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October 1, 2022

Virginia Medical Assistance Eligibility Manual
Transmittal #DMAS-25

The following acronyms are contained in this letter:

- COVID – Coronavirus Disease
- DMAS – Department of Medical Assistance Services
- FAMIS – Family Access to Medical Insurance Security
- LDSS – Local Department of Social Services
- LTSS – Long-term Services and Supports
- MDS – Minimum Data Survey
- PHE – Public Health Emergency
- TN – Transmittal

TN #DMAS-25 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 October 1, 2022. Note that COVID-19 PHE guidelines continue until the emergency is over and are not referenced in Medical Assistance Eligibility Policy.

The following changes are contained in TN #DMAS-25:

Changed Pages	Changes
Subchapter M0120 page 7	Clarified that an undocumented parent under 18 can apply for FAMIS Prenatal Coverage since the coverage is for the unborn child, but once coverage closes any subsequent applications for the minor prior to turning 18 need to be signed by someone legally authorized to sign for on the minor's behalf.
Subchapter M0130 Pages 9,10	For all case actions effective August 26, 2022, if the income attested to by the applicant is within 20% of the income information obtained from electronic sources it is reasonably compatible

Changed Pages	Changes
Subchapter M0140 Pages 1, 3, 5	Clarified the Emergency Services and pre-release application process for offenders. Updated policy references.
Subchapter M0220 Table of Contents Pages 14d, 22 Appendix 4 added page 2	Updated Table of Contents, added information about Ukrainian Humanitarian Paroles and incarcerated individuals applying for Emergency Services.
Chapter M04 Pages 15 and 16	Clarifies policy regarding income of tax dependents of any age.
Subchapter M0710 Page 2	For all case actions effective August 26, 2022, if the income attested to by the applicant is within 20% of the income information obtained from electronic sources it is reasonably compatible
Subchapter M1410 Page 2a	Clarified definitions of Assisted Living Facility/Memory Care Unit and Independent Living Facility
Subchapter M1420 Table of Contents Pages 1-3, 5	Added information about nursing facility use of Minimum Data Survey (MDS) and LTSS Screening Special Circumstances
Subchapter M1430 Page 1	Corrected reference in M1430.010.
Subchapter M1450 Page 36	An individual for whom a penalty period is imposed cannot be eligible for Medicaid unless the individual is eligible for Medicaid outside the 300% SSI covered group. This reverses the change made April 17, 2018 allowing the penalty period to be imposed if the individual had been screened and medically approved for LTSS services in the community.
Subchapter M1470 Page 20	Updated Special Earnings Allowance amount for 2022.
Subchapter M1480 Page 66	Updated Utility Standard Deduction
Chapter M17 Page 4	Corrected reference to partial review policy.

Chapter M21 Page 6	For all case actions effective August 26, 2022, if the income attested to by the applicant is within 20% of the income information obtained from electronic sources it is reasonably compatible
Chapter M23 Page 5, 6, Adjust pages 7-8	For all case actions effective August 26, 2022, if the income attested to by the applicant is within 20% of the income information obtained from electronic sources it is reasonably compatible; Explain system change regarding FAMIS Prenatal ACs.

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

M0120 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-25	10/1/22	Page 7
TN #DMAS-23	4/1/22	Pages 9, 10, 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

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

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

2. Non-custodial Parent Applying for Child

Eligibility for a child is based on the income of the parent with whom the child lives. If a non-custodial parent applies for his child, he must give written permission for the eligibility worker to contact the custodial parent. The eligibility worker must obtain the custodial parent's income information, written permission to verify income using available online data sources, and other information necessary to verify and calculate countable income, including Social Security Number and residence address. If either the non-custodial parent or the custodial parent fail to give the necessary permission, the child's eligibility cannot be determined using the application filed by the non-custodial parent.

3. Minor Parent Applying for Child

Parent*(s)* under age 18 years may apply for MA for *their* own child because *they are* the parent of the child. *An undocumented minor can apply for FAMIS Prenatal Coverage since the coverage is considered to be for the unborn child. If the individual is eligible, the parent can then be enrolled for the duration of the pregnancy and the 60 day postpartum period. Any future applications filed for the minor prior to turning age 18 would need to be signed by someone who is legally authorized to sign on the individual's behalf.*

4. Foster Care Child

a. IV-E

The Title IV-E Foster Care & Medicaid Application form, available at https://fusion.dss.virginia.gov/Portals/%5Bdfs%5D/Files/Copy%20of%20032-03-0636-06-eng.xlsx, is used for the IV-E Foster Care eligibility determination. A separate MA application is **not** required for a child who has been determined eligible for Title IV-E Foster Care. However, if there is a non-custodial agreement for the IV-E eligible child, the parent or legal guardian must sign an MA application for the child.

b. Non-IV-E

The Cover Virginia Application for Health Coverage & Help Paying Costs is used for the MA eligibility determination of a **non-IV-E** Foster Care child. Applications for non-IV-E Foster Care children may also be filed online. The MA application for a non-IV-E child who is in foster care must be signed by an authorized employee of the public or private agency that has custody of the child. Exception: If the child has been placed with and is living with a parent or care-taker relative, the parent or care-taker relative can sign the application.

If there is a non-custodial agreement, an MA application form must be filed and the parent or legal guardian must sign the application.

Changed With	Effective Date	Pages Changed
TN #DMAS-25	10/1/22	Pages 9,10
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

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

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

G. Health Insurance Premium Payment (HIPP) Program

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

The local DSS agency must give each applicant or enrollee who reports that he or someone in his family is employed more than 30 hours each week and is eligible for health insurance coverage under an employer's group health plan must be given a HIPP Fact Sheet, which provides a brief description of the program and the contact information for the HIPP Unit at DMAS. The HIPP Fact Sheet is available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms. Enrollees and other members of the public may contact the HIPP Unit for additional information at hippcustomerservice@dmas.virginia.gov.

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

H. Verification of Financial Eligibility Requirements

The eligibility worker must verify the following financial eligibility requirements:

- the value of all countable, non-excluded resources;
- asset transfer information for individuals in need of long-term care services, including the date of transfer, asset value, and compensation received.
- earned and unearned income. For all case actions effective *August 26, 2022*, if the income attested to by the applicant is within 20% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required.

  If the attested income is under the income limit and the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return. If the applicant meets a Medically Needy (MN) covered group, verification of income **is required** to determine spenddown liability.

  If the attested income is over the income limit and the individual does not meet a Medically Needy (MN) covered group, deny the application.

The agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information, and information from SSA through SVES or SOLQ-I. Verification of income

from these available sources, including the VEC, may be used if the information is less than 12 months old. The agency must include in each applicant's case record facts to support the agency's decision on the case.

1. Resources

The value of all countable, non-excluded resources must be verified. If an applicant's attested resources are over the resource limit, the applicant or authorized representative must be given the opportunity to provide verification of the resources. All available resource verification system(s) must be searched prior to requesting information from the applicant.

2. Use of Federal Income Tax Data

The Hub provides verification of income reported to the IRS. Income information reported to the IRS may be used for eligibility determinations for Families and Children (F&C), MAGI Adults, and ABD covered groups when IRS information is available. The income reported on the application is compared to the data obtained from the Hub for reasonable compatibility per M0420.100. When IRS verification is used for an ABD individual, reasonable compatibility is acceptable as verification of earned (i.e. taxable) income.

Note: Reasonable compatibility only applies to applications or reapplications; it does not apply to renewals.

3. SSA Data

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

4. Income

For all case actions effective *August 26, 2022*, the applicant's attested income, including when the applicant attests to having zero ($0.00) income, is considered the verified income if the income attested to by the applicant is within 20% of the income reported by electronic data sources OR both sources are below the applicable income limit.

If the attested income is under the income limit and the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return. If the applicant meets a MN covered group, verification of income **is required** to determine spenddown liability based on actual income received.

For individuals requesting long-term services and supports (LTSS), verification of income is required to calculate the patient pay. See M1470.

If the attested income is over the income limit and the individual does not meet a Medically Needy (MN) covered group, deny the application.

If the individual agrees that the discovered countable income was received, determine if the on-line information can be used to evaluate current/ongoing eligibility. If the discovered information is not sufficient to evaluate eligibility, send a written request for needed verifications and allow at least ten calendar days for the return of the verifications.

If the individual reports the income has stopped, ask when the income stopped to ensure all income needed to correctly determine prospective and retroactive eligibility (if appropriate) is evaluated. Note the date of termination of income (last pay received) in the record. If the income stopped during a month that is being evaluated for eligibility, the individual must provide verification of the termination of income.

M0140 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-25	10/1/22	Page 1, 3, 5
TN #DMAS-24	7/1/22	Page 3, 4
TN #DMAS-21	10/1/21	Page 1
TN #DMAS-18	1/1/21	Pages 3-5
TN #DMAS-14	10/1/19	Pages 4, 5

M0140.000 Incarcerated Individuals General Information

A. Introduction

An incarcerated individual, or offender, is an inmate of a public institution. Inmates include those under the authority of the Virginia Department of Corrections (DOC), held in a regional or local jail, those on work release, and inmates of a Virginia Department of Juvenile Justice (DJJ) facility.

For juveniles not in a facility but within the authority of DJJ, see section M0280.300 D. See section M0280.301 regarding an individual who is not considered to be an inmate of a public institution.

An individual released from jail under a court probation order due to a medical emergency is NOT an inmate of a public institution because he is no longer incarcerated.

B. Policy Principles

An individual is not eligible for full benefit Medicaid coverage while incarcerated. These individuals may apply for medical assistance and (if approved) receive coverage limited to inpatient hospitalization services. Inpatient hospitalization may include long-term inpatient services, such as admission to a rehabilitation facility.

