

May 1, 2014

## **MEDICAID MANUAL – VOLUME XIII**

### **POLICY UPDATE #10**

The following acronyms are used in this broadcast:

- ABD – Aged, Blind or Disabled
- FAMIS – Family Access to Medical Insurance Security Plan
- FPL – Federal Poverty Level
- HIM – Health Insurance Marketplace
- LDSS – Local Department of Social Services
- LTC – Long-term Care
- MAGI – Modified Adjusted Gross Income
- MMIS – Medicaid Management Information System
- MSP – Medicare Savings Programs
- QDWI – Qualified Disabled Working Individuals
- QI – Qualified Individuals
- QMB – Qualified Medicare Beneficiaries
- SLMB – Special Low Income Medicare Beneficiaries
- SPARK – Services, Programs, Answers, Resources, Knowledge
- SSI – Supplemental Security Income
- UP – Update
- VaCMS – Virginia Case Management System
- VDSS – Virginia Department of Social Services

Update #10 of the Medicaid Eligibility Manual contains revised, clarified and updated policies. Unless otherwise noted below, the changes are effective with coverage on or after May 1, 2014.

#### Revised Policies

UP #10 contains revisions to several policies. Revisions in chapter M01 direct local departments of social services to process certain individuals, who are not subject to MAGI methodology, outside the VaCMS eligibility determination system and to enroll them directly into MMIS. Additionally, the revisions in chapter M01 provide directions to refer cases processed outside the VaCMS eligibility determination system to the HIM through the use of VaCMS. Revisions in chapter M04 address how LDSS evaluate former foster care children under age 26. Additionally, the revisions in M04 provide clarifications on how the social security benefits of children are counted. Revisions in Chapter 15, addresses renewals processed outside of VaCMS for Non-MAGI individuals. It also provides instruction on how to refer denied cases processed outside of the VaCMS eligibility determination system to the HIM through the use of VaCMS.

### Clarified Policies

Several policies were clarified in UP #10, including Hospital Presumptive Eligibility and when an individual may be enrolled in Medicaid presumptively by approved hospital staff.

### Annual Updates

UP #10 also contains the SSI-based income limits and standards for 2014. UP #10 contains the Medicare premium amounts and MSP resource limits for 2014. These figures were posted in Broadcast 8364 and became effective January 22, 2014.

The Medicaid and FAMIS income limits that are based on a percentage of the FPL are also included in UP #10. These income limits were announced in Broadcast 8364 and were effective January 22, 2014 for individuals who do not receive Social Security benefits and all MEDICAID WORKS and QDWI enrollees. The income limits were effective March 1, 2014 for Social Security beneficiaries in the Individuals with Income  $ABD \leq 80\%$  FPL, QMB, SLMB, and QI covered groups.

UP #10 is available on SPARK and the VDSS public web site. The changes to the manual are as follows:

<b>Pages Changed</b>	<b>Significant Changes</b>
Subchapter M0120 pages 11, 16-20	On pages 11, 16, 17, 18, 19, and 20, revised and clarified the policy regarding presumptive eligibility. Pages 11a and 11b were deleted and pages 19 and 20 were added.
Subchapter M0130	On pages 8, 9, 10, 11, and 12, fixed hyperlinks and clarified the policy regarding enrolling individuals who are not subject to MAGI methodology and are enrolled directly into the MMIS. Also revised and clarified procedures for entering individuals who are not eligible for full Medicaid into VaCMS so that they could be referred to the HIM for consideration of APTC
Subchapter M0310 page 29	On page 29, revised the policy on foster care children in Independent Living.
Subchapter M0330 Pages 5, 8	On pages 5 and 8, revised the policy on foster care children in Independent Living.
Subchapter M0410 pages 8-14 Appendices, 1, 2, 6, and 7	On page 8, added former foster care children under 26 as a group not evaluated based on MAGI methodology. On page 12 and 13, revised and clarified countable income, noncountable income, and income exceptions. On page 14, added the steps for calculating MAGI. Appendices 1, and 2 reflect income limit changes. Appendix 7, which addresses the treatment of different income types under MAGI policy, was added.
Subchapter M0810 page 2	On page 2, updated the ABD income limit changes that went into effect 1/22/14 and 3/1/14.
Subchapter M1510	On page 7, 8, 8a, revised and clarified the procedures regarding hospital presumptive eligibility

<b>Pages Changed</b>	<b>Significant Changes</b>
Subchapter M1520 pages 8-13, 15	On page 8, revised the procedures on renewals for individuals who are not subject to MAGI methodology and referring these individuals to the HIM. On page 9, provided the link to SPARK where renewal forms for Non-MAGI individuals are found. On page 11, addressed the procedures for the receipt and processing of the Administrative Renewal forms or other paper renewal forms and necessary verifications. On page 15, revised policy stating that telephone interview-based renewals will not be used for QI renewals completed in 2014 and added policy on foster care children turning 18.
Chapter M21 pages 1, 2 Appendix 1, page 1	On page 1, clarified that case maintenance for FAMIS cases existing prior to October 1, 2013, will be handled by the Advanced Resolution Center staff located at the Cover Virginia Call Center until the first renewal beginning April 1, 2014 is due. On page 2, clarified the policy regarding children who were enrolled in Medicaid on December 31, 2013 and who lose Medicaid due to excess income at their first Medicaid renewal in which MAGI methodology was applied. These children 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. In Appendix 1, updated the FAMIS income limits that became effective 1/22/14.

Questions about information contained in UP #10 should be directed to Stephanie Sivert, Manager, Medical Assistance Programs, at 804-726-7660 or [stephanie.sivert@dss.virginia.gov](mailto:stephanie.sivert@dss.virginia.gov).

## M0120 Changes

<b>Changed With</b>	<b>Effective Date</b>	<b>Pages Changed</b>
UP #10	5/1/14	Table of Contents pages 11, 16-18 Pages 11a and 11b were deleted. Pages 19 and 20 were added.
TN #99	1/1/14	page 11 Pages 11a and b were added.
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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### **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.

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.

- 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. 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 *calendar* 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.

**C. Hospital  
Presumptive  
Eligibility (HPE)**

The Affordable Care Act requires states to allow *approved* hospitals to enroll patients who meet certain Families & Children covered groups in Medicaid for a limited time on the basis of their presumptive eligibility. The Department of Medical Assistance Services (DMAS) is responsible coordinating the *HPE agreement* with hospitals, *providing training and technical assistance*, and monitoring the appropriate use of the *HPE* enrollments. *HPE is not available to individuals who are already enrolled in Medicaid or FAMIS.*

**a. HPE Enrollment**

To enroll an individual in HPE coverage, the hospital obtains basic demographic information about the individual, as well as attestations from the individual of *Virginia residency including locality, U.S. citizenship or lawful presence, Social Security number, household size and income, and requirements related to covered group.* No verifications are required.

