

August 24, 2009

MEDICAID MANUAL – VOLUME XIII

POLICY UPDATE #2

Medicaid Policy Update #2 contains revised policy regarding the Health Insurance Premium Payment (HIPP) Program. HIPP is a cost savings program administered by the Department of Medical Assistance Services (DMAS) for Medicaid enrollees that reimburses some or all of the employee portion of a group health insurance premium. DMAS has recently revised its HIPP regulations to make participation in the program voluntary and rather than a mandatory non-financial requirement.

The policy revision and changes contained in Medicaid Policy Update #2 are effective for all eligibility determinations completed on or after August 24, 2009. Applications processed on or after that date must not be denied based on failure to comply with HIPP requirements.

Revised Policy

Effective immediately, the eligibility worker's responsibility for HIPP will be to provide a copy of the HIPP Fact Sheet with the Notice of Action to each applicant or enrollee who reports that he or someone in his family is employed more than 30 hours per week and is eligible for coverage under an employer's group health plan. The HIPP Fact Sheet contains information about the program, the application requirements, continued eligibility for Medicaid, and the responsibilities for participation in the program. The fact sheet is available on the VDSS public web site and on the SPARK interagency web site at <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>.

Individuals interested in applying for HIPP should be encouraged to download the application from the DMAS website at <http://www.dmas.virginia.gov/rcp-HIPP.htm> or contact the HIPP unit at 800-432-5924.

Applications for HIPP received by the local departments of social services must continue to be forwarded to the HIPP Unit at DMAS for processing. In addition, upon request local agency staff must provide HIPP applications to interested individuals

Electronic Version

Medicaid Policy Update #2 is available electronically on SPARK and the VDSS public web site. It has not been printed for distribution. The electronic version is the transmittal of record. Significant changes to the manual are as follows:

Pages Changed	Significant Changes
Table of Contents	Indicated that subchapter M0290 was removed.
M0130 pages 8, 9	On page 8, added new policy on the HIPP Program. On page 9, updated the references to the Medicaid Management Information System (MMIS).

Pages Changed	Significant Changes
M02 Table of Contents	Indicated that subchapter M0290 was removed.
M0210 pages 1, 2	Removed the HIPP participation requirement from both pages.
M0310 Table of Contents page 39	Added the definition for the HIPP Program
M0320 pages 26, 28, 32, 61, 63, 66	Removed the HIPP participation requirement from all pages.
M0330 pages 3, 6, 8, 16, 22	Removed the HIPP participation requirement from all pages.
M1510 page 11	Revised the policy on HIPP.
M1520 page 1, 2, 13, 14, 17, 18	Revised the policy on HIPP and removed reference to HIPP for Extended Medicaid.
M21 page 4	Removed the HIPP participation requirement.
M22 page 3	Removed the HIPP participation requirement.

Should you have questions about information contained in Medicaid Policy Update #2, please contact Stephanie Sivert, Manager, Medical Assistance Programs, at 804-726-7660 or stephanie.sivert@dss.virginia.gov.

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M0130 Changes

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TPL code for that benefit, the worker must email the information to the DMAS TPL Unit at TPLUnit@dmass.virginia.gov, or send the information to:

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

G. Health Insurance Premium Payment (HIPP) Program

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

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

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

H. Verification of Financial Eligibility Requirements

The eligibility worker must verify the following financial eligibility requirements:

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

Social Security and/or Supplemental Security Income must be verified through SSA. The State Data Exchange (SDX) system should only be used as an alternate method when the State Verification Exchange System (SVES) or State Online Query-Internet system (SOLQ-I) cannot be used. If the SDX system is used to verify benefits, the case record must be documented to show why SVES or SOLQ-I was not used.

Chapters M05 through M11 include specific instructions for the verification of resources and income. Subchapter M1450 includes instructions for verifying the transfer of assets.

M0130.300 Eligibility Determination Process

A. Evaluation of Eligibility Requirements

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

The evaluation of eligibility requirements must be documented in writing for cases not processed in the ADAPT system. The Evaluation of Eligibility

(form #032-03-823) may be used. The form is available online at <http://www.localagency.dss.state.va.us/divisions/bp/me/forms/general.cgi>. Agency-created evaluation forms are also acceptable as long as all information needed to determine eligibility is documented on the evaluation form. Because ADAPT has a built-in verification log and evaluation record, a written evaluation is not used for cases processed in ADAPT.

