

April 1, 2013

MEDICAID MANUAL – VOLUME XIII

POLICY UPDATE #9

The following acronyms are used in this update:

- ABD – Aged, Blind or Disabled
- AC – Aid Category
- CBC – Community-based Care
- CN – Categorically Needy
- DBHDS – Department of Behavioral Health and Disability Services
- DDS – Disability Determination Services
- DJJ – Department of Juvenile Justice
- DOC – Department of Corrections
- FAMIS – Family Access to Medical Insurance Security Plan
- FC/AA – Foster Care/Adoption Assistance
- FPL – Federal Poverty Level
- LTC – Long-term Care
- MSP – Medicare Savings Programs
- QDWI – Qualified Disabled Working Individuals
- QI – Qualified Individuals
- QMB – Qualified Medicare Beneficiaries
- SLMB – Special Low Income Medicare Beneficiaries
- SPARK – Services, Programs, Answers, Resources, Knowledge
- SSI – Supplemental Security Income
- UP - Update
- VDSS – Virginia Department of Social Services

Update #9 of the Medicaid Eligibility Manual contains revised, clarified and updated policies. Unless otherwise noted below, the changes are effective with coverage on or after April 1, 2013.

Revised Policies

UP #9 contains revisions to several policies. The policy regarding the place of application for DJJ/Court (Corrections) children who are being released from custody when they turn 18 has changed. Applications for these children are now handled in the same manner as pre-release applications submitted by DOC incarcerated individuals. The policy regarding the verification of the application for other benefits to which the individual is entitled has also been revised; the application for other benefits must now be verified prior to approval.

The policies on when a disability referral must be made to DDS have been revised. DDS will not accept a disability referral on an individual whose previous disability denial is still in an appeal status even after 12 months. Also, if an individual has a pending disability determination, the status cannot be changed to expedited status regardless of whether or not the individual would otherwise meet the criteria for an expedited referral.

Broadcast 7804 announced the February 10, 2013, implementation of SLMB Plus coverage for dually-eligible individuals who have Medicare and whose income is within the SLMB range. The new SLMB Plus ACs have been added to subchapters M0320 and M1460 of the Medicaid Eligibility Manual. The spenddown procedures in M1370 used for SLMB enrollees have also been revised.

Clarified Policies

Several policies were clarified in UP #9, including when a hearing officer may hold an appeal open and how government benefits are treated when they are deposited in debit card accounts.

Annual Updates

UP #9 also contains the SSI-based income limits and standards, as well as the LTC home equity limit, spousal standards and maintenance standards, for 2013. UP #9 also contains the Medicare premium amounts and MSP resource limits for 2013. These figures were posted in Broadcast 7732 and became effective January 1, 2013.

The Medicaid, FAMIS and FAMIS MOMS income limits that are based on a percentage of the FPL are also included in UP #9. These income limits were announced in Broadcast 7805 and were effective January 24, 2013 for individuals who do not receive Social Security benefits and all MEDICAID WORKS and QDWI enrollees. The income limits were effective March 1, 2013 for Social Security beneficiaries in the Individuals with Income $ABD \leq 80\%$ FPL, QMB, SLMB, and QI covered groups. The revised income limits were posted in Broadcast 7328.

Other updates in UP #9 include the addition of references to Plan First and SLMB Plus in the spenddown policy, and the inclusion of updated figures in the table used to calculate 40 quarters of work coverage.

UP #9 is available on SPARK and the VDSS public web site. The changes to the manual are as follows:

Pages Changed	Significant Changes
Subchapter M0120 pages 13, 15, 16	On pages 13, 15, and 16, revised the policy on the place of application for children in DJJ/court custody over 18 who apply prior to their release from a DJJ facility.
Subchapter M0130 pages 3, 5	On page 3, removed the reference to the defunct State and Local Hospitalization Program. On page 5, revised the policy on verifying the application for other benefits to which the individual is entitled.
Subchapter M0220 page 3 Appendix 1, pages 1, 17 Appendix 3, pages 3, 4	On page 3 and in Appendix 1, removed the references to the Birth Record Verification System, which was discontinued. In Appendix 3, updated the table used for the computation of 40 quarters of work coverage.
Subchapter M0270 page 3	Revised the policy on verifying the application for other benefits to which the individual is entitled.
Subchapter M0280 page 5	Clarified the bed capacity limit for group homes to be considered residential institutions.

Pages Changed	Significant Changes
Subchapter M0310 pages 24-27 Appendix 2	On pages 24 and 25, clarified that a DDS referral is not made when a disability denial is in appeal. On pages 26 and 27, clarified that a conventional disability claim cannot be converted to expedited claim. In Appendix 2, updated the fax number used for expedited DDS referrals submitted to the Roanoke DDS office.
Subchapter M0320 pages 11, 26, 32, 34-37, 45, 46, 55	On page 11, updated the Social Security and Medicare information for 2013. On page 26, updated the resource limit for MEDICAID WORKS. On all other pages, added the new ACs for SLMB Plus
Subchapter M0530 Appendix 1, page 1	Updated the deeming standards for 2013.
Subchapter M0710 Appendix 6, pages 1, 2 Appendix 7	In Appendices 6 and 7, updated the income limits for CN children under 19, VIEW participants, CN pregnant women, Plan First and Extended Medicaid for 2013.
Subchapter M0810 pages 1, 2	On both pages, updated the SSI-based and ABD CN income limits for 2013.
Subchapter S0820 pages 30, 31	On both pages, updated the blind or disabled student child earned income exclusion amount for 2013.
Subchapter S1110 page 2	Updated the resource limits for the QMB, SLMB and QI covered groups.
Subchapter S1130 Table of Contents, page ii pages 5, 62 Page 62a was added.	On page 5, clarified that equitable ownership of real property is not recognized in Virginia. On pages 62 and 62a, a new section on the treatment of dedicated bank accounts for back SSI benefits paid to children was added.
Subchapter S1140 pages 2, 17	On both pages, clarified that only government-issued debit card accounts are counted as cash on hand; other debit accounts that may have government benefits deposited into them are treated as bank accounts.
Chapter S11 Appendices Appendix 1, page 6 Appendix 2, page 5	On both pages, clarified that equitable ownership of real property is not recognized in Virginia
Subchapter M1310 pages 1-3	On both pages, added references to Plan First and updated the covered group references.
Subchapter M1370 Table of Contents pages 1-5 Page 6 was added.	On all pages, added policy on Plan First and SLMB Plus.
Subchapter M1440 page 5	Clarified the bed capacity limit for group homes to be considered residential institutions.

Pages Changed	Significant Changes
Subchapter M1460 Table of Contents pages 3, 35, 38, 41, 42, 50, 51	On page 3, updated the home equity limit for 2013. On page 35, updated the blind or disabled student child earned income exclusion amount for 2013. On pages 38 and 41, added the ACs for SLMB Plus coverage. On Page 42, corrected a policy reference. On pages 50 and 51, reorganized the policy on MN enrollment and post-eligibility requirements.
Subchapter M1470 pages 9, 16, 19, 20, 24, 43	On pages 9 and 24, updated the Medicare Part D benchmark premium amount for 2013. On page 16, clarified the treatment of patient pay for individuals with full Medicaid coverage whose stay in a medical facility is less than 30 days. On page 19, also updated the personal allowance amounts for 2013. On page 20, updated the special earnings allowance amounts for 2013.
Subchapter M1480 pages 7, 18c, 66, 69, 70	On page 7, updated the home equity limit for 2013. On page 18c, updated the spousal resource standards for 2013. On page 66, updated the maximum monthly maintenance needs allowance amount for 2013. On page 69, also updated the personal maintenance allowance amounts for 2013. On page 70, updated the special earnings allowance amounts for 2013.
Subchapter M1510 pages 2-4, 6, 7, 10-12, 14	On all pages, revised the covered group references. On page 2, also removed the reference to the defunct State and Local Hospitalization Program.
Subchapter M1520 pages 7b, 10a	On both pages, corrected form numbers.
Subchapter M1550 Appendix 1, page 1	Revised the contact list for the DBHDS Medicaid Technicians.
Chapter M16 page 8	Clarified that the hearing officer may hold the hearing open to allow the appellant to submit additional information.
Chapter M18 page 3	Removed FC/AA children from the list of individuals exempt from managed care.
Chapter M21 Appendix 1	Updated the FAMIS income limits for 2013.
Chapter M22 Appendix 1	Updated the FAMIS MOMS income limits for 2013.

Questions about information contained in UP #9 should be directed to Stephanie Sivert, Manager, Medical Assistance Programs, at 804-726-7660 or stephanie.sivert@dss.virginia.gov.

M0120 Changes

Changed With	Effective Date	Pages Changed
UP #9	4/1/13	page 13, 15, 16
UP #7	7/1/12	pages 1, 10-12
TN #96	10/1/11	Table of Contents pages 6-18
TN #95	3/1/11	pages 1, 8, 8a, 14
TN #94	9/1/10	pages 8, 8a
TN #93	1/1/10	pages 1, 7, 9-16
Update (UP) #1	7/1/09	page 8
TN #91	5/15/09	page 10

1. **Locality of Residence** Medical assistance applications that are completed and filed online are sent to the LDSS in the applicant's locality of residence.
 2. **Joint Custody Situations** A child whose residence is divided between two custodial parents living in different localities is considered to reside in the locality in which he attends school. If the child is not enrolled in school, the parents must decide which locality is the child's residence for Medicaid application/ enrollment purposes.
- B. Foster Care, Adoption Assistance, Department of Juvenile Justice**
1. **Foster Care** Responsibility for taking applications and maintaining the case belongs as follows:
 - a. **Title IV-E Foster Care**

Children in the custody of a Virginia local department of social services or private foster care agency who receive Title IV-E maintenance payments apply at the agency that holds custody. Title IV-E foster care children in the custody of another state's social services agency apply in the Virginia locality where they reside.
 - b. **State/Local Foster Care**

Non-Title IV-E (state/local) children in the custody of a Virginia local department of social services or a private child placing agency apply at the agency that holds custody.

Children in the custody of another state's social services agency who are not Title IV-E eligible do not meet the Virginia residency requirement for Medicaid and are not eligible for Medicaid in Virginia (see M0230).
 2. **Adoption Assistance** Children receiving adoption assistance through a Virginia local department of social services apply at the agency that made the adoption assistance agreement.

Children receiving adoption assistance through another state's social services agency apply at the local department of social services where the child is residing.
 3. **Virginia Department of Juvenile Justice/Court (Corrections Children)** *When a child is in the custody of the Virginia Department of Juvenile Justice (DJJ) or is the responsibility of a court (corrections children), responsibility for processing the application and determining eligibility rests with the department of social services in the locality in Virginia in which he last resided prior to going into the DJJ system.*

- the type of living arrangement and address to which the patient will be discharged (nursing facility, adult care residence, private home, relative's home, etc.), and
- the name and title of the person who completed the statement.

The discharge planner or case manager must follow up the application and statement with a telephone call to the agency worker on or after the patient's actual discharge to confirm the discharge date and living arrangement. The agency cannot enroll the patient without the confirmation of the discharge date and living arrangement.

b. Pending Discharge to a Facility

If a patient who was not Medicaid eligible in the DBHDS facility is being discharged to an assisted living facility or nursing facility, an application for Medicaid will be filed with the department of social services in the locality in which the patient last resided prior to entering an institution.

c. Pending Discharge to the Community

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

d. Eligibility Determination and Enrollment

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

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

e. Coverage Begin Date

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

E. Individuals In Virginia Veteran's Care Center

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

F. Incarcerated Individuals and DJJ Children Pre-release Planning

Inmates of state correctional facilities and *children in the custody of the DJJ or who are the responsibility of a court (corrections children) over 18 years*, may apply for Medicaid as part of pre-release planning. Responsibility for processing the application and determining eligibility rests with the local department of social services in the locality where the *individual* was living prior to incarceration or *DJJ/court custody*.

Applications are to be processed in the same manner and within the same processing time standards as any other Medicaid application, but if the incarcerated/*DJJ* individual is found eligible, he is **not** enrolled in the Medicaid program until after he has been released from the correctional facility.

Applications are not to be refused because an applicant is an inmate of a public institution at the time of application.

If the individual did not reside in Virginia prior to becoming incarcerated or *in the DJJ system*, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in which correctional facility is located.

**1. Department of
Corrections
Procedures
For NF
Placement**

The following procedures will be followed by correctional facility staff when an inmate in a Virginia Department of Corrections facility will require placement in a nursing facility upon release:

- The correctional facility staff will complete the Medicaid application and, if a disability determination is needed, the disability report and medical release forms. The correctional facility staff will notify the assigned Medicaid consultant and mail the forms to the local department of social services in the locality where the inmate was living prior to incarceration.
- The correctional facility staff will request a pre-admission screening for nursing home or community-based care from the health department or local department of social services in the locality where the correctional facility is located. This screening is to be done simultaneously with the determination of disability and determination of Medicaid eligibility. The staff will coordinate with nursing facilities in order to secure a placement.

**2. Eligibility
Determination
and Enrollment**

The local department of social services determines the patient's Medicaid eligibility BEFORE actual release, based on the type of living arrangement to which the applicant will be released. If the applicant is found eligible for Medicaid in the locality, he is not enrolled in Medicaid until the day he is released from the Department of Corrections facility or *DJJ/court custody*.

The Corrections facility's *or DJJ's* pre-release planner or the individual may call the local agency worker on the release date. The worker can then enroll the eligible applicant in the MMIS and provide the enrollee number.

**3. Coverage Begin
Date**

The eligible individual's coverage Begin Date cannot be earlier than the date of discharge from the correctional or DJJ facility.

M0130 Changes

Changed With	Effective Date	Pages Changed
UP #9	4/1/13	page 3, 5
UP #7	7/1/12	pages 4, 5
TN #96	10/1/11	pages 6-8
TN #95	3/1/11	page 8
TN #94	9/1/10	pages 2-6, 8
TN #93	1/1/10	pages 4-6, 8
Update (UP) #2	8/24/09	pages 8, 9

- a delay in receipt of information from an examining physician,
- a delay in the disability determination process,
- a delay in receiving DMAS decision on property transfer undue hardship claim, or
- an administrative or other emergency beyond the agency's control.

If action is not taken within the time standard, the case record must show the cause for the delay and the applicant must be notified in writing of the status of his application, the reason for the delay, and his right of appeal.

When an application is delayed after 90 days because of a disability decision and the agency has determined that excess resources exist at the time the delay notice is sent, the NOA must inform the applicant that he/she has excess resources and the amount. The notice must also state that:

- a final action cannot be taken until the disability decision is made;
- if the applicant is determined to be disabled, he/she will not be eligible unless the excess resources are reduced; and
- he will be notified when the disability decision is made.

C. Application for Retroactive Coverage

Retroactive Medicaid eligibility must be determined when an applicant for Medicaid or other medical assistance reports that he, or anyone for whom he requests assistance, received a medical service within the retroactive period - the three months prior to application.

The retroactive period is based on the month in which the application is filed with the agency. The retroactive period is the three months prior to the application month.

There is no administrative finality on determining retroactive eligibility if eligibility for the months in the retroactive period has not been determined. Retroactive coverage can be requested at any time subsequent to an application even if the application was denied or the applicant signed a statement saying he did not want retroactive coverage. The retroactive period is based on the application month regardless of whether the application was denied or approved.

If the application was denied, the application is reopened for determination of eligibility in the entire retroactive period – all three months prior to the application month – even if a covered medical service was received in only one retroactive month. The applicant must provide all verifications necessary to determine eligibility during the retroactive period.

If the applicant is found eligible for retroactive coverage and a Medicaid-covered medical service was received over one year prior to the date the

1. **Copy Verification Documents**

Legal documents and documents that may be needed for future eligibility determinations must be copied and preserved for the record. These include citizenship and identity documents, alien status documentation, verification of legal presence, trusts, annuities, contracts, wills, and life insurance policies. It is not necessary to retain a copy of verifications of income or the current value of resources in the case record. However, if a copy is not retained, the worker must document electronically or in the case record the date and method used to obtain the information (viewed, telephone call, etc.), the type of verification, the source, and a description of the information.

2. **Information Not Provided**

If information necessary to make an eligibility determination is requested but not provided by the applicant and cannot be obtained from any other source, the application must be denied (or the coverage cancelled) due to the inability to determine eligibility.

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

- C. **Verification of Nonfinancial Eligibility Requirements**

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

 1. **Verification Not Required**

Verification is not required for Virginia state residency.
 2. **Verification Required**

The following information must be verified:

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

See item E. below for instructions on the verification of legal presence. See subchapter M0220 for instructions on the verification of identity and citizenship. See subchapter M0310 for instructions on the verification of age, disability and pregnancy.

- D. **Social Security Numbers**

Applicants must provide the Social Security number (SSN) of any person for whom they request Medicaid. An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

M0220 Changes

Changed With	Effective Date	Pages Changed
UP #9	4/1/13	page 3 Appendix 1, pages 3, 17 Appendix 3, pages 3, 4
UP #8	10/1/12	Table of Contents pages 4, 7-8, 12, 14d-20 page 17a was deleted Appendix 5 , page 3 added new Appendix 7, pages 1-5
UP #7	7/1/12	Table of Contents pages 14d, 16-19 Appendix 5 , page 3
TN #96	10/1/11	Table of Contents pages 2, 3, 7, 8, 14d, 18-22a, 23 Appendix 5, page 3
TN #95	3/1/11	Table of Contents pages 3, 3a, 4-6a, 14a-14c, 17, 19, 20 pages 22a, 23, 24 Appendices 1-2a removed. Appendix 3 and Appendices 5-8 reordered and renumbered.
TN #94	9/1/10	pages 3-3b, 7-9, 14a-14d, 18, 21, 22a, 23 Appendix 1 Appendix 3, page 3
Update (UP) #3	3/1/10	pages 1-3a
TN #93	1/1/10	Table of Contents pages 7-8, 14a, 14c-14d, 15-20, 22a Appendix 1 Appendix 3, page 3 Appendix 4, pages 1 and 2 Appendix 6, page 2
TN #92	5/22/09	Table of Contents pages 1-6a Appendix 8 (18 pages) pages 4a-4t were removed and not replaced.
TN #91	5/15/09	page 7 pages 14a, 14b page 18 page 20 Appendix 3, page 3

- a. All foster care children and IV-E Adoption Assistance children;
- b. Individuals born to mothers who were eligible for Medicaid in any state on the date of the individuals' birth;
- c. Individuals entitled to or enrolled in Medicare, individuals receiving Social Security benefits on the basis of a disability and SSI recipients currently entitled to SSI payments. Former SSI recipients are not included in the exemption. The local department of social services (LDSS) must have verification from the Social Security Administration (such as a SVES response) of an individual's Medicare enrollment, benefits entitlement or current SSI recipient status.

When an individual loses an exception status and his C&I has not previously been verified, the individual must be given a reasonable opportunity to provide C&I.

NOTE: A parent or caretaker who is applying for a child, but who is NOT applying for Medicaid for himself, is NOT required to verify his or her C&I.