Hospital staff *determines eligibility and enrolls eligible individuals in HPE* via the provider portal in the *Medicaid Management Information System (MMIS).* The enrollment is not entered in the Virginia Case Management System (VaCMS). The individual is enrolled in the appropriate Aid Category (AC) for his covered group. Once the hospital receives confirmation of the HPE enrollment, the hospital is responsible for notifying the individual of his HPE coverage and that he must file a full MA application by the end of the following month *in order* for his continued eligibility to be *determined and his coverage to remain uninterrupted.*

The HPE covered groups and the ACs are:

- Pregnant Women (AC 035)
- Child Under Age 19 (AC 064)
- Low Income Families with Children (LIFC) (065)
- Former Foster Care Children Under Age 26 (077)
- Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) (067)
- *Plan First (084) (effective May 1, 2014).*

Individuals enrolled on the basis of HPE receive a closed period of coverage *beginning with the date of the HPE determination through the last day of the following month or the date MA eligibility is determined by an LDSS, whichever comes first. Enrollment in HPE is not based on the date of the hospital admission or on the first day of the month.*

While enrolled as HPE, *individuals in the Child Under Age 19 Years, LIFC, Former Foster Care Children Under Age 26 and BCCPTA covered groups*



*receive full Medicaid benefits. HPE pregnant women coverage (AC035) is limited to outpatient prenatal services; labor and delivery are not covered under HPE for AC 035. HPE coverage for Plan First enrollees is limited to family planning services only. Transportation to receive covered medical services is covered for all HPE enrollees.*

Enrollment as HPE is limited to one HPE period per calendar year for all individuals other than pregnant women. For pregnant women, enrollment is limited to one HPE eligibility period per pregnancy.

#### **b. LDSS Procedures**

*The MMIS User's Guide for DSS, available at [http://dmasva.dmas.virginia.gov/Content\\_pgs/dss-elgb\\_enrl.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/dss-elgb_enrl.aspx), contains procedures for completing the MA enrollment of an individual who was enrolled in HPE at the time of application.*

##### **1) Application Processing**

For MA coverage to continue beyond the following month, the individual must submit a full MA application to the LDSS. *While the LDSS does not determine eligibility for HPE, when an application is received and pended in VaCMS, the individual's coverage in the HPE AC must be extended by the eligibility worker, as necessary, while the application is processed. The worker must enter data directly into MMIS to extend the coverage; MMIS will calculate the 45 day period.*

**Example:** *Mary Smith is enrolled in HPE coverage in AC 065 (LIFC) by the hospital for the period of 3-5-14 through 4-30-14. On 4-20-14, she submits an MA application to her LDSS. The 45<sup>th</sup> processing day will fall after the HPE End date; therefore the worker reinstates HPE coverage in MMIS in AC 065, using the MA application date. The effective date of the reinstatement is 5-1-14, the day after the HPE coverage ends. MMIS will automatically populate the end date with 6-3-14, the MA application date plus 44 days.*

*Note: the 10-working day processing standard applies to applications submitted by pregnant women and BCCPTA individuals enrolled in HPE.*

##### **2) Applicant is Eligible**

*Full MA applications submitted by HPE enrollees are subject to the standard eligibility and entitlement policies. When an individual is determined eligible for MA coverage, his MA coverage under the appropriate MA AC includes any days to which he is entitled that are not already covered by HPE. If the individual submitted the MA application in the same month HPE coverage began and HPE began on any day other than the first day of the month, his MA coverage begins the first day of that month and the eligibility worker enrolls him in a closed period of coverage in the appropriate MA AC beginning with the first day of the month and ending the day before the HPE begin date.*

*If an individual who is eligible for ongoing coverage was enrolled in a full-benefit HPE covered group, his ongoing coverage is reinstated in the appropriate MA AC beginning the first day of the month after the effective date of the HPE coverage cancellation.*

**Example:** *Billy Jones is a child enrolled in HPE coverage (AC 064) by the hospital for the period of 2-14-14 through 3-31-14. His parent submits an MA application on 2-18-14. The parent did not indicate receipt of any medical services in the retroactive period. Billy is determined eligible for Medicaid coverage in AC 092.*

*The child's Medicaid entitlement begins with the month of the MA application. The worker enrolls him using AC 092 in a closed period of coverage from 2-1-14 through 2-13-14, the day before the begin date of HPE coverage. The worker also reinstates the child's ongoing coverage beginning 4-1-14.*

*If an individual who was enrolled in HPE in a partial-benefit covered group, (i.e. pregnant women or Plan First) is determined eligible for full MA coverage in the period covered by HPE, cancel HPE coverage retroactively and reinstate in full coverage for the retroactive months and ongoing, if eligible.*

**Example:** *Jane Scott was enrolled in HPE AC 035 (pregnant women) for the period of 3-13-14 through 4-30-14. She filed an MA application on 3-28-14. Based on the expected delivery date on the application, she was also pregnant during the month prior to her HPE determination. The worker determines that she was eligible for Medicaid as a pregnant woman in AC 091 and completes a retro cancel reinstate, using Cancel Reason 024, beginning 2-1-14.*

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

### 3) Applicant is Not Eligible

If the applicant is determined to not be eligible for ongoing MA coverage, *his entitlement to HPE coverage ends. Cancel the HPE coverage effective the current date (i.e. day of the eligibility determination), using Cancel Reason 008.*

Send a *Notice of Action* indicating that the individual's MA application was denied and that his HPE coverage was cancelled with the effective date. *Because* the individual receives notice of the HPE coverage period from the hospital at the time of the HPE enrollment, advance notice of the HPE cancellation is not required. *There are no appeal rights for HPE.*

The individual's HPE coverage is valid regardless of whether or not the individual is eligible for ongoing coverage; do not refer the case to the DMAS Recipient Audit Unit.

#### 4) MA Application Not Submitted

If the person does not submit an MA application prior to the end of the HPE coverage period, his HPE coverage will be automatically terminated. No involvement *or notice* from the LDSS is required.

### 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>
UP #10	5/1/14	Table of Contents pages 8-12 Page 13 was added.
TN #99	1/1/14	pages 10-12 Page 13 was added.
TN #98	10/1/13	Table of Contents pages 1-12
UP #9	4/1/13	page 3, 5
UP #7	7/1/12	pages 4, 5
TN #96	10/1/11	pages 6-8
TN #95	3/1/11	page 8
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Update (UP) #2	8/24/09	pages 8, 9

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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

When an MA application is received by the LDSS agency, the agency must determine through a “file clearance” search of the eligibility and enrollment systems whether or not the individual already has Medicaid or FAMIS coverage.

With the exception of individuals enrolled on the basis of presumptive eligibility (PE), applications for MA submitted by individuals who already have an application recorded or who are currently active are denied as duplicate applications.

Applications submitted by individuals currently enrolled as PE or as Newborn Children are not duplicate applications because they were initially enrolled without filing a full MA application. See M0120.300 A.5 for more information.

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.

If an applicant indicates that he has been receiving MA (Medicaid or Children's Health Insurance Program) coverage in another state prior to moving to Virginia, instruct him to contact his eligibility worker there and request that his coverage be cancelled, if he has not already done so. He is no longer considered a resident of the other state once he has moved to and intends to reside in Virginia and is not entitled to receive services paid for by the other state's MA program. As long as the individual meets the residency requirement per M230 and his cancellation in the other state is verified, he may be enrolled in Virginia Medicaid beginning the same month that his coverage ends in the other state.

