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Virginia Medical Assistance Eligibility Manual
Transmittal #DMAS-21

The following acronyms are contained in this letter:

- AC – Aid Category
- COFA – Compact of Free Association
- COVID – Coronavirus Disease
- DMAS – Department of Medical Assistance Services
- DOC – Department of Corrections
- FAMIS – Family Access to Medical Insurance Security
- LDSS – Local Department of Social Services
- LPR – Lawful Permanent Resident
- MMIS – Medicaid Management Information System
- TN – Transmittal
- VaCMS – Virginia Case Management System

TN #DMAS-21 includes policy clarifications, updates and revisions. Unless otherwise noted in the Cover Letter and/or policy, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after October 1, 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-21:

Changed Pages	Changes
Subchapter M0130 Page 14	Clarified the notice requirements for duplicate applications.
Subchapter M0140 Page 1	Clarified that inpatient hospitalization may include long-term inpatient services, such as admission to a rehabilitation facility.

Changed Pages	Changes
Subchapter M0240 Page 1, 3, 5	On pages 1, 3, and 5, clarified the language regarding AC assignment. On page 5, removed the obsolete policy on applications processed outside VaCMS.
Chapter M04 Pages 3, 15	On page 3, clarified that inpatient hospitalization may include long-term inpatient services, such as admission to a rehabilitation facility. On page 15, removed obsolete text.
Subchapter S1140 Page 26 Page 26a is a runover page.	Clarified the treatment of a revocable annuity.
Subchapter M1410 Page 9	Clarified the policy on when an applicant is evaluated as an institutionalized individual.
Subchapter M1470 Page 17	Clarified that patient pay is entered using VaCMS.
Subchapter M1480 Page 66	Updated the Utility Standard Deduction, effective October 1, 2021.
Subchapter M1510 Page 9a	Clarified the procedures for making a change in MMIS.
Subchapter M1520 Pages 6, 12	On page 6, clarified the enrollment process for infants born to mothers covered by FAMIS Prenatal Coverage. On page 12, corrected the mailing address for the DOC Health Services Reimbursement Unit.
Chapter M21 Pages 4, 5	Clarified that if the child's health insurance is terminated on a day other than the last day of the month, FAMIS coverage begins effective the day after the insurance ended if all other eligibility requirements are met.
Chapter M23 Pages, 6, 7	Clarified the language regarding AC assignment and the enrollment process for infants born to mothers covered by FAMIS Prenatal Coverage.

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

M0130 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-21	10/1/21	Page 14
TN #DMAS-20	7/1/21	Page 2 Page 2a is a runover page.
TN #DMAS-18	1/1/21	Pages 4, 8, 13
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

E. Notification for Retroactive Entitlement Only

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

M0130.400 Applications Denied Under Special Circumstances

A. General Principle

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

B. Withdrawal

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

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

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

C. Inability to Locate

The agency must send a letter to the last known address informing the applicant of the agency's attempt to locate him and asking that he contact the office. For applicants who are documented as homeless, maintain all correspondence at the local agency. If the applicant does not respond within 45 days of the date of application, deny the application.

D. Duplicate Applications

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

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

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

M0140 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-21	10/1/21	Page 1
TN #DMAS-18	1/1/21	Pages 3-5
TN #DMAS-14	10/1/19	Pages 4, 5

M0140.000 Incarcerated Individuals General Information

A. Introduction

An incarcerated individual, or offender, is an inmate of a public institution. Inmates include those under the authority of the Virginia Department of Corrections (DOC), held in a regional or local jail, those on work release, and inmates of a Virginia Department of Juvenile Justice (DJJ) facility.

For juveniles not in a facility but within the authority of DJJ, see section M0280.300 D. See section M0280.301 regarding an individual who is not considered to be an inmate of a public institution.

An individual released from jail under a court probation order due to a medical emergency is NOT an inmate of a public institution because he is no longer incarcerated.

