COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services

KAREN KIMSEY, M.S.W.
DIRECTOR

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786/7933
800/343-0634 (TDD)
www.dmas.virginia.gov

Virginia Medical Assistance Eligibility Manual
Transmittal #DMAS-23

The following acronyms are contained in this letter:

- ABD – Aged, Blind or Disabled
- ABLE – Achieving a Better Life Experience
- COVID – Coronavirus Disease
- DMAS – Department of Medical Assistance Services
- FAMIS – Family Access to Medical Insurance Security
- FPL – Federal Poverty Level
- LDSS – Local Department of Social Services
- MAGI – Modified Adjusted Gross Income
- MES – Medicaid Enterprise System
- RAU – Recipient Audit Unit
- TN – Transmittal

TN #DMAS-23 includes policy clarifications, updates and revisions. Unless otherwise noted in the Cover Letter and/or policy, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after April 1, 2022. Note that COVID-19 Public Health Emergency guidelines continue until the emergency is over and are not referenced in Medical Assistance Eligibility Policy.

The following changes are contained in TN #DMAS-23:

Changed Pages	Changes
Subchapter M0110 Page 10	Revised the policy on making the Medicaid and FAMIS Handbooks available.
Subchapter M0120 Pages 8, 9, 10, 16, 17, 19	On page 8, revised the terminology for adoption assistance children with special needs for medical or rehabilitative care. On pages 9 and 10, clarified that infants born to mothers eligible for FAMIS Prenatal Coverage do not need to file an application form. On pages 16, 17, and 19, added references to the new MES.

Changed Pages	Changes
Subchapter M0130 Pages 5, 12	Added references to MES.
Subchapter M0310 Pages 2, 5, 6, 6a	Revised the terminology for adoption assistance children with special needs for medical or rehabilitative care
Subchapter M0320 Page 27	Updated the income limits for entry into Medicaid Works, effective January 18, 2022.
Subchapter M0330 Table of Contents Pages 1, 2, 5, 7, 8, 29, 37, 39, 40	Revised the terminology for adoption assistance children with special needs for medical or rehabilitative care.
Chapter M04 Pages 3, 7, 16b, 18, 20, 32 Appendix 1, pages 1-2 Appendix 2, pages 1-2 Appendices 6 and 7	On pages 3, 7, and 20, revised the terminology for adoption assistance children with special needs for medical or rehabilitative care. On page 16b, clarified how to verify income from self-employment. On page 18, clarified the policy on income from crowdfunding or crowdsourcing. On page 32, added a reference to MES. In the appendices, updated the FPL-based income limits, effective January 18, 2022.
Subchapter M0810 Page 2	Updated the FPL-based income limits, effective January 18, 2022.
Subchapter M0830 Page 78	Added policy on gifts used to pay for educational expenses.
Subchapter M1130 Table of Contents, pages i, ii Pages 47, 48, 79 Page 48a was added. Page 48b was added as a runover page Page 78 is a runover page.	Revised the Table of Contents. On pages 47, 48, and 48a, added new policy on grants, scholarships, fellowships, and gifts. On page 79, added examples of qualified disability expenses for ABLE accounts.

Changed Pages	Changes
Subchapter M1140 Table of Contents, page i Page 16 Table of Contents, page ii was added as a runover page. Pages 16a-16e were added. Page 16e is a runover page.	Added new policy on Qualified Tuition Programs (also known as 529 Plans).
Subchapter M1460 Pages 12, 23	On page 12, revised text for improved clarity. On page 23, removed outdated system instructions.
Subchapter M1520 Pages 10, 11, 12, 13, 26, 27, 30 Appendix 2, page 1	On page 11, revised the terminology for adoption assistance children with special needs for medical or rehabilitative care. On pages 10, 12, 13, 26, 27, and 30, added references to MES and removed outdated system instructions. In Appendix 2, updated the income limits for Extended Medicaid, effective January 18, 2022.
Subchapter M1550 Page 1	Revised and updated the information about training centers.
Chapter M17 Page 4 Page 4a was added.	Revised the policy on post-eligibility RAU investigations.
Chapter M21 Appendix 1, Page 1	Updated the income limits for FAMIS, effective January 18, 2022.
Chapter M22 Page 6 Appendix 1, page 1	On page 6, added a reference to MES. In Appendix 1, updated the income limits for FAMIS MOMS, effective January 18, 2022.
Chapter M23 Page 6 Appendix 1, page 1	On page 6, added a reference to MES. In Appendix 1, updated the income limits for FAMIS Prenatal Coverage, effective January 18, 2022.

Please retain this TN letter for future reference. Should you have questions about information contained in this transmittal, please contact Cindy Olson, Director, DMAS Eligibility and Enrollment Services Division, at cindy.olson@dmas.virginia.gov or (804) 225-4282.

Sincerely,

Sarah Hatton

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

Attachment

M0110 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-23	4/1/22	Page 10
TN #DMAS-17	7/1/20	Pages 1, 5, 6, 8 Page 4a is a runover page.
TN #DMAS-15	1/1/20	Pages 4, 8 Page 4a was added.
TN #DMAS-14	10/1/19	Page 15
TN #DMAS-12	4/1/19	Table of Contents Page 1, 2, 9 Page 2a is a runover page
TN #DMAS-4	4/1/17	Page 15
TN #DMAS-3	1/1/17	Page 15
TN #DMAS-2	10/1/16	Pages 3, 13
TN #100	5/1/15	Pages 2, 7 Page 1 is a runover page.
TN #98	10/1/13	Table of Contents Pages 1-15 Page 6a was removed. Page 16 was added.
TN #97	9/1/12	Table of Contents Page 13 Page 14 was added. Appendix 1 was added.
Update #7	7/1/12	Pages 3, 6a, 7, 8
TN #96	10/1/11	Table of Contents Pages 2-6a
TN #95	3/1/11	Pages 2-4a
TN #94	9/1/10	Pages 2, 3
TN #93	1/1/10	Pages 1, 6

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

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

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

- The brochure "Virginia Department of Social Services Division of Benefit Programs," form # B032-01-0002, contains information about the Medicaid Program and must be given to all applicants;

- The Division of Child Support Enforcement (DCSE)'s booklet "Child Support and You," form #032-01-945 must be given to applicants who are applying on behalf of a child who has an absent parent; and

- *The Medicaid and FAMIS Handbooks are available online at. https://coverva.org/en/member-handbooks. A printed copy of the handbook corresponding to the individual's enrollment or request must be given to anyone who requests a hard copy.*

Applicants may also be given MA Fact Sheets as appropriate.

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

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

3. Voter Registration

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

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

a. Exceptions to Offering Voter Registration

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

M0120 Changes

Changed With	**Effective Date**	**Pages Changed**
TN #DMAS-23	4/1/22	Pages 10, 11, 16, 17, 19
TN #DMAS-18	1/1/21	Pages 11, 17 Page 12 is a runover page. Page 12a was added as a runover page.
TN #DMAS-17	7/1/20	Pages 2, 2a, 5, 7, 8, 13, 16 Page 6 is a runover page. Page 14 was removed. Pages 15-20 were renumbered.
TN #DMAS-14	10/1/2019	Pages 7, 10, 11, 18 Page 20a was deleted.
TN #DMAS-12	4/1/19	Pages 2, 12-13,15, 20a
TN #DMAS-10	10/1/18	Pages 2, 4, 15, 17-20 Page 20a was added as a runover page.
TN #DMAS-8	4/1/18	Page 12
TN #DMAS-6	10/1/17	Page 1
TN #DMAS-5	7/1/17	Page 2a
TN #DMAS-4	4/1/17	Pages 2a, 7, 10, 13
TN #DMAS-3	1/1/17	Page 15
TN #DMAS-2	9/1/16	Pages 2, 15 Page 2a is a runover page.
TN #DMAS-1	6/1/16	Pages 7, 10, 11, 16-20
TN #100	5/1/15	Table of Contents Pages 1, 2, 15, 20 Page 2a and 16 are runover pages.
UP #10	5/1/14	Table of Contents Pages 11, 16-18 Pages 11a and 11b were deleted. Pages 19 and 20 were added.
TN #99	1/1/14	Page 11 Pages 11a and b were added.
TN #98	10/1/13	Table of Contents Pages 1-17
UP #9	4/1/13	Page 13, 15, 16
UP #7	7/1/12	Pages 1, 10-12
TN #96	10/1/11	Table of Contents Pages 6-18
TN #95	3/1/11	Pages 1, 8, 8a, 14
TN #94	9/1/10	Pages 8, 8a
TN #93	1/1/10	Pages 1, 7, 9-16
Update (UP) #1	7/1/09	Page 8
TN #91	5/15/09	Page 10

- the deceased received a Medicaid-covered service on or before the date of death, and

- the date of service was within a month covered by the MA application.

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

- his guardian or conservator,

- attorney-in-fact,

- executor or administrator of his estate

- his surviving spouse, or

- his surviving family member, in this order of preference: adult child, parent, adult brother or sister, adult niece or nephew, or aunt or uncle.

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

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

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

E. Enrollee Turns 18

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

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

M0120.300 Medical Assistance Application Forms

A. General Principle – Application Required

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

- IV-E Foster Care/Adoption Assistance children
- Auxiliary Grant (AG) applicants
- Newborn children under age 1 born *to women eligible for* Medicaid, FAMIS*, FAMIS MOMS, or FAMIS Prenatal Coverage.*

1. Title IV-E Foster Care & Medicaid Application

The Title IV-E Foster Care & Medicaid Application, available at https://fusion.dss.virginia.gov/Portals/%5Bdfs%5D/Files/Copy%20of%20032-03-0636-06-eng.xlsx, is used for foster care or adoption assistance children who are eligible under Title IV-E of the Social Security Act. If the child requires a resource evaluation for a medically needy spenddown, Appendix E can be used to collect the information. The Appendix must be signed by the applicant's guardian.

For a IV-E FC child whose custody is held by an LDSS or a private FC agency, or for a IV-E adoption assistance (AA) child, the Title IV-E Foster Care & Medicaid Application is used to determine if the child meets Medicaid IV-E eligibility requirements. This form is also used to determine Medicaid eligibility for IV-E AA children. This form is **not** used for children in non-custodial agreement cases or non-IV-E FC or AA.

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

For non-IV-E FC children, a separate Medicaid application must be submitted by either the custodial agency or a parent or caretaker relative with whom the child has been placed. When a child enters care through a non-custodial agreement, or when a child is a non-IV-E AA child, a separate Medicaid application must be submitted by the parent or guardian.

2. Auxiliary Grant (AG)

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

3. Exception for Certain Newborns

A child born to a mother who was eligible for Medicaid, FAMIS, *FAMIS MOMS, or FAMIS Prenatal Coverage* at the time of the child's birth (including a child born to an emergency-services-only alien mother) is deemed to have applied and been found eligible for Medicaid on the date of the child's birth (see M0320.301). An application for the child is not required. The child's coverage is subject to renewal when he turns 1 year old.

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

4. Forms that Protect the Application Date

a. Low Income Subsidy (LIS) Medicaid Application

The Medicare Patient and Provider Improvement Act (MIPPA) requires LIS application data submitted by the Social Security Administration (SSA) to states to be treated as an application for Medicaid, if the LIS applicant agrees. LIS application data is sent to LDSS via the SSA Referral Inbox in VaCMS. The LDSS must generate an LIS Medicaid application and cover sheet and mail them to the individual. The individual must return the application or apply for Medicaid online or by telephone in order for his Medicaid eligibility to be determined. If the individual submits the application, the date of LIS application with the SSA is treated as the date of the Medicaid application.

C. Hospital Presumptive Eligibility

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

1. HPE Determination and Enrollment

To provide an individual HPE coverage, the hospital staff obtains basic demographic information about the individual, as well as the attestations from the individual regarding Virginia residency (including locality), U.S. citizenship or lawful presence, Social Security number, household size and income, and requirements related to a covered group. As the information is self attested, no verifications or additional proof is required.

Hospital staff determines eligibility and enters the approved individual's data into the HPE webpage located in the provider portal in the *Medicaid Enterprise System (MES—formerly the* Medicaid Management Information System [MMIS]). This information is electronically transferred to the Cover Virginia Central Processing Unit (CPU) which is responsible for enrolling the individual in the appropriate aid category (AC) in MMIS. The HPE enrollment **is not** entered in the Virginia Case Management System (VaCMS). HPE recipients are not entered into a managed care organization (MCO).

The hospital is responsible for providing immediate notification to the individual of his HPE coverage. They will request that he file a full MA application by the end of the following month so that continued eligibility for Medicaid can be evaluated without an interruption in coverage.

The HPE covered groups and the ACs are:

- Pregnant Women (AC 035)
- Child Under Age 19 (AC 064)
- Low Income Families with Children (LIFC) (AC 065)
- Former Foster Care Children Under Age 26 (AC 077)
- Breast & Cervical Cancer Prevention & Treatment Act (BCCPTA) (AC 067)
- Plan First (AC 084)
- MAGI Adults (AC 106) (effective January 1, 2019)

Individuals enrolled on the basis of HPE receive a closed period of coverage beginning with the date of the HPE determination through the last day of the following month or the date MA eligibility is determined, whichever comes first. Enrollment in HPE is not based on the date of the hospital admission nor the first day of the month.

While enrolled as HPE, individuals in the Child Under Age 19 years, LIFC, Former Foster Care Children Under Age 26, BCCPTA, and MAGI Adults covered groups receive full Medicaid benefits. HPE pregnant women coverage

(AC 035) is limited to outpatient prenatal services; labor and delivery are not covered under HPE for AC 035. HPE coverage for Plan First enrollees AC084 is limited to family planning services only. Transportation to receive covered medical services is covered for all HPE enrollees.

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

There are no appeal rights for an HPE determination.

2. Eligibility Procedures – Post HPE Enrollment

a) MA Application Not Submitted

If the person does not submit an MA application prior to the end of the HPE coverage period, no further worker action or additional notice not required because the enrollment was for a closed period of coverage.

b) MA Application Submitted

For MA coverage to continue beyond the initial HPE coverage period, the individual must submit a full MA application. MA applications submitted by HPE enrollees are subject to the standard eligibility and entitlement policies. The 7-calendar day processing standard applies to MA applications submitted by pregnant women. The 10-work day requirement applies to applications submitted by BCCPTA individuals enrolled in HPE.

While the LDSS does not determine eligibility for HPE, if an MA application is received and pended in VaCMS, the individual's coverage in the HPE AC may need to be extended or reinstated (if HPE coverage will end during the application processing period) while the application is processed. If HPE coverage needs to be extended/reinstated, alert a VDSS Regional Consultant or send an MMIS Coverage Correction Request form, available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, to the DMAS Eligibility and Enrollment Unit at enrollment@dmas.virginia.gov.

Example 1: Mary Smith is enrolled in HPE coverage in AC 065 (LIFC) for the period of 3-5-18 through 4-30-18. On 4-20-18, she submits an MA application; however, the 45th processing day will fall after the HPE end date of 4-30-18. Therefore, the worker must have the HPE coverage reinstated in *MES* under the same aid category (AC 065), using the MA application date. The effective date of the reinstatement is 5-1-18, the day after the HPE coverage ends. Once the application has been processed. the worker must act to cancel the HPE coverage, and if the individual remains eligible reinstate coverage in the appropriate AC.

Example 4 : Jane was enrolled in HPE AC 035 (pregnant women) for the period of 4-13-18 through 5-30-18. She files an MA application on 4-28-18 and is approved for AC 091 coverage. Jane would have coverage as AC 091 for the period beginning 4-1-18. However, based on her expected delivery date found on the application, Jane was pregnant during the months prior to her HPE determination. The worker determines and approves retro coverage. The worker ensures Jane has coverage for AC 091 with a begin date of 1-1-18. In *MES*, this transaction would be a retro cancel reinstate using Cancel Reason 024.

c) Retroactive Coverage

An individual cannot receive retroactive HPE coverage.

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

d) Applicant Determined Not Eligible for ongoing MA coverage

If the applicant is determined to not be eligible for ongoing MA coverage, his entitlement to HPE coverage ends. Unless the HPE coverage was extended, no further action is required by the worker. If cancellation of HPE coverage is needed, request that the effective cancel date be the current date (i.e. day of the eligibility determination), using Cancel Reason 008.

