COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

KAREN KIMSEY, M.S.W.
DIRECTOR

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

Virginia Medical Assistance Eligibility Manual
Transmittal #DMAS-20

The following acronyms are contained in this letter:

- ABD – Aged, Blind, or Disabled
- COVID – Coronavirus Disease
- DMAS – Department of Medical Assistance Services
- F&C – Families and Children
- FAMIS – Family Access to Medical Insurance Security
- FPL – Federal Poverty Level
- LIFC – Low Income Families with Children
- MAGI – Modified Adjusted Gross Income
- MN – Medically Needy
- PARIS – Public Assistance Reporting Information System
- TANF – Temporary Assistance for Needy Families
- TN – Transmittal

TN #DMAS-20 includes policy clarifications, updates and revisions. Unless otherwise noted in the Cover Letter and/or policy, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after July 1, 2021. Note that COVID-19 Public Health Emergency guidelines continue until the emergency is over and are not referenced in Medical Assistance Eligibility Policy.

The following changes are contained in TN #DMAS-20:

Changed Pages	Changes
M000 Table of Contents	Revised the Table of Contents.

Changed Pages	Changes
Subchapter M0130 Page 2 Page 2a is a runover page.	Clarified the treatment of documentation delayed by the postal service.
Subchapter M0220 Pages 14c, 15, 18, 21, 22a Appendix 5, page 3 Appendix 8, page 3 Page 15 is a runover page.	Added policy on FAMIS Prenatal Coverage.
Subchapter M0240 Table of Contents Pages 1, 3, 5 Page 6a was renumbered to Page 7. Pages 2, 4, 6 and 7 are runover pages.	Revised the Table of Contents. On pages 1, 3, and 5, added policy on infants born to mothers eligible for FAMIS Prenatal Coverage.
Subchapter M0270 Page 2	Added information regarding Social Security Title II benefits.
Subchapter M0280 Table of Contents Page 1 Appendix 2 was added.	Revised the Table of Contents. On page 1, added a reference to Appendix 2. Appendix 2 was added to the subchapter.
Subchapter M0310 Page 6 Pages 5 and 5a are runover pages.	Clarified that a letter from a state adoption assistance agency can be used to document special medical needs.
Subchapter M0320 Pages 24, 26-29	On pages 24, 27, and 28, revised the income limit for entry into Medicaid Works to 138% FPL, effective July 1, 2021. On page 26, clarified the income assistance unit. On page 29, clarified the enrollment procedures.
Subchapter M0330 Pages 1, 13, 14	Added policy on FAMIS Prenatal Coverage.

Changed Pages	Changes
Chapter M04 Pages 2, 14, 15, 16a, 16b, 19 Appendix 3 Appendix 5 Appendix 8	On page 2, added FAMIS Prenatal Coverage as a MAGI group. On pages 14 and 16b, clarified that electronic data sources should be used to verify income from self employment before requesting verification from the individual. On page 15, updated the tax filing threshold amount for 2021. On pages 16a, 19, and in Appendix 8, clarified that COVID-19 payments provided under federal law are excluded as income. In Appendices 3, updated the LIFC income limits, effective July 1, 2021. In Appendix 5, updated the Individuals Under Age 21 income limits, effective July 1, 2021.
Subchapter M0630 Page 5	Clarified that COVID-19 payments provided under federal law are excluded as countable resources for 12 months following the month of receipt.
Subchapter M0710 Appendices 2 and 3	In Appendix 2, updated the F&C MN income limits, effective July 1, 2021. In Appendix 3, updated the F&C 100% Standard of Assistance amounts, effective July 1, 2021.
Subchapter M0715 Page 2	Clarified that COVID-19 payments provided under federal law are excluded as income.
Subchapter M0810 Page 2	Updaed the ABD MN income limits, effective July 1, 2021.
Subchapter M0815 Pages 11, 12	Clarified that COVID-19 payments provided under federal law are excluded as income.
Subchapter M1110 Page 16	Revised the policy on equitable ownership of the home property.
Subchapter M1130 Table of Contents Pages 5, 73, 74 Page 74a is a runover page.	Revised the Table of Contents. On page 5, revised the policy on equitable ownership of the home property. On page 73, clarified the resource exclusion for COVID-19 payments provided under federal law. On page 74, added policy on TANF Individual Development Accounts.
Subchapter M1140 Pages 18, 26a Page 19 is a runover page.	On page 18, clarified the use of the Asset Verification System. On page 26a, revised a reference citation.
Subchapter M1340 Pages 4, 5	On page 4, removed dental services from the list of non-covered services. On page 5, added dental services to the list of Medicaid covered services.

Changed Pages	Changes
Subchapter M1430 Table of Contents Page 2 Appendix 1 was removed.	Revised the Table of Contents. On page 2, revised a reference citation.
Subchapter M1470 Pages 11, 20, 26	On pages 11 and 26, revised the policy on the treatment of dental expenses. On page 20, revised the minimum number of hours needed to receive the Special Earnings Allowance.
Subchapter M1480 Pages 66, 70	On page 66, updated the Monthly Maintenance Needs Allowance and the Excess Shelter Standard, effective July 1, 2021.
Subchapter M1520 Pages 2, 3, 5, 6, 13, 14 Page 2a is a runover page. Page 6a was added as a runover page.	On page 2, clarified the treatment of documentation delayed by the postal service. On page 3, clarified the treatment of a change in the level of benefits. On pages 5 and 6, added policy on the treatment of infants born to mothers who are eligible for FAMIS Prenatal Coverage. On pages 13 and 14, clarified the use of the Federal Hub for verifying deaths.
Subchapter M1550 Appendix 1	Revised the state hospital information.
Chapter M16 Table of Contents Pages 1-10 Pages 11-12 were added	The Table of contents and all pages were revised to incorporate guidance from the Office of the Attorney General.
Chapter M17 Page 7	Corrected the link to the PARIS User Guide.
Chapter M18 Page 7 Page 8 is a runover page.	Added dental coverage for adults in full-benefit Medicaid covered groups, effective July 1, 2021.
Chapter M21 Page 2	Added policy on FAMIS Prenatal Coverage.

Changed Pages	Changes
Chapter M22 Page 2	Added policy on FAMIS Prenatal Coverage
Chapter M23 Table of Contents Pages 1-8 Appendix 1	Chapter M23 was added. The chapter contains the policy for FAMIS Prenatal Coverage, effective July 1, 2021.

Please retain this TN letter for future reference. Should you have questions about information contained in this transmittal, please contact Cindy Olson, Director, DMAS Eligibility and Enrollment Services Division, at cindy.olson@dmas.virginia.gov or (804) 225-4282.

Sincerely,

Sarah Hatton

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

Attachment

TABLE OF CONTENTS Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-20	7/1/21	Page i, iii
TN #100	5/1/15	Page ii
TN #99	1/1/14	Pages i, iii
TN #98	10/1/13	Page i
TN #93	1/1/10	Page iii
Update (UP) #2	8/24/09	Page iii

TABLE OF CONTENTS

VIRGINIA *DEPARTMENT OF MEDICAL ASSISTANCE SERVICES, MEDICAL ASSISTANCE* ELIGIBILITY MANUAL

CHAPTER **SUBCHAPTER**

M0130 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-20	7/1/21	Page 2 Page 2a is a runover page.
TN #DMAS-18	1/1/21	Pages 4, 8, 13
TN #DMAS-17	7/1/20	Pages 2, 6, 10 Page 6a was added as a runover page.
TN #DMAS-15	1/1/20	Pages 9, 10
TN #DMAS-14	10/1/19	Pages 9, 10
TN #DMAS-11	1/1/19	Page 1
TN #DMAS-10	10/1/18	Table of Contents Pages 1, 2-2b, 9-12 Pages 2c-2e were added as runover pages.
TN #DMAS-9	7/1/18	Page 2b
TN #DMAS-8	4/1/18	Page 13
TN #DMAS-7	1/1/18	Pages 1, 9
TN #DMAS-5	7/1/17	Pages 1, 10
TN #DMAS-4	4/1/17	Page 6
TN #DMAS-3	1/1/17	Pages 5, 7, 11
TN #DMAS-2	10/1/16	Table of Contents Pages 2. 4, 5, 7-10, 12, 13 Page 2a is a runover page. Page 14 was added as a runover page.
TN #DMAS-1	6/1/16	Table of Contents Pages 4, 6, 10, 12 Page 11 is a runover page. Page 13 was added as a runover page.
TN #100	5/1/15	Pages 1, 2-2b, 5, 11 Pages 3, 6 and 2c are runover Pages.
UP #10	5/1/14	Table of Contents Pages 8-12 Page 13 was added.
TN #99	1/1/14	Pages 10-12 Page 13 was added.
TN #98	10/1/13	Table of Contents Pages 1-12
UP #9	4/1/13	Page 3, 5
UP #7	7/1/12	Pages 4, 5
TN #96	10/1/11	Pages 6-8
TN #95	3/1/11	Page 8
TN #94	9/1/10	Pages 2-6, 8
TN #93	1/1/10	Pages 4-6, 8
Update (UP) #2	8/24/09	Pages 8, 9

5. Delayed Verifications

If requested verifications or other information needed to process the case are delayed in the postal system due to no fault of the applicant's, accept the documentation, reopen the case if necessary, and complete application processing.

M0130.100 Processing Time Standards

A. Processing Time Standards

1. Expedited Application Requirements

a. Pregnant Women

Applications for pregnant women must be processed within **seven (7) calendar days** of the agency's receipt of the signed application.

If the pregnant woman also applies for other children or other persons in her family and the agency cannot determine the other persons' eligibility within 7 calendar days, the agency must determine just the MA eligibility of the pregnant woman within the 7 calendar days.

The agency must have all necessary verifications within the 7 calendar days in order to determine eligibility. If the agency does not receive the verifications within the 7 calendar days, the worker must send the applicant written notice on the 7th day. The notice must state why action on the application was not taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 days by which to submit the documentation.

Once all necessary verifications for the pregnant woman are received, an eligibility decision must be made immediately and the applicant must be immediately notified of the decision. If the pregnant woman applied for other persons in the family, and the eligibility determination for those persons has not been completed, the written notice must state that the application is still pending.

If all necessary verifications are not received, the application continues to pend until the 45-day processing time limit is reached.

b. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Applications

BCCPTA Medicaid applications filed by individuals who do not meet the description of an individual in the Low-income Families with Children (LIFC), Medicaid pregnant women, or SSI recipients covered groups must be processed within 10 working days of the agency's receipt of the signed application.

BCCPTA Medicaid applications filed by individuals who meet the description of an individual in the LIFC, pregnant women, or the SSI recipients covered groups must be processed as soon as possible, but no later than 45 days of the agency's receipt of the signed application.

If the BCCPTA Medicaid application is the only application required and no additional information is required, the eligibility decision must be made immediately and the applicant must be notified of the decision within 10 working days of the agency's receipt of the application.

Changed With	Effective Date	Pages Changed
TN DMAS-20	7/1/21	Pages 14c, 15, 18, 21, 22a Appendix 5, page 3 Appendix 8, page 3 Page 15 is a runover page.
TN #DMAS-19	4/1/21	Table of Contents Pages 7, 14a-14d, 16, 22a, 24 Appendix 3, page 1; Appendix 5, page 1; Appendix 8, pages 1, 3 Page 8 is a runover page. Pages 8a and 14e were added as runover pages.
TN #DMAS-18	1/1/21	Page 21
TN #DMAS-17	7/1/20	Table of Contents Page 21
TN #DMAS-14	10/1/19	Table of Contents Pages 3, 4, 23, 24 Page 25 was added as a runover page. Appendix 8 was added.
TN #DMAS-13	7/1/19	Page 21
TN #DMAS-12	4/1/19	Pages 20, 21, 23
TN #DMAS-10	10/1/18	Page 1
TN #DMAS-9	7/1/17	Page 1, 2, 14c
TN #DMAS-6	10/1/17	Page 15 Appendix 1, page 4
TN #DMAS-5	7/1/17	Pages 18, 19, 23, 24
TN #DMAS-3	1/1/17	Table of Contents Page 22a Appendix 1, page 1
TN #DMAS-2	10/1/16	Pages 13, 19-22, 23, 24
TN #DMAS-1	6/1/16	Pages 4, 4b, 5, 23
TN #100	5/1/15	Table of Contents Pages 4b, 12, 17, 18 Appendix 5, page 3 Page 4 was renumbered for clarity. Page 4a is a runover page.
TN #99	1/1/14	Table of Contents Pages19, 23, 24 Appendix 4 was removed.

Changed With	Effective Date	Pages Changed
TN #98	10/1/13	Pages 2-3b Appendix 1 Pages 1-5 Pages 6-18 were removed.
UP #9	4/1/13	Page 3 Appendix 1, pages 3, 17 Appendix 3, pages 3, 4
UP #8	10/1/12	Table of Contents Pages 4, 7-8, 12, 14d-20 Page 17a was deleted. Appendix 5 , page 3 Appendix 7 pages 1-5
UP #7	7/1/12	Table of Contents Pages 14d, 16-19 Appendix 5 , page 3
TN #96	10/1/11	Table of Contents Pages 2, 3, 7, 8, 14d, 18-22a, 23 Appendix 5, page 3
TN #95	3/1/11	Table of Contents Pages 3, 3a, 4-6a, 14a-14c, 17, 19, 20 Pages 22a, 23, 24 Appendices 1-2a removed. Appendix 3 and Appendices 5-8 reordered and renumbered.
TN #94	9/1/10	Pages 3-3b, 7-9, 14a-14d, 18, 21, 22a, 23 Appendix 1 Appendix 3, page 3
Update (UP) #3	3/1/10	Pages 1-3a
TN #93	1/1/10	Table of Contents Pages 7-8, 14a, 14c-14d, 15-20, 22a Appendix 1 Appendix 3, page 3 Appendix 4, pages 1 and 2 Appendix 6, page 2
TN #92	5/22/09	Table of Contents Pages 1-6a Appendix 8 (18 pages) Pages 4a-4t were removed and not replaced.
TN #91	5/15/09	Page 7 Pages 14a, 14b Page 18 Page 20 Appendix 3, page 3

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

A. Policy

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

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

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

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

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

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

B. Eligible Alien Groups

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

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

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

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

4. an alien who belongs to one of the following classes:

    a. aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C.§§ 1160 or 1255a, respectively),

b. aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. § 1254a), and pending applicants for TPS who have been granted employment authorization,

c. aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24),

d. Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended,

e. aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President,

f. aliens currently in deferred action status, except for individuals receiving deferred status as a result of the Deferred Action for Childhood Arrivals (DACA) process, announced by the U.S. Department of Homeland Security on June 15, 2012, or

g. aliens whose visa petition has been approved and who have a pending application for adjustment of status.

5. a pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158), or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231), or under the Convention Against Torture who has been granted employment authorization, *or* such an applicant under the age of *19* who has had an application pending for at least 180 days;

6. an alien who has been granted withholding of removal under the Convention Against Torture;

7. a child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J);

8. an alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806 (e); or

9. an alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

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.*7*00 contains the entitlement and enrollment procedures for emergency services aliens.

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. *Unqualfied aliens, with the exception of pregnant women who are eligible for FAMIS Prenatal Coverage,* are eligible for emergency services only if they meet all other Medicaid eligibility requirements. Unqualified aliens include illegal and non-immigrant aliens.

For a pregnant woman who is not lawfully residing in the U.S. per M0220.314, use Chapter M23 to evaluate her eligibility for FAMIS Prenatal Coverage. If she is not eligible for FAMIS Prenatal Coverage, evaluate her eligibility for the coverage of emergency services using M0220.500.

B. 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. Regardless of the individual's immigration status, accept declaration of Virginia residency on the application as verification of residency unless the individual resides on the grounds of a foreign embassy. Do **NOT** require individuals who have been admitted into the U.S. on non-immigrant visas to sign a statement of intended residency.

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.

Non-immigrants include:

1. Visitors visitors for business or pleasure, including exchange visitors;

2. Foreign Government Representative foreign government representatives on official business and their families and servants. Note: if the foreign government representative resides on the grounds of a foreign embassy, he does not meet the Virginia residency requirement;

3. Travel Status aliens in travel status while traveling directly through the U.S.;

4. Crewmen Crewmen on shore leave;

5. Treaty Traders treaty traders and investors and their families;

6. Travel Status aliens in travel status while traveling directly through the U.S.;

7. Financial Eligibility

the asset transfer requirements (see subchapter M1450) apply.

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

Income must be within the income limit appropriate to the individual's covered group (Chapter M04 for Modified Adjusted Gross Income [MAGI] covered groups; Chapter M07 for F&C Medically Needy covered groups, and Chapter S08 for ABD covered groups). Spenddown provisions apply to individuals who meet a Medically Needy covered group. All medical expenses count toward meeting the spenddown, but once an entitlement date is determined after the individual meets the spenddown, only emergency services rendered on or after the entitlement date and which are within the period of coverage on the Emergency Medical Certification form are covered for emergency services aliens.

B. Emergency Services Certification--Not Applicable to Full Benefit Aliens

Certification with completion of an Emergency Services Certification form (DMAS Form 2019NR - available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms) that the service provided was an emergency service is an additional eligibility requirement for emergency services aliens (not applicable to full benefit aliens). An eligibility worker can certify emergency services coverage for pregnancy-related labor and delivery services for limited, specified periods of time. The eligibility worker will complete and sign the form and send a copy to the hospital or provider. DMAS must certify emergency services coverage for all other requests and determine the period of coverage.

1. Eligibility Worker Certification for Pregnancy-Related Labor and Delivery Services

For pregnant women who do not meet the FAMIS Prenatal Coverage eligibility requirements in Chapter M23, an eligibility worker can certify emergency services payment for pregnancy-related labor and delivery services, including inpatient hospitalizations that did not exceed:

- 3 days for a vaginal delivery, or
- 5 days for a cesarean delivery.

To determine the length of stay, count the day of admission, but not the day of discharge. If the length of stay exceeded 3 days for a vaginal delivery or 5 days for a cesarean delivery, DMAS must approve the coverage following the procedures in M0220.500 B.2 below. Note that the enrollment period for the emergency service(s) includes the day of discharge even though it is not counted to determine the length of stay (see M0220.700).

For eligibility worker certifications, verification of the labor and delivery services must be obtained from the physician or hospital and include the following information:

- patient name, address and date of birth,
- facility name and address where the delivery took place
- type of delivery (vaginal or cesarean), and
- inpatient hospital admission and discharge dates.

If more than one period of service is requested, the records must be separated, and a separate certification form must be attached for each period of service.

If a request is received with one certification form and the records contain multiple dates of service, and/or DMAS is unable to make a determination with the medical records received, the entire request will be returned to the eligibility worker with a note specifying the information needed.

Do not include application forms for disability, FAMIS, etc. These forms contain protected health information that is not needed for the determination of medical necessity.

Do **not** take action to approve or enroll an emergency services alien until you receive the completed Emergency Medical Certification form back from DMAS. If approved, DMAS will provide the certification for Medicaid payment for emergency services and coverage begin and end dates.

M0220.600 FULL BENEFIT ALIENS ENTITLEMENT & ENROLLMENT

A. Policy

An alien who is determined eligible for full Medicaid benefits and who meets all Medicaid eligibility requirements (including covered group requirements) is eligible for all Medicaid-covered services available to the recipient's covered group.

B. Application & Entitlement

1. Application Processing

The eligibility worker must take the application and develop it in the same manner as any other individual's application. All eligibility requirements, including covered group requirements must be met.

2. Entitlement

If the applicant is found eligible for Medicaid, ongoing eligibility may exist unless the recipient is on a spenddown.

3. Spenddown

Spenddown provisions apply to medically needy individuals who have excess income.

4. Notice

Appropriate notice must be sent to the applicant of the status of his application and of his Medicaid eligibility.

C. Enrollment Procedures

Once a full benefit alien is found eligible for Medicaid, he must be enrolled in VaCMS using the following data:

1. Country

In this field, Country, enter the code of the alien's country of origin.

2. Cit Status

In this field, Citizenship Status, enter the Citizenship code that applies to the alien. Below, next to the Citizenship code, is the corresponding Alien Code from the Alien Code Chart in Appendix 5 to this subchapter. Eligible alien codes are:

R = refugee (Alien Chart codes F1, F2, G1, G2); also used for Afghan and Iraqi Special Immigrants (Alien Chart Code Z1).
E = entrant (Alien Chart code D1).
P = full benefit qualified aliens *and women eligible for FAMIS Prenatal Coverage* (Alien Chart codes A1, A2, A3, B1, B3, C1, CC1, E1, H1, H2, I1, J1, J2, K1);
I = legal immigrant children under age 19 only (Alien Chart codes Y1, Y2, Y3)

	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	Aliens not lawfully admitted or whose lawful admission status has expired* **For a pregnant woman who is not lawfully residing in the U.S., go to Chapter M23*.	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-I186; SW-434; I-95A]	Emergency Only W1	Emergency Only W2	Emergency Only W3

	LAWFULLY RESIDING NON-CITIZENS	**Effective 1/1/10**	**Effective 7/1/12**
Y	Non-citizen (alien) children under the age of 19 and pregnant women lawfully residing in the U.S. who meet the requirements in M0220.314.	Full Benefits for Medicaid children under age 19 (FAMIS Plus)	Full Benefits for Medicaid (FAMIS Plus), Medicaid pregnant women, FAMIS and FAMIS MOMS

	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, SQ1, SQ2, or SQ3 and bearing Department of Homeland Security stamp or notation]	Full Benefits Z1	Emergency Only Z2

		Immigration Status	Eligible for Full Medicaid Benefits?	MMIS Code
Non-Citizen				
No limitation on date of arrival to the U.S.	No time limitation on eligibility as long as covered group requirements are met	a. A qualified alien and veteran who was discharged honorably not on account of alienage, and who fulfills the minimum active-duty service requirements of section 5303A(d) of title 38, United States Code	Yes	P
		b. A qualified alien on active duty (other than active duty for training) in the Armed Forces of the United States (not in the Armed Forces Reserves)	Yes	R
		The spouse or the unmarried dependent child (see M0220.311 A) of a living (not deceased) qualified alien who meets the conditions in a. or b. above	Yes	P
		The unremarried surviving spouse of an individual described in a. or b. above who is deceased, if the spouse was married to the veteran • before the expiration of fifteen years after the termination of the period of service in which the injury or disease causing the death of the veteran was incurred or aggravated; or • for one year or more; or • for any period of time if a child was born of the marriage or was born to them before the marriage.	Yes	P
		Recipients of Supplemental Security Income (SSI)	Yes	P
		An alien who is • an American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (INA) apply, or • a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)),	Yes	P
		Effective 12-27-20, Lawful Permanent Resident who is a citizen of Micronesia, the Marshall Islands or Palau	Yes	P
Arrived in U.S. on or after 8/22/1996	Regardless of length of residency in U.S.	Individuals *other than pregnant women* with no immigration documents (undocumented) *For a pregnant woman who is not lawfully residing in the U.S., go to Chapter M23*.	No—Eligible for Emergency Services Coverage Only	A
		Deferred Action Childhood Arrivals (DACA)	No—Eligible for Emergency Services Coverage Only	A
		Individuals whose immigration status has expired and who do not meet any other immigration status	No—Eligible for Emergency Services Coverage Only	A
		Lawful Permanent Resident who has resided in the U.S. for fewer than 5 years, and/or prior to 4-1-21, without at least 40 qualify quarters of work coverage on record with the Social Security Administration. Effective 4-1-21, there is no longer a work requirement. The 5 year residency requirement remains in effect.	No—Eligible for Emergency Services Coverage Only	A

M0240 Changes

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

TABLE OF CONTENTS

M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

M0240.000 SOCIAL SECURITY NUMBER REQUIREMENTS

M0240.000 SOCIAL SECURITY NUMBER REQUIREMENTS

M0240.001 GENERAL PRINCIPLES

A. Policy

To be eligible for medical assistance (MA), an individual must provide his Social Security number (SSN) as well as the SSN of any person for whom MA is requested, or must provide proof of application for an SSN. This requirement applies to both the Medicaid and FAMIS Programs.