The offender must meet eligibility requirements for a full-benefit covered group. Medicaid non-financial eligibility requirements include

- Virginia residency requirements (see M0230)
- Citizenship or immigration status (see M0220)
- A Social Security Number (SSN) or proof of application for an SSN (see M0240)
- Institutional status requirement of being an inmate in a public institution (see M0280)

Medicaid financial eligibility requirements for the individuals covered group include

- Resources (if applicable) within resource limit (Chapter M06 for F&C; Chapter S11 for ABD)
- Income within income limit (Chapter M04 & M07 for F&C covered groups; Chapter S08 for ABD covered groups)

C. Covered Group

The individual is evaluated for eligibility in the covered group in which they would otherwise be eligible except for being incarcerated. The primary covered groups an offender may meet include:

- MAGI Adults (M0330.250)
- Pregnant Women (M0330.400)
- Child Under Age 19 (M0330.300)
- Aged, Blind or Disabled (M0320.300)
- Former Foster Care Child Under Age 26 Years (M0330.109)

D. Immigration Status Requirements

An incarcerated person must meet immigration requirements (see M0220). A non-citizen who meets all Medicaid eligibility requirements except for immigration status and has received an inpatient hospitalization may be evaluated for coverage as an Emergency Services Alien see M0140.200.*C.3*

A. Offender Application Processing

An application is not to be refused or denied because an applicant is incarcerated. A person is not required to have had an inpatient hospitalization in order to apply for Medicaid. The agency must evaluate the eligibility of all MA enrollees, with respect to circumstances that may change, at least every 12 months unless the enrollee is pregnant (see M1520.200 p.9).

1. New Application

An offender who does not have active Medicaid coverage may apply while incarcerated. Coverage is based on the month of application and can include up to three months of coverage (if requested) prior to the month of application, provided eligibility requirements are met.

Ongoing coverage in AC 108 or AC 109 is effective the first day of the month of application or the date when incarceration begins, whichever is later.

2. Re-entry Process

A medical assistance application for an offender with no active Medicaid coverage and an anticipated release date within 45 days is handled as part of a "Re-Entry" process *and will follow the same procedure as a New Application (ref M0140.200.C.1). If the offender is approved the case will have a redetermination conducted for ongoing Medicaid coverage*. This is a new application and an eligibility determination for Medicaid coverage will be made based on the information as reported or known at the time of release from the facility.

If the person is approved but is unable to or does not provide a post-release address where he will reside (e.g. reports as homeless or moving to a temporary shelter) the case will be transferred to the LDSS of his pre-incarceration, if known. If there is no known address, or the individual lived outside of Virginia prior to incarceration and intends to remain in the state, transfer the case to the LDSS where the correctional facility is physically located.

If the application is approved the worker will confirm that a new Commonwealth of Virginia Medicaid Card has been generated and a copy of the Notice of Action sent to the anticipated post-release address.

3. Emergency Services

A non-citizen who meets all Medicaid eligibility requirements except for immigration status, and has received an inpatient hospitalization, may qualify for coverage of emergency medical care. This care must have been provided in a hospital emergency room or as an inpatient in a hospital. Determine eligibility for emergency services using policy in *M0220.400* and enroll eligible individuals using the procedures in *M0220.600 D*.

For cases processed at the Cover Virginia Incarcerated Unit (CVIU) the individual will be enrolled in the appropriate AC 112 or AC 113 and the case will be retained at the CVIU for ongoing case maintenance.

Emergency Services coverage in AC 112 or AC 113 is effective the first day of the month of application, the first day of the retroactive period, or the date when incarceration begins, whichever is earliest

The worker will confirm a new Commonwealth of Virginia Medicaid Card has been generated and copy of the Notice of Action sent to the post-release address.

If eligibility for ongoing Medicaid is denied, cancel existing Medicaid coverage the day prior to actual date of release.

An offender with active Medicaid coverage (AC108/109) and released to the community before a Pre-Release Review can be conducted by the CVIU will transfer the offender's case to the locality for review. The CVIU will send a CPU to LDSS Communication Form to alert the locality for the need to review the member for ongoing Medicaid coverage and any other requested benefits.

1. Release to a Community Living Arrangement

An offender entering a household with existing benefits after incarceration may affect Medicaid eligibility for those in the household.

The CVIU will process Pre-Release Reviews if approved, the case will be assigned to the locality where the ex-offender plans to reside.

If the person is approved but cannot or will not provide an address where he will reside (e.g. reports as homeless or moving to a temporary shelter), the case will be transferred to the LDSS of his pre-incarceration, if known. If there is no known address or the individual lived outside of Virginia prior to incarceration and intends to remain in the state, transfer the case to the LDSS where the correctional facility is physically located.

2. Release to an Institutional Placement, LTSS, or HCBS

When an offender is being released and needs to be placed in an institution or receive home and community-based services (HCBS), the CVIU will collaborate with LDSS in the locality where the individual will be residing for processing the application to ensure the eligible individual can receive necessary medical support/services when released.

A. Split Cases

For case maintenance, an offender with active Medicaid coverage in aid category 108 or 109 should be placed in his own case in VaCMS and assigned to the CVIU. If the incarcerated individual is the case name and other household members with active coverage are on the case, the local agency will be responsible for removing any other member(s), setting up a new case, and transferring the offender's case to the CVIU.

M0220 Changes
Page 1 of 3

Changed With	Effective Date	Pages Changed
TN #DMAS-25	10/1/22	Table of Contents, Page 14d. Page 22 Appendix 4 added page 2.
TN #DMAS-24	7/1/22	Table of Contents Pages 1, 4a, 4b, 5, 6a, 8, 14d, 14e, 15, 17, 18, 21, 22, 23 Page 6b was added as a runover page. Appendix 9 was added. Pages 22a and 24-25 were removed.

TABLE OF CONTENTS

M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS

Appendices

- Afghan or Iraqi Special Immigrant (as defined in M0220.310 above *and in M0220, Appendix 4)*,

- *Ukraine Humanitarian Parolees (see Appendix 4)*

who entered the U.S. on or after 8-22-96 and who meets all other Medicaid eligibility requirements is eligible for the full package of Medicaid covered services available to the alien's covered group during the first 7 years of residence in the U.S. After 7 years of residence in the U.S., the refugee, Amerasian, asylee, deportee, Cuban or Haitian entrant, victim of a severe form of trafficking, or Afghan or Iraqi Special Immigrant who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and is eligible for emergency services only.

2. LPR

Effective 4-1-21, after five years of residence in the U.S., an LPR who entered the U.S. on or after 8-22-96 is eligible for the **full package of Medicaid benefits** available to the covered group he/she meets if he/she meets all other Medicaid eligibility requirements.

For eligibility determinations for months prior to April 2021, LPRs who DO NOT have at least 40 qualifying quarters of work remain emergency services aliens after 5 years have passed from the date of entry into the U.S.

***C.* Entitlement & Enrollment *for those* Eligible**

The Medicaid entitlement policy and enrollment procedures for full benefit qualified aliens who entered the U.S. on or after 8-22-96 are found in section M0220.600 below.

The Medicaid entitlement policy and enrollment procedures for emergency services qualified aliens who entered the U.S. on or after 8-22-96 are found in section M0220.700 below.

3. Entry Date THIS FIELD MUST BE ENTERED. Enter the date on which the alien entered the U.S., except for asylees and deportees. For asylees, enter the date asylum was granted. For deportees, enter the date deportation withholding was granted.

4. Appl Dt In this field, Application Date, enter the date of the alien's Medicaid application upon which the eligibility coverage period is based.

5. Coverage Begin Date In this field, Coverage Begin Date, enter the date the alien's Medicaid entitlement begins.

6. Coverage End Date Enter data in this field only if eligibility is a closed period of eligibility in the past. Enter the date the alien's Medicaid entitlement ended.

7. AC Enter the AC code applicable to the alien's covered group.

D. Emergency Services Only Aliens

Unqualified aliens, and qualified aliens eligible for emergency services only are eligible for Medicaid coverage of emergency medical care only. This care must be provided in a hospital emergency room or as an inpatient in a hospital.

Effective July 1, 2022, an emergency services only alien who meets all other Medicaid eligibility requirements is enrolled in Medicaid with ongoing coverage. Emergency services are no longer certified by the LDSS or DMAS, and the LDSS does not obtain an emergency services certification.

Applications received prior to July 1, 2022, are subject to the policies and procedures in M0220, Appendix 9. For an individual whose certification period begins prior to July 1, 2022 and expires on or after July 1, 2022, re-evaluate the individual's eligibility for ongoing coverage.

An emergency services alien will be assigned to one of the following Aid Categories (AC) by VaCMS:

- AC 112 for adults in Modified Adjusted Gross Income (MAGI) based covered groups
- AC 113 for children and adults in non-MAGI Families and Children's (F&C) and all Medically Needy (MN) covered groups.

For cases processed at Cover Virginia, the individual will be enrolled in the appropriate AC, and the case will be transferred to the local agency for ongoing case maintenance. *For CVIU incarcerated individuals refer to Policy M0140.200.3 C.*

Once an emergency services alien is found eligible in VaCMS, the enrollment will transfer into the Medicaid enrollment system. Any claims for emergency services will be sent by the provider or treating physician to DMAS for review and reimbursement. Medicaid coverage for emergency services only aliens will be restricted to emergency services (including dialysis).

Appropriate notice must be sent to the applicant of the status of his application and the duration of his eligibility. The notice must specify that their Medicaid coverage is limited to emergency services.

Afghan Special Immigrants

The majority of Afghan special immigrants entering into the U.S. fall into one of three groups:

1. Holders of a Special Immigrant Visa,

2. Special Immigrant Parolees (SIP), who are individuals granted Special Immigrant (SI/SQ) Parole (per section 602(B)(1) AAPA/Section 1059(a) NDAA 2006), and

3. Non Special Immigrant Parolees entering the United States without SI/SQ parole due to the urgent nature of their arrival (Humanitarian status).

The United States Congress passed a Continuing Resolution on October 1, 2021, allowing individuals with a humanitarian parole status to receive full Medicaid (within certain parameters). Section 2502 of the Continuing Resolution provides that certain Afghan nationals who receive parole "shall be eligible for resettlement assistance, entitlement programs, and other benefits available to refugees" to include Medicaid, until March 1, 2023 (or until their parole expires). Eligible parolees are those who either:

- Were paroled into the United States between July 31, 2021, and September 30, 2022

- Are a qualifying relative of someone who received parole in that period (CR section 2502(a)(1)(B)), even if they receive parole after Sept 30, 2022.

Individuals with (1) SIV status, (2) SIP status, and (3) Humanitarian Parolee Status issued between July 31, 2021, and September 30, 2021, are qualified for evaluation in Medicaid and FAMIS without a five-year residency bar (provided that all other eligibility requirements are met).

