COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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Virginia Medical Assistance Eligibility Manual
Transmittal #DMAS-19

The following acronyms are contained in this letter:

- ABD – Aged, Blind, or Disabled
- AC – Aid Category
- BCCPTA – Breast and Cervical Cancer Prevention and Treatment Act
- COVID – Coronavirus Disease
- DMAS – Department of Medical Assistance Services
- FAMIS – Family Access to Medical Insurance Security
- FPL – Federal Poverty Level
- HPE – Hospital Presumptive Eligibility
- IMD – Institutions for (for the Treatment of) Mental Diseases
- LPR – Lawful Permanent Resident
- LTSS – Long-term Supports and Services
- MAGI – Modified Adjusted Gross Income
- PRTF = Psychiatric Residential Treatment Facility
- TN – Transmittal

TN #DMAS-19 includes policy clarifications, updates and revisions. Unless otherwise noted in the Cover Letter and/or policy, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after April 1, 2021. Note that COVID-19 Public Health Emergency guidelines continue until the emergency is over and are not referenced in Medicaid Eligibility Policy.

The following changes are contained in TN #DMAS-19:

Changed Pages	Changes
Subchapter M0220 Table of Contents Pages 7, 8, 14a-14d, 16, 22a, 24 Appendix 3, page 1; Appendix 5, page 1; Appendix 8, pages 1, 3 Page 8 is a runover page. Pages 8a and 14e were added as runover pages.	Revised the Table of Contents. On pages 7, 14a, 16, 22a, 24, and the appendices, added policy regarding LPRs who are citizens of the Freely Associated States (Micronesia, the Marshall Islands, Palau). Effective 12-27-20, these individuals are eligible for full Medicaid benefits, if all Medicaid eligibility requirements are met, with no limitations on length of residency in the U.S. and no work requirement. On pages 7, 14b-14d, 16, and the appendices, revised the policy regarding LPRs and the 40-quarter work requirement. Effective 4-1-21, the 40-quarter requirement is eliminated.
Subchapter M0280 Pages 3, 4 Appendix 1 Page 4a was added.	Revised the policy regarding Medicaid coverage for individuals age 22 or over but under age 65 who are admitted to an IMD. Medicaid is no longer cancelled for these individuals.
Subchapter M0320 Pages 26a, 29	On page 26a, updated the Medicaid Works resource limit for earnings in the Work Incentive Account. On page 29, revised the information for sending Medicaid Works enrollment information to DMAS. Information must be emailed to dmas.evaluation@dmas.virginia.gov. Faxing is no longer available.
Subchapter M0330 Pages 14, 26	On page 14, clarified that an application for Medical Assistance must be submitted for a newborn born to a woman covered under HPE. On page 26, clarified the referral process for individuals who were diagnosed with breast or cervical cancer but do not provide a BCCPTA Application Form.
Chapter M04 Appendix 1, pages 1-2 Appendix 2, pages 1-2 Appendices 6 and 7	Revised the income limits for the MAGI-based covered groups, effective 1-13-21.
Subchapter M0520 Page 2	Revised the definition of a PRTF. The Level C designation is no longer used.
Subchapter M0810 Page 2	Updated the ABD income limits based on the FPL, effective 1-13-21 for individuals without Social Security income and 3-1-21 for individuals with Social Security income.
Subchapter M1110 Page 16	Clarified that Virginia does not recognize equitable ownership of real property.

Changed Pages	Changes
Subchapter M1420 Page 2	Added policy regarding the completion of LTSS screenings by nursing facilities.
Subchapter M1430 Pages 1, 2	Revised the policy regarding Medicaid coverage for individuals age 22 or over but under age 65 who are admitted to an IMD. Medicaid is no longer cancelled for these individuals.
Subchapter M1470 Pages 7, 8, 22, 23	Clarified which ACs receive a patient pay allowance for Medicare premiums.
Subchapter M1510 Pages 6, 8	Revised the policy regarding Medicaid coverage for individuals age 22 or over but under age 65 who are admitted to an IMD. Medicaid is no longer cancelled for these individuals.
Subchapter M1520 Appendix 2	Revised the Extended Medicaid income limits, effective 1-13-21.
Subchapter M1550 Pages 1, 2	Revised the policy regarding Medicaid coverage for individuals age 22 or over but under age 65 who are admitted to an IMD. Medicaid is no longer cancelled for these individuals.
Chapter M21 Appendix 1	Revised the FAMIS income limits, effective 1-13-21.
Chapter M22 Appendix 1	Revised the FAMIS Moms income limits, effective 1-13-21.

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

Changed With	Effective Date	Pages Changed
TN #DMAS-19	4/1/21	Table of Contents Pages 7, 8, 14a-14d, 16, 22a, 24 Appendix 3, page 1; Appendix 5, page 1; Appendix 8, pages 1, 3 Page 8 is a runover page. Pages 8a and 14e were added as runover pages.
TN #DMAS-18	1/1/21	Page 21
TN #DMAS-17	7/1/20	Table of Contents Page 21
TN #DMAS-14	10/1/19	Table of Contents Pages 3, 4, 23, 24 Page 25 was added as a runover page. Appendix 8 was added.
TN #DMAS-13	7/1/19	Page 21
TN #DMAS-12	4/1/19	Pages 20, 21, 23
TN #DMAS-10	10/1/18	Page 1
TN #DMAS-9	7/1/17	Page 1, 2, 14c
TN #DMAS-6	10/1/17	Page 15 Appendix 1, page 4
TN #DMAS-5	7/1/17	Pages 18, 19, 23, 24
TN #DMAS-3	1/1/17	Table of Contents Page 22a Appendix 1, page 1
TN #DMAS-2	10/1/16	Pages 13, 19-22, 23, 24
TN #DMAS-1	6/1/16	Pages 4, 4b, 5, 23
TN #100	5/1/15	Table of Contents Pages 4b, 12, 17, 18 Appendix 5, page 3 Page 4 was renumbered for clarity. Page 4a is a runover page.
TN #99	1/1/14	Table of Contents Pages19, 23, 24 Appendix 4 was removed.
TN #98	10/1/13	Pages 2-3b Appendix 1 Pages 1-5 Pages 6-18 were removed.
UP #9	4/1/13	Page 3 Appendix 1, pages 3, 17 Appendix 3, pages 3, 4

Changed With	Effective Date	Pages Changed
UP #8	10/1/12	Table of Contents Pages 4, 7-8, 12, 14d-20 Page 17a was deleted. Appendix 5 , page 3 Appendix 7 pages 1-5
UP #7	7/1/12	Table of Contents Pages 14d, 16-19 Appendix 5 , page 3
TN #96	10/1/11	Table of Contents Pages 2, 3, 7, 8, 14d, 18-22a, 23 Appendix 5, page 3
TN #95	3/1/11	Table of Contents Pages 3, 3a, 4-6a, 14a-14c, 17, 19, 20 Pages 22a, 23, 24 Appendices 1-2a removed. Appendix 3 and Appendices 5-8 reordered and renumbered.
TN #94	9/1/10	Pages 3-3b, 7-9, 14a-14d, 18, 21, 22a, 23 Appendix 1 Appendix 3, page 3
Update (UP) #3	3/1/10	Pages 1-3a
TN #93	1/1/10	Table of Contents Pages 7-8, 14a, 14c-14d, 15-20, 22a Appendix 1 Appendix 3, page 3 Appendix 4, pages 1 and 2 Appendix 6, page 2
TN #92	5/22/09	Table of Contents Pages 1-6a Appendix 8 (18 pages) Pages 4a-4t were removed and not replaced.
TN #91	5/15/09	Page 7 Pages 14a, 14b Page 18 Page 20 Appendix 3, page 3

TABLE OF CONTENTS

M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS

Appendices

M0220.300 FULL BENEFIT ALIENS

A. Policy

A "full benefit" alien is

- an alien who receives SSI (M0220.305);
- 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)) (M0220.306);
- a "qualified" alien (defined in M0220.310 below) who entered the U.S. before 8-22-96;
- a qualified alien refugee; asylee; deportee; Amerasian; Cuban or Haitian entrant; victim of a severe form of trafficking; or a qualified Afghan or Iraqi immigrant admitted to the U.S. on a Special Immigrant Visa; who entered the U.S. on or after 8-22-96, but only for the first **7** years of residence in the U.S. (M0220.313 C);
- *Effective 12-27-20, a qualified lawful permanent resident (LPR) who is a citizen of one of the countries of the Freely Associated States (Micronesia, the Marshall Islands, and Palau), with no limit on the length of residency in the U.S. or work requirements;*
- *Before 4-1-21*, a qualified *LPR* who entered the U.S. on or after 8-22-96 who has at least 40 qualifying quarters of work, but only **AFTER** 5 years of residence in the U.S. (M0220.313 B). *Effective 4-1-21, a qualified LPR who entered the U.S. on or after 8-22-96 and who has resided in the U.S. for at least five years is no longer required to have any qualifying quarters of work to receive full Medicaid benefits;*

  Exception: effective 12-27-20, an LPR who is a citizen of one of the countries of the Freely Associated States (Micronesia, the Marshall Islands, and Palau) is eligible for full Medicaid benefits with no limit on the length of residency in the U.S. or work requirements;
- a qualified alien who meets the veteran or active duty military requirements in M0220.311 below; or
- a lawfully residing non-citizen child under age 19 or pregnant woman who meets the requirements in M0220.314 below.

A full benefit alien is eligible for full Medicaid benefits if he/she meets all other Medicaid eligibility requirements.

Aliens who are not "full benefit" aliens are "emergency services" aliens and may be eligible for emergency Medicaid services only if they meet all other Medicaid eligibility requirements. See section M0220.400 for emergency services aliens.

B. Procedure

1. Step 1

First, determine if the alien receives SSI. Section M0220.305 describes this group of aliens who receive SSI.

If the alien does NOT receive SSI, go to Step 2.

If the alien receives SSI, go to Step 6.

2. Step 2

Second, determine if the alien is an American Indian born in Canada 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)). Section M0220.306 describes this group of aliens.

If NO, go to Step 3. If YES, go to Step 6.

3. Step 3

Third, determine if the alien is a "qualified" alien eligible for full benefits (a full benefit qualified alien).