Exceptions – the SSN requirement does not apply to:

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

An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

B. Failure to Meet SSN Requirement

Any individual for whom an application for an SSN has not been filed or for whom the SSN is not furnished **is not eligible** for MA EXCEPT for the following individuals.

1. Child Under Age 1

A child under age one born to a Medicaid-eligible or to a FAMIS-covered mother is deemed to have applied and been found eligible for MA, whether or not the eligibility requirements, including SSN, have actually been met. *This includes an infant born to a mother in FAMIS Prenatal Coverage who is enrolled in Aid Category 110 AND who is NOT in managed care.*

An infant born to a mother in FAMIS Prenatal Coverage who is enrolled in AC 110 and who IS in managed care OR who is enrolled in AC 111 is not a deemed newborn; however, the infant is not required to provide an SSN or proof of application for an SSN in order to be enrolled. See M0240.200 C.

2. Individual With Religious Objections

An individual who refuses to obtain an SSN due to well-established religious objections must provide documentation of (1) membership of a recognized religious sect of division of the sect and (2) adherence to the tenets or teachings of the sect or division of the sect and for that reason being conscientiously opposed to applying for or using a national identification number.

3. Emergency-Services Aliens and other Non-Citizens

An alien eligible for Medicaid payment of emergency services only, as defined in M0220.410 and M0220.41, is not required to provide or apply for an SSN.

Any non-citizen who is only eligible to receive an SSN for a valid non-work reason is not required to provide or apply for an SSN. These individuals include, but are not limited to, undocumented aliens, non-citizens admitted to the U.S. on non-immigrant visas and individuals who do not intend to work in the U.S. and would only have needed an SSN for the purposes of receiving public assistance.

C. Relationship to Other Medicaid Requirements

An applicant who cannot provide documentation that he is a citizen or legally present at the time of application must sign an affidavit under oath attesting that he is a U.S. citizen or legally present in the U.S. in order to temporarily meet the requirement for proof of legal presence (see M0210.150). **Submission of the affidavit without proof of application for an SSN does NOT meet the SSN requirement.**

D. Verification

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. It is important to spell the name correctly so that when the Medicaid Management Information System (MMIS) sends the enrollee information to SSA for the Medicare Buy-in or the citizenship and identity match, the enrollee can be matched to SSA records.

The Federally managed Data Services Hub verifies the individual's name and SSN with the SSA for cases processed in the Virginia Case Management System (VaCMS). For an individual whose name and SSN cannot be verified in VaCMS and for all individuals whose cases are not processed in VaCMS, either the State Verification Exchange System (SVES) or the State Online Query-Internet system (SOLQ-I) SSA Title II and Title XVI results may be used.

2. SSN

The individual's SSN must be verified. The worker may use the SOLQ-I or SVES to verify an individual's SSN.

3. Verification Systems - SVES & SOLQ-I

SVES verifies the individual's SSN, name spelling, entitlement to SSA benefits and the amount of the benefit, entitlement to SSI and the amount, and entitlement to Medicare & the Medicare premium amounts. SVES tells the worker what is wrong with the name, if the name is incorrectly spelled.

The SOLQ-I verifies the individual's SSN, entitlement to SSA benefits and the amount of the benefit, entitlement to SSI and the amount, and entitlement to Medicare & the Medicare premium amounts. SOLQ-I does <u>not</u> verify the individual's name according to the SSA records.

E. Procedure

Section M0240.100 below explains in detail how to determine if an individual meets the SSN requirements when the individual or child does not have an SSN.

M0240.100 APPLICATION FOR SSN

A. Policy

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

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

1. Newborns

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

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

2. Failure to Apply for SSN

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

3. Retroactive Eligibility

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

M0240.200 FOLLOW-UP REQUIREMENTS FOR SSN APPLICATION

A. Applicant Applied for SSN

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

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

B. Follow-Up Procedures *for Individuals Who Are Not Infants Born to Women Enrolled in FAMIS Prenatal Coverage*

The follow-up procedures below do not apply to individuals listed in M0240.100 B.

1. Documentation

If the applicant does not have an SSN, the agency must document in the record the date he applied for an SSN.

2. Entering Computer Systems

When entering the individual the eligibility/enrollment system, use the date the individual applied for an SSN, or the individual's date of birth, preceded by "000" as the individual's SSN.

For example, an individual applied for an SSN on October 13, 2006. Enter "000101306" as the individual's SSN in the eligibility/enrollment system.

3. Follow-up

a. Follow-up in 90 Days

After enrollment of the eligible individual, the agency must follow-up within 90 days of the Social Security number application date or 120 days if application was made through hospital enumeration:

b. Check for Receipt of SSN

Check the system records for the enrollee's SSN. If the SSN still has "000" the first 3 digits, contact the enrollee to obtain the enrollee's SSN verbally or by mail.

c. Verify SSN by a computer system inquiry of the SSA records.

d. Enter Verified SSN in the eligibility/enrollment system.

4. Renewal Action

If the enrollee's SSN has not been assigned by the 90-day follow-up, the worker must follow-up no later than the enrollee's annual renewal, by checking the systems for the enrollee's SSN and by contacting the enrollee if necessary.

a. Check for Receipt of SSN

Before or at renewal, the SSN must be entered into the eligibility/enrollment system. Check the system records for the enrollee's SSN. If the SSN has "000"as the first 3 digits, contact the enrollee to obtain the enrollee's SSN verbally or by mail, or on the renewal form if a renewal form is required.

b. Verify SSN by a computer system inquiry of the SSA records.

c. Enter Verified SSN in the eligibility/enrollment system.

d. SSN Not Provided by Renewal Deadline

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

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

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

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

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

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

An infant born to a mother in FAMIS Prenatal Coverage who is enrolled in AC 110 and who IS in managed care OR who is enrolled in AC 111 is not a deemed newborn; however, the infant is not required to provide an SSN or proof of application for an SSN in order to be enrolled. Follow the procedures in M0240.200 B.3 above 90 days following the infant's enrollment to determine if an SSN has been assigned. If the SSN number has not yet been issued at 90 days, obtain the SSN or proof of application for an SSN at the first renewal of the infant's coverage.

M0240.300 SSN Verification Requirements

A. SSN Provided By Individual

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

B. Procedures

1. Enter Verified SSN in Systems

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

2. SSN and Citizenship Update Report

For cases NOT processed in VaCMS, when an individual's SSN is entered into the eligibility/enrollment system, the SSN and identifying data is transmitted on the 21st day of the month to SSA for SSN verification. If SSA does not verify the individual's SSN, the individual will be listed on the SSN and Citizenship Update Report (RS-O-485A) that is posted on SPARK under Medicaid Management Reports.

3. Review Report Each Month

Eligibility staff is expected to review the report to see if the report lists any enrollees who were rejected because their SSN, name or date of birth did not match the information in the SSA records. If an enrolled individual is listed on the report with an "SSN Status" that is not verified, the worker must attempt to resolve the discrepancy.

4. Resolving Unverified SSN Discrepancies

a. Data Entry Error Caused Discrepancy

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

b. Discrepancy Not Caused by Data Entry Error

If the discrepancy is not the result of a typographical or other data entry error, the individual must be given a period of 10 days to resolve the issue or provide written verification from SSA of the individual's correct SSN. The eligibility worker must send a written notification to the enrollee that informs the enrollee of the SSN discrepancy and gives him 10 calendar days from the date of the notice to either resolve the discrepancy with the SSN or to provide written verification of his correct SSN to the worker. The notice must inform the individual that if he does not verify his SSN by the deadline, his Medicaid coverage will be canceled.

c. Individual Provides SSN Verification

If verification of the SSN is received within the 10 days, update the eligibility/enrollment system accordingly so that the enrollee's information will be included in a future data match.

d. SSN Verification Not Provided

If verification of the SSN is NOT received within the 10 days, send the individual an advanced notice of proposed cancellation and cancel the individual's coverage in *the eligibility/enrollment system.*

M0240.400 SOCIAL SECURITY NUMBER DISCREPANCIES

A. Policy

To be eligible for medical assistance (MA), an individual must provide his Social Security number (SSN) as well as the SSN of any person for whom MA is requested, or must provide proof of application for an SSN.

As required by 42 CFR 435.910(g), "the agency must verify each SSN of each applicant and recipient with the SSA [Social Security Administration], as prescribed by the Commissioner, to insure that each SSN was furnished to that individual, and to determine whether any others were issued."

In addition, 42 CFR 435.920 states, "In redetermining eligibility, the agency must review case records to determine whether they contain the recipient's SSN or, in the case of families, each family member's SSN."

The Medical Assistance enrollment system generates a Social Security number and citizenship report (RS-O-485-A) and makes the report available to the local departments of social services (LDSS) on a monthly basis. LDSS agencies are responsible for reviewing the monthly report and correcting any discrepancies. If the agency is not able to resolve SSN discrepancies in a timely manner, an ineligible individual should not receive Medicaid services. Refer to Medicaid Policy M0240.300 regarding SSN Verification Requirements.

Staff at the Department of Medical Assistance Services will oversee and monitor the process of SSN resolution on a monthly basis to ensure that action has been taken to correct Social Security Numbers in the system.

B. Process

1. Generation of the RS-O-485-A Report

The RS-O-485-A Report is produced monthly and posted for LDSS review.

2. VDSS Requirements

It is the responsibility of the LDSS to review the report and research each entry to resolve any discrepancies concerning an individual's social security number. An ineligible individual should not receive Medicaid services.

VDSS is responsible for implementing the necessary procedures to ensure that all corrections or changes will be made within a 30-day period and updated in the MMIS system accordingly. Policy guidelines are located in the Medicaid Policy Manual. See Policy M0240.300

3. DMAS Review

DMAS staff will concurrently review an internal report showing how long each individual discrepancy continues to appear. The number of new (first time) and repeat (not first time on report) occurrences will be noted. Repeat occurrences will be further broken down by those that have appeared from prior month, in the prior two months, in the prior three months, and the total that have been on the report for four or more months.

4. Forward List to VDSS

DMAS will provide a monthly outcome report of the number of discrepancies reported and the individuals with discrepancies that remain on the report after 90 days.

This report will be forwarded to the VDSS Medical Assistance Programs Manager and to the VDSS Regional Medicaid consultants for review. VDSS will review the report and provide to DMAS a corrective action plan for resolving the discrepancies. All discrepancies must be resolved within 30 days of receiving the report from DMAS.

M0270 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-20	7/1/21	Page 2
TN #DMAS-16	4/1/20	Page 3 Page 4 was added.
Update (UP) #9	4/1/13	page 3

B. Procedure

The types of benefits for which an individual must apply and/or accept are listed in section M0270.200 below.

The procedures to follow are in section M0270.300 below.

M0270.200 TYPES OF BENEFITS

A. Benefits Excluded From Requirement to Apply

An applicant is NOT required to apply for benefits or assistance that is based on the individual's need. An individual is not required to apply for cash assistance program benefits such as Supplemental Security Income (SSI) or Temporary Assistance For Needy Families (TANF).

Payments such as child support, alimony, accelerated life insurance, etc., are NOT benefits for which an individual must apply.

B. Types of Benefits For Which An Individual Must Apply

1. Benefit Characteristics

Benefits for which the individual must apply have the following characteristics in common:

- require an application or similar action;
- have conditions for eligibility;
- make payments on an ongoing or one-time basis.

2. Major Benefit Programs

Annuities, pensions, retirement and disability benefits to which an individual may be entitled and for which he must apply, if he appears to be entitled, include but are not limited to:

a. Veterans' Compensation and Pensions, including apportionment of augmented dependents' benefits

b. Social Security Title II benefits, *including full or reduced retirement benefits, survivors benefits, and disability benefits. See M0310.122 for more information about these benefits.*

c. Railroad Retirement Benefits

d. Unemployment Compensation

e. Worker's Compensation

f. Black Lung Benefits

g. Civil Service and Federal Employee Retirement System Benefits

h. Military Pensions

M0280 Changes

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

TABLE OF CONTENTS

M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

M0280.000 INSTITUTIONAL STATUS REQUIREMENTS

Appendix

.

M0280.000 INSTITUTIONAL STATUS REQUIREMENTS

M0280.001 GENERAL PRINCIPLES

A. Introduction

To be eligible for Medicaid, an institutionalized individual must meet the institutional status requirement. An individual does not necessarily have to live in an institution (facility) to be considered an "inmate of a public institution." While inmates of public institutions are generally NOT eligible for Medicaid, incarcerated individuals may be eligible for Medicaid payment limited to inpatient hospitalization, provided they meet all other eligibility requirements.

B. Procedure

This subchapter, M0280, contains the Medicaid institutional status policy, inmate of a public institution policy and procedures for determining whether an individual meets the Medicaid institutional status eligibility requirement.

M0280.100 DEFINITION OF TERMS

A. Child Care Institution

A child care institution is a

- non-profit private child-care institution, or
- a public child care institution that accommodates no more than 25 children which has been licensed by the state in which it is located or has been approved by the agency of the state responsible for licensing or approval of institutions of this type, as meeting the standards established for licensing.

The term "child care institution" does NOT include detention facilities, forestry camps, training schools or any other facility operated primarily for the detention of children who are determined to be delinquent.

B. Inpatient

Inpatient means a patient who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist and who is admitted and receives room, board and professional services in the institution for a 24 hour period or longer, or is expected by the institution to receive room, board and professional services in the institution for a 24 hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another medical facility and does not actually stay in the institution for 24 hours.

C. Institution

An institution is an establishment that furnishes (in single or multiple facilities) food, shelter and some treatment or services to four or more persons unrelated to the proprietor.

D. Institution for Mental Diseases (IMD)

An IMD is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, to persons with mental diseases. A psychiatric residential treatment facility for children and adolescents is an IMD. An institution for individuals with intellectual disabilities is NOT an IMD. *A list of IMDs in Virginia is contained in M0280, Appendix 2*

Institutions for the Treatment of Mental Diseases in Virginia

Facility	Location
State Facilities	
Catawba Hospital*	
Central State Hospital	Petersburg
Commonwealth Center (for children and adolescents)	Staunton
Eastern State Hospital*	Williamsburg
Northern Virginia State Mental Health Hospital	Falls Church
Piedmont Geriatric Hospital*	
Southern Virginia Mental Health Institute	Danville
Southwestern Virginia Mental Health Institute	Marion
Western State Hospital	Staunton
*Not covered by Medicaid	
Private Freestanding Psychiatric Hospitals	
Dominion Hospital	Falls Church
Kempsville Center for Behavioral Health	Norfolk
Keystone Newport News LLC	Newport News
North Spring Behavioral Health Inc.	Leesburg
Poplar Springs Hospital	Petersburg
Virginia Beach Psychiatric Center	Virginia Beach

Contact VaMedicaidQuestions@dmas.virginia.gov for guidance regarding other types of facilities, such as crisis stabilization units, psychiatric residential facilities, or Addiction and Recovery Treatment Services (ARTS) facilities.

Changed With	Effective Date	Pages Changed
TN #DMAS-20	7/1/21	Page 6 Pages 5 and 5a are runover pages.
TN #DMAS-18	1/1/21	Table of Contents, page ii Pages 26, 27 Appendix 1 was removed. Appendix 2 was renumbered to Appendix 1.
TN #DMAS-17	7/1/20	Page 7 Pages 8 and 9 are runover pages.
TN #DMAS-15	1/1/20	Pages 29, 30
TN #DMAS-14	10/1/19	Pages 24, 26, 27, 40
TN #DMAS-13	7/1/19	Pages 24 Page 24a is a runover page.
TN #DMAS-12	4/1/19	Pages 8, 9, 13
TN #DMAS-10	10/1/18	Table of Contents, page ii Pages 1-4 Page 40 was added.
TN #DMAS-9	7/1/18	Page 35 Appendix 2, Page 1
TN #DMAS-8	4/1/18	Page 9
TN #DMAS-7	1/1/18	Pages 34, Appendix 2, page 1
TN #DMAS-5	7/1/17	Pages 13, 37, 38
TN #DMAS-4	4/1/17	Pages 24, 30a Page 23 is a runover page. Page 24a was added as a runover page.
TN #DMAS-3	1/1/17	Pages 8, 13, 28b
TN #DMAS-2	10/1/16	Pages 4, 7, 29 Page 30 is a runover page. Appendix 2, page 1
TN #DMAS-1	6/1/16	Table of Contents, page ii Pages 13, 26, 28 Appendix 2, page 1

TN #100	5/1/15	Table of Contents, pages i, ii Pages 11, 23, 28b, Pages 27a-27c were renumbered to 28-28a for clarity. Page 10 is a runover page. Appendix 2
UP #10	5/1/14	Pages 29, 30
TN #99	1/1/14	Pages 6, 7, 21, 24, 25, 27a, 39
TN #98	10/1/13	Pages 2, 4, 27a, 27b, 28, 35, 36, 39
UP #9	4/1/13	Pages 24-27 Appendix 2
TN #97	9/1/12	Table of Contents, page i Pages 1-5a, 10-13 Pages 23, 28, 29, 30a, 31 Pages 33, 36, 38, 39
UP #7	7/1/12	Table of Contents, page ii Pages 23, 26, 27 Appendices 1-3 were removed. Appendices 3 and 4 were renumbered and are now Appendices 1 and 2, respectively.
TN #96	10/1/11	Appendix 4
TN #95	3/1/11	Pages 30, 30a
TN #94	9/1/10	Pages 21-27c, 28
TN #93	1/1/10	Page 35 Appendix 5, page 1
Update (UP) #2	8/24/09	Table of Contents Page 39
TN #91	5/15/09	Pages 23-25 Appendix 4, page 1 Appendix 5, page 1

2. F&C Groups

a. Children under age 18

b. Children under age 1

c. Pregnant Women

d. Special Medical Needs Adoption Assistance Children

e. Individuals under age 21

E. Refugees

"Refugees" are a special group of individuals who have an alien status of "refugee", and are eligible for Medicaid under a different federal funding source. Virginia receives full federal funding with no state matching funds for the medical assistance provided to these individuals during the first 8 months they are in the U.S.

There are two aid categories (ACs) for this group. AC 078 is used for Refugee Other and Refugee Medicaid Other and AC 079 is used for Refugee Medicaid Unaccompanied Minors. The policy and procedures used to determine whether an individual is eligible in this group are found in the Refugee Resettlement Program Manual, Volume XVIII.

M0310.100 DEFINITION OF TERMS

A. Introduction

The terms used in the covered groups policy and procedures and the procedures for determining if an individual meets a definition are stated in sections M0310.101 through 131 below.

M0310.101 ABD

A. ABD Definition

"ABD" is the short name used to refer to aged, blind or disabled individuals.

B. Procedures

See the following sections for the procedures to use to determine if an individual meets an ABD definition:

- M0310.105 Age and Aged
- M0310.106 Blind
- M0310.112 Disabled

M0310.102 ADOPTION ASSISTANCE

A. Definition

Adoption Assistance is a Title XX of the Social Security Act social services program that provides cash assistance and/or social services to adoptive parents who adopt "hard to place" foster care children who were in the custody of a local department of social services or a child placing agency licensed by the state of Virginia.

1. Residing in Virginia

Adoption assistance children are children who reside in Virginia who are adopted under a Title IV-E or Non-IV-E (state-local) adoption assistance agreement with a department of social services or in conjunction with a child-placing agency.

2. Child-placing Agency Definition

A child placing agency is an agency that is licensed by the State Department of Social Services for child placing services. Not all child placing agencies provide adoption services; some may provide foster home placement. The services offered must be identified in the description given for the license. The foster care service unit of the local department of social services should be familiar with the function of the child placing agency, and whether or not it is licensed.

3. When Adoption Assistance Is Effective

A child under 21 is usually considered an adoption assistance child when the adoption assistance agreement is signed, even if the interlocutory or judicial decree of adoption has not been issued or adoption subsidy payments are not being made. The adoptive parents are considered to be the adoption assistance child's parent(s) as of the date the adoption agreement is signed.