Eligibility decisions are made following a prescribed sequence:

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

Subchapter M0210 contains the Medicaid *non-financial requirements*.

B. Hierarchy of Covered Group

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

C. Applicant's Choice of Covered Group

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

D. Application Disposition

1. General Principle

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

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

2. Entitlement and Enrollment

a. Entitlement

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

b. Enrollment

Medicaid enrollees must be enrolled in the Medicaid Management Information System (MMIS). The Medicaid Eligibility Manual contains enrollment instructions based on the former MMIS. Some terminology and procedures used in the current MMIS differ from those used with the former MMIS. When following enrollment instructions in this manual, please note the following changes:

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M0260 RESERVED

NOTE: Policy references to M0260 that are still in effect have been moved to subchapter M0250.

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M0210 Changes

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Update (UP) #2	08/24/09	pages 1, 2

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

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

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

B. Eligibility Requirements

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

1. Nonfinancial Eligibility Requirements

The Medicaid nonfinancial eligibility requirements are:

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

2. Financial Eligibility Requirements

The Medicaid financial eligibility requirements are:

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

3. Example

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

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

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

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

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

B. Certain Recipients of General Relief (GR)

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

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

C. Essential Spouse of an ABD Individual

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

D. Individual Who Refuses to Assign Rights

An individual, who refuses to assign rights to third-party payments or support for himself or anyone for whom he can legally assign rights, is not eligible for Medicaid. Failure to assign rights for another person will not affect the eligibility of that other person.

M0310 Changes

Changed With	Effective Date	Pages Changed
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TN #91	05/15/09	Subchapter M0310 pages 23-25 Appendix 4 Appendix 5

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* *out of numerical order*

B. State Plan Governs Medicaid Eligibility Rules

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

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

M0310.132 TANF

A. Temporary Assistance for Needy Families (TANF)

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

M0310.133 BCCPTA

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

The BCCPTA created a Medicaid covered group for women age 40 through 64 who have been identified by the Centers for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program (BCCEDP) as being in need of treatment for breast or cervical cancer.

B. Procedures

Section M0320.312 contains the detailed requirements for the BCCPTA covered group.

M0310.134 VIEW PARTICIPANT

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

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

M0310.135 HIPP PROGRAM

A. Health Insurance Premium Payment (HIPP) Program

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

B. Procedures

M0130.200 G contains additional information about HIPP.

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M0320 Changes

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Update (UP) #2	08/24/09	pages 26, 28, 32, 61, 63, 66
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TN #91	05/15/09	pages 31-34 pages 65-68

M0320.203 ABD IN MEDICAL INSTITUTION, INCOME ≤ 300% SSI LIMIT

A. Policy

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

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

B. Nonfinancial Eligibility

An individual is eligible in this covered group if he meets the nonfinancial requirements in M1410.020:

1. Citizenship/alien status;
2. Virginia residency;
3. Social Security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Is institutionalized in a medical institution that is not an IMD; *and*
8. Meets either the Aged, Blind, or Disabled definition in M0310.

C. Financial Eligibility

1. Asset Transfer

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

2. Resources

a. Resource Eligibility – Married Individual

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

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

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

b. Resource Eligibility - Unmarried Individual

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

- 022 for an aged individual also QMB;
- 042 for a blind individual also QMB;
- 062 for a disabled individual also QMB.

2. Not QMB

If the individual is NOT a Qualified Medicare Beneficiary (QMB) - the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - the program designation is:

- 020 for an aged individual NOT also QMB;
- 040 for a blind individual NOT also QMB;
- 060 for a disabled individual NOT also QMB.

E. Ineligible In This Covered Group

If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy spenddown. If the individual is not eligible for Medicaid in this covered group because of resources, determine the individual's eligibility as QMB, SLMB, QDWI or QI if he/she has Medicare Part A.

M0320.204 ABD RECEIVING MEDICAID WAIVER SERVICES (CBC)

A. Policy

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

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

B. Nonfinancial Eligibility

An individual who receives Medicaid waiver services is eligible in this covered group if he/she meets the nonfinancial requirements in M1410:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Is not in a medical institution, may be in a residential institution that meets the institutional status requirements;
8. Meets either the Aged, Blind, or Disabled definition in M0310.