- Section M0220.310 defines "qualified" aliens.
- Section M0220.311 defines qualified veteran or active duty military aliens.
- Section M0220.312 describes qualified aliens who entered the U.S. before 8-22-96.
- Section M0220.313 describes qualified aliens who entered the U.S. on or after 8-22-96.

If the alien is NOT a qualified alien eligible for full benefits, go to step 4.

If the alien is a qualified alien eligible for full benefits, go to step 6.

4. Step 4

Fourth, determine if the alien is a lawfully residing non-citizen child under age 19 or pregnant woman. See section M0220.314.

If the alien is NOT a lawfully residing non-citizen under age 19 or pregnant woman, go to Step 5.

If the alien is a lawfully residing non-citizen child under age 19 or pregnant woman, go to Step 6.

5. Step 5

The alien is an "**emergency services**" alien. Go to Section M0220.400 which defines emergency services aliens, then to M0220.500 which contains the eligibility requirements applicable to all aliens, then to M0220.700 which contains the entitlement and enrollment policy and procedures for emergency services aliens.

6. Step 6

Use Section M0220.500, which contains the Medicaid eligibility requirements applicable to all aliens, to determine the alien's Medicaid eligibility. Then use Section M0220.600, which contains the entitlement and enrollment procedures for **full benefit** aliens, to enroll an eligible full benefit alien.

M0220.305 ALIENS RECEIVING SSI

A. Policy

An SSI recipient meets the Medicaid full benefit alien status requirements. Some SSI recipients who are aliens would have lost SSI and Medicaid eligibility. The Balanced Budget Act of 1997 restored SSI eligibility for certain groups of aliens:

- a legal alien who was receiving SSI on August 22, 1996, may continue to receive SSI if he/she meets all other SSI eligibility requirements.

- an alien who was blind or disabled on August 22, 1996, and who is residing legally in the U.S. may receive SSI in the future if he/she meets all other SSI eligibility requirements.

- a legal alien who is receiving SSI for months after July 1996 on the basis of an SSI application filed before January 1, 1979, is exempted from the SSI legal alien requirements, and is eligible for SSI if he/she meets all other SSI eligibility requirements.

B. Services Available To Eligibles A qualified alien who entered the U.S. before 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.

C. Entitlement & Enrollment of Eligibles The Medicaid entitlement policy and enrollment procedures for eligible qualified aliens who entered the U.S. before 8-22-96 are found in section M0220.600 below.

M0220.313 QUALIFIED ALIENS WHO ENTERED U.S. ON OR AFTER 8-22-96

A. No Limit on Residency in the U.S. *Effective 12-27-20, LPRs who are citizens of one of the countries of the Freely Associated States (Micronesia, the Marshall Islands, and Palau) are eligible for the full package of Medicaid benefits available to the covered group they meet (if they meet all other Medicaid eligibility requirements) with no limit on the length of residency in the U.S. or work requirements. This policy is applicable to eligibility determinations beginning with December.*

For eligibility determinations for months prior to December 2020, the individual is subject to the five year residency requirement and 40 quarter work requirement contained in M0220.313 C.

***B.* First 7 Years of Residence in U.S.** During the first seven years of residence in the U.S., six (6) groups of qualified aliens (as defined in M0220.310 above) who entered the U.S. on or after 8-22-96 are eligible for the full package of Medicaid benefits available to the covered group they meet (if they meet all other Medicaid eligibility requirements), even if their status is adjusted later to LPR.. These 6 groups of qualified aliens who entered the U.S. on or after 8-22-96 are:

1. Refugees Refugees under section 207 and Amerasian immigrants are full benefit aliens for 7 years from the date of entry into the U.S. Once 7 years have passed from the date the refugee entered the U.S., the refugee becomes an "emergency services" alien.

2. Asylees Asylees under section 208 are full benefit aliens for 7 years from the date asylum in the U.S. is granted. Once 7 years have passed from the date the alien is granted asylum in the U.S., the asylee becomes an "emergency services" alien.

3. Deportees Deportees whose deportation is withheld under section 243(h) or section 241(b)(3) are full benefit aliens for 7 years from the date withholding is granted. After 7 years have passed from the date the withholding was granted, the deportee becomes an "emergency services" alien.

NOTE: If the qualified alien is a veteran or in active duty military status, or is the spouse or the unmarried dependent child of a qualified alien who meets the conditions in M0220.313 above, the alien is a full benefit alien.

4. Cuban or Haitian Entrants Cuban and Haitian entrants as defined in section 501(e) of the Refugee Education Assistance Act of 1980 are full benefit aliens for 7 years from the date they enter the U.S. After 7 years have passed from the date they entered the U.S., a Cuban or Haitian entrant becomes an "emergency services" alien.

5. Victims of a Severe Form of Trafficking

Victims of a severe form of trafficking as defined by the Trafficking Victims Protection Act of 2000, P.L. 106-386 are full benefit aliens for 7 years **from the date they are certified or determined eligible** by the Office of Refugee Resettlement (ORR). Victims of a severe form of trafficking are identified by either a letter of certification (for adults) or a letter of eligibility (for children under age 18 years) issued by the ORR (see Appendix 5 of this subchapter). **The date of certification/eligibility specified in the letter is the date of entry for a victim of a severe form of trafficking.** After 7 years have passed from the certification/eligibility date, a victim of a severe form of trafficking becomes an "emergency services" alien unless his status is adjusted.

6. Afghan or Iraqi Immigrant Admitted to the U.S. on a Special Immigrant Visa

The Department of Defense Appropriations Act of 2010, enacted on December 19, 2009, provides that Iraqi and Afghan Special Immigrants are eligible for Medicaid benefits to the same extent and for the same time period as refugees. The legislation supersedes prior legislative authority that limited Special Immigrants to benefits for an 8-month time period. Provided that all other eligibility requirements are met, Iraqi and Afghan Special Immigrants are eligible for Medicaid benefits for the first seven years after entry into the United States (U.S.).

7. After 7 Years Residence in U.S.

After seven years of residence in the U.S., the qualified refugee, Amerasian, asylee, deportee, Cuban or Haitian entrant, victim of a severe form of trafficking, or Afghan or Iraqi Special Immigrant (as defined in M0220.310 above) who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an "emergency services" alien.

***C.* AFTER 5 Years of Residence in U.S.**

Effective 4-1-21, after five years of residence in the U.S., LPRs (as defined in M0220.310 above) who entered the U.S. **on or after 8-22-96** are eligible for the full package of Medicaid benefits available to the covered group they meet (if they meet all other Medicaid eligibility requirements).

For eligibility determinations for months prior to April 2021, an LPR who entered the U.S. on or after 8-22-96 and who has resided in the U.S. for five years must also have at least 40 qualifying quarters of work. *Effective 4-1-21, a qualified lawful permanent resident who entered the U.S. on or after 8-22-96 and who has resided in the U.S. for at least five years is no longer required to have any qualifying quarters of work to receive full Medicaid benefits.*

Exception: effective 12-21-20, an LPR who is a citizen of one of the countries of the Freely Associated States (Micronesia, the Marshall Islands, and Palau) is eligible for full Medicaid benefits with no limit on the length of residency in the U.S. or work requirements. See M0220.313 A.

1. LPR

When an LPR entered the U.S. on or after 8-22-96, the LPR is an **"emergency services" alien during the first 5 years** the LPR is in the U.S., regardless of work quarters. *Exception: effective 12-27-20, an LPR who is a citizen of one of the countries of the Freely Associated States (Micronesia, the Marshall Islands, and Palau) is eligible for full Medicaid benefits with no limit on the length of residency in the U.S. or work requirements.*

Note: If the LPR had prior immigration status in one of the "seven-year" alien groups listed in M0220.313.A, he is considered to have "seven-year" status for the purposes of Medicaid eligibility for the first seven years of residency in the U.S. To determine former status of a LPR, check the coding on the I-551 for codes RE-6, RE-7, RE-8, or RE-9. Contact the USCIS at 1-800-375-5283 for assistance in identifying the former status for other seven year aliens.

Effective 4-1-21, **AFTER** 5 years have passed from the date of entry into the U.S., LPRs are "full benefit" aliens. *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.

2. Qualifying Quarter

- A qualifying quarter of work means a quarter of coverage as defined under Title II of the Social Security Act which is worked by the alien and/or
- all the qualifying quarters worked by the spouse of such alien during their marriage and the alien remains married to such spouse or such spouse is deceased, and all of the qualifying quarters worked by a parent of such alien while the alien was under age 18 years.

See Appendix 3 to this subchapter for procedures for verifying quarters of coverage under Title II of the Social Security Act.

Any quarter of coverage, beginning after December 31, 1996, in which the alien, spouse or parent of the alien applicant received any federal means-tested public benefit (such as SSI, TANF, Supplemental Nutrition Assistance Program [SNAP] and **full-benefit** Medicaid) **cannot** be credited to the alien for purposes of meeting the 40 quarter requirement. Medicaid coverage for **emergency services** does not impact the 40 quarter requirement.

D. **Services Available To Eligibles**

1. Refugee, Amerasian, Asylee, Deportee, Cuban or Haitian Entrant, Victim of a Severe Form of Trafficking; Afghan or Iraqi Special Immigrant

The following immigrants:

- qualified refugee,
- Amerasian,
- asylee,
- deportee,
- Cuban or Haitian entrant,
- victim of a severe form of trafficking, or

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

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.

Exception: effective 12-27-20, an LPR who is a citizen of one of the countries of the Freely Associated States (Micronesia, the Marshall Islands, and Palau) is eligible for full Medicaid benefits with no limit on the length of residency in the U.S. or work requirements.

***E*. Entitlement & Enrollment of Eligibles**

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.

M0220.314 LAWFULLY RESIDING NON-CITIZEN CHILDREN UNDER AGE 19 AND PREGNANT WOMEN

A. Policy

Section 214 of CHIPRA of 2009 gives states the option to provide Medicaid and FAMIS/FAMIS MOMS coverage to certain individuals who are lawfully residing in the United States and are otherwise eligible for assistance. Virginia has elected to cover children under the age of 19 and pregnant women who are lawfully residing in the U.S.