If the child is not eligible because of the adoptive family's income, treat the adoption assistance child as a foster care child until the interlocutory or judicial decree of adoption has been issued. As a foster child, the child's assistance unit consists of one person and the adoptive parent's income is not deemed to the child.

B. IV-E and Non-IV-E

1. IV-E Adoption Assistance

a. Definition

The following children meet the IV-E adoption assistance definition:

1) Children adopted under a IV-E adoption assistance agreement with a Virginia local department of social services or in conjunction with a privat child placing agency, who reside in Virginia. Eligibility begins when the IV-E adoption assistance agreement is signed even if an interlocutory or judicial decree of adoption has not been issued, or subsidy payments are nc being made.

2) Children adopted under a IV-E adoption assistance agreement with another state's department of social services, who now reside in Virginia.

b. IV-E Adoption Assistance payment not required

The IV-E adoption assistance definition is met when the adoption assistance agreement specifies that cash and medical assistance is required or that the only assistance required is medical assistance. Receipt of cash assistance is not required to meet the Adoption Assistance definition.

2. Non-IV-E Adoption Assistance

a. Non-IV-E definition

The following children meet the Non-IV-E adoption assistance definition:

1) Children who reside in Virginia who are adopted under a Non-IV-E adoption assistance agreement with a Virginia local department of social services or in conjunction with a Virginia private child placing agency.

2) "Special Medical Needs" children adopted under a Non IV-E Adoption Assistance agreement with a Virginia local department of social services or a Virginia private, non-profit child placement agency in conjunction with a local department of social services, in accordance with policies established by the State Board of Social Services.

b. Special Medical Needs definition

A child with "special medical needs" is a child who was determined unlikely to be adopted because of:

- a physical, mental or emotional condition that existed prior to adoption; or

- a hereditary tendency, genetic defect, congenital problem or birth injury leading to a substantial risk of future disability.

c. *Documentation* must specify "special medical need(s)"

Documentation of the child's special medical need(s) must be in one of the following forms:

- *an* adoption assistance agreement *specifying* that the child has a special medical need; the agreement does NOT need to specify a particular diagnosis or condition. If an amendment was used to specify that the child has special medical needs, it must document that the special medical needs began prior to the effective date of the adoption assistance agreement.

- *an* amendment to the adoption assistance agreement specifying that the child has special medical needs. *The* amendment must document that the special medical needs began prior to the effective date of the adoption assistance agreement.

- *a signed letter on official letterhead from the state that facilitated the adoption assistance agreement confirming that the child has a special medical need.*

d. Virginia Medicaid coverage for Special Medical Needs children

Medicaid coverage is to be provided to any child who has been determined to be a Non-IV-E Special Medical Needs adoption assistance child for whom there is in effect an adoption assistance agreement between a local Virginia department of social services (LDSS) or a Virginia child-placing agency and an adoptive parent(s).

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

M0320 Changes

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

B. Financial Eligibility

1. Assistance Unit

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

2. Resources

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

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

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

3. Income

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

4. Income Exceeds 80% FPL

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

D. Entitlement

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

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

E. Enrollment

The ABD 80% group AC is:

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

M0320.400 MEDICAID WORKS

A. Policy

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

- at least age 16 and are under age 65, **and**
- who have countable income less than or equal to 80% FPL. *Effective July 1, 2021, the income limit is 138% FPL.*
  or
- or who are SSI recipients or 1619(b) individuals), **and**
- who have countable resources less than or equal to $2,000 for an individual and *$*3,000 for a couple; **and**

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

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

D. Financial Eligibility

1. Assistance Unit

Initial eligibility determination

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

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

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

b. Ongoing eligibility

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

2. Resources

a. Initial eligibility determination

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

Accounts are also excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees. The account must be exclusively used to hold resources accumulated while in MEDICAID WORKS (including interest) in order for the exclusion to continue.

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

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

3. Income

a. Initial eligibility determination

For the initial eligibility determination *on or after July 1, 2021*, the limit for total countable income (unearned and earned) is *less than or equal to 138%* of the FPL *($1,482 per month for an individual or $2,004 when the applicant has an* ABD spouse who is also applying for or covered by Medicaid). The income requirements in chapter S08 must be met. Individuals who receive SSI or who have 1619(b) status are considered to meet the income requirements and no evaluation of income is necessary for the initial eligibility determination (see M0320.101).

b. Ongoing eligibility

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

1) The income limit for earned income is $6,250 per month ($75,000 per year) (no change for 2021) as long as the funds are deposited in a WIN Account. The policy for determining countable earned income is contained in subchapter S0820.

   If the individual is self-employed, net earnings from self-employment (NESE) must be demonstrated through documentation of Internal Revenue Service (IRS) filings, quarterly estimated taxes, business records, and/or business plans. The individual's signed allegation of self-employment is acceptable if no other evidence of NESE can be obtained. Follow the policy in S0820.220 for determining NESE.

2) The income limit for unearned income remains less than or equal to *138%* of the FPL. The policy for determining countable unearned income is contained in subchapter S0830.

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

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

4. Income Exceeds *138%* FPL at Eligibility Determination

Spenddown does not apply to the Medicaid Works covered group. Therefore, admission into MEDICAID WORKS is not available to individuals whose income exceeds *138%* of the FPL. Evaluate the individual's eligibility in all other Medicaid covered groups.

E. Cost Sharing and Premium Payment

Cost sharing is required of all individuals enrolled in MEDICAID WORKS. Enrollees are responsible for copayments for services received (see M1850.100 B).

Premiums are assessed on a sliding scale based on the individual's income and are subject to change. Based on the sliding scale, some individuals may not owe a premium.

Note: premiums are not being charged at this time.

F. Good Cause

An individual may remain eligible for MEDICAD WORKS if one of the following good cause exceptions is met:

- If the individual is unable to maintain employment due to illness or unavoidable job loss, the individual may remain in MEDICAID WORKS for up to six months as long as any **required** premium payments continue to be made. The six-month period begins the first day of the month following the month in which the job loss occurred. The individual should be asked to provide documentation that he is unable to work from a medical or mental health practitioner or employer. However, do not cancel the individual's eligibility under MEDICAID WORKS due to the lack of documentation if the individual indicates that he is still seeking employment.
- DMAS may establish other good cause reasons. Requests for good cause other than the temporary loss of employment due to a documented illness or unavoidable job loss must be submitted to DMAS on the enrollee's behalf by the local department of social services.

G. Safety Net

Enrollees who are unable to sustain employment for longer than six months must be evaluated for continued coverage in all other Medicaid covered groups for which the individual meets the definition. Resources held in the WIN Account that are accumulated from the enrollee's earnings while in MEDICAID WORKS will be disregarded up to the 1619(b) threshold amount for this eligibility determination.

If found eligible and enrolled in another Medicaid covered group, the individual shall have a "safety-net" period of up to one year from MEDICAID WORKS termination and enrollment in another group to dispose of these excess resources before they are counted toward ongoing eligibility.

If the individual resumes working within the safety-net period, he may be re-enrolled in MEDICAID WORKS provided that all eligibility requirements are met, except that the resources in the WIN Account are disregarded up to the 1619(b) threshold amount. If the individual wishes to be re-enrolled in MEDICAID WORKS after the one-year safety net period, any resources retained in the WIN Account are countable.

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

H. Benefit Package

Individuals enrolled in MEDICAID WORKS are entitled to the standard benefits available to full-benefit Medicaid enrollees (see Chapter M18), as well as Personal Assistance Services; MEDICAID WORKS enrollees do **not** have a patient pay. Intensive Behavioral Dietary Counseling is also covered for MEDICAID WORKS enrollees when a physician determines that the service is medically necessary.

I. Entitlement and Enrollment

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

There is no retroactive coverage under MEDICAID WORKS. The application date in the Virginia Case Management System (VaCMS) is the date the individual signed the MEDICAID WORKS Agreement. Coverage shall begin on the first day of the month following the month in which all requirements are met. If the applicant has a future start date for employment, the effective date of eligibility shall be no earlier than the first day of employment. However, unless employment begins on the first day of the month, MEDICAID WORKS enrollment will begin on the first of the following month.

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

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

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

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

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

Changed With	Effective Date	Pages Changed
TN #DMAS-20	7/1/21	Pages 1, 13, 14
TN #DMAS-19	4/1/21	Pages 14, 26
TN #DMAS-14	10/1/19	Pages 1, 2, 10a
TN #DMAS-12	4/1/19	Pages 26, 28
TN #DMAS-11	1/1/19	Pages 1, 2, 12, 14-16, 24, 25
TN #DMAS-10	10/1/18	Table of Contents Page 1-2, 30 Page 10a-b were added as runover pages.

TN #DMAS-8	4/1/18	Pages 1, 9, 10, 25
TN #DMAS-6	10/1/17	Pages 8, 14
TN #DMAS-5	7/1/17	Pages 9, 14
TN #DMAS-4	4/1/17	Page 5
TN #DMAS-3	1/1/17	Pages 9, 10 Page 9a was removed.
TN #DMAS-2	10/1/16	Pages 8 Page 9b was renumbered to 9a.
TN #DMAS-1	6/1/16	Pages 2, 8, 9, 15, 31, 32-35 Page 9b was added as a runover page.
TN #100	5/1/15	Table of Contents Pages 4-8, 15-22, 24,25 36-38
UP #10	5/1/14	Pages 5, 8, 9
TN #99	1/1/14	Pages 1, 8, 9, 13, 24
TN #98	10/1/13	Table of Contents Pages 1-3, 6-16, 19, 22, 24-29
UP #8	10/1/12	Pages 4, 6
TN #97	9/1/12	Table of Contents Pages 1-40 (all pages)
UP #2	8/24/09	Pages 3, 6, 8, 16, 22
Update (UP) #1	7/1/09	Pages 20, 21
TN #DMAS-4	4/1/17	Page 5
TN #DMAS-3	1/1/17	Pages 9, 10 Page 9a was removed.
TN #DMAS-2	10/1/16	Pages 8 Page 9b was renumbered to 9a.
TN #DMAS-1	6/1/16	Pages 2, 8, 9, 15, 31, 32-35 Page 9b was added as a runover page.
TN #100	5/1/15	Table of Contents Pages 4-8, 15-22, 24,25 36-38
UP #10	5/1/14	Pages 5, 8, 9
TN #99	1/1/14	Pages 1, 8, 9, 13, 24
TN #98	10/1/13	Table of Contents Pages 1-3, 6-16, 19, 22, 24-29
UP #8	10/1/12	Pages 4, 6
TN #97	9/1/12	Table of Contents Pages 1-40 (all pages)
UP #2	8/24/09	Pages 3, 6, 8, 16, 22
Update (UP) #1	7/1/09	Pages 20, 21

M0330.000 FAMILIES & CHILDREN GROUPS

M0330.001 GENERAL POLICY PRINCIPLES

A. Overview

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

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

B. Procedure

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

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

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

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

1. If the individual meets the definition of a parent/caretaker relative, evaluate in the LIFC covered group.
2. If the individual is not eligible as LIFC, but meets the definition of a pregnant woman, evaluate in the pregnant woman/newborn child group. *If the pregnant women does not meet the definition of lawfully residing in M0220.314, evaluate for FAMIS Prenatal Coverage (see Chapter M23).*
3. If the individual has been screened and diagnosed with breast or cervical cancer or pre-cancerous conditions by the Every Woman's Life program and does not meet the definition of for coverage as SSI, LIFC, Pregnant Woman or Child under 19, evaluate in the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) covered group.
4. If the individual is a former foster care child under 26 years, and does not meet the definition of for coverage as SSI, LIFC, Pregnant Woman or Child under 19, evaluate in this covered group.
5. If the individual is between the ages of 19 and 64 and is not eligible for or entitled to Medicare, evaluate in the MAGI Adults group.
6. If the individual is not eligible as a MAGI Adult, as LIFC or as a pregnant woman, is in medical institution, has been screened and approved for Home and Community Based Services or has elected hospice, evaluate in the appropriate F&C 300 % of SSI covered group.

E. Enrollment

The Medicaid ACs for children are:

AC	Meaning
090	child under age 6; income greater than *109*% FPL, but less than or equal to 143% FPL
091	child under age 6; income less than or equal to 109% FPL
092	• child age 6-19; insured or uninsured with income less than or equal to 109% FPL; • child age 6-19; **insured** with income greater than 109% FPL and less than or equal to 143% FPL
094	child age 6-19; **uninsured** with income greater than 109% FPL and less than or equal to 143% FPL

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

M0330.400 PREGNANT WOMEN & NEWBORN CHILDREN

A. Policy

The federal Medicaid law requires the Medicaid State Plan to cover categorically needy (CN) pregnant women and newborn children whose family income is within 143% of the federal poverty level (FPL). The law allows the State Plan to cover these pregnant women and newborns regardless of their resources.

B. Nonfinancial Eligibility

1. Pregnant Woman

42CFR 435.116- The woman must meet the pregnant woman definition in M0310.124.

The pregnant woman must meet all the nonfinancial eligibility requirements in chapter M02.

Non-citizen pregnant women who meet the lawfully residing policy in M0220.314 meet the citizenship requirements for full coverage in the pregnant woman group.

A pregnant woman who does not meet the lawfully residing policy in M022.314 may be eligible for FAMIS Prenatal Coverage if they apply for coverage no later than the month their child is born. ***Use Chapter M23 to evaluate the pregnant woman for eligibility under FAMIS Prenatal Coverage***

2. Newborn Child

42 CFR 435.117 - A child born to a woman who was eligible for Medicaid or to an individual covered by FAMIS at the time the child was born (including a newborn child born to an alien eligible for Medicaid payment of emergency services only) is eligible as a newborn child under age 1 year.

Exceptions:

A child born to a women enrolled under Hospital Presumptive Eligibility (HPE); an application must be submitted for the child's Medicaid eligibility to be determined since no Medicaid application was submitted for the child's mother.

An infant born to a woman in FAMIS Prenatal Coverage who is enrolled in AC 111 and/or enrolled in managed care must be evaluated for ongoing coverage. The infant is not considered a deemed-eligible newborn. See Chapter M023.

a. Eligible To Age 1

A child no longer meets this covered group effective the end of the month in which the child reaches age 1, provided he was under age 1 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 1.

Any child born a Medicaid-eligible woman will continue to be eligible up to age 1. If the child's mother was covered by Medicaid as a categorically needy individual in a state other than Virginia at the time of the child's birth, verification of the mother's Medicaid coverage must be provided by the parent or authorized representative.

b. No Other Eligibility Requirements

No other nonfinancial or financial eligibility requirements need to be met by the newborn child.

C. Financial Eligibility

Eligibility for CN Pregnant Women is based on the Modified Adjusted Gross Income (MAGI) methodology contained in Chapter M04.

1. Assistance Unit

The unborn child or children are included in the household size for a pregnant woman's eligibility determination. Refer to the procedures for determining the MAGI household in Chapter M04.

2. Resources

There is no resource test.

3. Income

Women enrolled as Pregnant Women are not subject to renewals during the pregnancy. The income limits for Pregnant Women are contained in M04, Appendix 2.

4. Income Changes After Eligibility Established

a. Pregnant Woman

Once eligibility is established as a pregnant woman, changes in income do not affect her eligibility as long as she meets the pregnant definition and the other nonfinancial eligibility requirements. This also includes situations where eligibility is established in the retroactive period.

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

Changed With	Effective Date	Pages Changed
TN #DMAS-9	7/1/18	Table of Contents. Pages 5, 6, 11, 14a, 25-27 Appendices 3 and 5 Page 6a is a runover page. Page 28 was added as a runover page.
TN #DMAS-8	4/1/18	Table of Contents Pages 2-6a, 12-14b, 25 Pages 26 and 27 were added. Pages 14c was added as a runover pages. Appendices 1, 2, 6 and 7 Appendix 1, page 2 was added.
TN #DMAS-6	10/1/17	Pages 12, 13, 14b
TN #DMAS-5	7/1/17	Table of Contents Pages 5, 6, 12, 13, 14-14b Appendices 3, 4 and 5 Page 6a was added as a runover page. Page 13a, 14, and 14a were renumbered to pages 14, 14a and 14b.
TN #DMAS-4	4/1/17	Appendices 1, 2 and 6
TN #DMAS-3	1/1/17	Table of Contents Pages 3 -5, 13a, 20 Appendix 6, page 1 Page 20a was added.
TN #DMAS-2	10/1/16	Appendix 2, pages 1, 2 Appendices 3, 5
TN #DMAS-1	6/1/16	Pages 3, 5, 6, 12, 13, 14a Appendices 1, 2, 6 and 7 Appendix 2, page 2 was added. Page 13a is a runover page.
UP #11	7/1/15	Appendices 3 and 5
TN #100	5/1/15	Pages 2, 11, 12, 13, 14 Appendices 1, 2, 3, 5, 6 and 7 Page 1 is a runover page.
Update (UP) #10	5/1/14	Table Contents pages 2, 3, 5, 6, 10-15 Appendices 1, 2 and 6 Appendix 7 was added.
TN #99	1/1/14	Pages 2, 5, 6, 8, 14, 15 Appendix 6

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

1. MAGI Rules

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

2. Eligibility Based on MAGI

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

a. Children under 19

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

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

d. Individuals Under Age 21

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

f. Individuals in Plan First.

3. Eligibility NOT Based on MAGI

MAGI methodology is NOT used for eligibility determinations for:

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

G. Tax Filer, Her Son and Her Nephew

Daria lives with her son, Jack age 11, and her nephew Billy age 8. All applied for MA.

Daria is a tax filer who claims her son and nephew as dependents. Her MAGI household is the same as her tax household. Jack is a tax dependent and no exceptions exist; his MAGI household is the same as the tax household. Billy is a tax dependent claimed by a tax filer who is not his parent so an exception exists and non-filer rules are used. Billy's MAGI household consists of Billy only because he has no parents or siblings in the home. The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Daria	3 – Daria, Jack and Billy	Tax filer and dependents
Jack	3 – Daria, Jack and Billy	Tax filer and dependents
Billy	1 – Billy	Non filer rules; Daria is not his parent, Jack is not his sibling

H. Tax Filer, Spouse, Their Child, His Parent Not Living In the Home

Dave lives with his wife Jean and their child, Cathy age 8. Dave files taxes separately from his wife who files her own taxes each year. Dave claims their child Cathy and his mother, Becky, as his tax dependents. Dave, Jean and Cathy applied for MA.

Dave's MAGI household includes the individuals in his tax household and his wife, Jean because married spouses are always included in each other's MAGI household. Jean is also a tax filer with no additional dependents. Jean's MAGI household includes Dave because married spouses are always included in each other's MAGI household. Cathy is a tax dependent whose parents are not filing jointly so non-filer rules are used; her MAGI household includes herself and her parents. The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Dave	4 – Dave, Jean, Cathy and Becky	Tax filer, spouse, dependent child and dependent parent
Jean	2 – Dave, Jean,	Tax filer and spouse
Cathy	3 – Cathy, Dave, Jean	Non filer rules; child and parents in home

M0440.100 HOUSEHOLD INCOME

A. General Rule

The income counted under MAGI rules is the income counted for federal tax purposes with few exceptions. All taxable income sources and some non-taxable income sources are counted for the MA eligibility determinations.

Whenever possible, income, *including income from self-employment*, reported on the application will be verified through available electronic data sources. The agency must utilize online systems that are available to the agency without requiring verifications from the individual or family. If no data sources exist to verify the attestation, and the attestation is below the medical assistance income level, documentation of income is required. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information and information from SSA through SVES or SOLQ-I. Verification of income from available sources, including the VEC, may be used if it is dated within the previous 12 months. The agency must include in each applicant's case record facts to support the agency's decision on the case.

and the attestation is below the medical assistance income level, documentation of income is required.

The reported income of a child must be verified regardless of whether or not the attested income is above or below the tax-filing threshold amount.

If an income calculation must be made, use the information in subchapter M0710 for estimating income, subchapter M0720 for sources of earned income, and subchapter M0730 for sources of unearned income with the exceptions in B. below. The sources of income listed in this section are organized in table form in M04, Appendix 7.

B. MAGI Income Rules

1. Income That is Counted

a. Gross earned income is counted. There are no earned income disregards.

b. Earnings and unearned income, including Social Security benefits, of everyone in the household are counted, except the income of

- a tax dependent who is claimed by his parent(s), or
- a child under 19 in a non-filer household who is living with a parent or parents

who is not required to file taxes because the tax filing threshold is not met.

For children and tax dependents, Social Security income only counts toward the total household income if the individual is required to file a federal tax return.

c. Income of a child under 19 in a non-filer household who is NOT living with a parent or parents and who is not required to file taxes because the tax filing threshold is not met. Any Social Security benefits the child may have do not count in determining whether or not the tax filing threshold is met.

When determining the total household income of a child who is NOT living with a parent (for example, living with a grandparent), the child's income is always counted in determining the child's eligibility, even if the child's income is below the tax filing threshold.

Effective, January 1, *2021*, the Tax Filing Threshold for MAGI income counting purposes is $1,100 in unearned income and *$12,400* in earned income.

d. Interest, including tax-exempt interest, is counted.

e. Foreign income is counted.

f. Stepparent income is counted.

d. Interest paid on student loans is deducted from countable income.

e. Gifts, inheritances, and proceeds from life insurance are not counted.

h. A parsonage allowance is not counted.

i. Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are not counted.

j. Student loans

Effective January 1, 2019, student loan debt forgiven due to death or disability of student is not counted as income.

Amounts that an employer paid in 2020 for an employee's student loan principal and interest are not counted in the employee's MAGI.

k. Difficulty of Care Payments, which include (1) payments designated by the payer as compensation for providing additional care that is required for a physically, mentally or emotionally disabled qualified foster care individual living in the provider's home and (2) payments to care providers who provide care under a Medicaid home and-community-based Waiver to an individual in the care provider's home. The care provider's home is the residence in which the care provider resides and regularly performs the routines of the care provider's life. If the care provider moves into an individual's home to care for that individual and performs the routines of the care provider's life in that residence, it is considered the care provider's home.

l. General Welfare Payments for Indian Tribes are not countable To qualify under the general welfare exclusion, the payments must be made pursuant to a governmental program for the promotion of the general welfare based on need and not represent compensation for services (See https://www.irs.gov/pub/irs-drop/n-12-75.pdf)

m. Kinship Guardianship Payments are not income. These payments are a stipend paid to a relative caregiver who has assumed custody of a child as an alternative to that child remaining in foster care.

n. Under the Federal Pandemic Unemployment Compensation Program, eligible individuals who are collecting certain Unemployment Compensation, including regular unemployment compensation, will receive an additional $600 in federal benefits per week for weeks of unemployment ending on or before July 31, 2020. **The $600 weekly Pandemic Unemployment Compensation payments (monthly equivalent of $2,580) are not counted as income.**

o. *COVID-19 relief payments provided under federal law* are not counted as income.