Exception: Humanitarian Parolees who arrived **before July 31, 2021**, are eligible only for Medicaid coverage of emergency medical services and Health Insurance Marketplace coverage. Many of these individuals have already been enrolled in subsidized Marketplace coverage or have been granted asylum and are therefore eligible for Medicaid or FAMIS without the 5-year bar.

Children under 19 years and pregnant women with SIV, SIP, or Humanitarian status meet the definition of lawfully residing aliens for Medicaid and FAMIS/FAMIS MOMS coverage.

Afghan Special Immigrant visa holders will have either (1) a passport or I-94 form indicating category SI1, SI2, SI3, SQ1, SQ2, or SQ3 and bearing the Department of Homeland Security stamp or notation or an I-151 ("green card") indicating SI6, SI7, SI8, SQ6, SQ7, or SQ8.

Special Immigrant Parolees will have an I-94 form noting SQ or SI Parole (per section 602(B)(1) AAPA/Sec 1059(a) NDAA 2006).

If an individual has attested to eligible immigration status and is found otherwise eligible for Medicaid, but verification of that status cannot be obtained, do not deny or delay coverage. Enroll the individual and give a 90-day reasonable opportunity period.

Ukraine Humanitarian Parolees

The U.S. Department of Homeland Security (DHS) is providing support and humanitarian relief to Ukrainians who have been displaced by Russia's February 24, 2022 invasion and fled Ukraine. The United States Congress passed the Additional Ukraine Supplemental Appropriations Act (AUSAA) and was signed on May 21, 2022 by President Biden. This measure confers eligibility for all Ukrainian Humanitarian Parolees for mainstream federal benefits as well as resettlement services funded by the Office Refugee Resettlement (ORR).

Certain Ukraine nationals entering the U.S. may be eligible for health coverage through Medicaid, the Children's Health Insurance Program (CHIP), the Health Insurance Marketplace, or Refugee Medical Assistance (RMA). These individuals may be granted a range of lawful non-citizen statuses, including parole, temporary protected status (TPS), immigrant and nonimmigrant visas, and refugee or asylees. The primary non-citizen immigrant statuses include:

1. Parolees: Ukrainian nationals who enter the United States as parolees on or **between February 24, 2022 and September 30, 2023** are eligible for Medicaid or CHIP to the same extent as refugees, without a five-year waiting period, if they meet other eligibility requirements. These Ukrainian parolees are considered "qualified non-citizens" for purposes of Medicaid and CHIP eligibility since they are eligible for the same benefits as refugees.

   Ukrainian nationals who are paroled into the U.S. **after September 30, 2023** and are the spouse or child of a parolee described above, or who is the parent, legal guardian, or primary caregiver of a parolee described above who is determined to be an unaccompanied child will also be eligible for Medicaid and CHIP to the same extent as refugees.

2. Temporary Protected Status (TPS): Ukrainian nationals (and individuals having no nationality who last habitually resided in Ukraine) are eligible to apply for TPS. This includes Ukrainians granted TPS or have pending applications for TPS and who have been granted employment authorization. The TPS designation is effective **April 19, 2022 and will remain in effect through October 19, 2023**.

3. Refugees: Some Ukrainian nationals may be granted refugee status and resettled into the U.S. are eligible for full Medicaid or CHIP benefits, without application of the five-year waiting period, if they otherwise meet all other Medicaid eligibility requirements.

4. Lawfully Residing individual: Children under age 19 and pregnant women who are in one of the lawfully residing non-citizen alien groups (see M0220.314) and meet the definition of a lawfully residing alien for Medicaid and FAMIS/FAMIS MOMS coverage may be eligible for assistance.

5. Emergency Services: Ukrainian non-citizens who do not qualify for full Medicaid benefits based on their immigration status may be eligible for "emergency services Medicaid" if they meet all other eligibility requirements. An individual eligible only for emergency Medicaid is permitted to enroll in Marketplace coverage if they meet all Marketplace eligibility requirements.

Ukrainian parolees will generally have foreign passports with a DHS stamp admitting them with a PAR, DT, or UHP Class of Admission (COA). DHS will be using the existing COA code DT and PAR for some Ukrainians who were paroled into the U.S. Additional COA code(s) will be programmed into Hub logic in early fall of 2022.

If an individual has attested to eligible immigration status and is found otherwise eligible for Medicaid, but verification of that status cannot be obtained, do not deny or delay coverage. Enroll the individual and give a 90-day reasonable opportunity period.

Code	MEDICAID ALIEN CODE CHART QUALIFIED ALIEN GROUPS	Arrived Before August 22, 1996	Arrived On or After August 22, 1996	
			1st 5 years	After 5 years
A	Qualified aliens who are Veterans or Active Military (includes spouses/dependent children); certain American Indians [Form DD 214-veteran]	Full Benefit A1	Full Benefit A2	Full Benefit A3
B	Permanent Resident Aliens (Aliens lawfully admitted for permanent residence) who have worked 40 qtrs., except Amerasians [I-151; AR-3a; I-551; I-327; I-688B-274a.12(a)(1)]	Full Benefit B1	Emergency Only B2	Full Benefit B3
C	Permanent Resident Aliens (Aliens lawfully admitted for permanent residence) who have NOT worked 40 qtrs., except Amerasians and citizens of Micronesia, Marshall Islands, Palau [I-327; I-151; AR-3a; I-551; I688B-274 a.12(a)(1)]	Full Benefit C1	Emergency Only C2	Full Benefit effective 4-1-21 C1; Emergency Only for months prior to 4-21 C2
CC	Compact of Free Association (COFA) migrants who are citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau.	Full Benefit CC1	Full Benefits effective 12-27-20. CC1; Emergency Only for months prior to 12-20. CC2	Full Benefit effective 12-27-20. CC1; Emergency Only prior to 12-20. CC2
D	Conditional entrants-aliens admitted pursuant to 8 U.S.C. 1153(a)(7), section 203(a)(7) of the INA [I-94]	Full Benefit D1	Emergency Only D2	Full Benefit D3
E	Aliens, other than Cuban or Haitian Entrants, paroled in the US pursuant to 8 U.S.C. 1182(d)(5) section 212(d)(5) of INA [I-94; I-688B – 274a(12)(c)(11)] Afghan Special Immigrant Parolees paroled into the United States between July 31, 2021, and September 30, 2022 will have an I-94 form noting SQ or SI Parole (per section 602(B)(1) AAPA/Sec 1059(a) NDAA 2006). They are eligible for full coverage without a 5-year waiting period. See Appendix 4. *Ukraine Humanitarian Parolees. See Appendix 4.*	Full Benefit E1	Emergency Only E2	Full Benefit E3
I	Battered aliens, alien parents of battered children, alien children of battered parents [U.S. Attorney General]	Full Benefit I1	Emergency Only I2	Full Benefit I3
	QUALIFIED ALIEN GROUPS		1st 7 years	After 7 years
F	Aliens granted asylum pursuant to section 208 of the INA [I-94; I-688B – 274a.12(a)(5)]	Full Benefit F1	Full Benefit F2	Emergency Only F3
G	Aliens admitted as refugees pursuant to section 207 of the INA, or as Cuban or Haitian Entrants as defined in section 501(e) of Refugee Education Assistance Act of 1980 {including those under section 212(d)(5)}, or Amerasians [I-551; I-94; I-688B]	Full Benefit G1	Full Benefit G2	Emergency Only G3
H	Aliens whose deportation has been withheld pursuant to Section 243(h) or 241(b)(3) of the INA [I-688B – 274a.12(a)(10); Immigration Judge's Order]	Full Benefit H1	Full Benefit H2	Emergency Only H3

	UNQUALIFIED ALIEN GROUPS	Arrived Before 8-22-96	Arrived On or After 8-22-96	
J	Victims of a Severe Form of Trafficking pursuant to the Trafficking Victims Protection Act of 2000, P.L. 106-386 [ORR Certification/eligibility Letter]	N/A J1	Full Benefit J2	Emergency Only J3
K	Aliens residing in the US pursuant to an indefinite stay of deportation [I-94; Immigration Letter]	Emergency Only K1	Emergency Only K2	Emergency Only K3
L	Aliens residing in the US pursuant to an indefinite voluntary departure [I-94; Immigration Letter]	Emergency Only L1	Emergency Only L2	Emergency Only L3
M	Aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition who are entitled to voluntary departure under 8 CFR 242.5(a)(2)(vi) and whose departure the INS does not contemplate enforcing [I-94; I-210]	Emergency Only M1	Emergency Only M2	Emergency Only M3
N	Aliens who have filed an application for adjustment of status pursuant to §245 INA that the INS has accepted as properly filed and whose departure the INS does not contemplate enforcing [I-181; Endorsed Passport]	Emergency Only N1	Emergency Only N2	Emergency Only N3
O	Aliens granted stay of deportation by court order, statute or regulation, or by individual determination of the INS whose departure the agency does not contemplate enforcing [I-94; Court Order; INS Letter]	Emergency Only O1	Emergency Only O2	Emergency Only O3
P	Aliens granted voluntary departure pursuant to section 242(b) of the INA whose departure the INS does not contemplate enforcing [I-94; I-210; I-688B – 247a.12(a)(11) or (13)]	Emergency Only P1	Emergency Only P2	Emergency Only P3
Q	Aliens granted deferred action status pursuant to INS Operations Instruction 103.1(a)(ii) prior to 6/15/84 or 242.1a22 issued 6/15/84 and later [I-210; INS Letter]	Emergency Only Q1	Emergency Only Q2	Emergency Only Q3
R	Aliens residing in the U.S. under orders of supervision [I-220B]	Emergency Only R1	Emergency Only R2	Emergency Only R3
S	Aliens who entered before January 1972 and have continuously resided in the U.S. since January 1972 [Case Record]	Emergency Only S1	Emergency Only S2	Emergency Only S3