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

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

Changed With	Effective Date	Pages Changed
TN #DMAS-23	4/1/22	Pages 5, 12
TN #DMAS-21	10/1/21	Page 14
TN #DMAS-20	7/1/21	Page 2 Page 2a is a runover page.
TN #DMAS-18	1/1/21	Pages 4, 8, 13

M0130 Changes

TN #DMAS-17	7/1/20	Pages 2, 6, 10 Page 6a was added as a runover page.
TN #DMAS-15	1/1/20	Pages 9, 10
TN #DMAS-14	10/1/19	Pages 9, 10
TN #DMAS-11	1/1/19	Page 1
TN #DMAS-10	10/1/18	Table of Contents Pages 1, 2-2b, 9-12 Pages 2c-2e were added as runover pages.
TN #DMAS-9	7/1/18	Page 2b
TN #DMAS-8	4/1/18	Page 13
TN #DMAS-7	1/1/18	Pages 1, 9
TN #DMAS-5	7/1/17	Pages 1, 10
TN #DMAS-4	4/1/17	Page 6
TN #DMAS-3	1/1/17	Pages 5, 7, 11
TN #DMAS-2	10/1/16	Table of Contents Pages 2. 4, 5, 7-10, 12, 13 Page 2a is a runover page. Page 14 was added as a runover page.
TN #DMAS-1	6/1/16	Table of Contents Pages 4, 6, 10, 12 Page 11 is a runover page. Page 13 was added as a runover page.
TN #100	5/1/15	Pages 1, 2-2b, 5, 11 Pages 3, 6 and 2c are runover Pages.
UP #10	5/1/14	Table of Contents Pages 8-12 Page 13 was added.
TN #99	1/1/14	Pages 10-12 Page 13 was added.
TN #98	10/1/13	Table of Contents Pages 1-12
UP #9	4/1/13	Page 3, 5
UP #7	7/1/12	Pages 4, 5
TN #96	10/1/11	Pages 6-8
TN #95	3/1/11	Page 8
TN #94	9/1/10	Pages 2-6, 8
TN #93	1/1/10	Pages 4-6, 8
Update (UP) #2	8/24/09	Pages 8, 9

M0130.200 Required Information and Verifications

A. Identifying Information

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

1. Name

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

The Federally managed Data Services Hub verifies the individual's name and SSN with the SSA for cases processed in VaCMS (see M0130.200 B.1 below). For an individual whose name and SSN cannot be verified in VaCMS and for all individuals whose cases are not processed in VaCMS, either SVES or the State Online Query-Internet system (SOLQ-I) SSA Title II and Title XVI results may be used.

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

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

2. SSN

The SSN of an individual for whom medical assistance is requested and for whom having an SSN or proof of application for one is an eligibility requirement, must be provided by the applicant and verified by the worker through SSA. The Hub or SOLQ-I may be used to verify the individual's SSN. See M0240.001.

B. Required Verifications

1. The Federally-managed Data Services Hub

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

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

Income verification by the Hub is acceptable for retroactive eligibility determinations provided that reasonable compatibility is met (see M0420.100 B.9).

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

2. Other Verification Sources

An individual must provide verifications of certain MA eligibility requirements when they cannot be verified through EDSV. Before taking action on the application, the applicant must be notified in writing of the required information. The verification request (checklist) must be sent to the authorized representative, if one has been designated.

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.

If an applicant (other than a Medicare beneficiary, HPE, or deceased individual) is ineligible for MA for any reason other than the inability to determine eligibility, a referral to the HIM must be made so that his eligibility for the APTC in conjunction with a Qualified Health Plan (QHP) can be determined. Individuals who have Medicare, who are incarcerated, who are enrolled as HPE, and deceased individuals and are not referred to the HIM.

2. Entitle-ment and Enrollment

a. Entitlement

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

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

b. Enrollment

MA enrollees must be enrolled in the *MES*, either through the system interface with the eligibility determination system or directly by the eligibility worker.

Note: The MES was implemented in April 2022. Prior to April 2022, the Medicaid Management Information System (MMIS) was used for enrollment and claims processing. References to MMIS in the Medical Assistance Eligibility Manual will be updated as other policy revisions are made.

When an individual who does not have Medicare is eligible for only limited MA benefits, such as Plan First, a referral to the HIM must be made so that his eligibility for the APTC in conjunction with a QHP can be determined.

3. Notification to Applicant

Either a Notice of Action generated by the eligibility determination system or the equivalent form #032-03-006 (available at the DSS Fusion website) must be used to notify the applicant of the specific action taken on the application. The notice must be sent to the authorized representative, if one has been designated.

Changed With	**Effective Date**	**Pages Changed**
TN #DMAS-23	4/1/22	Pages 2, 5, 6, 6a
TN #DMAS-22	1/1/22	Page 28
TN #DMAS-20	7/1/21	Page 6 Pages 5 and 5a are runover pages.
TN #DMAS-18	1/1/21	Table of Contents, page ii Pages 26, 27 Appendix 1 was removed. Appendix 2 was renumbered to Appendix 1.
TN #DMAS-17	7/1/20	Page 7 Pages 8 and 9 are runover pages.
TN #DMAS-15	1/1/20	Pages 29, 30
TN #DMAS-14	10/1/19	Pages 24, 26, 27, 40
TN #DMAS-13	7/1/19	Pages 24 Page 24a is a runover page.
TN #DMAS-12	4/1/19	Pages 8, 9, 13
TN #DMAS-10	10/1/18	Table of Contents, page ii Pages 1-4 Page 40 was added.
TN #DMAS-9	7/1/18	Page 35 Appendix 2, Page 1
TN #DMAS-8	4/1/18	Page 9
TN #DMAS-7	1/1/18	Pages 34, Appendix 2, page 1
TN #DMAS-5	7/1/17	Pages 13, 37, 38
TN #DMAS-4	4/1/17	Pages 24, 30a Page 23 is a runover page. Page 24a was added as a runover page.

TN #DMAS-3	1/1/17	Pages 8, 13, 28b
TN #DMAS-2	10/1/16	Pages 4, 7, 29 Page 30 is a runover page. Appendix 2, page 1
TN #DMAS-1	6/1/16	Table of Contents, page ii Pages 13, 26, 28 Appendix 2, page 1
TN #100	5/1/15	Table of Contents, pages i, ii Pages 11, 23, 28b, Pages 27a-27c were renumbered to 28-28a for clarity. Page 10 is a runover page. Appendix 2
UP #10	5/1/14	Pages 29, 30
TN #99	1/1/14	Pages 6, 7, 21, 24, 25, 27a, 39
TN #98	10/1/13	Pages 2, 4, 27a, 27b, 28, 35, 36, 39
UP #9	4/1/13	Pages 24-27 Appendix 2
TN #97	9/1/12	Table of Contents, page i Pages 1-5a, 10-13 Pages 23, 28, 29, 30a, 31 Pages 33, 36, 38, 39
UP #7	7/1/12	Table of Contents, page ii Pages 23, 26, 27 Appendices 1-3 were removed. Appendices 3 and 4 were renumbered and are now Appendices 1 and 2, respectively.
TN #96	10/1/11	Appendix 4
TN #95	3/1/11	Pages 30, 30a
TN #94	9/1/10	Pages 21-27c, 28
TN #93	1/1/10	Page 35 Appendix 5, page 1
Update (UP) #2	8/24/09	Table of Contents Page 39
TN #91	5/15/09	Pages 23-25 Appendix 4, page 1 Appendix 5, page 1

M0310.002 LIST OF MEDICAID COVERED GROUPS

Group and Description Mandatory = required under federal regulations Optional = State Plan Option		**Categorically Needy (CN)**	**Medically Needy(MN)**
Aged, Blind, or Disabled (ABD)	SSI – mandatory	**X**	
	AG – mandatory	**X**	
	Protected – mandatory	**X**	
	≤ 80% FPL – optional	**X**	
	≤ 300% of SSI – optional (institutionalized only)	**X**	
	Medicaid Works – optional	**X**	
	Medicare Savings Programs (QMB, SLMB, QI, QDWI) --all mandatory	**X**	
	Aged Blind Disabled --all optional		**X**
Families & Children (F&C) `	IV-E Foster Care or Adoption Assistance - mandatory	**X**	
	LIFC Parent/Caretaker Relatives - mandatory	**X**	
	Pregnant woman/newborn child – mandatory	**X** mandatory	**X** optional
	Child under age 19 – mandatory	**X**	
	BCCPTA – optional	**X**	
	Plan First – optional	**X**	
	Child under 18 – optional		**X**
	Individuals under age 21, *Adoption Assistance Children with* Special Needs *for* Medical *or Rehabilitative Care* Adoption Assistance	**X** optional	**X** optional
	Former Virginia Foster Care Children under age 26 – mandatory (effective January 1, 2014)	**X**	
	MAGI Adults – optional (effective January 1, 2019)	**X**	

2. F&C Groups

a. Children under age 18

b. Children under age 1

c. Pregnant Women

d. Children *with* Special Needs *for Medical or Rehabilitative Care*

e. Individuals under age 21

E. Refugees

"Refugees" are a special group of individuals who have an alien status of "refugee", and are eligible for Medicaid under a different federal funding source. Virginia receives full federal funding with no state matching funds for the medical assistance provided to these individuals during the first 8 months they are in the U.S.

There are two aid categories (ACs) for this group. AC 078 is used for Refugee Other and Refugee Medicaid Other and AC 079 is used for Refugee Medicaid Unaccompanied Minors. The policy and procedures used to determine whether an individual is eligible in this group are found in the Refugee Resettlement Program Manual, Volume XVIII.

M0310.100 DEFINITION OF TERMS

A. Introduction

The terms used in the covered groups policy and procedures and the procedures for determining if an individual meets a definition are stated in sections M0310.101 through 131 below.

M0310.101 ABD

A. ABD Definition

"ABD" is the short name used to refer to aged, blind or disabled individuals.

B. Procedures

See the following sections for the procedures to use to determine if an individual meets an ABD definition:

- M0310.105 Age and Aged
- M0310.106 Blind
- M0310.112 Disabled

M0310.102 ADOPTION ASSISTANCE

A. Definition

Adoption Assistance is a Title XX of the Social Security Act social services program that provides cash assistance and/or social services to adoptive parents who adopt "hard to place" foster care children who were in the custody of a local department of social services or a child placing agency licensed by the state of Virginia.

***1.* Residing in Virginia**

Adoption assistance children are children who reside in Virginia who are adopted under a Title IV-E or Non-IV-E (state-local) adoption assistance agreement with a department of social services or in conjunction with a child-placing agency.

2) Children *with* special needs *for* medical *or rehabilitative care* adopted under a Non IV-E Adoption Assistance agreement with a Virginia local department of social services or a Virginia private, non-profit child placement agency in conjunction with a local department of social services, in accordance with policies established by the State Board of Social Services.

a. Documentation must indicate that the child has special needs *for medical or rehabilitative care*

One of the following *documents must indicate the child's* special needs *for* medical *or rehabilitative care*:

- an adoption assistance agreement specifying that the child has *a* special need *for* medical *or rehabilitative care*; the agreement does NOT need to specify a particular diagnosis or condition.
- an amendment to the adoption assistance agreement specifying that the child has *a* special need *for* medical *or rehabilitative care*.
- a signed letter on official letterhead from the state that facilitated the adoption assistance agreement confirming that the child has a special need *for* medical *or rehabilitative care.*

b. Virginia Medicaid coverage for children with special needs *for* medical *or rehabilitative care*

Medicaid coverage is to be provided to any child who has been determined to be a Non-IV-E Adoption Assistance Child with special needs *for* medical *or rehabilitative care* for whom there is in effect an adoption assistance agreement between a local Virginia department of social services (LDSS) or a Virginia child-placing agency and an adoptive parent(s).

Virginia Medicaid coverage MAY be provided to a child with special needs *for* medical *or rehabilitative care* for whom there is in effect an adoption assistance agreement between another state's child-placing agency and an adoptive parent(s) IF the other state reciprocates with Virginia per the Interstate Compact on Adoption and Medical Assistance (ICAMA).

3. Verification

a. Adoption assistance agreement with Virginia agency

A child's status as an adoption assistance child is verified by the LDSS agency foster care/adoption assistance worker. Documentation of the child's IV-E or Non-IV-E adoption assistance eligibility must be part of the Medicaid case record.

Verification of a child's status as a Virginia IV-E, Non-IV-E, or adoption assistance child with special needs *for medical or rehabilitative care* is obtained through the local agency's Service Programs Division.

b. IV-E adoption assistance agreement with another state

When the IV-E adoption assistance agreement is with another state and the IV-E child resides in Virginia, verification of the child's status as a Title IV-E adoption assistance recipient is verified through the Deputy Compact Administrator, Adoption Unit, Division of Family Services, Virginia Department of Social Services.

c. Non-IV-E adoption assistance agreement with another state

Verification of the child's Non-IV-E adoption assistance status with another state, and the state's reciprocal agreement under the Interstate Compact on Adoption and Medical Assistance (ICAMA), is obtained through the Deputy Compact Administrator, Adoption Unit, Division of Family Services, Virginia Department of Social Services.

If the state that signed the non-IV-E adoption assistance agreement does NOT reciprocate Non-IV-E adoption assistance eligibility with Virginia, then the Non-IV-E Adoption Assistance child is not eligible for Virginia Medicaid in the Adoption Assistance classification of the "Individuals Under Age 21" covered group.

M0310.103 AFDC

A. Aid To Families With Dependent Children (AFDC)

AFDC is the short name of the Aid to Families With Dependent Children cash assistance program that was operated in Virginia prior to the February 1, 1997, implementation of TANF (Temporary Assistance to Needy Families). It was a federally funded assistance program under Title IV-A of the Social Security Act. In Virginia, AFDC was replaced by TANF on February 1, 1997.

B. Procedure

AFDC is defined here because of the occasional references in Medicaid policy to the AFDC program that was in effect on July 16, 1996. There are no current recipients of AFDC because the AFDC program no longer exists.

M0310.104 AG

A. Auxiliary Grants (AG)

"AG" is the short name for the Auxiliary Grants Program. AG is Virginia's assistance program that supplements the federal Supplemental Security Income (SSI) assistance program. AG is Virginia's "State Supplementation of SSI." AG is available only to ABD financially eligible individuals who reside in licensed Adult Care Residences (ACRs).

B. Procedure

Check the local agency records of AG recipients. If the individual is eligible for and receiving an AG payment, he is an AG recipient for Medicaid purposes.

M0320 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-23	4/1/22	Page 27
TN #DMAS-22	1/1/22	Pages 11, 26a, 27
TN #DMAS-20	7/1/21	Pages 24, 26-29
TN #DMAS-19	4/1/21	Pages 26a, 29
TN #DMAS-18	1/1/21	Pages 11, 22, 26, 27
TN #DMAS-17	7/1/20	Pages 24. 25. 26, 27 Page 26a was added as a runover page.
TN #DMAS-15	1/1/20	Pages 11, 26, 27, 29
TN #DMAS-14	10/1/19	Page 40
TN #DMAS-13	7/1/19	Pages 1, 24-27
TN #DMAS-11	1/1/19	Pages 2a, 11, 35, 37
TN #DMAS-10	10/1/18	Page 1 1a added as a runover page
TN #DMAS-9	7/1/18	Page 2, 17
TN #DMAS-7	1/1/18	Page 2, 3, 4, 11, 26-27.
TN #DMAS-4	4/1/17	Page 26
TN #DMAS-3	1/1/17	Pages 11, 27, 29, 40, 41, 44, 45, 52
TN #DMAS-2	10/1/16	Pages 4, 15, 16, 18, 20, 22, 30, 33, Pages 39- 41, 43-45, 48, 51, 52, 55
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 1, 11, 25-27, 46-49 Page 50 is a runover page.
TN #100	5/1/15	Pages 6, 11, 24, 25-27, 29-30
TN #99	1/1/14	Page 11
TN #98	10/1/13	Pages 1, 54, 55.
UP #9	4/1/12	Pages 11, 26, 32, 34-37, 45, 46, 55
TN #97	9/1/12	Table of Contents Pages 1-56 (all pages)
UP #6	4/1/12	Pages 11, 12, 46a
TN #96	10/1/11	Table of Contents Pages 46f-50b Page 50c deleted
TN #95	3/1/10	Pages 11, 12, 42c, 42d, 50, 53, 69 Pages 70, 71 Page 72 added.
TN #94	9/1/10	Pages 49-50b
UP #3	3/1/10	Pages 34, 35, 38, 40, 42a, Pages 42b, 42f
TN #93	1/1/10	Pages 11-12, 18, 34-35, 38 Pages 40, 42a-42d, 42f-44, 49 Pages 50c, 69-71
UP #2	8/24/09	Pages 26, 28, 32, 61, 63, 66
Update (UP) #1	7/1/09	Pages 46f-48
TN #91	5/15/09	Pages 31-34 Pages 65-68

Accounts are also excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees. The account must be exclusively used to hold resources accumulated while in MEDICAID WORKS (including interest) in order for the exclusion to continue.

3) For **all** other resources, the resource requirements in chapter S11 and Appendix 2 to chapter S11 apply. All of the individual's countable, nonexempt resources must be verified and evaluated.

All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements. The resource limit for resources not excluded in 1) or 2) above is $2,000 for an individual.

3. Income

a. Initial eligibility determination

For the initial eligibility determination on or after July 1, 2021, the limit for total countable income (unearned and earned) is less than or equal to 138% of the FPL *($1,563* per month for an individual or *$2,106* when the applicant has an ABD spouse who is also applying for or covered by Medicaid). The income requirements in chapter S08 must be met. Individuals who receive SSI or who have 1619(b) status are considered to meet the income requirements and no evaluation of income is necessary for the initial eligibility determination (see M0320.101).

b. Ongoing eligibility

Once the individual is enrolled in MEDICAID WORKS, the following income policies apply:

1) The income limit for earned income is $6,250 per month ($75,000 per year) (no change for 2022) as long as the funds are deposited in a WIN Account. The policy for determining countable earned income is contained in subchapter S0820.

   If the individual is self-employed, net earnings from self-employment (NESE) must be demonstrated through documentation of Internal Revenue Service (IRS) filings, quarterly estimated taxes, business records, and/or business plans. The individual's signed allegation of self-employment is acceptable if no other evidence of NESE can be obtained. Follow the policy in S0820.220 for determining NESE.