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

1. Income From Self-employment

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

C. Steps for Calculating MAGI

For tax filers whose income is verified in the Hub as being reasonably compatible, no MAGI calculation is required.

For non-filers or any other individuals whose income cannot be verified by the Hub, use the following steps for calculating an individual's MAGI. Subtract or include any deductions listed below as reported by the individual.

Adjusted Gross Income (AGI)	
Include: • Wages, salaries, tips, etc. • Taxable interest • Taxable amount of pension, annuity or Individual Retirement Account (IRA) distributions and Social Security benefits • Business Income, farm income, capital gain, other gains (or loss) • Unemployment Compensation • Ordinary dividends • Rental real estate, royalties, partnerships • S corporations, trusts, etc. • Taxable refunds, credits, or offset of state and local income taxes • Other income	**Deduct:** • Certain self-employment expenses • Student loan interest deduction • Educator expenses • IRA deduction • Moving expenses • Penalty on early withdrawal of savings • Health savings account deduction • Domestic production activities deduction • Certain business expenses of reservists, performing artists, and fee-basis government officials • Alimony paid prior to January 1, 2019 (but not child support paid) • For tax filers who do not itemize and report the deduction, up to $300 in charitable contributions made by an eligible individual in tax years beginning in 2020.
Do Not Include: Veteran's disability payments, Worker's Compensation or child support received. Pre-tax contributions, such as those for child care, commuting, employer-sponsored health insurance, flexible spending accounts and retirement plans such as 401(k) and 403(b), are not included in AGI but are not listed above because they are already subtracted out of W-2 wages and salaries, amounts that an employer paid in 2020 for an employee's student loan principal and interest.	

Note: Check the IRS website for detailed requirements for the income and deduction categories above.

Add (+) back certain income	• Non-taxable Social Security benefits • Tax –exempt interest • Foreign earned income and housing expenses for Americans living abroad

Exclude (-)from income	• Social Security benefits received by a child are not countable for his eligibility when a parent is in the household, unless the child is required to file taxes. • Scholarships, awards, or fellowship grants used for education purposes and not for living expenses • Certain American Indian and Alaska Native income derived from distributions, payments, ownership interests, real property usage rights and student financial assistance • Gifts, inheritances, and proceeds from life insurance • An amount received as a lump sum is counted only in the month received. • Parsonage allowance • Effective January 1, 2019, student loan debt forgiven due to death or disability of student is not counted as income. • Grants for homes designed for wheelchair living and motor vehicles for veterans who lost their sight or the use of their limbs • Difficulty of Care Payments • General Welfare Payments for Indian Tribes • Kinship Guardianship Payments • Pandemic Unemployment Compensation payments paid under the Federal Pandemic Unemployment Compensation Program. • *COVID-19 relief payments provided under federal law*

LIFC INCOME LIMITS

EFFECTIVE *7/1/21*

Group I

Household Size	Monthly Amount	Annual Amount
1	*$266*	*$3,192*
2	*405*	*4,860*
3	*513*	*6,156*
4	*622*	*7,464*
5	*734*	*88,08*
6	*826*	*9,912*
7	*932*	*11,184*
8	*1,044*	*12,528*
Each additional person add	*110*	*1,320*

Group II

Household Size	Monthly Amount	Annual Amount
1	*$348*	*$4,176*
2	*498*	*5,976*
3	*625*	*7,500*
4	*746*	*8,952*
5	*878*	*10,536*
6	*989*	*11,868*
7	*1,108*	*13,296*
8	*1,226*	*14,712*
Each additional person add	*125*	*1,500*

Group III

Household size	Monthly Amount	Annual Amount
1	*$523*	*$6,276*
2	*698*	*8,376*
3	*855*	*10,260*
4	*1,003*	*12,036*
5	*1,186*	*14,232*
6	*1,318*	*15,816*
7	*1,467*	*17,604*
8	*1,622*	*19,464*
Each additional person add	*151*	*1,812*

INDIVIDUALS UNDER AGE 21 INCOME LIMITS EFFECTIVE *7/1/21*

Group I

Household Size	Monthly Income Limit	Annual Income Limit
1	*$254*	*$3,048*
2	*395*	*4,740*
3	*504*	*6,048*
4	*611*	*7,332*
5	*719*	*8,628*
6	*806*	*9,672*
7	*902*	*10,824*
8	*1,023*	*12,276*
Each additional person add	*106*	*1,272*

Group II

Household Size	Monthly Income Limit	Annual Income Limit
1	*$345*	*$4,140*
2	*499*	*5,988*
3	*623*	*7,476*
4	*747*	*8,964*
5	*882*	*10,584*
6	*1,086*	*13,032*
7	*1,108*	*13,296*
8	*1,234*	*14,808*
Each additional person add	*123*	*1,476*

Group III

Household Size	Monthly Income Limit	Annual Income Limit
1	*$458*	*$5,496*
2	*613*	*7,356*
3	*742*	*8,904*
4	*868*	*10,416*
5	*1,026*	*12,312*
6	*1,131*	*13,572*
7	*1,255*	*15,060*
8	*1,380*	*16,560*
Each additional person add	*124*	*1,488*

TREATMENT OF INCOME FOR FAMILIES & CHILDREN COVERED GROUPS

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

M0630 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-20	7/1/21	Page 5
TN #DMAS-17	7/1/20	Page 5 Page 6 is a runover page.
Transmittal (TN) #93	1/1/10	Page 8

Any life, retirement, or other related types of insurance policies with face values totaling $1500 or less on any one person 21 years old and over are excluded. When the face values of such policies of any one person exceed $1500, the cash surrender value of the policies is counted as a resource.

E. Burial Plots

1. All Groups Other Than MN For F&C covered groups other than MN, one burial plot per member of the family/budget unit is excluded.

2. MN All burial plots are excluded for MN.

F. EITC Refunds or Advance Payments For all classifications, Earned Income Tax Credit refunds and advance payments are excluded as resources in the month following the month of receipt. Any portion of the refund or advance payment retained after the month following the month of receipt is a countable resource.

G. Bona Fide Loans For all classifications, all bona fide loans are excluded, regardless of the intended use. See M0640.800.

***H. COVID-19 Relief* Payments** *COVID-19 relief payments provided under federal law* are not counted as income and are **not** counted as resources for **12 months following the month** of receipt. Interest earned on the payments is countable as income for individuals subject to a resource test per M0610.001.

M0630.121 BURIAL ARRANGEMENTS

A. All Groups Other Than MN

1. Bona Fide Funeral Agreement A bona fide funeral agreement covering a family/budget unit member with a maximum equity value of $1500 per individual is excluded. A bona fide funeral agreement is a formal agreement for funeral and burial expenses, such as a revocable burial contract, burial trust, or another funeral arrangement (generally with a licensed funeral director). Passbook bank accounts, or simple "set asides" of savings for funeral expenses, and cash surrender values of life insurance policies are not bona fide funeral agreements and **are not** excluded resources.

NOTE: Funds in excess of the $1500 burial limit per individual are counted against the resource limit. See section M0640.500.

2. Irrevocable Burial Contracts Irrevocable burial contracts, regardless of value, are not counted as resources since they cannot be converted to cash by the individual.

B. MN Burial funds are excluded from resources up to a maximum of $3,500 per individual. From August 1, 1994 on, in order for resources to be disregarded under the burial funds exclusion, they must be in the

M0710 Changes

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

F&C MEDICALLY NEEDY INCOME LIMITS
EFFECTIVE *7/1/21*

Number of Persons in Family/Budget Unit	GROUP 1		GROUP II		GROUP III	
	Semi-Annual Income	Monthly Income	Semi-Annual Income	Monthly Income	Semi-Annual Income	Monthly Income
1	*$2019.02*	*$336.50*	*$2329.65*	*$388.27*	*$3028.56*	*$504.76*
2	*2570.31*	*428.38*	*2868.64*	*478.40*	*3651.15*	*608.52*
3	*3028.56*	*504.76*	*3339.16*	*556.52*	*4115.75*	*685.95*
4	*3416.85*	*569.47*	*3732.46*	*622.07*	*4504.07*	*750.67*
5	*3805.14*	*634.19*	*4115.59*	*685.93*	*4871.69*	*811.94*
6	*4193.41*	*698.90*	*4504.04*	*750.67*	*5280.61*	*880.10*
7	*4581.69*	*763.61*	*4871.69*	*811.94*	*5668.94*	*944.82*
8	*5047.64*	*841.27*	*5358.26*	*893.04*	*6057.18*	*1009.53*
9	*5513.57*	*918.92*	*5880.16*	*980.02*	*6619.78*	*1103.29*
10	*6057.18*	*1009.53*	*6367.80*	*1061.30*	*7066.72*	*1177.78*
Each add'l person add	*521.80*	*86.96*	*521.80*	*86.96*	*521.80*	*86.96*

F&C 100% STANDARD OF ASSISTANCE EFFECTIVE *7/1/21*

(Used as the F&C Deeming Standard)

Group I

Household Size	Income Limit
1	*$261*
2	*398*
3	*505*
4	*612*
5	*721*
6	*813*
7	*916*
8	*1,025*
Each additional person add	*108*

Group II

Household Size	Income Limit
1	*$341*
2	*489*
3	*614*
4	*734*
5	*862*
6	*971*
7	*1,087*
8	*1,214*
Each additional person add	*123*

Group III

Household Size	Income Limit
1	*$513*
2	*726*
3	*841*
4	*987*
5	*1,165*
6	*1,296*
7	*1,442*
8	*1,595*
Each additional person add	*148*

M0715 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-20	7/1/21	Page 2
Transmittal (TN) #DMAS-17	7/1/20	Table of Contents Page 2

Example 2:

Mrs. X and Mrs. Y live in the same house which is rented in Mrs. X's name. Mrs. Y gives Mrs. X an established portion of the rent each month. Mrs. X adds her portion to Mrs. Y's and pays the rent. Since this is a shared shelter arrangement, Mrs. Y's portion of the rent is not considered income to Mrs. X.

M0715.200 CONVERSION OR SALE OF A RESOURCE

A. Policy

Receipts from the sale, exchange, or replacement of a resource are not income, but are resources that have changed their form.-

This includes cash or in-kind items that are provided to replace or repair a resource that has been lost, damaged, or stolen.

B. Reference

Casualty Property Loss Payments, M0630.130

M0715.270 INCOME TAX REFUNDS AND CREDITS

A. Policy

Income tax refunds and Earned Income Tax Credit payments are not income.

COVID-19 relief payments provided under federal law are considered tax credits and are not countable as income.

B. Tax Withheld Prior to Application Date

Income tax refunds are not income even if the income from which the tax was withheld or paid was received in a period prior to application for Medicaid.

M0715.350 PROCEEDS OF A LOAN

A. Introduction

Proceeds of a loan are not income to the borrower because of the borrower's obligation to repay the loan.

B. Policy

1. Loan Not Income

All bona fide loans, regardless of the intended use, are not income. This includes loans obtained for any purpose and may be from a private individual as well as from a commercial institution.

2. Documentation of Bona Fide

A simple statement signed by both parties indicating that the payment is a loan and must be repaid is sufficient to verify that a loan is bona fide.

3. Loan Not Bona Fide

If an individual indicates that money received was a loan but does not provide required verification, the money is to be treated as unearned income in the month received and a resource thereafter.

4. Interest on a Loan

Interest earned on the proceeds of a loan while held in a savings account, checking account, or other financial instrument will be counted as unearned income in the month received and as a resource thereafter.

M0810 Changes

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

3. Categorically Needy 300% of SSI

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

Family Size Unit	2020 Monthly Amount	2021 Monthly Amount
1	$2,349	$2,382

4. ABD Medically Needy

a. Group I	*7/1/20 – 6/30/21*		*7/1/21*	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$1,993.11	$332.18	*$2,019.02*	*$336.50*
2	2,537.36	422.89	*2,570.31*	*428.38*

b. Group II	*7/1/20 – 6/30/21*		*7/1/21*	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,299.75	$383.29	*$2,329.65*	*$388.27*
2	2,831.85	471.97	*2,868.64*	*478.40*

c. Group III	*7/1/20 – 6/30/21*		*7/1/21*	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,989.69	$498.28	*$3,028.56*	*$504.76*
2	3,604.37	600.72	*3,651.15*	*608.52*

5. ABD Categorically Needy

For:

ABD 80% FPL, QMB, SLMB, & QI <u>without</u> Social Security income; all QDWI; effective 1/13/21

ABD 80% FPL, QMB, SLMB, & QI <u>with</u> Social Security income; effective 3/1/21

All Localities	2020		2021	
ABD 80% FPL	Annual	Monthly	Annual	Monthly
1	$10,208	$851	$10,304	$859
2	13,792	1,150	13,936	1,162
QMB 100% FPL	Annual	Monthly	Annual	Monthly
1	$12,760	$1,064	$12,880	$1,074
2	17,240	1,437	17,420	1,452
SLMB 120% of FPL	Annual	Monthly	Annual	Monthly
1	$15,312	$1,276	$15,456	$1,288
2	20,688	1,724	20,904	1,742
QI 135% FPL	Annual	Monthly	Annual	Monthly
1	$17,226	$1,436	$17,388	$1,449
2	23,274	1,940	23,517	1,960
QDWI 200% of FPL	Annual	Monthly	Annual	Monthly
1	$25,520	$2,127	$25,760	$2,147
2	34,480	2,874	34,840	2,904

M0815 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-20	7/1/21	Pages 11, 12
TN #DMAS-17	7/1/20	Table of Contents Pages 11, 12
Transmittal (TN) #DMAS-7	1/1/18	Page 1

M0815.200 CONVERSION OR SALE OF A RESOURCE

A. Policy

Receipts from the sale, exchange, or replacement of a resource are **not income** but are resources that have changed their form.

This includes any cash or in-kind items that is provided to replace or repair a resource that has been lost, damaged, or stolen

Capital gains, which are profits made from the sale of capital assets (long-term assets such as land or buildings), are also not income. Any proceeds that remain the month after this type of sale must be evaluated as a resource.

B. Reference

See S1110.600 B.4. for a complete discussion of the policy.

C. Example

Jerry Wallace sells his 1974 Plymouth Satellite for $300. The money he receives is not income but a resource which has been converted from one form (a car) to another form (cash).

M0815.250 REBATES AND REFUNDS

A. Policy

When an individual receives a rebate, refund, or other return of money he or she has already paid, the money returned is **not income.**

CAUTION: The key idea is applying this policy is a return of an individual's own money. Some "rebates" do not fit that category. For example, if a cooperative operating as a jointly-owned business pays a "rebate" as a return on a member's investment, this money is unearned income similar to a dividend. Developmental guidelines for interest and dividends are in S0830.500.

See M0815.270 for the treatment of *COVID-19 relief payments provided under federal law*

B. Procedure

1. General

Unless you have reason to question the situation, accept an individual's signed allegation that a rebate or refund of money is a return of money already paid and do not count it as income.

2. Questionable Situation

In questionable situations, make copies for the file of any documents in the individual's possession, and contact the source of the payment, etc. to verify that the payment is a return of money already paid.

C. Example

Rose Woods, an elderly recipient, pays property taxes on the home she lives in. Because of her low income, the city government returns part of Mrs. Woods' property taxes in the form of a check. This return of money already paid by Mrs. Woods is not income.

D. References

See S0830.705 for rules on the exclusion of certain taxes.

S0815.270 INCOME TAX REFUNDS AND CREDITS

A. Policy

1. General — Any amount refunded on income taxes already paid is **not income**.

2. Tax Withheld Prior to Application Date — Income tax refunds are not income even if the income from which the tax was withheld or paid was received in a period prior to application for Medicaid.

3. Tax Refunds and Blind Work Expenses — Income tax refunds are **not income** even if the income taxes were included as work expenses of the blind. (See S0820.535 B.3.)

4. *COVID-19 Relief* Payments — *COVID-19 relief payments provided under federal law* are considered tax credits and are not countable as income, and are **not** counted as resources for **12 months following the month** of receipt. See M1130.675. Interest earned on the retained payments is countable as interest income.

S0815.300 CREDIT LIFE OR CREDIT DISABILITY INSURANCE PAYMENTS

A. Definition of Credit Life/Disability Insurance — Credit life and credit disability insurance policies are issued to or on behalf of borrowers, to cover payments on loans, mortgages, etc. in the event of death or disability. These insurance payments are made directly to loan or mortgage companies, etc. and are not available to the individual.

B. Policy

- Payments made under a credit life or credit disability insurance policy on behalf of an individual are **not income.**
- Food, clothing, or shelter received as the result of a credit life or credit disability payment is **not income.**

C. Example — Frank Fritz, a Medicaid recipient, purchased credit disability insurance when he bought his home. Subsequently Mr. Fritz was in a car accident and became totally disabled. Because of his disability, the insurance company pays off the home mortgage. Neither the payment nor the increased equity in the home is income to Mr. Fritz.

M1110 Changes

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

M1120.201 contains instructions for the resources treatment of trust established on or after August 11, 1993.

3. Equitable Home Ownership

If an individual alleges equitable ownership (e.g., an unwritten ownership interest or right of use for life) obtain any pertinent documents and a signed statement from each of the parties involved regarding any arrangement that has been agreed to. Forward the documents to a medical assistance program consultant for an opinion from legal counsel.

D. References

The following references pertain to trust situations:

- Financial institution/conservatorship accounts, S1140.200 - S1140.215
- Property held under a State's Uniform Gift to Minors Act, S1120.205
- Situations involving an agent acting in a fiduciary capacity on behalf of another party, S1120.020
- Trust established on or after August 11, 1993, M1120.201

S1110.520 PROPERTY RIGHTS WITHOUT OWNERSHIP OF THE PROPERTY

A. Introduction

An individual may have certain rights with respect to property without also having the right to dispose of the property. However, the individual may have the right to sell his/her right or interest (i.e. the right to use or possess the property).

B. Definitions

1. Leasehold

A leasehold does not designate rights of ownership. Rather, it conveys to an individual use and possession of property for a definite term and usually for an agreed rent.

2. Incorporeal Interests

There are several types of real property rights called "incorporeal interests." They do not covey ownership of the physical property itself. They convey the right to use the property but not to possess it. These rights encompass mineral and timber rights and easements (explained in more detail at S1140.110).

M1130 Changes

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

M1130.000 ABD RESOURCES EXCLUSIONS Section Page

RETAINED CASH AND IN-KIND PAYMENTS

OTHER EXCLUDED RESOURCES

Appendix

a. Evidence of life estate or similar property rights:

- a deed,
- a will,
- other legal document.

b. Equitable Ownership

If an individual alleges equitable ownership (e.g., an unwritten ownership interest or right of use for life) obtain any pertinent documents and a signed statement from each of the parties involved regarding any arrangement that has been agreed to. Forward the documents to a medical assistance program consultant for an opinion from legal counsel.

2. Principal Place of Residence--Operating Assumption

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

3. Indication of More than One Residence

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

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

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

4. Evidence Indicates Non-adjoining Property

a. Individual Agrees With Evidence

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

- **obtain** his statement to that effect; and

- **develop** the non-adjoining portion per S1140.100 (Non-home Real Property) or S1130.500 (Property Essential to Self-Support), as applicable.

b. Individual Disagrees With Evidence

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

- a sketch of the land showing the boundaries of the various plots and the location of the shelter used as the home; and

- evidence of how the land is treated for tax assessment purposes.

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

C. Procedure -- Initial Applications and Posteligibility

1. When to Develop

When an individual would otherwise be ineligible due to excess resources, determine if applying this exclusion would permit eligibility. If the exclusion would permit eligibility, develop per 2. below.

NOTE: If the individual is resources-eligible even without the application of this exclusion, it is not necessary to develop under this section.

2. Development and Documentation

If an individual alleges that his/her resources include unspent relocation assistance payments:

- follow the procedures in S0830.655D.;
- document the date(s), type(s) and amount(s) of such payments(s); and
- obtain a statement as to the date(s) and amount(s) of any account deposits corresponding to the payments.

D. References

Commingled funds, S1130.700.

*M*1130.675 TAX ADVANCES, REFUNDS AND REBATES RELATED TO EARNED INCOME TAX CREDITS AND *COVID-19* RELIEF

A. Policy

1. EITC Related Refunds

Effective with resource determinations made for the month of January 1991, an unspent Federal tax refund or payment made by an employer related to Earned Income Tax Credits (EITC's) is excluded from resources **only for the month following the month** the refund or payment is received.

Interest earned on unspent tax refunds related to EITC's is **not** excluded from income or resources by this provision (S0830.500).

2. *COVID-19 Relief Payments*

COVID-19 relief payments provided under federal law are **not** counted as resources for **12 months following the month** of receipt.

Interest earned on unspent *COVID-19 relief payments* is **not** excluded from income or resources by this provision (S0830.500).

B. Procedure--Initial Claims and Post-Eligibility

1. When to Develop

Develop these exclusions only when an individual alleges the receipt of assistance excludable under this provision and the exclusion would permit eligibility.

2. Development and Documentation

If an individual alleges that his or her resources include unspent EITC and/or *COVID-19 relief* refunds or payments:

- verify the source, date(s), and amount(s) of such refund(s) or payment(s) in accordance with S0820.400, and
- obtain a statement as to the date(s) and amount(s) of any account deposits corresponding to the EITC and/or *CARES* Act refunds or payments.

C. References

Commingled funds, S1130.700.

