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July 1, 2022

Virginia Medical Assistance Eligibility Manual
Transmittal #DMAS-24

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
- IMD – Institution for the Treatment of Mental Diseases
- LDSS – Local Department of Social Services
- LIFC – Low Income Families with Children
- LTSS – Long=term Services and Supports
- MAGI – Modified Adjusted Gross Income
- MES – Medicaid Enterprise System
- MN – Medically Needy
- PHE – Public Health Emergency
- TN – Transmittal

TN #DMAS-24 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, 2022. Note that COVID-19 PHE guidelines continue until the emergency is over and are not referenced in Medical Assistance Eligibility Policy.

The following changes are contained in TN #DMAS-24:

Changed Pages	Changes
Table of Contents Page ii	Updated the Table of Contents.

Changed Pages	Changes
Subchapter M0140 Pages 3, 4	Clarified the application process for offenders nearing release from incarceration.
Chapter M02 Table of Contents Page i	Updated the Table of Contents
Subchapter M0220 Table of Contents Pages 1, 4a, 4b, 5, 6a, 8, 14d, 14e, 15, 17, 18, 21, 22, 23 Page 6b was added as a runover page. Appendix 9 was added. Pages 24-25 were removed.	On pages 1, 4b, 5, 6a, and 6b, added policy on a 90-calendar-day reasonable opportunity period for providing documentation of immigration status. On pages 1, 4a, 8, 14d, 143, 15, 17, 18, 21, 22, and 23, revised the policy on emergency services certification and the enrollment of emergency services only aliens. Appendix 9 was added and contains the emergency services entitlement and enrollment policy prior to July 1, 2022.
Subchapter M0240 Pages 3-6	On pages 3-6, clarified that an individual is given at least a 90-calendar day reasonable opportunity period to apply for a Social Security Number,
Subchapter M0310 Page 36 Page 37 is a runover page.	Revised the post-partum coverage period for pregnant women in Medicaid and FAMIS MOMS. Coverage continues for 12 months following the end of the month in which the pregnancy ends.
Subchapter M0320 Pages 2, 30, 31, 33	Added the new AC for ABD emergency services only aliens. On pages 30, 31, and 33, revised the policy to make it consistent with the changes to M1420.
Subchapter M0330 Pages 1, 2, 15, 18, 29, 31, 32 Page 2a was added as a runover page.	On page 1, clarified that pregnant child is evaluated as a pregnant women for the eligibility determination. On pages 2 and 29, added the new ACs for emergency services only aliens. On pages 15, 31, and 32, revised the post-partum coverage period for pregnant women. On page 18, revised the policy to make it consistent with the changes to M1420.
Chapter M04 Appendix 3 Appendix 5	In Appendix 3, updated the LIFC income limits, effective July 1, 2022. In Appendix 4, updated the Individuals Under Age 21 income limits, effective July 1, 2022.
Subchapter M0710 Appendices 2, 3	In Appendix 2, updated the F&C MN income limits, effective July 1, 2022. In Appendix 3, updated the F&C 100% Standard of Assistance amounts, effective July 1, 2022.

Changed Pages	Changes
Subchapter M0810 Page 2	Updated the ABD MN income limits, effective July 1, 2022.
Subchapter M0830 Page 114	Revised the time period for receiving Refugee Cash Assistance to 12 months.
Chapter M14 Table of Contents Page ii	Updated the Table of Contents.
Subchapter M1410 Pages 2, 9, 13	On pages 2 and 9, revised the policy to make it consistent with the changes to M1420. On page 13, removed obsolete language.
Subchapter M1420 Table of Contents Pages 1-5 Appendix 1 Page 6 was removed. Appendix 1 was removed and Appendix 2 was renumbered to Appendix 1.	Updated the Table of Contents. On pages 1-5, revised the policies regarding the authorization for LTSS.
Subchapter M1430 Page 3	Revised the policy to make it consistent with the changes to M1420.
Subchapter M1460 Pages 11, 47, 48	Revised the policy to make it consistent with the changes to M1420.
Subchapter M1470 Pages 1, 15, 28a, 44, 48-50 Page 14a is a runover page.	On page 1, 28a, 44, 48-50, updated the system references to MES. On page 15, clarified that the DMAS 96 no longer includes information about the length of stay. A physician's written statement or a DMAS 225 from the managed care plan indicating that the individual is expected to return home within six months is required for the home maintenance deduction to be given.
Subchapter M1480 Pages 8a, 8b, 13, 50b, 51, 55, 57,66, 86, 87, 89, 91	On pages 8a, 8b, 13, 55, 57, 86, 87, 89, and 91, revised the policy to be consistent with the changes to M1420. On pages 50b and 51, removed obsolete language. On page 66, updated the Monthly Maintenance Needs Allowance and Excess Shelter Standard, effective July 1, 2022.
Subchapter M1510 Pages 8, 9a, 12-14	On page 8, revised the post-partum coverage period for pregnant women. On pages 9a and 12-14, updated the system references to MES.

Changed Pages	Changes
Subchapter M1520 Pages 1, 3, 10 Pages 2 and 11 are a runover pages	On page 1, added an explanation of the PHE. On pages3 and 10, revised the post-partum coverage period for pregnant women.
Chapter M21 Page 7	Clarified that coverage for a pregnant individual enrolled in FAMIS continues for 12 months following the end of the month in which the pregnancy ends, even if she turns 19.
Chapter M22 Pages 1, 2, 5, 6	On pages 1 and 6, revised the post-partum coverage period for pregnant women. On page 2, clarified that a pregnant woman who obtains health insurance after being enrolled in FAMIS MOMS remains eligible for FAMIS MOMS and that a pregnant woman receiving treatment for a substance use disorder in an IMD can be eligible for FAMIS MOMS in an IMD. On page 5, revised the policy on enrolling pregnant individuals under age 19 in FAMIS MOMS.
Chapter M23 Page 6	Clarified that the 12-month coverage period for pregnant women in Medicaid and FAMIS MOMS is not applicable to 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

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Changed With	Effective Date	Pages Changed
TN #DMAS-24	7/1/22	Page ii
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M07 FAMILIES AND CHILDREN INCOME

M08 ABD INCOME

M11 ABD RESOURCES

M13 SPENDDOWN

M14 LONG-TERM CARE

M0140 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-24	7/1/2022	Page 3, 4
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

A. Offender Application Processing

An application is not to be refused or denied because an applicant is incarcerated. A person is not required to have had an inpatient hospitalization in order to apply for Medicaid. The agency must evaluate the eligibility of all MA enrollees, with respect to circumstances that may change, at least every 12 months unless the enrollee is pregnant (see M1520.200 p.9).

1. New Application

An offender who does not have active Medicaid coverage may apply while incarcerated. Coverage is based on the month of application and can include up to three months of coverage (if requested) prior to the month of application, provided eligibility requirements are met.

Ongoing coverage in AC 108 or AC 109 is effective the first day of the month of application or the date when incarceration begins, whichever is later.

2. Re-entry *Process*

A medical assistance application for an offender with no active Medicaid coverage and an anticipated release date within 45 days is *handled as part of* a "Re-Entry" *process*. This is a new application and an eligibility determination for Medicaid coverage will be made based on the *information as reported or known at the time of* release from the facility.

If the person is approved but is unable to or does not provide a *post-release* address where he will reside (*e.g.* reports as homeless or moving to a temporary shelter) the case will be transferred to the LDSS of his pre-incarceration, if known. If there is no known address, or the individual lived outside of Virginia prior to incarceration and intends to remain in the state, transfer the case to the LDSS where the correctional facility is physically located.

If the application is approved the worker will confirm that a new Commonwealth of Virginia Medicaid Card has been generated and a copy of the Notice of Action sent to the anticipated post-release address.

3. Emergency Services

A non-citizen who meets all Medicaid eligibility requirements except for immigration status, and has received an inpatient hospitalization, may qualify for coverage of emergency medical care. This care must have been provided in a hospital emergency room or as an inpatient in a hospital. Determine eligibility for emergency services using policy in M0220.500 B and enroll eligible individuals using the procedures in M0220.*600*.

M0140.300 CASE MAINTENANCE

A. Ongoing Case Maintenance

Case maintenance may include updates such as when the inmate is moved to another facility, change of an authorized representative, updates to demographics, or other changes affecting Medicaid eligibility or coverage.

Update to an offender's case are handled by the CVIU. Facilities will use a CVIU Communication Form to report changes. Local agencies will use the LDSS to Cover Virginia Communication Form #032-03-0458-00-eng to report changes.

B. Partial Reviews

If a change occurs it may be necessary to re-evaluate the offender's Medicaid coverage. This may include release from incarceration, change of anticipated release date, death, an inmate turning age 65 years old, becoming eligible for Medicare, or end of a pregnancy (see M0140.001 G).

The eligibility worker will handle such changes within 30 days and re-evaluate the offender for continued coverage.

For an offender case that involves a spenddown, see M1350.850.

C. Redetermination

An offender with ongoing approved Medicaid coverage is subject to an annual (every 12 months) redetermination of coverage. The CVIU processes redeterminations of incarcerated individuals (see M1520.200 A).

Do not initiate a renewal of eligibility of a pregnant woman during her pregnancy. Eligibility as a pregnant woman ends effective the last day of the *12th month following the month in which her pregnancy ends.* When eligibility as a pregnant woman ends, prior to the cancellation of her coverage, determine if the woman meets the definition for another Medicaid covered group (see M0310.002). If the woman meets the definition of a full-benefit covered group, determine if an ex parte renewal can be completed or if a renewal form is required and take appropriate action.

Follow Ex Parte Renewal procedure as found in M1520.200 B. 1 if applicable. If unable to process an Ex Parte renewal, see M1520.200 B. 2 and 3 for procedures.

D. Pre-Release Review

An offender with active Medicaid coverage and a reported release date of 45 days or less requires a "Pre-Release" partial review. Eligibility will be evaluated for ongoing Medicaid coverage and processed based on the information as reported or known at the time of release.

If the offender is approved and remains eligible for ongoing Medicaid coverage, the worker will cancel the existing aid category (AC108 or AC109) on the day prior to the actual release date and *enter* coverage in the new AC as of the date of release.

M02 Table of Contents Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-24	7/1/22	Page i
TN #DMAS-15	1/1/20	Pages i, ii
TN #DMAS-10	10/1/18	Page ii
TN #95	3/1/11	Page i
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Changed With	Effective Date	Pages Changed
TN #DMAS-24	7/1/22	Table of Contents Pages 1, 4a, 4b, 5, 6a, 8, 14d, 14e, 15, 17, 18, 21, 22, 23 Page 6b was added as a runover page. Appendix 9 was added. Pages 24-25 were removed.

Changed With	Effective Date	Pages Changed
TN #DMAS-22	1/1/22	Table of Contents Pages 7, 12, 14a, 14b, 14d, 14e, 16, 22, 22a, 24 Appendix 5, pages 1, 3 Appendix 8, pages 1, 3 Appendix 4 was added.
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
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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

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M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS

M0220.001 GENERAL PRINCIPLES

A. Introduction

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

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

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

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

B. Declaration of Citizenship/Alien Status

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

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

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

a. Discrepancy Resolved With SSA Within 90 Days

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

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

b. Verification of C&I Provided Within 90 Days

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

3. Subsequent Applications

If the individual who lost coverage for failure to provide C&I documentation files a subsequent application, a new reasonable opportunity period is not granted. The individual must provide acceptable documentation of C&I prior to approval of the re-application.

M0220.200 ALIEN IMMIGRATION STATUS

A. Introduction

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

B. Procedure

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

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

C. Changes in Immigration Status

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

M0220.201 IMMIGRATION STATUS VERIFICATION

A. Verification Procedures

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

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

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

If the individual does not provide the information necessary to meet the documentation requirements by the 90th day, their coverage must be canceled. Send an advance notice, and cancel coverage at the end of the month in which the 90th day occurs.

NOTE: If the alien claims to be an illegal alien, do not use the verification procedures in this section or the SAVE procedures. Go to section M0220.400 below to determine the illegal alien's eligibility.

B. Documents That Verify Status

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

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

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

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

C. Letters that Verify Status

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

D. Local USCIS Office Documents

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

E. Expired or Absent Documentation

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

If the individual meets all other Medicaid eligibility requirements, do not delay, deny, reduce or terminate the individual's eligibility for Medicaid ***on the basis of alien status****. If the individual does not provide the information necessary to meet the documentation requirements by the 90th day, their coverage must be canceled. Send an advance notice, and cancel coverage at the end of the month in which the 90th day occurs.*

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

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

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

M0220.202 SYSTEMATIC ALIEN VERIFICATION FOR ENTITLEMENTS (SAVE)

A. SAVE

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

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

1. Primary Verification

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

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

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

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

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

Acceptable documentation includes:

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

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

C. Agency Action

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

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

Note: When a secondary verification is requested for an alien with an expired I-551, the G-845 or response to the on-line SAVE query should indicate that the person continues to have lawful permanent resident status. When a secondary verification is requested for an alien with an expired I-151, the G-845 or response to the on-line SAVE query will indicate that the documentation is expired; however, do not delay, deny, reduce or terminate an individual's eligibility for Medicaid on the basis of an expired I-151.

Once information has been obtained through SAVE, aliens with a permanent status are no longer subject to the SAVE process. Aliens with a temporary or conditional status are subject to SAVE at the time of application and when the temporary or conditional status expires.

B. Procedure

1. Step 1

First, determine if the alien receives SSI. Section M0220.305 describes this group of aliens who receive SSI.

If the alien does NOT receive SSI, go to Step 2.

If the alien receives SSI, go to Step 6.

2. Step 2

Second, determine if the alien is an American Indian born in Canada 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)). Section M0220.306 describes this group of aliens.

If NO, go to Step 3. If YES, go to Step 6.

3. Step 3

Third, determine if the alien is a "qualified" alien eligible for full benefits (a full benefit qualified alien).

- Section M0220.310 defines "qualified" aliens.
- Section M0220.311 defines qualified veteran or active duty military aliens.
- Section M0220.312 describes qualified aliens who entered the U.S. before 8-22-96.
- Section M0220.313 describes qualified aliens who entered the U.S. on or after 8-22-96.

If the alien is NOT a qualified alien eligible for full benefits, go to step 4.

If the alien is a qualified alien eligible for full benefits, go to step 6.

4. Step 4

Fourth, determine if the alien is a lawfully residing non-citizen child under age 19 or pregnant woman. See section M0220.314.

If the alien is NOT a lawfully residing non-citizen under age 19 or pregnant woman, go to Step 5.

If the alien is a lawfully residing non-citizen child under age 19 or pregnant woman, go to Step 6.

5. Step 5

The alien is an "**emergency services**" alien. Go to Section M0220.400 which defines emergency services aliens, then to M0220.500 which contains the eligibility requirements applicable to all aliens, then to *M0220.600 D,* which contains the entitlement and enrollment policy and procedures for emergency services aliens.

6. Step 6

Use Section M0220.500, which contains the Medicaid eligibility requirements applicable to all aliens, to determine the alien's Medicaid eligibility. Then use Section M0220.600, which contains the entitlement and enrollment procedures for **full benefit** aliens, to enroll an eligible full benefit alien.

a. 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,

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

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

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

e. 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

f. 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 *M0220.600 D* contains the entitlement and enrollment procedures for emergency services aliens.

C. AFTER 7 Years of Residence in U.S.

1. Refugees — After 7 years of residence in the U.S., a refugee or Amerasian immigrant who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an "emergency services" alien.

2. Asylees — After 7 years have passed since asylum was granted, an asylee who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an "emergency services" alien.

3. Deportees — After 7 years have passed since deportation was withheld, a deportee who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an "emergency services" alien.

4. Cuban or Haitian Entrants — After 7 years of residence in the U.S., a Cuban or Haitian Entrant who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an "emergency services" alien.

5. Afghan and Iraqi Special Immigrants — Medicaid coverage for Afghan and Iraqi Special Immigrants who are eligible in a Medicaid covered group cannot begin earlier than December 26, 2007. After 7 years of residence in the U.S., Afghan and Iraqi Special Immigrants are no longer eligible for full Medicaid benefits and become "emergency services" aliens.

After the applicable limited time period expires, individuals become "emergency services" aliens unless the requirements in M0220.313 B or M0220.314 are met.

