



COMMONWEALTH of VIRGINIA

DEPARTMENT OF SOCIAL SERVICES

June 16, 2005

MEDICAID MANUAL – VOLUME XIII

TRANSMITTAL #80

The following acronyms are used in this transmittal:

- ABD – Aged, Blind and Disabled
- BCCPTA – Breast and Cervical Cancer Prevention and Treatment Act
- BU – Budget Unit
- CPU – Central Processing Unit
- DDS – Disability Determination Services
- DMAS – Department of Medical Assistance Services
- F&C – Families and Children
- FAMIS – Family Access to Medical Insurance Security Plan
- FPL – Federal Poverty Level
- LDSS – Local Departments of Social Services
- LIFC – Low Income Families with Children
- LTC – Long-term Care
- MN – Medically Needy
- SSI – Supplemental Security Income

This transmittal adds the new chapter M22, "FAMIS MOMS." Chapter M22 contains the policy and procedures for determining eligibility and enrollment in the new FAMIS MOMS program for pregnant women whose income is over the Medicaid 150% FPL but less than or equal to 150% FPL. A new application form #FAMIS-2 will be used to determine eligibility for FAMIS MOMS. The FAMIS CPU will be responsible for determining eligibility for FAMIS MOMS. LDSS must submit applications to the FAMIS CPU for the determination. LDSS and the CPU must make every effort to ensure applications for pregnant women are processed for Medicaid and FAMIS MOMS within 10 working days from the date of application.

This transmittal also contains the new LIFC and MN income limits and LTC maintenance standards and allowances. The new income limits and maintenance standards are effective July 1, 2005.

Revisions to policy in this transmittal include: updated contact information for the DMAS transportation broker; and updated information about dental services for children, which will be

known as “Smiles for Children” and will be administered by a single contractor, Doral Dental, effective July 1, 2005.

Clarifications to policy in this transmittal include: determining actuarial soundness of an annuity; assessing when allowances from patient pay can be deducted; and canceling Medicaid coverage at the recipient’s request.

All policy clarifications and updates contained in this transmittal are effective for all eligibility determinations completed on or after July 1, 2005.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Medicaid Eligibility Manual Table of Contents, page iii	Medicaid Eligibility Manual Table of Contents, page iii	On page iii of the Table of Contents, M22 “FAMIS MOMS” was added.
Chapter M01 Table of contents pages i, ii	Chapter M01 Table of contents pages i, ii	Page i is a reprint. On page ii, reference to the “Health Insurance for Children and Pregnant Women,” was added and the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) application form title was revised.
Subchapter M0120 Table of Contents pages 7, 8 Appendix 7, pages 1-3	Subchapter M0120 Table of Contents pages 7, 8 Appendix 6a Appendix 7, pages 1-3	In the Table of Contents, reference to “Health Insurance for Children and Pregnant Woman” was added. Page 7 is a reprint. On page 8, the name of the form in Appendix 6 was revised. Appendix 6a was added for the new “Health Insurance for Children and Pregnant Woman” application form and instructions. In Appendix 7, the name of the form and the notification requirement for a delay in application processing were revised.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0310 pages 23, 24 pages 31, 32	Subchapter M0310 pages 23, 24 pages 31, 32	On page 23, the reference to the DDS Referral form was corrected. Page 24 is a reprint. On page 31, removed the word “deprived” from the definition of the LIFC covered group. On page 32, capitalized Social Security and Railroad Retirement.
Subchapter M0320 pages 47, 48 pages 69-71	Subchapter M0320 pages 47, 48 pages 69-71	Page 47 is a reprint. On page 48, added reference to FAMIS MOMS. On page 69, clarified that women diagnosed by a non-BCCEDP provider are not eligible in the BCCPTA group. On page 70, revised the reference to the BCCPTA Application form (#032-03-384). On page 71, updated the aid category for the BCCPTA covered group and clarified the form used for BCCPTA Medicaid renewals.
Subchapter M0520 pages 5-10 pages 21-28	Subchapter M0520 pages 5-10 pages 21-28b	Page 5 is a reprint. On page 6, clarified that an SSI child is always a Medicaid family unit of 1, even when living with his parents. On pages 6, 7 and 9, references to deprived children were removed from policy for non-parent caretakers. On page 8, the example was clarified. Pages 10, 21 are reprints. On pages 22, 23 and 26, clarified that the whole deeming standard is used when both parents are in the same BU and their child(ren)-in-common is excluded from the family unit. On pages 23 and 26, clarified that one-half of the deeming standard is used when at least one child-in-

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Subchapter M0710 Appendix 1, page 1 Appendix 3, pages 1-2 Appendix 5, page 1	Subchapter M0710 Appendix 1, page 1 Appendix 3, pages 1-2 Appendix 5, page 1	<p>common is included in the family unit. On page 24, clarified the deeming calculation examples. On page 25, changed item 3.b. to refer to one child. Page 27 is a runover page. On pages 28 and 28a, added an example of income deeming when the parents have an excluded child-in-common. Page 28b is a runover page.</p> <p>In Appendix 1, revised the LIFC 185% of Standards of Need for July 1, 2005. In Appendix 3, revised the F&C income limits for July 1, 2005. In Appendix 5, revised the MN income limits effective July 1, 2005.</p>
Subchapter M0810 pages 1, 2	Subchapter M0810 pages 1, 2	Page 1 is a reprint. On page 2, revised the ABD MN income limits effective July 1, 2005.
Chapter S11 Table of Contents	Chapter S11 Table of Contents	Added sections M1130.300 “Life Insurance” and M1130.400 “Burial Spaces & Burial Funds.”
Subchapter S1140 pages 25, 26	Subchapter S1140 pages 25, 26	Page 25 is a reprint. On page 26, clarified that payments from an annuity are actuarially sound if made over a total number of months less than or equal to the actuarial life expectancy of the annuitant.
Subchapter M1470 pages 3, 4 pages 21, 22	Subchapter M1470 pages 3, 4 pages 21, 22	On page 3, clarified when a patient has no remaining income after a deduction is subtracted from income, no

Remove and Destroy Pages

Insert Attached Pages

Significant Changes

Subchapter M1480
pages 65-68
pages 79, 80
pages 83, 84
pages 87, 88

Subchapter M1480
pages 65-68
pages 79, 80
pages 83, 84
pages 87, 88

further deductions can be made. On page 4, clarified that representative payee expenses cannot be deducted from patient pay. Page 21 is a reprint. On page 22, corrected the text for the special earnings allowance and clarified that representative payee expenses cannot be deducted from patient pay.

Page 65 is a reprint. On page 66, revised the LTC Monthly Maintenance Needs Standard and Excess Shelter Standard effective July 1, 2005. On pages 67, 79, 83 and 88 clarified that when a patient has no remaining income after a deduction is subtracted from patient pay, no further deductions can be made. On pages 83 and 88, also revised the text on closed periods of coverage. Pages 68, 80, 84 and 87 are reprints.

Subchapter M1520
Table of Contents
pages 7, 8
pages 11, 12

Subchapter M1520
Table of Contents
pages 7, 8
pages 11, 12

In the Table of Contents, corrected the page number for M1520.600. On page 7, revised the link to the BCCPTA Redetermination form (#032-03-653). Pages 8 and 11 are reprints. On page 12, revised the system procedures for canceling coverage and clarified the procedure for closing Medicaid coverage when the recipient requests cancellation.

Remove and Destroy Pages	Insert Attached Pages	Significant Changes
Chapter M18 pages 9, 10 pages 13-16	Chapter M18 pages 9, 10 pages 13-16	On pages 9 and 16, updated the phone number for the DMAS transportation broker. Page 10 is a reprint. On page 13, revised the information on dental services to include the “Smiles for Children” program. Page 14 is a runover page. Page 15 is a reprint.
Chapter M21 pages 3-6	Chapter M21 pages 3-6	On page 3, clarified that the child must meet the assignment of rights requirement. On page 4, deleted the policy on acquiring health coverage for a child already enrolled in FAMIS as a reason for termination, and clarified the age requirement. On page 5, clarified discontinued health insurance within 4 months of application without good cause precludes eligibility unless the child was pregnant. Page 6 is a runover page.
	Chapter M22 pages 1-8 Appendix 1, page 1	Added Chapter M22 “FAMIS MOMS” as a new chapter.

Please retain this transmittal letter in the back of Volume XIII.



S. Duke Storen, Director
Division of Benefit Programs

Attachment

M15 ENTITLEMENT POLICY & PROCEDURES

MEDICAID ENTITLEMENT.....M1510
MEDICAID ELIGIBILITY REVIEWM1520
DMHMRSAS FACILITIES.....M1550

M16 APPEALS PROCESS

M17 MEDICAID FRAUD AND RECOVERY

M18 MEDICAL SERVICES

**M21 TITLE XXI: FAMILY ACCESS TO MEDICAL SECURITY
INSURANCE PLAN (FAMIS)**

M22 FAMIS MOMS

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2. If the above conditions are met, an application may be made by any of the following:
 - his guardian or conservator,
 - attorney-in-fact,
 - executor or administrator of his estate,
 - his surviving spouse, or
 - his surviving family member, in this order of preference: adult child, parent, adult brother or sister, adult niece or nephew, or aunt or uncle.

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

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

E. Unsigned Application

An application that bears no signature is invalid. Return the application to the applicant with a letter requesting a signature.

F. Invalid Signature

An application that is signed by an individual who is not authorized to sign on behalf of the applicant is invalid. Return the application with a letter indicating who must sign the application to the individual who filed the application on behalf of the applicant. See M0120, Appendix 1 for a sample letter.

M0120.300 Medicaid Application Forms

A. General Principle

A signed application is required for all initial requests for medical assistance. The Request for Assistance---ADAPT---, form #032-03-875 (see M0120, Appendix 2) may be used to establish and preserve the application date, but a signed application must be submitted in order for eligibility to be determined.

A child born to a mother who was Medicaid eligible at the time of the child's birth, including a child born to an emergency services alien certified for Medicaid payment for labor and delivery, is deemed to have applied and been found eligible for Medicaid on the date of the child's birth. An application for the child is not required. The child remains eligible for Medicaid to age 1 year so long as the mother remains eligible for Medicaid, or would be eligible if she were *still* pregnant, and they live together.

**B. Medicaid
Application Forms**

An applicant may obtain a prescribed application form from a number of sources, including a variety of human service agencies, hospitals, and the internet.

There are specialized forms intended for use with certain covered groups, including medically indigent pregnant women, children, SSI recipients, and women who have been screened under the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). These forms should be used whenever possible because they do not ask the applicant to provide information that is not used in the eligibility determination.

Appendices 3 through 8 of this chapter contain sample prescribed Medicaid application forms. Other forms that serve as Medicaid application forms are listed in section [M0120.300.D](#).

The following forms have been prescribed as application forms for Medicaid:

- Application for Benefits, form #032-03-824, also referred to as the Combined application, may be used by any applicant (see [M0120, Appendix 3](#)).
- Application/Redetermination for Medicaid for SSI Recipients, form #032-03-091 (see [M0120, Appendix 4](#));
- Medicaid Application/Redetermination for Medically Indigent Pregnant Women, form #032-03-040 (see [M0120, Appendix 5](#));
- Application for Children's Health Insurance in Virginia, form FAMIS-1 (see [M120, Appendix 6](#));
- *Health Insurance for Children and Pregnant Women, form FAMIS-2* (see [M0120, Appendix 6a](#));
- Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application, form #032-03-384, is used only by women screened under the Breast and Cervical Cancer Early Detection Program. This form is not to be given to applicants by the local departments of social services ([M0120, Appendix 7](#) is provided for reference purposes);
- Signed ADAPT Statement of Facts (SOF). If any additional information is necessary (individual requires a resource evaluation), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant and attached to the SOF.
- Title IV-E Foster Care & Medicaid Application/Redetermination, form #032-03-636 (see [M0120, Appendix 8](#)).

Upon implementation of FAMIS MOMS, the Health Insurance for Children and Pregnant Women application will be added to this manual and made available on-line at the following web sites:

- <http://www.localagency.dss.state.va.us/divisions/dgs/warehouse.cgi>
- <http://www.dss.virginia.gov/form/index.html>

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application

AGENCY USE ONLY

DATE RECEIVED:

CASE NAME/NUMBER:

LOCALITY:

WORKER

Please complete all sections. If you need assistance, please contact an eligibility worker at your local Department of Social Services.

1. IDENTIFYING INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____ STATE OF RESIDENCE: _____

MAILING ADDRESS (If different): _____ CITY: _____ STATE: _____ ZIP: _____ HOME PHONE #: _____ DAYTIME PHONE #: _____

2. ADDITIONAL INFORMATION

RACE: WHITE AMERICAN INDIAN/ALASKA NATIVE BLACK ASIAN/PACIFIC ISLANDER HISPANIC OTHER
MARITAL STATUS: NEVER MARRIED MARRIED SEPARATED DIVORCED WIDOWED

DATE OF BIRTH: _____ PLACE OF BIRTH: _____
U. S. CITIZEN? YES NO IF NO, ALIEN NUMBER: _____

DO YOU RECEIVE SSI? YES NO ARE YOU PREGNANT? YES NO DO YOU HAVE A CHILD(REN) UNDER AGE 19 LIVING WITH YOU? YES NO

DO YOU HAVE HEALTH INSURANCE? YES NO IF YES, COMPANY NAME: _____
POLICY #: _____ EFFECTIVE DATE: _____ TYPE OF COVERAGE: _____

DID YOU RECEIVE MEDICAL CARE IN ANY OF THE THREE MONTHS BEFORE THIS APPLICATION? YES NO IF YES, LIST MONTHS: _____

3. BCCPTA CERTIFICATION

I CERTIFY THAT THE ABOVE NAMED INDIVIDUAL IS A VIRGINIA BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (BCCEDP) PARTICIPANT (TITLE XV) AND IS ELIGIBLE FOR MEDICAID UNDER THE BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT OF 2000.

SCREENING DATE: _____ DIAGNOSIS DATE: _____ FACILITY/SERVICE SITE: _____ PHONE #: _____

SIGNATURE OF BCCEDP CASE MANAGER: _____ DATE: _____

YOUR RIGHTS AND RESPONSIBILITIES

By signing below, I agree to the following:

I have the right to:

- ◆ Be treated fairly and equally regardless of my race, color, religion, national origin, gender, political beliefs or disability consistent with state and federal law and to file a complaint if I feel I have been discriminated against.
- ◆ Have my eligibility for Medicaid benefits determined within 10 working days of receipt of my application at my local department of social services *or be notified of the reason for any delay.*
- ◆ Appeal and have a fair hearing if I am: (1) not notified in writing of the decision regarding my application; (2) denied benefits from the Medicaid program; or (3) dissatisfied with any other decision that affects my receipt of Medicaid benefits.

I have the responsibility to:

- ◆ Not purposely withhold information, or give false information and understand if I do so my Medicaid coverage may be denied or ended.
- ◆ Report any changes in information provided on this form within 10 days to my local department of social services.
- ◆ Cooperate with a review of my Medicaid eligibility by Quality Control and understand that refusing to cooperate will make me ineligible for Medicaid until I cooperate with a review.

I further understand and agree that:

- ◆ This application is used only to apply for Medicaid under the Breast and Cervical Cancer Prevention and Treatment Act coverage group and that in order to apply under other coverage groups I must complete another application.
- ◆ The Department of Medical Assistance Services and the Department of Social Services are authorized to obtain any verification necessary to establish my eligibility for Medicaid.
- ◆ The Department of Medical Assistance Services has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services received by me.
- ◆ Each provider of medical services may release any medical records pertaining to any services received by me.
- ◆ I am assigning my rights to medical support and other third party payments to the Department of Medical Assistance Services in order to receive benefits from the Medicaid program.