S1130.678 INDIVIDUAL DEVELOPMENT ACCOUNTS – TANF FUNDED

A. Background

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 authorized states to use money from their Temporary Assistance for Needy Families (TANF) grant to fund Individual Development Accounts (IDAs). The Acts of Assembly of 2020, Special Session I allocated funding for the establishment of IDA accounts for Virginia TANF participants, effective July 1, 2021.

An IDA is a special bank account that helps an individual save for his/her education, the purchase of a first home, or to start a business. The individual uses earnings from their work to set up an approved bank account for an IDA and contributes money from their earnings to the IDA. The TANF program matches the contributions to the IDA. The matching money helps the individual reach his/her goal sooner.

B. Policy

1. Contributions

An individual's contributions that are deposited in a TANF IDA are excluded from resources.

2. Matching Funds

Any matching funds that are deposited in a TANF IDA are excluded from resources.

3. Interest

Any interest earned on the individual's contributions and matching funds that are deposited in a TANF IDA is excluded from resources.

C. Procedures

1. How To Verify TANF IDAs

Whenever possible, verify the individual's TANF IDA through available case records. If the TANF IDA cannot be verified through the case record, obtain verification from the individual that the account is a TANF IDA.

2. After TANF Eligibility Ends

The treatment of an IDA after an individual's TANF eligibility ends or after an individual moves from one state to another can vary from state to state. Check with the TANF Program in the appropriate state regarding whether an account stops being an IDA after TANF eligibility ends or an interstate move occurs, and how to treat funds that remain in the account and withdrawals from the account after TANF eligibility ends or an interstate move occurs.

S1130.680 RADIATION EXPOSURE COMPENSATION TRUST FUND PAYMENTS

A. Background

Fallout emitted during the U.S. Government's atmospheric nuclear testing in Nevada during the 1950's and during a brief period in 1962 exposed some individuals to doses of radiation that put their health at risk. In addition, some individuals employed in uranium mines during the period January 1, 1947 to December 31, 1971 were exposed to large doses of radiation. Public Law 101-426 created the Radiation Exposure Compensation Trust Fund (RECTF) and authorizes the Department of Justice (DOJ) to make compensation payments to individuals (or their survivors) who were found to have contracted certain diseases after exposure. The payments will be made as a one-time lump sum. Generally, the exposure occurred in parts of Arizona, Colorado, Nevada, New Mexico, Utah, and Wyoming.

B. Policy

1. Resource Exclusion

Unspent payments received from the RECTF are excluded from resources.

2. Interest On Unspent RECTF Payments

Interest earned on unspent RECTF payments prior to July 1, 2004 is not excluded from income or resources. Interest earned on unspent RECTF payments on or after July 1, 2004 is excluded from income and resources.

C. Procedure

1. When to Develop

When an individual would otherwise be ineligible due to excess resources, determine if applying this exclusion would permit eligibility.

If the exclusion would permit eligibility, develop per 2. below.

NOTE: If the individual is resources-eligible even without the application of this exclusion, it is not necessary to develop under this section.

S1140 Changes

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

4. Verification

Use the Asset Verification System whenever possible to verify the bank account. If the balance of the account when combined with other countable resources is within the resource limit for the individual's assistance unit size, no further development is necessary.

If the balance of the bank account places the individual's resources over the limit, any deposits for the month of the AVS results must be accounted for using the policy in M1140.200 B.6 below. Obtain deposit information from the individual.

5. Requesting Information from Financial Institutions

When it is necessary to request account information from a financial institution (FI), have the individual sign an authorization for release of the information.

If a financial institution refuses to provide the information needed for a determination, try to obtain its cooperation by explaining why assistance is required. If the institution still refuses to provide the information, inform the individual and ask him or her to try to get the information from the institution .

a. Acceptable Forms of FI Records

1. FI original records that appear to be complete and unaltered;
2. FI records other than bank statements issued by the FI, when individual:
   - alleges that no transactions have occurred that the records do not show; or
   - alleges that such transactions have occurred and provides appropriate evidence of them; **and**
   - the records, the allegation regarding additional transactions, and the alleged current account balance (on the application or renewal form) reflect a complete and consistent picture of the account;
3. Records verified by telephone contact with the FI and documented in the case record.

b. Examples of Acceptable FI Records Other than Bank Statements

- passbooks,
- the individual's check register,
- bank statements or account activity information printed from the FI's website and submitted by the individual,
- account ledgers,
- ATM transaction receipts, and
- deposit or withdrawal slips.

Accept an FI document in the format in which it is provided by the FI or the individual if it meets the criteria in *M1140.200 B.5* above.

***6.* Determining the Value of a Bank Account**

There is no single method for determining the countable value of a bank account. The countable value is the lower of:

- the balance before income is added, or
- the ending balance minus any income added during the month.

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

c. Balance Information

The financial institution may show the opening balance for the first day of a given month or the closing balance for the last business day of the previous month. Accept either, the amount will be the same. See M1110.001 for monthly determinations of resource eligibility.

C. Development and Documentation-- Posteligibility Only

If you discover a previously undeveloped checking or savings account after eligibility has been established, develop account balances and interest for the period that a determination can cover.

S1140.205 JOINT CHECKING AND SAVINGS ACCOUNTS

A. Introduction

The instructions in S1140.200, except for A.1. (ownership), apply to all checking and savings accounts. The instructions in this section, which apply to joint accounts only, supplement those in S1140.200.

B. Operating Policy-- Rebuttable Ownership Assumptions

1. Account Holders Include One Or More Applicants or Recipients and No Deemors

Assume that all the funds in the account belong to the applicant(s)/ recipient(s), in equal shares if there is more than one applicant or recipient.

2. Account Holders Include One or More Deemors

Provided that none of the account holders is an applicant or recipient (in which case the assumption in 1. above would apply), assume that all the funds in the account belong to the deemor(s), in equal shares if there is more than one deemor.

C. Development and Documentation-- Initial Applications and Posteligibility

1. Informing the Individual

Inform the individual:

- of the applicable ownership assumption;
- of the corresponding income implications (S0810.130); and
- of his or her right to provide evidence rebutting the ownership assumption, if he or she disagrees with it.

For individuals applying for long-term care services, annuities owned by either the applicant or the applicant's spouse must also be evaluated using the policy in M1450.200 to determine whether an uncompensated asset transfer has occurred.

S1140.300 PROMISSORY NOTES, LOANS, AND PROPERTY AGREEMENTS

A. Introduction

1. General

The context of the instruction in this section is the individual as the creditor (lender of money, seller of property) and, therefore, as the owner of the promissory note, loan, or property agreement.

For cash loans, see S1120.220.

2. Promissory Note

A promissory note is a written, unconditional agreement whereby one party promises to pay a specified sum of money at a specified time (or on demand) to another party. It may be given in return for goods, money loaned, or services rendered.

3. Loan

A loan is a transaction whereby one party advances money to or on behalf of another party, who promises to repay the lender in full, with or without interest. The loan agreement may be written or oral, and must be enforceable under State law. A written loan agreement is a form of promissory note.

4. Property Agreement

A property agreement is a pledge or security of particular property for the payment of a debt or the performance of some other obligation within a specified period. Property agreements on real estate generally are referred to as mortgages but also may be called land contracts, contracts for deed, deeds of trust, and so on. Personal property agreements—e.g., pledges of crops, fixtures, inventory, etc.—are commonly known as chattel mortgages.

B. Operating Policy

1. Real Estate Contracts Prior to Settlement

When an individual enters into a contract for the sale of real estate, he or she owns two items until the settlement of the sale is completed: the real estate and the contract. The real estate is not a resource because the individual cannot convert it to food or shelter. The contract is a property agreement whose status and value as a resource must be determined in accordance with this section.

2. Value as a Resource Assumption

Assume that the value of a promissory note, loan, or property agreement as a resource is its outstanding principal balance unless the individual furnishes reliable evidence that it has a CMV of less than the outstanding principal balance (or no CMV at all).

M1340 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS20	7/1/21	Paged 4, 5
TN #DMAS-15	1/1/20	Pages 16, 18 Page 17 is a runover page.
TN #DMAS-14	10/1/19	Page 2, 18
TN #DMAS-12	4/1/19	Page 2
TN #DMAS-9	7/1/18	Pages 6a
TN #DMAS-7	1/1/18	Pages 18, 20, 22
TN #100	5/1/15	Pages 4, 5
TN #95	3/1/11	Page 6
TN #94	9/1/10	Page 6
TN #93	1/1/10	Page 18

B. Noncovered Services

Noncovered services (not covered by Medicaid) include:

1. services of other licensed practitioners of the healing arts such as chiropractors, naturopaths or acupuncturists, unless the services are covered by Medicare and the individual has Medicare.

2. professional nursing services in an individual's home when prescribed by the individual's physician and the cost is not part of a home health program or a Medicaid CBC waiver.

3. medical services provided by non-participating providers (providers who do not participate in Virginia Medicaid) unless the services are covered by Medicare and the individual has Medicare.

4. over-the-counter medications and medical supplies when ordered by a physician and the cost is not covered by Medicaid or Medicare, if the individual has Medicare.

C. Not Medical/ Remedial Care Services

The following are examples of services that are NOT medical/remedial care services and CANNOT be deducted from a spenddown liability, even if ordered by a physician:

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

D. Verification

Verification of noncovered services expenses includes:

1. a copy of the provider's bill or the insurance company's explanation of benefits paid, that shows:
   - the amount still owed that is the patient's responsibility, and
   - the service provider's name, address, and profession.
2. a prescription, physician's referral, or statement from the patient's physician or dentist that the service was medically necessary.

M1340.500 COVERED SERVICES

A. Policy

Covered services expenses are incurred expenses for necessary medical or remedial care services which are covered by the Virginia Medicaid State Plan. Covered services expenses are deducted on the date the service was rendered. For medical supplies and equipment that are ordered, the date of service is the

date the supply or equipment was delivered to the individual. Expenses included in a prepaid package of services cannot be deducted prior to the date the service(s) is actually rendered.

B. Covered Services

Some of the medical services covered by Medicaid, and the limits on these services, are described in chapter M18. Medicaid covered services include:

- inpatient and outpatient hospital care
- physicians' services
- *dental services*
- prescription drugs
- lab and x-ray services
- nursing facility care
- home health care
- rehabilitative services
- psychiatrists' and psychologists services
- licensed clinical social worker and licensed professional counselor services
- physical therapy services
- medical supplies and equipment
- transportation to secure medical care which is purchased, not provided in the individual's own vehicle.

C. Verification

Medical supplies and drugs must be prescribed or ordered by a physician or dentist.

Covered services expenses verification includes:

1. A copy of the provider's bill or the insurance company's explanation of benefits paid, that shows:
    - the amount still owed that is the patient's responsibility, and
    - the service provider's name, address, and profession.
2. Documentation that the service is or was medically necessary. Documentation can include a prescription, physician's referral, statement from the patient's physician or dentist, or authorization from a licensed mental health provider or other individual as specified by DMAS to authorize a Medicaid covered service.

D. Medicare Part D Prescription Drug Expenses

Because enrollment in Medicare Part D is voluntary, not all Medicare beneficiaries will be enrolled in a Medicare PDP. For those enrolled in a PDP, not all drugs will be covered. Each PDP may have a different combination of deductibles, co-pays and coverage gaps.

The PDP must issue a periodic (at least monthly) statement to the beneficiary explaining all benefits paid and denied, and any deductible and/or co-pays incurred by the beneficiary. Use the PDP statement to verify prescription drug costs that remain the beneficiary’s responsibility.

To determine if drug costs incurred by Medicare beneficiaries are allowable under spenddown, apply the following rules:

M1430 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-20	7/1/21	Table of Contents Page 2 Appendix 1 was removed.
TN #DMAS-19	4/1/21	Pages 1, 2
TN #DMAS-10	10/1/18	Pages 3-5 Appendix 1
TN #DMAS-7	1/1/18	Pages 1, 2, 4 Appendix 1
TN #93	1/1/10	Appendix 1, page 1
Update (UP) #1	7/1/09	Appendix 1, page 1

TABLE OF CONTENTS

LONG-TERM CARE

M1430.000 FACILITY CARE

- is primarily for the diagnosis, treatment or rehabilitation of individuals with intellectual disabilities or related conditions, and
- provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or rehabilitative services to help each individual function at his greatest ability.

Some community group homes are certified as Intermediate Care Facilities for the Intellectually Disabled (ICF-IDs) by the Department of Health. Patients in these facilities may have income from participating in work programs.

NOTE: Medically needy (MN) individuals are not eligible for Medicaid payment of LTC services in an ICF-ID because ICF-ID services are not covered for the medically needy.

3. Institutions for Treatment of Mental Diseases (IMDs)

An **IMD** is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, of persons with mental diseases. An institution for those intellectually disabled is NOT an IMD. For a list of state-operated IMDs in Virginia, see *M0280, Appendix 2*.

Federal regulations in 42 CFR 435.1008 prohibit federal financial participation (FFP) in most Medicaid services provided to individuals under age 65 years who are patients in an institution for the treatment of mental diseases (IMD), unless they are under age 22 and are receiving inpatient psychiatric services. However, an individual who is age 22 or over, but under age 65 and who is enrolled in Medicaid at the time of admission to an IMD may remain enrolled in Medicaid. The Department of Medical Assistance Services (DMAS) will coordinate with the Centers for Medicare and Medicaid Services (CMS) to ensure that no unauthorized FFP occurs.

Medically needy (MN) patients over 65 years of age are not eligible for Medicaid payment of LTSS services in an IMD because these services are not covered for medically needy individuals age 65 or over.

4. Nursing Facility

A **nursing facility** is a medical institution licensed by the state to provide, on a regular basis, health-related services to patients who do not require hospital care, but whose mental or physical condition requires services, such as nursing supervision and assistance with activities of daily living, in addition to room and board and such services can be made available only in an institutional setting. Nursing facilities provide either skilled nursing care services or intermediate care services, or both.

5. Rehabilitation Hospitals

A **rehabilitation hospital** is a hospital certified as a rehabilitation hospital, or a rehabilitation unit of a hospital certified by the Department of Health as excluded from the Medicare prospective payment system, which provides inpatient rehabilitation services.

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

TN #DMAS-12	4/1/19	Pages 10, 12a, 14, 21, 28b
TN #DMAS-10	10/1/18	Page 10, 12a, 14, 21
TN #DMAS-9	7/1/18	Pages 12a, 28
TN #DMAS-8	4/1/18	Page 2a
TN #DMAS-7	1/1/18	Pages 19, 20, 43, 44.
TN #DMAS-5	7/1/17	Pages 1, 7-9, 11, 15, 19, 20, 28a, 43, 47-51, 53
TN #DMAS-4	4/1/17	Page 19
TN #DMAS-3	1/1/17	Table of Contents, page ii Pages 1, 14, 17, 19, 20, 28a, 45-47, 50 Appendix 1, pages 1 and 2
TN #DMAS-2	10/1/16	Pages 12, 27, 28 Pages 12a and 28a were added as runover pages.
UP #11	7/1/15	Pages 43-46 Page 46a was deleted.
TN #100	5/1/15	Pages 2a, 4, 29, 31, 32, 34, 43, 44, 45, 53, 54 Pages 1a, 2, 3a and 4 were renumbered for clarity. Pages 3, 4a, 46 and 46a are runover pages. Pages 1 and 3 are reprinted.
TN #99	1/1/14	Pages 9, 19, 20, 23, 24, 40
TN #98	10/1/13	Pages 9, 24
UP #9	4/1/13	Pages 9, 16, 19, 20, 24, 43
UP #7	7/1/12	Pages 19, 46-48
UP #6	4/1/12	Pages 4, 9, 19, 20, 24, 26
TN #96	10/1/11	Pages 3, 4, 7-9, 19, 22-24, 43
TN #95	3/1/11	Pages 9, 19, 20, 23
TN #94	9/1/10	Table of Contents pages 1, 1a, 3, 3a, 11, 12, pages 19, 20, 24, 28, 31
TN #93	1/1/10	Pages 9, 13, 19-20, 23, 43, 44
TN #91	5/15/09	Table of Contents Pages 1-56 Appendix 1

and the documentation to DMAS for approval (see M1470.230 C.5). DMAS will advise the eligibility worker if the adjustment is allowable and the amount that is to be allowed.

- dental services ***not covered by Medicaid.*** *Effective July 1, 2021, Medicaid covers dental services for full-benefit adults, as well as children (see M1850.100.D).* **Pre-approval for dental services that exceed $500 must be obtained from DMAS prior to receipt of the service;**
- routine eye exams, eyeglasses and eyeglass repair;
- hearing aids (when medically necessary), hearing aid batteries and hearing aid repair;
- batteries for power wheelchairs or other power mobility items owned by the recipient, not to exceed four batteries in a 12-month period;
- chiropractor services, except for Medicare recipients (Medicare covers chiropractor services and Medicaid covers the Medicare deductible and coinsurance amounts);
- dipyridamole (Persantine) and other prescription medications not covered by Medicaid but ordered by the recipient's physician;
- **transportation to medical, dental or remedial services not covered by Medicaid.**

2) Services received by a Medicaid enrollee during a period of limited Medicaid eligibility (e.g., LTC services not covered because of a property transfer) can be deducted in the patient pay calculation by the local agency without DMAS approval even when the amount of the service exceeds $500.

e. Medicare Part D

Individuals who:

- qualify for Medicare Part D,
- are NOT enrolled in a Medicare Prescription Drug Plan (PDP), and
- are NOT Medicaid eligible at the time of admission to a nursing facility,

will be fully responsible for their drug costs until Medicaid eligibility is determined and the Medicare Part D PDP enrollment process is completed. The individual remains responsible for any drugs purchased prior to the effective date of the PDP enrollment; Medicaid cannot pay for these drugs. The cost of drugs purchased before the PDP begin date can be deducted from patient pay.

Medicaid-enrolled nursing facility patients who are enrolled in a Medicare Part D PDP are **not** responsible for the payment of deductibles or co-pays, nor will

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

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

a. for individuals employed 20 hours or more per week, all earned income up to 300% of SSI ($2,382 in 2021) per month.

b. for individuals employed at least *4* but less than 20 hours per week, all earned income up to 200% of SSI ($1,588 in 2021) per month.

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

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

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

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

B. Couples

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

M1470.420 DEPENDENT CHILD ALLOWANCE

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

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

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

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

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

2) dental services ***not covered by Medicaid.*** *Effective July 1, 2021, Medicaid covers dental services for full-benefit adults, as well as children (see M1850.100.D)*;

3) routine eye exams, eyeglasses and eyeglass repair;

4) hearing aids (when medically necessary), hearing aid batteries and hearing aid repair;

5) batteries for power wheelchairs or other power mobility items owned by the recipient, not to exceed four batteries in a 12-month period;

6) chiropractor services, except for Medicare recipients (Medicare covers chiropractor services and Medicaid covers the Medicare deductible and coinsurance amounts);

7) dipyridamole (Persantine) and other prescription medications not covered by Medicaid but ordered by the recipient's physician;

8) copayments for prescription drugs obtained under Medicare Part D.

e. Medicare Part D copays

Individuals who:

- qualify for Medicare Part D,
- are NOT enrolled in a Medicare PDP, and
- are NOT Medicaid eligible at the time of admission to CBC

will be fully responsible for their drug costs until Medicaid eligibility is determined and the Medicare Part D PDP enrollment process is completed. The individual remains responsible for any drugs purchased prior to the effective date of the PDP enrollment; Medicaid cannot pay for these drugs. The cost of drugs purchased before the PDP begin date can be deducted from patient pay.

Full benefit Medicaid enrollees who have Medicare, are receiving Medicaid CBC services, and are enrolled in a Medicare Part D PDP were responsible for the payment of co-pays for prescriptions filled prior to January 1, 2012. Effective January 1, 2012, individuals receiving Medicaid CBC services are not responsible for co-pays for prescriptions covered under their Medicare Part D PDP. CBC recipients are not subject to payment of deductibles or a coverage gap in their Part D benefits.

1) Monthly Statements

PDPs must issue a periodic (at least monthly) statement to the beneficiary explaining all benefits paid and denied. Part D drugs that are not covered by the PDP may not be covered by Medicaid and, absent other drug coverage, remain the responsibility of the individual. When a PDP denies coverage of a prescription, the beneficiary has the right to request an exception for coverage of the drug. The beneficiary is notified in writing of the decision on any exception requested.

Changed With	Effective Date	Pages Changed
TN #DMAS-18	7/1/21	Pages 66, 70
TN #DMAS-18	1/1/21	Page 7, 18c, 66, 69, 70, 92
TN #DMAS-17	7/1/20	Pages 8b, 9, 14, 66, 77, 92
TN #DMAS-15	1/1/20	Pages 1, 7, 18c, 66, 69, 70 Page 2 is a runover page.
TN #DMAS-14	10/1/19	Pages 8a, 8b, 12, 15, 16, 18, 20, 21, 30, 32, 51

TN #DMAS-13	7/1/19	Page 66
TN #DMAS-11	1/1/19	Pages 2, 7, 8, 18c, 66, 69, 70
TN #DMAS-7	1/1/18	Pages 18c, 66
TN #DMAS-11	1/1/19	Page 2
TN #DMAS-6	10/1/17	Table of Contents, page i Pages 2, 50, 50a, 52, 52a, 55, 57, 59, 63, 66, 76, 79, 80, 82, 84, 86, 88, 89
TN #DMAS-5	7/1/17	Pages 66, 69, 70, 92
TN #DMAS-3	1/1/17	Pages 7, 9, 18, 18b, 18c, 20 Pages 47, 51, 66, 67, 77
TN #DMAS-2	10/1/16	Pages 66, 72
TN #DMAS-1	6/1/16	Pages 7, 11, 14, 18, 18c, 30, 66, 69, 70, 92, 93
UP #11	7/1/15	Page 18c
TN #100	5/1/15	Pages 7, 16, 18, 18a, 18c, 65, 66 Pages 8, 15, 17 and 18b are reprinted.
TN #99	1/1/14	Pages 7, 18c, 66, 69, 70
TN #98	10/1/13	Page 66
UP #9	4/1/13	Pages 7, 18c, 66, 69, 70
UP #8	10/1/12	Page 66
TN #97	9/1/12	Pages 3, 6, 8b, 16 Pages 20-25 Page 20a was deleted.
UP #7	7/1/12	Pages 11, 14, 18c, 21 Pages 32, 66, 67, 69
UP #6	4/1/12	Pages 7, 18c, 66, 68, 69, 70
TN #96	10/1/11	Pages 7, 14, 66, 71
UP #5	7/1/11	Page 66
TN #95	3/1/11	Pages 7-9, 13, 18a, 18c, 66, Pages 69, 70
TN #94	9/1/10	Pages 64, 66, 69, 70
TN #93	1/1/10	Table of Contents, page ii Pages 3, 8b, 18, 18c, 20a Pages 21, 50, 51, 66, Pages 69, 70, 93 Appendix 4 was removed.
Update (UP) #1	7/1/09	Page 66
TN # 91	5/15/09	Pages 67, 68 Pages 76-93

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

M1480.400 PATIENT PAY

A. Introduction

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

B. Married With Institutionalized Spouse in a Facility

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

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

Introduction

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

B. Monthly Maintenance Needs Allowance	\$2,155.00	7-1-20	
	$2,177.50	*7-1-21*	
C. Maximum Monthly Maintenance Needs Allowance	\$3,216.00	1-1-20	
	\$3,259.50	1-1-21	
D. Excess Shelter Standard	\$646.50	7-1-20	
	$653.25	*7-1-21*	
E. Utility Standard Deduction (SNAP)	\$303.00	1 - 3 household members	10-1-19
	\$379.00	4 or more household members	10-1-19
	\$302.00	1 - 3 household members	10-1-20
	\$377.00	4 or more household members	10-1-20

Note: the Utility Standard Deduction amount decreased effective 10-1-20.

