CHAPTER M03

COVERED GROUPS REQUIREMENTS

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SUBCHAPTER 10

GENERAL RULES & PROCEDURES

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TN #DMAS-18	1/1/21	Table of Contents, page ii Pages 26, 27 Appendix 1 was removed. Appendix 2 was renumbered to Appendix 1.
TN #DMAS-17	7/1/20	Page 7 Pages 8 and 9 are runover pages.
TN #DMAS-15	1/1/20	Pages 29, 30
TN #DMAS-14	10/1/19	Pages 24, 26, 27, 40
TN #DMAS-13	7/1/19	Pages 24 Page 24a is a runover page.
TN #DMAS-12	4/1/19	Pages 8, 9, 13
TN #DMAS-10	10/1/18	Table of Contents, page ii Pages 1-4 Page 40 was added.
TN #DMAS-9	7/1/18	Page 35 Appendix 2, Page 1
TN #DMAS-8	4/1/18	Page 9
TN #DMAS-7	1/1/18	Pages 34, Appendix 2, page 1
TN #DMAS-5	7/1/17	Pages 13, 37, 38
TN #DMAS-4	4/1/17	Pages 24, 30a Page 23 is a runover page. Page 24a was added as a runover page.
TN #DMAS-3	1/1/17	Pages 8, 13, 28b
TN #DMAS-2	10/1/16	Pages 4, 7, 29 Page 30 is a runover page. Appendix 2, page 1
TN #DMAS-1	6/1/16	Table of Contents, page ii Pages 13, 26, 28 Appendix 2, page 1

TN #100	5/1/15	Table of Contents, pages i, ii Pages 11, 23, 28b, Pages 27a-27c were renumbered to 28-28a for clarity. Page 10 is a runover page. Appendix 2
UP #10	5/1/14	Pages 29, 30
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UP #7	7/1/12	Table of Contents, page ii Pages 23, 26, 27 Appendices 1-3 were removed. Appendices 3 and 4 were renumbered and are now Appendices 1 and 2, respectively.
TN #96	10/1/11	Appendix 4
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M0310.000 GENERAL RULES & PROCEDURES

M0310.001 GENERAL PRINCIPLES OF MEDICAID COVERED GROUPS

A. Introduction

An individual who meets all the non-financial eligibility requirements in Chapter M02 and who is not an ineligible person listed in M0210.100, must meet a Medicaid covered group in order to be eligible for Medicaid. Chapter M03 explains in detail each of the Medicaid covered groups and how to determine if an individual meets the covered group requirements.

The Medicaid covered groups are divided into two classifications: the categorically needy (CN) and the medically needy (MN). CN individuals meet all Medicaid non-financial requirements (see M02) and the definition for a covered group. MN individuals meet all Medicaid non-financial requirements and resource requirements, but have income in excess of the Medicaid limits. MN individuals may be placed on a spenddown (SD). The covered groups are also divided into Aged, Blind and Disabled (ABD) and Families & Children (F&C) covered groups. Within some covered groups are several definitions of eligible individuals. Some individuals may meet the requirements of more than one group. The agency must verify the individual meets a definition for a covered group and the group's financial requirements.

B. Refugees

If the Medicaid applicant is a refugee, first determine if the refugee meets the requirements in a Medicaid covered group using the policy and procedures in this chapter. If the refugee does not meet the requirements of a Medicaid covered group, the refugee is not eligible for Medicaid under a Medicaid covered group. Go to the Refugee Resettlement Program Manual Volume XVIII to determine the refugee's eligibility for assistance under the Refugee Resettlement Program.

The requirements for the Refugee Other (Cash Assistance) and Refugee Medicaid Other and Refugee Medicaid Unaccompanied Minors programs are found in another manual: the Refugee Resettlement Program Manual Volume XVIII.

C. Covered Group Information

This subchapter contains the general principles for determining if the individual meets a definition and covered group(s).

- M0310.002 contains the list of Covered Groups;
- M0310.100 - M0310.134 contains the Definitions;
- M0320 contains the detailed policy and covered group requirements for the Aged, Blind and Disabled Groups;
- M0330 contains the detailed policy and covered group requirements for the Families & Children Groups, *and includes the Modified Adjusted Gross Income (MAGI) Adults covered group, effective January 1, 2019.*

M0310.002 LIST OF MEDICAID COVERED GROUPS

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

A. Categorically Needy (CN)

The ABD, and F&C (including the *MAGI Adults)* covered groups in the CN classification are listed below.

1. ABD Groups

a. SSI cash assistance recipients who meet more restrictive Medicaid resource eligibility requirements.

b. Auxiliary Grants (AG) cash assistance recipients.

c. ABD individuals who are institutionalized in a medical institution, who meet all Medicaid eligibility requirements and have income before exclusions that is less than 300% of the SSI individual payment limit.

d. ABD individuals who receive or are applying for Medicaid-approved community-based care services, who meet all Medicaid eligibility requirements and who have income before exclusions that is less than 300% of the SSI individual payment limit.

e. ABD individuals who have a "protected" status:

1) individuals who received OAA, AB, APTD, or ADC as of August 1972, and meet specified requirements.

2) individuals who are former SSI/AG recipients and meet specified requirements.

3) individuals who are widows(ers) and meet specified requirements.

4) individuals who are classified as 1619(b) by Social Security and meet specified requirements.

5)individuals who are adult disabled children and meet specified requirements

f. Hospice--a hospice patient is a person who is terminally ill and has elected to receive hospice care; if the individual is not aged, presume that the individual is disabled.

g. Qualified Medicare Beneficiaries (QMBs).

h. Special Low-income Medicare Beneficiaries (SLMBs).

i. Qualified Disabled and Working Individuals (QDWIs).

j. Qualified Individuals (QIs).

k. ABD With Income ≤ 80% Federal Poverty Limit (ABD 80% FPL).

l. MEDICAID WORKS.

2. F&C Groups, *Including the MAGI Adult Group*

a. foster care children receiving IV-E and adoption assistance children receiving IV-E.

b. Low income families with children (LIFC) eligible children, parents, non-parent caretaker-relatives, and EWBs (*essential to the well-being* applications submitted prior to October 1, 2013).

c. Children under age 1 born to mothers who were eligible for and receiving MA at the time of the child's birth.

d. Individuals under age 21
   1. Title IV-E Eligible Foster Care children who do not receive a Title IV-E maintenance payment
   2. Non-IV-E Foster Care
   3. Juvenile Justice Department children
   4. Non-IV-E Adoption Assistance children
   4. Individuals in an ICF or ICF-MR

e. Former foster care children under age 26 years (Effective January 1, 2014)

f. Pregnant women

g. Plan First; Family Planning Services

h. Children under age 19 years

i. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). Women and men screened and diagnosed with breast or cervical cancer under the Centers for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program (BCCEDP) and eligible to receive Medicaid under the BCCPTA.

j. *MAGI Adults, 19 – 64 years of age (Effective January 1, 2019)*

B. Medically Needy (MN)

The ABD and the F&C covered groups in the MN classification are listed below.

1. ABD Groups

a. Aged - age 65 years or older.

b. Blind - meets the blind definition

c. Disabled - meets the disability definition.

d. Individuals who received Medicaid in December 1973 as AB/APTD-related MN and who continue to meet the December 1973 eligibility requirements.

2. F&C Groups

a. Children under age 18

b. Children under age 1

c. Pregnant Women

d. *Special Medical Needs Adoption Assistance Children*

e. Individuals under age 21

E. Refugees

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

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

M0310.100 DEFINITION OF TERMS

A. Introduction

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

M0310.101 ABD

A. ABD Definition

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

B. Procedures

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

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

M0310.102 ADOPTION ASSISTANCE

A. Definition

Adoption Assistance is a Title XX of the Social Security Act social services program that provides cash assistance and/or social services to adoptive

parents who adopt "hard to place" foster care children who were in the custody of a local department of social services or a child placing agency licensed by the state of Virginia.

1. **Residing in Virginia**

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

2. **Child-placing Agency Definition**

A child placing agency is an agency that is licensed by the State Department of Social Services for child placing services. Not all child placing agencies provide adoption services; some may provide foster home placement. The services offered must be identified in the description given for the license. The foster care service unit of the local department of social services should be familiar with the function of the child placing agency, and whether or not it is licensed.

3. **When Adoption Assistance Is Effective**

A child under 21 is usually considered an adoption assistance child when the adoption assistance agreement is signed, even if the interlocutory or judicial decree of adoption has not been issued or adoption subsidy payments are not being made. The adoptive parents are considered to be the adoption assistance child's parent(s) as of the date the adoption agreement is signed.

If the child is not eligible because of the adoptive family's income, treat the adoption assistance child as a foster care child until the interlocutory or judicial decree of adoption has been issued. As a foster child, the child's assistance unit consists of one person and the adoptive parent's income is not deemed to the child.

B. IV-E and Non-IV-E

1. IV-E Adoption Assistance

a. **Definition**

The following children meet the IV-E adoption assistance definition:

1) Children adopted under a IV-E adoption assistance agreement with a Virginia local department of social services or in conjunction with a privat child placing agency, who reside in Virginia. Eligibility begins when the IV-E adoption assistance agreement is signed even if an interlocutory or judicial decree of adoption has not been issued, or subsidy payments are nc being made.

2) Children adopted under a IV-E adoption assistance agreement with another state's department of social services, who now reside in Virginia.

b. **IV-E Adoption Assistance payment not required**

The IV-E adoption assistance definition is met when the adoption assistance agreement specifies that cash and medical assistance is required or that the only assistance required is medical assistance. Receipt of cash assistance is not required to meet the Adoption Assistance definition.

2. Non-IV-E Adoption Assistance

a. **Non-IV-E definition**

The following children meet the Non-IV-E adoption assistance definition:

1) Children who reside in Virginia who are adopted under a Non-IV-E adoption assistance agreement with a Virginia local department of social services or in conjunction with a Virginia private child placing agency.

2) "Special Medical Needs" children adopted under a Non IV-E Adoption Assistance agreement with a Virginia local department of social services or a Virginia private, non-profit child placement agency in conjunction with a local department of social services, in accordance with policies established by the State Board of Social Services.

b. **Special Medical Needs definition**

A child with "special medical needs" is a child who was determined unlikely to be adopted because of:

- a physical, mental or emotional condition that existed prior to adoption; or
- a hereditary tendency, genetic defect, congenital problem or birth injury leading to a substantial risk of future disability.

c. **Agreement must specify "special medical need(s)"**

The adoption assistance agreement *or amendment to the agreement* must specify that the child has a special medical need; the agreement does NOT need to specify a particular diagnosis or condition. *If an amendment was used to specify that the child has special medical needs, it must document that the special medical needs began prior to the effective date of the adoption assistance agreement.*

d. **Virginia Medicaid coverage for Special Medical Needs children**

Medicaid coverage is to be provided to any child who has been determined to be a Non-IV-E Special Medical Needs adoption assistance child for whom there is in effect an adoption assistance agreement between a local Virginia department of social services (LDSS) or a Virginia child-placing agency and an adoptive parent(s).

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

3. Verification

a. Adoption assistance agreement with Virginia agency

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

Verification of a child's status as a Virginia IV-E, *Non-IV-E or Special Medical Needs* adoption assistance recipient is obtained through the local agency's Service Programs Division.

b. IV-E adoption assistance agreement with another state

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

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

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

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

M0310.103 AFDC

A. Aid To Families With Dependent Children (AFDC)

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

B. Procedure

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

M0310.104 AG

A. Auxiliary Grants (AG)

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

B. Procedure

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

M0310.105 AGE and AGED

A. Age

"Age" is the individual's age reached on the anniversary of birth. If the year but not the month and day of the individual's birth is known, July 1 is assigned for both eligibility determination and enrollment.

For covered groups with a maximum age requirement, an individual meets the age requirement for the month of his birthday unless his birthday falls on the first day of the month.

Examples:

Gracie has been enrolled in the Child Under 19 covered group. She turns 19 on August 15. She continues to be eligible in the Child Under 19 covered group through the month of August.

Oliver has been enrolled in the MAGI Adults covered group. He turns 65 on July 1. Therefore, he is no longer eligible for the MAGI Adults covered group for the month of July.

B. Aged

"Aged," means age 65 years or older.

C. Procedures

For individuals under age 21, accept the date of birth provided on the application/redetermination form. No verification is required.

For aged individuals, verify the individual's age by Social Security records or documents in the individual's possession. Acceptable documents include:

- birth certificate or notification of birth;
- hospital or physician's record;
- court record of adoption;
- baptismal record;
- midwife's record of birth;
- form VS95 from state Bureau of Vital Statistics; or
- marriage records.

M0310.106 BLIND

A. Definition

The Medicaid blindness definition is the same as that of the Supplemental Security Income (SSI) blindness definition.

Blindness is defined by using one of two criteria. The first criteria indicates that blindness is defined as having best corrected central visual acuity of 20/200 or less in the better eye. The second criteria indicates that blindness is defined as the contraction of the visual field in the better eye with the widest diameter subtending an angle around the point of fixation no greater than 20 degrees.

B. Procedures

An SSI recipient who receives SSI as blind meets the blindness definition for Medicaid. Verify the SSI recipient's SSI eligibility via SVES (State Verification Exchange System).

Virginia no longer maintains a central registry of individuals who have been certified as blind or visually impaired. For an individual who alleges blindness or a visual impairment but does not receive SSI or Social Security Disability Income benefits, refer to section M0310.112 B to establish whether or not the individual requires a referral to the Disability Determination Services (DDS). If the individual requires a determination of blindness, refer the individual to the DDS using the procedure in M0310.112 E. 1.

M0310.107 CARETAKER-RELATIVE

A. Definitions

1. Caretaker-relative

A "caretaker-relative" is an individual who is not a parent, but who

- is a relative, of a specified degree, of a dependent child (as defined in M0310.111) and
- is living with and assuming continuous responsibility for day to day care of the dependent child (as defined in M0310.111) in a place of residence maintained as his or their own home.

A caretaker-relative is also referred to as a "non-parent caretaker" to distinguish the caretaker-relative from the parent.

2. Specified Degree

A relative of specified degree of the dependent child is

- any blood relative, including those of half-blood and including first cousins, nephews or nieces and persons of preceding generations as denoted by prefixes of grand, great, or great-great;
- a stepfather, stepmother, stepbrother, and stepsister;
- a relative by adoption following entry of the interlocutory or final order, whichever is first; the same relatives by adoption as listed above: including first cousins, nephews or nieces and persons of preceding generations as denoted by prefixes of grand, great, or great-great, and stepfather, stepmother, stepbrother, and stepsister.
- spouses of any persons named in the above groups even after the marriage is terminated by death or divorce.

Neither severance of parental rights nor adoption terminates the relationship to biological relatives.

B. Procedures

1. Relationship

The relationship as declared on the application/redetermination form is used to determine the caretaker-relative's relationship to the child. No verification is required.

2. *Child* Living in the Home

A child's presence in the home as declared on the application/ redetermination form is used to determine if the child is living in the home with a parent or a caretaker-relative. No verification is required.

3. Parent and Stepparent in Home

The presence of a parent in the home does not impact a stepparent's eligibility in the Low Income Families with Children (LIFC) covered group. Both the parent and stepparent may be eligible in the LIFC covered group. See M0330.300.

4. Parent and Other Relative in Home

When a parent is in the home, no relative other than a stepparent can be eligible for Medicaid in the LIFC covered group. See M0330.300.

***2.* Caretaker-Relative Living in the Home**

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

M0310.108 CATEGORICALLY NEEDY (CN)

A. CN Definition

"CN" is the short name for "categorically needy." CN is a federal classification of a Medicaid covered group. The CN covered groups include both the mandatory categorically needy groups listed in the federal Medicaid regulations as well as the optional groups Virginia has chosen to cover in the Medicaid State Plan.

B. Procedures

See subchapter M0320 for the policy and procedures to use to determine if an individual meets an ABD CN covered group.

See subchapter M0330 for the policy and procedures to use to determine if an individual meets a F&C CN covered group.

M0310.109 COVERED GROUP

A. Definition

The federal Medicaid law and the State Plan for Medicaid describe the groups of individuals who may be eligible for Medicaid benefits. These groups of individuals are the Medicaid covered groups. The individuals in the covered groups must meet specified definitions, such as age or disability, and other specified requirements such as living in a medical facility.

The covered groups are classified in Virginia as CN and MN. The covered groups are divided into the ABD and F&C covered groups for financial eligibility purposes.

B. Procedure

The covered groups are listed in section M0310.002.

The detailed requirements of the covered groups are in subchapters M0320 and M0330.

M0310.110 CHILD

A. Definition

The definition of "child" that is applicable depends on the individual's covered group.

1. Covered Groups to Which Modified Adjusted Gross Income (MAGI) Is Applicable

a. Tax-filer Household

A child is an individual of any age who is claimed as a tax dependent by a biological or adopted parent or step-parent.

b. Non-filer Household

A child is an individual under age 19.

2. F&C Non-MAGI, ABD and MN covered groups

A child is an individual under age 21 years who has not been legally emancipated from his/her parent(s).

A married individual under age 21 is a child unless he/she has been legally emancipated from his/her parents by a court. Marriage of a child does not emancipate a child from his/her parents and does not relieve the parents of their legal responsibility to support the child.

M0310.111 DEPENDENT CHILD

A. Definition

The definition of "dependent child" is the definition in section 406(a) of the Social Security Act: the term "dependent child" means a child who is:

- under the **age of 18**, OR
- under the **age of 19** and is a **full-time student** in a secondary school or in the equivalent level of vocational or technical training, or in a General Educational Development (GED) program IF he may be reasonably expected to complete the secondary school, training or program before *or in the month* he attains age 19; **AND**

  NOTE: The above definition of a full-time student does NOT apply when determining student status for the student earned income exclusion. See sections M0720.500 B.2 and M0720.510 for the student income exclusion requirements.

- **living in the home of a parent or a caretaker-relative** of the first, second, third, fourth or fifth degree of relationship in a place of residence maintained by one or more of such relatives as his or their own home. See section M0310.107 for the definition of a caretaker-relative.

B. Age & School Enrollment

1. Age

The child's date of birth declared on the application/redetermination form is used to determine if the child meets the age requirement. No verification is required.

A child who becomes 18 after the first day of his birth month meets the age requirement in the month of his 18th birthday; he is still considered under age 18 during his birth month. If he becomes age 18 on the first day of his birth month, he is age 18 for the whole birth month.

An 18 year old child does **not** meet the age requirement in the month following the month in which his 18th birthday occurs unless the child is enrolled full-time in a secondary school or vocational/technical school of secondary equivalency, AND the child is reasonably expected to complete the program of secondary school or vocational/technical training before or in the month he attains age 19.

2. School Enrollment

Accept the declaration of school enrollment.

C. Living With a Parent or Caretaker-Relative

1. Relationship

The child's relationship to the parent or caretaker-relative with whom he lives as declared on the application or redetermination document is used to determine if the child is living with a relative. No verification is required.

For the purpose of determining a relationship, neither death, divorce, *nor* adoption terminates relationship to the biological relatives.

***3.* Child's Father**

Virginia law considers a man who is legally married to the mother of a child on the date of the child's birth to be the legal father of the child **UNLESS** DCSE or a court has determined that another man is the child's father. NOTE: The mother's marriage at the time of the child's birth does not require verification; the mother's declaration is sufficient.

The man listed on the application form as the child's father is considered the father when:

- the mother was not married to another man on the child's birth date, or
- the mother was married to another man on the child's birth date but DCSE or a court determined that the man listed on the application is the child's father

unless documentation, such as the child's birth certificate, shows that another man is the child's father.

See M0310.123 for the definition of a parent.

4. *Child* Living in the Home

A child's presence in the home as declared on the application/ redetermination is used to determine if the child is living in the home with a parent or caretaker-relative. No verification is required unless the information contained in the application does not clearly establish whether or not the child is living with the parent or care-taker relative.

A dependent child is considered living with only one parent for Medicaid eligibility purposes When separated/divorced parents who claim to have equal physical custody of the child both apply for Medicaid and neither spouse has other children under age 18 in the home, obtain a copy of the custody agreement and verify the custody arrangements. If the custody is divided exactly equally between both parents, the parents must decide which parent the dependent child lives with for Medicaid purposes.

A child who is living away from the home is considered living with his parents in the household if:

- the child is not emancipated, and
- the absence is temporary and the child intends to return to the parent's home when the purpose of the absence (such as vacation, visit, education, rehabilitation, placement in a facility for less than 30 days) is complete.

  NOTE: If the stay in the medical facility has been or is expected to be 30 days or more, go to M1410.010 to determine if the child is institutionalized in long-term care.

Children living in foster homes or medical institutions are NOT temporarily absent from the home. They are indefinitely absent from home and are NOT living with their parents or siblings for Medicaid purpose.

Children placed in Level C psychiatric residential treatment facilities (PRTF) are considered absent from their home if their stay in the facility has been 30 days or more. A child who is placed in a Level C PRTF is considered NOT living with his parents for Medicaid eligibility purposes as of the first day of the month in which the 30th day of residential placement occurs. Modified Adjusted Gross Income (MAGI) methodology contained in Chapter M04 is applicable to children in PRTFs; long-term care rules do not apply to these children.

5. *Parent Living in the Home*

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

PAGES 15 – 20 WERE INTENTIONALLY REMOVED FROM THIS SUBCHAPTER

M0310.112 DISABLED

A. Introduction

For individuals who meet no other full-benefit covered group and claim to have a disabling condition, Medicaid eligibility uses the same definition of "being disabled" that the Social Security Administration (SSA) uses.

1. Definition of a Disabled Individual

For an individual 18 or older, the SSA defines "being disabled" as an individual's inability to do any substantial gainful activity (SGA) or work because of a severe, medically determinable physical or mental impairment or combination of impairments. This impairment(s) has lasted or is expected to last for a continuous period of not less than 12 months, or the impairment is expected to result in death.

For a child under 18, the SSA defines "being disabled" as having a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations. These limitations must have lasted or be expected to last for a period of not less than 12 continuous months, or the impairment is expected to result in death. However, a child cannot be found disabled if, at application, the child is performing SGA and is not currently entitled to Supplemental Security Income (SSI) benefits.

2. Disability Determination Services

Disability Determination Services (DDS) is a division of the Virginia Department *for Aging and* Rehabilitative Services *(DARS)* DDS is charged with making disability determinations for individuals who allege they are disabled for the purpose of qualifying for Social Security Disability Insurance (SSDI) and/or Supplemental Security Income (SSI) disability or blindness benefits, and/or Medicaid. An individual must file separate applications for SSDI/SSI benefits with SSA and for Medicaid with LDSS.

The Department of Medical Assistance Services (DMAS) contracts with *DARS* to have DDS process disability and blindness claims and make determinations of "disabled" or "not disabled" based upon federal regulations. DDS uses the same definitions of disability and blindness and the same evaluation criteria for all three programs. See M0310.106 for the definition of blindness.

3. Factors Involved in a Disability Decision

The LDSS does not determine whether or not an individual meets the disability requirements. DDS determines whether or not an individual is disabled as defined by the SSA by evaluating a series of factors in sequential order. The following information is intended to provide a general overview for the LDSS worker of this sequential process and does not provide a complete explanation of the disability determination process:

a. Engaged in Substantial Gainful Activity (SGA)?