2) The income limit for unearned income remains less than or equal to 138% of the FPL. The policy for determining countable unearned income is contained in subchapter S0830.

3) Any increase in an enrollee's Social Security Disability benefits resulting from employment as a MEDICAID WORKS participant OR as a result of a COLA adjustment to the Social Security Disability benefits will not be counted as long as the increase is regularly deposited upon receipt into the individual's WIN account.

4) Unemployment insurance benefits received due to loss of employment through no fault of the individual's own are not counted during the six-month safety net period (see M0320.400 G) as income as long as the payments are regularly deposited upon receipt into the individual's WIN account.

M0330 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-23	4/1/22	Table of Contents Pages 1, 2, 5, 7, 8, 29, 37, 39, 40
TN #DMAS-20	7/1/21	Pages 1, 13, 14
TN #DMAS-19	4/1/21	Pages 14, 26
TN #DMAS-14	10/1/19	Pages 1, 2, 10a
TN #DMAS-12	4/1/19	Pages 26, 28
TN #DMAS-11	1/1/19	Pages 1, 2, 12, 14-16, 24, 25
TN #DMAS-10	10/1/18	Table of Contents Page 1-2, 30 Page 10a-b were added as runover pages.

M0330 Changes

TN #DMAS-8	4/1/18	Pages 1, 9, 10, 25
TN #DMAS-6	10/1/17	Pages 8, 14
TN #DMAS-5	7/1/17	Pages 9, 14
TN #DMAS-4	4/1/17	Page 5
TN #DMAS-3	1/1/17	Pages 9, 10 Page 9a was removed.
TN #DMAS-2	10/1/16	Pages 8 Page 9b was renumbered to 9a.
TN #DMAS-1	6/1/16	Pages 2, 8, 9, 15, 31, 32-35 Page 9b was added as a runover page.
TN #100	5/1/15	Table of Contents Pages 4-8, 15-22, 24,25 36-38
UP #10	5/1/14	Pages 5, 8, 9
TN #99	1/1/14	Pages 1, 8, 9, 13, 24
TN #98	10/1/13	Table of Contents Pages 1-3, 6-16, 19, 22, 24-29
UP #8	10/1/12	Pages 4, 6
TN #97	9/1/12	Table of Contents Pages 1-40 (all pages)
UP #2	8/24/09	Pages 3, 6, 8, 16, 22
Update (UP) #1	7/1/09	Pages 20, 21
TN #DMAS-4	4/1/17	Page 5
TN #DMAS-3	1/1/17	Pages 9, 10 Page 9a was removed.
TN #DMAS-2	10/1/16	Pages 8 Page 9b was renumbered to 9a.
TN #DMAS-1	6/1/16	Pages 2, 8, 9, 15, 31, 32-35 Page 9b was added as a runover page.
TN #100	5/1/15	Table of Contents Pages 4-8, 15-22, 24,25 36-38
UP #10	5/1/14	Pages 5, 8, 9
TN #99	1/1/14	Pages 1, 8, 9, 13, 24
TN #98	10/1/13	Table of Contents Pages 1-3, 6-16, 19, 22, 24-29
UP #8	10/1/12	Pages 4, 6
TN #97	9/1/12	Table of Contents Pages 1-40 (all pages)
UP #2	8/24/09	Pages 3, 6, 8, 16, 22
Update (UP) #1	7/1/09	Pages 20, 21

TABLE OF CONTENTS

M03 MEDICAID COVERED GROUPS

M0330.000 FAMILIES & CHILDREN GROUPS

	Section	Page
General Policy Principles	**M0330.001**	**1**
Families & Children Categorically Needy Groups	**M0330.100**	**2**
IV-E Foster Care & IV-E Adoption Assistance	**M0330.105**	**2**
Individuals Under Age 21	**M0330.107**	**4**
Adoption Assistance *Children With* Special Needs *for* Medical *or Rehabilitative Care*	**M0330.108**	**7**
Former Foster Care Children Under Age 26 Years	**M0330.109**	**8**
Low Income Families With Children (LIFC)	**M0330.200**	**9**
MAGI Adults (Effective January 1, 2019)	**M0330.250**	**10a**
Child Under Age 19 (FAMIS Plus)	**M0330.300**	**11**
Pregnant Women & Newborn Children	**M0330.400**	**13**
300% of SSI Income Limit Groups	**M0330.500**	**16**
F&C in Medical institution, Income ≤ 300% SSI	**M0330.501**	**16**
F&C Receiving Waiver Services (CBC)	**M0330.502**	**18**
F&C Hospice	**M0330.503**	**21**
Plan First - Family Planning Services	**M0330.600**	**24**
Breast and Cervical Cancer Prevention Treatment Act (BCCPTA)	**M0330.700**	**26**
Families & Children Medically Needy Groups	**M0330.800**	**29**
Pregnant Women	**M0330.801**	**30**
Newborn Children Under Age 1	**M0330.802**	**33**
Children Under Age 18	**M0330.803**	**34**
Individuals Under Age 21	**M0330.804**	**36**
Adoption Assistance *Children With* Special Needs *for* Medical *or Rehabilitative Care*	**M0330.805**	**39**

M0330.000 FAMILIES & CHILDREN GROUPS

M0330.001 GENERAL POLICY PRINCIPLES

A. Overview

A State Plan for Medicaid must include the mandatory federal categorically needy (CN) groups of individuals as well as the optional groups a state has elected to cover. This subchapter divides the Families & Children (F&C) covered groups into categorically needy and medically needy (MN) groups.

Enroll children and adults who receive Supplemental Security Income (SSI) in the SSI Medicaid covered group (see M0320.101). Evaluate other disabled children and adults for eligibility in the F&C CN covered groups first because they do not have a resource requirement. Individuals who are eligible for or entitled to Medicare cannot be eligible in the MAGI Adults covered group.

B. Procedure

Determine an individual's eligibility first in a CN covered group. If the individual is not eligible as CN or for the Family Access to Medical Insurance Security Plan (FAMIS), go to the MN groups.

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

1. If the child meets the definition of a foster care child, adoption assistance child, adoption assistance child *with* special needs *for* medical *or rehabilitative care*, or an individual under age 21, evaluate in these groups first.
2. If the child meets the definition of a newborn child, evaluate in the pregnant woman/newborn child group.
3. If the child is under age 18 or is an individual under age 21 who meets the adoption assistance or foster care definition or is under age 21 in an intermediate care facility (ICF) or facility for individuals with intellectual disabilities (ICF-ID), AND is in a medical institution or has been screened and approved for Home and Community Based Services (HCBS) or has elected hospice, evaluate in the appropriate F&C 300% of SSI covered group.
4. If a child is under the age of 19, evaluate in this group.
5. If a child is a former foster care child under age 26 years, evaluate for coverage in this group.
6. If a child has income in excess of limits individual, evaluate for the Family Access to Medical Insurance Security Plan (FAMIS) eligibility (chapter M21).
7. If the child is a child under age 1, child under age 18, an individual under age 21 or *an* adoption assistance child *with* special needs *for* medical *or rehabilitative care*, but has income in excess of the appropriate F&C CN income limit, evaluate as MN.

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

1. If the individual meets the definition of a parent/caretaker relative, evaluate in the LIFC covered group.
2. If the individual is not eligible as LIFC, but meets the definition of a pregnant woman, evaluate in the pregnant woman/newborn child group. If the pregnant women does not meet the definition of lawfully residing in M0220.314, evaluate for FAMIS Prenatal Coverage (see Chapter M23).
3. If the individual has been screened and diagnosed with breast or cervical cancer or pre-cancerous conditions by the Every Woman's Life program and does not meet the definition of for coverage as SSI, LIFC, Pregnant Woman or Child under 19, evaluate in the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) covered group.
4. If the individual is a former foster care child under 26 years, and does not meet the definition of for coverage as SSI, LIFC, Pregnant Woman or Child under 19, evaluate in this covered group.
5. If the individual is between the ages of 19 and 64 and is not eligible for or entitled to Medicare, evaluate in the MAGI Adults group.
6. If the individual is not eligible as a MAGI Adult, as LIFC or as a pregnant woman, is in medical institution, has been screened and approved for Home and Community Based Services or has elected hospice, evaluate in the appropriate F&C 300 % of SSI covered group.

If the individual is a parent or caretaker-relative of a dependent child and in a medical institution, the stay must be temporary while receiving treatment, rehabilitation, etc. for him to meet the definition of living in the home with the dependent child. There are no time limits on the amount of time the parent can be in a medical institution as long as he intends to return home. Verify with the parent the reason he is in a medical facility and ask about the intent to return home.

7. If the individual has excess income for full coverage in a Medicaid covered group and is between the ages of 19 and 64, evaluate for Plan First coverage.

8. If the individual is a pregnant woman but has excess income for coverage in a CN group or FAMIS MOMS evaluate as MN.

M0330.100 FAMILIES & CHILDREN CATEGORICALLY NEEDY

A. Introduction

An F&C individual must be a child under age 19 or must meet the adoption assistance, dependent child, foster care, parent or caretaker-relative of a dependent child living in the home, pregnant woman, or BCCPTA definition, or must have applied for Plan First.

The F&C covered groups are divided into the categorically needy (CN) and medically needy (MN) classifications. Always evaluate eligibility in the categorically needy groups and FAMIS before moving to MN.

B. Procedure

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

M0330.100 Families & Children Categorically Needy Groups
M0330.105 IV-E Foster Care & IV-E Adoption Assistance;
M0330.107 Individuals Under Age 21;
M0330.108 Adoption Assistance *Children With* Special Needs *for* Medical *or Rehabilitative Care*;
M0330.109 Former Foster Care Children Under Age 26 Years
M0330.200 Low Income Families With Children;
M0330.250 MAGI Adults Group
M0330.300 Child Under Age 19 (FAMIS Plus);
M0330.400 Pregnant Women & Newborn Children;
M0330.500 300% of SSI Covered Groups
M0330.600 Plan First--Family Planning Services;
M0330.700 Breast and Cervical Cancer Prevention and Treatment Act

C. Eligibility Methodology Used

With the exception of the F&C 300% of SSI covered groups for institutionalized individuals, the F&C covered groups that require a financial eligibility determination use Modified Adjusted Gross Income (MAGI) methodology for evaluating countable income. The policies and procedures for MAGI methodology are contained in chapter M04 unless otherwise specified.

MAGI methodology is not applicable to the F&C 300% of SSI covered groups. See M0330.501 – M0330.503 for information regarding the applicable financial eligibility policies.

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

A. Policy

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

1. Non IV-E Foster Care

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

a. Children Living In Public Institutions

Non-IV-E foster care recipients meet the Medicaid institutional status requirements when they live in a public child care institution if the facility has less than 25 beds, or if they live in a publicly operated community residence that has no more than 16 beds. See section M0280.100 for definitions of public institutions.

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

b. Child in Independent Living Arrangement

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

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

2. Non-IV-E Adoption Assistance

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

Adoption assistance c*hildren with* special needs *for* medical *or rehabilitative care* have additional requirements. See section M0330.805.

3. In ICF or ICF-ID

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

C. Assistance Unit

1. Non-IV-E Foster Care Children (Includes DJJ)

The child is an assistance unit of one effective the date the child is removed from the home and placed in foster care. Each child in foster care is evaluated as a separate assistance unit, even if the child is living with his/her siblings in a foster care home.

The child continues to meet the Individuals Under Age 21 covered group as long as he is under the supervision of the LDSS or DJJ, including during a trial visit in the child’s own home. The Modified Adjusted Gross Income (MAGI) household composition methodology contained in Chapter M04 is applicable.

2. Enrollment

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

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

M0330.108 ADOPTION ASSISTANCE *CHILDREN WITH* SPECIAL NEEDS *FOR* MEDICAL *OR REHABILITATIVE CARE*

A. Policy

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

- for whom a non-IV-E adoption assistance agreement between the state and the adoptive parent(s) is in effect;

- who cannot be placed with adoptive parents without Medicaid because the child has special needs for medical or rehabilitative care; and

- who was enrolled in Medicaid under any covered group before the adoption assistance agreement was entered into OR who would have been eligible for Medicaid before the adoption assistance agreement was entered into if the eligibility requirements and standards of the IV-E foster care program were used, without employing the threshold title IV-A eligibility determination.

If the child was not enrolled in Medicaid or would not have been eligible for Medicaid prior to the adoption assistance agreement being entered into, the child is **not** eligible for Medicaid in the Adoption Assistance *Children With* Special Needs *for* Medical *or Rehabilitative Care* covered group.

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

B. Nonfinancial Eligibility Requirements

The child must:

- be under age 21,
- meet the definition of a child *with* special needs *for* medical *or rehabilitative care adopted under a Non IV-E Adoption Assistance agreement* in M0310.102, and
- meet the nonfinancial requirements in chapter M02.

C. Financial Eligibility Requirements

1. Assistance Unit

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

2. Resources

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

3. Income

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

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

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

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

D. Entitlement & Enrollment

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

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

M0330.109 FORMER FOSTER CARE CHILDREN UNDER AGE 26 YEARS

A. Policy

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

- was in the custody of a local department of social services in Virginia, another state, or a U.S. Territory, and receiving Medicaid until his discharge from foster care upon turning 18 years or older, or

- was in the URM program in Virginia or another state and receiving Medicaid until his discharge upon turning 18 years or older.

- is not eligible for Medicaid in another mandatory Medicaid covered group (LIFC parent, Pregnant Woman, Child Under age 19 or SSI), and

- is under age 26 years.

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

F. Enrollment

The aid category for BCCPTA individuals is "066".

G. Benefit Package

The BCCPTA group is a full-benefit covered group. All Medicaid-covered services are available to BCCPTA enrollees, including long-term care in a facility or in a community-based care waiver.

H. Renewal

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

M0330.800 FAMILIES & CHILDREN MEDICALLY NEEDY GROUPS

A. Introduction

An F&C medically needy individual must

- be a child under age 18, or 21, or
- meet the adoption assistance, foster care or pregnant woman definition in subchapter M0310.

B. Procedure

The policy and procedures for determining whether an individual meets an F&C MN covered group are contained in the following sections:

- M0330.801 Pregnant Women;
- M0330.802 Newborn Children Under Age 1;
- M0330.803 Children Under Age 18;
- M0330.804 Individuals Under Age 21;
- M0330.805 Adoption Assistance *Children With* Special Needs *for* Medical *or Rehabilitative Care*.

C. Referral to Health Insurance Marketplace

When an individual meets an F&C MN covered group is not eligible solely due to excess income and is placed on a MN spenddown, the individual must be referred to the Health Insurance Marketplace (HIM) so that the applicant's eligibility for the APTC can be determined.

Note: Individuals with Medicare are not referred to the HIM.

c. Child in Independent Living Arrangement

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

2. Non-IV-E Adoption Assistance

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

Adoption assistance c*hildren with* special needs *for* medical *or rehabilitative care* have additional requirements. See section M0330.805.

3. In ICF or ICF-ID

Children under age 21 who are patients in either an ICF or ICF- ID meet the classification of "individuals in an ICF or ICF- ID" in the Individual Under Age 21 covered group.

D. Assistance Unit

a. Non-IV-E Foster Care Children (Includes DJJ)

The child is an assistance unit of one effective the date the child is removed from the home and placed in foster care. Each child in foster care is evaluated as a separate assistance unit, even if the child is living with his/her siblings in a foster care home.

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

b. Adoptive Placement

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

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

Financial eligibility is determined using the assistance unit procedures in subchapter M0520, which require the inclusion of the child's adoptive parent(s) and sibling(s). An adoption assistance child must have his/her eligibility determined by counting or deeming (as appropriate) his/her parent's and sibling's income.

M0330.805 ADOPTION ASSISTANCE *CHILDREN WITH* SPECIAL NEEDS *FOR* MEDICAL *OR REHABILITATIVE CARE*

A. Policy

42 CFR 435.308(b) - A state may choose to provide medically needy coverage to a child under age 21 years

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

If the child was not enrolled in Medicaid and would not have been eligible for Medicaid prior to the adoption assistance agreement being entered into, the child is **not** eligible for Medicaid in the Adoption Assistance *Children With* Special Needs *for* Medical *or Rehabilitative Care* MN covered group. The child may be eligible in the MN Non-IV-E Adoption Assistance classification of Individuals Under Age 21 in section M0330.804.

B. Nonfinancial Eligibility

The child must

- be under age 21,
- meet the definition of a child *with* special needs *for* medical *or rehabilitative care adopted under a Non IV-E Adoption Assistance agreement* in M0310.102, and
- meet the nonfinancial requirements in chapter M02.

C. Financial Eligibility

1. Assistance Unit

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

A child in an ICF or an ICF-MR is an institutionalized individual in a medical facility when he meets the definition of "institutionalized individual" in section M1410.010 B.2. When he meets the institutionalized individual definition, he is an assistance unit of one person. The child's eligibility is determined in the F&C 300% SSI covered group in M0330.501.

2. Resources

The resource limits and requirements are found in chapter M06.