D. Services Available To Eligibles — An emergency services alien who meets all Medicaid eligibility requirements is eligible for Medicaid coverage of emergency services only.

E. Entitlement & Enrollment of Eligibles — The Medicaid entitlement policy and enrollment procedures for emergency services aliens are found in section *M0220.600 D* below.

M0220.411 UNQUALIFIED ALIENS

A. Unqualified Aliens

Aliens who do not meet the qualified alien definition M0220.310 above and who are **NOT** lawfully residing non-citizen children under age 19 or pregnant women per M0220.314 above are "unqualified" aliens. Unqualified 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 *M0220.400 and M220.600 D*.

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 are covered for emergency services aliens.

M0220.600 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 (Alien Chart codes A1, A2, A3, B1, B3, C1, CC1, D1, D3, E1, E3, H1, H2, I1, *I3*, J1, J2, K1);
I = legal immigrant children under age 19 only (Alien Chart codes Y1, Y2, Y3)

3. Entry Date THIS FIELD MUST BE ENTERED. Enter the date on which the alien entered the U.S., except for asylees and deportees. For asylees, enter the date asylum was granted. For deportees, enter the date deportation withholding was granted.

4. Appl Dt In this field, Application Date, enter the date of the alien's Medicaid application upon which the eligibility coverage period is based.

5. Coverage Begin Date In this field, Coverage Begin Date, enter the date the alien's Medicaid entitlement begins.

6. Coverage End Date Enter data in this field only if eligibility is a closed period of eligibility in the past. Enter the date the alien's Medicaid entitlement ended.

7. AC Enter the AC code applicable to the alien's covered group.

D. *Emergency Services Only Aliens* Unqualified aliens, and qualified aliens eligible for emergency services only are eligible for Medicaid coverage of emergency medical care only. This care must be provided in a hospital emergency room or as an inpatient in a hospital.

Effective July 1, 2022, an emergency services only alien who meets all other Medicaid eligibility requirements is enrolled in Medicaid with ongoing coverage. Emergency services are no longer certified by the LDSS, and the LDSS does not obtain an emergency services certification.

Applications received prior to July 1, 2022, are subject to the policies and procedures in M0220, Appendix 9. For an individual whose certification period begins prior to July 1, 2022 and expires on or after July 1, 2022, re-evaluate the individual's eligibility for ongoing coverage.

An emergency services alien will be assigned to one of the following Aid Categories (AC) by VaCMS:

- *AC 112 for individuals in the Modified Adjusted Gross Income (MAGI) Adults covered group;*
- *AC 113 for individuals in all other covered groups.*

For cases processed at Cover Virginia, the individual will be enrolled in the appropriate AC, and the case will be transferred to the local agency for ongoing case maintenance. Incarcerated aliens eligible for coverage of emergency services only will be enrolled in AC 112 or 113, and their cases will be maintained by the Cover Virginia Incarcerated Unit.

Once an emergency services alien is found eligible in VaCMS, the enrollment will transfer into the Medicaid enrollment system. Any claims for emergency services will be sent by the provider or treating physician to DMAS for review and reimbursement. Medicaid coverage for emergency services only aliens will be restricted to emergency services (including dialysis).

Appropriate notice must be sent to the applicant of the status of his application and the duration of his eligibility. *The notice must specify that their Medicaid coverage is limited to emergency services.*

Once an emergency services alien is enrolled, any requests for coverage of emergency services will not require a new Medicaid application. The individual will be subject to an annual renewal following the policies in subchapter M1520.200. Follow the policies in subchapter M1520.100 for any reported change to the alien's situation.

A Medicaid card will not be generated for an individual enrolled as an emergency services alien.

The provider or treating physician will be responsible for submitting all claim request for payment of an emergency service for an approved member, including labor & delivery and dialysis. Refer providers to the Virginia Medicaid Hospital Provider Manual, Chapter VI "Documentation Guidelines."

Providers with questions regarding the submission or payment of claims for emergency services may contact DMAS at:

Division of Program Operations
Department of Medical Assistance Services (DMAS)
600 E. Broad Street, Suite 1300
Richmond, VA 23219

EMERGENCY SERVICES ALIENS ENTITLEMENT & ENROLLMENT PRIOR TO JULY 1, 2022

A. Policy

Unqualified aliens, and qualified aliens eligible for emergency services only are eligible for Medicaid coverage of emergency medical care only. This care must be provided in a hospital emergency room or as an inpatient in a hospital.

B. Entitlement-Enrollment Period

If the applicant is found eligible and is certified for emergency services, eligibility exists only for the period of coverage certified by the eligibility worker or DMAS staff on the Emergency Medical Certification form *#DMAS Form 2019NR.*

Once an eligibility period is established, additional requests for coverage of emergency services within 6 months will not require a new Medicaid application. However, each request for Medicaid coverage of an emergency service or treatment requires a new, separate certification and a review of the alien's income and resources and any change in situation that the alien reports.

With the exception of dialysis patients, an emergency services alien must file a new Medicaid application after the 6-month eligibility period is over if the individual receives an emergency service and wants Medicaid coverage for that service.

DMAS will certify dialysis patients for up to a one year period of services without the need for a new Medicaid application. However, due to edits in MMIS, only one six-month certification period at a time can be entered. The worker must manually enter the second certification period of up to six months (as certified by DMAS) after the first period expires.

The dialysis patient must reapply for Medicaid after his full certification period expires.

C. Enrollment Procedures

Once an emergency services alien is found eligible for coverage of emergency services, enroll the individual in the eligibility and enrollment system using the following data:

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

2. Citizenship Status

In this field, Citizenship Status code, enter :

A = Emergency services alien (Alien Chart codes B2, C2, C3, CC2, D2, E2, F3, G3, H3, I2, codes J3 through V3, Z2) other than dialysis patient.

D = Emergency services alien who receives dialysis.

V = Visitor, non-immigrant alien (Alien Chart codes W1, W2, W3).

The Alien Codes Chart is found in Appendix 5 to this subchapter.

NOTE: Foreign visitors are not usually eligible for Medicaid because usually they do not meet the Virginia state residency requirement.

3. **Entry date** — **THIS FIELD MUST BE ENTERED.** Enter the date on which the alien entered the U.S., except for asylees and deportees. For asylees, enter the date asylum was granted. For deportees, enter the date deportation withholding was granted.

4. **App Dt** — In this field, application date, enter the date of the alien's Medicaid application upon which the eligibility coverage period is based.

5. **Covered Dates Begin** — In this field, coverage begin date, enter the begin date of the emergency service(s).

6. **Covered Dates End** — In this field, coverage end date, enter the date when the alien's emergency service(s) ends. When the emergency service(s) received was related to labor and delivery, the end date includes the day of discharge even though it is not counted to determine the length of stay for certification purposes.

7. **AC** — Enter the code applicable to the alien's covered group.

D. Notices

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

The USCIS requires that all benefit applicants who are denied benefits based **solely or in part** on the SAVE response be provided with adequate written notice of the denial as well as the information necessary to contact USCIS, so that the individual may correct his records in a timely manner, if necessary. The fact sheet, "Information for Applicants: Verification of Immigration Status and How to Correct Your Record with USCIS" (Form # 032-03-0427-00) must be included with the Notice of Action when benefits are denied, **including the approval of emergency-services-only Medicaid coverage**, and with the Advance Notice of Proposed Action when benefits are subsequently cancelled based on the results of a SAVE inquiry. The fact sheet is available at https://fusion.dss.virginia.gov/Portals/[bp]/Files/SAVE/Inform%20for%20Applicants%20Verification%20of%20Immigration%20Status.pdf?ver=2019-05-29-135745-363.

A Medicaid card will not be generated for an individual enrolled as an emergency services alien.

The agency must contact the provider(s) and supply the eligibility dates and Medicaid number for billing purposes by sending a copy of the completed Emergency Medical Certification *#DMAS Form 2019NR*, to the provider(s).

M0240 Changes

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

M0240.100 APPLICATION FOR SSN

A. Policy

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

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

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

1. Newborns

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

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

2. Failure to Apply for SSN

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

3. Retroactive Eligibility

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

M0240.200 FOLLOW-UP REQUIREMENTS FOR SSN APPLICATION

A. Applicant Applied for SSN

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

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

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

*If a date is necessary w*hen 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 *Calendar* Days

After enrollment of the eligible individual, the agency must follow-up within 90 *calendar* days of the Social Security number application date or 120 *calendar* 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. *If the individual has not applied for an SSN, send advance notice that the individual is no longer eligible for coverage and cancel coverage.*

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.

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.

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 *calendar* 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 *calendar 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 *calendar* 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.

M0310 Changes
Page 1 of 2

Changed With	Effective Date	Pages Changed
TN #DMAS-24	7/1/22	Page 36 Page 37 is a runover page.
TN #DMAS-23	4/1/22	Pages 2, 5, 6, 6a
TN #DMAS-22	1/1/22	Page 28
TN #DMAS-20	7/1/21	Page 6 Pages 5 and 5a are runover pages.
TN #DMAS-18	1/1/21	Table of Contents, page ii Pages 26, 27 Appendix 1 was removed. Appendix 2 was renumbered to Appendix 1.
TN #DMAS-17	7/1/20	Page 7 Pages 8 and 9 are runover pages.
TN #DMAS-15	1/1/20	Pages 29, 30
TN #DMAS-14	10/1/19	Pages 24, 26, 27, 40
TN #DMAS-13	7/1/19	Pages 24 Page 24a is a runover page.
TN #DMAS-12	4/1/19	Pages 8, 9, 13
TN #DMAS-10	10/1/18	Table of Contents, page ii Pages 1-4 Page 40 was added.
TN #DMAS-9	7/1/18	Page 35 Appendix 2, Page 1
TN #DMAS-8	4/1/18	Page 9
TN #DMAS-7	1/1/18	Pages 34, Appendix 2, page 1
TN #DMAS-5	7/1/17	Pages 13, 37, 38
TN #DMAS-4	4/1/17	Pages 24, 30a Page 23 is a runover page. Page 24a was added as a runover page.

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

The definition of "pregnant woman" *for the purposes of the eligibility determination and covered group designation* is met for *12 months* following the last day the woman was pregnant regardless of the reason the pregnancy ended, and continues to be met until the last day of the month in which the *12th month* occurs.

After a woman's eligibility as a pregnant woman is established for Medicaid or FAMIS MOMS, her entitlement continues for 12 months following the end of the month in which her pregnancy ends, regardless of income changes. Medicaid and FAMIS MOMS coverage ends the last day of the 12th month.

B. Procedures

1. No Further Verification of Pregnancy Required

If the woman has indicated on the application that she is pregnant or subsequently reports a pregnancy, no further information regarding her pregnancy is to be requested nor verification is to be required unless the agency has reason to question the applicant's statement that she is pregnant.

If a woman is applying after the end of a pregnancy, her report of the birth or pregnancy end date is sufficient to establish (1) for purposes of retroactive coverage, her pregnancy in the three months prior to the child's birth month or pregnancy end date, or (2) for purposes of new, prospective coverage through the end of the 12-month postpartum period, her pregnancy in the twelve months prior.

2. Covered Groups Eligibility

A pregnant woman may be eligible for Medicaid if she meets all of the Medicaid eligibility requirements including any one or more of the covered groups. Once eligibility is established in any covered group, changes in income do not affect her eligibility as long as she continues to meet the definition of a pregnant woman and all non-financial eligibility requirements.

See section M0330.400 for the pregnant woman covered group requirements and M0330.801 for the MN Pregnant Woman requirements.

M0310.125 QDWI

A. Qualified Disabled & Working Individuals (QDWI)

QDWI is the short name used to designate the Medicaid covered group of Medicare beneficiaries who are "Qualified Disabled and Working Individuals." A qualified disabled and working individual means an individual

- who is entitled to enroll for Medicare Part A,
- whose resources do not exceed twice the maximum amount of resources that an individual or couple may have and be eligible for SSI,
- whose income does not exceed 200% of the federal poverty limit,
- who is NOT otherwise eligible for Medicaid.

B. Procedure

QDWI is a mandatory covered group that the state plan must cover for the purpose of paying the beneficiary's Medicare Part A premium. See section M0320.604 for the procedures to use to determine if an individual meets the QDWI covered group.

M0310.126 Qualified Individuals

A. Qualified Individuals (QI)

QI is the short name used to designate the Medicaid covered group of "Qualified Individuals." A qualified individual means a Medicare beneficiary

- who is entitled to Medicare Part A,
- who has resources that are within the resource limits for the Medicare Savings Programs (MSPs). See chapter section M1110.003 for the current resource limits; and
- whose income is equal to or more than 120% of the federal poverty level (FPL) and is less than 135% FPL.

B. Procedure

QI is a mandatory covered group that the State Plan must cover for the purpose of paying the Medicare Part B premium for the QI. See section M0320.603 for the procedures used to determine if an individual meets the QI covered group.

M0310.127 QMB

A. Qualified Medicare Beneficiary (QMB)

QMB is the short name used to designate the Medicaid covered group of "Qualified Medicare Beneficiary." A qualified Medicare beneficiary means an individual

- who is entitled to enroll for Medicare Part A,
- who has resources that are within the resource limits for the Medicare Savings Programs (MSPs). See chapter section M1110.003 for the current resource limits; and
- whose income does not exceed 100% of the FPL.

B. Procedure

QMB is a mandatory covered group that the state plan must cover for the purpose of paying the beneficiary's Medicare premiums and cost sharing expenses. See section M0320.601 for the procedures to use to determine if an individual meets the QMB covered group.

M0310.128 RSDI

A. Retirement, Survivors & Disability Insurance (RSDI)

Retirement, Survivors & Disability Insurance (RSDI) is another name for Old Age, Survivors & Disability Insurance (OASDI) - the federal insurance benefit program under Title II of the Social Security Act that provides cash benefits to workers and their families when the workers retire, become disabled or die.

M0320 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-24	7/1/22	Pages 2, 30, 31, 33
TN #DMAS-23	4/1/22	Page 27
TN #DMAS-22	1/1/22	Pages 11, 26a, 27
TN #DMAS-20	7/1/21	Pages 24, 26-29
TN #DMAS-19	4/1/21	Pages 26a, 29
TN #DMAS-18	1/1/21	Pages 11, 22, 26, 27
TN #DMAS-17	7/1/20	Pages 24. 25. 26, 27 Page 26a was added as a runover page.
TN #DMAS-15	1/1/20	Pages 11, 26, 27, 29
TN #DMAS-14	10/1/19	Page 40
TN #DMAS-13	7/1/19	Pages 1, 24-27
TN #DMAS-11	1/1/19	Pages 2a, 11, 35, 37
TN #DMAS-10	10/1/18	Page 1 1a added as a runover page
TN #DMAS-9	7/1/18	Page 2, 17
TN #DMAS-7	1/1/18	Page 2, 3, 4, 11, 26-27.
TN #DMAS-4	4/1/17	Page 26
TN #DMAS-3	1/1/17	Pages 11, 27, 29, 40, 41, 44, 45, 52
TN #DMAS-2	10/1/16	Pages 4, 15, 16, 18, 20, 22, 30, 33, Pages 39- 41, 43-45, 48, 51, 52, 55
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 1, 11, 25-27, 46-49 Page 50 is a runover page.
TN #100	5/1/15	Pages 6, 11, 24, 25-27, 29-30
TN #99	1/1/14	Page 11
TN #98	10/1/13	Pages 1, 54, 55.
UP #9	4/1/12	Pages 11, 26, 32, 34-37, 45, 46, 55
TN #97	9/1/12	Table of Contents Pages 1-56 (all pages)
UP #6	4/1/12	Pages 11, 12, 46a
TN #96	10/1/11	Table of Contents Pages 46f-50b Page 50c deleted
TN #95	3/1/10	Pages 11, 12, 42c, 42d, 50, 53, 69 Pages 70, 71 Page 72 added.
TN #94	9/1/10	Pages 49-50b
UP #3	3/1/10	Pages 34, 35, 38, 40, 42a, Pages 42b, 42f
TN #93	1/1/10	Pages 11-12, 18, 34-35, 38 Pages 40, 42a-42d, 42f-44, 49 Pages 50c, 69-71
UP #2	8/24/09	Pages 26, 28, 32, 61, 63, 66
Update (UP) #1	7/1/09	Pages 46f-48
TN #91	5/15/09	Pages 31-34 Pages 65-68

D. Aid Categories *Aid Categories (ACs) are used in the eligibility and enrollment systems to denote covered group. Some covered groups have multiple ACs for designating disability status, age, income, and other demographic information. These ACs may be used for reporting and funding purposes. The policy sections for each ABD covered group in this subchapter contain the assigned ACs*

Exception–ABD individuals of any age who have been determined to be eligible for Medicaid coverage of emergency services based on the alien status requirement policies in subchapter M0220 will be assigned to AC 113 regardless of their covered group.