Is the individual currently engaged in substantial gainful activity (SGA)? SGA means work that: (1) involves doing significant and productive physical or mental duties and (2) is done (or intended) for pay or profit and (3) earnings are above a certain amount. If an individual is working and earning SGA, a finding must be made that the person is not disabled, and no medical evaluation is done. If the individual is not earning SGA, DDS proceeds to the next step.

b. ***Severe Impairment?***

Does the individual have a severe impairment, as defined by SSA, that meets the durational requirement (i.e. has lasted or is expected to last for a continuous period of not less than 12 months, or which is expected to result in death)? If no, the person is not disabled. If yes, DDS will proceed to the next step.

c. ***Impairment Equals Severity Requirements?***

Does the individual have an impairment that meets or equals the severity requirements of a medical condition contained in the Social Security Listing of Impairments? If yes, a finding of disability is made. If no, DDS will proceed to the next step.

d. ***Prevents Performing Past Relevant Work?***

Does the individual have an impairment that prevents him from performing past relevant work? If the individual can perform past relevant work, the person will be found not disabled. If the individual cannot perform past relevant work, DDS will proceed to the next step.

e. ***Prevents Performing Any Work?***

Does the individual have an impairment that prevents him from performing any substantial gainful employment? If the individual cannot perform any work, the person will be found disabled. If the person has the capacity to adjust to other types of work, the person will be found not disabled. Age, education, training and skills acquired in past work are considered in making this determination.

4. Other Benefits Related to Disability

a. Benefits Administered by the SSA

The SSA uses the SSA disability definition in the determination of eligibility for SDDI and SSI benefits.

b. Benefits Administered by the Railroad Retirement Board (RRB)

The RRB makes disability determinations for railroad employees who have applied for the Railroad Retirement (RR) disability benefits. A determination of "total" disability means the individual is disabled for all regular work. "Occupational" disability means the individual is disabled for regular railroad occupation, but is not "totally" disabled. Individuals who receive a ***"total"*** *disability determination are disabled using the SSA criteria.*

B. Policy

The following individuals meet the definition of being disabled for the purposes of meeting a Medicaid covered group and are ***not to*** *be referred to DDS:*

- individuals who received SSDI or SSI disability benefits or RR total disability benefits in one or more of the 12 months preceding the Medicaid application and whose benefits were terminated for a reason **other than no longer meeting the disability or blindness requirements**.
- individuals who have been determined disabled or blind by DDS for Medicaid or for SSA, without a subsequent decision by SSA reversing the disability determination, and
- individuals who have been determined "totally" disabled by the RRB.

C. Procedures for Verifying Disability Status

1. Receives SSDI/SSI Disability Benefits

Verify SSDI/SSI disability status through a SVES (State Verification Exchange System) or SOLQ (State Online Verification Query) request or through documentation provided to the applicant by the SSA.

2. Receives RRB Disability Benefits

Verify RRB disability by contacting the RRB National Telephone Service at 1-877-772-5772 or through documentation provided to the applicant by the RRB.

3. Determined Disabled by DDS

If disability status cannot be ascertained **after** reviewing SVES or SOLQ, contact your regional DDS office to verify disability status. Contact information for the regional DDS offices is contained in Appendix 2 of this subchapter.

4. Incarcerated Disabled Individual

Although benefits administered by the Social Security Administration are suspended while an individual is incarcerated, a disabled individual continues to meet the definition of a disabled individual while incarcerated.

D. When a DDS Disability Determination is Required

- The DDS makes a disability determination for Medicaid when the individual alleges a disabling condition and has never applied for disability benefits from SSA or has not been denied disability within the past 12 months; **or**
- the individual alleges a disabling condition and SSA has not yet made a determination on a pending SSDI/SSI claim; **or**
- the individual alleges a disabling condition which is different from that considered by SSA or is in addition to that considered by SSA.

An individual must have his disability determined by DDS if he:

- is claiming to have a disabling condition but does not receive SS/SSI disability benefits or RR total disability benefits, **and**
- has not been denied SSDI or SSI disability benefits in the past 12 months.

1. Individual Under Age 19 and Not Receiving Long-term Care

A child under age 19 who is not receiving LTC services and who is claiming to have a disabling condition must have his disability determined by DDS if:

- he is not eligible for FAMIS Plus or FAMIS, or
- it is 90 calendar days prior to his 19th birthday.

Do **NOT** refer a disabled child under age 19 to DDS for the sole purpose of participation in the Health Insurance Premium Payment (HIPP) program

2. Individual Under 21 in LTC

a. Facility-based Care

An individual under age 21 in a nursing facility or intermediate care facility for the intellectually disabled (ICF-ID) must have his disability determined if

- he is not eligible in the Individuals Under 21 covered group, or
- it is 90 calendar days prior to his **21st** birthday.

b. **Home and Community-based Services (HCBS)**

A child who is receiving HCBS waiver services and has not previously had a disability determination must have his disability determined prior to his **18th** birthday because he will no longer be eligible in the F&C 300% SSI covered group (*under which parental income is not counted)*, once he turns 18. The child must be evaluated for coverage as a blind or disabled individual using the income and resource rules applicable to blind/disabled institutionalized individuals. For a child under 19 who is not disabled, MAGI income counting rules require that parental income be included in the eligibility determination.

Ninety days (90) prior to the child turning age 18, the eligibility worker must contact the parent or responsible party and send a verification checklist to request the required documents to start the DDS referral process. Follow the procedure in M0310.112 G below to make a referral to DDS.

Note: *The local DSS is not responsible for initiating a DDS referral for a child turning 18 who receives SSI. The child will have a review of continuing disability and SSI eligibility completed by the SSA.* The child remains disabled for Medicaid purposes unless and until his disability status is discontinued by SSA.

E. When an LDSS Referral to DDS is Required

1. Disability Determination Has Not Been Made

The DDS must make a determination of disability when the applicant alleges a disability and a disability determination has not been made by SSA or the RRB. The DDS must make a disability determination within a time frame that will allow the LDSS to process the application within 90 days, provided all medical information has been submitted.

2. SSA Denied Disability Within the Past 12 Months

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

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

OR

b) The applicant alleges his condition has **changed** or **deteriorated** causing a new period of disability **AND** he requested SSA reopen or reconsider his claim **AND** SSA has refused to do so or denied it for non-medical reasons. Proof of the decision made by SSA is required.

If the applicant indicates that one of the above exceptions applies, the Medicaid referral should be documented appropriately and sent to the DDS. After reviewing the Medicaid referral and Social Security decision, the DDS may determine that the SSA decision addressed all the conditions reported to Medicaid. In this situation, the DDS will determine that no exception applies and that the SSA decision is still binding. In this situation, the DDS will not make an independent disability determination for Medicaid. Instead, the DDS will document that an exception does not apply and that the SSA determination is still binding until the end of the 12-month period.

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

3. SSA Denied Disability More Than 12 Months Ago

If the applicant alleges a disability and SSA denied the disability more than 12 months ago, follow the procedure in M0310.112 G below to make a referral to DDS. DDS will accept and fully develop the Medicaid referral if more than 12 months have passed since the most recent SSA medical determination, regardless of appeal status with SSA, and for any reason.

F. Decision Pathway for DDS Referrals

When determining whether or not a referral to DDS is required, the worker should ask the following questions:

Has the individual applied for SSDI or SSI?

If no, refer to DDS.

If yes and a decision **has not** been made, refer to DDS.

If yes and a decision **has** been made, was the disability allowed or denied?

If allowed, refer to M0310.112 B, because another determination of disability may not be necessary.

If denied, look at the date of the last determination.

If the last SSA denial determination was made more than 12 months in the past, refer to DDS *regardless of whether or not the decision is in an appeal with SSA.*

If the last SSA denial determination was made less than 12 months in the past, and there is a new condition that has not been evaluated by SSA, refer to DDS.

If the last SSA denial determination was made less than 12 months in the past, and there has not been a worsening of a condition already evaluated by SSA, do not refer to DDS.

If the last SSA denial determination was made less than 12 months in the past, but there is a worsening of a condition already evaluated by SSA, ask if the individual has filed for a reconsideration or reopening of his case with SSA.

If yes and the case is currently under reconsideration, do not refer to DDS. The SSA decision remains binding unless SSA reverses the decision.

If yes and the SSA refused to reconsider his case <u>because he does not meet the SSI eligibility requirements,</u> refer to DDS.

If no, do **NOT** refer to DDS. The individual must initiate an appeal of his denial with SSA. Unless SSA refuses the appeal request or turns it down for non-disability related reasons, the disability determination remains binding for 12 months.

G. LDSS Procedures When a Disability Determination is Required

There are two types of DDS referrals for the purposes of Medicaid eligibility: non-expedited and expedited. Most referrals are non-expedited. Expedited referrals are limited to individuals who are hospitalized and require a Medicaid disability determination so they can be transitioned directly from the hospital to a rehabilitation facility

For both types of referrals, the eligibility worker must request the necessary verifications needed to determine eligibility so that the application can be processed when the disability determination is received.

1. LDSS Referrals to DDS for Non-expedited Cases

a. Send the following forms to the applicant for completion immediately, giving the applicant 10 calendar days to return the completed forms:

- a copy of the Frequently Asked Questions—Disability Determinations for Medicaid (form #032-03-0426), available on SPARK at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/References*, explaining the disability determination process and the individual's obligations;
- the Disability Report Adult (SSA-3368-BK), available at http://www.socialsecurity.gov/online/ssa-3368.pdf, or the Disability Report Child (SSA-3820-BK), available at http://www.socialsecurity.gov/online/ssa-3820.pdf,
- an Authorization to Disclose Information to the Social Security Administration form (SSA-827), available at http://www.socialsecurity.gov/online/ssa-827.pdf.

b. In most cases, the DDS referral is transmitted electronically to DDS through VaCMS. Form 3368-BK or 3830-BK and SSA-827 are uploaded to VaCMS for submission to DDS. No DDS Referral Form is used for electronic submissions. Follow the instructions in the Quick Reference Guide "Sending a DDS Referral in the VaCMS," available in VaCMS.

c. If the DDS referral cannot be completed in VaCMS, manually submit the referral. Complete the DDS Referral Form, available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms. Use the DDS Referral Form that corresponds with the DDS Regional Office to which the LDSS has been assigned (#032-03-0095, #032-03-0096, #032-03-0097, or #032-03-0098). To the form, attach the following:

- the completed Disability Report
- the signed Authorization to Disclose Information
- copies of paystubs, if the applicant is currently working.

If the individual's application was filed with the assistance of a hospital-based eligibility assistance organization, a copy of the consent to release information to the organization must be included with the referral so DDS staff can communicate with them, if necessary.

Mail the DDS Referral form and attachments to the *DDS Central Regional (Richmond)* Office. See *Appendix 1* to this subchapter for the *contact information*. **Do not send referrals to DDS via the courier.**

2. Expedited Referrals for Hospitalized Individuals Awaiting Transfer to a Rehabilitation Facility

The 2004 Budget Bill mandated that DDS make a disability determination within seven (7) working days of the receipt of a referral from the LDSS when the Medicaid applicant is hospitalized, needs to be transferred directly to a rehabilitation facility AND the individual does not already have a disability application pending with DDS. To ensure that the DDS is able to make the disability determination within the mandated timeframe, the procedures below shall be followed:

a. Hospital staff shall simultaneously send:

- the Medicaid application and a cover sheet, available on Fusion at to the LDSS or the hospital outstationed eligibility worker

- the medical documentation (disability report, authorizations to release information and medical records) and cover sheet to the DDS.

b. LDSS shall **immediately** upon receipt of the Medicaid application:

- fax a completed DDS Referral Form (#032-03-0095, #032-03-0096, #032-03-0097, or #032-03-0098) *available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, to the DDS Central Regional Office at 804- 527-4518* to verify receipt of the Medicaid application unless it is known to the agency that the individual already has a pending disability claim with DDS. If the individual already has a pending disability claim with DDS, the claim cannot be treated as an expedited referral.

- give priority to processing the applications and immediately request any verifications needed; and

- process the application as soon as the DDS disability determination and all necessary verifications are received; and

- notify the hospital contact identified on the cover sheet of the action on the application and provide the Medicaid enrollee number, if eligible.

c. DDS shall make a disability determination within seven (7) working days and fax the result of the disability decision to the LDSS. DDS is not responsible for notifying either the applicant or the hospital of the outcome of the disability determination.

If DDS is unable to render a decision within 7 working days, DDS will send a communication to the LDSS advising that the disability determination has been delayed.

3. Application Processing When DDS Referral is Pending

If the completed forms are not returned by the applicant within 45 calendar days from the date of application, the applicant is considered not to meet the covered group and the application must be denied.

Individuals who require a disability determination must meet all non-financial requirements other than covered group, within 45 calendar days or the application must be denied. If these requirements are met, the application timeframe may be extended to 90 days while DDS is making the disability determination. If any non-financial requirement other than covered group is not met by the 45th calendar day, his application must be denied and DDS must be notified of the denial.

DDS does NOT stop the disability determination process when the individual meets all non-financial requirements, but has excess resources (see M0130.100 B.4) because he might reduce his resources while the

application is pending for the disability determination. DDS does NOT stop the disability determination when the individual has excess income because of possible spenddown eligibility

4. LDSS Responsibilities for Communication with DDS

The LDSS must make every effort to provide DDS with complete and accurate information and shall report all changes in address, medical condition, and earnings to the DDS on pending applications.

5. Evaluation for Plan First and Referral to Health Insurance Marketplace

While an individual's application is pending during the non-expedited disability determination process, evaluate his eligibility for Plan First and enroll him if eligible (see M0330.600) and refer the individual to the Health Insurance Marketplace (HIM) for evaluation for the Advance Premium Tax Credit (APTC).

H. Notification of DDS Decision to LDSS

***1.* Hospitalized Individuals**

The DDS will advise the agency of the applicant's disability status as soon as it is determined by either SSA or the DDS. For hospitalized individuals who meet the requirements for an expedited disability determination, DDS will fax the outcome of the disability determination directly to the LDSS responsible for processing the application and enrolling the eligible individual.

***2.* Individuals Not Hospitalized**

For all other disability determinations, DDS will *notify* the LDSS responsible for processing the application and enrolling the eligible individual *by an alert in VaCMS*. If the claim is denied, DDS will also *include* a personalized denial notice to be sent to the applicant explaining the outcome of his disability determination.

***3.* Disability Cannot Be Determined Timely**

A disability determination cannot be completed within the allotted time when there is missing or incomplete medical information. DDS will notify the applicant about 75 days from the application date of the delay. *DDS will notify the LDSS by an alert in VaCMS*. The LDSS *must* send the applicant a Notice of Action to extend the pending application.

***4.* DDS Rescinds Disability Denial**

DDS will notify the agency if it rescinds its denial of an applicant's disability to continue an evaluation of the individual's medical evidence. If the Medicaid application has been denied, the agency must reopen the application and notify the applicant of the action. The application continues to pend until notification is received from DDS of the disability determination. If an appeal has been filed with DMAS, the agency must notify the DMAS Appeals Division so that the appeal may be closed (see M1650.100).

I. LDSS Action & Notice to the Applicant

The eligibility worker must complete the Medicaid eligibility determination immediately after receiving notice of the applicant's disability status and send the applicant a Notice of Action regarding the disability determination and the agency's decision on the Medicaid application.

J. Applicant is Deceased

When a Medicaid applicant who has been referred to DDS dies or when the applicant is deceased at the time of the Medicaid application, DDS will determine if the disability requirement for Medicaid eligibility was met. The LDSS must immediately notify DDS of the individual's death and make every effort to provide a copy of the death certificate.

K. Subsequent SSA or RRB Disability Decisions

When SSA or the RRB make a disability decision subsequent to the *DDS* (Medicaid) decision which differs from the *DDS* decision, the SSA or RRB decision must be followed in determining Medicaid eligibility unless one of the conditions in M0310.112 E.2 above applies.

***1.* SSA/RRB Approval**

If SSA approves disability or the RRB approves total disability, the disability definition is met. If DDS initially denied disability and the decision is reversed, re-evaluate the denied Medicaid application. The individual's Medicaid entitlement is based on the Medicaid application date, including the retroactive period, if all eligibility requirements were met during the retroactive period. However, eligibility as a disabled individual cannot begin prior to the disability onset date (month) established by SSA. Do not send the claim back to DDS for an earlier onset date.

Disability Approved More Than 12 Months Past

If, based upon the re-evaluation, the individual is determined to be eligible and more than 12 months have passed since the application was filed, complete an eligibility renewal to determine whether or not the individual remains eligible.

Spenddown

If, based upon the re-evaluation, the individual is determined not eligible for Medicaid but met the requirements in Chapter M13 for placement on a spenddown, a first prospective and additional 6 month spenddown budget periods may be established to cover the period of time between the date of application and the date action is taken on his case. A new application is not required for each 6 month spenddown budget period leading up to the date of processing, however, verification of all income and resources for those time periods must be obtained.

***2.* SSA Denial or Termination And Appeal**

If SSA denies disability, the disability definition is not met. If the individual has been enrolled in Medicaid as disabled and is not eligible in another covered group, send an advance notice to the enrollee to cancel Medicaid.

If the individual appeals the SSA's disability decision timely (within 60 calendar days from the SSA notification or with good cause for exceeding 60 days) and SSA agrees to reconsider the decision, the Medicaid coverage must be reinstated until the final decision on the SSA appeal is made. **The individual must provide verification that he filed the appeal and SSA agreed to reconsider the case**. The individual must also provide verification of the decisions made at all levels of appeal in order for Medicaid to continue during the process. The Medicaid coverage will continue until a final decision is made and the individual has no right to further SSA appeals.

The levels of administrative review are in the following order:

a. reconsideration,
b. the hearing before an administrative law judge (ALJ), and
c. the Appeals Council

For example: An individual is enrolled in Medicaid as disabled. However, his SSA claim is denied at the ALJ hearing level. If the individual fails to appeal the ALJ decision to the Appeals Council and the Appeals Council does not decide on its own to review the case, the ALJ decision becomes the final decision once the 60-day deadline for requesting further review has passed. Because the individual no longer meets the disabled definition for another covered group, his Medicaid coverage must be canceled.

***6.* RRB Denial, Termination and RRB Appeal**

If RRB denies disability, the disability definition is not met. If the individual has been enrolled in Medicaid as disabled and is not eligible in another covered group, send an advance notice to the recipient to cancel Medicaid.

Persons who believe that their claims have not been adjudicated correctly may ask for reconsideration by the Board's Office of Programs. If not satisfied with that review, the applicant may appeal to the Board's Bureau of Hearings and Appeals. Further, if the individual timely appeals the RRB disability decision, Medicaid coverage must be reinstated until the final decision on the RRB appeal is made. The individual must provide verification that he filed a timely appeal with RRB and must provide verification of the decisions made at all levels of appeal in order for Medicaid to continue during the process.

***7.* Subsequent SSA/SSI Disability Decisions**

If the individual appeals a disability denial and the decision is subsequently reversed, reopen and re-evaluate the denied Medicaid application as long as the disability onset month is prior to the month of application or is no later than 90 days after the month of application. If the individual has moved to another locality in Virginia, it is the responsibility of the agency that processed the application to reopen the application and determine eligibility prior to transferring the case. See M1510.104.

M0310.113 RESERVED

M0310.114 FAMILIES & CHILDREN (F&C)

"Families & Children (F&C)" is the group of individuals that consists of

- children under 19,
- pregnant women,
- specified subgroups of children under age 21,
- former Virginia foster care children under age 26 (effective January 1, 2014), and
- parent/caretakers of dependent children under age 18.

Also included in the F&C groups are individuals eligible only for family planning services (Plan First) and participants in BCCPTA.

M0310.115 FOSTER CARE

A. Definition

Foster Care provides maintenance and care for children whose custody is held by:

- a local board of social services;
- a licensed private, non-profit child placement agency;
- the Department of Juvenile Justice; or
- the child's parent(s), under a non-custodial agreement.

Federal regulations define "foster care" as "24-hour substitute care for children placed away from their parents or guardians and for whom the State agency has placement and care responsibility" (45 C.F.R. §1355.20). Transfer of the legal custody of the child is not a component when determining if a child is considered to be in foster care. The federal definition is based upon the child being placed outside of the home and who has placement and care responsibility for the child. If a child is placed outside of the home and LDSS is the case manager with placement and care responsibility, then the federal government considers the child to be in foster care. For the federal government, the term "placement and care" means that LDSS is legally accountable for the day-to-day care and protection of the child through either a court order or a voluntary placement agreement.

1. Custody

Custody may be given to an agency by the court or may be retained by the parent(s) or guardian when a non-custodial agreement is involved. If custody is retained by the parent under a parental agreement with the Community Policy and Management Team (CPMT), the child is NOT in foster care.

2. Child Placing Agency

A child placing agency is an agency that is licensed by the State Department of Social Services for child placing services. Not all child placing agencies provide adoption services; some may provide foster home placement. The services offered must be identified in the description given for the license. The foster care service unit of the local department of social services should be familiar with the function of the child placing agency, and whether or not it is licensed.

***3.* Independent Living and Fostering Futures**

A foster care child who is under age 18 who is in an Independent Living arrangement and receives full or partial support from a local social services agency, continues to meet the foster care definition and may be eligible in the covered group of Individuals Under Age 21. A child age 18 and over who is in an Independent Living arrangement with a local department of social services or in the Fostering Futures Program is considered a former foster care child and may be eligible in the Former Foster Care Child Under Age 26 covered group.

4. Kinship Guardianship Payments

Kinship Guardianship Payments are not income. These payments are a stipend paid to a relative caregiver who has assumed custody of a child as an alternative to that child remaining in foster care.

Children who are eligible for Title IV-E KinGAP (federal funds) Payments are categorically eligible for Medicaid.

***5.* Independent Living**

A foster care child who is under age 21, who is in an Independent Living arrangement and receives full or partial support from a local social services agency, continues to meet the foster care definition and may be eligible in the covered group of Individuals Under Age 21.

***6.* Non-custodial and Parental Agreements**

***a.* Non-custodial Agreement**

A non-custodial agreement is an agreement between the child's parent or guardian and the local Board of Social Services. The parent(s) or guardian retains legal custody of the child. The social services agency agrees to provide financial assistance and/or services to the child, such as placement in and payment for residential facility services.

Non-custodial agreements are used when LDSS serves as the case manager and has placement and care responsibilities to place a child outside of his home for treatment.

Children with non-custodial agreements are considered to be in foster care for Medicaid eligibility purposes.

***b.* Parental Agreement**

A parental agreement is an agreement between the child's parent or guardian and an agency **other than DSS** which is designated by the CPMT. The other agency designated by the CPMT has placement and care responsibility for the child and agrees to provide financial assistance and/or services to the child, such as placement in and payment for residential facility services.

Parental agreements are used when an agency other than LDSS is designated by the CPMT as case manager and the child is placed outside of the home for treatment.

Children with parental agreements ARE NOT considered to be in foster care for Medicaid eligibility purposes.

***c.* Placement**

Federal Title IV-E funds can only be claimed if LDSS has placement and care responsibility for the child **and** the child is placed by LDSS outside the child's home. If the LDSS has placement and care responsibility for the child and the child is placed in the child's home, the child is not eligible for Title IV-E funds and is a Non-IV-E foster child for Medicaid eligibility purposes.

***7.* Department of Juvenile Justice**

A child in the custody of the Virginia Department of Juvenile Justice or who is the responsibility of a court is a "Department of Juvenile Justice (DJJ) child."

B. Procedures

1. IV-E Foster Care

Children who are eligible for and receive Title IV-E (AFDC-FC) foster care maintenance payments *or Title IV-E KinGAP payments* are IV-E Foster Care for Medicaid eligibility purposes. A child of a IV-E foster care child is also considered to be a IV-E foster care child when the mother's IV-E payment includes an allocation for her child.

A child who is eligible for IV-E Foster Care but who does not receive a IV-E Foster Care maintenance payment is considered a "Non-IV-E Foster Care" child for Medicaid eligibility purposes.

Children in the custody of another state's social services agency, who are eligible for and receive Title IV-E Foster Care maintenance payments and who now reside in Virginia, are IV-E Foster Care for Medicaid eligibility purposes. Verify the child's IV-E eligibility from the other state's department of social services which makes the IV-E payment.

