- F&C Receiving Waiver(CBC) Services age 18 years and older*;
- F&C Hospice age 18 years and older*; and
- all F&C medically needy covered groups.

***Children under age 18 in the F&C 300% SSI covered group are not subject to a resource test.**

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

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

B. Policy Principles

1. Monthly Determinations

Eligibility with respect to resources is a determination made for each calendar month, beginning with the third month prior to the month in which the application is received. *Resource eligibility exists for the full month if countable resources were at or below the applicable resource limit for any part of the month. If resource amounts reported are reasonably compatible with values received from electronic verification sources, the evaluation can continue. If reported resource amounts and verified resource amounts are both below the established limit, resource eligibility is assumed to exist. If both amounts are over the resource limit, the applicant is not resource eligible. In all situations, the sources of the resources do not need to match.*

Make all resource determinations per calendar month. Resource eligibility exists for the full month if countable resources were at or below the resource standard for any part of the month. If resource amounts reported are reasonably compatible with values received from electronic verification sources, the evaluation can continue. If reported resource amounts and verified resource amounts are both below the established limit, resource eligibility is assumed to exist. If both amounts are over the resource limit, the applicant is not resource eligible. In all situations, the sources of the resources do not need to match. If the member attests to having resources below the limit and values received from electronic sources are above the limit, additional verification should be requested.

M0640 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Page 1
	8/1/2000	Page 3
	12/1/2003	TOC, Pages 1, 4, 5, 6,
	1/1/98	Page 2

M0640.000 TYPES OF COUNTABLE RESOURCES

M0640.001 OVERVIEW

A. Introduction

This subchapter contains instructions for the development of resources whose value ordinarily will count toward the resource limit. Use these instructions only after you have made certain that the asset:

- is a resource, based on instructions in the M0610 subchapter; and
- is not an excluded resource, based on instructions in the M0630 subchapter.
- *The reported values of the resources are not reasonably compatible with electronic sources AND below the resource limit. In all situations the sources of the resources do not have to match. See M0610.001.*

NOTE: A trust may or may not be a countable resource. See M0620.140 to determine if a trust established by a will is a countable resource. For all other trusts, see M1120.201.

NOTE: If the individual is a married institutionalized individual, go to subchapter M1480.

REAL PROPERTY

M0640.100 NON-HOME REAL PROPERTY

A. Definition

Non-home real property consists of land and buildings or immovable objects that are attached permanently to the land and that do not meet the definition of a home (house, lot and all contiguous property).

B. Development and Documentation of Fair Market Value

Ascertain fair market value from the Commissioner of Revenue or Assessor's Office.

C. Ownership/Value

1. Sole Owner

If the applicant/recipient is the sole owner, the property is a resource.

If the applicant/recipient is the sole owner with a living spouse, the property is a resource to the applicant/recipient regardless of the spouse's willingness to join in a deed to sell the property.

2. Tenants by Entirety

If the property is held by the applicant/recipient and spouse as tenants by the entirety with survivorship at common law:

a. When the applicant/recipient and spouse are living together, the property is a resource regardless of the spouse's consent to sell.

When the spouses live apart, if the separated spouse gives consent to dispose of property, one-half of the total value of the property is

M0710 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Appendices 2 and 3
TN #DMAS-25	10/1/22	Page 2
TN #DMAS-24	7/1/22	Appendices 2 and 3
TN #DMAS-20	7/1/21	Appendix 2 Appendix 3
TN #DMAS-17	7/1/20	Appendix 2 Appendix 3
TN #DMAS-14	10/1/19	Pages 1, 2, 7, 8 Page 2a was added as a runover page.
TN #DMAS-13	7/1/19	Appendix 2 Appendix 3
TN #DMAS-9	7/1/18	Appendix 2 Appendix 3
TN #DMAS-5	7/1/17	Appendix 1 Appendix 2 Appendix 3
TN #DMAS-2	10/1/16	Appendix 2 Appendix 3
UP #11	7/1/15	Appendix 5
TN #100	5/1/15	Table of Contents Pages 1-8 Pages 9-13 were deleted. Appendix 1 Appendix 2 Appendix 3 Appendices 4-7 were removed.
TN #98	10/1/13	pages 1-4, 8, 9 Page 1a was added. Appendix 1 Appendix 3 Appendix 5
UP #9	4/1/13	Appendix 6, pages 1, 2 Appendix 7
UP #7	7/1/12	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1
UP #6	4/1/12	Appendix 6, pages 1, 2 Appendix 7
TN #96	10/01/11	Appendix 6, page 1
UP #5	7/1/11	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1
TN #95	3/1/11	Appendix 6, pages 1, 2 Appendix 7
Update (UP) #1	7/1/09	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1

F&C MEDICALLY NEEDY INCOME LIMITS

EFFECTIVE 7/1/24

GROUP 1			GROUP II		GROUP III	
# of Persons in Family/Budget Unit	**Semi-Annual Income**	**Monthly Income**	**Semi-Annual Income**	**Monthly Income**	**Semi-Annual Income**	**Monthly Income**
1	*2,391.01*	*398.50*	*2,758.87*	*459.81*	*3,586.53*	*597.76*
2	*3,043.80*	*507.30*	*3,396.83*	*566.14*	*4,323.80*	*720.63*
3	*3,586.53*	*597.76*	*3,954.41*	*659.07*	*4,874.05*	*812.34*
4	*4,046.37*	*674.40*	*4,414.23*	*735.71*	*5,333.87*	*888.98*
5	*4,506.19*	*751.03*	*4,874.05*	*812.34*	*5,793.69*	*965.61*
6	*4,966.00*	*827.67*	*5,333.87*	*888.98*	*6,253.50*	*1,042.25*
7	*5,425.82*	*904.30*	*5,793.69*	*965.61*	*6,713.32*	*1,118.89*
8	*5,977.60*	*996.27*	*6,345.47*	*1,057.58*	*7,173.16*	*1,195.53*
Each add'l person	*617.93*	*102.99*	*617.93*	*102.99*	*617.93*	*102.99*

F&C 100% STANDARD OF ASSISTANCE
EFFECTIVE 7/1/24
(Used as the F&C Deeming Standard)

Group I

Household Size	Income Limit
1	*$314*
2	*472*
3	*601*
4	*730*
5	*857*
6	*966*
7	*1,088*
8	*1,221*
Each additional person add	*133*

Group II

Household Size	Income Limit
1	*$410*
2	*582*
3	*733*
4	*871*
5	*1,025*
6	*1,157*
7	*1,296*
8	*1,443*
Each additional person add	*148*

Group III

Household Size	Income Limit
1	*$614*
2	*820*
3	*1,001*
4	*1,173*
5	*1,385*
6	*1,541*
7	*1,717*
8	*1,897*
Each additional person add	*179*

M0810 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Page 2
TN #DMAS-31	4/1/24	Pages TOC i, 1, 2
TN #DMAS-29	10/1/23	Pages 6, 9
TN #DMAS-28	7/1/23	Pages 2, 6
TN #DMAS-27	4/1/23	Page 2, 25, 27, 28 Page 25a is a runover page
TN #DMAS-25	1/1/23	Pages 1, 2
TN #DMAS-24	7/1/22	Page 2
TN #DMAS-23	4/1/22	Page 2
TN #DMAS-22	1/1/22	Pages 1, 2, 3
TN #DMAS-20	7/1/21	Page 2
TN #DMAS-19	4/1/21	Page 2
TN #DMAS-18	1/1/21	Pages 1, 2
TN #DMAS-17	7/1/20	Page 2
TN #DMAS-16	4/1/20	Page 2
TN #DMAS-15	1/1/20	Pages 1, 2
TN #DMAS-14	10/1/19	Pages 20, 25, 27 Page 28 is a runover page.
TN #DMAS-12	4/1/19	Page 2
TN #DMAS-11	1/1/19	Pages 1, 2
TN #DMAS-10	10/1/18	Page 2
TN #DMAS-9	7/1/18	Page 2
TN #DMAS-8	4/1/18	Page 2
TN #DMAS-7	1/1/18	Pages 1, 2
TN #DMAS-5	7/1/17	Page 2
TN #DMAS-4	4/1/17	Page 2
TN #DMAS-3	1/1/17	Pages 1, 2
TN #DMAS-2	10/1/16	Page 2
TN #DMAS-1	6/1/16	Pages 1, 2
UP #11	7/1/15	Page 2
TN #100	5/1/15	Pages 1, 2
UP #10	5/1/14	Page 2
TN #99	1/1/14	Pages 1, 2
TN #98	10/1/13	Page 2
UP #9	4/1/13	Pages 1, 2
UP #7	7/1/12	Page 2
UP #6	4/1/12	Pages 1, 2
TN #95	3/1/11	Pages 1, 2
TN #93	1/1/10	Pages 1, 2
Update (UP) #1	7/1/09	Page 2

3. Categorically Needy 300% of SSI

For the covered groups that use the 300% of SSI income limit, all income is counted (even excluded income) when screening at 300% of SSI. Do not count any monies which are defined as "what is not income" in S0815.000.

Family Size Unit	2023 Monthly Amount	*2024* Monthly Amount
1	$2,742	*$2,829*

4. ABD Medically Needy

a. Group I	*7/1/23-6/30/24*		*7/1/24*	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	*$2,324.16*	*$387.36*	*$2,391.01*	*$398.50*
2	*2,925.70*	*493.11*	*3,043.80*	*507.30*

b. Group II	*7/1/23-6/30/24*		*7/1/24*	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	*$2,681.739*	*$446.95*	*$ 2,758.87*	*$ 459.81*
2	*3,302.13*	*550.35*	*3,396.83*	*566.14*

c. Group III	*7/1/23-6/30/24*		*7/1/24*	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	*$3,486.27*	*$581.04*	*$3,586.53*	*$597.76*
2	*4,202.86*	*700.47*	*4,323.80*	*720.63*

5. ABD Categorically Needy

For:

ABD 80% FPL, QMB, SLMB, & QI <u>without</u> Social Security income; all QDWI; effective 1/17/24

ABD 80% FPL, QMB, SLMB, & QI <u>with</u> Social Security income; effective 3/1/24

All Localities	2023		2024	
ABD 80% FPL	Annual	Monthly	Annual	Monthly
1	$11,664	$972	$12,048	$1,004
2	15,776	1,315	16,352	1,363
QMB 100% FPL	Annual	Monthly	Annual	Monthly
1	$14,580	$1,215	$15,060	$1,255
2	19,720	1,644	20,440	1,704
SLMB 120% of FPL	Annual	Monthly	Annual	Monthly
1	$17,496	$1,458	$18,072	$1,506
2	23,664	1,972	24,528	2,044
QI 135% FPL	Annual	Monthly	Annual	Monthly
1	$19,683	$1,641	$20,331	$1,695
2	26,622	2,219	27,594	2,300
QDWI 200% of FPL	Annual	Monthly	Annual	Monthly
1	$29,160	$2,430	$30,120	$2,510
2	39,440	3,287	40,880	3,407

M1110 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Pages 1 and 18
TN #DMAS-31	4/1/24	TOC, Pages 1, 6, 7
TN #DMAS-30	1/1/24	Page 2
TN #DMAS-27	4/1/23	Pages 6, 7
TN #DMAS-26	1/1/23	Page 2
TN #DMAS-22	1/1/22	Pages 1, 2
TN #DMAS-20	7/1/21	Page 16
TN #DMAS-19	4/1/21	Page 16
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TN #DMAS-17	7/1/20	Page 1
TN #DMAS-15	1/1/20	Page 2
TN #DMAS-12	4/1/19	Pages 10-10a
TN #DMAS-11	1/1/19	Page 2
TN #DMAS-3	1/1/18	Page 2
TN #DMAS-4	4/1/17	Pages 10, 10a
TN #DMAS-3	1/1/17	Pages 2, 7, 10, 11 Page 10a was added as a runover page.
TN #100	5/1/15	Page 2
TN #99	1/1/14	Page 2
UP #9	4/1/13	Page 2
UP #6	4/1/12	Page 2
TN #96	10/1/11	Page 2
TN #95	3/1/11	Page 2
Update (UP) #3	3/2/10	Table of Contents page 2
TN #93	1/1/10	Page 2
TN #91	5/15/09	Pages 14-16

OVERVIEW

M1110.001 ROLE OF RESOURCES

A. Introduction

As a program based on need, Medicaid uses the value of a person's countable resources as one of two financial criteria in determining eligibility. The other criterion is income. The following sections explain how to treat resources to determine eligibility in the Aged, Blind and Disabled covered groups in the Medicaid program. Virginia Medicaid follows Social Security Administration rules from the SSI section of the Program Operations Manual System (POMS) SSA's Policy Information Site - POMS. Some of the rules are adapted due to state laws and regulations. We have noted in each section if the section follows SSA policy without deviation by adding "per POMS'. This chapter explains how we count resources.