**3. Verification
Required One
Time**

Once verification of C&I has been provided, it is not necessary to obtain verification again. Documentary evidence may be accepted without requiring the individual to appear in person. C&I documentation must be stored in the case record.

**4. Enroll Under
Good Faith
Effort**

If an individual meets all other Medicaid eligibility requirements and declares that he is a citizen, he is to be enrolled under a good faith effort. **Do not request verification of C&I from the applicant, and do not delay or deny application processing for proof of C&I.**

If the applicant meets all other Medicaid eligibility requirements:

- Approve the application and enroll the applicant in Medicaid, *AND*
- Specify on the Notice of Action that the individual may have to provide documentation of C&I if it cannot be obtained by other means, *OR*
- Include the Reasonable Opportunity Insert, available on SPARK at: <http://spark.dss.virginia.gov/divisions/bp/me/citizenship/index.cgi>, with the Notice of Action.

The individual remains eligible for Medicaid while the agency attempts to verify C&I through the data matching process described in M0220.100 D below, or if necessary, requests verification from the individual. The same good faith effort requirements apply should an individual lose his exemption from providing C&I verification.

**D. Procedures for
Documenting C&I**

CHIPRA allows the option for verification of C&I for individuals newly enrolled in Medicaid or Family Access to Medical Insurance Security Plan (FAMIS) using a data match with SSA to confirm the consistency of a declaration of citizenship with SSA records in lieu of presentation of original documentation. This option, implemented in March 2010, allows for a monthly exchange of data between

Citizenship & Identity Procedures and Documentation Charts

Use the following procedures when citizenship and identity verification is required to determine the individual's continued eligibility.

A. Documents

Establishing U.S. Citizenship and Identity

1. Citizenship Document

To establish U.S. citizenship, the document must show:

- a U.S. place of birth, or
- that the person is a U.S. citizen.

NOTE: Children born in the U.S. to foreign sovereigns or diplomatic officers are **not** U.S. citizens.

NOTE: A state driver's license issued by any state or territory, including Virginia, does NOT prove citizenship. It will satisfy requirements for proof of **identity** if the license has either a photograph of the individual or other identifying information about the individual such as name, age, sex, race, height, weight or eye color.

2. Identity Document

To establish identity, a document must show evidence that provides identifying information that relates to the person named on the document.

3. Acceptable Documents

All documents must be either originals or copies certified by the issuing agency. Photocopies of original documents, including notarized copies, **are not** acceptable. The original must be viewed by the agency or other authorized staff and a copy made of the original; the copy must have written on it the date the original was seen and the name and title of the individual who saw the original. See item C.3., below, for details regarding which staff are authorized.

Exception:

Puerto Rico invalidated all birth certificates issued prior to July 1, 2010 and reissued the birth certificates. For individuals born in Puerto Rico **who are applying for Medicaid for the first time**, only a birth certificate issued on or after July 1, 2010 may be accepted from the individual. Should an individual born in Puerto Rico be unable to present a birth certificate issued on or after July 1, 2010, contact your Regional Medical Assistance Specialist, who will refer the case to DMAS. DMAS will obtain official birth verification on behalf of the local DSS. If the person is reapplying and the agency has a birth certificate issued prior to July 1, 2010 on record, no additional verification is required.

Unit. The DMAS FAMIS Plus Unit will accept the copy and place it in the record. This process will significantly reduce the likelihood of important and possibly irreplaceable documents being misplaced or destroyed.

5. **Birth Certificate Viewed By Out-of-State Agency** Local agencies are to accept copies of out-of-state birth certificates if the copies have statements on or attached to them that say the original birth certificates were viewed by staff of the issuing state's Department of Social Services or Medicaid state agency, and the statements are signed and dated by the issuing state's staff who viewed the originals.

6. **Individuals Who No Longer Meet Exception** When an individual loses the exception status, and his citizenship and identity has not been previously verified, it must be verified for him to remain eligible for Medicaid. If the individual's eligibility in another covered group must be determined (due to the loss of SSI benefits, for example), obtain the documentation of citizenship and identity at the time of the eligibility review. If the verification is not readily available, the individual must be allowed a reasonable opportunity to obtain the documentation. See M0220.100 A 3.

Verify the SSI recipient's or Medicare beneficiary's entitlement to benefits through SVES or SOLQ-I. A copy of the SVES or SOLQ-I printout must be placed in the case file.

7. **Individual NOT Required to Submit Documents in Person** Individuals do not have to submit their citizenship and identity to the agency worker in person. They may mail-in the **original document** for the agency to copy and mail back to the individual, with the exception of a copy of a Virginia birth certificate which may be furnished rather than the original. The worker must write on the copy made for the case record that "the original document was viewed on (date) and the original was mailed back to the individual on (date)."

8. **Special Populations Needing Assistance** The agency shall assist special populations who need additional assistance, such as the homeless, mentally impaired, or physically incapacitated individual who lacks someone who can act on his behalf, to provide necessary documentation.

For individuals born in Virginia who are mentally impaired or physically incapacitated and lack someone who can act on their behalf, the agency should initiate action to secure the documentation for these individuals using the BRVS to request Virginia birth verification. For individuals not born in another state, use the procedures described in the Procedures-Verifying Citizenship and Identity document posted on SPARK.

II. Establishing Quarters:

Use the following information to (1) determine whether the applicant's earnings as reported in section I.A were sufficient to establish quarters of coverage and (2) to determine the number of QQ during lag periods and when the reported employment is not a covered earning for Social Security reporting purposes:

- A quarter is a period of 3 calendar months ending with March 31, June 30, September 30 and December 31 of any year.
- Social Security quarters of coverage are credits earned by working at a job or as a self-employed individual. A maximum of four credits or quarters can be earned each year.
- For 1978 and later, credits are based solely on the total yearly amount of earnings. The number of creditable QQ are obtained by dividing the total earned income by the increment amount for the year. All types of earnings follow this rule. The amount of earnings needed to earn a credit increases and is different for each year. The amount of earnings needed for each credit and the amount needed for a year in order to receive four credits are listed below.
- A current year quarter may be included in the 40-quarter computation. Use the current year amount as the divisor to determine the number of quarters available.

If you need to use quarters before 1978:

- A credit was earned for each calendar quarter in which an individual was paid \$50 or more in wages (including agricultural wages for 1951-1955);
- Four credits were earned for each taxable year in which an individual's net earnings from self-employment were \$400 or more; and/or
- A credit was earned for each \$100 (limited to a total of 4) of agricultural wages paid during the year for years 1955-1977.

<i>Year</i>	<i>Increment Amount</i>	<i>Amount Required for 4 QCs</i>
2013	\$1,160	\$4,640
2012	\$1,130	\$4,520
2010 – 2011	\$1,120	\$4,480
2009	\$1,090	\$4,360
2008	\$1,050	\$4,200
2007	\$1,000	\$4,000
2006	\$970	\$3,880

<i>Year</i>	<i>Increment Amount</i>	<i>Amount Required for 4 QCs</i>
2005	\$920	\$3680
2004	\$900	\$3600
2003	\$890	\$3560
2002	\$870	\$3480
2001	\$830	\$3320
2000	\$780	\$3120
1999	\$740	\$2960
1998	\$700	\$2800
1997	\$670	\$2680
1996	\$640	\$2560
1995	\$630	\$2520
1994	\$620	\$2480
1993	\$590	\$2360
1992	\$570	\$2280
1991	\$540	\$2160
1990	\$520	\$2080
1989	\$500	\$2000
1988	\$470	\$1880
1987	\$460	\$1840
1986	\$440	\$1760
1985	\$410	\$1640
1984	\$390	\$1560
1983	\$370	\$1480
1982	\$340	\$1360
1981	\$310	\$1240
1980	\$290	\$1160
1979	\$260	\$1040
1978	\$250	\$1000

M0270 Changes

Changed With	Effective Date	Pages Changed
Update (UP) #9	4/1/13	page 3

- 3. Other Benefits** Other benefits to which an individual may be entitled and for which he must apply, if he appears to be entitled, include but are not limited to:
- a. private insurance company disability, income protection, etc., benefits when the individual has such a policy;
 - b. private pension plan benefits;
 - c. union benefits.

M0270.300 AGENCY PROCEDURES

- A. Written Notice** The local agency Eligibility Worker (EW) must advise the individual in writing on a dated notice that the individual must apply for other benefits for which he or she is potentially eligible. The written notice must list the benefits for which the individual must apply.
- B. Identify Potential Eligibility For Other Benefits** Obtain clues to an individual's possible eligibility for other benefits from:
- information obtained from the interview, including responses to leading questions on the application;
 - the recipient's responses on a redetermination form and/or interview;
 - inquiries received from another agency;
 - agency knowledge of pension plans and benefits;
 - third party reports;
 - computer system inquiries.
- C. Disability Referral Processing** Do not hold the Disability Determination Services (DDS) referral while waiting for the applicant to provide proof of his/her application for disability benefits; send it immediately to the DDS.
- D. Verification** *The individual must provide verification of application for the benefits specified on the notice prior to enrollment.*
- Verify the application for benefits via a systems search whenever possible. Written or verbal verification from the agency or organization issuing the benefit(s) is also acceptable. When verbal verification is provided, document the case record with the name of the individual who provided the verification and the date. Retain documentation of the application for other benefits in the case record.*
- If the individual cannot apply for the benefit before the end of the allowed processing time due to circumstances beyond his control (i.e. the agency or organization issuing the benefit cannot give him appointment within that time frame) accept verification of the appointment and enroll the individual if he is otherwise eligible. Follow up with the individual after the application for the benefit to obtain verification.*

M0280 Changes

Changed With	Effective Date	Pages Changed
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

Patients in the certified nursing facility portion of the District Home meet the institutional status requirement, unless they are incarcerated or are juveniles in detention as defined in this subchapter.

Residents in the residential portions of the District Homes are inmates of a public institution and are not eligible for Medicaid because the residential portion is a public residential facility of more than 16 beds.

A. Cross Reference

If the individual has been, or is expected to be, in the medical facility or medical section of the facility for 30 or more consecutive days, the individual is receiving long-term care. Chapter M14 contains additional eligibility policy for individuals in long-term care.

M0280.202 INDIVIDUALS IN RESIDENTIAL FACILITIES

A. Institutions With Medical and Residential Sections

1. Some institutions have both medical and residential sections. An individual in the medical certified section (or beds) of the institution is a patient in a medical facility. If the individual has been, or is expected to be, in the medical facility for 30 or more consecutive days, the individual is receiving long-term care. Go to New Volume XIII Chapter M1400 to determine the individual's eligibility.
2. An individual in the residential portion (or beds) of the institution is a resident of a residential facility. Use this subchapter to determine the resident's institutional status.

B. Private Residence or Group Home

An individual who lives in a private residence in the community that is not an institution (it is an establishment that provides food, shelter and some services to three or less persons unrelated to the proprietor) is not living in an institution. **A group home that has a capacity of no more than three residents is not an institution.**

However, the individual may be an inmate of a public institution because he/she is considered incarcerated or a juvenile in detention, as described below. If the individual is considered incarcerated or a juvenile in detention, he/she is not eligible for Medicaid because he does not meet the institutional status eligibility requirement.

C. Private Residential Facility

A resident of any age in a private residential facility meets the institutional status requirement for Medicaid UNLESS the individual is incarcerated, as defined below.

D. Public Residential Facility

A resident of any age in a PUBLIC residential facility meets the institutional status requirement for Medicaid UNLESS:

1. the public residential facility has more than 16 beds, or
2. the individual is an inmate - an incarcerated adult or a juvenile in detention - as described in section M0280.300 below, and is not an individual listed in M0280.301 below.

M0310 Changes

Changed With	Effective Date	Pages Changed
UP #9	4/1/13	pages 24-27 Appendix 2
TN #97	9/1/12	Table of Contents, page i pages 1-5a, 10-13 pages 23, 28, 29, 30a, 31 pages 33, 36, 38, 39
UP #7	7/1/12	Table of Contents, page ii pages 23, 26, 27 Appendices 1-3 were removed. Appendices 3 and 4 were renumbered and are now Appendices 1 and 2, respectively.
TN #96	10/1/11	Appendix 4
TN #95	3/1/11	Pages 30, 30a
TN #94	9/1/10	pages 21-27c, 28
TN #93	1/1/10	page 35 Appendix 5, page 1
Update (UP) #2	8/24/09	Table of Contents page 39
TN #91	5/15/09	pages 23-25 Appendix 4, page 1 Appendix 5, page 1

- if it is 90 calendar days prior to his 19th birthday.

Do **NOT** refer a disabled child under age 19 to DDS for the sole purpose of participation in the Health Insurance Premium Payment (HIPP) program

E. When an LDSS Referral to DDS is Required

1. Disability Determination Has Not Been Made

The DDS must make a determination of disability when the applicant alleges a disability and a disability determination has not been made by SSA or the RRB. The DDS must make a disability determination within a time frame that will allow the LDSS to process the application within 90 days, provided all medical information has been submitted.

2. SSA Denied Disability Within the Past 12 Months

SSA decisions made within the past 12 months are final decisions for Medicaid purposes unless:

- a) The applicant alleges a condition that is **new** or **in addition** to the condition(s) already considered by SSA,

OR

- b) The applicant alleges his condition has **changed** or **deteriorated** causing a new period of disability **AND** he requested SSA reopen or reconsider his claim **AND** SSA has refused to do so or denied it for non-medical reasons. Proof of decision made by SSA is required.

If the conditions in a. or b exist, DDS must make a disability determination.

If the conditions in a or b above do not exist, the SSA denial of disability is final for Medicaid purposes. **Do NOT make a referral to DDS for a disability determination. Deny the Medicaid application because SSA denied the applicant's disability and the applicant meets no other covered group.**

3. SSA Denied Disability More Than 12 Months Ago

If the applicant alleges a disability, SSA denied the disability more than 12 months ago, **and the decision is not in an appeal with SSA**, follow the procedure in M0310.112 G. below to make a referral to DDS. *If the decision is being appealed, do not make a referral to DDS because the individual has the opportunity to introduce additional documentation to SSA during the appeal to support his disability claim.*

F. Decision Pathway for DDS Referrals

When determining whether or not a referral to DDS is required, the worker should ask the following questions:

Has the individual applied for SSDI or SSI?

If no, refer to DDS.

If yes and a decision **has not** been made, refer to DDS.

If yes and a decision **has** been made, was the disability allowed or denied?

If allowed, refer to M0310.112 B, because another determination of disability may not be necessary.

If denied, look at the date of the last determination.

If the last SSA denial determination was made more than 12 months in the past *AND is not being appealed*, refer to DDS.

If the last SSA denial determination was made less than 12 months in the past, and there is a new condition that has not been evaluated by SSA, refer to DDS.

If the last SSA denial determination was made less than 12 months in the past, and there has not been a worsening of a condition already evaluated by SSA, do not refer to DDS.

If the last SSA denial determination was made less than 12 months in the past, but there is a worsening of a condition already evaluated by SSA, ask if the individual has filed for a reconsideration or reopening of his case with SSA.

If yes and the case is currently under reconsideration, do not refer to DDS. The SSA decision remains binding unless SSA reverses the decision.

If yes and the SSA refused to reconsider his case because he does not meet the SSI eligibility requirements, refer to DDS.

If no, do **NOT** refer to DDS. The individual must initiate an appeal of his denial with SSA. Unless SSA refuses the appeal request or turns it down for non-disability related reasons, the disability determination remains binding for 12 months.

**G. LDSS Procedures
When a Disability
Determination is
Required**

There are two types of DDS referrals for the purposes of Medicaid eligibility: non-expedited and expedited. Most referrals are non-expedited. Expedited referrals are limited to individuals who are hospitalized and require a Medicaid disability determination so they can be transitioned directly from the hospital to a rehabilitation facility

For both types of referrals, the eligibility worker must request the necessary verifications needed to determine eligibility so that the application can be processed when the disability determination is received.

1. LDSS Referrals to DDS for Non-expedited Cases

- a. Send the following forms to the applicant for completion immediately, giving the applicant 10 calendar days to return the completed forms:
- a copy of the Frequently Asked Questions—Disability Determinations for Medicaid (form #032-03-0426), available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>, explaining the disability determination process and the individual's obligations;
 - the Disability Report Adult (SSA-3368-BK), available at <http://www.socialsecurity.gov/online/ssa-3368.pdf>, or the Disability Report Child (SSA-3820-BK), available at <http://www.socialsecurity.gov/online/ssa-3820.pdf>,
 - a minimum of 3 signed, original Authorization to Disclose Information to the Social Security Administration forms (SSA-827), available at <http://www.socialsecurity.gov/online/ssa-827.pdf> or a form for each medical provider if more than 3.
- b. Complete the DDS Referral Form, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi> Use the DDS Referral Form that corresponds with the DDS Regional Office to which the LDSS has been assigned (#032-03-0095, #032-03-0096, #032-03-0097, or #032-03-0098). To the form, attach the following:
- the completed Disability Report
 - the signed copies of the Authorization to Disclose Information
 - copies of paystubs, if the applicant is currently working.

If the individual's application was filed with the assistance of a hospital-based eligibility assistance organization, a copy of the consent to release information to the organization must be included with the referral so DDS staff can communicate with them, if necessary.

Mail the DDS Referral form and attachments to the appropriate DDS Regional Office. See Appendix 2 to this subchapter for the locality assignments and addresses for DDS Regional Offices.

Do not send referrals to DDS via the courier.

2. Expedited Referrals for Hospitalized Individuals Awaiting Transfer to a Rehabilitation Facility

The 2004 Budget Bill mandated that DDS make a disability determination within seven (7) working days of the receipt of a referral from the LDSS when the Medicaid applicant is hospitalized, needs to be transferred directly to a rehabilitation facility *AND the individual does not already have a disability application pending with DDS*. To ensure that the DDS is able to make the disability determination within the mandated timeframe, the procedures below shall be followed:

- a. Hospital staff shall simultaneously send:
 - the Medicaid application and a cover sheet (see Appendix 1 to this subchapter for an example of the cover sheet) to the LDSS or the hospital outstationed eligibility worker
 - the medical documentation (disability report, authorizations to release information and medical records) and cover sheet to the DDS.
- b. LDSS shall **immediately** upon receipt of the Medicaid application:
 - fax a completed DDS Referral Form (#032-03-0095, #032-03-0096, #032-03-0097, or #032-03-0098) available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>, to the appropriate DDS region, to verify receipt of the Medicaid application *unless it is known to the agency that the individual already has a pending disability claim with DDS. If the individual already has a pending disability claim with DDS, the claim cannot be treated as an expedited referral.*
 - give priority to processing the applications and immediately request any verifications needed; and
 - process the application as soon as the DDS disability determination and all necessary verifications are received; and
 - notify the hospital contact identified on the cover sheet of the action on the application and provide the Medicaid enrollee number, if eligible.
- c. DDS shall make a disability determination within seven (7) working days and fax the result of the disability decision to the LDSS. DDS is not responsible for notifying either the applicant or the hospital of the outcome of the disability determination.