2. Non IV-E Foster Care

Children who are eligible for but do not receive IV-E maintenance payments or who are eligible for Non-IV-E (state/local) Foster Care (whether or not they receive a Non-IV-E payment), and who reside in Virginia are Non-IV-E Foster Care for Medicaid eligibility purposes.

3. Non-IV-E Children in Another State's Custody

A child in the custody of another state's social services agency who *is* not receiving IV-E foster care maintenance or SSI payments, *does* NOT meet the Virginia residency requirement for Medicaid (M0230) and *is* not eligible for Virginia Medicaid UNLESS *the child has been placed with and is residing in Virginia with a parent or care-taker relative.*

4. Trial Home Visits

A foster care or DJJ child continues to meet the foster care definition (either IV-E or non-IV-E) when placed by the agency in the child's own home for a trial period of up to six months, if the child continues to be in the agency's custody or remains the financial responsibility of DJJ or the court. Do not redetermine Medicaid eligibility during the 6 month trial home visit.

M0310.116 HOSPICE

A. Definition

"Hospice" is a covered group of terminally ill individuals whose life expectancy is 6 months or less and who have voluntarily elected to receive hospice care. The term "hospice" is also used to refer to the covered service for a terminally ill Medicaid recipient, regardless of his covered group. Hospice services can be provided in the individual's home or in a medical facility, including a nursing facility.

1. Hospice Care

"Hospice care" means items and services are provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan of care for the individual that is established and periodically reviewed by the individual's attending physician and the hospice program's medical director:

2. Hospice Program

A "hospice program" is a public agency or private organization which

- is primarily engaged in providing hospice care, makes hospice care services available as needed on a 24-hour basis, and provides bereavement counseling for the terminally ill individual's immediate family;
- provides hospice care in individuals' homes or in medical facilities on a short-term inpatient basis;
- meets federal and state staffing, record-keeping and licensing requirements.

B. Procedure

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

M0310.117 INSTITUTION

A. Definition

An **institution** is an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

B. Medical Institution (Facility)

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

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

C. Procedures

The procedures used to determine if an individual meets a covered group of individuals in institutions are contained in subchapters M0320 and M0330.

M0310.118 LIFC

A. Low Income Families with Children (LIFC)

Low Income Families with Children (LIFC) is a covered group of individuals in families who have a dependent child(ren) living in the home, and whose income is within the Medicaid F&C income limits.

B. Procedure

Section *M0330.200* contains the detailed requirements for the LIFC covered group.

M0310.120 MEDICALLY NEEDY (MN)

A. Definition

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

The MN individual is one who has income and resources enough to meet his maintenance needs, but not enough to meet his medical needs. MN individuals whose income exceeds the MN income limit *may be placed on a spenddown (SD) and establish eligibility when incurred medical and/or remedial expenses equal or exceed the SD amount.*

B. Procedure

The procedures used to determine if an individual meets a MN covered group are in subchapter M0320 *for ABD and M0330 for F&C.*

M0310.121 MEDICARE BENEFICIARY

A. Definition

A Medicare beneficiary is an individual who is entitled to Medicare (Title XVIII of the Social Security Act). Medicare is a federally funded and administered health insurance program and consists of hospital insurance (Part A), medical insurance (Part B) and, beginning January 1, 2006, prescription drug coverage (Part D).

1. Part A

A person is entitled to Medicare Part A if he

a. is age 65 or older and:

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

- would be eligible for Social Security benefits if his governmental employment were covered work under the Social Security Act; OR

b. is under age 65, disabled and

- entitled to or deemed entitled to Social Security disability benefits for more than 24 months,
- would be entitled to Social Security disability benefits for more than 24 months if his governmental employment were covered work under the Social Security Act,
- under specified circumstances, entitled to Railroad Retirement benefits because of disability,
- loses his entitlement to disability benefits and Medicare Part A solely because he is engaging in substantial gainful employment but voluntarily elects to enroll and pay a monthly premium; OR

c. is any age and has end-stage renal disease treated by a kidney transplant or a regular course of kidney dialysis and meets the special insured status requirements.

2. Part B

A person is eligible to enroll in Medicare Part B if he

a. is entitled to premium-free Medicare Part A or pays a premium for Medicare Part A, OR

b. is age 65 or older, a resident of the U.S., and either

- a citizen of the U.S., or
- an alien lawfully admitted for permanent residence who has resided in the U.S. continuously during the 5 years immediately prior to the month in which he or she applies for enrollment.

3. Part D

A person is eligible to enroll in Medicare Part D if he:

a. is entitled to Medicare Part A and/or enrolled in Medicare Part B; and

b. is a resident of the United States.

B. Procedures

A Medicare beneficiary may be eligible for Medicaid if he meets all of the Medicaid eligibility requirements including any one or more of the covered groups. Four of the Medicaid covered groups are specifically for Medicare beneficiaries and *provide a limited benefit package that pays costs related to Medicare, such as premiums, copays, and deductibles. These groups include Qualified Medicare Beneficiaries (QMBs), Special Low- income Medicare Beneficiaries (SLMBs), Qualified Disabled and Working Individuals (QDWIs) and Qualified Individuals (QI). QMBs, SLMBs, and QIs are also referred to as Medicare Savings Programs (MSP).*

See sections *M0320.601 (QMB), M0320.602 (SLMB), and M0320.603 (QI)* for the procedures to use to determine if an individual meets an MSP covered group. See section *M0320.604* for the procedures to use to determine if an individual meets the QDWI covered group.

M0310.122 OASDI

A. Old Age, Survivors & Disability Insurance (OASDI)

Old Age, Survivors & Disability Insurance (OASDI) is the federal insurance benefit program under Title II of the Social Security Act that provides cash benefits to workers and their families when the workers retire, become disabled or die.

OASDI is sometimes called RSDI - Retirement, Survivors & Disability Insurance. Because Title II of the Social Security Act is still officially called “Old Age, Survivors & Disability Insurance”, the Medicaid manual uses the abbreviation “OASDI” interchangeably with “Title II” to refer to Title II Social Security benefits.

B. Entitlement

An individual is fully insured if he has at least 1 credit for each calendar year after 1950, or if later, after the year in which he attained age 21, and prior to the year in which he or she attains age 62 or dies or becomes disabled, whichever occurs earlier.

A worker is entitled to retirement insurance benefits if he is at least age 62, is fully insured and files an application for retirement insurance benefits.

A claimant who is the worker's spouse is entitled to spouse's benefits on the worker's record if the claimant is age 62 or over, has in care a child under age 16 or disabled who is entitled to benefits on the worker's record, and the claimant has been married to the worker for at least 1 year before filing the claim or the claimant is the natural mother or father of the worker's biological child.

A child is entitled to child's insurance benefits on a parent's work record if an application for child's benefits is filed, the child is or was dependent on the parent, the child is unmarried, the child is under age 18 or is age 18-19 and a full-time elementary or secondary school student or age 18 or over and under a disability which began before the child attained age 22; and the parent is entitled to retirement or disability insurance benefits, or died and was either fully or currently insured at the time of death.

When an insured worker dies, monthly cash benefits may be paid to eligible survivors as follows: widow(er)'s benefits, surviving child's benefits, mother's or father's benefits, and parent's benefits.

C. Procedures

Verify an individual’s entitlement to OASDI by inquiring the MMIS computer system or entering the required data into the State Verification Exchange System (SVES). The individual’s award letter from SSA is acceptable verification of OASDI entitlement.

M0310.123 PARENT

A. Definition

Under federal regulations, a parent means either the mother or the father, married or unmarried, natural or adoptive following entry of the interlocutory or final adoption order, whichever comes first.

***1.* Mother Married on Child's Birth Date**

A mother who was married at the time of her child's birth may name on the application someone other than her husband as the child's father. The man to whom she was married at the time of the child's birth, however, is considered the child's father unless DCSE or a court determines otherwise. DCSE or the court must exclude the mother's husband, considered the legal father, as the child's father before the paternity status of the man named on the application is determined.

***2.* Mother NOT Married on Child's Birth Date**

If the mother was NOT married when the child was born, the man who is living in the home and who is listed on the application as the child's father is the child's acknowledged father, unless the agency receives evidence that contradicts the application, such as the child's birth certificate that has another man named as the child's father.

***3.* Paternity Evidence**

If evidence of paternity is required to establish eligibility or ineligibility, such evidence must be entered in the eligibility case record.

B. Procedures

NOTE: The mother's marital status at the time of the child's birth does not require verification; her declaration of her marital status is sufficient.

Section M0330.200 contains the detailed requirements for the LIFC covered group in which a parent of a dependent child can be eligible for Medicaid.

M0310.124 PREGNANT WOMAN

A. Definition

A woman of any age who attests that she is pregnant meets the definition of a pregnant woman.

At the time of application, applicants are asked if they are pregnant and if so, how many babies are expected. The pregnant woman definition is met the first day of the month *in which* the woman attests she is pregnant. She meets the definition of a pregnant woman for the retroactive period if she was pregnant during the retroactive months.

The definition of "pregnant woman" is met for sixty days following the last day the woman was pregnant regardless of the reason the pregnancy ended, and continues to be met until the last day of the month in which the 60th day occurs.

B. Procedures

1. *No Further* Verification *of Pregnancy Required*

If the woman has indicated on the application that she is pregnant or subsequently reports a pregnancy, no further information regarding her pregnancy is to be requested nor verification is to be required unless the agency has reason to question the applicant's statement that she is pregnant.

If a woman applying after the infant's birth requests retroactive coverage as a pregnant woman, her report of the birth is sufficient to establish her pregnancy in the three months prior to the child's birth month.

2. Covered Groups Eligibility

A pregnant woman may be eligible for Medicaid if she meets all of the Medicaid eligibility requirements including any one or more of the covered groups. *Once eligibility is established in any covered group, changes in income do not affect her eligibility as long as she continues to meet the definition of a pregnant woman and all non-financial eligibility requirements.*

See section M0330.*400* for the pregnant woman covered group requirements and M0330.801 for the MN Pregnant Woman requirements.

M0310.125 QDWI

A. Qualified Disabled & Working Individuals (QDWI)

QDWI is the short name used to designate the Medicaid covered group of Medicare beneficiaries who are "Qualified Disabled and Working Individuals." A qualified disabled and working individual means an individual

- who is entitled to enroll for Medicare Part A,
- whose resources do not exceed twice the maximum amount of resources that an individual or couple may have and be eligible for SSI,
- whose income does not exceed 200% of the federal poverty limit,
- who is NOT otherwise eligible for Medicaid.

B. Procedure

QDWI is a mandatory covered group that the state plan must cover for the purpose of paying the beneficiary's Medicare Part A premium. See section M0320.604 for the procedures to use to determine if an individual meets the QDWI covered group.

M0310.126 Qualified Individuals

A. Qualified Individuals (QI)

QI *is* the short name used to designate the Medicaid covered group of "Qualified Individuals." A qualified individual means a Medicare beneficiary

- who is entitled to Medicare Part A,
- *who has resources that are within the resource limits for the Medicare Savings Programs (MSPs). See chapter section M1110.003 for the current resource limits; and*
- whose income is equal to or more than 120% of the federal poverty level (FPL) and is less than 135% FPL.

B. Procedure

QI is a mandatory covered group that the State Plan must cover for the purpose of paying the Medicare Part B premium for the QI. See section *M0320.603* for the procedures used to determine if an individual meets the QI covered group.

M0310.127 QMB

A. Qualified Medicare Beneficiary (QMB)

QMB is the short name used to designate the Medicaid covered group of "Qualified Medicare Beneficiary." A qualified Medicare beneficiary means an individual

- who is entitled to enroll for Medicare Part A,
- *who has resources that are within the resource limits for the Medicare Savings Programs (MSPs). See chapter section M1110.003 for the current resource limits; and*
- whose income does not exceed *100%* of the FPL.

B. Procedure

QMB is a mandatory covered group that the state plan must cover for the purpose of paying the beneficiary's Medicare premiums and cost sharing expenses. See section *M0320.601* for the procedures to use to determine if an individual meets the QMB covered group.

M0310.128 RSDI

A. Retirement, Survivors & Disability Insurance (RSDI)

Retirement, Survivors & Disability Insurance (RSDI) is another name for Old Age, Survivors & Disability Insurance (OASDI) - the federal insurance benefit program under Title II of the Social Security Act that provides cash benefits to workers and their families when the workers retire, become disabled or die.

B. Procedure

RSDI Is not used in the Medicaid manual. Because Title II of the Social Security Act is still officially called "Old Age, Survivors & Disability Insurance", the Medicaid manual uses the abbreviation "OASDI" interchangeably with "Title II" to refer to Title II Social Security benefits.

M0310.129 SLMB

A. Special Low-income Medicare Beneficiary (SLMB)

SLMB is the short name used to designate the Medicaid covered group of "Special Low-income Medicare Beneficiary". A special low-income Medicare beneficiary means an individual

- who is entitled to enroll for Medicare Part A,
- *who has resources that are within the resource limits for the Medicare Savings Programs (MSPs). See chapter section M1110.003 for the current resource limits; and*
- whose income exceeds the QMB income limit (100% of the FPL) but does NOT exceed the higher SLMB income limit, which is 120% of the FPL.

B. Procedure

SLMB is a mandatory covered group that the state plan must cover for the purpose of paying the beneficiary's Medicare Part B premium. See section M0320.602 for the procedures to use to determine if an individual meets the SLMB covered group.

M0310.130 SSI

A. Supplemental Security Income (SSI)

Supplemental Security Income (SSI) is the federal cash assistance benefit program under Title XVI of the Social Security Act that provides cash assistance to eligible aged, blind or disabled individuals to meet their shelter, food and clothing needs.

B. Procedures

Individuals who receive SSI (SSI recipients) are not "automatically" eligible for Medicaid in Virginia. SSI recipients must meet all of the Medicaid nonfinancial eligibility requirements and must meet the Medicaid resource eligibility requirements that are more restrictive than SSI's resource requirements. See section M0320.101 for the procedures to use to determine if an SSI recipient meets a covered group.

M0310.131 STATE PLAN

A. Definition

The State Plan for Medical Assistance is a comprehensive written statement submitted by the Department of Medical Assistance Services (DMAS) describing the nature and scope of Virginia's Medicaid program. It contains all the information necessary for the federal Centers for Medicare and Medicaid Services (CMS) to determine whether the state plan can be approved for federal financial participation (FFP) in the state's Medicaid program expenses.

B. State Plan Governs Medicaid Eligibility Rules

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

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

M0310.132 TANF

A. Temporary Assistance for Needy Families (TANF)

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

M0310.133 BCCPTA

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

The BCCPTA created a Medicaid covered group for women and men age 18 through 64 who have been identified by the Centers for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program (BCCEDP) as being in need of treatment for breast or cervical cancer.

B. Procedures

Section M0330.700 contains the detailed requirements for the BCCPTA covered group.

M0310.134 VIEW PARTICIPANT

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

A VIEW participant is an individual who has signed the TANF Agreement of Personal Responsibility. *For renewals completed and changes reported prior to April 1, 2014,* VIEW participants have a higher earned income limit than non-VIEW participants. An individual under a TANF VIEW sanction is a VIEW participant for Medicaid purposes. An individual only receiving TANF transitional support services is not a VIEW participant for Medicaid purposes.

Modified Adjusted Gross Income (MAGI) methodology does not differ between VIEW participants and other individuals.

M0310.135 HIPP PROGRAM

A. Health Insurance Premium Payment (HIPP) Program

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

B. Procedures

M0130.200 G contains additional information about HIPP.

M0310.136 MAGI ADULT

A. Definition

A MAGI Adult is a person who is not defined as a "child" (see M0310.110).

The 2018 Appropriations Act mandated that Medicaid in Virginia be expanded effective January 1, 2019. This new expanded coverage group is called MAGI Adults and covers individuals ages 19-64 who are not eligible for or enrolled in Medicare and who have income at or below 138% of FPL. Several new aid categories have been added for the MAGI Adults covered group.

- Childless adults, income less than 100% FPL;
- Childless adults, income less than 138% FPL (133% + 5% income disregard);
- Parent/Caretaker adult relatives, above current LIFC income limit and at or below 100% FPL;
- Parent/Caretaker adult relatives, above 100% FPL and at or below 138% FPL (133% + 5% income disregard);
- Presumptive eligible adult, income at or below 138% FPL (133% + 5% income disregard);
- Incarcerated adult who otherwise meet a Medicaid MAGI Adult aid category but not enrolled due to incarceration.

B. Procedure

The procedures used to determine if an individual meets the MAGI Adults covered group are contained in subchapters M0320 and M0330.

Disability Determination Services (DDS) ***Contact Information***

Send ALL expedited and non-expedited disability referrals to the DDS Central Regional Office.

DDS Regional Office	Hearing Contacts
Central Regional Office Disability Determination Services 9960 Mayland Drive. Suite 200 Richmond, Virginia 23233 Phone: 800-523-5007 or 804-367-4700 General FAX: 804-527-4523 Expedited FAX: 804-527-4518 Professional Relations: Zachary Reynolds Office Manager: Karry Rouse Regional Director: Brett Fielding	Primary Contact (schedule): Jacqueline Fitzgerald 804-367-4838 Backup: Patrice Harris 804-367-4714 Hearings FAX: 804-527-4518

CHAPTER M03
MEDICAID COVERED GROUPS
SUBCHAPTER 20

AGED, BLIND & DISABLED GROUPS

M0320 Changes

Changed With	Effective Date	Pages Changed
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

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M0320.000 AGED, BLIND & DISABLED (ABD) GENERAL POLICY PRINCIPLES

A. Overview

A State Plan for Medicaid must include the mandatory federal categorically needy (CN) groups of individuals as well as the optional groups a state has elected to cover.

This subchapter divides the ABD covered groups into categorically needy and medically needy (MN) groups.

B. Procedure

Determine an individual's eligibility first in a CN covered group. This includes eligibility in the Modified Adjusted Gross Income (MAGI) Adults covered group (see M0330.250). If the individual is not eligible in a full-benefit CN covered group, determine the individual's eligibility as MN (on a spenddown).

An evaluation of eligibility for an aged, blind or disabled individual should follow this hierarchy:

1. If the individual is a current SSI/AG recipient, evaluate in this covered group. Exception-- if the individual requests MEDICAID WORKS, go to *5* below.
2. If the individual is a former SSI or AG recipient, evaluate first in the protected covered groups Exception-- if the individual requests MEDICAID WORKS, go to *5* below.
3. If the individual does not meet the criteria for SSI/AG or protected, is between ages 19 and 64, and is not eligible for or enrolled in Medicare, evaluate next in the MAGI Adults covered group.
4. If the individual is aged and/or is eligible for or has Medicare, evaluate next in the ABD with income ≤ 80% FPL covered group.
5. If a disabled individual has income at or below 80% FPL (including SSI recipients and 1619(b) individuals) and is going back to work, evaluate the individual in the MEDICAID WORKS covered group.
6. If the individual does not meet the requirements for MAGI Adults, 80% FPL group or MEDICAID WORKS, but meets the definition of an institutionalized individual, evaluate in the 300% of SSI covered groups.
7. If the individual is a Medicare beneficiary with income or resources in excess of the full-benefit Medicaid covered groups, evaluate in the Medicare Savings Programs (MSP) groups (QMB, SLMB, QI, QDWI).
8. If the individual is not eligible for Medicaid coverage in an MSP group AND he is at least age 19 years but under age 65 years or he requests a Plan First evaluation, evaluate in the Plan First covered group.
9. If the individual meets all the requirements, other than income, for coverage in a full benefit Medicaid group, evaluate as MN.

C. Referral to Health Insurance Marketplace

Unless an individual is incarcerated, an ABD individual who does not have Medicare and is not for eligible for full Medicaid coverage must be referred to the Health Insurance Marketplace (HIM) so the applicant's eligibility for the APTC can be determined. Incarcerated individuals and those with Medicare are not referred to the HIM.

M0320.001 ABD CATEGORICALLY NEEDY

A. Introduction

To be eligible in an ABD covered group, the individual must meet all Medicaid non-financial requirements in chapter M02 and an "Aged," "Blind" or "Disabled" definition in subchapter M0310. If he does not, then go to the Families & Children covered groups in subchapter M0330.

B. Procedures

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

- M0320.202 Conversion Cases
- M0320.203 Former SSI/AG Recipients
- M0320.206 Protected Adult Disabled Children
- M0320.207 Protected SSI Disabled Children
- M0320.300 ABD with Income ≤ 80% FPL
- M0320.400 MEDICAID WORKS
- M0320.501 ABD In Medical Institution, Income ≤ 300% SSI
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- M0320.503 ABD Hospice
- M0320.601 Qualified Medicare Beneficiary (QMB)
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- M0320.603 Qualified Individuals (QI)
- M0320.604 Qualified Disabled & Working Individual (QDWI))

M0320.100 ABD CASH ASSISTANCE COVERED GROUPS

A. Legal base

Medicaid eligibility for certain individuals is based on their receipt of cash assistance from another benefit program that has a cash assistance component.

B. Procedure

The policy and procedures for cash assistance recipients are found in the following sections:

- M0320.101 SSI Recipients
- M0320.102 AG Recipients

M0320.101 SSI RECIPIENTS

A. Introduction

42 CFR 435.121 - SSI recipients are a mandatory CN Medicaid covered group. Many states automatically *enroll an individual in* Medicaid when the individual is approved for SSI. However, in Virginia, not all SSI recipients are eligible for Medicaid. Virginia has chosen to impose real property eligibility requirements that are more restrictive than the federal SSI real property eligibility requirements. SSI recipients living in Virginia must apply separately for Medicaid because they are subject to a resource evaluation.

The Social Security Administration may approve an SSI applicant as conditionally or presumptively eligible for SSI. Conditionally-eligible SSI recipients are being allowed time to dispose of excess resources. Presumptively blind or disabled SSI recipients are presumed to be blind or disabled; no final blindness or disability determination has been made. An individual who has been conditionally or presumptively approved for SSI is NOT eligible for Medicaid in the SSI Recipients covered group. Evaluate the individual's eligibility in the MAGI Adults covered group.

SSI payments for eligible individuals are effective the first day of the month following the month in which the SSI application was filed. When the Medicaid application is filed in the same month as the SSI application, the applicant is not eligible for Medicaid as an SSI recipient until the month for which he receives his first SSI payment. See policy M0320.101.C. When the SSA record indicates a payment code(s) of "C01" and no payment amount is shown, the individual is considered to be a SSI recipient for Medicaid purposes. If the SSA record indicates a code of EO1 or E02 and no SSI payment has been received in more than twelve months, the individual's SSI status must be confirmed.

Eligibility for months prior to SSI entitlement must be evaluated *in the MAGI Adults* covered group.

B. Financial Eligibility

1. Resources

Determine if the SSI recipient has the following real property resource(s):

1) equity in non-exempt property contiguous to the individual's home which exceeds $5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 are applicable to the property;

2) interest in undivided heir property and the equity value of the individual's share that, when added to all other countable resources, exceeds the appropriate Medicaid resource limit. (The interest in the estate must be legally available.) If a partition suit is necessary to sell the interest, costs of partition and *individual's (recipient/applicant)* attorneys' fees may be deducted as described in M1120.215;

3) ownership (equity value) of the individual's former residence when the SSI recipient is in an institution for longer than 6 months. Determine if the former residence is excluded under policy in section M1130.100 D;

4) equity value in property owned jointly by the SSI recipient with another person in who is not the individual's spouse as tenants in common or joint tenants with the right of survivorship at common law. Determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;

5) other real property; determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property.

When an SSI recipient has any of the real property listed in 1) through 5) above, ALL of the recipient's resources must be verified, evaluated, and counted together to determine if the SSI recipient meets the Medicaid resource requirements. Calculate resources according to the assistance unit policy in chapter M05. If current resources are within the limit, go on to determine income eligibility. If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he may be eligible as MSP (which has more liberal resource methods and standards).