Individuals who meet the Hospice covered group may have their eligibility determined using the same financial requirements as institutionalized individuals.

B. Nonfinancial Eligibility

A terminally ill individual who elects hospice services is eligible in this covered group if he/she meets the following requirements:

1. Citizenship/alien status;
2. Virginia residency;
3. Social Security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Application for other benefits;
6. Institutional status requirements;
7. Meets either the Aged, Blind, or Disabled definition in M0310 or
8. **is “deemed” to be disabled because of the terminal illness. Do not refer the individual to the DDS for a disability determination.**

C. Financial Eligibility

1. Asset Transfer

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

2. Resources

The hospice services recipient is an assistance unit of 1 person. All of the individual’s resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements.

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

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

a. Unmarried Individual

If the individual is unmarried or is married and has no community spouse, use the resource policy in chapter S11 and subchapter M1460.

b. Married Individuals

If the individual is married and has a community spouse, use the resource policy in chapter S11 and subchapter M1480.

3. Income

To determine if an individual has income within the 300% of SSI limit, use **gross** income, not countable income. Determine what is income according to chapter S08 and subchapter M1460.

DO NOT subtract the \$20 general exclusion or any other income exclusions. The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual’s spouse or parent.

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Must be institutionalized in a medical institution, not an IMD;

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

C. Financial Eligibility

When determining **income** to compare to the 300% of SSI income limit, use the ABD income policy and procedures, regardless of the individual's definition or covered group. When determining **resources**, use F&C resource policy for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

1. Asset Transfer

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

2. Resources

a. Resource Eligibility - Married Individual

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

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

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

b. Resource Eligibility - Unmarried Individual

When determining resources for an unmarried F&C institutionalized individual, use the Medicaid F&C resource requirements in chapter M06. All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the F&C CNNMP resource limit of \$1,000. Pay close attention to

2. Not QMB

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

E. Ineligible In This Covered Group

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

Determine the individual’s eligibility as QMB, SLMB, QDWI or QI if he/she has Medicare Part A.

M0320.310 F&C RECEIVING WAIVER SERVICES (CBC)**A. Policy**

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

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

B. Nonfinancial Eligibility

An individual who receives Medicaid waiver services is eligible in this covered group if he/she meets the nonfinancial requirements in M1410.020:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Is not in a medical institution, may be in a residential institution that meets the institutional status requirements;
8. Meets an F&C definition in M0310.

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

Do not wait until the individual starts to receive the waiver services to determine his/her eligibility in this covered group. Determine his/her

M0320.311 F&C HOSPICE

A. Policy

SMM 3580-3584 - The State Plan includes the covered group of children under age 21, pregnant women and parents or caretaker-relatives of dependent children who are terminally ill and who elect hospice benefits. The hospice covered group is for individuals who are not eligible in any other full-benefit Medicaid covered group.

Individuals receiving hospice services in the F&C Hospice Covered group may also receive services under the Elderly and Disabled with Consumer Direction (EDCD) Waiver, if the services are authorized by DMAS (see M1440.101).

To be eligible in the hospice covered group, the individual must file an election statement with a particular hospice which must be in effect for 30 or more consecutive days. Eligibility in the Hospice covered group is ongoing as long as the individual continues to receive hospice care, subject to a renewal of eligibility at least once every 12 months. The eligibility worker must verify that the hospice agreement is current at the time of the annual renewal.

The 30-day requirement begins on the effective date of the hospice care election. Once the hospice election has been in effect for each of 30 consecutive days, the 300% of SSI income limit is used to determine Medicaid eligibility. If the individual's income is within the limit, eligibility begins the effective date of the hospice election.

In situations where the 30-day requirement has already been met, the individual does not have to meet it again when he/she elects hospice care. When there is no break in time between eligibility in a medical facility and the effective date of hospice election, the individual does not have to wait another 30 days for eligibility in the hospice covered group.

B. Nonfinancial Eligibility

A terminally ill individual who elects hospice services is eligible in this covered group if he/she meets the following requirements:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Is not in a medical institution, may be in a residential institution that meets the institutional status requirements;
8. Meets either the child, pregnant woman, or parent or caretaker-relative of a dependent child definition in subchapter M0310.

The individual must elect hospice care. Election of hospice care is verified either verbally or in writing from the hospice. If the verification is verbal, document case record.