If DDS is unable to render a decision within 7 working days, DDS will send a communication to the LDSS advising that the disability determination has been delayed.

3. Application Processing When DDS Referral is Pending

If the completed forms are not returned by the applicant within 45 calendar days from the date of application, the applicant is considered not to meet the covered group and the application must be denied.

Individuals who require a disability determination must meet all non-financial requirements other than covered group, within 45 calendar days or the application must be denied. If these requirements are met, the application timeframe may be extended to 90 days while DDS is making the disability determination. If any non-financial requirement other than covered group is not met by the 45th calendar day, his application must be denied and DDS must be notified of the denial.

DDS does NOT stop the disability determination process when the individual meets all non-financial requirements, but has excess resources (see M0130.100 B.4) because he might reduce his resources while the

DDS Regional Offices

Send all expedited and non-expedited disability referrals to the DDS Regional Office to which the local DSS agency is assigned, as indicated in the table below.

DDS Regional Office	Local DSS Agency Assignments
<p>Central Regional Office Disability Determination Services 9960 Mayland Drive, Suite 200 Richmond, Virginia 23233</p> <p>Phone: 800-523-5007 804-367-4700 FAX: 866-323-4810</p>	<p>Amelia, Brunswick, Buckingham, Charles City, Charlotte, Chesterfield, Colonial Heights, Cumberland, Danville, Dinwiddie, Emporia, Essex, Goochland, Greensville, Halifax, Hanover, Henrico, Hopewell, King and Queen, King William, Lancaster, Lunenburg, Mecklenburg, Middlesex, New Kent, Northumberland, Nottoway, Petersburg, Pittsylvania, Powhatan, Prince Edward, Prince George, Richmond County, Richmond City, South Boston, Surry, and Sussex</p>
<p>Tidewater Regional Office Disability Determination Services 5850 Lake Herbert Drive, Suite 200 Norfolk, Virginia 23502</p> <p>Phone: 800-379-4403 757-466-4300 FAX: 866-773-0244</p>	<p>Accomack, Chesapeake, Franklin, Gloucester, Hampton, Isle of Wight, James City, Mathews, Newport News, Norfolk, Northampton, Portsmouth, Poquoson, Southampton, Suffolk, Courtland, Virginia Beach, Williamsburg, York</p>
<p>Northern Regional Office Disability Determination Services 11150 Fairfax Boulevard, Suite 200 Fairfax, Virginia 22030</p> <p>Phone: 800-379-9548 703-934-7400 FAX: 866-843-3075</p>	<p>Albemarle, Alexandria, Arlington, Augusta, Caroline, Charlottesville, Clarke, Culpepper, Fairfax City, Fairfax County, Falls Church, Fauquier, Fluvanna, Frederick, Fredericksburg, Greene, Harrisonburg, Highland, King George, Loudoun, Louisa, Madison, Manassas City, Orange, Page, Prince William, Rappahannock, Rockingham, Shenandoah, Spotsylvania, Stafford, Staunton, Warren, Waynesboro, Westmoreland, and Winchester</p>
<p>Southwest Regional Office Disability Determination Services 612 S. Jefferson Street, Suite 300 Roanoke, Virginia 24011-2437</p> <p>Phone: 800-627-1288 540-857-7748 FAX: 866-802-5842 <i>FAX for Expedited Referrals:</i> 540-983-4977</p>	<p>Alleghany, Amherst, Appomattox, Bath, Bedford City, Bedford County, Bland, Botetourt, Bristol, Buchanan, Buena Vista, Campbell, Carroll, Covington, Craig, Dickenson, Floyd, Franklin, Galax, Giles, Grayson, Henry, Lee, Lexington, Lynchburg, Martinsville, Montgomery, Nelson, Patrick, Pulaski, Radford, Roanoke County, Roanoke City, Rockbridge, Russell, Salem, Scott, Smyth, Tazewell, Washington, Wise, and Wythe</p>

M0320 Changes

Changed With	Effective Date	Pages Changed
UP #9	4/1/12	pages 11, 26, 32, 34-37, 45, 46, 55
TN #97	9/1/12	Table of Contents pages 1-56 (all pages)
UP #6	4/1/12	pages 11, 12, 46a
TN #96	10/1/11	Table of Contents pages 46f-50b page 50c deleted
TN #95	3/1/10	pages 11, 12, 42c, 42d, 50, 53, 69 pages 70, 71 page 72 added.
TN #94	9/1/10	pages 49-50b
UP #3	3/1/10	pages 34, 35, 38, 40, 42a, pages 42b, 42f
TN #93	1/1/10	pages 11-12, 18, 34-35, 38 pages 40, 42a-42d, 42f-44, 49 pages 50c, 69-71
UP #2	8/24/09	pages 26, 28, 32, 61, 63, 66
Update (UP) #1	7/1/09	pages 46f-48
TN #91	5/15/09	pages 31-34 pages 65-68

Note: There was no COLA in 2010 or 2011.

Cost-of-living calculation formula:

- a. $\frac{\text{Current Title II Benefit}}{1.017 \text{ (1/13 Increase)}} = \frac{\text{Benefit Before}}{1/13 \text{ COLA}}$
- b. $\frac{\text{Benefit Before 1/13 COLA}}{1.036 \text{ (1/12 Increase)}} = \frac{\text{Benefit Before}}{1/12 \text{ COLA}}$
- c. $\frac{\text{Benefit Before 1/12 COLA}}{1.058 \text{ (1/09 Increase)}} = \frac{\text{Benefit Before}}{1/09 \text{ COLA}}$
- d. $\frac{\text{Benefit Before 1/09 COLA}}{1.023 \text{ (1/08 Increase)}} = \frac{\text{Benefit Before}}{1/08 \text{ COLA}}$
- e. $\frac{\text{Benefit Before 1/08 COLA}}{1.033 \text{ (1/07 Increase)}} = \frac{\text{Benefit Before}}{1/07 \text{ COLA}}$

5. Medicare Premiums

a. Medicare Part B premium amounts:

1-1-13	\$104.90
1-1-12	\$99.90
1-1-11	\$115.40
1-1-10	\$110.50
1-1-09	\$96.40
1-1-08	\$96.40
1-1-07	\$93.50

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

b. Medicare Part A premium amounts:

1-1-13	\$441.00
1-1-12	\$451.00
1-1-10	\$461.00
1-1-09	\$443.00
1-1-08	\$423.00
1-1-07	\$410.00

Contact a Medical Assistance Program Consultant for amounts for years prior to 2007.

6. Evaluation

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

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

D. Financial Eligibility

1. Assistance Unit

a. Initial eligibility determination

In order to qualify for MEDICAID WORKS, the individual must meet the assistance unit policy and procedures in chapter M05 that apply to ABD individuals with income less than or equal to 80% FPL. Resources and income 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.

2. Resources

a. Initial eligibility determination

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

b. Ongoing eligibility

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

- 1) For **earnings** accumulated **after** enrollment in MEDICAID WORKS, up to the current 1619(b) income threshold amount will be disregarded if deposited and retained in the WIN Account. The 1619(b) threshold amount for 2013 is \$33,747.
- 2) Resources accumulated while in MEDICAID WORKS and held in Internal Revenue Service (IRS)-approved retirement accounts, medical savings accounts, medical reimbursement accounts, education accounts, independence accounts, and other similar State-approved accounts are excluded. Examples of these accounts include Archer Medical Savings Accounts, 401(k) accounts, traditional Individual Retirement Accounts (IRAs), Roth IRAs, SEP-IRAs, SIMPLE IRAs, Thrift Savings Plans, and 503(b) plans. The account must be designated as a WIN Account in order to be excluded. **Resources accumulated while in MEDICAID WORKS and held in IRS-approved accounts that have been**

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible in an MSP covered group (which has more liberal resource methods and standards).

3. Income

To determine if an individual has income within the 300% of SSI limit, use **gross** income, not countable income. Determine what is income according to chapter S08 and subchapter M1460.

DO NOT subtract the \$20 general exclusion or any other income exclusions. The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Compare the total gross income to the 300% of SSI limit (see M0810.002 A. 3). If countable income is equal to or less than this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in this covered group. Evaluate his/her eligibility as medically needy.

C. Entitlement & Enrollment

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

If the individual has Medicare Part A, re-calculate the individual's income - subtract appropriate exclusions. Compare the countable income to the QMB *and* SLMB limits.

1. Dual-eligible As QMB or SLMB

If the individual is also a Qualified Medicare Beneficiary (QMB) *or* Special Low Income Medicare Beneficiary (SLMB) - the individual has Medicare Part A and has countable income within the QMB *or* SLMB income limits - the AC is:

- 022 for an aged individual also QMB;
- 042 for a blind individual also QMB;
- 062 for a disabled individual also QMB;
- 025 for an aged individual also SLMB;
- 045 for a blind or disabled individual also SLMB.

2. Not QMB or SLMB

If the individual is NOT a QMB or SLMB - the individual does NOT have Medicare Part A, OR has countable income over the QMB *and* SLMB income limits - the AC is:

- 020 for an aged individual NOT also QMB *or* SLMB;
- 040 for a blind individual NOT also QMB *or* SLMB;
- 060 for a disabled individual NOT also QMB *or* SLMB.

D. Ineligible In This Covered Group

If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy spenddown. If the individual is not eligible for Medicaid in this covered group because of resources, determine the individual's eligibility as QMB, SLMB, QDWI or QI if he/she has Medicare Part A.

living in the home. Count actual resources the parent makes available to the child.

If current resources are within the limit, then determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible for Medicaid in this covered group.

b. Resource Eligibility - Married Individual

If the individual is married and has a community spouse, use the resource policy in subchapter M1480. If the individual is married, but has no community spouse, use the resource policy in subchapter M1460. Evaluate countable resources using ABD resource policy in chapter S11.

If current resources are within the limit, then determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible in an MSP covered group (which has more liberal resource methods and standards).

3. Income

To determine if an individual has income within the 300% of SSI limit, use **gross** income, not countable income. Determine what is income according to chapter S08 and subchapter M1460.

DO NOT subtract the \$20 general exclusion or any other income exclusions. The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Compare the total gross income to the 300% of SSI limit (see M0810.002 A. 3). If countable income is equal to or less than this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in this covered group. Evaluate his/her eligibility as medically needy.

C. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met. Retroactive coverage does not apply to this covered group because an individual cannot be eligible in this covered group until he/she applies for Medicaid. [The individual cannot have received Medicaid covered waiver services in the retroactive period because he was not receiving Medicaid on or before the date he applied.]

If the individual has Medicare Part A, re-calculate the individual's income - subtract the appropriate exclusions. Compare the countable income to the QMB *and* SLMB limits.

1. Dual-eligible As QMB or SLMB

If the individual is also a Qualified Medicare Beneficiary (QMB) *or* Special Low Income Medicare Beneficiary (SLMB) - the individual has Medicare Part A and has countable income within the QMB *or* SLMB income limits - the AC is:

- 022 for an aged individual also QMB;
- 042 for a blind individual also QMB;
- 062 for a disabled individual also QMB;
- 025 for an aged individual also SLMB;
- 045 for a blind or disabled individual also SLMB.

2. Not QMB or SLMB

If the individual is NOT a QMB or SLMB - the individual does NOT have Medicare Part A, OR has countable income over the QMB and SLMB income limits - the AC is:

- 020 for an aged individual NOT also QMB or SLMB;
- 040 for a blind individual NOT also QMB or SLMB;
- 060 for a disabled individual NOT also QMB or SLMB.

D. Ineligible In This Covered Group

If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy spenddown. Determine the individual's eligibility as QMB, SLMB, QDWI or QI if he/she has Medicare Part A.

M0320.503 ABD HOSPICE

A. Policy

SMM 3580-3584 - The state plan includes the covered group of aged, blind or disabled individuals who are terminally ill and elect hospice benefits.

The ABD Hospice covered group is for individuals who have a signed a hospice election statement in effect for at least 30 consecutive days, and who are not eligible in any other full-benefit Medicaid covered group. Hospice care is a covered service for individuals in all full-benefit covered groups; individuals who need hospice services but who are eligible in another full-benefit covered group do not meet the Hospice covered group.

Individuals receiving hospice services in the ABD Hospice Covered group may also receive services under the Elderly and Disabled with Consumer Direction (EDCD) Waiver, if the services are authorized by the Department of Medical Assistance Services (DMAS) (see M1440.101).

The individual must elect hospice care. Election of hospice care is verified either verbally or in writing from the hospice. If the verification is verbal, document the case record. Eligibility in the Hospice covered group is ongoing as long as the individual continues to receive hospice care, subject to a renewal of eligibility at least once every 12 months. The eligibility worker must verify that the hospice agreement is current at the time of the annual Medicaid renewal.

The 30-day requirement begins on the day the hospice care election statement is signed. Once the hospice election has been in effect for 30 consecutive days, the 300% of SSI income limit is used to determine Medicaid eligibility. If the individual's income is within 300% of SSI, eligibility in the Hospice covered group may be determined beginning with the month in which the hospice election was signed.

Individuals who already meet the definition of institutionalization in M1410.010 B.2 at the time of hospice election meet the 30-day requirement, provided there is no break between institutionalization and hospice election.

Individuals who meet the Hospice covered group may have their eligibility determined using the same financial requirements as institutionalized individuals.

B. Financial Eligibility

1. Asset Transfer

The individual in the hospice covered group must meet the asset transfer policy in subchapter M1450.

2. Resources

The hospice services recipient is an assistance unit of 1 person. All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements.

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible for Medicaid in this covered group. He/she may be eligible in *an MSP* covered group (which has more liberal resource methods and standards).

a. Unmarried Individual

If the individual is unmarried or is married and has no community spouse, use the resource policy in chapter S11 and subchapter M1460.

b. Married Individuals

If the individual is married and has a community spouse, use the resource policy in chapter S11 and subchapter M1480.

3. Income

To determine if an individual has income within the 300% of SSI limit, use **gross** income, not countable income. Determine what is income according to chapter S08 and subchapter M1460.

DO NOT subtract the \$20 general exclusion or any other income exclusions. The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Compare the total gross income to the 300% of SSI limit (see M0810.002 A. 3). If countable income is equal to or less than this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in this covered group. Evaluate his/her eligibility as medically needy.

C. Entitlement

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the month in which all eligibility requirements are met. Retroactive coverage is applicable to this covered group.

If the individual has Medicare Part A, re-calculate the individual's income, applying the appropriate exclusions. Compare the countable income to the QMB *and* SLMB limits.

D. Enrollment

Eligible individuals must be enrolled in the appropriate AC. If the individual is aged, blind, or disabled as defined in M0310, he is enrolled under the AC. **AC (054) is used for “deemed-disabled” individuals only.** Use the appropriate Hospice AC when the individual is also authorized to receive EDCD Waiver services.

For individuals who are ABD and entitled/enrolled in Medicare Part A, income must be recalculated (allowing appropriate disregards) to determine if the individual is dually eligible as a QMB *or* SLMB.

1. ABD Individual

a. Dual-eligible As QMB *or* SLMB

If the individual is also a Qualified Medicare Beneficiary (QMB) *or* *Special Low Income Medicare Beneficiary (SLMB)* - the individual has Medicare Part A and has countable income within the QMB *or* SLMB income limits - the AC is:

- 022 for an aged individual also QMB;
- 042 for a blind individual also QMB;
- 062 for a disabled individual also QMB
- *025 for an aged individual also SLMB;*
- *045 for a blind or disabled individual also SLMB.*

b. Not QMB *or* SLMB

If the individual is NOT a Qualified Medicare Beneficiary (QMB) the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit – the AC is:

- 020 for an aged individual NOT also QMB *or* SLMB;
- 040 for a blind individual NOT also QMB *or* SLMB;
- 060 for a disabled individual NOT also QMB *or* SLMB.

**2. “Deemed”
Disabled
Individual**

An individual who is “deemed” disabled based on the hospice election is enrolled using AC 054. Individuals in this AC who have also been approved to receive services under the EDCD Waiver do not need a disability determination.

**E. Post-eligibility
Requirements
(Patient Pay)**

A patient pay must be calculated for individuals who receive hospice services in a nursing facility (see subchapter M1470). Individuals who receive hospice services outside of a nursing facility do not have a patient pay.

Individuals who have elected hospice services and who also receive Medicaid Long-term Care services available under the EDCD Waiver must have a patient pay calculation for the EDCD services (see subchapter M1470).

**F. Ineligible In This
Covered Group**

There is no corresponding medically needy hospice covered group. If the individual is aged or has been determined blind or disabled, the individual must be evaluated in a medically needy covered group for medically needy spenddown.

- 3. SLMB's AC Changes To Full Coverage AC** When an enrolled SLMB becomes eligible in another covered group which has full Medicaid coverage, except when he/she meets a spenddown, e.g., an SLMB's resources change to below the MN limits:
- cancel the SLMB coverage effective the last day of the month immediately prior to the month in which he/she became eligible in the full coverage covered group, using cancel reason "024";
 - reinstate the recipient's coverage with the begin date as the first day of the month in which he/she became eligible in the full coverage covered group, with the appropriate full coverage AC.
- 4. Spenddown Status** At application and redetermination, eligible SLMBs who meet an MN covered group and who have resources that are within the lower MN resource limits are also placed on two 6-month MN spenddowns.
- All spenddown periods are based on the application or renewal date, as appropriate. See M1370.
- SLMBs who are not determined disabled must be determined disabled or blind, or must be pregnant, under age 18 or under age 21 if in foster care or adoption assistance in order to meet a medically needy covered group for spenddown.
- 5. SLMB Meets Spenddown** When an SLMB meets a spenddown, cancel his AC "053" coverage effective the date before the spenddown was met, using cancel reason "024". Reinstatement the recipient's coverage with the first date the spenddown was met as the begin date of coverage, and enter the end date of the spenddown period as the end date of coverage. The AC is medically needy dual-eligible *as SLMB Plus*:
- 024 for an aged MN individual also eligible as SLMB;
 - 044 for a blind or disabled MN individual also eligible as SLMB.
- 6. Spenddown Period Ends** After the spenddown period ends, reinstate the SLMB-only coverage using the AC 053.
- The begin date of the reinstated AC 053 coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial SLMB eligibility.

7. SLMB Enters Long-term Care

- The enrollment of an SLMB who is admitted to long-term care and who becomes eligible for Medicaid in the *300% of SSI* covered group is handled like an SLMB who meets a spenddown. Cancel the SLMB-only coverage effective the last day of the month before the month of admission to long-term care, reason “024”. Reinstate the coverage with the begin date as the first day of the month of admission to long-term care using the appropriate *AC for SLMB Plus*.
 - *025 for an aged individual also SLMB;*
 - *045 for a blind or disabled individual also SLMB.*

M0320.603 QUALIFIED INDIVIDUALS (QI)

A. Policy

P.L. 105-33 (Balanced Budget Act of 1997) mandated Medicaid coverage of Qualified Individuals who would be Qualified Medicare Beneficiaries (QMBs) except that their income exceeds the QMB income limit. Implemented on January 1, 1998, individuals in the QI covered group receive Medicaid coverage for the payment of their Medicare Part B premium. QI funds are maintained in the MMIS for the current and previous year only.