When an SSI recipient has no real property resource listed in 1) through 5) above, do NOT determine the SSI recipient's resources. The SSI recipient meets the Medicaid resource requirements because he receives SSI and does not have a real property resource listed above.

2. Income

Verify the SSI recipient's eligibility for SSI payments by an SSI awards notice and inquiring the State On-line Query-Internet (SOLQ-I) system, SDX (State Data Exchange) or SVES (State Verification Exchange System). If the recipient is eligible for SSI, he meets the Medicaid income eligibility requirement.

C. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month, including the receipt of, or entitlement to, an SSI payment in that month. *When the SSA record indicates a payment code(s) of "C01" and no payment amount is shown, the individual is considered to be an SSI recipient for Medicaid purposes. If the SSA record indicates a code of EO1 or E02 and no SSI payment has been received in more than twelve months, the individual's SSI status must be confirmed.*

Retroactive coverage is applicable to this covered group. However, if the individual did not receive, or was not entitled to, an SSI payment in the retroactiv period, the individual is not eligible for retroactive Medicaid in the SSI recipients covered group. His retroactive eligibility must be evaluated in another Medicaid covered group.

The ACs are:

- 011 for an aged SSI recipient;
- 031 for a blind SSI recipient;
- 051 for a disabled SSI recipient.

D. Ineligible as SSI Recipient

If a non-institutionalized SSI recipient is ineligible for Medicaid because of resources, evaluate the individual's eligibility in all other Medicaid covered groups including, but not limited to, the ABD with Income ≤ 80% FPL and the MSP covered groups.

M0320.102 AG RECIPIENTS

A. Policy

42 CFR 435.234 - An Auxiliary Grants (AG) recipient is eligible for Medicaid if he meets the assignment of rights to medical support and third party payments requirements (see M0250). AG eligibility is determined using the AG eligibility policy in the Auxiliary Grant Eligibility Manual.

B. Financial Eligibility

Verify the AG recipient's eligibility for AG by agency records. *Individuals who receive AG as "**Conditional"** SSI recipients do **not** meet the requirements for this covered group.*

C. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

The ACs are:

- 012 for an aged AG recipient;
- 032 for a blind AG recipient;
- 052 for a disabled AG recipient.

M0320.200 PROTECTED COVERED GROUPS

A. Legal base

Federal law and regulations require that the Medicaid eligibility status of certain groups of persons be protected even though they may not meet current eligibility requirements. These groups, and the applicable eligibility requirements, are described in this section.

B. Procedure

- M0320.*201* Former Money Payment Recipients August 1972
- M0320.*202* Conversion Cases
- M0320.*203* Former SSI/AG Recipients
- M0320.*204* Protected Widows or Widowers
- M0320.*205* Qualified Severely Impaired Individuals (QSII)-1619(b)
- M0320.*206* Protected Adult Disabled Children
- M0320.*207* Protected SSI Disabled Children.

M0320.201 FORMER MONEY PAYMENT RECIPIENTS AUGUST 1972

A. Policy

42 CFR 435.114 and 42 CFR 435.134--The agency must provide Medicaid to individuals who meet the following conditions:

1. Entitled to OASDI In August 1972 & Received Cash Assistance

In August 1972, the individual was entitled to OASDI and

- he was receiving AFDC, Old Age Assistance (OAA), Aid to the Blind (AB), or Aid to the Permanently and Totally Disabled (APTD); or
- he would have been eligible for one of those programs if he had applied and the Medicaid plan covered this optional group. The Virginia plan covered this group; or

- he would have been eligible for one of those programs if he was not in a medical institution or intermediate care facility and the Medicaid plan covered this optional group. The Virginia plan covered this group.

2. Would Currently Be Eligible If Increase Were Excluded

The individual would meet the F&C income limits for LIFC or currently eligible for SSI or AG except that the increase in OASDI under P.L. 92-336 raised his income over the F&C income limits or SSI. This includes an individual who

- meets all LIFC requirements or current SSI requirements except for the requirement to file an application; or
- would meet all current LIFC or SSI requirements if he were not in a medical institution or intermediate care facility and the Medicaid plan covers this optional group. The Virginia plan covers this group

B. Nonfinancial Requirements

The protected individual must meet all of the following criteria:

- he was a recipient of OAA, AB, APTD, or AFDC cash assistance as of August, 1972;
- his money payment was subsequently discontinued as a result of the 20% increase in Social Security benefits received in October, 1972;
- his current countable resources are less than or equal to the current resource limit for Medicaid; and
- his current countable income is less than or equal to the F&C income limit or the current SSI income limit, as appropriate, after excluding the 20% increase amount received in 1972. The current SSI standards are in subchapter S0810; *the F&C income limit is available from a Regional Medical Assistance Program consultant.*

Contact a Medicaid Assistance Consultant if you have an applicant you believe meets this covered group.

M0320.202 CONVERSION CASES

A. Policy

42 CFR 435.131, 435.133--Conversion cases are classified as categorically needy and consist of the following individuals:

- blind or disabled individuals eligible in December 1973;
- individuals eligible as essential spouses of aged, blind or disabled individuals in December 1973.

B. Eligibility Determination

The agency must continue the individual's Medicaid if

- the ABD individual continues to meet the December 1973 eligibility requirements of the applicable cash assistance program; and

- the essential spouse continues to meet the conditions that were in effect in December 1973 under the applicable cash assistance plan for having his needs included in computing the payment to the ABD individual.

C. Essential Spouse

The agency must provide Medicaid to any person who was eligible for Medicaid in December 1973 as an essential spouse of an aged, blind or disabled individual who was receiving cash assistance, if the conditions below are met. An "essential spouse" is defined as one who is living with the individual, whose needs were included in determining the amount of cash payment to the individual under OAA, AB, or APTD in December 1973, and who is determined essential to the individual's well-being.

The spouse of the protected conversion person is included in the conversion case if:

- his/her needs were included in the OAA, AB, or APTD grant as of December, 1973, and
- he/she continues to live in the home of the protected individual

D. Blind or Disabled In December 1973

The agency must provide Medicaid to individuals who:

- meet all current Medicaid eligibility requirements except the criteria for blindness or disability;
- were eligible for Medicaid in December 1973 as blind or disabled individuals; and

for each consecutive month after December 1973, continue to meet the criteria for blindness or disability and the other eligibility requirements used under the Medicaid plan in December 1973.

Contact your Regional Medical Assistance Program Consultant if you have an applicant you believe meets this covered group.

M0320.203 FORMER SSI/AG RECIPIENTS

A. Policy

1. Nonfinancial Requirements

The protected former SSI/AG recipient must meet the nonfinancial eligibility requirements in chapter M02. The protected former SSI recipient is one who was eligible for and received **either:**

- SSA and SSI, or
- SSA and AG, or
- SSA, SSI, and AG

concurrently, but who became ineligible for SSI or AG due to any reason on or after April 1, 1977. The individual did not have to be receiving Medicaid at that time.

An individual who concurrently received these benefits does not meet this covered group's requirements if one of the benefit payments was later recouped because the individual was not entitled to the payment.

2. Financial Requirements

The former SSI/AG recipient is eligible for Medicaid if:

a. the individual meets the Medicaid resource requirements currently in effect, and the individual's income, less all SSA cost-of-living adjustments (COLAs) received since the most recent month SSI or AG was cancelled (including the COLA received in the month SSI or AG was cancelled) is within the current SSI income limit; OR

b. the individual meets the AG requirements in effect at the time of application or redetermination, including residing in an approved AG home, and the individual's income less the amount of all SSA COLAs received since the most recent month SSI or AG was cancelled (including the COLA received in the month SSI or AG was cancelled) is within the current AG income limit applicable to a resident of that home.

c. Any change in SSA benefits other than cost-of-living increases are not excluded, such as an increase due to change from disability benefits to widow's benefits.

EXAMPLE #1: Ms. C is age 71. She has never been enrolled in Medicaid before. She applied for Medicaid on February 12, 1997. She received SSA on her own record, in the amount of $280, until March 1, 1994 when she began receiving widow's benefits of $410. She received SSI until March 1, 1994, when SSI was cancelled due to her increased SSA benefit. She received COLA increases in her SSA in January of 1995, 1996, and 1997. Her current SSA is $537. Her countable resources are less than the current Medicaid resource limit.

Ms. C meets the former SSI recipient protected individual criteria because she was eligible for and received SSA and SSI concurrently. Her countable income is her SSA amount prior to the January 1, 1995 COLA - $410 - less the $20 disregard. The result, $390, is compared to the current SSI individual limit.

Because her resources are within the Medicaid limit, and her countable income of $390 is within the current SSI limit, she is eligible for Medicaid as a protected former SSI recipient.

B. Eligibility Procedures

1. Assistance Unit

Use the assistance unit composition and resource deeming procedures policy in chapter M05 to determine when a spouse's resources or income are counted or deemed in determining the individual's eligibility.

If the protected individual lives with his/her spouse (or parent in the case of a blind/disabled child) whose resources and income would be counted or deemed in determining the individual's SSI or AG eligibility, the SSA cost-of-

living increase(s) (COLAs) received by the spouse (or parent) since the individual lost SSI or AG eligibility is also excluded in determining the protected individual's income eligibility under this section.

2. Resource Eligibility

Resource eligibility is determined by comparing the former SSI recipient's resources to the current Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). Calculate resources according to the assistance unit policy in chapter M05. If current resources are within the limit, go on to determine income eligibility. If current resources are NOT within the limit, the individual is NOT eligible in this protected covered group.

3. Income Eligibility

a. Countable Income

In figuring income to compare to the current SSI or AG income limit, the income exclusions in chapter S08 are applicable including the $20 exclusion.

When the individual meets the above criteria for a protected case and the individual's assistance unit's resources are within the Medicaid resource limit:

1) Identify the individual's, and the individual's spouse's (or parent's when applicable), amount of Social Security Title II benefits at the time of SSI termination.

   If this amount is unknown and cannot be obtained, see item 4. below.

2) When the amount of Social Security Title II benefits at the time of SSI termination is determined:

   - add the Medicare premium amount to the Title II check amount if only the check amount is known (see item 5. below for Medicare premium amounts);
   - determine if any change in benefit had occurred between loss of SSI and the point of application. If questionable, multiply the prior Title II amount by the COLA percentages and compare to current entitlement. If the figures are significantly different, use the procedures in 4. below to obtain the amount of Title II at the time SSI was terminated;
   - if there were no changes, count the Title II amount at the time of SSI loss. Subtract the $20 general exclusion;
   - count all other current sources of income, apply appropriate exclusions, total countable income.

b. Allocation For NBD Child(ren)

When determining the amount of a spouse's or parent's deemable income, the allocation for a non blind or disabled (NBD) child(ren) in the home is the same regardless of locality (see M0530, Appendix 1). On the income worksheet, insert the SSI individual payment limit whenever the worksheet calls for the Medicaid income limit.

c. Income Limit

Countable income is compared to the AG or SSI income limit for an individual or couple, as appropriate.

The SSI limit for a couple is used whenever evaluating a couple when both meet an ABD definition and both request Medicaid. The SSI limit for an individual is used when only one member of a couple applies or meets an ABD definition.

The SSI income limit reduced by one-third is used whenever an applicant/recipient lives in the home of another person throughout a month and does not pay his/her pro rata share of food and shelter expenses.

Compare total countable income to current appropriate SSI or AG income limit/payment amount as follows:

1) for a protected individual living with a protected or aged, blind, disabled (ABD) spouse who applies for Medicaid, compare the countable income to the current SSI payment limit for a couple. The SSI couple limit is reduced by one-third only if both members of the couple have their shelter and food provided by another person.

   If income is within the appropriate limit, the individual spouse who meets the protected group criteria is eligible. If both spouses meet the protected group criteria, each is eligible as a former SSI recipient.

   The non-protected spouse's eligibility is evaluated in another covered group.

2) for an individual living with a spouse and/or minor dependent children who meet a families and children category or do not apply for Medicaid, count only the individual's income and the spouse's deemed income (as determined by deeming procedures in chapter M05) and compare it to the SSI limit for an individual or couple as appropriate. If all food and shelter needs are provided by the spouse or someone else, compare the countable income to the SSI limit for an individual, reduced by one-third.

3) for a blind or disabled child living with a parent, calculate the parent's income (as determined by deeming procedures in chapter M05) and compare the child's countable income to the SSI payment limit for an individual. If all food and shelter needs are provided by the child's parent(s) or someone else, compare the total countable income to the SSI limit for an individual, reduced by one-third.

4. COLA Formula

If only the current Title II benefit amount is known OR the benefit was changed or recalculated after loss of SSI, use the formula below to figure the base Title II amount to use in determining financial eligibility. Divide the current Title II entitlement amount by the percentages given. Then follow the steps in item B.3.b. above to determine income eligibility.

Note: There was no COLA in 2010, 2011 or 2016.

The Cost-of-living calculation formula
(The formula is the current Title II Benefit divided by the percentage increase to equal the benefit amount before the COLA change):

a. *Current Title II Benefit* = *Benefit Before 1/21 COLA*
1.013 (1/21 Increase)

b. Benefit Before 1/21/ COLA = Benefit Before 1/20 COLA
1.016 (1/20 Increase)

c. Benefit Before 1/20 COLA = Benefit Before 1/19 COLA
1.028 (1/19 Increase)

d. Benefit Before 1/19 COLA = Benefit Before 1/18 COLA
1.020 (1/18 Increase)

5. Medicare Premiums

a. Medicare Part B premium amounts:

1-1-21…$148.50
1-1-20 $144.60
1-1-19 $135.50
1-1-18 $134.00
1-1-17 $109.00

Note: These figures are based on the individual becoming entitled to Medicare during the year listed. The individual's actual Medicare Part B premium may differ depending on when he became entitled to Medicare. **Verify the individual's Medicare Part B premium in SVES or SOLQ-I if it is necessary to know the premium amount for Medicaid eligibility or post-eligibility purposes.**

b. Medicare Part A premium amount:

1-1-21 *$471.00*
1-1-20 $458.00
1-1-19 $437.00
1-1-18 $422.00
1-1-17 $413.00

Contact a Medical Assistance Program Consultant for amounts for years prior to 2016.

6. Evaluation

Individuals who are eligible when a cost-of-living increase is excluded are eligible.

Individuals who are ineligible because of excess income after the cost-of-living increase(s) is excluded can only become Medicaid-eligible in another covered group. If they do not meet an F&C covered group, are not institutionalized, are not receiving CBC or do not have Medicare Part A, they must be determined eligible in a medically needy covered group.

The cost-of-living increase(s) is not excluded when determining income eligibility in ANY other covered group. However, these individuals must be identified for possible future protection as the SSI and AG income limits increase.

C. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

The ACs are:

- 021 for an aged individual;
- 041 for a blind individual;
- 061 for a disabled individual.

D. Eligibility for Non-Protected Family Members

The amount of an SSA cost-of-living increase that must be excluded when determining eligibility for a former SSI recipient **cannot** be excluded when determining Medicaid eligibility of the individual's non-protected spouse and/or children living with the former SSI recipient.

The former SSI recipient is included in his/her non-protected spouse's unit if the non-protected spouse is aged, blind, or disabled.

The former SSI recipient is included as a member of the family unit when determining a child's eligibility in an F&C covered group. All of the protected recipient's income, including the cost-of-living increase(s), is counted.

M0320.204 PROTECTED WIDOWS OR WIDOWERS

A. Policy

Two groups of disabled widow(er)s who lost SSI eligibility because of receipt of or increase in Title II disabled widow(er)s' or Title II widow(er)'s benefits have their Medicaid categorically needy eligibility protected.

The first group consists of disabled widow(er)s who would be eligible for SSI except for the increase in disability benefits resulting from elimination of the reduction factor under P.L. 98-21 in January 1984.

The second group consists of *(1)* disabled widow(er)s age *60* through 64 *years* and *(2) disabled widow(er)s age 50 through 59 years* who would be eligible for SSI except for early receipt of Social Security benefits.

B. July 1989 Protected Widow(er)s

42 CFR 435.137 - A "July 1989 protected widow(er)" is an individual who became entitled to SSA benefits when he/she had attained age 50 but not age 60 years, and

- who applied for Medicaid before July 1, 1989,
- was entitled to monthly OASDI benefits under Title II of the Social Security Act for December 1983,
- was entitled to and received widow's or widower's disability benefits under section 202(e) or 202(f) of the Social Security Act for January 1984,
- lost SSI and/or AG because of the January 1984 increase in disabled widow(er)'s benefits due to elimination of the reduction factor,
- has been continuously entitled to an SSA widow(er)'s disability benefit under section 202(e) or 202(f) of the Social Security Act since the first month that increase was received, and
- would be eligible for SSI or AG if the amount of the increase and any subsequent COLAs in the widow(er)s' SSA benefits were excluded.

1. Nonfinancial Eligibility

Determine the widow(er)'s eligibility using the procedures below. The widow(er):

a. applied for Medicaid as a protected individual prior to July 1, 1989;

b. was entitled to and received a widow's or widower's benefit based on a disability under Section 202 (e) or (f) of the Social Security Act, for January 1984;

c. became ineligible for SSI and/or AG payments because of the increase in the amount of his/her widow(er)'s benefit and:

- the increase resulted from the elimination of the reduction factor for disabled widow(er)s entitled before age 60,
- he/she became ineligible for SSI and/or AG payments in the first month in which that increase was paid to him/her, and
- a retroactive payment of that increase for prior months was not made in that month;

d. has been continuously entitled to a widow(er)'s disability benefit under Section 202 (e) or (f) of the Social Security Act from the first month that the increase in his/her widow(er)'s benefit was received;

e. would be eligible for SSI or AG if the amount of that increase, and any subsequent cost-of-living adjustments (COLAs) in the widow(er)'s benefits, were deducted from his/her income.

2. Financial Eligibility

a. Assistance Unit

Determine whose resources and income will be counted or deemed available according to the assistance unit policy in chapter M05.

b. Resource Eligibility

Resource eligibility is determined by comparing the widow(er)'s resources to the current Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this protected group; he/she may be eligible as *an MSP* (which has more liberal resource methods and standards).

c. Income Eligibility

1) If the individual received SSI (or SSI and AG) and is not currently residing in an approved AG home, the individual's gross SSA benefit amount that was effective in December 1983 plus other current countable income must be within the current SSI individual limit, or couple limit if the individual is married and living with his/her spouse. Calculate income according to the assistance unit policy in chapter M05. Instead of the protected individual's current SSA benefit amount, use the amount effective in December 1983.

   Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected individual is eligible for Medicaid in this protected covered group.

2) If the individual received AG (or AG and SSI) and is currently residing in an approved AG home, the individual's income must be within the current AG limit (home's rate plus personal care allowance). Instead of the protected individual's current SSA benefit amount, use the amount effective in December 1983.

   Compare the total countable income to the current AG limit (home's rate plus personal care allowance). If countable income is within that limit, the protected individual is eligible for Medicaid in this protected covered group.

3) If the individual is not income-eligible, Medicaid eligibility may exist in another covered group. However, when determining eligibility in another covered group, count all current income including the current SSA benefit amount. If the individual does not meet an F&C covered group, is not institutionalized, is not receiving CBC or does not have Medicare Part A, he/she must be determined eligible in a medically needy covered group.

C. Protected Disabled Widow(er)

42 CFR § 435.138 specifies that categorically needy eligibility for Medicaid is protected for the group of disabled widow(er)s age 60 through 64 years who meet the criteria specified below. Under 42 USC § 1383c(d), Medicaid protected status was extended to the group of disabled widower(er)s age 50 through 59 years who meet the same criteria.

A protected disabled widow(er) is an individual who:

- is at least age 50 years (and has not attained age 65);
- is **not** eligible for Medicare Part A hospital insurance;
- becomes ineligible for SSI and/or AG because of mandatory application for and receipt of SSA Title II widow(er)'s disability benefits under section 202(e) or 202(f) of the Social Security Act (or any other provision of section 202 if they are also eligible for benefits under subsections (e) or (f) of the Act).
- would be eligible for SSI or AG if the SSA widow(er)’s benefit were excluded from income.

1. Nonfinancial Eligibility

The protected disabled widow(er) must:

a. have received SSI and/or AG for the month before the month in which he/she began receiving SSA Title II disabled widow(er)'s benefits or widow(er)'s benefits;

b. be eligible for SSI or AG if the SSA widow(er)s disability benefit were not counted as income.

2. Financial Eligibility

a. Assistance Unit

Determine whose resources and income will be counted or deemed available according to the assistance unit policy in chapter M05.

b. Resource Eligibility

Financial eligibility is determined by comparing the widow(er)'s resources to the current Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). If current resources are within the limit, go on to determine income eligibility.

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

c. Income Eligibility

When determining a protected widow(er)'s eligibility in this covered group, the agency must deduct from the individual's income all of the Social Security benefits that made him or her ineligible for SSI.

1) If the individual received SSI (or SSI and AG) and is not currently residing in an approved AG home, the individual's SSA benefit that made him/her ineligible for SSI must be excluded. Other current countable income must be within the current SSI individual limit, or couple limit if the individual is married and living with his/her spouse. Exclude the protected individual's current SSA widow(er)'s benefit amount.

   Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected individual is eligible for Medicaid in this protected covered group.

2) If the individual received AG (or AG and SSI) and is currently residing in an approved AG home, the individual's countable income must be within the current AG limit (home's rate plus personal care allowance). Exclude the protected individual's current SSA widow(er)'s benefit amount.

   Compare the total countable income to the current AG limit (home's rate plus personal care allowance). If countable income is within that limit, the protected individual is eligible for Medicaid in this protected group.

3) If the individual is not income eligible, the individual must be evaluated for Medicaid eligibility in other covered groups. However, when determining eligibility in another covered group, count all current income including the current SSA benefit amount.

D. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

The ACs are:

- 021 for an aged individual;
- 041 for a blind individual;
- 061 for a disabled individual.

M0320.205 QUALIFIED SEVERELY IMPAIRED INDIVIDUALS (QSII)-1619(B) STATUS

A. Introduction

42 CFR 435.121 - Under Section 1619(a) of the Social Security Act, a disabled individual who would otherwise lose SSI because of work and the demonstration of the ability to perform substantial gainful activity but continues to have a disabling impairment can continue to receive special SSI benefits if he continues to be financially eligible for SSI benefits based on income.

Section 1619(b) of the Act allows a disabled individual whose income is too high to retain financial eligibility for the special SSI benefit under Section 1619(a) and a blind individual who lost regular SSI payments to continue to receive Medicaid benefits under certain criteria specified in Section 1619(b).

The Social Security Administration (SSA) determines whether an individual who lost SSI because of earned income is eligible for 1619(b) status. The local department of social services determines whether an individual who has a 1619(b) status continues to be Medicaid eligible.

B. Identifying QSII Individuals

To identify a QSII individual, check the "Medicaid Test Indicator" field on the State Verification Exchange System (SVES) WMVE9068 screen *or the* SOLQ-I screen. If there is a code of A, B, or F, the individual has 1619(b) status.

Since eligibility for 1619(b) can change, check the SVES or SOLQ-I at each redetermination and when there is an indication that a change may have occurred.

C. Determining Eligibility

1. Nonfinancial Eligibility

The QSII individual must have been eligible for and receiving Medicaid coverage as an SSI recipient (must have met the more restrictive real property requirement) in the month immediately preceding the first month of the 1619(b) status. The "Current Pay Status Effective Date" field on the SVES WMVE9065 screen shows the first month of the 1619(b) status.

NOTE: If you cannot determine the first month of 1619(b) status, contact SSA.