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

3. Income

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

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

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

D. Entitlement & Enrollment

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

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

Changed With	Effective Date	Pages Changed
TN #DMAS-23	4/1/22	Pages 16b, 18, 32 Appendix 1, pages 1-2 Appendix 2, pages 1-2 Appendices 6 and 7
TN #DMAS-21	10/1/21	Pages 3, 15
TN #DMAS-20	7/1/21	Pages 2, 14, 15, 16a, 16b, 19 Appendix 3 Appendix 5 Appendix 8
TN #DMAS-19	4/1/21	Appendix 1, pages 1-2 Appendix 2, pages 1-2 Appendices 6 and 7
TN #DMAS-18	1/1/21	Pages 7, 16a, 18, 19 Page 16 b was added. Page 18a was added as a runover page.
TN #DMAS-17	7/1/20	Pages 15, 16, 16a, 19 Appendices 3, 5, and 8
TN #DMAS-16	4/1/20	Pages 16a, 20 Appendix 1, pages 1-2 Appendix 2, pages 1-2 Appendices 6 and 7
TN #DMAS-15	1/22/19	Pages 16, 16a, 19
TN #DMAS-14	10/1/19	Pages 1, 3, 4, 5, 14, 16, 32, 33 Appendix 8
TN #DMAS-13	7/1/19	Pages 32-34, 36 Appendices 3 and 5
TN #DMAS-12	4/1/19	Pages 2, 3, 5-8, 15-16, 19, 32-37 Page 16a was added as a runover page. Page 37 was removed. Appendices 1, 2, 6, 7, 8
TN #DMAS-11	1/1/19	Pages 8, 15, 32-35 Pages 36 and 37 were added.
TN #DMAS-10	10/1/18	Table of Contents Pages 1-5, 9, 10, 15, 16, 19, 22, 23, 30-32 Appendix 7 Appendix 8 was renumbered. Pages 6-8, 11-14, 17, 18, 20, 21, 24-29, 33-35 are runover pages.

Changed With	Effective Date	Pages Changed
TN #DMAS-9	7/1/18	Table of Contents. Pages 5, 6, 11, 14a, 25-27 Appendices 3 and 5 Page 6a is a runover page. Page 28 was added as a runover page.
TN #DMAS-8	4/1/18	Table of Contents Pages 2-6a, 12-14b, 25 Pages 26 and 27 were added. Pages 14c was added as a runover pages. Appendices 1, 2, 6 and 7 Appendix 1, page 2 was added.
TN #DMAS-6	10/1/17	Pages 12, 13, 14b
TN #DMAS-5	7/1/17	Table of Contents Pages 5, 6, 12, 13, 14-14b Appendices 3, 4 and 5 Page 6a was added as a runover page. Page 13a, 14, and 14a were renumbered to pages 14, 14a and 14b.
TN #DMAS-4	4/1/17	Appendices 1, 2 and 6
TN #DMAS-3	1/1/17	Table of Contents Pages 3 -5, 13a, 20 Appendix 6, page 1 Page 20a was added.
TN #DMAS-2	10/1/16	Appendix 2, pages 1, 2 Appendices 3, 5
TN #DMAS-1	6/1/16	Pages 3, 5, 6, 12, 13, 14a Appendices 1, 2, 6 and 7 Appendix 2, page 2 was added. Page 13a is a runover page.
UP #11	7/1/15	Appendices 3 and 5
TN #100	5/1/15	Pages 2, 11, 12, 13, 14 Appendices 1, 2, 3, 5, 6 and 7 Page 1 is a runover page.
Update (UP) #10	5/1/14	Table Contents pages 2, 3, 5, 6, 10-15 Appendices 1, 2 and 6 Appendix 7 was added.
TN #99	1/1/14	Pages 2, 5, 6, 8, 14, 15 Appendix 6

- Supplemental Security Income (SSI) recipients.
- IV-E foster care or adoption assistance recipients
- Deemed newborns
- BCCPTA (Breast and Cervical Cancer Prevention and Treatment Act) enrollees
- Auxiliary Grants.

b. individuals who are eligible on the basis of being aged (age 65 or older), blind or disabled;

- individuals eligible for or enrolled in Medicare;

- individuals evaluated as Medically Needy (MN);

5. Adoption Assistance Children *with* Special Needs *for* Medical *or Rehabilitative Care*

An adoption assistance child *with* special needs *for* medical *or rehabilitative care* is subject to MAGI methodology for the child's initial Medicaid eligibility determination. These children are in their own household apart from parents and siblings. Parents' and siblings' income is not counted for these children.

6. MAGI Adults

a. MAGI methodology is used to determine eligibility for the following individuals with income at or below 138% (133% + 5% disregard) of the Federal Poverty Limit:

- Parents and caretaker- relatives with excess income for LIFC

- Disabled individuals not eligible for or entitled to Medicare or individuals alleging disability who have not been determined disabled

- Childless adults ages 19-64

- Incarcerated individuals ages 19-64. Incarcerated individuals are eligible for inpatient hospital services only; inpatient hospitalization may include long-term inpatient services, such as admission to a rehabilitation facility.

- Non-citizens eligible for emergency services only

- Individuals eligible for Long Term Care Services and Support (LTSS) ages 19-64 Note: See Chapter M14 for LTSS screening requirements.

b. The following individuals are not eligible under the MAGI ADULTS group:

- Individuals pregnant at initial application or redetermination of eligibility

- Individuals under the age of 19 or 65 and over

- Individuals eligible for or enrolled in Medicare Part A or B

The tax filer household is composed of the individual who expects to file a tax return this year and does not expect to be claimed as a dependent by another tax filer. The household consists of the tax filer and all individuals the tax filer expects to claim as a tax dependent.

1. Tax Dependent Household Composition

means all dependents expected to be claimed by another tax filer for the taxable year. Except for adoption assistance children *with* special needs *for* medical *or rehabilitative care* and children who have been in a Level C PRTF for at least 30 consecutive days, the household of a tax dependent who does not meet an exception in M0430.100 B.2 below is the same as the tax filer's household.

If the tax dependent is living with a tax filer other than a parent or spouse or is living separately from the parent claiming him as a dependent, the tax dependent is included in the tax filer household, but the tax filer is NOT included in the tax dependent's household.

An adoption assistance child *with* special needs *for* medical *or rehabilitative care* or a child who has been in a Level C PRTF for at least 30 consecutive days is in his own household with no parents or siblings.

Exceptions to the tax household composition rules apply when:

- individuals other than biological, adopted or stepchildren are claimed as tax dependents,
- children are claimed by non-custodial parents,
- children under age 19 live with both parents and expect to be claimed as a tax dependent by one parent, but parents (married or unmarried) do not expect to file jointly,
- the tax dependent is *an* adoption assistance child *with* special needs *for* medical *or rehabilitative care* or a child who has been in a Level C PRTF for at least consecutive 30 days.

2. Non Filer Household Composition

The Non Tax Filer household rules mirror the tax filer rules to the maximum extent possible.

- The household consists of parents and children under age 19. Exception: An adoption assistance child *with* special needs *for* medical *or rehabilitative care* or a child who has been in a Level C PRTF for at least 30 consecutive days is in his own household with no parents or siblings.
- Non-filer rules are used when a child is claimed as a tax dependent of someone not living in the home.
- Non-filer rules are used in the case of a multi-generational household where the tax dependent is also the parent of a child.
- Spouses, parents, stepparents and children living together are included in the same household. Exception: An adoption assistance child *with* special needs *for* medical *or rehabilitative care* or a child who has been in a Level C PRTF for at least 30 consecutive days is in his own household with no parents or siblings.
- Children under age 19 living with a relative other than a parent are included in a household only with siblings/stepsiblings under age 19 who also live in the home.

i. Tax filers who do not itemize their deductions are permitted to deduct from their MAGI up to $300 in charitable contributions made by an eligible individual in tax years beginning in 2020.

3. Income From Self-employment

The agency must utilize online systems that are available to the agency to attempt to verify self-employment income. If the income cannot be verified through online data sources, an individual reporting self-employment income must provide verification of business expenses, income, *and applicable adjustments with forms or schedules including but not limited to* IRS Form 1040, *Schedule 1,* Schedule C (business expenses), Schedule E (expenses from rental income) and Schedule F (expenses from farming). If the individual alleges that his current income is not accurately represented by tax records, obtain additional information (such as business records) that documents current income.

a. distribution and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extractions and harvest from:

- rights of any lands held in trust located within the most recent boundaries of a prior Federal reservation or under the supervision of the Secretary of the Interior,
- federally protected rights regarding off-reservation hunting, fishing, gathering or usage of natural resources,
- distributions resulting from real property ownership interests related to natural resources and improvements,
  - located on or near a reservation of within the most recent boundaries of a prior Federal reservation, or
  - resulting from the exercise of federally-protected rights relating to such property ownership interests.

b. payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or right or rights that support subsistence or a traditional lifestyles according to applicable Tribal Law or custom.

c. Student financial assistance provided under the Bureau of Indian Affairs Education Program.

6. **Income from Crowdsourcing**

Crowdsourcing or crowdfunding is a practice to raise funds online for donations, fund a project, or underwrite a venture by requesting small amounts of money from a large number of people. Examples of crowdsourcing websites include GoFundME, YouCaring, Kickstarter, or IndieGoGo. The treatment of the funds as income depends on the reason the funds were solicited.

If the individual or someone on his behalf is raising donations to go toward medical costs or bills, money raised is considered a gift and is not countable under MAGI rules.

If there is an exchange of goods or services *between the beneficiary and donor*, money raised is considered earned income and is countable. Platform fees or costs, including the cost per transaction, percentage of donation to the online host site, and costs to a payment processer, are not counted as income.

7. **Withdrawals from Retirement Funds**

Money that is withdrawn from retirement funds, such as Individual Retirement Accounts (IRAs) and 401K accounts, on an early or emergency basis (i.e. before the individual is eligible to receive periodic payments) is not income. It is the conversion of the individual’s resource from one form to another.

M0450.100 STEPS FOR DETERMINING MAGI-BASED ELIGIBILITY

A. Determine Household Composition

1. Does the individual expect to file taxes?

a. If No - Continue to Step 2

b. If Yes - Does the individual expect to be claimed as a tax dependent by anyone else?

1) If No - the household consists of the tax filer, a spouse living with the tax filer, and all persons whom the tax filer expects to claim as a tax dependent. For a tax filer under age 19, parents living in the home are also in the individual's household.

2) If Yes - Continue to Step 2

2. Does the Individual Expect to be Claimed As a Tax Dependent?

a. If No - Continue to Step 3

b. If Yes - Does the individual meet **any** of the following exceptions?

1) the individual expects to be claimed as a tax dependent of someone other than a spouse or a biological, adopted, or stepparent; **or**

2) the individual is a child (under age 19) living with both parents, but the parents do not expect to file a joint tax return; **or**

3) the individual is a child who expects to be claimed by a non-custodial parent; **or**

4) the child is an adoption assistance child *with* special needs *for* medical *or rehabilitative care*.

If No to 1) through 4) above - the household is the household of the tax filer claiming her/him as a tax dependent.

If Yes to any of 1) through 4) above - Continue to Step 3.

3. Individual Is Neither Tax Filer Nor Tax Dependent Or Meets An Exception In 2. b Above

For individuals, other than adoption assistance children *with* special needs *for* medical *or rehabilitative care*, who neither expect to file a tax return nor expect to be claimed as a tax dependent, as well as tax dependents who meet one of the exceptions in 2.b above, the household consists of the individual and, if living with the individual:

- the individual's spouse;
- the individual's natural, adopted and step children under the age 19; and
    - In the case of individuals under age 19, the individual's natural, adopted and stepparents and natural, adoptive and stepsiblings under age 19.

The household of an adoption assistance child *with* special needs *for* medical *or rehabilitative care* consists only of the child.

Dee's eligibility determination:

Potential covered groups:

Child < Age 19
FAMIS

Monthly Income limits:

Child < Age 19 143% FPL for a HH of 2 = $1,962
FAMIS, 200% FPL for HH of 2 = $2,585
5% FPL for 2 = $65

HH monthly income:

$300 (Jane's gross earnings)

$300 is less than the Medicaid Child < Age 19 143% FPL income limit for 2 ($1,962) so Dee is eligible for Medicaid in the Child < Age 19 covered group. The 5% disregard is not applied because it is not necessary; her gross HH income is within the Medicaid Child < Age 19 income limit.

M0450.400 GAP-FILLING RULE EVALUATION

A. When to Complete Gap- Filling Evaluation

Complete a gap-filling evaluation to determine eligibility for Medicaid or FAMIS whenever **all** of the following conditions apply:

- The individual is in a tax filer household (regardless of whether or not a tax dependent exception in M0430.100 B.2 is met). APTC methodology does not apply to non-filer households or if married parents file separately and live in the same home.
- Current monthly household income, using Medicaid/FAMIS MAGI-based methods is over the applicable monthly income limit (including the 5% FPL disregard) for the individual's covered group.
- The total of income already received plus projected income for the **calendar** year in which eligibility is being determined, using MAGI methods applied by the HIM for the purposes of APTC eligibility, is below 100% FPL (i.e. the lower income threshold for APTC eligibility). See M04, Appendix 1. The individual's prior income for the calendar year, or lack of income, is included in the calculation of annual income when determining financial eligibility.

Note: The individual does not need to apply for the APTC prior to applying for Medicaid or having the gap-filling evaluation completed.

The gap-filling evaluation is applicable to the eligibility determination for retroactive and ongoing coverage.

If the eligibility and enrollment system is unable to determine eligibility using the gap-filling evaluation, the evaluation must be completed outside the system and documented in the electronic record. If the individual is eligible, the coverage must be entered directly into *the Medicaid Enterprise System (MES—formerly the Medicaid Management Information System* [MMIS]), and the renewal date must be updated for January of the following year.

5% FPL INCOME DISREGARD AMOUNTS
ALL LOCALITIES

EFFECTIVE *1/18/22*

Household Size	Monthly Amount
1	*$57*
2	*77*
3	*96*
4	*116*
5	*136*
6	*155*
7	*175*
8	*195*
Each additional, add	*20*

GAP-FILLING RULE EVALUATION
100% FPL
INCOME LIMITS

EFFECTIVE *1/18/22*

Household size	Annual (Use for Gap-filling Evaluation)	Monthly
1	*$13,590*	*$1,133*
2	*18,310*	*1,526*
3	*23,030*	*1,920*
4	*27,750*	*2,313*
5	*32,470*	*2,706*
6	*37,190*	*3,100*
7	*41,910*	*3,493*
8	*46,630*	*3,886*
Each additional	*4,720*	*394*

PREGNANT WOMEN
143% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/18//22*

Household Size	143% FPL Yearly Amount	143% FPL Monthly Amount	148% FPL (143% FPL + 5% FPL Disregard)
2*	*$26,184*	*$2,182*	*$2,259*
3	*32,933*	*2,745*	*2,841*
4	*39,683*	*3,307*	*3,423*
5	*46,433*	*3,870*	*4,005*
6	*53,182*	*4,432*	*4,587*
7	*59,932*	*4,995*	*5,169*
8	*66,681*	*5,557*	*5,752*
Each additional, add	*6,750*	*563*	*583*

*A pregnant woman’s household is at least two individuals when evaluated in the Pregnant Women covered group.