Noncitizens are lawfully residing in the U.S. if they have been admitted lawfully into the U.S. and have not overstayed the period for which they were admitted, or they have current permission to stay or live in the U.S.

This policy does **not** apply to individuals who receive temporary relief from removal under the Deferred Action for Childhood Arrivals (DACA) process announced by the U.S. Department of Homeland Security on June 15, 2012.

Children under age 19 and pregnant women who are in one of the lawfully residing non-citizen alien groups described below must have their immigration status verified at the time of the initial eligibility determination and at each annual renewal of eligibility to ensure that they are lawfully residing in the U.S. and that their immigration status has not changed.

NOTE: All aliens who meet the alien status eligibility requirements for Medicaid and FAMIS/FAMIS MOMS must also meet the Virginia state residency requirements to be eligible for coverage under the programs.

B. Eligible Alien Groups

Lawfully residing children under age 19 and pregnant women meet Medicaid and FAMIS/FAMIS MOMS alien requirements without regard to their date of arrival or length of time in the U.S. Children under 19 or pregnant women are lawfully residing aliens if they are:

1. a qualified alien as defined in section 431 of PRWORA (8 U.S.C § 1641). See M0220.310;

2. 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 . This group includes individuals with valid visas;

3. 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;

4. an alien who belongs to one of the following classes:

    a. aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C.§§ 1160 or 1255a, respectively),

    b. 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,

M0220.410 EMERGENCY-SERVICES-ONLY QUALIFIED ALIENS WHO ENTERED U.S. ON OR AFTER 8-22-96

A. First 5 Years of Residence in U.S.

During the first five years of residence in the U.S., four groups of qualified aliens (as defined in M0220.310 above) who entered the U.S. on or after 8-22-96 are eligible for **emergency Medicaid services only** provided they meet all other Medicaid eligibility requirements.

1. Lawful Permanent Residents (LPRs)

An LPR who enters the U.S. on or after 8-22-96 is an "emergency services" alien during the first 5 years the LPR is in the U.S., regardless of work quarters. *Exception: effective 12-27-20, an LPR who is a citizen of one of the countries of the Freely Associated States (Micronesia, the Marshall Islands, and Palau) is eligible for full Medicaid benefits with no limit on the length of residency in the U.S. or work requirements.*

Note: If the LPR had prior Refugee status, he may be considered to have Refugee status for the purposes of Medicaid eligibility. To determine former Refugee status of a Lawful Permanent Resident, check the coding on the I-551 for codes RE-6, RE-7, RE-8, or RE-9. Refer to M0220.313.A.1.

2. Conditional Entrants

A qualified Conditional Entrant who enters the U.S. on or after 8-22-96 is an "emergency services" alien.

3. Parolees

A qualified parolee who enters the U.S. on or after 8-22-96 is an "emergency services" alien.

4. Battered Aliens

A qualified battered alien who enters the U.S. on or after 8-22-96 is an "emergency services" alien.

B. AFTER 5 Years of Residence in U.S.

AFTER 5 years have passed from the date of entry into the U.S., the following groups of aliens who entered on or after 8-22-96 are eligible for emergency services only:

1. Lawful Permanent Residents Without 40 Work Quarters

For months prior to 4-1-21, Lawful Permanent Residents who DO NOT have at least 40 qualifying quarters of work remain emergency services aliens after residing in the U.S. for 5 years. *Effective 4-1-21*, Lawful Permanent Residents become full benefit aliens after 5 years of residing in the U.S. *with no work requirement.*

Exception: effective 12-27-20, an LPR who is a citizen of one of the countries of the Freely Associated States (Micronesia, the Marshall Islands, and Palau) is eligible for full Medicaid benefits with no limit on the length of residency in the U.S. or work requirements.

2. Conditional Entrants

A qualified Conditional Entrant who enters the U.S. on or after 8-22-96 is an "emergency services" alien.

3. Parolees

A qualified parolee who enters the U.S. on or after 8-22-96 is an "emergency services" alien.

4. Battered Aliens

A qualified battered alien who enters the U.S. on or after 8-22-96 is an "emergency services" alien.

If more than one period of service is requested, the records must be separated, and a separate certification form must be attached for each period of service.

If a request is received with one certification form and the records contain multiple dates of service, and/or DMAS is unable to make a determination with the medical records received, the entire request will be returned to the eligibility worker with a note specifying the information needed.

Do not include application forms for disability, FAMIS, etc. These forms contain protected health information that is not needed for the determination of medical necessity.

Do **not** take action to approve or enroll an emergency services alien until you receive the completed Emergency Medical Certification form back from DMAS. If approved, DMAS will provide the certification for Medicaid payment for emergency services and coverage begin and end dates.

M0220.600 FULL BENEFIT ALIENS ENTITLEMENT & ENROLLMENT

A. Policy

An alien who is determined eligible for full Medicaid benefits and who meets all Medicaid eligibility requirements (including covered group requirements) is eligible for all Medicaid-covered services available to the recipient's covered group.

B. Application & Entitlement

1. Application Processing

The eligibility worker must take the application and develop it in the same manner as any other individual's application. All eligibility requirements, including covered group requirements must be met.

2. Entitlement

If the applicant is found eligible for Medicaid, ongoing eligibility may exist unless the recipient is on a spenddown.

3. Spenddown

Spenddown provisions apply to medically needy individuals who have excess income.

4. Notice

Appropriate notice must be sent to the applicant of the status of his application and of his Medicaid eligibility.

C. Enrollment Procedures

Once a full benefit alien is found eligible for Medicaid, he must be enrolled in VaCMS using the following data:

1. Country

In this field, Country, enter the code of the alien's country of origin.

2. Cit Status

In this field, Citizenship Status, enter the Citizenship code that applies to the alien. Below, next to the Citizenship code, is the corresponding Alien Code from the Alien Code Chart in Appendix 5 to this subchapter. Eligible alien codes are:

R = refugee (Alien Chart codes F1, F2, G1, G2); also used for Afghan and Iraqi Special Immigrants (Alien Chart Code Z1).
E = entrant (Alien Chart code D1).
P = full benefit qualified aliens (Alien Chart codes A1, A2, A3, B1, B3, C1, *CC1,* E1, H1, H2, I1, J1, J2, K1).
I = legal immigrant children under age 19 only (Alien Chart codes Y1, Y2, Y3)

1. Cit Status

In this field, Citizenship Status code, enter :

A = Emergency services alien (Alien Chart codes B2, C2, C3, *CC2*, D2, D3, E2, E3, F3, G3, H3, I2, I3, codes J3 through V3, Z2) other than dialysis patient.

D = Emergency services alien who receives dialysis.

V = Visitor, non-immigrant alien (Alien Chart codes W1, W2, W3).

The Alien Codes Chart is found in Appendix 5 to this subchapter.

NOTE: Foreign visitors are not usually eligible for Medicaid because usually they do not meet the Virginia state residency requirement.

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. App Dt

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

5. Covered Dates Begin

In this field, coverage begin date, enter the begin date of the emergency service(s).

6. Covered Dates End

In this field, coverage end date, enter the date when the alien's emergency service(s) ends. When the emergency service(s) received was related to labor and delivery, the end date includes the day of discharge even though it is not counted to determine the length of stay for certification purposes.

7. AC

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

D. Notices

Appropriate notice must be sent to the applicant of the status of his application and the duration of his eligibility.

The USCIS requires that all benefit applicants who are denied benefits based **solely or in part** on the SAVE response be provided with adequate written notice of the denial as well as the information necessary to contact USCIS, so that the individual may correct his records in a timely manner, if necessary. The fact sheet, "Information for Applicants: Verification of Immigration Status and How to Correct Your Record with USCIS" (Form # 032-03-0427-00) must be included with the Notice of Action when benefits are denied, **including the approval of emergency-services-only Medicaid coverage**, and with the Advance Notice of Proposed Action when benefits are subsequently cancelled based on the results of a SAVE inquiry. The fact sheet is available at https://fusion.dss.virginia.gov/Portals/[bp]/Files/SAVE/Inform%20for%20Applicants%20Verification%20of%20Immigration%20Status.pdf?ver=2019-05-29-135745-363.

SSA Quarters of Coverage Verification Procedures for Lawful Permanent Residents *for Eligibility Determinations for Months Prior to April 1, 2021*

This appendix contains the process for determining the number of qualifying quarters (QQ) with which a lawful permanent resident (LPR) who entered the U.S. on or after 8-22-96 can be credited and is to be used in conjunction with the State Verification Exchange System (SVES) User Guide.

I. Procedures:

A. To determine the number of QQ available to a LPR applicant, ask the applicant the following questions:

1. How many years has the applicant, the applicant's spouse, or the applicant's parents (before the applicant turned 18) lived in this country?

2. How many years has the applicant, the applicant's spouse, or the applicant's parents (before the applicant turned 18) commuted to work in the U.S. from another country before coming to the U.S. to live, or worked abroad for a U.S. company, or worked in self-employment while a legal resident of the U.S.?

   (If the total number of years to both questions is less than 10 years, **STOP** because the applicant cannot meet the 40 QQ requirement.)

3. In how many of the years reported in the answer to question 1 did the applicant, the applicant's spouse, or the applicant's parent earn money through work?

B. To determine whether the applicant's earnings were sufficient to establish "quarters of coverage" in those years, refer to the income chart in section II .

   If the answer to question 3 is 10 years or more, verify from INS documents or other documents the date of entry into the country for the applicant, spouse and/or parent. If the dates are consistent with having 10 or more years of work, initiate a SVES inqiuiry.

C. Complete or obtain from the applicant a completed "Consent for Release of Information" (see page 4 of this appendix) with the full name, social security number and date of birth of each individual (self, spouse, or parent) whose work history is relevant. In addition, the applicant must provide a form signed by each such individual, except deceased persons, giving SSA permission to release information through SVES on that individual to the agency and/or the applicant. Retain the consent form in the case file to document the individual's consent. A consent form is valid for 12 months from the time of the signature.