B. Policy Principles

1. Monthly Determinations

Eligibility with respect to resources is a determination made for each calendar month, beginning with the month of application or, if retroactive eligibility is being determined, the third month prior to the month in which the application is submitted. Resource eligibility exists for the full month if countable resources were at or below the applicable resource limit for any part of the month. *If resource amounts reported are reasonably compatible with values received from electronic verification sources, the evaluation can continue. If reported resource amounts and verified resource amounts are both below the established limit, resource eligibility is assumed to exist. The sources of the resources do not need to match. If both amounts are over the resource limit, the applicant is not resource eligible. Again, the sources of the resources do not need to match. If the member attests to having resources below the limit and values received from electronic sources are above the limit, additional verification should be requested.*

2. Countable Resources

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

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

3. Whose Resources Can Count

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

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

DETERMINING ELIGIBILITY BASED ON RESOURCES

M1110.600 RULE FOR MAKING DETERMINATIONS

A. Policy Principle--Rule

Make all resource determinations per calendar month. Resource eligibility exists for the full month if countable resources were at or below the resource standard for any part of the month. *If resource amounts reported are reasonably compatible with values received from electronic verification sources, the evaluation can continue. If reported resource amounts and verified resource amounts are both below the established limit, resource eligibility is assumed to exist. If both amounts are over the resource limit, the applicant is not resource eligible. In all situations the sources of the resources do not need to match. If the member attests to having resources below the limit and values received from electronic sources are above the limit, additional verification should be requested.*

B. Policy Principle--Significance of the Rule

1. Increase in Value of Resources

Consider any increase in the value of an individual's resources in the resources determination the month following the month in which:

- the value of an existing resource increase (e.g., the value of a share of stock goes up or installment payments increase a property's equity value);
- an individual acquires an additional resource (e.g., inherits property); or
- an individual replaces an excluded resource with one that is not excluded (e.g., sells an excluded automobile for nonexcludable cash).

2. Decrease in Value of Resources

Consider any decrease in the value of an individual's resources in the resource determination the month in which:

- the value of an existing resource decreases (e.g., the value of a share of stock goes down);
- an individual spends a resource (e.g., withdraws $150 from a savings account to pay bills); or
- an individual replaces a countable resource with one that is not countable (e.g., trades a countable piece of real property for an excluded automobile).

3. Treatment of Assets Under Income and Resource Counting Rules

When an individual receives an asset (real or personal property) during a month, it is evaluated under the appropriate income-counting rules in that month. If the individual retains the item into the month following the month of receipt, it is evaluated under the resource-counting rules. Do not evaluate the same asset under two sets of counting rules for the same month.

Funds cannot be both income and a resource in the same month. Income that has been added to a bank account during the month must be subtracted from the ending balance to ensure that the income is not also counted as a resource. See M1140.200.

EXCEPTION: Trusts established on or after August 11, 1993, have different counting rules. See M1120.201.

M1140 Changes

Updated With	Effective Date	Pages Changed
TN #DMAS-32	7/1/24	Pages 1, 3 and 4
TN #DMAS-23	4/1/22	Table of Contents, page i Page 16 Table of Contents, page ii was added as a runover page. Pages 16a-16e were added. Page 16e is a runover page.
TN #DMAS-21	10/1/21	Page 26 Page 26a is a runover page.
TN #DMAS-20	7/1/21	Pages 18, 26a Page 19 is a runover page.
TN #DMAS-11	1/1/19	Page 17
TN #DMAS-7	1/1/18	Page 30
TN #DMAS-5	7/1/17	Page 7
UP #9	4/1/13	pages 2, 17
TN #97	9/1/12	Table of Contents, page i Table of Contents page ii was removed. pages 2, 16-19, 26, 26a
TN #96	10/1/11	pages 12-12a, 24
TN #93	1/1/10	pages 13-15 pages 24, 25
TN #91	5/15/09	pages 11-12a

TYPES OF COUNTABLE RESOURCES

*M*1140.001 PURPOSE OF SUBCHAPTER

Introduction

This subchapter contains instructions for the development of resources whose value ordinarily will count toward the resource limit. Use these instructions only after you have made certain that the property at issue:

- is a resource, based on instructions in the S1110 and S1120 subchapters; and
- is not an excluded resource, based on instructions in the S1130 subchapter.
- *The reported values of the resources are not reasonably compatible with electronic sources AND below the resource limit. See M1110.600.*

M1140.010 GENERAL VERIFICATION REQUIREMENTS -- INITIAL APPLICATIONS

A. Development and Documentation-- Any Resources

1. General Rule: Verify

Except as indicated in 2. and B. below, always verify the value of resources for any month for which you must determine eligibility.

If an applicant appeals a denial related to a particular resource, the evidence in the file must clearly establish the value of that resource. It must do so even if the issue under appeal is not the value itself (e.g., when the issue under appeal is ownership). This requirement ensures that at each level in the appeals process, the file contains complete documentation of the resource in question.

2. Exceptions to the General Rule

You do not have to verify the value of resources for a given month if:

- the resource is **totally** excluded, regardless of its value; or
- the individual is ineligible for that month for a nonfinancial reason.

3. Values That Apply to Resources

See S1140.042 and M1110.400 for detailed instructions on "current market value (CMV) and "equity value" (EV).

Develop the EV of a resource whenever:

- the CMV of all countable resources exceeds the applicable limit; and
- the individual alleges a debt against the resource.

You do **not** have to develop the EV for a resource if the CMV of all countable resources does not exceed the applicable limit.

See S1110.510 for developing the value of a resource when there is a **shared ownership**.

*M*1140.020 GENERAL VERIFICATION REQUIREMENTS -- POSTELIGIBILITY

A. Development and Documentation— Any Resources

Evaluation of continued eligibility is required for redetermination and changes. Different types of Medicaid coverage may require additional months to be evaluated, i.e., QMB and SLMB reevaluation may require retroactive and ongoing medically needy evaluation. The following instructions apply to any period of review.

1. Value During Past Months

a. Reasonable Compatibility
You do not have to verify the value of resources for a period of review if the reported values of the resources are reasonably compatible with electronic sources AND below the resource limit (resource eligible), or both values are over the resource limit (resource ineligible). See M1110.600.

b. **Ineligibility for Entire Period**
You do not have to verify the value of resources for a period of review, **if** for the **entire** period, the individual is ineligible because of a nonfinancial reason.

c. **Eligibility for One or More Months**
Verify the value of resources for any month being reviewed for which the individual is not ineligible based on a. above.

2. Value in Current Month

As at initial application, always verify the value of resources for any month for which you must determine eligibility.

You do not have to verify the current value of resources if the individual is ineligible for a nonfinancial reason.

3. Developing Value When An Appeal is Filed

See S1140.010A.1. if an individual appeals a termination of Medicaid coverage due to the value of particular resource.

B. Development and Documentation--Non-Liquid Resources

1. General Rule-Apply Current Value

Use the current value of a nonliquid resource in determining resources for any months evaluated due to redetermination or change unless:

- the specific instructions for developing that resource say not to; or
- evidence indicates that it would be inappropriate to do so, as may be the case with a resource that continually appreciates in value.

2. Exception Chart

If the resource is...	then see...	regarding
real property	S1140.100 D.2	use of the tax-assessed value.
foreign property	S1140.100 G.3	the retroactive application of current foreign exchange rates
an automobile	M1130.200 C.4	use of the current N.A.D.A Guide.

C. Development and Documentation-Liquid Resources

1. General Rule--Verify — Verify the value of liquid resources for each month covered by an application unless 2 *or 3* below applies.

2. Exception--Cash — As in initial, accept the individual's allegation.

3. Reasonable Compatibility — *If the reported values of the resources are reasonably compatible with electronic sources AND below the resource limit (resource eligible), or both values are over the resource limit (resource ineligible) no additional development is required. See M1110.600.*

D. Related Policy

1. Photo-copying Restrictions — See M1140.010 D. for photocopying restrictions imposed by Federal or State law.

2. Current Market Value/Equity Value — See M1110.400 for detailed instructions on CMV and EV.

See M1140.010 A.3. for what values to apply to resources.

3. Shared Ownership — See S1110.510 for developing the value of a resource when there is shared ownership.

4. Determining Equity Value — See S1140.042.

S1140.030 OWNERSHIP

A. Operating Policy--Liquid Resources

1. Assumption — For presumably liquid resources (S1110.305), assume that the person whose name is shown as owner owns the entire resource. If more than one owner is shown, assume that each has equal ownership interest.

2. Exceptions: Checking/ Savings Accounts and Time Deposits — See S1140.200 and S1140.205 for checking and savings accounts. See S1140.210 for time deposits.

B. Operating Policy-Nonliquid Resources — For presumably nonliquid resources (S1110.310), assume, absent some indication to the contrary, that an individual's allegation of sole ownership is correct.

M1460 Changes

Changed With	Effective Date	Pages Changed
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

M1460.160 LONG-TERM CARE PARTNERSHIP POLICIES

A. Introduction

A Long-term Care Partnership Policy (Partnership Policy) is a type of LTC insurance. Under section 6021(a)(1)(A) of the Deficit Reduction Act (DRA) of 2005 states were permitted to develop LTC partnerships. In addition to paying for assisted living or long-term care services, a Partnership Policy allows for additional assets to be disregarded in the Medicaid eligibility determination.

The value of assets disregarded in the Medicaid eligibility determination is equal to the dollar amount of benefits paid to or on behalf of the individual as of the month of application, even if additional benefits remain available under the terms of the policy.

The Partnership Policy disregard is not applicable to the resource assessment for married individuals with a community spouse. See M1480 for more information regarding resource assessments and Partnership Policies.

