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January 1, 2024

Virginia Medical Assistance Eligibility Manual
Transmittal #DMAS-30

The following acronyms are contained in this letter:

- DMAS – Department of Medical Assistance Services
- FAMIS – Family Access to Medical Insurance Security Plan
- MAGI – Modified Adjusted Gross Income
- MN – Medically Needy
- SSI – Supplemental Security Income
- TN – Transmittal
- VIM – Virginia Insurance Marketplace

TN #DMAS-30 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 January 1, 2024.

The following changes are contained in TN #DMAS-30:

Changed Pages	Changes
Subchapter M0140	Incarcerated children under 19 are eligible for 12 months of continuous in-patient hospitalization coverage. Do not initiate a renewal for an individual under 19 before their 12th month of eligibility unless they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased. Children under 19 should be given a new 12 month period of continuous eligibility at renewal.
Subchapter M0220.100; Appendix 4	Children enrolled under good faith effort are not eligible for 12 months of continuous eligibility. Updates for Afghan Special Immigrants.

Subchapter M0320.200	Children under 19 receive 12 months of continuous eligibility unless they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.
Subchapter M0330	Children under 19 receive 12 months of continuous eligibility unless they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.
Chapter M04	For a child with 12 months continuous eligibility, coverage ends the last day of the 12th month after the first month of eligibility (not including retroactive coverage). Complete a renewal 30 days prior to the end of coverage.
Subchapter M1310.100	MN Children under age 18 with $0 spenddown liability; Enroll the child in a 12 month period of coverage, without the need for a new application, and complete an annual renewal. Continue to enroll the child in 12 month periods of coverage per year as long as he continues to be eligible as MN at renewal.
Subchapter M1360.100	Income increases during a spenddown budget period are excluded for MN children and pregnant women.
Subchapter M 1410	Continuity of LTSS is broken by 180 or more consecutive day's absence from a medical institution or by non-receipt of waiver services. 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 180 days of the date of the Notice of Action on Medicaid. If LTSS did not start within 180 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.
Subchapter M 1420.100	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 unless community LTSS has been authorized.
Subchapter M 1430.100	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 180 days from the date on the Notice of Action to begin services.
Subchapter M 1440.100	If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has 180 days from the date on the Notice of Action to begin receiving CBC services.
Subchapter M 1460	300% of SSI Covered Group: Married individuals over age 18 must meet the ABD resource requirement unless eligible in a MAGI group. For the definition of institutionalization, continuity is broken by 180 or more days of absence from a medical institution or non-receipt of Medicaid waiver services.
Subchapter M1470	Maintenance allowance, 300% SSI, 200% SSI.
Subchapter M1480	Home Equity limit increase, spousal resource standards, monthly maintenance allowance increases, 300% SSI, 200% SSI, Utility standards. Continuity is broken only by 180 or more days absence from a medical institution or 180 or more days of non-receipt of waiver services.

Subchapter M1510	Medically needy pregnant women who apply for and are enrolled in Medicaid on or before the date the pregnancy terminates are eligible until the end of the 12th month after the pregnancy ends. MN children are eligible for 12 months coverage after they are determined eligible. Income increases are excluded for these MN children and pregnant women. Children's 12 month continuous eligibility does not apply to children enrolled as HPE.
Subchapter M1520.100	Eligibility in all other covered groups must be evaluated when a child reaches age 19; is no longer a Virginia resident; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased. Children under 19 are eligible for 12 months continuous eligibility.
Subchapter M1520.300 B.3	The Social Security Administration will verify that an individual is dead, but not the date of death. Accept the date of death reported to the agency from a family representative or medical provider as accurate. If there is conflicting information regarding the date of death, contact the parent/caretaker relative or authorized representative to obtain the date of death. Information from a medical professional/facility is also acceptable. If the worker is unable to determine the actual date of death, use the date that a HUB inquiry verifies that the member is deceased.
Subchapter M1520.402 C.1	Determining Extension period (Extended Medicaid), The extension starts the first month following the month in which the family is no longer eligible for LIFC Medicaid because of excess income due to the increased earnings of the parent or caretaker/relative AND the Benefits Worker can give 10 days notice prior to taking action.
Chapter M21	FAMIS children under 19 receive 12 months of continuous eligibility unless they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased. 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. A new 12 month period of eligibility will begin. Enrollment in other health insurance **does not** impact the period of eligibility once it begins.
Chapter M23	A child born to a mother eligible as FAMIS Prenatal is eligible for 12 months of continuous coverage from their date of birth if the child is a deemed newborn. If the child is not a deemed newborn, the child is eligible for 12 months of coverage from when the mother was enrolled as FAMIS Prenatal.

Please retain this TN letter for future reference. Should you have questions about information contained in this transmittal, please contact Sara Cariano, Director, DMAS Eligibility Policy & Outreach Division, at sara.cariano@dmas.virginia.gov or (804) 229-1306.

Sincerely,

Sarah Hatton

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

Attachment

M0140 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-30	1/1/24	Page 1
TN #DMAS-25	10/1/22	Page 1, 3, 5
TN #DMAS-24	7/1/22	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

M0140.000 Incarcerated Individuals General Information

A. Introduction

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

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

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

B. Policy Principles

An individual is not eligible for full benefit Medicaid coverage while incarcerated. These individuals may apply for medical assistance and (if approved) receive coverage limited to inpatient hospitalization services. Inpatient hospitalization may include long-term inpatient services, such as admission to a rehabilitation facility. *Children under 19 are eligible for 12 months of continuous in-patient hospitalization coverage.*

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

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

Medicaid financial eligibility requirements for the individuals covered group include

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

C. Covered Group

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

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

D. Immigration Status Requirements

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

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 for an individual under 19 before their 12th month of eligibility unless they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased. 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. *Children under 19 should be given a new 12 month period of continuous eligibility at renewal.*

Changed With	Effective Date	Pages Changed
TN #DMAS-30	1/1/24	Page 3; Appendix 4, page 1
TN #DMAS-27	4/1/23	Page 17 Appendix 4, page 1 Appendix 5, page 1
TN #DMAS-25	10/1/22	Table of Contents, Page 14d. Page 22 Appendix 4 added page 2.
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 22a and 24-25 were removed.

a. All foster care children and IV-E Adoption Assistance children;

b. Individuals born to mothers who were eligible for MA in any state on the date of the individuals' birth;

c. Individuals entitled to or enrolled in Medicare, individuals receiving Social Security benefits on the basis of a disability and SSI recipients currently entitled to SSI payments. Former SSI recipients are not included in the exemption. The local department of social services (LDSS) must have verification from the Social Security Administration (such as a SVES response) of an individual's Medicare enrollment, benefits entitlement or current SSI recipient status.

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

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

3. Verification Required One Time

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

4. Enroll Under Good Faith Effort

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

If the applicant meets all other eligibility requirements:

- Approve the application and enroll the applicant in MA, AND
- Specify on the Notice that the individual may have to provide documentation of C&I if it cannot be obtained by other means, OR
- Include the Reasonable Opportunity Insert, available at https://fusion.dss.virginia.gov/Portals/[bp]/Files/Medical%20Assistance%20Guidance/medicaid_reasonable_opportunity_insertrev_03-09-10.pdf?ver=2019-06-04-151050-230 with the Notice.

The individual remains eligible for MA while the agency attempts to verify C&I through the data matching process described in M0220.100 D below, or if necessary, requests verification from the individual. The same good faith effort requirements apply should an individual lose his exemption from providing C&I verification. ***Children enrolled under good faith effort are not eligible for 12 months of continuous eligibility***.

D. Procedures for Documenting C&I

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

Afghan Special Immigrants

The United States Congress passed the Continuing Resolution on October 1, 2021. Section 2502 of the Continuing Resolution provides that certain Afghan nationals who receive parole between July 31, 2021 and March 31, 2023 "shall be eligible for resettlement assistance, entitlement programs, and other benefits available to refugees" to include Medicaid, until March 1, 2023 (or until their parole expires). *On December 23, 2022 Congress passed the Consolidated Continuing Appropriations Act 2023* which extended the date that parole must have been received by to September 30, 2023 and expanded the *groups of eligible for services.*

Eligibility continues until the parole expires. Afghan parolees who have a pending re-parole application, a pending asylum application, or a pending adjustment of status application with U.S. Citizenship and Immigration Services (USCIS), under the U.S. Department of Homeland Security (DHS) are still eligible for the ***continuation of Medicaid if they were enrolled prior to the expiration of their initial period of*** *parolee.*

Eligible Parolees are:

1. Special Immigrant Parolees (SIP), who are individuals granted Special Immigrant (SI/SQ) Parole (per section 602(B)(1) AAPA/Section 1059(a) NDAA 2006) *who entered the United States between July 1, 2021 and September 30, 2023, including Unaccompanied Afghan Minors,*
2. *Humanitarian* Parolees entering the United States without SI/SQ parole due to the urgent nature of their arrival (Humanitarian status), *who entered the United States between July 1, 2021 and September 30, 2023,*
3. *Afghan SIPs or Humanitarian Parolees who are the spouses or children of eligible Afghan Parolees who entered between July 1, 2021 and September 30, 2023, even if they entered after September 30, 2023, and*
4. *Afghan SIPs or Humanitarian Parolees who are the parents or legal guardians unaccompanied Afghan minors who entered between July 1, 2021 and September 30, 2013, even if they entered after September 30, 2023.*

Afghan nationals who have another Qualifying immigration status, such as refugees, Special Immigrant Visa (SIV) holders, or asylees, are eligible for Medicaid in the standard manner. They are not required to enter within a particular timeframe. Children under 19 years and pregnant women with SIP, or Humanitarian status meet the definition of lawfully residing aliens for Medicaid and FAMIS/FAMIS MOMS coverage.