M0320.001 ABD CATEGORICALLY NEEDY

A. Introduction To be eligible in an ABD covered group, the individual must meet all Medicaid non-financial requirements in chapter M02 and an "Aged," "Blind" or "Disabled" definition in subchapter M0310. If he does not, then go to the Families & Children covered groups in subchapter M0330.

B. Procedures The policy and procedures for determining whether an individual meets an ABD CN covered group are contained in the following sections:

- M0320.202 Conversion Cases
- M0320.203 Former SSI/AG Recipients
- M0320.206 Protected Adult Disabled Children
- M0320.207 Protected SSI Disabled Children
- M0320.300 ABD with Income ≤ 80% FPL
- M0320.400 MEDICAID WORKS
- M0320.501 ABD In Medical Institution, Income ≤ 300% SSI
- M0320.502 ABD Receiving CBC Services
- M0320.503 ABD Hospice
- M0320.601 Qualified Medicare Beneficiary (QMB)
- M0320.602 Special Low-income Medicare Beneficiary (SLMB)
- M0320.603 Qualified Individuals (QI)
- M0320.604 Qualified Disabled & Working Individual (QDWI))

M0320.100 ABD CASH ASSISTANCE COVERED GROUPS

A. Legal base Medicaid eligibility for certain individuals is based on their receipt of cash assistance from another benefit program that has a cash assistance component.

B. Procedure The policy and procedures for cash assistance recipients are found in the following sections:

- M0320.101 SSI Recipients
- M0320.102 AG Recipients

Current Enrollee

1. Cancel current coverage using Cancel Code 042.
2. Reinstate in AC 059 beginning the first day of the following month. **Use the date the MEDICAID WORKS Agreement was signed for the application date**.

Send a Notice of Action to the applicant/recipient advising him of his eligibility and acceptance into MEDICAID WORKS. Do not send the Advance Notice of Proposed Action when a recipient moves to MEDICAID WORKS, because his Medicaid coverage has not been reduced or terminated.

Eligibility for MEDICAID WORKS continues as long as the enrollee continues to:

- be employed,
- meet the definition of disability or blindness,
- meet the age limitation, and
- does not exceed the income and resource limits for MEDICAID WORKS.

The MEDICAID WORKS enrollee continues to meet the disability criteria as long as SSA has not completed a Continuing Disability Review and has not determined that the individual no longer has a disabling condition. The fact that the MEDICAID WORKS enrollee is earning over the SSA substantial gainful activity amount has no bearing on whether he meets the disability criteria. If the enrollee's disability status is unclear, contact a Regional Medical Assistance Program Consultant for assistance.

The individual's continuing eligibility must be determined at least every 12 months.

If the individual is no longer eligible for MEDICAID WORKS, the eligibility worker must determine whether the individual remains eligible in any other covered group. **The policy in M0320.400 G above must be reviewed to determine whether the resource exclusion safety net rules apply**. If the individual is not eligible for Medicaid in any other covered group, coverage shall be cancelled effective the first of the month following the expiration of the 10-day advance notice.

M0320.500 300% of SSI INCOME LIMIT GROUPS

A. Introductions

The 300% of SSI income limit groups are for individuals who meet the definition of an institutionalized individual or have been *authorized* for long-term care (LTC) services (see M1410. B. 2) and are not eligible in any other full-benefit Medicaid covered group.

B. Covered Groups

- M0320.501 ABD in a Medical Institution, Income $\leq$ 300% of SSI
- M0320.502 ABD Receiving Medicaid Waiver Services (CBC)
- M0320.503 ABD Hospice

M0320.501 ABD IN MEDICAL INSTITUTION, INCOME ≤ 300% SSI LIMIT

A. Policy

42 CFR 435.236 - The state plan includes the covered group of aged, blind or disabled individuals in medical institutions who

- meet the Medicaid resource requirements, and
- have income that does not exceed 300% of the SSI individual payment limit (see M0810.002 A. 3).

Individuals who are *authorized* for nursing facility care prior to admittance and are likely to receive the services for 30 days or more consecutive days may also be included in this covered group.

B. Financial Eligibility

1. Asset Transfer

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

2. Resources

a. Resource Eligibility – Married Individual

If the individual is married, use the resource policy in subchapter M1480. Evaluate countable resources using ABD resource policy in chapter S11.

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

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

b. Resource Eligibility - Unmarried Individual

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. Pay close attention to:

1) equity In non-exempt property contiguous to the individual's home which exceeds $5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property; and

2) ownership of his/her former residence when the individual is in an institution for longer than 6 months. Determine if the former home is excluded in M1130.100 D.

If the individual is a blind or disabled child, DO NOT DEEM any resources or income from the child's parent; count only actual resources the parent makes available to the child. If current resources are within the limit, go on to determine income eligibility.

M0320.502 ABD RECEIVING MEDICAID WAIVER SERVICES (CBC)

A. Policy

42 CFR 435.217 - The state plan includes the covered group of aged, blind or disabled individuals in the community who

- would be eligible for Medicaid if institutionalized;
- are *authorized* to receive Medicaid waiver services and have selected the option to receive Medicaid waiver services in lieu of nursing facility services;
- in the absence of the waiver services would require the level of care furnished in a hospital, nursing facility or ICF-MR; and
- have income that does not exceed 300% of the SSI individual payment limit (see M0810.002 A. 3).

Do not wait until the individual starts to receive the waiver services to determine eligibility in this covered group. Determine eligibility in this covered group if the individual is *authorized* (see subchapter M1420) to receive Medicaid waiver services and has selected the option to receive Medicaid waiver services in lieu of nursing facility services. Presume the individual will receive the services and go on to determine financial eligibility using the policy and procedures in C. below.

If the individual's eligibility was determined as an institutionalized individual prior to the receipt of waiver services, the EW must verify the receipt of Medicaid CBC services within 30 days of the date of the Notice of Action on Medicaid. If Medicaid CBC services 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.

B. Financial Eligibility

1. Asset Transfer

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

2. Resources

a. Resource Eligibility - Unmarried Individual

All of the individual’s resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements in chapter S11 (ABD Resources). Pay close attention to:

1) equity in non-exempt property contiguous to the individual’s home which exceeds $5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property, and
2) ownership of his/her former residence when the individual has been away from his home property for longer than 6 months. Determine if the home property is excluded in M1130.100.

DO NOT DEEM any resources from a blind or disabled child’s parent

M0330 Changes
Page 1 of 2

Changed With	Effective Date	Pages Changed
TN #DMAS-24	7/1/22	Pages 1, 2, 15, 18, 29, 31, 32 Page 2a was added as a runover page.
TN #DMAS-23	4/1/22	Table of Contents Pages 1, 2, 5, 7, 8, 29, 37, 39, 40
TN #DMAS-20	7/1/21	Pages 1, 13, 14
TN #DMAS-19	4/1/21	Pages 14, 26
TN #DMAS-14	10/1/19	Pages 1, 2, 10a
TN #DMAS-12	4/1/19	Pages 26, 28
TN #DMAS-11	1/1/19	Pages 1, 2, 12, 14-16, 24, 25
TN #DMAS-10	10/1/18	Table of Contents Page 1-2, 30 Page 10a-b were added as runover pages.

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, adoption assistance child with special needs for medical or rehabilitative care, or an individual under age 21, evaluate in these groups first.
2. If the child meets the definition of a *pregnant woman or* 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 *authorized* 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 an adoption assistance child with special needs for medical or rehabilitative care, but has income in excess of the appropriate F&C CN income limit, evaluate as MN.

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

1. If the individual 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, LIFC individual, or pregnant woman *but* is in a medical institution, has been *authorized* for Home and Community Based Services or has elected hospice, evaluate in the appropriate F&C 300 % of SSI covered group.

   If the individual is a parent or caretaker-relative of a dependent child and in a medical institution, the stay must be temporary while receiving treatment, rehabilitation, etc. for him to meet the definition of living in the home with the dependent child. There are no time limits on the amount of time the parent can be in a medical institution as long as he intends to return home. Verify with the parent the reason he is in a medical facility and ask about the intent to return home.

7. If the individual has excess income for full coverage in a Medicaid covered group and is between the ages of 19 and 64, evaluate for Plan First coverage.

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

M0330.100 FAMILIES & CHILDREN CATEGORICALLY NEEDY

A. Introduction

An F&C individual must be a child under age 19 or must meet the adoption assistance, dependent child, foster care, parent or caretaker-relative of a dependent child living in the home, pregnant woman, or BCCPTA definition, or must have applied for Plan First.

The F&C covered groups are divided into the categorically needy (CN) and medically needy (MN) classifications. Always evaluate eligibility in the categorically needy groups and FAMIS before moving to MN.

B. Procedure

The policy and procedures for determining whether an individual meets an F&C CN covered group are contained in the following sections:

M0330.100 Families & Children Categorically Needy Groups
M0330.105 IV-E Foster Care & IV-E Adoption Assistance;
M0330.107 Individuals Under Age 21;
M0330.108 Adoption Assistance Children With Special Needs for Medical or Rehabilitative Care;
M0330.109 Former Foster Care Children Under Age 26 Years
M0330.200 Low Income Families With Children;

M0330.250 MAGI Adults Group
M0330.300 Child Under Age 19 (FAMIS Plus);
M0330.400 Pregnant Women & Newborn Children;
M0330.500 300% of SSI Covered Groups
M0330.600 Plan First--Family Planning Services;
M0330.700 Breast and Cervical Cancer Prevention and Treatment Act

C. Eligibility Methodology Used

With the exception of the F&C 300% of SSI covered groups for institutionalized individuals, the F&C covered groups that require a financial eligibility determination use Modified Adjusted Gross Income (MAGI) methodology for evaluating countable income. The policies and procedures for MAGI methodology are contained in chapter M04 unless otherwise specified.

MAGI methodology is not applicable to the F&C 300% of SSI covered groups. See M0330.501 – M0330.503 for information regarding the applicable financial eligibility policies.

D. Aid Categories

Aid Categories (ACs) are used in the eligibility and enrollment systems to denote covereage groups. Some covered groups have multiple ACs for designating disability status, age, income, and other demographic information. These ACs may be used for reporting and funding purposes. The policy sections for each CN covered group contain the assigned ACs.

Exception—F&C individuals who have been determined to be eligible for Medicaid coverage of emergency services only based on the alien status requirement policies in subchapter M0220 will be assigned to the following ACs regardless of their covered group:

- ***AC 112 for individuals in the Modified Adjusted Gross Income (MAGI) Adults covered group;***
- ***AC 113 for all other individuals.***

M0330.105 IV-E FOSTER CARE OR IV-E ADOPTION ASSISTANCE RECIPIENTS

A. Policy

42 CFR 435.145--The federal Medicaid law requires the State Plan to cover children who are eligible for foster care or adoption assistance payments under Title IV-E of the Social Security Act.

For example, a married pregnant woman applies for Medicaid on October 10. She received a medical service in the retroactive period. Her expected delivery date is January 15. She and her husband have been unemployed since June 23. Her husband began earning $3,000 a month on October 9; she remains unemployed. Since they had no income during the retroactive period, she is found eligible for retroactive coverage effective July 1.

Because her available income (from her husband) changed after she established eligibility on July 1, the change in income does not affect her eligibility and she remains eligible for Medicaid in October and subsequent months until she no longer meets the pregnant woman definition or other nonfinancial requirements.

b. Newborn

Income changes do NOT affect the certain newborn's eligibility for the first year of the child's enrollment as a certain newborn.

The mother's failure to complete a renewal of her own eligibility and/or the eligibility of other children in the household does NOT affect the eligibility of the certain newborn.

5. Income Exceeds Limit

If the pregnant woman's income exceeds the 143% FPL limit, she is not eligible in this covered group. Determine her eligibility for FAMIS MOMS. If the pregnant woman is not eligible for FAMIS MOMS, evaluate her eligibility as MN (see M0330.801). Ineligible women, other than incarcerated women, must be referred to the Health Insurance Marketplace for evaluation for the APTC.

D. Entitlement

Eligible pregnant women are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group if the woman was pregnant during the retroactive month(s).

The newborn's Medicaid coverage begins the date of the child's birth. A renewal must be completed for the newborn in the last month in which the child meets the Newborn Children Under Age 1 covered group and must include SSN or proof of application, as well as verification of income.

Eligible pregnant women and newborns are entitled to all Medicaid covered services as described in chapter M18.

After her eligibility is established as a pregnant woman, the woman's Medicaid entitlement continues *for 12 months following the end of the month in which her pregnancy ends,* regardless of income changes. Medicaid coverage ends the last day of *the 12th month*.

If a Medicaid or FAMIS MOMS recipient who applied effective November 1, 2021 [or a CHIPRA214 (lawfully residing individual) who applied effective April 1, 2022] whose pregnancy has ended reapplies for coverage after July 1, 2022, she is entitled to the remainder of the 12 month post-partum period she would have received had her coverage not been canceled.

E. Enrollment

The AC for pregnant women who are not incarcerated is 091. The AC for pregnant women who are incarcerated is 109. The AC for newborns born to women who were enrolled in Medicaid is 093.

2. Not QMB

If the individual is NOT a Qualified Medicare Beneficiary (QMB) - the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - the AC is "060."

E. Ineligible In This Covered Group

If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy. For unmarried individuals, redetermine resources using the F&C medically needy policy in chapter M06. Do not recalculate resources of a married individual.

Determine the individual's eligibility as QMB, SLMB, QDWI or QI if *the individual* has Medicare Part A.

M0330.502 F&C RECEIVING WAIVER SERVICES (CBC)

A. Policy

42 CFR 435.217 - The State Plan includes the covered group of individuals who meet a families & children definition who live in the community, who

would be eligible for Medicaid if institutionalized;

are *authorized* to receive Medicaid waiver services and have selected the option to receive Medicaid waiver services in lieu of nursing facility care;

in the absence of the waiver services would require the level of care furnished in a hospital, nursing facility or ICF- ID; and

have income that does not exceed 300% of the SSI individual payment limit (see M0810.002 A. 3).

B. Nonfinancial Eligibility

An individual who receives Medicaid waiver services is eligible in this covered group if *the individual*:

1. meets the nonfinancial requirements in M02.
2. is not in a medical institution, may be in a residential institution that meets the institutional status requirements; and
3. is a child under age 18, under age 21 and meets the adoption assistance or foster care definition, a parent or caretaker-relative of a dependent child, or a pregnant woman as defined in M0310.

Verify receipt of Medicaid waiver services; use the procedures in chapter M14.

Do not wait until the individual starts to receive the waiver services to determine eligibility in this covered group. Determine eligibility in this covered group if the *individual* is *authorized* to receive Medicaid waiver services, has not been placed on a waiting list for services, and has selected the option to receive Medicaid waiver services in lieu of nursing facility services. Presume that the *individual* will receive the services and go on to determine financial eligibility using the policy and procedures in C. below. If determined eligible, the individual is not entitled to Medicaid in this covered group unless the policy in item D. below is met. See item D. below for the entitlement and enrollment procedures.

F. Enrollment

The aid category for BCCPTA individuals is "066".

G. Benefit Package

The BCCPTA group is a full-benefit covered group. All Medicaid-covered services are available to BCCPTA enrollees, including long-term care in a facility or in a community-based care waiver.

H. Renewal

Annual renewal requirements are applicable to the BCCPTA covered group. At the time of the annual renewal, the recipient must provide a statement from a medical provider verifying continued treatment for breast or cervical cancer. The BCCPTA Redetermination (form #032-03-653) is used for the renewal. See M1520.200 for renewal requirements.

M0330.800 FAMILIES & CHILDREN MEDICALLY NEEDY GROUPS

A. Introduction

An F&C medically needy individual must

- be a child under age 18, or 21, or
- meet the adoption assistance, foster care or pregnant woman definition in subchapter M0310.