I declare that all information I have given on this application is true and correct to the best of my knowledge and belief. I understand that if I give false information, withhold information or fail to report a change promptly or on purpose I may be breaking the law and could be prosecuted for perjury, larceny and/or fraud. I understand that my signature on this application signifies, under penalty of perjury, that I am a U.S. citizen or alien in lawful immigration status.

Signature or Mark

Date

Witness/Authorized Representative

Date

VOTER REGISTRATION

Check one of the following:

- () I am not registered to vote where I currently live now, and I would like to register to vote here today. I certify that a voter registration form was given to me to complete. (If you would like help in filling out the voter registration, we will help you. The decision to have us help you is yours. You also have the right to complete your form in private.)
- () I am registered to vote at my current address. (If already registered at your current address, you are not eligible to register to vote.)
- () I do not want to apply to register to vote.
- () I do want to apply to register to vote, please send me a voter registration form.

Applying to register or declining to register to vote will not affect the assistance or services that you will be provided by this agency. A decision not to apply to register to vote will remain confidential. A decision to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right in applying to register to vote, you may file a complaint with: Secretary of Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497. The phone number is (804) 786-6551.

**BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT
(BCCPTA) MEDICAID APPLICATION**

FORM NUMBER - 032-03-384

PURPOSE OF FORM - This form is the Medicaid application form for women who have been screened and diagnosed with breast or cervical cancer by a medical provider operating under the Center for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program (BCCEDP) and who have been certified as needing treatment.

USE OF THE FORM - This form is used to collect the information needed to determine Medicaid eligibility in the BCCPTA covered group and enroll eligible *women* in the VaMMIS. Initial eligibility in the BCCPTA covered group cannot be determined unless the screening certification in Section 3 is signed by a provider or certifying individual under the authority of the CDC BCCEDP.

NUMBER OF COPIES - Original.

DISPOSITION OF FORM - The original is filed in the case record.

INSTRUCTIONS FOR PREPARATION OF THE FORM

- Section 1: Section 1 is used to collect identifying information for the applicant/recipient.
- Section 2: Section 2 is used to obtain the nonfinancial information used to determine eligibility in the BCCPTA covered group.
- Section 3: Section 3 is the certification that the woman is a BCCEDP participant and is eligible for Medicaid under the BCCPTA. This certification must be signed by a provider or certifying individual under the authority of the CDC BCCEDP.

The rights and responsibilities and voter registration are on the reverse side of the form.

The DDS makes a determination of disability when the:

- applicant alleges a disabling condition and has never applied for a disability from SSA or has not been denied disability within the past 12 months;
- SSA has not made a decision on a pending SS/SSI claim; or
- applicant alleges a disabling condition which is different from that considered by SSA or is in addition to that considered by SSA.

1. Hospital Referrals to DDS for Expedited Disability Determination

The 2004 Budget Bill mandated DDS make a disability determination within 7 working days of receipt of a referral from DSS when the Medicaid applicant is hospitalized and needs to be transitioned to a rehabilitation facility. To identify those hospitalized individuals who require an expedited disability determination, the following procedures have been established:

a. Hospital staff will:

- send DSS the Medicaid application and a cover sheet (see [Appendix 5](#) for an example of the cover sheet); and simultaneously
- send DDS the medical documentation (disability report, authorizations to release information and medical records) needed to make the disability determination and a copy of the cover sheet.

b. DDS must:

- make a disability determination within 7 working days; and
- fax the result of the disability decision to the DSS.

c. DSS must:

- fax a completed DDS Referral Form (see [Appendix 4](#) to this subchapter) to DDS at (804) 662-9366, verifying receipt of the Medicaid application;
- give priority to processing the applications and immediately request any verifications needed;
- process the application as soon as the DDS disability determination and all necessary verifications are received; and
- notify the hospital contact identified on the cover sheet of the action on the application and provide the Medicaid enrollee number, if eligible.

Should DDS be unable to render a decision within 7 working days, DDS will send a communication to the DSS advising that the disability determination has been delayed.

2. DSS Referral to DDS Required When Disability Determination Has Not Been Made

The DDS must make a determination of disability when the applicant alleges a disability and a disability determination has not been made by SSA or the RRB. The DDS must make a disability determination within a time frame that will allow the DSS to process the application within 90 days, provided all medical information has been submitted. Follow the procedure in E. 1. below for making a referral to DDS except when a hospital has initiated an expedited disability determination (see D.1. above).

3. DSS Referral to DDS Required When SSA Denied Disability Within Past 12 Months

SSA decisions made within the past 12 months are final decisions for Medicaid purposes unless:

- a. The applicant alleges a condition that is new or in addition to the condition(s) already considered by SSA,

OR

- b. The applicant alleges his condition has changed or deteriorated causing a new period of disability, AND
- he no longer meets the SSI financial requirements but might meet Medicaid financial requirements, or
 - he applied to SSA for a reconsideration or a reopening and SSA has refused to reconsider or reopen his case.

If the conditions in a. or b. exist, DDS must make a disability determination. The eligibility worker must follow the procedure in E. 1. below to make a referral to DDS. Information regarding the new, changed and/or deteriorated condition(s) must be identified and sent to DDS using the procedure in E. 1. below.

If the conditions in a. or b. do not exist, the SSA denial of disability is final for Medicaid purposes. Do not make a referral to DDS for a disability determination.

4. Referral to DDS When SSA Denied Disability More Than 12 Months Ago

If the applicant alleges a disability and SSA denied the disability more than 12 months ago, the eligibility worker must follow the procedure in E. 1. below to make a referral to DDS.

- B. Procedure** The individual must elect hospice care in a non-institutional setting. Election of hospice care is verified either verbally or in writing from the hospice care provider. If verification is verbal, document the case record.

M0310.117 INSTITUTION

- A. Definition** An **institution** is an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.
- B. Medical Institution (Facility)** A **medical institution** is an institution that:
- is organized to provide medical care, including nursing and convalescent care,
 - has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,
 - is authorized under state law to provide medical care, and
 - is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.
- C. Procedures** The procedures used to determine if an individual meets a covered group of individuals in institutions are contained in subchapters [M0320](#) and [M0330](#).

M0310.118 LIFC

- A. Low Income Families with Children (LIFC)** Low Income Families with Children (LIFC) is a covered group of individuals in families who have a dependent child(ren) living in the home, and whose income is within the Medicaid F&C income limits.
- B. Procedure** Section [M0320.306](#) contains the detailed requirements for the LIFC covered group.

M0310.119 MEDICALLY INDIGENT (MI)

- A. Definition** "MI" is the short name for "medically indigent." MI is the name Virginia uses for the subclassification of federally mandated categorically needy covered groups that do not receive cash assistance and that have income within a percentage of the federal poverty income guidelines.
- An MI individual is one who is not eligible for cash assistance, but who meets the requirements of an MI covered group and has income within the specified percentage of the federal poverty limit.

- B. Procedure** The procedures used to determine if an individual meets an MI covered group are in subchapter M0320.

M0310.120 MEDICALLY NEEDED (MN)

- A. Definition** "MN" is the short name for "medically needy." MN is one of the two federal classifications of Medicaid covered groups. All medically needy covered groups are optional; the state can choose whether or not to cover medically needy individuals in its state plan. However, if the state chooses to cover medically needy individuals, it must at least cover children under age 18, pregnant women and the protected group of individuals who were eligible as medically needy blind or disabled in December 1973 and continue to meet the December 1973 eligibility criteria. The state may choose to cover additional groups of individuals as medically needy.

The medically needy individual is one who has income and resources enough to meet his maintenance needs, but not enough to meet his medical needs. He is not eligible for a cash assistance payment because his income and/or resources exceed the cash assistance limits. Medically needy individuals whose income exceeds the MN income limit may become eligible as MN by incurring medical and/or remedial care expenses to establish eligibility (spenddown).

- B. Procedure** The procedures used to determine if an individual meets a medically needy covered group are in subchapter [M0330](#).

M0310.121 MEDICARE BENEFICIARY

- A. Definition** A Medicare beneficiary is an individual who is entitled to Medicare (Title XVIII of the Social Security Act). Medicare is a federally funded and administered health insurance program and consists of hospital insurance protection (Part A) and medical insurance protection (Part B).

- 1. Part A** A person is entitled to Medicare Part A if he/she

a. is age 65 or older and:

- eligible for monthly Social Security benefits on the basis of covered work under the Social Security Act,
- a qualified *Railroad Retirement* beneficiary,
- not eligible for *Social Security* or *Railroad Retirement* benefits but meets the requirements of a special transitional provision,
- not eligible for *Social Security* or *Railroad Retirement* benefits but voluntarily enrolls and pays a monthly premium, or

a. Eligible To Age 1

Any child born a Medicaid-eligible woman will continue to be eligible up to age 1 as long as the following conditions are met:

- 1) the child remains in the home with the mother, and
- 2) the child's mother remains eligible for Medicaid or the child's mother would be eligible for Medicaid if she were *still* pregnant.

b. Living With Mother

A newborn child is considered living with its mother from the moment of birth until the child is

- entrusted or committed into foster care,
- institutionalized, or
- goes to live with someone other than the child's mother.

c. No Other Nonfinancial Eligibility Requirements

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

C. Financial Eligibility

1. Assistance Unit

Use the assistance unit policy in chapter M05 to determine the pregnant woman's financial eligibility.

If a pregnant woman also applies for other family unit members living with her who do not meet the pregnant woman, newborn child or child under age 19 years covered group requirements, separate financial eligibility calculations must be completed for the unit. One is the MI pregnant woman determination; the other is based on the other members' covered group(s).

2. Asset Transfer

The asset transfer rules in subchapter [M1450](#) apply to institutionalized MI individuals.

3. Resources

There is no resource limit.

4. Income

The income requirements in chapter [M07](#) must be met by a pregnant woman. The income limits are 133% of the federal poverty limit and are found in subchapter [M710](#), [Appendix 6](#).

5. Income Changes After Eligibility Established

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

For example, a married pregnant woman applies for Medicaid on October 10. She received a medical service in the retroactive period. Her expected delivery date is January 15. She and her husband have been unemployed since June 23. Her husband began earning \$3,000 a month on October 9; she remains unemployed. Since they had no income during the retroactive period, she is found eligible for retroactive coverage effective July 1. Because her available income (from her husband) changed after she established eligibility on July 1, the change in income does not affect her eligibility and she remains eligible for Medicaid in October and subsequent months until she no longer meets the pregnant woman definition or other nonfinancial requirements.

6. Income Exceeds MI Limit

A pregnant woman whose income exceeds the MI income limit may be eligible for Virginia's Title XXI program, FAMIS MOMS. The income limit for FAMIS MOMS is 150% FPL. See chapter M22 to determine FAMIS MOMS eligibility.

Spenddown does not apply to the medically indigent. If the pregnant woman's income exceeds the medically indigent limit, she is not eligible as medically indigent regardless of medical expenses. Eligibility as medically needy (MN) must then be determined in order for spenddown to apply, and all medically needy eligibility requirements must be met, including resource limits.

D. Entitlement

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

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

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

After her eligibility is established as a medically indigent pregnant woman, the woman's Medicaid entitlement continues through her

M0320.312 BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT (BCCPTA)

A. Policy

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000 (P.L. 106-354) provides for payment of medical services for certain women with breast and cervical cancer. Virginia chose to cover this group beginning July 1, 2001.

Women eligible for the BCCPTA program must be age 40 through 64. They must have been screened and certified as needing treatment for breast or cervical cancer (including pre-cancerous conditions) by a medical provider operating under the Center for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program (BCCEDP) and referred to LDSS for a Medicaid eligibility determination. These women must not have creditable health insurance coverage for treatment of breast or cervical cancer.

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

B. Nonfinancial Eligibility

1. Required Nonfinancial Requirements

BCCPTA women must meet the following Medicaid nonfinancial requirements in chapter [M02](#):

- citizenship/alien status;
- Virginia residency;
- Social Security number provision/application requirements;
- assignment of rights to medical benefits requirements;
- application for other benefits; and
- institutional status.

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

- LIFC;
- MI Pregnant Women;
- SSI recipients.

2. Creditable Health Insurance Coverage

BCCPTA women must not have creditable health insurance coverage for the treatment of breast or cervical cancer. Creditable health insurance coverage includes:

- a group health plan;
- health insurance coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;

- Medicare;
- Medicaid;
- armed forces insurance a medical care program of the Indian Health Service (IHS) or of a tribal organization;
- a state health risk pool.

There may be situations where a woman has creditable health insurance coverage as defined above, but the coverage does not include treatment of breast or cervical cancer due to a period of exclusion or exhaustion of lifetime benefits.

C. Financial Eligibility

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

D. Application Procedures

The application procedures for women who meet the BCCPTA non-financial requirements have been streamlined to facilitate the prompt enrollment and immediate access to services for women who are in need of treatment for breast or cervical cancer. In addition to the nonfinancial information required to evaluate eligibility in the BCCPTA covered group, the following information is needed for enrollment in Medicaid:

- name,
- address,
- sex and race,
- date of birth,
- country of origin and entry date, if an alien.

Women who meet the description of individuals in the LIFC, MI pregnant women or SSI recipients covered groups must complete the appropriate Medicaid application for the covered group and must have a Medicaid eligibility determination completed prior to determining their eligibility in the BCCPTA covered group. If not eligible in the LIFC, MI pregnant women or SSI recipients covered groups, then determine their eligibility in the BCCPTA covered group.

1. Application Form

This covered group has a special application, BCCPTA Medicaid Application (form #032-03-384), that must be initiated by a BCCEDP provider. The application includes the *BCCEDP* certification of the woman's need for treatment and the information needed to determine the nonfinancial eligibility in the BCCPTA covered group. Appendix 7 to subchapter M0120 contains a sample of the BCCPTA Medicaid Application form.

If eligibility in another Medicaid covered group must first be determined, the applicant must be given the appropriate Medicaid application.

2. Application Processing Time Frames

BCCPTA Medicaid applications filed by women who do not meet the description of an individual in the LIFC, MI pregnant women or the SSI recipients covered groups must be processed within 10 working days of the agency's receipt of the signed application.

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

3. Notices

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

If a decision cannot be made within 10 working days of receipt of the BCCPTA application, the worker must send a "Notice of Action on Medicaid", form #032-03-008, on the 10th day stating why action has not been taken, specifying what information is needed and a deadline for submitting the information.

E. Entitlement

1. Entitlement Begin Date

Medicaid eligibility in the BCCPTA covered group can begin no earlier than July 1, 2001. Eligibility under this covered group is met the beginning of the month the screening is completed if the woman later has a positive diagnosis as a result of the screening and is determined to be in need of treatment for her breast and/or cervical cancer.

Eligible BCCPTA women are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month, but no earlier than July 1, 2001.

2. Retroactive Entitlement

Retroactive coverage is applicable to this covered group if the individual was screened by a medical provider operating under the *BCCEDP* and diagnosed as needing treatment for breast or cervical cancer in the retroactive month(s). However, coverage can begin no earlier than July 1, 2001.

F. Enrollment

The *aid category* for BCCPTA women is "066".

G. Renewal

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

Children in medical institutions (facilities) are temporarily absent from home if their stay in the medical facility is less than 30 consecutive days. If the stay has been, or is expected to be, 30 or more consecutive days, go to section [M1410.010](#) to determine if the child is institutionalized in long-term care. A child who is institutionalized in a medical facility or Medicaid waiver services is NOT considered living with his parents for Medicaid eligibility purposes.

Children placed in residential treatment facilities are considered absent from their home if their stay in the residential facility has been 30 days or more. A child who is placed in a residential facility is considered NOT living with his parents for Medicaid eligibility purposes as of the first day of the month in which the 30th day of residential placement occurs. Long-term care rules do not apply to these children.