Afghan Special Immigrant visa holders will have either (1) a passport or I-94 form indicating category SI1, SI2, SI3, SQ1, SQ2, or SQ3 and bearing the Department of Homeland Security stamp or notation or an I-151 ("green card") indicating SI6, SI7, SI8, SQ6, SQ7, or SQ8. Special Immigrant Parolees will have an I-94 form noting SQ or SI Parole (per section 602(B)(1) AAPA/Sec 1059(a) NDAA 2006).

If an individual has attested to eligible immigration status and is found otherwise eligible for Medicaid, but verification of that status cannot be obtained, do not deny or delay coverage. Enroll the individual and provide the 90-day reasonable opportunity period.

Exception: Humanitarian Parolees who arrived **before July 31, 2021**, are eligible only for Medicaid coverage of emergency medical services and Health Insurance Marketplace coverage. Many of these individuals have already been enrolled in subsidized Marketplace coverage or have been granted asylum and are therefore eligible for Medicaid or FAMIS without the 5-year bar.

M0320 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-30	12/1/24	Page 23
TN #DMAS-27	4/1/23	Pages 11, 24, 25, 27
TN #DMAS-26	1/1/23	Page 11
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

2. Resource Eligibility

Resource eligibility is determined by comparing the SSI disabled child's countable resources to the current ABD Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). Calculate resources according to the assistance unit policy in subchapter M0530. If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the child is NOT eligible in the protected SSI disabled children covered group; he/she may be eligible as *FAMIS Plus – Medicaid for Children (see M0330.300)* if he/she is under age 19 years.

3. Income Eligibility

Income eligibility is determined by comparing the SSI disabled child's income to the current SSI payment limit for an individual. Determine countable income using policy in Chapter S08. Calculate income according to the assistance unit policy in subchapter M0530. If countable income is within the SSI payment limit, the child is eligible for Medicaid in the covered group of protected SSI disabled children.

D. Entitlement & Enrollment

Children eligible for Medicaid in the covered group of protected SSI disabled children 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.

Children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

Eligible protected SSI disabled children are enrolled with program designation "61."

M0320.300 ABD WITH INCOME ≤ 80% FEDERAL POVERTY LIMIT (FPL)

A. Policy

Section 1902(m) of the Social Security Act allows a State to provide full Medicaid benefits to the categorically needy covered group of aged, blind and disabled individuals whose income is less than or equal to a percentage of the federal poverty limit (FPL).

The 2000 Appropriations Act mandated that effective July 1, 2001, the State Plan for Medical Assistance be amended to add the covered group of aged, blind and disabled individuals with income less than or equal to 80% FPL.

An eligible individual's resources must be within the SSI resource limits.

M0330 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-30	1/1/24	Pages 1, 2, 4, 6, 8, 10, 12, 17, 20, 23, 34, 35, 38, 40 Page 1a is a runover page
TN #DMAS-26	1/1/23	Page 10
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.

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.**

A federal mandate requires that as of January 1, 2024, all children under 19 receive 12 months of continuous eligibility unless

- *they reach age 19;*
- *are no longer Virginia residents;*
- *the child or child's representative requests eligibility be closed;*
- *the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or*
- *the child is deceased.*

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 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.

3. 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.

4. 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.

5. 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.

6. 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;

B. Entitlement

Children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

1. IV-E Foster Care Child

Entitlement to Medicaid as a IV-E Foster Care child begins the first day of the month of commitment or entrustment if a Medicaid application is filed within 4 months of commitment or entrustment. Retroactive entitlement prior to the month of commitment or entrustment is not allowed.

If the Medicaid application is filed more than 4 months after entrustment or commitment, entitlement may be retroactive up to 3 months prior to application if the child met all Medicaid eligibility requirements in the retroactive months. However, Medicaid entitlement cannot go back to the month of entrustment or commitment when the application is filed more than 4 months after entrustment or commitment.

2. IV-E Adoption Assistance Child

Entitlement to Medicaid as a IV-E Adoption Assistance child begins the first day of the application month if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

C. Enrollment

The aid category (AC) for IV-E foster care children is "076." The AC for IV-E Adoption Assistance children is "072".

M0330.107 INDIVIDUALS UNDER AGE 21

A. Policy

42 CFR 435.222 – The federal Medicaid law allows the State Plan to cover reasonable classifications of individuals under age 21 years who do not receive cash assistance but who meet the income requirements of the state's July 16, 1996 AFDC State Plan. Children under age 19 should be evaluated in the FAMIS Plus covered group if not eligible as individuals under age 21.

Individuals ages 19 and 20 should be evaluated in the Individuals Under Age 21 covered group when they are not eligible for Medicaid in any other full-benefit covered group.

The reasonable classifications of individuals under age 21 are:

- IV-E eligible foster care children who do NOT receive a IV-E maintenance payment,
- Non-IV-E foster care children,
- Department of Juvenile Justice (DJJ) children,
- Non-IV-E Adoption Assistance children,
- Children in intermediate care nursing facilities (ICF), and
- Children in intermediate care facilities for the intellectually disabled (ICF-ID).

B. Nonfinancial Eligibility Requirements

The individual must be under age 21 and meet the nonfinancial requirements in chapter M02.

C. Reasonable Classifications

The individual under age 21 must meet one of the following classifications:

1. Adoptive Placement

While in adoptive placement, the child may continue to be treated as a foster care child. However, once the interlocutory or the final order of adoption is entered, the child must be treated as a Non-IV-E adoption assistance child; see 3. below.

2. Non-IV-E Adoption Assistance-Interlocutory or Final Order Entered

For applications received prior to October 1, 2013 and renewals completed prior to April 1, 2013, financial eligibility is determined using the assistance unit procedures in subchapter M0520, which require the inclusion of the child's adoptive parent(s) and sibling(s). An adoption assistance child must have his/her eligibility determined by counting or deeming (as appropriate) his/her parent's and sibling's income.

For applications received on or after October 1, 2013, use the policies and procedures contained in chapter M04.

3. Child in ICF or ICF- ID

A child in an ICF or an ICF-ID is an institutionalized individual in a medical facility when he meets the definition of "institutionalized individual" in section M1410.010 B.2. When he meets the institutionalized individual definition, he is an assistance unit of one person.

D. Resources

There is no resource test for the Individuals Under Age 21 covered group.

E. Income

1. Income Limits

For the Individuals Under Age 21 covered group, the income limit is the income limit found in M04, Appendix 5.

The foster care or adoption subsidy payment is excluded when determining the unit's income eligibility.

Foster care and Adoption Assistance children in residential facilities do not have a different income limit. For a foster care/adoption assistance child living outside the State of Virginia, the income limit for the assistance unit is the income limit for the Virginia locality which holds custody, pays the adoption subsidy, or signed the adoption assistance agreement.

2. Income Exceeds F&C 100% Income Limit

For foster care (including DJJ) and adoption assistance children whose income exceeds the Individuals Under Age 21 income limit, determine the child's Medicaid eligibility in the Child Under 19 covered group and for FAMIS if the child under 19 or as an MN Individual Under Age 21 if the child is over 19 but under 21 (see M0330.804). Ineligible individuals must be referred to the Health Insurance Marketplace for evaluation for the Advance Premium Tax Credit (APTC).

F. Entitlement & Enrollment

Children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

1. Entitlement

Entitlement to Medicaid begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

2. Resources There is no resource test for the Adoption Assistance Children With Special Needs for Medical or Rehabilitative Care covered group.

3. Income Adoption assistance children in residential facilities do not have a different income limit. The income limit for Individuals Under Age 21 for one person in the child's locality is used to determine eligibility in the Adoption Assistance Children With Special Needs for Medical or Rehabilitative Care covered group. See M04, Appendix 4.

For a Virginia adoption assistance child with special needs for medical or rehabilitative care living outside the State of Virginia, the income limit for the unit is the income limit for the Virginia locality that signed the adoption assistance agreement.

The adoption subsidy payment is excluded when determining the child's financial eligibility.

If the child's countable income exceeds the income limit for Individuals Under Age 21, evaluate the child in the Adoption Assistance Children With Special Needs for Medical or Rehabilitative Care MN covered group (see M0330.805). Ineligible individuals must be referred to the Health Insurance Marketplace for evaluation for the APTC.

