



# COMMONWEALTH of VIRGINIA

## DEPARTMENT OF SOCIAL SERVICES

October 1, 2013

MEDICAID ELIGIBILITY MANUAL – VOLUME XIII

TRANSMITTAL #98

The following acronyms are used in this transmittal:

- ABD – Aged, Blind and Disabled
- ACA – Affordable Care Act
- APTC – Advance Premium Tax Credit
- BCCPTA – Breast and Cervical Cancer Prevention and Treatment Act
- CBC – Community-based Care
- CPU – Central Processing Unit
- CHIP – Children’s Health Insurance Program
- CN – Categorically Needy
- CNNMP – Categorically Needy Non-Money Payment
- DMAS – Department of Medical Assistance Services
- EWB – Essential to the Well Being
- F&C – Families & Children
- FAMIS – Family Access to Medical Insurance Security Plan
- HIM – Health Insurance Marketplace
- LDSS – Local Departments of Social Services
- LIFC – Low-income Families with Children
- MA – Medical Assistance
- MAGI – Modified Adjusted Gross Income
- MI – Medically Indigent
- MN – Medically Needy
- PRTF – Psychiatric Residential Treatment Facility
- SNAP – Supplemental Nutrition Assistance Program
- SPARK – Services Programs Answers Resources Knowledge
- SSI – Supplemental Security Income
- SSN – Social Security Number
- TANF – Temporary Assistance for Needy Families
- TN – Transmittal
- VaCMS – Virginia Case Management System
- VDSS – Virginia Department of Social Services

This transmittal includes new, revised and clarified Medicaid eligibility policy and procedures effective October 1, 2013, unless otherwise indicated.

### **New Policy**

Transmittal #98 contains major changes to F&C Medicaid eligibility methodology. The Patient Protection and Affordable Care Act of 2010 (Pub. L. No. 111-148), generally referred to as the ACA, mandates the methodology changes for the Medicaid and CHIP (FAMIS) programs, referred to as MA programs. Beginning with applications received on or after October 1, 2013, determinations of eligibility for most F&C Medicaid covered groups and FAMIS will be done using MAGI methodology. 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.

MAGI methodology does NOT apply to individuals who apply before October 1, 2013, or to individuals enrolled as of September 30, 2013 until the time of their next renewal completed on or after April 1, 2014. Renewals completed before April 1 continue to be processed in ADAPT. Information about completing renewals effective April 1, 2014 will be included in Medicaid Transmittal #99 scheduled for January release. Procedures will be posted for adding a person to an existing case (i.e. a new application).

MAGI eligibility rules are based on federal tax rules for determining adjusted gross income, with some modifications. MAGI methodology uses gross income, with most types of income being countable. If an individual is ineligible due to excess income, an amount equal to 5% of the FPL for his household size is deducted from his gross monthly income. The remaining income is compared to income limit of the full-benefit covered group with the highest income limit that the individual meets. There is no asset test.

New F&C applicants who meet the definition of an institutionalized individual in M1410 will have their eligibility determined in the applicable F&C 300% of SSI covered group. MAGI methodology is not used to determine their eligibility.

Effective January 1, 2014, the ACA mandates Medicaid coverage to be provided to former Virginia foster care children between the ages of 18 and 26. The policy has been added to TN #98 to acclimate LDSS to the new covered group prior to its implementation.

The ACA incorporates several other components to achieve the coordinated system of eligibility and enrollment. Trained Certified Application Counselors and Navigators will be available to assist individuals with applying for affordable health insurance and MA programs. Premium assistance in the form of tax credits will be available to qualified individuals who are not eligible for MA. Virginia will refer ineligible individuals, as well as applicants whose applications are pending while a disability determination is being completed, individuals enrolled in Plan First, and individuals placed on a spenddown, to the Federal Health Insurance Marketplace for their eligibility to be determined for the APTC. Medicare beneficiaries will not be referred to the HIM.

### **Revised Policy**

The FAMIS CPU will be transitioning responsibility for FAMIS and FAMIS MOMS cases to the LDSS. October 1, 2013, LDSS will retain all new FAMIS and FAMIS MOMS cases for case maintenance. The FAMIS CPU will also transfer FAMIS cases to the appropriate LDSS at the time of the renewal. Changes to existing FAMIS cases will be handled by the FAMIS CPU until the case comes up for renewal.

Effective January 1, 2014, no new pregnant women will be enrolled in FAMIS MOMS. Women enrolled in FAMIS MOMS as of December 31, 2013 will remain covered through the end of their post-partum period. The policy on verification of pregnancy was revised to meet the ACA requirement that a woman may attest to her pregnancy on the application. No further verification is obtained unless the agency has contradictory information.

Effective October 1, 2013, the definition of LIFC no longer includes an EWB. For applications submitted prior to October 1, the EWB is covered under the LIFC definition.

The list of acceptable forms of documentation for U.S. citizenship contained in M0220 was modified, and the residency policy in M0230 was revised slightly to meet ACA requirements.

**Updated Policy**

The ACA requires states to ensure that current Medicaid enrollees are not impacted by the loss of earned income disregards under the new methodology. The F&C income limits were converted to figures that incorporate the lost earned income disregards. The new income limits are contained in the transmittal.

The income limit for Plan First is being lowered to 100% of FPL effective January 1, 2014. The policy has been added to TN #98 to alert LDSS of the upcoming change.

While the majority of changes contained in TN #98 are related to the implementation of MAGI and other ACA changes, the transmittal also contains updated income limits for the MN covered groups and updated spousal standards effective July 1, 2013 unless otherwise specified.

**Electronic Version**

Transmittal #98 is available electronically on SPARK and the VDSS public web site. It has not been printed for distribution. The electronic version is the Transmittal of record. Significant changes to the manual are as follows:

<b>Pages With Significant Changes</b>	<b>Changes</b>
subchapter M0110 pages 1-5	On pages 1-3, added references to FAMIS and introduced the concept of Medicaid and FAMIS as MA programs. On pages 4 and 5, added information about Certified Application Counselors and Navigators.
subchapter M0120 pages 1, 11, 12	On page 1, clarified that applications bearing electronic signatures are valid. On page 11, clarified the various means of submitting applications and added information about the new streamlined MA applications. On page 12, revised the policy on the use of other application forms.
subchapter M0130 pages 1, 5, 9, 11	On page 1, added information about aspects of the ACA that impact the MA eligibility determination process. On page 5, added policy on the use of the Hub. On page 9, added policy on the use of federal income tax data. On page 11, revised the policy on processing applications and added information about the APTC.

<b>Pages With Significant Changes</b>	<b>Changes</b>
subchapter M0210 pages 1-3	On page 1, added a reference to Chapter M04. On page 2, clarified that an individual assigns his rights to third party payments by signing the application. On page 3, clarified the requirement to pursue medical support from an absent parent.
subchapter M0220 page 3a Appendix 1, pages 1-5	On page 3a, clarified that the citizenship/identity data match occurs at the time of application for applications processed by VaCMS. In Appendix 1, pages 1-5, the list of acceptable documentation of citizenship and identity (applicable when documentation must be provided) was significantly simplified, and the levels of acceptable documentation were eliminated.
subchapter M0230 pages 3-5	On page 3, revised the policy on residency for individuals under age 21 and not in an institution. Non-emancipated children who do not live with a parent but who presently reside in Virginia and intend to reside in Virginia meet the residency requirement. On pages 4 and 5, revised the policy on residency for adults. Adults who presently reside in Virginia and intend to reside in Virginia meet the residency requirement.
subchapter M0240 pages 1, 2	On page 1, revised the SSN policy to include FAMIS children. The policy on exceptions to the SSN requirement was revised to include both newborns born Medicaid eligible or FAMIS-covered mothers. On page 2, information on the use of the HUB was added.
subchapter M0250 pages 1, 2	On page 1, clarified that the assignment of rights policy applies to children eligible for FAMIS, as well as Medicaid. On page 2, clarified that the assignment of rights is incorporated into both the paper and on-line applications
subchapter M0310 pages 2, 4, 27a, 28, 35, 36, 39	On pages 2, 4 and 28, added former Virginia foster care children under age 26 years to the list of F&C covered groups. On page 4, also revised the references to the BCCPTA covered group to include both woman and men. On page 27a, clarified that individuals awaiting a non-expedited disability determination are referred to the HIM. On page 28, also revised the definition of an EWB. On pages 35 and 36, revised the definition of a pregnant woman to indicate that pregnancy is established by the woman's attestation on the application; no further verification is required. On page 39, revised the references to the BCCPTA covered group to include both woman and men.
subchapter M0320 pages 1, 55	On pages 1 and 55, added policy specifying a referral to the HIM for ABD individuals who are not eligible for full Medicaid coverage and those placed on a spenddown, when the individual does not have Medicare.

<b>Pages With Significant Changes</b>	<b>Changes</b>
subchapter M0330 pages 1, 2, 6-16, 19 pages 22, 24-29	On page 1, added the Former Virginia Foster Care Children Under Age 26 covered group. On page 2, added information on which eligibility methodology applies to the various F&C covered groups. On page 6, revised the policies and procedures. On pages 7 and 8, revised the policies and procedures on the Special Medical Needs Adoption Assistance covered group. On pages 8 and 9, added the policies and procedures for the Former Virginia Foster Care Children Under Age 26. On pages 9 and 10, revised the policies and procedures for the LIFC covered group. On pages 10-13, revised the policies and procedures for the Children Under Age 19 Years covered group. On page 13-15, revised the policies and procedures for the Pregnant Woman and Newborn Children covered groups. On pages 16, 19 and 22, clarified that MAGI methodology is not used for the F&C 300% of SSI covered groups. On pages 24 and 25, revised the policies and procedures for the Plan First covered group. On pages 26-29 revised the policies and procedures for the BCCPTA covered group. On page 29, also added policy specifying a referral to the HIM for individuals placed on a spenddown.
chapter M04 pages 1-25 Appendices 1-6	Chapter M04, MAGI, was added.
subchapter M0510 page 1	On page 1, added information on which eligibility methodology, policies and procedures apply to the various F&C covered groups.
subchapter M0520 pages 1, 2, 9	On page 1, added a reference to M0510 for determining which eligibility methodology, policies and procedures apply to the various F&C covered groups. On page 2, clarified that children in Level C PRTFs are considered indefinitely absent from the home and not living with parents or siblings. On page 9, clarified that EWB coverage is only applicable prior to October 1, 2013.
subchapter M0710 pages 1, 3, 4, 8, 9 Appendices 1, 3, 5	On page 1, added a reference to M0510 for determining which eligibility methodology, policies and procedures apply to the various F&C covered groups. On pages 3, 4, 8 and 9, clarified the covered groups and effective dates of the policy. The appendices were updated with the F&C income limits effective July1, 2013.
subchapter M0720 pages 6, 10	On page 6, revised the policy on deducting depreciation when calculating profit from self-employment. On page 10, clarified which income disregards apply under MAGI methodology.
subchapter M0730 pages 7, 8	On page 7, clarified that Workers Compensation is excluded for the LIFC covered group for applications submitted before October 1, 2013 and for renewals made before April 1, 2014. On Page 8, clarified that child support is not counted as income under MAGI methodology.

<b>Pages With Significant Changes</b>	<b>Changes</b>
subchapter M0810 page 2	On page 2, updated the ABD MN income limits, which were effective July 1, 2013.
subchapter M1470 pages 9, 24	On pages 9 and 24, corrected the Medicare Part D benchmark premium amount.
subchapter M1480 page 66	On page 66, updated the spousal maintenance standards, which were effective July 1, 2013, as well as the SNAP Utility Standard, effective October 1, 2013.
Chapter M21 pages 1, 2, 7, 9	On page 1, revised the policy on the maintenance of FAMIS cases. On page 2, added the policy on protected children and the SSN requirement for FAMIS. On page 7, clarified that MAGI methodology applies to FAMIS income evaluations. On page 10, clarified that electronic data sources are to be used to verify reported changes in income.
Chapter M22 pages 1-3, 5, 7 Appendix 1	On page 1, clarified that FAMIS MOMS coverage will not accept new enrollees after December 31, 2013. On page 2, added policy requiring an SSN or application for SSN. On page 3, revised the policy on verification of pregnancy. On page 5, clarified that MAGI methodology applies to FAMIS MOMS income evaluations. On page 7, added policy on making a referral to the Health Insurance Marketplace for ineligible women. In Appendix 1, changed the income limits to 211% FPL

Please retain this transmittal letter for future reference. Should you have questions about information contained in this transmittal, please contact Stephanie Sivert, Manager, Medical Assistance Programs, at 804-726-7660 or [stephanie.sivert@dss.virginia.gov](mailto:stephanie.sivert@dss.virginia.gov).



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Commissioner

Electronic Attachment

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<b>Changed With</b>	<b>Effective Date</b>	<b>Pages Changed</b>
TN #98	10/1/13	page i
TN #93	1/1/10	page iii
Update (UP) #2	8/24/09	page iii

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**M0110 Changes**

<b>Changed With</b>	<b>Effective Date</b>	<b>Pages Changed</b>
TN #98	10/1/13	Table of Contents pages 1-15 Page 6a was removed. Page 16 was added.
TN #97	9/1/12	Table of Contents page 13 Page 14 was added. Appendix 1 was added.
Update #7	7/1/12	pages 3, 6a, 7, 8
TN #96	10/1/11	Table of Contents pages 2-6a
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### M01 APPLICATION FOR MEDICAL ASSISTANCE

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## M0110 General Information

### M0110.100 Legal Base and Agency Responsibilities

#### A. Introduction

*Virginia's two medical assistance programs are Medicaid and the Family Access to Medical Insurance Security Plan (FAMIS). Collectively, these programs are referred to as medical assistance (MA). The MA programs pay medical service providers for medical services rendered to eligible individuals. When an individual submits an application for MA, his eligibility is determined for Medicaid first. If he is not eligible for Medicaid due to excess income, his eligibility is determined for FAMIS.*

*The policies and procedures for determining Medicaid eligibility are contained in Chapters 1 through 18 of this manual; the policies and procedures for determining FAMIS eligibility for children and pregnant women (FAMIS MOMS) are contained in Chapters 21 and 22, respectively.*

The MA eligibility determination consists of an evaluation of an individual's situation that compares each of the individual's circumstances to an established standard. Requests for Virginia MA must be made on an approved electronic or paper application form or telephonically through the Cover Virginia Call Center.

All activity of the agency in receiving and acting upon an application must be consistent with the objectives of the MA programs and be conducted in a manner which respects the personal dignity and privacy of the individual.

#### B. Legal Base

The Medicaid Program is established under Title XIX of the Federal Social Security Act and is financed by state and federal funds. The State Plan for Medical Assistance (State Plan) is the official body of regulations covering the operation of the Medicaid program in Virginia. *The FAMIS program is established under Title XXI of the Social Security Act.*

Virginia law provides that the MA programs be administered by the Department of Medical Assistance Services (DMAS). Determination of eligibility for medical assistance is the responsibility of local departments of social services under the supervision of the Virginia Department of Social Services (DSS).

Exception: DSS carries direct responsibility for the determination of eligibility of certain patients in Virginia Department of Behavioral Health and Developmental Services (DBHDS) facilities and for their enrollment in the Medicaid program.

#### C. Agency Responsibilities

##### 1. DMAS

The administrative responsibilities of DMAS are:

the development of the State Plan to cover eligibility criteria and scope of services, in conformity with federal law and regulation,

- the determination of medical care covered under the State Plan,
- the handling of appeals related to the *MA programs*,
- the approval of providers authorized to provide medical care and receive payments under the *MA programs*,
- the processing of claims and making payments to medical providers, and
- the recovery of *MA* expenditures in appropriate cases. Suspected applicant fraud is a combined responsibility of both DMAS and DSS.

**2. DSS**

The responsibilities of DSS are:

- the determination of initial and continuing eligibility for Medicaid *and FAMIS*,
- the enrollment of eligible persons in the Medicaid *or FAMIS programs*,
- the maintenance of case records pertaining to the eligibility of MA enrollees,
- *the referral of individuals with inappropriate MA payments to the DMAS Recipient Audit Unit, and*
- *the referral of certain individuals to the Health Insurance Marketplace.*

**M0110.110 Confidentiality**

**A. Confidentiality**

*MA* applicants and recipients are protected by federal and state confidentiality regulations, 42 CFR 431.300 and 12VAC30-20-90. These regulations were established to protect the rights of clients to confidentiality of their information.

**B. Release of Client Information**

Except as otherwise indicated, no person shall obtain, disclose or use, authorize, or permit the use of any client information that is directly or indirectly derived from the records, files or communications of the agency, except for purposes directly connected with the administration of the *MA* programs, which include but is not limited to:

- establishing eligibility,
- determining the amount of medical assistance,
- providing services for recipients, and
- conducting or assisting in an investigation, prosecution or a civil or criminal proceeding related to the administration of the program.

**C. Use of System Searches**

Searches of online information systems, including but not limited to the State Online Query-Internet (SOLQ-I), the State Verification Exchange System (SVES) and the Federal Data Hub are permitted **only** for applicants and family members whose income and/or resource information is required to determine eligibility for the applicant or patient pay for an enrollee. This includes spouses of applicants and parents of child applicants.

*The Federal Data Hub is to be accessed only for information necessary to determine eligibility for MA cases processed in the Virginia Case Management System (VaCMS). It may not be used for other public assistance programs.*

**D. Release of Information to Medical Providers**

Although certain individuals are authorized to receive information about an applicant's/recipient's case, only the minimum data necessary to respond to the request is to be released. Federal regulations stipulate that the disclosure of information about an applicant or recipient can only be for purposes related to administration of the Medicaid State Plan.

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

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

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

**E. Release to Authorized Representatives and Other Application Assistants**

**1. Authorized  
Representatives**

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

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

**2. Application  
Assistants**

*Application assistants are authorized under the Affordable Care Act (ACA) to provide assistance with completing the MA application and renewal, and with explaining and helping the individual to meet documentation requirements. They must be authorized by the individual, but they **cannot** sign forms, receive notices or other communications or otherwise act on behalf of the individual.*

*Although they do not have the same CommonHelp system privileges as authorized representatives, Certified Application Counselors (CAC) and Navigators are permitted access to certain information regarding an applicant's MA eligibility without a separate authorization from the applicant when they have assisted with the application.*

**a. Certified Application Counselors**

*CAC are individuals authorized to assist individuals with obtaining health insurance coverage, including Medical Assistance. CAC are generally under the supervision of a non-profit organization and do not receive a fee for providing application counseling.*

**b. Navigators**

*Navigators receive federal funding to assist individuals with obtaining health insurance coverage, including Medical Assistance.*

**F. Safeguarding  
Client  
Information**

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

- name, address, and all types of identification numbers assigned to the client;
- medical services provided to the client;
- social and economic conditions or circumstances of the client;
- agency evaluation of the client's personal information;

- medical data about the client, including diagnoses and past histories of disease or disabilities;
- information received for verifying income, eligibility, and amount of medical assistance payments;
- information received in connection with identification of legally liable third party resources; and
- information received in connection with processing and rendering decisions of recipient appeals.

**G. Ownership of Records**

All client information contained in the agency records is the property of the agency, and employees of the agency shall protect and preserve such information from dissemination except as indicated.

Original client records are not to be removed from the premises by individuals other than authorized staff of the agency, except by court order. The agency may destroy records pursuant to records retention schedules.

**H. Release of Client Information with Consent**

As part of the application process for MA, the client shall be informed of the need to consent to the release of information necessary for verifying eligibility. Whenever a person, agency or organization that is not performing one or more of the functions described in M0110.110 B above requests client information, the agency must obtain written permission to release the information from the client or the personal legally responsible for the client whenever possible. A release for information obtained from the client by the requesting agency also satisfies this requirement.

*Certified Application Counselors and Navigators are designated on the MA application and are deemed to have client consent to release information without an additional release of information. The client may revoke his consent to the release of information at any time by notifying the LDSS verbally or in writing. The revocation of consent is to be documented in the case record.*

**I. Release of Client Information without Consent**

Information from the applicant/recipient's case record may not be released to other agencies, such as public housing agencies, legal services, private organizations, the U.S. Citizenship and Immigration Services (USCIS), Virginia Employment Commission (VEC), school lunch programs, health departments or elected officials without the client's consent. An exception applies to agencies with which there is an agreement for specific types of sharing of information, such as wage information from the VEC, Systematic Alien Verification for Entitlements (SAVE) with USCIS, the State Verification Exchange System (SVES) with the Social Security Administration, etc.

Client information may be disclosed without client consent in the following situations:

**1. Social Services Employees**

to employees of state and local departments of social services for the purpose of program administration;

- |   |  |
|---|--|
| 2. <b>Program Staff in Other States</b> | to program staff in other states when a client moves or when there is a question of dual participation, or to verify the status of assistance in Virginia for applicants in another state; |
| 3. <b>DMAS &amp; LDSS Staff</b>         | between state/local department of social services staff and DMAS for the purpose of supervision and reporting;   |
| 4. <b>Auditors</b>                      | to federal, state and local employees for the purposes of auditing, monitoring, and evaluation; and  |
| 5. <b>For Recovery Purposes</b>         | for the purpose of recovery of monies for which third parties are liable for payment of claims.  |
- J. Client's Right of Access to Information**
- Any client has the right to obtain personal information held by the agency. Upon written or verbal request, the client shall be permitted to review or obtain a copy of the information in his record with the following exceptions:
- Information that the agency is required to keep confidential from the client pursuant to §2.2-3704 and §2.2-3705, Code of Virginia, Virginia Freedom of Information Act, Public Records to be open to Inspection; and
  - Information that would breach another individual's right to confidentiality
- |   |   |
|---|---|
| 1. <b>Freedom of Information Act (FOIA)</b> | Consistent with the Virginia Freedom of Information Act, §2.2-3704 and §2.2-3705, Code of Virginia, the agency shall provide access within five working days after the receipt of the request. The agency shall make disclosures to applicants and recipients during normal business hours. Copies of the requested documents shall be provided to the client or a representative at reasonable standard charges for document search and duplication.   |
| 2. <b>Client May Be Accompanied</b>         | The client shall be permitted to be accompanied by a person or persons of the client's choice and may grant permission verbally or in writing to the agency to discuss the client's file in such person's presence. Upon request and proper identification of any client or agent of the client, the agency shall grant to the client or agent the right to review the following: <ul style="list-style-type: none"> <li>• All personal information about the client except as provided in §2.2-3704 and §2.2-3705,</li> </ul> <p>The identity of all individuals and organizations not having regular access authority that request access to the client's personal information.</p> |
| 3. <b>Client May Contest Information</b>    | Pursuant to the Code of Virginia §2.2-3800, a client may contest the accuracy, completeness or relevancy of the information in his record. Correction of the contested information, but not the deletion of the original information if it is required to support receipt of state or federal financial participation, shall be inserted in the record when the agency concurs that such correction is justified.   |

When the agency does not concur, the client shall be allowed to enter a statement in the record refuting such information. Corrections and statements shall be made a permanent part of the record and shall be disclosed to any entity that receives the disputed information.

### **M0110.120 Address Confidentiality Program (ACP)**

- A. Purpose** The Virginia Attorney General's Office's ACP was created to help a victim of domestic violence who has recently moved to a new location that is unknown to the abuser. The victim wants to keep the new address confidential. Effective July 1, 2011, this program was made available statewide.
- B. All Mail Goes to Richmond P.O. Box Address** The ACP offers a substitute mailing address for the individual in a high risk situation. An individual participating in the ACP will have an ACP authorization card that can be used to verify participation in the program; a participant will use a post office box address in Richmond as his address. This address is to be accepted as a mailing address. No locality, FIPS code, or other geographic identification is included on the ACP authorization card.
- The actual physical address of the participant **MUST NOT** be entered in into any of the VDSS automated systems. Only the mailing address (which is P.O. Box 1133, Richmond, Virginia, 23218) is entered into the computer systems as the participant's residence address; no separate mailing address is entered.
- C. Accept Participant's Verbal Statement of Residency** Virginia state residency and locality residency is established by the participant's verbal statement that he is residing in the locality where he is applying for assistance.
- D. Refer to Local Domestic Violence Program** Please refer any victims of domestic violence to the local Domestic Violence Program for consideration of the ACP, for safety planning, and other services. Local domestic violence advocates are currently receiving training about the ACP. In most localities, the applications for the ACP program will be completed with the DV advocates as a part of in depth safety planning.

### **M0110.200 Definitions**

- A. Adult Relative** means an individual who is age 18 or older, who is not a parent, but who is related to a child by blood or marriage and who lives with and assumes responsibility for day-to-day care of the child in a place of residence maintained as his or their own home.
- B. Applicant** means an individual who has directly or through his authorized representative made written application for *MA* at the local social services department serving the locality in which he is a resident, or if institutionalized, the locality in which he last resided outside an institution.

**C. Application for Medical Assistance** means an official form prescribed by DMAS for requesting medical assistance that is used for initial eligibility determinations and redeterminations. An application for medical assistance is an application for the Medicaid, Family Access to Medical Insurance Security (FAMIS) and FAMIS MOMS programs.

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

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

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

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

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

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

- F. Child** means an individual under age 21 years.
- G. Competent Individual** means an individual who has **not** been judged by a court to be legally incapacitated.
- H. Conservator** means a person appointed by a court of competent jurisdiction to manage the estate and financial affairs of an incapacitated individual.
- I. Family Substitute Representative** means a spouse age 18 or older or designated relative age 18 or older who is willing and able to take responsibility for the individual's personal or financial affairs. Designated relatives other than the spouse who may be substitute representatives are, in this preferred order, the individual's child, parent, sibling, grandchild, niece or nephew, aunt or uncle.
- J. Guardian** means a person appointed by a court of competent jurisdiction to be responsible for the personal affairs of an incapacitated individual, including responsibility for making decisions regarding the person's support, care, health, safety, habilitation, education, and therapeutic treatment, and if not inconsistent with an order of commitment, residence.
- K. Incapacitated Individual** means an individual who, pursuant to an order of a court of competent jurisdiction, has been found to be incapable of receiving and evaluating information effectively or responding to people, events, or environments to such an extent that the individual lacks the capacity to (1) meet the essential requirements of his health, care, safety, or therapeutic needs without the assistance or protection of a guardian; or (2) manage property or financial affairs or provide for his or her support or the support of his legal dependents without the assistance or protection of a conservator.
- L. Legal Emancipation of a Minor** means a minor who has been declared emancipated by a court of competent jurisdiction. A married minor is not emancipated unless a court has declared the married minor emancipated from his parents.
- M. Medical Assistance** means any program administered by DMAS jointly with the Department of Social Services (DSS) that helps individuals or families pay for medical, dental and related health services. These programs are Medicaid, FAMIS and FAMIS MOMS.

### **M0110.300 Availability of Information**

#### **A. Information Required to be Given to the Applicant**

- 1. Explanation of the Medical Assistance Programs** The local agency must furnish the following information in written form, and orally as appropriate, to all applicants and enrollees, and to other individuals upon request:
- the eligibility requirements,
  - services covered *under the MA programs*,

- the rights and responsibilities of applicants and enrollees, and
- the appeals process.

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

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

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

Applicants may also be given *MA* Fact Sheets as appropriate.

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

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

**3. Voter Registration**

The National Voter Registration Act of 1993 (NVRA) requires local social services agencies to offer each *Temporary Assistance to Needy Families* (TANF), *Supplemental Nutrition Assistance Program* (SNAP), and *MA* applicant an opportunity to apply to register to vote at initial application and at each review of eligibility. Additionally, voter registration application services must be provided any time a change of address is reported in person to the local agency.

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

**a. Exceptions to Offering Voter Registration**

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

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

**b. Prohibitions**

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

- seeking to influence an individual's political preference;
- displaying any political preference or party affiliation;
- making any statement to the or taking any action the purpose or effect of which is to discourage the individual from applying to register to vote; or
- making any statement to an individual or taking any action the purpose of which is to lead the individual to believe that a decision to register or not register has any impact on the individual's eligibility for assistance or the benefit level that they may be entitled to receive.

**c. Voter Registration Services**

Each local social services agency must provide the following voter registration services:

- distribution of voter registration application forms;
- assistance to individuals in completing the registration application form, unless such assistance is refused, and ensuring that all spaces on the form are completed;
- ensuring that the certification statement on the application for benefits or statement of facts is completed; and
- acceptance of voter registration application forms for transmittal to the local general registrar.

- 1) Each completed registration application must be submitted to the local general registrar every Friday (if Friday is a holiday, the forms must be forwarded to the local registrar on the last working day before Friday.) Completed forms are to be forwarded to the local registrar in an envelope, notated with an "A" in the upper left-hand corner and listing the number of completed registration applications included in the envelope.

- 1) For split/combined agencies, all voter registration applications are to be transmitted to the general registrar in the locality where the local social services agency is located.
- 2) If the individual chooses, he may take a voter registration application to be mailed to the State Board of Elections at his own cost.

**d. Voter Registration Application**

In Virginia, one voter registration application form will be used to serve a twofold purpose:

- the voter registration application will be completed by the individual with necessary assistance from local agency staff during the application/review process and left at the local agency for transmittal to the local general registrar; or
- for individuals who do not wish to complete the voter registration during the application process, they may take a voter registration form for mail-in registration.

**e. Individuals Required to be Offered Voter Registration Services**

In order to be offered voter registration services, an individual must:

- be a member of the *MA household* or family unit.
- be at least 18 years old by the next general election. General elections are held in all localities on the Tuesday after the first Monday in November or on the first Tuesday in May to fill offices regularly scheduled by law to be filled at those times.

If any question arises as to whether the individual will turn 18 before the next general election, complete the registration application and the local registrar will determine if the individual may be registered.

- be present in the office at the time of the application or renewal interview if an interview takes place, or when a change of address is reported in person. If a change of address is not reported in person, a registration application will be sent to the individual upon request. Any change in the *household* composition that does not occur concurrent with an application, renewal or change of address will be handled at the next scheduled renewal.

Any individual accompanying the applicant/enrollee to the local agency who is not a member of the assistance unit (including payees and authorized representatives) will not be offered voter registration services by the local agency. However, a registration application is to be provided to the non-unit member upon request.

Any request for a mail-in application for assistance must include a mail-in voter registration application. When an authorized representative is applying on another individual's behalf, the local agency is to offer a mail-in voter registration application. In both situations, the bottom of the certification form is to be completed accordingly.

**f. Voter Registration Application Sites**

Local social services agencies are required to offer voter registration application services at each local office (including satellite offices) for applicants/recipients of TANF, SNAP, and Medical Assistance. Voter registration application services are also offered by out-stationed staff taking MA applications at hospitals or local health departments and by Medicaid staff at the state's *Department of Behavioral Health and Developmental Services'* facilities.

**B. Information  
Made Available  
to the Public in  
General**

**1. Availability of  
Manual**

Federal regulations require copies of the State Plan and eligibility rules and policies to be available in agency offices and other designated locations. Policy manuals must be made available in agency offices and other designated locations to individuals who ask to see them.

Upon request, copies of program policy materials must be made available without charge or at a charge related to the cost of reproduction. Copies of manual pages may be made at the local departments of social services. *The full Medicaid Eligibility Manual is available on the Virginia DSS web site at [www.dss.virginia.gov](http://www.dss.virginia.gov).*

**2. MA  
Handbooks  
and Fact  
Sheets**

Federal regulation 42 CFR 435.905 requires the state agency to publish bulletins or pamphlets describing eligibility in easy to understand language. The handbooks *available for each MA program* include basic information about the programs and provide a listing of rights and responsibilities. To supplement the MA handbooks, fact sheets that explain specific policy areas are available to local social services agencies from the state department of social services. *A copy of the handbook corresponding to the program in which the individual was enrolled must be given to all recipients after enrollment and must be given to others upon request. The handbook is also available on the internet at [www.dmas.state.va.us](http://www.dmas.state.va.us).*

**C. Inquiries**

**1. General Inquiries**

The following information has been developed to give guidance to employees of the State and local departments of social services about how to respond to inquiries:

- Limit verbal and written information to explaining the written materials provided. Those written materials may include copies of manual pages, MA handbooks, or fact sheets. The individual may also be referred to the Virginia Department of Social Services website at [www.dss.state.va.us](http://www.dss.state.va.us) and the Virginia Department of Medical Assistance Services website at [www.dmas.state.va.us](http://www.dmas.state.va.us) for additional information.
- Do not go beyond the scope of the written materials. Questions about hypothetical situations, such as (but not limited to) "what would happen if a certain value of resources were transferred?" or "what would be the effect on Medicaid if a trust were written in a certain way?" should not be answered.

Medicaid rules and policies are applied to the facts of a specific application after an application is received. Prior to receipt, do not give hypothetical advice or answers to hypothetical questions to applicants, their attorneys or anyone applying on behalf of the applicant. Answering hypothetical questions is inappropriate for two reasons:

- Until a complete application is received, the local agency cannot be sure it has all the relevant facts. An attempt to be helpful could be futile or lead to incorrect advice. In the event of a dispute, the applicant may then assert that the agency is bound by the incorrect advice. The applicant or other persons affected by the applicant's actions (such as those affected by a property transfer or those otherwise responsible for the care of the applicant) may attempt to hold the agency employee or employees involved individually liable for damages suffered as a result of alleged negligent advice.
- Providing responses to hypothetical questions may under some circumstances constitute the practice of law. The practice of law includes advising another for compensation, direct or indirect, in any matter involving the application of legal principles to facts or purposes or desires. Local agency workers, regional MA consultants, and central office MA employees, even if they are attorneys, are not functioning as legal counsel and must not give legal advice which may affect the rights of applicants, recipients, or others who may not be applying or eligible for MA.

All MA staff are bound by these guidelines for the dissemination of information. Do not refer inquiries from attorneys, applicants or others acting on behalf of the applicant to regional or state MA staff.

## 2. Case Specific Inquiries

Send questions that occur as a direct result of the receipt of an application to the regional MA consultant. Do not refer questions from attorneys (or legal questions in general) to the *Office of the Attorney General*. These attorneys are responsible for providing legal advice to the regional MA consultant and are not authorized to give legal advice to the public.

## M0110.400 Retention of Case Information

### A. Introduction

The agency must maintain case records that contain information necessary to support the facts essential to the determination of initial and continuing eligibility as well as any basis for discontinuing or denying assistance. The case record shall consist of a hard (i.e. paper) record, an electronic record, or a combination of the two. Records of active cases must be maintained for as long as the client receives benefits, while closed records must be maintained for a minimum of three years from the date of closure.

### B. Policy

Case records must contain the following elements:

- the date of application,
- the date of and basis for the disposition of the application,
- facts essential to the determination of initial and continuing eligibility,
- the provision of medical assistance (i.e. enrollment),
- the basis for discontinuing medical assistance,
- the disposition of income and eligibility verification information, and
- the name of the agency representative taking action on the case and the date of the action.

The agency must include in each applicant's case record documentation to support the agency's decision on his application and the fact that the agency gave recipients timely and adequate notice of proposed action to terminate, discontinue or suspend their eligibility or to reduce or discontinue services they may receive under the medical assistance programs. Types of documentation that support the agency's decision include evaluations of eligibility, case narratives, and permanent verifications.