**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.

*Applications for individuals who are not subject to MAGI methodology are processed outside the eligibility system, and eligible individuals must be enrolled directly into the MMIS. These individuals are:*

- *aged, blind or disabled individuals who have Medicare,*
- *Families and Children individuals in long-term care,*
- *Supplemental Security Income Medicaid enrollees,*
- *Auxiliary Grant recipients, and*
- *children in Title IV-E foster care or adoption assistance.*

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. Ineligible for Full Benefits – Referral to the HIM**

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. *If the individual's application was not processed in VaCMS, the application must be entered in VaCMS in order for the HIM referral to be made.*

**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.

## M0310 Changes

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

## M0310.115 FOSTER CARE

### A. Definition

Foster Care provides maintenance and care for children whose custody is held by:

- a local board of social services;
- a licensed private, non-profit child placement agency;
- the Department of Juvenile Justice; or
- the child's parent(s), under a non-custodial agreement.

Federal regulations define "foster care" as "24-hour substitute care for children placed away from their parents or guardians and for whom the State agency has placement and care responsibility" (45 C.F.R. §1355.20). Transfer of the legal custody of the child is not a component when determining if a child is considered to be in foster care. The federal definition is based upon the child being placed outside of the home and who has placement and care responsibility for the child. If a child is placed outside of the home and LDSS is the case manager with placement and care responsibility, then the federal government considers the child to be in foster care. For the federal government, the term "placement and care" means that LDSS is legally accountable for the day-to-day care and protection of the child through either a court order or a voluntary placement agreement.

#### 1. Custody

Custody may be given to an agency by the court or may be retained by the parent(s) or guardian when a non-custodial agreement is involved. If custody is retained by the parent under a parental agreement with the Community Policy and Management Team (CPMT), the child is NOT in foster care.

#### 2. Child Placing Agency

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

#### 3. Independent Living

A foster care child *under age 18* who is in an Independent Living arrangement and receives full or partial support from a local social services agency continues to meet the foster care definition and may be eligible in the covered group of Individuals Under Age 21.

*A child age 18 and over who is in an Independent Living arrangement with a local department of social services no longer meets the definition of a foster care child and may be eligible for Medicaid in the covered group of Former Foster Care Children Under Age 26 Years group. See M0330.109*

**4. Non-custodial and Parental Agreements**

**a. Non-custodial Agreement**

A non-custodial agreement is an agreement between the child's parent or guardian and the local Board of Social Services. The parent(s) or guardian retains legal custody of the child. The social services agency agrees to provide financial assistance and/or services to the child, such as placement in and payment for residential facility services.

Non-custodial agreements are used when LDSS serves as the case manager and has placement and care responsibilities to place a child outside of his home for treatment.

**Children with non-custodial agreements are considered to be in foster care for Medicaid eligibility purposes.**

**b. Parental Agreement**

A parental agreement is an agreement between the child's parent or guardian and an agency **other than DSS** which is designated by the CPMT. The other agency designated by the CPMT has placement and care responsibility for the child and agrees to provide financial assistance and/or services to the child, such as placement in and payment for residential facility services.

Parental agreements are used when an agency other than LDSS is designated by the CPMT as case manager and the child is placed outside of the home for treatment.

**Children with parental agreements ARE NOT considered to be in foster care for Medicaid eligibility purposes.**

**c. Placement**

Federal Title IV-E funds can only be claimed if LDSS has placement and care responsibility for the child **and** the child is placed by LDSS outside the child's home. If the LDSS has placement and care responsibility for the child and the child is placed in the child's home, the child is not eligible for Title IV-E funds and is a Non-IV-E foster child for Medicaid eligibility purposes.

**5. Department of Juvenile Justice**

A child in the custody of the Virginia Department of Juvenile Justice or who is the responsibility of a court is a "Department of Juvenile Justice (DJJ) child."

**B. Procedures**

**1. IV-E Foster Care**

Children who are eligible for and receive Title IV-E (AFDC-FC) foster care maintenance payments are IV-E Foster Care for Medicaid eligibility purposes. 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.

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M0330 Changes

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UP #10	5/1/14	Pages 5, 8, 9
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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

- 1. Non IV-E Foster Care** Children who meet the foster care definition in M0310.115 but do not receive a IV-E maintenance payment are “individuals in foster homes, private institutions or independent living arrangements for whom a public or private nonprofit child-placing agency is assuming full or partial financial responsibility.” This group also includes DJJ children.

**a. Children Living In Public Institutions**

Non-IV-E foster care 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.

When these children are placed in public residential institutions, the facility must not have capacity for more than 16 children (see M0280).

**b. Child in Independent Living Arrangement**

A child *under age 18* in an independent living arrangement is eligible for Medicaid in this covered group if the child is receiving services from the local social services agency.

*A child age 18 and over who is in an Independent Living arrangement with a local department of social services no longer meets the definition of a foster care child and may be eligible for Medicaid in the covered group of Former Foster Care Children Under Age 26 Years group. See M0330.109*

- 2. Non-IV-E Adoption Assistance** Children under age 21 who meet the adoption assistance definition in M0310.102 for whom a Non-IV-E adoption assistance agreement between the local department of social services (LDSS) and the adoptive parent(s) is in effect are “individuals in adoptions subsidized in full or in part by a public agency.” If the child receives a Non-IV-E adoption assistance payment, or if the child was adopted under an adoption assistance agreement and is not eligible as a IV-E Adoption Assistance child, then the child meets the “Non-IV-E adoption assistance” definition.

Non IV-E adoption assistance children who have “special medical needs” have additional requirements. See section M0330.805 for the Special Medical Needs Adoption Assistance requirements.

- 3. In ICF or ICF-MR** Children under age 21 who are patients in either an ICF or ICF-MR meet the classification of “individuals in an ICF or ICF-MR” in the Individual Under Age 21 covered group.

**C. Assistance Unit**

- 1. Non-IV-E Foster Care Children (Includes DJJ)** The child is an assistance unit of one effective the date the child is removed from the home and placed in foster care. Each child in foster care is evaluated as a separate assistance unit, even if the child is living with his/her siblings in a foster care home.

A foster care or DJJ child continues to be a single person unit during a trial visit in his own home. A “trial visit” is no longer than six months for this section’s purposes.



**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 in the custody of a local department of social services in Virginia 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.

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

**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 local department of social services in Virginia 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.

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M04 Changes

Changed With	Effective Date	Pages Changed
UP #10	5/1/14	Table Contents pages 2, 3, 5, 6, 10-15 Appendices 1, 2 and 6 Appendix 7 was added.
TN #99	1/1/14	pages 2, 5, 6, 8, 14, 15 Appendix 6

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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.

**1. 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. Plan First.

**2. 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).

3. **Special Medical Needs Adoption Assistance (AA) Children**      *Special Medical Needs AA children are subject to modified MAGI methodology for their Medicaid eligibility determinations. Special Medical Needs AA children are in their own household apart from parents and siblings. Parents' and siblings' income is not counted for these children.*

## 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 tax filers 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.

- 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.

Except for *Special Medical Needs* AA children, 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.

***A Special Medical Needs AA child is in his own household with no parents or siblings.***

**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.
- the tax dependent is a *Special Medical Needs* AA child.

**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.  
Exception: *A Special Medical Needs* AA child is in his own household with no parents or siblings.

- 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. Exception: *A Special Medical Needs AA child is in his own household with no parents or siblings.*
- 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



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 (*also see M0440.100 D and M04, Appendix 7*).

