

July 1, 2012

MEDICAID MANUAL – VOLUME XIII

POLICY UPDATE #7

The following acronyms are used in this update:

- ABD – Aged, Blind or Disabled
- ADAPT – Application/Benefit Delivery Automation Project
- AIDS – Acquired Immunodeficiency Syndrome
- DMAS – Department of Medical Assistance Services
- EDCD – Elderly or Disabled with Consumer Direction
- F&C – Families and Children
- FAMIS – Family Access to Medical Insurance Security
- LIFC – Low Income Families with Children
- LTC – Long-term Care
- MN – Medically Needy
- PACE – Program for All-inclusive Care for the Elderly
- PRTF – Psychiatric Residential Treatment Facility
- QI – Qualified Individuals
- RAU – Recipient Audit Unit
- SLH – State and Local Hospitalization
- SPARK – Services Programs Answers Resources Knowledge
- SSA – Social Security Administration
- UP - Update
- VDSS – Virginia Department of Social Services

Medicaid Update #7 contains significant revisions to the alien status policies for pregnant women and children, as well as several clarifications and updates to the Medicaid Eligibility Manual. Changes are effective with coverage on or after July 1, 2012.

Lawfully Residing Non-citizen Pregnant Children Under Age 19 and Children

Effective July 1, 2012, all lawfully residing non-citizen children under age 19 and pregnant women meet the alien status requirement for full coverage under Medicaid, FAMIS and FAMIS MOMS. The same policy previously in place for lawfully residing non-citizen children under age 19 under Medicaid will apply to lawfully residing children under FAMIS, as well as to pregnant women under Medicaid and FAMIS MOMS. The definition of lawfully residing children and pregnant women has also been expanded to include certain non-immigrant individuals with special protected status. Because all programs will follow the same alien status policies, children and pregnant women are to be enrolled in the appropriate program based on their income. The policy changes are contained in subchapter M0220 and Chapters 21 and 22.

Effective July 1, 2012, the AIDS Waiver expired, and the references to this waiver were removed from the Medicaid Eligibility Manual in UP #7. Individuals receiving services under the AIDS Waiver as of June 30, 2012 were offered the opportunity to be enrolled in the EDCD Waiver or PACE or admission to a Medicaid-participating nursing facility. Because the personal maintenance allowance for individuals receiving services under the AIDS Waiver was greater than the allowance for other LTC, patients transitioning from the AIDS Waiver into other LTC arrangements will need a recalculation in their patient pay. Broadcast 7473 contains additional information about the expiration of the AIDS Waiver.

UP #7 also contains clarifications to Plan First evaluation policy for children under 19 years and adults age 65 years and older posted in Broadcast 7291, as well as the clarifications to the DMAS RAU referral process posted in Broadcast 7373.

UP #7 contains the new LIFC, F&C and MN income limits and LTC spousal standards. The new income limits contained in UP #7 are effective for coverage on or after July 1, 2012. The updated LTC spousal standards are effective beginning with July 2012 patient pays. UP #7 also contains other minor clarifications and corrections, as described below.

Medicaid Policy Update #7 is available electronically on SPARK and the VDSS public web site. The electronic version is the transmittal of record. Changes to the manual are as follows:

Pages Changed	Significant Changes
M0110 pages 3, 6a, 7, 8	On page 3, clarified the information that LDDS staff can and cannot share with providers and their contractors. On page 6a, clarified the definition of an authorized representative. On page 7, clarified that when the individual's rights and responsibilities are explained orally, the case record must be documented with the individual's acknowledgment. On page 8, the reference to the obsolete <i>Benefit Programs Booklet</i> was updated to the current brochure, <i>Virginia Department of Social Services Division of Benefit Programs</i> .
M0120 pages 1, 10-12	On page 1, clarified that one spouse can apply for the other spouse whether or not the other spouse is incapacitated. On page 10, clarified that applications may be made on paper forms or electronically. On page 11, clarified the of the ADAPT Statement of Facts. On page 12, clarified the use of the Plan First Application Form and removed the policy on the defunct SLH Program.
M130 pages 4, 5	On page 4, clarified that an individual must be given at least 10 calendar days to provide requested verifications and that the eligibility worker must try to assist the applicant obtain certain verifications if asked. Page 5 is a runover page.
M0220 Table of Contents pages 14d, 16-19 Appendix 5 , page 3	Revised the Table of Contents. On page 14d and 16-19, added new policy on lawfully residing pregnant women and revised the policy on lawfully-residing non-citizen children under age 19 to include several alien status groups. Revised Appendix 5 to incorporate the new and revised policies.

Pages Changed	Significant Changes
M0280 Table of Contents page 8 Appendix 1 (removed)	Revised the Table of Contents. On page 8, added a link to the list of secure detention facilities in Virginia on the Department of Juvenile Justice web site, which is regularly updated. Removed Appendix 1.
M0310 Table of Contents, page ii pages 23, 26, 27 Appendices 1-4	Revised the Table of Contents. On pages 23, 26 and 27, added revised links to the disability forms on the SSA web site. Appendices 1-3 were removed. Appendices 3 and 4 were renumbered and are now Appendices 1 and 2, respectively.
M0320 pages 49-50b	On page 49, clarified that children under 19 years and adults 65 years and older do not automatically receive an evaluation for Plan First. On page 50, clarified that Plan First enrollees who meet a MN covered group are placed on two spenddown periods. Pages 50a and 50b are runover pages.
M0520 Table of Contents pages 2-5	Revised the Table of Contents. On pages 2 and 4, clarified that only children in Level C PRTFs are evaluated as an assistance unit of one. Pages 2a, 3 and 5 are runover pages.
M0710 Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1	In Appendix 1, added the new LIFC 185% Standards of Need. In Appendix 3, added the new F&C income limits. In Appendix 5, added the new F&C MN income limits.
M0810 page 2	On page 2, added the new ABD MN income limits.
M0830 page 24	On page 24, revised the reference to the QI covered group.
S1130 page 24	On page 24, clarified that verification of burial plots is not required
M1310 Table of Contents pages 1-5 Page 6 (new)	Revised the Table of Contents. On page 1, clarified that individuals with limited Medicaid coverage, including Plan First enrollees, must be placed on a spenddown if they meet a MN covered group. Pages 2-6 are runover pages.
M01410 pages 6, 7	On pages 6 and 7, removed references to the AIDS Waiver.
M1420 pages 3, 4	On page 3, removed the reference to the AIDS Waiver. On page 4, clarified when a LTC preadmission screening is required.

Pages Changed	Significant Changes
M01440 Table of Contents pages 2, 14, 15, 18a-18c pages 19, 20	Revised the Table of Contents. On pages 2, 14, 8a-18c, 19 and 20, removed the references to the AIDS Waiver. Page 15 is a runover page.
M1450 Table of Contents pages 37-43 page 43a (new)	Revised the Table of Contents. On page 37, replaced the list of northern Virginia localities, which was inadvertently removed in a previous transmittal. On page 38, replaced the policy on apportioning penalty periods for spouses, which was inadvertently removed in a previous transmittal. On page 39, clarified the example on the subsequent receipt of compensation. On pages 40-43a, clarified the policy on claiming undue hardship regarding the application of a penalty period.
M1460 page 4a	On page 4a, removed the obsolete reference to instructions for entering LTC insurance in MMIS.
M1470 pages 19, 46-48	On page 19, removed the reference to the AIDS Waiver. On pages 46-48, revised the threshold for referrals to the RAU for patient pay underpayments.
M1480 pages 11, 14, 18c, 21 pages 32, 66, 67, 69	On pages 11, 14, 18c, 21, 32 and 67, revised the links to the various LTC worksheets now located on SPARK. On page 66, added the new dollar amounts for the spousal Monthly Maintenance Needs Allowance and Excess Shelter Standard. On page 69, removed the reference to the AIDS Waiver.
M1510 pages 8, 9	On page 8, clarified when the original application can be used after a disability denial is reversed on appeal. On page 9, corrected the link to the sample eligibility delay letter and clarified when the coverage dates need to be included in the letter.
M1520 pages 1, 7, 7c, 7g	On page 1, clarified that children under 19 years and adults 65 years and older do not automatically receive an evaluation for Plan First. On page 7, corrected the reference to M1430. On page 7c, clarified the use of a statement for individuals reporting no income, On page 7g, clarified that telephone interview-based renewals can be used for QI renewals.
M1550 Appendix 1, page 1	In Appendix 1, updated the listing of Medicaid Technicians.

Pages Changed	Significant Changes
M17 Table of Contents Pages 1-8 Appendix 1 Appendices 3 and 4 (removed)	The Table of Contents was revised. On pages 1-8, added references to the new RAU forms and reorganized the policy. Links to the forms on SPARK were added. Appendix 1 is now an RAU referral desk tool, and Appendixes 3 and 4 were removed.
M18 page 12	On page 12, removed the reference to the AIDS Waiver.
M21 pages 3, 4 Appendix 2, pages 1 Appendix 3, pages 1 and 2	On pages 3 and 4, revised the alien status policy for FAMIS to include lawfully-residing non-citizen children under age 19. In Appendix 2, removed the Virginia Credit Union from the list of state agencies because it is not a state agency. Revised Appendix 3 to include the new alien status policy.
M22 pages 2, 3	On pages 2 and 3, revised the alien status policy for FAMIS MOMS to include lawfully-residing non-citizen pregnant women.

Questions about information contained in Medicaid Policy Update #7 should be directed to Stephanie Sivert, Manager, Medical Assistance Programs, at 804-726-7660 or stephanie.sivert@dss.virginia.gov.

Virginia DSS, Volume XIII

M0110 Changes

Changed With	Effective Date	Pages Changed
Update #7	7/1/12	pages 3, 6a, 7, 8
TN #96	10/1/11	Table of Contents pages 2-6a
TN #95	3/1/11	pages 2-4a
TN #94	9/1/10	pages 2, 3
TN #93	1/1/10	pages 1, 6

Information in the case record related to an individual's medical treatment, or method of reimbursement for services may be released to Virginia Medicaid providers by DMAS without the applicant's/enrollee's consent. Enrollee consent is not needed for the DSS agency to provide confirmation of an individual's eligibility, the dates of eligibility, and any patient pay responsibility if the medical provider is unable to obtain that information from the member verification system or from DMAS staff. The provider **is not** entitled to specific information about an applicant's/recipient's income or resources because the provider does not need that information for medical treatment or payment.

Provider contractors, such as application assistance companies, operate under the authority of the provider. A patient's consent is not required for the agency to provide the contractor with information related to reimbursement for services rendered or medical treatment. Providers *and their* contractors **are not** entitled to receive detailed financial or income information contained in an applicant's or recipient's case record. *Information should not be provided from case records unless the release of such information is for purposes directly related to the administration of the Medicaid State Plan.*

Local agencies may release Medicaid enrollee identification numbers to medical providers by telephone if the provider cannot contact the DMAS provider/recipient verification telephone number. This procedure does not conflict with federal or State confidentiality regulations, if the local agency is satisfied that the number is being released to an identifiable provider.

**E. Release to
Authorized
Representatives**

Individuals not determined to be incapacitated by a court can designate whomever they choose to be their authorized representatives, including a provider or a provider's contractor (such as an application assistance company). The designation must be in writing, with the applicant or recipient specifying the information to be released to the authorized representative.

It is not sufficient to indicate that any information in the case record may be released; the designation must state the specific information to be released (i.e. notices, the ability to make application or provide information necessary to determine eligibility, and what, if any, other information can be released to the authorized representative). The authorized representative designation is valid for the life of the application.

**F. Safeguarding
Client
Information**

All information associated with an applicant or recipient that could disclose the individual's identity is confidential and shall be safeguarded. Such information includes but is not limited to:

- name, address, and all types of identification numbers assigned to the client;
- medical services provided to the client;

**D. Attorney-In-Fact
(Named in a
Power of
Attorney
Document)**

means a person authorized by a power of attorney document (also referred to as a “POA”) to act on behalf of another individual, either for some particular purpose or for the transaction of business in general. **A power of attorney document does not necessarily authorize the attorney-in-fact to apply for Medicaid on behalf of the applicant.** The eligibility worker must read the power of attorney document to determine (1) if the person has the power to act as the applicant in any of the applicant's business and (2) whether or not the document grants durable power of attorney. If the document is a general power of attorney or includes the power to conduct the applicant's financial business, the attorney-in-fact is considered the applicant's authorized representative as long as the person for whom the attorney-in-fact is authorized to act is not legally incapacitated.

If the individual on whose behalf the attorney-in-fact is acting is incapacitated and not able to act on his own behalf, the eligibility worker must examine the document to determine that it grants a durable power of attorney. The contents of the document must indicate that the power of attorney does not stop upon the incapacity of the person. **If the power of attorney is not durable, it is no longer valid when the individual on whose behalf it is executed becomes legally incapacitated.**

**E. Authorized
Representative**

An authorized representative is a person age 18 years or older who is authorized to conduct business for an individual. A competent individual age 18 years or older must designate the authorized representative in a written statement (*which defines the representative's responsibilities*). The authorized representative statement is valid until:

- the application is denied;
- medical assistance coverage is canceled; or
- the individual changes his authorized representative.

The authorized representative of an incompetent or incapacitated individual is the individual's spouse, parent, attorney-in-fact (person who has the individual's power-of-attorney), legally appointed guardian, legally appointed conservator (committee), or family substitute representative. *An individual's spouse is permitted to be an authorized representative for Medicaid purposes as long as the spouse and applicant are living together, or lived together immediately before the applicant's institutionalization; no written designation is required.*

EXCEPTION: Staff in DBHDS facilities may *also act as authorized representatives in their facilities without a written statement.*

F. Child

means an individual under age 21 years.

**G. Competent
Individual**

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

H. Conservator

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

- I. Family Substitute Representative** means a spouse age 18 or older or designated relative age 18 or older who is willing and able to take responsibility for the individual's personal or financial affairs. Designated relatives other than the spouse who may be substitute representatives are, in this preferred order, the individual's child, parent, sibling, grandchild, niece or nephew, aunt or uncle.
- J. Guardian** means a person appointed by a court of competent jurisdiction to be responsible for the personal affairs of an incapacitated individual, including responsibility for making decisions regarding the person's support, care, health, safety, habilitation, education, and therapeutic treatment, and if not inconsistent with an order of commitment, residence.
- K. Incapacitated Individual** means an individual who, pursuant to an order of a court of competent jurisdiction, has been found to be incapable of receiving and evaluating information effectively or responding to people, events, or environments to such an extent that the individual lacks the capacity to (1) meet the essential requirements of his health, care, safety, or therapeutic needs without the assistance or protection of a guardian; or (2) manage property or financial affairs or provide for his or her support or the support of his legal dependents without the assistance or protection of a conservator.
- L. Legal Emancipation of a Minor** means a minor who has been declared emancipated by a court of competent jurisdiction. A married minor is not emancipated unless a court has declared the married minor emancipated from his parents.
- M. Medical Assistance** means any program administered by DMAS jointly with the Department of Social Services (DSS) that helps individuals or families pay for medical, dental and related health services. These programs are Medicaid, Family Access to Medical Insurance Security (FAMIS) and FAMIS MOMS.

M0110.300 Availability of Information

A. Information Required to be Given to the Applicant

1. Explanation of Medicaid Program

The *local* agency must furnish the *following information in written form, and orally as appropriate, to all applicants and enrollees, and to other individuals upon request:*

- the eligibility requirements,
- available *Medicaid* covered services,
- the rights and responsibilities of applicants and enrollees, and
- *the appeals process.*

When the Medicaid rights and responsibilities are explained verbally, the eligibility worker must document in the case record (electronic or hard copy) that they were explained and the applicant/enrollee's acknowledgement. The applicant/enrollee's failure to acknowledge receipt of the rights and responsibilities is not a condition for Medicaid eligibility and cannot be used to deny, delay or terminate Medicaid coverage.

The following materials must be given to the individuals specified below:

- The *brochure "Virginia Department of Social Services Division of Benefit Programs,"* form # B032-01-0002, contains information about the Medicaid Program and must be given to all applicants;
- The Division of Child Support Enforcement (DCSE)'s booklet "Child Support and You," form #032-01-945 must be given to applicants who are applying on behalf of a child who has an absent parent; *and*
- The "Virginia Medicaid Handbook" must be given to all recipients and must be given to others upon request.

Applicants may also be given Medicaid Fact Sheets as appropriate.

2. Early Periodic Screening, Diagnosis and Treatment (EPSDT)

All Medicaid applicants who are under age 21 are eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. Information on the availability and benefits of EPSDT must be provided for all applicants under age 21 within 60 days of the date that eligibility is determined. EPSDT information is included in the booklet "Virginia Social Services Benefit Programs."

3. Voter Registration

The National Voter Registration Act of 1993 (NVRA) requires local social services agencies to offer each TANF, Food Stamp, and Medicaid applicant an opportunity to apply to register to vote at initial application and at each review of eligibility. Additionally, voter registration application services must be provided any time a change of address is reported in person to the local agency.

In complying with the requirements of the NVRA, local agency staff must provide each applicant and enrollee the same degree of assistance in completing his/her voter registration application as they do in completing the application for public assistance.

a. Exceptions to Offering Voter Registration

The only exception to offering voter registration application services is when:

- the individual has previously indicated that he is currently registered to vote where he lives,
- there is a completed agency certification form in the individual's case record indicating the same, and
- the individual has not moved from the address where he stated that he was registered to vote.

b. Prohibitions

Local social services agencies and agency staff are prohibited from the following activities when providing voter registration application services:

- seeking to influence an individual's political preference;
- displaying any political preference or party affiliation;

M0120 Changes

Changed With	Effective Date	Pages Changed
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

M0120.000 Medical Assistance Application

M0120.100 Right to Apply

An individual cannot be refused the right to complete an application for himself (the applicant) or any other individual for whom he is authorized to apply. Under no circumstances can an individual be discouraged from asking for assistance for himself or any person for whom he is a legally responsible or authorized to represent. An applicant may be assisted with the application by an individual of his choice. A face-to-face interview is not required.

M0120.200 Who Can Sign the Application

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

B. Applicants Age 18 or Older The applicant must sign the application, even if the form is filled out by another person, unless the application is filed and signed by the applicant's legal guardian, conservator (known as the "committee" for persons declared incompetent prior to the 1997 changes in the guardianship section of the Code of Virginia), attorney in fact, or authorized representative. *A spouse, aged 18 or older, may sign the application for his spouse when they are living together.*

EXCEPTION: A parent can submit and sign an application for a child under age 21, when the child is living with the parent. The child does not need to authorize the parent to apply or conduct Medicaid business on his behalf.

If the applicant cannot sign his or her name but can make a mark, the mark must be correctly designated (the individual's first and last name and the words "his mark" or "her mark" must be printed adjacent to the mark) and witnessed by one person as in the example below:

E.g.: (X) John Doe, his mark

Witness's signature: _____

1. Authorized Representative

An authorized representative is a person age 18 years or older who is authorized to conduct business for an individual. A competent individual age 18 years or older must designate the authorized representative in a written statement (*which defines the representative's responsibilities*). The authorized representative statement is valid until:

- the application is denied;
- medical assistance coverage is canceled; or
- the individual changes his authorized representative.

The authorized representative of an incompetent or incapacitated individual is the individual's spouse, parent, attorney-in-fact (person who has the individual's power-of-attorney), legally appointed guardian, legally appointed conservator (committee), or family substitute representative.

EXCEPTION: Patients in the DBHDS facilities may have applications submitted by DBHDS staff.

The model application form may be viewed on the SSA web site at:
<http://www.socialsecurity.gov/prescriptionhelp/MSP-Model-Application-ENG.pdf>.

B. Application Forms

Medical assistance must be requested on a *signed paper application form or electronic application* prescribed (published) by the Department of Medical Assistance Services (DMAS) and the Virginia Department of Social Services (VDSS). *Applications must be signed by the applicant or authorized representative or meet the prescribed electronic signature requirements prescribed by DMAS and VDSS.*

An applicant may obtain a prescribed application form from a number of sources, including a variety of human service agencies, hospitals, and the internet.

1. Forms for Specific Covered Groups

There are specialized forms intended for use with certain covered groups, including pregnant women, children, SSI recipients, Plan First and women who have been screened under the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). These forms should be used whenever possible because they do not ask the applicant to provide information that is not used in the eligibility determination for those specific covered groups.

2. Applicant Use of Incorrect Form

Applicants may not know for which covered group they should apply, so they may apply using an incorrect application form. Another application form is **not** to be requested of the applicant if the incorrect form is used.

If additional information is required to determine an applicant's eligibility in another covered group, send the applicant the appropriate pages from the Application for Benefits or the other application form that asks for the information and give the applicant at least 10 business days to return the pages and the required verifications to the agency.

The following forms have been prescribed as application forms for Medicaid and FAMIS:

3. Application For Benefits

Application for Benefits, form #032-03-824, also referred to as the Combined Application, may be used by any applicant (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>). Eligibility for all medical assistance programs, except BCCPTA, can be determined with this application form.

4. Application/Redetermination For SSI Recipients

The Application/Redetermination for Medicaid for SSI Recipients, form #032-03-091 (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) is used for SSI recipients. If the applicant is not eligible for Medicaid in the SSI recipients covered group, his eligibility in other Medicaid covered groups and for FAMIS can be determined using this application form.

5. Medicaid Application/Redetermination For Medically Indigent Pregnant Women

The Medicaid Application/Redetermination for Medically Indigent Pregnant Women, form #032-03-040 (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) is acceptable if submitted for pregnant women. If any additional information is necessary (individual requires a resource evaluation for medically needy spenddown or for SLH), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant.