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).

c. Special Earnings Allowance For CCC Plus, CL, IS, and BI Waivers

[EXAMPLE #19 was deleted]

For the CCC Plus, CL, IS, and BI waivers, deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

- for individuals employed 20 hours or more per week, all earned income up to 300% of SSI ($2,382 in 2021) per month.

- for individuals employed at least *4* but less than 20 hours per week, all earned income up to 200% of SSI ($1,588 in 2021) per month.

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

EXAMPLE #20: (Using January 2000 figures)

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

$ 928.80	gross earned income
- 1,024.00	200% SSI maximum
$ 0	remainder

$928.80 = special earnings allowance

His personal maintenance allowance is calculated as follows:

$ 512.00	maintenance allowance
+ 928.80	special earnings allowance
$1,440.80	personal maintenance allowance

Changed With	Effective Date	Pages Changed
TN #DMAS-20	7/1/21	Pages 2, 3. 5. 6, 13, 14 Page 2a is a runover page. Page 6a was added as a runover page
TN #DMAS-19	4/1/21	Appendix 2
TN #DMAS-18	10/1/19	Pages 1, 4, 4a, 5, 11, 13 Content that was inadvertedly deleted in a previous transmittal was restored. No policy was revised.
TN #DMAS-17	7/1/20	Pages 2, 4, 25, 30 Page 3 is a runover page.
TN #DMAS-16	4/1/20	Pages 3, 4, 7, 9 Appendix 2 Pages 3a and 4 were renumbered to pages 4 and 4a. Page 4a is a runover page.
TN #DMAS-15	1/1/20	Pages 8, 8a
TN #DMAS-14	10/1/19	Pages 2, 3, 4, 6a, 8, 9, 10, 13 Page 4a is a runover page. Page 10a was added as a runover page. Page 7a was deleted.
TN #DMAS-13	7/1/19	Page 14
TN #DMAS-12	4/1/19	Table of Contents Pages 2, 5, 6, 6a, 7, 8, 8a, 11, 12, 15-18, 20 Appendix 2 Page 24a was added. Pages, 19, 21-24, 25 are runover pages.
TN #DMAS-11	1/1/19	Pages 2, 5, 6, 7, 9
TN #DMAS-8	4/1/18	Pages 2, 18 Appendix 2
TN #DMAS-7	1/1/18	Pages 2, 3, 3a, 5, 6, 7 Pages 6a and 7a are runover pages.
TN #DMAS-5	7/1/17	Pages 1, 2, 6, 8 Pages 3, 7, 7a and 9 are runover pages.
TN #DMAS-4	4/1/17	Pages 25-27 Appendix 2, page 1 Pages 28-30 were added.
TN #DMAS-3	1/1/17	Pages 1, 2, 4, 6, 7, 8, 14, 26

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

M1520.100 PARTIAL REVIEW

A. Enrollee's Responsibility

Enrollees must report changes in circumstances that may affect eligibility and/or patient pay within 10 days from the day the change is known. For enrollees participating in the Health Insurance Premium Payment (HIPP) Program, changes that may affect participation in HIPP must be reported to the DMAS HIPP Unit within the 10-day timeframe.

B. Eligibility Worker's Responsibility

The eligibility worker is responsible for keeping a record of changes that may be anticipated or scheduled and for taking appropriate action on those changes.

Appropriate agency action on a reported change must be taken within 30 days of the report. If the enrollee reports any changes requiring verifications, such as changes in income or resources, or an asset transfer for enrollees receiving long-term services and supports (LTSS), if possible, use available online systems information to verify the reported change. If the online-information is compatible with the reported change, determine eligibility based upon the information available.

If verifications must be obtained from the enrollee, send a verification checklist, and allow at least 10 calendar days for the information to be returned. If information is not provided by the deadline and continued eligibility cannot be determined, send advance notice to the enrollee/ authorized representative *stating* the cancellation date and the reason. Document the information and evaluation in the VaCMS case record. *If requested verifications are received after the deadline due to circumstances beyond the individual's control (e.g. a postal system delay), reopen the case, and complete processing of the change.*

1. Changes That Require Partial Review of Eligibility

When an enrollee reports a change or the agency receives information indicating a change in the enrollee's circumstances (i.e. Supplemental Security Income [SSI] purge list, reported transfer of assets), the worker must take action to partially review the enrollee's continued eligibility.

The following changes must be verified:

- A decrease in income or termination of employment that causes the individual to move from limited Medicaid coverage to full Medicaid coverage,
- An increase in income that causes the individual to move from Medicaid to FAMIS, or to need a Medically Needy spenddown calculation.

If a reported change is not compatible with information obtained from online system searches, obtain verification from enrollee or authorized representative.

The agency may not deny an increase in benefits, terminate coverage, or reduce benefits for any individual unless the agency has sought additional information from the individual and provided proper notification.

2. Changes That Do Not Require Partial Review

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

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

3. HIPP

The eligibility worker must provide the enrollee with a copy of the HIPP FACT Sheet when it is reported that he or a family member is employed more than 30 hours per week and is eligible for coverage under an employer's group health plan. The HIPP Fact Sheet is available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/References.

The eligibility worker must report to the HIPP Unit at DMAS any changes in an enrollee's situation that may affect the premium payment. The worker may report changes by e-mail to hipp@dmas.virginia.gov. This e-mail address is for use by the local agency staff only. See M0130.200 G for additional information about HIPP requirements.

3. Program Integrity

The MA eligibility of enrollees is subject to periodic review through the program integrity process (such as Medicaid Quality Control and the DMAS Recipient Audit Unit). It may be necessary for program integrity staff to request information, such as income verification, from the enrollee. The enrollee will be notified in writing and given a reasonable amount of time, as determined by the program integrity staff, to provide the information.

Should the enrollee not provide the requested information to the program integrity staff within the specified time, program integrity staff will notify the eligibility worker, and the worker must take action to follow up by requesting the appropriate verifications and/or sending advance notice, if necessary, to cancel coverage due to the inability to determine continued eligibility. An individual's failure to provide information to program integrity staff does not affect any future Medicaid applications.

C. Covered Group and Aid Category Changes

1. Enrollee's Situation Changes

When a change in an enrollee's situation results in a potential change in covered group, his eligibility in all other covered groups must be evaluated. Examples of such changes include when:

- a pregnant woman reaches the end of her post-partum period (the month in which the 60th day after the end of the pregnancy occurs),
- an infant who has been enrolled as a Newborn Child reaches age one year,
- a Families & Children (F&C) enrollee becomes entitled to SSI,
- an SSI Medicaid enrollee becomes a Qualified Severely Impaired Individual (QSII) (1619(b),
- an individual enrolled in a Modified Adjusted Gross Income (MAGI) Adults aid category turns 65 years old, or becomes entitled for/begins receiving Medicare.

2. Change in Level of Benefits

When an individual who has been enrolled in limited coverage, such as Plan First, experiences a change, such as pregnancy *or entitlement to Medicare*, that results in eligibility for full coverage *or a Medicare Savings Program*, the individual's entitlement to *the new level of* coverage begins the month the individual is first eligible for *the new level of* coverage, regardless of when or how the agency learns of the change. If change in income is reported, the agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family.

E. Recipient Enters LTC

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

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

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

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

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

F. Woman Enrolled in FAMIS Prenatal Coverage Delivers Her Infant

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

An infant born to a woman enrolled in AC 111 and/or enrolled in managed care must be evaluated for ongoing coverage. The enrollment is treated as a change in circumstances. The infant is not considered a deemed-eligible newborn but has rather been enrolled prenatally through the mother's enrollment in FAMIS Prenatal Coverage. The infant's birth is treated as an "add a person" case change in the enrollment system and enrolled using the procedures in M1520.200 F 1-F.2 below.

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

1. ***Required Information***

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

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

2. ***Enrollment and Aid Catogory***

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

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

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

M1520.200 RENEWAL REQUIREMENTS

A. Policy

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

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

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

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

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

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

B. Procedures

1. Change Results in Adverse Action

Following a determination that eligibility no longer exists or that the enrollee's Medicaid services must be reduced, the Advance Notice of Proposed Action, available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, or system-generated advance notice must be sent to the enrollee at least 10 days plus one day for mail, before action is taken to cancel or reduce Medicaid coverage.

If the action to cancel or reduce benefits cannot be taken in the current month due to MMIS cut-off, then the action must be taken by MMIS cut-off in the following month. The Advance Notice of Proposed Action must inform the enrollee of the last day of Medicaid coverage.

Unless the individual has Medicare, a referral to the HIM must be made when coverage is cancelled. The notice must state that the individual has been referred to the HIM for determination of eligibility for the APTC.

2. Enrollee Appeals Action

If the enrollee requests an appeal hearing before the effective date of the action, subject to approval by the DMAS Appeals Division, the enrollee may choose to have eligibility continued at the current level of services until a decision is reached after a hearing. The DMAS Appeals Division will notify the local agency that the enrollee's coverage must be reinstated during the appeal process. **Do not reinstate coverage until directed to do so by the Department of Medical Assistance Services (DMAS) Appeals Division.**

If the decision is adverse to the recipient, the amount Medicaid paid on the services being appealed that were received by the recipient during the continuation is subject to recovery by DMAS.

Medicaid coverage at the prior level is not continued when a request for appeal is filed on or after the effective date of the action.

When notification is received from DMAS that the agency's proposed adverse action was sustained, the recipient's eligibility must be terminated effective the date of the receipt of that letter. No further advance notice to the recipient is necessary since he/she is also informed of DMAS' decision.

3. Death of Enrollee

The eligibility worker must take the following action when it is determined that an enrollee is deceased:

If the enrollee has an SSN, the worker must verify the date of death. *A match with Social Security Administration data occurs when the individual's information is sent through the Hub in VaCMS.*

Alternatively, the worker *can* run a SVES or SOLQ-I request to verify the date of death. SVES will display an "X" and the date of death in the "SSN VERIFICATION CODE" field on Screen 1.

If the recipient does not have an SSN, or if *the Hub*, SOLQ-I, or SVES does not return information showing that the recipient is deceased, contact the parent/caretaker relative or authorized representative to obtain the date of death. Information from a medical professional/facility is also acceptable.

The worker must document the VaCMS case record. Send adequate notice of cancellation to the estate of the enrollee at the enrollee's last known address and to any authorized representative(s) using the Notice of Action on Medicaid.

Cancel the enrollee's coverage, using the date of death as the effective date of cancellation.

4. Enrollee Enters Ineligible Institution

When an enrollee who is not incarcerated enters an institution and is no longer eligible (e.g. an individual between the ages of 22 and 65 enters an institution for the treatment of mental diseases), cancel coverage as soon as possible after learning of the enrollee's admission to an ineligible institution. **DO NOT cancel coverage retroactively.** Cancel coverage effective the current date (date the worker enters the cancel transaction in the system).

If an enrollee becomes incarcerated, a partial review must be completed to determine if he continues to meet the requirements for coverage in a full-benefit CN covered group. If he continues to be eligible, cancel the existing coverage and reinstate in AC 109 for ongoing coverage the date of incarceration. If the individual no longer meets the requirements for a full benefit CN covered group, cancel the coverage, effective the day prior to entering incarceration. See M0140.000.

5. End of Spenddown Period

When eligibility terminates at the end of a six-month spenddown period, advance notice is not required. The individual is notified of the limited period of spenddown eligibility on the Notice of Action sent at the time the spenddown application is approved. Explanation of this limitation and information relative to re-application is provided at the time of the spenddown eligibility determination and enrollment.

6. Reason "012" Cancellations

Cancellations by DMAS staff due to returned mail are reported in the monthly System Cancellation Report (RS-O-112) available in the Data Warehouse Medicaid Management Reports. The report is issued between the 21st and 25th day of each month and is to be monitored so that appropriate follow up may be made.

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

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

M1550 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-20	7/1/21	Appendix 1
TN #DMAS-19	4/1/21	Pages 1, 2
TN #DMAS-17	7/1/20	Table of contents Pages 1, 2 Appendix 1, page 1 Pages 3-9 and Appendix 1, page 2 were deleted.
TN #DMAS-16	4/1/20	Page 2 Appendix 1, page 1
TN #DMAS-14	10/1/19	Appendix 1, page 1 Appendix 1, page 2 was added.
TN #DMAS-8	4/1/18	Page 3
TN #DMAS-7	1/1/18	Page 1 Appendix 1, page 1
TN #DMAS-4	4/1/17	Appendix 1,page 1
TN #DMAS-3	1/1/17	Pages 4-6, 8, 9
TN #100	5/1/15	Appendix 1,page 1
UP #9	4/1/13	Appendix 1, page 1
Update (UP) #7	7/1/12	Appendix 1, page 1
TN #96	10/1/11	Appendix 1, page 1
TN #93	1/1/10	Title page Table of Contents Pages 1-9 Appendix 1, page 1
TN #91	5/15/09	Appendix 1

DBHDS FACILITIES
PSYCHIATRIC HOSPITALS

Central State Hospital – Petersburg
Western State Hospital – Staunton
Northern Virginia *State* Mental Health *Hospital* – Falls Church
Southern Virginia Mental Health Institute – Danville
Southwestern Virginia Mental Health Institute – Marion
Piedmont Geriatric Hospital – Burkeville*
Catawba Hospital – Catawba*
Commonwealth Center (for Children and Adolescents) –Staunton
*Eastern State Hospital**

**These facilities admit for Temporary Detention Orders (TDOs); stays are not covered by Medicaid.*

M16 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-20	7/1/21	Table of Contents Pages 1-10 Pages 11 and 12 were added.
N/A	10/15/20	Pages 3, 8 Page 8a was added as a runover page.
TN DMAS-12	4/1/19	Page 7
TN #DMAS-8	4/1/18	Page 7
TN #DMAS-4	4/1/17	Page 7 Pages 8-10 are runover pages.
TN #DMAS-2	10/1/16	Page 3
TN #DMAS-1	6/1/16	Page 1
TN #100	5/1/15	Page 3
Update #9	4/1/13	Page 8

TABLE OF CONTENTS

M16 APPEALS PROCESS

M1600.00 APPEALS PROCESS

M1610.100 PURPOSE AND SCOPE

A. Legal Base

The Social Security Act requires that the State Plan for Medical Assistance provide individuals affected by the administration of the Medical Assistance Program an opportunity for a fair hearing. The act establishes the right of any individual to appeal and receive a fair hearing before the administering agency, the Department of Medical Assistance Services (DMAS), when DMAS or any of its designated agents:

- takes an action to terminate, deny, suspend, or reduce benefits,
- fails to take an application for medical assistance,
- fails to act on an application for medical assistance with reasonable promptness, or
- takes any other action that adversely affects receipt of medical assistance.

This chapter applies to client appeals resulting from eligibility determinations made by the Virginia Department of Social Services, as well as its local offices. It also applies to eligibility determinations made by the Department of Medical Assistance Services and its agents, including Cover Virginia.

Many Medicaid members are enrolled with a Managed Care Organization (MCO). The MCO appeals process differs from the Eligibility appeals process and the procedures contained within this chapter do not apply to MCO appeals.

B. Participants

The DMAS Appeals Division provides the Hearing Officer who makes arrangements for the fair hearing. The Appeals Division is separate and apart from operational divisions and units within and outside of DMAS. The Division provides a neutral forum for appeals. The Hearing Officer is an impartial decision-maker who will conduct hearings, decide on questions of evidence, procedure and law, and render a written final decision. The Hearing Officer is one who has not been directly involved in the initial adverse action which is the issue of the appeal.

The *Agency or Contractor* taking the action being appealed and the appellant (the individual appealing some aspect of entitlement to medical assistance or its scope of services) or their representative must participate in the hearing. Most hearings will be conducted by telephone.

Appeals that result from a self-directed application in the eligibility and enrollment system are handled by the local department of social services (LDSS) that houses *processed* the application.

C. *Ex Parte* Communication

***Ex parte* communication with the Hearing Officer is strictly prohibited.** *Ex parte* communication is any off-the-record communication (oral or written) between the Hearing Officer and an interested party outside the presence of the other parties to the proceeding during the life of the appeal proceeding.

The Hearing Officer cannot discuss the substantive issues of an appeal with anyone outside of the hearing. Therefore, it is not appropriate to contact the Hearing Officer to discuss the Agency's action prior to or after the hearing.

Any information provided to the Hearing Officer must be provided to all parties of the proceeding. However, as noted in M1620.100, it is appropriate to notify all parties to the appeal when an action is taken by an Agency to resolve the issue of the appeal. Communication is also allowed for *administrative* reasons such as scheduling hearings, canceling hearings, and indicating a desire to withdraw an appeal.

D. Notification and Rights

At the time of application or redetermination, and at the time of any action or proposed action affecting eligibility for medical assistance, medical services or patient pay, every applicant for and *enrollee* of medical assistance shall be informed in writing of the right to a hearing. Appellants shall also be notified of the method by which they may obtain a hearing, and of their right to represent themselves at the hearing or to be represented by an authorized representative such as an attorney, relative, friend, or other spokesperson.

M1620.100 LOCAL AGENCY CONFERENCE

A. Definition and Scope

The Local Agency Conference is an informal process outside of the standard appeal process and does not involve the DMAS Appeals Division. At the conference, the Agency must:

- *give the applicant/enrollee an explanation of the action;*
- *allow the applicant/enrollee to present any information to support their disagreement with the action; and*
- *allow the applicant/enrollee to represent themselves or be represented by an authorized representative such as a legal counsel, a friend, or a relative.*

B. Time Limits

A dissatisfied applicant or enrollee must be given the opportunity to request a Local Agency Conference. If a conference is requested, it must be scheduled within 10 business days of receiving the request.

C. The Conference and Right to Appeal

The Local Agency Conference must <u>not</u> be used as a barrier to the individual's right to a fair hearing. Participation in a conference does not extend the 30-day time limit for requesting an appeal.

D. Failure to Request a Conference

The applicant's or enrollee's failure to request a conference does not affect the right to appeal within 30 days of the Notice of Action on Benefits and does not affect the right to continued eligibility if the appeal is requested to the DMAS Appeals Division prior to the effective date of the action.

E. Decision Notification

The Local Agency Conference may or may not result in a change in the Agency's decision to take the action in question; however, an Agency may reverse its decision at any time between making the original decision and when a decision is rendered by the Hearing Officer.

If the Agency decides not to take the adverse action indicated on the notice, the Agency must inform the appellant in writing. The Agency must send a new notice regarding the changed action. The Agency must send a copy of the new notice to the DMAS Appeals Division.

If the Agency's decision is to stand by its action, the applicant/enrollee must be informed, but written notice of this decision is not required.

M1630.100 APPEAL REQUEST PROCEDURES

A. Appeal Definition

An appeal is a request for a fair hearing. The request must be a clear expression by an applicant or enrollee, their legal representative (such as a guardian, conservator, or person having power of attorney), or authorized representative acting at *their* request, of a desire to present their case to a higher authority.

B. *Appeal Request*

An applicant may submit an appeal using a "Virginia Medicaid/FAMIS Appeal Request Form," which is available from DMAS at ***https://www.dmas.virginia.gov/appeals/***. Applicants may also write their own letters to request an appeal. The DMAS Appeals Division also accepts telephonic appeal requests.

C. How to File an Appeal Request

1. ***Electronically. Via the Appeals Information Management System (AIMS) portal at https://www.dmas.virginia.gov/appeals/ or*** *email an appeal request to* ***appeals@dmas.virginia.gov***
2. **By fax.** Fax an appeal request to DMAS at **(804) 452-5454**
3. **By mail or in person.** Send or bring an appeal request to:
   Department of Medical Assistance Services
   Appeals Division
   600 East Broad Street
   Richmond, Virginia 23219
4. **By phone.** Call the Appeals Division at (**804) 371-8488 (TTY: 1-800-828-1120).**

C. Assuring the Right to Appeal

The right to appeal must not be limited or interfered with in any way. When requested to do so, the Agency must assist the applicant/enrollee in preparing and submitting a request for a fair hearing. *The Agency may not discourage an applicant/enrollee from requesting an appeal and may not pressure an appellant to withdraw an appeal that they have already filed.*

D. Appeal Time Standards

A request for an appeal must be made within 30 days of receipt of notification that Medicaid coverage or medical services has been denied, terminated, reduced, adversely affected, or that it has not been acted upon with reasonable promptness.