- 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 *income*, but is not required to file income taxes because his income is below the tax filing threshold, will not have his *income* counted in his own eligibility determination. *The income* must be counted if he is also the parent of a dependent child whose eligibility is determined using non-filer rules.
- h. *When a parent or stepparent is included in the child's household, the child's Social Security benefits are **not** countable for his eligibility determination unless the child is required to file taxes.*
- i. *Alimony **paid** to a separated or former spouse outside the home is deducted from countable income.*
- j. *Interest paid on student loans is deducted from countable income.*
- k. *Foreign income and interest, including tax-exempt interest, are counted.*

**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**

*For a child's eligibility determination, when at least one parent or stepparent is included in the child's household, the child's Social Security benefits of any type are **not** countable unless the child is required to file taxes because the tax-filing threshold is met.*

*If no parent is included in the child's household and the child's eligibility is being determined based on his own income alone, all of the child's Social Security benefits are counted.*

*Social Security benefits received by the parent are countable for both the parent's and child's eligibility determinations.*

**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.

**D. Steps for  
Calculating MAGI**

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

For tax filers whose income is verified in the Hub, the steps below are not followed: no MAGI calculation is required.

<p><b>Adjusted Gross Income (AGI)</b></p> <p>Line 4 on Internal Revenue Service (IRS) Form 1040 EZ</p> <p>Line 21 on IRS Form 1040A</p> <p>Line 37 on IRS Form 1040</p>	<p><b>Include:</b></p> <ul style="list-style-type: none"> <li>• Wages, salaries, tips, etc</li> <li>• Taxable interest</li> <li>• Taxable amount of pension, annuity or Individual Retirement Account (IRA) distributions and Social Security benefits</li> <li>• Business Income, farm income, capital gain, other gains (or loss)</li> <li>• Unemployment Compensation</li> <li>• Ordinary dividends</li> <li>• Alimony received</li> <li>• Rental real estate, royalties, partnerships</li> <li>• S corporations, trusts, etc.</li> <li>• Taxable refunds, credits, or offset of state and local income taxes</li> <li>• Other income</li> </ul>	<p><b>Deduct:</b></p> <ul style="list-style-type: none"> <li>• Certain self-employment expenses</li> <li>• Student loan interest deduction</li> <li>• Educator expenses</li> <li>• IRA deduction</li> <li>• Moving expenses</li> <li>• Penalty on early withdrawal of savings</li> <li>• Health savings account deduction</li> <li>• Alimony paid</li> <li>• Domestic production activities deduction</li> <li>• Certain business expenses of reservists, performing artists, and fee-basis government officials</li> </ul>
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*Note: Check the IRS website for detailed requirements for the income and deduction categories above. Do not include Veteran's disability payments, Worker's Compensation or child support received. Pre-tax contributions, such as those for child care, commuting, employer-sponsored health insurance, flexible spending accounts and retirement plans such as 401(k) and 403(b), are not included in AGI but are not listed above because they are already subtracted out of W-2 wages and salaries.*

<p><b>Add (+) back certain income</b></p>	<ul style="list-style-type: none"> <li>• Non-taxable Social Security benefits (line 20a minus 20 b on Form 1040)</li> <li>• Tax –exempt interest (Line 8b on Form 1040)</li> <li>• Foreign earned income and housing expenses for Americans living abroad (calculated in IRS Form 2555)</li> </ul>
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<p><b>Exclude (-)from income</b></p>	<ul style="list-style-type: none"> <li>• Social Security benefits received by a child are not countable for his eligibility when a parent is in the household, unless the child is required to file taxes.</li> <li>• Scholarships, awards, or fellowship grants used for education purposes and not for living expenses</li> <li>• Certain American Indian and Alaska Native income derived from distributions, payments, ownership interests, real property usage rights and student financial assistance</li> <li>• An amount received as a lump sum is counted only in the month received.</li> </ul>
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## 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) 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.
    - 4) the child is a *Special Medical Needs* AA child?

If yes, continue to Step 3 below.
  
3. **Individual Is Neither Tax Filer Nor Tax Dependent Or Meets An Exception In 2. b Above**

For individuals, *other than Special Medical Needs AA children*, 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.

The household of a *Special Medical Needs* AA child consists only of the child.

**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.
- *Social Security benefits received by a child are not countable for his eligibility when a parent is in the household, unless the child is required to file taxes.*
- *Alimony paid and interest paid on student loans is deducted from income.*
- *Foreign income and interest, including tax-exempt interest, are counted.*

**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.

<b>5% FPL DISREGARD</b>	
<b>EFFECTIVE 1/22/14</b>	
<b># of Persons in Household or Family Size</b>	<b>Monthly Amount</b>
1	\$ 49
2	66
3	82
4	99
5	116
6	133
7	150
8	167
Each additional, add	17



<b>CHILD UNDER AGE 19 and PREGNANT WOMEN 143% FPL INCOME LIMITS ALL LOCALITIES  EFFECTIVE 1/22/14</b>	
<b># of Persons in Household or Family Size</b>	<b>Monthly Amount</b>
1	\$1,391
2	1,874
3	2,358
4	2,842
5	3,326
6	3,810
7	4,294
8	4,777
Each additional, add	484

**PLAN FIRST  
100% FPL  
INCOME LIMITS  
ALL LOCALITIES**  
**EFFECTIVE 1/22/14**

<b>Household Size</b>	<b>Monthly Income Limit</b>
1	\$ 973
2	1,311
3	1,649
4	1,988
5	2,326
6	2,664
7	3,003
8	3,341
For each additional person, add	338

**TREATMENT OF INCOME FOR  
FAMILIES & CHILDREN COVERED GROUPS**

INCOME	MAGI COVERED GROUPS	MEDICALLY NEEDY AND 300% SSI F&C COVERED GROUPS
<b>Earnings</b>	Counted with no disregards	Counted with appropriate earned income disregards
<b>Social Security Benefits Adult's MAGI household</b>	Benefits received by a parent or stepparent are counted for his eligibility determination, as well as the eligibility determinations of his spouse and children in the home.	Counted if anyone in the Family Unit/Budget Unit receives
<b>Social Security Benefits Child's MAGI household</b>	Benefits received by a child with at least one parent/stepparent in household are not countable unless the child is required to file taxes.  When the child is in his own household, benefits are always countable.	Counted if anyone in the Family Unit/Budget Unit receives
<b>Child Support Received</b>	Not counted	Counted – subject to \$50 exclusion
<b>Child Support Paid</b>	Counted	Counted
<b>Alimony Received</b>	Counted	Counted – subject to \$50 exclusion if comingled with child support
<b>Alimony Paid</b>	Deducted from income	Not deducted from income
<b>Worker's Compensation</b>	Not counted	Counted
<b>Veteran's Benefits</b>	Not counted	Counted
<b>Scholarships, fellowships, grants and awards used for educational purposes</b>	Not counted	Not counted
<b>Foreign Income (whether or not excluded from taxes)</b>	Counted	Counted
<b>Interest (whether or not excluded from taxes)</b>	Counted	Counted
<b>Lump Sums</b>	Income in month of receipt	Income in month of receipt
<b>Gifts and Inheritances</b>	Not counted	Counted as lump sum in month of receipt

M0810 Changes

<b>Changed With</b>	<b>Effective Date</b>	<b>Pages Changed</b>
UP #10	5/1/14	Page 2
TN #99	1/1/14	pages 1, 2
TN #98	10/1/13	page 2
UP #9	4/1/13	pages 1, 2
UP #7	7/1/12	page 2
UP #6	4/1/12	pages 1, 2
TN #95	3/1/11	Pages 1, 2
TN #93	1/1/10	pages 1, 2
Update (UP) #1	7/1/09	page 2