6. **Health Insurance For Children and Pregnant Women**
- The Health Insurance for Children and Pregnant Women, form FAMIS-1 (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) is an application form for children and/or pregnant women. If any additional information is necessary (individual requires a resource evaluation for medically needy spenddown or for SLH), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant.
7. **BCCPTA Medicaid Application**
- The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application, form #032-03-384, is used only by women screened under the Breast and Cervical Cancer Early Detection Program. **This form is not to be given to applicants by the local departments of social services** (M0120, Appendix 2 is provided for reference purposes only).
8. **ADAPT Statement of Facts**
- A signed ADAPT Statement of Facts (SOF) is a valid application for anyone in an ADAPT case, including ABD Medicaid applicants who are in an ADAPT case, EXCEPT for BCCPTA. The SOF cannot be used as a BCCPTA application. If any additional information is necessary (individual requires a resource evaluation), the appropriate pages from an Application for Benefits or Eligibility Review Form Part B if that form was obtained for Food Stamps can be used to collect the additional information. The pages must be signed by the applicant and attached to the SOF.
9. **Title IV-E Foster Care & Medicaid Application**
- The Title IV-E Foster Care & Medicaid Application, form #032-03-636 (available at: http://spark.dss.virginia.gov/divisions/dfs/iv_e/) is used for foster care or adoption assistance children who are eligible under Title IV-E of the Social Security Act. If any additional information is necessary (individual requires a resource evaluation for medically needy spenddown or for SLH), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant's guardian.

For a IV-E FC child whose custody is held by a local department of social services or a private FC agency, or for a IV-E adoption assistance (AA) child, the Title IV-E Foster Care & Medicaid Application, form #032-03-636, is used to determine if the child meets Medicaid IV-E eligibility requirements. This form is also used to determine Medicaid eligibility for IV-E FC and IV-E AA children, and for non-IV-E FC children in the custody of a local agency in Virginia. This form is **not** used for children in non-custodial agreement cases or non-IV-E AA. When a child enters care through a non-custodial agreement, or when a child is a non-IV-E AA child, a separate Medicaid application must be completed and signed by the parent or guardian.

For IV-E FC children in the custody of another state's social services agency and for IV-E AA children, a separate Medicaid application is not required. The worker must verify the IV-E maintenance payment (for FC) or the IV-E status (for AA). Virginia residency (by declaration) and current third party liability (TPL) information must be obtained. This information may be supplied by the foster/adoptive parent or obtained from the agency that entered into the FC or AA agreement.

10. Application for Adult Medical Assistance

The Application for Adult Medical Assistance is intended for adults who are aged, blind or disabled or who need long-term care. The paper form is available online at:

www.localagency.dss.state.va.us/divisions/bp/me/forms/general.cgi. The online application is available at: <https://jupiter.dss.state.va.us/VDAMedicaid>.

In addition to the online Application for Adult Medical Assistance that individuals may submit on their own behalf, starting in January 2010, LDSS will receive online Applications for Adult Medical Assistance that are generated as a result of Extra Help low-income subsidy (LIS) data on individuals received by VDSS from the Social Security Administration (SSA). These Adult Medical Assistance Applications are designated in the SPARK Adult Medical Assistance Application administrative web site by the term "LIS." The Medicare Patient and Provider Improvement Act (MIPPA) requires LIS application data submitted by SSA to states to be treated as an application for Medicaid if the LIS applicant agrees.

11. Auxiliary Grant (AG)

An application for AG is also an application for Medicaid. A separate Medicaid application is not required.

12. Plan First Application Form

The Plan First Application form may be submitted by an individual who is primarily interested in requesting Plan First family planning services. The applicant may have been referred to the local DSS by his local Department of Health or other medical provider.

*If the information contained in the application indicates **potential** eligibility in a full-benefit Medicaid covered group (e.g., the applicant has a child under 18 in the home or alleges disability), in another limited benefit covered group (e.g., the individual has Medicare), or in FAMIS or FAMIS MOMS, the worker must determine whether eligibility exists in another covered group before the individual can be determined eligible for Plan First. If additional information is needed to complete the eligibility determination in another Medicaid covered group, the applicant must be given the opportunity to provide the information. The Plan First Application form is available on SPARK at: <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>*

M0120.400 Place of Application**A. Principle**

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

M0130 Changes

Changed With	Effective Date	Pages Changed
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

retroactive eligibility is determined, the applicant must be given an "Eligibility Delay" letter to give to the medical provider so that Medicaid will pay the claim (use the sample letter on the intranet at:

<http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>). Once retroactive eligibility is established, Medicaid coverage begins the first day of the earliest retroactive month in which *retroactive* eligibility exists.

M0130.200 Required Information and Verifications

A. Identifying Information

An application must contain basic identifying information about the applicant. Basic identifying information is the applicant's name, address, Social Security number (SSN) or a statement that the individual applied for the SSN, and date of birth.

1. Name

The name entered in the official case record and computer enrollment systems for an applicant must match the applicant's name on his Social Security card or Social Security Administration (SSA) records verification. This is important because of the Medicare Buy-in and other computer matches the Medicaid Management Information System (MMIS) performs with SSA. **At the time of the initial Medicaid application, the State Verification Exchange System (SVES) must be used to verify the SSA record of the individual's name because SVES verifies the spelling, etc., of the individual's name in the SSA records.** For subsequent reapplications, the State Online Query-Internet system (SOLQ-I) may be used.

If the individual says his name is different from the name on his Social Security card, he must first notify SSA and have his name changed on SSA records. When SSA changes his name and SSA verification of the name change is received, the worker can change his name in the case record and on the eligibility and MMIS computer systems.

For purposes of the case record only, the agency may choose to set up the case in the individual's alleged name before it is changed on the Social Security card.

2. SSN

The SSN of an individual for whom Medicaid or other medical assistance is requested must be provided by the applicant and verified by the worker through SSA. SVES or SOLQ-I may be used to verify the individual's SSN.

B. Required Verifications

An individual must provide verifications of most Medicaid eligibility requirements. Before taking action on the application, the applicant must be notified in writing of the required information.

The eligibility worker must allow at least 10 *calendar* days for receipt of the necessary verifications, but additional time may be allowed depending on the type of information requested. The specific information requested and the deadline for receipt of the verifications must be documented in the case record.

If the applicant reports to the EW that he needs help to obtain certain verifications, the EW must attempt to assist the applicant. If the verification cannot be obtained, the application must be denied.

- 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,
 - application for other benefits.
- 2. Verification Required** The following information must be verified:
- 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.

Virginia DSS, Volume XIII

M0220 Changes

Changed With	Effective Date	Pages Changed
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

TABLE OF CONTENTS

M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS

	Section	Page
General Principles	M0220.001	1
Citizenship and Naturalization.....	M0220.100	2
Alien Immigration Status.....	M0220.200	4
Immigration Status Verification	M0220.201	4
Systematic Alien Verification for Entitlements (SAVE)	M0220.202	5
Full Benefit Aliens	M0220.300	7
Aliens Receiving SSI.....	M0220.305	8
Certain American Indians	M0220.306	9
Qualified Aliens Defined	M0220.310	9
Veteran & Active Military Aliens	M0220.311	12
Qualified Aliens Who Entered U.S. Before 8-22-96.....	M0220.312	14
Qualified Aliens Who Entered U.S. On/After 8-22-96	M0220.313	14a
Lawfully Residing Non-citizen Children under age 19 <i>and Pregnant Women</i>	M0220.314	14d
Emergency Services Aliens	M0220.400	17
Emergency-Services-Only Qualified Aliens Who Entered U.S. On/After 8-22-96	M0220.410	17
Unqualified Aliens	M0220.411	19
Aliens Eligibility Requirements.....	M0220.500	20
Full Benefit Aliens Entitlement & Enrollment	M0220.600	22a
Emergency Services Aliens Entitlement & Enrollment	M0220.700	23

Appendices

Citizenship & Identity Procedures and Documentation Charts	Appendix 1.....	1
Sample Letters of Certification/Eligibility for Victims of a Severe Form of Trafficking	Appendix 2.....	1
SSA Quarters of Coverage Verification Procedures for Lawful Permanent Residents	Appendix 3.....	1
Emergency Medical Certification (Form 032-03-628).....	Appendix 4.....	1
Alien Codes Chart	Appendix 5.....	1
Proof of U.S. Citizenship and Identity for Medicaid	Appendix 6.....	1

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

A. Policy

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

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

B. Eligible Alien Groups

Non-citizen children under 19 *and pregnant women* who are lawfully residing immigrants meet one of the following alien groups:

1. Lawful Permanent Resident

an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act.

2. Refugees

an alien who is admitted to the U.S. under the Immigration and Nationality Act as a refugee under any section of the INA. The refugee will have a Form I-94 identifying him/her as a refugee under the INA.

3. Conditional Entrant

an alien who is granted conditional entry pursuant to section 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980. Aliens admitted to the United States as conditional entrants pursuant to 203(a)(7) of the Immigration and Nationality Act (INA) (8 USC 1153(a)(7)) have an USCIS Form I-94 bearing the stamped legend "Refugee - Conditional Entry" and a citation of the INA section.

NOTE: section 203(a)(7) of the INA was made obsolete by the Refugee Act of 1980 (P.L.96-212) and replaced by section 207 of the INA effective April 1, 1980

4. Parolee

parolees are:

aliens paroled into the United States, including Cuban/Haitian entrants, pursuant to section 212(d)(5) of the INA (8 USC 1182(d)(5)); or

admitted to the United States for similar reasons as a refugee, i.e., humanitarian. However, this group, unlike refugee status, does not grant legal residence status. Parole status allows the alien temporary status until an USCIS determination of his/her admissibility has been made, at which time another status may be granted.

- b. Aliens in this group will have a Form 1-181 or their passports will be stamped with either of the following: "adjustment application" or "employment authorized during status as adjustment applicant."
- 4. Deferred Action Status** Aliens granted deferred action status pursuant to USCIS operating instructions.
- a. Aliens in this group are similar to those under an order of supervision except there have been no formal deportation proceedings initiated.
- b. Aliens in this group will have a Form I-210 or a letter indicating that the alien's departure has been deferred.
- 5. Deportation Suspended** Aliens granted suspension of deportation pursuant to section 244 of the INA (8 USC 1254) whose departure the USCIS does not contemplate enforcing.
- a. Aliens in this group have been found deportable, have met a period of continuous residence and have filed an application for USCIS to suspend deportation in an effort to be granted lawful permanent resident status.
- b. If the suspension is granted, the alien must wait through two full sessions of the Congress. If the Congress does not take action on the application, USCIS will grant the alien lawful permanent residence.
- c. These aliens will have a letter/order from the immigration judge and a Form I-94 with employment authorized for 1 year. After lawful permanent residence is granted, the alien will have a Form I-551, or I-151.
- 10. Compact of Free Association States** Aliens who are citizens of a Compact of Free Association State (Federated States of Micronesia, Republic of the Marshall Islands and the Republic of Palau) who have been admitted to the U.S. as a non-immigrant and are permitted by the Department of Homeland Security to reside permanently or indefinitely in the United States.
- 11. Other Eligible Groups**
- a. Aliens described in 8 CFR 103.12(a)(4) who do not have a permanent residence in the country of their nationality and are in statuses that permit them to remain in the U.S. for an indefinite period of time pending adjustment of their status. This includes:
- 1) aliens currently in temporary resident status as an Amnesty beneficiary pursuant to section 210 or 245A of the Immigration and Nationality Act (INA);
 - 2) aliens currently under a Temporary Protected Status pursuant to section 244 of the INA;
 - 3) aliens classified as a Family Unit beneficiary pursuant to section 301 of Public Law 101-649 as well as pursuant to section 1504 of Public Law 106-554;
 - 4) aliens currently under a Deferred Enforced Departure pursuant to a decision made by the President; and

- 5) alien children whose parent is a U.S. citizen, whose visa petition has been approved and who has a pending application for adjustment of status.
- 6) *Individuals in nonimmigrant classifications who are permitted to remain in the United States for an indefinite period, including the following who are specified in 101(a)(15) of the INA:*
 - a) *Parents or children of individuals with special immigrant status under 101(a)(27) of the INA as permitted under 101(a)(15) of the INA;*
 - b) *Fiancées of a citizen as permitted under 101(a)(15)(R) of the INA;*
 - c) *Religious workers under 101(a)(15)(R);*
 - d) *Individuals assisting the Department of Justice in a criminal investigation as permitted under 101(a)(15)(U) of the INA*
 - e) *Battered aliens; and*
 - f) *Individuals with a petition pending for three years or more as permitted under 101(a)(5)(V) of the INA.*

M0220.400 EMERGENCY SERVICES ALIENS

A. Policy

Any alien who does NOT meet the requirements for full benefits as described in section M0220.300 through 314 above is an “emergency services” alien and is eligible for emergency Medicaid services only, if he or she meets all of the Medicaid nonfinancial and financial eligibility requirements.

B. Procedure

Section M0220.410 describes the qualified aliens who entered the U.S. on or after 8-22-96 who are emergency services aliens.

Section M0220.411 defines “unqualified” aliens.

Section M0220.500 contains the Medicaid eligibility requirements applicable to full benefit and emergency services aliens.

Section M0220.700 contains the entitlement and enrollment procedures for emergency services aliens.

M0220.410 EMERGENCY-SERVICES-ONLY QUALIFIED ALIENS WHO ENTERED U.S. ON OR AFTER 8-22-96

A. First 5 Years of Residence in U.S.

During the first five years of residence in the U.S., four groups of qualified aliens (as defined in M0220.310 above) who entered the U.S. on or after 8-22-96 are eligible for **emergency Medicaid services only** provided they meet all other Medicaid eligibility requirements.

1. LPRs

An LPR who enters the U.S. on or after 8-22-96 is an “emergency services” alien during the first 5 years the LPR is in the U.S., regardless of work quarters.

Note: If the LPR had prior immigration status in one of the “seven-year” alien groups listed in M0220.313.A, he is considered to have “seven year” status for the purposes of Medicaid eligibility for the first seven years of residency in the U.S. To determine former status of a LPR, check the coding on the I-551 for codes RE-6, RE-7, RE-8, or RE-9. Contact the USCIS at 1-800-375-5283 for assistance in identifying the former status for other seven year aliens.

2. **Conditional Entrants** A qualified Conditional Entrant who enters the U.S. on or after 8-22-96 is an “emergency services” alien.
 3. **Parolees** A qualified parolee who enters the U.S. on or after 8-22-96 is an “emergency services” alien.
 4. **Battered Aliens** A qualified battered alien who enters the U.S. on or after 8-22-96 is an “emergency services” alien.
- B. AFTER 5 Years of Residence in U.S.** **AFTER** 5 years have passed from the date of entry into the U.S., the following groups of aliens who entered on or after 8-22-96 are eligible for emergency services only:

- | | |
|---|--|
| 1. Lawful Permanent Residents Without 40 Work Quarters | Lawful Permanent Residents who DO NOT have at least 40 qualifying quarters of work remain emergency services aliens after residing in the U.S. for 5 years. Lawful Permanent Residents who have at least 40 qualifying quarters of work become full benefit aliens after 5 years of residing in the U.S. |
| 2. Conditional Entrants | A qualified Conditional Entrant who enters the U.S. on or after 8-22-96 is an “emergency services” alien. |
| 3. Parolees | A qualified parolee who enters the U.S. on or after 8-22-96 is an “emergency services” alien. |
| 4. Battered Aliens | A qualified battered alien who enters the U.S. on or after 8-22-96 is an “emergency services” alien. |
| C. AFTER 7 Years of Residence in U.S. | |
| 1. Refugees | After 7 years of residence in the U.S., a refugee or Amerasian immigrant who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an “emergency services” alien. |
| 2. Asylees | After 7 years have passed since asylum was granted, an asylee who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an “emergency services” alien. |
| 3. Deportees | After 7 years have passed since deportation was withheld, a deportee who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an “emergency services” alien. |
| 4. Cuban or Haitian Entrants | After 7 years of residence in the U.S., a Cuban or Haitian Entrant who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an “emergency services” alien. |
| 5. Afghan and Iraqi Special Immigrants | Medicaid coverage for Afghan and Iraqi Special Immigrants who are eligible in a Medicaid covered group cannot begin earlier than December 26, 2007. After 7 years of residence in the U.S., Afghan and Iraqi Special Immigrants are no longer eligible for full Medicaid benefits and become “emergency services” aliens.

After the applicable limited time period expires, individuals become “emergency services” aliens unless the requirements in M0220.313 B or M0220.314 are met. |
| D. Services Available To Eligibles | An emergency services alien who meets all Medicaid eligibility requirements is eligible for Medicaid coverage of emergency services only. |
| E. Entitlement & Enrollment of Eligibles | The Medicaid entitlement policy and enrollment procedures for emergency services aliens are found in section M0220.700 below. |

M0220.411 UNQUALIFIED ALIENS

- A. Unqualified Aliens** Aliens who do not meet the qualified alien definition M0220.310 above and who are **NOT** *lawfully residing non-citizen* children under age 19 *or pregnant women per* M0220.314 above are “unqualified” aliens and are eligible for emergency services only if they meet all other Medicaid eligibility requirements. Unqualified aliens include illegal and non-immigrant aliens.
- B. Illegal aliens** Illegal aliens were never legally admitted to the U.S. or were legally admitted for a limited period of time and did not leave when that period expired. If an alien remains in the U.S. after his visa expires, he becomes an illegal alien.
- C. Non-immigrant Aliens** Aliens who are lawfully admitted to the U.S. for a temporary or limited period of time, and the limited period has **not** expired, are non-immigrant aliens. Non-immigrants, such as visitors, tourists, some workers, and diplomats, are not eligible for Medicaid because of the temporary nature of their admission status (they do not meet the state residency requirement). Non-immigrants have the following types of USCIS documentation:
- Form I-94 Arrival-Departure Record,
 - Form I-185 Canadian Border Crossing Card,
 - Form I-186 Mexican Border Crossing Card,
 - Form SW-434 Mexican Border Visitor's Permit,
 - Form I-95A Crewman's Landing Permit.

Note: If the alien remains in the U.S. after the limited time period (visa) is over, he becomes an illegal alien.

	UNQUALIFIED ALIEN GROUPS (cont.)	Arrived Before 8-22-96	Arrived On or After 8-22-96	
T	Aliens granted suspension of deportation pursuant to Section 244 of the INA and whose deportation the USCIS does not contemplate enforcing [Immigration Judge Court Order]	Emergency Only T1	Emergency Only T2	Emergency Only T3
U	Any other aliens living in the US with the knowledge and permission of the USCIS whose departure the agency does not contemplate enforcing [USCIS Contact]	Emergency Only U1	Emergency Only U2	Emergency Only U3
V	Illegal aliens – aliens not lawfully admitted or whose lawful admission status has expired	Emergency Only V1	Emergency Only V2	Emergency Only V3
W	Visitors (non-immigrants): tourists, diplomas, foreign students, temp. workers, etc. [I-688B – 274a.12(b)(1)-(20); I-94; I-185; I-1186; SW-434; I-95A]	Emergency Only W1	Emergency Only W2	Emergency Only W3

	LAWFULLY RESIDING NON-CITIZEN CHILDREN UNDER AGE 19 AND PREGNANT WOMEN			
Y	Non-citizen (alien) children under the age of 19 <i>and pregnant women</i> lawfully residing in the U.S. who meet the requirements in M0220.314.	N/A	Full Benefits	Full Benefits

	AFGHAN AND IRAQI SPECIAL IMMIGRANTS	First 7 Years after Entry into U.S.	After 7 Years
Z	Afghan and Iraqi Special Immigrants admitted on a Special Immigrant Visa (SIV), including the spouse and children under age 21 living in the home with the principal visa holder. [I-551 or passport/ I-94 indicating categories SI1, SI2, SI3, QQ1, SQ2, or SQ3 and bearing Department of Homeland Security stamp or notation]	Full Benefits Z1	Emergency Only Z2

M0280 Changes

Changed With	Effective Date	Pages Changed
Update #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

TABLE OF CONTENTS

M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

M0280.000 INSTITUTIONAL STATUS REQUIREMENTS

	Section	Page
General Principles	M0280.001	1
Definition of Terms	M0280.100	1
Institutional Status Rule	M0280.200	3
Individuals In Medical Facilities.....	M0280.201	3
Individuals In Residential Facilities	M0280.202	5
Inmate of A Public Institution.....	M0280.300	6
Who Is NOT An Inmate of A Public Institution	M0280.301	8
Procedures For Determining Institutional Status	M0280.400	10
Individuals Moving To or From Public Institutions	M0280.500	12
Departmental Responsibility	M0280.600	13

A juvenile who has criminal charges pending (no court disposition has been made) who is ordered by the judge to go to a treatment facility, then come back to court for disposition when the treatment is completed, is an inmate of a public institution.

- 2) A juvenile who is in a detention center due to care, protection or in the best interest of the child is NOT an inmate of a public institution.

2. After Court Disposition

Juveniles who are on probation with a plan of release which includes residence in a detention center are inmates of a public institution. If they go to any of the secure juvenile correctional facilities, they are inmates of a public institution. A list of secure detention facilities in Virginia is *available on the Department of Juvenile Justice's web site at http://www.djj.virginia.gov/Residential_Programs/Secure_Detention/pdf/Detention_Home_Contacts_02242011rev.pdf*. Because this list is subject to change, consult the list whenever eligibility must be evaluated for a juvenile who is reportedly in a detention center.

If they go to a non-secure group home, they are NOT inmates of a public institution because a non-secure group home is not a detention center.

3. Type of Facility

The type of facility, whether it is residential or medical and whether it is public or private must be determined. A juvenile is not eligible if he/she is a resident of an ineligible public residential facility.

EXAMPLE #1: A juvenile is detained for criminal activity. He is placed on probation with specific conditions of release, including a stay of 30 days or longer at a detention facility. The facility is identified as a juvenile detention center, not a treatment center. Upon release from the detention center, he will be placed on probation and will live with his mother. Because of the nature of his custody (criminal activity) and the nature of the facility (a detention center is a public institution) he is not eligible for Medicaid during the period of incarceration. After he is released from the detention center and while he is on probation, he is NOT an inmate of a public institution and may be eligible for Medicaid.

4. Ineligible Juveniles in Detention

The following juveniles in detention are inmates of a public institution and are not eligible:

- a. A minor in a juvenile detention center prior to disposition (judgment) due to criminal activity is not eligible for Medicaid.
- b. A minor placed on probation by a juvenile court with specific conditions of release, including residence in a secure juvenile detention center is not eligible for Medicaid.