4. Pregnant Woman

An individual who meets the pregnant woman definition is counted as at least **two persons** when her eligibility is being determined in the MI Pregnant Woman or MN Pregnant Woman covered group. The unborn child (or children, if medical documentation verifies more than one fetus) must be included in the unit with the pregnant woman when determining her eligibility. A separate calculation is required for the other family unit members who do not meet a pregnant woman covered group. This calculation does NOT include the unborn child(ren) as part of the family unit and/or budget unit (BU).

When an individual is pregnant but her eligibility is determined in a covered group other than MI or MN Pregnant Woman, such as blind, disabled or Low Income Families with Children (LIFC), the pregnant woman is counted as just one person.

5. Cohabitant

A cohabitant is not the child(ren)'s parent and is not legally responsible for anyone in the family unit. Therefore, the cohabitant is not included in the family unit. Do not count a cohabitant's income or resources.

C. Examples

1. Household With Excluded Child

EXAMPLE #1: Household listed on application consists of applicant, her disabled spouse, her 15-year old son, and husband's 20-year old daughter. The 20-year old daughter is employed full-time. Medicaid is requested for applicant, her spouse, and her son. She specifies in writing that she wishes to exclude her husband's 20-year old daughter. The family unit consists of:

- the applicant
- her husband, and
- her 15-year old son.

The family unit's income is determined using the F&C income policy and procedures.

2. Household With Acknowledged Father

EXAMPLE #2: Household listed on the Medicaid application consists of pregnant woman applicant, her 5-year old son and her boyfriend, who is the acknowledged father of the 5-year old. They all request Medicaid.

The family unit for the Medicaid eligibility determination for the 5-year old child, and the acknowledged father consists of:

- the woman,
- the 5-year old child and
- the child's acknowledged father.

The family unit for the Medicaid eligibility determination for the pregnant woman consists of:

- the pregnant woman,
- her unborn child,
- the 5-year old child, and
- the child's acknowledged father.

The family unit's income is determined using the F&C income policy and procedures.

M0520.101 MULTIPLE FAMILY UNITS

A. Policy

Multiple family units exist in a household in the following situations:

1. Non-parent Caretaker

When the individual is applying for Medicaid as a non-parent caretaker of a dependent child, multiple family units exist.

2. EWB (Essential to the Well-Being)

When the individual is applying for Medicaid as an individual who is EWB to family with a dependent child, multiple family units exist.

3. Child--No Responsible Relative In Home

When the individual applying is a child under age 21 but has no responsible relative living in the household and is not a sibling of another child(ren) in the household, multiple family units exist.

4. Adult--No Responsible Relative In Home

When the individual applying is age 21 or older and is not legally responsible for the other applicant(s) in the household, multiple family units exist.

5. Foster Care Child

When the individual applying is a foster care child whose parent(s) live in the household and who is placed in his/her home for a trial visit (see [M0520.701](#) below), multiple family units exist.

6. Siblings

Siblings under age 21 are included in the same family unit.

7. SSI Child

A child receiving SSI is always a separate family unit of one person.

B. Procedures

When an applicant applies for a child in the household, begin forming the family unit by identifying the child(ren) who applies and meets an F&C covered group. Divide the household into multiple family units when:

- the household contains an individual(s) who applies for Medicaid but who is not a legally responsible relative of the other individual(s) who has applied; or
- the household contains a foster care child under age 21 who is placed in the home for a trial visit.

Each family unit must contain only those individuals among whom legal responsibility for *financial* support exists.

M0520.102 NON-PARENT CARETAKER IN HOUSEHOLD**A. Policy**

An individual who is not the parent of a dependent child who lives in the household, but who meets the definition of a caretaker-relative (subchapter [M0310](#)) is called a “non-parent caretaker.” Only one **non-parent** caretaker in a household can meet the LIFC covered group. An individual cannot meet the caretaker-relative definition when the child’s parent lives in the household.

A non-parent caretaker is in a family unit that is separate from the dependent child(ren) for whom the individual is a caretaker-relative.

B. Family Unit Composition

To determine the non-parent caretaker-relative’s family unit, identify the non-parent caretaker-relative who requests Medicaid and meets the LIFC covered group. Include the caretaker-relative’s spouse and/or the caretaker-relative’s children under age 21 who live in the household in the family unit with the non-parent caretaker-relative. The dependent child(ren) is in a separate family unit.

C. Determine Income Eligibility

Add together all of the countable income received by the members of the non-parent caretaker-relative’s family unit. Compare the total countable income to the LIFC 185% and F&C 90% income limits.

If the family unit’s income is within the F&C 185% and the 90% limits, the non-parent caretaker-relative is eligible as LIFC. Also, the children under age 18 (or under age 19 if in school) and the spouse in the non-parent caretaker-relative’s family unit are eligible regardless of her status as a non-parent caretaker-relative of another child, because her family unit meets the LIFC covered group.

If the family unit’s income exceeds the LIFC income limits, determine if the family unit can be broken into BUs units to test the BUs’ income against the LIFC limits. See [M0520.200](#) below. If the family unit cannot be broken into BUs, the non-parent caretaker-relative is not eligible for Medicaid as LIFC because of excess income.

D. Examples--Non-Parent Caretaker-Relative Family Units

EXAMPLE #3: Household listed on application consists of applicant (aunt), her 10-year old niece, and her 8-year old nephew, who is not a sibling of the niece. She requests Medicaid for herself and the children.

The household consists of three family units:

1. the 8-year old nephew, who has no legally responsible relatives or siblings living in the household;
2. the *10-year old* niece, who has no legally responsible relatives or siblings living in the household; and
3. the aunt.

The financial eligibility for each family unit is determined using F&C financial policy and procedures and comparing the result to the limits for the covered group(s) for which eligibility is being determined. If each child's countable income is within the MI child income limits for an assistance unit of 1, each child is income eligible. If the aunt's countable income is within the F&C limits for the locality, the aunt is income eligible for the LIFC covered group.

EXAMPLE #4: Household listed on application consists of woman applicant (aunt), her husband (uncle), their 15-year old son, their 10-year-old niece, and their 8-year old nephew who is not a sibling of the niece. They all request Medicaid.

The household consists of three family units:

1. the 8-year old nephew, who has no legally responsible relatives or siblings living in the household;
2. the 10-year old niece, who has no legally responsible relatives or siblings living in the household; and
3. the aunt, uncle, and their son.

The financial eligibility for each family unit is determined using F&C financial policy and procedures and comparing the result to the limits for the covered group(s) for which eligibility is being determined. If the nephew's and niece's countable income is within the MI child income limits for an assistance unit of 1, each child is income eligible. If the aunt, uncle, and their son's countable income is within the F&C limits for the locality, the aunt, uncle, and their son are income eligible for the LIFC covered group. Their son is also income eligible for the MI child covered group.

M0520.103 EWB IN HOUSEHOLD**A. Policy**

When the household includes an individual who applies for Medicaid who meets the definition of an EWB in subchapter M0310, and the person to whom the EWB provides essential services meets the nonfinancial and income requirements for Medicaid in the LIFC covered group, the EWB is in a separate family unit. An EWB does not exist if the family to whom he/she provides essential services is not eligible for Medicaid as LIFC.

The EWB's financial eligibility for Medicaid is determined by using the income of the EWB's family unit members only. The income of the individual to whom he/she is providing essential services is NOT counted because that individual is not legally responsible for the EWB, nor is the EWB legally responsible for the individual.

B. Family Unit Composition

To determine the EWB's family unit, start with the EWB who requests Medicaid and meets the LIFC covered group as an EWB. Include the EWB's spouse and/or the EWB's children under age 21 who live in the household. The dependent child(ren) and the caretaker for whom the EWB is providing essential services are in a separate family unit(s).

C. Determine Income Eligibility

Add together all of the countable income received by the members of the EWB's family unit. Compare the total countable income to the LIFC 185% and F&C 90% income limits.

If the EWB's family unit's income is within the F&C 185% and 90% limits, the EWB is eligible as LIFC, if the family to whom the EWB provides essential services is eligible as LIFC.

If the EWB's family unit's income exceeds the LIFC limit, determine if the family unit can be broken into BUs to test the BUs' income against the limits. See [M0520.200](#) below. If the EWB's family unit cannot be broken into BUs, the EWB is not eligible for Medicaid as LIFC because of excess income.

D. Example--EWB In Household

EXAMPLE #5: Household listed on application consists of an applicant mother, her 6-year old son and her 20-year old niece. They all request Medicaid. Her niece takes care of her son while the mother works. The niece meets the definition of an EWB because she provides child care which enables the mother to work full time.

Because the niece is an EWB, the household contains multiple family units:

1. the 6-year old son and his mother; and
2. the EWB niece, who has no legally responsible relatives in the household.

The mother and son's family unit's income is determined using the F&C income policy and procedures. If their countable income is within the MI income limit for 2 persons, the son is eligible in the MI child covered group. If their countable income is **within** the LIFC income limit for 2 persons, the mother is eligible for Medicaid as LIFC, and her niece meets the LIFC covered group as an EWB. Because the niece has no income, she is eligible for Medicaid as an LIFC EWB.

If the mother's family unit income **exceeds** the LIFC limit, the mother is not eligible for Medicaid because of excess income. She cannot be placed on a spenddown because she does not meet a medically needy covered group. The niece is not eligible for Medicaid because the mother is not eligible as LIFC and the niece does not meet a Medicaid covered group.

M0520.200 BUDGET UNIT RULES

A. Policy

BUs are formed to assure that only the individual's resources and income and the resources and income of those persons legally responsible for the individual are used to determine the individual's Medicaid financial eligibility. If the individual's family unit has resources or income which cannot be verified or which exceed the limit for the individual's covered group, determine if the family unit can be broken into BU. Forming BUs based on resources is only applicable to the F&C MN covered groups. A family unit must be broken into BUs when:

1. a child in the family unit has his/her own income;
2. a child in the family unit has his/her own resources (applicable only for F&C MN covered groups);
3. the child's stepparent is in the family unit;
4. the child's parent with whom he/she lives is a Medicaid minor (under age 21) and they live with the minor parent's parent(s);
5. the child is married and living with his/her spouse and his/her parent(s);
6. the child(ren)'s acknowledged father lives in the household and is not married to the child(ren)'s mother.

All members of a family unit must be placed in a BU when the family unit can be divided into BUs. Although they will be included in a BU, persons found eligible at the family unit level do NOT have their eligibility redetermined at the BU level.

BU #1 spouse deeming calculations:

a. Resource Deeming

\$ 800	husband's ½ of joint savings
<u>-1,000</u>	resource deeming standard
0	excess (no resources deemed to F&C spouse)

b. Income Deeming

\$3,200	husband's earnings
<u>- 90</u>	standard work exclusion
3,110	countable income
<u>- 229</u>	deeming standard for deemor's BU (2 persons in Group I)
2,881	excess
<u>÷ 2</u>	PG woman (spouse) and 14-year-old child
\$1,440.50	deemed to each

The parents' deemed resources and income to the pregnant woman's BU are calculated according to [M0520.400](#) below. The parents' deemed income is added to the spouse's deemed income to determine the minor PG woman's income eligibility.

M0520.400 DEEMING FROM PARENT

A. Policy

A parent's resources (F&C MN only) and income are considered available (either counted in the unit or deemed) to a child under age 21 living with a parent. The parent's resources and income are deemed to the child when the child is in a separate BU from the parent, unless

- the parent is an SSI recipient or has a 1619b status,
- the parent receives IV-E foster care or adoption assistance,
- the child is living away from home per [M0520.001 B.3](#), or
- the child is a foster care child placed in the home for a trial visit of 3 months or less.

1. Deeming Standard

The deeming standard is the portion of the parent's countable resources or income that is not considered available to the child who is in a separate BU from the parent. The resource deeming standard is \$1,000. The income deeming standard is the locality F&C 100% income limit for the deemor parent's BU plus any excluded children.

- 2. Single Parent or Parent and Stepparent with No Child in Common** When each child in the home has only one parent in the home and the parent is in a separate BU, subtract the whole deeming standard from the parent's countable resources and income.
- Note: A stepparent is not a "parent" for deeming purposes.
- 3. Both Parents In Same BU-Married With Child in Common**
- a. No Stepchildren**
- When both parents (at least one child in common) are in the same BU and there are no stepchildren, subtract the whole deeming standard from the parents' resources and income.
- b. Stepchildren**
- When both parents (at least one child in common) are in the same BU and *they have at least one child in common in the home who is included in the family unit*, subtract one-half of the deeming standard for the parents' BU from deemor parent's resources and income.
- When both parents are in the same BU and all their children-in-common are excluded from the family unit, subtract the whole deeming standard for the parents' BU from the deemor parent's resources and income.*
- 4. Both Parents In Different BUs** When both parents (at least one child in common) are in separate BUs, subtract the whole deeming standard from the deemor parent's countable resources and income.
- B. Deeming Resources (F&C MN Only)**
- To determine how much of the deemor parent's resources to deem to the child, use the following procedures:
- 1. Determine Countable Resources** Determine the value of countable resources owned solely by the parent and the value of countable resources owned jointly with the parent's spouse or another person, according to policy in chapter M06. All resources that are in the deemor parent's name only plus the deemor's share of jointly held resources are counted.
- 2. Subtract Resource Deeming Standard**
- a. Single Parent or Parent and Stepparent with No Child in Common**
- Subtract the whole resource deeming standard of \$1,000 from the deemor's total countable resources (those in the deemor's name only plus the deemor's share of jointly held resources).
- Separate deeming calculations for each deemor parent must be done to ensure stepparent resources are not deemed.
- b. Both Parents In Same BU With Child in Common**
- 1) Subtract the whole deeming standard of \$1,000 from the parents' countable resources when there are children in common and no stepchildren in the home.

When both parents are deeming only to children in common, their resources are combined and only one deeming calculation is done.

- 2) Subtract one-half of the resource deeming standard (\$500) from each deemor parent's countable resources, when there are children in common **and** stepchildren in the home, *and at least one child-in-common in the home is included in the family unit.*

Separate deeming calculations for each deemor parent must be done to ensure stepparent resources are not deemed.

c. Both Parents In Different BUs

When both parents are in the home but in different budget units, subtract the whole resource deeming standard of \$1,000 from the deemor's total countable resources (those in the deemor's name only plus the deemor's share of jointly held resources).

Separate deeming calculations must be completed for each deemor parent.

3. Deem Resources Remainder

The remaining value, if any, is deemed available to the non-excluded F&C child(ren) who are not in the parent's BU. If the parent has more than one non-excluded child in the household who is not in the parent's BU, divide the remaining resource value by the number of non-excluded children who are not in the parent's BU.

NOTE: Deeming resources does not reduce countable resources for the deemor's eligibility determination.

4. Example-- Resource Deeming From Parent

EXAMPLE #13: A woman lives with her husband, their 5-year old child, her 11- year old and 12-year old children from a previous marriage, and his 14-year old child from a previous marriage. They apply for everyone in the family. They live in Group I. Due to excess income, a medically needy eligibility determination must be done.

The family's resources consist of a savings account of \$1,050 owned jointly by the woman and her spouse, one car owned by the husband with an equity value of \$1,000 and a second car (owned jointly by the woman and her spouse) with an equity value of \$50. Each child owns a U.S. savings bond valued at \$100.

The Medicaid family unit is broken into budget units to determine resource eligibility.

- budget unit #1 = her husband's 14-year old child;
- budget unit #2 = their 5 year old child;
- budget unit #3 = her 11 year old child;
- budget unit #4 = her 12 year old child;
- budget unit #5 = the woman, her husband.