Eligible QIs are placed on a medically needy spenddown if resources are within the medically needy limit.

1. Not An Entitlement

Medicaid coverage for this covered group is not an individual entitlement, which means that when the Department of Medical Assistance Services (DMAS) runs out of money for this covered group, no additional eligible individuals in this covered group will receive Medicaid benefits. DMAS will notify the DSS Central Office when the money for this covered group will run out.

Local departments of social services must continue to take and process applications for this covered group even after the funds run out. The MMIS will generate and send a notice to the recipient if the recipient will not receive the benefit because the funds have run out.

Applications for QI coverage for an upcoming year may not be taken until January 1 of that year.

2. Qualified Individual (QI)

A Qualified Individual (QI)

- is entitled to Medicare Part A hospital insurance benefits, but not entitled to Medicare Part A solely because he/she is a QDWI (enrolled in Part A under section 1818A of the Act);
- has resources that are within the resource limits for the Medicare Savings Programs (MSPs). See chapter section M1110.003 for the current resource limits; and
- has income that is equal to or exceeds the SLMB limit (120% of the FPL) but is less than the QI limit (135% of the FPL).

C. Entitlement

Individuals who become eligible after meeting a spenddown are entitled to full Medicaid coverage beginning the day the spenddown was met and ending the last day of the sixth month in the spenddown budget period. Retroactive coverage is applicable to this covered group.

Note: Individuals receiving LTC services are placed on monthly spenddowns (see M1460.700).

D. Enrollment

Eligible individuals in this group are classified as medically needy (MN). If the individual has Medicare Part A, compare the individual's countable income to the QMB *and* SLMB limits.

The following ACs are used when the individual is ABD MN and QMB *or* SLMB:

- 028 for an aged individual also QMB;
- 048 for a blind individual also QMB;
- 068 for a disabled individual also QMB;
- 024 for an aged MN individual also SLMB;
- 044 for a blind or disabled MN individual also SLMB.

The following ACs are used when the individual is ABD MN and not QMB *or* SLMB:

- 018 for an aged individual NOT QMB *or* SLMB;
- 038 for a blind individual NOT QMB *or* SLMB;
- 058 for a disabled individual NOT QMB *or* SLMB.

M0320.702 DECEMBER 1973 ELIGIBLES**A. Policy**

42 CFR 435.340 - If the State Plan covers the medically needy, the Plan must provide protected medically needy coverage for blind and disabled individuals eligible in December 1973.

B. Blind or Disabled in December 1973

This is an MN covered group of blind and disabled individuals who:

- were eligible as medically needy under the state plan in December 1973 on the basis of the blindness or disability criteria of the AB or APTD plan;
- for each consecutive month after December 1973 continue to meet the December 1973 blindness or disability criteria and the December 1973 financial eligibility requirements; and
- meet the **current** medically needy eligibility requirements except the blindness or disability criteria.

Continuing eligibility is determined on the basis of eligibility requirements in effect as of December, 1973 and current medically needy requirements.

Contact your Regional Medical Assistance Program Consultant if you have an applicant you believe meets this covered group.

M0530 Changes

Changed With	Effective Date	Pages Changed
UP #9	4/1/13	Appendix 1, page 1
UP #6	4/1/12	Appendix 1, page 1
Update (UP) #5	7/1/11	page 14
TN #95	3/1/11	page 1 Appendix 1, page 1
TN #93	1/1/10	pages 11, 19 Appendix 1, page 1

Deeming Allocations

The deeming policy determines how much of a legally responsible relative's income is deemed to the applicant/recipient. The allocation amount increases automatically whenever the SSI payment limit increases.

NBD (Non-blind/disabled) Child Allocation

The NBD child allocation is equal to the difference between the SSI payment for two persons and the SSI payment for one person.

SSI payment for couple - SSI payment for one person = NBD child allocation

2013: $\$1,066 - \$710 = \$356$

2012: $\$1,048 - \$698 = \$350$

Parental Living Allowance

The living allowance for one parent living with the child is the SSI payment for one person.

SSI payment for one person = $\$710$ for 2013; $\$698$ for 2012.

The living allowance for both parents living with the child is the SSI payment for a couple.

SSI payment for both parents = $\$1,066$ for 2013; $\$1,048$ for 2012.

Deeming Standard

The NABD (non-age/blind/disabled) spouse deeming standard is the difference between the SSI payment for two persons and the SSI payment for one person.

SSI payment for couple - SSI payment for one person = deeming standard

2013: $\$1,066 - \$710 = \$356$

2012: $\$1,048 - \$698 = \$350$

M0710 Changes

Changed With	Effective Date	Pages Changed
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

CHILD UNDER AGE 19 (FAMIS PLUS) AND PLAN FIRST INCOME LIMITS FEDERAL POVERTY LEVEL (FPL) EFFECTIVE 1-24-13* ALL LOCALITIES			
# of persons in Family/Budget Unit	100% FPL Monthly Limit	133% FPL Monthly Limit	200% FPL Monthly Limit*
1	\$958	\$1,274	\$1,915
2	1,293	1,720	2,585
3	1,628	2,165	3,255
4	1,963	2,611	3,925
5	2,298	3,056	4,595
6	2,633	3,502	5,265
7	2,968	3,947	5,935
8	3,303	4,393	6,605
Each additional person add	335	446	670

AC 091 - MI Child under age 6 with income less than or equal to 100% FPL

AC 092 - MI Child age 6 to 19 with income less than or equal to 100% FPL

AC 090 - MI Child under age 6 with income greater than 100% FPL and less than or equal to 133% FPL

AC 092 - **Insured** MI Child age 6 to 19 with income greater than 100% FPL and less than or equal to 133% FPL

AC 094 - **Uninsured** MI Child age 6 to 19 with income greater than 100% FPL and less than or equal to 133% FPL

*AC 080 – Plan First for men and women with income less than or equal to 200% FPL (effective **10-01-2011**).

MEDICALLY INDIGENT PREGNANT WOMAN INCOME LIMITS 133% FPL EFFECTIVE 1-24-13 ALL LOCALITIES	
# of persons in Family/Budget Unit	133% FPL Monthly Limit
2	<i>\$1,720</i>
3	<i>2,165</i>
4	<i>2,611</i>
5	<i>3,056</i>
6	<i>3,502</i>
7	<i>3,947</i>
8	<i>4,393</i>
Each additional person add	<i>446</i>

AC 091 - Pregnant Woman with income less than or equal to 133% FPL

TWELVE MONTH EXTENDED MEDICAID INCOME LIMITS 185% of FEDERAL POVERTY LIMITS EFFECTIVE 1-24-13 ALL LOCALITIES	
# of Persons in Family Unit/Budget Unit	185% FPL Monthly Limit
1	\$1,772
2	2,392
3	3,011
4	3,631
5	4,251
6	4,871
7	5,490
8	6,110
Each additional person add	620

AC 081 – LIFC one parent or caretaker in home

AC 083 – LIFC both parents in home

M0810 Changes

Changed With	Effective Date	Pages Changed
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

GENERAL

M0810.001 INCOME AND ELIGIBILITY

A. Introduction The following sections explain how to treat income in the Medicaid program. This chapter explains how we count income.

B. Policy Principles

1. Who is Eligible An individual is eligible for Medicaid if the person:

- meets a covered group; and
- meets the nonfinancial requirements; and
- meets the covered group's resource limits; and
- meets the covered group's income limits.

2. General Income Rules

- Count income on a monthly basis.
- Not all income counts in determining eligibility.
- If an individual's countable income exceeds a classification's monthly limit, a medically needy spenddown may be established, if appropriate.

M0810.002 INCOME LIMITS

A. Income Limits The Medicaid covered group determines which income limit to use to determine eligibility.

1. Categorically Needy Supplemental Security Income (SSI) and State Supplement (Auxiliary Grant) recipient's money payments meet the income eligibility criteria in the ABD Categorically Needy covered group.

2. Categorically Needy Protected Cases Only

Categorically-Needy Protected Covered Groups Which Use SSI Income Limits		
Family Unit Size	2013 Monthly Amount	2012 Monthly Amount
1	\$710	\$698
2	1,066	1,048
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size	2013 Monthly Amount	2012 Monthly Amount
1	\$473.34	\$465.33
2	710.67	698.67

**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.

Categorically Needy 300% of SSI		
Family Size Unit	2013 Monthly Amount	2012 Monthly Amount
1	\$2,130	\$2,094

**4. Medically
Needy (Effective
July 1, 2012)**

a. Group I		
Family Unit Size	Semi-annual	Monthly
1	\$1,773.32	\$295.55
2	2,257.91	376.31
b. Group II		
Family Unit Size	Semi-annual	Monthly
1	\$2,046.14	\$341.02
2	2,519.76	419.16
c. Group III		
Family Unit Size	Semi-annual	Monthly
1	\$2,659.99	\$443.33
2	3207.19	534.53

**5. ABD
Categorically
Needy**

For:

ABD 80% FPL,
QMB, SLMB, &
QI without Social
Security income;
all QDWI; all
MEDICAID
WORKS,
effective 1/24/13

ABD 80% FPL,
QMB, SLMB, &
QI with Social
Security income,
effective 3/1/13

ABD 80% FPL	Annual	Monthly
1	\$9,172	\$766
2	12,408	1,034
QMB 100% FPL	Annual	Monthly
1	\$11,490	\$958
2	15,510	1,293
SLMB 120% of FPL	Annual	Monthly
1	\$13,788	\$1,149
2	18,612	1,551
QI 135% FPL	Annual	Monthly
1	\$15,512	\$1,293
2	20,939	1,745
QDWI and MEDICAID WORKS 200% of FPL	Annual	Monthly
1	\$22,980	\$1,915
2	31,020	2,585

S0820 Changes

Changed With	Effective Date	Pages Changed
UP #9	4/1/13	pages 30, 31
Update (UP) #6	4/1/12	pages 30, 31
TN #95	3/1/11	pages 3, 30, 31
TN #93	1/1/10	pages 30, 31
TN #91	5/15/09	Table of Contents pages 29, 30

3. Other Earned Income

Then, other income exclusions are applied, in the following order, to the rest of earned income in the month:

- a. Federal earned income tax credit payments.
- b. Up to \$10 of earned income in a month if it is infrequent or irregular.
- c. For 2013, up to \$1,730 per month, but not more than \$6,960 in a calendar year, of the earned income of a blind or disabled student child.

For 2012, up to \$1,700 per month, but not more than \$6,840 in a calendar year, of the earned income of a blind or disabled student child.

- d. Any portion of the \$20 monthly general income exclusion which has not been excluded from unearned income in that same month.
- e. \$65 of earned income in a month.
- f. Earned income of disabled individuals used to pay impairment-related work expenses.
- g. One-half of remaining earned income in a month.
- h. Earned income of blind individuals used to meet work expenses.
- i. Any earned income used to fulfill an approved plan to achieve self-support.

4. Unused Exclusion

Earned income is never reduced below zero. Any unused earned income exclusion is never applied to unearned income.

Any unused portion of a monthly exclusion cannot be carried over for use in subsequent months.

6. Couples

The \$20 general and \$65 earned income exclusions are applied only once to a couple, even when both members (whether eligible or ineligible) have income, since the couple's earned income is combined in determining Medicaid eligibility.

B. References

For exclusions which apply to both earned and unearned income, see:

- S0810.410 for infrequent/irregular income
- S0810.420 \$20 general exclusion
- S0810.430 amount to fulfill a plan for achieving self-support

For exclusions applicable only to earned income, see S0820.510 - S0820.570.

S0820.510 STUDENT CHILD EARNED INCOME EXCLUSION

A. Policy

- 1. General** For a blind or disabled child who is a student regularly attending school, earned income is excluded under this provision, limited to the maximum amounts shown below.

For Months	Up to per month	But not more than in a calendar year
<i>In calendar year 2013</i>	<i>\$1,730</i>	<i>\$6,960</i>
<i>In calendar year 2012</i>	<i>\$1,700</i>	<i>\$6,840</i>

- 2. Qualifying for the Exclusion** The individual must be:
- a child under age 22; and
 - a student regularly attending school.
- 3. Earnings Received Prior to Month of Eligibility** Earnings received prior to the month of eligibility do not count toward the yearly limit.
- 4. Future Increases** The monthly and yearly limits will be adjusted annually based on increases in the cost of living index. Under this calculation, these amounts will never be lower than the previous year's amounts. However, there may be years when no increases result from the calculation.

B. Procedure

- 1. Application of the Exclusion** Apply the exclusion:
- consecutively to months in which there is earned income until the exclusion is exhausted or the individual is no longer a child; and
 - only to a student child's own income.
- 2. School Attendance and Earnings** Develop the following factors and record them:
- whether the child was regularly attending school in at least 1 month of the current calendar quarter, or expects to attend school for at least 1 month in the next calendar quarter, and
 - the amount of the child's earned income (including payments from Neighborhood Youth corps, Work-Study, and similar programs).

Verify wages of a student child even if they are alleged to be \$65 or less per month.

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S1110 Changes

Changed With	Effective Date	Pages Changed
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

M1110.003 RESOURCE LIMITS

A. Introduction

The resource limit is the maximum dollar amount of countable assets an individual, couple, or family may own and still meet the established criteria for Medical Assistance in an ABD category. These amounts are established by law.

B. Policy Principles

1. Resource Ineligibility

An individual (or couple) with countable resources in excess of the applicable limit is not eligible for Medicaid.

2. Resource Limits

ABD Eligible Group	One Person	Two People
Categorically Needy Medically Needy	\$2,000	\$3,000
ABD With Income \leq 80% FPL	\$2,000	\$3,000
QDWI	\$4,000	\$6,000
QMB SLMB QI	Calendar Year 2013 \$7,080 2012 \$6,940	Calendar Year 2013 \$10,620 2012 \$10,410

3. Change in Marital Status

A change in marital status can result in a change to the applicable resource limit. The resource limit change is effective with the month that we begin treating both members of a couple as individuals. For example, separation from an ineligible spouse can change the limit from \$3,000 to \$2,000. See M1110.530 B.

4. Reduction of Excess Resources

Month of Application

Excess resources throughout the month of application causes ineligibility for the application month. Reduction of excess resources within the application month can cause resource eligibility for that month.

S1130 Changes

Changed With	Effective Date	Pages Changed
UP #9	4/1/13	Table of Contents, page ii pages 5, 62 pages 62a was added.
TN#97	9/1/12	page 14
Update #7	7/1/12	page 24
TN #96	10/1/11	Table of Contents, page ii pages 4, 73, 74 Appendix 1, pages 1-14 Appendix 2, page 1 Appendix 4, pages 1-8 added
TN #95	3/1/11	pages 28, 29, 33
TN #94	9/1/10	pages 20, 20a, 28-29a
TN #93	1/1/10	pages 63-65 pages 70, 74, 75
TN #91	5/15/09	page 13

S1130.000 ABD RESOURCES EXCLUSIONS

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Determining the Countable Value of Non-Home Real Property	Appendix 4	1

e. Equitable Ownership

Virginia does not recognize equitable ownership of real property.

2. Principal Place of Residence-- Operating Assumption

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

3. Indication of More than One Residence

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

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

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

4. Evidence Indicates Non-adjointing Property

a. Individual Agrees With Evidence

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

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

b. Individual Disagrees With Evidence

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

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

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

RETAINED CASH AND IN-KIND PAYMENTS**S1130.600 RETROACTIVE SSI AND SS PAYMENTS****A. Definitions**

1. **Retroactive SSI Benefits** Retroactive SSI benefits -- which include any federally administered State supplementation -- are SSI benefits issued in any month after the calendar month for which they are paid. Thus, benefits for January that are issued in February are retroactive.
2. **Retroactive SS Benefits** Retroactive SS benefits are those issued in any month that is more than a month after the calendar month for which they are paid. Therefore, SS benefits for January that are issued in February are not retroactive, but SS benefits for January that are issued in March are retroactive.

B. Policy Principles

1. **9-Month Exclusion** The unspent portion of retroactive SSI and SS benefits received on or after 11/01/05 is excluded from resources for the nine (9) calendar months following the month in which the individual receives the benefits.
2. **6-Month Exclusion** The unspent portion of retroactive SSI and SS benefits received before 11/01/05 is excluded from resources for the six (6) calendar months following the month in which the individual receives the benefits.

C. Related Policies

1. **Interest** Interest earned by funds excluded under this provision is not excluded from income under this provision. Develop interest per S0830.500.
2. **Commingled Funds** See S1130.700 if excluded funds have been commingled with other funds.

S1130.601 DEDICATED ACCOUNTS FOR PAST-DUE BENEFITS DUE TO INDIVIDUALS UNDER 18 WHO HAVE A REPRESENTATIVE PAYEE

- A. **Background and Definitions** *Section 213 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, P.L. 104-193, enacted August 22, 1996, requires that when an eligible individual under age 18 is eligible for past-due Supplemental Security Income (SSI) monthly benefits which exceeds the amount specified in SSI policy, the representative payee **must** establish a dedicated account in a financial institution into which the past-due benefits will be paid. Subsequent amounts of past-due benefits that exceed this amount must also be paid into this account.*
 1. **Dedicated Account** *A dedicated account is an account in a financial institution, the sole purpose of which is to receive and maintain SSI past-due benefits which are required or allowed to be paid into such an account and the use of which is restricted by section 1631(a)(2)(F) of the Social Security Act. Funds other than those allowed by SSI policy may not be deposited into a dedicated account.*

2. *Past-Due SSI Benefits*

Past-due SSI benefits are:

- a. *benefits due but unpaid which accrue prior to the month payment was effectuated;*
- b. *benefits due but unpaid which accrue during a period of suspension for which the recipient was subsequently determined to have been eligible; and*
- c. *any adjustment to benefits which results in an accrual of unpaid benefits.*

B. *Policy Principles*

1. *Resources*

Past-due benefits and other underpayments described above deposited into a dedicated financial institution account and any accrued interest or other earnings on such an account are excluded from resources. For any month that funds other than accrued interest or other earnings on the account are commingled in this account, the exclusion does not apply to any funds in the account.

EXCEPTION: *Funds, other than past-due benefits, required by a financial institution to open the dedicated account may be commingled in the account, but only until the end of the month following the month that the past-due benefits are paid. However, these funds other than past-due benefits in the account are **not** excluded from resources.*

2. *Interest and Other Earnings*

Interest and other earnings (e.g., dividends) earned on and left to accrue in the excluded dedicated account are excluded from income and resources.

3. *Exclusion During a Period of SSI Suspension or Termination*

Restrictions on the use of funds in a dedicated account continue to apply during a period of suspension of SSI benefits (e.g., status S06), non-pay (e.g., status N04), and eligibility but no payment (status E01). The exclusion from resources of the funds in the account continues to apply during a period of suspension, non-pay, or eligibility but no payment, prior to termination (i.e., the 12 months prior to status T31).