	UNQUALIFIED ALIEN GROUPS **(cont.)**	**Arrived Before 8-22-96**	**Arrived On or After 8-22-96**	
T	Aliens granted suspension of deportation pursuant to Section 244 of the INA and whose deportation the USCIS does not contemplate enforcing [Immigration Judge Court Order]	Emergency Only T1	Emergency Only T2	Emergency Only T3
U	Any other aliens living in the US with the knowledge and permission of the USCIS whose departure the agency does not contemplate enforcing [USCIS Contact]	Emergency Only U1	Emergency Only U2	Emergency Only U3
V	Aliens not lawfully admitted or whose lawful admission status has expired* *For a pregnant woman who is not lawfully residing in the U.S., go to Chapter M23.	Emergency Only V1	Emergency Only V2	Emergency Only V3
W	Visitors (non-immigrants): tourists, diplomas, foreign students, temp. workers, etc. [I-688B – 274a.12(b)(1)-(20); I-94; I-185: I-I186; SW-434; I-95A]	Emergency Only W1	Emergency Only W2	Emergency Only W3

	LAWFULLY RESIDING NON-CITIZENS	**Effective 1/1/10**	**Effective 7/1/12**
Y	Non-citizen (alien) children under the age of 19 and pregnant women lawfully residing in the U.S. who meet the requirements in M0220.314.	Full Benefits for Medicaid children under age 19 (FAMIS Plus)	Full Benefits for Medicaid (FAMIS Plus), Medicaid pregnant women, FAMIS and FAMIS MOMS

	AFGHAN AND IRAQI SPECIAL IMMIGRANTS	**First 7 Years after Entry into U.S.**	**After 7 Years**
Z	Afghan and Iraqi Special Immigrants admitted on a Special Immigrant Visa (SIV), including the spouse and children under age 21 living in the home with the principal visa holder. [I-551 or passport/ I-94 indicating categories SI1, SI2, SI3, SQ1, SQ2, or SQ3 and bearing Department of Homeland Security stamp or notation] *For Afghan special immigrants admitted prior to being granted a Special Immigrant Visa, see M0220, Appendix 4.*	Full Benefits Z1	Emergency Only Z2

Alien Status Reference Guide

		Immigration Status	Eligible for Full Medicaid Benefits?	MMIS Code
Qualified Non-Citizen				
Arrived in U.S. before 8/22/1996	Exempt from 5 year waiting period and no time limit on eligibility	Lawful Permanent Resident	Yes	P
		Refugee under section 207	Yes	R
		Amerasian Immigrant	Yes	P
		Conditional Entrant Under Section 303(a)(7)	Yes	P
		Asylee Under Section 208	Yes	P
		Parolee under section 212(d)(5)	Yes	P
		Deportee whose deportation is withheld under section 243(h) or 241(b)(3)	Yes	P
		Cuban or Haitian Entrant	Yes	P
		Battered alien, alien parent of a battered child, and/or alien child of a battered parent	Yes	P
		Alien who arrived prior to 8/22/96 with unqualified status and who remained physically present in U.S. from date of entry to date of adjustment to a status listed above	Yes	See above
Arrived in U.S. on or after 8/22/1996	Has resided in the U.S. for 7 years or less; exempt from 5 year waiting period	Refugee	Yes	R
		Asylee	Yes	P
		Deportee	Yes	P
		Cuban or Haitian Entrant	Yes	P
		Victim of a severe form of trafficking	Yes	P
		Afghan or Iraqi immigrant admitted on a Special Immigrant Visa	Yes	P
Arrived in U.S. on or after 8/22/1996	Has resided in the U.S. for more than 7 years	Refugee	No—Eligible for Emergency Services Coverage Only	A
		Asylee		A
		Deportee		A
		Cuban or Haitian Entrant		A
		Victim of a severe form of trafficking		A
		Afghan or Iraqi immigrant admitted on a Special Immigrant Visa		A
Arrived in U.S. on or after 8/22/1996	Has resided in the U.S. for at least 5 years	*Effective 4-1-21*, Lawful Permanent Resident	Yes	P
		Conditional Entrants *Parolees, other than Cuban or Haitian Entrants* *Battered aliens, alien parents of battered children, alien children of battered parents*	*Yes*	*P*

		Immigration Status	Eligible for Full Medicaid Benefits?	MMIS Code
Lawfully Residing Non-Citizen Children Under Age 19 Years and Pregnant Women				
No limitation on date of arrival to the U.S.	No time limitation on eligibility as long as covered group requirements are met	A qualified alien as defined in section 431 of PRWORA (8 U.S.C § 1641) (see M0220.310)	Yes	<19 I Pregnant P
		An alien in a nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission, including individuals with valid visas.	Yes	<19 I Pregnant P
		An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and nationality Act (INA) (8 U.S.C § 1182 (d)(5)) for less than I year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings	Yes	<19 I Pregnant P
		An alien who belongs to one of the following classes:	Yes	<19 I Pregnant P
		• aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C.§§ 1160 or 1255a, respectively)	Yes	<19 I Pregnant P
		• aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. § 1254a), and pending applicants for TPS who have been granted employment authorization	Yes	<19 I Pregnant P
		• aliens who have been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24)	Yes	<19 I Pregnant P
		• Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649, as amended	Yes	<19 I Pregnant P
		• aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President	Yes	<19 I Pregnant P
		• aliens currently in deferred action status, except for individuals receiving deferred status as a result of the Deferred Action for Childhood Arrivals (DACA) process, announced by the U.S. Department of Homeland Security on June 15, 2012	Yes	<19 I Pregnant P
		• aliens whose visa petition has been approved and who have a pending application for adjustment of status	Yes	<19 I Pregnant P
		A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. § 1158), or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231), or under the Convention Against Torture who has been granted employment authorization, or such an applicant under the age of 19 who has had an application pending for at least 180 days	Yes	<19 I Pregnant P
		An alien who has been granted withholding of removal under the Convention Against Torture	Yes	<19 I Pregnant P
		A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J)	Yes	<19 I Pregnant P
		An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806 (e)	Yes	<19 I Pregnant P
		An alien who is lawfully present in American Samoa under the immigration laws of American Samoa	Yes	<19 I Pregnant P

		Immigration Status	Eligible for Full Medicaid Benefits?	MMIS Code
Non-Citizen				
No limitation on date of arrival to the U.S.	No time limitation on eligibility as long as covered group requirements are met	a. A qualified alien and veteran who was discharged honorably not on account of alienage, and who fulfills the minimum active-duty service requirements of section 5303A(d) of title 38, United States Code	Yes	P
		b. A qualified alien on active duty (other than active duty for training) in the Armed Forces of the United States (not in the Armed Forces Reserves)	Yes	R
		The spouse or the unmarried dependent child (see M0220.311 A) of a living (not deceased) qualified alien who meets the conditions in a. or b. above	Yes	P
		The unremarried surviving spouse of an individual described in a. or b. above who is deceased, if the spouse was married to the veteran • before the expiration of fifteen years after the termination of the period of service in which the injury or disease causing the death of the veteran was incurred or aggravated; or • for one year or more; or • for any period of time if a child was born of the marriage or was born to them before the marriage.	Yes	P
		Recipients of Supplemental Security Income (SSI)	Yes	P
		An alien who is • an American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (INA) apply, or • a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)),	Yes	P
		Compact of Free Association (COFA) migrants who are citizens of the Federated States of Micronesia, the Republic of the Marshall Islands, or the Republic of Palau.	Yes Effective 12/27/20	P
Arrived in U.S. on or after 8/22/1996	Regardless of length of residency in U.S.	Individuals other than pregnant women with no immigration documents (undocumented) For a pregnant woman who is not lawfully residing in the U.S., go to Chapter M23.	No—Eligible for Emergency Services Coverage Only	A
		Deferred Action Childhood Arrivals (DACA)	No—Eligible for Emergency Services Coverage Only	A
		Individuals whose immigration status has expired and who do not meet any other immigration status	No—Eligible for Emergency Services Coverage Only	A
		Lawful Permanent Resident who has resided in the U.S. for fewer than 5 years, and/or prior to 4-1-21, without at least 40 qualify quarters of work coverage on record with the Social Security Administration. Effective 4-1-21, there is no longer a work requirement. The 5 year residency requirement remains in effect.	No—Eligible for Emergency Services Coverage Only	A

Changed With	Effective Date	Pages Changed
TN #DMAS-25	10/1/22	Pages 5, 15, 16
TN #DMAS-24	7/1/22	Appendix 3 Appendix 5
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.

1. **Dependent Child** means a child under age 18, or age 18 and a full-time student in a secondary school is expected is to graduate prior to his 19th birthday, and who lives with his parent or caretaker-relative.

2. **Family** means the tax filer (including married tax filers filing jointly) and all claimed tax dependents.

3. **Family Size** means the number of persons counted as an individual's household. The family size of a pregnant woman's household includes the pregnant woman plus the number of children she is expected to deliver. When determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted as just one person.

4. **Household** A household is determined by tax dependency. Parents, children and siblings are included in the same household. A child claimed by non-custodial parent is evaluated for eligibility in the household in which he is living and is also counted in the family size of the parent claiming him as a dependent. There can be multiple households living in the home.

   This definition is different from the use of the word household in other programs such as the Supplemental Nutrition Assistance Program (SNAP).

5. **MAGI Adult** is an individual between the ages of 19-64 who is not eligible for or enrolled in Medicare and who has income at or below 138% of FPL.

6. **Non-filer Household** means individuals who do not expect to file a Federal tax return and/or do not expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made. A non-filer household can also be a child who lives in the household with his custodial parent who is claimed on his non-custodial parent's taxes.

7. **Parent** for the purposes of MAGI methodology, means a natural, biological, adoptive, or stepparent. When both the child's parent and stepparent are living in the home with the dependent child, both may be eligible in the LIFC covered group.

8. **Reasonable Compatibility** means the income attested to (declared) by the applicant is within 20% of income information obtained from electronic sources OR that both the attested income and any electronic income verification are below the applicable income limit. If the income from both sources meets the 20% requirement or the income from both sources is below the limit, then the attestation is considered verified.

   The applicant's income reported on the application is compared through a match with income verification available from electronic income sources. The eligibility/enrollment system will compare the reported income with the income from the data match and determine if reasonable compatibility exists. If reasonable compatibility exists, the income will be labeled verified, and no further verification of the income is necessary.

   If reasonable compatibility does not exist or income data was not available through available electronic sources and the attestation is below the medical assistance income level, additional verification of income is required.

The reported income of a child must be verified regardless of whether or not the attested income is above or below the tax-filing threshold amount.