2. Financial Eligibility

a. Resource Eligibility

Use the following to determine if the QSII recipient has real property resource(s):

1) equity in non-exempt property contiguous to the individual's home which exceeds $5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 are applicable to the property;

2) an interest in undivided heir property and the equity value of the individual's share that, when added to all other countable resources exceeds the appropriate Medicaid resource limit. (The interest in the estate must be legally available. If a partition suit is necessary to sell the interest, costs of partition and attorneys' fees may be deducted as described in M1120.215;

3) ownership (equity value) of an individual's former residence when the QSII recipient is in an institution for longer than 6 months. Determine if the former residence is excluded under policy in section M1130.100 D;

4) equity value in property owned jointly by the QSII recipient and another person who is not the individual's spouse as tenants in common or joint tenants with the right of survivorship at common law. Determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;

5) other real property; determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property.

When a QSII recipient has any of the real property listed in 1) through 5) previously, ALL of the recipient's resources must be verified, evaluated, and counted together to determine if the recipient meets the Medicaid resource requirements. Calculate resources according to the assistance unit policy in chapter M05. If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible for Medicare Savings Program (MSP) limited-benefit Medicaid (which has more liberal resource methods and standards).

When a QSII recipient has no real property resource listed in 1) through 5) previously, do NOT determine the recipient's resources. The QSII recipient meets the Medicaid resource requirements because his resource eligibility for QSII has been determined by SSA and he does not have a real property resource as listed previously.

b. Income Eligibility

There are no income eligibility requirements for QSII individuals once they have been determined eligible as 1619(b).

D. Entitlement & Enrollment

Eligible individuals are entitled to full Medicaid coverage. The *ACs are:*

- 21 for an aged individual;
- 41 for a blind individual; or
- 61 for a disabled individual.

***E.* Individuals Ineligible as QSII**

Individuals who are ineligible as QSII because they:

- did not receive Medicaid in the month immediately preceding the month in which SSA first determined them eligible under 1619(b) or

- lost 1619(b) status

must be evaluated for Medicaid eligibility in other covered groups.

NOTE: An individual who has 1619(b) status continues to meet the disabled definition. An individual who no longer has 1619(b) status may not meet the disabled definition.

M0320.206 PROTECTED ADULT DISABLED CHILDREN

A. Policy

Section 1634(c) of the Social Security Act was amended in 1987 (P.L. 99-643 §6(b)) to state that if any individual who has attained the age of 18 and is receiving benefits under Title XVI (the Supplemental Security Income program) on the basis of blindness or a disability which began before he or she attained the age of 22

- becomes entitled, on or after the effective date of this subsection (July 1, 1987), to child's insurance benefits which are payable under section 202(d) on the basis of such disability or to an increase in the amount of the child's insurance benefits which are so payable; and

- ceases to be eligible for SSI because of such child's insurance benefits under the title or because of the increase in such child's insurance benefits,

shall be treated as receiving SSI benefits for Medicaid eligibility purposes so long as he/she would be eligible for SSI in the absence of such child's insurance benefits or such increase.

B. Nonfinancial Eligibility

A protected adult disabled child is one who:

- has reached the age of 18 years and receives SSI payments on the basis of blindness or a disability which began before he or she reached the age of 22 years;

- on or after July 1, 1987, becomes entitled to SSA Title II disabled child's insurance benefits on the basis of such disability, or receives an increase in Title II disabled child's insurance benefits;

- becomes ineligible for SSI on or after July 1, 1987 because of the receipt of, or increase in, Title II disabled child's benefits;
- has resources within the current Medicaid resource limit; and
- has income which, in the absence of the Title II disabled child's benefit, or in the absence of the increase in such benefit, is within the current SSI income limit.

C. Financial Eligibility

Determine whose resources and income will be counted or deemed available according to the assistance unit policy in chapter M05.

1. Resources

Financial eligibility is determined by comparing the protected individual's resources to the current Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). Calculate resources according to the assistance unit policy in chapter M05. If current resources are within the limit, go on to determine income eligibility.

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

2. Income

a. Receipt of SSA Child's Benefits Causes SSI Ineligibility

If the individual began receiving adult disabled child's benefits and this receipt caused SSI ineligibility, then the entire adult disabled child's benefit amount and any subsequent increases in the benefit are excluded when determining the individual's countable income.

In determining whether the adult disabled child's income, in absence of the Title II adult disabled child's benefit is within the current SSI income limit, all of the adult disabled child's other current countable income must be within the current SSI individual limit, or couple limit if the individual is married and living with his/her spouse. Calculate income according to the assistance unit policy in chapter M05, including deeming of parent(s)' income when the individual is under age 21 and living with a parent(s). **Exclude all of the protected individual's current SSA adult disabled child's benefit amount.**

Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected individual is eligible for Medicaid in this protected covered group.

If countable income exceeds the SSI limit, determine the individual's eligibility in another Medicaid covered group.

b. Increase In SSA Child's Benefits Causes SSI Ineligibility

If the individual received an increase in disabled child's benefits and this increase caused SSI ineligibility, only the increase which caused SSI

ineligibility is excluded when determining the individual's countable income. Calculate income according to the assistance unit policy in chapter M05, including deeming of parent(s)' income when the individual is under age 21 and living with a parent(s). Exclude the amount of the increase which caused SSI ineligibility.

1) Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected individual is eligible for Medicaid in this protected covered group.

   In this situation, the adult disabled child received SSI and SSA concurrently, and lost SSI because of an increase in SSA disabled child's benefits. The amount of the increase that caused SSI ineligibility is excluded. No subsequent increases in the disabled child's benefit are excluded when reviewing the individual's eligibility as a protected adult disabled child. However, if the protected adult disabled child becomes ineligible for Medicaid, evaluate his/her Medicaid eligibility as a protected former SSI recipient using the policy and procedures in Section M0320.201 of this chapter.

2) If countable income exceeds the SSI limit, determine the individual's eligibility in another covered group. If the individual does not meet an F&C MI covered group, is not institutionalized, is not receiving CBC or does not have Medicare Part A, he/she must be evaluated in a medically needy covered group.

D. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

The ACs are:

- 021 for an aged individual;
- 041 for a blind individual;
- 061 for a disabled individual.

M0320.207 PROTECTED SSI DISABLED CHILDREN

A. Introduction

The Balanced Budget Act of 1997 (P.L. #105-33) created a new covered group which protects Medicaid eligibility for disabled children who received SSI, whose SSI is canceled solely because the children do not meet the SSI definition of childhood disability (revised per section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996), and who would be paid SSI but for the change in the childhood disability definition.

Note: The group of Protected SSI Disabled Children is no longer applicable as all affected children are over age 18; however, it remains in federal regulations.

B. Nonfinancial Eligibility Requirements

To be eligible in this protected covered group, the protected SSI disabled child must

- have had his/her SSI canceled solely because he/she does not meet the SSI definition of childhood disability (revised per section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996);
- continue to meet the SSI childhood disability definition and regulations that were in effect prior to the effective date of the change in the disability definition (August 22, 1996); and
- be under age 18 years.

Note: All affected children are now over age 18 years.

1. Disability Determination Referral to Disability Determination Services (DDS)

An SSI disabled child is presumed to meet the childhood disability definition
in effect prior to August 22, 1996, until he/she reaches age 18 years, unless there is an improvement in the child's condition. If the child's condition improves, complete

- DDS Referral Form, available on SPARK at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms*
- the Disability Report Child (SSA-3820-BK), available at http://www.socialsecurity.gov/online/ssa-3820.pdf **and**
- a minimum of 3 signed, original Authorization to Disclose Information to the Social Security Administration forms (SSA-827), available at http://www.socialsecurity.gov/online/ssa-827.pdf **or** a form for each medical provider if more than 3. "General Authorization for Medical Information" (form #032-03-311) for each medical practitioner reported by the individual on the report.

Send the report(s) and authorization forms to the DDS.

2. DDS Decision

If the DDS decides that the child continues to meet the childhood disability definition in effect prior to August 22, 1996, the child continues eligible in the protected group of SSI disabled children, provided the child meets the financial eligibility requirements in item C. below.

If the DDS decides that the child no longer meets the childhood disability definition in effect prior to August 22, 1996, the child no longer meets the protected group of SSI disabled children. Determine the child's eligibility in another covered group. If the child is not eligible in any covered group, send an advance notice to the authorized representative and take action to cancel the child's Medicaid coverage.

C. Financial Eligibility Procedures

1. Assistance Unit

Follow the policy and procedures in M0530.

2. Resource Eligibility

Resource eligibility is determined by comparing the SSI disabled child's countable resources to the current ABD Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). Calculate resources according to the assistance unit policy in subchapter M0530. If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the child is NOT eligible in the protected SSI disabled children covered group; he/she may be eligible as *FAMIS Plus (see M0330.300)* if he/she is under age 19 years.

3. Income Eligibility

Income eligibility is determined by comparing the SSI disabled child's income to the current SSI payment limit for an individual. Determine countable income using policy in Chapter S08. Calculate income according to the assistance unit policy in subchapter M0530. If countable income is within the SSI payment limit, the child is eligible for Medicaid in the covered group of protected SSI disabled children.

D. Entitlement & Enrollment

Children eligible for Medicaid in the covered group of protected SSI disabled children are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible protected SSI disabled children are enrolled with program designation "61."

M0320.300 ABD WITH INCOME ≤ 80% FEDERAL POVERTY LIMIT (FPL)

A. Policy

Section 1902(m) of the Social Security Act allows a State to provide full Medicaid benefits to the categorically needy covered group of aged, blind and disabled individuals whose income is less than or equal to a percentage of the federal poverty limit (FPL).

The 2000 Appropriations Act mandated that effective July 1, 2001, the State Plan for Medical Assistance be amended to add the covered group of aged, blind and disabled individuals with income less than or equal to 80% FPL.

An eligible individual's resources must be within the SSI resource limits.

B. Financial Eligibility

1. Assistance Unit

The assistance unit policy and procedures in chapter M05 apply to ABD individuals with income less than or equal to 80% FPL. If not institutionalized, deem or count any resources and income from the individual's spouse with whom he lives. If institutionalized with a community spouse, go to subchapter M1480.

2. Resources

The resource limit is $2,000 for an individual and $3,000 for a couple.

The resource requirements in chapter S11 and Appendix 2 to chapter S11 apply to this covered group.

All of the individual's resources must be verified and evaluated. All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements.

3. Income

The income limits are ≤ 80% of the FPL and are in section M0810.002. The income requirements in chapter S08 must be met.

4. Income Exceeds 80% FPL

Spenddown does not apply to this covered group. If the individual's income exceeds the 80% FPL limit, he is not eligible in this covered group. Determine the individual's eligibility in all other Medicaid covered groups.

D. Entitlement

If all eligibility factors are met in the application month, entitlement to full Medicaid coverage in this covered group begins the first day of the application month.

ABD individuals in this covered group are entitled to retroactive coverage if they meet all the requirements in the retroactive period.

E. Enrollment

The ABD 80% group AC is:

- 029 for an aged individual;
- 039 for a blind individual;
- 049 for a disabled individual; or
- 109 for all incarcerated individuals.

M0320.400 MEDICAID WORKS

A. Policy

The Appropriations Act of 2006 authorized an amendment to the Virginia State Plan for Medical Assistance that allows disabled (including blind) individuals to work and earn higher income while retaining Medicaid coverage. This program is called MEDICAID WORKS and includes individuals:

- at least age 16 and are under age 65, **and**
- who have countable income less than or equal to 80% of the FPL, (or who are SSI recipients and 1619(b) individuals) **and**
- who have countable resources less than or equal to $2,000 for an individual and $3,000 for a couple; **and**

- who are working or have a documented date for employment to begin in the future.

These individuals can retain Medicaid coverage by cost-sharing through the payment of a premium as long as they remain employed and their earned income is less than or equal to $6,250 per month. This type of cost-sharing arrangement is known as a **Medicaid** buy-in (MBI) program. MEDICAID WORKS is Virginia's MBI program.

B. Relationship Between MEDICAID WORKS and 1619(b) Status

An individual with SSI or eligible for Medicaid as a Qualified Severely Impaired Individual (QSII) (1619(b)) meet the income requirement for entry into MEDICAID WORKS and must not be discouraged from enrolling in MEDICAID WORKS. An individual who meets the criteria for 1619(b) status may choose to participate in MEDICAID WORKS because of the higher resource limit.

C. Nonfinancial Eligibility

The individual must also meet the following additional nonfinancial criteria:

- The individual must be competitively employed in an integrated setting. Work must occur in a work setting in the community or in a personal business alongside people who do not have disabilities. Work performed in a sheltered workshop or similar setting is **not** considered competitive employment in an integrated setting. Contact a Regional Medical Assistance Program Consultant if there is a question about whether the employment meets the criteria for MEDICAID WORKS.

- The individual must receive pay at the minimum wage or at the prevailing wage or "going rate" in the community, and the individual must provide documentation that payroll taxes are withheld. Self-employment must be documented according to the policy contained in S0820.210.

- The individual must establish a Work Incentive (WIN) Account at a bank or other financial institution, such as a checking or savings account. The individual must provide documentation for the case record designating the account(s) as a WIN Account. The account must either be a new account or an existing account with *only the wages earned while in MEDICAID WORKS deposited into it. Increases in an enrollee's Social Security Disability benefits resulting from employment as a MEDICAID WORKS participant OR as a result of a COLA adjustment to the Social Security Disability benefits may also be deposited into the WIN account and will be excluded as described in M0320.400 D.3.b.3) as long as the increase is regularly deposited upon receipt into the WIN account.* The WIN account cannot contain the individual's *other* Social Security benefits.

1. LDSS Referrals to DDS for Non-expedited Cases

d. Send the following forms to the applicant for completion immediately, giving the applicant 10 calendar days to return the completed forms:

- a copy of the Frequently Asked Questions—Disability Determinations for Medicaid (form #032-03-0426), available on SPARK at *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/References*, explaining the disability determination process and the individual's obligations;
- the Disability Report Adult (SSA-3368-BK), available at http://www.socialsecurity.gov/online/ssa-3368.pdf, or the Disability Report Child (SSA-3820-BK), available at http://www.socialsecurity.gov/online/ssa-3820.pdf,
- an Authorization to Disclose Information to the Social Security Administration form (SSA-827), available at http://www.socialsecurity.gov/online/ssa-827.pdf.

e. In most cases, the DDS referral is transmitted electronically to DDS through VaCMS. Form 3368-BK or 3830-BK and SSA-827 are uploaded to VaCMS for submission to DDS. No DDS Referral Form is used for electronic submissions. Follow the instructions in the Quick Reference Guide "Sending a DDS Referral in the VaCMS," available in VaCMS.

f. If the DDS referral cannot be completed in VaCMS, manually submit the referral. Complete the DDS Referral Form, available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms. Use the DDS Referral Form that corresponds with the DDS Regional Office to which the LDSS has been assigned (#032-03-0095, #032-03-0096, #032-03-0097, or #032-03-0098). To the form, attach the following:

- the completed Disability Report
- the signed Authorization to Disclose Information
- copies of paystubs, if the applicant is currently working.

If the individual's application was filed with the assistance of a hospital-based eligibility assistance organization, a copy of the consent to release information to the organization must be included with the referral so DDS staff can communicate with them, if necessary.

Mail the DDS Referral form and attachments to the *DDS Central Regional (Richmond)* Office. See *Appendix 1* to this subchapter for the *contact information*. **Do not send referrals to DDS via the courier.**

2. Expedited Referrals for Hospitalized Individuals Awaiting Transfer to a Rehabilitation Facility

The 2004 Budget Bill mandated that DDS make a disability determination within seven (7) working days of the receipt of a referral from the LDSS when the Medicaid applicant is hospitalized, needs to be transferred directly to a rehabilitation facility AND the individual does not already have a disability application pending with DDS. To ensure that the DDS is able to make the disability determination within the mandated timeframe, the procedures below shall be followed:

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 *$36,836*.

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**

c. Hospital staff shall simultaneously send:

- the Medicaid application and a cover sheet, available on Fusion at to the LDSS or the hospital outstationed eligibility worker

- the medical documentation (disability report, authorizations to release information and medical records) and cover sheet to the DDS.

d. LDSS shall **immediately** upon receipt of the Medicaid application:

- fax a completed DDS Referral Form (#032-03-0095, #032-03-0096, #032-03-0097, or #032-03-0098) *available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, to the DDS Central Regional Office at 804- 527-4518* to verify receipt of the Medicaid application unless it is known to the agency that the individual already has a pending disability claim with DDS. If the individual already has a pending disability claim with DDS, the claim cannot be treated as an expedited referral.

- give priority to processing the applications and immediately request any verifications needed; and

- process the application as soon as the DDS disability determination and all necessary verifications are received; and

- notify the hospital contact identified on the cover sheet of the action on the application and provide the Medicaid enrollee number, if eligible.

c. DDS shall make a disability determination within seven (7) working days and fax the result of the disability decision to the LDSS. DDS is not responsible for notifying either the applicant or the hospital of the outcome of the disability determination.

If DDS is unable to render a decision within 7 working days, DDS will send a communication to the LDSS advising that the disability determination has been delayed.

3. Application Processing When DDS Referral is Pending

If the completed forms are not returned by the applicant within 45 calendar days from the date of application, the applicant is considered not to meet the covered group and the application must be denied.

Individuals who require a disability determination must meet all non-financial requirements other than covered group, within 45 calendar days or the application must be denied. If these requirements are met, the application timeframe may be extended to 90 days while DDS is making the disability determination. If any non-financial requirement other than covered group is not met by the 45th calendar day, his application must be denied and DDS must be notified of the denial.

DDS does NOT stop the disability determination process when the individual meets all non-financial requirements, but has excess resources (see M0130.100 B.4) because he might reduce his resources while the

4. Income Exceeds 80% FPL at Eligibility Determination

Spenddown does not apply to the Medicaid Works covered group. Therefore, admission into MEDICAID WORKS is not available to individuals whose income exceeds 80% of the FPL. Evaluate the individual's eligibility in all other Medicaid covered groups.

E. Cost Sharing and Premium Payment

Cost sharing is required of all individuals enrolled in MEDICAID WORKS. Enrollees are responsible for copayments for services received (see M1850.100 B).

Premiums are assessed on a sliding scale based on the individual's income and are subject to change. Based on the sliding scale, some individuals may not owe a premium.

Note: premiums are not being charged at this time.

F. Good Cause

An individual may remain eligible for MEDICAD WORKS if one of the following good cause exceptions is met:

- If the individual is unable to maintain employment due to illness or unavoidable job loss, the individual may remain in MEDICAID WORKS for up to six months as long as any **required** premium payments continue to be made. The six-month period begins the first day of the month following the month in which the job loss occurred. The individual should be asked to provide documentation that he is unable to work from a medical or mental health practitioner or employer. However, do not cancel the individual's eligibility under MEDICAID WORKS due to the lack of documentation if the individual indicates that he is still seeking employment.
- DMAS may establish other good cause reasons. Requests for good cause other than the temporary loss of employment due to a documented illness or unavoidable job loss must be submitted to DMAS on the enrollee's behalf by the local department of social services.

G. Safety Net

Enrollees who are unable to sustain employment for longer than six months must be evaluated for continued coverage in all other Medicaid covered groups for which the individual meets the definition. Resources held in the WIN Account that are accumulated from the enrollee's earnings while in MEDICAID WORKS will be disregarded up to the 1619(b) threshold amount for this eligibility determination.

If found eligible and enrolled in another Medicaid covered group, the individual shall have a "safety-net" period of up to one year from MEDICAID WORKS termination and enrollment in another group to dispose of these excess resources before they are counted toward ongoing eligibility.

If the individual resumes working within the safety-net period, he may be re-enrolled in MEDICAID WORKS provided that all eligibility requirements are met, except that the resources in the WIN Account are disregarded up to the 1619(b) threshold amount. If the individual wishes to be re-enrolled in MEDICAID WORKS after the one-year safety net period, any resources retained in the WIN Account are countable.

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 fax cover sheet, and fax it together with the following information to DMAS at 804-786-1680:

- 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).

Current Enrollee

1. Cancel current coverage using Cancel Code 042.
2. Reinstate in AC 059 beginning the first day of the following month. **Use the date the MEDICAID WORKS Agreement was signed for the application date**.

Send a Notice of Action to the applicant/recipient advising him of his eligibility and acceptance into MEDICAID WORKS. Do not send the Advance Notice of Proposed Action when a recipient moves to MEDICAID WORKS, because his Medicaid coverage has not been reduced or terminated.

Eligibility for MEDICAID WORKS continues as long as the enrollee continues to:

- be employed,
- meet the definition of disability or blindness,
- meet the age limitation, and
- does not exceed the income and resource limits for MEDICAID WORKS.

The MEDICAID WORKS enrollee continues to meet the disability criteria as long as SSA has not completed a Continuing Disability Review and has not determined that the individual no longer has a disabling condition. The fact that the MEDICAID WORKS enrollee is earning over the SSA substantial gainful activity amount has no bearing on whether he meets the disability criteria. If the enrollee's disability status is unclear, contact a Regional Medical Assistance Program Consultant for assistance.

The individual's continuing eligibility must be determined at least every 12 months.

If the individual is no longer eligible for MEDICAID WORKS, the eligibility worker must determine whether the individual remains eligible in any other covered group. **The policy in M0320.400 G above must be reviewed to determine whether the resource exclusion safety net rules apply**. If the individual is not eligible for Medicaid in any other covered group, coverage shall be cancelled effective the first of the month following the expiration of the 10-day advance notice.

M0320.500 300% of SSI INCOME LIMIT GROUPS

A. Introductions

The 300% of SSI income limit groups are for individuals who meet the definition of an institutionalized individual or have been screened and approved for long-term care (LTC) services (see M1410. B. 2) and are not eligible in any other full-benefit Medicaid covered group.

B. Covered Groups

- M0320.501 ABD in a Medical Institution, Income ≤ 300% of SSI
- M0320.502 ABD Receiving Medicaid Waiver Services (CBC)
- M0320.503 ABD Hospice

M0320.501 ABD IN MEDICAL INSTITUTION, INCOME ≤ 300% SSI LIMIT

A. Policy

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

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

Individuals who are screened and approved for nursing facility care prior to admittance and are likely to receive the services for 30 days or more consecutive days may also be included in this covered group.

***B.* Financial Eligibility**

1. Asset Transfer

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

2. Resources

a. Resource Eligibility – Married Individual

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

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

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

b. Resource Eligibility - Unmarried Individual

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

1) equity In non-exempt property contiguous to the individual's home which exceeds $5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property; and

2) ownership of his/her former residence when the individual is in an institution for longer than 6 months. Determine if the former home is excluded in M1130.100 D.

If the individual is a blind or disabled child, DO NOT DEEM any resources or income from the child's parent; count only actual resources the parent makes available to the child. If current resources are within the limit, go on to determine income eligibility.

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

3. Income

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

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

Compare the total gross income to the 300% of SSI limit (see M0810.002 A. 3). If countable income is equal to or less than this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in this covered group. Evaluate his/her eligibility as medically needy.

C. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

If the individual has Medicare Part A, re-calculate the individual's income - subtract appropriate exclusions. Compare the countable income to the QMB *and SLMB* limits.

1. Dual-eligible As QMB *or SLMB*

If the individual is also a Qualified Medicare Beneficiary (QMB) *or Special Low Income Medicare Beneficiary (SLMB)* - the individual has Medicare Part A and has countable income within the QMB *or SLMB* income limits - the AC is:

- 022 for an aged individual also QMB;
- 042 for a blind individual also QMB;
- 062 for a disabled individual also QMB;
- *025 for an aged individual also SLMB;*
- *045 for a blind or disabled individual also SLMB.*

2. Not QMB *or SLMB*

If the individual is NOT a QMB or SLMB - the individual does NOT have Medicare Part A, OR has countable income over the QMB *and SLMB* income limits - the AC is:

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

D. Ineligible In This Covered Group

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

M0320.502 ABD RECEIVING MEDICAID WAIVER SERVICES (CBC)

A. Policy

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

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

Do not wait until the individual starts to receive the waiver services to determine eligibility in this covered group. Determine eligibility in this covered group if the individual is screened and approved (see subchapter M1420) to receive Medicaid waiver services and has selected the option to receive Medicaid waiver services in lieu of nursing facility services. Presume the individual will receive the services and go on to determine financial eligibility using the policy and procedures in C. below.