M0280.301 WHO IS NOT AN INMATE OF A PUBLIC INSTITUTION

A. Who Is NOT An Inmate of a Public Institution

An individual is NOT an inmate of a public institution if

- he is in a public educational or vocational training institution for purposes of securing education or vocational training OR
- he is in a public institution for a temporary period pending other arrangements appropriate to his needs.

M0310 Changes

Changed With	Effective Date	Pages Changed
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

Hospice	M0310.116	30a
Institution	M0310.117	31
LIFC	M0310.118	31
Medically Indigent (MI).....	M0310.119	31
Medically Needy (MN)	M0310.120	32
Medicare Beneficiary	M0310.121	32
OASDI	M0310.122	34
Parent	M0310.123	35
Pregnant Woman.....	M0310.124	35
QDWI	M0310.125	36
QI	M0310.126	37
QMB	M0310.127	37
RSDI	M0310.128	37
SLMB.....	M0310.129	38
SSI.....	M0310.130	38
State Plan	M0310.131	38
TANF	M0310.132	39
View Participant	M0310.134	39

Appendices

Cover Sheet for Expedited Referral to DDS	Appendix 1	1
DDS Regional Offices.....	Appendix 2	1

- individuals who received SSDI or SSI disability benefits or RR total disability benefits in one or more of the 12 months preceding the Medicaid application and whose benefits were terminated for a reason **other than no longer meeting the disability or blindness requirements.**
- individuals who have been determined disabled or blind by DDS for Medicaid or for SSA, without a subsequent decision by SSA reversing the disability determination, and
- individuals who have been determined “totally” disabled by the RRB.

C. Procedures for Verifying Disability Status

1. **Receives SSDI/SSI Disability Benefits** Verify SSDI/SSI disability status through a SVES (State Verification Exchange System) or SOLQ (State Online Verification Query) request or through documentation provided to the applicant by the SSA.
2. **Receives RRB Disability Benefits** Verify RRB disability by contacting the RRB at 804-771-2997 or 1-800-808-0772, or through documentation provided to the applicant by the RRB.
3. **Determined Disabled by DDS** If disability status cannot be ascertained **after** reviewing SVES or SOLQ, contact your regional DDS office to verify disability status. *Contact information for the regional DDS offices is contained in Appendix 2 of this subchapter.*

D. When a DDS Disability Determination is Required

- The DDS makes a disability determination for Medicaid when the individual alleges a disabling condition and has never applied for disability benefits from SSA or has not been denied disability within the past 12 months; **or**
 - the individual alleges a disabling condition and SSA has not yet made a determination on a pending SSDI/SSI claim; **or**
 - the individual alleges a disabling condition which is different from that considered by SSA or is in addition to that considered by SSA.
1. **Individual Age 19 Years or Older** An individual age 19 years or older must have his disability determined by DDS if he:
 - is claiming to have a disabling condition but does not receive SS/SSI disability benefits or RR total disability benefits, **and**
 - has not been denied SSDI or SSI disability benefits in the past 12 months.
 2. **Individual Under Age 19** A child under age 19 who is claiming to have a disabling condition must have his disability determined by DDS:
 - if he is not eligible for FAMIS Plus or FAMIS, **or**

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 and needs to be transferred directly to a rehabilitation facility. 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) to the appropriate DDS region, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>, to verify receipt of the Medicaid application; and
 - 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

SAMPLE

Cover Sheet for Expedited Referral to DDS and DSS

This is an example of a cover sheet that is used when a Medicaid Disability Determination is required to transition a hospitalized patient to a rehabilitation facility. The address, phone number and fax number for the appropriate Regional DDS Office will be included in the cover letter. Expedite procedures do not apply if the person will be discharged home, to long term care, or to hospice.

Patient: _____ SSN: _____

DISABILITY is defined as:

The inability to do any substantial gainful work, because of a severe, medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or is expected to last for a continuous period of not less than 12 months.

All of these conditions must be met for a Medicaid claim to qualify as an Expedite.

1. The patient is hospitalized.
2. The patient is able to participate in rehabilitative activities, requires transitioning to a rehabilitation facility, and cannot be discharged without a determination of Medicaid eligibility.
3. The patient's impairment is so severe it can be expected to prevent all work activity for at least one year.
4. The hospital has provided sufficient evidence to document an impairment that is expected to prevent work activity for at least one year.

Physician's Signature: _____ Date: _____

The Medicaid application has been faxed/sent to this Dept. of Social Services (DSS):

DSS Name: _____ Address: _____

FAX Number: _____ Date Faxed: _____

The information checked below is being faxed or sent overnight to DDS:

DDS Address : _____ FAX Number: _____

_____ Form SSA-3368 Disability Report Form

_____ SSA-827 Authorizations to Disclose Information

_____ Medical Reports

_____ Medical History & Physical, including consultations

_____ Clinical Findings (such as physical/mental status examination findings)

_____ Laboratory findings (such as latest x-rays, scans, pathology reports.)

_____ Diagnosis.

_____ Signed Expedite Cover Sheet with physician's certification that the claim meets the conditions necessary to be treated as an Expedite.

Name of Hospital: _____ Date Completed: _____

Your Name Printed: _____ Your Signature: _____

Your Telephone: (_____) _____ Your Fax: (_____) _____

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

M0320.302 PLAN FIRST - FAMILY PLANNING SERVICES (FPS)**A. Policy**

Effective October 1, 2011, Plan First, Virginia's family planning services health program covers individuals whose income is less than or equal to 200% FPL for their family size and who are not eligible for another full or limited-benefit Medicaid covered group, FAMIS or FAMIS MOMS. This optional covered group is available to individuals regardless of their age, gender, disability status, insured status or if they previously had a sterilization procedure. Plan First covers only family planning services, including transportation to receive family planning services.

While there are no specific age requirements for Plan First, eligibility for Plan First is not determined for children under 19 years or for individuals age 65 years and older unless the child's parent or the individual requests to an evaluation for Plan First.

1. Application Forms

Eligibility for Plan First can be determined using any valid application form. An individual does not need to request Plan First for his eligibility to be determined. The Plan First and Application for Benefits forms allow individuals to specifically request a Plan First eligibility determination on the forms. If an individual indicates on the application or to the agency that he does not want his eligibility for Plan First determined, do not do so.

2. Determine Eligibility in Other Medicaid Covered Groups, FAMIS or FAMIS MOMS First

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

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

When an individual between the ages of 19 and 64 years is not eligible for Medicaid in any other covered group, evaluate his eligibility for Plan First unless the individual has indicated otherwise on the application or communicated the desire to opt out to the LDSS by other means.

When a Medicaid enrollee no longer meets the requirements for his current covered group, prior to cancelling his coverage he must be evaluated in all covered groups for which he may meet the definition. If the individual is between the ages of 19 and 64 and is not eligible for full-benefit Medicaid coverage or as a Medicare beneficiary, he must be evaluated for Plan First unless he has declined that coverage. If a child is under age 19 or an individual is age 65 or older, evaluate for Plan First only if the child's parent or the individual requests the coverage.

- B. Nonfinancial Requirements** Individuals in this covered group must meet the Medicaid nonfinancial requirements in chapter M02.
- DCSE services are available to all Medicaid recipients, but cooperation with DCSE is not a condition of eligibility for this covered group.
- C. Financial Eligibility**
- 1. Assistance Unit** Use the assistance unit policy in chapter M05 to determine financial eligibility.
 - 2. Resources** There is no resource limit.
 - 3. Income** The income requirements in chapter M07 must be met for this covered group. The income limits are 200% FPL and are found in subchapter M0710, Appendix 6.
 - 4. Spenddown** Spenddown does not apply to *Plan First*. *However, because an individual enrolled in the Plan First covered group does not receive full Medicaid coverage, if he meets a MN covered group listed in M0320.001, 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. See Chapter M13 for spenddown instructions.*
- D. Entitlement and Enrollment**
- 1. Begin Date** Eligibility in the Plan First covered group begins the first day of the month in which the application is filed, if all eligibility factors are met in the month.
 - 2. Retroactive Coverage** Individuals in this covered group are entitled to retroactive coverage if they meet all the requirements in the retroactive period. If eligible for retroactive coverage, however, coverage can begin no earlier than October 1, 2011.
 - 3. Enrollment** The AC for Plan First enrollees is “080.”

M0320.303 MI CHILD UNDER AGE 19 (FAMIS PLUS)

- A. Policy** Section 1902(a)(10)(A)(i)(VI) and 1902 (l)(1)(C) of the Act - The federal Medicaid law requires the Medicaid State Plan to cover children from birth to age 6 years whose countable income is less than or equal to 133% of the federal poverty limit (FPL). Section 1902(a)(10)(A)(i)(VII) and 1902 (l)(1)(D) of the Act - The federal Medicaid law requires the Medicaid State Plan to cover children who have attained age 6 years but are under age 19 years whose countable income is less than or equal to 100% of the FPL and allows states to cover children at higher income limits.

Virginia has elected to cover children from age 6 to age 19 with countable income less than or equal to 133% of the FPL. The federal law allows the State Plan to cover these children regardless of their families' resources; Virginia has chosen to waive the resource eligibility requirements for these children. Coverage under the MI Child Under Age 19 covered group is also referred to as FAMIS Plus.

B. Nonfinancial Eligibility

The child must meet the nonfinancial eligibility requirements in chapter M02. The child must be under age 19 years. The child's date of birth must be provided, but birth verification is not required. Any child under age 19 years can be eligible in this covered group regardless of the child's living arrangements or the child's mother's Medicaid eligibility.

A child no longer meets this covered group effective the end of the month in which the child reaches age 19 years, provided he was under age 19 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 19.

NOTE: a child who does not meet a Medicaid non-financial eligibility criterion AND who has excess income for Medicaid may be evaluated for FAMIS eligibility.

C. Financial Eligibility

1. Assistance Unit

Use the assistance unit policy in chapter M05 to determine the child's financial eligibility.

2. Asset Transfer

The asset transfer rules in subchapter M1450 apply to institutionalized MI individuals.

3. Resources

There is no resource limit.

4. Income

The income requirements in chapter M07 must be met by the child. The income limits are 133% of the FPL and are found in subchapter M0710, Appendix 6.

5. Income Changes

Any changes in an MI child's income that occur after his eligibility has been established affect eligibility. Recalculate income and compare to the MI 133% FPL income limits.

6. Income Exceeds MI Limit

A child under age 19 whose income exceeds the MI income limit may be eligible for Virginia's Title XXI program, Family Access to Medical Insurance Security (FAMIS). The income limit for FAMIS is 200% FPL. See chapter M21 to determine FAMIS eligibility.

Spenddown does not apply to the medically indigent. If the child's income exceeds the medically indigent limit, he/she is not eligible as medically indigent regardless of medical expenses. Eligibility as medically needy (MN) must then be determined in order for spenddown to apply, and all medically needy eligibility requirements must be met, including resource limits.

D. Entitlement

Eligible MI children are entitled to full Medicaid coverage beginning the first day of the child's application month if all eligibility requirements are met in that month, but no earlier than the date of the child's birth. Retroactive coverage is applicable to this covered group; however, the income limit for children age 6 – 19 cannot exceed 100% FPL for any period prior to September 1, 2002.

Eligible MI children are entitled to all Medicaid covered services as described in chapter M18.

E. Enrollment

The ACs for MI children are:

AC	Meaning:
090	• MI child under age 6; income greater than 100% FPL, but less than or equal to 133% FPL
091	• MI child under age 6; income less than or equal to 100% FPL
092	• MI child age 6-19; insured or uninsured with income less than or equal to 100% FPL; • MI child age 6-19; insured with income greater than 100% FPL and less than or equal to 133% FPL
094	• MI child age 6-19; uninsured with income greater than 100% FPL and less than or equal to 133% FPL

Do not change the AC when a child's health insurance is paid for by Medicaid through the HIPP program.

Virginia DSS, Volume XIII

M0520 Changes

Changed With	Effective Date	Pages Changed
UP #7	7/1/12	Table of Contents pages 2-5
Update (UP) #4	7/1/10	pages 2, 2a

TABLE OF CONTENTS

M05 MEDICAID ASSISTANCE UNIT

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

	Section	Page
Overview.....	M0520.001.....	1
Definitions	M0520.010.....	2a
Family Unit Rules	M0520.100.....	3
Multiple Family Units	M0520.101.....	6
Non Parent Caretaker.....	M0520.102.....	7
EWB in Household	M0520.103.....	9
Budget Unit Rules.....	M0520.200.....	10
Child(ren) With Resources and/or Income	M0520.201.....	12
Married Medicaid Minor or Medicaid Minor Caretaker Living With Parent	M0520.202.....	13
Stepparent In Household	M0520.203.....	16
Acknowledged Father in Household	M0520.204.....	17
Deeming From Spouse.....	M0520.300.....	17
Deeming From Parent	M0520.400.....	21
Changes In Status	M0520.500.....	27
Family/Budget Unit Changes.....	M0520.501.....	28
Deeming Changes	M0520.502.....	29
Pregnant Woman Budget Unit	M0520.600.....	30
Unmarried PG Woman Over Age 21 Unit	M0520.601.....	31
Married PG Woman Unit	M0520.602.....	32
Unmarried Minor PG Woman Under Age 21 Unit.....	M0520.603.....	33
Individual Under Age 21 Family Unit	M0520.700.....	35
Foster Care Child Family Unit.....	M0520.701.....	35
Adoption Assistance Child Family Unit	M0520.702.....	36
Special Medical Needs Adoption Assistance Child Family Unit.....	M0520.703.....	38
Child in ICF or ICF-MR Family Unit	M0520.704.....	38

Appendix

Medicaid F&C Resource and Income Deeming Worksheet ... Appendix 1	1
---	---

4. Psychiatric Residential Treatment Facilities (PRTFs)

a. Children Living in a PRTF

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

If the child is placed in a PRTF, verify that it is a Level C facility on the Department of Medical Assistance Services' web site at http://dmasva.dmas.virginia.gov/Content_pgs/obh-home.aspx. If the facility is not a Level C facility, the child is considered not to be living away from his parents.

b. Children's Mental Health Program Services Received After Discharge From a PRTF

Children who receive Medicaid-covered treatment in a *PRTF* **may** receive a special benefit package through the Children's Mental Health Program following discharge from the facility. Effective July 1, 2010, children who receive Children's Mental Health Program services after discharge from a *PRTF* continue to be eligible for Medicaid without the need for an eligibility review. When determining the Medicaid eligibility of these children, each child is considered an assistance unit of one (1) as long as the child continues to receive Children's Mental Health Program Services.

See section M1520.100 E for documentation required for children who receive Children's Mental Health Program Services in their own homes after discharge from the *PRTF*.

5. Medical Facilities

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

C. Procedure

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

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

M0520.010 DEFINITIONS

A. Introduction

This section contains definitions of the terms used in the F&C family/budget unit policy and procedures.

B. Acknowledged Father

In Virginia, a man who is legally married to the mother of a child on the child's date of birth is considered to be the legal father of the child **UNLESS** another man has been determined by DCSE or a court to be the child's father. The man listed on the application form as the child's father is considered to be the child's acknowledged father when:

- the mother was not married to another man on the child's birth date, or
- the mother was married to another man on the child's birth date but DCSE or a court determined that the man listed on the application is the child's father,

unless documentation, such as the child's birth certificate, shows that another man is the child's father.

NOTE: Her declaration on the application of the child's father's name is sufficient unless there is evidence that contradicts the application. The mother's marital status at the time of the child's birth does not require verification; her declaration of her marital status is sufficient. See M0310.123 for the definition of a parent.

C. Household

For this subchapter's purposes, the "household" is everyone living in the residence and who is listed on the Application for Benefits as living in the residence.

D. Legal Emancipation

"Legal emancipation" from parents means that the parents and child have gone through court and a judge has declared that the parents have surrendered the right to the care, custody and earnings of the child and have renounced parental duties.

A married Medicaid minor is NOT emancipated unless a court has declared the married minor emancipated from his or her parent(s).

E. Legally Responsible Relative

A legally responsible relative is a person who is related to the individual applicant or recipient and who has a legal obligation under federal and state law to support the individual applicant/recipient.

Under federal Medicaid law and regulations, the only relatives who are legally responsible relatives are the following relative(s) with whom the individual applicant or recipient lives:

- the individual's spouse, and
- the individual's parent if the individual is a child under age 21 years.

F. Medicaid Minor A child under age 21 years is a Medicaid minor.

M0520.100 FAMILY UNIT RULES

A. Introduction This section contains the rules that apply to the family unit within a household applying for Medicaid. The family unit consists of the individuals in the household among whom legal responsibility for support exists. A parent or non-parent caretaker can choose to exclude any child from the family unit by excluding the child from the Medicaid application (see M0520.001 B).

B. Family Unit Composition When determining composition of the F&C family unit, start with the individual who applies for Medicaid and who meets an F&C covered group's requirements. These covered groups are:

- Pregnant women (MI and MN);
- Low income families with children (LIFC) (CNNMP);
- Newborn children (MI and MN);
- Children under age 19 (MI);
- Children under age 18 (MN);
- Individuals < 21 in foster care, adoption assistance, and ICF or an ICF-MR (CNNMP and MN).

Begin forming the family unit(s) by identifying a pregnant woman in the household, if any. If the household does not contain a pregnant woman, begin forming the family unit(s) by identifying the child(ren) who meets an F&C covered group.

1. Member In One Unit At A Time An applicant/recipient's Medicaid eligibility can only be determined in one F&C family unit at a time.

2. Include Responsible Relative(s) The unit must include the legally responsible relative(s) with whom the individual lives (parent for child under age 21 and spouse for spouse), EXCEPT when:

- the child is in foster care and is placed in his/her home for a trial visit; or
- the spouse or the parent receives an SSI or IV-E foster care/adoption subsidy payment. Do not include SSI and IV-E Foster Care/Adoption Assistance recipients in the unit.

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

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

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

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

3. Child Under 21 Living Away From Home

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

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

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

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

If the child is placed in a PRTF, verify that it is a Level C facility on the Department of Medical Assistance Services web site at http://dmasva.dmas.virginia.gov/Content_pgs/obh-home.aspx. If the facility is not a Level C facility, the child is considered not to be living away from his parents.

4. Pregnant Woman

An individual who meets the pregnant woman definition is counted as at least **two persons** when her eligibility is being determined in the MI Pregnant Woman or MN Pregnant Woman covered group. The unborn child (or children, if medical documentation verifies more than one fetus) must be included in the unit with the pregnant woman when determining her eligibility. A separate calculation is required for the other family unit members who do not meet a pregnant woman covered group. This calculation does NOT include the unborn child(ren) as part of the family unit and/or budget unit (BU).

When an individual is pregnant but her eligibility is determined in a covered group other than MI or MN Pregnant Woman, such as blind, disabled or Low Income Families with Children (LIFC), the pregnant woman is counted as just one person.

5. Cohabitant

A cohabitant is not the child(ren)'s parent and is not legally responsible for anyone in the family unit. Therefore, the cohabitant is not included in the family unit. Do not count a cohabitant's income or resources.

C. Examples**1. Household With Excluded Child**

EXAMPLE #1: Household listed on application consists of applicant, her disabled spouse, her 15-year old son, and husband's 20-year old daughter. The 20-year old daughter is employed full-time. Medicaid is requested for applicant, her spouse, and her son. She specifies in writing that she wishes to exclude her husband's 20-year old daughter. The family unit consists of:

- the applicant
- her husband, and
- her 15-year old son.

The family unit's income is determined using the F&C income policy and procedures.

M0710 Changes

Changed With	Effective Date	Pages Changed
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

**LIFC 185% OF STANDARDS OF NEED (MAXIMUM MONTHLY
INCOME)
EFFECTIVE 7/01/12**

Family/Budget Unit Size	GROUP I	GROUP II	GROUP III
1	<i>\$368.35</i>	<i>\$439.04</i>	<i>\$613.12</i>
2	<i>577.79</i>	<i>648.48</i>	<i>825.08</i>
3	<i>744.34</i>	<i>812.37</i>	<i>991.67</i>
4	<i>903.35</i>	<i>974.00</i>	<i>1153.19</i>
5	<i>1064.91</i>	<i>1153.19</i>	<i>1367.68</i>
6	<i>1193.54</i>	<i>1284.38</i>	<i>1496.39</i>
7	<i>1350.03</i>	<i>1438.35</i>	<i>1652.86</i>
8	<i>1519.10</i>	<i>1604.91</i>	<i>1816.95</i>
Each additional person add	<i>153.86</i>	<i>153.86</i>	<i>153.86</i>

F&C Monthly Income Limits Effective 7/01/12

Group I

Family/Budget Unit Size	100%	90%
1	\$199.11	\$178.64
2	312.32	282.31
3	402.35	361.42
4	488.30	439.19
5	575.63	518.31
6	645.16	582.42
7	729.75	657.45
8	821.14	737.92
Each additional person add	83.17	76.34

Group II

Family/Budget Unit Size	100%	90%
1	\$237.32	\$214.12
2	350.53	315.05
3	439.12	396.91
4	526.49	473.29
5	623.35	557.92
6	694.26	624.70
7	777.49	698.36
8	867.52	780.23
Each additional person add	83.17	76.34

Group III

Family/Budget Unit Size	100%	90%
1	\$331.42	\$300.06
2	445.99	401.00
3	536.04	482.84
4	623.35	559.25
5	739.29	665.63
6	808.86	728.38
7	893.44	804.77
8	982.14	886.62
Each additional person add	83.17	76.34

MEDICALLY NEEDY INCOME LIMITS EFFECTIVE 7/01/12

# of Persons in Family/Budget Unit	GROUP I		GROUP II		GROUP III	
	Semi-Annual	Monthly	Semi-Annual	Monthly	Semi-Annual	Monthly
1	\$1773.32	\$295.55	\$2046.14	\$341.02	\$2659.99	\$443.33
2	2257.91	376.31	2519.76	419.96	3207.19	534.53
3	2659.99	443.33	2932.82	488.80	3614.87	602.47
4	3001.02	500.17	3273.84	545.64	3955.89	659.31
5	3342.05	557.00	3614.87	602.47	4296.93	716.15
6	3683.07	613.84	3955.89	659.31	4637.95	772.99
7	4024.10	670.68	4296.93	716.15	4978.98	829.83
8	4433.33	738.88	4706.15	784.35	5320.01	886.66
Each addt'l person add	458.31	76.38	458.31	76.38	458.31	76.38

M0810 Changes

Changed With	Effective Date	Pages Changed
UP #7	7/1/12	page 2
UP #6	4/1/12	pages 1, 2
TN #95	3/1/11	Pages 1, 2
TN #93	1/1/10	pages 1, 2
Update (UP) #1	7/1/09	page 2

**3. Categorically
Needy-Non
Money Payment
(CNNMP) –
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-Non Money Payment 300% of SSI		
Family Size Unit	2012 Monthly Amount	2011 Monthly Amount
1	\$2,094	\$2,022

**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	3702.19	534.53

**5. ABD Medically
Indigent**

For:

**ABD 80% FPL,
QMB, SLMB, &
QI without Social
Security income;
all QDWI; all
MEDICAID
WORKS,
effective 1/26/12**

**ABD 80% FPL,
QMB, SLMB, &
QI with Social
Security income,
effective 3/1/12**

ABD 80% FPL	Annual	Monthly
1	\$8,936	\$745
2	12,104	1,009
QMB 100% FPL	Annual	Monthly
1	\$11,170	\$931
2	15,130	1,261
SLMB 120% of FPL	Annual	Monthly
1	\$13,404	\$1,117
2	18,156	1,513
QI 135% FPL	Annual	Monthly
1	\$15,080	\$1,257
2	20,426	1,703
QDWI and MEDICAID WORKS 200% of FPL	Annual	Monthly
1	\$22,340	\$1,862
2	30,260	2,522

Virginia DSS, Volume XII

S0830 Changes

Changed With	Effective Date	Pages Changed
Update #7	7/1/12	page 24
TN #94	9/1/10	page 29
TN #93	1/1/10	Table of Contents, page iv pages 28, 67, 119-120 pages 122-125
TN #91	5/15/09	Table of Contents, page i page 29

SMI premiums for January - March 1987, April - June 1987, and July - September 1987. A Title II check sent in July 1987 includes full benefits for January - June 1987 and refunds SMI premiums for August - September 1987, which will be withheld from future checks. For Medicaid purposes, the part of the check which represents full benefits for January - June 1987 is unearned income in July 1987 and the refunded SMI premiums for August - September 1987 are not income.