Once an individual's eligibility has been terminated, the exclusion of the funds in a dedicated account cannot be carried over if the individual establishes a new period of SSI eligibility by filing a new application for SSI. Reopening of a prior period of eligibility following termination is not a new period of eligibility and, therefore, the exclusion may be reapplied. Any remaining funds are a countable resource.

4.. *Nine (9)-month Exclusion of SSI Underpayments from Resources*

*When an individual receives past-due benefits that **may** be, but have not yet been, deposited into a dedicated account, the exclusion in S1130.600 applies for the lesser of 9 months or until the payee deposits the payment into the dedicated account.*

S1140 Changes

Updated With	Effective Date	Pages Changed
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

B. Development and Documentation- Exceptions for Liquid Resources Only

1. Cash on Hand

Accept an allegation of cash on hand, regardless of amount. Never ask to see or count cash.

2. Government-Issued Debit Cards

Government-administered benefits may be issued via government-sponsored debit cards, such as the Direct Express Debit MasterCard used for Social Security, Supplemental Security Income, Railroad Retirement and other government benefits. If the debit card account is funded solely by deposits from a government program, the money in the debit card account, minus any income deposited to the account for the month, is considered cash on hand and is countable unless otherwise excluded. See subchapter S1130 for information about benefits that are excluded as resources.

Debit cards that are *not government-sponsored* (e.g. the Green Dot pre-paid Visa or MasterCard) are considered bank accounts *even if the individual's government benefits are deposited into the debit account*. See S1140.200.

C. Development and Documentation-- Photocopying Restrictions

U.S. Government Securities and Obligations

It is legal to photocopy checks issued by the Federal Government, U.S. Savings Bonds, Treasury notes, and other securities and obligations of the U.S. Government **only if** the photocopies are:

- in black and white; and
- of a size less than three-fourths or more than one and one-half, in linear dimension, of each part of the item illustrated.

Photocopying Not Legal

If equipment limitations or restrictions imposed by State or Federal law do not permit legal photocopying of a document, make a certification from the original document involved. If the document appears to have been altered in some way, certify it "as is" with a notation as to the apparent alteration.

6. Examples of Evidence to the Contrary

a. Use Restricted by Court Order

Even with ownership interest and the legal ability to access property, a legal restriction against the property's use for the owner's own support and maintenance means the property is not the owner's resources (S1110.100).

EXAMPLE: An account is titled, "Aristotle Iris by Hester Pry, Representative Payee," where Ms. Pry is an officer of the institution in which Mr. Iris lives. A statewide court order prohibits such officers from using the funds of an institutionalized person for support and maintenance provided by the State. Therefore, the funds in the account are not a resource while Mr. Iris is in the institution.

b. Special Purpose Accounts

An account is titled, "Thomas Green, Kiwanis Club Fund for Heart Surgery." While Mr. Green has unrestricted access to funds, development shows that their use is restricted to the expenses of his surgery. Therefore, they are not a resource.

7. Debit Card Accounts

Debit cards that are *not government-sponsored* (e.g. the Green Dot pre-paid Visa or MasterCard) are considered bank accounts *even if the individual's government benefits are deposited into the debit account.*

If the debit card is sponsored by a government program such as the Social Security Administration and the individual cannot deposit other money into the account, the money in the debit card account, minus any income deposited to the account for the month, is considered cash on hand and is verified by the client's statement of the balance in the account. See M1140.010.

B. Development and Documentation Initial Applications and Post-eligibility

1. Informing the Individual of Reporting Responsibilities

Be sure the individual understands that:

- he must report any bank account on which his or her name appears, regardless of any special purpose for which the account may have been established or whose money is in it;
- DSS may use other statements or forms to obtain information from any bank account or financial institution to verify the allegations.

2. Curtailing Development

Do not verify account balances under any of the following circumstances:

- a. the individual alleges that his name does not appear on any accounts, and there is no evidence to the contrary;
- b. the individual is ineligible for a non-financial reason.

3. Minimum Documentation - Account Balances Must Be Verified

Document, in addition to the balances themselves;

- the name and address of the financial institution;
- the account number(s); and
- the exact account designation.

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Chapter S11, Appendices

Changed With	Effective Date	Pages Changed
Update (UP) #9	4/1//13	Appendix 1, page 6 Appendix 2, page 5

B. Development and Documentation - Initial Claims

1. Ownership

a. Use of Allegation

Accept an individual's allegation of home ownership unless the file raises a question about it (e.g., a life estate is involved, the individual is under age 18, does not live with a parent, and does not live with someone else). If there is a question, have the individual submit one of the items of evidence listed in b. - d., below.

b. Evidence of Real Property Ownership

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

c. Evidence of Personal Property Ownership (e.g., a Mobile Home)

- **title;**
- **current registration.**

d. Evidence of Life Estate or Similar Property Rights

- deed;
- will;
- other legal document.

e. Equitable Ownership

Virginia does not recognize equitable ownership of real property.

- other legal document.

e. **Equitable Ownership**

Virginia does not recognize equitable ownership of real property.

2. **Principal Place of Residence -- Operating Assumption**

Absent ownership in more than one residence or evidence that raises a question about the matter, **assume** that the alleged home is the individual's principal place of residence.

3. **Indication of More than One Residence**

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

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

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

4. **Evidence Indicates Nonadjoining Property**

a. **Individuals Agrees With Evidence**

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

- **obtain** his or her statement to that effect and
- **develop** the nonadjoining portion per S1140.100 (Nonhome Real Property) or S1130.500 (Property Essential to Self-Support), as applicable.

b. **Individual Disagrees With Evidence**

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

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

M13 Table of Contents Changes

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Update #9	4/1/13	Table of Contents, page ii

CHANGES PRIOR TO MEETING SPENDDOWN ...M1350

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 Increase In Assistance Unit Size M1350.2002
 Decrease In Unit Size Not Due To Institutionalization. M1350.2103
 Decrease In Unit Size Due to Institutionalization M1350.2205
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 Income Limit Changes..... M1350.4007
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CHANGES AFTER SPENDDOWN IS METM1360

Changes After Spenddown Is Met..... M1360.1001

SPENDDOWN –LIMITED BENEFIT

***ENROLLEES*M1370**

Spenddown ABD Medically Indigent..... M1370.1001
 QMBs, SLMBs, QDWIs
 & Plan First Enrollees M1370.2002
 QI-1s and QI-2s..... M1370.3003

M1310 Changes

Changed With	Effective Date	Pages Changed
UP #9	4/1/13	pages 1-3
UP #7	7/1/12	Table of Contents pages 1-5 Page 6 was added.
TN #95	3/1/11	page 4

M1310.000 SPENDDOWN GENERAL PRINCIPLES AND DEFINITIONS

M1310.100 GENERAL PRINCIPLES OF MEDICAID SPENDDOWN

A. Introduction

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

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

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

Contact your Regional *Medical Assistance Program* Consultant for the policy and procedures for Medicaid spenddowns established prior to July 1, 1999.

B. Applicability

Spenddown applies only to medically needy (MN) covered groups. Individuals and families must meet the MN nonfinancial and resource requirements in order to be placed on a spenddown.

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

C. Opportunity to Receive Full Medicaid Coverage

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

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

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

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

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

2. Plan First Enrollees

Individuals enrolled in Plan First do not necessarily meet a MN covered group. Plan First enrollees who meet a MN covered group and its requirements in M0330 are placed on two six-month spenddown budget periods within the 12 month renewal period. They may also be eligible for a retroactive MN spenddown determination.

M1310.200 INSTITUTIONALIZED INDIVIDUALS IN MEDICAL FACILITIES OR RECEIVING MEDICAID CBC

A. General Principle Do not use this subchapter for institutionalized Medically Needy individuals in long-term care [medical facilities or Medicaid Community-based Care (CBC)] who have income over the MNIL.

Go to subchapter M1460 when the individual is institutionalized in a medical facility or when the individual receives Medicaid Community-based Care (CBC) waiver services. Subchapter M1460 contains the policy and procedures for determining the eligibility and spenddown liability for individuals in long-term care.

M1310.300 SPENDDOWN DEFINITIONS

A. Introduction This section contains the definitions of terms used in the spenddown chapter, Chapter M13.

B.

C. Definitions

- 1. Applicable Exclusions** Applicable exclusions are the amounts that are deducted from income in determining an individual's income eligibility as identified under the July 16, 1996, AFDC State Plan for Families & Children covered groups, and under the SSI program for aged, blind or disabled individuals.
- 2. Assistance Unit** The Medicaid assistance unit is the individual or family who applies for Medicaid and whose financial eligibility is determined. The assistance unit for the Families & Children (F&C) covered groups is called the "family unit" or the "budget unit." The assistance unit for an ABD individual is just the individual, unless the individual is married, living with his/her spouse and the spouse is also ABD or the spouse is NABD and has deemable income. In this situation, the assistance unit is the married ABD couple.
- 3. Available Income** Available income means the earned and unearned income before exclusions used in determining the income eligibility of a medically needy individual.
- 4. Break in Spenddown Eligibility** A break in spenddown eligibility only occurs after an individual has, at least once, established eligibility by meeting a spenddown in a prior budget period. A break in spenddown eligibility occurs when:
 - there is a break between spenddown budget periods;
 - the individual establishes Medicaid eligibility in the ABD 80% FPL covered group *or a CN F&C covered group*; or
 - the individual establishes Medicaid eligibility as medically needy (MN) without a spenddown; or

NOTE: MN determinations are completed when the individual is not eligible as CN.

- the individual does not meet the spenddown liability in a spenddown budget period.

- 5. Budget Period** Budget period means a period of time during which an individual's income is calculated to determine Medicaid eligibility.
- 6. Carry-over Expenses** Carry-over expenses are the balance due on medical, dental, and remedial care expenses incurred in the retroactive or prospective budget periods prior to the current budget period which were not used in establishing eligibility and which may be deducted in consecutive budget periods when there has been no break in spenddown eligibility.
- 7. Consecutive Budget Period** A consecutive budget period is any spenddown budget period that immediately follows a spenddown budget period in which eligibility was established.
- 8. Countable Income** Countable income means, for the medically needy, the amount of the individual's gross income after deducting allowable exclusions that is measured against the medically needy income limit (MNIL).
- 9. Covered Expenses** Covered expenses means expenses for services that are included in the State Plan for Medical Assistance (Medicaid State Plan).
- 10. Current Payments** Current payments are payments made in the current spenddown budget period on expenses incurred before the current spenddown budget period, which were not used in establishing eligibility in a previous spenddown budget period and when there has been a break in spenddown eligibility. The payment amount allowed is the actual payment amount paid to the provider and is deducted from the spenddown liability on the date the payment is actually made.
- 11. First Prospective Budget Period** The first prospective budget period is the spenddown budget period that begins:
- the first day of the month the individual first applied for Medicaid and is placed on spenddown, or
 - the first day of the month after the cancellation of Medicaid coverage due to excess income, or
 - when a new Medicaid application is filed after a break in spenddown eligibility.

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M1370 Changes

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TN #94	9/1/2010	Table of Contents pages 1-5

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M1370 SPENDDOWN –*LIMITED BENEFIT ENROLLEES*

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M1370.000 SPENDDOWN – LIMITED BENEFIT ENROLLEES

M1370.100 SPENDDOWN – LIMITED BENEFIT ENROLLEES

A. Introduction

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

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

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

This policy does not apply to individuals in the ABD 80 % FPL covered group. Individuals in the ABD 80% FPL covered group receive full Medicaid coverage.

1. Placement on Spenddown

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

QI enrollees who meet the MN covered group and resource requirements are placed on two six month spenddown budget periods at a time, beginning with the month of application. Spenddown budget periods continue to run consecutively, with no new application required, as long as the individual remains QI eligible.

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

2. QMB, SLMB, and QDWI

If an enrolled QMB, SLMB, or QDWI does not meet the spenddown, he continues to be eligible *for limited benefits*. *As long as the individual is enrolled in Medicaid*, the ABD Medicaid Renewal form (#032-03-0186) may be used as an application for establishing additional spenddown budget periods. The Eligibility Review Part A (#032-03-729A) and the Eligibility Review Part B (#032-03-729B) forms should only be used when they are required by another program under which the individual is receiving benefits.

The spenddown budget period is based on the application date. At renewal, the new spenddown budget period begins the month following the end of the previous spenddown budget period if the renewal is filed in the last month of the spenddown budget period or the following month. If the renewal is filed two or more months after the end of the last spenddown budget period, the new spenddown budget periods (retroactive or prospective) are based on the

date the renewal form was received in the LDSS. Do not complete an early renewal on a spenddown case because the spenddown period must not be shortened by the completion of an early renewal.

3. QI

The QI enrollees who meet the MN covered group and resource requirements are placed on a MN spenddown. If an enrolled QI medically indigent enrollee does not meet the spenddown, he continues to be eligible as QI for the calendar year, or as long as the program is funded.

QI coverage can be renewed for the following year as long as the QI completes and returns the ABD Medicaid Renewal form (#032-03-0186) and the renewal is completed by December 31 of each year. If the renewal form is not returned and the QI renewal is not completed by December 31, the individual must reapply for Medicaid for the coverage to resume.

Spenddown budget periods for QIs are based on the initial application month. Unless the individual applied in January, his spenddown budget periods will not coincide with the renewal certification period. Spenddown budget periods continue to run consecutively, with no new application required, as long as the QI's Medicaid coverage remains open.

4. QI Spend-down Procedures

a. New Applications

At the time of initial application, the agency will calculate two spenddown periods. When the second spenddown period expires, the agency will continue to calculate additional spenddown periods, two at a time, without a new application as long as the person remains active in Medicaid. The worker shall send a Notice of Action containing the information about the new spenddown periods each time the worker calculates another two spenddown periods.

b. QIs who were enrolled and on a spenddown as of July 1, 2010

When the QI's current spenddown period ends, the agency will continue to calculate additional spenddown periods, two at a time, without a new application as long as the person remains active in Medicaid. The worker shall send a Notice of Action containing the information about the new spenddown periods each time the worker calculates another two spenddown periods.

When bills are submitted, the worker shall contact the individual to see if living situation, income or resources have changed. If changes have occurred, verification must be provided and a re-evaluation must be completed.

The spenddown cycle does not affect the QI renewal cycle—QI renewals will be due in December regardless of when the person applied for Medicaid.

5. Plan First

If an individual enrolled in the Plan First covered group meets a MN covered group listed in M0320 or M0330, he must be evaluated to determine if he could become eligible for full Medicaid coverage as medically needy (MN) by meeting a spenddown. At application and redetermination, Plan First enrollees who meet the MN covered group and resource requirements are placed on two six-month spenddown budget periods within the 12 month renewal period. They may also be eligible for a retroactive MN spenddown determination.

M1370.200 QMBs, SLMBs, QDWIs & *PLAN FIRST ENROLLEES*

A. Policy QMBs are eligible only for Medicaid coverage of their Medicare premiums, the Medicare deductible and coinsurance charges for Medicare covered services. Medicare does not cover all of the services that Medicaid covers. For example, Medicare does not cover non-emergency transportation.

SLMBs and QDWIs are eligible only for Medicaid coverage of their Medicare premiums.

Plan First enrollees are eligible only for limited Medicaid coverage related to family planning services and transportation to access those services.

B. Entitlement After Meeting Spenddown When an enrolled QMB, SLMB, QDWI or *Plan First enrollee* meets a medically needy spenddown, he is eligible for Medicaid as medically needy beginning the date the spenddown was met and ending the last day of the spenddown budget period.

C. Enrollment Procedures The MMIS enrollment must be canceled and then reinstated in order for the individual to receive the full scope of Medicaid services for the portion of the spenddown budget period in which he is eligible as medically needy. Take the following actions:

1. Cancel Limited Benefit Coverage **Cancel** the enrollee's current coverage line that has the *limited-benefit* aid category (AC).

- a. Cancel date is the date **before** the date the spenddown was met.
- b. Cancel reason is "024".

2. Reinstatement MN Coverage Reinstatement the enrollee in the appropriate medically needy aid category (AC).

- enter the eligibility begin date as the date the spenddown was met.
- enter the eligibility end date - the date the spenddown budget period ends.

Be sure that the application date is the first month in the spenddown budget period. The MMIS will cancel eligibility effective the end date entered.

D. Continuing Eligibility and Enrollment After Spenddown Ends

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

To establish a new spenddown budget period, use the ABD Medicaid Renewal form (#032-03-669) for *QMB, SLMB, and QDWI enrollees*. The Eligibility Review Part A (#032-03-729A) and Eligibility Review Part B (#032-03-729B) forms should only be used when they are required by another program under which the individual is receiving benefits. When the annual redetermination is filed, new spenddown budget periods are established. Eligibility for each spenddown budget period is evaluated.

For Plan First enrollees who meet a MN covered group, use the procedures in section M1520.200 for completing a contact-based renewal for Plan First enrollees. Because Plan First enrollees do not have a resource test, it is necessary to obtain resource information for Plan First enrollees who meet an MN covered group. The resource pages from the ABD Medicaid Renewal form or Eligibility Review Part B may be used.

E. Example--QMB Meets Spenddown

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

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

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

M1370.300 QUALIFIED INDIVIDUALS (QI)

- A. Introduction** QIs are eligible only for limited Medicaid payment of their Medicare premiums. They are NOT eligible for any other Medicaid-covered services.
- If all eligibility factors are met in the application month, eligibility for Medicaid as QI begins the first day of the application month and ends December 31 of the calendar year, if funds are still available. QI coverage can be renewed for the following year if the renewal form is submitted by December 31 of each year. If the renewal form is not returned by December 31, the individual must reapply for Medicaid for the coverage to resume.
- B. Entitlement After Meeting Spenddown** When an enrolled QI meets a spenddown, he is eligible for Medicaid as medically needy. MN eligibility begins the date the spenddown was met and ends the last day of the spenddown budget period.
- C. Enrollment Procedures** The MMIS ABD MI enrollment must be canceled and the MN coverage reinstated in order for him to receive the full scope of Medicaid services for the portion of the spenddown budget period in which he is MN-eligible. Take the following actions:
- 1. Cancel QI Coverage** Cancel the enrollee's current eligibility in the QI aid category.
 - a. Cancel date is the date before the date the spenddown was met.
 - b. Cancel reason is "024".
 - 2. Reinstate MN Coverage** Reinstate the enrollee in the appropriate MN AC (**NOT dual-eligible**).
 - enter the eligibility begin date as the date the spenddown was met.
 - enter the end date as the last date of the spenddown budget period.