B. LTC Insurance Policy Issued Prior to 9/01/2007

LTC policies issued prior to 9/01/2007 are **not** Partnership Policies. See M1470.230 B.*7*, *and* M1470.430 B.5 for more information regarding these types of insurance policies.

C. LTC Insurance Policy Issued on or After 9/01/2007

LTC policies issued on or after 9/01/2007 may or may not be Partnership Policies. For a policy to be considered a Partnership Policy, it must meet the following conditions:

- issued on or after 09/01/2007,
- contain a disclosure statement indicating that it meets the requirements under § 7702B(b) of the Internal Revenue Service Code of 1986, and
- provide inflation protection:
    - under 61 years of age, compound annual inflation protection,
    - 61 to 76 years of age, some level of inflation protection, or
    - 76 years or older, inflation protection may be offered, but is not required.

Obtain a copy of the Partnership Disclosure Notice and the LTC Partnership Certification Form (See M1460, Appendices 1 and 2) for verification of the requirements noted above. Also, verification of the amount of benefit paid to or on behalf of an individual as of the month of application must be obtained. This can be found on the Explanation of Benefits statement or by calling the insurance carrier.

Partnership Policies that are issued in other states may or may not meet Virginia's requirements. Please contact your Medicaid Consultant to verify reciprocity with Virginia.

Verifications and documentation regarding a Partnership Policy must be kept with other permanent verifications in the case record.

M1470 Changes
Page 1 of 2

Changed With	Effective Date	Pages Changed
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 supports and services (LTSS), loses eligibility in the MAGI Adults covered group and is eligible in another full coverage group, patient pay policy will apply.

B. Policy

The state's Medicaid program must reduce its payment to the LTC provider by the amount of the eligible patient's monthly income, after allowable deductions. Patient pay is calculated after an individual has been determined eligible for Medicaid and for Medicaid LTC services. A Medicaid recipient who is admitted to a nursing facility, facility for individuals with intellectual disability (ICF-ID) or Medicaid waiver services for less than 30 *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.

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

Gross monthly income is considered available for patient pay. Gross monthly income is the same income 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.

Deduct a special earnings allowance if the patient participates in a work program as part of treatment. The special earnings allowance is deducted from earned income only. Subtract:

- the first $75 of gross monthly earnings, PLUS
- ½ the remaining gross earnings,
- up to a maximum of $190 per month.

The special earnings allowance cannot exceed $190 per month.

4. Example - Calculation of Personal Needs Allowance

A patient in the nursing facility is employed as a telephone salesperson as part of *the* plan of care in the facility. Has a legally appointed guardian who charges a 2% fee. *The* only income is gross earnings of $875 per month. The patient receives deductions for the basic allowance, the guardianship fee, and the special earning allowance.

Special earnings allowance is calculated first:

$875 gross earned income
- 75 first $75 per month 800 remainder
□ 2
400 ½ remainder
+ 75 first $75 per month
$475 which is > $190

Personal needs allowance is computed as follows:

$ 40.00	basic allowance
+190.00	special earnings allowance
+ 17.50	guardian fee (2% of $875)
$247.50	personal needs allowance

M1470.220 DEPENDENT CHILD ALLOWANCE

A. Unmarried Individual or Married Individual With No Community Spouse

An unmarried individual, or married individual without a community spouse, who has a minor dependent child(ren) under age 21 in the community, can have a dependent child allowance**.** When the individual verifies a dependent child(ren) in the community:

- Calculate the difference between the appropriate monthly medically needy income limit (MNIL) for the child's locality for the number of minor dependent children in the home, and the child(ren)'s gross monthly income. If the child lives outside of Virginia, use the Group III MNIL.

- The result is the dependent child allowance. If the result is greater than $0, deduct it from the patient's monthly income as the dependent child allowance. If the result is $0 or less, there is NO dependent child allowance.

they be subject to a coverage gap in their Part D benefits. Do NOT deduct from patient pay any Medicare PDP deductibles, co-pays or coverage gap costs beyond the month of admission into the nursing facility.

If a full-benefit Medicaid/Medicare recipient was subject to PDP co-pays prior to *the* admission to a nursing facility, *the individual* may continue to be assessed co-pays until the PDP is notified of *the* admission to the nursing facility. Deduct PDP co-pays incurred during the month of admission to the nursing facility only.

If an individual is enrolled in Part D and is in a nursing facility but was not eligible for Medicaid at the time of admission to the nursing facility, *the individual* may continue to be charged co-pays or deductibles until the PDP is notified of his eligibility as a full-benefit Medicaid enrollee. Deduct PDP co-pays incurred during first month of Medicaid eligibility in the nursing facility only.

3. Services NOT Allowed

Types of services that CANNOT be deducted from patient pay include:

a. medical supplies and equipment that are part of the routine facility care and are included in the Medicaid per diem, such as:

- diabetic and blood/urine testing strips,
- bandages and wound dressings,
- standard wheelchairs,
- air or egg-crate mattresses,
- IV treatment,
- splints,
- certain prescription drugs (placebos).

b. TED stockings (billed separately as durable medical supplies),
c. acupuncture treatment,
d. massage therapy,
e. personal care items, such as special soaps and shampoos,
f. ancillary services, such as physical therapy, speech therapy and occupational therapy provided by the facility or under arrangements made by the facility.

i. services that are NOT medical/remedial care services, even if ordered by a physician:

- air conditioners or humidifiers,
- refrigerators, whole house generators and other non-medical equipment,
- assisted living facility (ALF) room & board and services**,**
- personal comfort items, such as reclining chairs or special pillows,
- health club memberships and costs,
- animal expenses such as for seeing eye dogs,
- cosmetic procedures.

B. Temporary Care

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

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

C. Amount Deducted

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

M1470.300 FACILITY PATIENTS

A. Overview

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

B. Policy and Procedures

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

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

M1470.310 FACILITY ADMISSION FROM A COMMUNITY LIVING ARRANGEMENT

A. Policy

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

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

B. Procedures

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

a) 3 number of days in the nursing facility that are NOT covered by the individual's Medicaid coverage period (October 8 through October 10)
x 120 facility private pay daily rate
$ 360 amount of the spenddown liability for which the individual is responsible.

b) $90 is the spenddown balance on the date the spenddown was met, therefore, the individual is responsible to pay the $90 to the nursing facility. Medicaid will pay the remainder of the cost.

c) $360 amount of the spenddown liability for which the individual is responsible (October 8 - October 10)
+ 90 spenddown balance on October 11; begin date of coverage
$450 individual's patient pay for October 11 through October 31

If his dates in the nursing facility include part of a second month, his patient pay for the second month would be $0.

3. Individual Who Does Not Meet Spenddown

An individual who meets the spenddown on a date after the *discharge* date has full responsibility for the days in the facility. Send the individual a Notice of Action showing the dates of Medicaid coverage and that the facility care was not covered by Medicaid. Send the provider a DMAS-225 regarding the individual's eligibility status.

M1470.400 MEDICAID CBC PATIENTS - ALLOWABLE DEDUCTIONS FROM INCOME

A. Introduction

Sections M1470.410 through 430 are the only allowable deductions from a Medicaid CBC patient's gross monthly income when calculating patient pay when the patient does not have a community spouse. If the patient has a community spouse, go to subchapter M1480 to determine patient pay.

Medicaid CBC patients are not allowed a home maintenance deduction because shelter costs are included in the personal maintenance allowance.

B. Procedure

Subtract the deduction(s) from gross monthly income in the order presented below:

1. Medicaid CBC Personal Maintenance Allowance (M1470.410)

2. Dependent Child Allowance (M1470.420)

3. Medicaid CBC - Incurred Medical Expenses (M1470.430)

C. Appeal Rights

The patient or *the* representative has the right to appeal the patient pay determination, the amounts used in the calculation and denial of any request for adjustment. If a recipient or his representative appeals the patient pay, the EW who made the decision prepares the appeal summary and attends the hearing.

M1470.410 MEDICAID CBC - PERSONAL MAINTENANCE ALLOWANCE

A. Individuals

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

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

1. Basic Maintenance Allowance

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

- Commonwealth Coordinated Care Plus (CCC Plus) Waiver (formerly the Elderly or Disabled with Consumer-Direction Waiver and the Technology-Assisted Individuals Waiver),
- Community Living (CL) Waiver (formerly Intellectual Disabilities Waiver),
- Family and Individual Supports (IS) Waiver (formerly Individual and Family Developmental Disabilities Support Waiver), and
- Building Independence (BI) Waiver (formerly Day Support Waiver).

Individuals enrolled in the Program for All Inclusive Care for the Elderly (PACE) are also allowed the basic PMA.

The PMA is:

- January 1, 2021 through December 31, 2021: $1,311
- January 1, 2022 through December 31, 2022: $1,388
- January 1, 2023 through December 31, 2023: $1,509
- *January 1, 2024 through December 31, 2024: $1,556*

Contact a Medical Assistance Program Consultant for the PMA in effect for years prior to 2021.

2. Guardianship Fee

Deduct an amount up to 5% of the patient's gross monthly income (including amounts not counted as income and excluded income) for guardianship fees, if the patient has a legally appointed guardian or conservator AND the guardian or conservator charges a fee. The guardianship **filing** fees CANNOT be deducted from the individual's income. Document how it was determined that the guardian/conservator charges a fee and the amount of the fee.

No deduction is allowed if the patient's guardian receives a payment for providing guardianship services from a public agency or organization that receives funding for guardianship services.

No deduction is allowed for representative payee or "power of attorney" fees or expenses.

3. Special Earnings Allowance for Recipients in CCC Plus, CL, IS and BI Waivers

Deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

a. for individuals employed 20 hours or more per week, all earned income up to 300% of SSI ($2,829 in 2024) per month.

b. for individuals employed at least 4 but less than 20 hours per week, all earned income up to 200% of SSI ($1,886 in 2024) per month.

4. Example – Special Earnings Allowance (Using January 2018 figures)

A working patient receiving CCC Plus Waiver services is employed 18 hours per week. Income is gross earnings of $1228.80 per month and SSA of $300 monthly. Special earnings allowance is calculated by comparing gross earned income ($1128.80) to the 200% of SSI maximum ($1,500.00). Gross earned income is less than 200% of SSI; therefore, entitled to a special earnings allowance. Personal maintenance allowance is computed as follows:

$ 1,238.00 CBC basic maintenance allowance
+ 1,128.80 special earnings allowance
$ 2,360.80 PMA

Because the PMA may not exceed 300% of SSI, the PMA for the patient in this example must be reduced to $2,250.00.

B. Couples

The Medicaid CBC waivers do not specify personal maintenance allowances for a married couple living together when both spouses receive Medicaid CBC because each spouse is considered an individual for patient pay purposes. The individual maintenance allowance in section M1470.410 applies to each spouse in a couple when each receives Medicaid CBC.

M1470.420 DEPENDENT CHILD ALLOWANCE

A. Unmarried Individual, or Married Individual With No Community Spouse

For an unmarried Medicaid CBC patient, or a married Medicaid CBC patient without a community spouse, who has a dependent child(ren) under age 21 years in the community:

- Calculate the difference between the appropriate MN income limit for the **child's** home locality for the number of children in the home and the child(ren)'s gross monthly income. If the children are living in different homes, the children's allowances are calculated separately using the MN

- The result is the dependent child allowance. If the result is greater than $0, deduct it from the patient's income as the dependent child allowance. If the result is $0 or less, do not deduct a dependent child allowance.