[5]
D. Entitlement & Enrollment Entitlement to Medicaid begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

Children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

The AC for individuals in the Adoption Assistance Children With Special Needs for Medical or Rehabilitative Care covered group is "072."

M0330.109 FORMER FOSTER CARE CHILDREN UNDER AGE 26

A. Policy P.L. 111-148 (The Affordable Care Act) - The federal Medicaid law requires the State Plan to cover individuals who were formerly in Title IV-E or non-IV-E foster care or the Unaccompanied Refugee Minors Program (URM) when the individual:

- was in the custody of a local department of social services in Virginia, another state, or a U.S. Territory, and receiving Medicaid until his discharge from foster care upon turning 18 years or older, or
- was in the URM program in Virginia or another state and receiving Medicaid until his discharge upon turning 18 years or older.
- is not eligible for Medicaid in another mandatory Medicaid covered group (LIFC parent, Pregnant Woman, Child Under age 19 or SSI), and
- is under age 26 years.

A child age 18 and over who is in an Independent Living arrangement or in the Fostering Futures Program with a local department of social services may be eligible in this covered group.

A LIFC child must meet the definition of a dependent child in M0310.111. The adult with whom the child lives must be the child's parent or caretaker-relative, as defined in M0310.107. The presence of a parent in the home does not impact a stepparent's eligibility in the LIFC covered group. Both the parent and stepparent may be eligible in the LIFC covered group. When a parent(s) is in the home, no relative (i.e. caretaker/relative) other than another parent or a stepparent can be eligible for Medicaid in the LIFC covered group.

C. Financial Eligibility

Modified Adjusted Gross Income (MAGI) methodology is applicable to the LIFC covered group. The policies and procedures contained in Chapter M04 are used to determine eligibility for LIFC individuals.

1. Basis For Eligibility ("Assistance Unit")

The basis for financial eligibility is the LIFC individual's MAGI household. See M0430.100.

2. Resources

There is no resource test for the LIFC covered group.

3. Income

The income limits, policies and procedures used to determine eligibility in the LIFC covered group are contained in Chapter M04.

4. Income Exceeds Limit

If the individual's income exceeds the LIFC income limit, the individual is not eligible as LIFC. Individuals should then be evaluated as MAGI. If over the MAGI limit, LIFC families who have been enrolled in Medicaid for at least three of the past six months and who are no longer eligible due to excess earned income must be evaluated for continued eligibility in LIFC Extended Medicaid. See M1520.400.Ineligible individuals must be referred to the Health Insurance Marketplace for evaluation for the APTC. Spenddown does not apply to the LIFC income limits.

D. Entitlement

Entitlement to Medicaid as an LIFC individual begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period. ***Children under 19 receive 12 months of continuous eligibility unless*** *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

E. Enrollment

The ACs for individuals in the LIFC covered group are:

- 081 for an LIFC individual in a family with one or no parent in the home;
- 083 for LIFC individuals in a two-parent (including a stepparent) household.

C. Financial Eligibility

Modified Adjusted Gross Income (MAGI) methodology is applicable to this covered group. The MAGI policies and procedures are contained in Chapter M04.

1. Assistance Unit

The assistance unit for this covered group is the MAGI household.

2. Resources

There is no resource test.

3. Income

MAGI income rules are applicable to this covered group. The income limits for the Child Under Age 19 covered group are contained in M04, Appendix 2.

4. Income Changes

Any changes in a Medicaid-eligible child's income that occur after his eligibility has been established affect eligibility. Recalculate income and compare to the income limits.

5. Income Exceeds Limit

A child under age 19 whose income exceeds the income limit for this covered group may be eligible for FAMIS. The income limit for FAMIS is 200% FPL plus a 5% FPL income disregard. See Chapters M21 and M04 to determine FAMIS eligibility.

If countable income exceeds the limit for Medicaid and FAMIS and the child is under age 18, the opportunity for a Medically Needy (MN) evaluation must be offered (see M0330.803). Ineligible children, other than incarcerated children, must be referred to the Health Insurance Marketplace for evaluation for the APTC.

D. Entitlement

Eligible children are entitled to full Medicaid coverage beginning the first day of the child's application month if all eligibility requirements are met in that month, but no earlier than the date of the child's birth. Retroactive coverage is applicable to this covered group.

Children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

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

b. Resource Eligibility – Unmarried Individual Age 18 and Older

When determining resources for an unmarried F&C institutionalized individual, use the Medicaid F&C resource requirements in chapter M06. All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the F&C resource limit of $1,000. Pay close attention to ownership of his/her former residence when the individual is in an institution. Determine if the former home is excluded in **M06.**

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/she may be eligible in a different covered group.

c. Resource Eligibility – Child Under Age 18

Children under age 18 are not subject to a resource test.

2. Income

To determine if an individual has income within the 300% SSI income limit, **use gross income**, not countable income, and **use the ABD income policy and procedures in chapter S08 and subchapter M1460.** Determine what is income according to subchapter S0815, ABD What Is Not Income and subchapter M1460, LTC Financial Eligibility. DO NOT subtract the $20 general exclusion or any other income exclusions.

The individual is an assistance unit of 1 person. DO NOT deem any income from a spouse or parent.

Compare the **total gross income** to the 300% of SSI income limit (see M810.002 A. 3.). If gross income is less than or equal to this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds the 300% of SSI income limit, the individual is not eligible for Medicaid in the covered group of F&C individuals in medical institutions.

D. Entitlement & Enrollment

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

Children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

Eligible individuals in this group are classified as **300% SSI.** If the individual has Medicare Part A, re-calculate the individual's income - subtract appropriate ABD income exclusions. Compare the countable income to the QMB limit.

1. Dual-eligible As QMB

If the individual is also a Qualified Medicare Beneficiary (QMB) – the individual has Medicare Part A and has countable income within the QMB income limit - the program designation is "062."

2. Income

To determine if an individual has income within the 300% SSI income limit, **use gross income**, not countable income, and use the ABD income policy and procedures in **chapter S08** and **subchapter M1460.** Determine what is considered income according to subchapter **S0815, ABD What Is Not Income** and subchapter **M1460, LTC Financial Eligibility**. DO NOT subtract the $20 general exclusion or any other income exclusions.

The F&C waiver services individual is an assistance unit of 1 person. DO NOT deem any income from a spouse or parent.

Compare the **total gross income** to the 300% of SSI income limit (see M0810.002 A.3). If gross income is less than or equal to this limit, the individual is eligible for Medicaid in the CN covered group of F&C individuals receiving Medicaid waiver services.

If the total gross income **exceeds** the 300% of SSI income limit, the individual is **not** eligible for Medicaid in the covered group of F&C individuals receiving Medicaid waiver services.

D. Entitlement & Enrollment

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

Children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

Eligible individuals in this group are classified as 300% of SSI. If the individual has Medicare Part A, re-calculate the individual's income - subtract the appropriate ABD income exclusions. Compare the countable income to the QMB limit.

1. Dual-eligible As QMB

If the individual is also a Qualified Medicare Beneficiary (QMB) – the individual has Medicare Part A and has countable income within the QMB income limit - the AC is "062."

2. Not QMB

If the individual is NOT a 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 spenddown. For unmarried individuals, re-determine 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 he/she has Medicare Part A.

The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

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

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

D. Entitlement & Enrollment

The hospice services recipient must elect hospice services and the election must be in effect for 30 days. The 30 day period begins on the effective date of the hospice election. Upon 30 days elapsing from the effective date of the hospice election, and the election is in effect for the entire 30 days, eligibility in the hospice covered group begins with the effective date of the hospice election if all other eligibility factors are met.

1. Entitlement

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

Children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

Eligible individuals in this group are classified as categorically needy CN. If the individual has Medicare Part A, evaluate his/her eligibility as ABD hospice in M0320.402.

2. Enrollment

If the individual is eligible in any other full-coverage Medicaid covered group, he is enrolled under that aid category (AC) and not the Hospice AC (054). Enroll with AC 054 for an individual who meets an F&C definition, has income within 300% of the SSI limit, but who is not eligible in any other full-coverage Medicaid covered group.

E. Post-eligibility Requirements (Patient Pay)

Individuals who receive hospice services in a nursing facility have a patient pay calculation (see subchapter M1470). Individuals who receive hospice services outside of a nursing facility do not have a patient pay.

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

F. Ineligible In This Covered Group

There is no corresponding medically needy hospice covered group. Evaluate the individual in another covered group.

B. Financial Eligibility

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

C. Entitlement & Enrollment

Eligible newborns in this MN group are entitled to full Medicaid coverage beginning the date of the child's birth. Retroactive coverage is applicable to this covered group, but coverage cannot begin prior to the date of the child's birth. A renewal must be completed for the newborn before system cut-off 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 and resources.

Children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

Eligible children in this group are enrolled in aid category 099.

M0330.803 CHILDREN UNDER AGE 18

A. Nonfinancial Eligibility

42 CFR 435.301(b)(1)(ii) - If the state chooses to cover the medically needy, the State Plan must provide medically needy coverage to all children under 18 years of age who, except for income and resources, would be eligible for Medicaid as categorically needy.