Be sure that the application date is the first month in the spenddown budget period. The MN coverage will end the last date of the spenddown budget period.
- D. Continuing Eligibility and Enrollment After Spenddown Ends** When the spenddown budget period ends, reinstate the enrollee's Medicaid eligibility as medically indigent QI beginning the day after the MN spenddown eligibility cancel date. Use the initial Medicaid application date. The QI medically indigent coverage begin date is the first day of the month following the end of the spenddown budget coverage period.
- E. Example- QI Meets Spenddown** **EXAMPLE #2:** Mr. P. is 69 years old. He has Medicare Parts A & B, and applied for Medicaid on May 14. Resources are within the medically needy limit. His income exceeds the medically needy limit, but is less than the QI limit. His eligibility is determined on June 1. He is enrolled in Medicaid QI coverage beginning May 1. He is placed on a spenddown for the budget period May 1 through October 31. The agency enrolls him in the MMIS with an eligibility begin date of May 1, AC 056.

On July 15 he brings in prescription drug bills. He meets the spenddown on July 13. On July 25 the agency cancels his QI (AC 056) coverage effective July 12. His Medicaid eligibility as MN is reinstated using AC 018 (medically needy aged) with an application date May 14, eligibility begin date of July 13, and eligibility end date of October 31.

His spenddown eligibility ends October 31. On November 1, the agency worker reinstates his QI Medicaid coverage with a begin date of November 1, AC 056, application date May 14. Because his coverage was uninterrupted, he is placed on two additional spenddowns, November 1 through April 30 of the following year and May 1 through October 31 of the following year. He completes an ABD Renewal form and returns it to the agency in December, and his QI coverage is also renewed for the following year.

M1440 Changes

Changed With	Effective Date	Pages Changed
UP #9	4/1/13	page 5
Update (UP) #7	7/1/12	Table of Contents pages 2, 14, 15, 18a-18c pages 19, 20
TN #94	9/1/2010	Table of Contents pages 13, 16, 18b, 19-22
TN #93	1/1/2010	pages 14, 16
TN #91	5/15/2009	Table of Contents page 12 pages 17-18c

for the detention of children who are determined to be delinquent.

5. Facility for the Mentally Retarded

A facility (institution) for the mentally retarded (ICF-MR) is not an IMD. Therefore, an individual under age 65 who is in a facility for the mentally retarded meets the institutional status eligibility requirement, unless he is incarcerated, as defined below.

C. Policy

Two groups of individuals are NOT eligible for Medicaid:

- individuals who are inmates of a public institution.
- individuals under age 65 years who are patients in an institution for the treatment of mental diseases (IMDs), unless they are under age 22 and are receiving inpatient psychiatric services.

Because a patient in an IMD cannot receive Medicaid CBC waiver services, this section only addresses the inmate of a public institution policy and procedures.

1. Private Residence or Group Home

An individual who lives in a private residence in the community that is not an institution (it is an establishment that provides food, shelter and some services to *no more than* three persons unrelated to the proprietor) is not living in an institution. A group home that *has a capacity of no more than* three residents is not an institution.

However, the individual may be an inmate of a public institution because he/she is considered incarcerated or a juvenile in detention, as described below. If the individual is considered incarcerated or a juvenile in detention, he/she is not eligible for Medicaid because he does not meet the institutional status eligibility requirement.

2. Private Residential Facility

A resident of any age in a private residential facility meets the institutional status requirement for Medicaid UNLESS the individual is incarcerated, as defined below.

3. Public Residential Facility

A resident of any age in a PUBLIC residential facility meets the institutional status requirement for Medicaid UNLESS:

- the public residential facility has more than 16 beds, or
- the individual is incarcerated or a juvenile in detention as described below.

D. Inmate of a Public Institution

Inmates of public institutions fall into three groups:

- individuals living in public residential facilities;
- incarcerated individuals;
- juveniles in detention.

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M1460 Changes

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UP #9	4/1/13	Table of Contents pages 3, 35, 38, 41, 42, 50, 51
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UP #6	4/1/12	pages 3, 35
TN #96	10/1/11	pages 3, 20, 21
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10. Old Bills

Old bills are unpaid medical, dental, or remedial care expenses which:

- were incurred prior to the Medicaid application month and the application's retroactive period,
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and
- remain a liability to the individual.

EXCEPTION: Bills paid by a state or local program and which meet the definition of "old bills" are treated as old bills even though they are not the individual's liability.

11. Projected Expenses

Expenses for services that have not yet been incurred but are reasonably expected to be incurred are projected expenses.

12. Spenddown Liability

The spenddown liability is the amount by which the individual's countable income exceeds the MNIL for the budget period.

M1460.150 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LTC

A. Applicability

The policy in this section applies to nursing facility and CBC/PACE patients, who meet the requirements for LTC on or after January 1, 2006. This includes individuals who filed reapplications after a break in Medicaid eligibility. It does **not apply** to Medicaid recipients who were approved for LTC prior to January 1, 2006, and who maintain continuous Medicaid eligibility.

For Medicaid applicants or enrollees approved for LTC on or after July 1, 2006, the amount of equity in the home at the time of the initial LTC determination and at each renewal must be evaluated.

B. Policy

Individuals with equity value (tax assessed value minus encumbrances) in home property that exceeds the limit are NOT eligible for Medicaid payment of long-term care services unless the home is occupied by

- a spouse,
- a dependent child under age 21 years, or
- a blind or disabled child of any age.

Individuals with substantial home equity may be eligible for Medicaid payment of other covered services if they meet all the other Medicaid eligibility requirements.

1. Home Equity Limit

The home equity limit applied is based on the date of the application or request for LTC coverage. Effective January 1, 2011, the home equity limit is subject to change annually. The home equity limit is:

- Effective January 1, 2006 through December 31, 2010: \$500,000
- Effective January 1, 2011: \$506,000
- Effective January 1, 2012: \$525,000.
- *Effective January 1, 2013: \$536,000*

6. **Domestic Travel Tickets** Gifts of domestic travel tickets [1612(b)(15)].
7. **Victim's Compensation** Victim's compensation provided by a state.
8. **Tech-related Assistance** Tech-Related Assistance for Individuals with Disabilities [ref. P.L. 100-407].
9. **\$20 General Exclusion** \$20 a month general income exclusion for the unit.
EXCEPTION: Certain veterans (VA) benefits are not subject to the \$20 income exclusion. Refer to subchapter S0830 for complete explanation of which VA payments are entitled to the \$20 general exclusion.
10. **PASS Income** Any unearned income used to fulfill an SSI approved plan to achieve self-support (PASS). See item 12 below for earned income used to fulfill a PASS [1612(b) (4)(A) & (B)].
11. **Earned Income Exclusions** The following earned income exclusions are not deducted for the 300% SSI group:
- a. For 2013, up to \$1,730 per month, but not more than \$6,960 in a calendar year, of the earned income of a blind or disabled student child.

For 2012, up to \$1,700 per month, but not more than \$6,840 in a calendar year, of the earned income of a blind or disabled student child.
 - b. Any portion of the \$20 monthly general income exclusion which has not been excluded from unearned income in that same month [1612(b) (2)(A)].
 - c. \$65 of earned income in a month [1612(b) (4)(C)].
 - d. IRWE - earned income of disabled individuals used to pay impairment-related work expenses [1612(b) (4)(B)].
 - e. One-half of remaining earned income in a month [1612(b) (4)(C)].
 - f. BWE - Earned income of blind individuals used to meet work expenses [1612(b) (4)(A)].
 - g. Earned income used to fulfill an SSI approved plan to achieve self-support (PASS) [1612(b) (4)(A) & (B)].
12. **Child Support** Child support payments received from an absent parent for a blind or Disabled child [1612(b) (9)].

Income for all LTC recipients is determined on a monthly basis. Upon receipt of long term care services, the spenddown budget period is one month. A separate monthly spenddown budget period is established for each month of receipt of LTC services.

A spenddown case is considered denied; however, the application is valid for a certification period of 12 months from the last application or redetermination.

B. Spenddown Procedures

The spenddown procedures for facility patients differ from the spenddown procedures for CBC patients. The expected monthly cost of the facility care is projected at the beginning of the month. The cost of CBC is NOT projected and must be deducted daily as incurred. Specific instructions for determining MN income eligibility for facility and CBC patients are provided in the following sections:

- M1460.710 Spenddown For Facility Patients
- M1460.740 Spenddown For Patients Receiving CBC
- M1460.750 *Medically Needy* Spenddown Enrollment and Post-eligibility Procedures.

M1460.710 SPENDDOWN FOR FACILITY PATIENTS

A. Policy

Facility patients in the MN classification fall into two distinct subgroups for the purpose of spenddown eligibility determination. These subgroups are:

1. individuals with a spenddown liability less than or equal to the monthly Medicaid rate for the facility.
2. individuals with a spenddown liability greater than the monthly Medicaid rate for the facility.

Entitlement and enrollment procedures depend on whether the individual's spenddown liability is less than, equal to or greater than the facility's Medicaid rate.

Applications for individuals who are placed on spenddown are valid for a 12 month period and the cases are subject to annual redetermination.

B. Determine the Spenddown Liability

Calculate the individual's monthly MN income:

1.
 - a. Start with the gross monthly income for the ABD MN income determination found in section M1460.640 B. 4.
 - b. Subtract the applicable ABD MN income exclusions. The result is the MN countable income.

**2. F&C MN
Groups**

- c. Subtract the monthly MN income limit for 1 person in the individual's home locality from the MN monthly countable income. The remainder is the ABD individual's spenddown liability.
- a. Start with the gross monthly income for the F&C MN income determination found in section M1460.640 B. 4.
- b. If the unit has earned income, subtract the F&C earned income exclusions in M0720.500 except for the 30 + 1/3 exclusion which is not applicable to this group.

If the Unit has child support income, subtract the \$50 child support exclusion. See section M0730.400.

- c. The remainder is the MN monthly countable income.
- d. Subtract the monthly MN income limit appropriate to the individual's home locality from the MN monthly countable income. The remainder is the F&C individual's spenddown liability.

**C. Determine the
Facility's
Projected
Medicaid Rate**

The facility's projected Medicaid rate is the Medicaid per diem multiplied by 31 days. For the month of entry, use the actual number of days that care was received or is projected to be received in the facility.

D. Compare

Compare the individual's spenddown liability to the facility's Medicaid rate.

**E. SD Liability Is
Less Than or
Equal To
Medicaid Rate**

If the spenddown liability is less than or equal to the facility's Medicaid rate, the individual is income eligible as medically needy for the full month. Individuals with a spenddown liability less than or equal to the Medicaid rate will meet their spenddown based on the Medicaid rate alone. The Medicaid rate is projected and compared to the spenddown liability. Because the spenddown liability is less than the monthly Medicaid rate, eligibility begins the first day of the month.

Go to section M1460.750 below for enrollment procedures.

**F. SD Liability Is
Greater Than
Medicaid Rate**

If the spenddown liability is greater than the facility's Medicaid rate, the individual is NOT income eligible as MN. The individual must incur medical expenses, including old bills, carry-over expenses and the facility's cost of care at the private rate, that equal or exceed the spenddown liability for the month. These determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred.

To determine spenddown eligibility for a medically needy individual whose spenddown liability is greater than the Medicaid rate, go to G. below.

Her May application is denied and she is placed on a monthly spenddown for the certification period of May 1, 2000 through April 30, 2001.

On June 3, she submits verification of expenses for May. In May, she received CBC services from one provider for 28 days, 6 hours per day, 7 days per week, at the private hourly rate of \$10. The private cost of care for May is calculated:

\$ 10	per hour private rate
<u>x 6</u>	hours per day, 7 days a week
\$ 60	private per diem cost
<u>x 28</u>	days received services in May
\$1,680	private cost of care

The private cost of care, \$1,680, is more than her spenddown liability of \$1,295.33. Therefore, she is eligible for the period 5-1-2000 through 5-31-2000.

M1460.750 MEDICALLY NEEDY ENROLLMENT AND POST-ELIGIBILITY PROCEDURES

A. AC

1. Individual Does Not Have Medicare Part A

If the individual does Not have Medicare Part A, use the appropriate MN AC:

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

2. Individual Has Medicare Part A

If the individual has Medicare Part A, compare the individual's monthly MN countable income to the QMB and SLMB monthly income limits for 1 person (see section M0810.002 for the current *income* limits):

a. Enroll the individual in one of the following ACs when he is ABD MN and QMB or SLMB:

- 028 for an aged individual also QMB;
- 048 for a blind individual also QMB;
- 068 for a disabled individual also QMB;
- 024 for an aged individual also SLMB;
- 044 for a blind or disabled individual also SLMB

b. The following ACs are used when income is greater than the QMB and SLMB limits:

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

B. Patient Pay Determine patient pay according to subchapter M1470.

C. MN Post-eligibility Requirements

1. Spenddown Liability Less Than or Equal to Medicaid Rate

When the individual's spenddown liability is less than or equal to the 31-day Medicaid rate for the facility, the individual has ongoing eligibility for the 12-month certification period. The individual must file a redetermination after the 12-month certification period ends.

2. Spenddown Liability Greater Than Medicaid Rate

When the individual's spenddown liability exceeds the facility's Medicaid rate and the spenddown is met, the individual does NOT have ongoing eligibility. Therefore, the individual will need to submit monthly reports of actual expenses and changes in income and resources so that spenddown eligibility can be determined each month. This report, "Medical Expense Record - Medicaid" (form # 032-03-023) is found in subchapter M1330, Appendix 1. Instructions for use and completion are also in subchapter M1330, Appendix 1.

The notification to the applicant (and his representative) approving the application with spenddown must include a copy of the "Medical Expense Record - Medicaid" for the individual to use to provide verification of the expenses used to meet the spenddown.

a. When Spenddown Liability is Met

When expenses have been incurred, the individual must submit the "Medical Expense Record - Medicaid" with bills or receipts for medical services either paid or incurred, and evidence of third party payment or denial of payment if applicable. Entitlement begins the first day of the month in which the spenddown is met, and ends on the last day of the month.

Appropriate notice of action must be sent to the applicant every time spenddown eligibility is evaluated. After eligibility is established, the usual reporting and notification processes apply. The individual must provide verification of income and resources for any month for which bills are presented.

b. Certification Period

The certification period is 12 months; therefore, a new application is not required each month. However, the applicant must file a redetermination for Medicaid when the 12-month certification period ends. If the redetermination is not filed, the individual's Medicaid must be canceled, the case must be closed and the individual will have to file a new application.

M1470 Changes

Changed With	Effective Date	Pages Changed
UP #9	4/1/13	pages 9, 16, 19, 20, 24, 43
UP #7	7/1/12	pages 19, 46-48
UP #6	4/1/12	pages 4, 9, 19, 20, 24, 26
TN #96	10/1/11	pages 3, 4, 7-9, 19, 22-24, 43
TN #95	3/1/11	pages 9, 19, 20, 23
TN #94	9/1/10	Table of Contents pages 1, 1a, 3, 3a, 11, 12, pages 19, 20, 24, 28, 31
TN #93	1/1/10	pages 9, 13, 19-20, 23, 43, 44
TN #91	5/15/09	Table of Contents pages 1-56 Appendix 1

6. Medicare Part D Premiums

The federal government sets a yearly “benchmark” premium for Medicare Part D Prescription Drug Plans (PDP). An individual who is eligible for Medicare and Medicaid is entitled to premium-free enrollment in a Medicare Part D basic prescription drug plan (PDP) with a “benchmark” premium. However, the individual may elect enrollment in a basic plan with a premium above the benchmark or in an enhanced plan, which offers additional benefits.

Individuals who enroll in a higher-premium basic plan or an enhanced plan are responsible for that portion of the premium attributable above the benchmark rate. When a full-benefit Medicaid enrollee is enrolled in a higher-premium PDP, the portion of the premium that remains the individual’s responsibility is an allowable deduction from patient pay.

The benchmark Medicare Part D premium for Virginia for 2013 is \$36.57.

7. LTC Insurance

a. Deduct LTC premium in admission month only

When an individual has an LTC insurance policy, the individual stops paying premiums beginning the month after he is admitted to LTC. The premium paid for the policy in the admission month can be deducted from the admission month’s patient pay only. The LTC insurance premium is not deducted from patient pay for the months following the admission month.

b. LTC insurance benefits

LTC insurance benefits are treated as TPL. If the individual receives the payment from the insurance company, the payment is not income for patient pay or eligibility determinations. The individual should assign it to the nursing facility. If the individual cannot do this, or the policy prohibits assignment, the LTC insurance payment should be given directly to the nursing facility. The facility should report the payment as a third party payment on its claim form.

If the provider is unable to accept payment directly from the individual, the individual must send the insurance payment to:

DMAS Fiscal Division, Accounts Receivable
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

C. Non-covered Medical/Dental Services

Deductions for the cost of a patient’s medically necessary medical or dental services not covered by Medicaid, other insurance (such as Medicare), or another person are subtracted from income to determine patient pay. Some deductions for noncovered services must be approved by DMAS before they can be subtracted from the patient’s income.

Services that are covered by Medicaid in the facility’s per diem rate cannot be deducted from patient pay as a noncovered service. See M1470.230 C.3 for examples of services that are included in the facility per diem rate.

1. Zero Patient Pay Procedures

If deductions from patient pay cannot be allowed because the recipient has no income remaining after deducting the personal needs allowance, dependent child allowance(s) and health insurance premiums, or the recipient has no income available for patient pay, deny the request.

1. **All Covered Groups Except MN Spenddown**

For an individual admitted to a facility (except an individual who meets a spenddown), take the following steps in the order presented, to the extent that income remains:

 - a. Count all income received in the admission month (M1470.100).
 - b. Deduct a personal needs allowance:
 - \$40.00 basic personal needs;
 - additional amount for guardianship fees, if appropriate;
 - additional amount for special earnings allowance, if working.
 - c. Deduct a dependent child allowance, if appropriate (M1470.220).
 - d. Deduct the Medicare premium withheld if the applicant is a Medicare recipient and was not receiving Medicaid prior to admission (see M1470.230).
 - e. Deduct other health insurance premiums, deductibles or co-insurance charges, if appropriate (M1470.230).
 - f. Deduct other allowable noncovered medical expenses, if appropriate (M1470.230).
 - g. Deduct the home maintenance (MNIL) deduction **if appropriate**, if a doctor has certified that the individual is likely to return home within a six-month period (see M1470.240). For recipients who are admitted for a stay that has been for less than 30 days, a physician certification of length of stay is NOT required.
 - h. Any remainder is the patient pay for the month(s).
2. **MN Spenddown Individual in Facility for Less than 30 Days**

For a medically needy individual on a spenddown who is in a facility for less than 30 days, see section M1470.320 B. for procedures.
3. **MN Spenddown Individual In Facility For More Than 30 Days**

For an institutionalized medically needy individual, see Section M1470.600 for procedures.

M1470.320 PATIENT PAY FOR FACILITY STAY OF LESS THAN 30 DAYS

- A. **All Full Coverage Groups Except MN Spenddown**

To determine patient pay for a non-institutionalized individual *with full Medicaid coverage* admitted to a facility for less than 30 days (except an individual who meets a spenddown), use the procedures in subsection M1470.310 B.1 for the admission month and for the subsequent month when the facility stay continues into the month after admission. *Individuals with limited-coverage Medicaid do not have a patient pay since facility care is not covered.*

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:

- Elderly or Disabled with Consumer-Direction (EDCD) Waiver,
- Intellectual Disabilities/Mental Retardation (ID/MR) Waiver, Technology-Assisted Individuals Waiver,
- Individual and Family Developmental Disabilities Support (DD) Waiver , and
- Day Support (DS) Waiver.