B. Policy Principles

An individual is not eligible for full benefit Medicaid coverage while incarcerated. These individuals may apply for medical assistance and (if approved) receive coverage limited to inpatient hospitalization services. *Inpatient hospitalization may include long-term inpatient services, such as admission to a rehabilitation facility.*

The offender must meet eligibility requirements for a full-benefit covered group. Medicaid non-financial eligibility requirements include

- Virginia residency requirements (see M0230)
- Citizenship or immigration status (see M0220)
- A Social Security Number (SSN) or proof of application for an SSN (see M0240)
- Institutional status requirement of being an inmate in a public institution (see M0280)

Medicaid financial eligibility requirements for the individuals covered group include

- Resources (if applicable) within resource limit (Chapter M06 for F&C; Chapter S11 for ABD)
- Income within income limit (Chapter M04 & M07 for F&C covered groups; Chapter S08 for ABD covered groups)

C. Covered Group

The individual is evaluated for eligibility in the covered group in which they would otherwise be eligible except for being incarcerated. The primary covered groups an offender may meet include:

- MAGI Adults (M0330.250)
- Pregnant Women (M0330.400)
- Child Under Age 19 (M0330.300)
- Aged, Blind or Disabled (M0320.300)
- Former Foster Care Child Under Age 26 Years (M0330.109)

D. Immigration Status Requirements

An incarcerated person must meet immigration requirements (see M0220). A non-citizen who meets all Medicaid eligibility requirements except for immigration status and has received an inpatient hospitalization may be evaluated for coverage as an Emergency Services Alien (see M0140.200 A 3).

M0240 Changes

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

M0240.000 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 *assigned to* Aid Category 110 AND who is NOT in managed care.

An infant born to a mother in FAMIS Prenatal Coverage who *is assigned to* AC 110 and who IS in managed care OR who *is assigned to* 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.

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 *assigned to* AC 110 and who is in managed care OR who is enrolled in AC 111, see M0240.200 C.

2. Failure to Apply for SSN

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

3. Retroactive Eligibility

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

M0240.200 FOLLOW-UP REQUIREMENTS FOR SSN APPLICATION

A. Applicant Applied for SSN

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

For an infant born to a mother in FAMIS Prenatal Coverage who is 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.

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

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

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

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

M0240.300 SSN Verification Requirements

A. SSN Provided By Individual

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

B. Procedures

1. Enter Verified SSN in Systems

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

2. Resolving Unverified SSN Discrepancies

a. Data Entry Error Caused Discrepancy

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

Changed With	Effective Date	Pages Changed
TN #DMAS-21	10/1/21	Pages 3, 15
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

- Supplemental Security Income (SSI) recipients.
- IV-E foster care or adoption assistance recipients
- Deemed newborns
- BCCPTA (Breast and Cervical Cancer Prevention and Treatment Act) enrollees
- Auxiliary Grants.

b. individuals who are eligible on the basis of being aged (age 65 or older), blind or disabled;

- individuals eligible for or enrolled in Medicare;

- individuals evaluated as Medically Needy (MN);

5. Special Medical Needs Adoption Assistance Children

A Special Medical Needs Adoption Assistance (AA) child is subject to MAGI methodology for the child's initial Medicaid eligibility determination. These children are in their own household apart from parents and siblings. Parents' and siblings' income is not counted for these children.

6. MAGI Adults

a. MAGI methodology is used to determine eligibility for the following individuals with income at or below 138% (133% + 5% disregard) of the Federal Poverty Limit:

- Parents and caretaker- relatives with excess income for LIFC

- Disabled individuals not eligible for or entitled to Medicare or individuals alleging disability who have not been determined disabled

- Childless adults ages 19-64

- Incarcerated individuals ages 19-64. Incarcerated individuals are eligible for inpatient hospital services only; i*npatient hospitalization may include long-term inpatient services, such as admission to a rehabilitation facility*.

- Non-citizens eligible for emergency services only

- Individuals eligible for Long Term Care Services and Support (LTSS) ages 19-64
  Note: See Chapter M14 for LTSS screening requirements.

b. The following individuals are not eligible under the MAGI ADULTS group:

- Individuals pregnant at initial application or redetermination of eligibility

- Individuals under the age of 19 or 65 and over

- Individuals eligible for or enrolled in Medicare Part A or B

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.

A. 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.

S1140 Changes

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

M1140.260 ANNUITIES

A. Introduction

An annuity is a sum paid yearly or at other specific times in return for the payment of a fixed sum. Annuities may be purchased by an individual or by an employer. For Medicaid purposes, an annuity means a contract or an agreement by which one receives fixed, non-variable payments on an investment for a lifetime or a specified number of years. An annuity must be issued by an insurance company, bank, or other registered or licensed entity approved to do business in the state in which the annuity was established.

B. Operating Policy

1. Revocable Annuity

An annuity that names revocable beneficiaries is considered to be an available resource because it can be surrendered, cashed in, assigned, transferred or have the beneficiary changed. Annuities are presumed to be revocable when the annuity contract does not state that it is irrevocable. The countable value of the revocable annuity is the amount of the funds in the annuity minus any fees required for surrender.