3. **Categorically  
Needy 300% of  
SSI**

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

Categorically Needy 300% of SSI		
Family Size Unit	2014 Monthly Amount	2013 Monthly Amount
1	\$2163	\$2,130

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	3,261.66	543.61

5. **ABD  
Categorically  
Needy**

For:

ABD 80% FPL,  
QMB, SLMB, &  
QI without Social  
Security income;  
all QDWI; all  
MEDICAID  
WORKS,  
effective 1/22/14

ABD 80% FPL,  
QMB, SLMB, &  
QI with Social  
Security income,  
effective 3/1/14

ABD 80% FPL	Annual	Monthly
1	\$9,336	\$778
2	12,584	1,049
QMB 100% FPL	Annual	Monthly
1	\$11,670	\$973
2	15,730	1,311
SLMB 120% of FPL	Annual	Monthly
1	\$14,004	\$1,167
2	18,876	1,573
QI 135% FPL	Annual	Monthly
1	\$15,755	\$1,313
2	21,236	1,770
QDWI and MEDICAID WORKS 200% of FPL	Annual	Monthly
1	\$23,340	\$1,945
2	31,460	2,622

M1510 Changes

<b>Changed With</b>	<b>Effective Date</b>	<b>Pages Changed</b>
UP #10	5/1/14	Table of Contents pages 7-8a Page 8b was added.
TN #99	1/1/14	Table of Contents pages 1, 2, 8, 8a, 9-11 Page 11a was added.
UP #9	4/1/13	pages 2-7, 10-12, 14
UP #7	7/1/12	pages 8, 9
TN #96	10/01/11	pages 8a, 10
TN #95	3/1/11	Table of Contents Pages 8, 11-15
TN #94	9/1/10	pages 2a, 8-8a
TN #93	1/1/10	page 6
Update (UP) #2	8/24/09	page 11
TN #91	5/15/09	page 14

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his local agency a Medicaid application which is received on August 18. The facility's statement notes that he will be discharged on September 17 to ABC Nursing Home, a nursing facility. The agency completes the determination on August 27 and finds that he will be eligible once he is discharged to the nursing facility.

The agency does not enroll Mr. A until the discharge is confirmed. The CSB case manager calls the agency on September 21 and informs the agency that the patient was discharged to the ABC Nursing Home on September 18. The patient is enrolled in Medicaid with a begin date of September 18.

**B. Coverage End Date**

Medicaid entitlement ends the last day of the month in which the recipient fails to meet all of the Medicaid eligibility requirements, unless the recipient is a CN pregnant woman or is age 21-64 and admitted to an IMD or other ineligible institution (see below).

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

**1. CN Pregnant Woman**

For an eligible CN pregnant woman, entitlement to Medicaid continues after eligibility is established regardless of any changes in family income, as long as she meets the pregnant category (during pregnancy and the 60-day period following the end of pregnancy) and all other non-financial criteria.

**2. Individual Age 21-64 Admitted to Ineligible Institution**

**a. Entitlement - applicants**

For a Medicaid enrollee age 21-64 years, entitlement to Medicaid begins on the first day of the application month and ends on the date following the date he is admitted to an IMD or other ineligible institution. When enrolling the individual in the MMIS, enter the begin date and the end date of coverage.

**b. Cancel procedures for ongoing enrollees**

Cancel coverage as soon as possible after learning of the enrollee's admission to an ineligible institution. **DO NOT cancel coverage retroactively.** Cancel coverage in the MMIS effective the current date (date the worker enters the cancel transaction in MMIS), using cancel reason code "008."

**c. Notice**

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

**3. Spenddown Enrollees**

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



**C. Ongoing Entitlement After Resources Are Reduced**

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

Reduction of resources is an asset transfer and must be evaluated under asset transfer policy (subchapter M1450).

When excess resources are reduced, entitlement to ongoing Medicaid may begin no earlier than the first day of the month in which the resources were reduced to the Medicaid limit. When retroactive coverage is requested, policy in M1510.101 above must be followed.

## **M1510.103 HOSPITAL PRESUMPTIVE ELIGIBILITY**

**A. Policy**

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

**B. Procedures**

When an HPE enrollee submits a full MA application and it is pended in VaCMS, the individual's coverage in the HPE AC is extended *by the eligibility worker in MMIS, as necessary, while the application is processed.* *The MMIS User's Guide for DSS, available at [http://dmasva.dmas.virginia.gov/Content\\_pgs/dss-elgb\\_enrl.aspx](http://dmasva.dmas.virginia.gov/Content_pgs/dss-elgb_enrl.aspx), contains procedures for completing the MA enrollment of an individual who was enrolled in HPE at the time of application.*

*The 10-working day processing standard applies to applications submitted by pregnant women and BCCPTA individuals enrolled in HPE.*

**1. Enrollment**

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

- 2. Individuals Enrolled in HPE as Pregnant Women or in Plan First** *If an individual who was enrolled in HPE with partial coverage as a pregnant woman or in Plan First is determined eligible for full MA coverage in the period covered by HPE, cancel HPE coverage retroactively and reinstate in full coverage for the retroactive months and ongoing, if eligible.*
- 3. Retroactive Entitlement** *An individual's eligibility for retroactive coverage for the three months prior to the month of the MA application is determined when the individual had a medical service within the three months prior to the month of the full MA application. If the individual had full coverage while enrolled as HPE, only enroll him for the portion of the retroactive period that he was not enrolled as HPE.*
- 4. HPE Enrollee Not Eligible for Ongoing Coverage** *If the applicant is determined to not be eligible for ongoing MA coverage, his entitlement to HPE coverage ends. Cancel the HPE coverage effective the current date (i.e. day of the eligibility determination), using Cancel Reason 008.*
- Send a Notice of Action indicating that the individual's MA application was denied and that his HPE coverage was cancelled with the effective date. The individual receives notice of the HPE coverage period from the hospital at the time of the HPE enrollment; advance notice of the HPE cancellation is not required. There are no appeal rights for HPE.*

## M1510.104 DISABILITY DENIALS

### A. Policy

When an individual concurrently applies for SSI or SS and Medicaid as disabled, and either the DDS or the Social Security Administration (SSA) denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.

When an individual applies for Medicaid as disabled or concurrently applies for SS/SSI and Medicaid as disabled, and DDS denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.

### B. Procedures

- 1. Subsequent SSA/SSI Disability Decisions** *The SSA disability decision takes precedence over a DDS decision (DDS will make a decision before SSA if SSA does not take action within the 90-day Medicaid application processing time). If SSA denies disability and the decision is appealed and subsequently reversed, reopen and re-evaluate the denied Medicaid application as long as the disability onset month is prior to the month of application or is no later than 90 days after the month of application.*
- 2. Use Original Application** *The original application is used as long as the application was denied because the individual was not disabled and the subsequent disability onset month is no later than 90 days from the month of application.*

- 3. Entitlement** If the re-evaluation determines that the individual is eligible, 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 when the disability onset date falls after the application date.
- 4. Redetermination Required When More Than 12 Months Have Passed** 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 a redetermination to determine whether or not the individual remains eligible.
- 5. Spenddown** If, based upon the re-evaluation, the individual is determined not eligible but met the requirements in Chapter M13 for placement on a spenddown, a first prospective and additional 6 month spenddown budget period are 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.