If an income calculation must be made, use the information in subchapter M0710 for estimating income, subchapter M0720 for sources of earned income, and subchapter M0730 for sources of unearned income with the exceptions in B. below. The sources of income listed in this section are organized in table form in M04, Appendix 7.

A. MAGI Income Rules

1. Income That is Counted

a. Gross earned income is counted. There are no earned income disregards.

b. Earnings and unearned income, including Social Security benefits, of everyone in the household are counted, except the income of

- a tax dependent *of any age* who is claimed by his parent(s), or
- a child under 19 in a non-filer household who is living with a parent or parents

who is not required to file taxes because the tax filing threshold is not met.

For children and tax dependents, Social Security income only counts toward the total household income if the individual is required to file a federal tax return. *Any Social Security benefits the child or dependent may receive do not count as unearned income in determining whether the tax filing threshold is met.*

c. Income of a child under 19 in a non-filer household who is NOT living with a parent or parents and who is not required to file taxes because the tax filing threshold is not met.

When determining the total household income of a child who is NOT living with a parent (for example, living with a grandparent) *or an individual being claimed by a non-parent*, the *dependent*'s income is always counted in determining *their own* eligibility, even if the income is below the tax filing threshold.

Effective, January 1, 202*2*, the Tax Filing Threshold for MAGI income counting purposes is $1,100 in unearned income and $12,*5*50 in earned income. *Social Security benefits do not count as unearned income in determining whether the tax filing threshold is met.*

d. Interest, including tax-exempt interest, is counted.

e. Foreign income is counted.

f. Stepparent income is counted.

g. Effective January 1, 2019, alimony received is not countable.

Alimony received prior to January 1, 2019, is countable. An individual whose divorce decree was finalized prior to January 1, 2019, has the option with the IRS to adopt the new IRS alimony rule by modifying the divorce agreement. If an individual whose divorce decree was finalized prior to January 1, 2019, does not want alimony received on or after January 1, 2019 to be countable for the MAGI income determination, the individual must provide a copy of the modified divorce agreement to the eligibility worker.

h. An amount received as a lump sum is counted only in the month received

i. Military pay based upon age or years of service (other types of military pay are also counted and excluded; see M0720.290)

j. Census income.

k. Unemployment Compensation is counted as unearned income.

Exception: Additional benefits of $600 per week paid under the under the Federal Pandemic Unemployment Compensation program are not counted. See M0440.100 B.2.n.

2. Income That is Not Counted

a. Child support received is not counted as income (it is not taxable income).

b. Workers Compensation is not counted.

c. When a child *or other dependent* is included in a parent or stepparent's household, the *individual's* income is not countable as household income unless *they are* required to file taxes because the tax-filing threshold is met. Any Social Security benefits the individual may have do not count in determining whether the tax filing threshold is met.

d. Veterans benefits which are **not** taxable in IRS Publication 525 are not counted:

- Education, training, and subsistence allowances,
- Disability compensation and pension payments for disabilities paid either to veterans or their families,
- Veterans' insurance proceeds and dividends paid either to veterans or their beneficiaries, including the proceeds of a veteran's endowment policy paid before death,
- Grants for homes designed for wheelchair living and motor vehicles for veterans who lost their sight or the use of their limbs,
- Interest on insurance dividends left on deposit with the VA,
- Benefits under a dependent-care assistance program,
- The death gratuity paid to a survivor of a member of the Armed Forces who died after September 10, 2001, or
- Payments made under the VA's compensated work therapy program.

e. For divorce agreements finalized on or after January 1, 2019, no deduction is allowed for alimony paid. For divorce agreements finalized prior to January 1, 2019, alimony **paid** to a separated or former spouse outside the home is deducted from countable income.

M0710 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-25	10/1/22	Page 2
TN #DMAS-24	7/1/22	Appendix 2 Appendix 3
TN #DMAS-20	7/1/21	Appendix 2 Appendix 3
TN #DMAS-17	7/1/20	Appendix 2 Appendix 3
TN #DMAS-14	10/1/19	Pages 1, 2, 7, 8 Page 2a was added as a runover page.
TN #DMAS-13	7/1/19	Appendix 2 Appendix 3
TN #DMAS-9	7/1/18	Appendix 2 Appendix 3
TN #DMAS-5	7/1/17	Appendix 1 Appendix 2 Appendix 3
TN #DMAS-2	10/1/16	Appendix 2 Appendix 3
UP #11	7/1/15	Appendix 5
TN #100	5/1/15	Table of Contents Pages 1-8 Pages 9-13 were deleted. Appendix 1 Appendix 2 Appendix 3 Appendices 4-7 were removed.
TN #98	10/1/13	pages 1-4, 8, 9 Page 1a was added. Appendix 1 Appendix 3 Appendix 5
UP #9	4/1/13	Appendix 6, pages 1, 2 Appendix 7
UP #7	7/1/12	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1
UP #6	4/1/12	Appendix 6, pages 1, 2 Appendix 7
TN #96	10/01/11	Appendix 6, page 1
UP #5	7/1/11	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1
TN #95	3/1/11	Appendix 6, pages 1, 2 Appendix 7
Update (UP) #1	7/1/09	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1

C. Individual Income Eligibility

An individual's income eligibility is based on the total countable income available to his/her FU/BU.

Each source of income received by a member of the FU/BU is evaluated and the countable amount determined based on the policy in this chapter. The countable amount of each FU/BU member's income is added to the countable amount of the income of all other FU/BU members. That total is used to determine the income eligibility of each individual within that FU/BU. The FU/BU's total countable income is compared to the income limit that is applicable to the individual's classification and to the number of members in the FU/BU.

D. Policy Principles

1. Income

Everything an individual owns and all monies received are assets. Monies received are income in the month received when the monies are cash or its equivalent.

Income may be either earned or unearned. See M0720 for earned income and M0730 for unearned income.

2. Verification

The agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information, and information from SSA through SVES or SOLQ-I. Verification of income from available sources, including the VEC, may be used if it is dated within the previous 12 months. See M0130.001.B.3.

For all case actions effective *August 26, 2022*, if the income attested to by the applicant is within 20% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required. If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return.

All income other than Workforce Investment Act and the earned income of a student under age 19 must be verified. When attempts to verify income are unsuccessful because the person or organization who is to provide the information cannot be located or refuses to provide the information to both the applicant/recipient and the eligibility worker, a third party statement, a collateral contact, or as a last resort, the applicant's/recipient's written statement can be used as verification and to determine the amount of income to be counted.

Failure of the applicant/enrollee to verify his income results in the agency's inability to determine Medicaid eligibility and the applicant/enrollee's Medicaid coverage must be denied or canceled.

M1140 Changes

Updated With	Effective Date	Pages Changed
TN #DMAS-25	10/1/2022	Page 33
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

M1140.500 WORKERS' COMPENSATION MEDICARE SET-ASIDE ARRANGEMENT ACCOUNTS

A. Introduction

A Workers' Compensation Medicare Set-aside Arrangement (WCMSA) is an arrangement which allocates a portion of a Workers' Compensation settlement for future medical expenses. The initial amounts of any set asides are determined on a case-by-case basis and are reviewed by the Centers for Medicare and Medicaid Services (CMS). Most WCMSAs will be placed in interest bearing accounts and are self-administered by applicants/enrollees, or by a competent administrator.

Funds authorized by a WCMSA are unearned income in the month of receipt, and any amount retained following the month of receipt is a countable resource. Section S0830.235 contains information on Workers' Compensation payments.

B. Operating Policy

1. Ownership

Assume that the person designated as owner in the account title owns all the funds in the account.

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 Use for Support and Maintenance

Although funds are intended for specific medical expenses, there are no legal restrictions as to how an individual uses the funds. Assume that an individual who owns and has the legal right to withdraw funds from a WCMSA also has the legal right to use them for his own support and maintenance.

C. Development and Documentation

The development and documentation instructions for checking and savings accounts contained in section S1140.200 apply to WCMSA accounts.

M1410 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-25	10/1/22	Page 2a
TN #DMAS-24	7/1/22	Pages 2, 9, 13
TN #DMAS-21	10/1/21	Page 9
TN #DMAS-18	1/1/21	Page 1
TN #DMAS-17	7/1/20	Table of Contents Pages 1, 4, 8, 11-13 Pages 4a and 7 were removed. Pages 8-14 were renumbered 7-13.
TN #DMAS-14	10/1/19	Pages 10, 12-14
TN #DMAS-12	4/1/19	Page 4, 10-11 Page 4a was added as a runover page.
TN #DMAS-11	1/1/19	Pages 6, 7
TN #DMAS-10	10/1/18	Pages 8-14
TN #DMAS-9	7/1/18	Page 1
TN #DMAS-8	4/1/18	Page 9
TN #DMAS-7	1/1/18	Page 7
TN #DMAS-5	7/1/17	Pages 4-7
TN #DMAS-3	1/1/17	Pages 6, 7, 12-14
TN #DMAS-1	6/1/16	Pages 12-14
TN #100	5/1/15	Page 2
TN #99	1/1/14	Page 10
Update #7	7/1/12	Pages 6, 7
TN #96	10/1/11	Page 11, 12
TN #95	3/1/11	Pages 13, 14 Page 15 was removed.
TN #94	9/1/10	Pages 6, 7, 13
TN #93	1/1/10	Pages 1, 7, 9, 12
TN #91	5/15/09	Pages 11-14

6. Medical Institution (Facility)

A **medical institution** is an institution (facility) that:

- is organized to provide medical care, including nursing and convalescent care,
- has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,
- is authorized under state law to provide medical care, and
- is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

An acute care hospital is a medical institution.

7. Patient

An individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or lessening of illness, disability, or pain, is a **patient.**

8. Inpatient

An **inpatient** is a patient who has been admitted to a medical institution on the recommendation of a physician or dentist **and** who:

- receives room, board, and professional services in the institution for a 24-hour period or longer, **or**
- is expected by the institution to receive room, board, and professional services in the institution for a 24-hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility, and does not actually stay in the institution for 24 hours.

9. Assisted Living Facility (ALF) / Memory Care Unit

An assisted living facility (ALF) or memory care unit are not long-term care facilities or a Medicaid medical institution. An ALF or memory care unit may be located within the same setting or campus such as a continuing care or a long-term care facility, however the level of care differs from that of a Medicaid medical institution.