4. Retroactive State Buy-In

When a State "buys-in" for Medicare on behalf of an individual, a different amount of Title II income may be posted because of the Title II rounding provisions.

5. Underpayments

Title II benefits can be received in regular monthly checks (or by direct deposit) or in retroactive payments. If an individual receives a check because of an underpayment, charge the amount of the check (plus any SMI premiums withheld) as unearned income in the month received; do not look back and allocate an underpayment being made in the current month to prior months. See S0830.010 B. on counting retroactive RSDI benefits for an offset period. See S1120.022 for the treatment of reissued Title II monies in change-of-payee situations.

6. Facility of Payment Provisions

When a Title II auxiliary or survivor beneficiary who is subject to work deductions receives Title II benefits in his name because of the facility (something that makes an operation or action easier) of payment provisions but the benefits are those of other beneficiaries, the amount of Title II benefits of each of the involved beneficiaries must be determined separately. Count the benefits as income to the appropriate beneficiaries.

M0830.211 SPECIAL EXCLUSION OF TITLE II COLA FOR ABD MI

A. Policy

The cost-of-living adjustment (COLA) in the individual's Social Security Title II benefit is excluded through the month following the month in which the new federal poverty limits (FPLs) are published when determining the income eligibility of an individual in the following ABD medically indigent (MI) covered groups:

- Qualified Medicare Beneficiary (QMB)
- Special Low-income Medicare Beneficiary (SLMB),
- Qualified Individuals (QI), and
- ABD with Income \leq 80% FPL (ABD 80% FPL).

B. Procedure

Exclude the COLA in the individual's SSA Title II benefit until the first day of the second month following the publication month of the new FPL. Local agency staff are notified of the FPL publication via the Department of Social Services' Central Office broadcast system.

C. Example

A QMB-only Medicaid recipient who receives SSA Title II benefits receives a COLA in the benefit amount received in January 1998. The worker does not take any action on this change in income until the

Virginia DSS, Volume XIII

S1130 Changes

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

M1130.400 BURIAL SPACES

A. Policy –The Exclusion

1. General

A burial space or agreement which represents the purchase of a burial space held for the burial of the individual, his or her spouse, or any other member of his or her immediate family is an excluded resource, regardless of value.

Cemetery plots are not *counted as resources, regardless of the number owned*, except when evaluating eligibility as QDWI. For QDWI, exclude one cemetery plot (see Appendix 1 to chapter S11). *Accept declaration regarding ownership of cemetery plots. Verification is not required.*

2. No Effect on Burial Funds Exclusion

The burial space exclusion is in addition to, and has no effect on, the burial funds exclusion (M1130.410).

3. Multiple Burial Spaces

When items other than cemetery plots serve the same purpose, exclude only one per person. For example, exclude a cemetery plot and a casket for the same person, but not a casket and an urn.

B. Definitions

1. Burial Space

A burial space is a(n).

- Gravesite (either an existing grave or a plot);
- crypt;
- mausoleum;
- casket;
- urn;
- niche; or
- other repository customarily and traditionally used for the deceased's bodily remains.

The term also includes necessary and reasonable improvements or additions to such spaces, including but not limited to:

- vaults;
- headstones, markers, or plaques;
- burial containers (e.g., for caskets); and
- arrangements for the opening and closing of the gravesite.

For example, a contract for care and maintenance of the gravesite, sometimes referred to as endowment or perpetual care, can be excluded as a burial space.

M1310 Changes

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

TABLE OF CONTENTS

M13 SPENDDOWN

M1310 SPENDDOWN GENERAL PRINCIPLES AND DEFINITIONS

	Section	Page
General Principles of Medicaid Spenddown.....	M1310.100.....	1
Individuals In Medical Facilities or Receiving Medicaid CBC.....	M1310.200.....	2
Spenddown Definitions	M1310.300.....	2

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 Medicaid 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 MI 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 as categorically needy (CN), categorically needy non-money payment (CNNMP), in the ABD 80% FPL covered group, or as F&C MI; 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 or CNNMP.

- 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.

- 12. Incurred Expenses** Incurred expenses means expenses for medical, dental, or remedial care services:
- which are recognized under state law;
 - which are rendered to an individual, family, or legally responsible relative;
 - which the individual is liable for in the current budget period or was liable for in the three-month retroactive period; and
 - which are not subject to payment by any liable third party.
- An expense for a medical or remedial service is an incurred expense from the date the liability arises until the end of the budget period in which the expense is fully used to meet a spenddown.
- 13. Initial Application** An initial application is the individual’s first Medicaid MN spenddown application. There are two ways an individual can have an initial application:
- this is the individual’s first application for Virginia Medicaid, or
 - this is the first time the individual has been placed on a spenddown.
- 14. Legally Responsible Relative** A legally responsible relative is the individual’s spouse and/or, when the individual is under age 21, a parent who is responsible by law to support the individual. The legally responsible relative’s resources and income may be used in determining the individual’s Medicaid eligibility.
- 15. Liable Third Party** Liable third party means any individual, entity or program that is or may be liable to pay all or part of the cost of medical or remedial treatment for injury, disease or disability of a Medicaid applicant or recipient.
- 16. Medical Expense Record Form** The “Medical Expense Record-Medicaid” (#032-03-023) is a form provided to the client for keeping a chronological record of his medical expenses. It is used by the eligibility worker to determine if the spenddown has been met.
- 17. Medically Needy Income Limit (MNIL)** MNIL means the medically needy income limit. This is the income standard established to determine the financial eligibility of medically needy individuals and families.
- 18. Noncovered Expenses** Noncovered expenses are expenses for necessary medical and remedial services recognized under state law but not covered under the Medicaid State Plan, including those that exceed the Medicaid limitation on amount, duration, or scope of the service covered under the State Plan.

- 19. Old Bills** Old bills are unpaid medical, dental, or remedial care expenses which:
- were incurred prior to the Medicaid application’s retroactive period or
 - were incurred during the retroactive period if the individual either did not meet the retroactive spenddown or was not eligible for Medicaid in the retroactive period (for example, due to excess resources), and
 - were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and
 - remain a liability to the individual.

Old bills that are based on previous applications do not meet the definition of “old bills” when there has been a break in spenddown eligibility.

EXCEPTION: Bills paid by a state or local program are treated as old bills even though they are not the individual’s liability.

- 4. Prospective Budget Period** A prospective budget period is the prospective period of time during which income is projected for the purpose of determining spenddown eligibility.
- 21. Re-application** Re-application means any Medicaid medically needy spenddown application which is filed after the initial application.
- 22. Retroactive Spenddown Budget Period** The retroactive spenddown budget period is the retroactive period in which the individual is on a spenddown. The retroactive spenddown budget period is the 3 months immediately prior to the application month, when none of the months overlap (was included in) a previous MN spenddown budget period in which spenddown eligibility was established.
- When some of the months overlap a previous MN spenddown budget period in which spenddown eligibility was established, the retroactive spenddown budget period is shortened (prorated) to include only the month(s) which were not included in the previous MN spenddown budget period in which spenddown eligibility was established.
- 23. Spenddown** Spenddown is the process through which countable income is compared to the MNIL for the budget period and incurred expenses are deducted from excess countable income.
- 24. Spenddown Budget Period** A spenddown budget period is the budget period during which the individual’s or family’s countable income exceeds the MNIL for the budget period and during which the individual or family is placed on a spenddown.

- 25. Spenddown Eligibility** Spenddown eligibility means the individual established eligibility by meeting a spenddown within a spenddown budget period.
- 26. Spenddown Liability** The spenddown liability is the amount by which the individual's or family's countable income exceeds the MNIL for the budget period.
- 27. State or Territorial Public Program** A state or territorial public program is a public health program that is wholly or partially funded and administered by a state or territory, including a political subdivision thereof (i.e., SLH, GR, AG and CSB services).
- 28. State or Territorially-Financed Program** A state or territorially-financed program is a state or territorial public program whose funding, except for deductibles and coinsurance amounts required from program beneficiaries, is either:
- appropriated by the state or territory directly to the administering agency, or
 - transferred from another state or territorial public agency to the administering agency.

M1410 Changes

Changed With	Effective Date	Pages Changed
Update #7	7/1/12	pages 6, 7
TN #96	10/1/11	page 11, 12
TN #95	3/1/11	pages 13, 14 Page 15 was removed.
TN #94	9/1/10	pages 6, 7, 13
TN #93	1/1/10	pages 1, 7, 9, 12
TN #91	5/15/09	pages 11-14

2. Intellectual Disabilities/Mental Retardation Waiver

The Intellectual Disabilities/Mental Retardation (ID/MR) Waiver program is targeted to provide home and community-based services to individuals with mental retardation and individuals under the age of six years at developmental risk who have been determined to require the level of care provided in an ICF/MR, and to individuals with related conditions currently residing in nursing facilities who require specialized services. Services available through the ID/MR waiver include:

- day support
- supported employment
- residential support
- therapeutic consultation
- personal assistance
- respite care
- nursing services
- environmental modification
- assistive technology

3. Technology-Assisted Individuals Waiver

"Technology-Assisted" individual is one who is chronically ill or severely impaired, who needs both a medical device to compensate for the loss of a vital body function and substantial and ongoing skilled nursing care to avert death or further disability. The services provided through the waiver are expected to prevent placement, or to shorten the length of stay, in a hospital or nursing facility.

The services provided under this waiver include:

- private duty nursing
- respite care
- nutritional supplements
- medical supplies and equipment not otherwise available under the Medicaid State Plan.
-
-

4. Individual and Family Developmental Disabilities Support Waiver (DD Waiver)

The Individual and Family Developmental Disabilities (DD) waiver provides home and community-based services to individuals with developmental disabilities who do not have a diagnosis of mental retardation. The developmental disability must have manifested itself before the individual reached age 21 and must be likely to continue indefinitely.

The services provided under this waiver include:

- support coordination (case management)
- adult companion services
- assistive technology
- crisis intervention/stabilization
- environmental modifications
- residential support
- skilled nursing
- supported employment
- therapeutic consultation
- respite care
- personal attendant services
- consumer-directed personal and respite care.

5. Day Support Waiver for Individuals with Intellectual Disabilities/Mental Retardation

The Day Support Waiver for Individuals with *Intellectual Disabilities*/Mental Retardation (DS Waiver) is targeted to provide home and community-based services to individuals with mental retardation who have been determined to require the level of care provided in an ICF/MR. These individuals may currently reside in an ICF/MR or may be in the community at the time of assessment for DS Waiver services. Only those individuals on the urgent and non-urgent waiting lists for the *ID/MR* Waiver are considered for DS Waiver services. Individuals may remain on the *ID/MR* Waiver waiting list while receiving DS Waiver Services.

The services provided under this waiver include:

- day support
- prevocational services.

6. Alzheimer's Assisted Living Waiver

The Alzheimer's Assisted Living (AAL) Waiver is available only to individuals who are Auxiliary Grants (AG) recipients, have a diagnosis of Alzheimer's Disease or a related dementia, no diagnosis of mental illness or mental retardation, and who are age 55 or older. The AAL Waiver allows for the provision of services to individuals in approved assisted living facilities who, without the waiver, might require nursing home placement.

Individuals in this waiver do not have Medicaid eligibility determined as institutionalized individuals, and there are no post-eligibility requirements.

The services provided under the AAL waiver include:

- assistance with activities of daily living
- medication administration by licensed professionals.

Virginia DSS, Volume XIII

M1420 Changes

Changed With	Effective Date	Pages Changed
UP#7	7/1/12	pages 3, 4
TN #94	09/01/2010	Table of Contents pages 3-5 Appendix 3
TN #93	01/01/2010	pages 2, 3, 5 Appendix 3, page 1 Appendix 4, page 1

3. **Intellectual Disabilities/Mental Retardation (ID/MR) Waiver**
Local Community Mental Health Services Boards (CSBs) and the Department of Rehabilitative Services (DRS) are authorized to screen individuals for the ID/MR waiver. Final authorizations for ID/MR waiver services are made by DBHDS staff.
4. **Individual and Family Developmental Disabilities Support (DD) Waiver**
DMAS and the Virginia Health Department child development clinics are authorized to screen individuals for the DD waiver.
5. **Alzheimer's Assisted Living (AAL) Waiver**
Local screening committees or teams and hospital screening committees or teams are authorized to screen individuals for the AAL waiver; however, a copy of the pre-admission screening is not required for the Medicaid eligibility record. Documentation of the verbal assurance by the screeners must be included in the case record.
6. **Day Support Waiver for Individuals with Intellectual Disabilities/Mental Retardation (DS) Waiver**
Local CSB and DBHDS case managers are authorized to screen individuals for the DS waiver. Final authorizations for DS waiver services are made by DBHDS staff.

- D. PACE**
Local screening committees or teams and hospital screening committees or teams are authorized to screen individuals for PACE. If the individual is screened and approved for LTC, the committee/team will inform the individual about any existing PACE program that serves the individual's locality.

M1420.300 COMMUNICATION PROCEDURES

- A. Introduction**
To ensure that nursing facility/PACE placement or receipt of Medicaid CBC services are arranged as quickly as possible, there must be prompt communication between screeners and eligibility staff.
- B. Procedures**
 1. **LDSS Contact**
The LDSS agency should designate an appropriate staff member for screeners to contact. Local social services staff, hospital staff and DRS staff should be given the name and contact information for that person to facilitate timely communication between screeners and eligibility staff.
 2. **Screeners**
Screeners must inform the individual's eligibility worker when the screening process has been initiated and completed.

**3. Eligibility
Worker (EW)
Action**

The EW must inform both the individual and the provider once eligibility for Medicaid payment of LTC services has been determined. If the individual is found eligible for Medicaid and verbal or written assurance of approval by the screening committee has been received, the eligibility worker must give the LTC provider the enrollee's Medicaid identification number.

M1420.400 SCREENING CERTIFICATION

A. Purpose

The screening certification authorizes the local DSS to determine financial eligibility using the more liberal rules for institutionalized individuals, including the 300% SSI covered group and the special rules for married institutionalized individuals with a community spouse. The screening certification is valid for one year.

**B. Exceptions to
Screening**

Pre-admission screening is NOT required when:

- the individual is a patient in a nursing facility at the time of application;
- the individual received Medicaid LTC in one or more of the preceding 12 months and LTC was terminated for a reason other than no longer meeting the level of care;
- the individual is no longer in need of long-term care but is requesting assistance for a prior period of long term care;
- the individual enters a nursing facility directly from the EDCD waiver or PACE;
- the individual leaves a nursing facility and begins receiving EDCD waiver services or enters PACE and a pre-admission screening was completed prior to the nursing facility admission; or
- the individual enters a nursing facility from out-of-state.

C. Documentation

If the individual has not been institutionalized for at least 30 consecutive days *and a screening is required*, the screener's certification of approval for Medicaid long-term care must be substantiated in the case record by one of the following documents:

- Medicaid Funded Long-term Care Service Authorization Form (DMAS-96) for nursing facilities, PACE and EDCD and Tech Waivers (see Appendix 1);
- Technology Assisted Waiver Level of Care Eligibility Form (see Appendix 2);
- ID/MR Waiver Level of Care Eligibility Form (see Appendix 3);

Virginia DSS, Volume XIII

M1440 Changes

Changed With	Effective Date	Pages Changed
Update #7	7/1/12	Table of Contents pages 2, 14, 15, 18a-18c pages 19, 20
TN #94	09/01/2010	Table of Contents pages 13, 16, 18b, 19-22
TN #93	01/01/2010	pages 14, 16
TN #91	05/15/2009	Table of Contents page 12 pages 17-18c

TABLE OF CONTENTS

M14 LONG-TERM CARE

M1440.000 COMMUNITY-BASED CARE WAIVER SERVICES

	SECTION	Page
Governing Laws	M1440.001	1
Basic Eligibility Requirements	M1440.010	2
Institutional Status.....	M1440.020	3
CBC Waiver Descriptions	M1440.100	11
Elderly or Disabled with Consumer-Direction Waiver	M1440.101	11
Intellectual Disabilities/Mental Retardation Waiver.....	M1440.102.....	13
AIDS Waiver (<i>Expired July 1, 2012</i>)	M1440.103	14
Technology-Assisted Individuals Waiver	M1440.104	15
Day Support Waiver	M1440.105	16
Alzheimer's Assisted Living Waiver	M1440.106	17
Individual and Family Developmental Disabilities Support Waiver	M1440.107	17
Program of All-inclusive Care for the Elderly (PACE)	M1440.108	18
Covered Services	M1440.200	18a
Personal Care/Respite Care Services	M1440.201	18b
Adult Day Health Services	M1440.202	18b
<i>Reserved</i>	M1440.203	18c
Private Duty Nursing Services.....	M1440.204	19
Nutritional Supplements	M1440.205	19
Environmental Modifications	M1440.206	20
Residential Support Services	M1440.207	20
Personal Assistance Services.....	M1440.208	21
Assistive Technology Services.....	M1440.209	21
Day Support Services.....	M1440.210	21
Supported Employment Services	M1440.211	21
Therapeutic Consultation Services	M1440.212	22
Personal Emergency Response System (PERS)	M1440.213	22
Prevocational Services	M1440.214	22

M1440.010 BASIC ELIGIBILITY REQUIREMENTS

- A. Introduction** Services provided through the Waivers can be covered by Medicaid when the applicant or recipient meets the Medicaid eligibility requirements in this section.
- B. Waiver Requirements** The individual must meet the pre-admission screening criteria for CBC waiver services and the targeted population group requirement. Some of the targeted population groups are:
- individuals age 65 or older, blind or disabled
 - individuals with mental retardation
 - individuals who need a medical device to compensate for loss of a vital bodily function
 - individuals with developmental disabilities who do not have a diagnosis of mental retardation
- The eligibility worker does NOT make the determination of whether the individual meets the waiver requirements; this is determined by the pre-admission screener or by DMAS.
- NOTE: The individual cannot be authorized to receive services under more than one waiver at a time.
- C. Non-financial Eligibility** The individual must meet the Medicaid non-financial and financial eligibility requirements listed below:
- 1. Citizenship/ Alienage** The citizenship and alien status policy is found in subchapter M0220.
 - 2. Virginia Residency** The Virginia state resident policy specific to CBC waiver services patients is found in subchapter M0230.
 - 3. Social Security Number** The social security number policy is found in subchapter M0240.
 - 4. Assignment of Rights/ Cooperation** The assignment of rights and support cooperation policy is found in subchapters M0250 and M0260.
 - 5. Application for Other Benefits** The application for other benefits policy is found in subchapter M0270.
 - 6. Institutional Status** The institutional status requirements specific to CBC waiver services recipients are in section M1440.020 below.
 - 7. Covered Group** The requirements for the covered groups are found in subchapters M0320 and M0330.

All recommendations are submitted to Department of Behavioral Health and Developmental Services (DBHDS) or DMAS staff for final authorization.

1. CSB

The CSB case manager may only recommend waiver services if:

- the individual is found Medicaid eligible; and
- the individual is mentally retarded, or is under age 6 and at developmental risk; and
- the individual is not an inpatient of a nursing facility or hospital.

2. DRS

The DRS case manager may only recommend waiver services if:

- the individual is found Medicaid eligible, and
- the individual is in a nursing facility and has a related condition such as defined in the federal Medicaid regulations.

M1440.103 AIDS WAIVER (*Expired July 1, 2012*)

**A. General
Description**

The AIDS Waiver expired on July 1, 2012. The AIDS waiver provided services to individuals with HIV infection to prevent hospitalization or nursing facility placement. Individuals enrolled in the AIDS Waiver as of June 30, 2012 were given the option of enrolling in the EDCD Waiver, PACE or a Medicaid-participating nursing facility.