2. Annuities Purchased with Assets of a Third Party

Annuities purchased with the assets of a third party such as those received through a legal settlement are not considered to be countable resources.

3. Annuity Purchased Prior to February 8, 2006

An annuity purchased prior to February 8, 2006, is considered a countable resource if the annuity can be surrendered. The countable value of the annuity is the amount of the funds in the annuity minus any fees required for surrender.

4. *Irrevocable* Annuity Purchased on or after February 8, 2006

A non-employment related annuity purchased by or for an individual *using that individual's assets* on or after February 8, 2006, *is no*t considered an available resource *if it is irrevocable.*

Prior to receiving long-term *services and supports (LTSS)* paid by Medicaid, all annuities purchased by the institutionalized individual or the community spouse on or after February 8, 2006, must name the Commonwealth of Virginia as the primary beneficiary for at least the total amount of medical assistance paid on behalf of the institutionalized individual. If there is a community spouse or minor or disabled child, the Commonwealth must be named as the remainder beneficiary behind the spouse or minor or disabled child.

For individuals applying for *LTSS*, 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).

M1410 Changes

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

3. Processing

EW completes the application processing. Processing includes receipt of required verifications, completion of the non-financial and financial eligibility determinations, and necessary case record documentation. See chapter M15 for the processing procedures.

An individual's eligibility is determined as an institutionalized individual if he is in a medical facility or has been screened and approved for Medicaid *LTSS*. For any month in the retroactive period, an individual's eligibility can only be determined as an institutionalized individual if he met the definition of institutionalization in that month (i.e. he had been a patient in a medical institution—including nursing facility or an ICF-ID-- for at least 30 consecutive days).

If it is known at the time the application is processed that the individual did not or will not receive *LTSS* services (i.e. the applicant has died since making the application) do not determine eligibility as an institutionalized individual.

If the individual's eligibility was determined as an institutionalized individual prior to the receipt of waiver services, the EW must verify that *LTSS* started within 30 days of the date of the Notice of Action on Medicaid. If *LTSS* did not start within 30 days of the date of the Notice of Action on Medicaid, the individual's continued eligibility must be re-evaluated as a non-institutionalized individual.

4. Notices

See section M1410.300 for the required notices.

M1410.200 INITIATING LONG-TERM CARE FOR CURRENT RECIPIENTS

A. Introduction

Individuals who currently receive Medicaid and enter LTSS must have their eligibility redetermined using the special rules that apply to *LTSS*.

For example, an enrollee may be ineligible for Medicaid payment of LTSS because he/she transferred assets without receiving adequate compensation. The asset transfer policy found in M1450 applies to individuals who receive any type of *LTSS*. Individuals who are ineligible for Medicaid payment of LTSS may remain eligible for other Medicaid-covered services.

B. LTSS Screening

An LTSS screening is used to determine if an individual meets the level of care for Medicaid payment for LTSS. Medicaid enrollees must be screened and approved before Medicaid will authorize payment for LTSS.

M1470 Changes

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

B. Non-Institutionalized Individuals on MN Spenddown

A non-institutionalized MN individual who is on a spenddown is not eligible for Medicaid until the spenddown is met. Non-institutionalized MN individuals are either on a three-month retroactive or six-month ongoing spenddown.

1. Individual Who Meets the Spenddown

For a non-institutionalized MN individual who meets the spenddown on a date that is within the dates of facility service, take the following steps to determine patient pay:

a. Add together the number of days in the facility stay that are NOT covered by Medicaid. Multiply the result by the facility's private pay daily rate.

b. Determine the remaining balance of the spenddown prior to applying the bill that caused the spenddown to be met.

c. Add the amount in a. above to the figure obtained in b. above. The total is the individual's patient pay for the part of the facility stay that occurs in the spenddown coverage period.

d. Enter patient pay *using* VaCMS.

2. Example – Spenddown Met

Mr. B, an unmarried 70 year-old individual living in a Group II locality, filed an initial application for Medicaid on October 5, 1999. He had excess income and was placed on a spenddown of $2000 for the period October 1, 1999 through March 31, 2000. On October 8, 1999, he was admitted to a nursing facility for temporary care that is expected to be less than 30 days.