Do not deduct an allowance if the child(ren)'s monthly income exceeds the MN income limit in the child's home locality for the number of dependent children in the home. Do not deduct an allowance for any other family member.

4. Documentation Required

a. Requests For Adjustments From A Patient or An Authorized Representative

Request the following documentation from the patient or representative:

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

b. Requests For Adjustments From CBC Providers

If the request for an adjustment to patient pay to deduct a noncovered expense is made by a Medicaid CBC waiver service provider or case manager, the request must be accompanied by:

1) the recipient's correct Medicaid ID number;

2) the current physician's order for the non-covered service (not required for replacement of hearing aid batteries or eyeglass frames or for repair of hearing aids or eyeglasses);

3) actual cost information;

4) documentation that the recipient continues to need the equipment for which repair, replacement, or battery is requested; and

5) a statement of denial or non-coverage by other insurance. The denial may be from the insurance carrier or may be a written statement from the facility that the insurance company was contacted and the item/service is not covered.

If the request from a provider or case manager does not include all the above documentation, return the request to the provider or case manager asking for the required documentation.

5. Procedures

a. Determine Deduction

When the individual receives CBC services, DMAS approval **is not required** for deductions of noncovered services from patient pay, regardless of the amount of the deduction.

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

D. Example--CBC Deduction of Noncovered Services (Using January 2009 Figures)

An aged, single individual, with no dependent child and no guardian or conservator, who lives in Group II, applied for Medicaid for the first time in June. I s approved by the screener for long-term care under the *EDCD* waiver. Gross income is $950 Civil Service Annuity (CSA) and $500 SSA. Resources are within the Medicaid limit. Has Medicare and federal employee's health insurance (Medicare is withheld from the SSA check at the rate of $96.40 per month and $80 is withheld from his CSA for the Health Insurance). Because income is less than 300% of the SSI income limit, *the individual* meets the 300% SSI group.

Retroactive eligibility *is denied* because *there were* no Medicaid covered service*s* in the retroactive period. *The individual* owes $1,500 on a hospital bill incurred the prior September and is making payments. Patient pay for June is determined in the following steps:

Step 1. gross income:

$ 950	CSA
+ 500	SSA
$1,450	total gross income

Step 2. deduct the correct personal maintenance allowance:

$ 1,450	total gross income
- 1,112	personal maintenance allowance
$ 338	remaining income

Step 3. deduct the appropriate medical expense deductions in the correct sequential order:

$ 338.00	remaining income
- 176.40	96.40 Medicare + 80.00 health insurance premium
161.60	remaining income
- 161.60	non-covered medical expenses ($1,500-161.60=$1,338.40)
$ 0	patient pay for June

The $1,338.40 balance remaining from the $1,500 hospital bill that was not deducted from the June patient pay can be deducted in subsequent month(s) *if* it remains a liability.

M1470.500 MEDICAID CBC PATIENTS

A. Overview

This section is only for unmarried individuals and or married individuals who have no community spouse. For married patients who have a community spouse, go to subchapter M1480 for patient pay determination.

This section provides policy and procedures for calculating Medicaid CBC recipients' patient pay.

B. Policy and Procedures

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

- Community Living Arrangement Admission to Medicaid CBC (M1470.510)
- PACE (M1470.520)

M1470.510 COMMUNITY LIVING ARRANGEMENT ADMISSION TO MEDICAID CBC WAIVER SERVICES

A. Policy

The policy in this section describes the procedures for calculating patient pay for the month of admission and ongoing months for **all** persons residing in the community who are screened and approved for Medicaid CBC waiver services.

B. Procedures

1. All Covered Groups Except MN Spenddown

For an individual admitted to Medicaid CBC waiver services (EXCEPT an individual who meets a spenddown**),** use these procedures:

a. Count all income received in the admission month (M1470.100).
b. Deduct a personal needs allowance (M1470.410):

- basic maintenance allowance based on the waiver;
- guardianship fees, if any;
- special earnings allowance, if any.

c. Deduct a dependent child allowance, if any (M1470.420).
d. Deduct the Medicare premium withheld if the individual is a Medicare recipient and was not receiving Medicaid prior to admission, if any (see M1470.430).
e. Deduct other health insurance premiums, deductibles or co-insurance charges, if any (M1470.430).
f. Deduct other allowable noncovered medical expenses, if any (M1470.430).

Any remainder is the patient pay for the month(s).

2. MN Individual Who Meets Spenddown

An MN individual who is on a spenddown is not eligible for Medicaid until the spenddown is met. If an individual is screened and approved for Medicaid waiver services, is considered "institutionalized" and eligibility for Medicaid is determined as an institutionalized individual. If the individual's income exceeds the 300% SSI income limit, must meet an MN institutionalized individual monthly spenddown.

Go to section M1470.600 below to determine patient pay for a CBC patient who is on a spenddown.

- document admission or discharge of a patient to an institution or community-based care services;
- provide information on health insurance, LTC insurance or VA contract coverage, and
- provide other information unknown to the provider that might cause a change in eligibility status or patient pay amount.

Do not use the DMAS-225 to relay the patient pay amount. Providers are responsible for obtaining patient pay information from the ARS/MediCall verification systems.

C. When to Complete the DMAS-225

Complete the DMAS-225 at the time of eligibility determination and/or the recipient's entry into LTC. Complete a new DMAS-225 when the recipient's eligibility status changes, such as when the recipient's Medicaid coverage is canceled or changed to limited QMB or SLMB coverage, or when the LTC provider changes.

Additionally, complete a DMAS-225 for an ongoing enrollee whose patient pay has been initially transitioned into MES to notify the provider that the patient pay information is available through ARS/MediCall.

D. Where to Send the DMAS-225

Refer to M1410.300 B.3.b to determine where to send the form. The worker must complete, send, and return the form timely.

M1470.900 ADJUSTMENTS AND CHANGES

A. Policy

The Medicaid recipient or authorized representative is responsible to report any changes in his or her situation within 10 days of the day the change is known. In situations where the patient pay amount is less than the Medicaid rate the patient pay must be adjusted within 30 days of notification or discovery of the change. This section contains the procedures for when and how to adjust patient pay.

There are situations when the EW **cannot increase** the patient pay, such as when the current patient pay amount equals the Medicaid rate for the month. In this situation, an adjustment that results in an increase in patient pay cannot be made and a referral to the DMAS Recipient Audit Unit (RAU) must be completed following the procedures in M1470.900 D.3.c.1) below.

B. Action When A Change Is Reported

Upon receipt of notice that a change in an enrollee's income or deductions has occurred, the EW must evaluate continued income eligibility (see subchapter M1460). If eligibility no longer exists, follow the procedures for LTC medically needy income and spenddown (see M1460.700). If eligibility continues to exist, the EW must:

1. Recalculate the patient pay.
2. If the patient pay remains the same, send written notification to the person handling the patient's income that the patient pay is unchanged.
3. If the patient pay decreases, follow the instructions found in Item C. below. If the patient pay increases, follow the instructions found in Item D. below.

Prior to initiating the following procedures, contact the individual or his authorized representative and tell him of the alternatives available. In the case record, document the conversation and the decision made. If unable to make contact by phone, send the Advance Notice of Proposed Action for cancellation due to excess resources.

2. Reduce Excess Resources

When the patient agrees to use the excess resources toward the cost of care, take the following steps for the month in which the 10-day advance notice period expires:

Step 1 Determine amount of excess resources (total resources minus the resource limit).

Step 2 Determine the monthly Medicaid rate:

* for a facility patient, the monthly rate is the *patient's daily RUG* rate multiplied by 31 days.

- for a CBC patient, the monthly rate is each CBC service provider's hourly rate multiplied by the number of hours of services provided to the patient in the month.

Step 3 Add the amount of excess resources to the current patient pay.

Step 4 If the result of Step 3 is less than the monthly Medicaid rate obtained in Step 2, adjust the patient pay for one month to allow the excess resources to be reduced.

Step 5 If the result of Step 3 is more than the monthly Medicaid rate obtained in Step 2, the patient is ineligible due to excess resources. Send an "Advance Notice of Proposed Action" to cancel Medicaid coverage due to excess resources.

D. Example-- Recipient Reduces Resources

An institutionalized Medicaid recipient's resources accumulate to $2,200 in February. Monthly income is $500 from Social Security (SS) and $100 VA Compensation. Patient pay of $560 is less than the Medicaid rate. *The individual* pays the amount of his excess resources ($200) to the nursing facility as part of March's patient pay, remains eligible.

$ 500 SS
+ 100 VA Compensation
$ 600 total gross income
- 40 personal needs allowance
$ 560 current patient pay (prior to adding excess resources)

$ 560 current patient pay
+ 200 excess resources
$760 patient pay for March only

Patient pay for April and subsequent months is calculated:

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

M1470.1200 INCORRECT PAYMENTS TO PROVIDER

A. Introduction

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

B. Procedures

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

M1470.1210 ADJUSTMENTS NOT ALLOWED

A. Policy

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

B. Do Not Adjust Patient Pay

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

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

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

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

C. Entitlement Benefits Adjustment

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

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

Changed With	Effective Date	Pages Changed
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 Page 2 is a runover page.
TN #DMAS-14	10/1/19	Pages 8a, 8b, 12, 15, 16, 18, 20, 21, 30, 32, 51

20. Monthly Maintenance Needs Standard

The monthly maintenance needs standard is 150% of 1/12 of the federal poverty level for a family of two in effect on July 1 of each year [Section 1924(d)(3)(A)(i)].

See section M1480.410 below for the current monthly maintenance needs standard.

21. Otherwise Available Income or Resources

means income and resources which are legally available to the community spouse and to which the community spouse has access and control.

22. Promptly Assess Resources

means within 45 *calendar* days of the request for resource assessment, unless the delay due to non-receipt of documentation or verification, if required, from the applicant or from a third party.

23. Protected Period

means a period of time, not to exceed 90 *calendar* days after an initial determination of Medicaid eligibility. During the protected period, the amount of the community spouse resource allowance (CSRA) will be excluded from the institutionalized spouse's countable resources IF the institutionalized spouse expressly indicates his intention to transfer resources to the community spouse.

24. Resource Assessment

means a calculation, completed by request or upon Medicaid application, of a couple's combined countable resources at the beginning of the **first** continuous period of institutionalization of the institutionalized spouse beginning on or after September 30, 1989.

25. Spousal Protected Resource Amount (PRA)

means at the time of Medicaid application as an institutionalized spouse, the greater of:

- the spousal resource standard in effect at the time of application;
- the spousal share, not to exceed the maximum spousal resource standard in effect at the time of application;
- the amount of resources designated by a DMAS Hearing Officer, or
    - an amount actually transferred to the community spouse by the institutionalized spouse pursuant to a court spousal support order issued as the result of an appeal of the DMAS Hearing Officer's decision.

26. Spousal Resource Standard

means the <u>minimum</u> amount of the couple's combined countable resources ($12,000 in 1989) necessary for a community spouse to maintain himself in the community. This amount increases each calendar year after 1989 by the same percentage increase as in the Consumer Price Index (CPI). [1924(f)(2)(A)(i)].