The case record must contain a duplicate, either electronically or in writing, of all notices sent to the client. Copies of the documents used for verification of citizenship and identity, such as birth certificates, must also be maintained within the case record.

Active cases may be purged with the exception of documentation that supports the information shown in the paragraphs above. Agencies may wish to retain other information used in future eligibility determinations, such as resource assessments and burial contracts. Closed cases are required to be retained by the agency for a period of no less than three years from the date of closure.

The case record shall be organized as to enable audit and program integrity entities to properly discharge their respective responsibilities for reviewing the manner in which the *MA* programs *are* being administered.

## **M0110.500 VIRGINIA DSS STRENGTHENING FAMILIES INITIATIVE PRACTICE MODEL**

### **A. Introduction**

The Virginia DSS Strengthening Families Initiative (SFI) Practice Model sets forth standards of professional practice and serves as a values framework to define relationships, guide thinking and decision-making, and structure beliefs about individuals, families, and communities. The Practice Model suggests a desired approach to working with and delivering services to Virginia's citizens.

### **B. Practice Model Principles**

The principles of the Practice Model are:

1. All children, adults and communities deserve to be safe and stable.
2. All individuals deserve a safe, stable and healthy family that supports them through their lifespan.
3. Self-sufficiency and personal accountability are essential for individual and family well-being.
4. All individuals know themselves best and should be treated with dignity and respect.
5. When partnering with others to support individual and family success, we use an integrated service approach.
6. How we do our work has a direct impact on the well-being of the individuals, families, and communities we serve.

M0110, Appendix 1 contains the full SFI Practice Model.

### **C. Policy**

Medicaid and other benefit programs are designed to provide supportive benefits to assist families who are unable to provide the necessities of life and maintain minimum standards of health and well-being through their own efforts. Gathering relevant information about a family's situation and evaluating that information against the eligibility criteria for the benefit programs are the basis for making the eligibility determinations.

The process of gathering relevant information also includes an assessment of need for service programs and other resources to assist the family. This process includes following the Practice Model described above. If other needs exist, the eligibility worker must refer the family for appropriate services or resources within the agency or community. Eligibility workers may consult with their supervisors and other agency staff as necessary to gather information to facilitate making such referrals.

**M0120 Changes**

<b>Changed With</b>	<b>Effective Date</b>	<b>Pages Changed</b>
TN #98	10/1/13	Table of Contents pages 1-17
UP #9	4/1/13	page 13, 15, 16
UP #7	7/1/12	pages 1, 10-12
TN #96	10/1/11	Table of Contents pages 6-18
TN #95	3/1/11	pages 1, 8, 8a, 14
TN #94	9/1/10	pages 8, 8a
TN #93	1/1/10	pages 1, 7, 9-16
Update (UP) #1	7/1/09	page 8
TN #91	5/15/09	page 10

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#### M0120.000 MEDICAL ASSISTANCE APPLICATION

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**M0120.000 Medical Assistance Application****M0120.100 *Applying for Medical Assistance***

- A. Right to Apply** An individual cannot be refused the right to complete an application for medical assistance (MA) for himself (the applicant) or any other individual for whom he is authorized to apply. Under no circumstances can an individual be discouraged from asking for assistance for himself or any person for whom he is a legally responsible or authorized to represent. An applicant may be assisted with the application by an individual of his choice. A face-to-face interview is not required.
- B. Signed Application Required** *An application for MA must be signed to be valid. Paper forms must bear the signature of the applicant or an individual authorized to apply on his behalf. Applications submitted electronically or through the approved telephonic process meet the signature requirement.*
- 1. Unsigned Application** A paper application that bears no signature is invalid. Return the application to the applicant with a letter requesting a signature.
- 2. Invalid Signature** A paper application that is signed by an individual who is not authorized to sign on behalf of the applicant is invalid. Return the application with a letter indicating who must sign the application to the individual who filed the application on behalf of the applicant. See M0120, Appendix 1 for a sample letter.

**M0120.200 Who Can Sign the Application**

- A. Patients in DBHDS Facilities** Patients of any age in the Department of Behavioral Health and Developmental Services (DBHDS) facilities may have applications submitted and signed by DBHDS staff. The DBHDS facilities are listed in subchapter M1550.
- B. Applicants Age 18 or Older** The applicant must sign the application, even if the form is filled out by another person, unless the application is filed and signed by the applicant's legal guardian, conservator (known as the "committee" for persons declared incompetent prior to the 1997 changes in the guardianship section of the Code of Virginia), attorney in fact, or authorized representative. A spouse, aged 18 or older, may sign the application for his spouse when they are living together.

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

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

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

Witness's signature: \_\_\_\_\_

**1. Authorized  
Representative**

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

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

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

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

**2. Family  
Substitute  
Representative**

When it is reported that an applicant cannot sign the application and the applicant does not have a guardian, conservator, attorney in fact or designated authorized representative, one of the individuals listed below who is age 18 years or older and is willing to take responsibility for the applicant's MA business will be the applicant's "family substitute" representative. The family substitute representative will be, in this preferred order, the applicant's:

- spouse,
- child,
- parent,
- sibling,
- grandchild,
- niece or nephew, or
- aunt or uncle.

**3. No Individual authorized to sign**

If the applicant is unable to sign the application and does not have an attorney in fact, authorized representative, or family substitute representative, the applicant's inability to sign the application must be verified. Verification is by a written statement from the applicant's doctor that says that the applicant is not able to sign the *MA* application because of the applicant's diagnosis or condition. Follow these procedures:

- a. Determine if anyone has begun the process to have a guardian or conservator appointed for the applicant.
- b. If action has been initiated to obtain a guardian for the applicant, meaning a court guardianship hearing is scheduled on the court docket, request verification that the action is on the court docket. Give 10 days for this verification to be provided.

If the verification is provided within the 10 day period, continue to pend the application until the guardian or conservator is appointed. If the application pends for 45 days, send written notice to the applicant to extend the pending application.

Once the guardian/conservator has been appointed, request verification of the appointment and that the application be signed by the guardian or conservator. Retain a copy of the application and mail the original application to the guardian/conservator. Allow 10 days for the signed application and guardian/conservator papers to be returned. If the application form and guardian/conservator papers are not returned to the agency by the specified date, deny the application because it is invalid.

- c. If guardianship/conservator procedures have not begun or have not been verified as being on the court docket, refer the applicant to Adult Protective Services (APS) in the local agency.

If the report to APS meets all criteria for a valid report, an investigation will be conducted to learn whether protective services are needed and, if so, what services are needed. The protective services identified will be provided or arranged by APS.

Continue to pend the application until the APS investigation is completed. If the completed APS investigation concludes that guardianship proceedings will not be initiated, the application must be signed by the applicant, or the applicant must sign a statement designating an authorized representative. Give the applicant 10 working days to return the signed application to the agency.

- d. If the application form is not signed by the applicant or the authorized representative and returned to the agency by the specified date, deny the application because it is invalid.

**4. Procedure for  
Who Can Sign  
the Application**

When preparing to determine the *MA* eligibility of an individual age 18 or older, examine the application to determine if the applicant can complete and sign the application form or if the applicant has an authorized representative. Ask the following questions:

Has the applicant been judged legally incapacitated by a court of law, as evidenced by a copy of the conservator or guardian certificate of appointment in the record?

YES: The authorized representative is the appointed conservator or guardian. STOP.

NO: The applicant is competent. Does the applicant have an attorney in fact who has the power of attorney to apply for *MA* for the applicant as evidenced by a copy of the power of attorney document in the record?

YES: The authorized representative is the attorney in fact. STOP.

NO: Has the applicant signed a written statement authorizing a person (or staff of an organization) to apply for *MA* on his behalf?

YES: The authorized representative is the person or organization authorized by the applicant to represent him. STOP.

NO: Is the applicant able to sign or make a mark on a Medicaid application form?

YES: Ask the applicant for his signature or mark on the application form or for a written statement authorizing someone to apply for *MA* on his behalf. Give the applicant 10 working days to return the completed and signed form(s). If the completed and correctly signed form(s) are not returned by the specified date, DENY *MA* because of an invalid application.

NO: Does the applicant have at least one of the following who is age 18 or older:

- spouse,
- child,
- parent,
- sibling,
- grandchild, niece or nephew, or
- aunt or uncle?

YES: The authorized representative is the individual identified above who is willing and able to act on the applicant's behalf.

NO: Verify the inability of the applicant to sign the application because of a diagnosis or condition through a written statement from the applicant's doctor. Refer to APS. Pend the application. At the conclusion of the APS investigation, if APS concludes that guardianship proceedings will not be initiated, the applicant must sign or make a mark on the application or designate an authorized representative in writing. If the signed application form is not received by the specified date, deny *MA*.

**C. Applicants Under  
Age 18****1. Child Applicant**

A child under age 18 years is not legally able to sign his own *MA* application unless he is legally emancipated from his parents. If the child is not legally emancipated, one of the following individuals who is age 18 or older must sign the application:

- his parent,
- legal guardian,
- authorized representative, or
- an adult related by blood or marriage with whom the child lives (documentation of the relationship is not required).

If the child under 18 years of age is married and living with his spouse who is age 18 or older, the child's spouse may sign the application.

**a. No Guardian or Legal Custody**

If the child does not live with a parent or an adult relative and no adult is the child's guardian or has legal custody of the child, whomever the child is living with is responsible for seeking custody or guardianship of the child in the Juvenile and Domestic Relations court. Determine if the person submitting the application, or another person, has begun the process to obtain legal guardianship or custody of the child applicant.

**b. Action Is Initiated To Appoint Guardian/Award Custody**

If action has been initiated to appoint a guardian for or seek legal custody of the child, meaning a court guardianship or custody hearing is scheduled on the court docket, request verification that the action is on the court docket. Give 10 calendar days for this verification to be provided.

If the verification is provided within the 10-calendar-day period, continue to pend the application until a guardian is appointed or custody is awarded. If the application pends for 45 calendar days, send a notice to the applicant explaining that the application pending period will be extended.

Once the guardian has been appointed or custody awarded, request verification of the appointment or award and that the application be signed by the guardian or adult who was awarded custody. Allow 10 calendar days for the signed application and guardianship or custody papers to be returned.

If the court refuses to appoint a guardian or custodian and there is no adult who is legally able to sign an application for the child, deny the application as invalid.

**c. Action Not Initiated – Refer to Child Welfare Services**

If guardianship or custody procedures have not begun or have not been verified as being on the court docket, refer the child to the appropriate Family Services worker.

Continue to pend the application until the service investigation is completed and any court proceedings are completed. Once the guardian has been appointed or custody awarded, request verification of the appointment or award and that the application be signed by the guardian or adult who was awarded custody. Retain a copy of the application and mail the original application to the guardian or custodian. Allow 10 calendar days for the signed application and guardian or custody papers to be returned.

If the child was emancipated by the court, request the child's signature on the application. If the application is mailed to the child, allow 10 calendar days for the signed application form to be returned.

If the application form is not signed by the applicant, the guardian, the custodial adult, or the emancipated child and returned to the agency by the specified date, deny the application because it is invalid.

**2. Minor Parent Applying for His Child**

A parent under age 18 years may apply for *MA* for his own child because he is the parent of the child.

**3. Foster Care Child**

**a. IV-E**

The Title IV-E Foster Care & Medicaid Application form, posted on SPARK at [http://spark.dss.virginia.gov/divisions/dfs/iv\\_e/](http://spark.dss.virginia.gov/divisions/dfs/iv_e/) is used for the IV-E Foster Care eligibility determination. A separate *MA* application is **not** required for a child who has been determined eligible for Title IV-E Foster Care. However, if there is a non-custodial agreement for the IV-E eligible child, the parent or legal guardian must sign an *MA* application for the child.

**b. Non-IV-E**

The Title IV-E Foster Care & Medicaid Application form, posted on SPARK at [http://spark.dss.virginia.gov/divisions/dfs/iv\\_e/](http://spark.dss.virginia.gov/divisions/dfs/iv_e/) is also used for the **non-IV-E** Foster Care eligibility determination. The *MA* application for a non-IV-E child who is in foster care must be signed by an authorized employee of the public or private agency that has custody of the child. If there is a non-custodial agreement, *an MA* application form must be filed and the parent or legal guardian must sign the application.

**4. Adoption Assistance & Special Medical Needs Children**

**a. IV-E**

A separate *MA* application is not required for a child who has been determined eligible for Title IV-E Adoption Assistance, regardless of which state has the adoption assistance agreement with the adoptive parents. IV-E Adoption Assistance children who have been placed for adoption through the Interstate Compact for Adoption and Medical Assistance (ICAMA) should have an ICAMA form 6.01 which verifies their Title IV-E eligibility for Medicaid. The ICAMA form 6.01 serves as the *MA* application form.

**b. Non-IV-E**

**Non-IV-E Adoption Assistance children include Non-IV-E Special Medical Needs children.**

1) Placed by a Virginia agency

*An MA* application is required for all non-IV-E Adoption Assistance and Non-IV-E Special Medical Needs children whose parents have adoption assistance agreements with a Virginia public or private child-placing agency. The child's adoptive parent signs and files the application for the child.

2) Placed by another state

Non-IV-E Adoption Assistance children who have been placed for adoption through the Interstate Compact for Adoption and Medical Assistance (ICAMA) should have an ICAMA form 6.01 which verifies their adoption assistance status (IV-E or non-IV-E). The ICAMA form 6.01 serves as the *MA* application form and a separate application is not required when:

- the other state is an ICAMA member state, and
- the ICAMA member state **reciprocates** Medicaid coverage of Virginia Non-Title IV-E Adoption Assistance children.

All states and territories EXCEPT Vermont, Wyoming, Puerto Rico and Virgin Islands are members or associate members of ICAMA. A list of the ICAMA member states and whether they reciprocate Medicaid coverage for Non-IV-E Adoption Assistance children is in M0120, Appendix 3.

***An MA* application must be filed for Non-IV-E Adoption Assistance children from non-member states and ICAMA member or associate member states which do NOT reciprocate.**

The child's adoptive parent signs and files the *MA* application for the child.

**D. Deceased Applicant**

An application may be made on the behalf of a deceased person within a three-month period subsequent to the month of his death if both of the following conditions were met:

- the deceased received a Medicaid-covered service on or before the date of death, and
- the date of service was within a month covered by the *MA* application.

If the above conditions were met, an application may be made by any of the following:

- his guardian or conservator,
- attorney-in-fact,
- executor or administrator of his estate
- his surviving spouse, or
- his surviving family member, in this order of preference: adult child, parent, adult brother or sister, adult niece or nephew, or aunt or uncle.

Under no circumstances can an employee of, or an entity hired by, the medical service provider who stands to obtain *MA* payment file an *MA* application on behalf of a deceased individual.

Medicaid coverage can begin no earlier than three months prior to the application month. The entitlement rules for retroactive coverage apply to the application's retroactive period.

*Retroactive FAMIS coverage is available ONLY to an eligible child who was born within the 3 months prior to the FAMIS application month.*

**E. Enrollee Turns 18**

When a child who is enrolled in *MA* Medicaid turns 18, it is not necessary to obtain a new application signed by the enrollee.

As long as the enrollee is under age 21, he does not need to authorize a parent with whom he lives for the parent to continue to conduct the enrollee's *MA* business.

**M0120.300 Medical Assistance Application Forms**

**A. General Principle –  
Application  
Required**

A signed application for *MA* is required for all initial requests for medical assistance, except for:

- IV-E Foster Care/Adoption Assistance children
- Auxiliary Grant (AG) applicants
- Newborn children under age 1 born to a Medicaid or *FAMIS*-eligible mother.

**1. Title IV-E  
Foster Care &  
Medicaid  
Application**

The Title IV-E Foster Care & Medicaid Application, form #032-03-636 (available at: [http://spark.dss.virginia.gov/divisions/dfs/iv\\_e/](http://spark.dss.virginia.gov/divisions/dfs/iv_e/)) is used for foster care or adoption assistance children who are eligible under Title IV-E of the Social Security Act. If any additional information is necessary (individual requires a resource evaluation for medically needy spenddown), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant's guardian.

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

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

**2. Auxiliary Grant  
(AG)**

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

**3. Exception for  
Certain  
Newborns**

A child born to a mother who was Medicaid *or* FAMIS eligible at the time of the child's birth (including a child born to an emergency-services-only alien mother) is deemed to have applied and been found eligible for Medicaid on the date of the child's birth (see M0320.301). An application for the child is not required. The child remains eligible for medical assistance to age 1 year.

If the child was born to a mother who was covered by Medicaid outside Virginia *or by another state's Children's Health Insurance Program* at the time of the child's birth, verification of the mother's MA Medicaid coverage must be provided by the parent or authorized representative or an application must be filed for the child's eligibility to be determined in another MA group.

**4. Forms that  
Protect the  
Application  
Date**

***a. Low Income Subsidy (LIS) Medicaid Application***

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

### b. Model Application for Medicare Premium Assistance Form

The Model Application for Medicare Premium Assistance Form was developed by the federal Centers for Medicare & Medicaid Services (CMS) that states can choose to use for the Medicare Savings Program applicants. The model application is **NOT** a prescribed Virginia Medicaid application form at this time.

Should a local department of social services (LDSS) receive a model application form, the agency is to send *a valid Virginia MA Application* to the applicant with a request that it be completed, signed, and returned to the agency within 30 calendar days. The date of application on the model Application for Medicare Premium Assistance is to be preserved as the application date for purposes of Medicaid entitlement.

The processing time for the LDSS begins when the agency receives the Virginia application form back from the applicant. If the Virginia application form is not returned within 30 days, no further action is necessary on that application. The agency does not send a Notice of Action because no Virginia application was received. The model application date is not preserved beyond 30 calendar days. Should the person later submit a valid Virginia application, the date the Virginia application is received by the LDSS is the application date.

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

## B. Application Forms

Medical assistance must be requested using an application method or form approved by the Departments of Medical Assistance Services (DMAS) and Social Services (VDSS). *Applications may be made electronically through CommonHelp or the Health Insurance Marketplace. When an individual applies for assistance through the Marketplace and is assessed as being Medicaid-eligible, his application data is electronically transmitted to the local DSS for a final determination of eligibility.*

*Applications may also be made telephonically through the Cover Virginia Call Center or with a paper application form.*

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

### 1. Streamlined Applications

*The following forms are used to apply for affordable health insurance, including qualified health plans with the Advance Premium Tax Credit (APTC), through the Health Insurance Marketplace or the local DSS:*

- *the Cover Virginia Application for Health Coverage & Help Paying Costs and all applicable appendices, including Appendix D for applications submitted for aged, blind or disabled and/or long-term care applicants.*
- *the federal Application for Health Coverage & Help Paying Costs for multiple individuals and all applicable appendices and*
- *the federal Application for Health Coverage & Help Paying Costs (Short Form) for individuals and all applicable appendices.*

*The Cover Virginia application form contains additional questions regarding health insurance ending and state employee benefit plans necessary to determine FAMIS eligibility. If a federal form is used to apply for a child who is not eligible for Medicaid, the worker will need to obtain the additional information from the applicant.*

**2. BCCPTA  
Medicaid  
Application**

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application, form #032-03-384, is used only by *individuals* screened under the Breast and Cervical Cancer Early Detection Program. **This form is not to be given to applicants by the local departments of social services** (M0120, Appendix 2 is provided for reference purposes only).

**3. Replaced  
Application  
Forms**

*The following forms were replaced by the streamlined application forms effective October 1, 2013. While agencies should accept and process any of these forms should they be submitted, additional information will need to be obtained using the new forms.*

- *Application for Benefits (#032-03-824)*
- *The Application/Redetermination for Medicaid for SSI Recipients (#032-03-091)*
- *The Medicaid Application/Redetermination for Medically Indigent Pregnant Women (#032-03-040)*
- *The Health Insurance for Children and Pregnant Women (#FAMIS-1)*
- *The Application for Adult Medical Assistance form (#032-03-0222)*
- *The Plan First Application (#DMAS-65E)*

**4. If Additional  
Information is  
Required**

*Applicants may apply for MA on any valid application form. Regardless of which new application form is used, if additional information is required to determine an applicant's eligibility in another covered group, send the applicant a written request asking for the information and give the applicant at least 10 business days to return the pages and the required verifications to the agency.*

## **M0120.400 Place of Application**

### **A. Principle**

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

**1. Locality of  
Residence**

Medical assistance applications that are completed and filed online are sent to the LDSS in the applicant's locality of residence or where the individual last lived outside of an institution .

**2. Joint Custody  
Situations**

A child whose residence is divided between two custodial parents living in different localities is considered to reside in the locality in which he attends school. If the child is not enrolled in school, the parents must decide which locality is the child's residence for application/ enrollment purposes.

**B. Foster Care,  
Adoption  
Assistance,  
Department of  
Juvenile Justice**

**1. Foster Care**

Responsibility for taking applications and maintaining the case belongs as follows:

**a. Title IV-E Foster Care**

Children in the custody of a Virginia local department of social services or private foster care agency who receive Title IV-E maintenance payments apply at the agency that holds custody. Title IV-E foster care children in the custody of another state's social services agency apply in the Virginia locality where they reside.

**b. State/Local Foster Care**

Non-Title IV-E (state/local) children in the custody of a Virginia local department of social services or a private child placing agency apply at the agency that holds custody.

Children in the custody of another state's social services agency who are not Title IV-E eligible do not meet the Virginia residency requirement for *MA* and are not eligible for *MA* in Virginia (see M0230).

**2. Adoption  
Assistance**

Children receiving adoption assistance through a Virginia local department of social services apply at the agency that made the adoption assistance agreement.

Children receiving adoption assistance through another state's social services agency apply at the local department of social services where the child is residing.

**3. Virginia  
Department of  
Juvenile  
Justice/Court  
(Corrections  
Children)**

When a child is in the custody of the Virginia Department of Juvenile Justice (DJJ) or is the responsibility of a court (corrections children), responsibility for processing the application and determining eligibility rests with the department of social services in the locality in Virginia in which he last resided prior to going into the DJJ system.

**C. Institutionalized  
Individual (Not  
Incarcerated)**

When an individual of any age is a resident or patient in a medical or residential institution, except DBHDS facilities and the Virginia Veteran's Care Center, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in Virginia in which he last resided outside of an institution.

**Exception:** If the applicant is applying for or receives SNAP, responsibility for processing the *MA* application and determining *MA* eligibility rests with the department of social services in the locality in which the institution where he is receiving care is located.

If the individual did not reside in Virginia prior to entering an institution, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in which the institution where he is receiving care is located.

**D. Individuals in  
DBHDS Facilities**

**1. Patient in a  
DBHDS Facility**

If an individual is a patient in a state DBHDS institution, is not currently enrolled in Medicaid, and is eligible in an Aged, Blind or Disabled (ABD) covered group, responsibility for processing the application and determining eligibility rests with the state department of social services' eligibility technicians located in DBHDS facilities. A listing of facilities and technicians as well as further information on the handling of cases of Medicaid applicants and recipients in DBHDS facilities is located in Subchapter M1550.

If an individual is a patient in a State DBHDS Institution, is not currently enrolled in Medicaid, and is eligible in a Families and Children's (F&C) covered group, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in Virginia in which he last resided outside of an institution.

**2. Patient Pending  
Discharge (Pre-  
release  
Planning)**

**a. General Policy**

For DBHDS facility patients who will be discharged, local agencies will take the applications received on behalf of these patients and process them within the established time frames. Eligibility will be determined based on the type of living arrangement to which the patient will be discharged.

If the patient was not Medicaid eligible in the DBHDS facility but *MA* eligibility in the patient's new circumstances needs to be determined, an application must be sent to the appropriate local department of social services. The facility physician or discharge planning authority must attach a written statement that includes the following information:

- the date of the proposed discharge,
- the type of living arrangement and address to which the patient will be discharged (nursing facility, adult care residence, private home, relative's home, etc.), and
- the name and title of the person who completed the statement.

The discharge planner or case manager must follow up the application and statement with a telephone call to the agency worker on or after the patient's actual discharge to confirm the discharge date and living arrangement. The agency cannot enroll the patient without the confirmation of the discharge date and living arrangement.

**b. Pending Discharge to a Facility**

If a patient who was not Medicaid eligible in the DBHDS facility is being discharged to an assisted living facility or nursing facility, an application for Medicaid will be filed with the department of social services in the locality in which the patient last resided prior to entering an institution.

**c. Pending Discharge to the Community**

If a patient who was not Medicaid eligible in the DBHDS facility will live outside of an institution, the responsibility for processing the application and determining eligibility rests with the locality in which he will be living.

**d. Eligibility Determination and Enrollment**

The local agency determines the patient's *MA* eligibility BEFORE actual discharge, based on the type of living arrangement to which the patient will be discharged. If the patient is found eligible for *MA* in the locality, he is not enrolled in *MA* until the day he is discharged from the DBHDS institution.

When the individual is discharged, the DBHDS discharge planner, or the individual, may call the local agency worker on the discharge date. The worker can then enroll the patient in the MMIS and give the enrollee number to the discharge planner.

**e. Coverage Begin Date**

The eligible individual's coverage Begin Date cannot be earlier than the date of discharge from the DBHDS institution.

**E. Individuals In Virginia Veteran's Care Center**

*MA* applications for patients in the Virginia Veteran's Care Center in Roanoke may be filed, processed and maintained at the Roanoke City Department of Social Services.

**F. Incarcerated Individuals and DJJ Children Pre-release Planning**

Inmates of state correctional facilities and children in the custody of the DJJ or who are the responsibility of a court (corrections children) over 18 years, may apply for *MA* as part of pre-release planning. Responsibility for processing the application and determining eligibility rests with the local department of social services in the locality where the individual was living prior to incarceration or DJJ/court custody.

Applications are to be processed in the same manner and within the same processing time standards as any other *MA* application, but if the incarcerated/DJJ individual is found eligible, he is **not** enrolled in the program until after he has been released from the correctional facility.

Applications are not to be refused because an applicant is an inmate of a public institution at the time of application.

If the individual did not reside in Virginia prior to becoming incarcerated or in the DJJ system, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in which correctional facility is located.

- 1. Department of Corrections Procedures For NF Placement**
- The following procedures will be followed by correctional facility staff when an inmate in a Virginia Department of Corrections facility will require placement in a nursing facility upon release:
- The correctional facility staff will complete the *MA* application and, if a disability determination is needed, the disability report and medical release forms. The correctional facility staff will notify the assigned *MA* consultant and mail the forms to the local department of social services in the locality where the inmate was living prior to incarceration.
  - The correctional facility staff will request a pre-admission screening for nursing home or community-based care from the health department or local department of social services in the locality where the correctional facility is located. This screening is to be done simultaneously with the determination of disability and determination of Medicaid eligibility. The staff will coordinate with nursing facilities in order to secure a placement.
- 2. Eligibility Determination and Enrollment**
- The local department of social services determines the patient's *MA* eligibility BEFORE actual release, based on the type of living arrangement to which the applicant will be released. If the applicant is found eligible for *MA* in the locality, he is not enrolled in *MA* until the day he is released from the Department of Corrections facility or DJJ/court custody.
- The Corrections facility's or DJJ's pre-release planner or the individual may call the local agency worker on the release date. The worker can then enroll the eligible applicant in the MMIS and provide the enrollee number.
- 3. Coverage Begin Date**
- The eligible individual's coverage Begin Date cannot be earlier than the date of discharge from the correctional or DJJ facility.

## M0120.500 Receipt of Application

- A. General Principle**
- An applicant or authorized representative may submit an application for medical assistance only or may apply for *MA* in addition to other programs.
- An applicant may be assisted with completing the various aspects of the application by an individual(s) of his choice and may designate in writing that such individual(s) may represent him in subsequent contacts with the agency.
- B. Qualified Individuals (QI)**
- Eligibility for Medicaid as a QI begins the first day of the application month, and ends December 31 of the calendar year, if funds are still available for this covered group. New applications for QI coverage for an upcoming year may not be taken until January 1 of that year (see M0320.208).
- If the initial QI application is processed in November or December, the QI coverage may be renewed for the following year without obtaining a separate renewal form. See section M1520.200 C.11.

**C. Application Date** The application date is the earliest date the signed, application for medical assistance is received by the local agency, an outstationed site, or an entity contracted with DMAS to accept applications. The application must be on a form prescribed by DMAS and signed by the applicant or person acting on his behalf.

The application may be received by mail, fax, hand delivery, electronically or telephonically. The date of receipt by the agency must be recorded. If an application is received after the agency's business hours, the date of the application is the next business day. The date of application for foster care children in the custody of a local department of social services is the date the application is received by the eligibility worker.

If an application for a pregnant woman or child is denied due to excess income, the applicant must be given the opportunity to request a medically needy evaluation. If the evaluation is requested within 10 days of the date the notice of denial was mailed, the application date is protected, and the date of application is the date the denied application was received.

## **M0120.600 When An Application Is Required**

**A. New Application Required** A new application is required when there is:

- an initial request for medical assistance, or
- a request to add a person to an existing case.

When an application is received because there is a new person in the family for whom medical assistance is requested, the annual renewal for the existing enrollees is done using the same application form. See subchapter M1520 for renewal policy and procedures.

**B. Application NOT Required** A new application is not required when an individual is already an active Medicaid enrollee or is enrolled in another medical assistance program. Changes in the enrollee's circumstances do not require a new application. Changes that do not require a new application include, but are not limited to, the following:

- a change in the case name,
- a change in living arrangements, and
- a change in income.

A change in living arrangements may require a partial review of the individual's eligibility when the change results in a change to the assistance unit. Whenever the change requires verifications that can be used to complete a renewal, the annual renewal should be completed at the time the change is reported.

**M0130 Changes**

<b>Changed With</b>	<b>Effective Date</b>	<b>Pages Changed</b>
TN #98	10/1/13	Table of Contents pages 1-12
UP #9	4/1/13	page 3, 5
UP #7	7/1/12	pages 4, 5
TN #96	10/1/11	pages 6-8
TN #95	3/1/11	page 8
TN #94	9/1/10	pages 2-6, 8
TN #93	1/1/10	pages 4-6, 8
Update (UP) #2	8/24/09	pages 8, 9

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## ***M0130.001 Medical Assistance Application Processing Principles***

### ***A. Introduction***

*Under the Affordable Care Act (ACA), the Medicaid and FAMIS medical assistance (MA) programs are part of a continuum of health insurance options available to Virginia residents. MA application processing is based on several principles that are prescribed by the ACA.*

### ***B. Principles***

#### ***1. Single Application***

*Applications for affordable health insurance, including qualified health plans with Advance Premium Tax Credit (APTC) assistance and MA, are made on a single, streamlined application. The application gathers information needed to determine eligibility for both APTC and MA.*

#### ***2. No Wrong Door***

*Individuals may apply for MA through their local department of social services (LDSS), through the Health Insurance Marketplace (HIM) and for Modified Adjusted Gross Income (MAGI) applicants, through the Cover Virginia Call Center. Applications are coordinated between the HIM and LDSS to ensure that the individual is enrolled in the appropriate program.*

#### ***3. Use of Electronic Data Source Verification***

*The eligibility determination process for MA is based on electronic data source verification (EDSV) to the fullest extent possible. LDSS are to rely on EDSV as the first course of action and are to request information from the applicant only when it is not available through an approved data source or the information is inconsistent with agency records.*

*The Federally-managed Data Services Hub (the Hub) provides verification of a number elements related to eligibility for MA applications processed in the Virginia Case Management System (VaCMS).*

*Searches of online information systems, including but not limited to the Hub, State Online Query-Internet (SOLQ-I) and the State Verification Exchange System (SVES) are permitted **only** for applicants and family members whose income and/or resource information is required to determine eligibility for the applicant or patient pay for an enrollee. This includes spouses of applicants and parents of child applicants.*

#### ***4. Processing Time***

*Agencies are required by the State Plan to adhere to prescribed standards for the processing of MA applications. The amount of time allowed to process an application is based on the availability of required information and verifications, as well as the covered group under which the application must be evaluated.*

*When all necessary information is available through EDSV, it is expected that the application be processed without delay.*

*When it is necessary to request information from the applicant and/or a disability determination is required, the processing standards in M0130.100 are applicable.*

**M0130.100 Processing Time Standards****A. Processing Time Standards****1. 10 Day Requirement (Expedited Application)****a. Pregnant Women**

Applications for pregnant women must be processed within 10 working days of the agency's receipt of the signed application.

If the pregnant woman also applies for other children or other persons in her family and the agency cannot determine the other persons' eligibility within 10 working days, the agency must determine just the MA eligibility of the pregnant woman within the working 10 days.

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

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

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

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

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

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

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

If a decision cannot be made within 10 working days of receipt of the BCCPTA application, the worker must send a written notice on the 10<sup>th</sup> day stating why action has not been taken, specifying what information is needed, and a deadline for submitting the information.

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

- 2. 45/90 Day Requirement** Applications for which information in addition to that provided on the application is required, including requests for retroactive coverage, must be processed within 45 calendar days for all applicants other than pregnant women, women in the BCCPTA covered group, or individuals needing a disability determination.
- For individuals who require a disability determination to meet the covered group requirement, the time standard for processing an application is 90 calendar days. Other non-financial requirements, however, must be met and verified by the 45<sup>th</sup> calendar day, or the application must be denied and DDS must be notified to stop action on the disability determination (see M0310.112 E.2).
- The time standard begins with the date of receipt of a signed application and ends with the date of enrollment or the date the notification of denial of MA is mailed to the applicant. The applicant must be informed of the agency's time standards.
- The eligibility worker must allow at least 10 calendar days to receive the necessary verifications. If all necessary verifications are not received, the application continues to pend until the 45-day processing time limit is reached.
- 3. Early Denial Before Deadline Date** When the 45-day processing deadline date falls on a weekend or a holiday, the LDSS may deny an individual's application on the last business day before the deadline date if all necessary verifications have not been received. If the early denial action is taken, however, the LDSS must re-open the application if the individual provides the necessary information on or before the 45<sup>th</sup> day deadline.
- If the individual's application is re-opened and he is determined eligible, the LDSS must enroll the individual and send a notice to the individual notifying him of the approval and the begin date of coverage.
- 4. Processing Priority** Application processing priority must be given to applicants who are in need of Medicaid coverage for nursing facility or community-based long-term care, hospice care, or who are in emergent need of other covered services. These applications must be processed as quickly as possible.
- 5. Time Standard Exceptions** The specified time standards apply unless the agency cannot reach a decision within the time standard because of one of the following reasons:
- the applicant's inability to furnish necessary information for a reason beyond his/her control,
  - a delay in receipt of information from an examining physician,
  - a delay in the disability determination process,
  - a delay in receiving DMAS decision on property transfer undue hardship claim, or
  - an administrative or other emergency beyond the agency's control.

If action is not taken within the time standard, the case record must show the cause for the delay and the applicant must be notified in writing of the status of his application, the reason for the delay, and his right of appeal.