B. Procedure

The policy and procedures for determining whether an individual meets an F&C MN covered group are contained in the following sections:

- M0330.801 Pregnant Women;
- M0330.802 Newborn Children Under Age 1;
- M0330.803 Children Under Age 18;
- M0330.804 Individuals Under Age 21;
- M0330.805 Adoption Assistance Children With Special Needs for Medical or Rehabilitative Care.

C. Referral to Health Insurance Marketplace

When an individual meets an F&C MN covered group is not eligible solely due to excess income and is placed on a MN spenddown, the individual must be referred to the Health Insurance Marketplace (HIM) so that the applicant's eligibility for the APTC can be determined.

Note: Individuals with Medicare are not referred to the HIM.

D. Aid Categories

Aid Categories (ACs) are used in the eligibility and enrollment systems to denote coverage groups. Some covered groups have multiple ACs for designating disability status, age, income, and other demographic information. These ACs may be used for reporting and funding purposes. The policy sections for each MN covered group contain the assigned ACs

Exception–MN individuals of any age who have been determined to be eligible for Medicaid coverage of emergency services based on the alien status requirement policies in subchapter M0220 will be assigned to AC 113 regardless of their covered group.

2. Resources

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. The resources policy in chapter M06 applies.

If the individual is married and institutionalized, use the resource policy in subchapter M1480.

a. Resources Within The Limit

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

b. Resources Exceed The Limit

If current resources exceed the limit, she is not eligible in this covered group.

3. Income

Determine MN countable income according to chapter M07. Subtract the appropriate exclusions. Compare the total countable income to the MN income limit for the individual's locality group (see M0710, Appendix 5 for the MN income limits).

4. Income Exceeds MN Limit

Because the MN pregnant woman's income exceeds the 133% FPL limit, it also exceeds the MN limit. She becomes eligible in this MN covered group when she has incurred medical expenses equal to the difference between her income and the MN income limit (spenddown). See chapter M13 for spenddown policy and procedures.

5. Income Changes

Any changes in a medically needy pregnant woman's income that occur after her eligibility has been established, **do not** affect her eligibility as long as she meets the pregnant woman definition, the nonfinancial and MN resource eligibility requirements.

The spenddown liability must be recalculated when an income change is reported prior to eligibility being established.

C. Entitlement

Eligible women in this MN group are entitled to full Medicaid coverage beginning the first day the spenddown is met. The woman is entitled to MN coverage *for 12 months following the end of the month in which her pregnancy ends*. Her MN Medicaid coverage ends the last day of *the 12th month following the month her pregnancy ends*, regardless of when the spenddown period ends, without the need for a new application or an additional spenddown period.

Retroactive coverage is applicable to this covered group.

Example:

A pregnant woman applied for Medicaid on January 5, *2022*. Her estimated date of delivery is May 10, *2022*. Her income exceeds the income limit for 2 persons for Medicaid and FAMIS MOMS. Her resources are within the medically needy resource limit for the retroactive period and ongoing, and she is placed on a retroactive spenddown for the period October 1, *2021,* through December 31, 2021, and a prospective spenddown for the period January 1, *2022* through June 30, *2022*. She delivered the child and met the spenddown on May 20, *2022*. She was enrolled in MN coverage effective May 20, *2022*. Although her spenddown period ends on June 30, her MN Medicaid coverage does not end until May 31, *2023, the last day of the 12th month following the end of the month the child was born.*

Note: The eligibility worker must evaluate the individual's eligibility in all other covered groups prior to taking action to cancel the MN coverage.

D. Enrollment

Eligible individuals in this group are enrolled in AC 097.

Changed With	Effective Date	Pages Changed
TN #DMAS-24	7/1/22	Appendix 3 Appendix 5
TN #DMAS-23	4/1/22	Pages 16b, 18, 32 Appendix 1, pages 1-2 Appendix 2, pages 1-2 Appendices 6 and 7
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

LIFC Income Limits

Effective *7/1/2022*

Group I

Household Size	Monthly Amount	Annual Amount
1	*$282*	*$3,384*
2	*429*	*5,148*
3	*544*	*6,528*
4	*659*	*7,908*
5	*778*	*9,336*
6	*875*	*10,500*
7	*987*	*11,844*
8	*1,106*	*13,272*
Additional	*117*	*1,404*

Group II

Household Size	Monthly Amount	Annual Amount
1	*$369*	*$4,428*
2	*528*	*6,336*
3	*662*	*7,944*
4	*791*	*9,492*
5	*930*	*11,160*
6M0310	*1,048*	*12,576*
7	*1,174*	*14,088*
8	*1,299*	*15,588*
Additional	*133*	*1,596*

Group III

Household size	Monthly Amount	Annual Amount
1	*$554*	*$6,648*
2	*740*	*8,880*
3	*906*	*10,872*
4	*1,063*	*12,756*
5	*1,256*	*15,072*
6	*1,396*	*16,752*
7	*1,554*	*18,648*
8	*1,718*	*20,616*
Additional	*160*	*1,920*

INDIVIDUALS UNDER AGE 21 INCOME LIMITS

EFFECTIVE *7/1/22*

Group I

Household Size	Monthly Income Limit	Annual Income Limit
1	*$269*	*$3,228*
2	*419*	*5,028*
3	*534*	*6,408*
4	*648*	*7,776*
5	*762*	*9,144*
6	*854*	*10,248*
7	*956*	*11,472*
8	*1,084*	*13,008*
Each additional person add	*113*	*1,356*

Group II

Household Size	Monthly Income Limit	Annual Income Limit
1	*$366*	*$4,392*
2	*529*	*6,348*
3	*660*	*7,920*
4	*792*	*9,504*
5	*935*	*11,220*
6	*1,151*	*13,812*
7	*1,174*	*14,088*
8	*1,307*	*15,684*
Each additional person add	*131*	*1,572*

Group III

Household Size	Monthly Income Limit	Annual Income Limit
1	*$486*	*$5,832*
2	*650*	*7,800*
3	*786*	*9,432*
4	*920*	*11,040*
5	*1,087*	*13,044*
6	*1,198*	*14,376*
7	*1,330*	*15,960*
8	*1,462*	*17,544*
Each additional person add	*132*	*1,584*

M0710 Changes

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

F&C MEDICALLY NEEDY INCOME LIMITS

EFFECTIVE 7/1/22

GROUP 1			GROUP II		GROUP III	
# of Persons in Family/Budget Unit	**Semi-Annual Income**	**Monthly Income**	**Semi-Annual Income**	**Monthly Income**	**Semi-Annual Income**	**Monthly Income**
1	*$2138.14*	*$356.35*	*$2467.09*	*$411.18*	*$3207.24*	*$534.54*
2	*2721.95*	*453.65*	*3037.88*	*506.31*	*3866.55*	*644.42*
3	*3207.24*	*534.54*	*3536.17*	*589.36*	*4358.58*	*726.43*
4	*3618.44*	*603.07*	*3952.68*	*658.78*	*4769.81*	*794.96*
5	*4029.64*	*671.60*	*4358.40*	*726.40*	*5159.12*	*859.85*
6	*4440.82*	*740.13*	*4769.77*	*794.96*	*5592.16*	*932.02*
7	*4852.00*	*808.66*	*5159.12*	*859.85*	*6003.34*	*1000.55*
8	*5345.43*	*890.90*	*5674.39*	*945.73*	*6414.55*	*1069.09*
9	*5838.87*	*973.14*	*6227.08*	*1037.84*	*7010.35*	*1168.39*
10	*6414.55*	*1069.09*	*6743.50*	*1123.91*	*7483.65*	*1247.27*
Each add'l person	*552.59*	*92.09*	*552.59*	*92.09*	*552.59*	*92.09*

F&C 100% STANDARD OF ASSISTANCE

EFFECTIVE 7/1/22

(Used as the F&C Deeming Standard)

Group I

Household Size	Income Limit
1	*$277*
2	*422*
3	*535*
4	*649*
5	*764*
6	*861*
7	*971*
8	*1,086*
Each additional person add	*115*

Group II

Household Size	Income Limit
1	*$362*
2	*518*
3	*651*
4	*778*
5	*913*
6	*1,029*
7	*1,152*
8	*1,286*
Each additional person add	*131*

Group III

Household Size	Income Limit
1	*$544*
2	*769*
3	*891*
4	*1,046*
5	*1,234*
6	*1,373*
7	*1,528*
8	*1,690*
Each additional person add	*157*

M0810 Changes

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

3. Categorically Needy 300% of SSI

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

Family Size Unit	2021 Monthly Amount	2022 Monthly Amount
1	$2,382	$2,523

4. ABD Medically Needy

a. Group I	*7/1/21 – 6/30/22*		*7/1/22 (To be added by 7/1/22)*	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,019.02	$336.50	*$2,138.14*	*$356.35*
2	2,570.31	428.38	*2,721.95*	*453.65*

b. Group II	*7/1/21 – 6/30/22*		*7/1/22*	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,329.65	$388.27	*$2,467.09*	*$411.18*
2	2,868.64	478.40	*3,037.88*	*506.31*

c. Group III	*7/1/21 – 6/30/22*		*7/1/22*	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$3,028.56	$504.76	*$3,207.24*	*$534.54*
2	3,651.15	608.52	*3,866.55*	*644.42*

5. ABD Categorically Needy

For:

ABD 80% FPL, QMB, SLMB, & QI <u>without</u> Social Security income; all QDWI; effective 1/18/22

ABD 80% FPL, QMB, SLMB, & QI <u>with</u> Social Security income; effective 3/1/22

All Localities	2021		2022	
ABD 80% FPL	Annual	Monthly	Annual	Monthly
1	$10,304	$859	$10,872	$906
2	13,936	1,162	14,648	1,221
QMB 100% FPL	Annual	Monthly	Annual	Monthly
1	$12,880	$1,074	$13,590	$1,133
2	17,420	1,452	18,310	1,526
SLMB 120% of FPL	Annual	Monthly	Annual	Monthly
1	$15,456	$1,288	$16,308	$1,359
2	20,904	1,742	21,972	1,831
QI 135% FPL	Annual	Monthly	Annual	Monthly
1	$17,388	$1,449	$18,347	$1,529
2	23,517	1,960	24,719	2,060
QDWI 200% of FPL	Annual	Monthly	Annual	Monthly
1	$25,760	$2,147	$27,180	$2,265
2	34,840	2,904	36,620	3,052

S0830 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-24	7/1/22	Page 114
TN #DMAS-23	4/1/22	Page 78
TN #DMAS-17	7/1/20	Page 29
TN #DMAS-12	4/1/19	Page 113
TN #DMAS-7	1/1/18	Table of Contents, page iii, iv. Pages 7-8, 17-18, 20, 29, 48, 79a, 82, 124a-124b, 125.
TN #DMAS-4	4/1/17	Table of Contents, page i Pages 24, 24c
TN #DMAS-2	10/1/16	On page 109, updated the format of the header. Neither the date nor the policy was changed.
TN #DMAS-1	3/23/16	Table of Contents, page iii Pages 18, 82
Update #7	7/1/12	Page 24
TN #94	9/1/10	Page 29
TN #93	1/1/10	Table of Contents, page iv Pages 28, 67, 119-120 Pages 122-125
TN #91	5/15/09	Table of Contents, page i Page 29

S0830.645 REFUGEE CASH ASSISTANCE, CUBAN AND HAITIAN ENTRANT CASH ASSISTANCE, AND FEDERALLY REIMBURSED GENERAL ASSISTANCE PAYMENTS TO REFUGEES

A. Background

Refugee Cash Assistance and Cuban Haitian Entrant Cash Assistance and federally funded programs which make ongoing needs-based payments to refugees during their first *12* months in the United States.

B. Policy Principles

1. Refugee Cash Assistance, Cuban and Haitian Entrant Cash Assistance and federally reimbursed general assistance payments to refugees are federally funded income based on need and, unless excluded under a PASS (S0810.430) are counted as income. The $20 general income exclusion (S0810.420) does not apply to this income.

2. A payment under one of these programs is always considered to be a cash payment.

C. Operating Procedures

If a payment is made under one of these programs to a family unit or a group of people, the amount of the grant attributable to one individual in the family is determined by the incremental method (i.e., the income is the difference between the amount paid and the amount which would have been paid had the individual not been included).

CHAPTER M14

LONG-TERM CARE

M14 Table of Contents Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-24	7/1/22	Page i
TN # DMAS-17	7/1/20	Page 1
TN #DMAS-3	1/1/17	page i
TN #97	9/1/12	page ii
TN #96	10/1/11	pages i, ii

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M1410 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-24	7/1/22	Pages 2, 9, 13
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

individual has been *authorized* to receive LTC *or Long-term Services and Supports (LTSS)* and it is anticipated that he is likely to receive the services for 30 or more consecutive days. If it is known at the time the application is processed that the individual did not or will not meet the 30 consecutive day requirement, the individual is not to be treated as an institutionalized individual.

The 30-consecutive-days requirement is expected to be met if the *authorization for LTSS is provided* verbally or in writing. This allows the agency to begin the evaluation of the applicant in the 300% SSI covered group for institutionalized individuals and to use the special rules for married institutionalized individuals who have a community spouse, if appropriate. However, prior to approval of the individual for Medicaid payment of *LTSS*, the worker must have received the DMAS-96 that was signed by the supervising physician *(or an electronic equivalent)* or the signed Waiver Level of Care form *(or an electronic equivalent)*. Applicants must be evaluated as non-institutionalized individuals for the months prior to the month in which the completed form is dated.

The worker must verify that *LTSS* started within 30 days of the date on the Notice of Action on Medicaid. If services do not start within 30 days of the Notice of Action on Medicaid, the individual can no longer be considered an institutionalized individual and continued eligibility must be re-evaluated as a non-institutionalized individual.

CBC Waiver applicants cannot receive Medicaid payment of CBC services prior to the date the DMAS-96 was signed by the supervising physician. For applicants for whom a Waiver Level of Care form is the appropriate authorization document, Medicaid payment of CBC services cannot begin prior to the date the form has been signed.

For purposes of this definition, continuity is broken by 30 or more consecutive day's absence from a medical institution or by non-receipt of waiver services. For applicants in a nursing facility, if it is known at the time of application processing that the individual left the nursing facility and did not stay for 30 consecutive days, the individual is evaluated as a non-institutionalized individual. Medicaid recipients without a community spouse who request Medicaid payment of *LTSS*, except MN individuals, and are in the nursing facility for less than 30 consecutive days will have a patient pay determination (see M1470.320).

3. Institution 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 is an **institution**.

4. In An Institution **"In an institution"** refers to an individual who is admitted to live in an institution and receives treatment or services provided there that are appropriate to his requirements.

5. **Long-term Care** **Long-term care** is medical treatment and services directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or lessening of illness, disability or pain which have been received, or are expected to be received, for longer than 30 consecutive days.

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 *authorized* 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 (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. *Authorization for LTSS*

An individual must have an assessment to determine that LTSS are appropriate, and LTSS must be authorized for Medicaid payment for LTSS. Subchapter M1420 contains the policies and procedures regarding LTSS authorization.

a. Advance Notice of Proposed Action

The system-generated Advance Notice of Proposed Action or hard equivalent **(#032-03-0018)**, available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, must be used when:

- eligibility for Medicaid will be canceled,
- eligibility for full-benefit coverage Medicaid changes to QMB, SLMB, or QWDI limited coverage, or
- Medicaid payment for *LTSS* services will not be allowed for a period of time because of an asset transfer.

b. Notice of Patient Pay Responsibility

When a change in the patient pay amount is entered in VaCMS, a "Notice of Patient Pay Responsibility" will be generated and sent as the advanced notice to the recipient or the authorized representative.

Patient pay must be entered into VaCMS no later than close-of-business on the system cut-off date, to meet the advance notice requirement.

Do not send the "Advance Notice of Proposed Action" when patient pay increases.

5. Administrative Renewal Form

A system-generated paper Administrative Renewal Form is used to redetermine Medicaid eligibility of an individual who is in long-term care. The individual or his authorized representative completes and signs the form where indicated. The EW completes and signs the eligibility evaluation sections on the form.

A renewal can also be completed online using CommonHelp or by telephone by calling the Cover Virginia Call Center. See M1520.200 for information regarding Medicaid renewals.