Notification is presumed received by the applicant/enrollee within five days of the date the notice was mailed, unless the applicant/enrollee demonstrates that the notice was not received in the five-day period through no fault of his/her own.

An appeal request shall be deemed to be filed timely if it is mailed, faxed, electronically transmitted, or otherwise delivered to the DMAS Appeals Division before the end of last day of filing (30 days plus five mailing days after the date the Agency mailed the notice of adverse action). The date of filing will be determined by:

- the postmark date,
- the date of an internal DMAS receipt date-stamp, or

the date the request was faxed or hand-delivered.

In computing the time period, the day of the act or event from which the period of time begins to run shall be excluded, and the last day included. If the time limit would expire on a weekend or state or federal holiday, it shall be extended until the next regular business day.

The DMAS Appeals Division will, at its discretion, grant an extension of the time limit for requesting *an appeal* if failure to comply with the time limit is due to a good cause such as illness of the appellant or their representative, failure to have been notified of the right to appeal, delay due to the postal service or to an incorrect address, or other unusual or unavoidable circumstances.

M1640.100 CONTINUED COVERAGE PENDING APPEAL DECISION

A. Appeal Validation

Following receipt of a written request for a hearing, the DMAS Appeals Division will determine whether the request *is valid. A valid* appeal is one that *involves* an action over which the DMAS Appeals Division has hearing authority, and that is received within the required time limit or extended time limit. During the process of validating an appeal request, a representative of the DMAS Appeals Division may contact the Agency to request a copy of the notice of the adverse action. Upon receipt of such a request, the Agency must immediately send a copy of the notice to the DMAS Appeals Division.

When an appeal is determined to be valid, the DMAS Appeals Division will send official notification to the Agency and identify the issue and Hearing Officer.

B. Coverage May Continue

When an appeal is received and validated, the DMAS Appeals Division decides if Medicaid coverage must continue and notifies the Agency. The Agency should not continue coverage due to the appeal until it has been contacted by the Appeals Division. Upon being informed, by telephone or correspondence, that the enrollee is eligible to receive continued coverage, the Agency must reinstate coverage immediately.

An enrollee's Medicaid coverage must continue until a final appeal decision is made when an appeal hearing is requested prior to the effective date of the action stated on the *Notice of Action on Benefits, or when the appeal is requested after the effective date but within 10 days of the Notice of Action on Benefits.*

In the case of a patient pay adjustment, the patient pay obligation must return to the amount that was effective prior to the change shown on the Notice of Obligation for Long Term Care Costs that is the subject of the appeal.

C. ***When Continued Coverage Does Not Apply***

Coverage **will not** continue *through the date of the appeal decision* when:

- *an appeal hearing is requested after the effective date of action, or more than 10 days after the Notice of Action on Benefits if the appellant is given less than 10 days of advanced notice; or*

  the sole issue under appeal is one of Federal or State law or policy, and the Agency promptly informs the appellant that services will be terminated or reduced pending the appeal hearing decision.

D. Recovery of Continued Coverage Costs

When the Hearing Officer determines that the appellant is not eligible for coverage, the cost of medical care received during the period of continued coverage may be recovered by DMAS, to the extent they were furnished solely by reason of this section. (See M1670.100)

M1650.100 PRE-HEARING ACTIONS

A. **Invalidation**

A request for an appeal may be invalidated if it was not filed within the time limit imposed or if it was not filed by the applicant/enrollee or an authorized representative. *The Hearing Officer shall issue a final decision.*

1. Appeal Not Filed Timely

If DMAS determines that the appellant has failed to file a timely appeal, DMAS shall notify the appellant or the appellant's representative of the opportunity to show good cause for the late appeal.

If there is no response, or if after evaluating the response, the Hearing Officer determines that the reason for failing to file a timely appeal does not meet good cause criteria, the appeal request will be considered invalid *and the Hearing Officer will issue the appropriate final decision.*

2. Factual Dispute of Timeliness

If a factual dispute exists about the timeliness of the request for an appeal, the Hearing Officer shall receive testimony and evidence at the hearing prior to receiving testimony and evidence about the substantive issue of the appeal. A decision on the timeliness issue will be made prior to a determination of whether to make a decision about the substantive issue of the appeal.

3. When Individual Filing Appeal Is Not the Appellant

If the individual filing the appeal is not the appellant or an authorized representative of the appellant, DMAS will request that the appellant and/or representative provide proof of authorization to represent the appellant. If proof is not provided, the appeal request will be considered invalid *and the Hearing Officer will issue the appropriate final decision.*

B. Administrative Dismissal

A request for an appeal may be administratively dismissed without a hearing if the appellant has no right to a hearing. *The Hearing Officer shall issue a final decision.*

1. No Adverse Action Taken

If DMAS learns that no adverse action was taken prior to the date of the appeal request, *the Hearing Officer will issue a final decision dismissing the appeal.*

2. Disability Decision Rescinded By DDS

If the appellant's Medicaid application is returned to a pending status because the Disability Determination Services analyst rescinds the denial of disability, *the Hearing Officer will issue a final decision dismissing the appeal.*

C. Withdrawal

If the appellant requests that the appeal be withdrawn, *the Hearing Officer will send the appellant a letter acknowledging the withdrawal and no further action will be taken on the appeal. A copy of the letter will be sent to the Agency.*

- *The appellant must provide the Appeals Division with a statement clearly indicating that they wish to withdraw their appeal. The statement or form must be mailed, e-mailed, or faxed to the DMAS Appeals Division.*
- *In lieu of a written statement, the appellant may make a recorded verbal statement clearly indicating that they wish to withdraw their appeal by calling the Appeals Division at **(804) 371-8488.** Verbal notification to the LDSS by the appellant to withdraw an appeal is **not** sufficient.*

D. Failure to Appear

If the appellant or their representative fails to appear at the scheduled hearing, and does not reply within 10 days to the Hearing Officer's request for an explanation that meets good cause criteria, or if the appellant does reply and the Hearing Officer decides that the reply does not meet good cause criteria, the appeal will be closed as "abandoned," *and the Hearing Officer will issue a final decision.*

E. Administrative Resolution

If, upon reevaluation by the LDSS, the appellant's coverage is reinstated to the full amount of coverage that was in effect prior to closure or reduction of benefits, the appeal will be closed as administratively resolved, *and the Hearing Officer will issue a final decision.*

***NOTE**: The Agency should not assume that any new Notice of Action on Benefits automatically ends the appeal. The Agency must send any new Notices to the Appeals Division, and the Appeals Division will decide whether the appeal is administratively resolved. The Agency will receive a copy of final letters for administrative closures.*

F. Judgment on the Record

If the Hearing Officer determines from the record that the Agency's action was clearly in error and that the case should be resolved in the appellant's favor, he shall issue a judgment on the record instead of holding a hearing. The Hearing Officer will provide the Agency with a clear explanation of the reason(s) for issuing a judgment on the record and which actions must be taken by the Agency to correct the case. The decision to issue a judgment on the record is at the Hearing Officer's discretion

G. Remand to the Agency Prior to the Hearing

If the Hearing Officer determines from the record that the case might be resolved in the appellant's favor if the Agency obtains and develops additional information, documentation, or verification, they may remand the case to the Agency for action consistent with the Hearing Officer's written instructions. The Agency must complete the remand evaluation within 30 days or 45 days as applicable.

H. Defective Notices

If the appealed Notice of Action on Benefits is defective on its face, the Hearing Officer may remand the appeal to the Agency for the issuance of a legally compliant Notice.

For Notices reducing or terminating existing coverage or services, the Hearing Officer will issue a decision that finds in favor of the appellant by ordering the Agency/contractor to reinstate the existing level of coverage or services at issue for a period of at least 30 calendar days; and
Requires the Agency/contractor to issue a new compliant notice prior to the end of the 30 calendar day period by reviewing the same application or service authorization request. If the Agency/contractor requires additional information to process the application or service authorization request, they must ensure that the information is requested and obtained in order to timely issue the new compliant notice.

For Notices concerning new applications for eligibility or requests for new services, the Hearing Officer may issue a decision remanding the Notice to the entity that issued it and order that, within a reasonable period determined by the Hearing Officer, a new compliant Notice be issued to the member on the same eligibility application or service authorization request. If the Agency/contractor requires additional information to process the application or service authorization request, they must ensure that the information is requested and obtained in order to timely issue the new compliant notice. Alternatively, the appellant will be given the option to waive the deficient notice and continue with the State Fair Hearing process.

M1660.100 SCHEDULING THE HEARING

A. Scheduling and Location

The Hearing Officer will select a date and time for the hearing. Typically, hearings are scheduled at least three weeks in advance.

Hearings will be held at the local Agency if a local department of social services office is responsible for the action. The applicant/enrollee will be at the Agency. The Hearing Officer will participate in any hearing by telephone unless the appellant requests a face-to-face hearing. Appellants may also request to participate in their hearing telephonically, rather than appearing at the local Agency.

Hearings regarding actions taken by Contractors will be conducted telephonically.

B. Confirmation Letter

The schedule letter is mailed to the appellant and representative, and a copy is mailed to the Agency.

The schedule letter contains information about summary due dates and other pertinent information.

If the Agency representative cannot be available on the date and time selected by the Hearing Officer, he/she must notify the DMAS Appeals Division as soon as possible and request an alternate date and time for the hearing.

M1670.100 AGENCY APPEAL SUMMARY

A. Agency Appeal Summary Form

Upon notification that a fair hearing has been requested, the Agency must complete an Agency Appeal Summary. There is a form for the Agency Appeal Summary (form #032-03-805) available on *Fusion*.

When preparing the Agency Appeal Summary, the Agency must consider all documents submitted up until that point, even if the information/documents were submitted for the first time during the appeal process, as discussed below at M1680.100 (A)(5). The Agency Appeal Summary must thoroughly explain the facts, policy, and other relevant information that support the Agency's position on the appeal. The Agency must submit all documents relevant to the Agency's determination with the Agency Appeal Summary.

If new documentation submitted by the appellant during the appeals process would not result in a finding of MA eligibility, then the Agency or Contractor must produce an appeal summary explaining why the new documentation did not result in a finding of eligibility and should attend the hearing prepared to explain why the Agency or Contractor maintains its position on the appeal.

B. Send to Appeals Division and Appellant

The Agency must send one copy of the Agency Appeal Summary and all relevant documentation to the following parties by the due date specified by the Appeals Division at the time of the notification:

- *Department of Medical Assistance Services, Appeals Division*
  - *Electronically via the AIMS portal at www.dmas.virginia.gov/appeals. Use of the AIMS portal is the preferred method for filing the appeal summary with DMAS.*
  - *Via USPS: 600 East Broad Street, Appeals Division*
    Richmond, Virginia 23219
  - *Via email: appeals@dmas.virginia.gov*
  - *Via fax: 804-452-5454*

- The appellant or their authorized representative, if the appellant has designated a representative for the appeal.

The Agency must keep a copy of the Agency Appeal Summary and all relevant documentation, including applications, notices, and DMAS appeal decisions for its records.

C. Deadline for Submission *In most cases, the Agency Appeal Summary must be submitted to the DMAS Appeals Division and the appellant or their authorized representative within 21 days after the Agency or Contractor is notified of the appeal. The only exception is when the Appeals Division certifies an expedited appeal*

M1680.100 THE HEARING PROCEDURE

A. Hearing Procedure The hearing will be conducted in an informal manner. Formal rules of evidence do not apply in these proceedings. The appellant is entitled to guarantees of fair hearings established in *Goldberg v. Kelly*, 397 US 245 (1970). The proceedings will be governed by the following rules:

1. Record The Hearing Officer will swear-in all hearing participants who will be presenting evidence or facts and will record the hearing proceedings.

2. Appellant The appellant will present *their* own case or have it presented by an authorized representative. *They* will be allowed to bring witnesses, establish all pertinent facts and circumstances, advance any testimony or evidence, and question witnesses called on *their* own behalf and by the Agency.

3. Agency Representatives *The worker at the Agency* who took the action being appealed and/or the worker's supervisor should be present at the hearing, and must be prepared to explain the Agency's action. The Agency may be represented by its county or city attorney. The Agency has the authority to ask its county or city attorney to attend the hearing.

When the action being appealed is a disability decision made by the DDS, a representative from DDS must be present at the hearing. When the action being appealed is a denial of a medical or dental covered service, a representative from DMAS or its contractor who made the decision must be present at the hearing.

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

5. *De Novo* Hearing *The DMAS state fair hearing is a de novo hearing in front of a DMAS Hearing Officer. That means that the DMAS Hearing Officer will issue an entirely new determination based upon all relevant evidence that the appellant offers during the appeal process. This includes evidence that may not have been available to the Agency or Contractor at the time the appealed eligibility determination was made. The DMAS Hearing Officer will review all information that was submitted for the initial eligibility determination, as well as any additional documentation and testimony that is submitted during the appeal process. Appellants who wish for additional documentation to be reviewed may submit it with their appeal request, prior to the scheduled hearing, during the hearing itself, or after the hearing if the Hearing Officer agrees to hold the record open for submission of additional documentation.*

Further, a de novo hearing is a hearing that starts over from the beginning. This means the Hearing Officer must allow the appellant to develop the record fully. The record will consist of any relevant evidence, documentation, and testimony, regardless of whether it was available at the time of the adverse determination. The Hearing Officer's decision will be based solely on the record developed during the de novo hearing process, and it will include an explanation of how the facts apply to the relevant laws, regulations, and policies.

Agencies and Contractors will receive a copy of any new documentation that has been submitted to the DMAS Appeals Division during the appeal process to determine whether it is possible to approve MA coverage. If the Agency or Contractor receives new documentation from the appellant independently during the appeal process, copies of such documentation must be sent to the DMAS Appeals Division. The Agency or Contractor can use new documentation to determine that the appellant is eligible for coverage. If the Agency or Contractor determines that the appellant is eligible, then they shall issue a new Notice of Action on Benefits and provide it to all parties to the appeal. The Hearing Officer must then decide whether it is appropriate to resolve the appeal based upon the new Notice of Action on Benefits.

If the new documentation submitted by the appellant would not result in a finding of MA eligibility, then the Agency or Contractor must produce an appeal summary explaining why the new documentation did not result in a finding of eligibility and must attend the hearing prepared to explain why the Agency or Contractor maintains its position on the appeal.

After the hearing, the DMAS Hearing Officer will issue a decision as to whether or not the appellant is approved for coverage based upon all of the documentation, evidence, and testimony provided by the appellant and the Agency or Contractor.

B. Hearing Officer Evaluation and Decision

1. Evaluation

Following the hearing, the Hearing Officer will prepare a decision taking into account the Agency Appeal Summary, evidence provided by the appellant or their representative, testimony, and additional information provided by the parties. The Hearing Officer *will evaluate* all evidence, research laws, regulations and policy, and *will decide* if the applicant or recipient is *approved for coverage*.

2. Hearing Officer Decision

Examples of the Hearing Officer's decisions include:

a. Sustain

When the Hearing Officer's decision *is consistent with the Agency's action*, the decision is "sustained."

b. Reverse

When the Hearing Officer's decision *overturns the Agency's action, including when the Hearing Officer finds the appellant eligible for Medical Assistance under the de novo hearing process*, the decision is "reversed."

c. Remand

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

3. Failure to Provide Requested Information

If the *Agency* denies an application or terminates coverage because of failure to provide requested information, the *Hearing Officer* can hold the hearing record open for a period of time to allow the appellant to submit additional information *to receive a* de novo *eligibility determination. The Hearing Officer may decide to reconvene the hearing if appropriate.*

C. Local Agency Action

The decision of the Hearing Officer is the final administrative action taken on the appeal. The local *Agency or Contractor* must comply with the Hearing Officer's decision.

1. Agency Action - Sustained Cases

If the Hearing Officer's decision is to sustain the Agency's action, and coverage was continued during the appeal process, the case must be closed without an additional notice to the enrollee from the Agency. The Hearing Officer's decision letter to the appellant is the appropriate official notice of cancellation.

The Agency must take action to close the case in the Medicaid computer using cancel reason "015" effective the date the Agency receives the decision.

2. Agency Action - Remanded Cases

a. Do Not Send Documents to Hearing Officer

If the Hearing Officer's decision is to remand the case to the local Agency, the local Agency must not send documentation of the evaluation or a copy of the remand notice to the Hearing Officer.

b. Enrollment Actions

If the Hearing Officer's decision is to remand the case for further evaluation and coverage was continued during the appeal process, coverage must be continued until the local Agency completes the evaluation and makes a new decision.

If the remand evaluation results in the appellant's continuous eligibility, the Agency must notify the appellant in writing of *their* continuing eligibility for coverage.

If the remand evaluation results in the appellant's continuous eligibility and coverage was *not* continued during the appeal process, the local Agency must reinstate coverage back to the original termination date (no break in coverage) and notify the appellant of their continued eligibility.

If the remand evaluation results in the appellant's ineligibility and coverage was continued during the appeal process, the enrollee's coverage must be canceled at the completion of the evaluation, and the appellant must be notified in writing.

c. Take Action in 30 *or* 45 Days

The Agency must complete the remand evaluation within 30 days or 45 days *according to the Hearing Officer's instructions in the decision*.

Agency Action-Reversed Cases

Following a Hearing Officer's decision to reverse an Agency's action to deny, reduce, or terminate coverage, the Agency must reinstate coverage retroactive to the date of closure or month of application (including retroactive coverage months, if applicable) *according to the Hearing Officer's instructions in the decision.*

M1690.100 RECOVERY OF BENEFITS PAID DURING APPEAL

A. Applicable Circumstances

The Medicaid Program may recover expenses paid on behalf of appellants whose Medicaid coverage was continued during the appeal process, when the Agency's proposed action is upheld by the Hearing Officer.

DMAS will be responsible for recovering these expenses from the appellant, not the service provider. The appellant will be notified, after the hearing decision is made, of how much money if any is owed to the Medicaid Program.

B. Recovery Period

Medicaid expenditures for services received from the original effective date of the proposed adverse action (as stated on the notice) until the actual cancellation of Medicaid coverage or payment will be recovered.

M17 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-20	7/1/21	Page 7
TN #DMAS-16	4/1/20	Appendix 4, page 1 Appendix 4, page 2 was added
TN #DMAS-15	1/1/20	Page 7 Page 8 was added as a runover page.
TN #DMAS-14	10/1/19	Table of Contents Pages 1, 2, 4, 6, 7 Appendix 1, pages i and ii Appendix 2, pages i and ii Appendix 4 was added.
TN #DMAS-7	1/1/18	Table of Contents, page i Appendix 1, pages i and ii Appendix 2, pages i and ii Appendix 3 was added.
TN #DMAS-6	10/1/17	Table of Contents Pages 4. Appendix 1 was deleted Appendices 2 and 3 were renumbered Appendices 1 and 2, respectively.
TN #DMAS-5	7/1/17	Table of Contents Pages 1, 2, 4 Appendix 2 Appendix 3 was added.
TN #DMAS-4	4/1/17	Pages 4, 5 Pages 6 and 7 are runover pages.
TN #DMAS-2	10/1/16	Table of Contents, page i Pages 1-7 Appendix 2 Page 8 was deleted.
TN #97	9/1/12	Page 3 Appendix 1, page 1
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

1. PARIS Match Data

The Public Assistance Reporting Information System (PARIS) is a Federal computer matching initiative that the Virginia Department of Social Services (VDSS) participates in quarterly. VDSS participates in the data exchange with all active Medicaid enrollees and they are matched for the receipt of Veteran benefits and enrollment in multiple state's Medicaid programs. Each public assistance report is matched by social security number.

The worker must evaluate all matches for current and ongoing eligibility and take appropriate case action within 30 days. Multiple matches must be assessed as a whole for the entire case. Workers must document findings in VaCMS under Case Comments. Once the evaluation of the match is completed and the case comments are documented, send the **Public Assistance Reporting Information System (PARIS) Notice of Recipient Fraud/Non-Fraud Recovery, (form #DMAS 754R)** to the DMAS Program Integrity Division, where steps will be conducted to complete the match and Benefit Impact Screen (BIS). Procedures for researching and reporting PARIS matched individuals are found in the PARIS User Guide at *https://fusion.dss.virginia.gov/ac/Compliance-Home/FRAUD-MANAGEMENT/PARIS-Public-Assistance-Reporting-Information-System*.

Complete and send the **Public Assistance Reporting Information System (PARIS) Notice of Recipient Fraud/Non-Fraud Recovery (form #DMAS 754R)** located at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, to

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

The form may be faxed to 804-452-5472 or emailed to recipientfraud@dmas.Virginia.gov.

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.

4. 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).

5. Incarcerated Individuals/ Offenders

The Cover Virginia Incarcerated Unit (CVIU) is responsible for evaluating PARIS matches for offenders whose cases are being held at the CVIU and reporting findings to the RAU as outlined in M1700.400 B.1 above.

C. DMAS Response

The RAU shall send a referral acknowledgement letter to the LDSS worker making the referral. RAU may send out additional communication to the LDSS should additional verifications/documentation be required to complete the investigation.

M18 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-20	7/1/21	Page 7 Page 8 is a runover page.
TN #DMAS-12	04/01/2019	Page 3, 5
TN #11 DMAS -11	01/01/2019	Page 3
TN #DMAS-10	10/1/18	Pages 3-5
TN #DMAS-6	10/1/17	Table of Contents Pages 3-5 Page 6 is a runover page. Page 6a was added.
TN #100	5/1/15	Table of Contents Pages 1-9 Pages 10-17 were deleted. Appendix 1 was removed.
UP #9	4/1/13	Page 3
UP #7	7/1/12	Page 12
TN #96	10/01/11	Pages 3, 4, 16
TN #95	3/1/11	Page 9
TN #94	9/1/10	Page 12
TN #93	1/1/10	Pages 4, 5
TN #91	5/15/09	Page 2 Pages 5, 6 Page 8

C. Services with No Copayments

The following services do not have copayments:

- emergency-room services,
- pregnancy-related services,
- family planning services, and
- dialysis services.