Each parent has a child who is not the child of his/her spouse; therefore, separate deeming calculations are used.

a. Mom's Resource Deeming Calculation

The mother's resources are deemed available to each of her children who are not in her BU (including her child-in-common with her husband):

$$\begin{array}{r} \$ 525 \quad \frac{1}{2} \text{ savings account} \\ + \underline{25} \quad \text{her } \frac{1}{2} \text{ equity in the second car (not excluded)} \\ 550 \quad \text{countable resources} \\ - \underline{500} \quad \frac{1}{2} \text{ resource deeming standard (parents in same BU, child in common)} \\ 50 \quad \text{deemable resources} \\ \div \underline{3} \quad \text{number of her children not in her BU} \\ \$16.67 \quad \text{deemed to each of her children not in her BU} \end{array}$$

b. Dad's Resource Deeming Calculation

The Dad's resources are deemed available to each of his children who are not in his BU (including his child-in-common with his wife):

$$\begin{array}{r} \$ 525 \quad \frac{1}{2} \text{ savings account} \\ + \underline{25} \quad \text{his } \frac{1}{2} \text{ equity in the second car (not excluded)} \\ 550 \quad \text{countable resources} \\ - \underline{500} \quad \frac{1}{2} \text{ resource deeming standard (parents in same BU, child in common)} \\ 50 \quad \text{deemable resources} \\ \div \underline{2} \quad \text{number of his children not in his BU} \\ \$ 25 \quad \text{deemed to each of his children not in his BU} \end{array}$$

c. Budget Units #3 and #4

$$\begin{array}{r} \$ 100.00 \quad \text{child's savings bond} \\ + \underline{16.67} \quad \text{deemed from Mom} \\ \$ 116.67 \quad \text{child's countable resources} \end{array}$$

Each child has total resources of \$116.67. Each child's resources are less than the MN resource limit; each is resource-eligible and is placed on an MN spenddown.

d. Budget Unit #1

$$\begin{array}{r} \$ 100.00 \quad \text{child's savings bond} \\ + \underline{25.00} \quad \text{deemed from Dad} \\ \$ 125.00 \quad \text{child's countable resources} \end{array}$$

The child has total resources of \$125. Dad's child's resources are less than the MN resource limit, so the child is resource-eligible and is placed on an MN spenddown.

e. Budget Unit #2

$$\begin{array}{r} \$100.00 \quad \text{child's savings bond} \\ + 16.67 \quad \text{deemed from Mom} \\ + \underline{25.00} \quad \text{deemed from Dad} \\ \$141.67 \quad \text{child's countable resources} \end{array}$$

Their child's countable resources are less than the MN resource limit, so their child is resource-eligible and is placed on an MN spenddown.

C. Deeming Income

To determine how much of the deemor parent's income to deem to the F&C child(ren), use the following procedures:

1. Determine Countable Income

Determine the deemor parent's gross monthly countable unearned and earned income according to chapter [M07](#).

2. Subtract Earned Income Exclusions

Subtract the applicable earned income exclusions listed in section [M0720.500](#):

- standard work exclusion of \$90 ([M0720.520](#)), and
- child/incapacitated adult care exclusion([M0720.540](#)).

Do NOT subtract the \$30 plus 1/3 or \$30 earned income exclusions.

3. Subtract Income Deeming Standard

a. Single Parent or Parent and Stepparent with No Child in Common

Subtract the whole income deeming standard. The income deeming standard is the F&C 100% income limit for the locality (see [M710, Appendix 3](#)) for

- the number of persons in the deemor's BU, **plus**
- the number of children under age 21 in the household who are excluded from the Medicaid application (not included in **any** Medicaid assistance unit) and who are or can be claimed as dependents on the deemor's federal income tax return. If the deemor has not previously filed a tax return or states that he/she will claim a different number of dependents for the current year, use the number of dependents he/she intends to claim for the current year. Do not count children who receive SSI when determining the income deeming standard.

A deeming calculation must be done for each deemor parent.

NOTE: For the deeming calculation, a pregnant woman is only 1 person.

b. Both Parents In Same BU and Child-in-Common

- 1) Subtract the whole income deeming standard from the parents' income when there *is a* child(ren)-in-common and no stepchildren in the home.

When both parents are deeming only to child(ren)-in-common, only one deeming calculation is done.

- 2) Subtract one-half of the income deeming standard from the parent's countable income when there are children in common **and** stepchildren in the home, *and at least one child-in-common in the home was included in the family unit.*

Separate deeming calculations for each deemor parent must be done to ensure stepparent income is not deemed.

- 3) *When both parents are in the same BU and ALL their children-in-common are **excluded** from the family unit, subtract the whole income deeming standard for the parents' BU from the deemor parent's income.*

Separate deeming calculations for each deemor parent must be done to ensure stepparent income is not deemed.

c. Both Parents In Different BUs

Subtract the whole income deeming standard from the deemor parent's countable income.

Separate deeming calculations must be done for each deemor parent.

4. Subtract Support Payments Made

Subtract actual alimony and/or child support payments made to individuals not in the home, *regardless of whether or not the individuals are claimed as dependents on the deemor's federal income tax return.*

5. Deem Remainder

Deem the remaining income as unearned income to the non-excluded F&C child(ren) in the household who are not in the parent's BU. If the parent has more than one non-excluded F&C child in the household who is not in the parent's BU, divide the remaining income by the number of non-excluded children who are not in the parent's BU (plus the parent's minor spouse, if any, who is not in the parent's BU).

NOTE: Deeming income does not reduce the deemor's countable income for the deemor's eligibility determination.

6. Example—Income Deeming From Parent; Stepchildren In Home

EXAMPLE #14: (Using July 2002 figures)

An application is filed for a woman who lives with her husband, their 5-year-old child, her 11-year-old and 12-year-old children from a previous marriage, and his 14-year-old child from a previous marriage. They live in Group I. Her husband earns \$2,200 monthly. She earns \$800 monthly. Her children each receive \$150 monthly child support. They have no resources. The Medicaid family unit's countable income exceeds the income limits for all appropriate covered groups.

The Medicaid family unit is broken into budget units because there are stepparents in the home and some of the children have their own income.

- budget unit #1 = Dad's 14-year old child
- budget unit #2 = Mom's 11-year old child
- budget unit #3 = Mom's 12-year old child
- budget unit #4 = Mom, Dad, and their child

Each parent has a child who is not the child of his/her spouse; therefore, separate deeming calculations are used.

a. Mom's Income Deeming Calculation

Mom's countable income is deemed to each of her children who are not in her BU.

\$ 800.00	Mom's earnings
<u>- 90.00</u>	standard work exclusion
710.00	countable income
<u>- 156.63</u>	½ deeming standard for 3 in Group I (\$313.25)
553.37	deemable income
<u>÷ 2</u>	number of her children not in her BU
\$ 276.69	deemed to each child

b. Dad's Income Deeming Calculation

Dad's countable income is deemed to his child.

\$2,200.00	Dad's earnings
<u>- 90.00</u>	standard work exclusion
2,110.00	countable income
<u>- 156.63</u>	½ deeming standard for 3 in Group I (\$313.25)
\$1,953.37	deemable income

c. BU #1

\$1,953.37 countable income (deemed from Dad) exceeds MI child limit for BU of 1 and child is placed on a MN spenddown.

d. BUs #2 and #3

\$ 276.69	deemed unearned income from Mom
+ 150.00	child's own income
<u>- 50.00</u>	child support disregard
376.69	countable income is within MI child limit for both BUs of 1

e. BU #4

\$2,200	husband's earnings
+ 800	woman's earnings
<u>- 180</u>	standard work exclusions (\$90 x 2 = 180)
2,820	countable earned income exceeds LIFC income limit

**7. Example—
Income Deeming
From Parent;
All Children-in-
Common Excluded**

EXAMPLE #14a: (Using July 2005 figures)

A woman lives with her husband, their 5-year old child, her 11-year old and 12 year-old children from a previous marriage, and his 14-year old child from a previous marriage. They exclude their child, and apply for themselves and the other 3 children. They live in Group III. Her husband earns \$2,200 monthly. She earns \$800 monthly. Her children each receive \$150 monthly child support. They have no resources. The Medicaid family unit's countable income exceeds the income limits for all appropriate covered groups.

The Medicaid family unit is broken into budget units because there are stepparents in the home and Mom's two children have their own income.

- budget unit #1 = Dad's 14-year old child
- budget unit #2 = Mom's 11-year old child
- budget unit #3 = Mom's 12-year old child
- budget unit #4 = Mom and Dad

Their excluded child is not included in the parents' BU, but is counted when determining the deeming standard. Each parent has a child who is not the child of his/her spouse; therefore, separate deeming calculations are used.

a. Mom's Income Deeming Calculation

Mom's countable income is deemed to each of her children who are not in her BU.

\$ 800.00	Mom's earnings
- 90.00	standard work exclusion
<u>710.00</u>	countable income
- 437.58	whole deeming standard for 3 in Group III
<u>272.42</u>	deemable income
÷ 2	number of her children not in her BU
\$136.21	deemed to each child

b. Dad's Income Deeming Calculation

Dad's countable income is deemed to his child.

\$2,200.00	Dad's earnings
- 90.00	standard work exclusion
<u>2,110.00</u>	countable income
- 437.58	whole deeming standard for 3 in Group III
\$1,672.42	deemable income

c. BU #1

\$1,672.42 countable income (deemed from Dad) exceeds MI child limit for BU of 1 and child is placed on a MN spenddown.

d. BUs #2 and #3

\$ 136.21	deemed income from Mom
+ 150.00	child's own income
- 50.00	child support disregard
<u>236.21</u>	countable income is within MI 133% FPL limit for 1 person

Mom's children are eligible for Medicaid as MI children under age 19.

e. BU #4

\$2,200	Dad's earnings
+ 800	Mom's earnings
- 180	standard work exclusions (\$90 x 2 = 180)
<u>2,820</u>	countable income exceeds LIFC income limit for 2

Mom and Dad are not eligible for Medicaid because their income exceeds the LIFC income limit and they do not meet any other covered group.

M0520.500 CHANGES IN STATUS

- A. Policy** When the household composition changes, or the circumstances of the household members change, the F&C family and budget unit may change, and the requirements to deem a spouse's or parent's resources (*F&C MN only*) and income may change.
- B. Procedure** See [M0520.501](#) for Family/Budget Unit Changes.
See [M0520.502](#) for Deeming Changes.

M0520.501 FAMILY/BUDGET UNIT CHANGES

- A. Introduction** Some changes in the household composition which require changes in the family unit or budget units are listed and described in this section.
- B. Spouses Separate or Divorce** If a married F&C individual and his/her spouse separate or divorce and no longer live together, the spouse is not included in the F&C individual's family or budget unit beginning the month after the month in which the separation or the divorce occurred. If a married F&C individual and his/her spouse divorce but they remain living in the same household, the divorced father is considered an acknowledged father beginning the month after the month in which the divorce occurred.
- C. Individual Begins Living With A Spouse** For applicants, if an F&C individual or deemor begins living with a spouse, the spouse is included in the family or budget unit beginning with the month in which they begin living together.
- For recipients, if an F&C individual or deemor begins living with a spouse, the spouse is included in the family or budget unit beginning with the month after the month they begin living together.

**D. Parent and Child
Begin Living in
Same Household**

For applicants, if an F&C child begins living with a parent in the same household (e.g., a child comes from aunt's home to live in mother's home), the child and parent are included in the family unit for purposes of determining eligibility beginning the month in which they begin living together.

For recipients, if an F&C child begins living with a parent in the same household (e.g., a child comes from aunt's home to live in mother's home), the child and parent are included in the family unit for purposes of determining eligibility beginning the month **after** the month they begin living together.

NOTE: A newborn child is considered living with the parent(s) as of the date the child is born, unless the child is entrusted into foster care on that date.

**E. Spouse or Parent
Dies**

If a spouse or parent dies, the spouse or parent is deleted from the family or budget unit effective with the month following the month of death.

**F. Individual
Becomes
Institutionalized**

If an F&C individual becomes institutionalized, either in a medical facility or in Medicaid CBC waiver services, the individual is a separate family unit effective with the first month in which the individual is institutionalized.

**G. Individual Leaves
Home**

If an F&C individual leaves the household, the individual is deleted from the family or budget unit beginning with the month following the month in which he left the household.

**LIFC 185% OF STANDARDS OF NEED (MAXIMUM MONTHLY INCOME)
EFFECTIVE 7/01/05**

FAMILY/BUDGET UNIT SIZE	GROUP I	GROUP II	GROUP III
1	300.72	358.41	500.52
2	471.70	529.37	673.55
3	607.64	663.28	809.53
4	737.43	795.11	941.35
5	869.27	941.35	1116.46
6	974.31	1048.47	1221.51
7	1102.04	1174.13	1349.23
8	1240.06	1310.10	1483.20
9	1353.34	1425.46	1604.66
10	1479.03	1553.18	1728.20
each add ¹ person add	125.63	125.63	125.63

F&C Monthly Income Limits Effective 7/01/05

Group I

Family/Budget Unit Size	100%	90%
1	162.55	145.85
2	254.97	230.47
3	328.45	295.05
4	398.61	358.53
5	469.88	423.11
6	526.65	475.44
7	595.70	536.68
8	670.30	602.37
9	731.54	658.05
10	799.47	720.40
Each person above 10	67.91	62.33

Group II

Family/Budget Unit Size	100%	90%
1	193.74	174.80
2	286.15	257.20
3	358.53	324.00
4	429.78	386.35
5	508.84	455.44
6	566.74	509.96
7	634.67	570.08
8	708.16	636.90
9	770.52	693.68
10	839.56	754.92
Each person above 10	67.91	62.33

F&C Monthly Income Limits Effective 7/01/05

Group III

Family/Budget Unit Size	100%	90%
1	270.55	244.96
2	364.09	327.35
3	437.58	394.16
4	508.84	456.52
5	603.49	543.37
6	660.27	594.58
7	729.31	656.94
8	801.72	723.75
9	867.39	780.54
10	934.15	840.66
Each person above 10	67.91	62.33

MEDICALLY NEEDY INCOME LIMITS EFFECTIVE 7-01-05

GROUP I			GROUP II		GROUP III	
# of Persons In Family/ Budget Unit	Semi-Annual Income	Monthly Income	Semi-Annual Income	Monthly Income	Semi-Annual Income	Monthly Income
1	1447.52	241.25	1670.22	278.37	2171.28	361.88
2	1843.37	307.22	2056.98	342.83	2618.02	436.33
3	2171.28	361.88	2393.98	398.99	2950.73	491.78
4	2449.66	408.27	2672.35	445.39	3229.09	538.18
5	2728.03	454.67	2950.73	491.78	3507.47	584.57
6	3006.40	501.06	3229.09	538.18	3785.84	630.97
7	3284.77	547.46	3507.47	584.57	4064.21	677.36
8	3618.81	603.13	3841.51	640.25	4342.58	723.76
9	3952.86	658.81	4175.56	695.92	4732.30	788.71
10	4342.58	723.76	4565.28	760.88	5066.35	844.39
each add'l person add	374.12	62.35	374.12	62.35	374.12	62.35

GENERAL

M0810.001 INCOME AND ELIGIBILITY

A. Introduction The following sections explain how to treat income in the Medicaid program. This chapter explains how we count income.

B. Policy Principles

1. Who is Eligible

An individual is eligible for Medicaid if the person:

- meets a category/classification; and
- meets the nonfinancial requirements; and
- meets the classification's resource limits; and
- meets the classification's income limits.

2. General Income Rules

- Count income on a monthly basis.
- Not all income counts in determining eligibility.
- If an individual's countable income exceeds a classification's monthly limit, a medically needy spenddown may be established, if appropriate.

M0810.002 INCOME LIMITS

A. Income Limits The Medicaid classification determines which income limit to use to determine eligibility.

1. Categorically Needy

Supplemental Security Income (SSI) and State Supplement (Auxiliary Grant) recipient's money payments meet the income eligibility criteria in the ABD Categorically Needy classification.