CHILD UNDER AGE 19
143% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/18/22*

# of Persons in House-hold	**109% FPL (for Determining Aid Category)**	**143% FPL**		**148% FPL (143% FPL + 5% FPL Disregard)**
	Monthly Limit	*Annual Limit*	Monthly Limit	Monthly Limit
1	*$1,235*	*$19,434*	*$1,620*	*$1,677*
2	*1,664*	*26,184*	*2,182*	*2,259*
3	*2,092*	*32,933*	*2,745*	*2,841*
4	*2,521*	*39,683*	*3,307*	*3,423*
5	*2,950*	*46,433*	*3,870*	*4,005*
6	*3,379*	*53,182*	*4,432*	*4,587*
7	*3,807*	*59,932*	*4,995*	*5,169*
8	*4,236*	*66,681*	*5,557*	*5,752*
Each add'l, add	*429*	*6,750*	*563*	*583*

PLAN FIRST
200% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/18/22*

Household Size	**200% FPL Yearly Amount**	**200% FPL Monthly Amount**	**205% FPL (200% FPL + 5% FPL Disregard)**
1	*$27,180*	*$2,265*	*$2,322*
2	*36,620*	*3,052*	*3,128*
3	*46,060*	*3,839*	*3,935*
4	*55,500*	*4,625*	*4,741*
5	*64,940*	*5,412*	*5,547*
6	*74,380*	*6,199*	*6,354*
7	*83,820*	*6,985*	*7,160*
8	*93,260*	*7,772*	*7,966*
Each additional, add	*9,440*	*787*	*807*

MAGI ADULTS
133% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/18/22*

Household Size	***133% FPL Yearly Amount***	**133% FPL Monthly Amount**	**138% FPL (133% FPL + 5% FPL Disregard)**
1	*$18,075*	*$1,507*	*$1,563*
2	*24,353*	*2,030*	*2,106*
3	*30,630*	*2,553*	*2,649*
4	*36,908*	*3,076*	*3,192*
5	*43,186*	*3,599*	*3,735*
6	*49,463*	*4,122*	*4,277*
7	*55,741*	*4,646*	*4,820*
8	*62,018*	*5,169*	*5,363*
Each additional, add	*6,278*	*524*	*543*

M0810 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-23	4/1/22	Page 2
TN #DMAS-22	1/1/22	Pages 1, 2, 3
TN #DMAS-20	7/1/21	Page 2
TN #DMAS-19	4/1/21	Page 2
TN #DMAS-18	1/1/21	Pages 1, 2
TN #DMAS-17	7/1/20	Page 2
TN #DMAS-16	4/1/20	Page 2
TN #DMAS-15	1/1/20	Pages 1, 2
TN #DMAS-14	10/1/19	Pages 20, 25, 27 Page 28 is a runover page.
TN #DMAS-12	4/1/19	Page 2
TN #DMAS-11	1/1/19	Pages 1, 2
TN #DMAS-10	10/1/18	Page 2
TN #DMAS-9	7/1/18	Page 2
TN #DMAS-8	4/1/18	Page 2
TN #DMAS-7	1/1/18	Pages 1, 2
TN #DMAS-5	7/1/17	Page 2
TN #DMAS-4	4/1/17	Page 2
TN #DMAS-3	1/1/17	Pages 1, 2
TN #DMAS-2	10/1/16	Page 2
TN #DMAS-1	6/1/16	Pages 1, 2
UP #11	7/1/15	Page 2
TN #100	5/1/15	Pages 1, 2
UP #10	5/1/14	Page 2
TN #99	1/1/14	Pages 1, 2
TN #98	10/1/13	Page 2
UP #9	4/1/13	Pages 1, 2
UP #7	7/1/12	Page 2
UP #6	4/1/12	Pages 1, 2
TN #95	3/1/11	Pages 1, 2
TN #93	1/1/10	Pages 1, 2
Update (UP) #1	7/1/09	Page 2

3. Categorically Needy 300% of SSI

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

Family Size Unit	2021 Monthly Amount	2022 Monthly Amount
1	$2,382	$2,523

4. ABD Medically Needy

a. Group I	7/1/20 – 6/30/21		7/1/21	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$1,993.11	$332.18	$2,019.02	$336.50
2	2,537.36	422.89	2,570.31	428.38

b. Group II	7/1/20 – 6/30/21		7/1/21	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,299.75	$383.29	$2,329.65	$388.27
2	2,831.85	471.97	2,868.64	478.40

c. Group III	7/1/20 – 6/30/21		7/1/21	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,989.69	$498.28	$3,028.56	$504.76
2	3,604.37	600.72	3,651.15	608.52

5. ABD Categorically Needy

For:

ABD 80% FPL, QMB, SLMB, & QI <u>without</u> Social Security income; all QDWI; effective *1/18/22*

ABD 80% FPL, QMB, SLMB, & QI <u>with</u> Social Security income; effective *3/1/22*

All Localities	2021		*2022*	
ABD 80% FPL	Annual	Monthly	Annual	Monthly
1	$10,304	$859	*$10,872*	*$906*
2	13,936	1,162	*14,648*	*1,221*
QMB 100% FPL	Annual	Monthly	Annual	Monthly
1	$12,880	$1,074	*$13,590*	*$1,133*
2	17,420	1,452	*18,310*	*1,526*
SLMB 120% of FPL	Annual	Monthly	Annual	Monthly
1	$15,456	$1,288	*$16,308*	*$1,359*
2	20,904	1,742	*21,972*	*1,831*
QI 135% FPL	Annual	Monthly	Annual	Monthly
1	$17,388	$1,449	*$18,347*	*$1,529*
2	23,517	1,960	*24,719*	*2,060*
QDWI 200% of FPL	Annual	Monthly	Annual	Monthly
1	$25,760	$2,147	*$27,180*	*$2,265*
2	34,840	2,904	*36,620*	*3,052*

S0830 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-23	4/1/22	Page 78
TN #DMAS-17	7/1/20	Page 29
TN #DMAS-12	4/1/19	Page 113
TN #DMAS-7	1/1/18	Table of Contents, page iii, iv. Pages 7-8, 17-18, 20, 29, 48, 79a, 82, 124a-124b, 125.
TN #DMAS-4	4/1/17	Table of Contents, page i Pages 24, 24c
TN #DMAS-2	10/1/16	On page 109, updated the format of the header. Neither the date nor the policy was changed.
TN #DMAS-1	3/23/16	Table of Contents, page iii Pages 18, 82
Update #7	7/1/12	Page 24
TN #94	9/1/10	Page 29
TN #93	1/1/10	Table of Contents, page iv Pages 28, 67, 119-120 Pages 122-125
TN #91	5/15/09	Table of Contents, page i Page 29

M0830.520 GIFTS

A. Policy

1. Definition

- A gift is something a person receives which is **not repayment** for goods or services the person provided and is **not** given because of a **legal obligation** on the givers' part.
- To be a gift, something must be given **irrevocably** (i.e., the donor relinquishes all control).
- **"Donations,** and **"contributions"** (*including income from crowdsourcing or crowdfunding)* may meet the definition of a gift.

NOTE: A gift received as the result of a death is a death benefit. See S0830.545.

2. Gift as Income

A gift is unearned income subject to the general rules pertaining to income and income exclusions.

3. Gifts Used to Pay Tuition, Fees, or Other Necessary Educational Expenses

Gifts (or a portion of a gift) used to pay for tuition, fees, or other necessary educational expenses at any educational institution, including vocational and technical education, are excluded from income.

B. Procedure

1. Apply Appropriate Rules

Determine the nature of the gift and apply the appropriate operating instructions pertaining to income and income exclusions (see C. below).

C. References

- Cash income, S0810.020
- Bills paid by a third party, S0815.400
- Home energy assistance and support and maintenance assistance, S0830.605
- Infrequent or irregular income exclusion, S0810.410
- $20 general income exclusion S0810.420
- Trusts, M1120.200
- Uniform gifts to minors, S1120.205
- Gifts of domestic travel tickets, S0830.521

M1130 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-23	4/1/23	Table of Contents, pages i, ii Pages 47, 48, 79 Page 48a was added. Page 48b was added as a runover page Page 78 is a runover page.
TN #DMAS-20	7/1/21	Table of Contents, page ii Pages 5, 73, 74 Page 74a was added as a runover page.
TN #DMAS-18	1/1/21	Pages 31, 33, 34
TN #DMAS-17	7/1/20	Table of Contents, page ii Pages 73, 74 Page 5 is a runover page.
TN #DMAS-12	4/1/19	Page 13
TN #DMAS-9	7/1/18	Pages 1, 3
TN #DMAS-7	1/1/18	Pages 45,78-79 Appendix 1, pages 3,5
TN #DMAS-5	7/1/17	Pages 13, 15, 78, 79 Page 14 is a runover page.
TN #DMAS-3	1/1/17	Table of Contents, page ii Page 76 Page 77 is a runover page. Pages 78 and 79 were added.
TN #DMAS-1	6/1/16	Pages 4, 14, 15
TN #100	5/1/15	Pages 13, 15, 21, 31, 33, 34 Pages 16 and 32 are runover pages.
UP #9	4/1/13	Table of Contents, page ii Pages 5, 62 Pages 62a was added.
TN#97	9/1/12	Page 14
Update #7	7/1/12	Page 24
TN #96	10/1/11	Table of Contents, page ii Pages 4, 73, 74 Appendix 1, pages 1-14 Appendix 2, page 1 Appendix 4, pages 1-8 added
TN #95	3/1/11	Pages 28, 29, 33
TN #94	9/1/10	Pages 20, 20a, 28-29a
TN #93	1/1/10	Pages 63-65 Pages 70, 74, 75
TN #91	5/15/09	Page 13

TABLE OF CONTENTS

M1130.000 ABD RESOURCES EXCLUSIONS

Section **Page**

REAL PROPERTY

The Home .... **M1130.100** **1**
Home Replacement Funds .... **S1130.110** **8**
Real Property Whose Sale Would Cause Undue Hardship, Due to Loss of Housing, To a Co-Owner -For QMB, SLMB, QI and ABD 80% FPL Only .... **S1130.130** **12**
Real Property Following Reasonable but Unsuccessful Efforts to Sell .... **M1130.140** **13**
Interests of Individual Indians in Trust or Restricted Lands .... **S1130.150** **16**
Other Real Property .... **M1130.160** **16**

PERSONAL PROPERTY

Automobile .... **M1130.200** **17**
Life Insurance .... **M1130.300** **18**
Burial Spaces .... **M1130.400** **24**
Burial Funds Exclusion -- August 1, 1994 and Continuing .... **M1130.410** **27**
Burial Funds Exclusion -- July 1, 1988 Through July 31, 1994 .... **M1130.411** **35**
Prepaid Burial Contracts .... **M1130.420** **36**
Life Insurance Funded Burial Contracts and the Burial Space/Funds Exclusion .... **M1130.425** **42**
Household Goods and Personal Effects .... **M1130.430** **47**
Grants, Scholarships, Fellowships, and Gifts .... ***S1130.455*** ***47***

REAL OR PERSONAL PROPERTY

Property Essential to Self-Support - Overview .... **S1130.500** ***48b***
Essential Property Excluded Regardless of Value or Rate of Return .... **M1130.501** **50**
Essential Property Excluded up to $6,000 Equity Regardless of Rate of Return .... **S1130.502** **53**
Essential Property Excluded up to $6,000 Equity if It Produces a 6 Percent Rate of Return .... **S1130.503** **54**
Essential Property - Current Use Criterion .... **S1130.504** **58**
Resources Set Aside as Part of a Plan for Achieving Self-Support .... **S1130.510** **59**
Trusts Established Between July 1, 1993 and August 11, 1993 .... **M1130.520** **60**

M1130.000 ABD RESOURCES EXCLUSIONS Section Page

RETAINED CASH AND IN-KIND PAYMENTS

Retroactive SSI and RSDI Payments M1130.600 62
Dedicated Accounts For Past Due Benefits Due to Individuals Under 18 Who Have a Representative Payee S1130.601 62
Netherlands WUV Payments to Victims of Persecution S1130.605 63
German Reparations Payments S1130.610 64
Austrian Social Insurance Payments S1130.615 65
Disaster Assistance S1130.620 66
Cash and In-Kind Items Received for the Repair or Replacement of Lost, Damaged, or Stolen Excluded Resources S1130.630 67
Benefits Excluded from Both Income and Resources by a Federal Statute Other Than Title XVI S1130.640 70
Agent Orange Settlement Payments S1130.660 70
Victim's Compensation Payments S1130.665 71
State or Local Relocation Assistance Payments S1130.670 72
Tax Advances, Refunds, and Rebates Related to Earned Income Tax Credits And Coronavirus Aid, Relief, And Economic Security (Cares) Act M1130.675 73
Radiation Exposure Compensation Trust Fund Payments S1130.680 74
Walker v. Bayer Settlement Payments M1130.685 75

OTHER EXCLUDED RESOURCES

Identifying Excluded Funds That Have Been Commingled With Non-excluded Funds S1130.700 76
Achieving a Better Life Experience (ABLE) Accounts *M*1130.740 78

Appendix

Determining the Countable Value of Home & Contiguous Property .... Appendix 1 1
ABD Home Property Evaluation Worksheet .... Appendix 2 1
Burial Fund Designation .... Appendix 3 1
Determining the Countable Value of Non-Home Real Property .... Appendix 4 1

G. Procedures--Redetermination Development

For a previously developed life insurance funded burial contract, redevelop and document the value of the contract using applicable life insurance development procedures if:

- ownership and/or proceeds of the policy have been **revocably** assigned (i.e., the CSV of the policy must be reverified); or
- ownership of the policy has been **irrevocably** assigned (or a revocably assigned policy has been placed irrevocably in trust) and the individual has other excluded burial funds (i.e., the value of the contract reduces the amount of other funds that may be excluded).

M1130.430 HOUSEHOLD GOODS AND PERSONAL EFFECTS

A. Policy Principle

Household goods and personal effects are excluded resources for Medicaid evaluations.

B. Definitions

1. Household Goods

Household goods are items of personal property customarily found in the home and used in connection with the maintenance, use, and occupancy of the premises as a home. They include, but are not limited to: furniture, appliances, televisions sets, carpets, cooking and eating utensils, dishes, etc.

2. Personal Effects

Personal effects are items of personal property that are worn or carried by an individual or that have an intimate relation to him or her. They include, but are not limited to: clothing, jewelry, personal care items, prosthetic devices, and educational or recreational items such as books, musical instruments, or hobby materials.

S1130.455 GRANTS, SCHOLARSHIPS, FELLOWSHIPS, AND GIFTS

A. Policy Principle

Section 435 of The Social Security Protection Act of 2004, Public Law 108-203, provides a 9-month resource exclusion for grants, scholarships, fellowships, and gifts used to pay for tuition, fees, and other necessary educational expenses at any educational institution, including vocational and technical education.

B. Definitions

1. Grants, Scholarships, and Fellowships

Grants, scholarships, and fellowships are amounts paid by private nonprofit agencies, the U.S. Government, instrumentalities, or agencies of the U.S., State and local governments, foreign governments, and private concerns (e.g. a private citizen) to enable qualified individuals to further their education and training by scholastic or research work, etc.

2. Gifts

A gift is something a person receives which is not repayment for goods or services the person provided and is not given because of a legal obligation on the giver's part. To be a gift, something must be given irrevocably (i.e., the

donor relinquishes all control). "Donations" and "contributions" (including crowdsourcing and crowdfunding) may meet the definition of a gift. See M0830.520.

3. Tuition, Fees, and Other Necessary Educational Expenses

Educational expenses include laboratory fees, student activity fees, transportation, stationery supplies, books, technology fees, and impairment-related expenses necessary to attend school or perform schoolwork (e.g., special transportation to and from classes, special prosthetic devices necessary to operate school machines or equipment, etc.).

C. Policy – Assistance Under Title IV Of The Higher Education Act Of 1965 (HEA) Or Bureau Of Indian Affairs (BIA)

1. Title IV of HEA or BIA Involvement

All student financial assistance received under HEA, or under BIA student assistance programs, is excluded from income and resources, regardless of use. The resource exclusion for this educational assistance does not have a time limit, i.e. regardless of how long the assistance is held, it is excluded from resources.

Examples of HEA Title IV Programs:

- *Pell grants*
- *State Student Incentives*
- *Academic Achievement Incentive Scholarships*
- *Byrd Scholars*
- *Federal Supplemental Educational Opportunities Grants (FSEOG)*
- *Federal Educational Loans (Federal PLUS Loans, Perkins Loans, Stafford Loans, Ford Loans, etc.)*
- *Upward Bound*
- *Gear Up (Gaining Early Awareness and Readiness for Undergraduate Programs)*
- *LEAP (Leveraging Educational Assistance Partnership)*
- *SLEAP (Special Leveraging Educational Assistance Partnership)*
- *Work-Study Programs.*

***NOTE**: State educational assistance programs, including work-study, funded by LEAP or SLEAP are programs under Title IV of HEA.*

2. Interest and Dividends Earned on Title IV of HEA or BIA Educational Assistance

- *Interest and dividends earned on unspent educational assistance under Title IV of HEA or under BIA are excluded from income. See M0830.500.*

D. Policy - Other Grants, Scholarships, Fellowships, and Gifts

Any portion of a grant, scholarship, fellowship, or gift used or intended to be used to pay the cost of tuition, fees, or other necessary educational expenses at any educational institution, including vocational and technical education, is excluded from resources for 9 months beginning the month after the month it was received. This exclusion does not apply to any portion set aside or actually used for food or shelter.

Grants, scholarships, fellowships, and gifts that are retained after the 9-month exclusion period are countable resources beginning the month following the end of the 9th month.

If any portion of this excluded educational assistance is used for something other than tuition, fees, or other necessary educational expenses or the individual no longer intends for the funds to be used to pay tuition, fees, or other necessary educational expenses, then the funds are income at the earliest of the following points: in the month they are spent, or the month the individual no longer intends to use the funds to pay tuition, fees, or other necessary educational expenses.

Interest and dividends earned on unspent educational assistance under Title IV of HEA or under BIA are excluded from income. Interest or dividends earned on other forms of excluded educational assistance are counted as income. Interest or dividends earned on countable educational assistance are excluded from income. See M00830.500.

REAL OR PERSONAL PROPERTY

S1130.500 PROPERTY ESSENTIAL TO SELF-SUPPORT – OVERVIEW

A. Introduction

The Social Security Act provides for the exclusion from resources of property that the Secretary determines is so essential to an individual's means of self-support as to warrant exclusion.

B. Policy Principles

1. Categories Of Property Excluded Under This Provision

Resources excluded under this provision generally fall into 3 categories. Each is listed below and then described in more detail in a subsequent section.

a. Property Excluded Regardless of Value or Rate of Return
This category encompasses:

- property used in a trade or business (effective 5/1/90);
- property that represents government authority to engage in an income producing activity;
- property used by an individual as an employee for work (effective 5/1/90); and
- property required by an employer for work (before 5/1/90).

See S1130.501.

b. Property Excluded up to $6,000 Equity, Regardless of Rate of Return
This category includes **nonbusiness** property used to produce **goods** or **services** essential to daily activities. For example, it covers land used to produce vegetables or livestock **solely** for consumption by the individual's household. See S1130.502.

c. Property Excluded up to $6,000 Equity if it Produces a 6% Rate of Return
This category encompasses:

- property used in a trade or business in the period before 5/1/90;
- nonbusiness income-producing property. However, the exclusion does not apply to equity in excess of $6,000 and does not apply if the property does not produce an annual return of at least 6% of the excluded equity. If there is more than one potentially excludable property, the rate of return requirement applies individually to each. See S1130.503.

2. Current Use Criterion

Resources that are excluded under this provision must be in current use in the type of activity described. If not in current use, there must be a reasonable expectation that the required use will resume. See S1130.504.