M1440.104 TECHNOLOGY-ASSISTED INDIVIDUALS WAIVER

- A. General Description** "Technology-Assisted" means any individual defined as chronically ill or severely impaired who needs both a medical device to compensate for the loss of a vital body function and substantial and ongoing skilled nursing care to avert death or further disability. The objective of the waiver is to provide medically appropriate and cost-effective coverage of services necessary to maintain these individuals in the community.
- B. Targeted Population** Individuals who need both 1) a medical device to compensate for the loss of a vital body function and 2) substantial and ongoing skilled nursing care.
- C. Eligibility Rules** The individual must meet the following basic requirements:
1. has a live-in primary care giver who accepts responsibility for the individual's health and welfare.
 2. is not receiving services in a general acute care hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded.
 3. is not residing in a board and care facility or adult care residence.
 4. All patients under the waiver must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid-eligible in a medical facility.
 5. Financial eligibility rules that apply to institutionalized individuals apply to patients under this waiver. Resource and income rules apply to waiver eligible individuals as if the individual were residing in a medical institution.
- The income limit used for this waiver is 300% of the current SSI payment standard for one person, or the medically needy (MN) income limit and spenddown.
- D. Services Available** The services provided under this waiver include:
- private duty nursing
 - respite care

Individuals who meet the criteria for the EDCD Waiver may be enrolled in PACE in lieu of the EDCD Waiver.

C. Eligibility Rules

For Medicaid to cover PACE services, the individual must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid eligible in a medical institution. The resource and income rules are applied to PACE-eligible individuals as if the individuals were residing in a medical institution.

The income limit used for PACE is 300% of the SSI limit (see M0810.002 A. 3.) or the MN income limit and spenddown.

PACE is not available to individuals who reside in an assisted living facility (ALF) and receive Auxiliary Grant (AG) payments. Individuals who reside in an ALF may be enrolled in PACE if they meet the functional, medical/nursing, and financial requirements, but they will not be permitted to receive an AG payment.

D. Services Available

The following services are provided through PACE:

- adult day care that offers nursing, physical, occupational, speech and recreational therapies;
- meals and nutritional counseling; social services;
- medical care provided by a PACE physician; personal care and home health care;
- all necessary prescription drugs;
- access to medical specialists such as dentists, optometrists and podiatrists; respite care;
- hospital and nursing facility care when necessary; and transportation.

E. Assessment and Service Authorization

Participation in PACE is **voluntary**. The nursing home pre-admission screening team will advise the individual of the availability of PACE and will facilitate enrollment if the Medicaid enrollee chooses PACE. The PACE team is responsible for authorizing as well as providing the services.

Eligibility for PACE must begin on the first day of a month and end on the last day of a month.

M1440.200 COVERED SERVICES

A. Introduction

This section provides general information regarding the LTC services provided under the waivers. This is just for your information, understanding, and referral purposes. The information does not impact the Medicaid eligibility decision.

B. Waiver Services Information

Information about the services available under a waiver is contained in the following sections:

- M1440.201 Personal Care/Respite Care Services
- M1440.202 Adult Day Health Services
- M1440.203 *Reserved*
- M1440.204 Private Duty Nursing Services

- M1440.205 Nutritional Supplements
- M1440.206 Environmental Modifications
- M1440.207 Residential Support Services
- M1440.208 Personal Assistance Services
- M1440.209 Assistive Technology Services
- M1440.210 Day Support Services
- M1440.211 Supported Employment Services
- M1440.212 Therapeutic Consultation Services
- M1440.213 Personal Emergency Response System (PERS)
- M1440.214 Prevocational Services

M1440.201 PERSONAL CARE/RESPITE CARE SERVICES

- A. What Are Personal Care Services** Personal Care services are defined as long term maintenance or support services which are necessary in order to enable the individual to remain at home rather than enter an institution. Personal Care services provide eligible individuals with aides who perform basic health-related services, such as helping with ambulation/exercises, assisting with normally self-administered medications, reporting changes in the recipient's conditions and needs, and providing household services essential to health in the home.
- B. What are Respite Care Services** Respite Care services are defined as services specifically designed to provide temporary but periodic or routine relief to the primary caregiver of an individual who is incapacitated or dependent due to frailty or physical disability. To receive this service the individual must meet the same criteria as the individual who is authorized for Personal Care, but the focus in Respite Care is on the needs of the caregiver for temporary relief. This focus on the caregiver differentiates Respite Care from programs which focus on the dependent or disabled care receiver.
- C. Relationship to Other Services** An individual may receive Personal Care or Respite Care in conjunction with Adult Day Health Care services as needed.
- When an individual receives Hospice services, the hospice is required to provide the first 21 hours per week of personal care needed and a maximum of an additional 38.5 hours per week.
- D. Who May Receive the Service** An individual must meet the criteria of the EDCD Waiver, the Technology-Assisted Waiver or the ID/MR Waiver in order to qualify for Personal/Respite Care services.

M1440.202 ADULT DAY HEALTH CARE SERVICES

- A. What Is Adult Day Health Care** Adult Day Health Care (ADHC) is a congregate service setting where individuals receive assistance with activities of daily living (e.g., ambulating, transfers, toileting, eating/feeding), oversight of medical conditions, administration of medications, a meal, care coordination including referrals to rehabilitation or other services if needed, and recreation/social activities. A person may attend half or whole days, and from one to seven days a week, depending on the patient's capability, preferences, and available support system.

- B. Relationship to Other Services** ADHC centers may provide transportation and individuals may receive this service, if needed, to enable their attendance at the center. An individual may receive ADHC services in conjunction with Personal Care or Respite Care services as needed.
- C. Who May Receive the Service** An individual must meet the EDCD Waiver criteria to qualify for ADHC services.

M1440.203 *Reserved*

M1440.204 PRIVATE DUTY NURSING SERVICES

- A. What is Private Duty Nursing** Private Duty Nursing services are called "nursing services" in the ID/MR waiver. These services are offered to medically fragile patients who require substantial skilled nursing care. Patients receive nursing services from Registered Nurses or Licensed Practical Nurses. Services are offered as needed by the patient, but always exceed what is available through the Home Health program.
- For example, in the Technology-Assisted waiver, most patients receive 8 hours or more of continuous nursing services at least four times per week. ID/MR Waiver patients may need the service for either routine nursing or in lieu of Home Health nursing.
- B. Relationship to Other Services** There are no requirements that other waiver services be or not be received.
- C. Who May Receive the Service** An individual must meet the Technology-Assisted waiver criteria or be eligible under the ID/MR waiver for nursing services. A Medicaid recipient who qualifies under EPSDT (Early & Periodic Screening, Diagnosis & Treatment) to receive private duty nursing services may also receive private duty nursing.

M1440.205 NUTRITIONAL SUPPLEMENTS

Nutritional Supplements (enteral nutrition products) are provided through DME (durable medical equipment) providers for patients who have an identified nutritional risk. Nutritional supplements are ordered by the individual's physician to cover a six-month period and Medicaid payment is authorized by the pre-admission screener or DMAS.

M1440.206 ENVIRONMENTAL MODIFICATIONS

- A. What is Environmental Modification** Environmental modification provides physical adaptations or modifications to the recipient's house or place of residence, work site or vehicle. The adaptations or modifications are needed to ensure the recipient's health or safety and enable him/her to live and function in a non-institutional setting.
- B. Relationship to Other Services** This service is available to patients who are receiving at least one other waiver service along with Case Management services.
- C. Who May Receive the Service** The service is available to individuals who qualify under the ID/MR waiver.

M1440.207 RESIDENTIAL SUPPORT SERVICES

- A. What is Residential Support** Residential Support services consist of training, assistance, and/or specialized supervision provided primarily in a recipient's home or in a licensed/certified residence considered to be his or her home. This cannot include room and board costs.
- These services can be provided in the individual's own home or in a licensed Adult Care Residence or with a certified Foster Care/Family Care provider. The services may be provided by the ACR, the foster family or by an external provider.
- B. Relationship to Other Services** This service cannot be offered to an individual who receives assisted living services in an ACR.
- C. Who May Receive the Service** This service is available to ID/MR Waiver patients.

M1440.208 PERSONAL ASSISTANCE SERVICES

- A. What is Personal Assistance Services** Personal Assistance services are available to recipients who do not receive Residential Support services, and for whom training and skills development are not primary objectives or are received in another service or program. Assistance is provided with bathing, dressing, eating, personal hygiene, activities of daily living, medication and/or other medical needs, and monitoring health status and physical condition.

M1450 Changes

Changed With	Effective Date	Pages Changed
UP #7	6/1/12	Table of Contents pages 37-43 Page 43a was added.
TN #96	10/1/11	Table of Contents pages 4-8 pages 15, 16, 25, 26 pages 31-38 page 31a removed.
TN #95	3/1/11	pages 4, 24,32, 36, 37, 37a, pages 39, 42, 43
TN #94	9/1/10	Table of Contents pages 36-37a, 39-44
TN #93	1/1/10	Table of Contents pages 3, 17-18, 29 Appendix 2, page 1
TN #91	5/15/09	pages 41, 42

TABLE OF CONTENTS

M14 LONG-TERM CARE

M1450.000 TRANSFER OF ASSETS

	Section	Page
Overview.....	M1450.001.....	1
Legal Base.....	M1450.002.....	1
Definition of Terms.....	M1450.003.....	2
Transfer of Assets Flow Chart	M1450.004.....	6
Reserved	M1450.100.....	7
Policy Principles.....	M1450.200.....	7
Assets That Are Not Resources for Transfer Rule	M1450.300.....	8
Transfers That Do Not Affect Eligibility	M1450.400.....	10
Transfers That Affect Eligibility	M1450.500.....	15
Purchase of Term Life Insurance.....	M1450.510.....	16
Purchase of Annuity Before February 8, 2006.....	M1450.520.....	17
Purchase of Annuity On or After February 8, 2006.....	M1450.530.....	18
Purchase of a Promissory Note, Loan, of Mortgage On or After February 8, 2006.....	M1450.540.....	19
Transfers Involving Life Estates	M1450.545.....	20
Transfers Involving Trusts	M1450.550.....	20
Income Transfers.....	M1450.560.....	23
Services Contracts	M1450.570.....	24
Applying a Penalty Period	M1450.600.....	25
Uncompensated Value.....	M1450.610.....	25
Reserved	M1450.620.....	31
Penalty Period Calculation	M1450.630.....	36
Subsequent Receipt of Compensation.....	M1450.640.....	39
Claim of Undue Hardship.....	M1450.700.....	40
Agency Action	M1450.800.....	43
Applicant/Enrollee Notice.....	M1450.810.....	43
Provider Notice	M1450.820.....	43a
DMAS Notice	M1450.830.....	44

Appendices

Average Monthly Private Nursing Facility Cost Prior to October 1, 1996.....	Appendix 1.....	1
Life Expectancy Table.....	Appendix 2.....	1
Settlement Statement, HUD-1	Appendix 3.....	1

C. Penalty Period Calculation

The penalty period is the number of months, including any fractional portion of a month that an individual will be ineligible for the Medicaid payment of LTC services.

The period is calculated by taking the uncompensated value of the assets transferred on or after the look-back date, divided by the average monthly cost of nursing facility services to a private-pay patient in his locality at the time of the application for Medicaid. The remainder is divided by the daily rate (the monthly rate divided by 31).

When the uncompensated value of an asset transfer is less than the monthly nursing facility rate, go to step #4 in E below to calculate the partial month penalty period.

D. Average Monthly Nursing Facility Cost (Figures Provided by Virginia Health Information)

Average Monthly Private Nursing Facility Cost

<u>Application Date</u>	<u>Northern Virginia*</u>	<u>All Other Localities</u>
10-1-96 to 9-30-97	\$2,564	\$2,564
10-1-97 to 12-31-99	\$3,315	\$2,585
01-01-00 to 12-31-00	\$3,275	\$2,596
01-01-01 to 12-31-01	\$4,502	\$3,376
01-01-02 to 12-31-03	\$4,684	\$3,517
01-01-04 to 9-30-07	\$5,403	\$4,060
10-1-07 to 12-31-10	\$6,654	\$4,954
01-01-11 and after	\$7,734	\$5,933

**The northern Virginia localities are: Alexandria, Arlington, Fairfax, Fairfax County, Falls Church, Manassas, Manassas Park and Prince William County.*

See M1450, Appendix 1 for amounts prior to October 1, 1996.

E. Partial Month Transfer

The following example shows how to compute a penalty period for an uncompensated transfer that occurred on or after February 8, 2006 and involving a partial month.

Example #19: An individual makes an uncompensated asset transfer of \$30,534 in April 2006, the same month he applies for Medicaid. The uncompensated value of \$30,534 is divided by the average monthly rate of \$4,060 and equals 7.52 months. The full 7-month penalty period runs from April 2006, the month of the transfer, through October 2006, with a partial penalty calculated for November 2006. The partial month penalty is calculated by dividing the partial month penalty amount (\$2,114) by the daily rate. The calculations are as follows:

Step #1	\$30,534.00	uncompensated value of transferred asset
	÷ 4,060.00	avg. monthly nursing facility rate at time of application
	= 7.52	penalty period (7 full months, plus a partial month)
Step #2	\$4,060.00	avg. monthly nursing facility rate at time of application
	X 7	seven-month penalty period
	\$28,420.00	penalty amount for seven full months

Step #3 \$30,534.00 uncompensated value
- 28,420.00 penalty amount for seven full months
\$ 2,114.00 partial month penalty amount

Step #4 \$2,114.00 partial penalty amount
÷ 130.97 daily rate (\$4,060 ÷ 31)
= 16.14 number of days for partial month penalty

For November 2006, the partial month penalty of 16 days would be added to the seven (7) month penalty period. This means that Medicaid would authorize payment for LTC services beginning November 17, 2006.

F. Penalty Period for a Couple When Both Are Eligible and Institutionalized

When an institutionalized individual is ineligible for Medicaid payment of long-term care services because of a transfer made by the spouse, and the spouse is or becomes institutionalized and eligible for Medicaid, the penalty period must be apportioned between the spouses. *The couple may choose to either:*

- *have the penalty period, or the remaining time in the penalty period, divided between the spouses, or*
- *assign the penalty period or remaining penalty period to one of the two spouses.*

*When one spouse is no longer subject to the penalty, such as one spouse is no longer institutionalized or one spouse dies, the remaining penalty period applicable to **both** spouses must be applied to the remaining spouse.*

EXAMPLE #18: *Mr. A. enters a nursing facility and applies for Medicaid. Mrs. A. transfers an asset that results in a 36 month penalty period for Mr. A. 12 months into the penalty period, Mrs. A. enters a nursing facility and is eligible for Medicaid. The penalty period against Mr. A. still has 24 months to run. Because Mrs. A. is now in a nursing facility and a portion of the penalty period remains, the penalty period is reviewed. Mr. and Mrs. A. decide to have the penalty period divided between them. Therefore, both Mr. A. and Mrs. A. are ineligible for Medicaid payment of LTC services for 12 months beginning the first day of Mrs. A's Medicaid eligibility.*

After 6 months, Mr. A. leaves the facility and is no longer institutionalized. Mrs. A. remains institutionalized. Because Mr. A. is no longer subject to the penalty, the remaining total penalty period for the couple, 12 months (6 months for Mr. A. and 6 months for Mrs. A.), must be imposed on Mrs. A. If Mr. A. becomes institutionalized again before the end of the 12 months, the remaining penalty period is again reviewed and divided or applied to one spouse, depending on the couple's choice.

M1450.640 SUBSEQUENT RECEIPT OF COMPENSATION**A. Policy**

When all assets transferred are returned to the individual, no penalty for transferring assets can be assessed. When a penalty has been assessed and payment for services has been denied, a return of the assets requires a retroactive evaluation, including erasure of the penalty, back to the beginning of the penalty period.

However, such an evaluation does not necessarily mean that Medicaid payment for LTC services must be paid on behalf of the individual. Return of the assets in question to the individual leaves the individual with assets which must be evaluated in determining eligibility during the retroactive period. Counting those assets as available may result in the individual being ineligible (because of excess income or resources) at the time of evaluation as well as for a period of time after the assets are returned.

NOTE: To void imposition of a penalty, all of the assets in question or their fair market equivalent must be returned. For example, if the asset was sold by the individual who received it, the full market value of the asset must be returned to the transferor.

When only part of an asset or its equivalent value is returned, a penalty period can be modified but not eliminated. For example, if only half of the value of the asset is returned, the penalty period can be reduced to one-half.

**B. Example #20
Full Compensation
Received**

Example #20 Mr. G., who is in a nursing facility, applied for Medicaid on November 24, 2011. On October 10, 2011, he transferred his non-home real property worth \$46,404 to his son. The transfer did not meet any of the criteria in M1450.400, so a penalty period was imposed from October 1, 2011, through April 30, 2012.

On December 12, 2011, Mr. G.'s son paid *some outstanding* medical bills *that were not related to long-term care* for his father totaling \$47,000. The agency re-evaluated the transfer and determined a penalty period was no longer appropriate since full compensation was received. Mr. G.'s eligibility for Medicaid payment of long-term care services was re-evaluated, beginning with October 1, 2011.

**C. Example #21
Partial
Compensation
Received**

Example #21: Ms. H. applied for Medicaid on November 2, 2004, after entering a nursing facility on March 15, 2004. On October 10, 2004, she transferred her non-home real property worth \$40,000 to her son and received no compensation in return for the property. Ms. H.'s Medicaid application was approved, but she was ineligible for Medicaid payment of long-term care services for 9 months beginning October 1, 2004 and continuing through June 30, 2005.

On December 12, 2004, the agency verified that Ms. H.'s son paid her \$20,000 for the property on December 8, 2004. The agency re-evaluated the transfer and determined a remaining uncompensated value of \$20,000 and a penalty period of 4 months, beginning October 1, 2004, and continuing through January 31, 2005.

The \$20,000 payment must be evaluated as a resource in determining Ms. H.'s Medicaid eligibility for January 2005.

M1450.700 CLAIM OF UNDUE HARDSHIP

A. Policy

The opportunity to claim an undue hardship must be given when the imposition of a penalty period affects Medicaid payment for LTC services. An undue hardship may exist when the imposition of a transfer of assets penalty period would deprive the individual of medical care such that the individual's health or life would be endangered or he would be deprived of food, clothing, shelter, or other necessities of life. An undue hardship may be granted when documentation is provided that shows:

- that the assets transferred cannot be recovered, and
- that the immediate adverse impact of the denial of Medicaid coverage for payment of LTC services due to the uncompensated transfer would result in the individual being removed from the institution or becoming unable to receive life-sustaining medical care, food, clothing, shelter or other necessities of life.

Applicants, recipients, or authorized representatives may request an undue hardship evaluation. Additionally, the Deficit Reduction Act of 2005 authorized nursing facilities to act on behalf of their patients, when necessary, to submit a request for undue hardship. The nursing facility must have written authorization from the recipient or his authorized representative in order to submit the claim of undue hardship.

A claim of undue hardship:

- can be made for an individual who meets all Medicaid eligibility requirements and is subject to a penalty period,
- cannot be made on a denied or closed Medicaid case,
- *cannot be made when the penalty period has already expired, and*
- cannot be used to dispute the value of a resource.

B. Procedures

If the individual chooses to make a claim of an undue hardship, documentation regarding the transfer and the individual's circumstances must be sent to the Department of Medical Assistance Services (DMAS) for an undue hardship determination **prior** to the eligibility worker taking action to impose a penalty period.

The individual has the burden of proof and must provide written evidence to clearly substantiate what was transferred, the circumstances surrounding the transfer, attempts to recover the asset or receive compensation, and the impact of the denial of Medicaid payment for LTC services.

1. Eligibility Worker

The eligibility worker must inform the individual of the undue hardship provisions and, if an undue hardship is claimed, send the claim and supporting documentation to DMAS for evaluation.

The eligibility worker must send a letter to the individual informing him of each asset transfer and the corresponding penalty period, as well as the right to claim an undue hardship. An Asset Transfer Hardship Claim Form, available on the VDSS local agency intranet at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi, must be included with the letter. The Asset Transfer Hardship Claim Form serves as the request for an undue hardship evaluation.

a. Undue Hardship Claimed - Required Documentation

When requesting an undue hardship, the individual must provide the following documentation:

- the reason(s) for the transfer;
- attempts made to recover the asset, including legal actions and the results of the attempts;
- notice of pending discharge from the facility or discharge from CBC services due to denial or cancellation of Medicaid payment for these services;
- physician's statement that inability to receive nursing facility or CBC services would result in the applicant/recipient's inability to obtain life-sustaining medical care;
- documentation that individual would not be able to obtain, food, clothing or shelter;
- list of all assets owned and verification of their value at the time of the transfer if the individual claims he did not transfer resources to become Medicaid eligible; and
- documents such as deeds or wills if ownership of real property is an issue.

b. 10 Days to Return Undue Hardship Claim

The individual must be given 10 calendar days to return the completed form and documentation to the local agency. *If the form and documentation are not returned within 10 calendar days, the penalty period must be imposed.*

c. Documentation for DMAS

If an undue hardship is claimed, the eligibility worker must send to DMAS:

- a copy of the undue hardship claim form
- a description of each transfer:
 - what was transferred
 - parties involved and relationship
 - uncompensated amount
 - date of transfer

- the penalty period(s)
- a brief summary of the applicant/recipient's current eligibility status and living arrangements (nursing facility or community), and
- other documentation provided by the applicant/recipient

Send the documentation to DMAS at the following address:

DMAS, Division of Policy and Research
Eligibility Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

A copy of all documentation submitted with the undue hardship claim must be retained in the case record.

d. When Applicant/Recipient Was Victim

If the applicant/recipient was a victim of an individual who is not the individual's attorney in fact, guardian, conservator or trustee and undue hardship is claimed, the **agency** must provide a statement documenting the facts and what actions were taken by the agency with regard to their findings. If the transfer was by a court-appointed guardian or conservator, documentation of any bond insurance that would cover the loss must be provided.

e. Undue Hardship Not Claimed or Not Granted by DMAS

If undue hardship is not claimed or if a penalty period must be imposed per DMAS, follow the procedures in M1450.800 through M1450.830 for notifying the individual and DMAS of the action. The individual must be

informed that a denial of a claim for undue hardship may be appealed in accordance with the provisions of 12 VAC 30-110. If the individual meets all other eligibility requirements, he is eligible for Medicaid payment of all covered services other than LTC.