## M1520 Changes

<b>Changed With</b>	<b>Effective Date</b>	<b>Pages Changed</b>
UP #10	5/1/14	Pages 7-13, 14, 15
TN #99	1/1/14	Table of Contents Pages 1-34 (entire subchapter)
UP #9	4/1/13	pages 7b and 10a
TN #97	9/1/12	page 1
UP #7	7/1/12	pages 1, 7, 7c, 7g
TN #96	10/1/11	Table of Contents pages 1-7g pages 11-13 pages 21-24
TN #95	3/1/11	pages 6a, 7, 21, 22
TN #94	9/1/10	Table of Contents pages 3, 4b, 5, 6-6a, 10 Appendix 1 was removed.
UP #4	7/1/10	page 4
TN #93	1/1/10	pages 3, 4b, 5-6, 10, 15 pages 21, 22
Update (UP) #2	8/24/09	pages 1, 2, 13, 14, 17, 18
Update (UP) #1	7/01/09	page 3

- 4. Individual on a Spenddown** When an individual on a spenddown enters LTC, his Medicaid eligibility must be determined using the procedures in subchapter M1460.
- An individual on a spenddown in an assistance unit with a spouse and/or children becomes a separate assistance unit when he enters LTC. The spouse's and/or children's spenddown liability is recalculated to reflect a decrease in assistance unit size. See M1350.220 for additional information.
- 5. Married Institutionalized Individuals with a Community Spouse** Rules for determining Medicaid eligibility for married institutionalized recipients who have a community spouse are found in subchapter M1480.

## M1520.200 RENEWAL REQUIREMENTS

- A. Policy** The agency must evaluate the eligibility of all MA enrollees, with respect to circumstances that may change, at least every 12 months. Each renewal must be authorized by an eligibility worker or supervisor, although administrative staff may assist in the gathering of information.
- 1. Required Verifications** An individual's continued eligibility for MA requires verification of income for all covered groups and resources for covered groups with resource requirements. Blindness and disability are considered continuing unless it is reported that the individual is no longer blind or disabled.
- 2. SSN Follow Up** If the enrollee's Social Security Number (SSN) has not been assigned by the renewal date, the worker must obtain the enrollee's assigned SSN at renewal in order for coverage to continue. See subchapter M0240 for detailed procedures for obtaining the SSN.
- 3. Evaluation and Documentation** An evaluation of the information used to determine continued eligibility must be completed and included in the case record. For SSI Medicaid ex parte renewals, the Record of Ex Parte Medicaid Renewal (#032-03-0740) is recommended. For contact-based renewals, either a paper renewal form or the Record of Telephone Interview for Medicaid Renewal (#032-03-0741), available on SPARK at <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi> must be used to document the case record.

For the period of April 2014 until March 2015, individuals who were in MMIS as existing enrollees prior to October 1, 2013, *and who are in covered groups to which MAGI methodology applies* are to have their renewals conducted using the approved paper Administrative Renewal form. This renewal form allows for the gathering of applicant information necessary to determine an individual's eligibility for affordable healthcare, including MA. *Local agencies are to accept the Cover Virginia Application for Health Coverage & Help Paying Costs Medicaid application should an enrollee submit that application in lieu of the Administrative Renewal form.*

Certain demographic information regarding the enrollee will be pre-filled on the Administrative Renewal form that is sent to the enrollee. New or revised information provided by the enrollee (or any applicant new to the case) must be entered into the Virginia Case Management System (VaCMS).

**Note: For individuals who were new enrollees as of October 1, 2013 going forward, a new renewal process will be utilized. Policy guidance regarding that renewal process will be explained in a future transmittal.**

*Renewals for individuals who are not subject to MAGI methodology and/or referral to the HIM are processed outside the eligibility system.*

- *aged, blind or disabled individuals who have Medicare,*
- *Families and Children individuals in long-term care,*
- *Supplemental Security Income Medicaid enrollees,*
- *Auxiliary Grant recipients, and*
- *children in Title IV-E foster care or adoption assistance.*

*If the individual's eligibility continues, the renewal date is updated directly in MMIS. If the individual is no longer eligible, his coverage must be cancelled directly in MMIS. For individuals not enrolled in Medicare who lose full-benefit Medicaid coverage, if the individual's renewal was not processed in VaCMS, his case must be entered in VaCMS in order for the HIM referral to be made.*

The enrollee must be informed in writing of the findings of the renewal and the action taken using the Notice of Action or system generated notice when continued eligibility exists. Advance written notice must be used when there is a reduction of benefits or termination of eligibility.

**4. Voter  
Registration  
Requirement**

The National Voter Registration Act of 1993 (NVRA) requires local social services agencies to offer Medicaid enrollees an opportunity to apply to register to vote at each renewal (redetermination) of eligibility (see M0110.300.A.3).

**5. Renewal Period**

Renewals must be completed prior to cut-off in the 12<sup>th</sup> month of eligibility. The first 12-month period begins with the month of application for Medicaid.

**EXCEPTION:** For F&C MA renewals using Modified Adjusted Gross Income (MAGI) methodology, a 90-day reconsideration period must be allowed. A renewal application may be submitted within 90 days of case closure and re-evaluated without penalty. After 90 days, a new application will be required.

Subsequent renewals must be completed by the MMIS cut-off date no later than 12 months following the month in which the last renewal was filed/initiated. Monthly annual renewal lists are generated by the VDSS Data Warehouse using MMIS data. These reports notify eligibility workers of enrollees due and overdue for renewal.

**6. Scope of  
Renewals**

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

**7. Types of  
Renewals**

Whenever the necessary renewal information is available to the worker through data verification sources and policy permits, the client is not to be contacted and the renewal is to be completed. When it is necessary to obtain information

and/or verifications from the enrollee, a contact-based renewal must be completed.

The agency must make all reasonable efforts to obtain relevant information from Medicaid files and other sources (subject to confidentiality requirements).

**Note:** For the period of April 2014 until March 2015, all individuals *who are in covered groups to which MAGI methodology applies and who were in MMIS as existing enrollees prior to October 1, 2013*, are to have their renewals conducted using the approved paper Administrative Renewal form.

### **Ex Parte Renewal**

An ex parte renewal is an internal review of eligibility based on information available to the agency. By relying on information available, the agency avoids unnecessary and repetitive requests for information from individuals and families that can add to administrative burdens, make it difficult for individuals and families to retain coverage, and cause eligible individuals and families to lose coverage. The procedures for completing an ex parte renewal are in M1520.200 B, below. **Ex parte renewals cannot be used for individuals who are in covered groups to which MAGI methodology applies and who were in MMIS as existing enrollees prior to October 1, 2013.**

#### **b. Telephone Interview Renewal Process**

If an ex parte renewal cannot be done, the eligibility worker may conduct a telephone interview renewal, either in conjunction with the renewal for other benefits or for Medicaid only. The procedures for completing a telephone renewal interview are in M1520.200 C below. **Telephone interview renewals cannot be used for individuals who are in covered groups to which MAGI methodology applies and who were in MMIS as existing enrollees prior to October 1, 2013.**

#### **c. Renewal Using a Paper Renewal Form**

If ongoing eligibility cannot be established solely using information available from electronic data sources (or telephone for renewals, *as appropriate to the covered group*) the agency must provide the individual the opportunity to present additional or new information on a paper renewal form and to present verifications necessary to determine ongoing eligibility. The procedures for completing a renewal when a paper form is used are in section M1520.200 D, below.