When an application is delayed after 90 days because of a disability decision and the agency has determined that excess resources exist at the time the delay notice is sent, the NOA must inform the applicant that he/she has excess resources and the amount. The notice must also state that:

- a final action cannot be taken until the disability decision is made;
- if the applicant is determined to be disabled, he/she will not be eligible unless the excess resources are reduced; and
- he will be notified when the disability decision is made.

**B. Application for Retroactive Coverage**

Retroactive Medicaid eligibility must be determined when an applicant for medical assistance reports that he, or anyone for whom he requests assistance, received a *covered* medical service within the retroactive period - the three months prior to application.

The retroactive period is based on the month in which the application is filed with the agency. The retroactive period is the three months prior to the application month.

There is no administrative finality on determining retroactive eligibility if eligibility for the months in the retroactive period has not been determined. Retroactive coverage can be requested at any time subsequent to an application even if the application was denied or the applicant signed a statement saying he did not want retroactive coverage. The retroactive period is based on the application month regardless of whether the application was denied or approved.

If the application was denied, the application is reopened for determination of eligibility in the entire retroactive period – all three months prior to the application month – even if a covered medical service was received in only one retroactive month. The applicant must provide all verifications necessary to determine eligibility during the retroactive period.

If the applicant is found eligible for retroactive coverage and a Medicaid-covered medical service was received over one year prior to the date the retroactive eligibility is determined, the applicant must be given an "Eligibility Delay" letter to give to the medical provider so that Medicaid will pay the claim (use the sample letter on the intranet at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>). Once retroactive eligibility is established, Medicaid coverage begins the first day of the earliest retroactive month in which retroactive eligibility exists.

## M0130.200 Required Information and Verifications

### A. Identifying Information

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

#### 1. Name

The name entered in the official case record and computer enrollment systems for an applicant must match the applicant's name on his Social Security card or Social Security Administration (SSA) records verification. This is important because of the Medicare Buy-in and other computer matches the Medicaid Management Information System (MMIS) performs with SSA. *At the time of the initial MA application, verify the SSA record of the individual's name.* SVES data must be used because SVES verifies the spelling, etc., of the individual's name in the SSA records.

For subsequent reapplications, the State Online Query-Internet system (SOLQ-I) *SSA Title II and Title XVI results* may be used.

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

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

#### 2. SSN

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

### B. Required Verifications

#### 1. *The Federally-managed Data Services Hub*

*The Hub is a data center that links the following federal systems:*

- *Social Security Administration*
- *Internal Revenue Service (IRS)*
- *Systematic Alien Verification for Entitlements (SAVE).*

*Information from other sources, such as the Work Number, may become available via the Hub in the future.*

#### 2. *Other Verification Sources*

An individual must provide verifications of *certain MA* eligibility requirements *when they cannot be verified through EDSV.* Before taking action on the application, the applicant must be notified in writing of the required information.

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

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

**2. Copy  
Verification  
Documents**

Legal documents and documents that may be needed for future eligibility determinations must be copied and preserved for the record. These include citizenship and identity documents, alien status documentation, verification of legal presence, trusts, annuities, contracts, wills, and life insurance policies. It is not necessary to retain a copy of verifications of income or the current value of resources in the case record. However, if a copy is not retained, the worker must document electronically or in the case record the date and method used to obtain the information (viewed, telephone call, etc.), the type of verification, the source, and a description of the information.

**3. Information  
Not Provided**

If information necessary to make an eligibility determination is requested but not provided by the applicant and cannot be obtained from any other source, the application must be denied (or the coverage cancelled) due to the inability to determine eligibility.

When the deadline date falls on a weekend or holiday, LDSS may choose to deny the application (or cancel coverage) before the deadline date. However, if the early denial or cancel action is taken, LDSS must re-open the application if the individual provides the necessary information on or before the original deadline date. If the individual's application is re-opened and he/she is determined eligible, the LDSS must send a notice to the individual notifying him of the changed action.

**C. Verification of  
Nonfinancial  
Eligibility  
Requirements**

**1. Verification  
Not Required**

The applicant's statements on the application may be accepted for the following identifying information and nonfinancial eligibility requirements unless the eligibility worker has reason to question the applicant's statements:

- Virginia state residency;
- pregnancy.

**2. Verification  
Required**

The following information must be verified:

- application for other benefits;
- citizenship and identity;
- Social Security number (see section D below);
- legal presence in the U.S. of applicants age 19 or older;
- age of applicants age 65 and older; and
- disability and blindness.

See M0130.200 E below for instructions on the verification of legal presence. See subchapter M0220 for instructions on the verification of identity and citizenship. See subchapter M0310 for instructions on the verification of age and disability.

**D. Social Security Numbers**

Applicants must provide the Social Security number (SSN) of any person for whom they request Medicaid. An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

**1. SSN Verification**

*The Federal Hub, SVES* or SOLQ-I may be used to verify the individual's SSN. However, to verify the SSA record of the individual's name at the initial Medicaid application, *SSA data from the Hub* or SVES must be used because it verifies the spelling, etc., of the individual's name in the SSA records.

**2. Exceptions to SSN Requirements**

Children under age one born to Medicaid-eligible mothers *or born to mothers covered by FAMIS* are deemed to have applied and been found eligible for Medicaid, whether or not eligibility requirements have actually been met. A child eligible in this covered group does not need *to provide* a Social Security number.

Illegal aliens who are eligible only for Medicaid payment of emergency services are not required to provide or apply for SSNs (see M0220).

**3. SSN Not Yet Issued**

If an SSN has not been issued, the applicant must cooperate by applying for a number with the local Social Security Administration (SSA) office. Instruct the applicant to submit form SS-5, the Application for Social Security Number, to the SSA and to obtain a receipt from the SSA verifying that the application was submitted. The SS-5 is available online at: <http://www.socialsecurity.gov/ssnumber/ss5.htm>. The applicant must provide the SSN to the local social services department as soon as it is received and the number must be entered in the MMIS. Applicants who refuse to furnish an SSN or to show proof of application for a number will be ineligible for medical assistance.

In the case of a newborn child not eligible in a child under 1 covered group, the applicant can request hospital staff to apply for an SSN for the child through hospital enumeration procedures. Form #SSA-2853 will be given to the applicant as proof of application for an SSN.

When entering the individual in the *eligibility/enrollment system*, use the date the individual applied for an SSN, or the individual's date of birth, preceded by "999" as the individual's SSN. For example, an individual applied for an SSN on October 13, 2006, enter "999101306" as the individual's SSN.

**E. Legal Presence (Effective January 1, 2006)**

Effective January 1, 2006, Section 63.2-503.1 of the Code of Virginia requires most applicants for or recipients of public assistance who are age 19 or older to provide proof of citizenship or legal presence in the U.S. Applicants or recipients age 19 or older for whom medical assistance is requested must prove their citizenship or legal presence.

Individuals who, on June 30, 1997, were Medicaid-eligible and were residing in long-term care facilities or participating in home and community-based waivers, and who continue to maintain that status (eligible for Medicaid and reside in long-term care facilities or participate in home and community-based waivers) are exempt from this requirement.

**Non-citizens applying for Medicaid payment limited to emergency services are not subject to the legal presence requirement.** An individual who is applying on behalf of another and is not requesting assistance for himself is not subject to the legal presence requirement.

**2. Documents That Demonstrate Legal Presence**

An applicant may demonstrate legal presence by presenting one of the following documents:

- valid evidence of U.S. citizenship;
- valid evidence of legal permanent resident status;
- valid evidence of conditional resident alien status;
- a valid SSN verified by SSA;
- a U.S. non-immigrant visa;
- a pending or approved application for legal asylum;
- a refugee or temporary protected status document; or
- a pending application for an adjustment of residence status.

**3. Failure to Provide Proof of Legal Presence**

An applicant who cannot provide documentation that he is a citizen or legally present at the time of application must sign an affidavit under oath attesting that he is a U.S. citizen or legally present in the U.S. in order to meet the requirement for proof of legal presence for either:

- a period of 90 days or until it is determined that he is not legally present in the U.S., whichever is earlier; or
- indefinitely if the applicant provides a copy of a completed application for a birth certificate that has been filed and is pending and being actively pursued in accordance with federal or state law. Such extension shall terminate upon the applicant's receipt of a birth certificate or determination that a birth certificate does not exist because the applicant is not a U.S. citizen.

The affidavit form is on the intranet at:

<http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>.

NOTE: The individual's address on the affidavit form must be the individual's **residence** address, not the mailing address.

**4. Relationship to Other Medicaid Requirements**

Providing proof of legal presence or submitting a signed affidavit meets the legal presence eligibility requirement. To be eligible for Medicaid, however, the individual must meet all other state and federal Medicaid eligibility requirements. Submission of the affidavit without proof of application for an SSN as required by M0130.200 D. does **NOT** meet the SSN requirement.

**F. Third Party Liability (TPL)**

Applicants must be asked to provide information about any health insurance they may have. Verification of health insurance information is not required.

In the event the client is eligible for benefits to be used exclusively for the payment of medical expenses (i.e. an insurance settlement), but there is no TPL code for that benefit, the worker must email the information to the DMAS TPL Unit at [TPLUnit@dmas.virginia.gov](mailto:TPLUnit@dmas.virginia.gov), or send the information to:

DMAS Third Party Liability Section  
600 East Broad Street, Suite 1300  
Richmond, Virginia 23219

**G. Health Insurance Premium Payment (HIPP) Program**

The HIPP program is a cost-savings program for individuals enrolled in Medicaid which may reimburse some or all of the employee portion of the employer group health insurance premium. Eligibility for HIPP is determined by the HIPP Unit at DMAS. Participation in HIPP is voluntary.

The local DSS agency must give each applicant or enrollee who reports that he or someone in his family is employed more than 30 hours each week and is eligible for health insurance coverage under an employer's group health plan must be given a HIPP Fact Sheet, which provides a brief description of the program and the contact information for the HIPP Unit at DMAS. The HIPP Fact Sheet is available on-line at: <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>. Enrollees and other members of the public may contact the HIPP Unit for additional information at [hippcustomerservice@dmas.virginia.gov](mailto:hippcustomerservice@dmas.virginia.gov).

If the health insurance policy holder lives outside of the home, a HIPP Consent Form must be completed by both the policy holder and the parent/authorized representative so the DMAS HIPP Unit can process the HIPP application. If the form is required, the DMAS HIPP Unit will send it to the applicant for completion.

**H. Verification of Financial Eligibility Requirements**

The eligibility worker must verify the following financial eligibility requirements:

- the value of all countable, non-excluded resources;
- all earned and unearned income; and
- asset transfer information for individuals in need of long-term care services, including the date of transfer, asset value, and compensation received.

**1. Use of Federal Income Tax Data**

*Federal Income Tax data is used for the income eligibility determination for the MAGI population. The Hub provides verification of income reported to the IRS. When an applicant is a member of a tax household for which federal income taxes were filed in the previous calendar year, the income information reported to the IRS may be used for the eligibility determination. The income reported on the application is compared to the data obtained from the Hub for reasonable compatibility per M0420.100.*

**2. SSA Data**

Social Security and/or Supplemental Security Income must be verified through SSA. *The Federal Hub links to SSA data. SOLQ-I may also be used. The State Data Exchange (SDX) system should only be used as an alternate method when the Hub or SOLQ-I is not available.*

## M0130.300 Eligibility Determination Process

### A. Evaluation of Eligibility Requirements

The eligibility determination process consists of an evaluation of an individual's situation that compares each of the individual's circumstances to an established standard or definition. The applicant must be informed of all known factors that affect eligibility.

The evaluation of eligibility requirements must be documented in writing for cases not processed in the *eligibility determination computer* system. The Evaluation of Eligibility (form #032-03-823) may be used. The form is available online at <http://www.localagency.dss.state.va.us/divisions/bp/me/forms/general.cgi>. Agency-created evaluation forms are also acceptable as long as all information needed to determine eligibility is documented on the evaluation form.

Eligibility decisions are made following a prescribed sequence:

- The applicant must meet all non-financial requirements, including a covered group.
- If applicable to the covered group, resource limits must be met.
- The income limits appropriate to the covered group must be met.

Subchapter M0210 contains the Medicaid non-financial requirements.

### B. Hierarchy of Covered Group

An applicant must be evaluated for eligibility in all potential covered groups and enrolled in the group that is the most beneficial to the applicant. First, evaluate under covered groups offering full coverage and if the applicant is not eligible, evaluate under groups offering limited coverage. Further specific instructions regarding the determination of covered group are contained in chapter M03.

### C. Applicant's Choice of Covered Group

An individual who meets more than one covered group may choose the covered group under which he wishes his eligibility determined. Appropriate policy used is based on that individual's choice. If the choice is not clear on the application/redetermination form, the individual must state his covered group choice in writing. If the applicant does not make a choice, enroll him in the covered group that is the most beneficial.

### D. Application Disposition

#### 1. General Principle

Each application must be disposed of by a finding of eligibility or ineligibility as supported by the facts in the case record, unless the application is withdrawn or terminated (see M0130.400).

If an applicant dies during the application process, his eligibility can only be established for the period during which he was alive.

#### 2. Entitlement and Enrollment

##### a. Entitlement

Entitlement to medical assistance is based on the application month. However, entitlement cannot begin prior to an individual's date of birth, and cannot continue after an individual's date of death. See section M1510.100 for detailed entitlement policy and examples.

**b. Enrollment**

MA enrollees must be enrolled in the Medicaid Management Information System (MMIS), *either through the system interface with the eligibility determination system or directly by the eligibility worker.*

When enrolling an individual in the MMIS, the appropriate aid category (AC) for the applicant's covered group must be used. Enrollment procedures and a list of ACs are found in the MMIS Users' Guide for DSS, available at:  
[http://localagency.dss.virginia.gov/divisions/bp/me/vammis\\_documents.cgi](http://localagency.dss.virginia.gov/divisions/bp/me/vammis_documents.cgi).

*When an individual who does not have Medicare is eligible for only limited MA benefits, such as Plan First, a referral to the HIM must be made so that the individual's eligibility for the APTC in conjunction with a Qualified Health Plan (QHP) can be determined. Medicare beneficiaries are not referred to the HIM.*

**c. Denials**

*Applications for MA which are denied, including when an individual is placed on a spenddown) must be referred to the HIM so that the applicant's eligibility for the APTC can be determined.*

**3. Notification to Applicant**

*Either a Notice of Action generated by the eligibility determination system or the Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs (NOA), form #032-03-008 (available at: <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi>) must be used to notify the applicant of the specific action taken on the application. A copy of the notice must also be mailed to an individual who has applied on behalf of the applicant.*

**a. Approvals**

*As applicable, the notice must state that:*

- the application has been approved, including the effective date(s) of Medicaid or FAMIS coverage;
- retroactive Medicaid coverage was approved, including the effective dates.
- *For approvals of limited coverage, that the application has been referred to the HIM for determination of eligibility for the APTC.*

**b. Denials**

*As applicable, the notice must state that:*

- the application has been denied, including the specific reason(s) for denial cited from policy;
- retroactive Medicaid coverage was denied, including the specific reason(s) for denial cited from policy.
- *the application has been referred to the HIM for determination of eligibility for the APTC.*

*c. Delays*

*The notice must state that there is a delay in processing the application, including the reason.*

*d. Other Actions*

*Other actions for which a notice must be sent include when a request for re-evaluation of an application in spenddown status has been completed.*

**E. Notification for Retroactive Entitlement Only**

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

**M0130.400 Applications Denied Under Special Circumstances**

**A. General Principle**

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

**B. Withdrawal**

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

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

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

**C. Inability to Locate**

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

**D. Duplicate Applications**

Applications received requesting *MA* for individuals who already have an application recorded or who are currently active will be denied due to duplication of request. A notice will be sent to the applicant when a duplicate application is denied.

**M0210 Changes**

<b>Changed With</b>	<b>Effective Date</b>	<b>Pages Changed</b>
TN #98	10/1/13	pages 1-3
TN #97	9/1/12	page 3
Update (UP) #2	8/24/09	pages 1, 2

**M0210.000 GENERAL RULES & PROCEDURES****M0210.001 PRINCIPLES OF MEDICAID ELIGIBILITY DETERMINATION****A. Introduction**

Medicaid is an assistance program which pays medical service providers for services rendered to eligible needy individuals. An individual's need for medical care, the state of his health, or his coverage by private health insurance, have no effect on his Medicaid eligibility.

The eligibility determination consists of an evaluation of an individual's situation which compares each of the individual's circumstances to an established standard or definition. The evaluation provides a structured decision-making process. An individual must be evaluated for eligibility in all covered groups for which he meets the definition, and the applicant/enrollee shall be informed of all known factors that affect eligibility.

**B. Eligibility Requirements**

Although all the requirements that follow may not be applicable in a particular individual's situation, they must be looked at and evaluated.

**1. Nonfinancial Eligibility Requirements**

The Medicaid nonfinancial eligibility requirements are:

- a. Legal presence in the U.S., effective January 1, 2006 (M0210.150).
- b. Citizenship/alien status (M0220).
- c. Virginia residency (M0230).
- d. Social Security number (SSN) provision/application requirements (M0240).
- e. Assignment of rights to medical benefits and pursuit of support from the absent parent requirements (M0250).
- f. Application for other benefits (M0270).
- g. Institutional status requirements (M0280).
- h. Covered group requirements (M03).

**2. Financial Eligibility Requirements**

The Medicaid financial eligibility requirements are:

- a. Asset transfer for individuals who need long-term care (subchapter M1450).
- b. Resources within resource limit appropriate to the individual's covered group. (Chapter M06 for F&C covered groups; Chapter S11 for ABD covered groups).
- c. Income within income limit appropriate to the individual's covered group. (Chapters M04 and M07 for F&C covered groups; Chapter S08 for ABD covered groups).

**3. Example**

**EXAMPLE:** On January 5, 2006, Mr. H applies for Medicaid. He is in a nursing facility in Virginia, and has been there since July 5, 2005. When evaluating his application, the worker finds that he:

- is a U.S. citizen,
- is currently a Virginia resident residing in a medical institution in Virginia,
- provided his SSN,
- refused to provide third party liability and medical support information,
- has applied for all benefits to which he is entitled,
- meets the institutional status requirements,
- is age 67 years and meets a covered group requirement.

He currently has \$5,000 in the bank. His income is \$600 per month Social Security (SS). Since he refused to provide third party liability and medical support information, he does not meet the assignment of right requirements and his application must be denied. He is also informed of the resource limit and that he is ineligible for Medicaid because his resources exceed the limit.

**M0210.100 INELIGIBLE PERSONS****A. Introduction**

The individuals listed in this section are not eligible for Medicaid. However, their income and resources may be considered in determining the eligibility of others in the household who have applied for Medicaid.

**B. Certain Recipients of General Relief (GR)**

A recipient of General Relief (GR) maintenance who does not meet a Medicaid covered group is not eligible for Medicaid.

An applicant for Medicaid and Supplemental Security Income (SSI) who receives GR from the interim assistance component may become eligible for Medicaid following the establishment of SSI eligibility. Eligibility for an SSI payment is effective the month **following** the SSI application month. When the Medicaid application is dated in the same month as the SSI application, Medicaid eligibility can be effective the month of application if the applicant meets all Medicaid eligibility requirements and another covered group requirement in the application month.

**C. Essential Spouse of an ABD Individual**

An essential spouse of an aged, blind, or disabled person who does not himself/herself meet a covered group is not eligible for Medicaid.

**D. Individual Who Refuses to Assign Rights**

*By signing the application for medical assistance, an applicant assigns his rights to third party payments. Should the individual for any reason subsequently refuse to assign rights to third-party payments or support for himself or anyone for whom he can legally assign rights, he is not eligible for Medicaid. Failure to assign rights for another person will not affect the eligibility of that other person.*

- E. Individual Who Refuses to Pursue Support From an Absent Parent** *An individual applying for Medicaid for himself and on behalf of a child meets the requirement to cooperate with the pursuit of medical support from an absent parent for the child by signing the application. If DMAS requires the individual, other than a categorically needy pregnant woman, to take further action to cooperate with the pursuit of medical support, the individual must cooperate to continue to be eligible for Medicaid. If the individual refuses to cooperate in the pursuit of medical support, he is not eligible for Medicaid. Eligibility could exist if the individual meets a covered group and the individual chooses not to apply for the child.*
- F. Individual Found Guilty of Medicaid Fraud** An individual found guilty by a court of Medicaid fraud is not eligible for Medicaid. Ineligibility will last for a period of 12 months beginning with the month of conviction.
- G. Individual Who Refuses to Supply or Apply For an SSN** Any individual, except a child under age 1 born to a Medicaid or FAMIS eligible mother, or an illegal alien, who does not apply for an SSN account number or who fails or refuses to furnish all SSNs to the Department of Social Services is not eligible for medical assistance coverage.

## M0210.150 LEGAL PRESENCE

- A. Legal Presence (Effective January 1, 2006)** Effective January 1, 2006, Section 63.2-503.1 of the Code of Virginia requires most applicants for or recipients of public assistance who are age 19 or older to provide proof of citizenship or legal presence in the U.S. Applicants or recipients age 19 or older for whom medical assistance is requested must prove their citizenship or legal presence. Individuals who, on June 30, 1997, were Medicaid eligible and were residing in long-term care facilities or participating in home and community-based waivers, and who continue to maintain that status (eligible for Medicaid and reside in long-term care facilities or participate in home and community-based waivers) are **exempt** from this requirement. **Non-citizens applying for Medicaid payment for emergency services are not subject to the legal presence requirement.**
- An individual who is applying on behalf of another and is not requesting assistance for himself is not subject to the legal presence requirement.
- B. Documents That Demonstrate Legal Presence** An applicant may demonstrate legal presence by presenting one of the following documents:
- valid evidence of U.S. citizenship;
  - valid evidence of legal permanent resident status;
  - valid evidence of conditional resident alien status;
  - a valid SSN verified by the Social Security Administration (SSA);
  - a U.S. non-immigrant visa;
  - a Resident Alien Card, form I-551, showing lawful permanent residence (green card);
  - a pending or approved application for legal asylum;

## M0220 Changes

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

**M0220.100 CITIZENSHIP AND NATURALIZATION****A. Introduction**

A citizen or naturalized citizen of the United States meets the citizenship requirement for medical assistance (*MA*) eligibility, and is eligible for all *MA* services if he meets all other eligibility requirements.

**B. Citizenship Determination****1. Individual Born in the United States**

An individual born in the United States, any of its territories (Guam, Puerto Rico, United States Virgin Islands, or Northern Mariana Islands), American Samoa, or Swain's Island is a United States citizen.

A child born in the United States to non-citizen parents who are in the United States as employees of a foreign country's government may not meet the United States citizen requirement. When a child born in the United States to non-citizen parents is a United States citizen by birth, the child may not meet the Virginia residency requirements in M0230.201 because of the parents' temporary stay in the United States.

**2. Individual Born Outside the U.S.****a. Individual Born to or Adopted by U.S. Citizen Parents**

A child or individual born outside the United States to U.S. citizen parents (the mother, if the child was born out-of-wedlock) automatically becomes a citizen by birth. A child under age 18 years who is a lawful permanent resident, who is currently residing permanently in the U.S. in the legal and physical custody of a U.S. citizen parent, and who meets the requirements applicable to adopted children under immigration law automatically becomes a citizen when there is a final adoption of the child, and does not have to apply for citizenship.

**b. Individual Born to Naturalized Parents**

A child born outside the United States to alien parents automatically becomes a citizen after birth, if his parents (the mother, if the child was born out-of-wedlock) are naturalized before he becomes 16 years of age.

**c. Naturalized Individual**

A child or individual born outside the U.S. and not automatically a citizen as in a) or b) above must have been naturalized to be considered a citizen.

**C. Verification****1. Requirements**

The DRA requires that satisfactory documentation of citizenship and identity must be obtained for all enrollees who claim to be U.S. citizens. Enrollees who claim U.S. citizenship must have a declaration of citizenship AND documentary evidence of citizenship and identity in their case records.

**2. Exceptions to Verification Requirements**

The following groups of individuals are NOT required to provide verification of C&I. Document in the case record why an individual is exempt from verifying C&I:

- 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 on SPARK at: <http://spark.dss.virginia.gov/divisions/bp/me/citizenship/index.cgi>, 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.

**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

(MMIS) and SSA for the documentation of C&I for individuals enrolled in the Medicaid and FAMIS programs. In order for this process to be used to verify citizenship and identity, the individual's SSN must be verified by SSA (see M0240).

*For eligibility determinations processed through VaCMS, the Social Security data match takes place when the individual's information is sent through the Hub. For cases not processed in VaCMS, the SSA data match will take place after the individual has been enrolled in MMIS.*

**1. MMIS Data Matches SSA**

If the information in the MMIS matches the information contained in the SSA files, the MMIS will be updated to reflect the verification of C&I. No further action is needed on the part of the eligibility worker, and the enrollee will not be required to provide any additional documentation, if the SSA match code in MMIS shows that SSA verified the individual's C&I.

**2. MMIS Data Does Not Match SSA**

If the information in the MMIS does not match the information in the SSA files, a discrepancy report will be generated monthly listing the inconsistent information. Eligibility staff is expected to review the report to see if the report lists any enrollees who were rejected because SSA could not verify the enrollee's citizenship and identity.

**a. SSA Cannot Verify C&I**

If the SSA data match result does not verify the individual's C&I, eligibility workers must review the information in the *system* to determine if a typographical or other clerical error occurred. If it is determined that the discrepancy was the result of an error, steps must be taken to correct the information in the *system* so that SSA can verify C&I when a new data match with SSA occurs in the future.

If the inconsistency is not the result of a typographical or other clerical error, the individual must be given a reasonable opportunity period of 90 days to either resolve the issue with SSA or provide verification of C&I. The eligibility worker must send a written notification to the enrollee that informs the enrollee of the discrepancy and gives him 90 calendar days from the date of the notice to either resolve the discrepancy with the SSA and to provide written verification of the correction, OR provide acceptable documentation of C&I to the LDSS.

The notice must specify the date of the 90<sup>th</sup> day, and must state that, if the requested information is not provided by the 90<sup>th</sup> day, the individual's Medicaid coverage will be canceled. Include with the notice the "Proof of U.S. Citizenship and Identity for Medicaid" document available on SPARK at

<http://spark.dss.virginia.gov/divisions/bp/me/citizenship/index.cgi#forms>.

Acceptable forms of documentation for C & I are also included in Appendix 1 to this subchapter.

**b. Individual Does Not Provide Verification in 90 Days**

If the individual does not provide the information necessary to meet the C&I documentation requirements by the 90<sup>th</sup> day, his coverage must be canceled. Send an advance notice, and cancel coverage at the end of the month in which the 90<sup>th</sup> day occurs.

**c. Discrepancy Resolved With SSA Within 90 Days**

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

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

**d. Verification of C&I Provided Within 90 Days**

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

**3. Subsequent Applications**

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

## Citizenship & Identity Procedures and Documentation Charts

Workers are to use the following procedures when citizenship and identity verification is required to determine the individual's continued eligibility.

### A. Documents

#### Establishing U.S. Citizenship and Identity

1. *Documents that Verify Citizenship and Identity* Both U.S. Citizenship and identity are verified by a:
- U.S. Passport,
  - Certificate of Naturalization, or
  - Certificate of U. S. Citizenship

*Documentary evidence issued by a federally recognized Indian tribe which identifies the tribe that issued the document, indentifies the individual by name and confirms membership, enrollment or affiliation with the tribe (tribal enrollment card, certificate of degree of Indian blood, Tribal census. document, documents on Tribal letterhead)If the individual presents one of these documents, he has verified his citizenship and identity. **Photocopies of original documents are acceptable.***

2. *Documents that Verify Identity* a. *Documents*

*The agency must accept any of the documents listed below as proof of identity, provided such document has a photograph or other identifying information including, but not limited to, name, age, sex, race, height, weight, eye color or address. **Photocopies of original documents are acceptable.***

- *Identity documents listed at 8 CFR 274a.2(b)(1)(v)(B)(1), except a driver's license issued by a Canadian government authority*
- *Driver's license issued by a State or Territory*
- *School identification card*
- *U.S. military card or draft record*
- *Identification card issued by the Federal, State or local government*
- *Military dependent's identification card*
- *U.S. Coast Guard Merchant Mariner's card*
- *For children under age 19, a clinic, doctor, hospital or school record, including preschool or daycare records*

- *Two documents containing consistent information that corroborates an applicant's identity. Such documents include, but are not limited to, employer identification cards, high school and college diplomas (including high school equivalency diplomas), marriage certificates, divorce decrees and property deeds or titles.*
- *Finding of identity from a Federal or State governmental agency. The agency may accept as proof of identity a finding of identify from a Federal agency or another State agency, including but not limited to a public assistance, law enforcement, internal revenue or tax bureau, or corrections agency, if the agency has verified and certified the identity of the individual*

***b. Affidavit***

*If the applicant does not have any document specified above and identity is not verified, the applicant may submit an affidavit signed, under penalty of perjury, by another person who can reasonably attest to the applicant's identity. Such affidavit must contain the applicant's name and other identifying information. The affidavit does not have to be notarized.*

**3. Documents that  
Verify  
Citizenship**

***a. Documents***

The agency must accept any of the documents listed below as proof of U.S. Citizenship. ***Photocopies of original documents are acceptable.***

- *Civil Service employment by the U.S. government prior to 1976*
- *Evidence of compliance with the Child Citizen Act of 2000*
- *Final adoption decree showing U.S. birth, or if adoption is not final, a statement from a State-approved adoption agency that shows the child's name and U.S. place of birth*
- *Homeland Security's Systematic Alien Verification for Entitlements Database (used when individual has become a Naturalized Citizen but information did not show up in SSA database)*
- *Northern Mariana Card for individuals born before 11/4/1986 ( I-873)*
- *Office of Vital Records*
- *Official Military Records showing a U.S. birth Report/Certificate of birth abroad of U.S. citizen (dS-1350, FS-240 or FS-545)*
- *U.S. Birth Certificate*
- *U.S. citizen ID card (I-197 or I-179)*

- *Medical records, including but not limited to, hospital, clinic or doctor records or admission papers from a nursing facility, skilled care facility or other institution that indicate a U.S. place of birth*
- *Life, health or other insurance records that indicate a U.S. place of birth*
- *Official religious record recorded in the U.S. indicating a U.S. birth*
- *School records, including pre-school, Head Start and day care, showing child's name and U.S. place of birth*
- *Federal or state census records showing U.S. citizenship or U.S. place of birth*
- *Certification of U.S. birth*
- *A Certification of Report of Birth, issued to U.S. citizens who were born outside the U.S.*
- *A report of Birth Abroad of a U.S. citizen*

**b. Affidavit**

*If no other documentation exists, the individual may submit an affidavit signed, under penalty of perjury, by another person who can reasonably attest to the applicant's identity. Such affidavit must contain the applicant's name and other identifying information. The affidavit does not have to be notarized.*

**C. Agency Actions**

**1. Documentation From Case Record and Individual**

Documentation of citizenship and/or identity may be obtained from a number of different sources, *including the sources listed below. Photocopies of original documents are acceptable.*

- Existing LDSS agency records, as long as the documentation conforms to Medicaid policy for citizenship and identity verification in M0220 of the Medicaid Eligibility Manual.
- *A federal agency or another State agency. A verification of citizenship made by a federal or state agency is acceptable, as long as the verification was done on or after July 1, 2006. No further documentation of citizenship or identity is required.*

- Applicants and Recipients. All applicants and recipients, **except** SSI recipients, Medicare beneficiaries, SSDI beneficiaries, individuals born to Medicaid-eligible mothers, all foster care children and IV-E Adoption Assistance children, must provide documents that show proof of United States citizenship and proof of the person’s identity *if the local DSS is unable to verify citizenship and identity using a data match with the SSA*. Contact information for obtaining the various acceptable documents is available on the VDSS local agency intranet and the DSS public website and may be given to individuals to facilitate their obtaining documentation.
- DMAS, for individuals born in Puerto Rico who are unable to provide a birth certificate issued on or after July 1, 2010.

Puerto Rico invalidated all birth certificates issued prior to July 1, 2010 and reissued the birth certificates. For individuals born in Puerto Rico **who are applying for Medicaid for the first time**, only a birth certificate issued on or after July 1, 2010 may be accepted from the individual. Should an individual born in Puerto Rico be unable to present a birth certificate issued on or after July 1, 2010, contact your Regional Medical Assistance Specialist, who will refer the case to DMAS. DMAS will obtain official birth verification on behalf of the local DSS. If the person is reapplying and the agency has a birth certificate issued prior to July 1, 2010 on record, no additional verification is required.

**2. Authorized Representative**

For individuals who have authorized representatives, such as the disabled or individuals who are institutionalized, initiate efforts to assist in securing documentation with the appropriate representative.

**3. Individuals Who No Longer Meet Exception**

When an individual loses the exception status, and his citizenship and identity has not been previously verified, it must be verified for him to remain eligible for Medicaid. If the individual’s eligibility in another covered group must be determined (due to the loss of SSI benefits, for example), obtain the documentation of citizenship and identity at the time of the eligibility review. If the verification is not readily available, the individual must be allowed a reasonable opportunity to obtain the documentation. See M0220.100 A 3.

Verify the SSI recipient’s or Medicare beneficiary’s entitlement to benefits through *the Federal Hub* or SOLQ-I. A copy of the printout must be placed in the case file.

**4. Individual NOT Required to Submit Documents in Person**

Individuals do not have to submit their citizenship and identity to the agency worker in person. They may mail the original document for the agency to copy and mail back to the individual, **or they may submit a photocopy of the document(s)**.

**5. Special Populations Needing Assistance**

The agency shall assist special populations who need additional assistance, such as the homeless, mentally impaired, or physically incapacitated individual who lacks someone who can act on his behalf, to provide necessary documentation.

- 6. Failure to Provide Requested Verifications**

Failure to provide satisfactory evidence of citizenship and identity, after being provided a reasonable opportunity to present such documentation, is to result in the termination of MA.

An enrollee who fails to cooperate with the agency in presenting documentary evidence of citizenship may be denied or terminated. Failure to cooperate consists of failure by a recipient or that individual's representative, after being notified, to take a required action within the reasonable opportunity time period.
- 7. Notification Requirements**

Prior to the termination of benefits, the enrollee must be sent written notice at least 10 calendar days (plus one day for mailing) prior to the effective date of the closure.

A Notice of Action and appeal rights must be sent to an individual whose application is denied because of failure to provide citizenship and/or identity verification.
- 8. Maintain Documents in Case Record**

The agency must maintain copies of the documents used to verify citizenship and identity in the individual's case record or data base and must make the documents available for state and federal audits.
- 9. No Reporting Requirements**

There are no monthly reporting requirements. However, the Medical Assistance Program Consultants may conduct reviews of cases where eligibility was denied or terminated because of lack of citizenship and/or identity verification.
- 10. Refer Cases of Suspected Fraud to DMAS**

If documents are determined to be inconsistent with pre-existing information, are counterfeit, or are altered, refer the individual to DMAS for investigation into potential fraud and abuse. See section M1700.200 for fraud referral procedures.