2. DMAS

DMAS will review the documentation provided with the undue hardship claim to determine if an undue hardship may be granted and send written notification to the eligibility worker. If additional *information* is needed to *clarify the documentation received* with the Undue Hardship claim, DMAS will notify the agency and provide a time frame for submitting the documentation. A copy of the decision must be retained in the individual's case record.

3. Subsequent Claims

If DMAS is unable to *approve an undue hardship request because sufficient supporting documentation was not submitted, the claim must be denied. Once a claim is denied, no further decision related to the same asset transfer* will be made by DMAS, should the individual reapply for Medicaid coverage of LTC services.

M1450.800 AGENCY ACTION

- A. Policy** If an individual's asset transfer is not allowable by policy, the individual is not eligible for Medicaid payment of long-term care services. The individual, the service provider, and the Department of Medical Assistance Services (DMAS) must be notified of his/her ineligibility for *the* Medicaid payment of long-term care services, *as well as his eligibility or ineligibility for Medicaid per M1450.810 below.*
- B. Procedures** The procedures used for notifying the recipient, the provider and DMAS are in sections M1450.810, 820, and 830 below.

M1450.810 APPLICANT/RECIPIENT NOTICE

- A. Policy** Whenever an institutionalized individual is not eligible for Medicaid payment of long-term care services because of an asset transfer, the notice to the individual must contain the following:
- 1. Notice Includes Penalty Period** The form which notifies him/her of Medicaid eligibility must include the penalty period during which Medicaid will not cover LTC services for the individual.
 - 2. Individual In Facility - Eligible** An individual in a nursing or other medical facility continues to meet the definition of an institutionalized person. If the individual meets all other Medicaid eligibility requirements, he is eligible for Medicaid in the 300% SSI covered group, except for payment for LTC services.
 - 3. Individual Not in Facility - Not Eligible** An individual outside a medical facility (i.e. living in the community) **does not** meet the definition of an institutionalized person if he is not receiving Medicaid covered CBC services, *PACE or hospice services*. Therefore, an individual for whom a penalty period is imposed cannot be eligible for Medicaid unless the individual is eligible for Medicaid outside the 300% SSI covered group.
 - 4. Referral to DMAS Recipient Audit Unit (RAU)** *If the individual already received Medicaid long-term care services during a penalty period or made a claim of an undue hardship for imposition of a penalty period and the claim was approved, a referral to the DMAS RAU must be made. The DMAS Eligibility Section will make the referral to RAU for approved claims of an asset transfer undue hardship. The LDSS must make all other referrals for recovery.*
- B. Notice Contents** The Notice of Action on Medicaid sent to the individual must specify that:
- Medicaid will not pay for nursing facility or CBC waiver services for the months (state the begin and end dates of the penalty period) because of the uncompensated asset transfer(s) that occurred on (date/dates);
 - the penalty period may be shortened if compensation is received.

The notice must also specify that either:

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

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

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

C. Advance Notice

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

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

M1450.820 PROVIDER NOTICE

A. Introduction

Use the Medicaid LTC Communication Form (DMAS-225) to notify the provider of the individual's Medicaid eligibility and ineligibility for Medicaid payment of long-term care services.

B. Medicaid LTC Communication Form (DMAS-225)

The DMAS-225 should include:

- the individual's full name, Medicaid and Social Security numbers;
- the individual's birth date;
- the patient's Medicaid coverage begin date; and
- that the patient is not eligible for Medicaid payment of nursing facility/CBC waiver services for the months (state the penalty period begin and end dates) because of an asset transfer(s).

Virginia DSS, Volume XIII

M1460 Changes

Changed With	Effective Date	Pages Changed
UP #7	7/1/12	pages 4a
UP #6	4/1/12	pages 3, 35
TN #96	10/1/11	pages 3, 20, 21
TN #95	3/1/11	pages 3, 4, 35
TN #94	9/1/10	page 4a
TN #93	1/1/10	pages 28, 35
TN #91	5/15/09	pages 23, 24

- provide inflation protection:
 - under 61 years of age, compound annual inflation protection,
 - 61 to 76 years of age, some level of inflation protection, or
 - 76 years or older, inflation protection may be offered, but is not required.

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

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

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

M1460.200 DETERMINATION OF COVERED GROUP

A. Overview

An individual in LTC who meets the Medicaid non-financial eligibility requirements in M1410.010 must also meet the requirements of at least one covered group in order to be eligible for Medicaid and Medicaid payment of LTC services.

1. Covered Groups Eligible for Long Term Care Services

The covered groups whose benefit packages include long-term care services are the following groups:

- a. All categorically needy (CN) covered groups.
- b. All categorically needy non-money payment (CNNMP) covered groups.
- c. ABD with income \leq 80% FPL (ABD 80% FPL).
- d. All medically indigent (MI) Families & Children (F&C) covered groups:
 - pregnant women and newborns under age 1 year,
 - children under age 19.
- e. All medically needy (MN) covered groups; however, Medicaid will not pay for the following services for MN individuals:
 - services in an intermediate care facility for the mentally retarded (ICF-MR),
 - services in an institution for the treatment of mental disease (IMD),
 - Intellectual Disabilities/Mental Retardation (ID/MR) Waiver services, and
 - Individual and Family Development Disability Support (DD) Waiver services.

M1470 Changes

Changed With	Effective Date	Pages Changed
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

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, 2012 through December 31, 2012: \$1,151
- January 1, 2011 through December 31, 2011: \$1,112.

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.

**D. Patient Pay
Increases**

Using the MMIS Patient Pay process, reflect a patient pay increase effective the month following the month in which the 10-day advance notice period ends when:

- the patient's income increases;
- an allowable deduction stops or decreases.

**1. Prospective
Month(s)**

Calculate the new patient pay based on the current income and make the change effective the month following the month in which the 10-day advance notice period ends. This will be the new ongoing patient pay.

**2. Current and
Past Month(s)**

Determine the amount of the recipient underpayment when:

- the income counted was less than the income actually received; or
- an allowable deduction stopped or decreased.

Do not revise the patient pay retroactively for the current and past month(s) unless the requirements in section M1470.910 below are met.

3. Procedures

a. Determine the amount of the underpayment(s):

- 1) Calculate the new monthly patient pay based on the change(s), beginning with the month in which the change occurred.
- 2) Subtract the "old" monthly patient pay from the "new" monthly patient pay amount. The result is the amount of the recipient's underpayment for that month.
- 3) Add the monthly underpayment(s) together to determine the total amount of the recipient's underpayment. If the underpayment is less than \$1,500, follow the procedures in "b" below. If the underpayment is \$1,500 or more, follow the procedures in "c" below.

b. Total underpayment of less than \$1,500

To adjust the patient pay obligation for the month following the month in which the 10-day advance notice period ends, take the following steps:

- 1) Add the total underpayment to the new ongoing patient pay. This is the total patient pay obligation.
- 2) Compare the total patient pay obligation to the provider's Medicaid rate.
 - a) If the total patient pay obligation is less than the provider's Medicaid rate, the total amount of the patient's underpayment can be collected in one month. The total patient pay obligation is the patient pay for the month following the month in which the 10-day advance notice period ends.

- b) If the total patient pay obligation exceeds the provider's Medicaid rate, determine the difference between the ongoing patient pay and the provider's Medicaid rate. The difference is the amount of the underpayment that can be collected the first month. The patient pay for the first month (current patient pay and a portion of the underpayment) will equal the Medicaid rate. The balance of the underpayment must be collected in subsequent months. Repeat these procedures for subsequent months until the total amount of the underpayment has been reduced to zero.

c. Total underpayment of \$1,500 or more

- 1) Underpayment amounts totaling \$1,500 or more must be referred to the DMAS Recipient Audit Unit for collection.
 - a) Complete and send a "Notice of Recipient Fraud/Non-Fraud Overissuance" (see Appendix 1 to chapter M17) to:

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

- b) Complete and send a "Notice of Action on Medicaid" (available at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) informing the patient of the referral to DMAS for collection of the underpayment.

- 2) Prospective months' patient pay

MMIS will automatically generate and send a "Notice of Obligation for LTC Costs" to the patient or the patient's representative for the month following the month in which the 10-day advance notice period ends.

**4. Example--
Patient Pay
Increase -Total
Underpayment
Less than
\$1,500**

Mr. S is an aged individual who has received Medicaid covered CBC services for two years. His "old" monthly patient pay was \$300. On February 25, he reports his pension increased \$50 per month in February. On March 22 the EW recalculated the patient pay based on the current income. His new monthly patient pay is \$350. Because of the 10-day advance notice requirement the change could not be made for April and must be made for May 1.

His "old" patient pay is subtracted from his "new" patient pay for February, March and April to determine his underpayment for those months. The \$50 underpayment for three months (\$150) is added to his "new" ongoing patient pay (\$350) and the total patient pay obligation (\$500) is compared to the Medicaid rate of \$1,700. Since the total patient pay obligation of \$500 is less than the Medicaid rate of \$1,700, the patient pay for May is \$500. The ongoing patient pay starting in June is \$350.

**5. Example--
Patient Pay
Increase -Total
Underpayment
\$1,500 or More**

Mr. M is an institutionalized individual. On February 25, he reports his pension increased \$600 per month in February. On March 22 the EW recalculated the patient pay based on the current income. His new monthly patient pay is \$1,800. His "old" monthly patient pay was \$1200.

Because of the 10-day advance notice requirement the change could not be made for April and must be made for May 1. His "old" patient pay is subtracted from his "new" patient pay for February, March and April to determine his underpayment for those months. The \$600 underpayment for three months totals \$1,800. Since the total underpayment exceeds \$1,500, a patient pay adjustment can not be made. A referral must be made to the DMAS Recipient Audit Unit for collection and the recipient must be notified of the referral (see M1470.900 D. 3. c).

M1470.910 RETROACTIVE ADJUSTMENTS FOR PRIOR MONTHS

**A. Retroactive
Adjustment**

If a change was reported timely and the patient pay for prior months is incorrect, adjust the patient pay for the prior months only in the following situations:

1. a deceased individual had health insurance premiums or noncovered medical expenses that should have reduced patient pay; *or*
2. a community spouse is owed money for a spousal allowance and the institutionalized spouse is deceased or no longer in long-term care. However, if the community spouse had decreased income and did not report the change in a timely manner, do not adjust the patient pay.

In these situations, adjust the patient pay retroactively using MMIS Patient Pay process for the prior months in which the patient pay was incorrect. **In all other situations when a change is reported timely, do not adjust the patient pay retroactively.**

**B. Notification
Requirements**

MMIS automatically generates and sends the Notice of Obligation for LTC Costs.

M1470.920 LTC PROVIDER CHANGE WITHIN A MONTH

A. Policy

A change in LTC providers requires a review of patient pay to determine if a patient pay amount needs to be paid to the new provider. When a recipient changes LTC providers within a month, revise the patient pay if necessary.

B. Procedures

This procedure applies to the following changes in LTC Providers during a month:

- CBC Provider to CBC Provider;
- Nursing Facility Provider to Nursing Facility Provider;
- CBC Provider to Nursing Facility Provider; and
- Nursing Facility Provider to CBC Provider

M1480 Changes

Changed With	Effective Date	Pages Changed
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

- 3. Verification** The EW must advise the requesting party of the verification necessary to complete the assessment. Ownership interest and value of resources held **on the first moment of the first day of** the first month of the first continuous period of institutionalization must be verified.

Verify all non-excluded resources. Acceptable verification, for example, is a copy of the couple's bank statement(s) for the period. Do not send bank clearances; the requesting party is responsible to obtain verification of resources.

The EW is not required to assist the requesting party in obtaining any required verification for the resource assessment.

- 4. Failure To Provide Verification** If the applicant refuses to or fails to provide requested verification of resources held at the beginning of the first continuous period of institutionalization and does not notify the EW of difficulty in securing the requested data, the worker is unable to complete the resource assessment and is unable to determine the spousal share of resources. Go to item 8 below, "Notification Requirements."

- 5. Processing Time Standard** A resource assessment must be processed within 45 days of the date on which the agency receives the written and signed Medicaid Resource Assessment Request form.

If the requestor fails to provide requested verification within 45 days of receipt of notification, notify the applicant that the assessment cannot be completed, and of the reason(s) why. Use the Notice of Medicaid Resource Assessment (#032-03-817).

- 6. Completing the Medicaid Resource Assessment Form or Electronic Workbook** When verification is provided, completion of the resource assessment establishes the spousal share which is equal to ½ of a couple's total countable resources as of **the first moment of the first day of** the first month of the first continuous period of institutionalization that began on or after September 30, 1989.

a. Compile the Couple's Resources

The value of non-excluded resources must be verified and recorded. Either the Medicaid Resource Assessment form (#032-03-816) or the electronic Resource Assessment and Eligibility Workbook may be used. The workbook is located on *SPARK* at <http://spark.dss.virginia.gov/divisions/bp/me/training/index.cgi>.

Excluded resources must be listed separately on the form or electronic workbook, but their value does not need to be noted or verified.

On the assessment form, list all resources in which the couple has an ownership interest, including resources in their joint names, those in the institutionalized spouse's name and those in the community spouse's name, including those resources owned jointly with others. List each resource separately.

Resources owned in the name of one or both spouses are considered available regardless of whether either spouse agrees to sell or liquidate the resource, and regardless of whether either spouse refuses to make the resource available. The resource assessment is not affected by the amount disregarded in the eligibility determination as a result of a Partnership Policy.

C. Appeal Rights

When the resource assessment is completed as part of a Medicaid application and eligibility determination, the spousal share calculation can be appealed pursuant to the existing Client Appeals regulations (VR 460-04-8.7).

D. Eligibility Worker Responsibility

Each application for Medicaid for a person receiving LTC services who has a community spouse requires the completion of a resource assessment to determine the spousal share used in determining eligibility.

The EW must provide the applicant with a written request for verification of:

- all reported countable resources owned by the couple **on the first moment of the first day of the first month (FOM)** of the first continuous period of institutionalization. Request this information using the Medicaid Resource Assessment form (#032-03-816) when the FOM is prior to the application's retroactive period.
- all reported countable resources owned by the couple on the first moment of the first day of the month of application, and
- all reported countable resources owned by the couple as of the first moment of the first day of each retroactive month for which eligibility is being determined.

To expedite the application processing, the EW may include a copy of the "Intent to Transfer Assets to A Community Spouse" form, available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi with the request for verifications.

The same verification requirements as for all Medicaid applications apply to the resource assessment.

If the applicant reports to the EW that he cannot obtain certain verifications, the EW must determine why he cannot obtain them and what the EW can do to assist the applicant.

E. Procedures

The resource assessment is only a part of the eligibility determination process. The spousal share is calculated as a result of the resource assessment. The spousal share is used in the calculation of the spousal protected resource amount (PRA) and the institutionalized spouse's countable resources.

1. Forms

The applicant or his representative does not complete a Medicaid Resource Assessment Request form. The Medicaid application is the resource assessment request.

Either the Medicaid Resource Assessment form (#032-03-816) or the electronic Resource Assessment and Eligibility Workbook may be used to complete the assessment of resources and spousal share calculation at the time of the first continuous period of institutionalization. The workbook is located on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/training/index.cgi>.

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	\$22, 728	1-1-12
	\$21,912	1-1-11

C. Maximum Spousal Resource Standard	\$113, 640	1-1-12
	\$109,560	1-1-11

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.

**C. Example--
 Calculating the PRA**

EXAMPLE #4: (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>.)

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

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

Step 2: $\$130,000 \div 2 = 65,000$. The spousal share is \$65,000.

Step 3: The couple's total countable resources as of December 1, 1997 (the first moment of the first day of the month for which eligibility is being determined), are \$67,000.

Step 4: Determine the spousal protected resource amount (PRA). The spousal PRA is the greatest of:

- \$65,000 (the spousal share, which is less than the maximum spousal resource standard of \$79,020 in December 1997, the time of application).
- \$15,804 (the spousal resource standard in December 1997, the time of the application).
- \$0 (court-ordered spousal support resource amount or DMAS hearing decision amount; there is neither in this case).

Since \$65,000 is the greatest, \$65,000 is the PRA.

Step 5: Deduct the PRA from the couple’s combined countable resources as of December 1, 1997 (the first moment of the first day of the month for which eligibility is being determined).

\$67,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined (December 1, 1997)
-	65,000
Step 4 PRA	
\$2,000	countable resources in month for which eligibility is being determined (December 1, 1997).

B. CSRA Calculation Procedures

Use the following procedures for calculating the CSRA. 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> may be used to determine countable resources and the CSRA.

1. Determine Community Spouse's Resources

Determine the amounts of the couple's total resources which are in the community spouse's name only and the community spouse's share of jointly owned resources owned as of the first moment of the first day of the initial month for which eligibility was established.

2. Determine Institutionalized Spouse's Resources

Determine the amounts of the couple's total resources which are in the institutionalized spouse's name only and the institutionalized spouse's share of jointly owned resources owned as of the first moment of the first day of the initial month for which eligibility was established. If the institutionalized spouse's resources changed during initial month (after the first moment of the first day of the initial month which eligibility was established) verify the institutionalized spouse's resources owned as of the first moment of the first day of the month following the initial month.

3. Calculate CSRA

To calculate the Community Spouse Resource Allowance (CSRA):

a. Determine PRA

Find the spousal PRA (determined in section M1480.232 above).

b. Subtract CS Resources from the PRA

Subtract from the PRA an amount equal to the resources in the community spouse's name only and the community spouse's share of jointly owned resources as of the first moment of the first day of the initial month in which eligibility was established.

c. Remainder

The remainder, if greater than zero, is the CSRA and the amount to be disregarded in the institutionalized spouse's Medicaid eligibility determination during the protected period. This is the amount to be transferred to the community spouse during the protected period.

If the remainder is \$0 or a negative number, the CSRA = \$0. The community spouse does not have a CSRA.

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**

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

<i>\$2,841.00</i>	<i>1-1-12</i>		
<i>\$2,739.00</i>	<i>1-1-11</i>		
- D. Excess Shelter Standard**

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

<i>\$274</i>	<i>1 - 3 household members</i>	<i>10-1-11</i>	
<i>\$345</i>	<i>4 or more household members</i>	<i>10-1-11</i>	
<i>\$303</i>	<i>1 - 3 household members</i>	<i>10-1-10</i>	
<i>\$382</i>	<i>4 or more household members</i>	<i>10-1-10</i>	

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).

- B. What Is Patient Pay** The institutionalized spouse's gross monthly income, less all appropriate deductions according to this section, constitutes the patient pay - the amount of income the institutionalized spouse will be responsible to pay to the LTC facility or waiver services provider. The community spouse's and family member's monthly income allowances rules for patient pay apply to all institutionalized spouses with community spouses, regardless of when institutionalization began.
- C. Dependent Allowances** A major difference in the institutionalized spouse patient pay policy is the allowance for a dependent child and for a dependent family member. If the institutionalized spouse has a dependent child, but the dependent child does NOT live with the community spouse, then **NO** allowance is deducted for the child. Additionally, an allowance may be deducted for other dependent family members living with the community spouse.
- D. Home Maintenance Deduction** A major difference in the institutionalized spouse patient pay policy is the home maintenance deduction policy. A married institutionalized individual with a community spouse living in the home is **NOT allowed** the home maintenance deduction because the community spouse allowance provides for the home maintenance, **UNLESS**:
- the community spouse is not living in the home (e.g., the community spouse is in an ACR), and
 - the institutionalized spouse still needs to maintain their former home.
- E. MMIS Patient Pay Process** The patient pay is calculated in the Medicaid Management Information System (MMIS) using the Patient Pay process. The patient pay must be updated in MMIS whenever the patient pay changes, but at least once every 12 months. Refer to the MMIS User Guide for information regarding data entry into MMIS.
- The MMIS Allowance and Medically Needy Workbook is available to facilitate the calculation of certain allowances that must be computed outside of MMIS and to calculate patient pay for Medically Needy determinations. The workbook is available at <http://spark.dss.virginia.gov/divisions/bp/me/training/index.cgi>.
- The Automated Response System (ARS) and the MediCall System convey the necessary patient pay information to the provider.

M1480.430 ABD 80% FPL and 300% SSI PATIENT PAY CALCULATION

- A. Patient Pay Gross Monthly Income** Determine the institutionalized spouse's patient pay gross monthly income for patient pay. Use the gross income policy in section M1480.310 B.1 for both covered groups.
- B. Subtract Allowable Deductions** **If the patient has no patient pay income, he has no patient pay deductions.**
- When the patient has patient pay income, **deduct the following amounts in the following order** from the institutionalized spouse's gross monthly patient pay income. Subtract each subsequent deduction as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.

\$875	gross earned income
- 75	first \$75 per month
800	remainder
<u>± 2</u>	
400	½ remainder
<u>± 75</u>	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, 2012 through December 31, 2012: \$1,151
- January 1, 2011 through December 31, 2011: \$1,112.

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.

M1510 Changes

Changed With	Effective Date	Pages Changed
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

- 3. Spenddown Enrollees** Medicaid entitlement ends on the last day of the last month in the spenddown budget period, unless the individual's or family's circumstances change before that date.
- C. Ongoing Entitlement After Resources Are Reduced** When an applicant has excess resources throughout the application month, he is not eligible for Medicaid for the month of application. An applicant who reduces excess resources during the month of application or a subsequent month before action is taken on the application may become eligible in the month in which the value of his resources is reduced to, or below, the Medicaid resource limit. In order to reduce resources, the resources must actually be expended and the expenditure documented. (For example: a receipt, a canceled check, or a bank statement).
- Reduction of resources is an asset transfer and must be evaluated under asset transfer policy (subchapter M1450).
- When excess resources are reduced, entitlement to ongoing Medicaid may begin no earlier than the first day of the month in which the resources were reduced to the Medicaid limit. When retroactive coverage is requested, policy in M1510.101 above must be followed.