M1420 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-24	7/1/22	Table of Contents Pages 1-5 Appendix 1 Page 6 was removed. Appendix 1 was removed and Appendix 2 was renumbered to Appendix 1.
TN #DMAS-19	4/1/21	Page 2
TN #DMAS-17	7/1/20	Pages 1-6
TN #DMAS-12	4/1/19	Page 2
TN #DMAS-11	1/1/19	Entire subchapter
TN #DMAS-7	1/1/18	Table of Contents Pages 2, 5. Appendix 2.
TN #DMAS-5	7/1/17	Pages 2-6
TN #DMAS-1	1/1/17	Table of Contents Pages 3-6 Appendix 3 Appendices 4 and 5 were removed.
TN #DMAS-1	6/1/16	Pages 3-5 Page 6 is a runover page. Appendix 3, page 1
TN #99	1/1/14	Page 4
UP#7	7/1/12	Pages 3, 4
TN #94	09/01/10	Table of Contents Pages 3-5 Appendix 3
TN #93	01/01/10	Pages 2, 3, 5 Appendix 3, page 1 Appendix 4, page 1

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LONG-TERM SERVICES AND SUPPORTS

M1420.000 *AUTHORIZATION* FOR MEDICAID LTSS

M1420.000 *AUTHORIZATION* FOR MEDICAID LTSS

M1420.100 MEDICAID LTSS *AUTHORIZATION REQUIREMENTS*

A. Introduction

Medicaid covers long-term services and supports (LTSS) in a medical facility or community-based setting for individuals whose mental or physical condition requires or assistance with activities of daily living. For Medicaid to cover LTSS, the individual must:

- *meet the definition of an institutionalized individual in subchapter M1410. The individual's eligibility as an institutionalized individual may be determined when the individual is already in a medical facility at the time of the application, or the individual has been authorized to receive LTSS and it is anticipated that they are likely to receive the services for 30 or more consecutive days. If it is known at the time the application is processed that the individual did not or will not meet the 30 consecutive day requirement, the individual is not to be treated as an institutionalized individual.*
- *meet all Medicaid non-financial eligibility requirements in Chapter M02;*
- *be financially eligible based on the policy and procedures in subchapter M1460 for unmarried individuals and married institutionalized individuals without a community spouse or subchapter M1480 for institutionalized individuals with a community spouse; and*
- *Meet the asset transfer policies in subchapter M1450.*

This subchapter describes the LTSS authorization required for the types of LTSS, which are facility-based care, home-and-community-based (HCBS) services covered under a Section 1915(c) waiver, and the Program for All Inclusive Care for the Elderly (PACE).

B. Operating Policies

1. Payment Authorization

An LTSS authorization is needed for Medicaid payment of nursing facility (medical institution), HCBS waiver, and PACE services for Medicaid recipients. The authorization allows the local DSS to determine financial eligibility using the more liberal rules for institutionalized individuals, including the 300% SSI covered group and the special rules for married institutionalized individuals with a community spouse. The appropriate authorization document (form or screen print) must be maintained in the individual's case record

2. Required Authorization Documentation

a. Nursing facility-based care, the Commonwealth Coordinated Care Plus Waiver, and PACE

The Medicaid LTSS Authorization Form, DMAS 96 or the equivalent information printed from the electronic Medicaid LTSS Screening system (eMLS) is used to authorize nursing facility-based care, the Commonwealth Coordinated Care (CCC) Plus Waiver, and PACE. The Authorization form certifies the type of LTSS service

If documentation is not available when placement needs to be made, verbal assurance from a screener or DMAS that the form approving LTSS will be mailed or delivered is sufficient to determine Medicaid eligibility as an institutionalized individual. This information must be received prior to approval and enrollment in Medicaid as an institutionalized individual.

b. The Community Living Waiver, Building Independence Waiver, and Family and Individual Supports Waiver.

The Waiver Authorization System (WaMS) (see M1420, Appendix 3) or Intellectual Disability On-line System (IDOLS) are used to authorize services received under the Community Living (CL) Waiver, Building Independence (BI) Waiver, and Family and Individual Supports Waiver. Copies of the authorization screens are acceptable.

3. Authorization Not Received

If the appropriate documentation *authorizing LTSS* is not received, Medicaid eligibility for an individual who is living in the community must be determined as a non-institutionalized individual.

4. Authorization Rescinded

The authorization for Medicaid payment of LTSS may be rescinded by the physician or by DMAS at any point that the individual is determined to no longer meet the required Medicaid level of care criteria via level of care review process.

When an individual is no longer eligible for a HCBS Waiver service, the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

When an individual leaves the PACE program and no longer receives LTSS services, the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

For an individual in a nursing facility who no longer meets the level of care but continues to reside in the facility, **continue to use the eligibility rules for institutional individuals** even though the individual no longer meets the level of care criteria. Medicaid will not make a payment to the facility for LTSS.

M1420.200 RESPONSIBILITY FOR *THE* LTSS *AUTHORIZATION*

A. Introduction

The process for completing the required assessment and authorizing services depends on the type of LTSS.

B. Nursing Facility

In order to qualify for nursing facility care, an individual must be determined to meet functional criteria, have a medical or nursing need and be at risk of nursing facility or hospital placement within 30 days without services. An assessment known as the LTSS Screening is completed by a designated screener.

The screener's approval for Medicaid LTSS must be substantiated in the case record by a DMAS-96 or the equivalent information printed from the eMLS system. Medicaid payment for LTSS cannot begin prior to the date the DMAS-96 or other authorization is signed and prior authorization of services for the individual has been given to the provider by DMAS or the managed care plan.

An overview of the screening requirements when an individual needs nursing home care is listed below:

- For hospital patients who are currently enrolled in Medicaid and will be admitted to a nursing facility with Medicaid as the payment source, the screening is completed by hospital staff.

- Nursing facilities are permitted to admit individuals who are discharged directly from a hospital to a nursing facility for skilled services without an LTSS screening if the skilled services are not covered in whole or partially by Virginia Medicaid. Once the individual is admitted to the nursing facility, if the individual requests an LTSS screening or applies for Medicaid coverage for LTSS, nursing facility staff complete the screening.

- For individuals who are not inpatients in a hospital or are incarcerated prior to nursing facility admission, the screening is completed by local community-based teams (CBT) composed of agencies contracting with the Department of Medical Assistance Services (DMAS). The community-based teams usually consist of the local health department physician, a local health department nurse, and a local social services department service worker. Incarcerated individuals will be screened by the community-based team in the locality in which the facility is located.

C. CCC Plus Waiver

Effective July 1, 2017, the Elderly or Disabled with Consumer-Direction (EDCD) Waiver and the Technology Assisted (Tech) Waiver were combined and are known as the Commonwealth Coordinated Care Plus (CCC Plus) Waiver. Community-based teams, hospital screening teams and nursing facility screening teams are authorized to screen individuals for the CCC Plus Waiver. See M1420.400 C *for more information*.

An individual screened and approved for the CCC Plus Waiver *will* have a DMAS-96 signed and dated by the screener and the physician or the equivalent information printed from the eMLS system.

If the individual elects consumer-directed services, DMAS or its contractor must give final authorization. If services are not authorized, the service facilitator will notify the LDSS, and the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

For individuals who qualify for Private Duty Nursing (PDN) under the CCC Plus Waiver, a Medicaid LTSS Communication form (DMAS-225) and a Commonwealth Coordinated Care Plus Waiver PDN Level of Care Eligibility form (DMAS-108 for Adults or DMAS-109 for children) will be completed and sent to the LDSS.

D. PACE

Community-based screening teams, hospital screening teams and nursing facility screening teams are authorized to screen individuals for PACE. If the individual is screened and approved for LTSS, the team will inform the individual about any PACE program that serves the individual's locality. *Individuals approved for PACE* will have a DMAS-96 signed and dated by the screener and the supervising physician or the equivalent information printed from the eMLS system.

***E*. Community Living Waiver**

Local Community Services Boards (CSBs) are authorized to screen individuals for the Community Living Waiver. Final authorizations for waiver services are made by Department of Behavioral Health and Developmental Services (DBHDS) staff.

Individuals screened and approved for the Community Living Waiver will have a printout of the WaMS or Intellectual Disability On-line System (IDOLS) authorization screen completed by the DBHDS representative. The screen print will be accompanied by a completed DMAS-225 form identifying the client, the Community Services Board providing the service, and begin date of service.

***F*. Family and Individual Supports Waiver**

CSBs are authorized to screen individuals for the Family and Individual Supports Waiver. Final authorizations for waiver services are made by DBHDS staff.

Individuals screened and approved for the Family and Individual Supports Waiver will have a printout of the WaMS or IDOLS authorization screen completed by the DBHDS representative. The screen print will be accompanied by a completed DMAS-225 form identifying the client, the Community Services Board providing the service, and begin date of service.

***G*. Building Independence Waiver**

Local CSB and DBHDS case managers are authorized to screen individuals for the Building Independence Waiver. Final authorizations for waiver services are made by DBHDS staff.

Individuals screened and approved for the Building Independence Waiver will have a printout of the WaMS or IDOLS authorization screen completed by the DBHDS representative. The screen print will be accompanied by a completed DMAS-225 form identifying the client, the Community Services Board providing the service, and begin date of service.

M1420.300 COMMUNICATION PROCEDURES

A. Introduction

To ensure that nursing facility, PACE placement or receipt of Medicaid HCBS services are arranged as quickly as possible, there must be prompt communication between screeners and eligibility staff.

B. Procedures

1. LDSS Contact

The LDSS should designate an appropriate staff member for screeners to contact. Local social services, hospital staff, CBTs and nursing facilities should be given the name and contact information for that person to facilitate timely communication between screeners and eligibility staff.

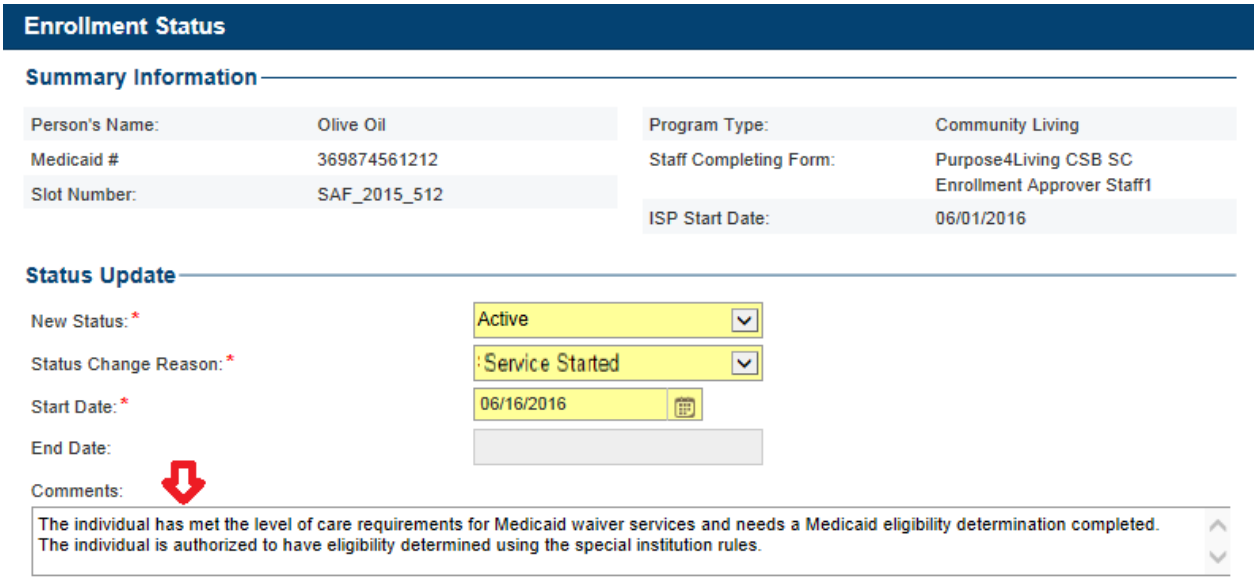
2. Screeners

Screeners must inform the individual's eligibility worker when the screening process has been completed.

3. Eligibility Worker (EW) Action

The EW must inform both the individual and the provider once eligibility for Medicaid payment of LTSS has been determined. If the individual is found eligible for Medicaid and written assurance of approval by the screening team, DMAS, or the managed care plan has been received (DMAS-96or WaMS printout), the eligibility worker must give the LTSS provider the enrollee's Medicaid identification number.

Waiver Management System (WaMS) Screen Print for Community Living Waiver, Building Independence Waiver, and Family and Individual Supports Waiver Authorizations



Enrollment Status

Summary Information

Person's Name:	Olive Oil	Program Type:	Community Living
Medicaid #	369874561212	Staff Completing Form:	Purpose4Living CSB SC Enrollment Approver Staff1
Slot Number:	SAF_2015_512	ISP Start Date:	06/01/2016

Status Update

New Status:* Active

Status Change Reason:* Service Started

Start Date:* 06/16/2016

End Date:

Comments:

The individual has met the level of care requirements for Medicaid waiver services and needs a Medicaid eligibility determination completed. The individual is authorized to have eligibility determined using the special institution rules.

M1430 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-24	7/1/22	Page 3
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

M1430.100 BASIC ELIGIBILITY REQUIREMENTS

A. Overview

To be eligible for Medicaid payment of long-term care, an individual must be eligible for Medicaid. The Medicaid non-financial eligibility requirements in Chapter M02 apply to all individuals in long-term care. The eligibility requirements and the location of the manual policy are listed below in this section.

B. Citizenship/ Alienage

The citizenship and alien status policy is found in subchapter M220.

C. Virginia Residency

The Virginia state resident policy specific to facility patient is found in subchapter M0230 and section M1430.101 below.

D. Social Security Number

The social security number policy is found in subchapter M0240.

E. Assignment of Rights

The assignment of rights is found in subchapter M0250.

F. Application for Other Benefits

The application for other benefits policy is found in subchapter M0270.

G. Institutional Status

The institutional status requirements specific to long-term care in a facility are in subchapter M0280.

H. Covered Group (Category)

The Medicaid covered groups eligible for LTC services, also called long-term services and supports (LTSS), are listed in M1460. The requirements for the covered groups are found in chapter M03.

I. Financial Eligibility

An individual who has been a patient in a medical institution (such as a nursing facility) for at least 30 consecutive days of care or who has been *authorized for LTSS* is treated as an institutionalized individual for the Medicaid eligibility determination. Financial eligibility for institutionalized individuals is determined as a one-person assistance unit separated from his/her legally responsible relative(s).

The 30-consecutive-days requirement is expected to be met if *authorization for LTSS is provided verbally or in writing*. If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has 30 days from the date on the Notice of Action to begin services.

For unmarried individuals, and for married individuals without community spouses other than MAGI Adults, the resource and income eligibility criteria in subchapter M1460 is applicable.

MAGI Adults in LTC are evaluated using the resource policy in M1460 and the MAGI income policy in M04. Only certain resource eligibility requirements are applicable to individuals in the Modified Adjusted Gross Income (MAGI) Adult covered group who are institutionalized.

M1460 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-24	7/1/22	Pages 11, 47, 48
TN #DMAS-23	4/1/22	Pages 12, 23
TN #DMAS-22	1/1/22	Pages 3, 35
TN #DMAS-18	1/1/21	Pages 3, 35
TN #DMAS-15	1/1/20	Pages 3, 35
TN #DMAS-14	10/1/19	Pages 4, 29
TN #DMAS-13	7/1/19	Page 42
TN #DMAS-11	1/1/19	Pages 3-5, 10, 26, 31
TN #DMAS-10	10/1/18	Table of Contents, page i Pages 1-3, 4b, 5, 6, 9, 10, 13, 15, 17a, 18, 18a, 26, 27, 30a, 37, 38 Pages 8a, 11, 19, 30, 39 and 40 are runover pages.
TN #DMAS-8	4/1/18	Pages 18a, 32, 35
TN #DMAS-7	1/1/18	Pages 3, 7
TN #DMAS-3	1/1/17	Pages 3, 4, 4b, 24, 25, 29
TN #DMAS-2	10/1/16	Page 35
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 3, 8a, 17, 32
TN #100	5/1/15	Table of Contents, page i Pages 1, 2, 5, 6, 10, 15, 16-17a, 25,41-51
TN #99	1/1/14	Pages 3, 35
UP #9	4/1/13	Table of Contents Pages 3, 35, 38, 41, 42, 50, 51
TN #97	9/1/12	Table of Contents Pages 1, 4-7, 9-17 Page 8a was deleted. Pages 18a-20, 23-27, 29-31 Pages 37-40, 43-51 Pages 52 and 53 were deleted
UP #6	4/1/12	Pages 3, 35
TN #96	10/1/11	Pages 3, 20, 21
TN #95	3/1/11	Pages 3, 4, 35
TN #94	9/1/10	Page 4a
TN #93	1/1/10	Pages 28, 35
TN #91	5/15/09	Pages 23, 24

M1460.220 300% of SSI PAYMENT LIMIT GROUP

A. Description

These are ABD or F&C individuals in medical facilities or who receive Medicaid CBC waiver services, who meet the appropriate CN resource requirements and resource limit and whose income is less than or equal to 300% of the SSI payment limit for an individual.