10. Independent living facility

A senior living center/senior apartment/retirement community are independent living arrangements or residences and are not medical institutions.

M1420 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-25	10/1/22	Table of Contents Pages 1-5
TN #DMAS-24	7/1/22	Table of Contents Pages 1-5 Appendix 1 Page 6 was removed. Appendix 1 was removed and Appendix 2 was renumbered to Appendix 1.
TN #DMAS-19	4/1/21	Page 2
TN #DMAS-17	7/1/20	Pages 1-6
TN #DMAS-12	4/1/19	Page 2
TN #DMAS-11	1/1/19	Entire subchapter
TN #DMAS-7	1/1/18	Table of Contents Pages 2, 5. Appendix 2.
TN #DMAS-5	7/1/17	Pages 2-6
TN #DMAS-1	1/1/17	Table of Contents Pages 3-6 Appendix 3 Appendices 4 and 5 were removed.
TN #DMAS-1	6/1/16	Pages 3-5 Page 6 is a runover page. Appendix 3, page 1
TN #99	1/1/14	Page 4
UP#7	7/1/12	Pages 3, 4
TN #94	09/01/10	Table of Contents Pages 3-5 Appendix 3
TN #93	01/01/10	Pages 2, 3, 5 Appendix 3, page 1 Appendix 4, page 1

TABLE OF CONTENTS

LONG-TERM SERVICES AND SUPPORTS

M1420.000 *AUTHORIZATION* FOR MEDICAID LTSS

M1420.000 AUTHORIZATION FOR MEDICAID LTSS

M1420.100 MEDICAID LTSS AUTHORIZATION REQUIREMENTS

A. Introduction

Medicaid covers long-term services and supports (LTSS) in a medical facility or community-based setting for individuals whose mental or physical condition requires assistance with activities of daily living. For Medicaid to cover LTSS, the individual must:

- meet the definition of an institutionalized individual in subchapter M1410. The individual's eligibility as an institutionalized individual may be determined when the individual is already in a medical facility at the time of the application, or the individual has been authorized to receive LTSS and it is anticipated that they are likely to receive the services for 30 or more consecutive days. If it is known at the time the application is processed that the individual did not or will not meet the 30 consecutive day requirement, the individual is not to be treated as an institutionalized individual.
- meet all Medicaid non-financial eligibility requirements in Chapter M02;
- be financially eligible based on the policy and procedures in subchapter M1460 for unmarried individuals and married institutionalized individuals without a community spouse or subchapter M1480 for institutionalized individuals with a community spouse; and
- Meet the asset transfer policies in subchapter M1450.

This subchapter describes the LTSS authorization required for the types of LTSS, which are facility-based care, home-and-community-based (HCBS) services covered under a Section 1915(c) waiver, and the Program for All Inclusive Care for the Elderly (PACE).

B. Operating Policies

1. Payment Authorization

An LTSS authorization is needed for Medicaid payment of nursing facility (medical institution), HCBS waiver, and PACE services for Medicaid recipients. The authorization allows the local DSS to determine financial eligibility using the more liberal rules for institutionalized individuals, including the 300% SSI covered group and the special rules for married institutionalized individuals with a community spouse. The appropriate authorization document (form or screen print) must be maintained in the individual's case record

2. Required Authorization Documents

a. **Nursing facility-based care, the Commonwealth Coordinated Care Plus Waiver, and PACE**

The Medicaid LTSS Authorization Form, DMAS 96 or the equivalent information printed from the electronic Medicaid LTSS Screening system (eMLS) *or the Minimum Data Survey (MDS)* is used to authorize nursing facility-based care, the Commonwealth Coordinated Care (CCC) Plus Waiver, and PACE. The Authorization form certifies the type of LTSS service

If documentation is not available when placement needs to be made, verbal assurance from a screener that the form approving LTSS will be mailed or *electronically available* is sufficient to determine Medicaid eligibility as an institutionalized individual. This information must be received prior to approval and enrollment in Medicaid as an institutionalized individual.

b. **The Community Living Waiver, Building Independence Waiver, and Family and Individual Supports Waiver**.

The Waiver Authorization System (WaMS) (see M1420, Appendix 3) or Intellectual Disability On-line System (IDOLS) are used to authorize services received under the Community Living (CL) Waiver, Building Independence (BI) Waiver, and Family and Individual Supports Waiver. Copies of the authorization screens are acceptable.

3. Authorization Not Received

If the appropriate documentation authorizing LTSS is not received, Medicaid eligibility for an individual who is living in the community must be determined as a non-institutionalized individual.

4. *Continuing* Authorization

Providers re-evaluate the individual's level of care periodically. The authorization for Medicaid payment of LTSS may be rescinded by the physician or by DMAS at any point that the individual is determined to no longer meet the required Medicaid level of care criteria via level of care review process.

When an individual is no longer eligible for a HCBS Waiver service, the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

When an individual leaves the PACE program and no longer receives LTSS services, the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

Facilities document the level of care using the Minimum Data Survey (MDS). For an individual in a nursing facility who no longer meets the level of care but continues to reside in the facility, **continue to use the eligibility rules for institutional individuals** even though the individual no longer meets the level of care criteria. Medicaid will not make a payment to the facility for LTSS.

M1420.200 RESPONSIBILITY FOR THE LTSS AUTHORIZATION

A. Introduction

The process for completing the required assessment and authorizing services depends on the type of LTSS.

B. Nursing Facility

In order to qualify for nursing facility care, an individual must be determined to meet functional criteria, have a medical or nursing need and be at risk of nursing facility or hospital placement within 30 days without services. An assessment known as the LTSS Screening is completed by a designated screener. *For individuals who apply for Medicaid after entering a nursing facility, medical staff at* f*acilities document the level of care needed using the Minimum Data Survey (MDS). The Eligibility Worker does not need to see any screening authorization if the individual applying is already a resident of a nursing facility when the Medicaid application is filed.*

The screener's approval for Medicaid LTSS for new admissions must be substantiated in the case record by a DMAS-96 or the equivalent information from the eMLS system, *WaMS printout or the Minimum Data Survey (MDS)*. Medicaid payment for LTSS cannot begin prior to the date the DMAS-96 *is signed by the physician* and prior authorization of services for the individual has been given to the provider by DMAS or the managed care plan.

An overview of the screening requirements when an individual needs nursing home care is listed below:

- For hospital patients who are currently enrolled in Medicaid and will be admitted to a nursing facility with Medicaid as the payment source, the screening is completed by hospital staff.

- Nursing facilities are permitted to admit individuals who are discharged directly from a hospital to a nursing facility for skilled services without an LTSS screening if the skilled services are not covered in whole or partially by Virginia Medicaid. Once the individual is admitted to the nursing facility, if the individual requests an LTSS screening or applies for Medicaid coverage for LTSS, nursing facility staff *will conduct a LTSS screening. The Eligibility Worker does not need to see the screening authorization if the individual applying is already a resident of a nursing facility when the Medicaid application is filed. DMAS will not pay for LTSS services unless the facility has documented that the applicant meets the nursing facility level of care.*

- For individuals who are not inpatients in a hospital or are incarcerated prior to nursing facility admission, the screening is completed by local community-based teams (CBT) composed of agencies contracting with the Department of Medical Assistance Services (DMAS). The community-based teams usually consist of the local health department physician, a local health department nurse, and a local social services department service worker. Incarcerated individuals will be screened by the community-based team in the locality in which the facility is located.

C. CCC Plus Waiver

Effective July 1, 2017, the Elderly or Disabled with Consumer-Direction (EDCD) Waiver and the Technology Assisted (Tech) Waiver were combined and are known as the Commonwealth Coordinated Care Plus (CCC Plus) Waiver. Community-based teams, hospital screening teams and nursing facility screening teams are authorized to screen individuals for the CCC Plus Waiver. See M1420.400 C for more information.

An individual screened and approved for the CCC Plus Waiver will have a DMAS-96 signed and dated by the screener and the physician *(or the nurse practitioner or the physician's assistant working with the physician)* or the equivalent information printed from the eMLS system.

If the individual elects consumer-directed services, DMAS or its contractor must give final authorization. If services are not authorized, the service facilitator will notify the LDSS, and the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

For individuals who qualify for Private Duty Nursing (PDN) under the CCC Plus Waiver, a Medicaid LTSS Communication form (DMAS-225) and a Commonwealth Coordinated Care Plus Waiver PDN Level of Care Eligibility form (DMAS-108 for Adults or DMAS-109 for children) will be completed and sent to the LDSS.

D. *Program for All Inclusive Care for the Elderly* (PACE)

Community-based screening teams, hospital screening teams and nursing facility screening teams are authorized to screen individuals for PACE. If the individual is screened and approved for LTSS, the team will inform the individual about any PACE program that serves the individual's locality. Individuals approved for PACE will have a DMAS-96 signed and dated by the screener and the supervising physician (or the nurse practitioner or the physician's assistant working with the physician) or the equivalent information printed from the eMLS system.

E. Community Living Waiver

Local Community Services Boards (CSBs) are authorized to screen individuals for the Community Living Waiver. Final authorizations for waiver services are made by Department of Behavioral Health and Developmental Services (DBHDS) staff.

Individuals screened and approved for the Community Living Waiver will have a printout of the WaMS or Intellectual Disability On-line System (IDOLS) authorization screen completed by the DBHDS representative. The screen print will be accompanied by a completed DMAS-225 form identifying the client, the Community Services Board providing the service, and begin date of service.

F. Family and Individual Supports Waiver

CSBs are authorized to screen individuals for the Family and Individual Supports Waiver. Final authorizations for waiver services are made by DBHDS staff.

Individuals screened and approved for the Family and Individual Supports Waiver will have a printout of the WaMS or IDOLS authorization screen completed by the DBHDS representative. The screen print will be accompanied by a completed DMAS-225 form identifying the client, the Community Services Board providing the service, and begin date of service.

G. Building Independence Waiver

Local CSB and DBHDS case managers are authorized to screen individuals for the Building Independence Waiver. Final authorizations for waiver services are made by DBHDS staff.

Individuals screened and approved for the Building Independence Waiver will have a printout of the WaMS or IDOLS authorization screen completed by the DBHDS representative. The screen print will be accompanied by a completed DMAS-225 form identifying the client, the Community Services Board providing the service, and begin date of service.