M1510.103 DISABILITY DENIALS

- A. Policy** When an individual concurrently applies for SSI or SS and Medicaid as disabled, and either the DDS or the Social Security Administration (SSA) denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.
- When an individual applies for Medicaid as disabled or concurrently applies for SS/SSI and Medicaid as disabled, and DDS denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.
- B. Procedures**
- 1. Subsequent SSA/SSI Disability Decisions** The SSA disability decision takes precedence over a DDS decision (DDS will make a decision before SSA if SSA does not take action within the 90-day Medicaid application processing time). If SSA denies disability and the decision is appealed and subsequently reversed, reopen and re-evaluate the denied Medicaid application as long as the disability onset *month is prior to the month of application or is no later than 90 days after the month of application.*
 - 2. Use Original Application** The original application is used as long as the application was denied because the individual was not disabled and the subsequent disability onset *month* is no later than 90 days from the *month* of application.
 - 3. Entitlement** If the re-evaluation determines that the individual is eligible, the individual's Medicaid entitlement is based on the Medicaid application date including the retroactive period if all eligibility requirements were met during the retroactive period. However, eligibility as a disabled individual

retroactive period. If the Medicaid application is filed more than 4 months after entrustment or commitment, retroactive entitlement as a foster care child exists in the 3 months prior to Medicaid application. Entitlement cannot go back more than 3 months prior to the Medicaid application month.

M1510.105 DELAYED CLAIMS

A. When Applicable

Medicaid will not pay claims from providers that are filed more than 12 months after the date the service was provided, unless the reason for the delayed filing was a delay in the enrollee's eligibility determination and enrollment. If the applicant is eligible for Medicaid and the coverage begin date is 12 months or more prior to the month during which the enrollee is enrolled on the Medicaid computer, the agency must write a letter for the applicant to give to all medical providers who will bill Medicaid for services provided over 1 year ago.

B. Eligibility Delay Letter Requirements

The letter must:

- be on the agency's letterhead stationery and include the date completed.
- be addressed to the "Department of Medical Assistance Services, Claims Processing Unit."
- state the enrollee's name and Medicaid recipient I.D. number.
- state that "the claim for the service was delayed for more than one year because eligibility determination and enrollment was delayed."

C. Procedures

The "eligibility delay" letter and a sufficient number of copies must be given to the enrollee to give to each provider who provided a covered medical service to the recipient over one year ago. The provider must attach the letter to the claim invoice in order to receive Medicaid payment for the service. If the date the letter was prepared by the agency is not included on the letter, the claim will be denied. *If the individual was enrolled in a closed period of coverage, include the dates of coverage in the letter.*

A sample eligibility delay letter is available on the local agency intranet at: <http://spark.dss.virginia.gov/divisions/bp/me/forms/>.

M1510.200 NOTICE REQUIREMENTS

A. Policy

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

- of his right to a hearing;
- of the method by which he may obtain a hearing; and
- that he may represent himself or use legal counsel, a relative, a friend or other spokesperson.

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

M1520 Changes

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

M1520.000 MEDICAID ELIGIBILITY REVIEW**M1520.001 GENERAL PRINCIPLE****A. Policy**

A Medicaid recipient's eligibility must be partially reviewed whenever the agency becomes aware of any change in the enrollee's circumstances that might affect the enrollee's continued Medicaid eligibility.

An annual review of all of the enrollee's Medicaid eligibility requirements is called a "renewal." A renewal of the enrollee's eligibility must be completed at least once every 12 months. The renewal should be initiated in the 11th month to ensure timely completion of the renewal.

When a Medicaid enrollee no longer meets the requirements for his current covered group, prior to cancelling his coverage, he must be evaluated in all covered groups for which he may meet the definition. *If the individual is between the ages of 19 and 64 and is not eligible for full-benefit Medicaid coverage or as a Medicare beneficiary, he must be evaluated for Plan First unless he has declined that coverage. If a child is under age 19 or an individual is age 65 or older, evaluate for Plan First only if the child's parent or the individual requests the coverage.*

**1. Negative Action
Requires
Advance Notice**

When a change is reported that impacts eligibility or a renewal is completed and the enrollee is no longer eligible, the Advanced Notice of Proposed Action must be sent to the enrollee before the enrollee's benefits can be reduced or his eligibility can be terminated (see M1520.401).

**2. Renewal
Approval
Requires Notice**

When a change is reported and eligibility continues, no notice is necessary. When a renewal is completed and eligibility continues, the Notice of Action is used to inform the enrollee of continued eligibility and the next scheduled renewal.

**3. Voter
Registration**

If the individual reports a change of address in person, voter registration application services must be provided (see M0110.300 A.3).

**B. Procedures For
Partial Review and
Renewals**

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

- the requirements for **partial reviews** are in section M1520.100;
- the requirements for **renewals** are in section M1520.200;
- the policy and procedures for **cancelling** a enrollee's Medicaid coverage or reducing the enrollee's Medicaid services (benefit package) are in section M1520.400;
- the policy and procedures for **extended Medicaid coverage** are in section M1520.500;
- the policy and procedures for **transferring cases** within Virginia are in section M1520.600.

- 3. SSI Recipients** For an SSI recipient who has no community spouse and owns no countable real property, verify continued receipt of SSI through SOLQ-I or SVES, obtain information regarding asset transfer from the enrollee or authorized representative, and document the case record. As long as the individual continues to receive SSI, do not change the AC. If the individual loses SSI, evaluate his Medicaid eligibility in other covered groups. See *M1430.103* for additional information regarding an SSI recipient who enters a nursing facility.
- 4. Individual on a Spenddown** When an individual on a spenddown enters LTC, his Medicaid eligibility must be determined using the procedures in subchapter M1460.
- An individual on a spenddown in an assistance unit with a spouse and/or children becomes a separate assistance unit when he enters LTC. The spouse's and/or children's spenddown liability is recalculated to reflect a decrease in assistance unit size. See M1350.220 for additional information.
- 5. Married Institutionalized Individuals with a Community Spouse** Rules for determining Medicaid eligibility for married institutionalized recipients who have a community spouse are found in subchapter M1480.

M1520.200 RENEWAL REQUIREMENTS

- A. Policy** The agency must evaluate the eligibility of all Medicaid enrollees, with respect to circumstances that may change, at least every 12 months. Each renewal must be authorized by an eligibility worker or supervisor, although administrative staff may assist in the gathering of information.
- 1. Required Verifications** An individual's continued eligibility for Medicaid requires verification of income for all covered groups and resources for covered groups with resource requirements. Blindness and disability are considered continuing unless it is reported that the individual is no longer blind or disabled.
- 2. SSN Follow Up** If the enrollee's Social Security Number (SSN) has not been assigned by the renewal date, the worker must obtain the enrollee's assigned SSN at renewal in order for Medicaid coverage to continue. See subchapter M0240 for detailed procedures for obtaining the SSN.
- 3. Evaluation and Documentation** An evaluation of the information used to determine continued eligibility must be completed and included in the case record. For ex parte renewals, the Record of Ex Parte Medicaid Renewal (#032-03-0740) is recommended. For contact-based renewals, either a paper renewal form or the Record of Telephone Interview for Medicaid Renewal (#032-03-0741), available on SPARK at <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi> must be used to document the case record.
- The enrollee must be informed of the findings of the renewal and the action taken using the Notice of Action when continued eligibility exists. The Advance Notice of Proposed Action must be used when there is a reduction of benefits or termination of eligibility.
- 4. Voter Registration Requirement** The National Voter Registration Act of 1993 (NVRA) requires local social services agencies to offer Medicaid enrollees an opportunity to apply to register to vote at each renewal (redetermination) of eligibility (see M0110.300.A.3).

b. Income Verification

The eligibility worker must document the date and method used to obtain the verification information (viewed pay stub dated xx/xx/xxxx, telephone call on xx/xx/xxxx date, etc.), the type of verification, the source and a description of the information. Income verification that is no older than 6 months old may be used unless the agency has reason to believe it is no longer accurate. It is not necessary to retain a copy of income verifications in the case record. If the renewal is not processed and documented in ADAPT, the documentation must be in the case record.

An enrollee who has previously reported \$0 income must provide confirmation of income at each renewal, either on a renewal form or by a written statement. If the agency has not obtained written confirmation for another program (e.g. SNAP), do not complete an ex parte renewal when an enrollee has reported \$0 income. \$0 income statements must be no more than 30 days old to be used. If written confirmation was provided for another program, it cannot be used if it is more than 30 days old.

1. Renewal Procedures For SSI Recipients and 1619(b) Individuals

a. Review Case Record

An ex parte renewal for an SSI recipient (including an LTC recipient with no community spouse) who has reported no ownership interest in countable real property can be completed by verifying the individual's continued receipt of SSI through SVES or SOLQ-I and documenting the case record. The ex parte process cannot be used for an SSI recipient who owns non-excluded real property. He is subject to a resource evaluation and the agency has no internal means to verify all his resources.

For a 1619(b) individual, check the Medicaid Test Indicator field in SVES or SOLQ-I to verify there is a code of A, B or F.

The case record must also contain documentation that the individual reported no ownership interest in countable real property, either on the application form or on a subsequent renewal form. If the case record does not contain documentation that the individual reported no ownership interest in real property, a contact-based (telephonic or paper form) renewal is to be completed at the next annual renewal.

b. Individual Loses SSI or 1619(b) Status

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

C. Telephone Interview Renewal Procedures

When an ex parte renewal cannot be completed for an enrollee in any covered group, the eligibility worker may contact the enrollee by telephone. When a renewal *interview* is *conducted* by telephone, no renewal form is sent to the enrollee, and the enrollee's signature is **not** required. Send the enrollee a written request for the necessary verifications, and allow at least 10 calendar days for the information to be returned. **If an enrollee whose renewal is conducted by telephone interview reports \$0 income, obtain a written statement indicating that he has no income. A signed renewal form can be used in lieu of a written statement.**

- 8. Hospice Covered Group** At the annual renewal for an individual enrolled in the Hospice covered group (AC 054), the worker must verify the enrollee's continued election and receipt of hospice services, in addition to determining continued Medicaid eligibility.
- 9. Qualified Individuals** Coverage for individuals enrolled in the Qualified Individuals (QI) covered group (AC 056) is automatically cancelled effective December 31 of the current year. However, coverage for QIs can be renewed annually provided that there is no break in Medicaid eligibility. *Renewals are to be completed by sending a renewal form or through the telephone renewal process.*

Renewals for all QIs are due by December 31 of each year. On or after November 1 of each year, send the [ABD Medicaid Renewal Form \(#032-03-0186\)](#) to all individuals currently enrolled in the QI covered group. Follow the ABD Medicaid renewal procedure to request verifications and complete the evaluation.

a. Telephone interview conducted or the renewal form is returned BEFORE December 31st

If the individual remains eligible for QI coverage, do not change the renewal date in MMIS prior to December 31. On or after January 1 of the following year, reinstate the QI coverage in MMIS, effective January 1. Change the renewal date in MMIS to December 31 of the current year. Send a [Notice of Action on Medicaid and FAMIS \(form #032-03-0008\)](#) indicating that the individual's coverage continues and the date of the next renewal.

b. Telephone interview could not be conducted and the renewal form is returned AFTER December 31st

If a telephone interview is not conducted or the renewal form is not returned by December 31st the individual must submit a new application for Medicaid. The MMIS-generated cancellation notice will serve as the 10-day advance notice for cancellation of the individual's QI coverage.

G. LTC

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

For all others, the eligibility worker may complete a telephone interview renewal or a paper-based renewal. Use the Medicaid Redetermination for Long-Term Care form *for all renewals* for individuals age 19 and over. For children under age 19, the paper Families & Children Medicaid and FAMIS Plus Renewal Form or the *Record of Ex Parte Medicaid Renewal (#032-03-0740)* are appropriate.

Send the enrollee a written request for the necessary verifications, and allow at least 10 calendar days for the information to be returned. Document the renewal information and evaluation in the case record. Send all required notices (see section 1410.300).

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

M1550 Transmittal Changes

Changed With	Effective Date	Pages Changed
Update #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
Brenda Wolhfert, Supervisor (T006)	Central Virginia Training Center Medicaid Office Madison Heights, VA Mail to: P. O. Box 1098 Lynchburg, VA 24505	434-947-2754 cell 434-906-0024 FAX-434-947-2114	CVTC-caseload-A-L NVTC-A-L
Mary Lou Spiggle (T003)	Central Virginia Training Center Medicaid Office Madison Heights, VA Mail to: P. O. Box 1098 Lynchburg, VA 24505	434-947-6256 FAX-434-947-2114	CVTC-caseload-M-Z PGH/VCBR-caseload-all WSH-caseload-all NVMHI-caseload-all SVMHI-caseload-all NVTC-M-Z
VACANT T002			
Frances Jones (T004)	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0841 FAX-276-782-9732	SWVTC-caseload-all ESH-caseload-A-O SSVTC-caseload-A-G Catawba-caseload-all
Vickie C. Simmons (T005)	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0842 FAX-276-782-9732	SEVTC-caseload-all ESH-caseload-P-Z SSVTC-caseload-H-Z SWVMHI-caseload-all HDMC-caseload-all

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

Virginia DSS, Volume XIII

M17 Changes

Changed With	Effective Date	Pages Changed
UP #7	7/1/12	Table of Contents Pages 1-8 Appendix 1 Appendices 3 and 4 were removed.
TN #94	9/1/10	Title Page Table of Contents pages 1-7 Appendix 1 Appendix 2
TN #93	1/1/10	page 3

TABLE OF CONTENTS

M17 MEDICAID FRAUD AND NON-FRAUD RECOVERY

M1700.000 MEDICAID FRAUD NON-FRAUD RECOVERY

	Section	Page
Introduction.....	M1700.100.....	1
Fraud Recovery.....	M1700.200.....	1
Non-Fraud Recovery	M1700.300.....	4
Responsibility of the Local DSS.....	M1700.400.....	6

Appendix 1

<i>Medicaid Fraud/Non-Fraud Referral Chart</i>	<i>Appendix 1.....</i>	<i>1</i>
Managed Care Capitation Fees Recovery Form.....	Appendix 2.....	1

M1700 MEDICAID FRAUD AND NON-FRAUD RECOVERY

M1700.100 INTRODUCTION

A. Administering Agency The Department of Medical Assistance Services (DMAS) investigates and accepts referrals regarding fraudulent and non-fraudulent payments made by the Medicaid Program. *DMAS has the authority to recover any payment incorrectly made for services received by a Medicaid recipient or former Medicaid recipient. DMAS will attempt to recover these payments from the recipient or the recipient's income, assets, or estate, unless such property is otherwise exempt from collection efforts by State or Federal law or regulation.*

The DMAS Recipient Audit Unit (RAU) is responsible for the investigation of allegations of acts of fraud or abuse committed by recipients of the Medicaid and FAMIS programs. The RAU recovers overpayments due to recipient fraud, abuse, and overpaid benefits through voluntary repayments and criminal prosecution of recipient fraud.

The Third Party Liability Unit (TPL) at DMAS is responsible for investigating and recovering funds paid by DMAS from recipients' estates, trust accounts, annuities and/or other health insurance policies. This unit performs investigations to find "third party resources" that result when Medicaid pays medical costs that a third party should have paid. Medicaid is always the payor of last resort.

B. Utilization Review Recipients' utilization of all covered services is monitored regularly by DMAS. Whenever utilization of services is unusually high, claims for services are reviewed for medical necessity. If some services are determined not to be medically necessary, the recipient will be contacted by the DMAS Recipient Monitoring Unit.

DMAS also reviews hospital claims prior to payment to determine if the 21-day limit is exceeded or if the length of stay regulations are met. All provider claims are reviewed and audited after payment.

M1700.200 FRAUD

A. Definitions Fraud is defined as follows:

"Whoever obtains, or attempts to obtain, or aids and abets a person in obtaining, by means of a willful false statement or representation, or by impersonation, or other fraudulent device, assistance or benefits from other programs designated under rules and regulations of the State Board of Social Services or State Board of Health to which he is not entitled, or fails to comply with the provisions of 63.2-522, 32.1-321.1, 32.1-321.2, 1-112, shall be deemed guilty of larceny..." (Code of Virginia, §63.1-124).

"If at any time during the continuance of assistance there shall occur any change, including but not limited to, the possession of any property or the receipt of regular income by the recipient, in the circumstances upon which current eligibility or amount of assistance were determined, which would materially affect such determination, it shall be the duty of such recipient immediately to notify the local department of such change, and thereupon the local board may either cancel the assistance, or alter the amount thereof." (Code of Virginia, §63.1-112).

**B. DMAS
Authority**

DMAS has sole authority over cases of suspected Medicaid fraud when eligibility for a public assistance payment is not involved (Medicaid only cases). The local department of social services (LDSS) *must* refer all Medicaid cases involving suspected fraud to the DMAS Recipient Audit Unit, 600 E. Broad Street, Suite 1300, Richmond, Virginia 23219, using the Notice of Recipient Fraud/Non-Fraud Recovery (form #DMAS 751R) located on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.

The following information must be provided when making a referral:

- confirmation that ongoing eligibility has been reviewed (in relation to the allegation) with evaluation results attached;
- reasons for and exact dates of ineligibility for Medicaid;
- the recipient's name and Medicaid enrollee identification number;
- the recipient's Social Security number;
- applicable Medicaid applications or review forms for the referral/ineligibility period;
- address and telephone number of any attorney-in fact, authorized representative, or other individual who assisted in the application process;
- relevant covered group, income, resource, and/or asset transfer documentation for the time period in question;
- any record of communication between the agency and the client or representative, such as case narratives, letters, and notices; and
- information obtained from the agency's fraud investigation, including names and addresses of knowledgeable individuals for testimony and/or interviews.

**1. Amount of
Loss**

There is no fiscal threshold for any case for fraudulent and non-fraudulent erroneous payments made by the Medicaid Program.

In order to determine the amount of the loss of Medicaid funds related to the enrollee's eligibility when LDSS has jurisdiction because of participation in another public assistance program, a Medicaid Claims Request (form #DMAS 750R, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms>) must be sent to DMAS to obtain the amount of the loss. The local agency should allow a three-week turnaround for the documents. There may be exceptional circumstances when claims can be provided within a shorter time, i.e., expedited trial dates. Once the information is received and the agency determines that it will not make a joint criminal prosecution referral, the LDSS must send DMAS the Notice of Recipient Fraud/Non-Fraud Recovery. DMAS will determine if administrative non-fraud recovery is appropriate and request restitution.

For those cases where Medicaid claims only include Managed Care Organization (MCO) capitation fees, the MCO Capitation Fees Recovery Form (*DMAS 752RMCO*) will be included with the claims and the custodian certificate (see Appendix 2 to this chapter). The MCO Capitation Fees Recovery Form provides an explanation of the MCO capitation fees submitted and paid as claims on the recipient's behalf during the recovery period. The TANF/Medicaid related claims information should be included with this form.

2. Recipient Fraud

a. *Medical Assistance Only*

Cases of suspected fraud involving medical assistance must be referred to the RAU for investigation. The LDSS must provide the RAU with the recipient's identifying information, address, and information regarding the circumstances of the suspected fraud. The LDSS is also responsible for reviewing and taking appropriate action for ongoing eligibility or termination of coverage, as appropriate. The RAU will determine the amount of the misspent funds and pursue recovery and/or legal action as appropriate.

b. **Auxiliary Grants (AG) Cases**

Individuals who receive AG payments also receive Medicaid coverage. Cases of suspected fraud involving AG payments are the responsibility of the local department of social services. For AG cases, the LDSS *must* determine whether the enrollee would have been eligible for Medicaid had he not been receiving AG. If the individual was eligible for Medicaid solely due to his AG eligibility, the agency shall determine the period of ineligibility for Medicaid. The LDSS shall report any period of ineligibility. The RAU will determine the amount of Medicaid payments made.

The amount of misspent Medicaid funds shall be included in the AG fraud case, whether the action results in prosecution or in voluntary restitution. The final disposition on all money payment fraud cases shall be communicated to the RAU no later than 5 business days after disposition for inclusion in federal reporting.

c. **Cases in which Medicaid is received with TANF, SNAP, GR, Energy Assistance, etc.**

For suspected fraud involving cases with combined Medicaid and TANF, Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), General Relief (GR), Energy Assistance, or other such assistance which does not directly relate to the provision of Medicaid, the local agency shall notify the RAU of the agency's action on the other assistance case so that Medicaid may take concurrent action, if necessary.

3. Provider Fraud

Cases of suspected fraud involving enrolled providers of medical services to Medicaid recipients shall be referred to the Medicaid Fraud Control Unit in the Office of the Attorney General, and a copy of the referral correspondence shall be sent to the Provider Review Unit at the Department of Medical Assistance Services.

**C. Medicaid
Ineligibility
Following
Fraud
Conviction**

- 1. Period of Eligibility** An individual who has been convicted of Medicaid fraud is ineligible for Medicaid for a period of 12 months beginning with the month of fraud conviction. Action to cancel the individual's Medicaid coverage shall be taken in the month of conviction or in the month the agency learns of the conviction, using cancel reason 014 (42 United States Code §1320a-7b.(a)(6)(ii); 12 Virginia Administrative Code 30-10-70).
- 2. Who is Ineligible**
- a. TANF or Families and Children (F&C) Cases**
- Only the parent/caretaker of a TANF/Medicaid or F&C Medicaid case is ineligible for Medicaid when the parent/caretaker has been convicted of Medicaid fraud. The TANF payment made to the caretaker on a child's behalf shall not be affected.
- b. Aged, Blind, Disabled (ABD) or Pregnant Women Cases**
- In an ABD or pregnant woman case, only the individual found guilty of Medicaid fraud will be ineligible. If only one spouse of a married couple is convicted, the eligibility of the innocent spouse is not affected.
- 3. Family Unit**
- If both spouses of an eligible couple are found guilty of fraud, neither is eligible for Medicaid. If only one member of a family unit is convicted of fraud, only that member's Medicaid coverage is canceled. The fraud conviction does not affect the composition of the family unit or the treatment of the family unit's income or resources. The convicted individual is included in the family unit according to Medicaid policy, but is not eligible for Medicaid coverage and is not enrolled.