For individuals *who are in covered groups to which MAGI methodology applies and who were in MMIS as existing enrollees prior to October 1, 2013*, LDSS are to send Administrative Renewal forms. All paper renewal forms must be signed. Information from the forms must be entered into VaCMS upon receipt from the enrollee.

For individuals in covered groups that are not subject to MAGI methodology, the following Medicaid renewal forms are available on SPARK at <http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi> are used:

- The ABD Medicaid Renewal Form (#032-03-0186) ;

- The BCCPTA Redetermination Form (#032-03-0653), for woman enrolled in the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) covered group.
- The Medicaid Application/Redetermination for Long-Term Care (#032-03-0369), available at: [http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm\\_care.cgi](http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi), for individuals receiving LTC services;
- The Eligibility Review Part A (#032-03-729A) and Eligibility Review Part B (#032-03-729B) for individuals required to complete them for another benefit program.

**B. Ex Parte Renewal Process**

Conduct renewals of ongoing Medicaid eligibility through the ex parte renewal process when:

- *the individual is in a covered group that is not subject to MAGI methodology, and*
- the local agency has access to on-line systems information for verifications necessary to determine ongoing eligibility and/or income verifications obtained for other benefit programs, and
- the enrollee's covered group is not subject to a resource test.

**1. F&C Ex Parte Renewal Procedures**

**a. Use Available Information**

The agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family, and must make efforts to align renewal dates for all programs. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information, information from SSA through SVES or SOLQ-I and information from child support and child care files.

The eligibility worker is to take every opportunity to renew Medicaid eligibility when information is reported/verified that will allow a renewal of eligibility to be completed. For example, when an ongoing Medicaid enrollee applies for SNAP or TANF or reports a change in income, use the income information obtained to complete an early ex parte Medicaid renewal and extend the Medicaid renewal for another 12 months.

**b. Income Verification**

The eligibility worker must document the date and method used to obtain the verification information (viewed pay stub dated xx/xx/xxxx, telephone call on xx/xx/xxxx date, etc.), the type of verification, the source and a description of the information. Income verification that is no older than 6 months old may be used unless the agency has reason to believe it is no longer accurate. It is not necessary to retain a copy of income verifications in the case record. If the renewal is not processed and documented in ADAPT, the documentation must be in the case record.



**An enrollee who has previously reported \$0 income must provide confirmation of income at each renewal, either on a renewal form or by a written statement. If the agency has not obtained written confirmation for another program (e.g. SNAP), do not complete an ex parte renewal when an enrollee has reported \$0 income. \$0 income statements must be no more than 30 days old to be used. If written confirmation was provided for another program, it cannot be used if it is more than 30 days old.**

**2. Renewal Procedures For SSI Recipients and 1619(b) Individuals**

**a. Review Case Record**

An ex parte renewal for an SSI recipient (including an LTC recipient with no community spouse) who has reported no ownership interest in countable real property can be completed by verifying the individual's continued receipt of SSI through SVES or SOLQ-I and documenting the case record. The ex parte process cannot be used for an SSI recipient who owns non-excluded real property. He is subject to a resource evaluation and the agency has no internal means to verify all his resources.

For a 1619(b) individual, check the Medicaid Test Indicator field in SVES or SOLQ-I to verify there is a code of A, B or F.

The case record must also contain documentation that the individual reported no ownership interest in countable real property, either on the application form or on a subsequent renewal form. If the case record does not contain documentation that the individual reported no ownership interest in real property, a contact-based (telephonic or paper form) renewal is to be completed at the next annual renewal.

**b. Individual Loses SSI or 1619(b) Status**

If the individual is no longer an SSI recipient or no longer has 1619(b) status and the information needed to determine continued eligibility is not known to the agency, a contact-based (telephone interview or paper form) renewal must be completed and necessary verifications obtained to evaluate the individual's eligibility in all other covered groups prior to canceling his Medicaid coverage.

**C. Telephone Interview Renewal Procedures**

When an ex parte renewal cannot be completed for an enrollee in any covered group, the eligibility worker may contact the enrollee by telephone. When a renewal interview is conducted by telephone, no renewal form is sent to the enrollee, and the enrollee's signature is **not** required. Send the enrollee a written request for the necessary verifications, and allow at least 10 calendar days for the information to be returned. **If an enrollee whose renewal is conducted by telephone interview reports \$0 income, obtain a written statement indicating that he has no income. A signed renewal form can be used in lieu of a written statement.**

The renewal information and evaluation must be documented in the case record. The enrollee must be informed of the findings of the renewal.

**D. Paper Renewal Procedures**

The enrollee must be allowed 30 days to return the Administrative Renewal form *or other paper renewal form* and the necessary verifications. The form needs to be sent to the enrollee no later than the beginning of the 11th month of the eligibility cycle to allow for the 30 day return period and processing prior to the MMIS cutoff on the 16<sup>th</sup> of the month. The specific information requested and the deadline for receipt of the verification must be documented in the case record.

All enrollees who were in MMIS as existing enrollees prior to October 1, 2013, will have their renewals conducted using the approved paper Administrative Renewal form from April 2014 until March 2015, with the exception of SSI Medicaid individuals.

For F&C cases housed in VaCMS, certain demographic enrollee information will be pre-filled and printed on the form from VaCMS.

The paper Administrative Renewal form will also be used for ABD enrollees, but the forms will not be pre-filled. LDSS are to send Administrative Renewal forms to all enrollees. All paper renewal forms must be signed. Information from the forms must be entered into VaCMS upon receipt from the enrollee.

**E. Dual Renewal Procedures for Some F&C Enrollees for the Period Between January 1, 2014 and March 31, 2014**

The ACA requires states to ensure that F&C enrollees whose renewals *were* completed between January 1, 2014 and March 31, 2014 under the eligibility rules in place prior to October 1, 2013 and who *were* found to be ineligible are provided an opportunity to be evaluated under MAGI and new household composition rules.

For renewals completed during this period, if the enrollee is no longer eligible under the non-MAGI F&C policies contained in Chapter M07 (which were in place prior to October 1, 2013), his eligibility using MAGI methodology needs to be determined before his coverage is cancelled. *After obtaining a completed and signed* Cover Virginia Application for Health Coverage & Help Paying Costs, enter the application into VaCMS for his continued eligibility to be evaluated using MAGI methodology. If he is not eligible using MAGI rules, send advance notice and cancel his coverage.

**F. Disposition of Renewal**

**1. Renewal Completed**

Notify the enrollee in writing of the findings of the renewal and the action taken. When eligibility continues, use the Notice of Action, and include the month and year of the next scheduled renewal. When the individual is no longer eligible, use the Advance Notice of Proposed Action and include spenddown information, if applicable. When there is a reduction of benefits, use the Advance Notice of Proposed Action and include the month and year of the next scheduled renewal.

**2. Renewal Not Completed**

If information necessary to redetermine eligibility is not available through online information systems that are available to the agency and the enrollee has been asked but has failed to provide the information, the renewal must be denied and the coverage cancelled due to the inability to determine continued eligibility. Action cannot be taken to cancel coverage until after the deadline for the receipt of verifications has passed, except for situations when the deadline falls on a weekend or holiday.