2. Categorically Needy Non-Money Payment-Protected Cases Only

<ul style="list-style-type: none"> • Categorically-Needy Non-Money Payment Protected Covered Groups Which Use SSI Income Limits 	
Family Unit Size	Monthly Amount
1	\$579
2	869
<ul style="list-style-type: none"> • For individual or couple whose total food and shelter needs are contributed to him or them 	
Family Unit Size	Monthly Amount
1	\$386
2	579.34

3. Categorically Needy-Non Money Payment (CNNMP) - 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](#).

<ul style="list-style-type: none"> Categorically Needy-Non Money Payment 300% of SSI 	
Family Size Unit 1	Monthly Amount \$1,737

4. Medically Needy

a. Group I		
Family Unit Size	Semi-annual	Monthly
1	\$ 1,447.52	\$ 241.25
2	1,843.37	307.22
b. Group II		
Family Unit Size	Semi-annual	Monthly
1	\$ 1,670.22	\$ 278.37
2	2,056.98	342.83
c. Group III		
Family Unit Size	Semi-annual	Monthly
1	\$ 2,171.28	\$ 361.88
2	2,618.02	436.33

5. ABD Medically Indigent

**For:
ABD 80%
FPL, QMB,
SLMB, & QI
without Social
Security (SS)
and QDWI,
effective
2/18/05; and
ABD 80%
FPL, QMB,
SLMB, & QI
with SS,
effective
4/01/05**

ABD 80% FPL	Annual	Monthly
1	\$ 7,656	\$638
2	10,264	856
QMB 100% FPL	Annual	Monthly
1	\$ 9,570	\$ 798
2	12,830	1,070
SLMB 120% of FPL	Annual	Monthly
1	\$ 11,484	\$ 957
2	15,396	1,283
QI 135% FPL	Annual	Monthly
1	\$12,920	\$1,077
2	17,321	1,444
QDWI 200% of FPL	Annual	Monthly
1	\$19,140	\$1,595
2	25,660	2,139

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3. **Value**
 - a. **Series E, EE, and I paper bonds**
 - **On-line Verification at:**
<http://www.publicdebt.treas.gov/sav/savcalc.htm>
 - Current copy of the Table of Redemption Values for US Savings Bonds
 - **Bank Verification** As a last alternative, obtain the value by telephone from a local bank and record it. The bank will need the series, denomination, date of purchase and/or date.
 - b. **Series E, EE, and I electronic bonds**
 - Ask individual to obtain his “Current Holdings” list from the Treasury web site at: <http://www.savingsbonds.gov/>
 - Use Current Holding Summary to verify number of bonds, face value, issue dates, confirmation numbers and value.
 - c. **Series H and HH Bond After Maturity**

After maturity, the redemption value of a series H or HH bond is its face value. Verification of value per a. or b. above is unnecessary.
4. **Photocopy**

Document the file with a photocopy or certification of the bond(s). See [S1140.010 C.](#) on photocopying U.S. Government obligations.
5. **Follow-up, if Appropriate**

If an individual owns a U.S. Savings Bond which, upon maturity, may cause countable resources to exceed the limit, recontact the recipient shortly before the bond matures in order to redevelop the value of countable resources.

S1140.250 MUNICIPAL, CORPORATE, AND GOVERNMENT BONDS

A. Introduction

1. **Bond**

A bond is a written obligation to pay a sum of money at a specified future date. Bonds are negotiable and transferable.
2. **Municipal Bond**

A municipal bond is the obligation of a State or a locality (county, city, town, villages or special purpose authority such as a school district).
3. **Corporate Bond**

A corporate bond is the obligation of a private corporation.
4. **Government Bond**

A government bond, as distinct from a U.S. Savings Bond (see [S1140.240](#)), is a **transferable** obligation issued or backed by the Federal Government.

B. Operating Policy Municipal corporate, and government bonds are negotiable and transferable. Therefore, their value as a resource is their CMV. Their redemption value, available only at maturity, is immaterial.

C. Development and Documentation Development and documentation instructions for stocks ([S1140.220](#)) also apply to bonds.

M1140.260 ANNUITIES (Effective for All Applications Received On or After December 1, 2004)

A. Introduction

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

B. Operating Policy

1. An annuity containing a balloon payment is considered an available resource, and the value of the annuity is counted.
2. An annuity that names revocable beneficiaries is considered to be an available resource because it can be surrendered, cashed in, assigned, transferred or have the beneficiary changed. Annuities are presumed to be revocable when the annuity contract does not state that it is irrevocable.
3. A non-employment related annuity purchased by or for an individual using that individual's assets will be considered an available resource unless it meets all of the following criteria: the annuity (a) is irrevocable; (b) pays out principal and interest in equal monthly installments (no balloon payment) to the individual over a total number of months that is *less than or equal to* the actuarial life expectancy of the annuitant; (c) names the Commonwealth of Virginia as the residual beneficiary of funds remaining in the annuity not to exceed the amount of any Medicaid funds expended on the individual during his lifetime; and (d) is issued by an insurance company, bank, or other registered or licensed entity approved to do business in the jurisdiction in which the annuity is established. Payments from the annuity to the Commonwealth of Virginia cannot exceed the total amount of funds for long-term care services expended on behalf of the individual.
4. Annuities issued prior to 12-01-04 which do not: (a) provide for the payout of principal and interest in equal monthly installments and (b) for which documentation is received from the issuing company that the payout arrangements cannot be changed will be considered to meet the above requirements once amended to name the Commonwealth of Virginia as the primary beneficiary of funds remaining in the annuity, not to exceed the amount of any Medicaid funds expended on the individual during his lifetime.
5. Have the individual submit documentation showing ownership of an annuity. If the owner is the Medicaid applicant or the applicant's spouse, the value of the annuity is a countable resource unless it meets the criteria listed in B.3 above.

4. **CBC Additional Care** Additional care purchased outside of a CBC recipient's plan of care is not counted as income available for patient pay if it is purchased by someone other than the recipient. This additional care may be purchased from any source including the agency providing the CBC.
5. **Advance Payments That Will Be Refunded** Advance payments made by a person other than the patient which are expected to be reimbursed once Medicaid is approved and payments made by outside sources to hold the facility bed while the patient is hospitalized, are **not counted as income** in determining eligibility or patient pay.

There are instances when the family of a prospective Medicaid patient, or other interested party(ies), makes an advance payment on the cost of facility care prior to or during the Medicaid application process to assure the patient's admission and continued care. The individual may have been promised that the advance payment will be refunded if Medicaid eligibility is established.

Any monies contributed toward the cost of patient care pending a Medicaid eligibility determination must be reimbursed to the contributing party by the facility once Medicaid eligibility is established.

M1470.200 FACILITY PATIENTS - ALLOWABLE DEDUCTIONS FROM INCOME

A. Introduction This section describes the only deductions which are subtracted from a facility patient's gross monthly income when calculating patient pay in the month of entry and subsequent months when the patient does not have a community spouse.

Deductions are allowed only for items that are described in sections [M1470.210](#) through 240 below.

NOTE: If the individual is married and his spouse is in a nursing facility, then there is no community spouse and each spouse is treated as an unmarried individual for patient pay purposes. When the patient is an institutionalized spouse with a community spouse, as defined in subchapter [M1480](#), go to subchapter M1480 to determine the institutionalized spouse's patient pay.

B. Order of Patient Pay Deductions Subtract the deduction(s) from gross monthly income in the order presented below. *If the patient has no income remaining after a deduction, no further deductions can be made.*

1. **Personal Needs** See section [M1470.210](#) "Facility Personal Needs Allowance."
2. **Dependent Child Allowance** See section [M1470.220](#) "Dependent Child Allowance."

3. **Noncovered Medical Expenses** See section [M1470.230](#) "Facility - Noncovered Medical Expenses."

4. **Home Maintenance Deduction** See section [M1470.240](#) "Facility - Home Maintenance Deduction."

C. Appeal Rights

The patient or his representative has the right to appeal the patient pay determination, the amounts used in the calculation and denial of any request for adjustment. If a recipient or his representative appeals the patient pay, the EW or Medicaid Technician who made the decision prepares the appeal summary and attends the hearing.

M1470.210 FACILITY PERSONAL NEEDS ALLOWANCE

A. Policy

The personal needs allowance is calculated according to the instructions in this section for the month of entry and subsequent months. The amount of the personal needs allowance depends on whether or not:

- the patient has a guardian or conservator who charges a fee; or
- the patient has earnings from employment that is part of the treatment plan.

1. **Basic Personal Allowance** Deduct \$30 per individual.

2. **Guardianship Fee** Deduct an amount up to 5% of the patient's gross monthly income (including amounts not counted as income and excluded income) for guardianship fees, if the patient has a legally appointed guardian or conservator AND the guardian or conservator charges a fee. Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

NOTE: The guardianship filing fees CANNOT be deducted from the individual's income.

NOTE: No deduction is allowed for *representative payee* or "power of attorney" fees or expenses.

3. **Special Earnings Allowance** Working patients are allowed a higher personal needs allowance if they meet the following criteria. These patients will be identified by the facility. The patient must regularly participate in vocational activity which is a planned habilitation program and is carried out as a therapeutic work program, such as:

- sheltered workshops
- vocational training
- pre-vocational training.

- B. Procedure** Subtract the deduction(s) from gross monthly income in the order presented below:
1. Medicaid CBC Personal Maintenance Allowance ([M1470.410](#))
 2. Dependent Child Allowance ([M1470.420](#))
 3. Medicaid CBC - Incurred Medical Expenses ([M1470.430](#))
- C. Appeal Rights** The patient or his representative has the right to appeal the patient pay determination, the amounts used in the calculation and denial of any request for adjustment. If a recipient or his representative appeals the patient pay, the EW who made the decision prepares the appeal summary and attends the hearing.

M1470.410 MEDICAID CBC - PERSONAL MAINTENANCE ALLOWANCE

- A. Individuals** For the month of entry and subsequent months, deduct from the patient's gross monthly countable income a personal maintenance allowance. The amount of the allowance depends upon under which Medicaid CBC waiver the patient receives LTC services.
1. **Basic Maintenance Allowance**
 - a. **Elderly or Disabled with Consumer-Direction (EDCD) Waiver, Mental Retardation (MR) Waiver, Technology-Assisted Individuals Waiver, and Individual and Family Developmental Disabilities Support (DD) Waiver**

Patients receiving Medicaid CBC under the following waivers are allowed a monthly basic personal maintenance allowance deduction that equals the monthly SSI individual payment limit (see [M0810.002 A. 2.](#)):

 - EDCD Waiver,
 - MR Waiver,
 - Technology-Assisted Individuals Waiver, and
 - DD Waiver.
 - b. **AIDS Waiver**

Patients under the AIDS waiver are allowed a monthly basic personal maintenance allowance that equals 300% of the SSI payment limit for one person (see [M0810.002 A. 3.](#)).
 2. **Guardianship Fee**

Deduct an amount up to 5% of the patient's gross monthly income (including amounts not counted as income and excluded income) for guardianship fees, if the patient has a legally appointed guardian or conservator AND the guardian or conservator charges a fee. Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

NOTE: The guardianship filing fees CANNOT be deducted from the individual's income.

NOTE: No deduction is allowed for *representative payee* or "power of attorney" fees or expenses.

3. Special Earnings Allowance for Recipients in EDCD, DD, or MR Waivers

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

- 1) for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (see [M0810.002 A. 3.](#)) per month.
- 2) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI per month.

The total amount of the personal maintenance allowance and the special earnings allowance cannot exceed 300% SSI.

EXAMPLE #9: (Using January 2005 figures)

A working patient receiving EDCD waiver services is employed 18 hours per week. His income is gross earnings of \$928.80 per month and SSA of \$300 monthly. His special earnings allowance is calculated *by comparing his gross earned income (\$ 928.80) to the 200% of SSI maximum (\$ 1,158.00). His gross earned income is less than 200% of SSI; therefore, he is entitled to a special earnings allowance.* His personal maintenance allowance is computed as follows:

\$ 579.00	CBC personal maintenance allowance
<u>+ 928.80</u>	special earnings allowance
\$ 1,507.80	total personal maintenance allowance

B. Couples

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

February spenddown eligibility evaluated.

M1480.350 SPENDDOWN ENTITLEMENT

- A. Entitlement After Spenddown Met** When an institutionalized spouse meets a spenddown within a month, the begin date of eligibility will be the first day of the month in which the spenddown was met. Eligibility will end on the last day of the month in which the spenddown was met.
- B. Procedures**
- 1. Coverage Dates** Coverage begin date is the first day of the month; the coverage end date is the last day of the month.
 - 2. Program Designation**
 - a. If the institutionalized spouse does NOT have Medicare Part A:**
 - Aged = 18
 - Blind = 38
 - Disabled = 58
 - Child Under 21 in ICF/ICF-MR = 98
 - Child Under Age 18 = 88
 - Juvenile Justice Child = 85
 - Foster Care/Adoption Assistance Child = 86
 - Pregnant Woman = 97
 - b. If the institutionalized spouse has Medicare Part A:**

Compare the individual's monthly MN countable income to the QMB monthly income limit for 1 person (see [M0810.002](#) for the current QMB limit):

 - 1) When income is less than or equal to the QMB limit, enroll using the following PDs:
 - Aged = 28
 - Blind = 48
 - Disabled = 68
 - 2) When income is greater than the QMB limit, enroll using the following PDs:
 - Aged = 18
 - Blind = 38
 - Disabled = 58
 - 3. Patient Pay** Determine patient pay according to section [M1480.400](#) below.
 - 4. Notices & Re-applications** The institutionalized spouse on a spenddown must have his eligibility re-evaluated monthly, unless he is in a facility and the spenddown liability is less than or equal to the Medicaid rate. The institutionalized spouse must complete an annual redetermination.

After eligibility is established, the usual reporting and notification processes apply. Send the “Notice of Action on Medicaid” and the “Notice of Obligation for LTC Costs” for the month(s) during which the individual establishes Medicaid eligibility.

M1480.400 PATIENT PAY

- A. Introduction** This section contains the policy and procedures for determining an institutionalized spouse’s (as defined in section [M1480.010](#) above) patient pay in all covered groups.
- B. Married With Institutionalized Spouse in a Facility** For a married LTC patient with an institutionalized spouse in a facility, **NO** amount of the patient’s income is deducted for the spouse’s needs in the patient pay calculation.

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

- A. Introduction** This subsection contains the standards and their effective dates that are used to determine the community spouse’s and other family members’ income allowances. The income allowances are deducted from the institutionalized spouse’s gross monthly income when determining the monthly patient pay amount. Definitions of these terms are in section [M1480.010](#) above.
- B. Monthly Maintenance Needs Standard**

<i>\$1,603.75</i>	7-1-05		
<i>\$1,561.25</i>	7-1-04		
- C. Monthly Maintenance Needs Allowance Maximum**

<i>\$2,377.50</i>	1-1-05		
<i>2,319</i>	1-1-04		
- D. Excess Shelter Standard**

<i>\$481.13</i>	7-1-05		
<i>\$468.37</i>	7-1-04		
- E. Utility Standard Deduction (Food Stamps Program)**

<i>\$229</i>	1 - 3 household members		10-1-04
<i>\$283</i>	4 or more household members		10-1-04
<i>\$206</i>	1 - 3 household members		10-1-03
<i>\$253</i>	4 or more household members		10-1-03

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

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

- B. What Is Patient Pay** The institutionalized spouse's gross monthly income, less all appropriate deductions according to this section, constitutes the patient pay - the amount of income the institutionalized spouse will be responsible to pay to the LTC facility or waiver services provider. The community spouse's and family member's monthly income allowances rules for patient pay apply to all institutionalized spouses with community spouses, regardless of when institutionalization began.
- C. Dependent Allowances** A major difference in the institutionalized spouse patient pay policy is the allowance for a dependent child and for a dependent family member. If the institutionalized spouse has a dependent child, but the dependent child does NOT live with the community spouse, then **NO** allowance is deducted for the child. Additionally, an allowance may be deducted for other dependent family members living with the community spouse.
- D. Home Maintenance Deduction** A major difference in the institutionalized spouse patient pay policy is the home maintenance deduction policy. A married institutionalized individual with a community spouse living in the home is **NOT allowed** the home maintenance deduction because the community spouse allowance provides for the home maintenance, **UNLESS**:
- the community spouse is not living in the home (e.g., the community spouse is in an ACR), and
 - the institutionalized spouse still needs to maintain their former home.