**M0230 Changes**

<b>Changed With</b>	<b>Effective Date</b>	<b>Pages Changed</b>
TN #98	10/1/13	Table of Contents pages 3-6 Page 7 was deleted.
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### M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

#### M0230.000 VIRGINIA RESIDENCY REQUIREMENTS

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**M0230.200 RESIDENCY REQUIREMENTS****M0230.201 INDIVIDUALS UNDER AGE 21****A. Under Age 21  
NOT In An  
Institution**

An individual under age 21 is considered a resident of Virginia if he:

- a. is married or emancipated from his parents, is capable of indicating intent and is residing in Virginia with *the intent to reside Virginia*.
- b. *is not emancipated but is not living with a parent or caretaker and is presently residing in Virginia with the intent to reside in Virginia;*
- c. lives with a *parent or caretaker who is presently residing in Virginia with the intent to reside in Virginia;*
- d. is a non-IV-E (state/local) foster care child whose custody is held by Virginia (see M230.204 C. and D.);
- e. is a non-IV-E child adopted under an adoption assistance agreement with Virginia (see M230.204 C. and D.);
- f. is a non-IV-E foster care child whose custody is held by a licensed, private foster care agency in Virginia, regardless of the state in which the child physically resides;
- g. is under age 21 and is residing in another state for temporary period (for reasons such as medical care, education or training, vacation, (or visit) but is still in the custody of his/her parent(s) who reside in Virginia.
- h. is living with a parent(s) who is a non-immigrant alien (admitted to the U.S. for a temporary or limited time) when the parent has declared his intent to reside in Virginia permanently or for an indefinite period of time, and no other information is contrary to the stated intent.

**B. Under Age 21 In  
An Institution**

**If the individual was placed in the institution by a state government agent, go to section M0230.203 below.**

An institutionalized individual (who was not placed in the institution by a state government) who is under age 21 and is not married or emancipated, is a resident of Virginia if:

1. the individual's parent or legal guardian was a Virginia resident at the time of the individual's institutional placement;
2. the individual's parent or legal guardian who applies for Medicaid is a Virginia resident and the individual is institutionalized in Virginia; or
3. the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, and the individual is institutionalized in Virginia.

- C. Under Age 21, Custody or Adoption Agreement with Another State**
- When another state's child-placing agency has custody of a child who lives in Virginia with a foster family, the child is NOT a Virginia resident unless the child is eligible as a IV-E Foster Care child and receives a IV-E Foster Care maintenance payment.
- 1. IV-E Eligible Children**
- A Title IV-E Foster Care child who lives in Virginia and who receives a Title IV-E maintenance payment from another state meets the Virginia residency requirements for Medicaid.
- A Title IV-E Adoption Assistance child who lives in Virginia and has a Title IV-E Adoption Assistance agreement in effect with another state's child-placing agency meets the Virginia residency requirements for Medicaid.
- 2. Non-IV-E Foster Care Children**
- A non-IV-E Foster Care child placed in Virginia from another state does NOT meet the Virginia residency requirements for Medicaid.
- 3. Foster Care Children with SSI**
- A foster care child who receives Supplemental Security Income (SSI) benefits meets the Virginia residency requirement regardless of which state's child-placing agency maintains custody.
- 4. Non-IV-E Adoption Assistance and Adoptive Placement Children**
- A child who lives in Virginia with an adoptive family is considered to be living with a parent, regardless of whether a final order of adoption has been entered in court. When his adoptive parent is a Virginia resident, the child is a Virginia resident for Medicaid eligibility purposes. A Non-IV-E Adoption Assistance child whose adoption assistance agreement is signed by another state's child-placing agency is a Virginia resident when the child lives in Virginia with the adoptive parent(s).

## M0230.202 INDIVIDUALS AGE 21 OR OLDER

- A. Introduction**
- For an individual age 21 or older, the determination of state residency depends on
- whether or not the individual is in an institution, and
  - whether or not the individual is capable of indicating his or her intent to reside in the state.
- B. Age 21 Or Older NOT In An Institution**
- For any individual age 21 or older NOT residing in an institution, the state of residence is Virginia when:
- the individual is living in Virginia *with or without a fixed address with the intention to reside in Virginia*;
  - the individual is living in Virginia and entered the state with a job commitment or seeking employment (whether or not currently employed).
  - the individual is incapable of indicating intent and the individual is living in Virginia.

- C. Age 21 Or Older In An Institution**      **If the individual was placed in the institution by a state government agent, go to section M0230.203 below.**
- 1. Capable of Stating Intent**      An individual in an institution who is age 21 or over and who is capable of declaring his intent to reside in Virginia, is a resident of Virginia if the individual is in an institution in Virginia with the intent to remain permanently or for an indefinite period.
  - 2. Incapable of Stating Intent**      An individual in an institution who is age 21 or over and who became incapable of stating intent at or after age 21 is a Virginia resident if he or she is residing in Virginia.

## **M0230.203 STATE PLACEMENT IN INSTITUTION**

### **A. Policy**

Any agency of the state, including an entity recognized under state law as being under contract with the state for such purposes, that arranges for an individual to be placed in an institution located in another state, is recognized as acting on behalf of the state in making the placement. The state arranging or actually making the placement is considered the individual's state of residence. When an individual is placed by state or local government in an institution in another state, the individual remains the responsibility of the placing state unless the state or local government agency in the other state assumes responsibility for the individual's care or Medicaid eligibility.

When an individual is placed by a Virginia government agency in an institution in another state, the individual remains the responsibility of Virginia unless

- a state or local government agency in the other state assumes responsibility for the individual's care or Medicaid eligibility,
- the individual is a child who receives a IV-E foster care or adoption assistance payment, or
- the individual is a child who receives **non-IV-E adoption assistance** and the state in which he is placed is a reciprocal state under the interstate compact, verified by the central office Deputy Compact Administrator, Adoption Unit, Division of Family Services, Virginia Department of Social Services (DSS).

### **B. State Placement**

Placement by a state government agency is any action taken by the agency, beyond providing general information to the individual and his family, to arrange admission to an institution for the individual. The following actions do not constitute state placement:

- providing basic information to individuals about other states' Medicaid programs or about the availability of health care services and facilities in other states;
- assisting an individual, who is capable of declaring intent and who independently decides to move out-of-state, in locating an institution in another state.

1. **Lack Of Facilities** When a placement is initiated by a state because the state lacks a sufficient number of appropriate facilities to provide services to its residents, the state making the placement is the individual's state of residence for Medicaid purposes.
  2. **Individual Leaves Facility** When a competent individual leaves the facility in which he was placed by a state, that individual's state of residence for Medicaid purposes is the state where the individual is physically located.
- C. Individual Placed Out-of-State by Virginia Government** An individual can leave Virginia and retain Virginia residency if he is placed in an institution outside Virginia by a Virginia government agency. Out-of-state placement into a long-term care facility must be preauthorized by the Director of the Virginia Department of Medical Assistance Services for Virginia Medicaid to pay for the institutional care.
- When a competent individual voluntarily leaves the facility in which Virginia placed him, he becomes a resident of the state where he is physically located.

## M0230.204 CASH ASSISTANCE PROGRAM RECIPIENTS

- A. Introduction** Certain individuals are considered residents of Virginia for Medicaid purposes if they live in Virginia and receive a cash assistance payment specified below in this section. Some recipients of cash assistance from a Virginia social services agency who do NOT reside in Virginia are considered residents of Virginia for Medicaid purposes, as specified below.
- B. Auxiliary Grants Recipients** An individual receiving an Auxiliary Grants (AG) payment from a locality in Virginia is considered a Virginia resident.
- An individual who receives a State Supplement of SSI payment from another state is considered a resident of the state making the State Supplement payment.
- C. IV-E Payment Recipients** For an individual of any age who receives federal foster care or adoption assistance payments under Title IV-E of the Social Security Act, the state of residence for Medicaid eligibility is the state where the child lives.
- D. Non-IV-E Foster Care Payment Recipients** The non IV-E (state/local) foster care payment recipient is a resident of the state that is making the non IV-E payment.
- E. Non-IV-E Adoption Assistance Payment Recipients** The non IV-E (state/local) Adoption Assistance recipient is a resident of the state in which the child's adoptive parent(s) resides, regardless of whether a final order of adoption has been entered in court.

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M0240 Changes

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TN #91	5/15/09	pages 1, 2

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## **M0240.000 SOCIAL SECURITY NUMBER REQUIREMENTS**

### **M0240.001 GENERAL PRINCIPLES**

#### **A. Policy**

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

*Exceptions – the SSN requirement does not apply to:*

- an alien who is eligible only for Medicaid payment of emergency services, as defined in subchapter M0220, or
- a child under age one born to a Medicaid-eligible or FAMIS-covered mother (see M0330.301 B. 2 and M2220.100.).

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

#### **B. Failure to Meet SSN Requirement**

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

##### **1. Child Under Age 1**

A child under age one born to a Medicaid-eligible *or to a FAMIS-covered mother* is deemed to have applied and been found eligible for MA, whether or not the eligibility requirements, including SSN, have actually been met.

##### **2. Emergency-Services-Only Alien**

An alien eligible for Medicaid payment of emergency services only, as defined in M0220.410 and M0220.411 does not have to provide or apply for an SSN.

#### **C. Relationship to Other Medicaid Requirements**

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

#### **D. Verification**

##### **1. Name**

The name entered in the official case record and computer enrollment systems for an applicant must match the applicant's name on his Social Security card or Social Security Administration (SSA) records verification. It is important to spell the name correctly so that when the Medicaid Management Information System (MMIS) sends the enrollee information to SSA for the Medicare Buy-in or the citizenship and identity match, the enrollee can be matched to SSA records.

At the time of the initial MA application, *verify the SSA record of the individual's name. SSA is available via the Federal Hub. SSA data from the Hub or SVES data must be used because it verifies the spelling, etc., of the individual's name in the SSA records.*

For subsequent reapplications, the State Online Query-Internet system (SOLQ-I) may be used.

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

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

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

Workers may use either the SOLQ-I or SVES to verify the individual's SSN and entitlement to Social Security benefits and Medicare. However, to verify the SSA record of the individual's name at the initial application, SVES must be used.

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

## **M0240.100 APPLICATION FOR SSN**

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

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

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

2. **Failure to Apply for SSN** Applicants who refuse to furnish an SSN or to show proof of application for a number are ineligible for Medicaid.
3. **Retroactive Eligibility** An individual who provides proof of application for an SSN after he applies for medical assistance, meets the application for SSN requirement in the three months retroactive to his medical assistance application.

## M0240.200 FOLLOW-UP REQUIREMENTS FOR SSN APPLICATION

- A. **Applicant Applied for SSN** When an applicant who has applied for an SSN is determined eligible for medical assistance, he is enrolled with a pseudo-SSN. The worker must obtain the enrollee's SSN when it is assigned and enter it into the enrollee's records.
- B. **Follow-Up Procedures**
  1. **Documentation** The follow-up procedures below do not apply to individuals listed in M0240.100 B.  
If the applicant does not have an SSN, the agency must document in the record the date he applied for an SSN.
  2. **Entering Computer Systems** When entering the individual *the eligibility/enrollment system*, use the date the individual applied for an SSN, or the individual's date of birth, preceded by "999" as the individual's SSN.  
  
For example, an individual applied for an SSN on October 13, 2006. Enter "999101306" as the individual's SSN in *the eligibility/enrollment system*.
  3. **Follow-up**
    - a. **Follow-up in 90 Days**  
After enrollment of the eligible individual, the agency must follow-up within 90 days of the Social Security number application date or 120 days if application was made through hospital enumeration:
    - b. **Check for Receipt of SSN**  
Check the *system* records for the enrollee's SSN. If the SSN still has "999" the first 3 digits, contact the enrollee to obtain the enrollee's SSN verbally or by mail.
    - c. **Verify SSN by a computer system inquiry of the SSA records.**
    - d. **Enter Verified SSN in *the eligibility/enrollment system*.**

#### 4. Renewal Action

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

##### a. Check for Receipt of SSN

Before or at renewal, the SSN must be entered into *the eligibility/enrollment system*. Check the *system* records for the enrollee's SSN. If the SSN has "999" as the first 3 digits, contact the enrollee to obtain the enrollee's SSN verbally or by mail, or on the renewal form if a renewal form is required.

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

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

##### d. SSN Not Provided by Renewal Deadline

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

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

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

If the problem is an SSA administrative problem, such as a backlog of SSN applications causing the delay in issuing an SSN to the enrollee, the enrollee continues to meet the MA SSN eligibility requirement. The worker will assist the enrollee with obtaining the SSN and will periodically check with the computer systems and the enrollee.

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

## M0240.300 SSN Verification Requirements

### A. SSN Provided By Individual

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

### B. Procedures

#### 1. Enter Verified SSN in Systems

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

- 2. SSN and Citizenship Update Report**

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

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

  - a. Data Entry Error Caused Discrepancy**

If it is determined that the discrepancy was the result of an error made while entering the SSN in the system, steps must be taken to correct the information in *the eligibility/enrollment system* so that a new data match with SSA can occur in the next month.
  - b. Discrepancy Not Caused by Data Entry Error**

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

If verification of the SSN is received within the 10 days, update *the eligibility/enrollment system* accordingly so that the enrollee's information will be included in a future data match.
  - d. SSN Verification Not Provided**

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

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**M0250 Changes**

<b>Changed With</b>	<b>Effective Date</b>	<b>Pages Changed</b>
TN #98	10/1/13	pages 1-4 Page 5 was deleted.
TN #97	9/1/12	page 5
TN #96	10/1/11	page 3
TN #94	9/1/10	pages 3-5

## **M0250.000 ASSIGNMENT OF RIGHTS AND PURSUIT OF SUPPORT FROM THE ABSENT PARENT REQUIREMENTS**

### **M0250.001 GENERAL PRINCIPLES**

- A. Introduction**                      The assignment of rights to medical support and the pursuit of support from absent parent(s) are Medicaid nonfinancial requirements that must be met as a condition of Medicaid eligibility. *The assignment of rights to medical support requirement also applies to children eligible for the Family Access to Medical Insurance Security Plan (FAMIS).*
- B. Policy and Procedures**                      The policy and procedures for the local agency to follow in determining if an individual has met the Medicaid assignment of rights and pursuit of support from absent legally responsible relatives are contained in the following sections:
- M0250.100 Assignment of Rights.
  - M0250.200 Procedures for the Assignment of Rights.
  - M0250.300 Pursuit of Medical Support From the Absent Parent.

### **M0250.100 ASSIGNMENT OF RIGHTS**

- A. Assignment of Rights Policy**                      To be eligible for Medicaid, a Medicaid applicant or recipient must:
- assign his rights to medical support and payment for medical care from any third party to the Department of Medical Assistance Services (DMAS) if he is applying for himself;
  - assign the rights of any other individual for whom he applies and can make an assignment of rights to support and third party payments;
  - cooperate with the agency in identifying (to the extent he is able) potentially liable insurers and other third parties who may be liable to pay for the individual's, and any other individual for whom he applies and can assign rights for care and medical services.
- B. Individual Unable To Assign Rights**                      If the individual is unable to his assign rights, a spouse, legally appointed guardian or conservator, attorney-in-fact (person who has the individual's power-of-attorney), or the authorized representative can make such an assignment. If the individual is a child, the parent, legal custodian, authorized representative, or the adult relative with whom the child lives and who signed the application can assign rights.
- If the person who has the authority to assign the applicant's/recipient's rights refuses to assign the rights, the person who has the authority to assign the rights will be ineligible for Medicaid. However, the applicant/recipient will meet the assignment of rights requirement and can be eligible for Medicaid if he meets all other eligibility requirements.



- 2. Documentation** Document the case record with the reason(s) the individual refuses to cooperate in identifying and providing liable third party information and the reason(s) the agency finds that cooperation is against the best interests of the individual or other person for whom he/she can assign rights.

## **M0250.300 PURSUIT OF MEDICAL SUPPORT FROM THE ABSENT PARENT**

- A. Policy** To be eligible for Medicaid, an individual applicant or recipient must cooperate with the agency in obtaining medical support and payments from, or derived from, the absent parent(s) of a child for whom the individual is applying, unless the individual establishes good cause for not cooperating. The individual's non-cooperation does NOT affect the individual's Plan First eligibility, nor the individual's child(ren)'s Medicaid eligibility.

A pregnant woman is not required to cooperate with DCSE when requesting assistance for herself and her child(ren) born out of wedlock. If she is or was married, she is required to cooperate in pursuing medical support for her legitimate child(ren) from the legitimate child(ren)'s absent father.

A married pregnant woman who meets the medical assistance support requirement **cannot be denied** medical assistance for failure to cooperate in pursuing support even when ineligible for another program because of failure to cooperate with pursuit of support.

### **B. Definition of Cooperation**

- 1. Application** By signing the application for Medicaid, the individual meets the eligibility requirement to cooperate in pursuing support from the absent parent(s) of the child for whom the individual is applying. No further action by the applicant is required at the time of application.

The individual is not required to contact DCSE about pursuing support from the absent parent. If the individual chooses to request DCSE services, the individual's continued cooperation with DCSE **is required** for the individual to remain eligible for Medicaid.

- 2. Ongoing** After the individual's application has been approved, if DCSE, DMAS or the local agency requests information from the individual about the absent parent, or otherwise requires the individual's cooperation with the pursuit of medical support from the absent parent, the individual must cooperate in order for the individual's eligibility to continue.

Medicaid enrollees who were approved for Medicaid before January 1, 2007, and who were referred to DCSE, must continue to cooperate with DCSE in the pursuit of medical support from the absent parent to remain eligible for Medicaid.

### **C. Local DSS Agency Responsibility**

**1. Applicants**

Explain and offer the Division of Child Support Enforcement (DCSE) services to all Medicaid applicants who apply for Medicaid for themselves and/or on behalf of children who have an absent parent. A child's parent is not considered absent if the absence is due to death, single parent adoption, artificial insemination, or termination of parental rights.

Give the applicant the DCSE Fact Sheet available on the intranet at:  
<http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>.

**2. Enrollees**

If the local agency or DMAS requires from the enrollee information related to medical support from the absent parent, such as the policy number of the health insurance policy the absent parent has that covers the child, and the enrollee refuses to give it to the requesting agency but does not have good cause for refusing, the enrollee is no longer eligible for Medicaid because of failure to cooperate in pursuing medical support and third party liability. The child(ren) remain eligible for Medicaid.

**a. Enrollees who were approved before January 1, 2007**

For a Medicaid enrollee who was approved for Medicaid before January 1, 2007, and was referred to DCSE, the local agency must take action when notified by DCSE that the enrollee is not cooperating in the pursuit of medical support from the absent parent. The child(ren)'s eligibility for Medicaid is NOT affected.

**b. Enrollees who applied on or after January 1, 2007**

If the enrollee who applied for Medicaid on/after January 1, 2007, chooses to apply for DCSE services and DCSE opens a case for the applicant, the enrollee must cooperate with DCSE in the pursuit of medical support from the absent parent, unless there is good cause for not cooperating. If the agency is notified by DCSE that the enrollee is not cooperating, the agency worker must take appropriate action on the enrollee's Medicaid coverage; the child(ren)'s eligibility for Medicaid is NOT affected.

If the recipient wants to claim good cause for not cooperating, contact a Medical Assistance Program Consultant for instructions.

**3. TANF Recipients**

If an applicant for or recipient of Temporary Assistance for Needy Families (TANF) fails to cooperate with DCSE, the individual's eligibility for Medicaid is not impacted unless the individual previously requested assistance from DCSE for Medicaid purposes per M0250.300 C.2.b above.

**D. DCSE**

DCSE District Offices have the responsibility of pursuing support from absent legally responsible parent(s), establishing paternity when the alleged father is absent from the home, and notifying the local DSS when the enrollee does not cooperate. This responsibility entails locating the parent(s), determining ability to support, collecting support from legally responsible parent(s), establishing medical support and/or health insurance covering the applicant child(ren), and court action to secure support from the absent legally responsible parent.

The booklet, "Child Support and You", form #032-01-945, gives an overview of DCSE services and the addresses for the district offices.

## M0310 Changes

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

**M0310.002 LIST OF MEDICAID COVERED GROUPS**

<b>Group and Description</b>		<b>Categorically Needy (CN)</b>	<b>Medically Needy(MN)</b>
<b>Aged, Blind, or Disabled (ABD)</b>	SSI	<b>X</b>	
	AG	<b>X</b>	
	Protected	<b>X</b>	
	≤ 80% FPL	<b>X</b>	
	≤ 300% of SSI (institutionalized only)	<b>X</b>	
	Medicaid Works	<b>X</b>	
	Medicare Savings Programs (QMB, SLMB, QI, QDWI)	<b>X</b>	
	Aged Blind Disabled		<b>X</b>
<b>Families &amp; Children (F&amp;C)</b>	IV-E Foster Care or Adoption Assistance	<b>X</b>	
	LIFC Parent/Caretaker Relatives	<b>X</b>	
	Pregnant woman/newborn child	<b>X</b>	<b>X</b>
	Child under age 19	<b>X</b>	
	BCCPTA	<b>X</b>	
	Plan First	<b>X</b>	
	Child under 18		<b>X</b>
	Individuals under age 21, Special Medical Needs Adoption Assistance	<b>X</b>	<b>X</b>
	<i>Former Virginia Foster Care Children under age 26 (effective January 1, 2014)</i>	<b>X</b>	

**2. F&C Groups**

- a. foster care children receiving IV-E and adoption assistance children receiving IV-E.
- b. Low income families with children (LIFC) eligible children, parents, non-parent caretaker-relatives, and EWBs (*for applications submitted prior to October 1, 2013*).
- c. Children under age 1 born to mothers who were eligible for and receiving MA at the time of the child's birth.
- d. Individuals under age 21
  - 1. Title IV-E Eligible Foster Care children who do not receive a Title IV-E maintenance payment
  - 2. Non-IV-E Foster Care
  - 3. Juvenile Justice Department children
  - 4. Non-IV-E Adoption Assistance children
  - 4. Individuals in an ICF or ICF-MR
- e. *Effective January 1, 2014, former foster care children under age 26 years*
- f. Pregnant women and newborns under age 1 year
- g. Plan First; Family Planning Services
- h. Children under age 19 years
- i. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). Women *and men* screened and diagnosed with breast or cervical cancer under the Centers for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program (BCCEDP) and eligible to receive Medicaid under the BCCPTA.

**B. Medically Needy (MN)**

The ABD and the F&C covered groups in the MN classification are listed below.

**1. ABD Groups**

- a. Aged - age 65 years or older.
- b. Blind - meets the blind definition
- c. Disabled - meets the disability definition.
- d. Individuals who received Medicaid in December 1973 as AB/APTD-related MN and who continue to meet the December 1973 eligibility requirements.

application is pending for the disability determination. DDS does NOT stop the disability determination when the individual has excess income because of possible spenddown eligibility

**4. LDSS Responsibilities for Communication with DDS**

The LDSS must make every effort to provide DDS with complete and accurate information and shall report all changes in address, medical condition, and earnings to the DDS on pending applications.

**5. Referral to Health Insurance Marketplace**

*Refer individuals whose applications are pending during the non-expedited disability determination process to the Health Insurance Marketplace (HIM) for evaluation for the Advance Premium Tax Credit (APTC).*

**H. Notification of DDS Decision to LDSS**

**1. Hospitalized Individuals**

The DDS will advise the agency of the applicant's disability status as soon as it is determined by either SSA or the DDS. For hospitalized individuals who meet the requirements for an expedited disability determination, DDS will fax the outcome of the disability determination directly to the LDSS responsible for processing the application and enrolling the eligible individual.

**2. Individuals Not Hospitalized**

For all other disability determinations, DDS will mail the determination to LDSS responsible for processing the application and enrolling the eligible individual. If the claim is denied, DDS will also send a personalized denial notice to be sent to the applicant explaining the outcome of his disability determination.

**3. Disability Cannot Be Determined Timely**

A disability determination cannot be completed within the allotted time when there is missing or incomplete medical information. In the event that this situation occurs, the DDS will notify the applicant on or about 75 days from the application date of the delay and/or the need for additional information. A copy of the DDS's notice to the applicant will also be sent to the LDSS. The LDSS shall send the applicant a Notice of Action to extend the pending application.

**4. DDS Rescinds Disability Denial**

DDS will notify the agency if it rescinds its denial of an applicant's disability to continue an evaluation of the individual's medical evidence. If the Medicaid application has been denied, the agency must reopen the application and notify the applicant of the action. The application continues to pend until notification is received from DDS of the disability determination. If an appeal has been filed with DMAS, the agency must notify the DMAS Appeals Division so that the appeal may be closed (see M1650.100).

**I. LDSS Action & Notice to the Applicant**

The eligibility worker must complete the Medicaid eligibility determination immediately after receiving notice of the applicant's disability status and send the applicant a Notice of Action regarding the disability determination and the agency's decision on the Medicaid application.

**J. Applicant is Deceased** When a Medicaid applicant who has been referred to DDS dies or when the applicant is deceased at the time of the Medicaid application, DDS will determine if the disability requirement for Medicaid eligibility was met. The LDSS must immediately notify DDS of the individual's death and make every effort to provide a copy of the death certificate.

**K. Subsequent SSA or RRB Disability Decisions** When SSA or the RRB make a disability decision subsequent to the Medicaid decision which differs from the Medicaid decision, the SSA or RRB decision must be followed in determining Medicaid eligibility unless one of the conditions in M0310.112 E.2 above applies.

**1. SSA/RRB Approval** If SSA approves disability or the RRB approves total disability, the disability definition is met. If DDS initially denied disability and the decision is reversed, re-evaluate the denied Medicaid application. The individual's Medicaid entitlement is based on the Medicaid application date, including the retroactive period, if all eligibility requirements were met during the retroactive period. However, eligibility as a disabled individual cannot begin prior to the disability onset date (month) established by SSA. Do not send the claim back to DDS for an earlier onset date.

**Disability Approved More Than 12 Months Past**

If, based upon the re-evaluation, the individual is determined to be eligible and more than 12 months have passed since the application was filed, complete an eligibility renewal to determine whether or not the individual remains eligible.

**Spenddown**

If, based upon the re-evaluation, the individual is determined not eligible for Medicaid but met the requirements in Chapter M13 for placement on a spenddown, a first prospective and additional 6 month spenddown budget periods may be established to cover the period of time between the date of application and the date action is taken on his case. A new application is not required for each 6 month spenddown budget period leading up to the date of processing, however, verification of all income and resources for those time periods must be obtained.

**2. SSA Denial or Termination And Appeal** If SSA denies disability, the disability definition is not met. If the individual has been enrolled in Medicaid as disabled and is not eligible in another covered group, send an advance notice to the enrollee to cancel Medicaid.

If the individual appeals the SSA's disability decision timely (within 60 calendar days from the SSA notification or with good cause for exceeding 60 days) and SSA agrees to reconsider the decision, the Medicaid coverage must be reinstated until the final decision on the SSA appeal is made. **The individual must provide verification that he filed the appeal and SSA agreed to reconsider the case.** The individual must also provide verification of the decisions made at all levels of appeal in order for Medicaid to continue during the process. The Medicaid coverage will continue until a final decision is made and the individual has no right to further SSA appeals.

## M0310.113 EWB

### A. Essential to the Well-Being (EWB)

EWB is the short name for a person who is “essential to the well-being” of a child in the household. *For applications submitted prior to October 1, 2013*, an EWB who is living in the household and who is providing services which are essential to the well-being of the dependent child(ren) in the household may be eligible for Medicaid in the LIFC covered group, if the individual

- does not meet any other Medicaid covered group, and
- the individual to whom the EWB provides the service(s) is eligible for Medicaid in the LIFC covered group. Services which are essential to the well-being of the dependent child(ren) in the household are listed in item B.

*Effective October 1, 2013, the LIFC definition no longer includes an EWB.*

### B. Services Essential to Well-Being

Services which are essential to the well-being of the dependent child(ren) in the household are limited to:

- provision of care for an incapacitated family member in the home;
- provision of child care which enables the caretaker to work on a full-time basis outside the home;
- provision of child care which enables the caretaker to receive training full-time;
- provision of child care which enables the caretaker to attend high school or GED classes full-time;
- provision of child care for a period not to exceed 2 months to enable the caretaker to participate in employment search.

### C. Procedure

Section M0320.304 contains the detailed requirements for the LIFC covered group in which an EWB can be eligible for Medicaid.

## M0310.114 FAMILIES & CHILDREN (F&C)

"Families & Children (F&C)" is the group of individuals that consists of

- children under 19,
- pregnant women,
- specified subgroups of children under age 21,
- *former Virginia foster care children under age 26 (effective January 1, 2014)*, and
- parent/caretakers of dependent children

Also included in the F&C groups are individuals eligible only for family planning services (Plan First) and participants in BCCPTA.

## M0310.123 PARENT

### A. Definition

Under federal regulations, a parent means either the mother or the father, married or unmarried, natural or adoptive following entry of the interlocutory or final adoption order, whichever comes first.

#### 1. Mother Married on Child's Birth Date

A mother who was married at the time of her child's birth may name on the application someone other than her husband as the child's father. The man to whom she was married at the time of the child's birth, however, is considered the child's father unless DCSE or a court determines otherwise. DCSE or the court must exclude the mother's husband, considered the legal father, as the child's father before the paternity status of the man named on the application is determined.

#### 2. Mother NOT Married on Child's Birth Date

If the mother was NOT married when the child was born, the man who is living in the home and who is listed on the application as the child's father is the child's acknowledged father, unless the agency receives evidence that contradicts the application, such as the child's birth certificate that has another man named as the child's father.

#### 3. Paternity Evidence

If evidence of paternity is required to establish eligibility or ineligibility, such evidence must be entered in the eligibility case record.

### B. Procedures

NOTE: The mother's marital status at the time of the child's birth does not require verification; her declaration of her marital status is sufficient.

Section *M0330.200* contains the detailed requirements for the LIFC covered group in which a parent of a dependent child can be eligible for Medicaid.

## M0310.124 PREGNANT WOMAN

### A. Definition

A woman of any age who *attests that she is pregnant* meets the definition of a pregnant woman.

#### 1. Effective Date

*At the time of application, applicants are asked if they are pregnant and if so, how many babies are expected. The pregnant woman definition is met the first day of the month which in which the woman attests she is pregnant. She meets the definition of a pregnant woman for the retroactive period if she was pregnant during the retroactive months.*

The definition of “pregnant woman” is met for sixty days following the last day the woman was pregnant regardless of the reason the pregnancy ended, and continues to be met until the last day of the month in which the 60th day occurs.

**B. Procedures**

**1. No Further Verification of Pregnancy Required**

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

*If a woman applying after the infant’s birth requests retroactive coverage as a pregnant woman, her report of the birth is sufficient to establish her pregnancy in the three months prior to the child’s birth month.*

**2. Covered Groups Eligibility**

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

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

**M0310.125 QDWI**

**A. Qualified Disabled & Working Individuals (QDWI)**

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

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

**B. Procedure**

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

**B. State Plan Governs Medicaid Eligibility Rules**

The State Plan consists of preprinted material that covers the basic Medicaid requirements and individualized material written by DMAS that reflects the particular requirements and choices made by Virginia for its Medicaid program. The State Plan is included in DMAS' state regulations promulgated according to the Virginia Administrative Process Act (APA). The State Plan is kept and updated by DMAS.

The State Plan shows the eligibility requirements for Virginia Medicaid, including the mandatory and optional groups of individuals covered by Virginia Medicaid and the medical services covered by Medicaid for those groups. The covered groups eligibility requirements in this chapter are based on the State Plan.

### M0310.132 TANF

**A. Temporary Assistance for Needy Families (TANF)**

TANF is the federally-funded (with matching funds from the states) block grant program in Title IV Part A of the Social Security Act that provides temporary cash assistance to needy families. In Virginia, TANF replaced the previous Title IV-A program called Aid to Families With Dependent Children (AFDC) on February 1, 1997.

### M0310.133 BCCPTA

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

The BCCPTA created a Medicaid covered group for women *and men* age 18 through 64 who have been identified by the Centers for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program (BCCEDP) as being in need of treatment for breast or cervical cancer.

**B. Procedures**

Section M0330.700 contains the detailed requirements for the BCCPTA covered group.

### M0310.134 VIEW PARTICIPANT

**A. Virginia Initiative for Employment not Welfare (VIEW) Participants**

A VIEW participant is an individual who has signed the TANF Agreement of Personal Responsibility. VIEW participants have a higher earned income limit than non-VIEW participants. An individual under a TANF VIEW sanction is a VIEW participant for Medicaid purposes. An individual only receiving TANF transitional support services is not a VIEW participant for Medicaid purposes.

### M0310.135 HIPP PROGRAM

**A. Health Insurance Premium Payment (HIPP) Program**

HIPP is a cost savings program administered by the DMAS for Medicaid enrollees which reimburses some or all of the employee portion of group health insurance premiums. HIPP is available to Medicaid enrollees when a family member is employed at least 30 hours per week and is enrolled in an employer's group health plan. Eligibility for HIPP is determined by the HIPP Unit at DMAS. Participation in HIPP is voluntary.

**B. Procedures**

M0130.200 G contains additional information about HIPP.

## M0320 Changes

<b>Changed With</b>	<b>Effective Date</b>	<b>Pages Changed</b>
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

**M0320.000 AGED, BLIND & DISABLED (ABD) 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 ABD covered groups into categorically needy and medically needy (MN) groups.

**B. Procedure**

Determine an individual's eligibility first in a CN covered group. If the individual is not eligible in a full-benefit CN covered group, determine the individual's eligibility as MN (on a spenddown).

An evaluation of eligibility for an aged, blind or disabled individual should follow this hierarchy:

1. If the individual is a current SSI/AG recipient, evaluate in this covered group.
2. If the individual is a former SSI or AG recipient, evaluate first in the protected covered groups.
3. If the individual does not meet the criteria for SSI/AG or protected, evaluate next in the ABD with income  $\leq$  80% FPL covered group.
4. If the disabled individual has income at or below 80% FPL and is going back to work, evaluate the individual in the Medicaid Works covered group.
5. If the individual does not meet the requirements for the 80% FPL group or MEDICAID WORKS, but meets the definition of an institutionalized individual, evaluate in the 300% of SSI covered groups.
6. If the individual is a Medicare beneficiary with income or resources in excess of the full-benefit Medicaid covered groups, evaluate in the Medicare Savings Programs (MSP) groups (QMB, SLMB, QI, QDWI).
7. If the individual is not eligible for Medicaid coverage in an MSP group AND he is at least age 19 years but under age 65 years or he requests a Plan First evaluation, evaluate in the Plan First covered group.
8. If the individual meets all the requirements, other than income, for coverage in a full benefit Medicaid group, evaluate as MN.