Individuals who have been *authorized* for Medicaid LTC *or Long-term Services and Supports (LTSS)* may be evaluated in this covered group. If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has 30 days from the date on the Notice of Action to begin services.

B. ABD Groups

Aged, blind or disabled individuals institutionalized in medical facilities, or who require institutionalization and are approved to receive Medicaid CBC waiver services are those who:

- meet the Medicaid ABD resource requirements; and
- have gross income, determined according to the ABD income requirements, that does not exceed 300% of the SSI individual payment limit.

See sections M0320.501 and M0320.502 for details about these covered groups.

C. F&C Groups

Individuals who meet an F&C definition (foster care or adoption assistance children under age 21, parents or caretaker-relatives of dependent children, and pregnant women) in medical facilities, or who require institutionalization and who are approved to receive Medicaid home and community-based care (CBC) waiver services, are those who:

meet the F&C CN resource requirements if unmarried,
(married individuals over age 18 must meet the ABD resource requirement); and

- have gross income, determined according to the ABD income requirements, that does not exceed 300% of the SSI individual payment limit.

Children under age 18 in the 300% of SSI covered group have no resource requirement.

See sections M0330.501 and M0330.502 for details about these covered groups.

M1460.740 SPENDDOWN FOR PATIENTS RECEIVING CBC

A. Policy

An individual meets the definition of "institutionalized" when he is *authorized* for Medicaid waiver services and the services are being provided. An individual who has been *authorized* for Medicaid waiver services and whose income exceeds the 300% SSI income limit is not eligible for Medicaid until he meets the monthly spenddown liability. These determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred. The private cost of his home-based medical care is deducted as a noncovered medical expense.

For an individual on spenddown **before** starting Medicaid CBC waiver services, the spenddown budget period and the spenddown liability are prorated and recalculated to include the months prior to the receipt of Medicaid CBC services. A separate monthly spenddown budget period is calculated for each month of receipt of Medicaid CBC services.

A MN CBC patient must incur medical expenses, including old bills, carry-over expenses and the cost of CBC at the private rate, which equal or exceed the spenddown liability for the month. From the spenddown liability, deduct old bills, carry-over expenses and incurred medical/remedial care expenses per section M1340.210. When the monthly spenddown liability is reduced to $0, eligibility is established. Eligibility can be established only AFTER the expenses are actually incurred. Do not project CBC expenses. The eligibility begin date is the first day of the month in which the spenddown was met and the end date is the last day of the month.

B. CBC Spenddown Eligibility Procedures

To determine spenddown eligibility for a CBC institutionalized individual, take the following actions:

1. Calculate Private Cost of Care

Multiply the CBC provider's (or providers' if the individual has multiple CBC providers) **private** hourly rate by the number of hours of service the individual actually received from the provider in the month.

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

2. Compare to Spenddown Liability

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

3. Spenddown Liability Less Than Private Cost of Care

If the individual's spenddown liability is less than or equal to the private cost of care, the individual meets the spenddown in the month because of the private cost of care. He is entitled to **full-month coverage** for the month in which the spenddown was met.

Enroll the individual in Medicaid with the begin date of the first of the month, the end date the last day of the month. Go to section M1460.750 below for enrollment procedures. Determine patient pay according to subchapter M1470.

4. Spenddown Liability Greater Than Private Cost of Care

If the individual's spenddown liability is greater than the private cost of care, **determine spenddown on a day-by-day basis** in the month by deducting allowable incurred expenses from the spenddown liability. Refer to section M1340.210 to determine allowable deductions from the individual's spenddown liability.

If the spenddown is met any time in the month, the individual is eligible for full-month Medicaid coverage beginning the first day of the month in which the spenddown was met and ending the last day of the month.

5. Example - No Prior Spenddown, Spenddown Liability Greater than Private Cost of Care (Using July 2014 Figures)

EXAMPLE #6: Mr. May lives in Group III and applied for Medicaid on April 21, 2015. He was *authorized* for the EDCD waiver on April 10, 2015. The DDS determined that he is disabled. He has no health insurance. His income is $2,800 per month disability benefit from a private company. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His resources are within the Medicaid limit in April 2015 (application month).

He is not eligible as CN because his $2,800 gross income exceeds the 300% SSI income limit. His MN income is calculated:

$2,800.00	disability benefit
- 20.00	general income exclusion
$2,780.00	MN countable income
- 457.63	MNIL for 1 month for 1 person in Group III
$2,322.37	spenddown liability

His CBC costs cannot be projected. Eligibility can be established only after the expenses are actually incurred. He received 20 days of CBC services in April.

His April application is denied and he is placed on a monthly spenddown for the certification period of 4-1-2015 through 3-31-2016.

$ 8	per hour private rate
x 6	hours per day
$ 48	private per diem cost
x 20	days in April
$ 960	private cost of care

Mr. May's spenddown liability of $2,322.37 is greater than the private cost of care, $960. His Medicaid eligibility was not established in April.

6. Example - On Prior Spenddown, Spenddown Liability Less Than Private Cost of Care (Using July 2014 Figures)

EXAMPLE #7: Ms. Gray lives in Group I and applied for Medicaid on May 6, 2015. She was *authorized* for Medicaid EDCD waiver services on May 2, 2015; the services started on May 4, 2015. She had applied for Medicaid previously and was on a spenddown from December 1, 2013 through May 31, 2014, which she met on May 2, 2014. She did not re-apply until May 2015. She verifies that she has an unpaid $2,300 hospital bill and a $1,500 physician's bill for September 10 to September 12, 2014 (total = $3,800) on which she pays $50 a month. She also has an incurred expense in the retroactive period - a $678 outpatient hospital bill for services dated February 13, 2015. She has no health insurance and is not eligible for Medicare.

Changed With	Effective Date	Pages Changed
TN #DMAS-24	7/1/22	Pages 1, 15, 28a, 44, 48-50 Page 14a is a runover page.
TN #DMAS-22	1/1/22	Pages 19, 20
TN #DMAS-21	10/1/21	Page 17
TN #DMAS-20	7/1/21	Pages 11, 20, 26
TN #DMAS-19	4/1/21	Pages 7, 8, 22, 23
TN #DMAS-18	1/1/21	Pages 19, 20
TN #DMAS-17	7/1/20	Table of Contents, page ii Pages 1, 14, 28a, 47, 48, 50, 55 Appendix 1, page 1
TN #DMAS-15	1/1/20	Pages 19, 20
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.

M1470.000 PATIENT PAY-POST-ELIGIBILITY TREATMENT OF INCOME

M1470.001 OVERVIEW

A. Introduction

"Patient pay" is the amount of the long-term care (LTC) patient's income which must be paid as his share of the LTC services cost. This subchapter provides basic rules regarding the post-eligibility determination of the amount of the LTC patient's income which must be paid toward the cost of his care. **MAGI Adults have no responsibility for patient pay.** If an individual receiving LTC, also called long-term supports and services (LTSS), loses eligibility in the MAGI Adults covered group and is eligible in another full coverage group, patient pay policy will apply.

B. Policy

The state's Medicaid program must reduce its payment to the LTC provider by the amount of the eligible patient's monthly income, after allowable deductions. Patient pay is calculated after an individual has been determined eligible for Medicaid and for Medicaid LTC services. A Medicaid recipient who is admitted to a nursing facility, facility for individuals with intellectual disability (ICF-ID) or Medicaid waiver services for less than 30 days must have a patient pay determined for the month(s) in which the recipient is in the facility or waiver services**.** The provider collects the patient pay from the patient or his authorized representative. Patient pay information is fed to the Automated Response System (ARS) and the MediCall Systems for provider verification of patient pay. These systems report the amount of patient pay and the date of service to the provider responsible for collecting patient pay.

C. VaCMS Patient Pay Process

The patient pay calculation is completed in VaCMS. Refer to the VaCMS Help feature for information regarding data entry. The patient pay must be updated in the system whenever the patient pay changes, but at least once every 12 months. If VaCMS is not able to process required transactions, a Patient Pay Correction form (DMAS 9PP), available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, should be submitted to patientpay@dmas.virginia.gov.

D. Patient Notification

The patient or the authorized representative is notified of the patient pay amount on the Notice of Patient Pay Responsibility. VaCMS will generate and send the Notice of Patient Pay Responsibility. M1470, Appendix 1 contains a sample Notice of Patient Pay Responsibility generated by VaCMS. DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into *the Medicaid Enterprise System (MES, formerly MMIS).*

The provider is the only entity with the authority to take action when residents do not pay their patient pay amount. If a resident, or his authorized representative is negligent in paying his patient pay amount to the provider, the provider will provide written documentation regarding the requirement to pay the patient pay amount to the resident or authorized representative and follow the provider's collection procedures to collect the funds. The provider will report the resident's negligence in paying the patient pay amount to the LDSS.

The provider's failure to collect the patient pay, or the patient's failure to pay the patient pay, does not itself affect the patient's Medicaid eligibility. However, the

A process is in development to develop a process for distinguishing MCO enhanced benefit services from allowable patient pay deductions. Until further notice, providers and nursing facilities will continue sending all patient pay adjustment requests to the patient's LDSS eligibility worker.

Eligibility workers will review and process patient pay adjustment requests without requiring submission of the request to the individual's CCC Plus plan.

M1470.240 FACILITY - HOME MAINTENANCE DEDUCTION

A. Policy

A single institutionalized individual can be allowed a deduction for the cost of maintaining a home for not more than six months, if a physician has certified he or she is likely to return home within that period.

Home maintenance means that the individual has the responsibility to pay shelter costs on his former place of residence in Virginia, such as rent, mortgage, utilities, taxes, room and board, or assisted living facility (ALF) payments, and that the home, apartment, room or bed is being held for the individual's return to his former residence in Virginia. Individuals who have no responsibility to pay shelter costs are not permitted a home maintenance deduction. If responsibility for shelter costs is questionable, documentation must be requested and provided.

EXCEPTION: For an individual admitted to a nursing facility from an ALF, deduct a home maintenance allowance for the month of entry even if the admission to the nursing facility is not temporary.

Only one spouse of an institutionalized married couple (both spouses are in a medical facility) is allowed the deduction to maintain a home for up to six months, if a physician certifies that he is likely to return home within that period.

B. Temporary Care

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

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

C. Amount Deducted

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

M1470.300 FACILITY PATIENTS

A. Overview

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

B. Policy and Procedures

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

- Facility Admission From A Community Living Arrangement (M1470.310)
- Medicaid CBC Recipient Entering A Facility (M1470.320)
- Facility Admission From Another Facility (M1470.340)

M1470.310 FACILITY ADMISSION FROM A COMMUNITY LIVING ARRANGEMENT

A. Policy

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

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

B. Procedures

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

1) Upon receipt of the requested documentation, determine the amount of the bill that is a valid deduction. Do not deduct more than the available income that remains after the personal needs, dependent child allowance(s), and health insurance premiums are deducted.

   If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service is requested, deduct the new noncovered services after the first noncovered service deductions have been completed.

2) Subtract the deduction for the current month. If the deduction exceeds the available income, the remaining balance can be carried over to the following month(s).

b. Notice Procedures

Upon the final decision to allow the deduction, use the VaCMS Patient Pay process to adjust the patient pay. VaCMS will generate and send the Notice of Patient Pay Responsibility If VaCMS is not able to process required transactions, a Patient Pay Correction form (DMAS 9PP), available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, should be submitted to patientpay@dmas.virginia.gov. DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into *MES*.

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

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

C. When to Complete the DMAS-225

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

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

D. Where to Send the DMAS-225

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

M1470.900 ADJUSTMENTS AND CHANGES

A. Policy

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

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

B. Action When A Change Is Reported

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

1. Recalculate the patient pay.

2. If the patient pay remains the same, send written notification to the person handling the patient's income that the patient pay is unchanged.

3. If the patient pay decreases, follow the instructions found in Item C. below. If the patient pay increases, follow the instructions found in Item D. below.

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

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

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

M1470.910 RETROACTIVE ADJUSTMENTS FOR PRIOR MONTHS

A. Retroactive Adjustment

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

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

In these situations, adjust the patient pay retroactively using the VaCMS Patient Pay process for the prior months in which the patient pay was incorrect. **In all other situations when a change is reported timely, do not adjust the patient pay retroactively.** If VaCMS is not able to process required transactions, submit a Patient Pay Correction form (DMAS 9PP), available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, to patientpay@dmas.virginia.gov.

B. Notification Requirements

VaCMS automatically generates and sends the Notice of Patient Pay Responsibility. DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into *MES*.

M1470.920 LTC PROVIDER CHANGE WITHIN A MONTH

A. Policy

A change in LTC providers requires a review of the type of provider and living arrangements to determine the correct personal needs allowance and new patient pay, if applicable.

B. Procedures

DMAS has implemented changes effective for dates of service on or after April 1, 2017, to simplify responsibility for collecting patient pay in the transition month. For any month that an individual is enrolled in a nursing facility on the DMAS eligibility file, patient pay will be deducted only from nursing facility claims and not from agency personal care, respite care, and/or adult day health care claims.

For patients in the CCC Plus Waiver with a patient pay, *MES* will deduct patient pay from the claims submitted by waiver providers for services following the transition month. It may take a short period of time for the local department of social services to revise the patient pay (reflecting a change in status from nursing facility to CCC Plus). This will result in *MES* initially using a higher patient pay that will be adjusted by DMAS after the patient pay is revised. During this time, waiver or nursing facility providers will still be responsible for collection of identified patient pay amounts owed and should work together to collect the appropriate patient pay.

Eligibility staff will continue to calculate monthly patient pay. **There is no need to divide or apportion the patient pay when a patient changes providers or moves from one type of provider/care to another (e.g. CBC to a nursing facility) nor any a need to inform the provider via a DMAS-225.** Changes in patient pay will be made prospectively, based on advance notice requirements. Changes not requiring advance notice can be processed up to the last day of the month. If an individual has moved from NF to CBC, adjust the patient pay effective the month after the change. Patient Pay underpayment corrections should follow the procedures contained in M1470.900.

C. PACE

Enrollment in PACE begins on the first day of a month and ends on the last day of a month. Patient pay for PACE participants is not adjusted due to provider changes within a month.

M1470.930 DEATH OR DISCHARGE FROM LTC

A. Policy

The LTC provider may not collect an amount of patient pay that is more than the Medicaid rate for the month. When a patient dies or is discharged from LTC to another living arrangement that does not include LTC services, do not recalculate patient pay for the month in which the patient died or was discharged. The provider is responsible for collecting an amount of patient pay for the month of death or discharge that does not exceed the Medicaid rate for the month.

B. Procedure

Refer to the VaCMS Help feature for procedures regarding death or discharge from LTC. Send a DMAS-225 to the provider regarding the eligibility status of the patient. Send a notice to the patient or the patient's representative that reflects the reduction or termination of services. If VaCMS is not able to process required transactions or additional correction is needed, submit a Patient Pay Correction form (DMAS 9PP), available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, to patientpay@dmas.virginia.gov. DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into *MES*.

M1470.1000 LUMP SUM PAYMENTS

A. Policy

Lump sum payments of income or accumulated benefits are counted as income in the month they are received. Patient pay must be adjusted to reflect this income change for the month following the month in which the 10-day advance notice period expires. Any amount retained becomes a resource in the following month.

B. Lump Sum Defined

Income such as interest, trust payments, royalties, etc., which is received regularly but is received less often than quarterly (i.e., once every four months or three times a year, once every five months, once every six months or twice a year, or once a year) is treated as a lump sum for patient pay purposes.

EXCEPTION: Income that has previously been identified as available for patient pay, but which was not actually received because the payment source was holding the payment(s) for some reason or had terminated the payment(s) by mistake, is **NOT** counted again when the corrective payment is received.