M1420.300 COMMUNICATION PROCEDURES

A. Introduction

To ensure that nursing facility, PACE placement or receipt of Medicaid HCBS services are arranged as quickly as possible, there must be prompt communication between screeners and eligibility staff.

B. Procedures

1. LDSS Contact

The LDSS should designate an appropriate staff member for screeners to contact. Local social services, hospital staff, CBTs and nursing facilities should be given the name and contact information for that person to facilitate timely communication between screeners and eligibility staff.

2. Screeners

Screeners must inform the individual's eligibility worker when the screening process has been completed.

3. Eligibility Worker (EW) Action

The EW must inform both the individual and the provider once eligibility for Medicaid payment of LTSS has been determined. If the individual is found eligible for Medicaid and written assurance of approval by the screening team, DMAS, or the managed care plan has been received (DMAS-96, WaMS printout or *the Minimum Data Survey [MDS])*, the eligibility worker must give the LTSS provider the enrollee's Medicaid identification number.

M1420.400 LTSS SCREENING EXCLUSIONS (Special Circumstances)

A. Purpose

The screening certification authorizes the local DSS to determine financial eligibility using the more liberal rules for institutionalized individuals, including the 300% SSI covered group and the special rules for married institutionalized individuals with a community spouse. The Eligibility Worker does not need to see any screening authorization if the individual applying is already a resident of a nursing facility when the Medicaid application is filed.

B. Screening Special Circumstances

Screening for LTSS is NOT required when:

- *the individual is a resident in a nursing facility, receiving CCC Plus Waiver services or in PACE at the time of application and was admitted to the service prior to July 1, 2019;*
- *the individual resides out of state (either in a community, hospital or nursing facility setting) and seeks direct admission to a nursing facility;*
- *the individual is an inpatient at an in-state owned/operated facility licensed by DBHDS, in-state or out of state Veterans hospital, military hospital or VA Medical Center, and seeks direct admission to a nursing facility;*
- *the individual enters a nursing facility directly from the CCC Plus Waiver or PACE services;*
- *the individual is being enrolled in Medicaid hospice.*

M1430 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-26	10/1/22	Page 1
TN #DMAS-24	7/1/22	Page 3
TN #DMAS-20	7/1/21	Table of Contents Page 2 Appendix 1 was removed.
TN #DMAS-19	4/1/21	Pages 1, 2
TN #DMAS-10	10/1/18	Pages 3-5 Appendix 1
TN #DMAS-7	1/1/18	Pages 1, 2, 4 Appendix 1
TN #93	1/1/10	Appendix 1, page 1
Update (UP) #1	7/1/09	Appendix 1, page 1

M1430.000 FACILITY CARE

A. Introduction

Medicaid covers care provided in a facility to persons whose physical or mental condition requires nursing supervision and assistance with activities of daily living.

This subchapter (M1430) contains the specific policy and rules that apply to individuals needing or receiving long-term supports and services (LTSS), also referred to as long-term care (LTC) services in medical institutions (facilities).

B. Definitions

Definitions for terms used when policy is addressing types of *LTSS*, institutionalization, and individuals who are receiving that care are found in Subchapter M1410.

M1430.010 TYPES OF FACILITIES & CARE

A. Introduction

This section contains descriptions of the types of medical facilities in which Medicaid provides payment for services received by eligible patients. *Also refer to M1410.010.B for additional guidance.*

B. Medical Facility Defined

A **medical facility** is an institution that:

- is organized to provide medical care, including nursing and convalescent care,
- has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,
- is authorized under state law to provide medical care, and
- is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

C. Types of Medical Facilities

The following are types of medical facilities in which Medicaid will cover part of the cost of care:

1. Chronic Disease Hospitals

Chronic disease hospitals are specially certified hospitals, also called "long-stay hospitals". There are two of these hospitals enrolled as Virginia Medicaid providers:

- Hospital for Sick Children in Washington, D.C.;
- Lake Taylor Hospital in Norfolk, Virginia.

2. Intermediate Care Facilities for the Intellectually Disabled (ICF-ID)

An **ICF-ID** is an institution for the intellectually disabled or persons with related conditions is an institution or a distinct part of an institution that

M1450 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-25	10/1/22	Page 36
TN #DMAS-17	7/1/20	Page 45
TN #DMAS-15	1/1/20	Page 46
TN #DMAS-14	10/1/19	Pages 19, 41, 42, 46
TN #DMAS-10	10/1/18	Pages 1, 2 Appendix 3, page 2 Page 24a was added back; it was inadvertently removed in a previous transmittal. Page 2a was added as a runover page.
TN #DMAS-9	7/1/18	Page 35-36a, 37-38, 43
TN #DMAS-7	1/1/18	Page 4, 24, 36, 36a, 37, 41, 42 Appendix 1, Page 1.
TN #DMAS-5	7/1/17	Table of Contents Pages 13, 35, 41-44 Page 43a was renumbered. Pages 45 and 46 were added as runover pages.
TN #DMAS-3	1/1/17	Pages 30, 40-42, 44
TN #DMAS-1	6/1/16	Pages 13, 15, 35 Pages 14 and 16 are runover pages.
TN #100	5/1/15	Table of Contents Pages 17-19, 36, 37 Page 35 is a runover page.
TN #99	1/1/14	Page 7, 10, 21
UP #7	6/1/12	Table of Contents Pages 37-43 Page 43a was added.
TN #96	10/1/11	Table of Contents Pages 4-8 Pages 15, 16, 25, 26 Pages 31-38 Page 31a removed.
TN #95	3/1/11	Pages 4, 24, 32, 36, 37, 37a, Pages 39, 42, 43
TN #94	9/1/10	Table of Contents Pages 36-37a, 39-44
TN #93	1/1/10	Table of Contents Pages 3, 17-18, 29 Appendix 2, page 1
TN #91	5/15/09	Pages 41, 42

1. Penalty Periods Cannot Overlap

When multiple asset transfers result in multiple penalty periods, the penalty periods cannot overlap. One penalty period must be completed prior to the beginning of the next penalty period.

2. Nursing Facility

If the individual in a nursing facility meets all Medicaid eligibility requirements, he is eligible for Medicaid payment of all other covered services.

3. HCBS, PACE, Hospice

a. Transfer Reported at Application

If the individual has been screened and approved for or is receiving Medicaid HCBS, PACE, or hospice services, he cannot be eligible for Medicaid in the 300% of SSI covered group or for the Medicaid payment of LTSS in any other covered group. The individual's Medicaid eligibility in other covered groups must be determined. His penalty period cannot be imposed unless and until he is (1) eligible for Medicaid in a full-benefit covered group other than the 300% of SSI covered group, (2) he meets a spenddown and would otherwise be eligible for the Medicaid payment of LTSS, or (3) he is admitted to a nursing facility.

An individual outside a medical facility (i.e. living in the community) does not meet the definition of an institutionalized person if he is not receiving Medicaid covered HCBS, PACE or hospice services. Therefore, an individual for whom a penalty period is imposed cannot be eligible for Medicaid unless the individual is eligible for Medicaid outside the 300% SSI covered group.

Any penalty periods imposed under the rules effective April 17, 2018 through October 1, 2022 are valid and continue until the penalty period is exhausted.

Changed With	Effective Date	Pages Changed
TN #DMAS-25	10/1/22	Page 20
TN #DMAS-24	7/1/22	Pages 1, 15, 28a, 44, 48-50 Page 14a is a runover page.
TN #DMAS-22	1/1/22	Pages 19, 20
TN #DMAS-21	10/1/21	Page 17
TN #DMAS-20	7/1/21	Pages 11, 20, 26
TN #DMAS-19	4/1/21	Pages 7, 8, 22, 23
TN #DMAS-18	1/1/21	Pages 19, 20
TN #DMAS-17	7/1/20	Table of Contents, page ii Pages 1, 14, 28a, 47, 48, 50, 55 Appendix 1, page 1
TN #DMAS-15	1/1/20	Pages 19, 20
TN #DMAS-14	10/1/19	Table of Contents, page i Pages 1, 14, 28a, 31, 32, 43, 47, 48, 50 Appendix 1, page 2 Page 14a was added as a runover page.

3. Special Earnings Allowance for Recipients in CCC Plus, CL, IS and BI Waivers

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

a. for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (*$2,523* in *2022*) per month.

b. for individuals employed at least *8* but less than 20 hours per week, all earned income up to 200% of SSI (*$1,682* in *2022*) per month.

4. Example – Special Earnings Allowance (Using January 2018 figures)

A working patient receiving CCC Plus Waiver services is employed 18 hours per week. His income is gross earnings of $1228.80 per month and SSA of $300 monthly. His special earnings allowance is calculated by comparing his gross earned income ($1128.80) to the 200% of SSI maximum ($1,500.00). His gross earned income is less than 200% of SSI; therefore, he is entitled to a special earnings allowance. His personal maintenance allowance is computed as follows:

$ 1,238.00 CBC basic maintenance allowance
+ 1,128.80 special earnings allowance
$ 2,360.80 PMA

Because the PMA may not exceed 300% of SSI, the PMA for the patient in this example must be reduced to $2,250.00.

B. Couples

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

M1470.420 DEPENDENT CHILD ALLOWANCE

A. Unmarried Individual, or Married Individual With No Community Spouse

For an unmarried Medicaid CBC patient, or a married Medicaid CBC patient without a community spouse, who has a dependent child(ren) under age 21 years in the community:

- Calculate the difference between the appropriate MN income limit for the **child's** home locality for the number of children in the home and the child(ren)'s gross monthly income. If the children are living in different homes, the children's allowances are calculated separately using the MN income limit for the number of the patient's dependent children in each home.

Changed With	Effective Date	Pages Changed
TN #DMAS-25	10/1/22	Page 66
TN #DMAS-24	7/1/22	Pages 8a, 8b, 13, 50b, 51, 55, 57, 66, 87, 89, 91
TN #DMAS-22	1/1/22	Pages 7, 18c, 66, 69, 70
TN #DMAS-21	10/1/21	Page 66
TN #DMAS-20	7/1/21	Pages 66, 70
TN #DMAS-18	1/1/21	Page 7, 18c, 66, 69, 70, 92
TN #DMAS-17	7/1/20	Pages 8b, 9, 14, 66, 77, 92
TN #DMAS-15	1/1/20	Pages 1, 7, 18c, 66, 69, 70 Page 2 is a runover page.
TN #DMAS-14	10/1/19	Pages 8a, 8b, 12, 15, 16, 18, 20, 21, 30, 32, 51

After eligibility is established, the usual reporting and notification processes apply. Send written notice for the month(s) during which the individual establishes Medicaid eligibility. VaCMS will generate the "Notice of Patient Pay Responsibility" and it will be sent to the individual or his authorized representative.