The PMA is:

- *January 1, 2013 through December 31, 2013: \$1,171*
- *January 1, 2012 through December 31, 2012: \$1,151*

Contact a Medical Assistance Program Consultant for the PMA in effect for years prior to 2009.

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 EDCD, DD, ID/MR or DS 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 (\$2,130 in 2013) per month.
- b. for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI (\$1,420 in 2013) per month.

4. Example – Special Earnings Allowance (Using January 2009 figures)

A working patient receiving EDCD waiver services is employed 18 hours per week. His income is gross earnings of \$928.80 per month and SSA of \$300 monthly. His special earnings allowance is calculated by comparing his gross earned income (\$928.80) to the 200% of SSI maximum (\$1,348.00). His gross earned income is less than 200% of SSI; therefore, he is entitled to a special earnings allowance. His personal maintenance allowance is computed as follows:

\$ 1,112.00 CBC basic maintenance allowance
+ 928.80 special earnings allowance
\$ 2,040.80 PMA

Because the PMA may not exceed 300% of SSI, the PMA for the patient in this example must be reduced to \$2,022.00.

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 income limit for the number of the patient's dependent children in each home.
- 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.

rate. When a full benefit Medicaid enrollee is enrolled in a higher-premium PDP, the portion of the premium that remains the individual's responsibility is an allowable deduction from patient pay.

The benchmark Medicare Part D premium for Virginia for 2013 is \$36.57.

5. LTC Insurance

a. Deduct LTC premium in admission month only

When an individual has an LTC insurance policy that covers long-term care services received in the home, the individual stops paying premiums beginning the month after he is admitted to the home-based LTC. The premium paid for the policy in the LTC admission month can be deducted from the admission month's patient pay only. The LTC insurance premium is not deducted from patient pay for the months following the admission month.

b. LTC insurance benefits

LTC insurance benefits are treated as TPL. If the individual receives the payment from the insurance company, the payment is not income for patient pay or eligibility determinations. The individual should assign it to the waiver services provider. If the individual cannot do this, or the policy prohibits assignment, the LTC insurance payment should be given directly to the provider. The provider should report the payment as a third party payment on its claim form.

If the provider is unable to accept payment directly from the individual, the individual must send the insurance payment to:

DMAS Fiscal Division, Accounts Receivable
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

C. Noncovered Medical/Dental Services

Deductions for the cost of a patient's medically necessary medical or dental services not covered by Medicaid, other insurance (such as Medicare), or another person are subtracted from income to determine patient pay.

See M1470.430 B.3 for the procedures used to deduct Medicare Part D prescription drug co-pays for patients who have Medicare.

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

1. Zero Patient Pay Procedures

If deductions from patient pay cannot be allowed because the recipient has no income remaining after deducting the personal maintenance allowance, dependent child allowance(s) and health insurance premiums, or the recipient has no income available for patient pay, deny the request.

Notify the patient or the patient's representative using the Notice of Action.

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

Retrospective spenddown eligibility determinations are made monthly after the month has passed and the expenses have actually been incurred. The PACE rate (minus the Medicare Part D premium) along with other allowable medical and dental expenses are deducted daily and chronologically as the expenses are incurred. The individual's income and resources must be verified each month before determining if the spenddown has been met. See M1470.520 for allowable medical deductions.

When incurred medical expenses equal or exceed the monthly spenddown liability, the individual is eligible for the full month of Medicaid coverage beginning the first day of the month and ending the last day of the month.

4. Patient Pay

a. Projected Spenddown Eligibility Determinations

Medicaid must assure that enough of the individual's income is allowed so that he can have a personal maintenance allowance. Therefore, the spenddown liability is NOT subtracted from his gross income nor added to the available income for patient pay.

When the spenddown liability exceeds the monthly PACE rate (minus the Medicare Part D premium), subtract the allowances listed in M1470.400 from gross monthly income, as applicable. Compare the remaining income for patient pay to the monthly PACE rate (minus the Medicare Part D premium) for the month. The patient pay is the lesser of the two amounts.

b. Retrospective Spenddown Eligibility Determinations

Because the spenddown eligibility determination is completed after the month in which the PACE services were received and expenses are not projected, the spenddown liability is NOT added to the available income for patient pay. Follow the instructions in M1470.630 for calculating the spenddown and patient pay when the spenddown liability exceeds the monthly PACE rate (minus the Medicare Part D premium).

M1470.800 COMMUNICATION BETWEEN LOCAL DSS AND LTC PROVIDER

A. Introduction

Certain information related to the individual's eligibility for and receipt of Medicaid LTC services must be communicated between the local agency and the LTC provider. The Medicaid LTC Communication Form (form DMAS-225) is used by both the local agency and LTC providers to exchange information.

B. Purpose

The DMAS-225 is available on SPARK at: http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi. The form is used to:

- notify the LTC provider of a patient's Medicaid eligibility status;
- notify a new provider that the patient pay is available through the verification systems;
- reflect changes in the patient's deductions, such as a medical expense allowance;
- document admission, death or discharge of a patient to an institution or community-based care services;

M1480 Changes

Changed With	Effective Date	Pages Changed
UP #9	4/1/13	pages 7, 18c, 66, 69, 70
UP #8	10/1/12	page 66
TN #97	9/1/12	pages 3, 6, 8b, 16 pages 20-25 Page 20a was deleted.
UP #7	7/1/12	pages 11, 14, 18c, 21 pages 32, 66, 67, 69
UP #6	4/1/12	pages 7, 18c, 66, 68, 69, 70
TN #96	10/1/11	pages 7, 14, 66, 71
UP #5	7/1/11	page 66
TN #95	3/1/11	pages 7-9, 13, 18a, 18c, 66, pages 69, 70
TN #94	9/1/10	pages 64, 66, 69, 70
TN #93	1/1/10	Table of Contents, page ii pages 3, 8b, 18, 18c, 20a pages 21, 50, 51, 66, pages 69, 70, 93 Appendix 4 was removed.
Update (UP) #1	7/1/09	page 66
TN # 91	5/15/09	pages 67, 68 pages 76-93

27. **Spousal Share** means ½ of the couple's combined countable resources at the beginning of the **first** continuous period of institutionalization, as determined by a resource assessment.
28. **Spouse** means a person who is legally married to another person under Virginia law.
29. **Waiver Services** means Medicaid-reimbursed home or community-based services covered under a 1915(c) waiver approved by the Secretary of the United States Department of Health and Human Services.

M1480.015 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LONG-TERM CARE

- A. Applicability** The policy in this section applies to nursing facility and CBC/PACE patients, who meet the requirements for LTC on or after January 1, 2006. This includes individuals who filed reapplications after a break in Medicaid eligibility. It does **not apply** to Medicaid recipients who were approved for LTC prior to January 1, 2006, and who maintain continuous Medicaid eligibility.

For Medicaid applicants or enrollees approved for LTC on or after July 1, 2006, the amount of equity in the home at the time of the initial LTC determination and at each renewal must be evaluated.

- B. Policy** Individuals with equity value (tax assessed value minus encumbrances) in home property that exceeds the limit are NOT eligible for Medicaid payment of long-term care services unless the home is occupied by

- a spouse,
- a dependent child under age 21 years, or
- a blind or disabled child of any age.

Individuals with substantial home equity may be eligible for Medicaid payment of other covered services if they meet all the other Medicaid eligibility requirements.

- 1. Home Equity Limit** The home equity limit applied is based on the date of the application or request for LTC coverage. Effective January 1, 2011, the home equity limit is subject to change annually. The home equity limit is:
- Effective January 1, 2006 through December 31, 2010: \$500,000
 - Effective January 1, 2011: \$506,000
 - Effective January 1, 2012: \$525,000.
 - *Effective January 1, 2013: \$536,000*
- 2. Reverse Mortgages** Reverse mortgages **do not** reduce equity value until the individual begins receiving the reverse mortgage payments from the lender.

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 he reapplies as an institutionalized individual, use only the resources of the institutionalized spouse for his eligibility determination.

C. Institutionalized Spouse Resource Eligibility Worksheet Use the “Institutionalized Spouse Resource Eligibility Worksheet,” available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi, or the electronic Resource Assessment and Eligibility Workbook located at <http://spark.dss.virginia.gov/divisions/bp/me/training/index.cgi>. to determine the institutionalized spouse’s resource eligibility.

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 \$23, 184 1-1-13
 \$22, 728 1-1-12

C. Maximum Spousal Resource Standard \$115, 920 1-1-13
 \$113, 640 1-1-12

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.

After eligibility is established, the usual reporting and notification processes apply. Send the “Notice of Action on Medicaid” for the month(s) during which the individual establishes Medicaid eligibility. MMIS will generate the “Notice of Obligation for LTC Costs” 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 LTC 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 Standard**

\$1,891.25	7-1-12	
\$1,838.75	7-1-11	
- C. Maximum Monthly Maintenance Needs Allowance**

\$2,898.00	1-1-13	
\$2,841.00	1-1-12	
- D. Excess Shelter Standard**

\$567.38	7-1-12	
\$551.63	7-1-11	
- E. Utility Standard Deduction (SNAP)**

\$277	1 - 3 household members	10-1-12
\$348	4 or more household members	10-1-12
\$274	1 - 3 household members	10-1-11
\$345	4 or more household members	10-1-11

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

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

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

His personal needs allowance is calculated as follows:

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

**2. Medicaid CBC
Waiver
Services and
PACE**

a. Basic Maintenance Allowance

For the Elderly or Disabled with Consumer Direction Waiver (EDCD Waiver), Intellectual Disabilities/Mental Retardation (ID/MR) Waiver, Technology-Assisted Individuals Waiver, Individual and Family Developmental Disabilities Support (DD) Waiver, Day Support (DS) Waiver or PACE, deduct the appropriate maintenance allowance for one person as follows:

- *January 1, 2013 through December 31, 2013: \$1,171*
- January 1, 2012 through December 31, 2012: \$1,151.

Contact a Medical Assistance Program Consultant for the amount in effect for years prior to 2010.

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 amounts) for guardianship fees, IF:

- * the patient has a legally appointed guardian 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.

NOTES: 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.

c. Special Earnings Allowance For ED CD, DD, DS and ID/MR Waivers

[EXAMPLE #19 was deleted]

For ED CD, DD, DS and ID/MR 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:

- 1) for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (\$2,130 for 2013) per month.
- 1) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI (\$1,420 for 2013) per month.

The total of the basic maintenance allowance, the guardianship fee and the special earnings allowance cannot exceed 300% SSI.

EXAMPLE #20: (Using January 2000 figures)

A working patient in the ID/MR Waiver is employed 18 hours per week. He has gross earnings of \$928.80 per month and SS of \$300 monthly. His special earnings allowance is calculated first:

\$ 928.80	gross earned income
- <u>1,024.00</u>	200% SSI maximum
\$ 0	remainder

\$928.80 = special earnings allowance

His personal maintenance allowance is calculated as follows:

\$ 512.00	maintenance allowance
+ <u>928.80</u>	special earnings allowance
\$1,440.80	personal maintenance allowance

M1510 Changes

Changed With	Effective Date	Pages Changed
UP #9	4/1/13	pages 2-7, 10-12, 14
UP #7	7/1/12	pages 8, 9
TN #96	10/01/11	pages 8a, 10
TN #95	3/1/11	Table of Contents Pages 8, 11-15
TN #94	9/1/10	pages 2a, 8-8a
TN #93	1/1/10	page 6
Update (UP) #2	8/24/09	page 11
TN #91	5/15/09	page 14

M1510.101 RETROACTIVE ELIGIBILITY & ENTITLEMENT

A. Definitions

- 1. Retroactive Period** The retroactive period is the three months immediately prior to the application month. Within this retroactive period, the individual may be *Categorically Needy* (CN) in one or two months and *Medically Needy* (MN) in the third month, or any other combination of classifications.
- 2. Retroactive Budget Period** The "budget period" is the period of time during which an individual's income is calculated to determine income eligibility. The retroactive budget period depends on the individual's covered group.

B. Policy

An application for Medicaid or Auxiliary Grants (AG) is also an application for retroactive Medicaid coverage whenever the applicant reports that he/she received a Medicaid-covered service in retroactive period. Eligibility for retroactive coverage is determined at the same time as the ongoing eligibility is determined, using the same application.

When an applicant reports that he/she, or anyone for whom he/she is applying, received a Medicaid covered service in any one of the three retroactive months, determine the applicant's eligibility for all three retroactive months, regardless of the service date. Determine nonfinancial, resource and income eligibility for each month in the retroactive period.

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.

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; 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.

**1. Excess Income
In One or More
Retroactive
Months**

When an applicant has excess income in one or more of the retroactive months, he must verify that he met the nonfinancial and resource requirements in the month(s). He must verify the income he received in **all 3** retroactive months in order to determine his MN income or spenddown eligibility in the retroactive month(s).

If he fails to verify income in all three months, he **CANNOT** be eligible as MN in the retroactive period. His application for the retroactive months in which excess income existed must be denied because of failure to provide income verification for that month(s). However, coverage for the retroactive month(s) in which he was eligible as CN must be approved.

EXAMPLE #2: (Using July 2006 figures)

A parent of a child under age 19 applies for Medicaid in April. She requests retroactive coverage for the child's medical bills incurred in January, February and March, including a hospital stay in February. She also has unpaid medical bills (old bills) from December. The retroactive period is January - March.

The eligibility worker determines that the child met all the Medicaid nonfinancial requirements in the retroactive period, and that the countable income of \$3,250 per month in January and February exceeded the F&C, CN and the MN income limits. The income of \$800 starting March 1 is within the F&C CN income limit. The parent verifies that the resources in January, February were within the MN resource limit, but does not verify the March resources because the income is within the CN income limits.

The application is approved for retroactive coverage as CN beginning March 1 and for ongoing coverage beginning April 1. The child's spenddown liability is calculated for January and February. The eligibility worker deducts the old bills and the incurred medical expenses, and a spenddown liability remains. The retroactive Medicaid coverage is denied for January and February because the spenddown was not met.

**2. Excess Income
In All 3
Retroactive
Months**

When excess income existed in all classifications in all 3 retroactive months, the applicant must verify that he met all eligibility requirements in all 3 months. If he fails to verify nonfinancial, resource or income eligibility in any of the retroactive months, the retroactive period cannot be shortened and he **CANNOT** be placed on a retroactive spenddown. His application for retroactive coverage must be denied because of excess income and failure to provide eligibility verification for the retroactive period.

EXAMPLE #3: (Using July 2006 figures)

A parent of a child under age 19 applies for Medicaid in April. She requests retroactive coverage for the child's medical bills incurred in January, February and March, including a hospital stay in March. The retroactive period is January – March.

The worker verifies that the child met all the Medicaid nonfinancial requirements in the retroactive period, and that their countable income of \$3,250 in January, February and March exceeded the F&C *CN* and the MN income limits. The worker verifies that their resources in January and February were within the MN resource limits, but is unable to verify the resources for March.

The application is denied for retroactive coverage as *CN* Medicaid because of excess income and denied for MN spenddown because of failure to provide resource verification for all months in the retroactive period.

E. Disabled Applicants

If the applicant was not eligible for SS or SSI disability benefits during the retroactive period and the recipient alleges he/she was disabled during the retroactive period, follow the procedures in M0310.112 for obtaining an earlier disability onset date.

F. Excess Resources in Retroactive Period

If the applicant had excess resources during part of the retroactive period, retroactive resource eligibility exists only in the month(s) during which the resources were at or below the limit at any time within the month. The applicant's eligibility must be denied for the month(s) during which excess resources existed during the entire month.

EXAMPLE #4: (Using July 2006 figures)

Mr. A applied for Medicaid for himself on July 8. He reported receiving a Medicaid covered service in each retroactive month; no hospital service was received. The retroactive period is April 1 through June 30. He currently receives SS disability benefits of \$1500 per month and received SS disability of \$1500 monthly during the retroactive period. He is not eligible for Medicare Part A. His verified resources exceeded the MN limit in April and part of May; the resources were reduced to below the MN limit on May 20. He met the retroactive spenddown on April 5. His application was approved for retroactive MN coverage beginning May 1, and April coverage was denied because of excess resources.

G. Income Determination

Countable income for the applicant's unit is that income which was actually received in the three months prior to the application month.

1. Monthly Determination for CN

When an individual in the family unit meets a *CN* covered group, compare each month's countable income to the appropriate *CN* income limit for the month. When the countable income is within the *CN* income limit in the month, the *CN* individual meets the income eligibility requirement for that retroactive month. Enroll the eligible *CN* unit member(s) **for that month(s) only**, using the appropriate *CN* covered group program designation.

2. MN

When the family unit's countable income exceeds the *CN* income limit in one or more of the retroactive months, and all other

1. **Applicant Has Excess Income** When all eligibility requirements are met except for income, entitlement begins the date the spenddown is met. Only medically needy applicants can be eligible after meeting a spenddown. See subchapter M1330 to determine retroactive spenddown eligibility.
2. **QMB Applicant** Entitlement to Medicaid for a medically indigent Qualified Medicare Beneficiary (QMB) begins the first day of the month **following** the month in which the individual's QMB eligibility is determined.
3. **SLMB and QDWI** Ongoing entitlement for the Special Low Income Medicare Beneficiary (SLMB) and the Qualified Disabled and Working Individuals (QDWI) covered groups is the first day of the application month when all eligibility factors are met at any time in the month of application.
4. **Applicant Age 21-64 Is Admitted To Ineligible Institution** An applicant who is age 21-64 years and who is admitted to an IMD or other ineligible institution (such as a jail) in a month is NOT eligible for Medicaid while he is a patient in the IMD (or is residing in the ineligible institution). If otherwise eligible for Medicaid in the application month, his entitlement to Medicaid begins the date he is discharged from the ineligible institution in the month.

EXAMPLE #6: Mr. A is a 50 year old man who applies for Medicaid at his local agency on October 1, 2006. He receives Social Security disability benefits. He was admitted to Central State Hospital (an IMD) on October 20, 2006, and was discharged on November 2, 2006, back to his home locality. The agency completes the Medicaid determination on November 5 and finds that he is eligible for Medicaid in October 2006 and ongoing, except for the period of time he was in Central State Hospital.

The worker enrolls him in Medicaid for a closed period of coverage beginning October 1, 2006, and ending October 20, 2006. The worker also enrolls him in an ongoing period of Medicaid coverage beginning November 2, 2006.

5. **Applications From CSBs For IMD Patients Ages 21-64 Years** A patient who is age 21 years or older but is less than 65 years and who is in an institution for treatment of mental diseases (IMD) is not eligible for Medicaid while in the IMD. Local agencies will take the **applications received from the CSBs** for Department of Behavioral Health and Developmental Services (DBHDS) IMD patients who will be discharged within 30 days and process the applications within the established time frames. Eligibility will be determined based on the type of living arrangement to which the patient will be discharged. If eligible, do not enroll the patient until the date the patient is discharged from the IMD.