See section M1480.231 for the current spousal resource standard.

M1480.200 RESOURCE ASSESSMENT RULES

A. Introduction

A resource assessment must be completed when an institutionalized spouse with a community spouse applies for Medicaid coverage of long term care services and may be requested without a Medicaid application.

A resource assessment is strictly a:

- compilation of a couple's reported resources that exist(ed) at the first moment of the first day of the month in which the first continuous period of institutionalization began on or after September 30, 1989.
- calculation of the couple's total countable resources at that point, and
- calculation of the spousal share of those total countable resources.

A resource assessment does not determine resource eligibility but is the first step in a multi-step process. A resource assessment determines the spousal share of the couple's combined countable resources.

B. Policy Principles

1. Applicability

The resource assessment and resource eligibility rules apply to individuals who began a continuous period of institutionalization on or after September 30, 1989 and who are likely to remain in the medical institution for a continuous period of at least 30 consecutive days, or have been authorized for Medicaid CBC waiver services, or have elected hospice services.

The resource assessment and resource eligibility rules do **NOT** apply to individuals who were institutionalized before September 30, 1989, **unless** they leave the institution (or Medicaid CBC waiver services) for at least 30 consecutive days and are then re-institutionalized for a new continuous period that began on or after September 30, 1989.

Resource Assessment policy does not apply to individuals eligible in the MAGI Adult covered group. However, a resource assessment may be needed when a married individual FORMERLY received LTSS as a MAGI Adult and needs to be re-evaluated for LTSS in a non-MAGI group. If the individual is currently married but was not married on the first day of the first continuous period of institutionalization, no resource assessment is needed.

2. Who Can Request

A resource assessment without a Medicaid application can be requested by the institutionalized individual in a medical institution, *the* community spouse, or an authorized representative. See section M1410.100.

3. When to Do A Resource Assessment

a. Without A Medicaid Application

A resource assessment without a Medicaid application may be requested when a spouse is admitted to a **medical institution**. Do not do a resource assessment **without** a Medicaid application unless the individual is in a medical institution.

b. With A Medicaid Application

The spousal share is used in determining the institutionalized individual's resource eligibility. A resource assessment must be completed when a married institutionalized individual has a community spouse and

- is in a nursing facility, or is *authorized* to receive nursing facility or Medicaid CBC waiver services, or
- has elected hospice services

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

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

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

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

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

c. Both Spouses Request Medicaid CBC

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

C. Responsible Local Agency

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

2. Send Judgments to DMAS

When the resource assessment or eligibility determination identifies a judgment against resources, send the documents pertaining to the judgment to DMAS for review and how it relates to the resource before taking action on the application. Send the documents, along with case identifying information (institutionalized spouse's and community spouse's names, address, SSN, case number) to:

DMASEvaluation@dmas.virginia.gov

Or mailed to:
Eligibility *Policy and Outreach* Division – Policy Unit
DMAS
600 East Broad Street, Suite 1300

3. Determining the First Continuous Period of Institutionalization

The spousal share is based on the couple's resources owned **on the first moment of the first day of** the first month of the first continuous period of institutionalization which occurred on or after September 30, 1989. This may be different from the current period of institutionalization. Use the information below to determine exactly when the individual's first continuous period of institutionalization began.

Inquire if the individual was ever institutionalized prior to current institutionalization but not earlier than September 30, 1989. If yes, ascertain the first date on or after September 30, 1989, on which the individual was admitted to a medical institution or the first date Medicaid CBC waiver services began.

Ask the following:

- From where was *the individual* admitted?

If admitted from a home in the community which is not an institution as defined in section M1410.010, determine if Medicaid CBC waiver services were received and covered by Medicaid while the individual was in the home. If so, the days of Medicaid CBC receipt are "institutionalization" days.

If admitted from another institution, ascertain the admission and discharge dates, institution's name and type of institution. The days in a medical institution are institutionalization days if there was less than a 30-day break between institutionalizations.

- What was the last date the individual resided outside a medical institution (in the community, at home, or in a non-medical institution)?

4. Failure to Provide Verification

a. Applicant Does Not Notify Agency of Difficulty Securing Verifications

If the applicant fails to provide requested verification of the value of the couple's resources held at the beginning of the first continuous period of institutionalization and does not notify the EW of difficulty in securing the

On the Medicaid Resource Assessment form the worker lists the couple's resources as of December 1, 1995 as follows:

Resource	Owner	Countable	Countable Value
Home	Mr & Mrs	No	0
Savings	Mr & Mrs	Yes	$100,000
CD	Mr	Yes	$31,000

$131,000 Total Value of Couple's Countable Resources
$ 65,500 Spousal Share

In the eligibility evaluation, the worker uses the spousal share amount ($65,500) as one factor to determine the spousal protected resource amount (PRA) that is subtracted from the couple's current resources to determine the institutionalized spouse's resource eligibility.

F. Notice Requirements

Do not send the Notice of Medicaid Resource Assessment when a resource assessment is completed as a part of a Medicaid application.

Include a copy of the Medicaid Resource Assessment form with the Notice of Action on Medicaid that is sent when the eligibility determination is completed.

M1480.225 INABILITY TO COMPLETE THE RESOURCE ASSESSMENT-UNDUE HARDSHIP

A. Policy

Federal law states that a resource assessment must be completed on all Medicaid applications for institutionalized individuals who have a community spouse. On occasion, however, it is difficult to comply with this requirement because the applicant is unable to establish marital status or locate a separated spouse, or the community spouse refuses or fails to provide information necessary to complete the resource assessment. *A claim of undue hardship cannot be made on a denied or closed Medicaid case or when the individual is deceased.* In situations where the applicant is unable to provide information necessary to complete the resource assessment, undue hardship can be claimed if <u>each</u> of the following criteria is met:

1. The applicant establishes by affidavit specific facts sufficient to demonstrate (a) that all *reasonable* steps *have been taken* under the circumstances to locate the spouse, to obtain relevant information about the resources of the spouse, and to obtain financial support from the spouse (including information about any legal proceedings initiated, protective orders in effect, etc.); and (b) that *these efforts have* been unsuccessful;

   <u>Absent extraordinary circumstances, determined by DMAS, the requirements of A.1 (a) cannot be met unless the applicant and spouse have lived separate and apart without cohabitation and without interruption for at least 36 months.</u>

2. Upon such investigation as DMAS may undertake, no relevant facts are revealed that refute the statement contained in the applicant's affidavit, as required by paragraph A.1.

3. The applicant has assigned to DMAS, to the full extent allowed by law, all claims to financial support from the spouse; and
4. The applicant cooperates with DMAS in any effort undertaken or requested by DMAS to locate the spouse, to obtain information about the spouse's resources and/or to obtain financial support from the spouse. *If the applicant cannot complete the Resource Assessment due to a medical condition, a physician's statement must be provided documenting the medical condition.*

B. Procedures

1. Assisting the Applicant

The *Benefits Worker* must advise the applicant of the information needed to complete the resource assessment and assist the applicant in contacting the separated spouse to obtain resource and income information.

If the applicant cannot locate the separated spouse, document the VaCMS case record. Refer to M1480.225 B.2.b below.

If the applicant locates the separated spouse, the *Benefits Worker* must contact the separated spouse to explain the resource assessment requirements for the determination of spousal eligibility for long-term care services.

If the separated spouse refuses to cooperate in providing information necessary to complete the resource assessment, document the VaCMS case record. Refer to M1480.225 B.2.b below.

EXCEPTION: If the separated spouse is institutionalized and is a Medicaid applicant/recipient, the definition of "community spouse" is not met, and a resource assessment is not needed.

2. Undue Hardship

If the applicant is unable to provide the necessary information to complete the resource assessment, he/she must be advised of the hardship policy and the right to claim undue hardship.

a. **Undue hardship not claimed**

If the applicant does not wish to claim undue hardship, the *Benefits Worker* must document the VaCMS case record, and the application must be processed using rules for non-institutionalized individuals. Payment for *LTSS* services must be denied for failure to verify resources held at the beginning of institutionalization.

b. **Undue hardship claimed**

If the applicant claims an undue hardship, a written statement requesting an undue hardship evaluation *must be provided*. A Resource Assessment Undue Hardship Request Form, including affidavit and assignment forms, may be given to the applicant to be used instead of an original statement but is **not required**. The forms are available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms.

1) Applicant or Authorized Representative

The applicant or his authorized representative must provide a letter or the Resource Assessment Undue Hardship Request Form – DMAS-E10 indicating the following:

- The applicant is requesting an undue hardship evaluation;
- The name of the applicant's attorney-in-fact (i.e. who has the power of attorney) or authorized representative (if applicable);
- The length of time the couple has been separated;
- The name of the estranged spouse and his
  - Last known address,
  - Last known employer,
  - The types (i.e. telephone, in-person visit) and number of attempts made to contact the spouse:
    - Who made the attempt
    - Date(s) the attempt(s) were made,
    - The name of the individual contacted and relationship to estranged spouse; and
- Any legal proceeding initiated, protective orders in effect, etc.

If not included with the request, the applicant or authorized representative may also be asked to provide:

- A completed, signed, and notarized Affidavit Form (DMAS-E11);
- A signed and dated Assignment Form (DMAS-E12)

A completed Resource Assessment Undue Hardship Request Form (including the affidavit and assignment forms) may be used instead of a letter from the worker but is **not required**.

2) *Benefits* Worker

A cover sheet is to be prepared that includes the following information:

- The applicant's name and case number;
- Documentation of any actions the *Benefits Worker* took to locate or contact the estranged spouse; and
- Include any documentation provided by the applicant or authorized representative.

The cover sheet and all information supporting the claim must be sent to:
DMASEvaluation@dmas.virginia.gov

Or mailed to:
Eligibility *Policy and Outreach* Division – Policy Unit
DMAS
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If DMAS determines that undue hardship does not exist, and the resource assessment cannot be completed, the *Benefits Worker* must deny the application due to failure to verify resources held at the beginning of institutionalization.

If DMAS determines an undue hardship does exist, the *Benefits Worker* will be sent instructions for continued processing of the case.

2. After Eligibility is Established

Once an institutionalized spouse has established Medicaid eligibility as an institutionalized spouse, count only the institutionalized spouse's resources when determining the institutionalized spouse's Medicaid eligibility. Do not count or deem the community spouse's resources available to the institutionalized spouse.

If an institutionalized spouse's Medicaid coverage was cancelled and reapplies as an institutionalized individual, use only the resources of the institutionalized spouse for *the applicant's* eligibility determination.

M1480.231 SPOUSAL RESOURCE STANDARDS

A. Introduction

This section provides the amounts and the effective dates of the standards used to determine an institutionalized spouse's initial and ongoing resource eligibility. Use the standard in effect on the date of the institutionalized spouse's Medicaid application. Definitions of the terms are found in section M1480.010.

B. Spousal Resource Standard

$30,828	1-1-24
$29,724	1-1-23
$27,480	1-1-22

C. Maximum Spousal Resource Standard

$154,140	1-1-24
$148,620	1-1-23
$137,400	1-1-22

M1480.232 INITIAL ELIGIBILITY DETERMINATION PERIOD

A. Policy

The initial eligibility determination period begins with the month of application. If the institutionalized spouse is eligible for the month of application, the initial eligibility determination period will both begin and end with that month.