D. Covered Services

The services listed below are covered:

- case management services;
- certified pediatric nurse and family nurse practitioner services;
- clinical psychologist services;
- community-based services for individuals with intellectual disabilities, including day health rehabilitation services and case management;
- dental services for *children enrolled in Medicaid and FAMIS,* pregnant women *enrolled in Medicaid, FAMIS MOMS, and FAMIS Prenatal Coverage, and effective July 1, 2021, all other adults with* ***full*** *Medicaid benefits.*
- emergency hospital services;
- Early Periodic Screening, Diagnostic and Treatment (EPSDT) services;
- family planning services;
- Federally Qualified Health Center clinic services;
- home and community-based care waiver services (see subchapter M1440);
- home health services: nurse, aide, supplies, treatment, physical therapy, occupational therapy, and speech therapy services;
- hospice services;
- inpatient hospital services;

- Intensive Behavioral Dietary Counseling, for individuals in MEDICAID WORKS;
- intermediate care facility services for the intellectually disabled (ICF-ID);
- laboratory and x-ray services;
- Medicare premiums: Hospital Insurance (Part A); Supplemental Medical Insurance (Part B) for the Categorically Needy (CN) and Medically Needy (MN);
- mental health services, including clinic services, case management, psychosocial rehabilitation, day treatment/partial hospitalization, therapeutic day treatment for children and adolescents, intensive in-home services for children and adolescents, and crisis intervention services;
- nurse-midwife services;
- nursing facility care;
- other clinic services: services provided by rehabilitation agencies, ambulatory surgical centers, renal dialysis clinics, and local health departments;
- outpatient hospital services;
- personal assistance services, for individuals in MEDICAID WORKS;
- physical therapy and related services;
- physician services;
- podiatrist services;
- prescribed drugs;
- prosthetic devices;
- Rural Health Clinic services;
- skilled nursing facility services for individuals under age 21 years;
- substance abuse services;
- transplant services;
- transportation to receive medical services; and
- vision services.

M21 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-20	7/1/21	Page 2
TN #DMAS-19	4/1/21	Appendix 1, page 1
TN #DMAS-16	4/1/20	Appendix 1, page 1
TN #DMAS-14	10/1/19	Pages 4-6
TN #DMAS-12	4/1/19	Appendix 1, page 1
TN #DMAS-9	7/1/18	Page 5
TN #DMAS-8	4/1/18	Appendix 1, page 1
TN #DMAS-4	4/1/17	Appendix 1, page 1
TN #DMAS-2	1/1/17	Appendix 1, page 1
TN #DMAS-2	10/1/16	Page 3
TN #DMAS-1	6/1/16	Appendix 1, page 1
TN #100	5/1/15	Table of Contents Pages 1-7 Appendices 1 Pages 8-10 and Appendices 2 and 3 were deleted.
UP #10	5/1/14	Pages 1-3 Appendix 1
TN #99	1/1/14	Pages 1-3 Appendix 1
TN # 98	10/1/13	Table of Contents Pages 1-10 Pages 10a and 11-16 were deleted.
UP #9	4/1/13	Pages 3, 4
UP #8	10/1/12	Table of Contents Pages 2-4 Appendix 3 deleted
TN #97	9/1/12	Pages 3, 4
UP #7	7/1/12	Pages 3, 4 Appendix 2, pages 1 Appendix 3, pages 1 and 2
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	Pages 3, 8
TN #95	3/1/11	Table of Contents Pages 5, 6, 14, 15, Page 16 added Appendix 1
TN #94	9/1/10	Page3 Appendix 3, pages 1 and 2
UP #3	3/1/10	Pages 2-5
TN #93	1/1/10	Page 2-4, 8
Update (UP) #2	8/24/09	Page 4

M2120.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

The child must meet, with certain exceptions, the Medicaid Nonfinancial Eligibility Requirements in chapter M02 and the nonfinancial eligibility requirements imposed by FAMIS.

B. M02 Requirements

The nonfinancial eligibility requirements in chapter M02 that must be met for FAMIS eligibility are:

- the citizenship and alienage requirements, with the exception noted in M2120.100 C below;
- Virginia residency requirements;
- Provision of a Social Security Number (SSN) or proof of application for an SSN.
- Assignment of rights to payment for medical care from any liable third party is a condition of eligibility for the child;
- institutional status requirements regarding inmates of a public institution.

C. FAMIS Alien Status Requirements

Lawfully residing children under age 19 meet the FAMIS alien requirements without regard to their date of arrival or length of time in the U.S. The lawfully residing alien groups are contained in section M0220.314.

Exception to M02:

FAMIS does **not** provide emergency services only coverage for non-citizens who are not lawfully residing in the U.S., such as illegal aliens or those whose lawful admission status has expired. These aliens are not eligible for FAMIS.

If the child meets the definition of a pregnant woman in M0310.124 and does not meet the definition of a lawfully residing child under 19 in M0220.314, use Chapter M23 to evaluate the child for eligibility under FAMIS Prenatal Coverage.

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. IMD Prohibition

The child cannot be an inpatient in an institution for the treatment of mental diseases (IMD).

M22 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-20	7/1/21	Page 2
TN #DMAS-19	4/1/21	Appendix 1, page 1
TN #DMAS-18	1/1/21	Page 6
TN #DMAS-16	4/1/20	Appendix 1, page 1
TN #DMAS-14	10/1/19	Page 5
TN #DMAS-12	4/1/19	Appendix 1, page 1
TN #DMAS-8	4/1/18	Appendix 1, page 1
TN #DMAS-6	10/1/17	Page 7 Appendix 1, page 1
TN #DMAS-4	4/1/17	Appendix 1, page 1
TN #DMAS-1	6/1/16	Page 4 Appendix 1, page 1
TN #100	5/1/15	Table of Contents Pages 1, 2, 5, 6, 7 Appendix 1 Pages 3 and 4 are runover Pages.
TN #98	10/1/13	Table of Contents Pages 1-7 Appendix 1 Pages 8-10 were deleted.
UP #9	4/1/13	Appendix 1
UP #8	10/1/12	Pages 2, 3 Page 3a deleted
UP #7	7/1/12	Pages 2, 3
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	Pages 3, 3a
TN #95	3/1/11	Pages 4-6 Appendix 1
UP #4	7/1/10	Page 10
TN #94	9/1/10	Page 3
UP #3	3/01/10	Page 2
TN #93	1/1/10	Pages 2-10
UP #2	8/24/09	Page 3
Update (UP) #1	7/1/09	Pages 1, 2, 7 Appendix 1, page 1

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, with the exception noted in M2220.100 C below;
  - Virginia residency requirements;
  - Provision of a Social Security Number (SSN) or proof of application for an SSN;
  - assignment of rights;
  - application for other benefits;
  - institutional status requirements regarding inmates of a public institution.

C. FAMIS MOMS Alien Status Requirements

Lawfully residing pregnant women meet the FAMIS alien requirements without regard to their date of arrival or length of time in the U.S. The lawfully residing alien groups are contained in section M0220.314.

Exception to M02:

FAMIS MOMS does **not** provide emergency services only coverage for non-citizens who are not lawfully residing in the U.S., such as illegal aliens or those whose lawful admission status has expired. These aliens are not eligible for FAMIS MOMS *but may be eligible for FAMIS Prenatal Coverage if they apply for coverage no later than the month their child is born.* ***Use Chapter M23 to evaluate the pregnant woman for eligibility under FAMIS Prenatal Coverage.***

D. FAMIS MOMS Covered Group Requirements

1. Declaration of Pregnancy

The woman's pregnancy is declared on the application and requires no further verification unless the agency has received conflicting information. See M0310.124 for the definition of a pregnant woman.

2. Must be Uninsured

The pregnant woman must be uninsured; that is, she must not be covered under any creditable health insurance plan offering hospital and medical benefits. If a pregnant woman has creditable health insurance that does not cover pregnancy, labor and/or delivery services, the pregnant woman is ineligible for FAMIS MOMS because she is insured.

3. IMD Prohibition

The pregnant woman cannot be in inpatient in an institution for the treatment of mental diseases (IMD).

CHAPTER M23

FAMIS PRENATAL COVERAGE

TABLE OF CONTENTS

M23 – FAMIS PRENATAL COVERAGE

APPENDIX

M2300.000 FAMIS PRENATAL COVERAGE

M2310.100 FAMIS PRENATAL COVERAGE GENERAL INFORMATION

A. Introduction

The 2021 Special Sessions I Appropriations Act directed the Department of Medical Assistance Services (DMAS) to amend the Family Access to Medical Insurance Security Plan (FAMIS) and expand medical coverage to uninsured pregnant women and their unborn children

- who are ineligible for full-benefit Medicaid or FAMIS Moms due to the woman's immigration status and
- whose Modified Adjusted Gross Income (MAGI) household income is less than or equal to 200% of the federal poverty level (FPL).

FAMIS Prenatal Coverage is effective beginning July 1, 2021.

Eligibility for FAMIS Prenatal Coverage is determined by either the local DSS, including a DSS outstationed site, or the Cover Virginia Central Processing Unit (CPU). Applications processed by the Cover Virginia CPU will be transferred to the appropriate local DSS for case maintenance.

Eligible women are enrolled for benefits effective the first day of the application month if all eligibility requirements are met in that month. There is no retroactive coverage in FAMIS Prenatal Coverage. If the woman applies for coverage after the month in which the child is born but within the application's retroactive period, she may be eligible for Medicaid coverage of the labor and delivery as emergency services if the woman's countable MAGI household income is within the Medicaid limit. See M0220.400.

Pregnant women found eligible for FAMIS Prenatal Coverage receive the same benefits as Medicaid and FAMIS MOMS pregnant women, including comprehensive dental services.

An eligible woman will receive coverage through her pregnancy and the end of the month in which the 60th day following the end of the pregnancy occurs. An infant born to a woman enrolled in FAMIS Prenatal Coverage will receive ongoing coverage beginning on the date of the infant's birth. The infant's coverage will be in Medicaid or FAMIS, based on the mother's MAGI household unit income at the time of application. The infant's birth is evaluated as a case change; an application does not need to be submitted for the infant.

B. Policy Principles

FAMIS Prenatal Coverage covers uninsured low-income pregnant women who are not eligible for Medicaid or FAMIS MOMS due to the woman's immigration status and whose countable income is less than or equal to 200% of the FPL.

A pregnant woman **of any age** is eligible for FAMIS Prenatal Coverage if all of the following are met:

- she applies for coverage while pregnant or in the month of the birth of her infant child;

- she does not meet the definition of a **lawfully residing non-citizen pregnant woman in M0220.314**.
- she is a resident of Virginia;
- she is uninsured;
- she is not an inmate of a public institution;
- she is not an inpatient in an institution for mental diseases; and
- she has countable MAGI household income less than or equal to 205% FP (200% FPL plus 5% FPL disregard)..

M2320.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

A. Policy

The pregnant woman must meet, with certain exceptions, the Medicaid nonfinancial eligibility requirements in Chapter M02 and must be uninsured.

B. M02 Applicable Requirements

The Medicaid nonfinancial eligibility requirements in Chapter M02 that must be met are:

- Virginia residency requirements (M0230)
- assignment of rights (M0250)
- application for other benefits (M0270)
- institutional status requirements regarding inmates of a public institution (M0280).

The Social Security Number (SSN) requirement does not apply to the pregnant woman.

C. Alien Status and FAMIS Prenatal Coverage

FAMIS Prenatal Coverage is limited to a pregnant woman of any age who **does not** meet the lawfully residing alien status requirement for pregnant women for full-benefit coverage in M0220.314 and who applies for coverage while pregnant or no later than the month in which the infant is born.

A pregnant woman who does not meet the lawfully residing alien status requirement and who applies for coverage after the month in which the child is born but within the application's retroactive period may be eligible for Medicaid coverage of the labor and delivery as emergency services if the woman's countable MAGI household income is within the Medicaid or limit or she is eligible as Medically Needy. See M0220.400.

D. FAMIS Prenatal Coverage Covered Group Requirements

1. Declaration of Pregnancy

The woman's pregnancy and the number of unborn children are declared on the application and require no further verification unless the agency has received conflicting information. See M0310.124 for the definition of a pregnant woman.

2. Must be Uninsured

The pregnant woman must be uninsured; that is, she must not be covered under any creditable health insurance plan offering hospital and medical benefits. If a pregnant woman has creditable health insurance that does not cover pregnancy, labor and/or delivery services, the pregnant woman is ineligible for FAMIS Prenatal Coverage because she is insured.

3. IMD Prohibition

The pregnant woman cannot be an inpatient in an institution for mental diseases (IMD).

M2320.200 HEALTH INSURANCE COVERAGE

A. Introduction

A pregnant woman who has creditable health insurance coverage is not eligible for FAMIS Prenatal Coverage.

FAMIS Prenatal coverage provides the same coverage as FAMIS MOMS, including coverage of prenatal care, other medical care, dental care, and transportation to received covered services. Pregnant women enrolled in FAMIS Prenatal Coverage will receive care through a managed care organization (see M1830.100)

B. Definitions

1. Creditable Coverage

For the purposes of FAMIS Prenatal Coverage, 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; Medicare;
- a public health plan; and
- any other health benefit plan under section 5(e) of the Peace Corps Act.
- The definition of creditable coverage includes short-term limited coverage.

2. Employer-Sponsored Dependent Health Insurance

Employer-sponsored dependent health insurance means the employer pays a portion of the premium payment. COBRA coverage in which the employer makes no contribution to the payment of the premium is not employer-sponsored insurance.

3. Health Benefit Plan

"Health benefit plan" is defined in the Virginia Bureau of Insurance Regulations (14VAC5-234-30) and means:

- any accident and health insurance policy or certificate,
- health services plan contract,
- health maintenance organization subscriber contract,
- plan provided by a Multiple Employer Welfare Arrangement (MEWA)".

Health benefit plan does NOT mean:

- Medicaid;
- accident only;
- credit or disability insurance;
- long-term care insurance;
- dental only or vision only insurance;
- specified disease insurance;
- hospital confinement indemnity coverage;
- limited benefit health coverage;
- coverage issued as a supplement to liability insurance;
- insurance arising out of workers' compensation or similar law;
- automobile medical payment insurance; or
- insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

4. Insured means having creditable health insurance coverage or coverage under a health benefit plan. A woman is considered to be insured if she is covered by a creditable health insurance plan, even if the policy or plan does not cover pregnancy-related services.

5. Uninsured means having no insurance; having insurance that is not creditable; having coverage which is not defined as a health benefit plan, or having a health insurance plan that does not have a network of providers in the area where the pregnant woman resides.

C. Policy

1. Must be Uninsured A nonfinancial requirement of FAMIS Prenatal Coverage is that the pregnant woman be uninsured. A pregnant woman **cannot:**

- have creditable health insurance coverage; or
- have coverage under a group health plan (TRICARE, federal employee benefit plan, private group insurance such as Anthem, etc.) or Medicare.

2. Prior Insurance Prior insurance coverage is not a factor as long as the pregnant woman is uninsured during the month for which FAMIS Prenatal Coverage eligibility is being determined.

M2320.300 NO CHILD SUPPORT COOPERATION REQUIREMENTS

A. Policy There are no requirements for FAMIS Prenatal Coverage applicants or members to cooperate in pursuing support from an absent parent.

M2330.100 FINANCIAL ELIGIBILITY

A. Financial Eligibility

1. Income

MAGI methodology contained in Chapter M04 is used for the FAMIS Prenatal Coverage income evaluation. To the maximum extent possible, attested income must be verified by information obtained from electronic data sources, such as the federal hub or another reliable data source, prior to requesting paystubs or employer statements. If the income attested to by the applicant is within 10% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required. If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return. If the documentation is delayed in the mail due to no fault of the applicant, accept delayed documentation and complete application processing.

The FAMIS Prenatal Coverage income limit is 200% of the FPL (see Appendix 1 to this chapter) for the number of individuals in the pregnant woman's MAGI household composition as defined in M04. The pregnant woman is counted as herself plus the number of children she is expected to deliver. Per MAGI policy in chapter M04, a 5% FPL income disregard is applicable.

2. Resources

Resources are not evaluated for FAMIS Prenatal Coverage.

3. No Spenddown

Spenddown does not apply to FAMIS Prenatal Coverage. If countable income exceeds the FAMIS Prenatal Coverage income limit, the pregnant woman is not eligible for the FAMIS Prenatal Coverage program. If the woman has no documentation of immigration status, DO NOT make a referral to the Health Insurance Marketplace

M2340.100 APPLICATION and CASE PROCEDURES

A. Application Requirements

The policies in subchapters M0120 and M0130 apply.

B. Eligibility Determination

1. 7 Calendar Day Processing

Applications for pregnant women must be processed as soon as possible, but no later than seven (7) calendar days from the date the signed application was filed. If all necessary verifications are not received, the application continues to pend until the 45 day processing time limit is met.

2. Notice Requirements

The applicant/recipient must be notified in writing of the required information and the deadline by which the information must be received.

The agency must have all necessary verifications within 7 calendar days in order to determine eligibility. If the agency does not receive the verifications within the 7 calendar days, the worker must send the applicant written notice on the 7th day. The notice must state why action on the application could not be taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 calendar days to submit the verification.

Once all necessary verifications for the pregnant woman are received, an eligibility determination must be made immediately and the applicant must be notified of the decision.

C. Case Setup Procedures for Approved Cases

A woman enrolled as FAMIS Prenatal Coverage may have the same base case number in the Virginia Medicaid Management Information System (MMIS) as Medicaid enrollees.

D. Entitlement and Enrollment

1. Begin Date of Coverage

Pregnant women determined eligible for FAMIS Prenatal Coverage are enrolled for benefits in the Virginia Medicaid Management Information System (MMIS) effective the first day of the application month, if all eligibility requirements are met in that month.

2. No Retroactive Coverage

There is no retroactive coverage in the FAMIS Prenatal Coverage program.

3. Aid Categories

The FAMIS Prenatal Coverage aid categories (AC) are:

- 110 for pregnant women with income ≤143% FPL
- 111 for pregnant women with income >143% FPL but ≤ 200% FPL.

4. Coverage Period

After her eligibility is established as a pregnant woman, the woman's FAMIS Prenatal Coverage entitlement continues through her pregnancy and the 60-day period following the end of her pregnancy regardless of income changes. Her coverage ends the last day of the month in which the 60th postpartum day occurs.

E. Notification Requirements

Written notice must be sent to the pregnant woman informing her of the action taken on the application. The notice must include the eligibility determination results for FAMIS Prenatal Coverage.

If the woman is not eligible for FAMIS Prenatal Coverage and has no documentation of immigration status, DO NOT make a referral to the Health Insurance Marketplace.

F. Enrolling Infant Born to a Woman in FAMIS Prenatal Coverage

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

An infant born to a woman in FAMIS Prenatal Coverage who is enrolled in AC 111 and/or enrolled in managed care must be evaluated for ongoing coverage. The enrollment is treated as a change in circumstances. The infant is not considered a deemed-eligible newborn but has rather been enrolled prenatally through the mother's enrollment in FAMIS Prenatal Coverage. The infant's birth is treated as an "add a person" case change in the enrollment system. Follow the procedures in M2340.100 F.1 – F.3 below.

1. Required Information

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

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

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

2. Enrollment and Aid Category

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

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

3. Renewal

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

G. Examples

Example 1

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

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

Because she received an emergency service during the retroactive period and her income is under the Medicaid limit for a pregnant woman, she is evaluated for Emergency Services coverage.

Rose's son, AJ, is born on February 25, 2022, and is enrolled in AC 090 beginning February 25, 2022. His Medicaid renewal is due in January 2023. Rose's FAMIS Prenatal Coverage ends on April 30, 2022.

Example 2

Jo lives with her husband Al and daughter Em, who was born on October 31, 2021. Jo was born outside the U.S. She applies for Medical Assistance on November 25, 2021 and requests retroactive coverage for her pregnancy. She does not request coverage for her husband.

Jo is unable to verify that she is lawfully residing in the U.S.; therefore, she cannot be eligible for full-benefit Medicaid or FAMIS Moms. Because Jo applied for coverage the month after her infant's birth, she cannot be eligible for FAMIS Prenatal Coverage

Jo's MAGI household consists of three people—Jo, her infant, and her husband. The verified countable monthly income for the household is $3,473.

Jo's countable income is over the limit of 143% FPL for Medicaid and has excess resources for Medically Needy eligibility; therefore, she cannot be approved for Medicaid coverage of emergency services for the labor and delivery.

Em is determined to be eligible for FAMIS, which covers an eligible child who was born within the 3 months prior to the application month. Em is enrolled effective October 31, 2021, in AC 006. Her renewal is due in September 2022.

The eligibility worker sends a Notice of Action indicating Jo is not eligible for Medicaid or FAMIS Prenatal Coverage and Em has been enrolled in FAMIS.

M2350.100 REVIEW OF ADVERSE ACTIONS

An applicant for FAMIS Prenatal Coverage may request a review of an adverse determination regarding eligibility for FAMIS Prenatal Coverage. FAMIS Prenatal Coverage follows the procedures established by Medicaid for client appeals (see Chapter M16).

The payment of medical services on the part of any pregnant woman or any right to participate in the program is not subject to review if the reason for denial or cancellation is that funds for the FAMIS Prenatal Coverage program are exhausted.

FAMIS PRENATAL COVERAGE
200% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE 7/1/21

	Enroll Using Aid Category 110			Enroll Using Aid Category 111		
Household Size	**143% FPL Yearly Amount**	**143% FPL Monthly Amount**	**148% FPL (143% FPL + 5% FPL Disregard)**	**200% FPL Yearly Amount**	**200% FPL Monthly Amount**	**205% FPL (200% FPL + 5% FPL Disregard)**
2	24,911	2,076	2,149	34,840	2,904	2,976
3	31,403	2,617	2,709	43,920	3,660	3,752
4	37,895	3,158	3,269	53,000	4,417	4,528
5	44,388	3,699	3,829	62,080	5,174	5,303
6	50,880	4,240	4,389	71,160	5,930	6,079
7	57,372	4,781	4,949	80,240	6,687	6,854
8	63,864	5,322	5,509	89,320	7,444	7,630
Each additional, add	6,493	542	560	9,080	757	776