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such as prescription drugs and long-term care are not covered for the ABD MI.

M0330.201 AGED INDIVIDUALS

A. Nonfinancial Eligibility

42 CFR 435.330 - An individual is eligible in this covered group if he/she has attained age 65 years (M0310.105) and meets the following nonfinancial requirements in chapter M02:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Institutional status requirements;

B. Financial Eligibility

1. Asset Transfer

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

2. Assistance Unit

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

3. Resources

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. The resources policy in chapter S11 applies.

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

a. Resources Within The Limit

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

b. Resources Exceed The Limit

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

5. Cooperation in pursuing support;
6. Application for other benefits;
7. Institutional status requirements;

B. Financial Eligibility

1. **Asset Transfer** The individual must meet the asset transfer policy in subchapter M1450.
2. **Assistance Unit** The assistance unit policy and procedures in chapter M05 apply to blind medically needy individuals. If not institutionalized, deem any resources and income from the individual's spouse with whom he/she lives, and his/her parent(s), if individual is under age 21, with whom he/she lives.
3. **Resources**

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. The resources policy in chapter S11 applies.

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

 - a. **Resources Within The Limit**

If current resources are within the limit, go on to determine income eligibility.
 - b. **Resources Exceed The Limit**

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

If the individual is not eligible because of other excess resources and he/she has Medicare Part A, determine if the individual meets a medically indigent (MI) ABD covered group because the MI ABD resource requirements are more liberal than the MN requirements. See M0320.206 through 208 for the ABD MI covered groups.

If current resources are NOT within the limit, the individual is NOT eligible for Medicaid as medically needy because of excess resources.
4. **Income** Determine gross income according to chapter S08. Subtract the \$20 general exclusion and other exclusions. Note the special earned income exclusions for blind individuals.

Cancel the MN coverage effective the end of the month. Reinstatement of the recipient's coverage in the QMB-only AC effective the first day of the month immediately following the cancellation date.

3. QMB Meets Spenddown

When an eligible QMB meets the spenddown, cancel the QMB-only coverage effective the day before the spenddown was met, using cancel reason "024". Reinstatement of the recipient's coverage with the begin date as the first date the spenddown was met, *end date is the last date of the spenddown period*. AC is blind MN dual-eligible QMB "048."

4. Spenddown Period Ends

a. Not QMB Eligible

Spenddown coverage will automatically cancel in the MMIS after the end date of the coverage (spenddown) period. The individual must file a new application for Medicaid.

b. QMB Eligible

After the spenddown period ends, reinstate the QMB-only coverage using the appropriate QMB-only *aid category*. The begin date of the reinstated coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial QMB eligibility.

M0330.203 DISABLED INDIVIDUALS

A. Nonfinancial Eligibility

42 CFR 435.330 - An individual is eligible in this covered group if he/she meets the disabled definition in M0310.112 and meets the following nonfinancial requirements in chapter M02:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Institutional status requirements;).

B. Financial Eligibility

1. Asset Transfer

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

2. Assistance Unit

The assistance unit policy and procedures in chapter M05 apply to disabled medically needy individuals. If not institutionalized, deem any

M0330.301 PREGNANT WOMEN**A. Nonfinancial Eligibility**

42 CFR 435.301(b)(1)(i)--If the state chooses to cover the medically needy, the State Plan must provide medically needy coverage to all pregnant women during the course of their pregnancy who, except for income and resources, would be eligible for Medicaid as categorically needy.

A pregnant woman's Medicaid eligibility is first determined in the MI pregnant women covered group which has no resource limit and has an income limit that is higher than the medically needy income limit.

If a pregnant woman is not eligible as MI because her income is too high, then she may spenddown to the lower MN income limit IF her resources are within the MN resource limit.

A pregnant woman is eligible in this MN covered group if she meets the pregnant woman definition in M0310.119 and meets the following nonfinancial requirements in chapter M02:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
NOTE: an MN pregnant woman must cooperate in pursuing support; see subchapter M0250);
6. Application for other benefits;
7. Institutional status requirements;

B. Financial Eligibility**1. Asset Transfer**

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

2. Assistance Unit

The assistance unit policy and procedures in chapter M05 apply to medically needy pregnant women. If the pregnant woman is not institutionalized, consider the resources and income of a pregnant woman's spouse with whom she lives and, if the pregnant woman is under age 21, the pregnant woman's parent(s) with whom she lives. If a pregnant woman also applies for other assistance unit members living with her who do not meet an F&C medically needy covered group, separate financial eligibility determinations are done for the unit. One is the F&C medically needy determination for the pregnant woman. The other financial eligibility determination is based on the other individual's(s) classification and covered group(s).