On November 10, 1999, his authorized representative asks for his spenddown to be re-evaluated due to his admission to the nursing facility. The representative also submits medical bills incurred before October 8, 1999, that the worker determines leave a spenddown balance of $500 as of October 8, 1999. The nursing facility charges him $120 per day; the Medicaid per diem is $85. His spenddown is determined:

$2000	spenddown liability October 1, 1999-March 31, 2000
- 1500	old bills incurred prior to October 1, 1999
500	spenddown balance on October 1, 1999
- 50	doctor's charge on October 5, 1999 (after TPL pays)
- 120	private pay rate on October 8, 1999
330	spenddown balance beginning October 9, 1999
- 120	private pay rate on October 9,1999
210	spenddown balance beginning October 10, 1999
- 120	private pay rate on October 10, 1999
90	spenddown balance beginning October 11, 1999
- 120	private pay rate on October 11, 1999
$ 0	spenddown met on October 11, 1999

Mr. B met his spenddown on October 11, 1999. Medicaid coverage begins on October 11, 1999 and ends on March 31, 2000, the end of the six month spenddown budget period.

He is discharged from the nursing facility to his home without CBC on November 1, 1999. He was in the nursing facility for less than 30 days. His patient pay for the October 8, 1999 through November 1, 1999 stay is determined:

M1480 Changes
Page 1 of 2

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

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)	$302.00	1 - 3 household members	10-1-20
	$377.00	4 or more household members	10-1-20
	$322.00	1 - 3 household members	*10-1-21*
	$402.00	4 or more household members	*10-1-21*

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).

M1510 Changes
Page 1 of 2

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

Changed With	Effective Date	Pages Changed
TN #DMAS-10	10/1/18	Pages 7, 8a, 9a, 14 Pages 8b and 8c are runover pages.
TN #DMAS-9	7/1/18	Table of Contents Page 5. Page 9a was added.
TN #DMAS-8	4/1/18	Pages 2, 8a, 8b Page 8c was added.
TN #DMAS-6	10/1/17	Table of Contents Pages 1, 2 Page 2a is a runover page. Page 2b was added as a runover page.
TN #DMAS-5	7/1/17	Page 1 Page 2 is a runover page.
TN #DMAS-4	4/1/17	Pages 2a, 10
TN #DMAS-2	1/1/17	Table of Contents Pages 1, 8, 8a, 12-15 Page 11a was deleted.
TN #DMAS-2	10/1/16	On pages 3-15, corrected the subchapter number in the headers. Neither the dates nor the policies were changed.
TN #DMAS-1	6/1/16	Pages 2 Pages 1 and 2a are runover pages.
TN #100	5/1/15	Table of Contents Pages 1-2a, 5-8b
UP #10	5/1/14	Table of Contents Pages 7-8a Page 8b was added.
TN #99	1/1/14	Table of Contents Pages 1, 2, 8, 8a, 9-11 Page 11a was added.
UP #9	4/1/13	Pages 2-7, 10-12, 14
UP #7	7/1/12	Pages 8, 9
TN #96	10/01/11	Pages 8a, 10
TN #95	3/1/11	Table of Contents Pages 8, 11-15
TN #94	9/1/10	Pages 2a, 8-8a
TN #93	1/1/10	Page 6
Update (UP) #2	8/24/09	Page 11
TN #91	5/15/09	Page 14

M1510.107 Enrollment Changes

~~D~~. Enrollment Changes

VaCMS is the MA eligibility system of record, however some enrollment functions can only be handled by the DMAS Eligibility and Enrollment Unit. The VaCMS and MMIS systems **must** reflect correct coverage. Appropriate change requests include:

- Retroactive coverage that cannot be approved through VaCMS
- Duplicate linking
- Erroneous death cancellations
- Spenddown end-dates (if open-ended coverage was sent to MMIS)
- Missing newborn coverage
- Approved non-labor and delivery Emergency Services coverage
- Same day void
- Coverage corrections unable to be handled through VaCMS.

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

- First attempt to make the correction in VaCMS with the help of supervisors or other agency resources. If not successful;

- Contact the VDSS Regional *Practice* Consultant (RC) for assistance. The RC will help the local worker make the correction in VaCMS. If not successful;

- If either the agency resources or RC is unable to correct the enrollment in *VaCMS*, they can instruct the worker to submit a coverage correction to DMAS.

- The worker will complete a MMIS Coverage Correction Request Form (DMAS-09-1111-eng). The form can be found on the VDSS intranet. Follow the instructions as provided on the form.