M1480.430 ABD 80% FPL and 300% SSI PATIENT PAY CALCULATION

- A. Patient Pay Gross Monthly Income** Determine the institutionalized spouse's patient pay gross monthly income for patient pay. Use the gross income policy in section M1480.310 C. 1. for both covered groups.
- B. Subtract Allowable Deductions** **If the patient has no patient pay income, he has no patient pay deductions.**
- When the patient has patient pay income, **deduct the following amounts in the following order** from the institutionalized spouse's gross monthly patient pay income. *Subtract each subsequent deduction as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.*
- personal needs or maintenance allowance,
 - community spouse monthly income allowance,
 - family member's income allowance,
 - noncovered medical expenses.
 - home maintenance deduction, if applicable.

C. Personal Needs or Maintenance Allowance

The personal needs allowance for an institutionalized spouse in a facility is different from the personal maintenance allowance of an institutionalized spouse in a Medicaid CBC waiver. The amount of the personal needs or maintenance allowance also depends on whether or not the patient has a guardian or conservator who charges a fee, and whether or not the patient has earnings from employment that is part of the treatment plan.

1. Facility Care**a. Basic Allowance**

Deduct the \$30 basic allowance.

b. Guardian Fee

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

- the patient has a legally appointed guardian and/or conservator AND
- the guardian or conservator charges a fee.

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

NOTE: The guardianship filing fees CANNOT be deducted from the individual's income.

c. Special Earnings Allowance

Deduct a special earnings allowance if the patient participates in a work program as part of treatment. The special earnings allowance is deducted from earned income only. Deduct:

- the first \$75 of gross monthly earnings, PLUS
- ½ the remaining gross earnings,
- up to a maximum of \$190 per month.

The special earnings allowance cannot exceed \$190 per month.

d. Example - Facility Care Personal Needs Allowance

EXAMPLE #18: A patient in the nursing facility is employed as a telephone salesperson as part of his plan of care in the facility. He has a legally appointed conservator who charges a 2% fee. His only income is gross earnings of \$875 per month. His special earnings allowance is calculated first:

- patients age 65 or older
- patients age 22 - 64
- patients under age 22 years (children), unless the child is receiving inpatient psychiatric care.

NOTE: Patients in IMDs who are under age 65 are not eligible for Medicaid because they do not meet the nonfinancial institutional status requirement, unless they are under age 22 and in inpatient psychiatric care.

D. Patient Pay Procedures

Determine an MN institutionalized spouse's patient pay using the policy and procedures in the sections below:

- Facility Patient Pay - Spenddown Liability Less Than or Equal to Medicaid Rate (section [M1480.450](#)).
- Facility Patient Pay - Spenddown Liability Greater Than Medicaid Rate (section [M1480.460](#)).
- CBC - MN Institutionalized Spouse Patient Pay (section [M1480.470](#)).

M1480.450 FACILITY PATIENT PAY - SPENDDOWN LIABILITY LESS THAN OR EQUAL TO MEDICAID RATE

A. Policy

An MN institutionalized spouse in a facility whose spenddown liability is less than or equal to the Medicaid rate is eligible for a full month's Medicaid coverage effective the first day of the month, based on the projected Medicaid rate for the month. Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay his community spouse and family member allowances, and his personal needs and noncovered expenses not used to meet the spenddown. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability to the provider.

B. Procedures

Determine patient pay for the month in which the spenddown is met using the procedures below.

- 1. Patient Pay Gross Monthly Income** Determine the institutionalized spouse's patient pay gross monthly income according to section [M1480.330](#) (including any amounts excluded in determining MN countable income and the spenddown liability).
- 2. Subtract Patient Pay Deductions** Subtract the following from the patient pay gross monthly income *in the following order as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.*
 - a. a personal needs allowance (per section [M1480.430 C.](#)),
 - b. a community spouse monthly income allowance, if appropriate (per section [M1480.430 D.](#)),

- c. a family member’s income allowance, if appropriate (per section [M1480.430 E.](#)),
- d. any allowable noncovered medical expenses (per section [M1470.230](#)) **including** any old bills and carry-over expenses,
- e. a home maintenance deduction, if appropriate (per section [M1480.430 G.](#)).

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

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

4. DMAS-122 Complete and send a DMAS-122 form to the facility for the month in which the spenddown was met, showing the individual’s begin and end date of Medicaid coverage in the month, and the patient pay for the month.

5. Notice of Obligation Complete and send a “Notice of Obligation for Long-term Care” to the recipient and/or his authorized representative for the month in which the spenddown was met, showing the individual’s patient pay for the month.

C. Example--Facility Liability Less Than Medicaid Rate, Community Spouse Allowance

EXAMPLE #24: (Using July 2000 figures)

Mr. Hay is an institutionalized spouse who applied for Medicaid in *July*. He was admitted to the facility the prior November. He has a monthly CSA benefit of \$1,700 and a monthly Seminole Indian payment of \$235. He has Medicare Parts A & B and Federal Employees Health Insurance which costs \$75 per month. He last lived outside the facility in a Group III locality. His wife, Mrs. Hay, still lives in their home; she has income of \$500 per month from CSA. They have no dependent family members living with Mrs. Hay. Mr. Hay’s total income exceeds the CNNMP 300% of SSI income limit. His MN eligibility is determined for *July*. The MN determination results in a monthly spenddown liability of \$1,355:

$$\begin{array}{r}
 \$1,700 \text{ monthly MN income (Seminole Indian payment excluded)} \\
 - \quad 20 \text{ exclusion} \\
 \hline
 1,680 \text{ countable MN income} \\
 - \quad 325 \text{ MN limit for 1 (Group III)} \\
 \hline
 \$1,355 \text{ spenddown liability for month}
 \end{array}$$

The facility’s Medicaid rate is \$45 per day, or \$1,395 for a 31-day month. By projecting the month’s cost of facility care, Mr. Hay meets his spenddown effective the first day of the month and is eligible for Medicaid effective *July 1*. He is enrolled in Medicaid effective *July 1*, with a PD of 18.

\$1025.50 left to pay her personal needs, community spouse and family member's monthly income allowances, the old bills and her medical insurance premiums, totaling \$1025.50. Medicaid will pay \$755.50 of her spenddown liability (\$1,530 spenddown liability - 774.50 patient pay = \$755.50). This is allowed under section 1924 of the Social Security Act (Special Treatment For Married Institutionalized Spouses).

M1480.460 FACILITY PATIENT PAY - SPENDDOWN LIABILITY GREATER THAN MEDICAID RATE

A. Policy

An MN facility institutionalized spouse whose spenddown liability is greater than the Medicaid rate is not eligible for Medicaid unless he incurs additional medical expenses that meet the spenddown liability within the month. If he meets the spenddown liability, his Medicaid coverage begins the first day of the month in which the spenddown is met, and ends on the last day of that month. A patient pay for the month is calculated.

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

B. Procedures

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

1. Calculate Remaining Income for Patient Pay

a. Determine Gross Monthly Patient Pay Income

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

b. Subtract Allowable Deductions

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

- 1) a personal needs allowance (per section [M1480.430 C.](#)),
- 2) a community spouse monthly income allowance, if appropriate (per section [M1480.430 D.](#)),
- 3) a family member's monthly income allowance, if appropriate (per section [M1480.430 E.](#)),

- 4) allowable noncovered medical expenses (per section [M1470.230](#)) including any old bills, carry-over expenses and other noncovered expenses that were used to meet the spenddown, but NOT including the cost of the facility care, and
- 5) a home maintenance deduction, if appropriate (per section [M1480.430 G.](#)).

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

- 2. Patient Pay** Compare the remaining income for patient pay to the Medicaid rate for the month. The patient pay is the lesser of the two amounts.
- 3. DMAS-122** Complete and send a DMAS-122 form to the facility for the month in which the spenddown was met, showing the individual’s begin and end date of Medicaid coverage in the month, and the patient pay for the month.
- 4. Notice of Obligation** Complete and send a “Notice of Obligation for Long-term Care” to the recipient and/or his authorized representative for the month in which the spenddown was met, showing the individual’s patient pay for the month.

C. Example--Facility, Spenddown Liability Greater Than Medicaid Rate, Less Than Private Cost of Care

EXAMPLE #26: (Using July 2000 figures)
 Mr. L is an institutionalized spouse who applied for Medicaid in July. He was admitted to the facility the prior December. He has a monthly CSA benefit of \$1,900 and a monthly Seminole Indian payment of \$200. He has Medicare Parts A & B and Federal Employees Health Insurance which costs him \$75 per month. He last lived outside the facility in a Group III locality.

His wife, Mrs. L, still lives in their home with their dependent child age 20 years. Mrs. L has income of \$500 per month from CSA. Their child has no income. Mr. L’s income exceeds the CNNMP 300% SSI income limit. His MN eligibility is determined for July. The MN determination results in a spenddown liability of \$1,555:

\$1,900	monthly MN income (Seminole Indian payment excluded)
- 20	exclusion
1,880	countable MN income
- 325	MN limit for 1 (Group III)
\$1,555	spenddown liability for month

The facility’s Medicaid rate is \$45 per day, or \$1,395 for a month. The private pay rate is \$80 per day. By projecting the month’s Medicaid rate, he does not meet his spenddown in July. He has no old bills. He is placed on a monthly spenddown of \$1,555 for each month in the 12-month certification period beginning July 1.

On July 31, he submits expenses for July. The worker verifies that his resources were below the limit in July. His spenddown liability of \$1,555 is

Mrs. Bee's patient pay for July is calculated as follows:

\$2,000.00	SSA
+ 500.00	private pension
<u>2,500.00</u>	gross patient pay income
- 30.00	personal needs allowance
- <u>131.25</u>	community spouse allowance
2,338.75	
- <u>145.50</u>	noncovered Medicare & health ins. premium
\$2,193.25	remaining income (July)

Mrs. Bee's remaining income for patient pay in July is \$2,193.25, which is greater than the Medicaid rate for of July \$1,705. The facility can only collect the Medicaid rate; therefore, her patient pay for July is the Medicaid rate of \$1,705. The worker notifies her of her Medicaid coverage dates and her patient pay for July, and sends a DMAS-122 to the facility for July only.

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

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

M1480.470 CBC - MN INSTITUTIONALIZED SPOUSE PATIENT PAY

A. Policy

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

An institutionalized spouse who is screened and approved for waiver services, and whose income **exceeds the CNNMP 300% SSI income limit**, is placed on a monthly spenddown. **The monthly CBC costs cannot be projected** for the spenddown budget period. The CBC costs, along with any other spenddown deductions, are deducted daily and chronologically as the costs are incurred. If the spenddown is met any day in the month, Medicaid

coverage begins the first day of the month in which the spenddown is met, and ends on the last day of that month. A patient pay for the month is calculated.

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

B. Procedures

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

1. Calculate Available Income for Patient Pay

a. Determine Gross Monthly Patient Pay Income

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

b. Subtract Allowable Deductions

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

- 1) a personal maintenance allowance (per section [M1480.430 C.](#)),
- 2) a community spouse monthly income allowance, if appropriate (per section [M1480.430 D.](#)),
- 3) a family member's monthly income allowance, if appropriate (per section [M1480.430 E.](#)),
- 4) allowable noncovered medical expenses (per section [M1470.430](#)) including any old bills, carry-over expenses and other noncovered expenses that were used to meet the spenddown, but NOT including the cost of the community-based care.
- 5) a home maintenance deduction, if appropriate (per section [M1480.430 G.](#)).

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

2. Patient Pay

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

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group. If the recipient does meet the definition for another covered group, obtain the information to determine if the individual's resources and income are within the applicable limits. If the individual is eligible in another covered group, change the individual's aid category in the MMIS.

If the individual does not meet a definition for another covered group, send an advance notice and cancel the individual's Medicaid coverage because the individual does not meet a Medicaid covered group.

If the individual meets the definition for medically needy coverage but is not eligible because of income, send an advance notice and cancel the individual's Medicaid coverage because of excess income, and place the individual on a medically needy spenddown.

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

For FC or AA children placed by another state's social services agency, verification of continued IV-E or non-IV-E special medical needs status, current address, and TPL can be obtained from agency records, the parent or the other state.

**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 *renewal* form is available on-line at <http://www.localagency.dss.state.va.us/divisions/bp/files/me/forms/general/032-03-653.pdf>. The recipient 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. SSI and QSII
(1619(b))
Covered
Group
Recipients**

For recipients enrolled in the SSI and QSII Medicaid covered groups, the ex parte renewal consists of verification of continued SSI or 1619(b) status by inquiring SVES. 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 Medicaid Renewal, form #032-03-699, must be completed and necessary verifications obtained to allow the eligibility worker to evaluate the individual's eligibility in all other covered groups prior to canceling his Medicaid coverage.

**D. Recipient Becomes
Institutionalized**

When a recipient is admitted to long-term care in a medical facility or is screened and approved for Medicaid waiver services, eligibility as an institutionalized individual must be determined using the policies and procedures in chapter [M14](#).

E. LTC

LTC recipients, other than those enrolled in the Medicaid SSI covered group, must complete the Medicaid Redetermination for LTC, form #032-03-369 (see [Appendix 5 to subchapter M1410](#)) for the annual renewal. The DMAS-122 must be updated at least every 12 months even when there is no change in the patient pay.

Ongoing eligibility for LTC recipients enrolled in the Medicaid SSI covered group can be established through an ex parte renewal, i.e., SVES inquiry.

The following chart indicates some of the computer match sources which require a ten (10) day advance notice.

<u>Match Source</u>	<u>Notification Period</u>
Internal Revenue Service (IRS) unearned income files	10 days
Beneficiary and Earnings Data Exchange (Bendex)	10 days
State Data Exchange (SDX)	10 days
Enumeration Verification System (SSN)	10 days
Systematic Alien Verification For Entitlements (SAVE)	10 days
Department of Motor Vehicles (DMV)	10 days
Virginia Employment Commission (VEC)	10 days
Benefit Exchange Earnings Record (BEERS)	10 days

D. Procedures

**1. Action
Appealed**

Adverse action must not be taken if the recipient requests an appeal hearing before the effective date of the action. The DMAS Chief Hearing Officer will notify the local agency whether to continue coverage during the appeal.

If the recipient requests an appeal hearing before the effective date, the recipient may choose to have eligibility continued at the current level of services until a decision is reached after a hearing. In the event the decision is adverse to the recipient, the amount Medicaid paid on the services being appealed that were received by the recipient during the continuation is subject to recovery by the Department of Medical Assistance Services (DMAS).