A child is eligible in this MN covered group if he/she has not attained age 18 years and meets the nonfinancial requirements in chapter M02.

A child under age 18's Medicaid eligibility is first determined in the Child Under Age 19 covered group and for FAMIS, which have no resource limits and have income limits that are higher than the medically needy income limit. If a child under age 18 is not eligible for Medicaid in the Child Under 19 covered group or for FAMIS because the child's countable income is too high, and the child's resources are within the MN resource limit, evaluate the child's in the MN Children Under Age 18 covered group.

B. Financial Eligibility

1. Assistance Unit

The assistance unit policy and procedures in chapter M05 apply to this covered group. If not institutionalized, count or deem any resources and income from the child's spouse and/or parent with whom he/she lives.

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

a. Resources Within The Limit

If the child's resources are within the MN limit, go on to determine income eligibility.

b. Resources Exceed The Limit

If the child's resources are NOT within the limit, the child is NOT eligible for Medicaid because of excess resources.

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 child's locality group (see section M0710, Appendix 5 for the MN income limits).

4. Income Exceeds MN and FAMIS Limits

Because the Child Under Age 19 and FAMIS income limits are higher than the MN income limits, the child becomes eligible in the MN children under age 18 covered group when the child has incurred medical expenses equal to the difference between his/her income and the MN income limit (spenddown). See chapter M13 for spenddown policy and procedures.

5. Income is under the MN and FAMIS Limits

Because of the differences between the Child Under 19 covered group/FAMIS (MAGI) and MN (non-MAGI) income-counting rules, such as the treatment of a stepparent's income, a child may be ineligible for Medicaid as a Child Under 19 or for FAMIS coverage but have countable income under the income limit for MN coverage. In this case, the child's spenddown liability is $0.00 (zero dollars). Even if the spenddown liability is $0.00, MN coverage cannot be open-ended. Enroll the child in *one 12 month* period of coverage, without the need for a new application. Complete a renewal following the procedures in M1520 at the end of the second spenddown period. Continue to enroll the child in *one 12 month* period of coverage per year as long as he continues to be eligible as MN at renewal.

C. Entitlement & Enrollment

Children who become eligible after meeting a spenddown are entitled to full medically needy Medicaid coverage beginning the day the spenddown was met. Retroactive coverage is applicable to this covered group.

Children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

Eligible children in this group are enrolled in aid category 088.

a. **Child in ICF or ICF- ID**

A child in an ICF or an ICF- ID is an institutionalized individual in a medical facility when he meets the definition of "institutionalized individual" in section M1410.010 B.2. When he meets the institutionalized individual definition, he is an assistance unit of one person.

E. Resources

The resource limit and requirements are found in chapter M06.

If the resources exceed the limit, the child is not eligible for Medicaid. If the child is under age 19, determine the child's eligibility as FAMIS Plus because that classification has no resource limits.

F. Income

The MN income requirements are found in subchapter M0710.

Income Limits

For the MN Individuals Under Age 21 covered group, the income limit is the medically needy income limit found in chapter M0710, Appendix 5.

The foster care or adoption subsidy payment is excluded when determining the unit's income eligibility.

Foster care or adoption assistance children in residential facilities do not have a different income limit. For a foster care/adoption assistance child living outside the State of Virginia, the MN income limit for the unit is the income limit for the Virginia locality which holds custody, pays the adoption subsidy, or signed the adoption assistance agreement.

2. Income Exceeds MN Income Limit

If the unit's resources are within the medically needy limit, but the income exceeds the medically needy income limit, the unit is placed on a spenddown. All medical expenses of the unit members are used to meet the spenddown. Once the spenddown is met, only the child and family members who meet an MN covered group and who applied for Medicaid are enrolled in Medicaid.

G. Entitlement & Enrollment

1. Entitlement

Entitlement to Medicaid begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. If the individual is eligible after meeting a spenddown, entitlement begins the date the spenddown was met and ends after the last day of the spenddown period.

Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

Children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

2. Enrollment

The aid category for medically needy individuals in the MN covered group of Individuals Under Age 21 are:

- 086 for an MN Non-IV-E foster care, MN Non-IV-E adoption assistance,
- 085 for an MN Juvenile Justice Department child;
- 098 for an MN child under age 21 in an ICF or ICF- ID.

2. Resources

The resource limits and requirements are found in chapter M06.

If the resources exceed the limit, the child is not eligible for Medicaid as medically needy. If the child is under age 19, determine the child's eligibility as F&C CN because that classification has no resource limits.

3. Income

Adoption assistance children in residential facilities do not have a different income limit. The MN income limit for one person in the child's locality is used to determine the child's MN eligibility. For an adoption assistance child living outside the State of Virginia, the income limit for the child is the income limit for the Virginia locality which signed the adoption assistance agreement.

The adoption subsidy payment is excluded when determining the child's financial eligibility.

If the child's countable income exceeds the MN income limit, the child is placed on a spenddown. Only the child's medical expenses are used to meet the spenddown. Once the spenddown is met, the child is enrolled in Medicaid.

D. Entitlement & Enrollment

Eligible individuals in this MN group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Individuals who become eligible after meeting a spenddown are entitled to full Medicaid coverage beginning the day the spenddown was met and ending the last day of the sixth month in the spenddown period. Retroactive coverage is applicable to this covered group.

Children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

The AC for individuals in the Adoption Assistance Children With Special Needs for Medical or Rehabilitative Care MN covered group is "086.**"**

M04 Changes
Page 1 of 3

Changed With	Effective Date	Pages Changed
TN #DMAS-30	12/1/24	Pages 1, 34 Page 34a is a runover page
TN #DMAS-28	7/1/23	Page 37 Appendices 1,2,3,5,6 and 7

M0410.000 MODIFIED ADJUSTED GROSS INCOME (MAGI) M0410.100 MAGI GENERAL INFORMATION

A. Introduction

Effective October 1, 2013, determinations of eligibility for most families and children (F&C) Medicaid covered groups and the Family Access to Medical Insurance Security Plan (FAMIS) *were completed* using the Modified Adjusted Gross Income (MAGI) methodology.

Effective January 1, 2019, determination of eligibility for adults age 19-64 without Medicare *were* evaluated using MAGI income methodology. These individuals are referred to as MAGI Adults.

MAGI methodology is also used to determine eligibility for *Premium Tax Credits through Virginia's* Insurance Marketplace. Medicaid, FAMIS and *Virginia's* Insurance Marketplace (VIM) are called insurance affordability programs. Medicaid and FAMIS are collectively referred to as medical assistance (MA) programs.

For all case actions effective October 26, 2019, verification of earned and unearned income *were* evaluated using attested income and reasonable compatibility rules. Whenever possible, income reported on the application *are* verified through electronic data sources.

The goal of using MAGI methodology for all insurance affordability programs is to align financial eligibility rules, provide a seamless and coordinated system of eligibility and enrollment, and maintain the eligibility of low-income populations, especially children.

A federal mandate requires that as of January 1, 2024, all children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*

B. Legal Base

The Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111- 152) (collectively referred to as the Affordable Care Act [ACA]) is the legal base for the changes required to be made in the Medicaid and CHIP (FAMIS) eligibility determinations. The 2018 Appropriations Act provided funding for New Health Coverage Options for Virginia Adults. Effective January 1, 2019, determination of eligibility for adults between the ages of 19-64 without Medicare will be evaluated using MAGI income methodology. Adults eligible under the expansion of coverage will be referred to as Modified Adjusted Gross Income (MAGI) Adults. Individuals in the MAGI Adults covered group are not subject to a resource test unless the individual requests Medicaid payment for LTC/LTSS. The resource and home equity requirements for MAGI Adults are contained in M1460.

MAGI and household income are defined in section 36B(d)(2)(A) and (B) of the Internal Revenue Service Code (IRC). The MAGI-based methodology under the Medicaid statute includes certain unique income counting and household (HH) composition rules reflected in the Centers for Medicare and Medicaid Services (CMS) regulations at 42 CFR 435.603 and discussed in section III.B. of the preamble to the eligibility final rule published in the Federal Register on March 23, 2012.

C. Policy Principles

1. What is MAGI?

MAGI is a methodology for how income is counted and how household composition and family size are determined and is based on federal tax rules for determining adjusted gross income (with some modification), and has no resource test (Exception: MAGI Adults requesting coverage of Long Term Care services are subject to certain asset/resource requirements).

- First, add together income already received for the year. Do not convert the income.
- Next, calculate the projected income for the remainder of the year based on the current monthly income, unless the individual's income is expected to change (e.g. current employment is terminating).
- Add income already received to projected income to obtain the **annual** projected income for the current calendar year.
- Compare the **annual** projected income to the 100% FPL **annual** income limits for the MAGI household size in M04, Appendix 1.
- If the **annual** income is less than or equal to 100% FPL, compare the **annua**l income to the **annual** income limit for the individual's covered group.
- For the individual to be eligible for Medicaid as a result of applying the gap-filling rule, the countable income must be no more than the **annual i**ncome limit for the individual's covered group. The 5% income disregard used for the Medicaid MAGI determination does not apply. See M04 Appendices 2-6 for income limits.