**C. Referral to Health Insurance Marketplace**

*When an ABD individual who does not have Medicare is not for eligible for full Medicaid coverage, the individual must be referred to the Health Insurance Marketplace (HIM) so that the applicant's eligibility for the APTC can be determined. Individuals with Medicare are not referred to the HIM.*

**M0320.001 ABD CATEGORICALLY NEEDY****A. Introduction**

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

**B. Procedures**

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

**A. ABD MN Covered Groups** The ABD MN covered groups are:

- M0320.701 ABD
- M0320.702 December 1973 Eligibles

## **M0320.701 ABD MN INDIVIDUALS**

**A. Legal Base** The federal authority for covering ABD MN individuals is found in 42CFR435.330.

### **B. Financial Eligibility**

**1. Assistance Unit** The assistance unit policy and procedures in chapter M05 apply to ABD MN. If married and not institutionalized, deem or count any resources and income from the individual's spouse with whom he/she lives. If married and institutionalized, go to subchapter M1480 for resource and income determination policy and procedures.

**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 S11 applies.

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

If the individual is not eligible because of excess real property contiguous to the home, and he/she meets a medically needy Families & Children (F&C) definition, determine if the individual meets an F&C covered group since the F&C home property definition is more liberal for F&C. If the individual is not eligible because of other excess resources, he or she is not eligible as MN.

**3. Income** Determine gross income according to chapter S08. Subtract the \$20 general exclusion and other exclusions. Compare the total countable income to the MN income limit for the individual's locality group (see section S0810.002) and calculate the MN spenddown amount. See chapter M13 for spenddown policy and procedures.

**4. Income Eligibility** An individual becomes eligible in this MN covered group when he/she has incurred medical expenses equal to the difference between his/her income and the MN income limit (spenddown).

**C. Entitlement** 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 budget period. Retroactive coverage is applicable to this covered group.

Note: Individuals receiving LTC services are placed on monthly spenddowns (see M1460.700).

**D. Enrollment**

Eligible individuals in this group are classified as medically needy (MN). If the individual has Medicare Part A, compare the individual's countable income to the QMB and SLMB limits.

The following ACs are used when the individual is ABD MN and QMB or SLMB:

- 028 for an aged individual also QMB;
- 048 for a blind individual also QMB;
- 068 for a disabled individual also QMB;
- 024 for an aged MN individual also SLMB;
- 044 for a blind or disabled MN individual also SLMB.

The following ACs are used when the individual is ABD MN and not QMB or SLMB:

- 018 for an aged individual NOT QMB or SLMB;
- 038 for a blind individual NOT QMB or SLMB;
- 058 for a disabled individual NOT QMB or SLMB.

**D. Referral to Health Insurance Marketplace**

*When an ABD who does not have Medicare is placed on a spenddown, the individual must be referred to the Health Insurance Marketplace (HIM) so that the applicant's eligibility for the APTC can be determined. Individuals with Medicare are not referred to the HIM.*

## M0320.702 DECEMBER 1973 ELIGIBLES

**A. Policy**

42 CFR 435.340 - If the State Plan covers the medically needy, the Plan must provide protected medically needy coverage for blind and disabled individuals eligible in December 1973.

**B. Blind or Disabled in December 1973**

This is an MN covered group of blind and disabled individuals who:

- were eligible as medically needy under the state plan in December 1973 on the basis of the blindness or disability criteria of the AB or APTD plan;
- for each consecutive month after December 1973 continue to meet the December 1973 blindness or disability criteria and the December 1973 financial eligibility requirements; and
- meet the **current** medically needy eligibility requirements except the blindness or disability criteria.

Continuing eligibility is determined on the basis of eligibility requirements in effect as of December, 1973 and current medically needy requirements.

Contact your Regional Medical Assistance Program Consultant if you have an applicant you believe meets this covered group.

## Virginia DSS, Volume XIII

### M0330 Changes

<b>Changed With</b>	<b>Effective Date</b>	<b>Pages Changed</b>
TN #98	10/1/13	Table of Contents pages 1-3, 6-16, 19, 22, 24-29
UP #8	10/1/12	pages 4, 6
TN #97	9/1/12	Table of Contents pages 1-40 (all pages)
UP #2	8/24/09	pages 3, 6, 8, 16, 22
Update (UP) #1	7/1/09	pages 20, 21

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**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.
- 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 a child meets the definition of a foster care child, adoption assistance child, special medical needs adoption assistance child or an individual under age 21, evaluate in these groups first.
2. If the child meets the definition of a newborn child, evaluate in the pregnant woman/newborn child group.
3. If a child is under the age of 19, evaluate in this group.
4. *Effective January 1, 2014, if a child is a former Virginia foster care child under age 26 years, evaluate for coverage in this group.*
5. If a child has income in excess of limits individual, evaluate for the Family Access to Medical Insurance Security Plan (FAMIS) eligibility (*chapter M21*).
6. If the child is a child under age 1, child under age 18, an individual under age 21 or a special medical needs adoption assistance child, but has income in excess of the appropriate F&C income limit, evaluate as MN.

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

1. If meets the definition of a parent/caretaker relative, evaluate in the LIFC covered group.
2. If the individual is not LIFC, but meets the definition of a pregnant woman, evaluate in the pregnant woman/newborn child group.
3. *Effective January 1, 2014, if the individual is a former Virginia foster care child under 26 years, evaluate is this covered group.*
4. 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 SSL, LIFC, Pregnant Woman or Child Under 19 individual, evaluate in the BCCPTA covered group.
5. 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.
6. If the individual is a pregnant woman but has excess income for coverage in a CN group or FAMIS MOMS (*for applications submitted before 12/31/13 only*), 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 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 Special Medical Needs Adoption Assistance;
- M0330.200 Low Income Families With Children (LIFC);
- M0330.300 Child Under Age 19 (FAMIS Plus);
- M0330.400 Pregnant Women & Newborn Children;
- M0330.600 Plan First--Family Planning Services (FPS);
- M0330.700 Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA).

**C. Eligibility Methodology Used** *Effective October 1, 2013, there are two distinct methodologies used for determining assistance unit/household size and income eligibility for the F&C covered groups that require a **financial eligibility determination**: Modified Adjusted Gross Income (MAGI) and non-MAGI. Which methodology is used depends on the covered group AND when the application was submitted or, for renewals, when the renewal is completed. The policies and procedures for MAGI methodology are contained in chapter M04 unless otherwise specified. The policies and procedures for non-MAGI methodology are contained in subchapters M0510 and M0520 and chapter M06. The income policies in chapter M07 are applicable to both methodologies unless otherwise specified.*

F&C Covered Group With Financial Eligibility Determination	Application Submitted		Change Reported or Renewal Completed	
	Before 10/1/13	On or After 10/1/13	Before 4/1/14	On or After 4/1/14
<ul style="list-style-type: none"> <li>• Children under 19</li> <li>• Parent/caretaker relatives of children under the age of 18 (LIFC)</li> <li>• Pregnant women</li> <li>• Individuals Under Age 21</li> <li>• Plan First</li> </ul>	Non-MAGI	MAGI	Non-MAGI	MAGI
• F&C individuals who meet the definition of an institutionalized individual	ABD	ABD	ABD	ABD

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

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

- B. Children Who Receive SSI** Foster care or adoption assistance children who receive SSI meet the eligibility requirements for IV-E foster care or adoption assistance. They cannot receive both SSI and IV-E payments, so most of them elect to receive the higher SSI payment. These children are enrolled in Medicaid in the appropriate Foster Care or Adoption Assistance AC.
- C. Nonfinancial Eligibility Requirements** The child must be under age 21 years and must meet the IV-E foster care or IV-E adoption assistance definition in M0310.115 or M0310.102. The child meets the age requirement until the end of the month in which the child turns age 21.
- The child must meet all the nonfinancial eligibility requirements in chapter M02. The IV-E eligibility determination meets the Medicaid requirements for Virginia residency and cooperation in pursuing support.
- NOTE: IV-E eligible foster care or adoption assistance recipients meet the Medicaid institutional status requirements when they live in a public residential facility if the facility has less than 25 beds.
- D. IV-E Foster Care** 42 CFR 435.145---The federal Medicaid law requires the State Plan to cover children who are eligible for foster care maintenance payments under Title IV-E of the Social Security Act.
- The child must meet the IV-E foster care definition in M0310.115 and must be receiving IV-E foster care maintenance payments. A child of a IV-E foster care child is also considered to be a IV-E foster care child when the mother's IV-E payment includes an allocation for her child.
- The IV-E eligibility determination meets the Medicaid requirements for Virginia residency and cooperation in pursuing support.
- NOTE: IV-E eligible foster care maintenance payment recipients meet the Medicaid institutional status requirements when they live in a public child care institution if the facility has less than 25 beds, or if they live in a publicly operated community residence that has no more than 16 beds. See section M0280.100 for definitions of public institutions.
- E. IV-E Adoption Assistance** 42 CFR 435.145--The federal Medicaid law requires the State Plan to cover children who are eligible for adoption assistance under Title IV-E of the Social Security Act and for whom a IV-E adoption assistance agreement between the LDSS and the adoptive parent(s) is in effect.
- The child must meet the IV-E adoption assistance definition in M0310.102. The child does not have to receive a IV-E Adoption Assistance payment in order to meet the IV-E Adoption Assistance definition.
- The IV-E Adoption Assistance eligibility determination meets the Medicaid requirements for Virginia residency and cooperation in pursuing support.
- F. Financial Eligibility** A separate Medicaid financial eligibility determination is not made for IV-E eligible foster care or IV-E adoption assistance children, regardless of the state that makes the IV-E payment. Verify the child's IV-E foster care payment eligibility, or the child's IV-E adoption assistance eligibility via agency records.

- 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-MR** A child in an ICF or an ICF-MR 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 4*.

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**
- 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. Enrollment**

The aid category (AC) for individuals in the covered group of Individuals Under Age 21 is:

- 076 for a non-IV-E Foster Care child;
- 075 for a Department of Juvenile Justice child;
- 072 for a Non-IV-E Adoption Assistance child;
- 082 for a child under age 21 in an ICF or ICF-MR.

**M0330.108 SPECIAL MEDICAL NEEDS ADOPTION ASSISTANCE CHILDREN**

**A. Policy**

42 CFR 435.227 - The federal Medicaid law allows the State Plan to cover an individual under age 21 years:

- for whom a non-IV-E adoption assistance agreement between the state and the adoptive parent(s) is in effect;
- who cannot be placed with adoptive parents without Medicaid because the child has special needs for medical or rehabilitative care; and
- who was enrolled in Medicaid under any covered group before the adoption assistance agreement was entered into OR who would have been eligible for Medicaid before the adoption assistance agreement was entered into if the eligibility requirements and standards of the IV-E foster care program were used, without employing the threshold title IV-A eligibility determination.

If the child was not enrolled in Medicaid or would not have been eligible for Medicaid prior to the adoption assistance agreement being entered into, the child is **not** eligible for Medicaid “Special Medical Needs” covered group.

The child’s eligibility in another covered group must be evaluated. If the child is under age 19, evaluate his eligibility in the FAMIS Plus covered group of Child Under Age 19 (see M0330.300). If the child is over age 19 but under age 21, the child may be eligible as a Non-IV-E Adoption Assistance child in the MN Individuals Under Age 21 covered group. See section M0330.804.

**B. Nonfinancial Eligibility Requirements**

The child must

- be under age 21,
- meet the “special medical needs” adoption assistance definition in M0310.102, and
- meet the nonfinancial requirements in chapter M02.

**C. Financial Eligibility Requirements**

**1. Assistance Unit**

The assistance unit consists of only the child if the child was eligible for Medicaid prior to the adoption assistance agreement being entered into. The adoptive parent(s)’ income and resources are **not** counted or deemed; only the Special Medical Needs child’s own income and resources are counted.

- 2. Resources** There is no resource test for the Special Medical Needs Adoption Assistance Children 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 Special Medical Needs covered group. *See M04, appendix 4.*
- For a Virginia Special Medical Needs adoption assistance child 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 Special Medical Needs Adoption Assistance MN covered group (see M0330.805). *Ineligible individuals must be referred to the Health Insurance Marketplace for evaluation for the APTC.*
- 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.
- The AC for individuals in the covered group of Special Medical Needs Adoption Assistance children is "072."

***M0330.109 FORMER FOSTER CARE CHILDREN UNDER AGE 26 YEARS  
(EFFECTIVE JANUARY 1, 2014)***

- 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 when the individual:*
- *was under the responsibility of a Virginia-based foster care agency and receiving Medicaid until his discharge from foster care 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.*
- B. Nonfinancial Eligibility Requirements** *The individual must meet all the nonfinancial eligibility requirements in chapter M02.*
- C. Financial Eligibility** *A separate Medicaid financial eligibility determination is not made for former foster care children under age 26. Verify the child's former foster care status documentation provided by the applicant, agency records or contact with the local agency that held custody.*

**D. Entitlement**

*Entitlement as a former foster care child begins the first day of the month following the month the child was no longer in the custody of a Virginia-based foster care agency if the child was enrolled in Medicaid during the month foster care ended. However, coverage in this covered group cannot begin prior to January 1, 2014.*

*If Medicaid coverage of a former foster care child was previously discontinued when the child turned 18, he may reapply for coverage and be eligible in this covered group if he meets the requirements in this section. The policies regarding entitlement in M1510 apply.*

**E. Enrollment**

*The AC for former foster care children is "070."*

**M0330.200 LOW INCOME FAMILIES WITH CHILDREN (LIFC)****A. Policy**

Section 1931 of the Act - The federal Medicaid law requires the State Plan to cover dependent children under age 18 and parents or caretaker-relatives of dependent children who meet the financial eligibility requirements of the July 16, 1996 AFDC state plan. In addition, Medicaid covers dependent children and parents or caretaker-relatives of dependent children who participate in the Virginia Initiative for Employment not Welfare (VIEW) component of the Virginia Independence Program (VIP) and meet the requirements of the 1115 waiver. This covered group is called "Low Income Families With Children" (LIFC).

Public Law 111-148 (The Affordable Care Act) requires that coverage for all children under the age of 19 be consolidated in the Child Under Age 19 (FAMIS Plus) covered group. Virginia has chosen to implement this coverage effective October 1, 2013.

An exception is made for children under age 18 whose parents are receiving LIFC Extended Medicaid coverage (see M1520.500) In these situations, if family income exceeds the limit for coverage in the Child Under Age 19 group, the child must be evaluated for LIFC Extended Medicaid coverage with his family.

**B. Nonfinancial Eligibility**

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

The child(ren) 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 must meet the definition of a caretaker-relative of a dependent child in M0310.107. *For applications submitted prior to October 1, 2013, a child or adult who lives in the household but who is not the dependent child's parent or caretaker-relative may be eligible as LIFC if he/she meets the definition of an EWB in M0310.113. Effective October 1, 2013, EWB is not included in the definition of LIFC.*

**C. Financial Eligibility**

*The financial eligibility policy used for this covered group depends on when the application is submitted or renewal is processed. Refer to Chapters M05 and M07 for applications submitted before October 1, 2013 and renewals completed before April 1, 2014. Refer to Chapter M04 for eligibility determinations completed on applications submitted on or after October 1, 2013, and renewals completed on or after April 1, 2014.*

- 1. Assistance Unit**

The assistance unit policy in subchapter M0520 applies to the LIFC covered group *for applications submitted before October 1, 2013 and renewals completed before April 1, 2014*. The assistance unit's financial eligibility is determined first. If the family unit has income that cannot be verified or that exceeds the amount for the individual's covered group, the family unit is divided into budget units, if appropriate.

If the LIFC individual is living with his/her spouse or child who is aged, blind, or disabled, two different financial calculations must be completed for the unit if the family unit does not meet the LIFC income limits, because of the different resource and income limits used in the F&C and ABD determinations.
  - 2. EWB**

*For applications received prior to October 1, 2013*, an EWB meets the LIFC covered group only when the dependent child's family has income within the LIFC income limits and the family is eligible for Medicaid as LIFC. *Effective October 1, 2013, the LIFC definition no longer includes an EWB.*

When the LIFC household includes an individual who meets the EWB definition, the EWB's income eligibility is determined in a separate assistance unit. See M0520.103.
  - 3. Resources**

There is no resource test for the LIFC covered group.
  - 4. Income**

    - a. Non-VIEW Participants**

*Refer to chapter M05 and M07 for applications submitted before October 1, 2013 and renewals completed before April 1, 2014. Refer to chapter M04 for eligibility determinations of applications submitted on or after October 1, 2013 and renewals completed on or after April 1, 2014.*
    - b. VIEW Participants**

The method for determining income eligibility is different for VIEW participants *for renewals processed before April 1, 2014*. Use the income requirements in Chapter M0710.730D *for these renewals*.
  - 5. Income Exceeds Limit**

Spenddown does not apply to the LIFC income limits. If the family's income exceeds the LIFC income limit, the *family* is not eligible as LIFC and cannot spenddown to the LIFC limit. *Ineligible individuals must be referred to the Health Insurance Marketplace for evaluation for the APTC.*
- 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.
- 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 household.

## M0330.300 CHILD UNDER AGE 19

### A. Policy

*The Affordable Care Act requires that all coverage for children under age 19 be consolidated into one covered group. The authority for coverage of these children is found in 42CFR 435.11. 8 Virginia will begin covering children in this group effective October 1, 2013. The income limit for this group is 143% FPL.*

*Coverage under the Child Under Age 19 covered group is also known as FAMIS Plus in printed materials.*

### B. Nonfinancial Eligibility

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

The child must meet the nonfinancial eligibility requirements in chapter M02.

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

NOTE: a child who has excess income for Medicaid may be evaluated for FAMIS eligibility.

- C. Financial Eligibility** *Refer to Chapters M05 and M07 for applications submitted prior to October 1, 2013 and for renewals completed before April 1, 2014. Refer to Chapter M04 for eligibility determinations completed on applications submitted on or after October 1, 2013.*
- 1. Assistance Unit** Use the assistance unit policy in chapter M05 to determine the child’s financial eligibility *for renewals completed before April 1, 2014. Refer to Chapter M04 for eligibility determinations completed on or after October 1, 2014.*
  - 2. Resources** There is no resource *test.*
  - 3. Income** *Refer to chapter and M07 for renewals completed before April 1, 2014. Refer to chapter M04 for eligibility determinations completed on or after October 1, 2013. 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 143% FPL income limit may be eligible for FAMIS. The income limit for FAMIS is 200% FPL. See chapter M21 to determine FAMIS eligibility.  
  
*If countable income exceeds the limit for Medicaid and FAMIS, the opportunity for a Medically Needy (MN) evaluation must be offered (see M0330.803). Ineligible individuals 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.  
  
Eligible children are entitled to all Medicaid covered services as described in chapter M18.

**E. Enrollment**

The *Medicaid* ACs for children are:

AC	Meaning
090	child under age 6; income greater than 100% FPL, but less than or equal to <i>143%</i> FPL
091	child under age 6; income less than or equal to <i>109%</i> FPL
092	<ul style="list-style-type: none"><li>child age 6-19; insured or uninsured with income less than or equal to <i>109%</i> FPL;</li><li>child age 6-19; <b>insured</b> with income greater than <i>109%</i> FPL and less than or equal to <i>143%</i> FPL</li></ul>
094	child age 6-19; <b>uninsured</b> with income greater than <i>109%</i> FPL and less than or equal to <i>143%</i> FPL

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

**M0330.400 PREGNANT WOMEN & NEWBORN CHILDREN**

**A. Policy**

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

**B. Nonfinancial Eligibility**

**1. Pregnant Woman**

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

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

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

**2. Newborn Child**

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

**a. Eligible To Age 1**

A child no longer meets this covered group effective the end of the month in which the child reaches age 1, provided he was under age 1 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 1.

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

**b. No Other Eligibility Requirements**

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

**C. Financial Eligibility**

*Refer to chapters M05 and M07 for applications submitted prior to October 1, 2013 and renewals completed before April 1, 2014. Refer to Chapter M04 for eligibility determinations completed on applications submitted on or after October 1, 2013.*

**1. Assistance Unit**

*The unborn child or children are included in the assistance unit or household size for a pregnant woman's eligibility determination. Use the assistance unit policy in chapter M05 to determine the child's financial eligibility for applications submitted before October 1, 2013 and for renewals completed before April 1, 2014. Refer to Chapter M04 for eligibility determinations completed on applications submitted on or after October 1, 2013 and renewals completed on or after April 1, 2014.*

**2. Resources**

There is no resource test.

**3. Income**

*Use chapter M07 for applications submitted before October 1, 2013 and for renewals of newborns completed before April 1, 2014. Refer to Chapter M04 for eligibility determinations completed on applications submitted on or after October 1, 2014 and renewals of newborns completed on or after April 4, 2014. Women enrolled as Pregnant Women are not subject to renewals during the pregnancy. The income limits for Pregnant Women are contained in M04, Appendix 2.*

**4. Income Changes After Eligibility Established**

**a. Pregnant Woman**

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

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

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

**b. Newborn**

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

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

**6. Income Exceeds Limit**

If the pregnant woman's income exceeds the 143% FPL limit she is not eligible in this covered group. *Determine her eligibility for FAMIS MOMS (for applications submitted before 12/31/13 only. If she is not eligible for FAMIS MOMS, evaluate her eligibility as MN (see M0330.801). Ineligible individuals must be referred to the Health Insurance Marketplace for evaluation for the APTC.*

**D. Entitlement**

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

The newborn's Medicaid coverage begins the date of the child's birth. A Medicaid application for the newborn child is not required until the month in which the child turns age 1.

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

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

**E. Enrollment**

The aid category (AC) for CN pregnant women is "091." The AC for newborns born to women who were enrolled in Medicaid as CN *or to teens enrolled in FAMIS* is "093."

## M0330.500 300% of SSI INCOME LIMIT GROUPS

### M0330.501 F&C IN MEDICAL INSTITUTION, INCOME ≤ 300% SSI

#### A. Policy

42 CFR 435.236 - The State Plan includes the covered group of individuals who meet a families & children definition who are in medical institutions and who

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

#### B. Nonfinancial Eligibility

An individual is eligible in this covered group if he/she meets the nonfinancial requirements in M02.

The individual must be a child under age 19, under age 21 who meets the adoption assistance or foster care definition or under age 21 in an ICF or ICF-MR, or must be a parent or caretaker-relative of a dependent child, or a pregnant woman as defined in M0310.

#### C. Financial Eligibility

When determining income to compare to the 300% of SSI income limit, use the ABD income policy and procedures, regardless of the individual's definition or covered group. *MAGI methodology is not used to determine eligibility for this covered group.*

When determining resources, use F&C resource policy in *chapter M06* for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

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

#### 1. Resources

##### a. Resource Eligibility - Married Individual

When determining resources for a married F&C institutionalized individual with a community spouse, use the resource policy in subchapter M1480. When determining resources for a married F&C institutionalized individual who has no community spouse, use the resource policy in subchapter M1460. Evaluate countable resources using ABD resource policy in chapter S11.

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

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

**C. Financial Eligibility**

When determining **income** to compare to the 300% of SSI income limit, use the ABD income policy and procedures, regardless of the individual's definition or covered group. *MAGI methodology is not used to determine eligibility for this covered group.*

When determining **resources**, use F&C resource policy in *chapter M06* for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

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

**1. Resources**

**a. Resource Eligibility - Unmarried Individual**

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**.

DO NOT DEEM any resources from a child's parent living in the home.

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 as medically needy in a medically needy covered group.

**c. Resource Eligibility - Married Individual**

When determining resources for a married F&C institutionalized individual with a community spouse, use the resource policy in subchapter M1480. When determining resources for a married F&C institutionalized individual who has no community spouse, use the resource policy in subchapter M1460. **Evaluate countable resources using ABD resource policy in chapter S11.**

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

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible as medically needy in a medically needy covered group.

**C. Financial Eligibility**

When determining **income** to compare to the 300% of SSI income limit, use the ABD income policy and procedures, regardless of the individual's definition or covered group. *MAGI methodology is not used to determine eligibility for this covered group.*

When determining **resources**, use F&C resource policy in *chapter M06* for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

The individual must also meet the asset transfer policy in M1450. When determining **resources**, use F&C resource policy for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

**1. Resources**

**a. Resource Eligibility - Unmarried Individual**

When determining resources for an unmarried F&C hospice 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.

DO NOT DEEM any resources from a child's parent living in the home.

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 as medically needy in a medically needy covered group.

**c. Resource Eligibility - Married Individual**

When determining resources for a married F&C hospice individual with a community spouse, use the resource policy in subchapter M1480. When determining resources for a married F&C hospice individual who has no community spouse, use the resource policy in subchapter M1460. **Evaluate countable resources using ABD resource policy in chapter S11.**

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

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible as medically needy in a medically needy covered group.

**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**. Determine what is considered income according to **subchapter S0815, ABD What Is Not Income**. DO NOT subtract the \$20 general exclusion or any other income exclusions.

## M0330.600 PLAN FIRST - FAMILY PLANNING SERVICES

### A. Policy

Plan First, Virginia's family planning services health program covers individuals who are not eligible for another full or limited-benefit Medicaid covered group or FAMIS. This optional covered group is available to individuals regardless of their age, gender, disability status, insured status or if they previously had a sterilization procedure. Plan First covers only family planning services, including transportation to receive family planning services.

The income limit for this group is 211% FPL through December 31, 2013. *Effective January 1, 2014, the income limit for this group is 100% FPL.* While there are no specific age requirements for Plan First, eligibility for Plan First is not determined for children under 19 years or for individuals age 65 years and older unless the child's parent or the individual requests an evaluation for Plan First.

*Individuals who are eligible for Plan First must be referred to the Federal Health Insurance Marketplace for an evaluation for the APTC, because they are not eligible for full Medicaid coverage.*

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

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

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

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

**B. Nonfinancial Requirements**

Individuals in this covered group must meet the following Medicaid nonfinancial requirements in chapter M02.

DCSE services are available to all Medicaid recipients, but cooperation with DCSE is not a condition of eligibility for this covered group.

**C. Financial Eligibility**

*Refer to chapters M05 and M07 for applications submitted before October 1, 2013 and for renewals completed before April 1, 2014. Refer to Chapter M04 for eligibility determinations completed on applications submitted on or after October 1, 2013.*

**1. Assistance Unit**

Use the assistance unit policy in chapter M05 to determine the *individual's* financial eligibility for applications submitted before October 1, 2013 and for renewals completed before April 1, 2014. Refer to Chapter M04 for eligibility determinations completed on applications submitted on or after October 1, 2013.

**2. Resources**

There is no resource test.

**3. Income**

The income limits are 211% FPL through December 31, 2013 and 100% FPL beginning January 1, 2014. The income limits are contained in M04, Appendix 5

**4. Spenddown**

Spenddown does not apply to Plan First. However, because an individual enrolled in the Plan First covered group does not receive full Medicaid coverage, if he meets a MN covered group listed in M0320 or M0330, he must be evaluated to determine if he could become eligible for full Medicaid coverage as medically needy (MN) by meeting a spenddown. At application and redetermination, Plan First enrollees who meet the MN covered group and resource requirements are placed on two six-month spenddown budget periods within the 12 month renewal period. They may also be eligible for a retroactive MN spenddown determination. See Chapter M13 for spenddown instructions.

**D. Entitlement and Enrollment**

**1. Begin Date**

Eligibility in the Plan First covered group begins the first day of the month in which the application is filed, if all eligibility factors are met in the month.

**2. Retroactive Coverage**

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

**3. Enrollment**

The AC for Plan First enrollees is "080."

## M0330.700 BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT (BCCPTA)

### A. Policy

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000 (P.L. 106-354) provides for payment of medical services, including long-term care (LTC) (see Chapter M14) for certain women *and men* with breast cancer *or women with* cervical cancer

*Individuals* eligible for the BCCPTA program must be age 18 through 64. They must have been screened and certified as needing treatment for breast or cervical cancer (including pre-cancerous conditions) by a medical provider operating under the Center for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program (BCCEDP) and referred to LDSS for a Medicaid eligibility determination. These *individuals* must not have creditable health insurance coverage for treatment of breast or cervical cancer. Virginia's BCCEDP program, Every Woman's Life, is administered by the Virginia Department of Health.

Through an agreement between Virginia and the District of Columbia (D.C.), residents of northern Virginia (the cities of Alexandria, Fairfax, Falls Church, Manassas, Manassas Park and the counties of Arlington, Fairfax, Loudoun and Prince William) are allowed to be screened and diagnosed for breast or cervical cancer and pre-cancerous conditions through the DC Center for Disease Control and Prevention's "Project Wish" program. *Individuals* who are screened and certified as needing treatment for breast or cervical cancer through Project Wish may be eligible for Virginia Medicaid, provided they meet the requirements of the BCCPTA covered group. These *individuals* will receive a Virginia BCCPTA application form from the DC providers and will be instructed to submit the application directly to the local department of social services in their home locality.

***Individuals* diagnosed with cancer by a provider who is not operating under the BCCEDP are not eligible in this covered group.**

### B. Nonfinancial Eligibility

#### 1. Required Nonfinancial Requirements

BCCPTA *individuals* must meet the Medicaid nonfinancial requirements in chapter M02.

In addition, BCCPTA *individuals* must not be eligible for Medicaid under the following mandatory categorically needy covered groups:

- LIFC;
- Pregnant Women;
- Child Under Age 19;
- SSI recipients.

**2. Creditable Health Insurance Coverage**

BCCPTA *individuals* must not have creditable health insurance coverage. Creditable health insurance coverage includes:

- a group health plan;
- health insurance coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;
- Medicare;
- Medicaid;
- armed forces insurance a medical care program of the Indian Health Service (IHS) or of a tribal organization;
- a state health risk pool.

There may be situations where an *individual* has creditable health insurance coverage as defined above, but the coverage does not include treatment of breast or cervical cancer due to a period of exclusion or exhaustion of lifetime benefits, or the woman may have a high deductible. The *individual* is not eligible for Medicaid in the BCCPTA covered group because *of the* creditable health insurance.

**C. Financial Eligibility**

There are no Medicaid financial requirements for the BCCPTA covered group. The BCCEDP has income and resource requirements that are used to screen *individuals* for this program.

*Individuals* requesting Medicaid coverage of LTC services must provide verification of their resources and income and must meet all the LTC eligibility requirements in chapter M14.

**D. Application Procedures**

The application procedures for *individuals* who meet the BCCPTA non-financial requirements have been streamlined to facilitate the prompt enrollment and immediate access to services for *individuals* who are in need of treatment for breast or cervical cancer. In addition to the nonfinancial information required to evaluate eligibility in the BCCPTA covered group, the following information is needed for enrollment in Medicaid:

- name,
- address,
- sex and race,
- date of birth,
- country of origin and entry date, if an alien.

*Individuals* who meet the description of individuals in the LIFC, Pregnant Women, *Child Under Age 19*, or SSI recipients covered groups must complete the appropriate MA application for the covered group and must have an MA eligibility determination completed prior to determining their eligibility in the BCCPTA covered group. If not eligible in the LIFC,

Pregnant Women, FAMIS Plus, or SSI recipients covered groups, then determine their eligibility in the BCCPTA covered group.

**1. Application Form**

This covered group has a special application, BCCPTA Medicaid Application (form #032-03-384), **that must be initiated by a BCCEDP provider**, including those affiliated with Project Wish operating in the District of Columbia. The application includes the BCCEDP certification of the *individual's* need for treatment and the information needed to determine the nonfinancial eligibility in the BCCPTA covered group. Appendix 7 to subchapter M0120 contains a sample of the BCCPTA Medicaid Application form.

If eligibility in another Medicaid covered group must first be determined, the applicant must be given the appropriate Medicaid application.

**2. Application Processing Time Frames**

BCCPTA Medicaid applications filed by *individuals* who do not meet the description of an individual in the LIFC, Pregnant Women, FAMIS Plus, or SSI recipients covered groups must be processed within 10 working days of the agency's receipt of the signed application.

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

**3. Notices**

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

If a decision cannot be made within 10 working days of receipt of the BCCPTA application, the worker must send a "Notice of Action on Medicaid", form #032-03-008, on the 10<sup>th</sup> day stating why action has not been taken, specifying what information is needed and a deadline for submitting the information.

**E. Entitlement**

**1. Entitlement Begin Date**

Eligibility under this covered group is met the beginning of the month the screening is completed if the *individual* later has a positive diagnosis as a result of the screening and is determined to be in need of treatment for breast and/or cervical cancer.

Eligible BCCPTA *individuals* 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.

**2. Retroactive Entitlement**

Retroactive coverage is applicable to this covered group if the individual was screened by a medical provider operating under the BCCEDP and diagnosed as needing treatment for breast or cervical cancer in the retroactive month(s).

- F. Enrollment** The aid category for BCCPTA *individuals* is "066".
- G. Benefit Package** The BCCPTA group is a full-benefit covered group. All Medicaid-covered services are available to BCCPTA enrollees, including long-term care in a facility or in a community-based care waiver.
- H. Renewal** Annual renewal requirements are applicable to the BCCPTA covered group. At the time of the annual renewal, the recipient must provide a statement from a medical provider verifying continued treatment for breast or cervical cancer. The BCCPTA Redetermination (form #032-03-653) is used for the renewal. See M1520.200 for renewal requirements.

## M0330.800 FAMILIES & CHILDREN MEDICALLY NEEDY GROUPS

- A. Introduction** An F&C medically needy individual must
- be a child under age 18, or 21, or
  - meet the adoption assistance, foster care or pregnant woman definition in subchapter M0310.
- B. Procedure** The policy and procedures for determining whether an individual meets an F&C MN covered group are contained in the following sections:
- M0330.801 Pregnant Women;
  - M0330.802 Newborn Children Under Age 1;
  - M0330.803 Children Under Age 18;
  - M0330.804 Individuals Under Age 21;
  - M0330.805 Special Medical Needs Adoption Assistance.
- C. Referral to Health Insurance Marketplace** *When an individual meets an F&C MN covered group is not eligible solely due to excess income and is placed on a MN spenddown, the individual must be referred to the Health Insurance Marketplace (HIM) so that the applicant's eligibility for the APTC can be determined.*

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

## **CHAPTER M04**

### **MODIFIED ADJUSTED GROSS INCOME (MAGI)**

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## M0410.000 MODIFIED ADJUSTED GROSS INCOME (MAGI)

### M0410.100 MAGI GENERAL INFORMATION

#### A. Introduction

Beginning 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) will be done using the Modified Adjusted Gross Income (MAGI) methodology. MAGI methodology will also be used to determine eligibility for participation in the Federal Health Insurance Marketplace. Medicaid, FAMIS and the Federal Health Insurance Marketplace (HIM) are called insurance affordability programs. Medicaid and FAMIS are collectively referred to as medical assistance (MA) programs.

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.

#### 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.

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,
- is based on federal tax rules for determining adjusted gross income (with some modification), and
- has no asset test.

##### 2. MAGI Rules

- MAGI has an income disregard equal to 5% of the federal poverty level (FPL) for the individual's household size. The disregard is only given if the individual is not eligible for coverage due to excess income. It is applicable to individuals in both full-benefit and limited-benefit covered groups.

If the individual meets multiple Medicaid covered groups (and/or FAMIS) his gross income is compared first to the income limit of the group with the highest income limit under which the individual could be eligible. If the income exceeds the limit, the 5% FPL disregard can be allowed, and the income again is compared to the income limit.