4. Compare Remainder

Compare the remaining amount of the couple's resources to the appropriate Medicaid resource limit for one person.

a. Remainder Exceeds Limit

When the remaining resources exceed the limit and the institutionalized spouse does not have Medicare Part A, the institutionalized spouse is not eligible for Medicaid coverage because of excess resources.

If the institutionalized spouse has Medicare Part A, may be eligible for limited coverage QMB, SLMB or QI Medicaid (which will not cover the cost of the LTC services) because the resource requirements and limits are different. **The resource policies in subchapter M1480 do not apply to limited-coverage Medicaid eligibility determinations**. Follow the procedures for determining resource eligibility for an individual in Chapter S11. More information about the QMB, SLMB, and QI covered groups is contained in subchapter M0320.

Note: The institutionalized spouse cannot be eligible for QDWI Medicaid.

b. Remainder Less Than or Equal to Limit

When the remaining resources are equal to or less than the Medicaid limit, the institutionalized spouse is resource eligible in the month for which eligibility is being determined:

- determine the community spouse resource allowance (CSRA). To calculate the CSRA, see sections M1480.240 and 241 below;
- determine a protected period of eligibility for the institutionalized spouse, if the institutionalized spouse expressly states his intent to transfer resources that are in his name to the community spouse; see section M1480.240 below.

C. Example--Calculating the PRA

EXAMPLE #4:

Mr. A is married to a community spouse. He applied for Medicaid on December 2, 1997. The beginning of his first continuous period of institutionalization which began on or after 9-30-89 was October 12, 1993, when he was admitted to a nursing facility. He was discharged from the facility on February 5, 1995, then readmitted to the nursing facility on December 5, 1997 and remains there to date. Eligibility is being determined for December 1997.

Step 1:

The couple's total countable resources on October 1, 1993 (the first moment of the first day of the first continuous period of institutionalization) were $130,000.

- the amount of resources that may be transferred to bring the community spouse up to the PRA will reduce the resources in the institutionalized spouse's name to no more than $2,000, and

- the institutionalized spouse has expressly indicated in writing *the* intent to transfer resources to the community spouse.

The protected period is designed to allow the institutionalized spouse time to legally transfer some or all of his resources to the community spouse. Resources in the institutionalized spouse's name are excluded only for one 90-day period.

If the institutionalized spouse does not transfer resources to the community spouse within the 90-day period, all of the institutionalized spouse's resources will be counted available to the institutionalized spouse when the protected period ends. If the institutionalized spouse loses eligibility after the 90-day protected period is over, and then reapplies for Medicaid, *the applicant* CANNOT have resource eligibility protected again and a PRA is NOT subtracted from resources *in the applicant's name*.

B. Protected Period Is Not Applicable

A protected period of eligibility is not applicable to an institutionalized spouse when:

- the institutionalized spouse is not eligible for Medicaid;

- the institutionalized spouse previously established Medicaid eligibility as an institutionalized spouse, had a protected period of eligibility, became ineligible, and reapplies for Medicaid; or

- at the time of application, a community spouse has title to resources equal to or exceeding the PRA.

C. Intent to Transfer Resources To Community Spouse

The institutionalized spouse or authorized representative must expressly indicate in writing *the* intention to transfer resources to the community spouse. If not previously obtained, send an "Intent to Transfer Assets to A Community Spouse" form, available at *https://fusion.dss.virginia.gov/bp/BP- Home/Medical-Assistance/Forms*, to the institutionalized spouse or authorized representative, allowing 10 days from the date of mailing for return of the form.

If the completed Intent to Transfer Assets form is not returned by the time the application is processed, no protected period of eligibility may be established. All resources in the institutionalized spouse's name must be counted in *the* eligibility determination beginning with the month following the initial eligibility determination period. If eligible, enroll the institutionalized spouse for a closed period of coverage beginning with the retroactive period and ending with the last day of the month of the initial eligibility period.

If the institutionalized spouse submits a new application for Medicaid payment of long-term care services, the process starts again and a new Intent to Transfer form must be mailed.

When the community spouse is a Medicaid recipient, the eligibility worker must inform the couple that the transfer of resources to the community spouse could impact the community spouse's Medicaid eligibility.

D. How to Determine the Protected Period

The 90-day protected period begins with the date the local agency takes action to approve the institutionalized spouse's initial eligibility for Medicaid LTC services, if the institutionalized spouse or authorized representative has signed the Intent to Transfer Assets form.

E. Protected Period Ends

Set a special review for the month in which the 90-day period ends. When the protected period of eligibility is over, all resources owned in the institutionalized spouse's name are counted available to the institutionalized spouse. Extension of the protected period is NOT allowed.

F. Institutionalized Spouse Acquires Resources During the Protected Period of Eligibility

If the institutionalized spouse obtains additional resources during the protected period of eligibility, the additional resources shall be excluded during the protected period if:

- the new resources combined with other resources that the institutionalized spouse intends to retain do not exceed the appropriate Medicaid resource limit for one person, OR
- the institutionalized spouse intends to transfer the new resources to the community spouse during the protected period of eligibility and the total resources to be transferred do not exceed the balance remaining (if any) of the PRA.

NOTE: Some assets, such as inheritances, are income in the month of receipt. Be careful to count only those assets that are resources in the month of receipt, and to count assets that are income as a resource if retained in the month following receipt.

M1480.241 COMMUNITY SPOUSE RESOURCE ALLOWANCE (CSRA)

A. Policy

When the Intent to Transfer form has been completed, the institutionalized spouse's eligibility is protected for 90 days to allow time for resources in the institutionalized spouse's name to be transferred to the community spouse for the community spouse's support.

The community spouse resource allowance (CSRA) is the amount of the resources in the institutionalized spouse's name (including *the applicant's* share of jointly owned resources) which can be transferred to the community spouse to bring the resources in the community spouse's name up to the PRA. This amount is disregarded in the institutionalized spouse's Medicaid eligibility determination during the protected period.

M1480.260 SUSPENSION PROCEDURES

A. Policy

This section applies to institutionalized individuals who:

are enrolled in ongoing Medicaid coverage, have
Medicare Part A,
have a patient pay that exceeds the Medicaid rate, and have
resources between $2,000 and $4,000.

B. Procedures

If the conditions above are met, take the following actions:

1. Prepare and Send Advance Notice

Prepare and send an advance notice to reduce the recipient's full Medicaid coverage to the appropriate ABD covered group. Specify the effective date, which is the last day of the month in which the 10-day advance notice period expires. Write a note on the notice telling the recipient that if *verified resources* are less than or equal to the $2,000 resource limit before the specified date (specify the date which is 3 months from the cancel effective date), *the individual* should request reinstatement of Medicaid coverage.

2. Suspend Case Administratively

Suspend the case administratively for a maximum of 3 months; do not close the case statistically. The suspension effective date is the effective date of the Medicaid cancellation in the Virginia Case Management System (VaCMS). The case is counted as a "case under care" while suspended.
While suspended, the case remains open for a maximum of 3 months.

If, by the end of 3 months from the suspension effective date, the individual provides verification that resources have been reduced to or below the resource limit, update the latest application or redetermination form in the individual's case record. Reinstate his Medicaid coverage effective the first day of the month in which resources are less than or equal to the resource limit.

If the individual does NOT provide verification within 3 months of the suspension effective date that *the* resources *in the applicant's name* have been reduced to or below the resource limit, close the case administratively and statistically. Do not take any action on enrollment in the VaCMS because coverage has already been canceled. The individual will have to file a new Medicaid application.

M1480.320 RETROACTIVE MN INCOME DETERMINATION

A. Policy

The retroactive spenddown budget period is the three months immediately prior to the application month, when none of the months overlap (was included in) a previous MN spenddown budget period in which spenddown eligibility was established. When some of the months overlap a previous MN spenddown budget period in which spenddown eligibility was established, the retroactive spenddown budget period is shortened (prorated) to include only the month (s) which were not included in the previous MN spenddown budget period.

1. Institutionalized

For the retroactive months in which the individual was institutionalized, determine income eligibility on a **monthly basis** using the policy and procedures in this subchapter. A spenddown must be established for a month during which excess income existed.

2. Individual Not Institutionalized

For the retroactive months in which the individual was NOT institutionalized, determine income eligibility for ABD groups using the ABD policy and procedures in chapter S08. Determine income eligibility for F&C groups using policy and procedures in chapter M07. A spenddown must be established for a month(s) during which excess income existed.

3. Retroactive Entitlement

If the applicant meets all eligibility requirements, is entitled to Medicaid coverage for the month(s) in which all eligibility factors were met.

B. Countable Income

Countable income is that which was actually received in the retroactive month(s). Count the income received in the months in which the individual meets all other Medicaid eligibility requirements.

The countable income is compared to the appropriate income limit for the retroactive month, if the individual was CN in the month. **For the institutionalized MN individual, Medicaid income eligibility is determined monthly.**

C. Entitlement

Retroactive coverage cannot begin earlier than the first day of the third month prior to the application month. When an applicant reports that a medical service *was received* within the retroactive period, entitlement for Medicaid will begin with the first day of the third month prior to the application month, provided all eligibility factors were met in all three months. If the applicant had excess income in the retroactive period and met spenddown, *enrollment begins* the first day of the month in which *the* retroactive spenddown was met. For additional information refer to section M1510.101.

D. Retroactive Example

EXAMPLE #15: A disabled institutionalized spouse applies for Medicaid on June 5 and requests retroactive coverage for unpaid medical bills that *were* incurred in March, April, and May. *The* disability onset date was April 10. *Institutionalization began* on April 10. The retroactive period is March, April and May. *Not* eligible for March because a covered group *was not met* in March. Countable resources are less than $2,000 in April, May and June. The income received in April and May is counted monthly because *the individual* was institutionalized in each month.

April's income is calculated and compared to the monthly 300% SSI income limit. It exceeds that limit. May's income is calculated and compared to the monthly 300% SSI income limit; it is within the limit. Therefore, *the applicant* is placed on a one-month retroactive spenddown for April, and is enrolled in retroactive Medicaid in the 300% SSI covered group for May.

M1480.330 MEDICALLY NEEDY INCOME & SPENDDOWN

A. Policy

An institutionalized spouse whose income exceeds the 300% SSI income limit must be placed on a monthly MN spenddown if *the individual* meets a medically needy MN covered group and has countable resources that are less than or equal to the MN resource limit. Income is over the MN income limit because 300% of SSI is higher than the highest MN income limit for one person for one month.

MN countable income must be calculated to exclude income and portions of income that were counted in the 300% SSI income limit group calculation. Income is determined on a monthly basis and an institutionalized individual's spenddown budget period is one month. The certification period for all long term care cases is 12 months from the last application or redetermination month. This includes MN cases placed on spenddown.

B. Recalculate Income

Evaluate income eligibility for an institutionalized spouse who has income over the 300% SSI income limit using a one-month budget period and the following procedures:

1. ABD MN Covered Groups

The income sources listed in both sections M1460.610 "What is Not Income" and M1460.611 "Countable Income for 300% SSI Group" are NOT counted when determining income eligibility for the ABD MN covered groups.
Countable income is determined by the income policy in chapter S08; applicable exclusions are deducted from gross income to calculate the individual's countable income.