3. Renewals

A renewal of eligibility must be completed in January of the following year and annually thereafter. At the time of initial enrollment, change the renewal date to January of the following year. Evaluate the individual's eligibility using Medicaid/FAMIS MAGI methodology before applying gap-filling methodology. A gap-filling evaluation may not be necessary for future eligibility determinations/renewals since tax dependency status and/or income may have changed.

For a pregnant woman determined eligible based on gap-filling methodology, coverage ends the last day of the 12th month after the end of the month in which the pregnancy ends. Complete a renewal 30 days prior to the end of coverage.

For a child with 12 months continuous eligibility, coverage ends the last day of the 12th month after the first month of eligibility (not including retroactive coverage). Complete a renewal 30 days prior to the end of coverage.

4. Individual Not Eligible Using Gap-filling Methodology

If the individual's household income is determined to be over the Medicaid and FAMIS income limits after the gap-filling rule evaluation **and** he meets a MN covered group, he must be offered the opportunity to be placed on a MN spenddown. If the individual does not provide the necessary verifications for the gap-filling evaluation the application should be denied.

A. Example Situation – Coverage Gap and Gap Filling Rule

A 10-year-old child lives with both parents, who are not married, and the child is expected to be claimed as a tax dependent by one parent. His parents apply for the APTC through the *Virginia Insurance Marketplace*, which uses tax filers income methodology. The child is determined to not be eligible for the APTC because his countable income is below the lower income threshold (it is too low) for APTC eligibility.

Virginia's Health Insurance Marketplace refers the application to Virginia for a Medicaid/FAMIS eligibility determination. The child meets a tax dependent exception in M0430.100 B.2 (he lives with both parents, is claimed as a tax dependent by one parent, and the parents do not expect to file jointly). The child's eligibility for Medicaid or FAMIS is determined using non-filer methodology. Because he is under 19 and both parents are in his household, the income of both parents is counted. His household income with the 5% FPL disregard is over the limit for both Medicaid and FAMIS.

M1310 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-30	1/1/24	Page 2
TN #DMAS-27	4/1/23	Pages 1, 3
TN #DMAS-14	10/1/19	Page 1
TN #DMAS-10	10/1/18	Page 1 Pages 2 and 3 are runover pages.
TN #DMAS-2	10/1/16	Pages 1-6 On pages 1 and 4-6, corrected the subchapter number in the headers. Neither the dates nor the policies were changed.
UP #9	4/1/13	Pages 1-3
UP #7	7/1/12	Table of Contents Pages 1-5 Page 6 was added.
TN #95	3/1/11	Page 4

2. Plan First Enrollees

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

3. MN Children Under Age 18 With $0 Spenddown Liability

Due to differences in income counting methodology applicable to Categorically Needy (CN) and MN covered groups, a child under age 18 may be ineligible for coverage in a CN covered group but have countable income under the income limit for MN coverage. The child's spenddown liability is $0.00 (zero dollars); therefore, his spenddown is met on the first day of the spenddown period. Enroll the child in *a 12 month* period of coverage, without the need for a new application, and complete an annual renewal. Continue to enroll the child in *12 month* periods of coverage per year as long as he continues to be eligible as MN at renewal. See M0330.803.

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

A. General Principle

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

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

M1310.300 SPENDDOWN DEFINITIONS

A. Introduction

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

B. Definitions

1. Applicable Exclusions

Applicable exclusions are the amounts that are deducted from income in determining an individual's income eligibility as identified under the July 16, 1996, AFDC State Plan for Families & Children covered groups, and under the SSI program for aged, blind or disabled individuals.

2. Assistance Unit

The Medicaid assistance unit is the individual or family who applies for Medicaid and whose financial eligibility is determined. The assistance unit for the Families & Children (F&C) covered groups is called the "family unit" or the "budget unit." The assistance unit for an ABD individual is just the individual, unless the individual is married, living with his/her spouse and the spouse is also ABD or the spouse is NABD and has deemable income. In this situation, the assistance unit is the married ABD couple.

3. Available Income

Available income means the earned and unearned income before exclusions used in determining the income eligibility of a medically needy individual.

M1360 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-30	1/1/24	Page 4
TN #DMAS-13	7/1/19	Page 4 Page 4a was deleted
TN #DMAS-12	4/1/19	Page 4, 4a
TN #DMAS-9	7/1/18	Page 4 Page 4a was added.

E. Income Increases

Recalculate the spenddown liability for the spenddown budget period based on the actual income received. If the new spenddown liability has not been met, cancel eligibility. Notify the recipient of the new spenddown liability and the balance of the spenddown liability which must be met by the last day of the spenddown budget period.

NOTE: **This subsection does not apply to medically needy *children or* pregnant women who apply for and are enrolled in Medicaid on or before the date the pregnancy terminates. Income increases are excluded for these MN *children and* pregnant women.**

F. Resource Changes

Redetermine the assistance unit's eligibility based on a change in resources.

1. Resources Within Limit

When resources are within the Medicaid limit, the unit remains eligible as medically needy for the remainder of the spenddown budget period.

2. Resources Exceed Limit

When the resources exceed the limit, cancel the unit's Medicaid eligibility after the advance notice is sent if the effective date of cancellation is prior to the end of the spenddown budget period. Do not change the spenddown liability or the spenddown budget period.

3. Example--Resource Change

EXAMPLE #3: Mr. and Mrs. Jones applied for Medicaid on July 10. They were put on a spenddown for the spenddown budget period July - December, which they met on August 3. They were enrolled effective August 3 through December 31. On September 2, they reported that they inherited some real property worth $20,000. It is not excluded since it is saleable. They are sent an advance notice on September 4 stating their Medicaid eligibility is canceled effective September 30 because of excess resources.

G. Change Due to Incarceration

A review must be conducted for all individuals in the assistance unit when a member of the assistance unit becomes incarcerated. See M1350.850 for changes due to incarceration prior to meeting a spenddown.

M1410 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-30	1/1/24	Pages 2 and 9
TN #DMAS-29	10/1/23	Page 11
TN #DMAS-25	10/1/22	Page 2a
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 *unless community LTSS has been authorized*.

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 *180* days of the date on the Notice of Action on Medicaid. If services do not start within *180* 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 *180* 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 *or begin receiving another type of LTSS*, 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 *180* days of the date of the Notice of Action on Medicaid. If LTSS did not start within *180* 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.

M1420 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-30	1/1/24	Page 1
TN #DMAS-26	1/1/23	Pages 1 and 2
TN #DMAS-25	10/1/22	Table of Contents Pages 1-5
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

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 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 *unless community LTSS has been authorized*;
- 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 is not required for 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. If the individual meets the definition of institutionalization they are evaluated using these rules. The appropriate authorization document (form or screen print) or documentation of institutionalization must be maintained in the individual's case record.

2. Required Authorization Documents

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) or the Minimum Data Survey (MDS) 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.

M1430 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-30	1/1/24	Page 3
TN #DMAS-26	10/1/22	Page 1
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 *180* 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.

1440 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-30	1/1/24	Page 3
TN #DMAS-10	10/1/18	Pages 3, 5
TN #DMAS-7	1/1/18	Page 1. Appendix 1, Page 4.
TN #DMAS-5	7/1/17	Table of Contents Pages 3-9, 11, 12
TN #DMAS-3	1/1/17	Table of Contents Pages 3-12 Appendix 1 was added. Page 2 is a runover page. Pages 13-23 were deleted.
UP #9	4/1/13	Page 5
Update (UP) #7	7/1/12	Table of Contents Pages 2, 14, 15, 18a-18c Pages 19, 20
TN #94	9/1/2010	Table of Contents Pages 13, 16, 18b, 19-22
TN #93	1/1/2010	Pages 14, 16
TN #91	5/15/2009	Table of Contents Page 12 Pages 17-18c

6. Institutional Status

To be eligible for Medicaid, an individual approved for CBC waiver services must meet the institutional status requirement. A CBC waiver services recipient usually is not in a medical institution; most CBC recipients live in a private residence in the community. However, an individual who resides in a residential facility such as an assisted living facility (ALF) may be eligible for some CBC waiver services. The institutional status requirements applicable to CBC waiver services recipients are in subchapter M0280.

7. Covered Group

The requirements for the covered groups are found in subchapters M0320 and M0330.

D. Financial Eligibility

An individual who has been screened and approved for CBC services is treated as an institutionalized individual for the Medicaid eligibility determination. Financial eligibility is determined as a one-person assistance unit separated from his legally responsible relative(s) with whom he lives.

If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has *180* days from the date on the Notice of Action to begin receiving CBC 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 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.

For married individuals with community spouses, other than MAGI Adults, the resource and income eligibility criteria in subchapter M1480 is applicable.

The asset transfer policy in M1450 applies to all CBC waiver services recipients.