If the individual's eligibility was determined as an institutionalized individual prior to the receipt of waiver services, the EW must verify the receipt of Medicaid CBC services within 30 days of the date of the Notice of Action on Medicaid. If Medicaid CBC services did not start within 30 days of the date of the Notice of Action on Medicaid, the individual's continued eligibility must be re-evaluated as a non-institutionalized individual.

B. Financial Eligibility

1. Asset Transfer

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

2. Resources

a. Resource Eligibility - Unmarried Individual

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements in chapter S11 (ABD Resources). Pay close attention to:

1) equity in non-exempt property contiguous to the individual's home which exceeds $5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property, and
2) ownership of his/her former residence when the individual has been away from his home property for longer than 6 months. Determine if the home property is excluded in M1130.100.

DO NOT DEEM any resources from a blind or disabled child's parent

living in the home. Count actual resources the parent makes available to the child.

If current resources are within the limit, then determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible for Medicaid in this covered group.

b. Resource Eligibility - Married Individual

If the individual is married and has a community spouse, use the resource policy in subchapter M1480. If the individual is married, but has no community spouse, use the resource policy in subchapter M1460. Evaluate countable resources using ABD resource policy in chapter S11.

If current resources are within the limit, then determine income eligibility.

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

3. Income

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

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

Compare the total gross income to the 300% of SSI limit (see M0810.002 A. 3). If countable income is equal to or less than this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in this covered group. Evaluate his/her eligibility as medically needy.

C. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met. Retroactive coverage does not apply to this covered group because an individual cannot be eligible in this covered group until he/she applies for Medicaid. [The individual cannot have received Medicaid covered waiver services in the retroactive period because he was not receiving Medicaid on or before the date he applied.]

If the individual has Medicare Part A, re-calculate the individual's income - subtract the appropriate exclusions. Compare the countable income to the QMB *and SLMB* limits.

1. Dual-eligible As QMB *or SLMB*

If the individual is also a Qualified Medicare Beneficiary (QMB) *or Special Low Income Medicare Beneficiary (SLMB)* - the individual has Medicare Part A and has countable income within the QMB *or SLMB* income limits - the AC is:

- 022 for an aged individual also QMB;
- 042 for a blind individual also QMB;
- 062 for a disabled individual also QMB;
- 025 for an aged individual also SLMB;
- 045 for a blind or disabled individual also SLMB.

2. Not QMB or SLMB

If the individual is NOT a QMB or SLMB - the individual does NOT have Medicare Part A, OR has countable income over the QMB and SLMB income limits - the AC is:

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

D. Ineligible In This Covered Group

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

M0320.503 ABD HOSPICE

A. Policy

SMM 3580-3584 - The state plan includes the covered group of aged, blind or disabled individuals who are terminally ill and elect hospice benefits.

The ABD Hospice covered group is for individuals who have a signed a hospice election statement in effect for at least 30 consecutive days, and who are not eligible in any other full-benefit Medicaid covered group. Hospice care is a covered service for individuals in all full-benefit covered groups; individuals who need hospice services but who are eligible in another full-benefit covered group do not meet the Hospice covered group.

Individuals receiving hospice services in the ABD Hospice Covered group may also receive services the *Commonwealth Coordinated Care Plus (CCC Plus)* Waiver, if the services are authorized by the Department of Medical Assistance Services (DMAS) (see M1440.101).

The individual must elect hospice care. Election of hospice care is verified either verbally or in writing from the hospice. If the verification is verbal, document the case record. Eligibility in the Hospice covered group is ongoing as long as the individual continues to receive hospice care, subject to a renewal of eligibility at least once every 12 months. The eligibility worker must verify that the hospice agreement is current at the time of the annual Medicaid renewal.

The 30-day requirement begins on the day the hospice care election statement is signed. Once the hospice election has been in effect for 30 consecutive days, the 300% of SSI income limit is used to determine Medicaid eligibility. If the individual's income is within 300% of SSI, eligibility in the Hospice covered group may be determined beginning with the month in which the hospice election was signed.

Individuals who already meet the definition of institutionalization in M1410.010 B.2 at the time of hospice election meet the 30-day requirement, provided there is no break between institutionalization and hospice election.

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

B. Financial Eligibility

1. Asset Transfer

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

2. Resources

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

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

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

a. Unmarried Individual

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

b. Married Individuals

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

3. Income

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

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

Compare the total gross income to the 300% of SSI limit (see M0810.002 A. 3). If countable income is equal to or less than this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in this covered group. Evaluate his/her eligibility as medically needy.

C. Entitlement

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the month in which all eligibility requirements are met. Retroactive coverage is applicable to this covered group.

If the individual has Medicare Part A, re-calculate the individual's income, applying the appropriate exclusions. Compare the countable income to the QMB *and SLMB* limits.

D. Enrollment

Eligible individuals must be enrolled in the appropriate AC. If the individual is aged, blind, or disabled as defined in M0310, he is enrolled under the AC. **AC (054) is used for "deemed-disabled" individuals only**. Use the appropriate Hospice AC when the individual is also authorized to receive *CCC Plus* waiver services.

For individuals who are ABD and entitled/enrolled in Medicare Part A, income must be recalculated (allowing appropriate disregards) to determine if the individual is dually eligible as a QMB or SLMB.

1. ABD Individual

a. Dual-eligible As QMB or SLMB

If the individual is also a Qualified Medicare Beneficiary (QMB) or Special Low Income Medicare Beneficiary (SLMB) - the individual has Medicare Part A and has countable income within the QMB or SLMB income limits - the AC is:

- 022 for an aged individual also QMB;
- 042 for a blind individual also QMB;
- 062 for a disabled individual also QMB
- 025 for an aged individual also SLMB;
- 045 for a blind or disabled individual also SLMB.

b. Not QMB or SLMB

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

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

2. "Deemed" Disabled Individual

An individual who is "deemed" disabled based on the hospice election is enrolled using AC 054. Individuals in this AC who have also been approved to receive services under the EDCD Waiver do not need a disability determination.

E. Post-eligibility Requirements (Patient Pay)

A patient pay must be calculated for individuals who receive hospice services in a nursing facility (see subchapter M1470). Individuals who receive hospice services outside of a nursing facility do not have a patient pay.

Individuals who have elected hospice services and who also receive services available under the *CCC Plus* Waiver must have a patient pay calculation for the *CCC Plus* services (see subchapter M1470).

F. Ineligible In This Covered Group

There is no corresponding medically needy hospice covered group. If the individual is aged or has been determined blind or disabled, the individual must be evaluated in a medically needy covered group for medically needy spenddown.

M0320.600 MEDICARE SAVINGS PROGRAM (MSP)

A. Introductions

The Medicare Saving Program is limited Medicaid coverage for individuals who are eligible for Medicare Part A and have income and resources within specific limits.

B. Covered Groups

- M0320.6*01* QMB
- M0320.6*02* SLMB
- M0320.6*03* QI

M0320.601 QUALIFIED MEDICARE BENEFICIARY (QMB)

A. Policy

42 CFR 435.121 - Qualified Medicare Beneficiaries are a mandatory CN covered group. Medicaid will pay the Medicare Part A premium (as well as the Part B premium) and deductibles and coinsurance for individuals eligible as QMB only.

A QMB is an individual who:

- is entitled to Medicare Part A hospital insurance benefits, but not entitled solely because he/she is eligible to enroll in Part A under section 1818A of the Act (1818A is applicable to QDWI);
- has resources that are within the resource limits for the Medicare Savings Programs (MSPs). See section M1110.003 for the current resource limits; and
- has income that does not exceed 100% of the federal poverty level (FPL).

B. Nonfinancial Eligibility

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1. Entitled to Medicare Part A

The individual must be entitled to or must be enrolled in Medicare Part A. The individual does not have to be aged, blind or disabled. However, Medicare entitlement is limited to individuals who are age 65 or older, or who have received Title II social security benefits because of a disability for 24 months, or who have end stage renal (kidney) disease.

Enrollment in Part A of Medicare is verified by the individual's Medicare card, or by communication (such as SVES) with the Social Security Administration (SSA).

2. Individual Not Currently Enrolled In Medicare Part A

Individuals who are not currently enrolled in Medicare Part A must apply for and enroll in Medicare Part A at the local Social Security Administration (SSA) office, and must present verification of Medicare Part A enrollment to
the local department of social services (DSS) in order to be eligible for Medicaid as QMB.

If an individual appears to be eligible for Medicare but is not enrolled in Medicare, refer him to the SSA district office to apply for Medicare enrollment.

If an individual must pay a monthly premium for Medicare Part A, and cannot afford the premium, the SSA office will give the individual a bill for the premium when the individual is enrolled. The individual must present this bill and the Medicare Part A enrollment verification to the local DSS worker in order to be eligible for Medicaid as a QMB.

NOTE: A disabled working individual who is enrolled or is eligible to enroll in Medicare Part A under Section 1818A of the Social Security Act **cannot** be enrolled as a QMB; he may be eligible as a Qualified Disabled and Working Individual (QDWI). See M0320.604 below for information on the QDWI covered group.0

3. Verification Not Provided

If the applicant does not provide information documenting enrollment in Medicare Part A within the application processing time standard, he is not eligible for Medicaid as QMB, but may be eligible for Medicaid in another covered group.

C. Financial Eligibility

1. Assistance Unit

The assistance unit policy in chapter M05 applies to QMBs.

If the QMB individual is living with his spouse who is aged, blind, or disabled, but does not have Medicare Part A, and both apply for Medicaid, two different financial calculations must be completed for the unit because of the different income limits used in the eligibility determinations. One is the MSP QMB determination; the other is for the ABD spouse's CN or MN covered group.

2. Resources

The resource requirements in chapter S11 and Appendix 2 to chapter S11 must be met by the MSP Medicare beneficiary. Some of the real and personal property requirements are different for QMBs. The different requirements are identified in Appendix 2.

The resource limit for an individual is the resource limit for the MSPs. See section M1110.003 for the current resource limits.

3. Income

The income requirements in chapter S08 must be met by QMBs. The income limits are in M0810.002. By law, for QMBs who have SSA benefits, the new QMB income limits are effective the first day of the second month following the month in which the federal poverty limit is updated. For QMBs who do NOT have SSA benefits, the new QMB income limits are effective the date the updated FPL is published. Local DSS are notified each year of the new FPL via the broadcast system. Check that system to ascertain when the SSA COLA must be counted in determining QMB income eligibility.

4. Income Exceeds QMB Limit

Spenddown does not apply to the MSP income limits. If the individual's income exceeds the QMB limit, he is not eligible as QMB and cannot spenddown to the QMB limit. Determine the individual's eligibility in the SLMB covered group below in M0320.602.

At application and renewal, if the eligible QMB individual's resources are within the medically needy limit and the individual meets a MN covered group, place the individual on two 6-month spenddown based on the MN income limit.

D. QMB Entitlement

Entitlement to Medicaid coverage for QMB only begins the first day of the month **following** the month in which Medicaid eligibility as a QMB is *determined and approved, **not** the month of application. See M1520.102.A.2.*

Because QMB coverage does not begin until the month following the month in which eligibility is *determined and approved*, an applicant who is eligible for QMB coverage must apply for Extra Help in order to receive the subsidy for the month of QMB approval. See chapter M20 for more information on Extra Help.

Retroactive eligibility does **not** apply to the QMB covered group. To be eligible for Medicaid in the retroactive period, and in the application month, a QMB must meet the requirements of another Medicaid covered group.

E. Enrollment

1. Aid Categories

The following ACs are used to enroll individuals who are only eligible as QMBs; they do not meet the requirements of another covered group:

- 023 for an aged QMB only;
- 043 for a blind QMB only;
- 063 for a disabled or end-stage renal disease QMB only.

2. Enrollee's Covered Group Changes To QMB

If a Medicaid enrollee becomes **ineligible** for full-coverage Medicaid because of an increase in income or resources, but is eligible as a QMB, the agency must send an advance notice of proposed action to the enrollee because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare premiums, deductibles and coinsurance amounts as a QMB.

Cancel the enrollee's full coverage effective the last day of the month, using cancel reason "007." Reinstate the enrollee's coverage with the begin date as the first day of the month following the cancellation effective date. The AC is QMB-only.

3. QMB *Becomes Eligible For* Full Coverage

When an enrolled QMB-only becomes eligible in another covered group which has full Medicaid coverage, except when he/she meets a spenddown, e.g., a QMB-only individual's resources change to below the MN limits:

- cancel the QMB-only coverage effective the last day of the month immediately **prior** to the month in which he/she became eligible in the full coverage covered group, using cancel reason "024";
- reinstate the enrollee's coverage with the begin date as the first day of the month in which he/she became eligible in the full coverage covered group, with the appropriate full coverage AC.

4. Spenddown Status

At application and redetermination, eligible QMBs who meet an MN covered group and who have resources that are within the lower MN resource limits are placed on two 6-month medically needy spenddowns. All spenddown periods are based on the application or renewal date, as appropriate. See M1370.

In order to be placed on spenddown, QMBs with end-stage renal disease must meet a medically needy covered group.

5. QMB Meets Spenddown

When an eligible QMB meets the spenddown, cancel the QMB-only coverage effective the day before the spenddown was met, using cancel reason "024". Reinstate the enrollee's coverage with the first date the spenddown was met as the begin date of coverage, and enter the end date of the spenddown period as the end date of coverage. The aid category is medically needy dual-eligible:

- 028 for an aged MN individual also eligible as QMB;
- 048 for a blind MN individual also eligible as QMB;
- 068 for a disabled MN individual also eligible as QMB.

6. Spenddown Period Ends

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

7. QMB Enters Long-term Care

The enrollment of a QMB who is admitted to long-term care and who becomes eligible for Medicaid in another covered group is handled like a QMB who meets a spenddown. Cancel the QMB-only coverage effective the last day of the month before the month of admission to long-term care, reason “024". Reinstate the coverage with the begin date as the first day of the month of admission to long-term care.

M0320.602 SPECIAL LOW INCOME MEDICARE BENEFICIARY (SLMB)

A. Policy

1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act - Coverage of Special Low-income Medicare Beneficiaries is mandated by the federal Medicaid law. Medicaid will only pay the Medicare Part B premium for individuals eligible as SLMB.

An SLMB is an individual who meets all of the eligibility requirements for QMB (M0320.*601* above) EXCEPT for income that exceeds the QMB limit but is less than the higher limit for SLMB. Like QMBs, eligible SLMBs who meet an MN covered group are also placed on a medically needy spenddown if resources are within the medically needy limit.

An SLMB individual

- is entitled to Medicare Part A hospital insurance benefits, but not entitled solely because he/she is eligible to enroll in Part A under section 1818A of the Act (1818A is applicable to QDWI);
- has resources that are within the resource limits for the Medicare Savings Programs (MSPs). See section M1110.003 for the current resource limits; and
- has income that exceeds the QMB limit (100% of the FPL) but is less than 120% of the FPL.

B. Nonfinancial Eligibility

1. Entitled to Medicare Part A

The individual must be entitled to or must be enrolled in Medicare Part A. The individual does not have to be aged, blind or disabled.

Enrollment in Part A of Medicare is verified by the individual’s Medicare card, or by communication (such as SVES) with the Social Security Administration (SSA).

2. Individual Not Currently Enrolled In Medicare Part A

Individuals who are not currently enrolled in Medicare Part A must apply for and enroll in Medicare Part A at the local Social Security Administration (SSA) office, and must present verification of Medicare Part A enrollment to the local department of social services (DSS) in order to be eligible for Medicaid as SLMB.

If an individual appears to be eligible for Medicare but is not enrolled in Medicare, refer him/her to the SSA district office to apply for Medicare enrollment.

If an individual must pay a monthly premium for Medicare Part A, and cannot afford the premium, the SSA office will give the individual a bill for the premium when the individual is enrolled. The individual must present this bill and the Medicare Part A enrollment verification to the local DSS worker in order to be eligible for Medicaid as an SLMB.

NOTE: A disabled working individual who is enrolled or is eligible to enroll in Medicare Part A under Section 1818A of the Social Security Act **cannot** be enrolled as SLMB; he/she may be eligible as a Qualified Disabled and Working Individual (QDWI). See M0320.604 below for information on the QDWI covered group.

3. Verification Not Provided

If the applicant does not provide information documenting enrollment in Medicare Part A within the application processing time standard, he/she is not eligible for Medicaid as SLMB, but may be eligible in another covered group.

C. Financial Eligibility

1. Assistance Unit

The assistance unit policy in chapter M05 applies to SLMBs.

If the SLMB individual is living with his/her spouse who is aged, blind, or disabled, but does not have Medicare Part A, and both apply for Medicaid, two different financial calculations must be completed for the unit because of the different income limits used in the eligibility determinations. One is the MSP SLMB determination; the other is for the ABD spouse's CN or MN covered group.

2. Resources

The resource requirements in chapter S11 and Appendix 2 to Chapter S11 must be met by the SLMB. Some of the real and personal property requirements are different for SLMBs. The different requirements are identified in Appendix 2.

The resource limits are the resource limits for the Medicare Savings Programs (MSPs). See section M1110.003 for the current resource limits.

3. Income

The income requirements in chapter S08 must be met by SLMBs. The income limits for SLMBs are in M0810.002. An SLMB's income must exceed the QMB limit and must be less than the SLMB limit.

By law, for SLMBs who have Title II benefits, the new SLMB income limits are effective the first day of the second month following the month in which the federal poverty limit is updated. For SLMBs who do NOT have Title II benefits, the new SLMB income limits are effective the date the updated federal poverty level is published.

Local DSS are notified each year of the new poverty limits via the broadcast system. Check that system to ascertain when the Title II COLA must be counted in determining SLMB income eligibility.

4. Income Equals or Exceeds SLMB Limit

Spenddown does not apply to the MSP income limits. If the individual's income is equal to or exceeds the SLMB limit, he/she is not eligible as SLMB and cannot spenddown to the SLMB limit. At application and redetermination, if the individual's resources are within the medically needy limit and the individual meets a medically needy covered group, place the individual on two 6-month spenddowns based on the MN income limit.

D. SLMB Entitlement

If all eligibility factors are met in the application month, entitlement to Medicaid as an SLMB begins the first day of the application month.

SLMBs are entitled to retroactive coverage if they meet all the SLMB requirements in the retroactive period. However, coverage under this group cannot begin earlier than January 1, 1993.

The eligible SLMB will only receive Medicaid payment of his/her Medicare Part B premium through the Medicaid Buy-In Agreement with SSA. **The SLMB will not receive a Medicaid card.**

E. Enrollment

1. Aid Category

The AC for all SLMBs is "053".

2. Enrollee's *Covered Group Changes To SLMB*

If a Medicaid recipient becomes ineligible for full-coverage Medicaid or QMB-only coverage because of an increase in income, but is eligible as an SLMB, the agency must send an advance notice of proposed action to the enrollee because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare Part B premiums as an SLMB.

Cancel the enrollee's full coverage effective the last day of the month, using cancel reason "007." Reinstate the enrollee's coverage with the begin date as the first day of the month following the cancellation effective date. The aid category (AC) is "053."

3. SLMB *Becomes Eligible for* Full Coverage

When an enrolled SLMB becomes eligible in another covered group which has full Medicaid coverage, except when he/she meets a spenddown, e.g., an SLMB's resources change to below the MN limits:

- cancel the SLMB coverage effective the last day of the month immediately prior to the month in which he/she became eligible in the full coverage covered group, using cancel reason "024";
- reinstate the enrollee's coverage with the begin date as the first day of the month in which he/she became eligible in the full coverage covered group, with the appropriate full coverage AC.

4. Spenddown Status

At application and redetermination, eligible SLMBs who meet an MN covered group and who have resources that are within the lower MN resource limits are also placed on two 6-month MN spenddowns.

All spenddown periods are based on the application or renewal date, as appropriate. See M1370.

SLMBs who are not determined disabled must be determined disabled or blind, or must be pregnant, under age 18 or under age 21 if in foster care or adoption assistance in order to meet a medically needy covered group for spenddown.

5. SLMB Meets Spenddown

When an SLMB meets a spenddown, cancel his AC "053" coverage effective the date before the spenddown was met, using cancel reason "024". Reinstate the enrollee's coverage with the first date the spenddown was met as the begin date of coverage, and enter the end date of the spenddown period as the end date of coverage. The AC is medically needy dual-eligible as SLMB Plus:

- 024 for an aged MN individual also eligible as SLMB;
- 044 for a blind or disabled MN individual also eligible as SLMB.

6. Spenddown Period Ends

After the spenddown period ends, reinstate the SLMB-only coverage using the AC 053.

The begin date of the reinstated AC 053 coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial SLMB eligibility.

7. SLMB Enters Long-term Care

- The enrollment of an SLMB who is admitted to long-term care and who becomes eligible for Medicaid in the 300% of SSI covered group is handled like an SLMB who meets a spenddown. Cancel the SLMB-only coverage effective the last day of the month before the month of admission to long-term care, reason "024". Reinstate the coverage with the begin date as the first day of the month of admission to long-term care using the appropriate AC for SLMB Plus.

  - 025 for an aged individual also SLMB;
  - 045 for a blind or disabled individual also SLMB.

M0320.603 QUALIFIED INDIVIDUAL (QI)

A. Policy

P.L. 105-33 (Balanced Budget Act of 1997) mandated Medicaid coverage of Qualified Individuals who would be QMBs except that their income exceeds the QMB income limit. Implemented on January 1, 1998, individuals in the QI covered group receive Medicaid coverage for the payment of their Medicare Part B premium.

Prior to 2015, funding for the QI covered group was subject to annual availability by Congress. QI funding became permanent in 2015, and the QI covered group is subject to the same policies regarding entitlement and enrollment as the SLMB covered group.

A QI

- is entitled to Medicare Part A hospital insurance benefits, but not entitled to Medicare Part A solely because he/she is a QDWI (enrolled in Part A under section 1818A of the Act);

- has resources that are within the resource limits for the Medicare Savings Programs (MSPs). See chapter section M1110.003 for the current resource limits; and

- has income that is equal to or exceeds the SLMB limit (120% of the FPL) but is less than the QI limit (135% of the FPL).

B. Nonfinancial Eligibility

1. Entitled to Medicare Part A

The QI must be entitled to or must be enrolled in Medicare Part A. The individual does not have to be aged, blind or disabled.

Enrollment in Part A of Medicare is verified by the individual's Medicare card, or by communication (such as SVES) with the Social Security Administration (SSA).

2. Individual Not Currently Enrolled In Medicare Part A

Individuals who are not currently enrolled in Medicare Part A must apply for and enroll in Medicare Part A at the local Social Security Administration (SSA) office, and must present verification of Medicare Part A enrollment to the local department of social services (DSS) in order to be eligible for Medicaid as *a* QI.

If an individual appears to be eligible for Medicare but is not enrolled in Medicare, refer him/her to the SSA district office to apply for Medicare enrollment.

If an individual must pay a monthly premium for Medicare Part A, and cannot afford the premium, the SSA office will give the individual a bill for the premium when the individual is enrolled. The individual must present this bill and the Medicare Part A enrollment verification to the local DSS worker in order to be eligible for Medicaid as a QI.

NOTE: A disabled working individual who is enrolled or is eligible to enroll in Medicare Part A under Section 1818A of the Social Security Act **cannot** be enrolled as *a* QI; he/she may be eligible as a Qualified Disabled and Working Individual (QDWI). See M0320.604 below for information on the QDWI covered group.