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 Benefits effective 4-1-21 C1;* Emergency Only *for months prior to 4-21* C2
CC	*Permanent Resident Aliens who are citizens in the Freely Associated States (Micronesia, Marshall Islands, Palau)*	*Full Benefit* *CC1*	*Full Benefits effective 12-27-20. CC1; Emergency Only for months prior to 12-20. CC2*	*Full Benefits regardless of work quarters effective 12-27-20. CC1; Emergency Only with fewer than 40 quarters for months prior to 12-20. CC2*
			1st 7 years	After 7 years
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	Emergency Only 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)]	Full Benefit E1	Emergency Only E2	Emergency Only E3
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
I	Battered aliens, alien parents of battered children, alien children of battered parents [U.S. Attorney General]	Full Benefit I1	Emergency Only I2	Emergency Only I3
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

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
		Prior to 4-1-21, Lawful Permanent Resident **without** at least 40 qualify quarters of work coverage on record with the Social Security Administration	No—Eligible for Emergency Services Coverage Only	A

		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
		Effective 12-27-20, Lawful Permanent Resident who is a citizen of Micronesia, the Marshall Islands or Palau	*Yes*	*P*

Arrived in U.S. on or after 8/22/1996	Regardless of length of residency in U.S.	Individuals with no immigration documents (undocumented)	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

M0280 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-19	4/1/21	Pages 3, 4 Appendix 1 Page 4a was added.
TN #DMAS-17	7/1/20	Pages 7, 9, 10 Page 11 was deleted.
TN #DMAS-15	1/1/20	Page 9 Appendix 1
TN #DMAS-14	10/1/19	Pages 6, 7, 9, 11
TN #DMAS-2	10/1/16	Pages 7, 9
TN #100	5/1/15	Table of Contents Pages 1-11 Appendix 1 was added Pages 12 and 13 were deleted.
UP #9	4/1/13	Page 5
Update (UP) #7	7/1/12	Table of Contents Page 8 Appendix 1 was deleted.
TN #94	9/1/10	Page 1
TN #93	1/1/10	Page 13

- residential facilities located on the grounds of, or adjacent to, any large (more than 16 beds) institution;

- correctional or holding facilities for individuals who are prisoners, who have been arrested or detained pending disposition of charges, or who are held under court order as material witnesses or juveniles

- educational or vocational training institutions that primarily provide an approved, accredited or recognized program to individuals residing there

- hospitals, nursing facilities, and intermediate care facilities for individuals with intellectual disabilities.

NOTE: An individual residing in a public educational or vocational training institution for purposes of securing education or vocational training is NOT an inmate of a public institution, and therefore may be eligible for Medicaid, even though the educational or training facility is not a publicly operated community residence.

I. Residential Institution

An institution that does not meet the definition of a "medical facility."

M0280.200 INSTITUTIONAL STATUS RULE

A. Introduction

Federal regulations in 42 CFR 435.1008 prohibit federal financial participation (FFP) for individuals who are inmates of a public institution, *with certain exceptions for patients in an IMD.*

Federal regulations limit FFP for individuals who are age 22 years or over but under age 65 years and who are patients in an institution for the treatment of mental diseases (IMD). An individual who is age 22 or over, but under age 65 and who is enrolled in Medicaid at the time of admission to an IMD may remain enrolled in Medicaid. The Department of Medical Assistance Services (DMAS) will coordinate with the Centers for Medicare and Medicaid Services (CMS) to ensure that no unauthorized FFP occurs.

There is no prohibition on FFP for individuals under age 22 years if they are receiving inpatient psychiatric services.

NOTE: an ICF-*ID* is not an IMD.

B. Procedures

The policy and procedures for determining whether an individual is in an IMD are contained in subchapter M1430.

The policy and procedures for determining whether an individual is an inmate of a public institution are contained in the following sections:

- M0280.201 Individuals in Medical Facilities
- M0280.202 Individuals in Residential Facilities
- M0280.300 Inmate of A Public Institution
- M0280.301 Who Is NOT An Inmate of A Public Institution
- M0280.400 Procedures For Determining Institutional Status
- M0280.500 Individuals Moving To or From Public Institutions
- M0280.600 Departmental Responsibility.

See Appendix 1 to this subchapter for an Institutional Status Quick Reference Guide.

M0280.201 INDIVIDUALS IN MEDICAL FACILITIES

A. Public or Private

The public or private ownership or administration of a **medical** facility is irrelevant because a medical facility is not a public institution as defined in this subchapter.

B. Individuals in IMD*s*

The following individuals in public or private IMDs are NOT eligible for *enrollment into* Medicaid because they do not meet the institutional status requirement:

- an individual who is age 22 or over, but under age 65;
- an individual who is under age 22 who is NOT receiving inpatient psychiatric services in the IMD.

An individual who is age 22 or over, but under age 65 and who is enrolled in Medicaid at the time of admission to an IMD may remain enrolled in Medicaid. The Department of Medical Assistance Services (DMAS) will coordinate with the Centers for Medicare and Medicaid Services (CMS) to ensure that no unauthorized FFP occurs.

1. Patient *Under Age 22 or 65 Years and Older* in an IMD

An individual is in an IMD when he/she is admitted to live there and receive treatment or services provided there that are appropriate to his/her requirements. A patient in an IMD is 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. An individual is *considered to be* in an IMD from the date of admission to the IMD until discharge from the IMD.

An individual who is age 65 or older and who is a patient in a public or private IMD meets the institutional status requirement for Medicaid. An individual who is under age 22, who is a patient in a public or private IMD and who is receiving inpatient psychiatric services in the IMD meets the institutional status requirement for Medicaid.

2. ***Patient Age 22-65 Years***

An individual who is age 22 or over, but under age 65 and who is enrolled in a Medicaid at the time of admission to an IMD may remain enrolled in Medicaid. ***Do not cancel coverage****. The Department of Medical Assistance Services (DMAS) will coordinate with the Centers for Medicare and Medicaid Services (CMS) to ensure that no unauthorized FFP occurs.*

For an individual age 22 or over, but under age 65 and who is a patient residing in an IMD at the time of application, follow the policy and procedures in M1510.102 A.5.

3. **Conditional Release From IMD**

A patient in an IMD who is transferred or discharged to a medical facility that is not an IMD, including a patient under conditional release or convalescent leave from the IMD, meets the institutional status requirement and may be eligible for Medicaid.

C. ICF-ID

An ICF-ID is not an IMD. Therefore, an individual under age 65 who is in an ICF-ID meets the institutional status eligibility requirement.

D. Residential Facilities With Certified Medical Beds

Some institutions have both medical and residential sections. Individuals in the residential section (or beds) are residents of a residential facility. If the resident receives Medicaid Community-based Care (CBC) waiver services, use chapter M14 to determine the individual's eligibility. If the resident does not receive Medicaid CBC, he is not in long-term care; use the Medicaid eligibility requirements for non institutionalized individuals.

Individuals in the medical certified portion (or beds) of an institution are patients in a medical facility. Use chapter M14 in determining their Medicaid eligibility.

Institutional Status Quick Reference Guide

Placement or living arrangement	Full Benefit	Inpatient Only	Ineligible
IMDs			
age 22-65, *Medicaid open at time of admission*	***Medicaid Remains Open***		
age 22-65, *Medicaid not open at time of admission*			**X**
under age 22 and receiving inpatient psychiatric treatment	**X**		
age 65 and older	**X**		
conditional release	**X**		
ICF-ID – all ages	**X**		
Residential			
medical section	**X**		
private group home with no more than 3 beds	**X**		
private residential	**X**		
public residential			
less than 16 beds	**X**		
16 or more beds			**X**
educational or vocational Institution	**X**		
Correctional Facilities			
adults			
DOC		**X**	
regional jails		**X**	
local jails		**X**	
juveniles (DJJ) in secure facilities			
held for care, protection, best, interest	**X**		
on probation	**X**		
held for criminal activity		**X**	
juvenile on probation placed in psychiatric hospital or residential treatment center	**X**		
juvenile not on probation ordered to treatment in a psychiatric hospital/residential treatment facility		**X**	
Adult arrested, but not held in corrections			
in medical facility prior to correctional facility placement	**X**		
in regional or local jail prior to medical facility		**X**	
TDO			
not in jail prior to hospitalization	**X**		
in jail prior to hospitalization		**X**	
Individual out on bail/released on own recognizance	**X**		
Adult on probation, parole, conditional release, *or furlough*	**X**		

M0320 Changes

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

b. Ongoing eligibility

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

1) For **earnings** accumulated **after** enrollment in MEDICAID WORKS, up to the current 1619(b) income threshold amount will be disregarded if deposited and retained in the WIN Account. The current 1619(b) threshold amount is *$41,399*.

2) Resources accumulated while in MEDICAID WORKS and held in Internal Revenue Service (IRS)-approved retirement accounts, medical or health savings accounts, medical reimbursement (flex) accounts, education accounts, independence accounts, and other similar State-approved accounts are excluded. Examples of these accounts include Archer Medical Savings Accounts, 401(k)/403(b)/457(b)/503(b) accounts, traditional Individual Retirement Accounts (IRAs), Roth IRAs, SEP-IRAs, SIMPLE IRAs, and Thrift Savings Plans. The account must be designated as a WIN Account in order to be excluded. **Resources accumulated while in MEDICAID WORKS and held in IRS-approved accounts that have been designated as WIN**

Resources accumulated while in MEDICAID WORKS and retained in an IRS-approved account described in M0320.400 D. 2. b. 2) that has been designated as a WIN Account are excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees.

H. Benefit Package

Individuals enrolled in MEDICAID WORKS are entitled to the standard benefits available to full-benefit Medicaid enrollees (see Chapter M18), as well as Personal Assistance Services; MEDICAID WORKS enrollees do **not** have a patient pay. Intensive Behavioral Dietary Counseling is also covered for MEDICAID WORKS enrollees when a physician determines that the service is medically necessary.

I. Entitlement and Enrollment

Entitlement for MEDICAID WORKS is dependent upon meeting the requirements listed above.

There is no retroactive coverage under MEDICAID WORKS. The application date in the Virginia Case Management System (VaCMS) is the date the individual signed the MEDICAID WORKS Agreement. Coverage shall begin on the first day of the month following the month in which all requirements are met. If the applicant has a future start date for employment, the effective date of eligibility shall be no earlier than the first day of employment. However, unless employment begins on the first day of the month, MEDICAID WORKS enrollment will begin on the first of the following month.