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

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

- | | |
|-----------------------------------|--|
| 2. Death of Recipient | Adequate notice of cancellation must be sent to the estate of the recipient at the recipient's last known address when information is received that the recipient is deceased. The effective date of cancellation in the MMIS computer eligibility file is the date of death. |
| 3. End of Spenddown Period | When eligibility automatically terminates at the end of a six-month spenddown period, advance notice is not required. <i>The individual is notified of the limited period of spenddown eligibility on the "Notice of Action on Medicaid (NOA)" sent at the time the application is approved. Explanation of this limitation and information relative to reapplication is provided at the time of the eligibility determination and enrollment.</i> |

M1520.402 CANCELLATION ACTION OR SERVICES REDUCTION

A. Introduction

- | | |
|-------------------------------------|---|
| 1. MMIS Computer Transaction | A case must be canceled in the Medicaid computer prior to the date of the proposed action. The change to the MMIS recipient file must be made after cut-off in the month the proposed action is to become effective. For example, if the <i>NOA</i> specifies the intent to cancel on October 31, a change to the Medicaid computer is made <i>prior to</i> cut-off in October. |
|-------------------------------------|---|

In the event the proposed action is not taken or an appeal is filed prior to the proposed date of action, the case must be immediately reopened.

- | | |
|-------------------------------------|--|
| 2. Reason "12" Cancellations | When information is received from <i>DMAS</i> that a case is canceled for cancel reason "012", the local social services department must determine if the cancellation is valid. When cancellation is not valid, the case must be re-enrolled immediately. |
|-------------------------------------|--|

When the cancellation is valid, the local department must mail the individual an adequate notice of cancellation using the *NOA*. Adequate notice consists of specifying the date the cancel action took place, which is the date the notice is mailed, in the section marked "Other" on the notification form.

M1520.403 RECIPIENT REQUESTS CANCELLATION

A recipient may request cancellation of his Medicaid coverage. The request must be written and documented in the record. When the recipient requests cancellation of Medicaid, the local department must send an *NOA* to the recipient no later than the effective date of cancellation. On the notice:

- check the "other" block and list the reason as "recipient's request,"
- *instruct the recipient to discontinue using the card after the effective date of cancellation, and*
- *instruct the recipient to retain the Medicaid card for future use in case coverage is reinstated within the next 12 months (the system will generate a new card after 12 months).*

Cancel Medicaid coverage in the MMIS using the cancel reason "004".

For recipients who have been placed in the Client Medicaid Management Program, Medicaid payment for physicians' services will be limited to those services rendered by the primary physician (including a physician providing services to the patients of the primary physician when the primary physician is not available), physicians seen on referral from the primary physician, and emergency medical services. Prescriptions may be filled by a non-designated pharmacy only in emergency situations when the designated pharmacy is closed or cannot readily obtain the drug.

M1850.100 COVERED SERVICES

A. General Information

Information on Medicaid covered services is provided to assist the eligibility worker in responding to general inquiries from applicants/recipients. Recipients who have problems with bills or services from providers of care should be referred as follows:

Fee-for-Service Medicaid Recipients

Fee-for-service Medicaid recipients should be referred to the DMAS Recipient Helpline at 804-786-6145. Recipients who need assistance with transportation should be referred to the DMAS transportation broker at 866-386-8331.

Recipients Enrolled in Managed Care

Recipients enrolled in managed care should be referred to the Managed Care Helpline at 800-643-2273. Medallion II enrollees may also contact their MCO directly. MEDALLION enrollees who need assistance with transportation should be referred to the DMAS transportation broker at 866-386-8331. Medallion II enrollees who need assistance with transportation must contact their MCO directly.

B. Copayments

Most Medicaid covered services have a "copayment," which is the portion of the cost of the service for which the recipient is responsible. Copayment amounts range from \$1.00 to \$3.00 for most services. There is a \$100.00 copayment per admission for inpatient hospital stays. The provider collects the copayment directly from the recipient at the time the service is provided.

B. Individuals Exempt from Copayments

The following individuals are exempt from the Medicaid copayments:

- children under 21 years old,
- individuals who receive long-term care services in a nursing facility, rehabilitation hospital, or long-stay hospital, and
- individuals receiving Medicaid community-based care (CBC) waiver services and hospice care.

C. Services with No Copayments

The following services do not have copayments:

- emergency-room services,
- pregnancy-related services,
- family planning services, and
- dialysis services.

D. Covered Services

The services listed below are covered:

- case management services;
- certified pediatric nurse and family nurse practitioner services;
- clinical psychologist services;
- community mental retardation services, including day health rehabilitation services and case management;
- dental services for individuals under age 21 years;
- emergency hospital services;
- Early Periodic Screening, Diagnostic and Treatment (EPSDT) services;
- family planning services;
- Federally Qualified Health Center clinic services;
- home and community-based care waiver services, including personal care, adult day health care, respite care, private duty nursing, case management, mental retardation services, and services for the developmentally disabled;
- home health services: nurse, aide, supplies, treatment, physical therapy, occupational therapy, and speech therapy services;
- hospice services;

4. Dental Services

a. *Smiles for Children Program*

Beginning July 1, 2005, all Medicaid and FAMIS covered dental services are provided under the “Smiles For Children” program, administered by Doral Dental USA. The managed care organizations (MCOs) no longer provide dental services to Medicaid and FAMIS recipients who are enrolled in an MCO. All recipients use their Commonwealth of Virginia Department of Medical Assistance Services or MCO-issued ID card to receive dental services. Coverage for medical services is not impacted by this change.

The toll-free telephone number for the Smiles For Children member services is 888-912-3456 (Monday through Friday from 8:00 a.m. to 6:00 p.m.). Recipients can obtain provider lists, appointment assistance, member handbooks, and information about dental services and claims.

b. **Covered Dental Services For Recipients Under Age 21**

Covered services include services for relief of pain and elimination of infection, preventative services such as oral prophylaxis and fluoride treatment, routine therapeutic services for the restoration of carious teeth, and diagnostic services.

Procedures such as orthodontics, dentures, braces, partial and permanent bridge work must be preauthorized by *Smiles for Children*.

c. **Covered Dental Services For Recipients Over Age 21**

Covered services include limited oral surgery services when performed by a participating dentist and when generally covered under Medicare and/or are medically necessary. Examples of covered services include removal of cysts and tumors not related to the teeth, biopsies for suspected malignancies, repair of traumatic wounds, and extraction of teeth for severe abscesses.

Items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not covered.

5. **Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services**

a. **General**

1. Health screening services are provided to all eligible individuals under age 21 including those who are married or emancipated. The local agency must inform eligible individuals of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program; however, participation is voluntary. Screening services and treatment may be provided by local health departments and private practitioners.
2. Medicaid must cover any medical service identified as medically necessary by an EPSDT screening. When the identified service is not a Medicaid-covered service, DMAS must pre-authorize payment for the service. The service provider and the EPSDT screener are responsible for obtaining this pre-authorization.

3. Some examples of non Medicaid-covered medical services that must be covered by Medicaid under EPSDT are inpatient psychiatric hospitalization, chiropractic care, and specific therapies such as speech and language therapy.

b. Types of Screening

1. Initial physical examinations to screen all children committed to the care and custody of *an LDSS* to ascertain any physical or mental defects and other health needs of each child are covered.
2. Usually, not more than one screening examination per 12-month period is covered for each foster care child between the ages of 3 and 21 years.
3. Children from birth to age 3 may be covered for screening at more frequent intervals. Immunizations given during visits for screening examinations will be covered for foster care children.
4. Procedures for the EPSDT screening of children are specified in the Social Services Manual, Volume VII.

6. Family Planning Services

Covered family planning services are those family planning drugs, supplies, and devices provided under the supervision of a physician. They do not include any services to promote or restore fertility or sexual function.

7. Home Health Services

Covered home health services include all services provided by an authorized home health agency under a plan of treatment prescribed by a physician.

8. Hospice Services

Care in a Medicaid-certified and enrolled hospice is covered for terminally-ill Medicaid recipients. DMAS must pre-authorize the payment for eligible recipients.

9. Inpatient Hospital Services

- a. Inpatient hospital stays for recipients age 21 and over must be preauthorized by DMAS. Emergency admissions must be authorized within 24 hours of admission.

Inpatient hospital stays for children under age 21 years must be medically necessary and preauthorized by the DMAS.

- b. Inpatient psychiatric hospital stays are covered only for recipients over age 65 years, and for children under age 21 if identified as necessary by EPSDT screening or exam and pre-authorized by DMAS.

10. Laboratory and X-Ray Services

Laboratory and x-ray services are covered when ordered by a physician and may be provided in a physician's office, certified independent laboratory, State Health Department laboratory, or local health department.

- 11. Medical Supplies and Equipment**
- Medicaid will cover blood glucose self-monitoring test strips for children under the age of 21 with diabetes and pregnant women with gestational diabetes. Medicaid will cover blood glucose self-monitoring test strips for individuals over the age of 21 who are eligible for durable medical equipment, when certain criteria are met.
- Medicaid will cover prosthetic devices (artificial arms, legs, and supportive devices) when prescribed by the physician, preauthorized by the Department of Medical Assistance Services, and furnished by a qualified participating provider.
- Respiratory equipment and oxygen supplies are covered.
- Ostomy supplies are covered.
- Other medical supplies and equipment are covered only for patients receiving renal dialysis or home health care services, and for children under age 21 when the need for the supply or equipment is identified as medically necessary through an EPSDT screening or exam. Medicaid will cover the balance of charges for supplies and equipment covered by Medicare when Medicare has made partial payment on the supplies and/or equipment.
- 12. Nurse-Midwife Services**
- Services are covered when provided by a licensed Medicaid-enrolled nurse-midwife, as allowed under Virginia law.
- 13. Nursing Facility Care**
- a. Nursing facility services are covered when provided in medical institutions licensed as nursing facilities by the State Health Department and certified by DMAS.
- b. Nursing care in intermediate care facilities for the mentally retarded (ICF/MR) is not a covered service for recipients enrolled as MN.
- 14. Optometrist Services**
- Eye examinations that licensed optometrists and opticians are legally authorized to provide are covered. A routine, comprehensive eye examination is allowed once every 24 months. Preauthorization is not required. Eyeglasses (lenses and frames) are covered for children under age 21 years. Preauthorization for eyeglasses is not required.
- 15. Outpatient Hospital Services**
- Outpatient hospital services are covered when furnished by or under the direction of a physician or a doctor of dental surgery. Diagnostic services are covered only when ordered by a physician.
- 16. Physical, Occupational and Speech Therapy**
- Therapy services are covered only as an element of hospital care (inpatient or outpatient), nursing facility care, or home health care, or if prescribed by a physician and provided by a Medicaid-enrolled therapy provider.

- 17. Physician Services** Services are covered when provided by physicians licensed to practice medicine, osteopathy, and psychiatry.
- 18. Podiatrist Services** Medicaid payment is limited to medically necessary diagnostic, medical, or surgical treatment of the foot. Routine and preventive foot care is not covered.
- 19. Prescribed Drugs** Services are limited to generic legend drugs except when the physician specifies "brand necessary" name drugs. When prescribed by a physician, insulin, insulin syringes and needles, and family planning drugs and supplies are covered.
- 20. Rehabilitation Services**
- Preauthorization requirement**
- All rehabilitative services must be pre-authorized by DMAS.
- Intensive Inpatient Rehabilitation**
- Medicaid covers intensive inpatient rehabilitation services provided in facilities certified as rehabilitation hospitals or in rehabilitation units in acute care hospitals, which are certified by the Department of Health as excluded from the Medicare prospective payment system.
- Intensive Outpatient Rehabilitation**
- Intensive outpatient rehabilitation services provided by facilities certified as comprehensive rehabilitation facilities (CORFs), or by an outpatient program administered by a rehabilitation hospital or exempted rehabilitation unit of an acute care hospital, which are certified and participating in Medicaid are covered.
- 21. Transplant Services** Transplant services are covered as follows:
- kidney, cornea, heart, lung, liver without age limits;
 - liver, heart, lung, small bowel, bone marrow, and any other medically necessary transplant procedures that are not experimental or investigational for recipients under age 21; and
 - bone marrow transplants for individuals over age 21 for a diagnosis of lymphoma, breast cancer, leukemia, or myeloma.
- DMAS must preauthorize all transplants except corneal transplants.
- 22. Transportation to Receive Medical Services** Non-emergency transportation to a medical service is covered only when preauthorized by the DMAS transportation broker. *The toll-free telephone number for the transportation broker is 866-386-8331.*
- Transportation is only covered when the recipient is being transported for the purpose of receiving or returning home from a Medicaid-covered service.

C. M02 Exceptions

The exceptions to the Medicaid Nonfinancial Eligibility Requirements in Chapter M02 are:

1. Alienage Requirements

FAMIS alienage requirements are different from the Medicaid alienage requirements. Citizens and qualified aliens who entered before August 22, 1996 meet the citizenship/alienage requirements and are not subject to time limitations.

a. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **without regard to time limitations**:

- refugees (see M0220.310 A. 2),
- asylees (see M0220.310 A. 4),
- veteran or active military (see M0220.311),
- deportation withheld (see M0220.310 A. 6), and
- victims of a severe form of trafficking (see M0220.313 A.52)

b. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **after 5 years of residence in the United States**:

- lawful permanent residents (LPR),
- conditional entrants-aliens admitted pursuant to 8 U.S.C.1153(a)(7),
- aliens paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA, and
- battered aliens, alien parents of battered children, alien children of battered parents.

Unqualified aliens, including illegal and non-immigrant aliens, do not meet the alienage requirements.

[Appendix 7](#), FAMIS Alien Eligibility Chart, lists alien groups that meet or do not meet the alienage requirements.

2. SSN

A Social Security number (SSN) or proof of application for an SSN (M0240) is **not** a requirement for FAMIS.

3. Assignment of Rights

Assignment of rights to payment for medical care from any liable third party *is a condition of eligibility for the child.*

4. HIPP

Application requirements for the Health Insurance Premium Payment (HIPP) program (M0290) do not apply to 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/Local Choice 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. A child is also ineligible for FAMIS if he is a member of a family eligible for health benefits coverage on the basis of a family member's employment with a local governmental agency that participates in the Local Choice Program and the employer contributes to the cost of dependent health insurance.

4. IMD Prohibition

The child cannot be an inpatient in an institution for mental diseases (IMD).

M2120.200 HEALTH INSURANCE COVERAGE

A. Introduction

The intent of FAMIS is to provide health coverage to low-income uninsured children. Eligibility for this program is prohibited when creditable health insurance coverage is dropped within 4 months of the application for FAMIS unless good cause for discontinuing the insurance is demonstrated.

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;
- a public health plan; and
- any other health benefit plan under section 5(e) of the Peace Corps Act.

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

- dental only or vision only insurance;
- specified disease insurance;
- hospital confinement indemnity coverage;
- limited benefit health coverage;
- coverage issued as a supplement to liability insurance;
- insurance arising out of workers' compensation or similar law;
- automobile medical payment insurance; or
- insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

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

6. Uninsured means having no insurance; having insurance that is not creditable; having coverage which is not defined as a health benefit plan, or having a health insurance plan that does not have a network of providers in the area where the child resides.

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

- have creditable health insurance coverage;
- have coverage under a group health plan (TRICARE, federal employee benefit plan, private group insurance such as Anthem, etc.);
- be a member of a family eligible for health benefits coverage under a State Employee Health Insurance Plan (a full-time, salaried, classified State employee or a permanent, full-time, salaried State education institution faculty member) [see [Appendix 3](#) to this chapter];
- be a member of a family eligible for health benefits coverage on the basis of a family member's employment with a public agency in the State that participates in the Local Choice Program and the employer contributes to the cost of dependent health insurance (see [Appendix 2](#) to this chapter), or
- without good cause (*see item E. below*), have had creditable health insurance coverage terminated within 4 months prior to the month of application.

D. Health Insurance Coverage Discontinued A child is ineligible for FAMIS coverage if creditable health insurance coverage was terminated without good cause within 4 months prior to the month for which eligibility is being established, *unless the child was pregnant at the time of application.*

Example: A child's health insurance was terminated without good cause in November. A FAMIS application was filed the following February. The child is ineligible for February because his health insurance was terminated within 4 months of November. He may be eligible in March because his insurance was terminated more than 4 months prior to March.