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

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.

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

2. 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

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

M1520.200 RENEWAL REQUIREMENTS

A. Policy

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

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

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

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

12. FAMIS Renewal Period Extension For Declared Disaster Areas

Effective January 1, 2017, if the Governor or the Federal Emergency Management Agency (FEMA) declares Virginia or any area in Virginia to be a disaster area, children enrolled in FAMIS who reside in the declared disaster area may be granted a 90-day extension of the continuous coverage period before their next renewal is due. The next 12-month continuous eligibility period begins the month after the renewal completion date.

The extension of the renewal period applies only to children in a declared disaster area (1) for whom an ex parte renewal cannot be completed and (2) who do not return a renewal form or complete an online or telephonic renewal prior to the renewal due date. The three-month reconsideration period outlined in M1520.200 C.4 also applies to these children if their coverage is cancelled upon not completing a renewal at the end of the 90-day extension period.

E. LTC

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

ABD, as well as F&C individuals over age 18, in the 300% of SSI covered group LTC must complete a contact-based renewal due to the resource requirement.

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

F. Incarcerated Individuals

Incarcerated individuals who have active Medicaid are subject to annual renewals. Renewals for individuals in Department of Corrections and Department of Juvenile Justice facilities will be handled with assistance through the designated facility staff liaison.

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- For individuals incarcerated in DOC facilities, send the renewal form and related correspondence to the DOC Health Services Reimbursement Unit, 6900 Atmore Drive, Richmond, Virginia 23225.

- For individuals in DJJ facilities, send the renewal form and related correspondence to the DJJ Re-entry Services Unit, 600 E. Main Street, Richmond VA 23219.

- For individuals in regional or local jails, send the renewal form and related correspondence to the individual or his authorized representative.

M21 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-21	10/1/21	Pages 4, 5
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

Health benefit plan does not mean:

- Medicaid, FAMIS Plus, or State/Local Hospitalization;
- 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.

***3.* Insured** means having creditable health insurance coverage or coverage under a health benefit plan.

***4.* 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 child resides.

C. Policy A nonfinancial requirement of FAMIS is that the child be uninsured. A child **cannot:**

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

If the child's health insurance is terminated on a day other than the last day of the month, FAMIS coverage begins effective the day after the insurance ended if all other eligibility requirements are met.

M2130.100 FINANCIAL ELIGIBILITY

A. Financial Eligibility

1. Asset Transfer Asset transfer rules do not apply to FAMIS.

2. Resources Resources are not evaluated for FAMIS.

3. Income

a. Countable Income

FAMIS uses the MAGI methodology for counting income contained in chapter M04.

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.

FAMIS uses MAGI methodology for estimating income (see chapter M04).

b. Household Size

FAMIS uses MAGI methodology for determining household size (see Chapter M04).

c. Available Gross Income

Retroactive period (for newborns only) – available income is the gross income actually received in each month in the retroactive period.

Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months.

d. Income Limits

The FAMIS income limit is 200% of the FPL (see Appendix 1 to this subchapter) for the number of individuals in the FAMIS assistance unit. Per MAGI policy in chapter M04, a 5% FPL income disregard is applicable.

5. Spenddown

Spenddown does not apply to FAMIS. If the household's gross income exceeds the FAMIS income limits, the child is not eligible for the FAMIS program regardless of medical expenses.

M2140.100 APPLICATION and CASE PROCEDURES

A. Application Requirements

The policies in subchapters M0120 and M0130 apply.

B. Eligibility Determination

When an application is received and the child is not eligible for Medicaid due to excess income, determine eligibility for FAMIS. In order to complete an eligibility determination, both the FAMIS nonfinancial requirements in M2120.100 and the financial requirements in M2130.100 must be met

The applicant/enrollee must be notified in writing of the required information and the deadline by which the information must be received. Applications must be acted on as soon as possible, but no later than 45 days from the date the signed application was received.

C. Entitlement and Enrollment

1. Begin Date

Children determined eligible for FAMIS are enrolled for benefits effective the first day of the child's application month if all eligibility requirements are met in that month, **but no earlier than the date of the child's birth.**

If the child's health insurance is terminated on a day other than the last day of the month, FAMIS coverage begins effective the day after the insurance ended if all other eligibility requirements are met.

M23 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-21	10/1/21	Pages 6, 7

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

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

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

2. Enrollment and Aid Category

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

- Medicaid AC 090 for income > 109% FPL $\leq$ 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.