The AC for MEDICAID WORKS is 059. Use the following procedures to enroll the individual in VaCMS:

<u>New Application – Applicant Eligible as 80% FPL</u>

1. For the month of application and any retroactive months in which the person is eligible in the 80% FPL covered group, enroll the individual in a closed period of coverage using AC 039 (blind) or 049 (disabled), beginning the first day of the month in which eligibility exists. The cancel date is the last day of the month in which the MEDICAID WORKS Agreement was signed. Use Cancel Code 042.
2. Reinstate the individual's coverage in MEDICAID WORKS using AC 059 beginning the first day of the following month (the first day of the month following the month in which the MEDICAID WORKS Agreement is signed). Use the same application date (the actual date of the initial application) that was used for the month of application.

DMAS approval is not required for participation in MEDICAID WORKS; however, information must be sent to DMAS after the individual is enrolled for tracking purposes. Use the MEDICAID WORKS *Email* Cover Sheet *available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*, and ***email*** it together with the following information to DMAS at ***dmasevaluation@dmas.virginia.gov***:

- the signed MEDICAID WORKS Agreement,
- the Work Incentive Account (WIN) information (a bank account statement or verification from the bank that the account was opened), and
- one of the following verifications of employment:
  - a pay stub showing current employment or
  - an employment letter with start date or
  - self-employment document(s).

Changed With	Effective Date	Pages Changed
TN #DMAS-19	4/1/21	Pages 14, 26
TN #DMAS-14	10/1/19	Pages 1, 2, 10a
TN #DMAS-12	4/1/19	Pages 26, 28
TN #DMAS-11	1/1/19	Pages 1, 2, 12, 14-16, 24, 25
TN #DMAS-10	10/1/18	Table of Contents Page 1-2, 30 Page 10a-b were added as runover pages.

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

2. Newborn Child

42 CFR 435.117 - A child born to a woman who was eligible for Medicaid or to an individual covered by FAMIS at the time the child was born (including a newborn child born to an alien eligible for Medicaid payment of emergency services only) is eligible as a newborn child under age 1 year.

An exception is a child born to a women enrolled under Hospital Presumptive Eligibility (HPE); an application must be submitted for the child's Medicaid eligibility to be determined since no Medicaid application was submitted for the child's mother.

a. Eligible To Age 1

A child no longer meets this covered group effective the end of the month in which the child reaches age 1, provided he was under age 1 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 1.

Any child born a Medicaid-eligible woman will continue to be eligible up to age 1. If the child's mother was covered by Medicaid as a categorically needy individual in a state other than Virginia at the time of the child's birth, verification of the mother's Medicaid coverage must be provided by the parent or authorized representative.

b. No Other Eligibility Requirements

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

C. Financial Eligibility

Eligibility for CN Pregnant Women is based on the Modified Adjusted Gross Income (MAGI) methodology contained in Chapter M04.

1. Assistance Unit

The unborn child or children are included in the household size for a pregnant woman's eligibility determination. Refer to the procedures for determining the MAGI household in Chapter M04.

2. Resources

There is no resource test.

3. Income

Women enrolled as Pregnant Women are not subject to renewals during the pregnancy. The income limits for Pregnant Women are contained in M04, Appendix 2.

4. Income Changes After Eligibility Established

a. Pregnant Woman

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

M0330.700 BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT (BCCPTA)

A. Policy

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000 (P.L. 106-354) provides for payment of medical services, including long-term care (LTC) (see Chapter M14) for certain women and men with breast cancer or women with cervical cancer

Individuals eligible for the BCCPTA program must be age 18 through 64. They must have been screened and certified as needing treatment for breast or cervical cancer (including pre-cancerous conditions) by a medical provider operating under the Center for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program (BCCEDP) and referred to LDSS for a Medicaid eligibility determination. These individuals must not have creditable health insurance coverage for treatment of breast or cervical cancer.

Virginia's BCCEDP program, Every Woman's Life, is administered by the Virginia Department of Health. Screening locations can be found at http://www.vdh.virginia.gov/every-womans-life/clients / Information can also be obtained by calling 1-866-395-4968.

Through an agreement between Virginia and the District of Columbia (D.C.), residents of northern Virginia (the cities of Alexandria, Fairfax, Falls Church, Manassas, Manassas Park and the counties of Arlington, Fairfax, Loudoun and Prince William) are allowed to be screened and diagnosed for breast or cervical cancer and pre-cancerous conditions through the DC Center for Disease Control and Prevention's "Project Wish" program. Individuals who are screened and certified as needing treatment for breast or cervical cancer through Project Wish may be eligible for Virginia Medicaid, provided they meet the requirements of the BCCPTA covered group. These individuals will receive a Virginia BCCPTA Application Form from the DC providers and will be instructed to submit the application directly to the local department of social services in their home locality.

Individuals diagnosed with cancer by a provider who is not operating under the BCCEDP are not eligible in this covered group. ***Every Woman's Life is responsible for determining if an individual was diagnosed by a BCCEDP provider. Refer individuals who indicate to the local agency that they received a breast or cervical cancer diagnosis but do not provide the BCCPTA Application Form to Every Woman's Life (see above for contact information).***

B. Nonfinancial Eligibility

1. Required Nonfinancial Requirements

BCCPTA individuals must meet the Medicaid nonfinancial requirements in chapter M02.

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

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

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

5% FPL INCOME DISREGARD AMOUNTS ALL LOCALITIES

EFFECTIVE *1/13/21*
(No change from 2020)

Household Size	Monthly Amount
1	$54
2	73
3	92
4	111
5	130
6	149
7	168
8	187
Each additional, add	19

GAP-FILLING RULE EVALUATION
100% FPL
INCOME LIMITS

EFFECTIVE *1/13/20*

Household size	Annual (Use for Gap-filling Evaluation)	Monthly
1	*$12,880*	*$1,074*
2	*17,420*	*1,452*
3	*21,960*	*1,830*
4	*26,500*	*2,209*
5	*31,040*	*2,587*
6	*35,580*	*2,965*
7	*40,120*	*3,344*
8	*44,660*	*3,722*
Each additional	*4,540*	*379*

PREGNANT WOMEN
143% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/13//21*

Household Size	143% FPL Yearly Amount	143% FPL Monthly Amount	148% FPL (143% FPL + 5% FPL Disregard)
2*	*24,911*	*2,076*	*2,149*
3	*31,403*	*2,617*	*2,709*
4	*37,895*	*3,158*	*3,269*
5	*44,388*	*3,699*	*3,829*
6	*50,880*	*4,240*	*4,389*
7	*57,372*	*4,781*	*4,949*
8	*63,864*	*5,322*	*5,509*
Each additional, add	*6,493*	*542*	*560*

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

CHILD UNDER AGE 19
143% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/13/21*

# of Persons in House-hold	**109% FPL (for Determining Aid Category)**	**143% FPL**		**148% FPL (143% FPL + 5% FPL Disregard)**
	Monthly Limit	*Annual Limit*	Monthly Limit	Monthly Limit
1	*$1,170*	*$18,419*	*$1,535*	*$1,589*
2	*1,583*	*24,911*	*2,076*	*2,149*
3	*1,995*	*31,403*	*2,617*	*2,709*
4	*2,408*	*37,895*	*3,158*	*3,269*
5	*2,820*	*44,388*	*3,699*	*3,829*
6	*3,232*	*50,880*	*4,240*	*4,389*
7	*3,645*	*57,372*	*4,781*	*4,949*
8	*4,057*	*63,864*	*5,322*	*5,509*
Each add'l, add	*413*	*6,493*	*542*	*560*

PLAN FIRST
200% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/13/21*

Household Size	200% FPL Yearly Amount	200% FPL Monthly Amount	205% FPL (200% FPL + 5% FPL Disregard)
1	*$25,760*	*$2,147*	*$2,201*
2	*34,840*	*2,904*	*2,976*
3	*43,920*	*3,660*	*3,752*
4	*53,000*	*4,417*	*4,528*
5	*62,080*	*5,174*	*5,303*
6	*71,160*	*5,930*	*6,079*
7	*80,240*	*6,687*	*6,854*
8	*89,320*	*7,444*	*7,630*
Each additional, add	*9,080*	*757*	*776*

MAGI ADULTS
133% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/13/21*

Household Size	***133% FPL Yearly Amount***	**133% FPL Monthly Amount**	**138% FPL (133% FPL + 5% FPL Disregard)**
1	*$17,131*	*$1,428*	*$1,482*
2	*23,169*	*1,931*	*2,004*
3	*29,207*	*2,434*	*2,526*
4	*35,245*	*2,938*	*3,048*
5	*41,284*	*3,441*	*3,570*
6	*47,322*	*3,944*	*4,092*
7	*53,360*	*4,447*	*4,614*
8	*59,398*	*4,950*	*5,136*
Each additional, add	*6,039*	*504*	*523*

M0520 Changes

Changed With	Effective Date	Pages Changed
TN DMAS-19	4/1/21	Page 2
TN #DMAS-12	4/1/19	Page 1, 2
TN #DMAS-10	10/1/18	Page 2
TN #DMAS-3	1/1/17	Table of Contents Pages 3, 5-35 Pages 36-38 were removed.
TN #100	5/1/15	Page 2
TN #98	10/1/13	Title Page Table of Contents Pages 1,2,9
UP #7	7/1/12	Table of Contents Pages 2-5
Update (UP) #4	7/1/10	Pages 2, 2a

4. Psychiatric Residential Treatment Facilities (PRTFs)

Children residing in a PRTF *(formerly called a Level C PRTF)* are not temporarily absent from home. They are indefinitely absent from home and are not living with their parents or siblings for Medicaid purposes, if their stay in the facility has been 30 calendar days or longer. Long-term care rules do not apply to these children.

If the child is placed in a PRTF, verify *that the facility is* on the Magellan website at https://www.magellanofvirginia.com/for-providers/residential-program-process. Click on **Medicaid Contracted Residential Treatments Service Providers**. *PRTFs are denoted as Provider Type = 077 and Provider Specialty = blank.* If the facility is not a *PRTF* facility, the child is NOT considered living away from his parents.