M1700.300 NON-FRAUD RECOVERY

- A. Definition** The State Plan for *Medical Assistance* defines Non-Fraud Recovery as: "Investigation by the local department of social services of situations involving eligibility in which there is no reason to suspect that there has been deliberate misrepresentation by an applicant/recipient with intent to defraud." These cases are referred to DMAS when there is reason to suspect that an overpayment has occurred. (42 CFR§431).
- B. Recovery of Erroneous Payments** DMAS has the authority to investigate cases and recover expenditures made for services received by ineligible enrollees without fraudulent intent. Examples of when recovery of expenditures is possible include, but are not limited to:
- eligibility errors due to recipient misunderstanding,
 - agency errors,
 - medical services received during the appeal process, if the agency's cancellation action is upheld.

- *long-term care (LTC) patient pay underpayments totaling \$1,500 or more; underpayments less than \$1,500 can be collected by adjusting the ongoing patient pay (see M1470.900 for patient pay adjustments),*

Complete and send the Notice of Recipient Fraud/Non-Fraud Recovery (form #DMAS 751R) located on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi> to

*Department of Medical Assistance Services
Recipient Audit Unit,
600 E. Broad Street, Suite 1300,
Richmond, Virginia 23219*

The form may be faxed to 804-371-8891.

C. Uncompensated Asset Transfers

Individuals receiving long-term care services (LTC) who transfer assets and do not receive adequate compensation are subject to the imposition of a penalty period during which Medicaid cannot pay for long-term care services. When an uncompensated transfer resulted in a penalty period during which LTC services were received, a referral must be made to the RAU to recover the misspent dollars. RAU staff will contact the recipient or the recipient's authorized representative to pursue recovery.

*Section §20-88.02 of the Code of Virginia also allows DMAS to seek recovery from the **transferee** (recipient of the transfer) if the amount of the uncompensated transfer is \$25,000 or more and occurred within 30 months of the individual becoming eligible for or receiving Medicaid LTC services. The transferees may be liable to reimburse Medicaid for expenditures up to the amount of funds spent on the enrollee or the amount of the uncompensated transfer, whichever is less.*

LDSS must notify the recipient of the results of any transfer evaluation and the potential for administrative recovery (see M1450.810). The notice should also direct the recipient to inform the transferee of the RAU referral and the potential liability for repayment. DMAS staff will make the referral to the RAU for recovery when an undue hardship has been granted (see M1450.700) and the \$25,000 and 30 month requirements are met. In all other situations, LDSS must make the referral to the RAU.

D. Recovery of Correctly Paid Funds

Within specific restrictions, DMAS may recover funds correctly paid for medical services received by eligible recipients.

1. Deceased Recipient's Estate

*Under federal regulations and state law, DMAS may make a claim against a deceased enrollee's estate when the recipient was age 55 or over. The recovery may include any Medicaid payments made on his/her behalf. This claim may be waived if there are surviving dependents. (**42 CFR §433.36; Va. Code §32.1-326.1 and 32.1-327**).*

Section 1917(b)(1)(C)(ii) of the Social Security Act was amended by the Deficit Reduction Act of 2005 to exempt assets disregarded under a "qualified" Long-term Care (LTC) Partnership Policy from estate recovery, as defined in clause (iii) of 1917(b)(1)(C). The same amount of assets that was disregarded in the Medicaid eligibility determination for an individual under an LTC Partnership Policy will be

protected during estate recovery.

Referrals should be made to DMAS for estate recovery when the deceased recipient is over 55, has no surviving spouse, no children under 21 or a disabled/blind child of any age.

2. Insurance Settlements and Similar Recoveries

Settlements related to personal injuries are a form of third party liability (TPL). When a Medicaid enrollee has received an insurance settlement or similar settlement from a law suit related to a medical condition or injury, DMAS may seek recovery of any amount of medical assistance expended on the enrollee prior to the receipt of the settlement. Generally, the insurance company notifies DMAS of the settlement; however, if an agency discovers that an enrollee received a settlement, the agency shall report it to DMAS. An insurance settlement that is sent directly to a recipient, in his name only, should be reviewed for its impact on the recipient's eligibility.

3. Trusts

Refer trust documents, including irrevocable, discretionary, pooled, and special needs trusts, to DMAS TPL for potential recovery at the time of recipient's (beneficiary's) death. Refer trust documents in all instances in which a Medicaid recipient is a beneficiary of a trust and the trustee refuses to make the assets available for the medical expenses of the recipient. *Include a copy of the Medical Assistance Program Consultant's evaluation of the trust with the referral form, if available.*

Include in the referral any corrective action that has been or will be taken by the LDSS, as well as the name of the supervisor of the person submitting the form. The supervisor's signature is not required.

4. Notification to DMAS

Referrals must be made to the Third Party Liability Unit when: a recipient has received funds from a settlement; DSS has received information concerning a recipient being in an accident; DSS has information where a recipient has other third party payers; or the recipient is the beneficiary of a trust. The cases should be referred to DMAS using the Notice to DMAS of Estate Recovery/TPL/Trust Form (DMAS 753R) located on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi>, to make referrals to the TPL unit. The form should be completed and sent to:

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

The form may be faxed to 804-786-0729.

M1700.400 RECOVERY RESPONSIBILITIES: LDSS AND DMAS

A. VDSS/LDSS Responsibilities in Loss Prevention Efforts

VDSS Medicaid operates under an interagency agreement with DMAS which lists specific responsibilities of VDSS and, by extension, the LDSS, for active participation in loss prevention efforts. The responsibilities of the LDSS fall under the interagency agreement and are neither optional nor discretionary for the LDSS. VDSS shall supervise the programmatic activities of the LDSS to ensure compliance.

- B. LDSS Requirements**
- LDSS must participate in the identification, tracking, and correction of eligibility errors. LDSS must also determine and review ongoing or current recipient eligibility. **The DMAS RAU does not determine ongoing recipient eligibility, but rather reviews recipient eligibility in relation to allegations of fraud.** LDSS shall:
- 1. Report Individuals**
- Report to DMAS RAU every known instance relating to a non-entitled individual's use of Medicaid services, regardless of the reason for non-entitlement such as:
- instances where evidence of fraud may exist;
 - errors involving eligibility discovered by the LDSS in which it appears there has been deliberate misrepresentation by an applicant/recipient with intent to defraud;
 - eligibility errors discovered by the LDSS, independent of other audit or quality control functions, including cases in which the individual was enrolled incorrectly, added in error, not cancelled timely, allowed to remain on Medicaid during the conviction sanction period or when information known to the agency would render ineligibility;
 - cases in which the LDSS discovers that the enrollee failed to report information that impacts eligibility; and
 - LTC patient pay underpayments resulting from any cause *totaling \$1,500 or more.*
- 2. Corrective Action**
- Report to the DMAS RAU corrective action taken on all discovered eligibility errors. Corrective action is a function of the loss prevention process. All corrected errors shall be reported to DMAS.
- 3. Cancel Coverage**
- Cancel the eligibility of all persons convicted of public assistance fraud or medical assistance fraud to the extent allowable under federal and state regulations, using the cancel code for fraud convictions (Cancel Code 014).
- C. DMAS Response**
- The RAU shall send a written verification of the error to the individual making the referral, including the amount of misspent funds, as well as any further action required of the LDSS.
- D. Recipient Audit Reporting**
- The RAU has two prevention efforts for reporting fraud and abuse of Medicaid Services by individuals within the community. Both referral methods should be given to the individual by the LDSS, along with a copy of the Notice of Medicaid Fraud/Non-fraud Recovery. If an individual wishes to make an anonymous referral, the report may be made through.
- the web address, recipientfraud@dmas.virginia.gov.
 - the Recipient Audit fraud and abuse hotline. Both a local and a toll free number are available 24 hours daily for reporting suspected fraud and abuse: local (804) 786-1066; and toll free (866) 486-1971.

**E. Statute of
Limitations**

There is no "statute of limitations" for Medicaid fraud; cases that are referred for fraud *shall* be flagged to ensure that the information is not purged. Cases cannot be properly investigated without specific documents, i.e. signed applications, bank statements, burial or insurance information. DMAS will notify the agency of the results of the fraud investigation.

Medicaid Fraud Referrals			
Error discovered M1700.200	Refer to DMAS RAU	Refer to LDSS Fraud Investigator	Refer to Medicaid Fraud Control Unit at the Attorney General's Office 1-800-371-0824
Medicaid only case			
Case includes SNAP, TANF, AG or other public assistance payment		 will report to RAU on the DMAS 750R	
Provider Fraud			

**Medicaid Fraud/Non-Fraud Referrals to DMAS
Which form?**

<http://spark.dss.virginia.gov/divisions/bp/me/forms>

Reason for Referral M1700.300	Recipient Audit Unit <i>Notice of Recipient Fraud/Non-Fraud Recovery (DMAS 751R)</i>	TPL Unit <i>Notice to DMAS of Estate Recovery/TPL/Trusts (DMAS 753R)</i>
Recipient misunderstanding	X	
Agency error (report any corrective action to RAU)	X	
Medical services received during appeal process (if agency upheld)	X	
LTC Patient Pay under-payments \$1500 or more	X	
Uncompensated asset transfers	X	
Estate of deceased recipient (refer when deceased is over 55 and has no surviving spouse, child under 21 or disabled or blind child of any age)		X
Insurance settlements		X
Trusts - (Irrevocable, pooled, special needs, discretionary)		X

M18 Changes

Changed With	Effective Date	Pages Changed
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

Explanations of some covered services are provided below:

**1. Children's
Mental Health
Program
Services**

Intensive community-based services for children and youth who have been in a psychiatric residential treatment facility may be provided. The services available are:

- respite,
- in-home residential supports,
- companion services,
- training and counseling for unpaid caregivers,
- environmental modifications, and
- consultative clinical and therapeutic services.

2. Clinic Services

Covered clinic services include therapeutic, rehabilitative, or palliative items or services, and renal dialysis furnished to an outpatient by or under the direction of a physician, in a certified facility which is organized and operated to provide medical care to outpatients.

**3. Community-
Based Care
Waiver Services**

Virginia provides services under community-based care (CBC) waivers to specifically targeted individuals. These services are not available to all Medicaid recipients. The CBC waivers are:

- 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,
- Day Support (DS) Waiver, and
- Alzheimer's Assisted Living (AAL) Waiver.

Services covered under the waivers are listed in M1410.040.

**4. Community
Mental Health
and Mental
Retardation
Services**

Certain mental health and mental retardation services are covered for Medicaid-eligible recipients when provided by Medicaid-enrolled mental health providers. Examples of community mental health services are mental health case management, psychosocial rehabilitation, mental health support, day treatment/partial hospitalization, therapeutic day treatment for children and adolescents, intensive in-home services for children and adolescents, and crisis intervention services.

Mental retardation case management is available to recipients who are not enrolled in the ID/MR Waiver. Other community mental retardation services are available to recipients enrolled in the ID/MR Waiver and include mental retardation case management, day support, residential support, and supported employment services.

M21 Changes

Changed With	Effective Date	Pages Changed
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

opportunity period must be given to the applicant. The C&I verification requirements in M0220.100 apply to FAMIS, including use of the Social Security Administration (SSA) data match when a Social Security number (SSN) has been provided. If an SSN has not been provided for the child, a reasonable opportunity to provide acceptable documentation of C&I must be given. The reasonable opportunity period will last until the time of the first annual renewal.

If the child is not a U.S. citizen, the child must meet the FAMIS alienage requirements.

1. Alienage Requirements

Alien status must be verified. Refer to sections M0220.200, M0220.201 and M0220.202 for information about verifying alien status.

FAMIS alienage requirements are different from the Medicaid alienage requirements. Qualified aliens who entered the U.S. before August 22, 1996 meet the alienage requirements and are not subject to time limitations.

Lawfully residing non-citizen children under the age of 19 meet the alienage requirements for coverage in FAMIS.

2. No Emergency Services Only For Unqualified Aliens

Unqualified aliens, including illegal and non-immigrant aliens, do not meet the alienage requirements and are not eligible for FAMIS.

- | | |
|---|--|
| 4. Alien Eligibility Chart | Appendix 3, FAMIS Alien Eligibility Chart, lists alien groups that meet or do not meet the alienage requirements. |
| 5. SSN | A Social Security number (SSN) or proof of application for an SSN (M0240) is not a requirement for FAMIS. |
| 6. Assignment of Rights | Assignment of rights to payment for medical care from any liable third party is a condition of eligibility for the child. |
| D. FAMIS Nonfinancial Requirements | The child must meet the following FAMIS nonfinancial requirements: |
| 1. Age Requirement | The child must be under age 19 for at least one day during the month. No verification is required.

A child no longer meets the age requirements for FAMIS effective the end of the month in which the child reaches age 19 years, provided he was under age 19 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 19. |
| 2. Uninsured Child | The child must be uninsured, that is, he must not be covered under any health insurance plan offering hospital and medical benefits. See M2120.200. |
| 3. State Employee Prohibition | A child is ineligible for FAMIS if he is a member of a family eligible for health insurance coverage under any Virginia State Employee Health Insurance Plan on the basis of the family member's employment with a State agency. |
| 4. IMD Prohibition | The child cannot be an inpatient in an institution for mental diseases (IMD). |

M2120.200 HEALTH INSURANCE COVERAGE

- A. Introduction** The intent of FAMIS is to provide health coverage to low-income uninsured children. Eligibility for this program is prohibited when creditable health insurance coverage is dropped within 4 months of the application for FAMIS unless good cause for discontinuing the insurance is demonstrated, or the child is pregnant.
- B. Definitions**
- 1. Creditable Coverage** For the purposes of FAMIS, creditable coverage means coverage of the individual under any of the following:
- church plans and governmental plans;
 - health insurance coverage, either group or individual insurance;
 - military-sponsored health care;
 - a state health benefits risk pool;
 - the federal Employees Health Benefits Plan;

STATE AGENCY LISTING - 07/30/02

Accountancy, Board of	Crime Commission, Virginia Stat
Accounts, Dept. of	Criminal Justice Services, Dept. of
Administration, Secretary of	Dabney S. Lancaster Community College
Aging, Dept. for the	Danville Community College
Agriculture and Consumer Services, Dept. of	Deaf and Hard of Hearing, Dept. for the
Alcoholic Beverage Control, Dept. of	Delmarva Advisory Council
Arts, Virginia Commission for the	Eastern Shore Community College
Atlantic States Marine Fisheries Commission	Eastern State Hospital
Attorney General, Office of the	Economic Development Partnership, Virginia
Auditor of Public Accounts	Education, Dept. of
Aviation, Dept. of	Education, Secretary of
Bar Examiners, State Board of	Elections, State Board of
Blind and Vision Impaired, Dept. for the	Emergency Management, Dept. of
Blue Ridge Community College	Employment Commission, Virginia
Blue Ridge Hospital	Employment Dispute Resolution, Dept. of
Business Assistance, Virginia Dept. of	Environmental Quality, Dept. of
Capitol Police, Division of	Finance, Secretary of
Catawba Hospital	Fire Programs, Dept. of
Center for Innovative Technology	Forestry, Dept. of
Central State Hospital	Frontier Culture Museum of Virginia
Central Virginia Community College	Game and Inland Fisheries, Dept. of
Central Virginia Training Center	General Services, Dept. of
Charitable Gaming Commission	George Mason University
Chesapeake Bay Commission	Germanna Community College
Chesapeake Bay Local Assistance	Governor, Office of the
Child Day Care & Early Childhood Programs, Virginia Council on	Gunston Hall
Christopher Newport University	Health and Human Resources, Secretary of
Civil Air Patrol	Health Professions, Dept. of
College of William and Mary	Health, Dept. of
Commerce and Trade, Secretary of	Higher Education for Virginia, State Council of
Commonwealth Center for Children and Adolescents	Hiram W. Davis Medical Center
Commonwealth Competition Council	Historic Resources, Dept. of
Commonwealth, Secretary of the	House of Delegates
Commonwealths Attorneys Services Council	Housing and Community Development, Dept. of
Community College System, Virginia	Housing Development Authority, Virginia
Compensation Board	Housing Study Commission, Virginia
Conservation and Recreation, Dept. of	Human Resource Management, Dept. of
Corporation Commission, State	Human Rights, Council on
Correctional Education, Dept. of	Information Technology, Dept. of
Corrections, Dept. of	J. Sargeant Reynolds Community College
Court of Appeals of Virginia	James Madison University
	Jamestown-Yorktown Foundation

FAMIS ALIEN ELIGIBILITY CHART

<i>Lawfully Residing Alien Groups</i>	
Qualified aliens who are Veterans or Active Military (includes spouses/dependent children); certain American Indians Form DD 214-veteran	<i>Eligible</i>
Permanent Resident Aliens (Aliens lawfully admitted for permanent residence), except Amerasians I-151; AR-3a; I-551; I-327; I-688B-274a.12(a)(1)	<i>Eligible</i>
Conditional entrants-aliens admitted Pursuant to 8 U.S.C. 1153(a)(7), section 203(a)(7) of the INA I-94	<i>Eligible</i>
Aliens, other than Cuban or Haitian Entrants, paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA I-94; I-688B – 274a(12)(c)(11)	<i>Eligible</i>
Battered aliens, alien parents of battered children, alien children of battered parents U.S. Attorney General	<i>Eligible</i>
Aliens granted asylum pursuant to section 208 of the INA I-94; I-688B – 274a.12(a)(5)	<i>Eligible</i>
Aliens admitted as refugees pursuant to section 207 of the INA, or as Cuban or Haitian Entrants as defined in section 501(e) of the Refugee Education Assistance Act of 1980 {including those under section 212(d)(5)} I-551; I-94; I-688B	<i>Eligible</i>
Aliens whose deportation has been withheld pursuant to Section 243(h) or 241(b)(3) of the INA I-688-B – 274a.12(a)(10) Immigration Judge's Order	<i>Eligible</i>
Victims of a severe form of trafficking pursuant to the Trafficking Victims Protection Act of 2000 (P.L. 106-386) [ORR certification/eligibility letter]	<i>Eligible</i>
Iraqi and Afghan Special Immigrants admitted on a Special Immigrant Visa (SIV), including the spouse and children under age 21 living in the home with the principal visa holder. [I-551 or passport/ I-94 indicating categories SI1, SI2, SI3, QQ1, SQ2, or SQ3 and bearing Department of Homeland Security stamp or notation]	<i>Eligible</i>

<i>Lawfully Residing Alien Groups</i>	
Aliens residing in the US pursuant to an indefinite stay of deportation (I-94; Immigration Letter)	<i>Eligible</i>
Aliens residing in the US pursuant to an indefinite voluntary departure (I-94; Immigration Letter)	<i>Eligible</i>
Aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition who are entitled to voluntary departure under 8 CFR 242.5(a)(2)(vi) and whose departure the INS does not contemplate enforcing (I-94; I-210)	<i>Eligible</i>
Aliens who have filed an application for adjustment of status pursuant to §245 INA that the INS has accepted as properly filed and whose departure the INS does not contemplate enforcing (I-181; Endorsed Passport)	<i>Eligible</i>
Aliens granted stay of deportation by court order, statute or regulation, or by individual determination of the INS whose departure the agency does not contemplate enforcing (I-94; Court Order; INS Letter)	<i>Eligible</i>
Aliens granted voluntary departure pursuant to section 242(b) of the INA whose departure the INS does not contemplate enforcing (I-94; I-210; I-688B – 247a.12(a)(11) or (13))	<i>Eligible</i>
Aliens granted deferred action status pursuant to INS Operations Instruction 103.1(a)(ii) prior to 6/15/84 or 242.1a22 issued 6/15/84 and later (I-210; INS Letter)	<i>Eligible</i>
Aliens residing in the U.S. under orders of supervision (I-220B)	<i>Eligible</i>
Aliens who entered before January 1972 and have continuously resided in the U.S. since January 1972 (Case Record)	<i>Eligible</i>

M22 Changes

Changed With	Effective Date	Pages Changed
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

- she is **not** an inpatient in an institution for mental diseases; and
- she has countable family income less than or equal to 200% FPL.

M2220.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

- A. Policy** The pregnant woman must meet, with certain exceptions, the Medicaid nonfinancial eligibility requirements in Chapter M02 and the nonfinancial eligibility requirements imposed by FAMIS.
- B. M02 Applicable Requirements** The Medicaid nonfinancial eligibility requirements in Chapter M02 that must be met are:
- citizenship or alien status;
 - Virginia residency requirements;
 - assignment of rights;
 - application for other benefits;
 - institutional status requirements regarding inmates of a public institution.
- C. FAMIS Nonfinancial Requirements** The FAMIS nonfinancial eligibility requirements are:
- 1. Citizenship & Identity Verification Required** The Children’s Health Insurance Program Reauthorization Act (CHIPRA) of 2009 mandates that, effective January 1, 2010, all applicants for coverage in a Title XXI program must provide verification of citizenship and identity (C&I). If the pregnant woman is a United States (U.S.) citizen, she must meet the U.S. citizenship requirements in M0220.100. Verification of citizenship **is** required; declaration of the woman’s U.S. citizenship is **no longer** accepted. However, as with Medicaid, a reasonable opportunity period must be given.
- The C&I verification requirements in M0220.100 apply to FAMIS MOMS, including the use of the Social Security Administration (SSA) data match when a Social Security Number (SSN) has been provided. If an SSN has not been provided, a reasonable opportunity to provide acceptable documentation of C&I must be given.
- If not a U.S. citizen, the pregnant woman must meet the alienage requirements.
- 2. Alienage Requirements** FAMIS MOMS alienage requirements are the same as the FAMIS alienage requirements.
- Citizens and qualified aliens who entered the U.S. before August 22, 1996 meet the citizenship/alienage requirements.

Lawfully residing pregnant women meet the alienage requirements for coverage in FAMIS MOMS.

Appendix 3 to Chapter M21 contains a FAMIS Alien Eligibility Chart that lists the alien groups that meet or do not meet the FAMIS MOMS alienage requirements.

- 3. No Emergency Services for Unqualified Aliens** Unqualified aliens, including illegal and non-immigrant aliens do not meet the alienage requirements. FAMIS MOMS does not provide any emergency services eligibility for unqualified aliens.

- 4. SSN not Required** The applicant is not required to provide an SSN or proof of an application for an SSN.