The income actually received in the retroactive period is considered for retroactive eligibility. The income expected to be received within the application month is considered when determining eligibility in that month.

- Disabled = **058**
- Child Under 21 in ICF/ICF-MR = **098**
- Child Under Age 18 = **088**
- Juvenile Justice Child = **085**
- Foster Care/Adoption Assistance Child = **086**
- Pregnant Woman = **097**.

4) If the institutionalized spouse has Medicare Part A, compare the individual's monthly MN countable income to the QMB monthly income limit for 1 person (see section M0810.002 for the current QMB limit):

   a) When income is less than or equal to the QMB limit, enroll using the appropriate AC that follows:

      - Aged = **028**
      - Blind = **048**
      - Disabled = **068**

   b) When income is greater than the QMB limit, enroll using the appropriate AC that follows:

      - Aged = **018**
      - Blind = **038**
      - Disabled = **058**

5) Patient Pay: Determine patient pay according to section M1480.400 below.

d. SD Liability Is Greater Than Medicaid Rate

If the spenddown liability is **greater than** the facility's Medicaid rate, the institutionalized spouse is NOT eligible unless he incurs medical expenses which meet the spenddown liability in the month. To determine if the spenddown is met, go to section M1480.335 below.

2. Medicaid CBC Waiver Patients

The institutionalized spouse meets the definition of "institutionalized" when *they are* authorized for Medicaid waiver services and the services are being provided. An institutionalized spouse who has been authorized for Medicaid waiver services and whose income exceeds the 300% SSI income limit is not eligible for Medicaid until the monthly spenddown liability *is met*.

To determine if the spenddown is met, go to section M1480.335 below.

3. PACE Recipients

The individual's spenddown liability and the PACE monthly rate (minus the Medicare Part D premium) establish whether the spenddown eligibility determination can be projected or must be determined retrospectively.

To determine if the spenddown is met, go to section M1480.340 below.

M1480.335 FACILITY PATIENTS WITH SPENDDOWN LIABILITY GREATER THAN MEDICAID RATE & ALL MN CBC PATIENTS

A. Facility Patients – SD Liability Is Greater Than Medicaid Rate

An MN institutionalized spouse whose spenddown liability is greater than the facility's Medicaid rate is not eligible for Medicaid until *the individual* incurs medical expenses that meet the spenddown liability within the month. These determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred. The institutionalized spouse's resources and income must be verified each month before determining if the spenddown was met.

To determine if the institutionalized spouse met the spenddown, use the following procedures:

1. Calculate Private Cost of Care

Multiply the facility's **private** per diem rate by the number of days the institutionalized spouse was actually in the facility in the month. Do not count any days the institutionalized spouse was in a hospital during the month.

The result is the private cost of care for the month.

2. Compare to Spenddown Liability

Compare the private cost of care to the institutionalized spouse's spenddown liability for the month.

3. Cost of Care Greater Than Spenddown Liability

When the private cost of care is **greater than** the institutionalized spouse's spenddown liability, the institutionalized spouse meets the spenddown in the month because of the private cost of care. He is entitled to **full-month coverage** for the month in which the spenddown was met.

Enroll the institutionalized spouse in Medicaid with the begin date of the first of the month, the end date the last day of the month. Go to section M1480.350 below for enrollment procedures. Determine patient pay according to section M1480.440 below.

4. Cost of Care Less Than or Equal To Spenddown Liability

When the private cost of care is less than or equal to the institutionalized spouse's spenddown liability, **determine spenddown on a day-by-day basis** in the month by deducting allowable incurred expenses from the spenddown liability.

To determine spenddown eligibility:

- Go to section M1480.341 below if the institutionalized spouse was NOT previously on a spenddown.

Because the spenddown was met on November 1, Mr. Not is entitled to medically needy Medicaid for the budget period 11-1-99 through 11-30-99.

The old bills balance, or $7,545 ($9,000- 1,455 = $7,545) not used to achieve eligibility can be deducted in the subsequent month(s) from the subsequent spenddown liability if he continues to establish spenddown eligibility.

M1480.342 PREVIOUSLY ON SPENDDOWN

A. Procedure

To determine spenddown eligibility for the budget period for an institutionalized spouse who has previously been on spenddown, take the following actions:

B. Prorate Spenddown Prior To Institutionalization

If the institutionalized spouse is in a spenddown budget period when institutionalized, prorate the spenddown period and recalculate the spenddown liability for the months prior to the month in which *the individual* became institutionalized.

C. Old Bills

Deduct the remaining balance on old bills incurred prior to the retroactive period if there has been no break between spenddown budget periods and no break in spenddown eligibility (each spenddown was met in all prior budget periods). Only the amount NOT deducted in a previous spenddown, and which remains the liability of the individual, can be deducted.

D. Current Payments on Bills Incurred Prior to Retroactive Period

Deduct only the amount of the current payment(s) actually made on expenses incurred prior to the retroactive period, and which were not used previously to achieve eligibility, when there has been a break between spenddown budget periods or a break in spenddown eligibility (spenddown eligibility was NOT established in a prior spenddown budget period).

1. Legally Liable

Current payments for expenses that the applicant is legally liable to pay are deducted. For the expense to be deducted:

* the applicant must still owe the service provider a specific amount for the service and present current verification of the payment amount and date(s) paid.

* a claim for the expense must have been submitted to the liable third party and the applicant must provide evidence of the third party's payment denial or the amount paid for the expense.

2. Amount Deducted

The amount deducted is the amount of the payment.

3. When Deducted

Allowable current payments are deducted on the date the payments are made.

M1480.350 SPENDDOWN ENTITLEMENT

A. Entitlement After Spenddown Met

When an institutionalized spouse meets a spenddown within a month, the begin date of eligibility will be the first day of the month in which the spenddown was met. Eligibility will end on the last day of the month in which the spenddown was met.

B. Procedures

1. Coverage Dates

Coverage begin date is the first day of the month; the coverage end date is the last day of the month.

2. *Aid Category*

Enroll the institutionalized spouse in one of the following ACs:

- Aged = 018
- Blind = 038
- Disabled = 058
- Child Under 21 in ICF/ICF-MR = 098
- Child Under Age 18 = 088
- Juvenile Justice Child = 085
- Foster Care/Adoption Assistance Child = 086
- Pregnant *Individual* = 097

3. Patient Pay

Determine patient pay according to section M1480.400 below.

4. Notices & Re-applications

The institutionalized spouse on a spenddown must have *the* eligibility re-evaluated monthly, unless in a facility and the spenddown liability is less than or equal to the Medicaid rate. The institutionalized spouse must complete an annual redetermination.

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

M1480.400 PATIENT PAY

A. Introduction

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

B. Married With Institutionalized Spouse in a Facility

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

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

A. Introduction

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

B. Monthly Maintenance Needs Allowance

$2,177.50	7-1-21
$2,288.75	7-1-22
$2,465	7-1-23
$2,555	*7-1-24*

C. Maximum Monthly Maintenance Needs Allowance

$3,435.00	1-1-22
$3,715.50	1-1-23
$3,853.50	1-1-24

D. Excess Shelter Standard

$653.25	7-1-21
$686.63	7-1-22
$739.50	7-1-23
$766.50	*7-1-24*

E. Utility Standard Deduction (SNAP)

$374.00	1 - 3 household members	10-1-22
$473.00	4 or more household members	10-1-22
$414.00	1 - 3 household members	10-1-23
$524.00	4 or more household members	10-1-23

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

A. Policy

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

- personal needs or maintenance allowance,
- community spouse monthly income allowance,
- family member's income allowance,
- non-covered medical expenses,
- home maintenance deduction, if applicable.

C. Personal Needs or Maintenance Allowance

The personal needs allowance for an institutionalized spouse in a facility is different from the personal maintenance allowance of an institutionalized spouse in a Medicaid CBC waiver or PACE. The amount of the personal needs or maintenance allowance also depends on whether or not the patient has a guardian or conservator who charges a fee, and whether or not the patient has earnings from employment that is part of the treatment plan.

1. Facility Care

a. Basic Allowance

Deduct the $40 basic allowance, effective July 1, 2007. For prior months, the personal needs allowance is $30.

b. Guardian Fee

Deduct the actual fee a guardian or conservator charges, up to a maximum of 5% of the patient's actual gross income (including amounts not counted as income and excluded income) for guardianship fees, IF:

* the patient has a legally appointed guardian and/or conservator AND
* the guardian or conservator charges a fee.

Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

NOTE*S*: No deduction is allowed for representative payee or "power of attorney" fees or expenses. No deduction is allowed if the patient's guardian receives a payment for providing guardianship services from a public agency or organization that receives funding for guardianship services. The guardianship filing fees CANNOT be deducted from the individual's income.

- **Special Earnings Allowance**

Deduct a special earnings allowance if the patient participates in a work program as part of treatment. The special earnings allowance is deducted from earned income only. Deduct:

* the first $75 of gross monthly earnings, PLUS
  * ½ the remaining gross earnings,
  * up to a maximum of $190 per month.

The special earnings allowance cannot exceed $190 per month.

d. Example - Facility Care Personal Needs Allowance

EXAMPLE #18: A patient in the nursing facility is employed as a telephone salesperson as part of *the* plan of care in the facility. H as a legally appointed conservator who charges a 2% fee. *The* only income is gross earnings of $875 per month. Special earnings allowance is calculated first:

6. Example-- Allowance Not Deducted

EXAMPLE #21: (Using January 2000 figures)
A community spouse has $800 per month gross income; $600 from Civil Service and $200 VA pension. The community spouse's shelter expenses are: mortgage, taxes, and insurance of $439 per month, plus the standard utility allowance of $168 for a household of one person, totaling $607.
Total shelter costs of $607 exceed the excess shelter standard of $415 by $192. The excess shelter allowance is $192.

The minimum monthly maintenance needs allowance (MMMNA) is determined as follows:

$1,383.00	monthly maintenance needs standard
+ 192.00	excess shelter allowance
$ 1,575.00	MMMNA (less than maximum)

The community spouse monthly income allowance is calculated:

$1,575.00	MMMNA
- 800.00	community spouse's monthly gross income
$ 775.00	community spouse monthly income allowance

The institutionalized spouse has monthly income of $1,100. However, refuses to give the monthly income allowance to *the* spouse at home; therefore, the community spouse monthly income allowance cannot be deducted. Patient pay is calculated:

$1,100	gross income
- 30	personal needs allowance
$1,070	patient pay

7. Example-- Allowance Deducted

EXAMPLE #22: (Using January 2000 figures)
A community spouse has $900 per month gross income from Social Security. The community spouse's shelter expenses are: mortgage, taxes, and insurance of $502 per month, plus the standard utility allowance of $168 for a household of one person, totaling $670. Total shelter costs of $670 exceed $415 by $255. The excess shelter allowance is $255.

The minimum monthly maintenance needs allowance (MMMNA) is determined as follows:

$1,383	monthly maintenance needs standard
+ 255	excess shelter allowance
$1,638	MMMNA

The community spouse monthly income allowance is calculated:

$1,638 MMMNA
- 900 community spouse's gross income
$ 738 community spouse monthly income allowance

The institutionalized spouse has monthly income of $700. A grees to give the monthly income allowance to *the* spouse at home; therefore, the community spouse monthly income allowance is deducted. P atient pay is calculated:

$700 gross patient pay income
- 30 personal needs allowance
$670 remainder
- 670 community spouse income allowance
$ 0 patient pay

NOTE: The community spouse monthly income allowance of $738 is greater than the income remaining after the personal needs allowance is deducted, so only $670 is deducted from patient pay for the community spouse monthly income allowance.