M1440.100 CBC WAIVER DESCRIPTIONS

A. Introduction

This section provides a brief overview of the Medicaid CBC waivers. The overview is a synopsis of the target populations, basic eligibility rules, available services, and the assessment and service authorization procedure for each waiver.

The eligibility worker does not make the determination of whether the individual is eligible for the waiver services; this is determined by the pre- admission screener or by DMAS. The policy in the following sections is only for the eligibility worker's information to better understand the CBC waiver services.

B. Definitions

Term definitions used in this section are:

M1460 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-30	1/1/24	Pages 11 and 19
TN #DMAS-26	1/1/23	Pages 3, 35
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 *180* 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 *unless eligible in a MAGI group*); 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.

B. Definitions for This Section

1. Dependent

A dependent child or parent is one who may be claimed as a dependent for tax purposes under the Internal Revenue Service's Code by either the institutionalized individual or his spouse.

2. Institutionalization

a. Definition

Institutionalization means receipt of 30 consecutive days of :

- care in a medical facility (such as a nursing facility), or
- Medicaid waiver services (such as community-based care); or
- a combination of the two.

The definition of institutionalization is also met when an individual has a signed hospice election that has been in effect for 30 consecutive days.

The 30 consecutive days requirement is expected to be met if the pre-admission screening committee provides verbal or written confirmation of its approval for the individual's receipt of long-term care (LTC) services (see M1410.010).

NOTE: For purposes of this definition, continuity is broken by *180* or more consecutive days of:

- absence from a medical institution, or
- non-receipt of Medicaid waiver services.

EXCEPTION: When an individual is readmitted in less than 30 days due to a different diagnosis or a change in condition unforeseen at the time of discharge, a new 6-month home exclusion will begin if it was medically documented that the discharge occurred because facility services were no longer required and a physician documents that the change in circumstances could not be anticipated.

b. When Institutionalization Begins

Institutionalization begins the date of admission to a nursing facility or Medicaid waiver services when the pre-admission screening committee provides verbal or written confirmation of its approval for the individual's receipt of long-term care (LTC) services, or when the individual has been in the nursing facility for at least 30 consecutive days.

Institutionalization begins the date of admission to a hospital (acute care) when the individual has actually been a patient in the hospital for 30 consecutive days or more. For example, an individual was admitted to the general hospital on March 5. He applied for Medicaid on March 6. On April 3, he was still a patient in the general hospital. He was in the hospital for 30 consecutive days on April 3; his institutionalization began on the date he was admitted to the hospital, March 5. His eligibility for March is determined as an institutionalized individual.

The date of discharge from a medical institution into the community (and not receiving CBC waiver services) or death is **NOT** included in the 30 days.

M1470 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-30	1/1/24	Page 20
TN #DMAS-29	10/1/23	Pages 46-48
TN #DMAS-28	7/1/23	Page 19
TN #DMAS-27	4/1/23	Page 15
TN #DMAS-26	1/1/23	Pages 19, 20
TN #DMAS-25	10/1/22	Page 20
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

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

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

a. for individuals employed 20 hours or more per week, all earned income up to 300% of SSI ($*2,829 in 2024*) per month.

b. for individuals employed at least *4* but less than 20 hours per week, all earned income up to 200% of SSI ($*1,886 in 2024*) per month.

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

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

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

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

B. Couples

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

M1470.420 DEPENDENT CHILD ALLOWANCE

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

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

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

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

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

M1480 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-30	1/1/24	Pages 3, 7, 18c, 66, 69, 70
TN #DMAS-26	1/1/23	Pages 7, 18c, 66, 69, 70
TN #DMAS-25	10/1/22	Page 66
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

- an amount designated by a DMAS Hearing Officer, or
- an amount actually transferred to the community spouse by the institutionalized spouse following a court spousal support order issued as the result of an appeal of a DMAS Hearing Officer's decision

exceeds the amount of resources otherwise available to the community spouse.

5. Continuous Period of Institutionalization means 30 consecutive days of institutional care in a medical institution, or 30 consecutive days of receipt of Medicaid waiver services (CBC), or 30 consecutive days of a combination of institutional and waiver services. Continuity is broken only by *180* or more days absence from a medical institution or *180* or more days of non-receipt of waiver services.

6. Couple's Countable Resources means all of the couple's non-excluded resources, regardless of state laws relating to community property or division of marital property. For purposes of determining the combined and separate resources of the institutionalized and community spouses when determining the institutionalized spouse's eligibility, the couple's home, contiguous property, household goods, and one automobile are excluded.

7. Dependent Child **means a child 21 years old or older**, of either spouse, who lives with the community spouse and who may be claimed as a dependent by either member of the couple for tax purposes pursuant to the Internal Revenue Code. Tax dependency is verified by a verbal or a written statement of either spouse.

8. Dependent Family Member means a dependent parent, minor child, dependent child, or dependent sibling (including half brothers/sisters and adopted siblings) of either member of a couple who resides with the community spouse and who may be claimed as a dependent by either member of the couple for tax purposes under the Internal Revenue Code. Tax dependency is verified by a verbal or a written statement of either spouse.

9. Excess Shelter Allowance means the actual monthly expense of maintaining the community spouse's residence that exceeds the excess shelter standard (30% of the monthly maintenance needs standard). Actual monthly expenses are the total of:

- rent or mortgage including interest and principal;
- taxes and insurance;
- any maintenance charge for a condominium or cooperative; and
- the utility standard deduction under the Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps) that would be appropriate to the number of persons living in the community spouse's household, if utilities are not included in the rent or maintenance charge [Section 1924(d)(4) of the Social Security Act].

27. Spousal Share means ½ of the couple's combined countable resources at the beginning of the **first** continuous period of institutionalization, as determined by a resource assessment.

28. Spouse means a person who is legally married to another person under Virginia law.

29. Waiver Services means Medicaid-reimbursed home or community-based services covered under a 1915(c) waiver approved by the Secretary of the United States Department of Health and Human Services.

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

A. Applicability

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

For Medicaid applicants or enrollees approved for LTSS on or after July 1, 2006, the amount of equity in the home at the time of the initial LTC determination and at each renewal must be evaluated. For the purposes of the home equity evaluation, the definition of the home in M1130.100 A.2 is used; the home means the house and lot used as the principal residence and all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000.

B. Policy

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

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

If substantial home equity exists, the individual is not evaluated for or eligible for the Medicaid payment of LTSS. Do not evaluate asset transfers.

An individual with excess home equity is not eligible in the 300% of SSI covered group, but may be eligible for Medicaid payment of covered services other than LTSS if he is eligible in another covered group. Evaluate eligibility for an individual with substantial home equity in other covered groups.

***1.* Home Equity Limit**

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

- Effective January 1, 2022: $636,000
- Effective January 1, 2023: $688,000
- *Effective January 1, 2024: $713,000*

2. Reverse Mortgages

Reverse mortgages **do not** reduce equity value until the individual begins receiving the reverse mortgage payments from the lender.

2. After Eligibility is Established

Once an institutionalized spouse has established Medicaid eligibility as an institutionalized spouse, count only the institutionalized spouse's resources when determining the institutionalized spouse's Medicaid eligibility. Do not count or deem the community spouse's resources available to the institutionalized spouse.

If an institutionalized spouse's Medicaid coverage was cancelled and he reapplies as an institutionalized individual, use only the resources of the institutionalized spouse for his eligibility determination.

M1480.231 SPOUSAL RESOURCE STANDARDS

A. Introduction

This section provides the amounts and the effective dates of the standards used to determine an institutionalized spouse's initial and ongoing resource eligibility. Use the standard in effect on the date of the institutionalized spouse's Medicaid application. Definitions of the terms are found in section M1480.010.

B. Spousal Resource Standard

$30,828	*1-1-24*
$29,724	1-1-23
$27,480	1-1-22

C. Maximum Spousal Resource Standard

$154,140	*1-1-24*
$148,620	1-1-23
$137,400	1-1-22

M1480.232 INITIAL ELIGIBILITY DETERMINATION PERIOD

A. Policy

The initial eligibility determination period begins with the month of application. If the institutionalized spouse is eligible for the month of application, the initial eligibility determination period will both begin and end with that month.