5. Medical Facilities

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

6. Parent/ Caretaker-Relative Living in the Home

A parent/caretaker-relative who is absent from the home is considered living with a child in the household if the absence is temporary and the parent/caretaker-relative intends to return home when the purpose of the absence (such as military service, vacation, education, medical care or rehabilitation) is complete.

C. Procedure

This section contains an overview of the F&C family unit and budget unit rules. The detailed policy and procedures are contained in the following sections:

- M0520.010 Definitions;
- M0520.100 Family Unit Rules;
- M0520.200 Budget Unit Rules;
- M0520.300 Deeming From Spouse;
- M0520.400 Deeming From Parent;
- M0520.500 Changes In Status;
- M0520.600 Pregnant Woman Budget Unit;
- M0520.700 Individual Under Age 21 Family Unit.

M0810 Changes

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

3. Categorically Needy 300% of SSI

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

Family Size Unit	2020 Monthly Amount	*2021 Monthly Amount*
1	$2,349	*$2,382*

4. ABD Medically Needy

a. Group I	7/1/19 – 6/30/20		7/1/20	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$1,957.87	$326.31	$1,993.11	$332.18
2	2,492.57	415.42	2,537.36	422.89

b. Group II	7/1/19 – 6/30/20		7/1/20	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,259.09	$376.51	$2,299.75	$383.29
2	2,781.69	463.61	2,831.85	471.97

c. Group III	7/1/19 – 6/30/20		7/1/20	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,936.83	$489.47	$2,989.69	$498.28
2	3,540.71	590.11	3,604.37	600.72

5. ABD Categorically Needy

For:

ABD 80% FPL, QMB, SLMB, & QI <u>without</u> Social Security income; all QDWI; effective *1/13/21*

ABD 80% FPL, QMB, SLMB, & QI <u>with</u> Social Security income; effective *3/1/21*

All Localities	2020		*2021*	
ABD 80% FPL	Annual	Monthly	Annual	Monthly
1	$10,208	$851	*$10,304*	*$859*
2	13,792	1,150	*13,936*	*1,162*
QMB 100% FPL	Annual	Monthly	Annual	Monthly
1	$12,760	$1,064	*$12,880*	*$1,074*
2	17,240	1,437	*17,420*	*1,452*
SLMB 120% of FPL	Annual	Monthly	Annual	Monthly
1	$15,312	$1,276	*$15,456*	*$1,288*
2	20,688	1,724	*20,904*	*1,742*
QI 135% FPL	Annual	Monthly	Annual	Monthly
1	$17,226	$1,436	*$17,388*	*$1,449*
2	23,274	1,940	*23,517*	*1,960*
QDWI 200% of FPL	Annual	Monthly	Annual	Monthly
1	$25,520	$2,127	*$25,760*	*$2,147*
2	34,480	2,874	*34,840*	*2,904*

M1110 Changes

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

M1120.201 contains instructions for the resources treatment of trust established on or after August 11, 1993.

3. Equitable Home Ownership

Virginia does not recognize equitable ownership of real property.

D. References

The following references pertain to trust situations:

- Financial institution/conservatorship accounts, S1140.200 - S1140.215
- Property held under a State's Uniform Gift to Minors Act, S1120.205
- Situations involving an agent acting in a fiduciary capacity on behalf of another party, S1120.020
- Trust established on or after August 11, 1993, M1120.201

S1110.520 PROPERTY RIGHTS WITHOUT OWNERSHIP OF THE PROPERTY

A. Introduction

An individual may have certain rights with respect to property without also having the right to dispose of the property. However, the individual may have the right to sell his/her right or interest (i.e. the right to use or possess the property).

B. Definitions

1. Leasehold

A leasehold does not designate rights of ownership. Rather, it conveys to an individual use and possession of property for a definite term and usually for an agreed rent.

2. Incorporeal Interests

There are several types of real property rights called "incorporeal interests." They do not covey ownership of the physical property itself. They convey the right to use the property but not to possess it. These rights encompass mineral and timber rights and easements (explained in more detail at S1140.110).

M1420 Changes

Changed With	Effective Date	Pages Changed
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

M1420.200 RESPONSIBILITY FOR LTSS SCREENING

A. Introduction

In order to qualify for Medicaid payment of LTSS 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. The LTSS screening is completed by a designated screening team. The team that completes the screening depends on the type(s) of services chosen and needed by the individual. Below is a listing of the types of LTSS services an individual may receive and the teams responsible for completion of the screening for those services.

B. Nursing Facility Screening

For hospital patients who are currently enrolled in Medicaid and will be admitted to a nursing facility with Medicaid as the payment source (i.e. not a skilled-care admission covered by Medicare), 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 complete the screening.

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. Screening for HCBS Waivers

Screening and authorization for the Medicaid HCBS waivers are completed as follows:

1. Common-wealth Coordinated Care 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 and hospital screening teams are authorized to screen individuals for the CCC Plus Waiver. The authorization processes were not changed. See M1420.400 C.

2. 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 DBHDS staff.

3. Family and Individual Supports Waiver

CSBs are authorized to screen individuals for the Family and Individual Supports Waiver.

M1430 Changes

Changed With	Effective Date	Pages Changed
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.

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

- is primarily for the diagnosis, treatment or rehabilitation of individuals with intellectual disabilities or related conditions, and

- provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or rehabilitative services to help each individual function at his greatest ability.

Some community group homes are certified as Intermediate Care Facilities for the Intellectually Disabled (ICF-IDs) by the Department of Health. Patients in these facilities may have income from participating in work programs.

NOTE: Medically needy (MN) individuals are not eligible for Medicaid payment of LTC services in an ICF-ID because ICF-ID services are not covered for the medically needy.

3. Institutions for Treatment of Mental Diseases (IMDs)

An **IMD** is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, of persons with mental diseases. An institution for those intellectually disabled is NOT an IMD. For a list of *state-operated* IMDs in Virginia, see Appendix 1 to this subchapter.

Federal regulations in 42 CFR 435.1008 prohibit federal financial participation (FFP) in most Medicaid services provided to individuals under age 65 years who are patients in an institution for the treatment of mental diseases (IMD), unless they are under age 22 and are receiving inpatient psychiatric services. However, an individual who is age 22 or over, but under age 65 and who is enrolled in Medicaid at the time of admission to an IMD may remain enrolled in Medicaid. The Department of Medical Assistance Services (DMAS) will coordinate with the Centers for Medicare and Medicaid Services (CMS) to ensure that no unauthorized FFP occurs.

Medically needy (MN) patients over 65 years of age are not eligible for Medicaid payment of *LTSS* services in an IMD because these services are not covered for medically needy individuals age 65 or over.

4. Nursing Facility

A **nursing facility** is a medical institution licensed by the state to provide, on a regular basis, health-related services to patients who do not require hospital care, but whose mental or physical condition requires services, such as nursing supervision and assistance with activities of daily living, in addition to room and board and such services can be made available only in an institutional setting. Nursing facilities provide either skilled nursing care services or intermediate care services, or both.

5. Rehabilitation Hospitals

A **rehabilitation hospital** is a hospital certified as a rehabilitation hospital, or a rehabilitation unit of a hospital certified by the Department of Health as excluded from the Medicare prospective payment system, which provides inpatient rehabilitation services.

Changed With	Effective Date	Pages Changed
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.

TN #DMAS-12	4/1/19	Pages 10, 12a, 14, 21, 28b
TN #DMAS-10	10/1/18	Page 10, 12a, 14, 21
TN #DMAS-9	7/1/18	Pages 12a, 28
TN #DMAS-8	4/1/18	Page 2a
TN #DMAS-7	1/1/18	Pages 19, 20, 43, 44.
TN #DMAS-5	7/1/17	Pages 1, 7-9, 11, 15, 19, 20, 28a, 43, 47-51, 53
TN #DMAS-4	4/1/17	Page 19
TN #DMAS-3	1/1/17	Table of Contents, page ii Pages 1, 14, 17, 19, 20, 28a, 45-47, 50 Appendix 1, pages 1 and 2
TN #DMAS-2	10/1/16	Pages 12, 27, 28 Pages 12a and 28a were added as runover pages.
UP #11	7/1/15	Pages 43-46 Page 46a was deleted.
TN #100	5/1/15	Pages 2a, 4, 29, 31, 32, 34, 43, 44, 45, 53, 54 Pages 1a, 2, 3a and 4 were renumbered for clarity. Pages 3, 4a, 46 and 46a are runover pages. Pages 1 and 3 are reprinted.
TN #99	1/1/14	Pages 9, 19, 20, 23, 24, 40
TN #98	10/1/13	Pages 9, 24
UP #9	4/1/13	Pages 9, 16, 19, 20, 24, 43
UP #7	7/1/12	Pages 19, 46-48
UP #6	4/1/12	Pages 4, 9, 19, 20, 24, 26
TN #96	10/1/11	Pages 3, 4, 7-9, 19, 22-24, 43
TN #95	3/1/11	Pages 9, 19, 20, 23
TN #94	9/1/10	Table of Contents pages 1, 1a, 3, 3a, 11, 12, pages 19, 20, 24, 28, 31
TN #93	1/1/10	Pages 9, 13, 19-20, 23, 43, 44
TN #91	5/15/09	Table of Contents Pages 1-56 Appendix 1

The amount deducted is the amount of the **monthly** premium. If the patient pays the premium less often than monthly, such as quarterly, prorate the amount paid by the number of months covered by the payment to obtain the monthly amount to deduct in the patient pay calculation.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA (Multiple Employer Welfare Arrangement) or plan provided by another benefit arrangement.

Health benefit plan does not mean accident only, credit, or disability insurance; long-term care insurance; vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance (14VAC5-234-30).

Income protection insurance (indemnity) policy premiums are not medical expenses and are not deducted from the patient pay.

Membership fees for an organization that sponsors or provides the health insurance are not part of the premium and are not deductible.

2. Medicare Part A and/or B Premiums

Medicare Part B premiums and/or Medicare Part A premiums are paid by Medicaid for eligible individuals. The premiums are paid by Medicaid via the "buy-in" and are not usually deducted from patient pay. However, Medicaid does not start paying the premiums immediately for all eligible patients, so the Medicare premium(s) must be deducted from patient pay in those months for which Medicaid does not pay the premium.