- When considering tax dependents in the tax filer's household, the tax dependent may not necessarily live in the tax filer's home.
- Under MAGI counting rules, an individual may be counted in more than one household but is only evaluated for eligibility in his household.
- Use non-filer rules when the household does not file taxes.
- Use non-filer rules when the applicant is claimed as a tax dependent by someone outside the applicant's household.
- Non-filer rules may be used in multi-generational households.

**3. Eligibility  
Based on  
MAGI**

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

- a. Children under 19
- b. Parent/caretaker relatives of children under the age of 18 (LIFC)
- c. Pregnant women
- d. Individuals Under Age 21
- e. Special Medical Needs Adoption Assistance Children
- f. Plan First.

**4. Eligibility  
NOT Based on  
MAGI**

MAGI methodology is NOT used for eligibility determinations for:

- a. individuals for whom the agency is not required to make an income determination:
  - Supplemental Security Income (SSI) recipients
  - Auxiliary Grant recipients
  - IV-E foster care or adoption assistance recipients
  - Deemed newborns
  - BCCPTA (Breast and Cervical Cancer Prevention and Treatment Act) enrollees.
- b. individuals who are eligible on the basis of being aged (age 65 or older), blind or disabled;
- c. individuals eligible for Medicaid payment for long-term care services;
- d. individuals evaluated as Medically Needy;

- e. individuals who have Medicare and are eligible in a Medicare Savings Program (MSP) Medicaid covered group:
  - Qualified Medicare Beneficiaries (QMB)
  - Special Low-income Medicare Beneficiaries (SLMB)
  - Qualified Individuals (QI).

## M0420.100 Definitions

### A. Introduction

The definitions below are used in this chapter. Some of the definitions are also in subchapter M0310. Some of the definitions are from the IRC.

### B. Definitions

1. **Caretaker Relative** means a relative of a “dependent” child by blood, adoption, or marriage with whom the child lives, who assumes primary responsibility for the child’s care. This includes the caretaker relative’s spouse.
2. **Child** means a natural, biological, adopted, or stepchild.
3. **Dependent Child** means a child under age 18, or age 18 and a full-time student in a secondary school, who lives with his parent or caretaker-relative.
4. **Family** means the tax filer (including married taxfilers filing jointly) and all claimed tax dependents.
5. **Family Size** means the number of persons counted as an individual’s household. The family size of a pregnant woman’s household includes the pregnant woman plus the number of children she is expected to deliver. When determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted as just one person.
6. **Household** A household is determined by tax dependency. Parents, children and siblings are included in the same household. A child claimed by non-custodial parent is evaluated for eligibility in the household in which he is living and is also counted in the family size of the parent claiming him as a dependent. There can be multiple households living in the home.  
  
**This definition is different from the use of the word household in other programs such as the Supplemental Nutrition Assistance Program (SNAP).**
7. **Non-filer Household** means individuals who do not expect to file a Federal tax return and/or do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made. A non-filer household can also be a child who lives in the household with his custodial parent who is claimed on his non-custodial parent’s taxes.

- 8. Parent** means a natural, biological, adoptive, or stepparent.
- 9. Reasonable Compatibility** means the income attested to (declared) by the applicant is within 10% of income information obtained from electronic sources. If the income from both sources meets the 10% requirement, then the attestation is considered verified.
- The applicant's income reported on the application is verified through a match with income data in the federal Hub, if is available. The eligibility/enrollment system will compare the reported income with the income from the data match and determine if reasonable compatibility exists. If reasonable compatibility exists, the income will be labeled verified, and no further verification of the income is necessary.
- If reasonable compatibility does not exist or income data was not available through the Hub, the income will be labeled unverified. If the system indicates that the income is not verified and the attestation is below the medical assistance income level, documentation of income is required.
- 10. Sibling** means a natural, biological, stepsibling or half-sibling.
- 11. Tax-Dependent** means an individual for whom another individual claims a deduction for a personal exemption under section 151 of the Internal Revenue Code of 1986 for a taxable year.
- 12. Tax-filer Household** means individuals who expect to file a Federal tax return and/or who expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made.

## M0430.100 MAGI HOUSEHOLD COMPOSITION

- A. Introduction** The household composition is the basis for the financial eligibility determination for each person in the home who applies for MA. Eligibility is based on the countable income of the household members.
- The MAGI rules for household composition represent a major change for Medicaid. Included in the MAGI household composition are:
- stepparents and stepchildren,
  - children/siblings with income,
  - children ages 21 and older who are claimed as tax dependents, and
  - other adult tax dependents.
- B. Household Composition Rules** Tax filers and tax dependents use the tax household rules with limited exceptions. In most cases, the household is determined by principles of tax dependency.
- Parents, children and siblings are included in the same household.

- Stepparents and parents are treated the same.
- Children and siblings with or without income are included in the same household as the rest of the family.
- Older children are included in the family if claimed as tax dependent by the parents.
- Married couples living together are **always** included in each other's household even if filing separately.
- Dependent parents may be included in the household if they are claimed for income tax purposes.

**1. Tax Filer Household Composition**

The tax filer household is determined based on the rules of tax dependency. Parents, children and siblings are included in the same household. The tax filer's household consists of the tax filer and all tax dependents who **are expected to be claimed for the current year**. This could include non-custodial children claimed by the tax filer, but living outside the tax filer's home and dependent parents claimed by the tax filer, but living outside the tax filer's home.

The tax filer household is composed of the individual who expects to file a tax return this year and does not expect to be claimed as dependent by another tax filer. The household consists of the tax filer and all individuals the individual expects to claim as a tax dependent.

**2. Tax Dependent Household Composition**

means all dependents expected to be claimed by another tax filer for the taxable year.

The tax dependent's household consists of the tax dependent, his parents and his siblings living in the home. If the tax dependent is living with a tax filer other than a parent or spouse, the tax dependent is included in the tax filer household, but the tax filer is NOT included in the tax dependent's household.

The household consists of the tax filer and the tax dependents.

**Exceptions to the tax household composition rules apply when:**

- individuals other than biological, adopted or stepchildren are claimed as tax dependents,
- children are claimed by non-custodial parents,
- married couples and children of parents are not filing jointly.

**3. Non Filer Household Composition**

The Non Tax Filer household rules mirror the tax filer rules to the maximum extent possible.

- The household consists of parents and children under age 19.
- Non-filer rules are used when a child is claimed as a tax dependent of someone not living in the home.

- Non-filer rules are used in the case of a multi-generational household where the tax dependent is also the parent of a child.
- Children under age 19 living with a relative other than a parent are included only in their own household.
- Spouses, parents, stepparents and children living together are included in the same household.
- For non-filers, a “child” is defined as under age 19.

**4. Married Couple**

In the case of a married couple living together, the spouse is always included in the household of the other spouse, regardless of their tax filing status.

**M0430.200 TAX FILER HOUSEHOLD EXAMPLES**

**A. Married Parents and Their Tax Dependent Children**

Sam and Sally are a married couple. They file taxes jointly and claim their two children Susie and Sarah as tax dependents. All of them applied for MA.

The MAGI household is the same as their tax household because the tax filers are a married couple filing jointly and claiming their dependent children. No additional individuals live in the home.

Ask the following questions for each tax dependent to determine if exceptions exist:

- Is Susie the tax dependent of someone other than a spouse or a biological, adopted, or stepparent? No, also applies to Sarah
- Is Susie a child living with both parents, but the parents do not expect to file a joint tax return? No, also applies to Sarah
- Is Susie a child who expects to be claimed by a non-custodial parent? No, also applies to Sarah

The following table shows each person’s MAGI household:

Person	# - Household Composition	Reason
Sam	4 - Sam, Sally, Susie, Sarah	Tax-filer & dependents
Sally	4 – Sally, Sam, Susie, Sarah	Tax filer & dependents
Susie	4 – Susie, Sam, Sally, Sarah	Tax dependent, tax-filer parents and other tax dependent
Sarah	4 - Sarah, Sam, Sally, Susie	Tax dependent, tax-filer parents and other tax dependent

**B. Parent, Stepparent, and Parent’s Child (not child of stepparent)**

John and Joan are a married couple. They file taxes jointly and claim Joan’s son by a first marriage, JP age 17, as a tax dependent. All of them applied for MA.

The tax household includes John, Joan and JP. Since no one is claimed as a tax dependent by anyone else, the tax household and MAGI household are the same.

Ask the following questions for each tax dependent to determine if exceptions exist:

- Is JP the tax dependent of someone other than a spouse or a biological, adopted, or stepparent? No
- Is JP a child living with both parents, but the parents do not expect to file a joint tax return? No
- Is JP a child who expects to be claimed by a non-custodial parent? No

The following table shows each person’s tax filer household:

Person	# - Household Composition	Reason
John	3 – John, Joan, JP	Tax-filer & dependents
Joan	3 – Joan, John , JP	Tax-filer & dependents
JP	3 – JP, Joan, John	Tax dependent and tax-filer parents

**M0430.300 NON TAX FILER HOUSEHOLD EXAMPLES**

**A. Example for non-filer HH with child over age 19**

Jill lives with her daughter, Lea, age 19 and her son, Mike, age 15. Lea and Mike’s father is deceased. Jill and Mike receive Social Security survivor’s benefits. They do not file taxes. All applied for MA. The following table shows each person’s MAGI household:

For individuals who neither file a tax return nor are claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made, the household consists of the individual and, if living with the individual:

- the individual's spouse
- the individual's natural, adopted and stepchildren under the age 19
- the individual's natural, adopted and stepparents and natural, adoptive and step siblings under the age of 19.

Person	# - Household Composition	Reason
Jill	2 Jill, Mike	Non tax filer household-parent and child under age 19
Mike	2 Mike, Jill	Non tax filer household-child under age 19 and parent
Lea	Lea	Non-filer over age 19

**B. Married Parents and Their Dependent Children**

Josh and Penny are a married couple. They live with their children Daisy and Kate, both under age 18. They do not expect to file federal taxes this year so non-filer rules are used. All applied for MA. The following table shows each person’s MAGI household:

Person	# - Household Composition	Reason
Josh	Josh, Penny, Daisy, Kate	Non -filer household-married parents living with 2 children in common
Penny (Spouse)	Josh, Penny, Daisy, Kate	Non- filer household-married parents living with 2 children in common
Daisy	Josh, Penny, Daisy, Kate	Non- filer household-married parents living with 2 children in common
Kate	Josh, Penny, Daisy, Kate	Non- filer household-married parents living with 2 children in common

**C. Parent, Stepparent, and Parent’s Child (not child of stepparent)**

Paul and Pattie are a married couple. They live with Pattie’s son by a first marriage, Edgar age 17. They do not plan to file taxes this year. The household for the MAGI determination is the non-filer household which includes Paul (stepparent/spouse) , Pattie (parent/spouse) and Edgar(child/stepchild). All of them applied for MA. The following table shows each person’s tax filer household:

Person	# - Household Composition	Reason
Paul	3-Paul, Pattie, Edgar	Non filers – spouses, parent, stepparent and child/stepchild under age 19
Pattie	3-Pattie, Paul, Edgar	Non filers - spouses, parent, stepparent and child/stepchild under age 19
Edgar	2-Edgar, Pattie	Non filer lives with parent

**M0430.400 TAX FILER AND NON TAX FILER HOUSEHOLD EXAMPLES**

**A. Parent and Child Claimed by Non-custodial Parent**

Linda and her daughter, Liza, live in the home. Linda works and claims only herself as a tax dependent. Liza is claimed by her father who does not live in the home. Both applied for MA.

Linda’s is a tax filer claiming only herself. Her tax household and MAGI household are the same. Liza is a tax dependent claimed by a non-custodial parent so a tax dependent exception exists and non-filer rules must be used. The following table shows each person’s MAGI household:

Person	# - Household Composition	Reason
Linda	1– Linda	Tax-filer with no additional tax dependent
Liza	2 – Liza, Linda	Non-filer child and parent living in the home

**B. Three Generation Household – Grandmother is Tax Filer**

Mary is a working grandmother who claims her daughter, Samantha, age 20 and a full-time student, and granddaughter, Joy, age 2 as tax dependents. Although Samantha has a part-time job, she is not required to file taxes. All applied for MA.

The tax household includes Mary (the tax filer), Samantha (Mary’s dependent child), and Joy (Mary’s tax dependent). Mary’s MAGI household is the same as her tax household and includes Mary, Samantha and Joy. Samantha’s MAGI household is the same as Mary’s because Samantha is a tax dependent and no tax dependent exceptions exist. Joy’s is also a tax dependent, but meets an exception because she is not the child of the tax filer. Her MAGI household is a non-filer household and includes just Samantha and Joy; parent and child living in the home.

The following table shows each person’s MAGI household:

Person	# - Household Composition	Reason
Mary	3 – Mary, Samantha, Joy	Tax-filer & dependents
Samantha	3 – Samantha, Mary, Joy	Tax-filer & dependents
Joy	2 – Joy, Samantha	Non-filer parent and child

**C. Three Generation Household – Second Generation Tax Filer**

Rose is a tax dependent of her daughter, Lee, age 18. Lee works and claims her son, Peter, and Rose as tax dependents. All applied for MA.

The tax household includes Lee (tax filer), Rose (tax dependent), and Peter (tax dependent). Rose is not the child of the tax filer so a tax dependent exception exists and non-filer rules are used for her MAGI household. Lee is a tax filer with dependents so her MAGI household is the same as her tax household. Peter is a tax dependent living with his tax filer parent so his MAGI household is the same as the tax household.

The following table shows each person’s MAGI household:

Person	# - Household Composition	Reason
Rose	2– Rose and Lee	Non-filer, has child under age 19
Lee	3 – Lee, Rose and Peter	Tax-filer with dependents
Peter	3 – Peter, Lee and Rose	Tax dependent lives with tax-filer parent and parent’s other tax dependent

**D. Two Parents Not Married To Each Other, One Is Tax Filer; With Children, One Is Child Of One Parent And Other Is Child-In-Common**

Bob and Ann live together with Bob’s son, John age 14, and their child-in-common, Jane age 12. Ann works and files taxes claiming both children as dependents. Bob does not file taxes. All applied for MA.

Bob is a non-filer and is not claimed as a tax dependent of anyone. His MAGI household uses non-filer rules and includes Bob and his children living in the home. Ann is a tax filer with tax dependents; her MAGI household is the same as her tax household. John is a tax dependent of someone other than his parent so non-filer rules are used. John’s MAGI household includes John, his father Bob and his sibling Jane. Jane is a tax dependent of her tax filer mother, but her parents are not filing jointly so non-filer rules are used and her MAGI household includes her parents and siblings.

The following table shows each person’s MAGI household:

Person	# - Household Composition	Reason
Bob	3 - Bob, John and Jane	Non-filer with children
Ann	3 – Ann, John and Jane	Tax filer and her dependents
John	3 - John, Bob, and Jane	Non-filer with parent and siblings-no direct relation to tax filer Ann
Jane	4 – Jane, Bob, Ann and John	Non-filer child with 2 parents and half-sibling

**E. Two Parents Not Married To Each Other, Both File Taxes; 1 Child-In-Common, One Child Not In Common; Mom Is Pregnant**

Jill and Max are both tax filers. Also in the home are Max’s son, Mark and their child-in-common, May. Jill is pregnant, expecting 1 baby. Max claims both children on his taxes. All applied for MA.

Jill is a tax filer who claims no additional dependents. Her MAGI household is the same as her tax household for Medicaid coverage in the LIFC covered group and includes her unborn child when determining her eligibility as a pregnant woman. Max is a tax filer with two dependent children; his MAGI household is the same as his tax household. Mark is a tax dependent living with his tax filer parent and no exceptions exist; his MAGI household is the same as the tax household. May is a tax dependent, but her parents are not filing jointly so an exception exists and non-filer rules are used for her MAGI household.

The following table shows each person’s MAGI household:

Person	# - Household Composition	Reason
Jill	2 – Jill and 1 unborn	Tax-filer pregnant woman; no other dependents
Jill	1 – Jill	Tax filer household for determining eligibility as LIFC
Max	3 – Max, Mark and May	Tax filer and two dependent children
Mark	3 – Mark, Max and May	Tax filer rules, tax household rules for person filing for him
May	4 – May, Max, Jill and Mark	Non-filer rules child with parents not filing jointly non-married parents and half sibling.

**F. Tax Filer, Spouse, Their Child, His Child Not Living In the Home**

Gerry and Bree are married and file their taxes jointly. Also in the home is their son, Tad age 7, whom they claim as their dependent. They also claim Gerry’s daughter, Tansy age 10, who does not live with them. Gerry, Bree and Tad applied for MA.

Gerry and Bree are tax filers who are married, filing jointly claiming two dependent children. Their MAGI household is the same as their tax household.

Tad is a tax dependent child and no tax dependent exceptions exist; Tad’s MAGI household is the same as the tax household. The following table shows each person’s MAGI household:

Person	# - Household Composition	Reason
Gerry	4 – Gerry, Bree, Tad and Tansy	Tax filers and dependent children
Bree	4 – Gerry, Bree, Tad and Tansy	Tax filers and dependent children
Tad	4 – Gerry, Bree, Tad, Tansy	Tax filer and dependents

**G. Tax Filer, Her Son and Her Nephew**

Daria lives with her son, Jack age 11, and her nephew Billy age 8. Daria works and files taxes each year. Daria claims both children on her taxes. All applied for MA.

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

Person	# - Household Composition	Reason
Daria	3 – Daria, Jack and Billy	Tax filer and dependent children
Jack	2 – Jack and Daria	Non filer and parent living in home
Billy	1 – Billy	Non filer rules; Daria is not his parent, Jack is not his sibling

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

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

Dave is a tax filer who claims Cathy and Becky as his dependents. His MAGI household includes the individuals in his tax household and his wife, Jean because married spouses are always included in each other’s MAGI household. Jean is also a tax filer with no additional dependents. Jean’s MAGI household includes Dave because married spouses are always included in each other’s MAGI household. Cathy is a tax dependent whose parents are not filing jointly so non-filer rules are used. Cathy’s MAGI household includes Cathy and her parents.

The following table shows each person’s MAGI household:

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

## M0440.100 HOUSEHOLD INCOME

### A. General Rule

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

Whenever possible, income reported on the application will be verified through a data match with the federal Hub. If no data sources exists to verify the attestation, and the attestation is below the medical assistance income level, documentation of income is required.

If an income calculation must be made, use the information in subchapter M0710 for estimating income, subchapter M0720 for sources of earned income, and subchapter M0730 for sources of unearned income with the exceptions in B. below.

### B. MAGI Income and Exceptions

#### 1. Key Differences

The key differences unique to MAGI income counting rules are listed below.

- a. Child support is not counted as income (it is not taxable income).
- b. Workers Compensation is not counted.
- c. Veterans benefits which are **not** taxable in IRS pub 907 are not counted:
  - Education, training, and subsistence allowances,
  - Disability compensation and pension payments for disabilities paid either to veterans or their families,
  - Veterans' insurance proceeds and dividends paid either to veterans or their beneficiaries, including the proceeds of a veteran's endowment policy paid before death,
  - Interest on insurance dividends left on deposit with the VA,
  - Benefits under a dependent-care assistance program,
  - The death gratuity paid to a survivor of a member of the Armed Forces who died after September 10, 2001, or
  - Payments made under the VA's compensated work therapy program.
- d. Stepparent income is counted.
- e. Depreciation and capital losses are deducted in calculating countable income from self-employment and farming.
- f. There are no earned income disregards.
- g. A tax dependent child who has earnings, but is not required to file income taxes because his income is below the tax filing threshold, will not have his earnings counted in his own eligibility determination. Those earnings must be counted if he is also the parent of a dependent child whose eligibility is determined using non-filer rules.

**2. American Indian-  
Alaska Native  
Payments**

In addition, the following payments to American Indian/Alaska Natives are not counted as income:

- a. distributions received from the Alaska Native Corporations and Settlement Trusts (Public Law 100-241),
- b. distributions from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the Supervision of the Interior,
- c. distribution and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extractions and harvest from:
  - rights of any lands held in trust located within the most recent boundaries of a prior Federal reservation or under the supervision of the Secretary of the Interior,
  - federally protected rights regarding off-reservation hunting, fishing, gathering or usage of natural resources,
  - distributions resulting from real property ownership interests related to natural resources and improvements,
  - located on or near a reservation of within the most recent boundaries of a prior Federal reservation, or
  - resulting from the exercise of federally-protected rights relating to such property ownership interests.
- d. payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or right or rights that support subsistence or a traditional lifestyles according to applicable Tribal Law or custom.
- e. Student financial assistance provided under the Bureau of Indian Affairs Education Program.

**3. Social Security  
Benefits**

Social Security benefits (SSA) are counted as income even though most SSA benefits are not taxable income.

**C. Monthly Income  
Determinations**

Medicaid and FAMIS income eligibility is determined using current monthly income.

Sources and amounts of income that are verified electronically and are reasonably compatible do not require additional verification. When income cannot be verified electronically, the information reported is not reasonably compatible (see M0420.100 for the definition) and/or the source of income is new or has changed, the individual must be asked to provide current verification of the household income so a point-in-time income eligibility determination can be made.

## M0450.100 STEPS FOR DETERMINING MAGI-BASED ELIGIBILITY

### A. Determine Household Composition

1. **Does the individual expect to file taxes?**
  - a. If No - Continue to Step 2
  - b. If Yes - Does the individual expect to be claimed as a tax dependent by anyone else?
    - 1) If No - the household consists of the tax filer, a spouse living with the tax filer, and all persons whom the tax filer expects to claim as a tax dependent
    - 2) If Yes - Continue to Step 2
  
2. **Does the Individual Expect to be Claimed As a Tax Dependent?**
  - a. If No - Continue to Step 3
  - b. If Yes - Does the individual meet any of the following exceptions?
    - 1) the individual expects to be claimed as a tax dependent of someone other than a spouse or a biological, adopted, or stepparent;
    - 2) the individual is a child (under age 19) and a full-time student living with both parents, but the parents do not expect to file a joint tax return; or
    - 3) the individual is a child under age 19 who expects to be claimed by a non-custodial parent?
      - i. If no - the household is the household of the tax filer claiming her/him as a tax dependent.
      - ii. Is the individual married? If yes – does the household also include the individual’s spouse?
      - iii. If yes - Continue to Step 3.
  
3. **Individual Is Neither Tax Filer Nor Tax Dependent Or Meets An Exception In 2. b Above**

For individuals who neither expect to file a tax return nor expect to be claimed as a tax dependent, as well as tax dependents who meet one of the exceptions in 2.b above, the household consists of the individual and, if living with the individual:

  - the individual’s spouse;
  - the individual’s natural, adopted and step children under the age 19; and

- In the case of individuals under age 19, the individual's natural, adopted and stepparents and natural, adoptive and stepsiblings under age 19.

**B. Determine the MA Income for Each Member of the Household**

**1. Is Any Household Member The Child Or Expected Tax Dependent Of Another Member Of The Household?**

- a. If yes - is the individual expected to be required to file a tax return?
  - 1) If yes, continue to Step 2 and include child's income in total household income.
  - 2) If no, continue to Step 2, but do not include child's income in total household income.
- b. If no, continue to Step 2.

**2. Determine MAGI Income For Each Member**

Determine MAGI-based income of each member of the individual's household, unless income of such member is flagged as not being counted in step 1. Recall that, for purposes of MA eligibility, the following rules apply:

- an amount received as a lump sum is counted as income only in the month received
- scholarships, awards or fellowship grants used for education purposes and not for living expenses are excluded from income
- certain distributions, payments and student financial assistance for American Indians/Alaska Natives are excluded from income
- child support is not countable income.

**3. Using the 5% of FPL Disregard**

If the individual's household income is over the income limit for his covered group, subtract an amount equal to 5% of FPL for his household size (see M04, Appendix 1). Compare the countable income against the income limit for the individual's covered group to determine his income eligibility.

If the individual meets multiple Medicaid covered groups (and/or FAMIS) his gross income is compared first to the income limit of the full-benefit covered group with the highest income limit for which the individual could be eligible. If the income exceeds the limit, subtract 5% FPL based on his household size and compare the income again to the income limit. If he is still not eligible, the same process is followed for Plan First, if the individual is age 19 through 64 years.

**C. Household Income**

Household income is the sum of the MAGI-based income for every member of the individual's household as determined in step 2 above.

**M0450.200 INCOME EXAMPLES – TAX FILER HOUSEHOLDS**

**A. Example #1  
Tax Filer Single  
Parent, Two Children  
(Using Oct. 1, 2013  
figures)**

John is a single parent living with two children, Jack and Betty ages 6 and 10, who he claims as tax dependents. John earns \$3,000 per month, with projected annual income of \$36,000.

The MAGI households are:

Person	# - Household Composition	Reason
John	3 – John, Jack, Betty	Tax-filer & 2 dependents
Jack	3 – Jack, John, Betty	Tax dependent, taxpayer & other tax dependent
Betty	3 – Betty, John, Jack	Tax dependent, taxpayer & other tax dependent

John’s eligibility determination:

Potential covered groups:

LIFC  
Plan First

The full-coverage Medicaid covered group John meets that has the highest income limit is LIFC.

Monthly Income limits:

LIFC, Group II for HH of 3 = \$556  
Plan First 211% FPL for HH of 3 = \$3,436  
5% FPL for HH of 3 = \$82

John’s gross HH income of \$3,000.00 exceeds the LIFC income limit for 3 of \$556. He is entitled to the 5% FPL disregard.

\$3,000.00 gross household income  
- 82.00 5% FPL for 3  
\$2,918.00 countable income (after 5% FPL disregard)

His countable income of \$2,918.00 is compared to the LIFC income limit for 3 of \$556; it exceeds the LIFC limit so John is not eligible for full-coverage MA.

His gross HH income of \$3,000.00 is compared to the Plan First 211% FPL income limit for 3, \$3,436. John is eligible for Plan First.

John is also referred to the HIM.

Jack's eligibility determination:

Potential covered groups:

Child < Age 19  
FAMIS.

Monthly Income limits:

Child < 19 143% FPL for a HH of 3 = \$2,329  
FAMIS 200% FPL for HH of 3 = \$3,255  
5% FPL for 3 = \$82

Jack's gross HH income of \$3,000 (his father's earnings) exceeds the Medicaid Child < Age 19 143% FPL income limit for 3 (\$2,329) so Jack is entitled to the 5% disregard.

\$3,000.00 gross household income  
- 82.00 5% FPL for 3 disregard  
\$2,918.00 countable income (after 5% disregard)

Jack's countable income of \$2,918.00 exceeds the Medicaid Child < Age 19 143% FPL limit for 3 (\$2,329). He is not eligible for Medicaid.

His gross HH income of \$3,000.00 is then compared to the FAMIS income limit for a HH of 3, \$3,255. Jack's gross HH income is < the FAMIS income limit for 3 and Jack is eligible for FAMIS. (If his gross HH income had been over the FAMIS income limit, his countable income after the 5% disregard would have been compared to the FAMIS income limit).

Betty's income eligibility determination is the same as Jack's; she is eligible for FAMIS.

**B. Example #2  
Tax Filer Three  
Generation Household  
(Using Oct. 1, 2013  
figures)**

Mary Lewis is a working grandmother who claims her daughter (Samantha), age 20 and a full-time student, and granddaughter Joy (Samantha's daughter), age 2, as tax dependents.

Mary earns \$4,500/month (\$54,000/year).  
Samantha earns \$300/month (\$3,600/year)  
Projected annual income for tax household = Mary's income (Samantha not required to file) = \$54,000 per year

Tax household = Mary, Samantha and Joy.  
MAGI Households:

Person	# - Household Composition	Reason
Mary	3 – Mary, Samantha, Joy	Tax-filer & 2 tax dependents
Samantha	3 – Samantha, Mary, Joy	Tax dependent, tax filer, & other tax dependent
Joy	2 – Joy, Samantha	Non-filer child & child’s parent with whom child lives

Medicaid income limit = 143% FPL (\$1,849) for HH of two people

Mary’s eligibility determination:

Potential covered groups:

Plan First

Monthly Income Limits:

Plan First 211% FPL income limit for HH of 3 = \$3,436  
5% FPL for 3 = \$82

HH gross monthly income:

\$4,500 Mary’s earnings  
(Samantha’s earnings are excluded because she is a child for tax purposes and is not required to file taxes).

Her gross HH income of \$4,500.00 is compared to the Medicaid Plan First 211% FPL income limit for 3, \$3,436. Her gross HH income exceeds the Plan First limit. She is entitled to the 5% FPL disregard.

\$4,500.00 gross household income  
- 82.00 5% FPL for 3  
\$4,418.00 countable income (after 5% FPL disregard)

Her countable income of \$4,418.00 is then compared to the Plan First income limit of \$3,436; her countable income exceeds the Plan First limit. Mary is not eligible for Plan First.

Mary is referred to the HIM.

Samantha's eligibility determination:

Potential covered groups:

LIFC  
Plan First.

Monthly Income limits:

LIFC income limit, Group I for HH of 3 = \$457  
5% FPL for 3 = \$82  
Plan First 211% FPL income limit for HH of 3 = \$3,436

HH monthly income:

\$4,500 Mary's earnings  
(Samantha's income is not counted in this HH).

\$4,500 exceeds the LIFC limit for 3 (\$457) so she is entitled to the 5% disregard. Her income eligibility is determined as follows:

\$4,500.00	gross household income
- 82.00	5% FPL for 3
\$4,418.00	countable income

Samantha's countable income of \$4,418 still exceeds the LIFC income limit for 3 of \$457 so she is not eligible for full coverage MA.

Her gross HH income of \$4,500.00 is compared to the Plan First 211% FPL income limit for 3 of \$3,436. Her household income exceeds the Plan First income limit for 3 so she is entitled to the 5% FPL disregard. Her countable income of \$4,418 also exceeds the Plan First limit so Samantha is not eligible for MA.

Samantha is referred to the HIM.

Joy's eligibility determination:

Potential covered groups:

Child < Age 19  
FAMIS.

Monthly Income limits:

Child < 19 143% FPL for a HH of 2 = \$1,849  
FAMIS monthly 200% FPL for HH of 2 = \$2,585  
5% FPL for 2 = \$65

HH gross monthly income:

\$300 Samantha's earnings

\$300 is less than the Medicaid Child < Age 19 limit for 2 (\$1,849) so Joy is eligible for Medicaid in the Child < Age 19 covered group. The 5% disregard is not applied because it is not necessary since her gross household income is within the Medicaid Child < Age 19 income limit.

## M0450.300 INCOME EXAMPLES – NON TAX FILER HOUSEHOLDS

### A. Example #1 Non Tax Filer Single Parent, Two Children (Using Oct. 1, 2013 figures)

Mark is a single parent living with two children Mike and Ike, ages 6 and 10. He does not expect to file taxes this year because their only income is from private insurance disability benefits.

Mark receives of \$2,000 per month disability, with projected annual income of \$24,000. Mike and Ike each receive \$600 monthly or \$14,400 annually, from interest from the trusts their grandparents set up for them.

The MAGI households are:

Person	# - Household Composition	Reason
Mark	3 – Mark, Mike & Ike	Non tax filer & his 2 children < 19
Mike	3 – Mike, Mark & Ike	Non-filer child < 19, his parent & his sibling < 19
Ike	3 – Ike, Mark & Mike	Non-filer child < 19, his parent & his sibling < 19

Mark's eligibility determination:

Potential covered groups:

LIFC  
Plan First

Monthly Income limits:

LIFC, Group III for HH of 3 = \$762  
Plan First monthly income limit 211% FPL for 3 = \$3,436  
5% FPL for 3 = \$82

HH income:

\$2,000.00 Mark's benefits  
+ 600.00 Mike's trust income  
+ 600.00 Ike's trust income  
\$3,200.00 gross household income

Mark's gross HH's \$3,200 monthly income exceeds the LIFC income limit for 3 of \$762 per month. He is entitled to the 5% disregard. His income eligibility is determined as follows:

\$3,200.00 gross household income  
- 82.00 5% disregard  
\$3,118.00 countable income

Mark's countable income exceeds the LIFC Group III income limit for 3, \$762. Mark is ineligible for full coverage MA.

His gross HH income of \$3,200.00 is compared to the Plan First 211% FPL income limit for 3, \$3,436. His HH income is less than the Plan First income limit, so he is eligible for Plan First.

Mark is also referred to the HIM.

Mike's eligibility determination:

Potential covered groups:

Child < Age 19  
FAMIS.

Monthly Income limits:

Child < Age 19, 143% FPL for a HH of 3 = \$2,329  
FAMIS, 200% FPL for HH of 3 = \$3,255  
5% FPL for 3 = \$82

HH income:

\$2,000.00 Mark's benefits  
+ 600.00 Mike's income  
+ 600.00 Ike's income  
\$3,200.00 gross household income

Mike's gross HH's \$3,200 monthly income exceeds the Medicaid Child < Age 19 143% FPL income limit for 3, \$2,329. He is entitled to the 5% disregard. Mike's income eligibility is determined as follows:

\$3,200.00 gross household income  
- 82.00 5% FPL disregard  
\$3,118.00 countable income

Mike's countable income of \$3,118.00 exceeds the Medicaid Child < Age 19 143% FPL income limit for 3, \$2,329. Mike is not eligible for Medicaid.

His gross HH income of \$3,200.00 is compared to the FAMIS 200% FPL income limit for 3, \$3,255. He is eligible for FAMIS because his gross HH income is less than the FAMIS income limit for his household size.

Ike's income eligibility determination:

Potential covered groups:

Child < Age 19  
FAMIS

Monthly Income limits:

Child < Age 19, 143% FPL for a HH of 3 = \$2,329  
FAMIS, 200% FPL for HH of 3 = \$3,255  
5% FPL for 3 = \$82

HH income:

\$2,000.00 Mark's benefits  
+ 600.00 Mike's income  
+ 600.00 Ike's income  
\$3,200.00 gross household income

Ike’s gross HH’s \$3,200 monthly income exceeds the Medicaid Child < Age 19 143% FPL income limit for 3, \$2,329. He is entitled to the 5% disregard. Ike’s income eligibility is determined as follows:

\$3,200.00	gross household income
- 82.00	5% FPL disregard
\$3,118.00	countable income

Ike’s countable income of \$3,118.00 exceeds the Medicaid Child < Age 19 143% FPL income limit for 3, \$2,329. Ike is not eligible for Medicaid.

His gross HH income of \$3,200.00 is compared to the FAMIS 200% FPL income limit for 3, \$3,255. Ike is eligible for FAMIS because his gross HH income is less than the FAMIS income limit for his household size.

**B. Example #2  
Non Tax Filer Three  
Generation Household  
(Using Oct. 1, 2013  
figures)**

Sally Green is age 62, a grandmother who does not expect to file taxes this year. She is not disabled. She lives with her daughter Jane, age 20 and a full-time student, and her granddaughter Dee (Jane’s daughter), age 2. Sally takes care of Dee while Jane is attending school and working at her part-time job. Jane is pregnant with 1 unborn. They live in a Group I locality.

Income:

Sally receives SSA widow’s benefits of \$1,500 per month, with projected annual income of \$18,000.

Jane earns \$300 per month or \$3,600 annually and is not required to file taxes.