M1480.400 PATIENT PAY

A. Introduction

This section contains the policy and procedures for determining an institutionalized spouse's (as defined in section M1480.010 above) patient pay in all covered groups.

B. Married With Institutionalized Spouse in a Facility

For a married long-term services and support (LTSS) patient with an institutionalized spouse in a facility, **NO** amount of the patient's income is deducted for the spouse's needs in the patient pay calculation.

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

Introduction

This subsection contains the standards and their effective dates that are used to determine the community spouse's and other family members' income allowances. The income allowances are deducted from the institutionalized spouse's gross monthly income when determining the monthly patient pay amount. Definitions of these terms are in section M1480.010 above.

B. Monthly Maintenance Needs Allowance	$2,177.50 $2,288.75	7-1-21 7-1-22	
C. Maximum Monthly Maintenance Needs Allowance	$3,259.50 $3,435.00	1-1-21 1-1-22	
D. Excess Shelter Standard	$653.25 $686.63	7-1-21 7-1-22	
E. Utility Standard Deduction (SNAP)	$322.00 $402.00	1 - 3 household members 4 or more household members	10-1-21 10-1-21
	$374.00 *$473.00*	1 - 3 household members 4 or more household members	*10-1-22* *10-1-22*

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

A. Policy

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

M17 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-25	10/1/22	Page 4
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 *M1520.100*. The end point is the next scheduled renewal that the LDSS actually completed.

M21 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-25	10/1/22	Page 6
TN #DMAS-24	7/1/22	Page 7
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

1. Retroactive Coverage For Newborns Only

Retroactive coverage is available ONLY to an eligible child who was born within the 3 months prior to the FAMIS application month. Eligibility for FAMIS coverage will be effective retroactive to the child's date of birth if the child was born within the retroactive period and would have met all eligibility criteria during the retroactive period.

The following eligibility requirements must be met in order for a newborn child to be enrolled in FAMIS for retroactive FAMIS coverage:

a. Retroactive coverage must be requested on the application form or in a later contact.

b. The child's date of birth must be within the three months immediately preceding the application month (month in which the agency receives the signed application form for the child).

c. The child must meet all the FAMIS eligibility requirements during the retroactive period.

2. FAMIS Aid Categories

The aid categories (ACs) for FAMIS are:

AC	Meaning
006	child under age 6 with income > 150% FPL and ≤ 200% FPL
007	child 6 – 19 with income > 150% FPL and ≤ 200% FPL
008	child under age 6 with income > 143% FPL and ≤ 150% FPL
009	child 6 – 19 with income > 143% FPL and ≤ 150% FPL
010	FAMIS deemed newborn <1 year old
014	FAMIS deemed newborn above 150% FPL

D. Notification Requirements

The eligibility worker must send a Notice of Action on Medicaid and FAMIS to the family informing them of the action taken the application. The notice must include the eligibility determination for both Medicaid and FAMIS.

If the child is ineligible for both Medicaid and FAMIS, the family must be sent a notice that the child is not eligible for either program. A referral to the Health Insurance Marketplace must be made, and the child must be given the opportunity to have a Medicaid medically needy evaluation if he is under 18 years. Along with the notice, request verification of resources using Appendix E, which can be found at: http://www.coverva.org/mat/APPENDIX%20E%20Medically%20Needy%20application.pdf (Application for Health Insurance and Help Paying Costs (Medical Needy Spenddown). Advise the family that if the signed application is returned within 10 calendar days, the original application date will be honored.

E. Transitions Between Medicaid And FAMIS (Changes and Renewals)

When excess income for Medicaid causes the child's eligibility to change from Medicaid to FAMIS, the new income must be verified or determined reasonably compatible using an electronic data source such as the federal Hub or another reliable data source prior to requesting paystubs or employer statements. For all case actions effective *August 26, 2022*, if the income attested to by the applicant is within 20% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required. If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return.

M23 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-25	10/1/22	Pages 5 & 6. Adjust pages 7-8.
TN #DMAS-24	7/1/22	Page 6
TN #DMAS-23	4/1/22	Page 6 Appendix 1, page 1
TN #DMAS-21	10/1/21	Pages 6, 7

M2330.100 FINANCIAL ELIGIBILITY

A. Financial Eligibility

1. Income

MAGI methodology contained in Chapter M04 is used for the FAMIS Prenatal Coverage income evaluation. To the maximum extent possible, attested income must be verified by information obtained from electronic data sources, such as the federal hub or another reliable data source, prior to requesting paystubs or employer statements. If the income attested to by the applicant is within *20*% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required. If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return. If the documentation is delayed in the mail due to no fault of the applicant, accept delayed documentation and complete application processing.

The FAMIS Prenatal Coverage income limit is 200% of the FPL (see Appendix 1 to this chapter) for the number of individuals in the pregnant woman's MAGI household composition as defined in M04. The pregnant woman is counted as herself plus the number of children she is expected to deliver. Per MAGI policy in chapter M04, a 5% FPL income disregard is applicable.

2. Resources

Resources are not evaluated for FAMIS Prenatal Coverage.

3. No Spenddown

Spenddown does not apply to FAMIS Prenatal Coverage. If countable income exceeds the FAMIS Prenatal Coverage income limit, the pregnant woman is not eligible for the FAMIS Prenatal Coverage program. If the woman has no documentation of immigration status, DO NOT make a referral to the Health Insurance Marketplace

M2340.100 APPLICATION and CASE PROCEDURES

A. Application Requirements

The policies in subchapters M0120 and M0130 apply.

B. Eligibility Determination

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 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

1. 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.

3. 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.

Note: A change in the MMIS enrollment system was effective July 1, 2022 to display the FAMIS Prenatal aid categories AC110 / AC111. Anyone enrolled prior to July 1, 2022 will remain in aid category AC005 if eligibility is not run and updated to the new AC.

4. 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. The 12-month coverage period for pregnant women in Medicaid and FAMIS MOMS is not applicable to FAMIS Prenatal Coverage.

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.

Name, date of birth, sex (gender)

- Information about the infant's MAGI household and income, if not available in the case record.

Unless the agency has information about the infant's father living in the home (i.e. for another program), use only the mother's reported income to enroll the infant. Do not request information about the father or the father's income unless the agency has information about the father living in the home and his income.

Note: The infant is not required to provide an SSN or proof of application for an SSN in order to be enrolled. Follow the procedures in M0240.200 B.3 90 days following the infant's enrollment to determine if an SSN has been assigned. If the SSN number has not yet been issued at 90 days, obtain the SSN or proof of application for an SSN at the first renewal of the infant's coverage.

2. Enrollment and Aid Category

Update the case with the new infant's information, enrolling the child as a Medicaid child under 19 or in FAMIS, as appropriate based on the mother's countable income at the time of application. Use the appropriate AC below to enroll the infant:

- Medicaid AC 090 for income > 109% FPL ≤ 143% FPL
- Medicaid AC 091 for income ≤ 109% FPL
- FAMIS AC 006 for income > 150% FPL and ≤ 200% FPL
- FAMIS AC 008 for income > 143% FPL and ≤ 150% FPL

3. Renewal

The infant's first renewal is due 12 months from the month of the infant's enrollment.

G. Examples

Example 1

Rose is pregnant and is carrying one unborn child. She was born outside the U.S. She applies for Medicaid on October 27, 2021. She reported on the application that she visited the emergency room in August 2021. The retroactive period for her application is July – September 2021.

Rose is unable to verify that she is lawfully residing in the U.S.; therefore, she cannot be eligible for full-benefit Medicaid or FAMIS Moms and is evaluated for FAMIS Prenatal Coverage. Her verified countable monthly income is $1,756 per month, which is under the income limit for FAMIS Prenatal Coverage for her MAGI household size of two. She is approved for FAMIS Prenatal coverage and enrolled effective October 1, 2021, in AC 110, based on her countable income of under 143% FPL (see M23, Appendix 1). She is enrolled in Managed Care, so her infant will not be considered a deemed-eligible newborn.

Because she received an emergency service during the retroactive period and her income is under the Medicaid limit for a pregnant woman, she is evaluated for Emergency Services coverage.

Rose's son, AJ, is born on February 25, 2022, and is enrolled in AC 090 beginning February 25, 2022. His Medicaid renewal is due in January 2023. Rose's FAMIS Prenatal Coverage ends on April 30, 2022.

Example 2

Jo lives with her husband Al and daughter Em, who was born on October 31, 2021. Jo was born outside the U.S. She applies for Medical Assistance on November 25, 2021 and requests retroactive coverage for her pregnancy. She does not request coverage for her husband.

Jo is unable to verify that she is lawfully residing in the U.S.; therefore, she cannot be eligible for full-benefit Medicaid or FAMIS Moms. Because Jo applied for coverage the month after her infant's birth, she cannot be eligible for FAMIS Prenatal Coverage

Jo's MAGI household consists of three people—Jo, her infant, and her husband. The verified countable monthly income for the household is $3,473.

Jo's countable income is over the limit of 143% FPL for Medicaid and has excess resources for Medically Needy eligibility; therefore, she cannot be approved for Medicaid coverage of emergency services for the labor and delivery.

Em is determined to be eligible for FAMIS, which covers an eligible child who was born within the 3 months prior to the application month. Em is enrolled effective October 31, 2021, in AC 006. Her renewal is due in September 2022.

The eligibility worker sends a Notice of Action indicating Jo is not eligible for Medicaid or FAMIS Prenatal Coverage and Em has been enrolled in FAMIS.

M2350.100 REVIEW OF ADVERSE ACTIONS

An applicant for FAMIS Prenatal Coverage may request a review of an adverse determination regarding eligibility for FAMIS Prenatal Coverage. FAMIS Prenatal Coverage follows the procedures established by Medicaid for client appeals (see Chapter M16).

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