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

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Institutional status requirements;

B. Financial Eligibility

- 1. Asset Transfer** The child must meet the asset transfer policy in subchapter M1450.
- 2. Assistance Unit** The assistance unit policy and procedures in chapter M05 apply to this covered group. If not institutionalized, count or deem any resources and income from the child's spouse and/or parent with whom he/she lives.
- 3. Resources** All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. The resources policy in chapter M06 applies.

If the child is married and institutionalized, use the resource policy in subchapter M1480.
 - a. Resources Within The Limit**

If the child's resources are within the MN limit, go on to determine income eligibility.
 - b. Resources Exceed The Limit**

If the child's resources are NOT within the limit, the child is NOT eligible for Medicaid because of excess resources.
- 4. Income** Determine MN countable income according to chapter M07. Subtract the appropriate exclusions. Compare the total countable income to the MN income limit for the child's locality group (see section M0710, Appendix 5 for the MN income limits).
- 5. Income Exceeds MN Limit** Because the MI children income limits are higher than the MN income limits, the child becomes eligible in the MN children under age 18 covered group when the child has incurred medical expenses equal to the difference between his/her income and the MN income limit (spenddown). See chapter M13 for spenddown policy and procedures.

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MN spenddown because of excess resources. The notice must specify the dollar amount of the appropriate MN resource limit.

- 2) If the QMB's resources are within the MN income limit, and income exceeds the MI limit, the notice must state that the applicant is not eligible for *full-benefit* Medicaid because of excess income, but that the applicant can become eligible *by incurring medical or dental expenses that equal or exceed his excess income*. The notice must specify the spenddown amount, the spenddown period begin and end dates, and include a copy of the Spenddown Fact Sheet.

3. Retroactive Entitlement Only or Limited Period of Entitlement

There are instances when an applicant is not eligible for ongoing Medicaid coverage but is eligible for retroactive benefits, or when a change in the applicant's situation during the application process results in the applicant being eligible for only a limited period of time. Only one "*Notice of Action on Medicaid and FAMIS*" (Form 032-03-008) is sent to the applicant covering both actions. The *begin and end dates* of Medicaid coverage and the reason(s) for ineligibility must be included on this notice.

4. Example #7 Limited Period of Entitlement

A Medicaid application was filed on December 30. The client inherited real property on January 30. The agency processed the application on February 5 and determined the client was eligible for Medicaid for the months of December and January, but was ineligible for additional coverage beginning February because the countable value of the inheritance caused excess resources. One notice is sent to the applicant stating that his Medicaid application was approved beginning December 1 and ending January 31, and that he was denied coverage after January 31 because of excess resources (real property).

M1510.300 FOLLOW-UP RESPONSIBILITIES

M1510.301 THIRD PARTY LIABILITY (TPL)

A. Introduction

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

B. Private Health Insurance

Information on private health insurance coverage must be obtained and recorded in the *case record and in the MMIS*. This must include the company name (code number for the TPL file), the policy number, and the begin date of coverage. Health insurance policy or coverage changes must be updated in the eligibility record and TPL file.

If an applicant or enrollee reports that he or a family member is employed more than 30 hours each week and is eligible for health insurance coverage under an employer's group health plan, he or she must be given a HIPP Fact Sheet which provides a brief description of the program and the contact information for the HIPP Unit at DMAS. The HIPP Fact Sheet is available on-line at: <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>.

Changes to TPL coverage in MMIS for HIPP participants can only be made by the HIPP Unit at DMAS. Call the HIPP Unit at 1-800-432-5924 when changes to the TPL information in MMIS are needed.

M1520 Changes

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M1520.000 MEDICAID ELIGIBILITY REVIEW

M1520.001 GENERAL PRINCIPLE

A. Policy

A Medicaid recipient's eligibility must be partially reviewed whenever the agency becomes aware of any change in the enrollee's circumstances that might affect the enrollee's continued Medicaid eligibility.

An annual review of all of the enrollee's Medicaid eligibility requirements is called a "renewal." A renewal of the enrollee's eligibility must be completed at least once every 12 months.