NOTE: For purposes related to FAMIS eligibility, a child is NOT considered to have been insured if health insurance coverage was provided under Medicaid, HIPP, FAMIS, or if the insurance plan covering the child does not have a network of providers in the area where the child resides.

E. Good Cause for Dropping Health Insurance

The ineligibility period can be waived if there is good cause for the discontinuation of the health insurance. A parent, guardian, legal custodian, authorized representative, or adult relative with whom the child lives may claim to have good cause for the discontinuation of the child(ren)'s health insurance coverage. The local agency will determine that good cause exists and waive the period of ineligibility if the health insurance was discontinued for one of the following reasons:

- The family member who carried insurance changed jobs or stopped employment, and no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
- The employer stopped contributing to the cost of family coverage and no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
- The child's coverage was discontinued by an insurance company for reasons of uninsurability, e.g. the child has used up lifetime benefits or the child's coverage was discontinued for reasons unrelated to payment of premiums. Verification is required from the insurance company.
- Insurance was discontinued by a family member who was paying the full cost of the insurance premium under a COBRA policy AND no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.
- Insurance on the child is discontinued by someone other than the child (if 18 years of age), or, if under age 18, the child's parent or stepparent, e.g. the insurance was discontinued by the child's grandparent, aunt, uncle, godmother, etc. Verification is not required.
- Insurance on the child is discontinued because the cost of the health insurance premiums for all family members exceeds 10% of the family's GROSS monthly income or exceeded 10% of the family's GROSS monthly income at the time the insurance was discontinued.

CHAPTER M22

FAMIS MOMS

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M2200.000 FAMIS MOMS

M2210.100 FAMIS MOMS GENERAL INFORMATION

A. Introduction

The 2005 Appropriations Act directed the Department of Medical Assistance Services (DMAS) to amend the Family Access to Medical Insurance Security Plan (FAMIS) and expand medical coverage to uninsured pregnant women who are ineligible for Medicaid solely due to excess income, but whose family income is less than or equal to 150% of the federal poverty level (FPL). An eligible woman will receive coverage through her pregnancy and 60 days following the end of the pregnancy.

FAMIS 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 DMAS will notify the Department of Social Services (DSS) Central Office if funds for this program run out.

Initial eligibility for FAMIS MOMS is determined by local departments of social services (LDSS), including LDSS outstationed sites, or by the FAMIS Central Processing Unit (CPU). Pregnant women found eligible for FAMIS MOMS receive the same benefits as Medicaid pregnant women.

Eligible women are enrolled for benefits effective the first day of the application month if all eligibility requirements are met in that month. There is no retroactive coverage in FAMIS MOMS. Case management and ongoing case maintenance, and selections for managed care, are handled by the FAMIS CPU.

B. Policy Principles

FAMIS MOMS covers uninsured low-income pregnant women who are not eligible for Medicaid solely due to excess income, and whose countable income is less than or equal to 150% of the FPL.

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

- she is not eligible for Medicaid due to excess income;
- she is a resident of Virginia;
- she is uninsured;
- she is **not** a member of a family eligible for health benefits coverage under the State Employee Health Insurance Plan on the basis of a family member's employment with a State agency (see [Appendix 3](#) to chapter M21 for a list of state agencies);
- she is not an inmate of a public institution;

- she is **not** an inpatient in an institution for mental diseases; and
- she has countable family income less than or equal to 150% FPL.

M2220.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

- A. Policy** The pregnant woman must meet, with certain exceptions, the Medicaid nonfinancial eligibility requirements in chapter [M02](#) and the nonfinancial eligibility requirements imposed by FAMIS.
- B. M02 Applicable Requirements** The Medicaid nonfinancial eligibility requirements in chapter [M02](#) that must be met are:
- Virginia residency requirements;
 - assignment of rights
 - institutional status requirements regarding inmates of a public institution.
- C. M02 Exceptions** The exceptions to the Medicaid nonfinancial eligibility requirements in chapter [M02](#) are:
- 1. Citizenship & Alienage Requirements** FAMIS MOMS alienage requirements are different from the Medicaid alienage requirements; they are the same as the FAMIS alienage requirements.
- a. Citizens and qualified aliens who entered the U.S. before August 22, 1996 meet the citizenship/alienage requirements.
 - b. The following qualified aliens who entered the U.S. on or after August 22, 1996 meet the alienage requirements **without any time limitations**:
 - refugees (see [M0220.310 A. 2](#)),
 - asylees (see [M0220.310 A. 4](#)),
 - veteran or active military (see [M0220.311](#)),
 - deportation withheld (see [M0220.310 A. 6](#)), and
 - victims of a severe form of trafficking (see [M0220.313 A.52](#))
 - c. The following qualified aliens who entered the U.S. on or after August 22, 1996 meet the alienage requirements **after 5 years of residence in the United States**:
 - lawful permanent residents (LPRs),

- conditional entrants-aliens admitted pursuant to 8 U.S.C.1153(a)(7),
- aliens paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA, and
- battered aliens, alien parents of battered children, alien children of battered parents.

[Appendix 7](#) to chapter M21 contains a FAMIS Alien Eligibility Chart that lists the alien groups that meet or do not meet the FAMIS MOMS alienage requirements.

- 3. No Emergency Services for Unqualified Aliens** Unqualified aliens, including illegal and non-immigrant aliens do not meet the alienage requirements. FAMIS MOMS does not provide any emergency services eligibility for unqualified aliens.
- 4. SSN not Required** The applicant is not required to provide an SSN or proof of an application for an SSN.
- 5. HIPP not Applicable** Application requirements for the Health Insurance Premium Payment (HIPP) program ([M0290](#)) do NOT apply to FAMIS.

D. FAMIS MOMS Covered Group Requirements

- 1. Verification of Pregnancy** Verification of pregnancy, including the expected delivery date, must be provided. Acceptable verification is a written or verbal statement from a physician, public health nurse or similar medical practitioner. Documentation of how the pregnancy was verified must be included in the case record.
- 2. Must be Uninsured** The pregnant woman must be uninsured; that is, she must not be covered under any creditable health insurance plan offering hospital and medical benefits. If a pregnant woman has creditable health insurance that does not cover pregnancy, labor and/or delivery services, the pregnant woman is ineligible for FAMIS MOMS because she is insured.
- 3. IMD Prohibition** The pregnant woman cannot be an inpatient in an institution for mental diseases (IMD).
- 4. State Employee Health Benefits Prohibition** A pregnant woman is ineligible for FAMIS MOMS if she is eligible for health insurance coverage under any Virginia State Employee Health Insurance Plan on the basis of her or a family member's employment with a State agency. A woman who cannot be enrolled until an open enrollment period is not prohibited from FAMIS MOMS coverage.

See [Appendix 3](#) to chapter M21 for a list of state government agencies.

M2220.200 HEALTH INSURANCE COVERAGE

A. Introduction

The intent of FAMIS MOMS is to provide health coverage to low-income uninsured pregnant women. A pregnant woman who has creditable health insurance coverage is not eligible for FAMIS MOMS.

B. Definitions

1. Creditable Coverage

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

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

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

2. Employer-Sponsored Dependent Health Insurance

Employer-sponsored dependent health insurance means the employer pays a portion of the premium payment. COBRA coverage in which the employer makes no contribution to the payment of the premium is not employer-sponsored insurance.

3. Family Member

ONLY when determining whether the pregnant woman is eligible for coverage under a State Employee Health Insurance Plan, “family member” means the pregnant woman’s spouse with whom she lives, or her parent(s) with whom she lives when the pregnant woman is unmarried and is under age 23. “Family member” includes the pregnant woman’s stepparent with whom she is living if the pregnant woman is under age 21 and her stepparent claims the pregnant woman as a dependent on his federal tax return. State employee health benefits are available to the state employee’s unmarried **dependent** child or stepchild under age 23 years.

4. Health Benefit Plan

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

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

Health benefit plan does NOT mean:

- accident only;
- credit or disability insurance;

- long-term care insurance;
- dental only or vision only insurance;
- specified disease insurance;
- hospital confinement indemnity coverage;
- limited benefit health coverage;
- coverage issued as a supplement to liability insurance;
- insurance arising out of workers' compensation or similar law;
- automobile medical payment insurance; or
- insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

5. Insured means having creditable health insurance coverage or coverage under a health benefit plan. A woman is considered to be insured if she is covered by a creditable health insurance plan, even if the policy or plan does not cover pregnancy-related services.

6. Uninsured means having no insurance; having insurance that is not creditable; having coverage which is not defined as a health benefit plan, or having a health insurance plan that does not have a network of providers in the area where the pregnant woman resides.

C. Policy

1. Must be Uninsured A nonfinancial requirement of FAMIS MOMS is that the pregnant woman be uninsured. A pregnant woman **cannot**:

- have creditable health insurance coverage;
- have coverage under a group health plan (TRICARE, federal employee benefit plan, private group insurance such as Anthem, etc.);
- be a member of a family eligible for health benefits coverage under a State Employee Health Insurance Plan (a full-time, salaried, classified State employee or a permanent, full-time, salaried State education institution faculty member) [see [Appendix 3](#) to chapter M21].

2. Prior Insurance Prior insurance coverage is not a factor as long as the pregnant woman is uninsured during the month for which FAMIS MOMS eligibility is being determined.

M2220.300 NO CHILD SUPPORT COOPERATION REQUIREMENTS

A. Policy There are no requirements for FAMIS MOMS applicants or recipients to cooperate in pursuing support from an absent parent.

M2230.100 FINANCIAL ELIGIBILITY

A. Financial Eligibility

- 1. FAMIS MOMS Assistance Unit**

The FAMIS MOMS assistance unit policy is the same as the Medicaid pregnant woman assistance unit policy. Use subchapter M0520, F&C Family/Budget Unit, to determine the pregnant woman's family unit for her financial eligibility determination. If ineligible in the family unit, determine her eligibility in the budget unit (if appropriate).
- 2. Asset Transfer**

Asset transfer rules do not apply to FAMIS MOMS.
- 3. Resources**

Resources are not evaluated for FAMIS MOMS.
- 4. Income**

The FAMIS MOMS income limit is 150% of the FPL (see Appendix 1 to this chapter) for the number of individuals in the FAMIS MOMS family unit, and budget unit (if applicable).

The source and amount of all income other than Workforce Investment Act and student income, must be verified and counted. FAMIS MOMS uses the same income types and methods for estimating income as in Medicaid Families & Children (F&C) policy (see chapter M07).

Medicaid F&C income disregards, other than the \$30 plus 1/3 earnings disregard in LIFC, apply when determining countable income for FAMIS MOMS (see chapter M07).
- 5. No Spenddown**

Spenddown does not apply to FAMIS MOMS. If countable income exceeds the FAMIS MOMS income limit, the pregnant woman is not eligible for the FAMIS MOMS program and she must be given the opportunity to have a medically needy (MN) Medicaid evaluation.

M2240.100 APPLICATION and CASE PROCEDURES

A. Application Requirements

The following forms are acceptable application forms for FAMIS MOMS:

- Health Insurance for Children and Pregnant Women application,
- Medicaid Application for Medically Indigent Pregnant Women
- Application for Benefits, and
- ADAPT Statement of Facts.

Applications can be mailed to the LDSS or the FAMIS Central Processing Unit (CPU). A face-to-face interview is not required.

The date of the application is the date the signed application is received at the LDSS, including DSS outstationed sites, or at the FAMIS CPU.

For applicants under the age of 18, the parent, legal guardian, authorized representative, or an adult relative with whom the child lives must sign the application. The adult relative must be related by blood or marriage.

Documentation of the relationship is not required. The child's parent or legal guardian may designate in writing an authorized representative to complete and sign the application.

For applicants age 18 or older, the applicant, family substitute relative, authorized representative or the guardian can sign the application.

B. Eligibility Determination

When an application is received and the pregnant woman is not eligible for Medicaid due to excess income, determine eligibility for FAMIS MOMS. In order to complete an eligibility determination, both the FAMIS MOMS nonfinancial requirements in [M2220.100](#) and the financial requirements in [M2230.100](#) must be met.

1. 10-day Processing

Applications for FAMIS MOMS must be processed as soon as possible, but no later than 10 working days from the date the signed application was filed. If all necessary verifications are not received, the application continues to pend until the 45 day processing time limit is met.

2. Notice Requirements

The applicant/recipient must be notified in writing of the required information and the deadline by which the information must be received.

The agency must have all necessary verifications within 10 working days in order to determine eligibility. If all verifications are not received within 10 working days, a Notice of Action on Medicaid and FAMIS Programs (NOA), form #032-03-008 (see subchapter [M0130, Appendix 1](#)), or an ADAPT NOA, must be sent to the applicant. The NOA must state why action on the application could not be taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 calendar days to submit the information.

Once all necessary verifications for the pregnant woman are received, an eligibility determination must be made immediately and the applicant must be notified of the decision.

C. Case Setup Procedures for Approved Cases

Because Medicaid and FAMIS MOMS are separate programs, Medicaid eligible individuals and FAMIS MOMS eligible individuals cannot share the same base case number in the Virginia Medicaid Management Information System (MMIS). Only individuals eligible for the same program (Medicaid or FAMIS/FAMIS MOMS) can share the same base case number in the MMIS.

When an individual is determined eligible for FAMIS MOMS and the individual has family members enrolled in Medicaid, the FAMIS MOMS individual must be given a new MMIS base case number when enrolled.

After the pregnant woman is enrolled in MMIS, the MMIS case must be transferred to the FAMIS CPU by changing the worker number to "V0000."

The local DSS worker cannot change the FIPS code or make any other change to the case after the case has been transferred to the FAMIS CPU in MMIS.

D. Entitlement and Enrollment

- 1. Begin Date of Coverage** Pregnant women determined eligible for FAMIS MOMS are enrolled for benefits in the Virginia Medicaid Management Information System (MMIS) effective the first day of the application month, if all eligibility requirements are met in that month.
- 2. No Retroactive Coverage** There is no retroactive coverage in the FAMIS MOMS program.
- 3. Aid Category** The FAMIS MOMS aid category (AC) is “005.”

E. Notification Requirements

Notice must be sent to the pregnant woman informing her of the action taken on the application. The notice must include the eligibility determination results for both Medicaid and FAMIS MOMS.

If the pregnant woman is eligible for FAMIS MOMS, the notice must inform the pregnant woman that the case has been transferred to the FAMIS CPU and that further information on the program will come from the FAMIS CPU.

If the pregnant woman is ineligible for both Medicaid and FAMIS MOMS due to excess income, she must be sent a notice that she is not eligible for either program and must be given the opportunity to have a Medicaid medically needy evaluation completed. Send the notice and an Application for Benefits to the pregnant woman and advise her that if the signed application is returned within 10 days the original application date will be honored.

F. Transfer Case to FAMIS CPU

Once the enrolled FAMIS MOMS case is transferred in MMIS and the notice is sent to the family, the case must be transferred to the FAMIS CPU for ongoing case maintenance.

M2250.100 REVIEW OF ADVERSE ACTIONS

An applicant for FAMIS MOMS may request a review of an adverse determination regarding eligibility for FAMIS MOMS. FAMIS MOMS follows the procedures established by Medicaid for client appeals (see chapter [M16](#)).

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

<p style="text-align: center;">FAMIS MOMS INCOME LIMITS ALL LOCALITIES EFFECTIVE 7/1/05</p>		
<p style="text-align: center;"># of Persons in FAMIS MOMS Assistance Unit</p>	<p style="text-align: center;">FAMIS MOMS 150% FPL</p>	
	Annual Limit	Monthly Limit
1	\$14,355	\$1,197
2	19,245	1,604
3	24,135	2,012
4	29,025	2,419
5	33,915	2,827
6	38,805	3,234
7	43,695	3,642
8	48,585	4,049
each add'l person add	4,890	408