For Categorically Needy (CN) individuals enrolled in the 300% SSI covered group in Aid Categories (ACs) 020, 040, and 060 and Medically Needy (MN)-*only individuals in ACs 018, 038, and 058*, the Medicare buy-in is effective **2 months after the begin date** of Medicaid coverage. If the begin date of coverage is other than the first day of a month, the buy-in is effective the first of the month in which the 60th day occurs. Part B premiums (and Part A premiums if the recipient must pay the Part A premium) must be deducted from patient pay in the month(s) in which the buy-in is not effective.

Deduct the Medicare premium(s) for the first two months of coverage for *individuals in the following ACs:*

- *CN 300% SSI and not dually eligible as a Qualified Medicare Beneficiary (QMB) or a Special Low-income Medicare Beneficiary (SLMB) Plus - ACs 020, 040, 060*
- *MN and not also QMB or SLMB - ACs 018, 038, 058.*

For individuals *in other ACs*, the buy-in is effective with the begin date of Medicaid coverage. Therefore, do NOT deduct Medicare premiums in the patient pay determination for months in the retroactive and ongoing coverage periods.

The Medicaid Medicare buy-in does NOT pay for Medicare premiums in closed periods of coverage for LTC patients who are on spenddown and whose eligibility is for a closed period. Deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from patient pay in the month(s) in which the buy-in is NOT effective.

The Medicaid Medicare buy-in pays for Medicare premiums in retroactive coverage and closed periods of coverage EXCEPT for LTC patients who are on spenddown. DO NOT deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from the patient pay in the month(s) in which the buy-in is effective for LTC patients who are NOT on spenddowns.

3. Example--Dual Eligible QMB

Mrs. Q has Medicare coverage and SSA income of $580 per month. Her Medicare premiums are deducted from her SSA check. She was admitted to the nursing facility on September 9. Her daughter filed a Medicaid application for her on September 10.

Mrs. Q is eligible in the *CN* 300% SSI group in September and is eligible as QMB. Her Medicare premiums are not deducted for September because they will be paid by Medicaid.

4. Example--Not Dual Eligible QMB

Mr. A was admitted to a nursing facility on March 5. He applied for Medicaid on June 2. His monthly income is $1,295, and his Medicare Part B premium is deducted from his SSA check. He is determined to be eligible in the *CN* 300% SSI covered group effective March 1.

His patient pay for March (the month of entry) includes a deduction for the Medicare premium. Because he is not QMB eligible, the buy-in is effective in May, the second month following the month in which his ongoing Medicaid coverage began. The cost of his Medicare Part B premium is deducted from his patient pay for the months of March and April, as his buy-in will be in effect beginning with the month of May.

If the buy-in is delayed for any reason, the individual will be reimbursed by SSA for premiums deducted after the second month.

5. Medicare Advantage (Part C) Premiums

Medicare Advantage plans, also referred to as Medicare Part C, are voluntary managed-care Medicare plans. In addition to Medicare Part B premiums, some individuals may pay an extra Medicare Advantage premium. The Medicaid Medicare buy-in is initiated for individuals with Medicare Advantage ; however, the buy-in covers only the allowable Medicare Part A and/or B premiums. The individual is responsible for any additional Medicare Advantage monthly premium. The Medicare Advantage monthly premium remains the individual's responsibility and is an allowable deduction from patient pay.

- the premium is paid from the patient's own funds; OR

- the premium is paid by a relative (other than a spouse or parent for minor child) when that relative receives a benefit payment (income) which includes a benefit amount for the patient.

The amount deducted is the amount of the monthly premium. If the patient pays the premium less often than monthly, such as quarterly, prorate the amount paid by the number of months covered by the payment to obtain the monthly amount to deduct in the patient pay calculation.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA (Multiple Employer Welfare Arrangement) or plan provided by another benefit arrangement.

Health benefit plan does not mean accident only, credit, or disability insurance; long-term care insurance; vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance (14VAC5-234-30).

Income protection insurance (indemnity) policy premiums are not medical expenses and are not deducted from the patient pay.

Membership fees for an organization that sponsors or provides the health insurance are not part of the premium and are not deductible.

1. Medicare Part A and/or Part B Premiums

Medicare Part B premiums and/or Medicare Part A premiums are paid by Medicaid for eligible individuals. The premiums are paid by Medicaid via the "buy-in" and are not usually deducted from patient pay. However, Medicaid does not start paying the premiums immediately for all eligible patients, so the Medicare premium(s) must be deducted from patient pay in those months for which Medicaid does not pay the premium.

For CN individuals enrolled in the 300% SSI covered group in ACs 020, 040, and 060 and MN-*only individuals in ACs 018, 038, and 058,* the Medicare buy-in is effective **2 months after the begin date** of Medicaid coverage. If the begin date of coverage is other than the first day of a month, the buy-in is effective the first of the month in which the 60th day occurs. Part B premiums (and Part A premiums if the recipient must pay the Part A premium) must be deducted from patient pay in the month(s) in which the buy-in is not effective.

Deduct the Medicare premium(s) for the first two months of coverage for *individuals in the following ACs:*

- *CN 300% SSI and not dually eligible as QMB or SLMB Plus - ACs 020, 040, 060*

- *MN and not also QMB or SLMB - ACs 018, 038, 058.*

For individuals *in other ACs*, the buy-in is effective with the begin date of Medicaid coverage. Therefore, do NOT deduct Medicare premiums in the patient pay determination for months in the retroactive and ongoing coverage periods.

The Medicaid Medicare buy-in does NOT pay for Medicare premiums in closed periods of coverage for LTC patients who are on spenddown and whose eligibility is for a closed period. Deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from patient pay in the month(s) in which the buy-in is NOT effective.

The Medicaid Medicare buy-in pays for Medicare premiums in retroactive coverage and closed periods of coverage EXCEPT for LTC patients who are on spenddown. DO NOT deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from the patient pay in the month(s) in which the buy-in is effective for LTC patients who are NOT on spenddowns.

2. Example - Medicare Buy-in (Using January 2009 Figures)

Mr. A is 80 years old and started receiving CBC on February 15. He applied for Medicaid on February 2. His only income is $1500 per month. He has no Medicare Part A premium. His Part B premium is withheld from his SSA benefit. Therefore, his gross SSA entitlement is actually $1596.40. He is CN eligible, but he is not dually-eligible as QMB.

Mr. A submitted bills for January and met a retroactive spenddown in January. Ongoing Medicaid began in February because he began receiving Medicaid CBC in February and became CN. The Medicare Buy-in begins on April 1.

His Medicare Part B premium is deducted in February's and March's patient pay. April and subsequent months will not include a deduction for the Medicare premium.

3. Medicare Advantage (Part C) Premiums

Medicare Advantage plans, also referred to as Medicare Part C, are voluntary managed-care Medicare plans. In addition to Medicare Part B premiums, some individuals may pay an extra Medicare Advantage premium. The Medicaid Medicare buy-in is initiated for individuals with Medicare Advantage; however, the buy-in covers only the allowable Medicare Part A and/or B premiums. The individual is responsible for any additional Medicare Advantage monthly premium. The Medicare Advantage monthly premium remains the individual's responsibility and is an allowable deduction from patient pay.

4. Medicare Part D Premiums

An individual who is eligible for Medicare and Medicaid is entitled to enrollment in a basic Medicare Part D prescription drug plan (PDP) at no cost. However, the individual may elect enrollment in a plan with a premium.

When a full-benefit Medicaid enrollee is enrolled in a Medicare Part D PDP, *any* premium that is the individual's responsibility is an allowable deduction from patient pay.

Changed With	Effective Date	Pages Changed
TN #DMAS-19	4/1/21	Pages 6, 8
TN #DMAS-18	1/1/21	Pages 2b, 9, 12
TN #DMAS-17	7/1/20	Page 15
TN #DMAS-16	4/1/20	Pages 5, 6, 12, 13 Pages 14 and 15 are runover pages.
TN #DMAS-14	10/1/19	Pages 2b, 4, 5-7
TN #DMAS-12	4/1/19	Pages 7, 9a. Page 7a is a runover page.
TN #DMAS-11	1/1/19	Page 7

Changed With	Effective Date	Pages Changed
TN #DMAS-10	10/1/18	Pages 7, 8a, 9a, 14 Pages 8b and 8c are runover pages.
TN #DMAS-9	7/1/18	Table of Contents Page 5. Page 9a was added.
TN #DMAS-8	4/1/18	Pages 2, 8a, 8b Page 8c was added.
TN #DMAS-6	10/1/17	Table of Contents Pages 1, 2 Page 2a is a runover page. Page 2b was added as a runover page.
TN #DMAS-5	7/1/17	Page 1 Page 2 is a runover page.
TN #DMAS-4	4/1/17	Pages 2a, 10
TN #DMAS-2	1/1/17	Table of Contents Pages 1, 8, 8a, 12-15 Page 11a was deleted.
TN #DMAS-2	10/1/16	On pages 3-15, corrected the subchapter number in the headers. Neither the dates nor the policies were changed.
TN #DMAS-1	6/1/16	Pages 2 Pages 1 and 2a are runover pages.
TN #100	5/1/15	Table of Contents Pages 1-2a, 5-8b
UP #10	5/1/14	Table of Contents Pages 7-8a Page 8b was added.
TN #99	1/1/14	Table of Contents Pages 1, 2, 8, 8a, 9-11 Page 11a was added.
UP #9	4/1/13	Pages 2-7, 10-12, 14
UP #7	7/1/12	Pages 8, 9
TN #96	10/01/11	Pages 8a, 10
TN #95	3/1/11	Table of Contents Pages 8, 11-15
TN #94	9/1/10	Pages 2a, 8-8a
TN #93	1/1/10	Page 6
Update (UP) #2	8/24/09	Page 11
TN #91	5/15/09	Page 14

1. Applicant Has Excess Income

When all eligibility requirements are met except for income, entitlement begins the date the spenddown is met. Only medically needy applicants can be eligible after meeting a spenddown. See subchapter M1330 to determine retroactive spenddown eligibility.

2. QMB Applicant

Entitlement to Medicaid for QMB coverage begins the first day of the month **following** the month in which the individual's QMB eligibility is determined and approved, **not** the month of application. QMB-only coverage for new applicants or individuals with closed coverage who reapply outside a renewal reconsideration period cannot be retroactive.