When a Medicaid enrollee no longer meets the requirements for the covered group under which he is enrolled, the eligibility worker must evaluate the individual's eligibility in all other covered groups prior to canceling his Medicaid coverage.

When a change is reported that impacts eligibility or a renewal is completed and the enrollee is no longer eligible, the Advanced Notice of Proposed Action must be sent to the enrollee before the enrollee's benefits can be reduced or his eligibility can be terminated (see M1520.401). The individual may be eligible for the limited benefit family planning services covered group, Plan First. A Plan First Brochure or a Plan First Fact Sheet, available on SPARK at <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>, must be included with the Advance Notice of Proposed Action. Eligibility for Plan First is not determined unless the individual submits a Plan First application.

When a change is reported and eligibility continues, no notice is necessary. When a renewal is completed and eligibility continues, the Notice of Action is used to inform the enrollee of continued eligibility and the next scheduled renewal.

B. Procedures For Partial Review and Renewals

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

- the requirements for **partial reviews** are in section M1520.100;
- the requirements for **renewals** are in section M1520.200;
- the policy and procedures for **canceling** a enrollee's Medicaid coverage or reducing the enrollee's Medicaid services (benefit package) are in section M1520.400;
- the policy and procedures for **extended Medicaid coverage** are in section M1520.500;
- the policy and procedures for **transferring cases** within Virginia are in section M1520.600.

M1520.100 PARTIAL REVIEW

A. Enrollee's Responsibility

Enrollees must report changes in circumstances which may affect eligibility and/or patient pay within 10 days from the day the change is known. *For enrollees participating in the Health Insurance Premium Payment (HIPP) Program, changes that may affect participation in HIPP must also be reported to the DMAS HIPP Unit within the 10 day timeframe.*

B. Eligibility Worker's Responsibility

The eligibility worker has a responsibility for keeping a record of changes that may be anticipated or scheduled, and for taking appropriate action on those changes. The worker can set a follow-up review in the MMIS for anticipated changes. Examples of anticipated changes include, but are not limited to, the receipt of an SSN, receipt of SSA benefits and the delivery date for a pregnant woman.

1. Changes That Require Partial Review of Eligibility

When changes in an enrollee's situation are reported by the enrollee or when the agency receives information indicating a change in an enrollee's circumstances (i.e. SSI purge list, reported transfer of assets), the worker must take action to partially review the enrollee's continued eligibility.

A reported increase in income and/or resources can be acted on without requiring verification, unless a reported change causes the individual to move from a limited-benefit covered group to a full-benefit covered group. The reported change must be verified when it causes the individual to move from a limited-benefit covered group to a full-benefit covered group.

2. Changes That Do Not Require Partial Review

When changes in an enrollee's situation are reported or discovered, such as the enrollee's SSN and card have been received, the worker must document the change in the case record and take action appropriate to the reported change in the appropriate computer system(s).

Example: The Medicaid enrollee who did not have an SSN, but applied for one when he applied for Medicaid, reports by calling the worker that he received his SSN. The worker records the telephone call and the enrollee's newly assigned SSN in the case record, verifies the SSN via SPIDeR and enters the enrollee's verified SSN in MMIS and ADAPT.

3. HIPP

The eligibility worker must provide the enrollee with a copy of the HIPP FACT Sheet when it is reported that he or a family member is employed more than 30 hours per week and is eligible for coverage under an employer's group health plan. The HIPP Fact Sheet is available on-line at: <http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi>. The eligibility worker must report to the HIPP Unit at DMAS any changes in an enrollee's situation that may affect the premium payment.

4. Program Integrity

The Medicaid eligibility of enrollees is subject to periodic review through the program integrity process (such as Medicaid Quality Control and the DMAS Recipient Audit Unit). It may be necessary for program integrity staff to request information, such as income verification, from the enrollee. The enrollee will be notified in writing and given a reasonable amount of time, as determined by the program integrity staff, to provide the information.

Should the enrollee not provide the requested information to the program integrity staff within the specified time, program integrity staff will notify the eligibility worker, and the worker must take action to follow up by requesting the appropriate verifications and/or sending advance notice, if necessary, to cancel coverage due to the inability to determine continued eligibility. An individual's failure to provide information to program integrity staff does not affect any future Medicaid applications.