3. Verification Not Provided

If the applicant does not provide information documenting enrollment in Medicare Part A within the application processing time standard, he/she is not eligible for Medicaid as *a* QI, but may be eligible in another covered group.

C. Financial Eligibility

1. Assistance Unit

The ABD assistance unit policy in chapter M05 applies to *QIs*.

If the QI is living with his/her spouse who is aged, blind, or disabled, but does not have Medicare Part A, and both apply for Medicaid, two different financial calculations must be completed for the unit because of the different income limits used in the eligibility determinations. One is the QI determination; the other is for the ABD spouse's CN or MN covered group.

2. Resources

The resource requirements for QMBs in chapter S11 and Appendix 2 to Chapter S11 must be met by the QI.

The resource limits for QI are the resource limits for the MSPs. See section M1110.003 for the current resource limits.

3. Income

The income requirements in chapter S08 must be met by the QI. The income limits for QIs are in M0810.002. A QI's countable income must exceed the SLMB limit and must be less than the QI limit.

By law, for QIs who have Title II benefits, the new income limits are effective the first day of the **second** month following the month in which the federal poverty limit is updated. For QIs who do NOT have Title II benefits, the new income limits are effective the date the updated federal poverty limit is published. Local DSS are notified each year of the new poverty limits via the broadcast system. Check that system to ascertain when the Title II COLA must be counted in determining QI income eligibility.

4. Income Within QI Limit

When the individual's countable income is equal to or more than 120% of the FPL and is less than 135% of FPL (the QI limit), the individual is eligible for Medicaid as a QI. Go to subsection D below. If the individual's resources are within the MN limit and the individual meets a MN covered group, place the individual on two (2) 6-month spenddowns based on the MN income limit for his locality. See M0320.603 E.5 below.

5. Income Equals or Exceeds QI Limit

If the individual's income is equal to or exceeds the QI limit (135% of FPL), he/she is not eligible as QI.

D. QI Entitlement

If all eligibility factors are met in the application month, entitlement to Medicaid as a QI begins the first day of the application month. QIs are entitled to retroactive coverage if they meet all the QI requirements in the retroactive period.

E. Enrollment

1. Aid Category

The AC for all QIs is 056.

2. Enrollee's Covered Group Changes To QI

If Medicaid recipient becomes ineligible for full-coverage Medicaid but is eligible as a QI, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare Part B premiums as a QI.

Cancel the recipient's full coverage effective the last day of the month, using cancel reason 007. Reinstate the recipient's coverage with the begin date as the first day of the month following the cancellation effective date. Specify the appropriate QI AC.

3. Spenddown Status

At application and redetermination, eligible QIs who meet an MN covered group and who have resources that are within the lower MN resource limits are placed on two 6-month MN spenddowns. All spenddown periods are based on the application or renewal date, as appropriate. See M1370.

QIs who have not been determined disabled must be determined disabled or blind, or must be pregnant, under age 18 or under age 21 if in foster care or adoption assistance in order to meet a medically needy covered group for spenddown.

4. *QI Meets Spenddown*

When a QI meets a spenddown, cancel his AC 056 coverage effective the day before the spenddown was met, using cancel reason 024. Reinstate the recipient's coverage with the first date the spenddown was met as the begin date of coverage, and enter the end date of the spenddown period as the end date of coverage, using the appropriate AC:

- *018 for an aged MN individual;*
- *038 blind MN individual*
- *058 for a disabled MN individual.*

5. *Spenddown Period Ends*

After the spenddown period ends, reinstate the QI coverage using AC 056.

The begin date of the reinstated QI coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial QI eligibility.

6. *QI Enters LTC or Otherwise Becomes Eligible for Full Coverage*

When an enrolled QI becomes institutionalized or eligible in another covered group which has full Medicaid coverage, cancel the QI coverage effective the last day of the month immediately prior to the month in which he became eligible in the full coverage covered group, using cancel reason 024. Reinstate the coverage with the begin date as the first day of the month of admission to long-term care using the appropriate AC for the full-coverage group.

H. Covered Service

The eligible QI will only receive Medicaid payment of his/her Medicare Part B premium through the Medicaid Buy-In Agreement with SSA. The QI will not receive a Medicaid card.

M0320.604 QDWI (QUALIFIED DISABLED & WORKING INDIVIDUALS)

A. Policy

42 CFR 435.121 - Coverage of Qualified Disabled & Working Individuals is mandated by the federal Medicaid law. Medicaid will only pay the Medicare Part A premium for individuals eligible as QDWI.

B. Nonfinancial Eligibility

1. Definition Requirements

The individual must:

- be less than 65 years of age.
- be employed.
- have been entitled to Social Security disability benefits and Medicare Part A but lost entitlement solely because earnings exceeded the substantial gainful activity (SGA) amount.
- continue to have the disabling physical or mental impairment or be blind as defined by SSI and Medicaid but because he/she is working and earning income over the SGA limit does not meet the disability definition.
- be eligible to enroll or be enrolled in Medicare Part A (hospital insurance) under Section 1818A of the Social Security Act.
- not be eligible for Medicaid in any other covered group.

The above definition requirements must be verified by the Social Security Administration (SSA). The individual must be enrolled in Medicare Part A under Section 1818-A of the Social Security Act. Enrollment in Part A of Medicare is verified by the individual's Medicare card, or by communication (such as SVES) with SSA.

NOTE: Blind individuals who lose SSA and Medicare because of earnings over SGA still meet the blind category for Medicaid purposes. Therefore, a blind individual whose countable income is within the medically needy, or QMB limits cannot be eligible as a qualified disabled and working individual.

2. Verification Not Provided

If the applicant does not provide information documenting enrollment in Medicare Part A within the application processing time standard, he/she is not eligible for Medicaid as QDWI, but may be eligible in another covered group.

C. Financial Eligibility

The assistance unit policy in chapter M05 applies to QDWIs.

1. Assistance Unit

If the QDWI individual is living with his/her spouse who is aged, blind, or disabled, but does not have Medicare Part A, and both apply for Medicaid, two different financial calculations must be completed for the unit because of the different income limits used in the eligibility determinations. One is the QDWI determination; the other is for the ABD spouse's covered group.

2. Resources

The resource requirements in chapter S11 and Appendix 1 to Chapter S11 must be met by the QDWI Medicare beneficiary. Some of the real and personal property requirements are different for QDWIs. The different requirements are identified in Chapter S11, Appendix 1.

The resource limit for an individual is $4,000 (twice the SSI resource limit for an individual); the resource limit for a couple is $6,000 (twice the SSI resource limit for a couple).

3. Income

QDWIs must meet the income requirements in chapter S08. The income limits are in M0810.002. QDWIs do not receive Title II benefits.

4. Income Exceeds QDWI Limit

Spenddown does not apply to the MSP income limits. If the individual's income exceeds the QDWI limit, he/she is not eligible as QDWI and cannot spenddown to the QDWI limit. At application and redetermination, if the individual's resources are within the medically needy limit and the individual meets a medically needy covered group, place the individual on two 6-month spenddowns based on the MN income limit.

D. Entitlement

Entitlement to Medicaid as a QDWI begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month, including enrollment in Medicare Part A under Section 1818A of the Social Security Act. Retroactive entitlement, up to three months prior to application, is applicable if all QDWI eligibility criteria were met during the period.

If the individual is not enrolled in Medicare Part A under Section 1818A as of the month he/she meets the Medicaid eligibility requirements, the individual's entitlement to Medicaid cannot begin until the first day of the month in which his Medicare Part A enrollment under Section 1818A is effective.

The eligible QDWI will only receive Medicaid payment of his/her Medicare Part A premium through the Medicaid Buy-In Agreement with SSA. **The QDWI will not receive a Medicaid card.**

E. Enrollment

1. Aid Category

The AC for all QDWIs is "055."

2. Enrollee's AC Changes To QDWI

An enrolled enrollee's AC cannot be changed to AC "055" using a "change" transaction in *VaCMS*. If a Medicaid enrollee becomes ineligible for full-coverage Medicaid, but is eligible as a QDWI, the agency must send an advance notice of proposed action to the enrollee because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare Part A premiums as a QDWI.

Cancel the enrollee's full coverage effective the last day of the month, using cancel reason "007." Reinstate the enrollee's coverage as QDWI with the begin date as the first day of the month following the cancellation effective date. AC is "055."

3. QDWI's AC Changes To Full Coverage AC

When an enrolled QDWI becomes eligible in another covered group which has full Medicaid coverage (except when he/she meets a spenddown); e.g., he/she is no longer able to work and starts to receive SSA and SSI disability benefits:

- cancel the QDWI coverage effective the last day of the month immediately prior to the month in which he/she became eligible in the full coverage covered group, using cancel reason "024;"
- reinstate the enrollee's coverage with the begin date as the first day of the month in which he/she became eligible in the full coverage covered group, with the appropriate full coverage AC.

4. Spenddown Status

Eligible QDWIs who meet an MN covered group and who have resources that are within the lower MN resource limits are also placed on two 6-month medically needy spenddowns.

5. QDWI Meets Spenddown

When a QDWI meets a spenddown, cancel his AC "055" coverage effective the date before spenddown was met using cancel reason "024." Reinstate coverage as medically needy beginning the day the spenddown was met and ending the last day of the spenddown budget period.

The AC is NOT dual-eligible:

- 018 for an aged MN individual NOT eligible as QMB;
- 038 for a blind MN individual NOT eligible as QMB;
- 058 for a disabled MN individual NOT eligible as QMB.

6. Spenddown Period Ends

After the spenddown period ends, reinstate the QDWI-only coverage using the AC "055."

The begin date of the reinstated AC "055" coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial QDWI eligibility.

7. QDWI Enters Long-term Care

The enrollment of a QDWI who is admitted to long-term care and who becomes eligible for Medicaid in another covered group is handled like a QDWI who meets a spenddown. Cancel the QDWI-only coverage effective the last day of the month before the admission to long-term care, reason "024." Reinstate the coverage with the begin date as the first day of the month of admission to long-term care.

M0320.700 MEDICALLY NEEDY (MN) GROUPS

A. Introduction

1. Medically Needy Individuals

All medically needy covered groups are optional; the federal Medicaid law does not require the state to cover the MN groups in its Medicaid State Plan. Virginia has chosen to cover *individuals who*

- *meet all the nonfinancial requirements in chapter M02,*
- *meet the "Aged," "Blind" or "Disabled" definitions in subchapter M0310,*
- *have countable resources within the MN resource limits,*
- *are not financially eligible in a full-benefit CN covered group; and*
- *have insufficient income to meet their medical care needs.*

2. Spenddown Feature

The major feature of the MN covered groups is a spenddown. An individual who meets the nonfinancial and MN resource eligibility requirements but whose income exceeds the MN income limit may "spenddown" the excess income by deducting incurred medical expenses and become eligible for a limited period of MN Medicaid coverage. An individual who has excess income becomes eligible when he/she has incurred medical expenses equal to the difference between his/her income and the MN income limit.

3. Different Benefit Package

Some medical services that are covered for the CN covered groups are not available to the MN groups. ICF-MR services and IMD services are not covered for MN eligibles. However, the basic services such as inpatient and outpatient hospital, physicians, X-rays, prescription drugs, home health services and Medicare premiums, coinsurance and deductibles are covered for the MN. LTC nursing facility and most *CBC* waiver services are also covered for the MN.

***B.* ABD MN Covered Groups**

The ABD MN covered groups are:

- M0320.701 ABD
- M0320.702 December 1973 Eligibles

M0320.701 ABD MN INDIVIDUALS

A. Legal Base

The federal authority for covering ABD MN individuals is found in 42CFR435.330.

B. Financial Eligibility

1. Assistance Unit

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

2. Resources

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

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

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

3. Income

Determine gross income according to chapter S08. Subtract the $20 general exclusion and other exclusions. Compare the total countable income to the MN income limit for the individual's locality group (see section S0810.002) and calculate the MN spenddown amount. See chapter M13 for spenddown policy and procedures.

4. Income Eligibility

An individual becomes eligible in this MN covered group when he/she has incurred medical expenses equal to the difference between his/her income and the MN income limit (spenddown).

C. Entitlement

Individuals who become eligible after meeting a spenddown are entitled to full Medicaid coverage beginning the day the spenddown was met and ending the last day of the sixth month in the spenddown budget period. Retroactive coverage is applicable to this covered group.

Note: Individuals receiving LTC services are placed on monthly spenddowns (see M1460.700).

D. Enrollment

Eligible individuals in this group are classified as medically needy (MN). If the individual has Medicare Part A, compare the individual's countable income to the QMB and SLMB limits.

The following ACs are used when the individual is ABD MN and QMB or SLMB:

- 028 for an aged individual also QMB;
- 048 for a blind individual also QMB;
- 068 for a disabled individual also QMB;
- 024 for an aged MN individual also SLMB;
- 044 for a blind or disabled MN individual also SLMB.

The following ACs are used when the individual is ABD MN and not QMB or SLMB:

- 018 for an aged individual NOT QMB or SLMB;
- 038 for a blind individual NOT QMB or SLMB;
- 058 for a disabled individual NOT QMB or SLMB.

D. Referral to Health Insurance Marketplace

When an ABD who does not have Medicare is placed on a spenddown, the individual must be referred to the Health Insurance Marketplace (HIM) so that the applicant's eligibility for the APTC can be determined. Individuals with Medicare are not referred to the HIM.

M0320.702 DECEMBER 1973 ELIGIBLES

A. Policy

42 CFR 435.340 - If the State Plan covers the medically needy, the Plan must provide protected medically needy coverage for blind and disabled individuals eligible in December 1973.

B. Blind or Disabled in December 1973

This is an MN covered group of blind and disabled individuals who:

- were eligible as medically needy under the state plan in December 1973 on the basis of the blindness or disability criteria of the AB or APTD plan;

- for each consecutive month after December 1973 continue to meet the December 1973 blindness or disability criteria and the December 1973 financial eligibility requirements; and

- meet the **current** medically needy eligibility requirements except the blindness or disability criteria.

Continuing eligibility is determined on the basis of eligibility requirements in effect as of December, 1973 and current medically needy requirements.

Contact your Regional Medical Assistance Program Consultant if you have an applicant you believe meets this covered group.

CHAPTER M03
MEDICAID COVERED GROUPS

SUBCHAPTER 30

FAMILIES & CHILDREN GROUPS

M0330 Changes

Changed With	Effective Date	Pages Changed
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
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M0330.000 FAMILIES & CHILDREN GROUPS

M0330.001 GENERAL POLICY PRINCIPLES

A. Overview

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

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

B. Procedure

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

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

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

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

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

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

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

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

M0330.100 FAMILIES & CHILDREN CATEGORICALLY NEEDY

A. Introduction

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

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

B. Procedure

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

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

C. Eligibility Methodology Used

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

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

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

A. Policy

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

B. Children Who Receive SSI

Foster care or adoption assistance children who receive SSI meet the eligibility requirements for IV-E foster care or adoption assistance. They cannot receive both SSI and IV-E payments, so most of them elect to receive the higher SSI payment. These children are enrolled in Medicaid in the appropriate Foster Care or Adoption Assistance AC.

C. Nonfinancial Eligibility Requirements

The child must be under age 21 years and must meet the IV-E foster care or IV-E adoption assistance definition in M0310.115 or M0310.102. The child meets the age requirement until the end of the month in which the child turns age 21.

The child must meet all the nonfinancial eligibility requirements in chapter M02. The IV-E eligibility determination meets the Medicaid requirements for Virginia residency and cooperation in pursuing support.

NOTE: IV-E eligible foster care or adoption assistance recipients meet the Medicaid institutional status requirements when they live in a public residential facility if the facility has less than 25 beds.

D. IV-E Foster Care

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

The child must meet the IV-E foster care definition in M0310.115 and must be receiving IV-E foster care maintenance payments. A child of a IV-E foster care child is also considered to be a IV-E foster care child when the mother's IV-E payment includes an allocation for her child.

The IV-E eligibility determination meets the Medicaid requirements for Virginia residency and cooperation in pursuing support.

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

E. IV-E Adoption Assistance

42 CFR 435.145--The federal Medicaid law requires the State Plan to cover children who are eligible for adoption assistance under Title IV-E of the Social Security Act and for whom a IV-E adoption assistance agreement between the LDSS and the adoptive parent(s) is in effect.

The child must meet the IV-E adoption assistance definition in M0310.102. The child does not have to receive a IV-E Adoption Assistance payment in order to meet the IV-E Adoption Assistance definition.

The IV-E Adoption Assistance eligibility determination meets the Medicaid requirements for Virginia residency and cooperation in pursuing support.

F. Financial Eligibility

A separate Medicaid financial eligibility determination is not made for IV-E eligible foster care or IV-E adoption assistance children, regardless of the state that makes the IV-E payment. Verify the child's IV-E foster care payment eligibility, or the child's IV-E adoption assistance eligibility via agency records.

B. Entitlement

1. IV-E Foster Care Child

Entitlement to Medicaid as a IV-E Foster Care child begins the first day of the month of commitment or entrustment if a Medicaid application is filed within 4 months of commitment or entrustment. Retroactive entitlement prior to the month of commitment or entrustment is not allowed.

If the Medicaid application is filed more than 4 months after entrustment or commitment, entitlement may be retroactive up to 3 months prior to application if the child met all Medicaid eligibility requirements in the retroactive months. However, Medicaid entitlement cannot go back to the month of entrustment or commitment when the application is filed more than 4 months after entrustment or commitment.

2. IV-E Adoption Assistance Child

Entitlement to Medicaid as a IV-E Adoption Assistance child begins the first day of the application month if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

C. Enrollment

The aid category (AC) for IV-E foster care children is “076.” The AC for IV-E Adoption Assistance children is “072”.

M0330.107 INDIVIDUALS UNDER AGE 21

A. Policy

42 CFR 435.222 – The federal Medicaid law allows the State Plan to cover reasonable classifications of individuals under age 21 years who do not receive cash assistance but who meet the income requirements of the state’s July 16, 1996 AFDC State Plan. Children under age 19 should be evaluated in the FAMIS Plus covered group if not eligible as individuals under age 21.

Individuals ages 19 and 20 should be evaluated in the Individuals Under Age 21 covered group when they are not eligible for Medicaid in any other full-benefit covered group.

The reasonable classifications of individuals under age 21 are:

- IV-E eligible foster care children who do NOT receive a IV-E maintenance payment,
- Non-IV-E foster care children,
- Department of Juvenile Justice (DJJ) children,
- Non-IV-E Adoption Assistance children,
- Children in intermediate care nursing facilities (ICF), and
- Children in intermediate care facilities for the *intellectually disabled* (ICF-*ID*).

B. Nonfinancial Eligibility Requirements

The individual must be under age 21 and meet the nonfinancial requirements in chapter M02.

C. Reasonable Classifications

The individual under age 21 must meet one of the following classifications:

1. Non IV-E Foster Care

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

a. Children Living In Public Institutions

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

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

b. Child in Independent Living Arrangement

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

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

2. Non-IV-E Adoption Assistance

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

Non IV-E adoption assistance children who have "special medical needs" have additional requirements. See section M0330.805 for the Special Medical Needs Adoption Assistance requirements.

3. In ICF or ICF-ID

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

D. Assistance Unit

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

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

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

2. Adoptive Placement

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

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

For applications received prior to October 1, 2013 and renewals completed prior to April 1, 2013, financial eligibility is determined using the assistance unit procedures in subchapter M0520, which require the inclusion of the child's adoptive parent(s) and sibling(s). An adoption assistance child must have his/her eligibility determined by counting or deeming (as appropriate) his/her parent's and sibling's income.

For applications received on or after October 1, 2013, use the policies and procedures contained in chapter M04.

4. Child in ICF or ICF- ID

A child in an ICF or an ICF-ID is an institutionalized individual in a medical facility when he meets the definition of "institutionalized individual" in section M1410.010 B.2. When he meets the institutionalized individual definition, he is an assistance unit of one person.

E. Resources

There is no resource test for the Individuals Under Age 21 covered group.

F. Income

1. Income Limits

For the Individuals Under Age 21 covered group, the income limit is the income limit found in M04, *Appendix 5*.

The foster care or adoption subsidy payment is excluded when determining the unit's income eligibility.

Foster care and Adoption Assistance children in residential facilities do not have a different income limit. For a foster care/adoption assistance child living outside the State of Virginia, the income limit for the assistance unit is the income limit for the Virginia locality which holds custody, pays the adoption subsidy, or signed the adoption assistance agreement.

2. Income Exceeds F&C 100% Income Limit

For foster care (including DJJ) and adoption assistance children whose income exceeds the Individuals Under Age 21 income limit, determine the child's Medicaid eligibility in the Child Under 19 covered group and for FAMIS if the child under 19 or as an MN Individual Under Age 21 if the child is over 19 but under 21 (see M0330.804). Ineligible individuals must be referred to the Health Insurance Marketplace for evaluation for the Advance Premium Tax Credit (APTC).

G. Entitlement & Enrollment

1. Entitlement

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

2. Enrollment

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

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

M0330.108 SPECIAL MEDICAL NEEDS ADOPTION ASSISTANCE CHILDREN

A. Policy

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

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

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

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

B. Nonfinancial Eligibility Requirements

The child must:

- be under age 21,
- meet the "special medical needs" adoption assistance definition in M0310.102, and
- meet the nonfinancial requirements in chapter M02.

C. Financial Eligibility Requirements

1. Assistance Unit

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

2. Resources

There is no resource test for the Special Medical Needs Adoption Assistance Children covered group.

3. Income

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

For a Virginia Special Medical Needs adoption assistance child living outside the State of Virginia, the income limit for the unit is the income limit for the Virginia locality that signed the adoption assistance agreement.

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

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

D. Entitlement & Enrollment

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

The AC for individuals in the covered group of Special Medical Needs Adoption Assistance children is "072."

M0330.109 FORMER FOSTER CARE CHILDREN UNDER AGE 26 YEARS

A. Policy

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

- was in the custody of a local department of social services in Virginia, another state, *or a U.S. Territory,* and receiving Medicaid until his discharge from foster care upon turning 18 years or older, or
- was in the URM program in Virginia or another state and receiving Medicaid until his discharge upon turning 18 years or older.
- is not eligible for Medicaid in another mandatory Medicaid covered group (LIFC parent, Pregnant Woman, Child Under age 19 or SSI), and
- is under age 26 years.

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

B. Nonfinancial Eligibility Requirements

The individual must meet all the nonfinancial eligibility requirements in chapter M02. If the individual is not a U.S. citizen, he must meet the alien status requirements. These requirements differ depending on the age and pregnancy status of the individual. See subchapter M0220.

D. Entitlement

Entitlement as a former foster care child begins the first day of the month following the month the child was no longer in the custody of a local department of social services or the URM Program if the child was enrolled in Medicaid during the month foster care ended.

Accept the individual's declaration of enrollment in foster care or the URM Program and enrollment in Medicaid at the time turned at least 18.

If Medicaid coverage of a former foster care child was previously discontinued when the child turned 18, he may reapply for coverage and be eligible in this covered group if he meets the requirements in this section. The policies regarding entitlement in M1510 apply.

Individuals in this covered group receive full Medicaid coverage, including long-term care (LTC) services. Do not move enrollees in this covered group who need LTC to the 300% of SSI covered group.

E. Enrollment

The AC for former foster care children is "070."

M0330.200 LOW INCOME FAMILIES WITH CHILDREN (LIFC)

A. Policy

Section 1931 of the Act - The federal Medicaid law requires the State Plan to cover *(1)* dependent children under age 18 *or under the age of 19 and full-time students in a secondary school or in the equivalent level of vocational or technical training, or in a General Educational Development (GED) program IF they may be reasonably expected to complete the secondary school, training or program before or in the month they attain age 19; and (2)* parents or caretaker-relatives of dependent children who meet the financial eligibility requirements of the July 16, 1996 AFDC state plan. This covered group is called "Low Income Families With Children" (LIFC).