See section M1470.1030 below for instructions for determining patient pay when a lump sum is received.

M1470.1010 LUMP SUM REPORTED IN RECEIPT MONTH

A. Lump Sum Available

Lump sum payments reported in the month the payment was received are counted available for patient pay effective the first of the month following the month in which the 10-day advance notice period expires.

If the individual is no longer in the facility and is not receiving Medicaid CBC, adjust the patient pay for the lump sum receipt month if the money is still available.

B. Lump Sum Not Available

If the money is not available, complete and send a Notice of Recipient Fraud/Non-Fraud to the DMAS Recipient Audit Unit.

M1480 Changes
Page 1 of 2

Changed With	Effective Date	Pages Changed
TN #DMAS-24	7/1/22	Pages 8a, 8b, 13, 50b, 51, 55, 57, 66, 87, 89, 91
TN #DMAS-22	1/1/22	Pages 7, 18c, 66, 69, 70
TN #DMAS-21	10/1/21	Page 66
TN #DMAS-20	7/1/21	Pages 66, 70
TN #DMAS-18	1/1/21	Page 7, 18c, 66, 69, 70, 92
TN #DMAS-17	7/1/20	Pages 8b, 9, 14, 66, 77, 92
TN #DMAS-15	1/1/20	Pages 1, 7, 18c, 66, 69, 70 Page 2 is a runover page.
TN #DMAS-14	10/1/19	Pages 8a, 8b, 12, 15, 16, 18, 20, 21, 30, 32, 51

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

M1480.200 RESOURCE ASSESSMENT RULES

A. Introduction

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

A resource assessment is strictly a:

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

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

B. Policy Principles

1. Applicability

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

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

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

2. Who Can Request

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

3. When to Do A Resource Assessment

a. Without A Medicaid Application

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

b. With A Medicaid Application

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

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

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

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

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

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

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

c. Both Spouses Request Medicaid CBC

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

C. Responsible Local Agency

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

b. When the Assessment Is Completed

Both spouses and the guardian, conservator, or authorized representative must be notified in writing of the assessment results and the spousal share calculated. Use the form Notice of Medicaid Resource Assessment (#032-03-817). Attach a copy of the Medicaid Resource Assessment form (#032-03-816) to each Notice. A copy of all forms and documents used must be kept in the agency's case record.

M1480.220 RESOURCE ASSESSMENT WITH MEDICAID APPLICATION

A. Introduction

This section applies to married individuals with community spouses who are inpatients in medical institutions or nursing facilities, who have been *authorized* to receive Medicaid CBC waiver services, or who have elected hospice services. If a married individual with a community spouse is receiving private-pay home-based services, he **cannot** have a resource assessment done without also filing a concurrent Medicaid application.

B. Policy

1. Resource Assessment

If a resource assessment was **not completed** before the Medicaid application was filed, the spousal share of the couple's total countable resources that existed **on the first moment of the first day of** the first month of the first continuous period of institutionalization that began on or after September 30, 1989, is calculated when processing a Medicaid application for a married institutionalized individual with a community spouse.

If a resource assessment was completed before the Medicaid application was filed, use the spousal share calculated at that time in determining the institutionalized spouse's eligibility.

2. Use ABD Resource Policy

For the purposes of the resource assessment and spousal share calculation, countable and excluded resources are determined for all covered groups using the ABD resource policy in Chapter S11, **regardless of the individual's covered group and regardless of community property laws or division of marital property laws,** except for the following resources which are excluded as indicated below when completing the resource assessment and spousal share:

- the home and **all** contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SS & SSI payments for nine (9) calendar months following the month in which the individual receives the benefits; and
- up to **$1,500** of burial funds for each spouse (NOT $3,500), if there are designated burial funds.

C. ABD 80% FPL

The income limit for the ABD 80% FPL covered group is 80% of the federal poverty level (see M0810.002.A.5). See section M0320.210 for details about this covered group.

The ABD income policy in chapter S08 is used to determine countable income for the ABD 80% FPL covered group. Income is projected for the month for which eligibility for LTC is being determined. This calculation is based upon the income received in the past month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount expected to be received.

If the individual's countable income is less than or equal to the 80% FPL income limit, enroll the individual with the appropriate ABD 80% FPL Aid Category (AC) and determine patient pay according to the policy and procedures found in section M1480.400. The ABD 80% FPL ACs are:

- Aged = 029
- Blind = 039
- Disabled = 049

M1480.315 THIRD PARTY & LONG-TERM CARE INSURANCE PAYMENTS

A. Payments Made by Another Individual

Payment of an individual's bills (including Medicare supplementary medical insurance or other medical insurance premiums) by a third party directly to the supplier is not income.

Payments made directly to the service provider by another person for the individual's private room or "sitter" in a medical facility are NOT income to the individual. Refer all cases of Medicaid eligible enrollees in nursing facilities who have a "sitter" to DMAS, Division of Aging and Disability Services, for DMAS review to assure that DMAS is not paying the facility for services provided by the sitter.

B. LTC Insurance Policy Payments

The LTC insurance policy must be entered into the recipient's TPL file. The insurance policy type is "H" and the coverage type is "N." *Medicaid* will not pay the nursing facility's claim unless the claim shows how much the policy paid.

If the patient receives the payment from the insurance company, it is **not** counted as income. The patient should assign it to the provider. If the patient cannot do this, or the policy prohibits assignment, the payment should be given directly to the provider. The provider should report the payment as a third party payment on its claim form.

If the patient received the payment and cannot give it to the facility for some reason, then the patient should send the insurance payment to:

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

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

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

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

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

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

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

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

d. SD Liability Is Greater Than Medicaid Rate

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

2. Medicaid CBC Waiver Patients

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

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

3. PACE Recipients

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

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

B. All MN CBC Patients

An MN institutionalized spouse who has been *authorized* for Medicaid CBC waiver services is not eligible for Medicaid until he actually incurs medical expenses that meet the spenddown liability within the month. These determinations are made monthly, retrospectively, **after** the month has passed and the expenses have actually been incurred. The private cost of his home-based medical care is deducted on a day-by-day basis as a noncovered medical expense, along with any other incurred medical expenses.

The institutionalized spouse's resources and income must be verified each month before determining if the spenddown was met. To determine if the institutionalized spouse met the spenddown:

- Go to section M1480.341 below if the institutionalized spouse was NOT previously on a spenddown.
- Go to section M1480.342 below if the institutionalized spouse was previously on a spenddown.

M1480.340 MN PACE RECIPENTS

A. Policy

1. Monthly Spenddown Determination

PACE recipients who have income over the 300% of SSI income limit are placed on a monthly spenddown as institutionalized individuals because they have been *authorized* for LTC services.

Unlike CBC, PACE has a capitated monthly rate that is due and payable on the first day of the month. The monthly PACE rate is available from the PACE provider. When a MN individual is in PACE, the amount of allowed PACE expenses is the rate that is due as of the first day of each month.

PACE recipients are not responsible for Medicare Part D premiums, which are included in the monthly PACE rate. **Therefore, the cost of the Medicare Part D premium cannot be used to meet a spenddown and must be subtracted from the monthly PACE rate when determining if the spenddown has been met.**

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

2. Projected Spenddown Determination

If the MN individual's spenddown liability is less than or equal to the monthly PACE rate (minus the Medicare Part D premium), the individual is eligible for Medicaid effective the first day of the month in which the spenddown is met. As long as the individual's spenddown liability and the PACE monthly rate do not change, the individual is enrolled in ongoing coverage.

3. Retrospective Spenddown Determination

If the MN individual's spenddown liability exceeds the monthly PACE rate (minus the Medicare Part D premium), he is not eligible for Medicaid until he actually incurs medical expenses that meet the spenddown liability within the month. The monthly medical expenses are determined retrospectively; they cannot be projected for the spenddown budget period.

Retrospective spenddown eligibility determinations are made monthly after the month has passed and the expenses have actually been incurred. The PACE

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	\$2,177.50	7-1-21		
	$2,288.75	*7-1-22*		
C. Maximum Monthly Maintenance Needs Allowance	\$3,259.50	1-1-21		
	\$3,435.00	1-1-22		
D. Excess Shelter Standard	\$653.25	7-1-21		
	$686.63	*7-1-22*		
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).

Mrs. Bee's remaining income for patient pay in July is $2,193.25, which is greater than the Medicaid rate for of July $1,705. The facility can only collect the Medicaid rate; therefore, her patient pay for July is the Medicaid rate of $1,705.

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

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

M1480.470 CBC - MN INSTITUTIONALIZED SPOUSE PATIENT PAY

A. Policy

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

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

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

B. Procedures

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

1. Calculate Available Income for Patient Pay

a. Determine Gross Monthly Patient Pay Income

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

b. Subtract Allowable Deductions

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

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

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

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

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

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

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

2. Patient Pay

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

C. Example--CBC Institutionalized Spouse on Spenddown

EXAMPLE #28: (Using July 2000 figures)
Mr. T is an institutionalized spouse who applied for Medicaid in July. He was *authorized* for Medicaid E & D waiver services on July 1, and began receiving those services on that date. He has a monthly CSA benefit of $1,900 and a monthly Japanese-American Restitution payment of $200. He has Medicare Parts A & B and Federal Employees Health Insurance which costs him $75 per month. He last lived outside the facility in a Group III locality.

The CBC provider's Medicaid rate is $9.50 per hour, 5 hours per day or $47.50 per day, a total of $1,472.50 for July (31 days). Because Mr. T's remaining income is less than the Medicaid rate, his patient pay for July is $92.50.

From his July income of $2,100, Mr. T must pay the patient pay of $92.50. He has $2,007.50 left with which to meet his maintenance needs ($512), pay the community spouse and family member allowances, and pay his Medicare and health insurance premiums, a total of $2,007.50. In accordance with Section 1924 of the Social Security Act, Medicaid will assume responsibility for $1,462.50 of his spenddown liability ($1,555 - 92.50 patient pay = $1,462.50). Because he paid all of his income to the CBC provider in July, his resources are within the limit in August.

D. Example-CBC Institutionalized Spouse on Spenddown

EXAMPLE #29: (Using July 2000 figures)

Mrs. Bly is an aged individual who files an initial application for Medicaid on July 1. She was *authorized* for Medicaid E & D waiver services on July 1, and began receiving those services on July 1. She has a monthly SSA benefit of $2,000 and a monthly private pension payment of $500. She has Medicare Parts A & B and private Medicare supplement health insurance which costs her $100 per month. Mrs. Bly resides in a Group II locality. Her spouse, Mr. Bly, lives with her in their home. He has income of $1,800 per month from CSA. Mrs. Bly's income exceeds the 300% of SSI income limit.

Her MN eligibility is determined for July. The MN determination results in a spenddown liability of $2,230:

$2,000.00	SSA
+ 500.00	monthly private pension
2,500.00	total monthly income
- 20.00	exclusion
2,480.00	countable MN income
- 250.00	MN limit for 1 (Group II)
$2,230.00	spenddown liability for month

She is placed on a monthly spenddown for each month in the 12-month certification period beginning July 1. On August 2, she submits expenses for July. The private CBC rate is $14 per hour, 5 hours per day or $70 per day, for a total of $2,170 for July (31 days). The private cost of care, $2,170, is less than her spenddown liability of $2,230. Therefore, the worker must complete a day-by-day calculation to determine Mrs. Bly's eligibility for July:

$2,230.00	spenddown liability 7-1
- 140.00	CBC private pay rate for 7-1 & 7-2 @ $70 per day.
2,090.00	spenddown balance on 7-3
- 145.50	45.50 Medicare + 100.00 health ins. premium paid 7-3
- 1,890.00	private pay for 27 days @ $70 per day 7-3 through 7-29
54.50	spenddown balance at beginning of 7-30
- 70.00	CBC private pay for 7-30
$ 0	spenddown met on 7-30

M1480.480 PACE – MN INSTITUTIONALIZED SPOUSE PATIENT PAY

A. Policy

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

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

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

B. Procedures

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

1. Calculate Available Income for Patient Pay

a. Determine Gross Monthly Patient Pay Income

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

b. Subtract Allowable Deductions

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

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

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

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

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Changed With	Effective Date	Pages Changed
TN #DMAS-24	7/1/22	Pages 8, 9a, 12-14
TN #DMAS-22	1/1/22	Page 8a Page 8 is a runover page.
TN #DMAS-21	10/1/21	Page 9a
TN #DMAS-19	4/1/21	Pages 6, 8
TN #DMAS-18	1/1/21	Pages 2b, 9, 12
TN #DMAS-17	7/1/20	Page 15
TN #DMAS-16	4/1/20	Pages 5, 6, 12, 13 Pages 14 and 15 are runover pages.
TN #DMAS-14	10/1/19	Pages 2b, 4, 5-7
TN #DMAS-12	4/1/19	Pages 7, 9a. Page 7a is a runover page.
TN #DMAS-11	1/1/19	Page 7

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

B. Coverage End Date

Medicaid entitlement ends the last day of the month in which the recipient fails to meet all of the Medicaid eligibility requirements, unless the recipient is a CN pregnant woman or is age 22 or over, but under age 65 and was admitted to an IMD.

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

1. CN Pregnant Woman

After eligibility is established, a pregnant woman in any CN covered group continues to be eligible for Medicaid during the remainder of her pregnancy and *for 12 months following the end of the month in which her pregnancy ends,* regardless of any changes in family income, as long she continues to meet all non-financial criteria. *If the woman becomes pregnant while she is in the 12 month coverage period, she is entitled to an additional 12 months of coverage following the end of the second pregnancy.*

2. Individual Admitted to Ineligible Institution Other than an IMD

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

Note: An individual of any age who is **enrolled in Medicaid** at the time of admission to an **IMD** may remain enrolled in Medicaid. **Do not cancel coverage**. 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 for individuals age 22 years or over but under age 65 years.

3. Spenddown Enrollees

Medicaid entitlement ends on the last day of the last month in the spenddown budget period, unless the individual's or family's circumstances change before that date.

C. Ongoing Entitlement After Resources Are Reduced

When an applicant has excess resources throughout the application month, he is not eligible for Medicaid for the month of application. An applicant who reduces excess resources during the month of application or a subsequent month before action is taken on the application may become eligible in the month in which the value of his resources is reduced to, or below, the Medicaid resource limit. In order to reduce resources, the resources must actually be expended and the expenditure documented. (For example: a receipt, a canceled check, or a bank statement).

Reduction of resources is an asset transfer and must be evaluated under asset transfer policy (subchapter M1450). When excess resources are reduced, entitlement to ongoing Medicaid may begin no earlier than the first day of the month in which the resources were reduced to the Medicaid limit. When retroactive coverage is requested, policy in M1510.101 above must be followed.

M1510.107 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 *MES (Medicaid Enterprise System (formerly 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 *MES*)
- 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 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.

M1510.300 FOLLOW-UP RESPONSIBILITIES

M1510.301 THIRD PARTY LIABILITY (TPL)

A. Introduction

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

B. Private Health Insurance

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

Health insurance policy or coverage changes must be updated in VaCMS.

1. Verification Required - Policy or Coverage Termination

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

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

2. Health Insurance Premium Payment (HIPP)Program

If an applicant or enrollee reports that he or a family member is employed more than 30 hours each week and is eligible for health insurance coverage under an employer's group health plan, he or she must be given a HIPP Fact Sheet which provides a brief description of the program and the contact information for the HIPP Unit at DMAS. The HIPP Fact Sheet is available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/References.

If the enrollee opts to enroll in HIPP, update **VaCMS** with the TPL information when it is provided by the enrollee. Call the HIPP Unit at 1-800-432-5924 when an enrollee reports changes to the TPL information so that *MES* can be updated.

C. Medicare

Individuals are required to apply for coverage under Medicare A, B or D, or any combination of Medicaid A, B, and D, if it is likely that the individual would meet the eligibility criteria for any or all of those programs. The state agrees to pay any applicable premiums and cost-sharing (except those applicable under Part D) for individuals required to apply for Medicare.

Application for Medicare is a condition of eligibility unless the state does not pay the Medicare premiums, deductibles or co-insurance (except those applicable under Part D) for persons covered by the Medicaid eligibility group under which the individual is applying.

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

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

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

- Qualified Disabled and Working Individuals (QDWI).