**3. Action Taken  
After Cutoff but  
Prior to  
Cancellation  
Date**

When the enrollee fails to return the renewal form and verifications by the requested date and cutoff falls on a weekend or holiday, cancel the individual's coverage on the last business day before Medicaid cutoff, and send advance notice of the cancellation to the enrollee. However, if the early cancel action is taken, LDSS must re-evaluate the renewal if the individual provides the necessary information by the last day of the month in which the renewal is due.

EXCEPTION: For F&C Medical Assistance renewals using MAGI methodology, a 90-day reconsideration period must be allowed. A renewal application may be submitted within 90 days of case closure and re-evaluated without penalty. After 90 days, a new application will be required.

If the individual is determined eligible, the LDSS must reinstate the individual's coverage and send a notice to the individual notifying him of the reinstatement, his continued coverage and the next renewal month and year. If the re-evaluation determines that the enrollee is not eligible, send a Notice of Action indicating the correct reason for the cancellation (e.g. countable income exceeds the limit).

Unless the individual has Medicare, a referral to the Health Insurance Marketplace (HIM) must be made so that the individual's eligibility for the Advance Premium Tax Credit (APTC) in conjunction with a Qualified Health Plan (QHP) can be determined. *If the individual's renewal was not processed in VaCMS, his case must be entered in VaCMS in order for the HIM referral to be made.*

**G. Special  
Requirements for  
Certain Covered  
Groups**

**1. Pregnant  
Woman**

Do not initiate a renewal of eligibility of an MI pregnant woman, or a pregnant woman in any other covered group, during her pregnancy. Eligibility in a pregnant woman covered group ends effective the last day of the month in which the 60<sup>th</sup> day following the end of the pregnancy occurs.

When eligibility in a pregnant woman covered group ends, prior to the cancellation of her coverage, determine if the woman meets the definition for another Medicaid covered group (see M0310.002). If the woman meets the definition of a full-benefit covered group, or for limited coverage under Plan First, determine if an ex parte renewal can be completed or if a renewal form is required and take appropriate action.

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

First and send the Advance Notice of Proposed Action indicating that he has been enrolled in Plan First. On the notice, state that if he does not wish to remain covered by Plan First, to contact the eligibility worker and request that the coverage be cancelled. Include a Plan First Fact Sheet, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>, with the Advance Notice of Proposed Action.

**5. IV-E FC & AA  
Children and  
Special Medical  
Needs Children  
From Another  
State**

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

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

**6. Child Under 21  
Turns Age 21**

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

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

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

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

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

The BCCPTA Redetermination Form (#032-03-653), is used to redetermine eligibility for the BCCPTA covered group. The form is available on SPARK at: <http://spark.dss.virginia.gov/divisions/bp/me/forms/index.html>. The enrollee must provide a statement from her medical provider verifying continued treatment for breast or cervical cancer. There are no Medicaid financial requirements for the BCCPTA covered group.

**9. Hospice Covered  
Group**

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

**10. Qualified  
Individuals**

Coverage for individuals enrolled in the Qualified Individuals (QI) covered group (AC 056) is automatically cancelled effective December 31 of the current year. However, coverage for QIs can be renewed annually provided that there is no break in Medicaid eligibility. *Renewals are to be completed by a telephone interview or sending a renewal form.*

Renewals for all QIs are due by December 31 of each year. On or after November 1 of each year, follow the Aged, Blind or Disabled (ABD) Medicaid renewal procedure to request verifications and complete the evaluation.

**a. The renewal form is returned BEFORE December 31st**

If the individual remains eligible for QI coverage, do not change the renewal date in MMIS prior to December 31. On or after January 1 of the following year, reinstate the QI coverage in MMIS, effective January 1. Change the renewal date in MMIS to December 31 of the current year. Send a [Notice of Action on Medicaid and FAMIS \(form #032-03-0008\)](#) indicating that the individual's coverage continues and the date of the next renewal.

**b. The renewal form is returned AFTER December 31<sup>st</sup>**

If the renewal form is not returned by December 31<sup>st</sup> the individual must submit a new application for Medicaid. The MMIS-generated cancellation notice will serve as the 10-day advance notice for cancellation of the individual's QI coverage.

**H. LTC**

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

For other individuals in LTC *whose eligibility is not based on MAGI methodology and* who were enrolled in MMIS as of October 1, 2013, the eligibility worker may complete a telephone interview renewal or a paper-based renewal, *using* the Medicaid Redetermination for Long-Term Care form for individuals *in LTC*.

Send the enrollee a written request for the necessary verifications, and allow at least 10 calendar days for the information to be returned. Document the renewal information and evaluation in the case record. Send all required notices (see section 1410.300).

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

**M1520.300 MA CANCELLATION OR SERVICES REDUCTION**

**M1520.301 NOTICE REQUIREMENTS**

**A. Policy**

Following a determination that eligibility no longer exists or that the enrollee's Medicaid services must be reduced, the Advance Notice of Proposed Action or system-generated advance notice must be sent to the enrollee at least 10 days plus one day for mail, before action is taken to cancel or reduce Medicaid coverage.

## M21 Changes

<b>Changed With</b>	<b>Effective Date</b>	<b>Pages Changed</b>
UP #10	5/1/14	Pages 1-3 Appendix 1
TN #99	1/1/14	pages 1-3 Appendix 1
TN # 98	10/1/13	Table of Contents pages 1-10 Pages 10a and 11-16 were deleted.
UP #9	4/1/13	pages 3, 4
UP #8	10/1/12	Table of Contents Pages 2-4 Appendix 3 deleted
TN #97	9/1/12	pages 3, 4
UP #7	7/1/12	pages 3, 4 Appendix 2, pages 1 Appendix 3, pages 1 and 2
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	pages 3, 8
TN #95	3/1/11	Table of Contents pages 5, 6, 14, 15, page 16 added Appendix 1
TN #94	9/1/10	page3 Appendix 3, pages 1 and 2
UP #3	3/1/10	pages 2-5
TN #93	1/1/10	page 2-4, 8
Update (UP) #2	8/24/09	page 4

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

### M2110.100 FAMIS GENERAL INFORMATION

#### A. Introduction

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

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

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 *Advanced Resolution Center staff located at the Cover Virginia Call Center* 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, *other than those in an Institution for the Treatment of Mental Disease (IMD) and/or those who are eligible for health insurance coverage under any Virginia State Employee Health Insurance Plan*, who were:

- enrolled in Medicaid on December 31, 2013, and
- who lose Medicaid eligibility **due to excess income** 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 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;

**FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN  
(FAMIS)  
INCOME LIMITS  
ALL LOCALITIES**

**EFFECTIVE 1/22/14**

# of Persons in FAMIS Assistance Unit	FAMIS 150% FPL		FAMIS 200% FPL	
	Annual Limit	Monthly Limit	Annual Limit	Monthly Limit
1	\$17,505	\$1,459	\$23,340	\$1,945
2	23,595	1,966	31,460	2,622
3	29,685	2,474	39,580	3,298
4	35,775	2,981	47,700	3,975
5	41,865	3,489	55,820	4,652
6	47,955	3,996	63,940	5,328
7	54,045	4,504	72,060	6,005
8	60,135	5,011	80,180	6,682
Each additional, add	6,090	508	8,120	677