3. Liquid Resources

Liquid resources are not considered property essential to self-support except when used as part of a trade or business.

M1130.740 ACHIEVING A BETTER LIFE EXPERIENCE (ABLE) ACCOUNTS

A. Policy

The federal Stephen Beck, Jr. Achieving a Better Life Experience Act (ABLE Act), was enacted by Congress on December 19, 2014 and approved by the Virginia General Assembly and Governor in 2015. An ABLE account is a type of tax-advantaged account that an eligible individual can use to save funds for the disability related expenses of the account's designated beneficiary, who must be blind or disabled by a condition that began before the individual's 26th birthday. Funds retained in these accounts are not considered to be resources for Medicaid.

In Virginia, the qualified ABLE program is operated by the Virginia529 program and can be contacted Toll-Free: 1-844-NOW-ABLE (1-844-669-2253).

An eligible individual can be the designated beneficiary/account owner of only one ABLE savings trust account, which must be administered by a qualified ABLE program.

The designated beneficiary is the eligible individual who established and owns the ABLE account. To be an eligible individual, he or she must be:

- Eligible for Supplemental Security Income (SSI) based on disability or blindness that began before age 26;
- Entitled to disability insurance benefits, childhood disability benefits, or disabled widow's or widower's benefits based on disability or blindness that began before age 26; or
- Someone who has certified, or whose parent or guardian has certified, that he or she:
  - Has a medically determinable impairment meeting certain statutorily specified criteria; or is blind; and,
  - The disability or blindness occurred before age 26.

NOTE: A certification that someone meets disability requirements for the ABLE program does not replace a disability determination from either SSA or DDS in determining whether someone meets the Medicaid definition of a disabled individual.

Upon the death of the designated beneficiary, the State can seek to recover funds remaining in the ABLE account, after payment of any outstanding qualified disability expenses, to reimburse the State for Medicaid benefits that the designated beneficiary received.

B. Procedures

The designated beneficiary, or person acting on the individual's behalf, must provide a copy of the ABLE account documentation for the case record. The documentation should include the designated beneficiary's/account owner's name, address, and the date the ABLE account was established. The eligibility worker must retain the information in the case record.

A copy of the account documentation also must be sent to DMAS at the following address:

Department of Medical Assistance Services
Eligibility & Enrollment Services Division
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

C. Contributions to an ABLE Account

Third party contributions to an ABLE account are not counted as income or included in total resources of the beneficiary. This includes distributions from special needs or pooled trusts. Earnings on an ABLE account (e.g. interest) are part of the account and to be disregarded in determining Medicaid eligibility.

Income contributed into an ABLE account by the designated beneficiary is counted as available income, and not disregarded.

D. Distributions From an ABLE Account

Distributions from an ABLE account are not included in the designated beneficiary's taxable income or counted as income for eligibility determination as long as used for qualified disability expenses, *as determined by the Internal Revenue Service (IRS).*

Examples of Qualified Disability Expenses include, but are not limited to:

- *Education*
- *Housing*
- *Transportation*
- *Employment training and support*
- *Assistive technology and related services*
- *Health*
- *Prevention and wellness*
- *Financial management and administrative services*
- *Legal fees*
- *Expenses for oversight and monitoring*
- *Funeral and burial*
- *Basic living expenses*
- *Other expenses approved by the Secretary of the U.S. Treasury.*

M1140 Changes

Updated With	Effective Date	Pages Changed
TN #DMAS-23	4/1/22	Table of Contents, page i Page 16 Table of Contents, page ii was added as a runover page. Pages 16a-16e were added. Page 16e is a runover page.
TN #DMAS-21	10/1/21	Page 26 Page 26a is a runover page.
TN #DMAS-20	7/1/21	Pages 18, 26a Page 19 is a runover page.
TN #DMAS-11	1/1/19	Page 17
TN #DMAS-7	1/1/18	Page 30
TN #DMAS-5	7/1/17	Page 7
UP #9	4/1/13	pages 2, 17
TN #97	9/1/12	Table of Contents, page i Table of Contents page ii was removed. pages 2, 16-19, 26, 26a
TN #96	10/1/11	pages 12-12a, 24
TN #93	1/1/10	pages 13-15 pages 24, 25
TN #91	5/15/09	pages 11-12a

TABLE OF CONTENTS

M1140.000 TYPES OF COUNTABLE RESOURCES

	Section	Page
GENERAL RULES ON COUNTABLE RESOURCES		
Purpose of Subchapter	S1140.001	1
General Verification Requirements - Initial Application	M1140.010	1
General Verification Requirements – Post eligibility	M1140.020	3
Ownership	S1140.030	4
Determining Equity Value	S1140.042	5
Resources with Zero Value	S1140.044	5
REAL PROPERTY		
Non-home Real Property	S1140.100	6
Other Property Rights	S1140.110	11
Life Estate and Remainder Interest Tables	S1140.120	13
FINANCIAL INSTITUTION ACCOUNTS		
Qualified Tuition Programs (QTPs)	*S1140.150*	*16*
Checking, Savings and Debit Card Accounts -- General	*M*1140.200	*16e*
Joint Checking and Savings Accounts	S1140.205	19
Time Deposits	S1140.210	20
Conservatorship Accounts	S1140.215	21a
OTHER COMMON INVESTMENT VEHICLES		
Stocks	S1140.220	22
Mutual Fund Shares	S1140.230	23
U.S. Savings Bonds	S1140.240	24
Municipal, Corporate and Government Bonds	S1140.250	25
Annuities	M1140.260	26
CONTRACTS		
Promissory Notes, Loans, and Property Agreements	S1140.300	26a
Continuing-Care Retirement Community Entrance Fees	M1140.305	27
Life Insurance	M1140.310	28
TRUSTS		
Trusts Established By A Will	M1140.400	29
Trusts Which Were Not Created by a Will	M1140.401	29
Medicaid Qualifying Trusts (Created Prior to August 11, 1993)	M1140.402	30
Trusts Created After July 1, 1993 and Before August 11, 1993 With Corpus In Excess of $25,000	M1140.403	31
Trusts Established on or After August 11, 1993	M1140.404	32
Workers' Compensation Medicare Set-Aside Arrangement Accounts	M1140.500	33

RESOURCE GUIDE

Resources Guide -- Optional Desk Guide S1140.990 34

FINANCIAL INSTITUTION ACCOUNTS

M1140.150 QUALIFIED TUITION PROGRAMS (QTPS)

A. Operating Policies

Qualified Tuition Programs (QTPs), also referred to as Section 529 Plans, allow individuals to prepay or contribute to an account established for paying a designated beneficiary's education expenses at an eligible educational institution. QTPs can be established and maintained by states, agencies, instrumentalities of states, and eligible educational institutions. Individuals may contribute to a QTP regardless of the amount of their income.

There are two types of QTPs (529 Plans): savings plans and pre-paid plans.

Savings plans:

- *are accounts that provide investment options such as mutual funds or money market funds (similar to a retirement account (e.g. 401K)).*
- *are not guaranteed by the State and the value is subject to fluctuations in financial markets (e.g. the stock market).*
- *can be established for a beneficiary of any age.*

Prepaid plans

- *allow individuals to purchase units or credits at participating colleges and universities for tuition.*
- *allow individuals to lock-in future tuition rates at current prices.*
- *States may guarantee investments in plans that they sponsor.*
- *Most plans must be established for a beneficiary by a certain age or grade.*

B. Definitions

1. Account Owner

An account owner, also referred to as a donor, is the individual who has ownership of the account and directs use of the funds. Most plans allow the account owner to reclaim the funds deposited into a QTP at any time.

2. Designated Beneficiary

A designated beneficiary is the individual (i.e. a student or future student) who is to receive the benefit of the funds in the account. The designated beneficiary can be changed to a member of the beneficiary's family.

3. Beneficiary's Family

The beneficiary's family includes the beneficiary's spouse and the following other relatives of the beneficiary:

- *son, daughter, stepchild, foster child, adopted child, or a descendant of any of them;*
- *brother, sister, stepbrother, or stepsister;*
- *father, mother, or ancestor of either;*
- *stepfather or stepmother;*
- *son or daughter of a brother or sister;*
- *brother or sister of father or mother;*
- *son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law*
- *the spouse of any individual listed above; or*
- *first cousin.*

4. Eligible Educational Institutions

Eligible educational institutions include any college, university, or vocational school eligible to participate in a student aid program administered by the U.S. Department of Education. This includes virtually all accredited public, non-profit, and proprietary (i.e. privately owned profit making) institutions. It also includes certain educational institutions located outside the U.S.

Effective January 1, 2018, eligible educational institutions also include elementary or secondary public, private, or religious schools, but distributions are limited to $10,000 towards tuition per beneficiary per year.

5. Withdrawals or Distributions

Withdrawals or distributions are the issuance of funds from the account. Distributions are payable to an eligible educational institution, the QTP account owner, the designated beneficiary or the estate of the beneficiary, as directed by the account owner. The account owner determines when distributions are made from the account and for what purpose.

6. Gift

Distributions from a QTP meet the definition of a gift provided:

- *they are not repayment for goods or services provided by the designated beneficiary;*
- *they are not given because of a legal obligation on the donor's part; and*
- *they are given irrevocably (i.e. the donor relinquishes all control). For additional information on gifts, see S0830.520.*

7. Rollover Contribution

A rollover contribution is any amount "rolled over" or transferred to another QTP for the benefit of the same beneficiary or a member of the beneficiary's family. Effective December 22, 2017, rollovers can also include transfers from a QTP to the beneficiary's or another family member's Achieving a Better Life Experience (ABLE) account. For more information about ABLE accounts, see M1130.740.

8. Educational Expenses

Educational expenses are tuition, fees, and other necessary educational expenses at any educational institution. Examples of educational expenses include:

- *tuition and fees*
- *books*
- *laboratory fees*
- *student activity fees*
- *transportation*
- *stationary supplies*
- *technology fees*
- *impairment-related expenses necessary to attend school or perform schoolwork (e.g. special prosthetic devices necessary to operate school machines or equipment).*

NOTE: *Educational expenses do not include the cost of food and shelter.*

C. QTP as a Countable Resource

Funds in a QTP are a countable resource to the individual who owns the account (e.g. a parent or grandparent). Normally, the owner is the person who established the account. In most instances, the individual who establishes a QTP retains the ability to withdraw any or all of the funds in the account for his or her own benefit.

NOTE: In most cases, the designated beneficiary (i.e. the student or future student) is not the owner of the account and does not have any rights to the funds in the account.

1. Value of a QTP

The value of the QTP is the current market value minus any applicable penalties, but not minus taxes. In addition, any maintenance fees associated with the account, whether scheduled or collected, do not reduce its value.

2. Dividends and Interest Earned on a QTP

Dividends and interest are returns on capital investments such as stocks, bonds, or savings accounts. Exclude dividends and interest earned on QTPs from income.

3. Rule for Withdrawals or Distributions From a QTP

Withdrawals or distributions to the account owner are not income but a conversion of a resource (i.e. the resource in a different form). The distribution is a countable resource to the account owner.

Assume that any distribution the designated beneficiary receives from a QTP is a gift, unless there is evidence to the contrary (e.g. there is an allegation that the distribution must be repaid). Distributions, which meet the definition of a gift and are used for educational expenses of the designated beneficiary, are excluded as income in the month of receipt. If an excluded distribution is retained into the month following the month of receipt, it is an excluded resource of the designated beneficiary for 9 months beginning with the month after the month of receipt. For information on educational gifts, see M0830.520 and S1130.455.

If the designated beneficiary spends any portion of a QTP distribution for a purpose other than his or her educational expenses or no longer intends to

use the funds for his or her educational expenses, the funds are income at the earlier of two points:

- *in the month the funds are spent; or*
- *in the month the individual no longer intends to use the funds for educational expenses.*

If a countable distribution is retained into the month following the month of receipt, it is a countable resource.

4. Examples of QTP Distributions

EXAMPLE 1—Distributions excluded as income and resources

A disabled adult, age 19, is the designated beneficiary of a QTP. On January 10, the disabled adult receives $3,000 from the QTP. The disabled adult spends $2,800 for tuition and fees in January. As of February 1, $200 of the distribution remains. The disabled adult tells the eligibility worker (EW) they will use the rest of the money for future educational expenses.

The EW determines:

- *The disabled adult is not the owner of the QTP; therefore, it is not a resource to the individual.*
- *The distribution meets the definition of a gift for educational purposes and is excluded from income in the month of January.*
- *The remaining amount of $200 is excluded from resources for the months of February through October. As of November 1, any portion that remains is a countable resource of the disabled adult.*

EXAMPLE 2—Distributions counted as income and resources

A disabled adult, age 21, is the designated beneficiary of a QTP. On August 5, the disabled adult receives $1,500 from the QTP. During the month of August, the individual spends $1,350 on books. The individual spends $75 on groceries in August and saves $75. The disabled adult tells the EW that they intends to add the rest of the money to their "emergency fund" that they have set aside for non-educational expenses.

The EW determines:

- *The disabled adult is not the owner of the QTP; therefore, it is not a resource to the individual.*
- *That $1,350 of the distribution meets the definition of a gift for educational purposes and is excluded from income in the month of August.*

- *That $150 of the distribution is countable income to the individual for the month of August because the disabled adult spent $75 on non-educational expenses and intends to use $75 for non-educational expenses. As of September 1, any portion of the $75 that remains is a countable resource of the disabled adult.*

5. Rollover or Transfer of QTP Funds

Funds in a QTP may be transferred or "rolled over" to a member of the beneficiary's family. A transfer or "rollover" of QTP funds from a beneficiary to a family member does not necessarily indicate a transfer of account ownership. When there is a valid transfer, the original account owner no longer owns the property.

M1140.200 CHECKING, SAVINGS AND DEBIT CARD ACCOUNTS

A. Operating Policies

1. Ownership

Assume that the person designated as owner in the account title owns all the funds in the account (see S1140.205 regarding joint accounts).

2. Right to Withdraw Funds

Absent evidence to the contrary, assume that the person shown as owner in the account title has the legal right to withdraw funds from the account.

3. Fiduciaries

A fiduciary's right to withdraw funds is the same as the owner's right to withdraw them.

4. Right to Withdraw - Examples of Evidence to the Contrary

a. Right to Withdraw Funds Restricted to a Specified Account Holder

An account is titled, "In trust for John Jones and Mary Smith, subject to sole order of John Jones, balance at death of either to belong to survivor." Since John alone has unrestricted access, none of the funds in the account could be considered Mary's resources unless John were her fiduciary or his resources were deemed available to her.

b. Withdrawals Require Authorization of Third Party

An account is title, "George Dahey, restricted Individual Indian Money Account." Mr. Dahey cannot withdraw funds from the account without Bureau of Indian Affairs (BIA) authorization. Therefore, the account is not his resource.

c. "Blocked" Accounts

If State law specifically requires the funds be made available for the care and maintenance of an individual, assume, absent evidence to the contrary, that they are that individual's resource. This is true despite the fact that the individual or his/her agent is required to petition the court to withdraw funds for the individual's care. Refer to regional coordinator any questions regarding State law on "blocked accounts."

5. Right to Use for Support and Maintenance

Absent evidence to the contrary, assume that an individual who owns and has the legal right to withdraw funds from a bank account also has the legal right to use them for his or her own support and maintenance.

6. Right to Use - Examples of Evidence to the Contrary

a. Use Restricted by Court Order

Even with ownership interest and the legal ability to access property, a legal restriction against the property's use for the owner's own support and maintenance means the property is not the owner's resources (S1110.100).

M1460 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-23	4/1/22	Page 12, 23
TN #DMAS-22	1/1/22	Pages 3, 35
TN #DMAS-18	1/1/21	Pages 3, 35
TN #DMAS-15	1/1/20	Pages 3, 35
TN #DMAS-14	10/1/19	Pages 4, 29
TN #DMAS-13	7/1/19	Page 42
TN #DMAS-11	1/1/19	Pages 3-5, 10, 26, 31
TN #DMAS-10	10/1/18	Table of Contents, page i Pages 1-3, 4b, 5, 6, 9, 10, 13, 15, 17a, 18, 18a, 26, 27, 30a, 37, 38 Pages 8a, 11, 19, 30, 39 and 40 are runover pages.
TN #DMAS-8	4/1/18	Pages 18a, 32, 35
TN #DMAS-7	1/1/18	Pages 3, 7
TN #DMAS-3	1/1/17	Pages 3, 4, 4b, 24, 25, 29
TN #DMAS-2	10/1/16	Page 35
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 3, 8a, 17, 32
TN #100	5/1/15	Table of Contents, page i Pages 1, 2, 5, 6, 10, 15, 16-17a, 25,41-51
TN #99	1/1/14	Pages 3, 35
UP #9	4/1/13	Table of Contents Pages 3, 35, 38, 41, 42, 50, 51
TN #97	9/1/12	Table of Contents Pages 1, 4-7, 9-17 Page 8a was deleted. Pages 18a-20, 23-27, 29-31 Pages 37-40, 43-51 Pages 52 and 53 were deleted
UP #6	4/1/12	Pages 3, 35
TN #96	10/1/11	Pages 3, 20, 21
TN #95	3/1/11	Pages 3, 4, 35
TN #94	9/1/10	Page 4a
TN #93	1/1/10	Pages 28, 35
TN #91	5/15/09	Pages 23, 24

M1460.300 ASSISTANCE UNIT

A. Policy

An institutionalized individual is an assistance unit of one person, considered living separately from his spouse and/or parent(s), beginning the month in which he meets the definition of *an institutionalized individual* in section M1410.010.