The MAGI non-filer households are:

Person	# - Household Composition	Reason
Sally	1 – Sally	Non-filer grandmother
Jane (PG)	3 – Jane, Jane’s unborn child & Dee	Non-filer, her unborn child & non-filer’s child < 19
Jane (LIFC)	2 – Jane, Dee	Non-filer & non-filer’s child < 19
Dee	2 – Dee, Jane	Non-filer child < 19 & non-filer child’s parent

Sally’s eligibility determination:

Potential covered groups:

Plan First

Monthly Income limits:

Plan First 211% FPL income limit for HH of 1 = \$2,022  
5% FPL for 1 = \$48

HH gross monthly income = \$1,500 Sally's SSA benefits

Her gross HH income of \$1,500.00 is compared to the Plan First 211% FPL income limit for 1, \$2,022. Her countable income is less than the Plan First income limit. Sally is eligible for Plan First.

Sally is also referred to the HIM.

Jane's eligibility determination:

Potential covered groups:

LIFC  
Pregnant Women  
FAMIS MOMS (through December 31, 2013)

Monthly Income limits:

LIFC, Group I for HH of 2 = \$358  
Pregnant Women 143% FPL for a HH of 3 = \$2,329  
FAMIS MOMS, 210% FPL for HH of 3 = \$3,419  
5% FPL for 3 = \$82

HH monthly income = \$300 Jane's earnings.

Jane is over age 19 and not a child, so her earnings must be counted even though she is not required to file taxes. Her mother is not in her HH, so her mother's income is not counted when determining Jane's eligibility.

\$300 is less than the LIFC limit for 2 (\$358) so the 5% disregard is not applied (it is not necessary). Jane is eligible for Medicaid in the LIFC covered group.

Dee's eligibility determination:

Potential covered groups:

Child < Age 19  
FAMIS

Monthly Income limits:

Child < Age 19 143% FPL for a HH of 2 = \$1,849  
FAMIS, 200% FPL for HH of 2 = \$2,585  
5% FPL for 2 = \$65

HH monthly income:

\$300 (Jane's gross earnings)

\$300 is less than the Medicaid Child < Age 19 143% FPL income limit for 2 (\$1,849) so Dee is eligible for Medicaid in the Child < Age 19 covered group. The 5% disregard is not applied because it is not necessary; her gross HH income is within the Medicaid Child < Age 19 income limit.

<b>5% FPL DISREGARD</b>	
<b>EFFECTIVE 10/01/13</b>	
<b># of Persons in Household or Family Size</b>	<b>Monthly Amount</b>
1	\$ 48
2	65
3	82
4	99
5	115
6	132
7	149
8	166
Each additional, add	17

**CHILD UNDER AGE 19 and  
PREGNANT WOMEN  
143% FPL  
INCOME LIMITS  
ALL LOCALITIES  
  
EFFECTIVE 10/01/13**

<b># of Persons in Household or Family Size</b>	<b>Monthly Amount</b>
1	\$1370
2	1849
3	2329
4	2808
5	3287
6	3766
7	4245
8	4724
Each additional, add	480

**LIFC INCOME LIMITS**

**EFFECTIVE 10/01/13**

**Group I**

<b>Household Size</b>	<b>Income Limit</b>
1	\$235
2	358
3	457
4	554
5	653
6	736
7	831
8	931
Each additional person add	96

**Group II**

<b>Household Size</b>	<b>Income Limit</b>
1	\$308
2	442
3	556
4	665
5	782
6	881
7	987
8	1,102
Each additional person add	109

**Group III**

<b>Household Size</b>	<b>Income Limit</b>
1	\$465
2	623
3	762
4	895
5	1,058
6	1,177
7	1,310
8	1,449
Each additional person add	133

**GROUPING OF LOCALITIES EFFECTIVE 7/01/01**

GROUP I		GROUP II	GROUP III
<u>Counties</u>	Madison	<u>Counties</u>	<u>Counties</u>
Accomack	Mathews	Albemarle	Arlington
Alleghany	Mecklenburg	Augusta	Fairfax
Amelia	Middlesex	Chesterfield	Montgomery
Amherst	Nelson	Henrico	Prince William
Appomattox	New Kent	Loudoun	
Bath	Northampton	Roanoke	
Bedford	Northumberland	Rockingham	<u>Cities</u>
Bland	Nottoway	Warren	Alexandria
Botetourt	Orange		Charlottesville
Brunswick	Page		Colonial Heights
Buchanan	Patrick	<u>Cities</u>	Falls Church
Buckingham	Pittsylvania	Chesapeake	Fredericksburg
Campbell	Powhatan	Covington	Hampton
Caroline	Prince Edward	Harrisonburg	Manassas
Carroll	Prince George	Hopewell	Manassas Park
Charles City	Pulaski	Lexington	Waynesboro
Charlotte	Rappahannock	Lynchburg	
Clarke	Richmond County	Martinsville	
Craig	Rockbridge	Newport News	
Culpeper	Russell	Norfolk	
Cumberland	Scott	Petersburg	
Dickenson	Shenandoah	Portsmouth	
Dinwiddie	Smyth	Radford	
Essex	Southampton	Richmond	
Fauquier	Spotsylvania	Roanoke	
Floyd	Stafford	Staunton	
Fluvanna	Surry	Virginia Beach	
Franklin	Sussex	Williamsburg	
Frederick	Tazewell	Winchester	
Giles	Washington		
Gloucester	Westmoreland		
Goochland	Wise		
Grayson	Wythe		
Greene	York		
Greensville			
Halifax	<u>Cities</u>		
Hanover	Bristol		
Henry	Buena Vista		
Highland	Danville		
Isle of Wight	Emporia		
James City	Franklin		
King George	Galax		
King & Queen	Norton		
King William	Suffolk		
Lancaster			
Lee			
Louisa			
Lunenburg			

**INDIVIDUALS UNDER AGE 21 INCOME LIMITS**

**EFFECTIVE 10/01/13**

**Group I**

<b>Household Size</b>	<b>Income Limit</b>
1	\$225
2	348
3	448
4	543
5	640
6	718
7	812
8	913
Each additional person add	92

**Group II**

<b>Household Size</b>	<b>Income Limit</b>
1	\$305
2	443
3	555
4	666
5	786
6	881
7	987
8	1,101
Each additional person add	107

**Group III**

<b>Household Size</b>	<b>Income Limit</b>
1	\$405
2	545
3	661
4	773
5	915
6	1,009
7	1,119
8	1,232
Each additional person add	108

<b>PLAN FIRST 211% FPL INCOME LIMITS ALL LOCALITIES  EFFECTIVE 10/01/13</b>	
<b># of Persons in Household</b>	<b>Monthly Limit</b>
1	\$2,022
2	2,729
3	3,436
4	4,142
5	4,849
6	5,556
7	6,263
8	6,970
Each additional, add	707

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M05 Changes

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## M0510.000 GENERAL RULES & PROCEDURES

### M0510.001 ASSISTANCE UNIT GENERAL PRINCIPLES

**A. Introduction** Medicaid is an assistance program which pays medical service providers for services rendered to eligible needy individuals. An individual's need is based on his financial eligibility--the amount of his resources and income.

Financial eligibility is determined in relation to specific resource and income limits. The income and resource limits are established in relation to the number of persons in the assistance unit. The assistance unit is the basis for the financial eligibility determination. Eligibility is based on the countable income and resources of the assistance unit members and of legally responsible relatives who are not included in the assistance unit and who live in the home. All of the resources and income which the individual has available to him, including resources and income "deemed" to be available to him, are counted.

**B. Procedures** This subchapter contains the general policy and procedure for determining *the composition of* an individual's assistance unit for the financial eligibility determination.

- The Legal Base is contained in M0510.002;
- Definitions are contained in M0510.100;
- General Procedures are contained in M0510.200.

The detailed family/budget unit policy and procedures for individuals in *all Families & Children (F&C) Medically Needy (MN)* covered groups are contained in M0520.

*Chapter M04 contains the procedures for determining the household size for the following F&C covered groups for all **eligibility determinations for applications submitted on or after October 1, 2013 and renewals made after April 1, 2014:***

- *CN Pregnant Women & Newborn Children;*
- *Plan First;*
- *Child Under Age 19 (FAMIS Plus);*
- *Low Income Families With Children (LIFC);*
- *Individuals Under Age 21;*
- *Special Medical Needs Adoption Assistance.*

The detailed assistance unit policy and procedures for individuals in an ABD covered group are contained in M0530.

### M0510.002 LEGAL BASE

**A. Federal Law** The federal Medicaid law in Title XIX, section 1902(a)(17)(D), requires that a state plan for medical assistance include reasonable standards for determining

eligibility for and the extent of medical assistance under the state plan. These standards must provide for reasonable evaluation of resources and income. The standards must:

- take into account only such income and resources as are available to the applicant or recipient;
- take into account only such income and resources as would not be disregarded under the Supplemental Security Income (SSI) program for aged, blind and disabled individuals, or the title IV-A program (AFDC program in effect on 7-16-96) for all other individuals;
- NOT take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21.

**B. Federal Regulations**

Federal regulations in 42 CFR 435.601 state that when determining Medicaid eligibility, the agency must apply the financial methodologies and requirements of the cash assistance program that is most closely categorically related to the individual's covered group, EXCEPT:

- when determining the financial responsibility of relatives, and
- when using more restrictive or more liberal resource methodologies than those of the cash assistance program, as specified in the State Plan.

Federal regulations in 42 CFR 435.602 state that, except for a spouse of an individual or a parent for a child who is under age 21, the agency must not consider income and resources of any relative as available to an individual.

**C. Virginia Medicaid Policy**

When determining whose resources and income to count available to the individual applicant or recipient, Medicaid must take into account the resources and income of the individual's spouse or parent (if the individual is under age 21) with whom the individual lives. For the aged, blind and disabled (ABD) covered groups, Medicaid must use the SSI program methods for counting and "deeming" spouses' and parents' resources and income to an individual, except where they would result in "illegal" deeming of resources or income from a relative or person who is not legally responsible for the individual according to the federal Medicaid regulations. For the (F&C) *MN* covered groups, Medicaid must use the 7-16-96 AFDC program methods for counting and "deeming" spouses' and parents' resources and income to an individual, except where they would result in "illegal" deeming of resources or income from a relative or person who is not legally responsible for the individual according to the federal Medicaid regulations.

Subchapter M0520 explains how to count the resources and income of a spouse or parent for the F&C *MN* covered groups. Subchapter M0530 explains how to count the resources and income of a spouse or parent for the ABD covered groups.

**M0510.100 DEFINITIONS**

**A. Introduction**

The terms used in this subchapter are defined below in this section.

**B. 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 F&C *MN* 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. In this situation, the assistance unit is the married ABD couple.

**C. Budget Unit**

The budget unit (BU) is the term used for the assistance unit for F&C *MN* individuals in a family when specific circumstances exist. The BU is a sub-unit of the family unit (FU). It contains some, but not all, members of the family unit.

**D. Family Unit**

The family unit is the name for the assistance unit when determining eligibility for an F&C individual or family. The family unit consists of all individuals listed on the application form as living in the household and among whom legal responsibility for support exists.

Federal Medicaid law and regulations prohibit deeming resources or income from anyone other than a parent to a child under age 21 or from spouse to a spouse. An individual cannot be ineligible or have his spenddown liability increased because of counting income and resources of non-legally responsible individuals living in the household.

The family unit must be further divided into “budget units” when the family unit does not meet the resource or income limit, and

- the family unit contains a stepparent, an acknowledged father not married to the mother, a married Medicaid minor or a Medicaid minor parent in the home, or
- a child in the family unit has resources or income of his/her own.

The unit must include the legally responsible relative(s) with whom the individual lives (parent for child under age 21 and spouse for spouse) unless the spouse or the parent receives an SSI or IV-E foster care/adoption subsidy payment. Spouse refers to a person who would be defined as married to the individual under applicable state law. Parent refers to the natural or adoptive parent of the child.

**E. Deeming**

Deeming is the process of considering the income and resources of another person, who is not included in the assistance, family or budget unit, to be the income and resources of the individual who is applying for or receiving Medicaid. Deemed income and resources are counted available to the eligible individual whether or not they are actually made available to him/her.

The federal Medicaid regulations require that the income and resources of certain individuals other than the applicant be included (deemed available) when determining an individual's Medicaid eligibility. These individuals

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**M0520 Changes**

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**CHAPTER M05**  
**MEDICAID ASSISTANCE UNIT**  
**SUBCHAPTER 20**

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**FAMILIES & CHILDREN (F&C) *MEDICALLY NEEDY (MN)***  
**FAMILY/BUDGET UNIT**

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### M05 MEDICAID ASSISTANCE UNIT

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

### M0520.001 OVERVIEW

#### A. Introduction

This subchapter contains the policy and procedures for determining the assistance unit for *certain* individual or families who meet an F&C MN covered group. *Refer to M0510.001 for information and instructions on when to use the policies in M0520.*

For F&C MN financial eligibility determination purposes, the assistance unit is called the “family/budget” unit. A household is divided into one or more family units.

The family unit’s financial eligibility is determined first. If the family unit has resources or income that cannot be verified or that exceeds the limit for the individual’s covered group, the family unit is divided into “budget” units if certain requirements are met.

#### B. Policy

Medicaid law prohibits the consideration of resources and income of any person other than a spouse or parent in the final Medicaid eligibility determination. Resources and income CANNOT be counted

- from a stepparent to a stepchild;
- from a sibling to a sibling;
- from a child to a parent;
- from a spouse or parent living apart from the individual, unless it is a voluntary or court-ordered or DCSE-ordered contribution (exception for individuals in long-term care);
- from an alien sponsor to the alien.

The family unit will include any child(ren) under age 21 living in the home for whom a unit member is legally responsible regardless of whether or not the child(ren) meet(s) a covered group, unless the child is specifically excluded.

#### 1. Member In One Unit

An applicant/recipient can be a member of only one family unit or one budget unit at a time.

#### 2. May Exclude A Child

The applicant can choose to exclude any child(ren) from the family unit for any reason. If the parent wants to exclude a child who has been listed on the application, the request for exclusion must be in writing. None of the excluded child's needs are considered, and none of his income or resources are counted or deemed available to the unit. The advantages and disadvantages of the choice must be explained to the applicant or recipient.

#### 3. Living Away From Home

A parent, or a child under age 21 who has not been emancipated, is considered living in the household for family unit composition purposes if the absence is temporary and the parent or child intends to return to the home when the purpose of the absence (such as employment, military service, education, rehabilitation, medical care, vacation, visit) is completed.

Children living in foster homes/institutions are NOT temporarily absent from home. They are indefinitely absent from home and are NOT living with their parents or siblings for Medicaid purposes.

**4. Psychiatric Residential Treatment Facilities (PRTFs)**

**a. Children Living in a PRTF**

Children *residing* in Level C PRTFs are *not temporarily* absent from home. They are *indefinitely absent from home and are not living with their parents or siblings for Medicaid purposes, if their stay in the facility has been 30 calendar days or longer*. Long-term care rules do not apply to these children.

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

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

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

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

**5. Medical Facilities**

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

**C. Procedure**

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

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

**M0520.103 EWB IN HOUSEHOLD****A. Policy**

*For applications submitted prior to October 1, 2013, when the household includes an individual who applies for Medicaid who meets the definition of an EWB in subchapter M0310, and the person to whom the EWB provides essential services meets the nonfinancial and income requirements for Medicaid in the LIFC covered group, the EWB is in a separate family unit. An EWB does not exist if the family to whom he/she provides essential services is not eligible for Medicaid as LIFC.*

The EWB's financial eligibility for Medicaid is determined by using the income of the EWB's family unit members only. The income of the individual to whom he/she is providing essential services is NOT counted because that individual is not legally responsible for the EWB, nor is the EWB legally responsible for the individual.

*Effective October 1, 2013, the LIFC definition no longer includes an EWB.*

**B. Family Unit Composition**

To determine the EWB's family unit, start with the EWB who requests Medicaid and meets the LIFC covered group as an EWB. Include the EWB's spouse and/or the EWB's children under age 21 who live in the household. The dependent child(ren) and the caretaker for whom the EWB is providing essential services are in a separate family unit(s).

**C. Determine Income Eligibility**

Add together all of the countable income received by the members of the EWB's family unit. Compare the total countable income to the LIFC 185% and F&C 90% income limits.

If the EWB's family unit's income is within the F&C 185% and 90% limits, the EWB is eligible as LIFC, if the family to whom the EWB provides essential services is eligible as LIFC.

If the EWB's family unit's income exceeds the LIFC limit, determine if the family unit can be broken into BUs to test the BUs' income against the limits. See M0520.200 below. If the EWB's family unit cannot be broken into BUs, the EWB is not eligible for Medicaid as LIFC because of excess income.

**D. Example--EWB In Household**

**EXAMPLE #5:** Household listed on application consists of an applicant mother, her 6-year old son and her 20-year old niece. They all request Medicaid. Her niece takes care of her son while the mother works. The niece meets the definition of an EWB because she provides child care which enables the mother to work full time.

Because the niece is an EWB, the household contains multiple family units:

1. the 6-year old son and his mother; and
2. the EWB niece, who has no legally responsible relatives in the household.

## M0710 Changes

<b>Changed With</b>	<b>Effective Date</b>	<b>Pages Changed</b>
TN #98	10/1/13	pages 1-4, 8, 9 Page 1a was added. Appendices 1, 3, 5
UP #9	4/1/13	Appendix 6, pages 1, 2 Appendix 7
UP #7	7/1/12	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1
UP #6	4/1/12	Appendix 6, pages 1, 2 Appendix 7
TN #96	10/01/11	Appendix 6, page 1
UP #5	7/1/11	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1
TN #95	3/1/11	Appendix 6, pages 1, 2 Appendix 7
Update (UP) #1	7/1/09	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1

**M0710.000 GENERAL-- F&C INCOME RULES****M0710.001 OVERVIEW****A. Introduction**

Medicaid is a needs based program. Two financial criteria, income and resources, are used to determine if a person is in need and is financially eligible for Medicaid. *The income eligibility policies that are used for the eligibility determination depend on the individual's covered group, as well as the date of the determination.*

**1. Use Policies in Chapter M07**

*The policies in **chapter M07** apply for **all initial applications, reapplications and renewals** for the Families & Children (F&C) Medically Needy(MN) covered groups.*

*The policies and income limits in **chapter M07** apply for applications submitted before October 1, 2013, changes reported through March 31, 2014 and for renewals through March, 2014, for the covered groups listed below:*

- *Categorically Needy (CN) Pregnant Women & Newborn Children;*
- *Plan First;*
- *CN Child Under Age 19 (FAMIS Plus);*
- *Low Income Families With Children (LIFC);*
- *Individuals Under Age 21;*
- *Special Medical Needs Adoption Assistance.*

**2. Use Policies in Chapter M04 and Chapter M07 as Directed**

*For all **eligibility determinations** (other than renewals) on applications submitted **on or after October 1, 2013**, the income policies, procedures and income limits for Modified Adjusted Gross Income (MAGI) contained in **chapter M04** apply to the covered groups listed below.*

- *CN Pregnant Women & Newborn Children;*
- *Plan First;*
- *CN Child Under Age 19 (FAMIS Plus);*
- *Low Income Families With Children (LIFC);*
- *Individuals Under Age 21;*
- *Special Medical Needs Adoption Assistance.*

*The income types and verification procedures in chapter M07 are used with MAGI methodology as directed in chapter M04.*

**3. Use Other Policies**

*Income eligibility for Medicaid is not determined by the local DSS for the following F&C covered groups:*

- *IV-E Foster Care or IV-E Adoption Assistance Recipients;*
- *BCCPTA.*

*See subchapter M0330 for additional information about these covered groups.*

**B. Use of Family Units/Budget Units**

Family Units (FUs) are formed to establish whose income and resources are counted in determining financial eligibility. If financial eligibility does not exist at the family unit level for one or more persons for whom Medicaid was requested and if budget unit (BU) rules permit, form BUs.

Financial eligibility is determined at the BU level for each person for whom Medicaid was requested and who was financially ineligible in the FU determination. Eligibility is not determined for an individual who was found eligible in the FU determination.

See M0520 for F&C Family Unit/Budget Unit (FU/BU) policy and procedures.

**C. Individual Income Eligibility**

An individual's income eligibility is based on the total countable income available to his/her FU/BU.

Each source of income received by a member of the FU/BU is evaluated and the countable amount determined based on the policy in this chapter. The countable amount of each FU/BU member's income is added to the countable amount of the income of all other FU/BU members. That total is used to determine the income eligibility of each individual within that FU/BU. The FU/BU's total countable income is compared to the income limit that is applicable to the individual's classification and to the number of members in the FU/BU.

**D. Policy Principles**

**1. Income**

Everything an individual owns and all monies received are assets. Monies received are income in the month received when the monies are cash or its equivalent.

Income may be either earned or unearned. See M0720 for earned income and M0730 for unearned income.

**2. Verification**

All income other than Workforce Investment Act and the earned income of a student under age 19 must be verified. When attempts to verify income are unsuccessful because the person or organization who is to provide the information cannot be located or refuses to provide the information to both the applicant/recipient and the eligibility worker, a third party statement, a collateral contact, or as a last resort, the applicant's/recipient's written statement can be used as verification and to determine the amount of income to be counted.

Failure of the applicant/enrollee to verify his income results in the agency's inability to determine Medicaid eligibility and the applicant/enrollee's Medicaid coverage must be denied or canceled.

- 3. Converted Income**

For the ongoing evaluation period, all income received more frequently than monthly must be converted to a monthly amount.

  - Weekly income is multiplied by 4.3
  - Bi-weekly income is multiplied by 2.15
  - Semi-monthly income is multiplied by 2.
- 4. Available Income**

Retroactive period –available income is the gross income actually received in each month in the retroactive period.

Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months. The applicant's actual gross income received in the application month may be used to determine eligibility for that month if the application is processed after the month has passed and the person is eligible only when using the actual gross income for the month.
- 5. MN - Ongoing 6 Month Income Determination Period**

Medically Needy (MN) income eligibility for the ongoing period is based on income that is anticipated to be received within the six month period beginning with the month of application.
- 6. MN - Retro 3 Month Income Determination Period**

MN income eligibility for the retroactive period is based on income that was actually received in the three-month period immediately prior to the month of application.
- 7. Countable Income**

Assets that meet the definition of income minus the exclusions allowed by policy are countable income. Only countable income is used to determine income eligibility. See M0720 Earned Income, M0730 Unearned Income.
- 8. Whose Income is Counted**

The total countable income of all FU members is used in determining the income eligibility of each FU member. The total countable income of all BU members is used in determining the income eligibility of each BU member.
- 9. Income Eligibility**

If the total amount of the FU/BU's countable income is equal to or less than the income limit for the evaluation period, income eligibility exists.
- 10. Excluded Income**

State and federal policy require that certain types of income or portions of income be excluded (not counted) when determining income eligibility. See:

  - Earned Income Exclusions, M0720.500
  - Unearned Exclusions, M0730.099

## M0710.002 INCOME LIMITS

- A. Introduction** The individual's Medicaid classification determines which income limit to use to determine eligibility.
- B. Income Limits**
- 1. CN** *For changes reported through March 31, 2014 and for renewals through March, 2014* - Refer to M0710, Appendix 1 for the LIFC 185% of the Standard of Need Chart, M0710, Appendix 2 for the grouping of localities, and M0710, Appendix 3 for the F&C 90% and 100% Income Limit Charts.
- 2. MN** Refer to M0710, Appendix 2 for the grouping of localities and M0710, Appendix 5 for the MN income limits.

## M0710.003 NET COUNTABLE INCOME

- A. Policy Principle** Income is
- cash, or
  - its equivalent unless specifically listed in M0715 as not being income.
- B. Available Income** Retroactive period –available income is the gross income actually received in each month in the retroactive period.
- Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months. The applicant's actual gross income received in the application month may be used *to determine eligibility for that month* if the application is processed after the month has passed and the person is eligible only when using the actual gross income for the month.
- C. Net Countable Income** Net countable income is all money, both earned and unearned, which is available to the members of the FU/BU, after portions specifically excluded and all amounts that are not income are subtracted.

## M0710.004 INCOME EXCLUSIONS

- A. Introduction** Medicaid eligibility is based on countable income. See M0710.003 for the definition of countable income. In determining countable income *for the MN covered groups*, apply any income exclusions. Some exclusions totally negate the amount of income received. Other exclusions reduce the amount counted.
- B. Definition** Excluded income is an amount which is income but does not count in determining eligibility.
- C. Policy Principles** Some Federal laws other than the Social Security Act prohibit counting some income for Medicaid purposes. Section 402(a) of the Social Security Act provides for several income exclusions in determining countable income for Medicaid purposes.
- D. References**
- Earned income exclusions, M0720.500
  - Unearned income exclusions, M0730.099

## M0710.010 RELATIONSHIP OF INCOME TO RESOURCES

- A. Policy** In general, anything received in a month from any source is income to an individual, subject to the definition of income in M0710.003.
- Anything the individual owns in the month under consideration is subject to the resource counting rules.
- An item received in the current month is income for the current month only. If held by the individual until the following month, that item is subject to resource counting rules.
- B. References**
- Definition of Resources, M0610.100
  - Conversion or sale of a resource, M0715.200
  - Casualty property loss payments, M0630.650
  - Lump sums, M0730.800

## M0710.015 TYPES OF INCOME

- A. Policy Principle** Income is either earned or unearned, and different rules apply to each. *Sources of income may be counted in the MN determination but not counted in the MAGI determination. Differences are noted in the appropriate policy.*
- B. Types of Income**
- 1. Earned Income** .Earned income consists of the following types of payments:
- wages;
  - salaries, and/or commissions;
  - profits from self employment; or
  - severance pay.

**B. Procedure****1. When a Change Occurs**

An anticipated change in income occurs when you expect an individual's income to start, to stop, or to come in at a different rate in the future.

**2. How to Develop a Change**

When you anticipate an increase in income, use only that income which the individual is reasonably certain he will receive.

**3. Handling Changes in Income**

When a change in income occurs, redetermine Medicaid eligibility.

**C. Documentation****1. What the File Must Contain**

Verify and document the case record regarding the rate and frequency of payment (i.e., weekly, biweekly, semi-monthly, monthly, etc.) and the payment cycle (i.e., on what day the client is paid).

The case record must be documented to reflect the method used to arrive at the anticipated income.

**2. Who May Provide an Estimate**

Estimates of income may come from the applicant/recipient, employer, or representative.

**M0710.700 DETERMINING ELIGIBILITY BASED ON INCOME****M0710.720 Categorically Needy (CN) Pregnant Women and Child Under Age 19 – For changes reported through March 31, 2014 and for renewals through March, 2014, for the covered groups listed below**

The following procedures apply to the *CN* classification *except Individuals Under Age 21 and LIFC*:

**A. Income Charts**

The countable income of all FU/BU members allowing income exclusions when appropriate, is compared to the medically indigent income limits. Refer to subchapter M0710, Appendix 6 for the Income Limits.

**B. Gross Income**

Total gross income includes all gross earned income, other than Workforce Investment Act income and income of a child under age 19 who is a student. It also includes unearned income of all FU/BU members and any income deemed available to the family/budget unit.

**C. Excluded Income**

The following income is excluded when income is compared to *CN* limits:

1. **Unearned Income** All unearned income specifically excluded per M0730.099;
2. **Earned Income** Earned income is excluded in the following order:
  - standard work exclusion of the first \$90 of gross earned income for each employed member of the assistance unit whose income is not otherwise exempt per M0720.520;
  - child care/incapacitated adult care exclusion per M0720.540

**D. Income Eligibility** If the countable income (gross income minus above exclusions) is equal to or less than the *CN* income limit for that covered group, the members of the FU/BU meeting that classification are income eligible. If the countable income exceeds the income limit, the FU/BU is not eligible as *CN*.

Determine if any members of the FU/BU would be eligible for the *Family Access to Medical Insurance Security Plan (FAMIS)* or MN.

### **M0710.730 *CN Individuals Under age 21 and LIFC***

***For changes reported through March 31, 2014 and for renewals through March, 2014, for the covered groups listed below***

- A. **Individuals under 21 in Nursing Facilities or ICF/MR** Individuals under 21 in nursing facilities or ICF/MR are evaluated as individuals in medical facilities and their income is screened at 300% of SSI (see M0810.002 A. 3.).
- B. **Individuals under 21 in Foster Care/Adoption Assistance**
  1. **Step 1- 185% Screen** The child's countable income is the total gross earned income, other than Workforce Investment Act income and/or *other earned* income of a child under age 19 who is a student. It also includes unearned income, other than the unearned income listed in M0730.099.  
Screen income at LIFC 185% of the standard of need. Refer to M0710, Appendix 1 for the LIFC 185% of Standard of Need Chart.

If the countable income exceeds the LIFC 185% standard of need, the child is not eligible as an Individual Under 21 in FC/Adoption Assistance. If the income is equal to or less than LIFC 185% standard of need, proceed to Step 2.

**LIFC 185% OF STANDARDS OF NEED  
(MAXIMUM MONTHLY INCOME)  
EFFECTIVE 7/1/13**

*For changes reported through March 31, 2014 and for renewals through  
March, 2014, for the covered groups listed below*

	<b>Group I</b>	<b>Group II</b>	<b>Group III</b>
<b>Family /Budget Unit size</b>	<b>Monthly</b>	<b>Monthly</b>	<b>Monthly</b>
1	\$374.60	\$446.49	\$623.54
2	587.59	659.48	839.10
3	756.98	826.17	1,008.52
4	918.71	990.56	1,172.78
5	1,083.00	1,172.78	1,390.92
6	1,213.82	1,306.21	1,521.82
7	1,372.97	1,462.79	1,680.94
8	1,544.91	1,632.18	1,847.83
9	1,686.10	1,775.92	1,999.22
10	1,842.63	1,935.06	2,153.10
Each additional	156.47	156.47	156.47

F&C Monthly Income Limits Effective 7/1/13

*For changes reported through March 31, 2014 and for renewals through March, 2014, for the covered groups listed below*

**Group I**

<b>Family/Budget Unit Size</b>	<b>100%</b>	<b>90%</b>
1	202.49	181.67
2	317.62	287.10
3	409.18	367.56
4	496.60	446.65
5	585.41	527.12
6	656.12	592.32
7	742.15	668.62
8	835.09	750.46
Each additional person add	84.58	77.63

**Group II**

<b>Family/Budget Unit Size</b>	<b>100%</b>	<b>90%</b>
1	241.35	217.76
2	356.48	320.40
3	446.58	403.65
4	535.44	481.33
5	633.94	567.40
6	706.06	635.31
7	790.70	710.23
8	882.26	793.49
Each additional person add	84.58	77.63

**Group III**

<b>Family/Budget Unit Size</b>	<b>100%</b>	<b>90%</b>
1	337.05	305.16
2	453.57	407.81
3	545.15	491.04
4	633.94	568.75
5	751.85	676.94
6	822.61	740.76
7	908.62	818.45
8	998.83	901.69
Each additional person add	84.58	77.63

**MEDICALLY NEEDY INCOME LIMITS EFFECTIVE 7/1/13**

# of Persons in Family/Budget Unit	GROUP I		GROUP II		GROUP III	
	Semi-Annual Income	Monthly Income	Semi-Annual Income	Monthly Income	Semi-Annual Income	Monthly Income
1	\$1803.47	\$300.58	\$2080.93	\$346.82	\$2705.21	\$450.87
2	2296.23	382.70	2562.56	427.09	3261.66	543.61
3	2705.21	450.87	2982.68	497.11	3676.33	612.72
4	3052.04	508.67	3329.50	554.92	4023.15	670.52
5	3398.86	566.48	3676.33	612.72	4369.98	728.33
6	3745.68	624.28	4023.15	670.52	4716.80	786.13
7	4092.51	682.08	4369.98	728.33	5063.62	843.94
8	4508.70	751.45	4786.15	797.69	5410.46	901.74
9	4924.89	820.82	5185.29	864.21	5912.99	985.50
10	5410.46	901.74	5687.92	947.99	6312.20	1052.03
Each add'l person add	466.11	77.68	466.11	77.68	466.11	77.68

**Virginia DSS, Volume XIII**

**M0720 Changes**

<b>Changed With</b>	<b>Effective Date</b>	<b>Pages Changed</b>
TN #98	10/1/13	pages 6, 10
TN #94	9/01/2010	pages 5, 6
TN #91	5/15/2009	page 11

- the principal and interest on loans for capital improvements of real property;
- net losses from previous periods;
- federal, state, and local taxes;
- personal expenses, entertainment expenses, and personal transportation;
- money set aside for retirement purposes.
- Depreciation of equipment, machinery, or other capital investments necessary to the self-employment enterprise *are NOT deducted in calculating profit from self-employment for covered groups that are NOT subject to Modified Adjusted Gross Income (MAGI) methodology.*

*Depreciation and capital losses ARE deducted when calculating profit from self-employment for covered groups subject to MAGI methodology (see Chapter M04).*

**C. Verification**

Verification is proof of the gross amount of income received and proof of the business related expenses. Verify gross income received and business related expenses by self-employment bookkeeping or tax records.

**M0720.250 INCOME FROM REAL PROPERTY**

**A. Policy**

Income from real property is self-employment income when the individual is actively engaged in the managerial responsibilities of the income producing property. Income from real property is determined on a monthly basis except farm subsidies which are prorated over a twelve month period.

If the individual is not actively involved in the management responsibilities, income received from the property is unearned income. See M0730.505.

When income from real property is received, the case record must clearly indicate the basis for determining whether or not the individual produces it by his own efforts or whether or not he is actively engaged in management.

**B. Profit**

Deduct the amount of the allowable business expenses from the gross income to determine profit from real property.

**M0720.260 INCOME FROM ROOM AND BOARD**

**A. Policy**

Income from room and board is earned income from self-employment if the applicant/recipient produces the income from his own efforts or carries managerial responsibilities. Income from room and board is determined on a monthly basis.

**B. Procedure**

**1. Verify Gross Income**

Verify gross income received by self-employment bookkeeping records.

**E. Procedures**

1. **Additional Earnings** When a contract specifies a set amount to be paid over the contract period, plus additional monies of an uncertain amount if additional work is available and done, only the base contract is prorated. Additional monies earned over and above the base contract are counted as income when they can be anticipated.
2. **Decrease in Income** When a contract calls for no pay for those days not worked, the salary for those days should not be counted if it can be anticipated at the time that the prospective determination is made that certain days will be missed. Otherwise, the income calculation is to be based on the maximum salary. If the individual informs the local agency that days are missed, recalculate the countable monthly amount for the entire contract period.
3. **Changes in Contract** If the contract amount changes during the contract period, recalculate the amount of income to be received in the contract period. To determine the new monthly income amount, divide the contract amount by the number of months in the original contract period.