EXAMPLE #6: Ms. C is 55 years old and is disabled. She applied for Medicaid on May 8, 2019, and requested retroactive coverage. She began receiving Medicare in May 2019. She is approved for QMB coverage on June 9; therefore, her QMB coverage will begin on July 1. She is eligible to receive coverage in the MAGI Adults covered group for the retroactive months of February, March, and April. However, she is not eligible for MAGI Adults coverage in May or June due to her Medicare enrollment. QMB eligibility cannot extend to the retroactive period (see M1510.101.H). If she did not opt out of Plan First, she should be enrolled in Plan First coverage for May and June, 2019.

3. SLMB and QDWI

Ongoing entitlement for the Special Low Income Medicare Beneficiary (SLMB) and the Qualified Disabled and Working Individuals (QDWI) covered groups is the first day of the application month when all eligibility factors are met at any time in the month of application.

4. Applicant *Age 22 or Over, But Under Age 65* Is Admitted To An IMD *and Discharged From the IMD While the Application is Pending*

If an **applicant** *who is age 22 or over, but under age 65 is admitted to an IMD and discharged from the IMD while the application is pending, Medicaid entitlement begins the first day of the* application month (or retroactive month, if applicable) as long as he meets all other Medicaid eligibility requirements.

EXAMPLE #6a: Mr. A is a 50 year old man who applies for Medicaid at his local agency on October 1, *2020*. He was admitted to an IMD on October 20, *2020*, and was discharged from the IMD on November 2, *2020*, back to his home locality. The agency completes the Medicaid determination on November 5 and finds that he is eligible for Medicaid in October 2020. The worker enrolls him in Medicaid beginning October 1, 2020.

5. Applications From *Current* IMD Patients *Age 22 or Over, But Under Age 65*

An **applicant** who is *who is age 22 or over, but under age 65* and who is *currently* in an IMD is not eligible for Medicaid while in the IMD. Process the application within the established time frames *in M0130.100*. Eligibility will be determined based on the type of living arrangement to which the patient will be discharged. If eligible, do not enroll the patient until the date the patient is discharged from the IMD.

B. Coverage End Date

Medicaid entitlement ends the last day of the month in which the recipient fails to meet all of the Medicaid eligibility requirements, unless the recipient is a CN pregnant woman or *is age 22 or over, but under age 65 and* was admitted to an IMD.

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

1. CN Pregnant Woman

After eligibility is established, a pregnant woman in any CN covered group continues to be eligible for Medicaid during the remainder of her pregnancy and the 60-day post-partum period regardless of any changes in family income, as long she continues to meet all non-financial criteria.

2. *Individual Admitted to Ineligible Institution Other than an IMD*

Cancel coverage as soon as possible after learning of the enrollee's admission to an ineligible institution. **DO NOT cancel coverage retroactively.** Cancel coverage effective the current date (date the worker enters the cancel transaction in the system)." **An Advance Notice of Proposed Action is not required.** Send a Notice of Action to the enrollee or his authorized representative informing him of the cancel date and the reason.

*Note: An individual of any age who is **enrolled in Medicaid** at the time of admission to an **IMD** may remain enrolled in Medicaid. **Do not cancel coverage**. The Department of Medical Assistance Services (DMAS) will coordinate with the Centers for Medicare and Medicaid Services (CMS) to ensure that no unauthorized FFP occurs for individuals age 22 years or over but under age 65 years.*

3. Spenddown Enrollees

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

C. Ongoing Entitlement After Resources Are Reduced

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

Changed With	Effective Date	Pages Changed
TN #DMAS-19	4/1/21	Appendix 2
TN #DMAS-18	10/1/19	Pages 1, 4, 4a, 5, 11, 13 Content that was inadvertedly deleted in a previous transmittal was restored. No policy was revised.
TN #DMAS-17	7/1/20	Pages 2, 4, 25, 30 Page 3 is a runover page.
TN #DMAS-16	4/1/20	Pages 3, 4, 7, 9 Appendix 2 Pages 3a and 4 were renumbered to pages 4 and 4a. Page 4a is a runover page.
TN #DMAS-15	1/1/20	Pages 8, 8a
TN #DMAS-14	10/1/19	Pages 2, 3, 4, 6a, 8, 9, 10, 13 Page 4a is a runover page. Page 10a was added as a runover page. Page 7a was deleted.
TN #DMAS-13	7/1/19	Page 14
TN #DMAS-12	4/1/19	Table of Contents Pages 2, 5, 6, 6a, 7, 8, 8a, 11, 12, 15-18, 20 Appendix 2 Page 24a was added. Pages, 19, 21-24, 25 are runover pages.
TN #DMAS-11	1/1/19	Pages 2, 5, 6, 7, 9
TN #DMAS-8	4/1/18	Pages 2, 18 Appendix 2
TN #DMAS-7	1/1/18	Pages 2, 3, 3a, 5, 6, 7 Pages 6a and 7a are runover pages.
TN #DMAS-5	7/1/17	Pages 1, 2, 6, 8 Pages 3, 7, 7a and 9 are runover pages.
TN #DMAS-4	4/1/17	Pages 25-27 Appendix 2, page 1 Pages 28-30 were added.
TN #DMAS-3	1/1/17	Pages 1, 2, 4, 6, 7, 8, 14, 26

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

TWELVE MONTH EXTENDED MEDICAID INCOME LIMITS 185% of FEDERAL POVERTY LIMITS EFFECTIVE *1-13-21* ALL LOCALITIES

# of Persons in Family Unit/Budget Unit	185% FPL Monthly Limit
1	*$1,986*
2	*2,686*
3	*3,386*
4	*4,086*
5	*4,786*
6	*5,486*
7	*6,186*
8	*6,886*
Each additional person add	*700*

M1550 Changes

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

M1550.000 DBHDS FACILITIES

M1550.100 GENERAL PRINCIPLES

A. Introduction

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

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

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

M1550.200 DBHDS FACILITIES

A. Introduction

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

1. Training Centers

Training centers are medical facilities for patients diagnosed as mentally retarded (institutions for the mentally retarded). Training centers provide either or both intermediate and skilled nursing care. Some patients receiving intermediate care may be employed and have earned income.

Normally, patients in the training centers are disabled, but some are children who have not been determined disabled. Patients of any age in a training center may be Medicaid eligible if they meet all nonfinancial and financial Medicaid eligibility requirements.

The State training centers and locations are:

- Central Virginia Training Center (CVTC) – Madison Heights
- Southeastern Virginia Training Center (SEVTC) – Chesapeake
- Southwestern Virginia Training Center (SWVTC) – Hillsville

2. Psychiatric Hospitals

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

Federal regulations in 42 CFR 435.1008 prohibit federal financial participation (FFP) in most Medicaid services provided to patients residing in a psychiatric hospital unless they are:

- under age 21 years (if treatment began before age 21 and continues, they may be eligible up to age 22), or
- age 65 years or older,

and they meet all non-financial and financial Medicaid eligibility requirements.

An individual who is age 22 or over, but under age 65 and who is enrolled in a Medicaid at the time of admission to an IMD may remain enrolled in Medicaid. Do not cancel coverage. The Department of Medical Assistance Services (DMAS) will coordinate with the Centers for Medicare and Medicaid Services (CMS) to ensure that no unauthorized FFP occurs.

The following are psychiatric hospitals, offering differing levels of care:

a. Eastern State Hospital – Williamsburg
b. Central State Hospital – Petersburg
c. Western State Hospital – Staunton
d. Northern Virginia Mental Health Institute – Falls Church
e. Southern Virginia Mental Health Institute – Danville
f. Southwestern Virginia Mental Health Institute – Marion
g. Piedmont Geriatric Hospital – Burkeville
h. Catawba Hospital – Catawba
i. Commonwealth Center for Children and Adolescents (CCCA) – Staunton (formerly Dejarnette Center)

   CCCA is a psychiatric hospital for adolescents between the ages of 4 and 18. Children are provided schooling, counseling and medication. Most children have not been determined disabled. A child in CCCA can be Medicaid-eligible if the child meets all nonfinancial and financial Medicaid eligibility requirements.

2. General Hospital

General hospitals are medical facilities which provide care and services to acutely physically ill patients in the DBHDS facilities. The general hospitals may have patients of any age. There are general hospital acute care units within Eastern State and Western State Hospitals, and the Hiram Davis Medical Center general hospital located on the campus of Central State Hospital in Petersburg. Hiram Davis provides medical and surgical treatment for patients from any DBHDS facility. Hiram Davis also has some beds certified for nursing facility level of care.

Patients in the general hospitals may be Medicaid eligible if they meet all non-financial and financial Medicaid eligibility requirements.

M21 Changes

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

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

EFFECTIVE *1/13/21*

# of Persons in FAMIS House-hold	**FAMIS 150% FPL**		**FAMIS 200% FPL**		
	Annual Limit	Monthly Limit	Annual Limit	Monthly Limit	205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)
1	*$19,320*	*$1,610*	*$25,760*	*$2,147*	*$2,201*
2	*26,130*	*2,178*	*34,840*	*2,904*	*2,976*
3	*32,940*	*2,745*	*43,920*	*3,660*	*3,752*
4	*39,750*	*3,313*	*53,000*	*4,417*	*4,528*
5	*46,560*	*3,880*	*62,080*	*5,174*	*5,303*
6	*53,370*	*4,448*	*71,160*	*5,930*	*6,079*
7	*60,180*	*5,015*	*80,240*	*6,687*	*6,854*
8	*66,990*	*5,583*	*89,320*	*7,444*	*7,630*
Each add'l, add	*6,810*	*568*	*9,080*	*757*	*776*

M22 Changes

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

FAMIS MOMS
200% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/13/21*

Household Size	200% FPL Yearly Amount	200% FPL Monthly Amount	205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)
2	*34,840*	*2,904*	*2,976*
3	*43,920*	*3,660*	*3,752*
4	*53,000*	*4,417*	*4,528*
5	*62,080*	*5,174*	*5,303*
6	*71,160*	*5,930*	*6,079*
7	*80,240*	*6,687*	*6,854*
8	*89,320*	*7,444*	*7,630*
Each additional, add	*9,080*	*757*	*776*