C. Time Standard

Appropriate agency action on a reported change must be taken within 30 days of the report.

eligibility of the assistance unit at the time that the LIFC Medicaid eligibility terminated. It also includes family members born, adopted into, or returning to the family after extended benefits begin who would have been considered a member of the unit at the time the LIFC Medicaid eligibility terminated.

The earned income of family members added after the family loses LIFC Medicaid eligibility must be counted to determine gross family income.

B. Eligibility Conditions

The following conditions must be met:

1. Received LIFC Medicaid in 3 of 6 Months

The family received LIFC Medicaid in at least 3 of the 6 months immediately preceding the month in which the family became ineligible for LIFC.

2. Cancel Reason

LIFC Medicaid was canceled solely because of:

- the caretaker/relative's new employment,
- the caretaker/relative's increased hours of employment,
- the caretaker/relative's increased wages of employment, or
- expiration of any assistance unit member's \$30 plus 1/3, or \$30, earned income disregard.

3. Has A Child Living in Home

The family continues to have at least one child under age 18, or under age 19 if in school, living in the home.

4. No Fraud

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

C. Entitlement & Enrollment

Entitlement does not continue for any member of the unit who moves to another state.

Enrollees receiving this extension are categorically needy non-money payment, aid category (AC) "081" for an LIFC family unit with one parent or caretaker-relative or "083" for a two-parent family unit.

1. Determining Extension Period

Medicaid coverage will continue for six months beginning with the first month the family is not eligible for LIFC Medicaid because of excess income due to any unit member's expiration of the \$30 plus 1/3 or \$30 earned income disregard, or due to the increased earnings of the caretaker/relative. Extension for an additional 6-month period is possible if the reporting and financial requirements are met (below).

a. New/increased Earnings Not Reported Timely

When the new/increased earnings were not reported so that action to cancel LIFC Medicaid could be taken in a timely manner, the extension period begins the month following the month the assistance unit would have last received LIFC Medicaid if reported timely.

For example, if the increased earnings were received in April, but were not reported or discovered until a review of eligibility in June, the 12-month period begins with May, the first month the family's LIFC Medicaid should not have been received. The screening period to determine if the family unit received LIFC Medicaid in at least 3 of the six months immediately preceding the month in which the unit became ineligible for LIFC Medicaid will be November to April.

b. Simultaneous Income Changes

In situations where an earned income case has simultaneous income changes which cause LIFC Medicaid ineligibility, such as new or increased earned income plus an increase in support, the eligibility worker must determine if the case would have been ineligible due to new or increased earnings or loss of the disregards. This requires that the eligibility worker recalculate the LIFC income eligibility only considering the increased earned income or loss (expiration) of the disregards.

- 1) If the family would have been ineligible for one of these reasons, it will be considered the reason for LIFC Medicaid ineligibility and the family is eligible for the 12-month Medicaid extension.
- 2) If, however, the family would have continued to be eligible for LIFC Medicaid if the only change had been increased earnings or expiration of the disregards, the other changes which occurred simultaneously will be the reason for LIFC Medicaid ineligibility. The family is **not** eligible for the Medicaid extension.

2. Extension Ends

Entitlement to Medicaid under this extension period terminates at the end of the first month in which the family unit ceases to include a child under age 18 or under age 19 if in school, the family unit fails to comply with the reporting requirements in D below, or at the end of the extension period.

The child(ren)'s eligibility for Medicaid in another covered group or for FAMIS must be determined prior to canceling the child(ren)'s Medicaid coverage. An "Advance Notice of Proposed Action" must be sent prior to canceling extended Medicaid coverage.

D. Notice and Reporting Requirements**1. LIFC Medicaid Cancellation Month**

When LIFC Medicaid is canceled, the unit must be notified of its entitlement to extended Medicaid coverage for six months, and that

Medicaid coverage must be canceled unless the family establishes good cause for failure to report on a timely basis. Examples of good cause for failure to report timely are:

- illness or injury of family member(s) who is capable of obtaining and sending the material;
- agency failure to send the report notice to the family in the proper month of the extension.

a. Determine Child(ren)'s Eligibility

The child(ren)'s eligibility for Medicaid in another covered group or for FAMIS must be determined before canceling coverage. Contact the recipient and request current verification of the family's total income, including earned and unearned income. If the child is eligible, change the child's enrollment to the appropriate aid category before the **cut-off date** of the eighth extension month. If not eligible, leave the child's enrollment (the base case Follow-up Code and Follow-up Date fields) as it is and MMIS will cancel the child's coverage.