EXCEPTION: A pregnant woman's assistance unit includes the number of unborn children with which she is pregnant.

B. Financial Eligibility

The financial eligibility rules in this section apply to **both ABD and F&C individuals.**

1. Resources

The resources of an institutionalized child's parent(s) are **NOT** deemed available to the institutionalized child. The resources of an institutionalized individual's spouse are deemed available to the institutionalized individual in the initial eligibility determination (see subchapter M1480).

2. Income

The income of an institutionalized individual's spouse or parent(s) is **NOT** deemed available to the institutionalized individual.

For income eligibility, married institutionalized individuals are considered separated, not living together, and only that income which is voluntarily contributed to the institutionalized spouse by the separated spouse is considered available to the institutionalized spouse.

Institutionalized children are considered separated from, not living with, their parents and only that income which is voluntarily contributed to the child is considered available to the child.

M1460.400 STEPS FOR DETERMINING FINANCIAL ELIGIBILITY

A. Is person an SSI recipient?

Yes: Go to M1460.201 (determine ABD CN resources; if within limit, is eligible as SSI). If resources exceed the limit, does recipient also meet F&C *CN* covered group?

Yes: eligible as F&C *CN*; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay. (Remember to review asset transfer to evaluate whether Medicaid payment may be made for LTC services).

No: ineligible for Medicaid; STOP. Go to section M1460.660 for notice procedures.

No: Does person receive IV-E cash assistance?

b. F&C Covered Groups

1) Excluded Resources (section M0630.100).

2) Reasonable Effort To Sell (CN) (section M0630.105).

3) Reasonable Effort To Sell For the Medically Needy (section M0630.110).

F. Home No Longer Excluded

If the individual's home property is no longer excluded and the individual has excess resources, cancel Medicaid because of excess resources when the individual does not have Medicare Part A. If the individual has Medicare Part A, evaluate the individual's eligibility as ABD Medicare Savings Program (MSP) which has more liberal resource requirements and limits (see M0320.600).

1. Individual Has Medicare Part A

When the individual has Medicare Part A:

a. compare income with the ABD MSP limits; if the income is below one of the ABD MSP income limits, then

b. evaluate the resources using ABD MSP policy as found in Chapter S11, Appendix 2.

c. If eligible as ABD MSP only, Medicaid will not pay for nursing facility or CBC waiver services costs. Do the following:

- prepare and send an Advance Notice of Proposed Action to the recipient;
- cancel the recipient's coverage, then reinstate the recipient to ABD MSP limited coverage;
- send a Medicaid LTC Communication Form (DMAS-225) to the provider, stating that the recipient is no longer eligible for full Medicaid coverage because of excess resources, but is eligible for limited ABD MSP coverage; beginning (specify the date following the cancel date of the recipient's full coverage), Medicaid will not pay for the individual's care.

d. If NOT eligible as ABD MSP because of resources and/or income, cancel the recipient's Medicaid. Do the following:

- prepare and send an "Advance Notice of Proposed Action" to the recipient;
- cancel the recipient's Medicaid coverage because of excess resources or income;

M1520 Changes

Changed With	**Effective Date**	**Pages Changed**
TN #DMAS-23	4/1/22	Pages 10, 11, 12, 13, 26, 27, 30 Appendix 2, page 1
TN #DMAS-22	1/1/22	Page 14
TN #DMAS-21	10/1/21	Pages 6, 12
TN #DMAS-20	7/1/21	Pages 2, 3. 5. 6, 13, 14 Page 2a is a runover page. Page 6a was added as a runover page
TN #DMAS-19	4/1/21	Appendix 2
TN #DMAS-18	10/1/19	Pages 1, 4, 4a, 5, 11, 13 Content that was inadvertedly deleted in a previous transmittal was restored. No policy was revised.
TN #DMAS-17	7/1/20	Pages 2, 4, 25, 30 Page 3 is a runover page.
TN #DMAS-16	4/1/20	Pages 3, 4, 7, 9 Appendix 2 Pages 3a and 4 were renumbered to pages 4 and 4a. Page 4a is a runover page.
TN #DMAS-15	1/1/20	Pages 8, 8a
TN #DMAS-14	10/1/19	Pages 2, 3, 4, 6a, 8, 9, 10, 13 Page 4a is a runover page. Page 10a was added as a runover page. Page 7a was deleted.
TN #DMAS-13	7/1/19	Page 14
TN #DMAS-12	4/1/19	Table of Contents Pages 2, 5, 6, 6a, 7, 8, 8a, 11, 12, 15-18, 20 Appendix 2 Page 24a was added. Pages, 19, 21-24, 25 are runover pages.
TN #DMAS-11	1/1/19	Pages 2, 5, 6, 7, 9
TN #DMAS-8	4/1/18	Pages 2, 18 Appendix 2
TN #DMAS-7	1/1/18	Pages 2, 3, 3a, 5, 6, 7 Pages 6a and 7a are runover pages.

M1520 Changes

TN #DMAS-5	7/1/17	Pages 1, 2, 6, 8 Pages 3, 7, 7a and 9 are runover pages.
TN #DMAS-4	4/1/17	Pages 25-27 Appendix 2, page 1 Pages 28-30 were added.
TN #DMAS-3	1/1/17	Pages 1, 2, 4, 6, 7, 8, 14, 26
TN #DMAS-2	10/1/16	Pages 1, 3, 6, 8, 12, 14, 15 Pages 19-24
TN #DMAS-1	6/1/16	Pages 3, 6, 7, 9, 11-14, 17 Appendix 2, page 1 Pages 3a and 7a were added. Page 8 is a runover page.
TN #100	5/1/15	Table of Contents Pages 1-27 (entire subchapter –pages 28-34 were deleted) Appendices 1 and 2 were added.
TN #99	1/1/14	Table of Contents Pages 1-34 (entire subchapter)
UP #9	4/1/13	Pages 7b and 10a
TN #97	9/1/12	Page 1
UP #7	7/1/12	Pages 1, 7, 7c, 7g
TN #96	10/1/11	Table of Contents Pages 1-7g Pages 11-13 Pages 21-24
TN #95	3/1/11	Pages 6a, 7, 21, 22
TN #94	9/1/10	Table of Contents Pages 3, 4b, 5, 6-6a, 10 Appendix 1 was removed.
UP #4	7/1/10	Page 4
TN #93	1/1/10	Pages 3, 4b, 5-6, 10, 15 Pages 21, 22
Update (UP) #2	8/24/09	Pages 1, 2, 13, 14, 17, 18
Update (UP) #1	7/01/09	Page 3

D. Special Requirements for Certain Covered Groups

1. Pregnant Woman

Do not initiate a renewal of eligibility of a pregnant woman in other covered group during her pregnancy. Eligibility in a
pregnant woman covered group ends effective the last day of the month in which the 60th day following the end of the pregnancy (60th postpartum day) occurs.

Coverage for pregnant women who have reached the end of the month in which the 60th postpartum day occurs may be automatically reinstated in the MAGI Adults covered group. The next renewal will continue to be due in the month that was set during the enrollment into coverage as a pregnant woman. The impacted cases will be listed in the "MA-PG Summary Report."

For women whose coverage cannot be automatically reinstated, prior to the cancellation of coverage, determine if the woman meets the definition for another Medicaid covered group (see M0310.002). If the woman meets the definition of a full-benefit covered group, or for limited coverage under Plan First, determine if an ex parte renewal can be completed or if a renewal form is required and take appropriate action.

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

2. Newborn Child Turns Age 1

A renewal must be completed for a child enrolled as a Newborn Child Under Age 1 before *Medicaid Enterprise System (MES—formerly the Medicaid Management Information System [MMIS])* cut-off in the last month in which the child meets the Newborn Child Under Age 1 covered group and must include:

- SSN or proof of application
- verification of income
- verification of resources for the MN child.

The ex parte process may be used if appropriate.

3. Child Under Age 19—Income Exceeds FAMIS Plus Limit

When an enrolled FAMIS Plus child no longer meets the FAMIS Plus income limits and there is not an LIFC parent on the case, evaluate the child for the FAMIS, using the eligibility requirements in chapter M21. If the child is eligible for FAMIS, send the family an Advance Notice of Proposed Action that Medicaid will be cancelled effective the last day of the month in which the 10-day advance notice expires and the FAMIS coverage will begin the first day of the month following the Medicaid cancellation. Use cancel reason "042" when the child loses eligibility in Medicaid and is reinstated in FAMIS and there is no break in coverage.

Do not use change transactions to move a child between Medicaid and FAMIS. If the child is not eligible for FAMIS, the worker must provide an opportunity for the child to be evaluated as medically needy (MN) **prior** to sending an advance notice and canceling the child's Medicaid coverage.

If the child does not meet the definition for another covered group, determine the child's eligibility in Plan First using the eligibility requirements in M0320.302. If the child is eligible for Plan First, reinstate coverage in Plan First and send the Advance Notice of Proposed Action indicating that he has been enrolled in Plan First. On the notice, state that if he does not wish to remain covered by Plan First, to contact the eligibility worker and request that the coverage be cancelled. Include a Plan First Fact Sheet, available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/References, with the Advance Notice of Proposed Action.

6. IV-E FC & AA Children and *AA* Children *With* Special Needs *for* Medical *or Rehabilitative Care*

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

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

7. Child Under 21 Turns Age 21

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

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

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

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

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

The BCCPTA Redetermination Form (#032-03-653) is used to redetermine eligibility for the BCCPTA covered group. The form is available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms. The enrollee must provide a statement from his or her medical provider on the renewal form or else a separate written statement verifying continued treatment for breast or cervical cancer. There are no Medicaid financial requirements for the BCCPTA covered group.

10. Hospice Covered Group

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

11. Qualified Individuals

Funding for the QI covered group became permanent in 2015; the QI covered group is subject to the same policies regarding renewals as other ABD covered groups.

12. FAMIS Renewal Period Extension For Declared Disaster Areas

Effective January 1, 2017, if the Governor or the Federal Emergency Management Agency (FEMA) declares Virginia or any area in Virginia to be a disaster area, children enrolled in FAMIS who reside in the declared disaster area may be granted a 90-day extension of the continuous coverage period before their next renewal is due. The next 12-month continuous eligibility period begins the month after the renewal completion date.

The extension of the renewal period applies only to children in a declared disaster area (1) for whom an ex parte renewal cannot be completed and (2) who do not return a renewal form or complete an online or telephonic renewal prior to the renewal due date. The three-month reconsideration period outlined in M1520.200 C.4 also applies to these children if their coverage is cancelled upon not completing a renewal at the end of the 90-day extension period.

E. LTC

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

ABD, as well as F&C individuals over age 18, in the 300% of SSI covered group LTC must complete a contact-based renewal due to the resource requirement.

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

F. Incarcerated Individuals

Incarcerated individuals who have active Medicaid are subject to annual renewals. Renewals for individuals in Department of Corrections and Department of Juvenile Justice facilities will be handled with assistance through the designated facility staff liaison.
.

- For individuals incarcerated in DOC facilities, send the renewal form and related correspondence to the DOC Health Services Reimbursement Unit, 6900 Atmore Drive, Richmond, Virginia 23225.

- For individuals in DJJ facilities, send the renewal form and related correspondence to the DJJ Re-entry Services Unit, 600 E. Main Street, Richmond VA 23219.

- For individuals in regional or local jails, send the renewal form and related correspondence to the individual or his authorized representative.

B. Procedures

***1.* Change Results in Adverse Action**

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

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

Unless the individual has Medicare, a referral to the HIM must be made when coverage is cancelled. The notice must state that the individual has been referred to the HIM for determination of eligibility for the APTC.

***2.* Enrollee Appeals Action**

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

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

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

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

***3.* Death of Enrollee**

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

If the enrollee has an SSN, the worker must verify the date of death. A match with Social Security Administration data occurs when the individual’s information is sent through the Hub in VaCMS.

Alternatively, the worker can run a SVES or SOLQ-I request to verify the date of death. SVES will display an “X” and the date of death in the “SSN VERIFICATION CODE” field on Screen 1.

If the annual renewal is due in the month the LDSS plans to transfer the case, the following month, or is overdue, the renewal must be completed before transferring the case. If the enrollee applies for other benefit programs in another locality, the sending LDSS must transfer the case to the new locality by the end of the next business day after they receive information indicating the enrollee has moved, provided the agency has not started the redetermination case action in VaCMS

If the individual applies for other benefits in the new locality and the case is in the redetermination case action in VaCMS, the sending LDSS has 7 calendar days from the time they receive information indicating the individual has moved to complete the case action and transfer the case to the new locality. The worker will update VaCMS immediately with the new address so the information transfers over to *MES* to assure managed care continuity but will maintain ownership of the case in their FIPS until the renewal is completed.

The sending LDSS must process the renewal if a renewal or application is submitted during the reconsideration period and the enrollee indicates he has moved on the application or renewal form.

If the case is closed and in the reconsideration period, and the individual applies for other benefits programs in another locality, the case will be transferred to the new locality automatically when the new locality associates the application for other benefits with the closed case. The new locality will be responsible for processing the renewal if it is submitting within the reconsideration period.

b. Medical Assistance Case with Other Benefit Programs Attached

The sending locality must ensure that the MA program attached to the ongoing case is current and complete before transferring the case. If the annual renewal has been completed within the past 10 months, a partial review based on known information, as to whether or not the recipient will meet a covered group and the income and resource limits in the new locality, must be completed before transferring the case. If the case is in a current case action the agency must complete the case action before transferring the case.

If the annual MA renewal is due in the month the LDSS plans to transfer the case, the following month, or is overdue, the renewal must be completed before transferring the case. If the individual submits his interim or renewal for other benefit programs in another locality, the sending LDSS must transfer the case to the new locality by the end of the next business day after they receive information indicating the individual has moved, provided the agency has not started the redetermination case action in VaCMS.

If the individual submits his renewal for other benefits in the new locality and the case is in the redetermination case action, the sending LDSS has 7 calendar days from the time they receive information indicating the individual has moved to complete the case action and transfer the case to the new locality. The worker will update VaCMS immediately with the new address so the information transfers over to *MES* to assure managed care continuity but will maintain ownership of the case in their FIPS until the renewal is completed.

The sending LDSS must process the renewal if a renewal or application is submitted during the reconsideration period and the individual indicates he has moved on the application or renewal form.

If the MA is closed and in the reconsideration period, and the individual submits a renewal for other benefit programs in another locality, the sending LDSS will transfer the case to the new locality and the new locality will be responsible for processing the renewal if it is submitted within the reconsideration period.

c. Transfer Pending Medical Assistance Applications

Pending applications or cases in Intake/Screening in VaCMS must be transferred to the new locality for an eligibility determination.

d. Foster Care & Adoption Assistance

Foster care and adoption assistance Medicaid cases are not transferred unless custody or responsibility for services and/or payment is transferred.

e. Sending Transferred Cases

If the renewal or the partial review indicates that the enrollee(s) will continue to be eligible for Medical Assistance in the new locality, the sending locality must update the enrollment system. Transfer the electronic case, and if applicable, send the additional case record materials to the enrollee's locality of residence with a completed Case Record Transfer Form.

Required Document Management Imaging System (DMIS) items must be uploaded to VaCMS before case transfer. Document within VaCMS to indicate if there are documents uploaded to DMIS and/or additional case record materials outside of VaCMS. If additional case record materials exist, the materials and a completed Case Record Transfer Form must be sent by certified mail, delivered personally and a receipt obtained or, at the agency's discretion, the case may be sent via the courier pouch.

If the annual renewal or the partial review finds that eligibility no longer exists for one or all enrollees in the case, the agency must take the necessary action, including advance notice to the individuals, to cancel the ineligible individuals' coverage.

Step 4:
Has the person submitted an application for other programs?
-If yes, the worker has 7 calendar days to complete a partial review and transfer the case.
-If no, the worker must complete the renewal before transferring the case.

D. Spenddown Cases

Cases in spenddown status (denied or canceled and placed on a spenddown) must be transferred when the applicant notifies the agency that he/she has moved to a new Virginia locality.

1. Sending Locality Responsibilities

Within 10 working days of notification that the applicant has moved, the case must be transferred to the new locality, following the policies in M1520.500 E.1.e. The sending agency must:

- inform the applicant of the receiving agency's name, address, and telephone number;
- deduct all known spenddown items from the spenddown balance on the worksheet before sending the case record.

2. Receiving Locality Responsibilities

The receiving locality must review the case following the policies in M1520.500 E.2.

E. Receiving LDSS Case Management Procedure

To identify and manage transferred Medicaid cases, use the report titled “Caseworker Alpha Case/Enrollee Listing.” This report is posted in the Data Warehouse Medicaid Management Reports. It is updated on or about the 22nd of each month. The LDSS can also use the Case Assignment function in VaCMS to view current caseloads.