If the patient is discharged from the facility and the patient meets all eligibility factors, the agency will enroll the patient effective the date of discharge.

EXAMPLE #6a: Mr. A is a 50 year old patient at Central State Hospital (an IMD). He receives Social Security disability benefits. The CSB sends

his local agency a Medicaid application which is received on August 18. The facility's statement notes that he will be discharged on September 17 to ABC Nursing Home, a nursing facility. The agency completes the determination on August 27 and finds that he will be eligible once he is discharged to the nursing facility.

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

B. Coverage End Date

Medicaid entitlement ends the last day of the month in which the recipient fails to meet all of the Medicaid eligibility requirements, unless the recipient is a *CN* pregnant woman or is age 21-64 and admitted to an IMD or other ineligible institution (see below).

Medicaid coverage is canceled on the last day of the month in which the agency determines that the recipient no longer meets the eligibility requirements IF the agency can send an advance notice to the recipient at least 11 days before the last day of the month. If the agency cannot send the notice at least 11 days before the end of the month, coverage is canceled effective the last day of the next month.

1. *CN* Pregnant Woman

For an eligible *CN* pregnant woman, entitlement to Medicaid continues after eligibility is established regardless of any changes in family income, as long as she meets the pregnant category (during pregnancy and the 60-day period following the end of pregnancy) and all other non-financial criteria.

2. Individual Age 21-64 Admitted to Ineligible Institution

a. Entitlement - applicants

For a Medicaid enrollee age 21-64 years, entitlement to Medicaid begins on the first day of the application month and ends on the date following the date he is admitted to an IMD or other ineligible institution. When enrolling the individual in the MMIS, enter the begin date and the end date of coverage.

b. Cancel procedures for ongoing enrollees

Cancel coverage as soon as possible after learning of the enrollee's admission to an ineligible institution. **DO NOT cancel coverage retroactively.** Cancel coverage in the MMIS effective the current date (date the worker enters the cancel transaction in MMIS), using cancel reason code "008."

c. Notice

An Advance Notice of Proposed Action is not required. Send a Notice of Action to the enrollee or his authorized representative informing him of the cancel date and the reason.

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

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

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

When the application was filed by the applicant's authorized representative, a copy of the notification must be mailed to the applicant's authorized representative.

1. CN Children or Pregnant Women

When the application of a medically indigent child or pregnant woman is denied because of excess income, the denial notice ("Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs ") must state the reason for denial. The notice must also include the resource questions pages from the "Application For Benefits" form or the form "Eligibility Review Part B," and must advise the applicant of the following:

- a. that he/she may complete and return the enclosed form for a Medicaid spenddown to be evaluated, and
- b. if the information is returned within 10 days of this notice, the medically indigent application date will be used as the Medicaid spenddown application date.

2. Qualified Medicare Beneficiaries

a. Excess resources

When a Qualified Medicare Beneficiary's (QMB's) application for *full benefit* Medicaid coverage is denied because of excess resources, the denial notice must state that the applicant is not eligible for *full Medicaid coverage* because of excess resources.

b. Excess income

- 1) If the QMB's resources are within the *Medicare Savings Program (MSP)* limit but are over the MN limit, and the income exceeds the limit for *full Medicaid coverage*, the notice must state that the applicant is not eligible for QMB Medicaid because of excess income, and is not eligible for

MN spenddown because of excess resources. The notice must specify the dollar amount of the appropriate MN resource limit.

2) If the QMB's resources are within the MN income limit, and income exceeds the limit *for full Medicaid coverage*, the notice must state that the applicant is not eligible for full-benefit Medicaid because of excess income, but that the applicant can become eligible by incurring medical or dental expenses that equal or exceed his excess income. The notice must specify the spenddown amount, the spenddown period begin and end dates, and include a copy of the Spenddown Fact Sheet.

3. Retroactive Entitlement Only or Limited Period of Entitlement

There are instances when an applicant is not eligible for ongoing Medicaid coverage but is eligible for retroactive benefits, or when a change in the applicant's situation during the application process results in the applicant being eligible for only a limited period of time. Only one "Notice of Action on Medicaid and FAMIS" (Form 032-03-008) is sent to the applicant covering both actions. The begin and end dates of Medicaid coverage and the reason(s) for ineligibility must be included on this notice.

4. Example #7 Limited Period of Entitlement

A Medicaid application was filed on December 30. The client inherited real property on January 30. The agency processed the application on February 5 and determined the client was eligible for Medicaid for the months of December and January, but was ineligible for additional coverage beginning February because the countable value of the inheritance caused excess resources. One notice is sent to the applicant stating that his Medicaid application was approved beginning December 1 and ending January 31, and that he was denied coverage after January 31 because of excess resources (real property).

M1510.300 FOLLOW-UP RESPONSIBILITIES

M1510.301 THIRD PARTY LIABILITY (TPL)

A. Introduction

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

B. Private Health Insurance

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

Health insurance policy or coverage changes must be updated in the eligibility record and the MMIS TPL file.

1. Verification Required - Policy or Coverage Termination

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

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

2. HIPP

If an applicant or enrollee reports that he or a family member is employed more than 30 hours each week and is eligible for health insurance coverage under an employer's group health plan, he or she must be given a HIPP Fact Sheet which provides a brief description of the program and the contact information for the HIPP Unit at DMAS. The HIPP Fact Sheet is available on-line at: <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>.

Changes to TPL coverage in MMIS for HIPP participants can only be made by the HIPP Unit at DMAS. Call the HIPP Unit at 1-800-432-5924 when changes to the TPL information in MMIS are needed.

C. Medicare

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

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

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

1. Buy-In Procedure

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

2. Medicare Claim Numbers

Only two types of claim numbers correctly identify an individual's entitlement to Medicare coverage: a Social Security claim number or a Railroad Retirement claim number.

4. Buy-in Begin Date

Some individuals have a delay in Buy-in coverage:

Classifications	Buy-in Begin Date
SSI and AG recipients (includes dually-eligible)	1st month of eligibility
CN and MN who are dually-eligible (countable income < 100% FPL and Medicare Part A)	1st month of eligibility
CN and MN who are not dually-eligible (countable income > 100% FPL or no Medicare Part A)	3 rd month of eligibility

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

D. Other Third Party Liability

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

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

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

E. Pursuing Third Party Liability and Medical Support

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

M1510.302 SOCIAL SECURITY NUMBERS

A. Policy

Applicants must provide the Social Security number (SSN) of any person for whom they request Medicaid, or must apply for a Social Security number if he/she does not have one. An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

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

B. Procedures

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

M1520 Changes

Changed With	Effective Date	Pages Changed
UP #9	4/1/13	pages 7b and 10a
TN #97	9/1/12	page 1
UP #7	7/1/12	pages 1, 7, 7c, 7g
TN #96	10/1/11	Table of Contents pages 1-7g pages 11-13 pages 21-24
TN #95	3/1/11	pages 6a, 7, 21, 22
TN #94	9/1/10	Table of Contents pages 3, 4b, 5, 6-6a, 10 Appendix 1 was removed.
UP #4	7/1/10	page 4
TN #93	1/1/10	pages 3, 4b, 5-6, 10, 15 pages 21, 22
Update (UP) #2	8/24/09	pages 1, 2, 13, 14, 17, 18
Update (UP) #1	7/01/09	page 3

c. Renewal Using a Paper Form

If ongoing eligibility cannot be established through an ex parte renewal and a telephone renewal interview is not feasible, the agency must provide the individual the opportunity to present additional or new information on a paper renewal form and to present verifications necessary to determine ongoing eligibility. The procedures for completing a renewal when a paper form is used are in section M1520.200 D, below.

The following Medicaid renewal forms are available on SPARK at <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>:

- The Families & Children Medicaid and FAMIS Plus Renewal Form (#032-03-0187);
- The ABD Medicaid Renewal Form (#032-03-0186) ;
- The BCCPTA Redetermination Form (#032-03-0653), for woman enrolled in the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) covered group.
- The Medicaid Application/Redetermination for Long-Term Care (#032-03-0369), available at: http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi, for individuals receiving LTC services;
- The Eligibility Review Part A (#032-03-729A) and Eligibility Review Part B (#032-03-729B) for individuals required to complete them for another benefit program.

B. Ex Parte Renewal Process

Local departments of social services are **required** to conduct renewals of ongoing Medicaid eligibility through the ex parte renewal process when:

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

1. F&C Ex Parte Renewal Procedures

a. Use Available Information

The agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family, and must make efforts to align renewal dates for all programs. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information, information from SSA through SVES or SOLQ-I and information from child support and child care files.

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

**2. Reason "012"
Cancellations**

Cancel actions done by DMAS staff or MMIS are reported in the monthly *System Cancellation Report (RS-O-112)* available on SPARK at: <https://securelocal.dss.virginia.gov/reports/benefits/vammis/index.cgi>. The report is issued between the 21st and 25th day of each month and is to be monitored so that appropriate follow up may be made.

When information is received from DMAS that a case is canceled for cancel reason "012", the local social services department must determine if the cancellation is valid. When cancellation is not valid, the case must be re-enrolled immediately.

When the cancellation is valid, the local department must mail the individual an adequate notice of cancellation using the NOA. Adequate notice consists of specifying the date the cancel action took place, which is the date the notice is mailed, in the section marked "Other" on the notification form.

M1520.403 ENROLLEE REQUESTS CANCELLATION

A. Introduction

An enrollee may request cancellation of his and/or his children's medical assistance coverage at any time. The request can be verbal or written.

B. Written Request

A written withdrawal request must be placed in the case record.

C. Verbal Request

A verbal request for withdrawal can be accepted only from the enrollee or case head, or his authorized representative. A verbal request must be documented in the case record with the date and time the withdrawal request was received, the name of the person who made the withdrawal request, and the signature and title of the agency staff person who took the call.

D. Worker Action

When the enrollee requests cancellation of Medicaid, the local department must send a **Notice of Action** to the enrollee no later than the effective date of cancellation. Advance notice is not required when the enrollee requests cancellation.

**E. Notice
Requirements**

On the notice:

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

Cancel Medicaid coverage in MMIS using the cancel reason code "004."

M1550 Transmittal Changes

Changed With	Effective Date	Pages Changed
UP #9	4/1/13	Appendix 1, page 1
Update (UP) #7	7/1/12	Appendix 1, page 1
TN #96	10/1/11	Appendix 1, page 1
TN #93	1/1/10	Title page Table of Contents pages 1-9 Appendix 1, page 1
TN #91	5/15/09	Appendix 1

**DBHDS Facilities
Medicaid Technicians**

NAME	LOCATION	WORK TELEPHONE	CASELOAD
Mary Lou Spiggle <i>Acting Supervisor</i> (T003)	Central Virginia Training Center Medicaid Office Madison Heights, VA <i>Mail To:</i> P. O. Box 1098 Lynchburg, VA 24505- 1098	434-947-6256 FAX-434-947-2114	<i>CVTC-caseload-all PGH/VCBR-caseload-all NVMHI-caseload-all SVMHI-caseload-all WSH-caseload-all</i>
<i>Vacant</i> (T006)			
<i>Vacant</i> (T002)			
Frances Jones (T004)	Southwestern Virginia Mental Health Institute <i>Medicaid Office</i> 340 Bagley Circle Marion, VA 24354	276-783-0841 FAX-276-782-9732	<i>ESH-caseload-all NVTC-caseload-all SWVTC-caseload-all</i>
Vickie Simmons (T005)	Southwestern Virginia Mental Health Institute <i>Medicaid Office</i> 340 Bagley Circle Marion, VA 24354	276-783-0842 FAX-276-782-9732	<i>Catawba-caseload-all Hiram-Davis-caseload-all SEVTC-caseload-all SSVTC-caseload-all SWVMHI-caseload-all</i>

NOTE: Because the Medicaid Technicians handle various hospitals in their caseloads, LDSS staff should send transferred case records directly to the Medicaid Technician who requested the case record. In the case record transfer request, the Medicaid Technician will give specific instructions about where to send the case record.

DBHDS Facilities:

FIPS	Facility Initials and Full Name
997	Catawba – Catawba Hospital
990	CVTC – Central Virginia Training Center
994	ESH – Eastern State Hospital
988	NVMHI – Northern Virginia Mental Health Institute
986	NVTC – Northern Virginia Training Center
993	PGH/VCBR – Piedmont Geriatric Hospital/Virginia Center for Behavioral Rehabilitation
985	SEVTC – Southeastern Virginia Training Center
989	SSVTC – Southside Virginia Training Center
983	SVMHI – Southern Virginia Mental Health Institute
992	SWVMHI – Southwestern Virginia Mental Health Institute
984	SWVTC – Southwestern Virginia Training Center
991	WSH – Western State Hospital
996	HDMC-Hiram Davis Medical Center

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M16 Changes

Changed With	Effective Date	Pages Changed
Update #9	4/1/13	page 8

- 1. Opportunity to Examine Documents** The appellant or his representative must be given the opportunity to examine all documents and records to be used at the hearing, at a time before the hearing or during the hearing. Copies of case record information must be made available free of charge to the appellant at his request.

B. Hearing Officer Evaluation and Decision

- 1. Evaluation** Following the hearing, the Hearing Officer prepares a decision taking into account the summary prepared by the agency or medical provider involved, evidence provided by the appellant or his representative, and additional information provided by the agency. The Hearing Officer evaluates all evidence, researches laws, regulations and policy, and decides on the accuracy of the agency's action.

- 2. Hearing Officer Decision** Examples of the Hearing Officer's decisions include, but are not limited to:

a. Sustain

When the Hearing Officer's decision upholds the agency's action, the decision is "sustained."

b. Reverse

When the Hearing Officer's decision overturns the agency's action, the decision is "reversed."

c. Remand

When The Hearing Officer sends the case back to the agency for additional evaluation, the decision is "remanded." The Hearing Officer's decision will include instructions that must be followed when completing the remand evaluation.

- 3. Failure to Provide Requested Information** If the local department of social services denies an application *or terminates coverage* because of failure to provide requested information, *the hearing officer can hold the hearing open for a period of time to allow the appellant to submit additional information.* The hearing will address:

- whether or not the applicant was given appropriate notification of what was needed for the eligibility determination; and
- whether or not the applicant was given sufficient time to submit the information requested.

a. Sustained

If the local department of social services followed correct procedures (see M0130.200) and the applicant brings the requested information to the hearing, the action of the local department of social services will be sustained and the applicant will be required to file a new application.

M18 Changes

Changed With	Effective Date	Pages Changed
UP #9	4/1/13	page 3
UP #7	7/1/12	page 12
TN #96	10/01/11	pages 3, 4, 16
TN #95	3/1/11	page 9
TN #94	9/1/10	page 12
TN #93	1/1/10	pages 4, 5
TN #91	5/15/09	page 2 pages 5, 6 page 8

1. Provider Enrollment

In instances where an out-of-state provider is not currently enrolled as a DMAS provider, DMAS will accept the provider's initial billing and will contact the provider to determine the provider's wish to become enrolled so that subsequent services can be paid through the computerized Medicaid claims processing system.

M1830.100 MANAGED CARE**A. General Information**

Most Virginia Medicaid enrollees are required to receive medical care through *Medicaid's* managed care program. Medallion II is a program that requires mandatory enrollment into a contracted Managed Care Organization (MCO) for certain groups of Medicaid enrollees. Enrollment in managed care is based on information provided by the eligibility worker to the Medicaid Management Information System (MMIS) during Medicaid enrollment.

B. Enrollees Exempt from Managed Care**General**

The following enrollees are not required to enroll in a managed care program and may seek medical care from any provider enrolled by DMAS as eligible to receive payment:

- children in Residential Treatment Facility programs;
- inpatients in State mental hospitals, including but not limited to:
 - Central State Hospital,
 - Eastern State Hospital,
 - Western State Hospital,
 - Hiram W. Davis Medical Center,
 - Northern Virginia Mental Health Institute,
 - Southern Virginia Mental Health Institute,
 - Southwestern Virginia Mental Health Institute, and
 - The Commonwealth Center for Children and Adolescents (formerly known as the DeJarnette Center);
- inpatients in long-stay hospitals, nursing facilities, and intermediate care facilities for the mentally retarded (ICF-MR);
- enrollees approved for or receiving Medicaid community-based care services under the Technology Assisted Waiver;

M21 Changes

Changed With	Effective Date	Pages Changed
UP #9	4/1/13	Appendix 1
UP #8	10/1/12	Table of Contents Pages 2-4 Appendix 3 deleted
TN #97	9/1/12	pages 3, 4
UP #7	7/1/12	pages 3, 4 Appendix 2, pages 1 Appendix 3, pages 1 and 2
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	pages 3, 8
TN #95	3/1/11	Table of Contents pages 5, 6, 14, 15, page 16 added Appendix 1
TN #94	9/1/10	page3 Appendix 3, pages 1 and 2
UP #3	3/1/10	pages 2-5
TN #93	1/1/10	page 2-4, 8
Update (UP) #2	8/24/09	page 4

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

EFFECTIVE 1/24/13

# of Persons in FAMIS Assistance Unit	FAMIS 150% FPL		FAMIS 200% FPL	
	Annual Limit	Monthly Limit	Annual Limit	Monthly Limit
1	\$17,235	\$1,437	\$22,980	\$1,915
2	23,265	1,939	31,020	2,585
3	29,295	2,442	39,060	3,255
4	35,325	2,944	47,100	3,925
5	41,355	3,447	55,140	4,595
6	47,385	3,949	63,180	5,265
7	53,415	4,452	71,220	5,935
8	59,445	4,954	79,260	6,605
Each additional, add	6,030	503	8,040	670

M22 Changes

Changed With	Effective Date	Pages Changed
UP #9	4/1/13	Appendix 1
UP #8	10/1/12	pages 2, 3 page 3a deleted
UP #7	7/1/12	pages 2, 3
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	pages 3, 3a
TN #95	3/1/11	pages 4-6 Appendix 1
UP #4	7/1/10	page 10
TN #94	9/1/10	page 3
UP #3	3/01/10	page 2
TN #93	1/1/10	pages 2-10
UP #2	8/24/09	page 3
Update (UP) #1	7/1/09	pages 1, 2, 7 Appendix 1, page 1

FAMIS MOMS INCOME LIMITS ALL LOCALITIES		
EFFECTIVE 1/24/13		
# of Persons in FAMIS MOMS Assistance Unit	FAMIS MOMS 200% FPL	
	Annual Limit	Monthly Limit
2	<i>\$31,020</i>	<i>\$2,585</i>
3	<i>39,060</i>	<i>3,255</i>
4	<i>47,100</i>	<i>3,925</i>
5	<i>55,140</i>	<i>4,595</i>
6	<i>63,180</i>	<i>5,265</i>
7	<i>71,220</i>	<i>5,935</i>
8	<i>79,260</i>	<i>6,605</i>
Each additional, add	<i>8,040</i>	<i>670</i>