After eligibility is established, the usual reporting and notification processes apply. Send 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
	$2,465	*7-1-23*
C. Maximum Monthly Maintenance Needs Allowance	$3,435.00	1-1-22
	$3,715.50	1-1-23
	$3,853.50	*1-1-24*
D. Excess Shelter Standard	$653.25	7-1-21
	$686.63	7-1-22
	$739.50	*7-1-23*

E. Utility Standard Deduction (SNAP)	$374.00	1 - 3 household members	10-1-22
	$473.00	4 or more household members	10-1-22
	$*414.00*	1 - 3 household members	*10-1-23*
	$*524.00*	4 or more household members	*10-1-23*

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

A. Policy

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

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

His personal needs allowance is calculated as follows:

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

2. Medicaid CBC Waiver Services and PACE

a. Basic Maintenance Allowance

For the Commonwealth Coordinated Care Plus (CC Plus) Waiver (formerly the Elderly or Disabled with Consumer Direction Waiver and the Technology-Assisted Individuals Waiver), Community Living (CL) Waiver (formerly Intellectual Disabilities Waiver), Family and Individual Supports (IS) Waiver (formerly Individual and Family Developmental Disabilities Support Waiver), Building Independence (BI) Waiver (formerly Day Support Waiver), or PACE, deduct the appropriate maintenance allowance for one person as follows:

- January 1, 2021 through December 31, 2021: $1,311
- January 1, 2022 through December 31, 2022: $1,388
- January 1, 2023 through December 31, 2023: $1,509
- *January 1, 2024 through December 31, 2024: $1,556*

Contact a Medical Assistance Program Consultant for the amount in effect for years prior to 2017.

b. Guardian Fee

Deduct the actual fee a guardian or conservator charges, up to a maximum of 5% of the patient's actual gross income (including amounts not counted as income and excluded amounts) for guardianship fees, IF:

* the patient has a legally appointed guardian or conservator AND
* the guardian or conservator charges a fee.

Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

NOTES: No deduction is allowed for representative payee or "power of attorney" fees or expenses. No deduction is allowed if the patient's guardian receives a payment for providing guardianship services from a public agency or organization that receives funding for guardianship services. The guardianship filing fees CANNOT be deducted from the individual's income.

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

[EXAMPLE #19 was deleted]

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

- for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (*$2,829* in 2024) per month.

- for individuals employed at least 4 but less than 20 hours per week, all earned income up to 200% of SSI (*$1,886* in *2024*) per month.

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

EXAMPLE #20: (Using January 2000 figures)

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

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

$928.80 = special earnings allowance

His personal maintenance allowance is calculated as follows:

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

M1510 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-30	1/1/24	Page 1, 2a, 8a,
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

M1510.000 ENTITLEMENT POLICY & PROCEDURES M1510.100 MEDICAID ENTITLEMENT

A. Policy

An individual's entitlement to Medicaid coverage is based on the individual meeting all nonfinancial and financial eligibility requirements for the individual's covered group during a month covered by the application, as well as any additional entitlement policies that are applicable to the covered group.

1. Spenddown Met

If the applicant had excess income and met the spenddown within the month, he remains responsible for his spenddown liability and his coverage begin date cannot be any earlier than the date he met the spenddown. *Medically needy pregnant women who apply for and are enrolled in Medicaid on or before the date the pregnancy terminates are eligible until the end of the 12th month after the pregnancy ends. MN children are eligible for 12 months coverage after they are determined eligible. Income increases are excluded for these MN children and pregnant women.*

2. Individual is Deceased

If an application is filed on behalf of a deceased individual or the applicant dies during the application process, his eligibility is determined only for the days he was alive. He must have been eligible for Medicaid while he was alive in order to be entitled to enrollment in Medicaid. Any changes in the individual's resources or income after his death do not affect the eligibility determination.

Example: An individual applies on July 23 for retroactive and ongoing Medicaid. The worker determines that the individual had excess resources (cash value of life insurance) throughout the retroactive period and the application month. The individual dies on August 5. The family asserts that he no longer owned the life insurance policies on August 5 and meets the resource requirements for the month of August. The worker determines that the individual owned the policies on the date of his death, the countable value exceeded the resource limit and he was not eligible for medical assistance on or before the date of his death.

3. Applicant Has Open MA Coverage in Another State

If an applicant indicates that he has been receiving Medical Assistance (MA--Medicaid or Children's Health Insurance Program) coverage in another state prior to moving to Virginia, instruct him to contact his eligibility worker there and request that his coverage be cancelled, if he has not already done so. He is no longer considered a resident of the other state once he has moved and intends to reside in Virginia, and he is no longer entitled to receive services paid for by the other state's MA program. His enrollment may begin with the month of application or the earliest month in the application's retroactive period that he met the residency requirement per M0230.

M1510.101 RETROACTIVE ELIGIBILITY & ENTITLEMENT

A. Definitions

1. Retroactive Period

The retroactive period is the three months immediately prior to the application month. Within this retroactive period, the individual may be Categorically Needy (CN) in one or two months and Medically Needy (MN) in the third month, or any other combination of classifications.

Retroactive Medicaid eligibility must be determined when an applicant for medical assistance indicates on the application that he, or anyone for whom he requests assistance, received a covered medical service within the retroactive period. The covered service may be listed by the applicant as an actual medical service on the application, or information on the application may indicate that a service was received, such as the birth of a child or Medicare coverage during the retroactive period.

2. Retroactive Budget Period

The "budget period" is the period of time during which an individual's income is calculated to determine income eligibility. The retroactive budget period depends on the individual's covered group.

B. Policy

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

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

Pregnant women (with approved immigration status) who apply for and are enrolled in Medicaid on or before the date the pregnancy terminates are eligible until the end of the 12th month after the pregnancy ends. Children are eligible for 12 months coverage after they are determined eligible (at application and after each renewal). Income increases are excluded for these children and pregnant women.

M1510.103 HOSPITAL PRESUMPTIVE ELIGIBILITY

A. Policy

Individuals enrolled on the basis of Hospital Presumptive Eligibility (HPE) are covered by Medicaid beginning with the date of the HPE determination through the last day of the following month or the date MA eligibility is determined by an LDSS, whichever comes first. For their coverage to continue beyond the HPE enrollment period, they must submit a full MA application. If the individual does not submit an MA application, no further action is necessary on the part of the LDSS. See M0120.500 C.

B. Procedures

When an HPE enrollee submits a full MA application and it is pended in VaCMS, the individual's coverage in the HPE AC is extended by the eligibility worker, as necessary, while the application is processed.

Applications submitted by pregnant women enrolled on the basis of HPE must be processed within 7 calendar days of the agency's receipt of the signed application. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) applications submitted by individuals enrolled on the basis of HPE must be processed within 10 work days of the agency's receipt of the signed application.

1. Enrollment

When an individual is determined eligible for MA coverage, his MA coverage under the appropriate MA AC includes any days to which he is entitled that are not already covered by HPE. If the individual submitted the MA application in the same month HPE coverage began and HPE began on any day other than the first day of the month, his MA coverage begins the first day of that month and the eligibility worker enrolls him in a closed period of coverage in the appropriate MA AC beginning with the first day of the month and ending the day before the HPE begin date. The worker is to enroll the eligible individual in ongoing coverage in the appropriate MA AC beginning the first day of the month after the effective date of the HPE coverage cancellation.
See M0120.500 C.2

Children's 12 month continuous eligibility does not apply to children enrolled as HPE (unless they are found eligible for medical assistance after filing a full application).

2. Individuals Enrolled in HPE as Pregnant Women or in Plan First

If an individual who was enrolled in HPE with partial coverage as a pregnant woman or in Plan First is determined eligible for full MA coverage in the period covered by HPE, cancel HPE coverage retroactively and reinstate in full coverage for the retroactive months and ongoing, if eligible.
See M0120.500 C.2d

3. Retroactive Entitlement

An individual's eligibility for retroactive coverage for the three months prior to the month of the MA application is determined when the individual had a medical service within the three months prior to the month of the full MA application. If the individual had full coverage while enrolled as HPE, only enroll him for the portion of the retroactive period that he was not enrolled as HPE. See M0120.500 C.2e

M1520 Changes
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Changed With	Effective Date	Pages Changed
TN #DMAS-30	1/1/24	Pages 3, 10, 10a, 13, 14, 18
TN #DMAS-27	4/1/23	Page 1, 15, 24a
TN #DMAS-26	1/1/23	Pages 15 and 24a
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.

4. 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.

5. 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 child reaches age 19; is no longer a Virginia resident; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.*
- 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

Children under 19 receive 12 months of continuous eligibility unless

- *they reach age 19;*
- *are no longer Virginia residents;*
- *the child or child's representative requests eligibility be closed;*
- *the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or*
- *the child is deceased.*

4. Child Under Age 19 - Income Exceeds FAMIS Plus Limit

At renewal if 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.

5. **Child Receiving LTC Services Turns 18**

A child enrolled in the F&C 300% of SSI covered group no longer meets the covered group upon turning 18, unless he meets another F&C definition (e.g. pregnant woman or parent of a dependent child). A referral to Disability Determination Services (DDS) must be made at least 90 calendar days prior to the child's 18th birthday to allow the disability determination to be made prior to the child's 18th birthday.

6. **FAMIS Plus Child Turns Age 19**

When a FAMIS Plus child turns age 19, redetermine the child's continuing Medicaid eligibility in other covered groups.

If information in the case record indicates that the child is disabled or may be disabled, verify the child's SSI benefits through SVES or SOLQ-I. If the child does not receive SSI, complete a referral to DDS following the procedures in M0310.112. The referral to DDS must be made at least 90 calendar days prior to the child's 19th birthday to allow the disability determination to be made prior to the child's 19th birthday.

B. Procedures

1. Change Results in Adverse Action

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

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

Unless the individual has Medicare, a referral to *Virginia's Insurance Marketplace* must be made when coverage is cancelled. The notice must state that the individual has been referred to *VIM* for determination of eligibility for the APTC.