TWELVE MONTH EXTENDED MEDICAID INCOME LIMITS 185% of FEDERAL POVERTY LIMITS EFFECTIVE *1-18-22* ALL LOCALITIES

# of Persons in Family Unit/Budget Unit	185% FPL Monthly Limit
1	*$2,096*
2	*2,823*
3	*3,551*
4	*4,279*
5	*5,006*
6	*5,734*
7	*6,462*
8	*7,189*
Each additional person add	*728*

M1550 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-23	4/1/22	Page 1
TN #DMAS-20	7/1/21	Appendix 1
TN #DMAS-19	4/1/21	Pages 1, 2
TN #DMAS-17	7/1/20	Table of contents Pages 1, 2 Appendix 1, page 1 Pages 3-9 and Appendix 1, page 2 were deleted.
TN #DMAS-16	4/1/20	Page 2 Appendix 1, page 1
TN #DMAS-14	10/1/19	Appendix 1, page 1 Appendix 1, page 2 was added.
TN #DMAS-8	4/1/18	Page 3
TN #DMAS-7	1/1/18	Page 1 Appendix 1, page 1
TN #DMAS-4	4/1/17	Appendix 1,page 1
TN #DMAS-3	1/1/17	Pages 4-6, 8, 9
TN #100	5/1/15	Appendix 1,page 1
UP #9	4/1/13	Appendix 1, page 1
Update (UP) #7	7/1/12	Appendix 1, page 1
TN #96	10/1/11	Appendix 1, page 1
TN #93	1/1/10	Title page Table of Contents Pages 1-9 Appendix 1, page 1
TN #91	5/15/09	Appendix 1

M1550.000 DBHDS FACILITIES

M1550.100 GENERAL PRINCIPLES

A. Introduction

This subchapter contains a list and a brief description of the DBHDS facilities (M1550.200).

Prior to July 1, 2020, the Virginia Department of Social Services (VDSS) had eligibility workers, called Medicaid Technicians, located in Department of Behavioral Health and Developmental Services (DBHDS) facilities to determine the patients' eligibility for Medicaid. On July 1, 2020, VDSS suspended operations of the Medicaid Technicians.

Effective July 1, 2020, local DSS will process applications submitted by patients of DBHDS facilities and maintain cases for enrolled individuals who reside in DBHDS facilities.

M1550.200 DBHDS FACILITIES

A. Introduction

Three types of medical facilities are administered by DBHDS: training centers, psychiatric hospitals, and a general hospital with nursing facility beds. Below is a brief description of each type of facility.

1. *Southeastern Virginia* Training Center

Southeastern Virginia Training Center in Chesapeake is an institution and medical center for individuals with diagnosed with an intellectual or developmental disability. Some patients may be employed and have earned income. Patients of any age may be Medicaid eligible if they meet all nonfinancial and financial Medicaid eligibility requirements.

2. Psychiatric Hospitals

Psychiatric hospitals are medical facilities – institutions for the treatment of mental diseases (IMDs) – which provide care and services to mentally ill patients. There are two types of psychiatric hospitals: intensive psychiatric and psychiatric/chronically mentally ill. These hospitals may have patients of any age, although two of them are dedicated to geriatric patients and one serves only adolescents.

M17 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-23	4/1/22	Page 4 Page 4a was added.
TN #DMAS-20	7/1/21	Page 7
TN #DMAS-16	4/1/20	Appendix 4, page 1 Appendix 4, page 2 was added
TN #DMAS-15	1/1/20	Page 7 Page 8 was added as a runover page.
TN #DMAS-14	10/1/19	Table of Contents Pages 1, 2, 4, 6, 7 Appendix 1, pages i and ii Appendix 2, pages i and ii Appendix 4 was added.
TN #DMAS-7	1/1/18	Table of Contents, page i Appendix 1, pages i and ii Appendix 2, pages i and ii Appendix 3 was added.
TN #DMAS-6	10/1/17	Table of Contents Pages 4. Appendix 1 was deleted Appendices 2 and 3 were renumbered Appendices 1 and 2, respectively.
TN #DMAS-5	7/1/17	Table of Contents Pages 1, 2, 4 Appendix 2 Appendix 3 was added.
TN #DMAS-4	4/1/17	Pages 4, 5 Pages 6 and 7 are runover pages.
TN #DMAS-2	10/1/16	Table of Contents, page i Pages 1-7 Appendix 2 Page 8 was deleted.
TN #97	9/1/12	Page 3 Appendix 1, page 1
UP #7	7/1/12	Table of Contents Pages 1-8 Appendix 1 Appendices 3 and 4 were removed.
TN #94	9/1/10	Title Page Table of Contents pages 1-7 Appendix 1 Appendix 2
TN #93	1/1/10	Page 3

2. Family Unit

If both spouses of an eligible couple are found guilty of fraud, neither is eligible for Medicaid. If only one member of a family unit is convicted of fraud, only that member's Medicaid coverage is canceled. The fraud conviction does not affect the composition of the family unit or the treatment of the family unit's income or resources. The convicted individual is included in the family unit according to Medicaid policy, but is not eligible for Medicaid coverage and is not enrolled.

M1700.300 NON-FRAUD RECOVERY

A. Authority

Any person who, without intent to violate this article, obtains benefits or payments under medical assistance to which he is not entitled shall be liable for any excess benefits or payments received. (COV 32.1-321.2)

B. Recovery of Erroneous Payments

DMAS has the authority to investigate cases and recover expenditures made for services received by ineligible enrollees without fraudulent intent. Examples of when recovery of expenditures is possible include, but are not limited to:

- eligibility errors due to recipient misunderstanding,
- agency errors,
- medical services received during the appeal process, if the agency's cancellation action is upheld.
- long-term care (LTC) patient pay underpayments totaling $1,500 or more.

Complete and send the Notice of Recipient LTC Patient Pay Underpayment (form #DMAS752R) located at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, to
:

Department of Medical Assistance Services
Recipient Audit Unit,
600 E. Broad Street, Suite 1300,
Richmond, Virginia 23219

The form can be faxed to 804-452-5472 or emailed to recipientfraud@dmas.virginia.gov.

Underpayments less than $1,500 can be collected by adjusting the ongoing patient pay (see M1470.900 for patient pay adjustments).

C. Post-eligibility Investigations

1. Method-ology

The RAU conducts post eligibility investigations. Medicaid nonfinancial and financial requirements are reviewed and applied in accordance to Medicaid policy. See Chapter M02 for the nonfinancial eligibility requirements, and Chapters M06 and M11 for resource requirements.

RAU investigations are based on projected income consistent with the eligibility polices for counting ongoing income referenced in Chapters M04, M07, and M08. Post-eligibility determinations are made using a point-to-point method in which the income estimation period begins with an event that would have triggered a partial review under M1450.100. The end point is the next scheduled renewal that the LDSS actually completed.

2. Non-financial Issues

Investigations or audits of non-financial attestations by an enrollee (such as residency, pregnancy and household composition), that later become questionable due to the receipt of information that puts their eligibility into question, RAU has the discretion to request verification from the enrollee or obtain a third party statement. The following are some common non-financial circumstances where the RAU may require additional verifications when the recipient eligibility is questionable:

a. Residency

If an enrollee's Virginia residency is questionable, RAU may request or obtain documents such as school records, receipt of social service benefits and medical records as sources of evidence to validate the recipient's Virginia resident or non-resident status. RAU utilizes the PARIS match to identify recipients who have received benefits in other states and Virginia concurrently.

b. Pregnancy

When a recipient's pregnancy is questionable, the RAU may require the recipient to provide verification of pregnancy or the termination of her pregnancy. The RAU may also use medical records, if available, to verify termination of pregnancy.

c. Household composition

If the enrollee's household composition is in question (such as undeclared spouse, parent, or a unreported change of status of a child in the home, the RAU may require a written statement from the enrollee, a third party or other verifying evidence.

D. Uncompensated Asset Transfers

Individuals receiving long-term care services (LTC) who transfer assets and do not receive adequate compensation are subject to the imposition of a penalty period during which Medicaid cannot pay for long-term care services. When an uncompensated

M21 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-23	4/1/22	Appendix 1, page 1
TN #DMAS-21	10/1/21	Pages 4, 5
TN #DMAS-20	7/1/21	Page 2
TN #DMAS-19	4/1/21	Appendix 1, page 1
TN #DMAS-16	4/1/20	Appendix 1, page 1
TN #DMAS-14	10/1/19	Pages 4-6
TN #DMAS-12	4/1/19	Appendix 1, page 1
TN #DMAS-9	7/1/18	Page 5
TN #DMAS-8	4/1/18	Appendix 1, page 1
TN #DMAS-4	4/1/17	Appendix 1, page 1
TN #DMAS-2	1/1/17	Appendix 1, page 1
TN #DMAS-2	10/1/16	Page 3
TN #DMAS-1	6/1/16	Appendix 1, page 1
TN #100	5/1/15	Table of Contents Pages 1-7 Appendices 1 Pages 8-10 and Appendices 2 and 3 were deleted.
UP #10	5/1/14	Pages 1-3 Appendix 1
TN #99	1/1/14	Pages 1-3 Appendix 1
TN # 98	10/1/13	Table of Contents Pages 1-10 Pages 10a and 11-16 were deleted.
UP #9	4/1/13	Pages 3, 4
UP #8	10/1/12	Table of Contents Pages 2-4 Appendix 3 deleted
TN #97	9/1/12	Pages 3, 4
UP #7	7/1/12	Pages 3, 4 Appendix 2, pages 1 Appendix 3, pages 1 and 2
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	Pages 3, 8
TN #95	3/1/11	Table of Contents Pages 5, 6, 14, 15, Page 16 added Appendix 1
TN #94	9/1/10	Page3 Appendix 3, pages 1 and 2
UP #3	3/1/10	Pages 2-5
TN #93	1/1/10	Page 2-4, 8
Update (UP) #2	8/24/09	Page 4

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

EFFECTIVE *1/18/22*

# of Persons in FAMIS House-hold	**FAMIS 150% FPL**		**FAMIS 200% FPL**		
	Annual Limit	Monthly Limit	Annual Limit	Monthly Limit	205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)
1	*$20,385*	*$1,699*	*$27,180*	*$2,265*	*$2,322*
2	*27,465*	*2,289*	*36,620*	*3,052*	*3,128*
3	*34,545*	*2,879*	*46,060*	*3,839*	*3,935*
4	*41,625*	*3,469*	*55,500*	*4,625*	*4,741*
5	*48,705*	*4,059*	*64,940*	*5,412*	*5,547*
6	*55,785*	*4,649*	*74,380*	*6,199*	*6,354*
7	*62,865*	*5,239*	*83,820*	*6,985*	*7,160*
8	*69,945*	*5,829*	*93,260*	*7,772*	*7,966*
Each add’l, add	*7,080*	*590*	*9,440*	*787*	*807*

M22 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-23	4/1/22	Page 6 Appendix 1, page 1
TN #DMAS-20	7/1/21	Page 2
TN #DMAS-19	4/1/21	Appendix 1, page 1
TN #DMAS-18	1/1/21	Page 6
TN #DMAS-16	4/1/20	Appendix 1, page 1
TN #DMAS-14	10/1/19	Page 5
TN #DMAS-12	4/1/19	Appendix 1, page 1
TN #DMAS-8	4/1/18	Appendix 1, page 1
TN #DMAS-6	10/1/17	Page 7 Appendix 1, page 1
TN #DMAS-4	4/1/17	Appendix 1, page 1
TN #DMAS-1	6/1/16	Page 4 Appendix 1, page 1
TN #100	5/1/15	Table of Contents Pages 1, 2, 5, 6, 7 Appendix 1 Pages 3 and 4 are runover Pages.
TN #98	10/1/13	Table of Contents Pages 1-7 Appendix 1 Pages 8-10 were deleted.
UP #9	4/1/13	Appendix 1
UP #8	10/1/12	Pages 2, 3 Page 3a deleted
UP #7	7/1/12	Pages 2, 3
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	Pages 3, 3a
TN #95	3/1/11	Pages 4-6 Appendix 1
UP #4	7/1/10	Page 10
TN #94	9/1/10	Page 3
UP #3	3/01/10	Page 2
TN #93	1/1/10	Pages 2-10
UP #2	8/24/09	Page 3
Update (UP) #1	7/1/09	Pages 1, 2, 7 Appendix 1, page 1

1. 7 Calendar Day Processing

Applications for pregnant women must be processed as soon as possible, but no later than seven (7) calendar 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 7 calendar days in order to determine eligibility. If the agency does not receive the verifications within the 7 calendar days, the worker must send the applicant written notice on the 7th day. The notice must state why action on the application could not be taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 calendar days to submit the verification.

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

C. Case Setup Procedures for Approved Cases

A woman enrolled as FAMIS MOMS may have the same base case number in the *Medicaid Enterprise System (MES—formerly the* Virginia Medicaid Management Information System [MMIS]) as Medicaid enrollees.

D. Entitlement and Enrollment

1. Begin Date of Coverage

Pregnant women determined eligible for FAMIS MOMS are enrolled for benefits effective the first day of the application month, if all eligibility requirements are met in that month.

2. No Retroactive Coverage

There is no retroactive coverage in the FAMIS MOMS program.

3. Aid Category

The FAMIS MOMS aid category (AC) is “005.”

E. Notification Requirements

Written notice must be sent to the pregnant woman informing her of the action taken on the application. The notice must include the eligibility determination results for both Medicaid and FAMIS MOMS, as well as a referral to the Health Insurance Marketplace, if applicable.

If the pregnant woman is ineligible for both Medicaid and FAMIS MOMS due to excess income, she must be sent a written notice that she is not eligible for either program and that her case has been referred to the Health Insurance Marketplace. She must also be given the opportunity to have a Medicaid medically needy evaluation completed. Send the notice and a request for information about her resources to the pregnant woman and advise her that if the resource information is returned within 10 days the original application date will be honored.

FAMIS MOMS
200% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/18/22*

Household Size	200% FPL Yearly Amount	200% FPL Monthly Amount	205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)
2	*$36,620*	*$3,052*	*$3,128*
3	*46,060*	*3,839*	*3,935*
4	*55,500*	*4,625*	*4,741*
5	*64,940*	*5,412*	*5,547*
6	*74,380*	*6,199*	*6,354*
7	*83,820*	*6,985*	*7,160*
8	*93,260*	*7,772*	*7,966*
Each additional, add	*9,440*	*787*	*807*

M23 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-23	4/1/22	Page 6 Appendix 1, page 1
TN #DMAS-21	10/1/21	Pages 6, 7

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

C. Case Setup Procedures for Approved Cases

A woman enrolled as FAMIS Prenatal Coverage may have the same base case number in the *Medicaid Enterprise System (MES—formerly the* Virginia Medicaid Management Information System [MMIS]) as Medicaid enrollees.

D. Entitlement and Enrollment

2. Begin Date of Coverage

Pregnant women determined eligible for FAMIS Prenatal Coverage are enrolled for benefits effective the first day of the application month, if all eligibility requirements are met in that month.

2. No Retroactive Coverage

There is no retroactive coverage in the FAMIS Prenatal Coverage program.

4. Aid Categories

The FAMIS Prenatal Coverage aid categories (AC) are:

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

5. Coverage Period

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

E. Notification Requirements

Written notice must be sent to the pregnant woman informing her of the action taken on the application. The notice must include the eligibility determination results for FAMIS Prenatal Coverage.

If the woman is not eligible for FAMIS Prenatal Coverage and has no documentation of immigration status, DO NOT make a referral to the Health Insurance Marketplace.

F. Enrolling Infant Born to a Woman in FAMIS Prenatal Coverage

For women assigned to AC 110 under a fee for service (FFS) arrangement, her labor and delivery services are paid as emergency services, and the newborn is considered a deemed-eligible newborn. When the birth of the child born to a women enrolled in FAMIS Prenatal Coverage is reported, review the available systems to determine if the mother is assigned to AC110 under FFS. If so, the child is enrolled as a deemed newborn in AC 093.

An infant born to a woman in FAMIS Prenatal Coverage who is assigned to AC 111 and/or enrolled in managed care must be evaluated for ongoing coverage. The enrollment is treated as a change in circumstances. The infant is not considered a deemed-eligible newborn but has rather been enrolled prenatally through the mother's enrollment in FAMIS Prenatal Coverage. The infant's birth is treated as an "add a person" case change in the enrollment system. Follow the procedures in M2340.100 F.1 – F.3 below.

1. Required Information

To enroll the infant, the worker must have the information below. Use existing case data if possible. If additional information is needed, send a request for verification.

FAMIS PRENATAL COVERAGE
200% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/18/22*

	Enroll Using Aid Category 110			**Enroll Using Aid Category 111**		
Household Size	**143% FPL Yearly Amount**	**143% FPL Monthly Amount**	**148% FPL (143% FPL + 5% FPL Disregard)**	**200% FPL Yearly Amount**	**200% FPL Monthly Amount**	**205% FPL (200% FPL + 5% FPL Disregard)**
2	*$26,184*	*$2,182*	*$2,259*	*$36,620*	*$3,052*	*$3,128*
3	*32,933*	*2,745*	*2,841*	*46,060*	*3,839*	*3,935*
4	*39,683*	*3,307*	*3,423*	*55,500*	*4,625*	*4,741*
5	*46,433*	*3,870*	*4,005*	*64,940*	*5,412*	*5,547*
6	*53,182*	*4,432*	*4,587*	*74,380*	*6,199*	*6,354*
7	*59,932*	*4,995*	*5,169*	*83,820*	*6,985*	*7,160*
8	*66,681*	*5,557*	*5,752*	*93,260*	*7,772*	*7,966*
Each additional, add	*6,750*	*563*	*583*	*9,440*	*787*	*807*