1. Buy-In Procedure

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

2. Medicare Claim Numbers

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

a. SSA claim numbers consist of a nine-digit number followed by a letter, or a letter and numerical symbol. The most common symbols are T, M, A, B, J1, K1, D, W, and E.

b. RR annuity-claim numbers have a letter (alpha) prefix followed by a six or nine digit number. The most common prefixes are A, M, H, WCD, NCA, CA, WD, WCH, and PD.

c. Certain letters following nine digit numbers identify an individual as an SSI recipient and are not acceptable as a Medicare claim number. These claim symbols are AI, AS, BC, BI, BS, DC, DI, and DS.

3. Procedures for Obtaining Claim Numbers

a. Requesting Medicare Card

Each Medicaid applicant who appears to qualify for Medicare must be asked if he has applied for Medicare. Those that have applied and are eligible have received a white card with a red and a blue stripe at the top, with his name as it appears in the SSA files and the assigned claim number on the card. The name as it appears and the claim number must be included in the TPL section of the *MES* eligibility file maintained by *DMAS*.

b. Applicants Who Cannot Produce a Claim Number

In the event the applicant either does not have a Medicare card or does not know his claim number, inquire SSA via the SVES (State Verification Exchange System) using the applicant's own SSN.

If the applicant has never applied for Medicare, complete the Referral to Social Security Administration Form DSS/SSA-1 (form #032-03-099) and write in, "Buy-In" on the upper margin. Mail the form to the Social Security Office serving the locality in which the applicant resides. The SSA office will provide the correct claim number if the individual is on their records. Should the (local/area) SSA office have no record of an application for Medicare, a representative will contact the applicant to secure an application.

4. Buy-in Begin Date

Some individuals have a delay in Buy-in coverage:

Classifications	Buy-in Begin Date
SSI and AG recipients (includes dually-eligible)	1st month of eligibility
CN and MN with Medicare Part A who are dually-eligible as either Qualified Medicare Beneficiaries (QMB) or Special Low Income Medicare Beneficiaries (SLMB Plus)	1st month of eligibility
CN and MN with no Medicare Part A or who are not dually-eligible as either QMB or SLMB Plus	3rd month of eligibility

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

D. Other Third Party Liability

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

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Changed With	Effective Date	Pages Changed
TN #DMAS-24	7/1/22	Pages 1, 3, 10 Pages 2 and 11 are a runover pages.
TN #DMAS-23	4/1/22	Pages 10, 11, 12, 13, 26, 27, 30 Appendix 2, page 1
TN #DMAS-22	1/1/22	Page 14
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

M1520.000 MEDICAL ASSISTANCE ELIGIBILITY REVIEW

M1520.001 GENERAL PRINCIPLE

A. Policy

A MA recipient's eligibility must be partially reviewed whenever the agency becomes aware of any change in the enrollee's circumstances that might affect the enrollee's continued eligibility. The timeframe for acting on a change is 30 calendar days from the date the change is reported or the agency becomes aware of the change.

Exception: Children meeting the definition of a newborn in M0330.802 or M2240.100.F are to be enrolled as soon as possible upon report of the birth.

An annual review of all of the enrollee's eligibility requirements is called a "redetermination" or "renewal." A renewal of the enrollee's eligibility must be completed at least once every 12 months. The renewal can be initiated in the 10th month to ensure timely completion of the renewal.

When an enrollee no longer meets the requirements for his current covered group, prior to cancelling his coverage, evaluate the enrollee in all covered groups for which he may meet the definition. If the enrollee is not eligible for full benefit Medicaid coverage and is not eligible in any other limited-benefit covered group (i.e. the Medicare Savings Programs), evaluate the enrollee for Plan First, unless he has declined that coverage.

1. Public Health Emergency

*Effective January 31, 2020, a public health emergency (PHE) was declared by the U.S. Department of Health and Human Services a*s a result of the continued consequences of the Coronavirus Disease 2019 (COVID-19) pandemic. *Under the direction of the Centers for Medicare and Medicaid Services (CMS), state Medicaid agencies have not taken action to cancel or reduce medical assistance coverage for enrolled individuals, regardless of eligibility changes, unless the individual dies, moves out of the state, or requests cancelation of coverage. When the PHE is declared over, normal policies and procedures regarding reviews, renewals and cancelations will resume.*

***2.* Negative Action Requires Notice**

When a change is reported that impacts eligibility or a renewal is completed and the enrollee is no longer eligible, the Advance Notice of Proposed Action must be sent to the enrollee, before the enrollee's benefits can be reduced or his eligibility can be terminated (see M1520.301). Send the notice to the authorized representative if one has been designated.

Adequate notice using the Notice of Action must be provided when an enrollee dies, enters an ineligible institution, is incarcerated and no longer meets a covered group, moves out of Virginia, requests termination of his coverage, or is unable to be located by the local agency.

***3.* Renewal Approval Requires Notice**

When a change is reported and eligibility continues, no notice is necessary. When a renewal is completed and eligibility continues, a Notice of Action must be sent to enrollee or authorized representative, if one has been designated, informing him of continued eligibility and the next scheduled renewal.

***4.* Voter Registration**

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

B. Procedures For Partial Review and Renewals

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

- Partial reviews – M1520.100;
- Renewals – M1520.200;
- Canceling coverage or Reducing the level of benefits – M1520.300;
- Extended Medicaid coverage – M1520.400;
- Transferring cases within Virginia – M1520.500.

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.

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.

2. 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 *12th month* of post-partum *coverage*,
- 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.

D. Special Requirements for Certain Covered Groups

1. Pregnant Woman

Do not initiate a renewal of eligibility of a pregnant woman in other covered group during her pregnancy. Eligibility ends effective the last day of the *12th month following the month in which her pregnancy ends.*

The renewal for a woman who has been enrolled in post-partum coverage will be due the 12th month following the month in which the pregnancy ended. The partial review "batch process" will attempt to re-evaluate the coverage at the end of the 12 month of postpartum coverage.

If the woman does not meet the definition and/or the income requirements for another full-benefit covered group, determine her eligibility in the limited benefit Plan First covered group using the eligibility requirements in M0320.302.

2. Newborn Child Turns Age 1

A renewal must be completed for a child enrolled as a Newborn Child Under Age 1 before Medicaid Enterprise System (MES—formerly the Medicaid Management Information System [MMIS]) cut-off in the last month in which the child meets the Newborn Child Under Age 1 covered group and must include:

- SSN or proof of application
- verification of income
- verification of resources for the MN child.

The ex parte process may be used if appropriate.

3. Child Under Age 19—Income Exceeds FAMIS Plus Limit

When an enrolled FAMIS Plus child no longer meets the FAMIS Plus income limits and there is not an LIFC parent on the case, evaluate the child for the FAMIS, using the eligibility requirements in chapter M21. If the child is eligible for FAMIS, send the family an Advance Notice of Proposed Action that Medicaid will be cancelled effective the last day of the month in which the 10-day advance notice expires and the FAMIS coverage will begin the first day of the month following the Medicaid cancellation. Use cancel reason "042" when the child loses eligibility in Medicaid and is reinstated in FAMIS and there is no break in coverage.

Do not use change transactions to move a child between Medicaid and FAMIS. If the child is not eligible for FAMIS, the worker must provide an opportunity for the child to be evaluated as medically needy (MN) **prior** to sending an advance notice and canceling the child's Medicaid coverage

If the child does not meet the definition for another covered group, determine the child's eligibility in Plan First using the eligibility requirements in M0320.302. If the child is eligible for Plan First, reinstate coverage in Plan First and send the Advance Notice of Proposed Action indicating that he has been enrolled in Plan First. On the notice, state that if he does not wish to remain covered by Plan First, to contact the eligibility worker and request that the coverage be cancelled. Include a Plan First Fact Sheet, available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/References, with the Advance Notice of Proposed Action.

6. IV-E FC & AA Children and AA Children With Special Needs for Medical or Rehabilitative Care

The renewal of Medicaid coverage for Title IV-E foster care or adoption assistance children and non-IV-E adoption assistance children with special needs for medical or rehabilitative care requires only the following information:

- verification of continued IV-E eligibility status or non-IV-E special needs for medical or rehabilitative care status,
- the current address, and
- any changes regarding third-party liability (TPL).

7. Child Under 21 Turns Age 21

When an individual who is enrolled in the Child Under Age 21 covered group turns 21, redetermine his continuing Medicaid eligibility in other covered groups, including Plan First.

This information can be obtained from agency records, the parent or the Interstate Compact office from another state, when the child's foster care or adoption assistance agreement is held by another state. A renewal form is not required. The information must be documented in the case record.

***8.* Foster Care Child in an Independent Living Arrangement Turns Age 18**

A foster care child who is in an Independent Living arrangement with a local department of social services (LDSS) no longer meets the definition of a foster care child when he turns 18. Determine the child's eligibility in the Former Foster Care Children Under Age 26 Years covered group.

***9.* Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)**

The BCCPTA Redetermination Form (#032-03-653) is used to redetermine eligibility for the BCCPTA covered group. The form is available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms. The enrollee must provide a statement from his or her medical provider on the renewal form or else a separate written statement verifying continued treatment for breast or cervical cancer. There are no Medicaid financial requirements for the BCCPTA covered group.

10. Hospice Covered Group

At the annual renewal for an individual enrolled in the Hospice covered group (AC 054), the worker must verify the enrollee's continued election and receipt of hospice services, in addition to determining continued Medicaid eligibility.

11. Qualified Individuals

Funding for the QI covered group became permanent in 2015; the QI covered group is subject to the same policies regarding renewals as other ABD covered groups.

M21 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-24	7/1/22	Page 7
TN #DMAS-23	4/1/22	Appendix 1, page 1
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

F. FAMIS Select

Under the FAMIS program, a family, whose child(ren) are determined eligible for FAMIS and who has access to health insurance through an employer or wishes to purchase a private policy, has the option of enrolling the family in that health plan. "FAMIS Select" allows the choice of the private or employer's insurance instead of FAMIS. Children enrolled in FAMIS whose families have access to private or employer sponsored health insurance coverage may qualify to have the State pay part of the family's share of the health insurance premium.

If a child is enrolled in FAMIS and the family is interested in more information about FAMIS Select (and has access to health insurance), they may contact DMAS about the benefits of enrolling in the FAMIS Select component of FAMIS and information about how to participate in the program. Participation in the FAMIS Select component is voluntary.

G. 12-Month Continuous Coverage

Children under age 19 who are enrolled in FAMIS are entitled to 12 months of continuous coverage provided the family continues to reside in Virginia and the family income is less than or equal to 200% of the FPL.

Exception—If an individual enrolled in FAMIS becomes pregnant, reinstate her coverage in FAMIS MOMS. Her FAMIS MOMS coverage continues through the last day of the 12th month following the month in which the pregnancy ends. When her pregnancy ends, she will be redetermined for coverage in other covered groups.

Children enrolled in FAMIS who subsequently apply for Medicaid and are found eligible must have their FAMIS coverage cancelled so they can be reinstated in Medicaid.

H. 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 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 next 12-month continuous eligibility period begins the month after the renewal completion date.

M2150.100 REVIEW OF ADVERSE ACTIONS

A. Case Reviews

An applicant for FAMIS may request a review of an adverse determination regarding eligibility for FAMIS. FAMIS reviews follow the procedures established by Medicaid for client appeals (see chapter M16).

The payment of medical services on the part of any child or any right to participate in the program is not subject to review if funds for FAMIS are exhausted.

M22 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-24	7/1/22	Pages 1, 2, 5, 6
TN #DMAS-23	4/1/22	Page 6 Appendix 1, page 1
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

M2200.000 FAMIS MOMS

M2210.100 FAMIS MOMS GENERAL INFORMATION

A. Introduction

The 2005 Appropriations Act directed the Department of Medical Assistance Services (DMAS) to expand medical coverage to uninsured pregnant women who are ineligible for Medicaid and have income in excess of the Medicaid limits, but whose family income is less than or equal to 200% of the federal poverty level (FPL). The Family Access to Medical Insurance Security (FAMIS) MOMS program was subsequently established. FAMIS MOMS was closed to new applications from January 1, 2014 until November 30, 2014. Enrollment in the program resumed on December 1, 2014.

Eligibility for FAMIS MOMS 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 MOMS. Pregnant women found eligible for FAMIS MOMS receive the same benefits as Medicaid pregnant women, including comprehensive dental services. An eligible woman will receive coverage through her pregnancy and *for 12 months following the end of the month in which her pregnancy ends, regardless of income changes.*

B. Policy Principles

FAMIS MOMS covers uninsured low-income pregnant women who are not eligible for Medicaid due to excess income, and whose countable income is less than or equal to 200% of the FPL.

A pregnant woman is eligible for FAMIS MOMS if all of the following are met:

- she is not eligible for Medicaid and has income in excess of the Medicaid limits;
- 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 *at the time of application/reevaluation*; and
- she has countable family income less than or equal to 200% FPL.

M2220.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

A. Policy

The pregnant woman must meet, with certain exceptions, the Medicaid nonfinancial eligibility requirements in Chapter M02 and the nonfinancial eligibility requirements imposed by FAMIS.

B. M02 Applicable Requirements

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

- citizenship or alien status, 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. *If the pregnant woman obtains health insurance coverage after enrollment, she remains eligible for FAMIS MOMS coverage*.

3. IMD Prohibition

The pregnant woman cannot be in inpatient in an institution for the treatment of mental diseases (IMD) *at the time of application/reevaluation.*

M2230.100 FINANCIAL ELIGIBILITY

A. Financial Eligibility

1. Income

Modified Adjusted Gross Income (MAGI) methodology contained in Chapter M04 is used for the FAMIS MOMS 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. For all case actions effective October 26, 2019, 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.

The FAMIS MOMS 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 MOMS.

3. No Spenddown

Spenddown does not apply to FAMIS MOMS. If countable income exceeds the FAMIS MOMS income limit, the pregnant woman is not eligible for the FAMIS MOMS program. She must be referred to the Health Insurance Marketplace and be given the opportunity to have a MN Medicaid evaluation.

M2240.100 APPLICATION and CASE PROCEDURES

A. Application Requirements

The policies in subchapters M0120 and M0130 apply.

B. Eligibility Determination

1. Pregnant *Individual* Under Age 19

Process an application by a pregnant *individual* under age 19 in the following order:

. Determine eligibility for Medicaid as a pregnant woman; if not eligible because of excess income, go to item *b*.

. Determine eligibility for FAMIS MOMS; if not eligible because of excess income, go to item c .

c. If she is not eligible for FAMIS MOMS because of excess income, she must be referred to the Health Insurance Marketplace and given the opportunity to have a Medically Needy evaluation completed.

2. 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.

3. 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 MOMS may have the same base case number in the Medicaid Enterprise System (MES—formerly the Virginia Medicaid Management Information System [MMIS]) as Medicaid enrollees.

D. Entitlement and Enrollment

1. *Dates* of Coverage

Pregnant women determined eligible for FAMIS MOMS are enrolled for benefits effective the first day of the application month, if all eligibility requirements are met in that month. *FAMIS MOMS coverage ends the last day of the 12th month after the end of the month in which the pregnancy ends.*

2. No Retroactive Coverage

There is no retroactive coverage in the FAMIS MOMS program.

3. Aid Category

The FAMIS MOMS aid category (AC) is "005."

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 both Medicaid and FAMIS MOMS, as well as a referral to the Health Insurance Marketplace, if applicable.

If the pregnant woman is ineligible for both Medicaid and FAMIS MOMS due to excess income, she must be sent a written notice that she is not eligible for either program and that her case has been referred to the Health Insurance Marketplace. She must also be given the opportunity to have a Medicaid medically needy evaluation completed. Send the notice and a request for information about her resources to the pregnant woman and advise her that if the resource information is returned within 10 days the original application date will be honored.

M23 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-24	7/1/22	Page 6
TN #DMAS-23	4/1/22	Page 6 Appendix 1, page 1
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 Medicaid Enterprise System (MES—formerly the Virginia Medicaid Management Information System [MMIS]) as Medicaid enrollees.

D. Entitlement and Enrollment

2. Begin Date of Coverage

Pregnant women determined eligible for FAMIS Prenatal Coverage are enrolled for benefits 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.

4. 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.

5. 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. *The 12-month coverage period for pregnant women in Medicaid and FAMIS MOMS is not applicable to FAMIS Prenatal Coverage*.

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.