E. Family Member's Income Allowance

To be eligible for a family member's income allowance, the family member (as defined in section M1480.010) must live with the community spouse.

1. Minor Child NOT Living with Community Spouse

If an institutionalized spouse has a minor child who is **not** living with the community spouse, **no allowance** is calculated for that child and no deduction from the institutionalized spouse's income is made for that child.

2. Family Member Income Allowance Deductions

The family member income allowance is an amount equal to 1/3 of the amount by which the monthly maintenance needs standard exceeds the amount of the family member's gross monthly income: (maintenance needs standard - family member's income) ÷ 3 = family member's income allowance.

First, deduct the allowance(s) for minor child(ren) living with the community spouse in the home. Deduct other family members' allowances from patient pay after deducting the minor child(ren)'s allowance(s).

3. Calculate Family Member's Allowance

Calculate each family member's allowance as follows:

a. Subtract the family member's gross monthly income from the monthly maintenance needs standard. If the remainder is $0 or less, STOP. The family member is not entitled to an allowance.

b. Divide the remainder by 3.

c. The result is the family member's monthly income allowance. Do NOT round any cents to a dollar.

The patient pay for August is calculated as follows:

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

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

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

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

M1480.440 MEDICALLY NEEDY PATIENT PAY

A. Policy

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

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

An institutionalized spouse's resources and income must be verified each month before determining if the spenddown has been met. When the spenddown is met, an institutionalized spouse's patient pay for the month is calculated.

1. Patient Pay Deductions

Medicaid must assure that enough of an institutionalized spouse's income is "protected" for his personal needs, the community spouse and family member's income allowances, and noncovered medical expenses, NOT including the facility, CBC or PACE cost of care.

2. When Patient Pay Is Not Required

Intermediate Care Facility for the Mentally Retarded (ICF-MR) and Institution for Mental Diseases (IMD) services are not covered for medically needy (MN) eligible recipients. Therefore, a patient pay determination is not required when a MN enrolled recipient resides in an IMD or ICF-MR.

B. Patient Pay Procedures

Determine an MN institutionalized spouse's patient pay using the policy and procedures in the sections below:

* Facility Patient Pay - Spenddown Liability Less Than or Equal to Medicaid Rate (section M1480.450)

* Facility Patient Pay - Spenddown Liability Greater Than Medicaid Rate (section M1480.460)

- CBC - MN Institutionalized Spouse Patient Pay (section M1480.470)

- PACE - MN Institutionalized Spouse Patient Pay (section M1480.480).

M1480.450 FACILITY PATIENT PAY - SPENDDOWN LIABILITY LESS THAN OR EQUAL TO MEDICAID RATE

A. Policy

An MN institutionalized spouse in a facility whose spenddown liability is less than or equal to the Medicaid rate is eligible for a full month's Medicaid coverage effective the first day of the month, based on the projected Medicaid rate for the month. Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay *the* community spouse and family member allowances, and *the* personal needs and noncovered expenses not used to meet the spenddown. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability to the provider.

B. Procedures

Determine patient pay for the month in which the spenddown is met using the procedures below.

1. Patient Pay Gross Monthly Income

Determine the institutionalized spouse's patient pay gross monthly income according to section M1480.330 (including any amounts excluded in determining MN countable income and the spenddown liability).

bills and her medical insurance premiums, totaling $1025.50. M edicaid will pay $755.50 of her spenddown liability ($1,530 spenddown liability - 774.50 patient pay = $755.50). This is allowed under section 1924 of the Social Security Act (Special Treatment For Married Institutionalized Spouses).

M1480.460 FACILITY PATIENT PAY - SPENDDOWN LIABILITY GREATER THAN MEDICAID RATE

A. Policy

An MN facility institutionalized spouse whose spenddown liability is greater than the Medicaid rate is not eligible for Medicaid unless he incurs additional medical expenses that meet the spenddown liability within the month. If he meets the spenddown liability, Medicaid coverage begins the first day of the month in which the spenddown is met and ends on the last day of that month. A patient pay for the month is calculated.

Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay his personal needs, community spouse and family member allowances, and noncovered expenses. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability. Payment of part or all of the spenddown liability is permitted under Section 1924 (d) of the Social Security Act.

B. Procedures

The institutionalized spouse's spenddown eligibility was determined in section M1480.340 above. Because the spenddown *was met* in the month, the *individual* is enrolled in a closed period of coverage for the full month. Patient pay for the month must be determined using the procedures below.

1. Calculate Remaining Income for Patient Pay

a. Determine Gross Monthly Patient Pay Income

Determine the institutionalized spouse's patient pay gross monthly income according to section M1480.330 (including any amounts excluded in determining MN countable income and the spenddown liability).

b. Subtract Allowable Deductions

Deduct the following from the patient pay gross monthly income, in the following order as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.

1) a personal needs allowance (per section M1480.430 C.),

2) a community spouse monthly income allowance, if appropriate (per section M1480.430 D.),

3) a family member's monthly income allowance, if appropriate (per section M1480.430 E.),

greater than the Medicaid rate for of July $1,705. The facility can only collect the Medicaid rate; therefore, her patient pay for July is the Medicaid rate of $1,705.

From her July income of $2,500, she must pay the Medicaid rate of $1,705. Medicaid will not pay for any of her facility care in July because she is responsible for the whole Medicaid rate; Medicaid will cover all other medical services except her Medicare & health insurance premiums. She has $795 left with which to meet her personal needs ($30), pay the community spouse allowance, and pay her Medicare and health insurance premiums, a total of $306.75. She has $488.25 left from her July income. Medicaid will assume responsibility for $525 of her spenddown liability ($2,230 - 1,705 Medicaid rate = $525).

Since Mrs. Bee paid the private rate of $2,170 to the facility in July, the facility is responsible to reimburse her for the difference between the private rate and the Medicaid rate ($465). On August 25, she requests evaluation of her spenddown for August. She was reimbursed $465 on August 20, which was deposited into her patient fund account. The worker verifies that her resources exceed the Medicaid resource limit in August. The worker sends her a notice denying Medicaid for August because of excess resources, and stating that she must reapply for Medicaid if she reduces her resources and wants to be placed on spenddown again.

M1480.470 CBC - MN INSTITUTIONALIZED SPOUSE PATIENT PAY

A. Policy

When the Medicaid community-based care (CBC) institutionalized spouse has been authorized for waiver services and has **income less than or equal to 300% of the SSI income limit** for one person, *the applicant* is eligible for Medicaid as CNNMP and entitled to Medicaid for full-month, ongoing Medicaid coverage.

An institutionalized spouse who is authorized for waiver services, and whose income **exceeds the 300% SSI income limit**, is placed on a monthly spenddown. **The monthly CBC costs cannot be projected** for the spenddown budget period. The CBC costs, along with any other spenddown deductions, are deducted daily and chronologically as the costs are incurred. If the spenddown is met any day in the month, Medicaid coverage begins the first day of the month in which the spenddown is met, and ends on the last day of that month. A patient pay for the month is calculated.

Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay his personal needs, community spouse and family member allowances, and noncovered expenses. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability. Payment of part or all of the spenddown liability is permitted under Section 1924 (d) of the Social Security Act.

B. Procedures

The institutionalized spouse's spenddown eligibility was determined in section M1480.340 above. Because the spenddown *was met* in the month, he is enrolled in a closed period of coverage for the full month. Patient pay for the month must be determined for the month using the procedures below.

1. Calculate Available Income for Patient Pay

a. Determine Gross Monthly Patient Pay Income

Determine the institutionalized spouse's patient pay gross monthly income according to section M1480.330 (including any amounts excluded in determining MN countable income and the spenddown liability).

b. Subtract Allowable Deductions

Deduct the following from the patient pay gross monthly income, in the following order as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.

1) a personal maintenance allowance (per section M1480.430 C.),

2) a community spouse monthly income allowance, if any (per section M1480.430 D.),

3) a family member's monthly income allowance, if any (per section M1480.430 E.),

4) any allowable noncovered medical expenses (per section M1470.430) including any old bills, carry-over expenses and other noncovered expenses that were used to meet the spenddown, but NOT including the cost of the community-based care.

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

The result is the **remaining income** for patient pay.

2. Patient Pay

Compare the remaining income for patient pay to the Medicaid rate for the month. The patient pay is the lesser of the two amounts.

C. Example--CBC Institutionalized Spouse on Spenddown

EXAMPLE #28: (Using July 2000 figures)
Mr. T is an institutionalized spouse who applied for Medicaid in July. He was authorized for Medicaid E & D waiver services on July 1, and began receiving those services on that date. He has a monthly CSA benefit of has Medicare Parts A & B and Federal Employees Health Insurance which costs him $75 per month. He last lived outside the facility in a Group III locality.

M1480.480 PACE – MN INSTITUTIONALIZED SPOUSE PATIENT PAY

A. Policy

An institutionalized spouse who is authorized for PACE services, and whose income exceeds the 300% SSI income limit, is placed on a monthly spenddown. The individual's spenddown liability and the PACE monthly rate (minus the Medicare Part D premium) establish whether the spenddown eligibility determination can be projected or must be determined retrospectively. The instructions for determining spenddown eligibility for MN institutionalized spouse PACE recipients are in M1480.340.

If the spenddown is met, Medicaid coverage begins the first day of the month in which the spenddown is met and a patient pay for the month is calculated. If spenddown eligibility is projected, the patient pay is not calculated monthly as long as the monthly PACE rate (minus the Medicare Part D premium), income and allowances remain the same. If spenddown eligibility is determined retrospectively, the patient pay is calculated month- by-month.

Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay personal needs, community spouse and family member allowances, and noncovered expenses. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability. Payment of part or all of the spenddown liability is permitted under Section 1924 (d) of the Social Security Act.

B. Procedures

The institutionalized spouse's spenddown eligibility was determined in section M1480.340 above. Patient pay must be determined using the procedures below.

1. Calculate Available Income for Patient Pay

a. Determine Gross Monthly Patient Pay Income

Determine the institutionalized spouse's patient pay gross monthly income according to section M1480.330 (including any amounts excluded in determining MN countable income and the spenddown liability).

b. Subtract Allowable Deductions

Deduct the following from the patient pay gross monthly income, in the following order as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.

1) a personal maintenance allowance (per section M1480.430 C.),

2) a community spouse monthly income allowance, if any (per section M1480.430 D.),

3) a family member's monthly income allowance, if *any* (per section M1480.430 E.),

Changed With	Effective Date	Pages Changed
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

C. Budget Periods By Classification

1. CN

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

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

2. MN

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

D. Verification

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

Income verification from available electronic sources is acceptable for retroactive eligibility determinations provided that reasonable compatibility is met (see M0420.100 B.9). For all case actions effective October 26, 2019, if the income attested to by the applicant is within *20*% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required.

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

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

An applicant with a resource test must provide verification of resources held in the retroactive period.

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

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

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