If the child(ren)'s eligibility is not reviewed by the **cut-off date** of the eighth extension month, MMIS will cancel coverage. The agency must then reopen coverage and notify the recipient if the child is subsequently found eligible.

b. Cancellation Effective Date

Cancellation is effective the last of the eighth month of extension.

c. Report Received Timely

If the second three-month period's report is received by the 21st of the seventh month, change the case Follow-up Code in MMIS immediately upon receipt of the report and verifications. The family will continue to be eligible for extended Medicaid coverage unless:

- 1) no child under age 18, or under age 19 if in school, lives with the family;
- 2) the caretaker/relative had no earnings in one or more of the previous three months, unless the lack of earnings was due to:
 - the caretaker/relative's involuntary lay-off,
 - the business closed,
 - the caretaker/relative's illness or injury,
 - other good cause (such as serious illness of child in the home which required the caretaker/relative's absence from work);

- 3) the family unit's average gross monthly **earned** income (earned income only; unearned income is not counted) less costs for child care that was necessary for the employment of the caretaker/relative, during the preceding three-month period exceeds the 185% Federal Poverty Level (FPL) appropriate to the family unit size.

See subchapter M0710, Appendix 7, for the 185% FPL income limits.

d. Calculate Family's Gross Earned Income

- 1) The "family's" gross earned income means the earned income of all family unit members who worked in the preceding three-month period. "Gross" earned income is total earned income before any deductions or disregards. All earned income must be counted, including students' earned income, JTPA earned income, children's earned income, etc. No exclusions or disregards are allowed.
- 1) Child care costs that are "necessary for the caretaker/relative's employment" are expenses that are the responsibility of the caretaker/relative for child care that if not provided would prevent the caretaker/relative from being employed.
- 2) To calculate average gross monthly income:
 - add each month's cost of child care necessary for the caretaker/relative's employment; the result is the three-month period's cost of child care necessary for the caretaker/relative's employment.
 - add the family unit's total gross earned income received in each of the 3 months; the result is the family's total gross earned income.
 - subtract the three-month period's cost of child care necessary for the caretaker/relative's employment from the family's total gross earned income.
 - divide the remainder by 3; the result is the average monthly earned income.
 - compare the average monthly earned income to the monthly 185% FPL for the appropriate number of family unit members.

e. Family No Longer Entitled To Extended Medicaid

- 1) If the family is not entitled to further Medicaid coverage because of one of the reasons in item 5.c. above, each family member's eligibility for Medicaid in another covered group must be determined before canceling coverage.

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D. FAMIS Nonfinancial Requirements

The child must meet the following FAMIS nonfinancial requirements:

1. Age Requirement

The child must be under age 19 for at least one day during the month. No verification is required.

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

2. Uninsured Child

The child must be uninsured, that is, he must not be covered under any health insurance plan offering hospital and medical benefits. See M2120.200.

3. State Employee Prohibition

A child is ineligible for FAMIS if he is a member of a family eligible for health insurance coverage under any Virginia State Employee Health Insurance Plan on the basis of the family member's employment with a State agency.

4. IMD Prohibition

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

M2120.200 HEALTH INSURANCE COVERAGE

A. Introduction

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

B. Definitions

1. Creditable Coverage

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

- church plans and governmental plans;
- health insurance coverage, either group or individual insurance;
- military-sponsored health care;
- a state health benefits risk pool;
- the federal Employees Health Benefits Plan;
- a public health plan; and

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- 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.
- d. Afghan and Iraqi special immigrants who meet all other eligibility requirements for FAMIS MOMS are eligible for a limited period of time from the date they enter the U.S. or the date their immigrant status is converted to Special Immigrant Visa (SIV) status. See section M0220.313 A and Appendix 3 to Chapter M21 for the limited time periods and details about these special immigrants. When the limited time period (6 or 8 months, beginning with the month of entry or status conversion to SIV) is over, these special immigrants are no longer eligible for FAMIS MOMS because of their lawful permanent resident (LPR) status. LPRs are not eligible for FAMIS MOMS for the first 5 years they reside in the U.S.
- e. Appendix 3 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.

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.