2. Enrollee Appeals Action

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

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

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

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

3. Death of Enrollee

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

The Social Security Administration will verify that an individual is dead, but not the date of death. A match with Social Security Administration data occurs when the individual's information is sent through the Hub in VaCMS.

Accept the date of death reported to the agency from a family representative or medical provider as accurate. If there is conflicting information regarding the date of death, contact the parent/caretaker relative or authorized representative to obtain the date of death. Information from a medical professional/facility is also acceptable. *If the worker is unable to determine the actual date of death, use the date that a HUB inquiry verifies that the member is deceased.*

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

Cancel the enrollee's coverage, using the date of death *(or the date of the HUB inquiry)* as the effective date of cancellation.

4. Enrollee Enters an IMD

When an enrollee enters an institution for the treatment of mental diseases (IMD), **do not** cancel coverage. DMAS will coordinate with the Centers for Medicare and Medicaid Services (CMS) to ensure that no unauthorized FFP occurs.

5. Enrollee Becomes Incarcerated

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

6. End of Spenddown Period

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

7. Reason "012" Cancellations

DMAS staff *do not perform* cancellations due to returned mail. Cancellations for other reasons (such as aging out of the current aid category) are reported in the monthly System Cancellation Report (RS-O-112) available in the Data Warehouse Medicaid Management Reports. The report is issued between the 21st and 25th day of each month and *should* be monitored *by the LDSS worker for appropriate follow up*.

1. Received LIFC Medicaid in Three of Six Months

The family received LIFC Medicaid in at least three of the six months immediately before the month in which the family became ineligible for LIFC. A family who received Medicaid erroneously during three or more of the six months before the month of ineligibility does **not** qualify for the Medicaid extension. Months during which the family received Extended Medicaid are not considered months in which the family received LIFC Medicaid, and the family must be evaluated for eligibility in other covered groups.

2. Cancel Reason

LIFC Medicaid was canceled solely because of:

- the parent's or caretaker/relative's new employment,
- the parent's or caretaker/relative's increased hours of employment, or

the parent's or caretaker/relative's increased wages of employment.

3. Has A Child Living in Home

There continues to be at least one child under age 18 or if in school, a child who is expected to graduate before or in the month he turns 19, living in the home with the parent or caretaker/relative.

4. No Fraud

The family has not been determined to be ineligible for LIFC Medicaid at any time during the last six months in which the family received LIFC Medicaid because of fraud.

C. Entitlement & Enrollment

The AC for enrollees in the family receiving the twelve-month extension is "081" for an LIFC family with one parent or caretaker-relative or "083" for a two-parent family. Entitlement does not continue for any member of the family who moves to another state.

If a parent becomes eligible for extended Medicaid, the child(ren) remains in the current Aid Category until the end of the previous 12 month continuous eligibility period. Then, if no longer eligible, they are moved into extended Medicaid for the remainder of the extended period. Children under 19 remain eligible for 12 months unless a child reaches age 19; is no longer a Virginia resident; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.

1. Determining Extension Period

a. Establishing Initial Month of Eligibility
Medicaid coverage will continue for six months beginning with the first month following the month in which the family is no longer eligible for LIFC Medicaid because of excess income due to the increased earnings of the parent or caretaker/relative *AND the Benefits Worker can give 10 days notice prior to taking action*.

b. Extension for an additional six-month period is possible if the reporting and financial requirements below are met.

For example, if the increased earnings were received in April, but were not reported or discovered until a review of eligibility in June, the 12-month extension period *begins with July if the Benefits Worker takes action prior to June 20.* The screening period to determine if the family received LIFC Medicaid in at least three of the six months immediately preceding the month in which the family became ineligible for LIFC Medicaid is November through April.

M21 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-30	1/1/24	Pages 1, 3, 7
TN #DMAS-28	7/1/23	Appendix 1
TN #DMAS-25	10/1/22	Page 6
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

M2100.000 FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS)

M2110.100 FAMIS GENERAL INFORMATION

A. Introduction

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program, enacted as Title XXI of the Social Security Act, to provide funds to States to enable them to initiate the provision of child health insurance to **uninsured low-income children**.

FAMIS is not an entitlement program, which means that if funds for this program are exhausted, no additional individuals will receive benefits under the program. The Department of Medical Assistance Services (DMAS) will notify the Department of Social Services (DSS) Central Office if funds for this program run out.

Children found eligible for FAMIS receive benefits described in the State's Title XXI Child Health Insurance Program. Eligible children are enrolled for benefits effective the first day of the child's application month if all eligibility requirements are met in that month, but no earlier than the date of the child's birth.

Retroactive coverage is only available to an eligible child who was born within the 3 months prior to the FAMIS application month. Eligibility for FAMIS coverage will be effective retroactive to the child's date of birth if the child would have met all eligibility criteria during that time.

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

B. Legal Basis

The 1998 Acts of Assembly, Chapter 464, authorized Virginia's Children's Health Insurance Program by creating the Children's Medical Security Insurance Plan for uninsured children under 19 years of age. In August 2001, the program was revised and renamed the Family Access to Medical Insurance Security Plan (FAMIS).

C. Policy

FAMIS covers uninsured low-income children under age 19 who are not eligible for Medicaid (children's Medicaid) and whose gross family income is less than or equal to 200% of the federal poverty level (FPL) for the individual's household size (see M2130.100 for the definition of the FAMIS household and Appendix 1 for the income limits).

Federal mandate requires that children under 19 receive 12 months of continuous eligibility unless *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased. A FAMIS enrolled child who becomes eligible for Medicaid can be moved to a Medicaid Aid Category and given a new 12-month continuous eligibility period.*

M2120.200 HEALTH INSURANCE COVERAGE

A. Introduction

The intent of FAMIS is to provide health coverage to low-income uninsured children. Eligibility for this program is prohibited when a child has creditable health insurance coverage, with two exceptions:

1. A child who was enrolled in the Health Insurance Premium Payment (HIPP) Program while covered by Medicaid and who subsequently becomes income eligible for FAMIS *can remain enrolled in FAMIS.*
2. *A child who is found eligible for Medicaid and given a 12 month continuous eligibility period may be enrolled in other health insurance without penalty. Eligibility will be re-determined after 12 months.*

B. Definitions

1. Creditable Coverage

For the purposes of FAMIS, creditable coverage means coverage of the individual under any of the following:

- church plans and governmental plans;
- health insurance coverage, either group or individual insurance;
- military-sponsored health care;
- a state health benefits risk pool;
- the federal Employees Health Benefits Plan;
- Medicare
- a public health plan; and
- any other health benefit plan under section 5(e) of the Peace Corps Act.

The definition of creditable coverage includes short-term limited coverage.

2. Health Benefit Plan

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

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

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 ***unless*** *they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased. Income changes or enrolling in other health insurance do not affect the child's eligibility during the 12 month period.*

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 *are* subsequently *found eligible* for Medicaid *(because of a change or a new application)* must have their FAMIS coverage cancelled so they can be reinstated in Medicaid. *A new 12 month period of eligibility will begin.*

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.

M23 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-30	1/1/24	Pages 1, 6, 7, 8
TN #DMAS-28	7/1/23	Appendix 1
TN #DMAS-25	10/1/22	Pages 5 & 6. Adjust pages 7-8.
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

M2300.000 FAMIS PRENATAL COVERAGE

M2310.100 FAMIS PRENATAL COVERAGE GENERAL INFORMATION

A. Introduction

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

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

FAMIS Prenatal Coverage is effective beginning July 1, 2021.

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

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

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

An eligible woman will receive coverage through her pregnancy and the end of the month in which the 60th day following the end of the pregnancy occurs. An infant born to a woman enrolled in FAMIS Prenatal Coverage will receive ongoing coverage beginning on the date of the infant's birth *and ending 12 months after the child's birth month*. The infant's coverage will be in Medicaid or FAMIS, based on the mother's MAGI household unit income at the time of application. The infant's birth is evaluated as a case change; an application does not need to be submitted for the infant.

B. Policy Principles

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

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

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

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

1. 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.

3. Aid Categories

The FAMIS Prenatal Coverage aid categories (AC)* are:

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

Note: A change in the MMIS enrollment system was effective July 1, 2022 to display the FAMIS Prenatal aid categories AC110 / AC111. Anyone enrolled prior to July 1, 2022 will remain in aid category AC005 *until renewal* if eligibility is not run and updated to the new AC.

4. Coverage Period

After her eligibility is established as a pregnant woman, the woman's FAMIS Prenatal Coverage entitlement continues through her pregnancy and the 60-day period following the end of her pregnancy regardless of income changes. Her coverage ends the last day of the month in which the 60th postpartum day occurs. 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 *and is eligible for 12 months of continuous coverage.*

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.

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.

1. Required Information

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

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

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

2. Enrollment and Aid Category

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

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

3. Renewal

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

G. Examples

Example 1

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

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

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

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

Example 2

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

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

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

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

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

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

M2350.100 REVIEW OF ADVERSE ACTIONS

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

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