**EXAMPLES:****a. Decrease In Pay**

A school bus driver's 12 month contract states that she will receive \$1,250 for the year, but that she will not be paid for days the school is closed or for days she is sick. When she applies on February 10, she has already missed three days for snow in the contract year and she was sick for two days. The contract reads that \$10 will be deducted for each day not worked. The case is approved with income of \$100 per month.

$$(\$1,250 - 50 = \$1,200 \quad \$1,200 / 12 = \$100)$$

**b. Increase In Pay**

On December 11, the school bus driver reports that her 12 month contract which began September 1 will be increased by 10% effective January 1. The income that is anticipated to be received is recalculated for the months in the original contract period using the increased figure of \$110 ( $\$1,200 \times 10\% = \$120$ ;  $\$1,200 + 120 = \$1,320$ ;  $\$1,320 / 12 = \$110$ ). \$110 will be the contract income for January - August.

**EARNED INCOME EXCLUSIONS****M0720.500 GENERAL**

- A. **Policy** The source and amount of all earned income other than Workforce Investment Act and student income must be verified; however, not all earned income counts when determining Medicaid eligibility. Federal and state laws and regulations require that certain types of earned income be totally or partially excluded when determining Medicaid eligibility.

*For covered groups subject to MAGI methodology, the earned income disregards contained in M0720 do NOT apply. Follow the policies and procedures in Chapter M04 for determining eligibility for MAGI covered groups.*

M0730 Changes

<b>Changed With</b>	<b>Effective Date</b>	<b>Pages Changed</b>
TN #98	10/1/13	pages 7, 8 page 8a was removed.
TN #97	9/1/12	page 10
TN #94	9/1/2010	pages 7, 8
TN #93	1/1/2010	page 2
TN #91	5/15/2009	Table of Contents pages 7-8a

**B. Definitions**

- 1. Annuity** An annuity is a sum paid yearly or at other specific times in return for the payment of a fixed sum. Annuities may be purchased by an individual or by an employer.
- 2. Pensions and Retirement Benefits** Pensions and retirement benefits are payments to a worker following his retirement from employment. These payments may be paid directly by a former employer, by a trust fund, an insurance company, or other entity.
- 3. Disability Benefits** Disability benefits are payments made because of injury or other disability.

**C. List of Benefits**

The following are examples of benefits:

Social Security Benefits  
VA Payments – *certain types not counted under MAGI methodology (see Chapter M04)*  
Worker's Compensation – *not counted under MAGI methodology (see Chapter M04)*  
Railroad Retirement  
Black Lung Benefits  
Civil Service Payments  
Military Pensions  
VIEW Transitional Payments

**D. Procedure**

Verify entitlement amount and amount being received by documents in the applicant/enrollee's possession, such as an award letter or benefit payment check, or by contact with the entitlement source.

**M0730.200 UNEMPLOYMENT COMPENSATION**

**A. Policy**

Unemployment Compensation received by an individual is counted as unearned income. The amount counted is the gross benefit before any taxes or deductions.

**B. Procedures**

**1. General Procedures**

Count Unemployment Compensation as unearned income for all covered groups, but do not count it in the 185% income screening for LIFC.

**Exclude** Unemployment Compensation in the 185% income screening for LIFC. Count Unemployment Compensation in the 90% income screening.

**2. Special \$25 Weekly Exclusion**

The American Recovery and Reinvestment Act of 2009 (P.L. 111-5) authorized *increased* payments, called *Federal Additional Compensation (FAC)*, of \$25.00 per week to certain individuals receiving Unemployment Compensation payments. *FAC* increased payments are authorized for Unemployment Compensation payments made through *December 4, 2010, provided that the initial claim for compensation was filed on or before May 23, 2010. Claims filed after May 23, 2010 are not subject to the increased payments.*

The individual's entitlement to Unemployment Compensation is not affected—the individual will only receive the number of payments to which the individual would normally be entitled.

*FAC increased payments are excluded from countable income. If the individual's Unemployment Compensation claim was filed on or before May 23, 2010, exclude the first \$25.00 of Unemployment Compensation for payments made through December 4, 2010.*

*If the claim was filed after May 23, 2010, the individual does not receive the additional weekly \$25.00. DO NOT exclude the FAC payments from countable income.*

## M0730.210 TRADE ADJUSTMENT ASSISTANCE ACT INCOME

**A. Policy** The Trade Adjustment Assistance Act is administered by the Virginia Employment Commission. The Act allows qualified unemployed individuals to receive additional weeks of Unemployment Compensation (UC). UC benefits are counted as unearned income. The amount counted is the gross benefit before any taxes or deductions.

**B. Procedure** See M0730.200, above, for procedures to use in counting UC benefits.

## M0730.400 CHILD/SPOUSAL SUPPORT

**A. Policy** *For covered groups subject to Modified Adjusted Gross Income (MAGI) methodology, child support income is **NOT** counted (see chapter M04). However, spousal support (alimony) **is** counted as unearned income.*

*For covered groups that are not subject to MAGI methodology, support received by an individual, whether it comes directly from the provider or is redirected to the individual by DCSE, **is** unearned income. The support received by the individual is subject to the \$50 Support Exclusion. Use the policies and procedures below.*

### **B. Procedures**

- 1. Child Living in Home** *Child support payments received for a child who is living in the home is counted as income to the child for a non-MAGI determination.*
- 2. Child Not Living in Home** *Child support payments received for a child who is not living in the home are counted a income to the person receiving it for a non-MAGI determination if the money is not given to the child.*

M0810 Changes

<b>Changed With</b>	<b>Effective Date</b>	<b>Pages Changed</b>
TN #98	10/1/13	page 2
UP #9	4/1/13	pages 1, 2
UP #7	7/1/12	page 2
UP #6	4/1/12	pages 1, 2
TN #95	3/1/11	Pages 1, 2
TN #93	1/1/10	pages 1, 2
Update (UP) #1	7/1/09	page 2

**3. Categorically  
Needy 300% of  
SSI**

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

Categorically Needy 300% of SSI		
Family Size Unit	2013 Monthly Amount	2012 Monthly Amount
1	\$2,130	\$2,094

**4. Medically  
Needy (Effective  
July 1, 2013)**

a. Group I		
Family Unit Size	Semi-annual	Monthly
1	\$1,803.47	\$300.58
2	2,296.23	382.70
b. Group II		
Family Unit Size	Semi-annual	Monthly
1	\$2,080.93	\$346.82
2	2,562.56	427.09
c. Group III		
Family Unit Size	Semi-annual	Monthly
1	\$2,705.21	\$450.87
2	3261.66	543.61

**5. ABD  
Categorically  
Needy**

For:

**ABD 80% FPL,  
QMB, SLMB, &  
QI without Social  
Security income;  
all QDWI; all  
MEDICAID  
WORKS,  
effective 1/24/13**

**ABD 80% FPL,  
QMB, SLMB, &  
QI with Social  
Security income,  
effective 3/1/13**

ABD 80% FPL	Annual	Monthly
1	\$9,172	\$766
2	12,408	1,034
QMB 100% FPL	Annual	Monthly
1	\$11,490	\$958
2	15,510	1,293
SLMB 120% of FPL	Annual	Monthly
1	\$13,788	\$1,149
2	18,612	1,551
QI 135% FPL	Annual	Monthly
1	\$15,512	\$1,293
2	20,939	1,745
QDWI and MEDICAID WORKS 200% of FPL	Annual	Monthly
1	\$22,980	\$1,915
2	31,020	2,585

M1470 Changes

<b>Changed With</b>	<b>Effective Date</b>	<b>Pages Changed</b>
TN #98	10/1/13	pages 9, 24
UP #9	4/1/13	pages 9, 16, 19, 20, 24, 43
UP #7	7/1/12	pages 19, 46-48
UP #6	4/1/12	pages 4, 9, 19, 20, 24, 26
TN #96	10/1/11	pages 3, 4, 7-9, 19, 22-24, 43
TN #95	3/1/11	pages 9, 19, 20, 23
TN #94	9/1/10	Table of Contents pages 1, 1a, 3, 3a, 11, 12, pages 19, 20, 24, 28, 31
TN #93	1/1/10	pages 9, 13, 19-20, 23, 43, 44
TN #91	5/15/09	Table of Contents pages 1-56 Appendix 1

**6. Medicare Part D Premiums**

The federal government sets a yearly “benchmark” premium for Medicare Part D Prescription Drug Plans (PDP). An individual who is eligible for Medicare and Medicaid is entitled to premium-free enrollment in a Medicare Part D basic prescription drug plan (PDP) with a “benchmark” premium. However, the individual may elect enrollment in a basic plan with a premium above the benchmark or in an enhanced plan, which offers additional benefits.

Individuals who enroll in a higher-premium basic plan or an enhanced plan are responsible for that portion of the premium attributable above the benchmark rate. When a full-benefit Medicaid enrollee is enrolled in a higher-premium PDP, the portion of the premium that remains the individual’s responsibility is an allowable deduction from patient pay.

The benchmark Medicare Part D premium for Virginia for 2013 is \$30.06.

**7. LTC Insurance**

**a. Deduct LTC premium in admission month only**

When an individual has an LTC insurance policy, the individual stops paying premiums beginning the month after he is admitted to LTC. The premium paid for the policy in the admission month can be deducted from the admission month’s patient pay only. The LTC insurance premium is not deducted from patient pay for the months following the admission month.

**b. LTC insurance benefits**

LTC insurance benefits are treated as TPL. If the individual receives the payment from the insurance company, the payment is not income for patient pay or eligibility determinations. The individual should assign it to the nursing facility. If the individual cannot do this, or the policy prohibits assignment, the LTC insurance payment should be given directly to the nursing facility. The facility should report the payment as a third party payment on its claim form.

If the provider is unable to accept payment directly from the individual, the individual must send the insurance payment to:

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

**C. Non-covered Medical/Dental Services**

Deductions for the cost of a patient’s medically necessary medical or dental services not covered by Medicaid, other insurance (such as Medicare), or another person are subtracted from income to determine patient pay. Some deductions for noncovered services must be approved by DMAS before they can be subtracted from the patient’s income.

Services that are covered by Medicaid in the facility’s per diem rate cannot be deducted from patient pay as a noncovered service. See M1470.230 C.3 for examples of services that are included in the facility per diem rate.

**1. Zero Patient Pay Procedures**

If deductions from patient pay cannot be allowed because the recipient has no income remaining after deducting the personal needs allowance, dependent child allowance(s) and health insurance premiums, or the recipient has no income available for patient pay, deny the request.

rate. When a full benefit Medicaid enrollee is enrolled in a higher-premium PDP, the portion of the premium that remains the individual's responsibility is an allowable deduction from patient pay.

The benchmark Medicare Part D premium for Virginia for 2013 is \$30.06.

**5. LTC Insurance**

**a. Deduct LTC premium in admission month only**

When an individual has an LTC insurance policy that covers long-term care services received in the home, the individual stops paying premiums beginning the month after he is admitted to the home-based LTC. The premium paid for the policy in the LTC admission month can be deducted from the admission month's patient pay only. The LTC insurance premium is not deducted from patient pay for the months following the admission month.

**b. LTC insurance benefits**

LTC insurance benefits are treated as TPL. If the individual receives the payment from the insurance company, the payment is not income for patient pay or eligibility determinations. The individual should assign it to the waiver services provider. If the individual cannot do this, or the policy prohibits assignment, the LTC insurance payment should be given directly to the provider. The provider should report the payment as a third party payment on its claim form.

If the provider is unable to accept payment directly from the individual, the individual must send the insurance payment to:

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

**C. Noncovered  
Medical/Dental  
Services**

Deductions for the cost of a patient's medically necessary medical or dental services not covered by Medicaid, other insurance (such as Medicare), or another person are subtracted from income to determine patient pay.

See M1470.430 B.3 for the procedures used to deduct Medicare Part D prescription drug co-pays for patients who have Medicare.

DMAS approval **is not** required for deductions of noncovered services from patient pay when the individual receives CBC services, regardless of the amount of the deduction.

**1. Zero Patient  
Pay  
Procedures**

If deductions from patient pay cannot be allowed because the recipient has no income remaining after deducting the personal maintenance allowance, dependent child allowance(s) and health insurance premiums, or the recipient has no income available for patient pay, deny the request.

Notify the patient or the patient's representative using the Notice of Action.

If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service has been approved, notify the patient or his authorized representative that the deduction for the new non-covered service will be made after the first noncovered service deductions are completed.

## M1480 Changes

<b>Changed With</b>	<b>Effective Date</b>	<b>Pages Changed</b>
TN #98	10/1/13	page 66
UP #9	4/1/13	pages 7, 18c, 66, 69, 70
UP #8	10/1/12	page 66
TN #97	9/1/12	pages 3, 6, 8b, 16 pages 20-25 Page 20a was deleted.
UP #7	7/1/12	pages 11, 14, 18c, 21 pages 32, 66, 67, 69
UP #6	4/1/12	pages 7, 18c, 66, 68, 69, 70
TN #96	10/1/11	pages 7, 14, 66, 71
UP #5	7/1/11	page 66
TN #95	3/1/11	pages 7-9, 13, 18a, 18c, 66, pages 69, 70
TN #94	9/1/10	pages 64, 66, 69, 70
TN #93	1/1/10	Table of Contents, page ii pages 3, 8b, 18, 18c, 20a pages 21, 50, 51, 66, pages 69, 70, 93 Appendix 4 was removed.
Update (UP) #1	7/1/09	page 66
TN # 91	5/15/09	pages 67, 68 pages 76-93

After eligibility is established, the usual reporting and notification processes apply. Send *written notice* for the month(s) during which the individual establishes Medicaid eligibility. MMIS will generate the “Notice of Obligation for LTC Costs” and it will be sent to the individual or his authorized representative.

**M1480.400 PATIENT PAY**

- A. Introduction** This section contains the policy and procedures for determining an institutionalized spouse’s (as defined in section M1480.010 above) patient pay in all covered groups.
- B. Married With Institutionalized Spouse in a Facility** For a married LTC patient with an institutionalized spouse in a facility, **NO** amount of the patient’s income is deducted for the spouse’s needs in the patient pay calculation.

**M1480.410 MAINTENANCE STANDARDS & ALLOWANCES**

- A. Introduction** This subsection contains the standards and their effective dates that are used to determine the community spouse’s and other family members’ income allowances. The income allowances are deducted from the institutionalized spouse’s gross monthly income when determining the monthly patient pay amount. Definitions of these terms are in section M1480.010 above.
- B. Monthly Maintenance Needs Standard**

\$1,938.75	7-1-13	
\$1,891.25	7-1-12	
- C. Maximum Monthly Maintenance Needs Allowance**

\$2,898.00	1-1-13	
\$2,841.00	1-1-12	
- D. Excess Shelter Standard**

\$581.63	7-1-13	
\$567.38	7-1-12	
- E. Utility Standard Deduction (SNAP)**

\$275	1 - 3 household members	10-1-13
\$345	4 or more household members	10-1-13
\$277	1 - 3 household members	10-1-12
\$348	4 or more household members	10-1-12

**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).

M21 Changes

Changed With	Effective Date	Pages Changed
TN # 98	10/1/13	Table of Contents pages 1-10 Pages 10a and 11-16 were deleted.
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

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## 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.

Effective with applications submitted October 1, 2013 and ongoing, initial eligibility for FAMIS is determined by local DSS, including DSS outstationed sites. 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.

*Case management and ongoing case maintenance will be handled by the local DSS for all applications submitted on or after October 1, 2013.*

*Case maintenance for FAMIS cases existing prior to October 1, 2013, will be handled by the FAMIS Central Processing Unit (CPU) until the first renewal beginning April 1, 2014 is due. Cases will be transferred to the local agency the month prior to each renewal month, and the local agency is to complete the renewal.*

#### B. Legal Base

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).

**D. Children enrolled in Medicaid on December 31, 2013 who lose Medicaid eligibility**

Children who were:

- enrolled in Medicaid on December 31, 2013, and
- who lose Medicaid eligibility **due to the elimination of earned income disregards** at their first Medicaid renewal in which Modified Adjusted Gross Income (MAGI)-based methodology is applied

*are protected by Section 2101(f) of the Affordable Care Act. They must be enrolled in FAMIS for one year, regardless of whether or not their income is within the FAMIS limit.*

## **M2120.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS**

**A. Introduction**

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

**B. M02 Requirements**

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

- citizenship and alienage requirements, including Afghan and Iraqi special immigrants in M0220.313 A, with the exceptions noted in *M2120.100 C* below.
- Virginia residency requirements;
- *Provision of a Social Security Number (SSN) or proof of application for an SSN.*
- Assignment of rights to payment for medical care from any liable third party is a condition of eligibility for the child;
- institutional status requirements regarding inmates of a public institution.

**C. M02 Exception: No Emergency Services Only Coverage**

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

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

## **M2120.200 HEALTH INSURANCE COVERAGE**

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

- 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. Family Member** When determining whether the child is eligible for coverage under a State Employee Health Insurance Plan, or whether the discontinuance of health insurance affects the child's eligibility, family member means:
- parent(s) with whom the child is living, and
  - a stepparent with whom the child is living if the stepparent claims the child as a dependent on his federal tax return.

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

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

Health benefit plan does not mean:

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

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

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

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

- have creditable health insurance coverage;

- have coverage under a group health plan (TRICARE, federal employee benefit plan, private group insurance such as Anthem, etc.) or Medicare;
- be a member of a family eligible for health benefits coverage under a State Employee Health Insurance Plan (a full-time, salaried, classified State employee or a permanent, full-time, salaried State education institution faculty member) [see Appendix 2 to this chapter], or

without good cause (see item E. below), have had creditable health insurance coverage terminated within 4 months prior to the month of application.

**D. Health Insurance Coverage Discontinued**

If the child's insurance coverage was discontinued by a parent or other individual who does NOT live with the child, the discontinuance of the insurance does NOT affect the child's eligibility for FAMIS.

A child is ineligible for FAMIS coverage if creditable health insurance coverage was terminated by a family member, as defined in M2120.200 B.3, above, without good cause within four months prior to the month for which eligibility is being established, unless the child was pregnant at the time of application.

**Example:** A child's health insurance was terminated without good cause in November. A FAMIS application was filed the following February. The child is ineligible for February because his health insurance was terminated within four months of November. He may be eligible in April because his insurance was terminated more than four months prior to April.

NOTE: For purposes related to FAMIS eligibility, a child is NOT considered to have been insured if health insurance coverage was provided under FAMIS Plus, Medicaid, HIPP, FAMIS, FAMIS Select, or if the insurance plan covering the child does not have a network of providers in the area where the child resides.

**E. Good Cause for Dropping Health Insurance**

The ineligibility period can be waived if there is good cause for the discontinuation of the health insurance. A parent, guardian, legal custodian, authorized representative, or adult relative **with whom the child lives** may claim to have good cause for the discontinuation of the child(ren)'s health insurance coverage. The local agency or the CPU will determine that good cause exists and waive the period of ineligibility if the health insurance was discontinued for one of the following reasons:

**1. Employment Stopped**

The family member who carried insurance changed jobs or stopped employment, and no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.

**2. Employer Stopped Contributing**

The employer stopped contributing to the cost of family coverage and no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.

3. **Insurance Company Discontinued Insurance** The child's coverage was discontinued by an insurance company for reasons of uninsurability, e.g., the child has used up lifetime benefits or the child's coverage was discontinued for reasons unrelated to payment of premiums. Verification is required from the insurance company.
4. **Discontinued By Family Member** Insurance was discontinued by a family member who was paying the full cost of the insurance premium under a COBRA policy AND no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
5. **Discontinued By Other Contributor** Insurance on the child is discontinued by someone other than the child (if 18 years of age), or, if under age 18, the child's parent or stepparent, e.g. the insurance was discontinued by the child's grandparent, aunt, uncle, godmother, etc. Verification is not required.
6. **Discontinued Because Cost Exceeds 10% of Income** Insurance on the child is discontinued because the cost of the health insurance premiums for all family members exceeds 10% of the family's GROSS monthly income or exceeded 10% of the family's GROSS monthly income at the time the insurance was discontinued.

Documentation of the amount of the monthly health insurance premiums for all family members is required. If the amount of the premium is less than or equal to 10% of the family's current gross monthly income, a declaration from the family will be requested as to the amount of gross monthly income received at the time the child(ren)'s insurance was discontinued.

- a. Use the applicant's month-prior-to-application gross income verification.
- b. Calculate 10% of the family's gross monthly income.
- c. Compare to total amount of monthly premiums.
- d. If monthly premium is less than or equal to 10% of current gross monthly income:
  - 1) Ask applicant "what was your family's gross income in the month in which you discontinued the health insurance (include all amounts of income received in that month)?" Document the applicant's statement in the record.
  - 2) Calculate 10% of the family's gross monthly income (in the month in which the insurance was discontinued).
  - 3) Compare to total amount of monthly premiums.
    - i If monthly premiums are less than or equal to 10% of this gross monthly income, good cause is NOT met. The children are not eligible for 4 months following the discontinuance of the insurance.

- ii If monthly premiums are more than 10% of this gross monthly income, good cause is met and there is no waiting period for FAMIS.

## M2130.100 FINANCIAL ELIGIBILITY

### A. Financial Eligibility

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

2. **Resources**                              Resources are not evaluated for FAMIS.

3. **Income**                                  **a. Countable Income**

*FAMIS uses the MAGI methodology for counting income contained in chapter M04. The source and amount of all income that is not excluded in chapter M04 must be verified.*

*To the maximum extent possible, income must be verified by information obtained from electronic data sources, such as the federal hub or another reliable data source, prior to requesting paystubs or employer statements.*

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

**b. Available Gross Income**

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

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

**c. Income Limits**

The FAMIS income limit is 200% of the FPL (see Appendix 1 to this subchapter) for the number of individuals in the FAMIS assistance unit.

**5. Spenddown**

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

**M2140.100 APPLICATION and CASE PROCEDURES**

**A. Application Requirements**

*The policies in subchapters M0120 and M0130 apply.*

**B. Eligibility Determination**

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

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

**C. Entitlement and Enrollment**

**1. Begin Date**

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

**2. Retroactive Coverage For Newborns Only**

Retroactive coverage is available ONLY 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 was born within the retroactive period and would have met all eligibility criteria during the retroactive period.

The following eligibility requirements must be met in order for a newborn child to be enrolled in FAMIS for retroactive FAMIS coverage:

- a. Retroactive coverage must be requested on the application form or in a later contact.
- b. The child’s date of birth must be within the three months immediately preceding the application month (month in which the agency receives the signed application form for the child).
- c. The child must meet all the FAMIS eligibility requirements during the retroactive period.

**3. FAMIS Aid Categories**

The aid categories (ACs) for FAMIS are:

AC	Meaning
006	child under age 6 with income > 150% FPL and ≤ 200% FPL
007	child 6 – 19 with income > 150% FPL and ≤ 200% FPL
008	child under age 6 with income > 143% FPL and ≤ 150% FPL
009	child 6 – 19 with income > 143% FPL and ≤ 150% FPL

**D. Notification Requirements**

The local DSS worker must send a Notice of Action on Medicaid and FAMIS to the family informing them of the action taken the application. The notice must include the eligibility determination for both Medicaid and FAMIS.

If the child is ineligible for both Medicaid and FAMIS, the family must be sent a notice that the child is not eligible for either program, *and a referral to the Health Insurance Marketplace must be made and the child must be given the opportunity to have a Medicaid medically needy evaluation if he is under 18 years.* Along with the notice, send the *Application for Assistance* to the family and advise them that if the signed application is returned within 10 calendar days, the original application date will be honored.

**E. Transitions Between Medicaid And FAMIS (Changes and Renewals)**

When excess income for *Medicaid* causes the child’s eligibility to change from *Medicaid* to FAMIS, the new income must be verified using *an electronic data source such as the federal Hub or another reliable data source prior to requesting paystubs or employer statements.*

**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.

Once a child is enrolled in FAMIS, *the local agency worker* will identify if the family is interested in more information about FAMIS Select. Families who have access to health insurance will receive information from DMAS about the benefits of enrolling in the FAMIS Select component of FAMIS and information about how to participate in the program. Participation in the FAMIS Select component is voluntary.

**G. 12-Month  
Continuous  
Coverage**

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

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.

**M2150.100 REVIEW OF ADVERSE ACTIONS**

**A. Case Reviews**

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

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

M22 Changes

<b>Changed With</b>	<b>Effective Date</b>	<b>Pages Changed</b>
TN #98	10/1/13	Table of Contents pages 1-7 Appendix 1 Pages 8-10 were deleted.
UP #9	4/1/13	Appendix 1
UP #8	10/1/12	pages 2, 3 page 3a deleted
UP #7	7/1/12	pages 2, 3
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	pages 3, 3a
TN #95	3/1/11	pages 4-6 Appendix 1
UP #4	7/1/10	page 10
TN #94	9/1/10	page 3
UP #3	3/01/10	page 2
TN #93	1/1/10	pages 2-10
UP #2	8/24/09	page 3
Update (UP) #1	7/1/09	pages 1, 2, 7 Appendix 1, page 1

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## M2200.000 FAMIS MOMS

### M2210.100 FAMIS MOMS GENERAL INFORMATION

#### A. Introduction

The 2005 Appropriations Act directed the Department of Medical Assistance Services (DMAS) to amend the Family Access to Medical Insurance Security Plan (FAMIS) and expand medical coverage to uninsured pregnant women who are ineligible for Medicaid and have income in excess of the Medicaid limits, but whose family income is less than or equal to 210% of the federal poverty level (FPL). An eligible woman will receive coverage through her pregnancy and 60 days following the end of the pregnancy.

***FAMIS MOMS will no longer accept new applications after December 31, 2013. A women who is enrolled in FAMIS MOMS based on applications filed on or before December 31, 2013 will continue to receive coverage through the end of her post partum period.***

***Cases processed from October 1, 2013 through December 31, 2013 will be maintained at the local department of social services.***

*Beginning with applications filed January 1, 2014 and later, pregnant women with countable income in excess of the Medicaid income limit for pregnant women will given the opportunity to have a medically needy (MN) Medicaid evaluation and be referred to the Health Insurance Marketplace for evaluation for the Advance Premium Tax Credit (APTC).*

Eligibility for FAMIS MOMS is determined by local departments of social services (LDSS), including LDSS outstationed sites. Pregnant women found eligible for FAMIS MOMS receive the same benefits as Medicaid pregnant women.

Eligible women are enrolled for benefits effective the first day of the application month if all eligibility requirements are met in that month. There is no retroactive coverage in FAMIS MOMS. *Case maintenance for applications filed on October 1, 2013 through December 31, 2013 will be provided by the local DSS. Cases that were active prior to October 1, 2013 will continue to be maintained by the FAMIS Central Processing Unit.*

#### B. Policy Principles

FAMIS MOMS covers uninsured low-income pregnant women who are not eligible for Medicaid due to excess income, and whose countable income is less than or equal to 210% of the FPL.

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

- she is not eligible for Medicaid and has income in excess of the Medicaid limits;
- she is a resident of Virginia;
- she is uninsured;

- she is **not** a member of a family eligible for health benefits coverage under the State Employee Health Insurance Plan on the basis of a family member's employment with a State agency (see Appendix 3 to Chapter M21 for a list of state agencies);
- she is not an inmate of a public institution;
- she is **not** an inpatient in an institution for mental diseases; and
- she has countable family income less than or equal to 210% FPL.

## M2220.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

### A. Policy

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

### B. M02 Applicable Requirements

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

- citizenship or alien status;
- Virginia residency requirements;
- *Provision of a Social Security Number (SSN) or proof of application for an SSN;*
- assignment of rights;
- application for other benefits;
- institutional status requirements regarding inmates of a public institution.

### C. M02 Exception: No Emergency Services Only Coverage

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

**D. FAMIS MOMS  
Covered Group  
Requirements**

- 1. Declaration of Pregnancy** *The woman's pregnancy is declared on the application and requires no further verification unless the agency has received conflicting information. See M0310.124 for the definition of a pregnant woman.*
- 2. Must be Uninsured** *The pregnant woman must be uninsured; that is, she must not be covered under any creditable health insurance plan offering hospital and medical benefits. If a pregnant woman has creditable health insurance that does not cover pregnancy, labor and/or delivery services, the pregnant woman is ineligible for FAMIS MOMS because she is insured.*
- 3. IMD Prohibition** *The pregnant woman cannot be an inpatient in an institution for mental diseases (IMD).*
- 4. State Employee Health Benefits Prohibition** *A pregnant woman is ineligible for FAMIS MOMS if she is eligible for health insurance coverage under any Virginia State Employee Health Insurance Plan on the basis of her or a family member's employment with a State agency. A woman who cannot be enrolled until an open enrollment period is not prohibited from FAMIS MOMS coverage.*

See Appendix 2 to Chapter M21 for a list of state government agencies.

**M2220.200 HEALTH INSURANCE COVERAGE**

- A. Introduction** *The intent of FAMIS MOMS is to provide health coverage to low-income uninsured pregnant women. A pregnant woman who has creditable health insurance coverage is not eligible for FAMIS MOMS.*

**B. Definitions**

- 1. Creditable Coverage** *For the purposes of FAMIS MOMS, creditable coverage means coverage of the individual under any of the following:*
  - church plans and governmental plans;
  - health insurance coverage, either group or individual insurance;
  - military-sponsored health care;
  - a state health benefits risk pool;
  - the federal Employees Health Benefits Plan; Medicare;

- a public health plan; and
- any other health benefit plan under section 5(e) of the Peace Corps Act.

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

**2. Employer-Sponsored Dependent Health Insurance**

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

**3. Family Member**

ONLY when determining whether the pregnant woman is eligible for coverage under a State Employee Health Insurance Plan, “family member” means the pregnant woman’s spouse with whom she lives, or her parent(s) with whom she lives when the pregnant woman is unmarried and is under age 23. “Family member” includes the pregnant woman’s stepparent with whom she is living if the pregnant woman is under age 21 and her stepparent claims the pregnant woman as a dependent on his federal tax return. State employee health benefits are available to the state employee’s unmarried **dependent** child or stepchild under age 23 years.

**4. Health Benefit Plan**

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

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

Health benefit plan does NOT mean:

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

**5. Insured**

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

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

**C. Policy**

- 1. Must be Uninsured** A nonfinancial requirement of FAMIS MOMS is that the pregnant woman be uninsured. A pregnant woman **cannot**:
- have creditable health insurance coverage;
  - have coverage under a group health plan (TRICARE, federal employee benefit plan, private group insurance such as Anthem, etc.) or Medicare;
  - be a member of a family eligible for health benefits coverage under a State Employee Health Insurance Plan (a full-time, salaried, classified State employee or a permanent, full-time, salaried State education institution faculty member) [see Appendix 3 to chapter M21].
- 2. Prior Insurance** Prior insurance coverage is not a factor as long as the pregnant woman is uninsured during the month for which FAMIS MOMS eligibility is being determined.

**M2220.300 NO CHILD SUPPORT COOPERATION REQUIREMENTS**

- A. Policy** There are no requirements for FAMIS MOMS applicants or recipients to cooperate in pursuing support from an absent parent.

**M2230.100 FINANCIAL ELIGIBILITY**

**A. Financial Eligibility**

- 1. Income** *Modified Adjusted Gross Income (MAGI) methodology is used for the FAMIS MOMS income evaluation. Use the policies and procedures contained in Chapter M04.*
- The FAMIS MOMS income limit is 210% of the FPL (see Appendix 1 to this chapter) for the number of individuals in the *pregnant woman's MAGI household composition as defined in M04. The pregnant woman is counted as herself plus the number of children she is expected to deliver.*
- 2. Resources** Resources are not evaluated for FAMIS MOMS.
- 3. No Spenddown** Spenddown does not apply to FAMIS MOMS. If countable income exceeds the FAMIS MOMS income limit, the pregnant woman is not eligible for the FAMIS MOMS program. She must be *referred to the Health Insurance Marketplace and be given the opportunity to have a MN Medicaid evaluation.*

## M2240.100 APPLICATION and CASE PROCEDURES

- A. Application Requirements** The policies in subchapters M0120 and M0130 apply.
- B. Eligibility Determination**
- 1. Pregnant Teenager Under Age 19** Process an application by a pregnant teenager under age 19 in the following order:
    - a. *Determine* eligibility for Medicaid as a child under age 19; if not eligible because of excess income, go to item b.
    - b. *Determine* eligibility for Medicaid as a pregnant woman; if not eligible because of excess income, go to item c.
    - c. *Determine* eligibility for FAMIS; if not eligible because of excess income, go to item d.
    - a. *Determine* eligibility for FAMIS MOMS if the application was filed on or before December 31, 2013. To complete the eligibility determination, the FAMIS MOMS nonfinancial requirements in M2220.100 and the financial requirements in M2230.100 must be met. If she is not eligible for FAMIS MOMS because of excess income, she must be *referred to the Health Insurance Marketplace* and given the opportunity to have a MN evaluation completed.
  - 2. 10-day Processing** Applications for pregnant women must be processed as soon as possible, but no later than 10 working days from the date the signed application was filed. If all necessary verifications are not received, the application continues to pend until the 45 day processing time limit is met.
  - 3. Notice Requirements** The applicant/recipient must be notified in writing of the required information and the deadline by which the information must be received.

The agency must have all necessary verifications within 10 working days in order to determine eligibility. If all verifications are not received within 10 working days, *written notice* must be sent to the applicant. The *notice* must state why action on the application could not be taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 calendar days to submit the verification.

Once all necessary verifications for the pregnant woman are received, an eligibility determination must be made immediately and the applicant must be notified of the decision.
- C. Case Setup Procedures for Approved Cases** *For applications filed between October, 1, 2013 and December 31, 2013, a woman enrolled as FAMIS MOMS may have the same base case number in the Virginia Medicaid Management Information System (MMIS) as Medicaid enrollees.*

**D. Entitlement and Enrollment**

1. **Begin Date of Coverage** Pregnant women determined eligible for FAMIS MOMS are enrolled for benefits in the Virginia Medicaid Management Information System (MMIS) effective the first day of the application month, if all eligibility requirements are met in that month.
2. **No Retroactive Coverage** There is no retroactive coverage in the FAMIS MOMS program.
3. **Aid Category** The FAMIS MOMS aid category (AC) is “005.”

**E. Notification Requirements**

*Written* notice must be sent to the pregnant woman informing her of the action taken on the application. The notice must include the eligibility determination results for both Medicaid and FAMIS MOMS, *as well as a referral to the Health Insurance Marketplace, if applicable.*

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

**F. Application Not Required for Newborn**

The newborn child born to a FAMIS MOMS enrollee is deemed eligible for FAMIS coverage until his first birthday *and enrolled in AC 010.* A Medical Assistance application is not required until the month in which the child turns age 1. *Follow the procedures for enrolling a newborn in M0330.802.*

**M2250.100 REVIEW OF ADVERSE ACTIONS**

An applicant for FAMIS MOMS may request a review of an adverse determination regarding eligibility for FAMIS MOMS. FAMIS MOMS 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 MOMS program are exhausted.

<b>FAMIS MOMS 210% FPL INCOME LIMITS ALL LOCALITIES  EFFECTIVE 10/01/13</b>	
<b># of Persons in FAMIS MOMS Household</b>	<b>Monthly Limit</b>
2	\$2716
3	3419
4	4123
5	4826
6	5530
7	6233
8	6937
Each additional, add	704