Public Law 111-148 (The Affordable Care Act) requires that coverage for all children under the age of 19 be consolidated in the Child Under Age 19 (FAMIS Plus) covered group. Virginia has chosen to implement this coverage effective October 1, 2013. Children are not enrolled as LIFC except when the child *meets the definition of a dependent child in M0310.111* and his parents are receiving LIFC Extended Medicaid coverage (see M1520.500). In these situations, if the child's household income exceeds the limit for coverage in the Child Under Age 19 group, the child must be evaluated for LIFC Extended Medicaid coverage with his family.

B. Nonfinancial Eligibility

The individual must meet all the nonfinancial eligibility requirements in chapter M02.

A LIFC child must meet the definition of a dependent child in M0310.111. The adult with whom the child lives must be the child's parent or caretaker-relative, as defined in M0310.107. The presence of a parent in the home does not impact a stepparent's eligibility in the LIFC covered group. Both the parent and stepparent may be eligible in the LIFC covered group. When a parent*(s)* is in the home, no relative *(i.e. caretaker/relative)* other than *another parent or* a stepparent can be eligible for Medicaid in the LIFC covered group.

C. Financial Eligibility

Modified Adjusted Gross Income (MAGI) methodology is applicable to the LIFC covered group. The policies and procedures contained in Chapter M04 are used to determine eligibility for LIFC individuals.

1. Basis For Eligibility ("Assistance Unit")

The basis for financial eligibility is the LIFC individual's MAGI household. See M0430.100.

2. Resources

There is no resource test for the LIFC covered group.

3. Income

The income limits, policies and procedures used to determine eligibility in the LIFC covered group are contained in Chapter M04.

4. Income Exceeds Limit

If the individual's income exceeds the LIFC income limit, the individual is not eligible as LIFC. Ineligible individuals must be referred to the Health Insurance Marketplace for evaluation for the APTC. Spenddown does not apply to the LIFC income limits.

Note: LIFC families who have been enrolled in Medicaid for at least three of the past six months and who are no longer eligible due to excess earned income must be evaluated for continued eligibility in LIFE Extended Medicaid. See M1520.400.

D. Entitlement

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

E. Enrollment

The ACs for individuals in the LIFC covered group are:

- 081 for an LIFC individual in a family with one or no parent in the home;
- 083 for LIFC individuals in a two-parent (including a stepparent) household.

M0330.250 MAGI ADULTS (EFFECTIVE JANUARY 1, 2019)

A. Policy

The Virginia 2018 Appropriations Act mandated that effective January 1, 2019, the State Plan for Medical Assistance be amended to add a new covered group for adults between the ages of 19 – 64. This mandate is titled "New Health Coverage Options for Virginia Adults" and the new covered group will be known as MAGI (Modified Adjusted Gross Income) Adults.

This new group may be designated in various reports, documentation, or publications of other agencies as New Enrolled Adults, Newly Enrolled Adults, or Medicaid Expansion Adults.

The MAGI Adults Group includes:

- MAGI Parent/Caretaker Relatives (AC 100, AC 101) who meet Medicaid requirements within a MAGI Adult group and must be responsible for a dependent child under age 18 (or less than age 19, still in school and expected to graduate by his 19th birthday);

- MAGI Childless Adults (AC 102, AC 103) who meet Medicaid requirements within a MAGI Adults group and are not responsible for a dependent child or claim such a child on his tax return;

- MAGI Presumptive Eligible Adults (AC 106) who meet Medicaid requirements within a MAGI Adults group and have had a determination made by an authorized PE Hospital; and

- MAGI Incarcerated Adults (AC 108) who would otherwise be eligible for Medicaid as a MAGI Adult except for being incarcerated in a Department of Corrections (DOC) facility or a local / regional jail.

Note: All HPE applications are processed by hospitals and enrolled at Cover Virginia. See M0120.500.D - Hospital Presumptive Eligibility.

B. Procedure

Eligible individuals in the MAGI Adults group must:

- be an individual between the ages of 19 and 64;
- have income at or below 138% *FPL* (133% *FPL* + 5% *FPL* disregard);
- not be entitled to or enrolled in Medicare Part A or B;
- not be eligible in a Medicaid mandatory covered group or the BCCPTA covered group.
- meet any other criteria as outlined in the particular aid categories.

A person in the MAGI Adults covered group may receive long term services and supports (LTSS) in either a facility or home and community based services (waiver) setting. The individual is still required to be assessed and approved for such care.

C. Non-Financial Eligibility

The individual must meet all the nonfinancial eligibility requirements in chapter M02. If the individual is not a U.S. citizen, he must meet the alien status requirements. These requirements differ depending on the age and pregnancy status of the individual. See subchapter M0220.

D. Resources

Although no resource test is applicable for MAGI Adults coverage, the worker must evaluate certain resources for any individuals seeking Medicaid payment for LTSS. These include asset transfers, trusts, annuities, and the home equity limit. See M1410.050

E. Financial Eligibility

MAGI methodology is applicable to the MAGI Adults covered group. The policies and procedures contained in Chapters M04 are used to determine eligibility for these individuals.

1. Basis For Eligibility

The basis for financial eligibility is the individual's MAGI household. See M0430.100.

2. Income

The income limits, policies and procedures used to determine eligibility in this covered group are contained in Chapter M04.

3. Income Exceeds Limit

If the individual's income exceeds the MAGI Adults income limit, the individual must be evaluated for eligibility in any other full benefit Medicaid group. If not eligible in a full benefit category, the individual must be evaluated for any limited benefit coverage for which they may be eligible.

4. Spenddown

Spenddown does not apply to any MAGI Adults covered group.

F. Referral to Health Insurance Marketplace

If the individual is not eligible for any full benefit Medicaid coverage group due to income over the applicable limit, the individual must be referred to the HIM for evaluation for the APTC.

G. Entitlement

Entitlement in Medicaid as a MAGI Adult begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period; however, retroactive coverage in the MAGI Adults group is not available for any month prior to January 1, 2019.

H. Enrollment

The Medicaid aid categories for MAGI Adults are:

AC	*Meaning*
100	*Parent/caretaker relative; income above the LIFC limit and below 100% FPL (no 5% disregard)*
101	*Parent/caretaker relative; income greater than 100% FPL, but less than or equal to 138% FPL (133% + 5% disregard)*
102	*Childless adult; income at or below 100% FPL (no disregard)*
103	*Childless adult; income greater than 100% FPL, but less than or equal to 138% FPL (133% + 5% disregard)*
106	*Presumptively-eligible MAGI Adult; income at or below 138% FPL (133% + 5% disregard)*
108	*Incarcerated adult*

I. Long Term Services and Supports

Once medical assessment and financial evaluation are approved, a MAGI Adult may receive facility based or home and community based LTSS.

Patient pay does not apply to MAGI Adults.

M0330.300 CHILD UNDER AGE 19

A. Policy

The Affordable Care Act requires that all coverage for children under age 19 be consolidated into one covered group. The authority for coverage of these children is found in 42CFR 435.11. 8. Virginia will begin covering children in this group effective October 1, 2013. The income limit for this group is 143% FPL.

Coverage under the Child Under Age 19 covered group is also known as FAMIS Plus in printed materials.

B. Nonfinancial Eligibility

The child must be under age 19 years. The child's date of birth must be provided, but birth verification is not required. Any child under age 19 years can be eligible in this covered group regardless of the child's living arrangements or the child's mother's Medicaid eligibility.

The child must meet the nonfinancial eligibility requirements in chapter M02.

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

NOTE: a child who has excess income for Medicaid may be evaluated for FAMIS eligibility.

C. Financial Eligibility

Modified Adjusted Gross Income (MAGI) methodology is applicable to this covered group. The MAGI policies and procedures are contained in Chapter M04.

1. Assistance Unit

The assistance unit for this covered group is the MAGI household.

2. Resources

There is no resource test.

3. Income

MAGI income rules are applicable to this covered group. The income limits for the Child Under Age 19 covered group are contained in M04, Appendix 2.

4. Income Changes

Any changes in a Medicaid-eligible child's income that occur after his eligibility has been established affect eligibility. Recalculate income and compare to the income limits.

5. Income Exceeds Limit

A child under age 19 whose income exceeds the income limit for this covered group may be eligible for FAMIS. The income limit for FAMIS is 200% FPL *plus a 5% FPL income disregard.* See Chapters M21 *and M04* to determine FAMIS eligibility.

If countable income exceeds the limit for Medicaid and FAMIS *and the child is under age 18*, the opportunity for a Medically Needy (MN) evaluation must be offered (see M0330.803). Ineligible *children, other than incarcerated children*, must be referred to the Health Insurance Marketplace for evaluation for the APTC.

D. Entitlement

Eligible children are entitled to full Medicaid coverage beginning the first day of the child's application month if all eligibility requirements are met in that month, but no earlier than the date of the child's birth. Retroactive coverage is applicable to this covered group.

Eligible children are entitled to all Medicaid covered services as described in chapter M18.

E. Enrollment

The Medicaid ACs for children are:

AC	Meaning
090	child under age 6; income greater than *109*% FPL, but less than or equal to 143% FPL
091	child under age 6; income less than or equal to 109% FPL
092	• child age 6-19; insured or uninsured with income less than or equal to 109% FPL; • child age 6-19; **insured** with income greater than 109% FPL and less than or equal to 143% FPL
094	child age 6-19; **uninsured** with income greater than 109% FPL and less than or equal to 143% FPL

Do not change the AC when a child's health insurance is paid for by Medicaid through the HIPP program.

M0330.400 PREGNANT WOMEN & NEWBORN CHILDREN

A. Policy

The federal Medicaid law requires the Medicaid State Plan to cover categorically needy (CN) pregnant women and newborn children whose family income is within 143% of the federal poverty level (FPL). The law allows the State Plan to cover these pregnant women and newborns regardless of their resources.

B. Nonfinancial Eligibility

1. Pregnant Woman

42CFR 435.116- The woman must meet the pregnant woman definition in M0310.124.

The pregnant woman must meet all the nonfinancial eligibility requirements in chapter M02.

Non-citizen pregnant women who meet the lawfully residing policy in M0220.314 meet the citizenship requirements for full coverage in the pregnant woman group.

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 the Hospital Presumptive Eligibility (HPE) aid category 035; 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.

For example, a married pregnant woman applies for Medicaid on October 10. She received a medical service in the retroactive period. Her expected delivery date is January 15. She and her husband have been unemployed since June 23. Her husband began earning $3,000 a month on October 9; she remains unemployed. Since they had no income during the retroactive period, she is found eligible for retroactive coverage effective July 1.

Because her available income (from her husband) changed after she established eligibility on July 1, the change in income does not affect her eligibility and she remains eligible for Medicaid in October and subsequent months until she no longer meets the pregnant woman definition or other nonfinancial requirements.

b. Newborn

Income changes do NOT affect the certain newborn's eligibility for the first year of the child's enrollment as a certain newborn.

The mother's failure to complete a renewal of her own eligibility and/or the eligibility of other children in the household does NOT affect the eligibility of the certain newborn.

5. Income Exceeds Limit

If the pregnant woman's income exceeds the 143% FPL limit, she is not eligible in this covered group. Determine her eligibility for FAMIS MOMS. If the pregnant woman is not eligible for FAMIS MOMS, evaluate her eligibility as MN (see M0330.801). Ineligible women, *other than incarcerated women*, must be referred to the Health Insurance Marketplace for evaluation for the APTC.

D. Entitlement

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

The newborn's Medicaid coverage begins the date of the child's birth. A renewal must be completed for the newborn in the last month in which the child meets the Newborn Children Under Age 1 covered group and must include SSN or proof of application, as well as verification of income.

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

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

E. Enrollment

The AC for pregnant women who are not incarcerated is "091." The AC for pregnant women who are incarcerated is "109."

The AC for newborns born to women who were enrolled in Medicaid as or to teens enrolled in FAMIS is "093."

M0330.500 300% of SSI INCOME LIMIT GROUPS

M0330.501 F&C IN MEDICAL INSTITUTION, INCOME ≤ 300% SSI

A. Policy

42 CFR 435.236 - The State Plan includes the covered group of individuals who meet a families & children definition who are in medical institutions and who

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

B. Nonfinancial Eligibility

An individual is eligible in this covered group if he/she meets the nonfinancial requirements in M02.

The individual must be a child under age 18, under age 21 who meets the adoption assistance or foster care definition or under age 21 in an ICF or ICF-ID, or must be a parent or caretaker-relative of a dependent child, or a pregnant woman as defined in M0310. *If the individual is a parent or caretaker-relative of a dependent child, the stay in the medical institution must be temporary while receiving treatment, rehabilitation, etc. for him to meet the definition of living in the home with the dependent child.*

C. Financial Eligibility

When determining income to compare to the 300% of SSI income limit, use the ABD income policy and procedures, regardless of the individual's definition or covered group. MAGI methodology is not used to determine eligibility for this covered group.

When determining resources, use F&C resource policy in chapter **M06** for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

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

1. Resources

a. Resource Eligibility – Married Individual Age 18 and Older

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

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

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

b. Resource Eligibility – Unmarried Individual *Age 18 and Older*

When determining resources for an unmarried F&C institutionalized individual, use the Medicaid F&C resource requirements in chapter M06. All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the F&C resource limit of $1,000. Pay close attention to ownership of his/her former residence when the individual is in an institution. Determine if the former home is excluded in **M06.**

If current resources are within the limit, go on to determine income eligibility. If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible in a different covered group.

c. Resource Eligibility – Child Under Age 18

Children under age 18 are not subject to a resource test.

2. Income

To determine if an individual has income within the 300% SSI income limit, **use gross income**, not countable income, and **use the ABD income policy and procedures in chapter S08 and subchapter M1460.** Determine what is income according to subchapter S0815, ABD What Is Not Income and subchapter M1460, LTC Financial Eligibility. DO NOT subtract the $20 general exclusion or any other income exclusions.

The individual is an assistance unit of 1 person. DO NOT deem any income from a spouse or parent.

Compare the **total gross income** to the 300% of SSI income limit (see M810.002 A. 3.). If gross income is less than or equal to this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds the 300% of SSI income limit, the individual is not eligible for Medicaid in the covered group of F&C individuals in medical institutions.

D. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as **300% SSI.** If the individual has Medicare Part A, re-calculate the individual's income - subtract appropriate ABD income exclusions. Compare the countable income to the QMB limit.

1. Dual-eligible As QMB

If the individual is also a Qualified Medicare Beneficiary (QMB) – the individual has Medicare Part A and has countable income within the QMB income limit - the program designation is "062."

2. Not QMB

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

E. Ineligible In This Covered Group

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

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

M0330.502 F&C RECEIVING WAIVER SERVICES (CBC)

A. Policy

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

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

B. Nonfinancial Eligibility

An individual who receives Medicaid waiver services is eligible in this covered group if he/she:

1. meets the nonfinancial requirements in M02.
2. is not in a medical institution, may be in a residential institution that meets the institutional status requirements; and
3. *is a child under age 18, under age 21 and meets the adoption assistance or foster care definition, a parent or caretaker-relative of a dependent child, or a pregnant woman as defined in M0310.*

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

Do not wait until the individual starts to receive the waiver services to determine his/her eligibility in this covered group. Determine his/her eligibility in this covered group if he/she is screened and approved to receive Medicaid waiver services, has not been placed on a waiting list for services, and has selected the option to receive Medicaid waiver services in lieu of nursing facility services. Presume that he/she will receive the services and go on to determine financial eligibility using the policy and procedures in C. below. If determined eligible, the individual is not entitled to Medicaid in this covered group unless the policy in item D. below is met. See item D. below for the entitlement and enrollment procedures.

C. Financial Eligibility

When determining **income** to compare to the 300% of SSI income limit, use the ABD income policy and procedures, regardless of the individual's definition or covered group. MAGI methodology is not used to determine eligibility for this covered group.

When determining **resources**, use F&C resource policy in chapter **M06** for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

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

1. Resources

a.* Resource Eligibility - Married Individual *Age 18 and Older

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

b*. Resource Eligibility - Unmarried Individual *Age 18 and Older

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

ownership of his/her former residence when the individual is in an institution. Determine if the former home is excluded in **M06.**

DO NOT DEEM any resources from a child's parent living in the home.

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

If current resources are NOT within the limit, the individual is NOT eligible in this covered group. He/she may be eligible as medically needy in a medically needy covered group.

c. Resource Eligibility – Child Under Age 18

Children under age 18 are not subject to a resource test.

2. Income

To determine if an individual has income within the 300% SSI income limit, **use gross income**, not countable income, and use the ABD income policy and procedures in **chapter S08** and **subchapter M1460.** Determine what is considered income according to subchapter **S0815, ABD What Is Not Income** and subchapter **M1460, LTC Financial Eligibility**. DO NOT subtract the $20 general exclusion or any other income exclusions.

The F&C waiver services individual is an assistance unit of 1 person. DO NOT deem any income from a spouse or parent.

Compare the **total gross income** to the 300% of SSI income limit (see M0810.002 A.3). If gross income is less than or equal to this limit, the individual is eligible for Medicaid in the CN covered group of F&C individuals receiving Medicaid waiver services.

If the total gross income **exceeds** the 300% of SSI income limit, the individual is **not** eligible for Medicaid in the covered group of F&C individuals receiving Medicaid waiver services.

D. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as 300% of SSI. If the individual has Medicare Part A, re-calculate the individual's income - subtract the appropriate ABD income exclusions. Compare the countable income to the QMB limit.

1. Dual-eligible As QMB

If the individual is also a Qualified Medicare Beneficiary (QMB) – the individual has Medicare Part A and has countable income within the QMB income limit - the AC is "062."

2. Not QMB

If the individual is NOT a QMB – the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - the AC is "060."

E. Ineligible In This Covered Group

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

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

M0330.503 F&C HOSPICE

A. Policy

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

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

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

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

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

B. Nonfinancial Eligibility

A terminally ill individual who elects hospice services is eligible in this covered group if he/she meets the *non-financial requirements in M02, and*:

1. is not in a medical institution, may be in a residential institution that meets the institutional status requirements; and

2. *is a child under age 18, under age 21 and meets the adoption assistance or foster care definition, a parent or caretaker-relative of a dependent child, or a pregnant woman as defined in M0310.*

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

C. Financial Eligibility

When determining **income** to compare to the 300% of SSI income limit, use the ABD income policy and procedures, regardless of the individual's definition or covered group. *MAGI methodology is not used to determine eligibility for this covered group.*

When determining **resources**, use F&C resource policy in *chapter **M06*** for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

The individual must also meet the asset transfer policy in M1450.When determining **resources**, use F&C resource policy for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

1. Resources

a*. Resource Eligibility - Married Individual *Age 18 and Older

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

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

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible as medically needy in a medically needy covered group.

b*. Resource Eligibility - Unmarried Individual *Age 18 and Older

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

DO NOT DEEM any resources from a child's parent living in the home.

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

If current resources are NOT within the limit, the individual is NOT eligible in this covered group. He/she may be eligible as medically needy in a medically needy covered group.

c. Resource Eligibility – Child Under Age 18

Children under age 18 are not subject to a resource test.

2. Income

To determine if an individual has income within the 300% SSI income limit, **use gross income**, not countable income, and **use the ABD income policy and procedures in chapter S08.** Determine what is considered income according to **subchapter S0815, ABD What Is Not Income**. DO NOT subtract the $20 general exclusion or any other income exclusions.

The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Compare the total gross income to the 300% SSI income limit (see M0810.002 A. 3.). If countable income is equal to or less than this limit, the individual is eligible for Medicaid in the hospice covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in the hospice covered group. Evaluate his/her eligibility as medically needy.

D. Entitlement & Enrollment

The hospice services recipient must elect hospice services and the election must be in effect for 30 days. The 30 day period begins on the effective date of the hospice election. Upon 30 days elapsing from the effective date of the hospice election, and the election is in effect for the entire 30 days, eligibility in the hospice covered group begins with the effective date of the hospice election if all other eligibility factors are met.

1. Entitlement

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as categorically needy CN. If the individual has Medicare Part A, evaluate his/her eligibility as ABD hospice in *M0320.402*.

2. Enrollment

If the individual is eligible in any other full-coverage Medicaid covered group, he is enrolled under that aid category (AC) and not the Hospice AC (054). Enroll with AC *0*54 for an individual who meets an F&C definition, *has income within 300% of the SSI limit*, but who is not eligible in any other full-coverage Medicaid covered group.

E. Post-eligibility Requirements (Patient Pay)

Individuals who receive hospice services in a nursing facility have a patient pay calculation (see subchapter M1470). Individuals who receive hospice services outside of a nursing facility do not have a patient pay.

Individuals who have elected hospice services and who also receive Medicaid Long-term Care services available under the EDCD Waiver must have a patient pay calculation for the EDCD services (see subchapter M1470).

F. Ineligible In This Covered Group

There is no corresponding medically needy hospice covered group. Evaluate the individual in another covered group.

M0330.600 PLAN FIRST - FAMILY PLANNING SERVICES

A. Policy

Plan First, Virginia's family planning services health program covers individuals who are not eligible for another full or limited-benefit Medicaid covered group or FAMIS. This optional covered group is available to individuals regardless of their age, gender, disability status, insured status or if they previously had a sterilization procedure. Plan First covers only family planning services, including transportation to receive family planning services.

The income limit for Plan First is 200% FPL. While there are no specific age requirements for Plan First, eligibility for Plan First is not determined for children under 19 years or for individuals age 65 years and older unless the child's parent or the individual requests an evaluation for Plan First.

Individuals who are eligible for Plan First must be referred to the Federal Health Insurance Marketplace for an evaluation for the APTC, because they are not eligible for full Medicaid coverage.

If the information contained in the application indicates **potential** eligibility in a full-benefit Medicaid covered group (e.g., the applicant has a child under 18 in the home or alleges disability), in another limited benefit covered group (e.g., the individual has Medicare) or in FAMIS, the worker must determine whether eligibility exists in another covered group before the individual(s) can be determined eligible for Plan First.

If additional information is needed to complete the eligibility determination in another Medicaid covered group**,** the applicant must be given the opportunity to provide the additional information needed. If the additional information is not provided by the deadline, determine the applicant's eligibility for Plan First only.

When an individual age 19 through 64 years is not eligible for Medicaid in any other covered group, evaluate his eligibility for Plan First unless the individual has indicated otherwise on the application or communicated the desire to opt out to the LDSS by other means.

When a Medicaid enrollee no longer meets the requirements for his current covered group, prior to cancelling his coverage he must be evaluated in all covered groups for which he may meet the definition. If the individual is age 19 through 64 years and is not eligible for full-benefit Medicaid coverage or as a Medicare beneficiary, he must be evaluated for Plan First unless he has declined that coverage. If a child is under age 19 or an individual is age 65 or older, evaluate for Plan First only if the child's parent or the individual requests the coverage.

B. Nonfinancial Requirements

Individuals in this covered group must meet the Medicaid nonfinancial requirements in chapter M02.

Division of Child Support Enforcement (DCSE*)* services are available to all Medicaid recipients, but cooperation with DCSE is not a condition of eligibility for this covered group.

C. Financial Eligibility

Refer to chapters M05 and M07 for applications submitted before October 1, 2013 and for renewals completed before April 1, 2014. Refer to Chapter M04 for eligibility determinations completed on applications submitted on or after October 1, 2013.

1. Assistance Unit

Use the assistance unit policy in chapter M05 to determine the individual's financial eligibility for applications submitted before October 1, 2013 and for renewals completed before April 1, 2014. Refer to chapter M04 for eligibility determinations completed on applications submitted on or after October 1, 2013.

2. Resources

There is no resource test.

3. Income

The income limit for this group is 200% FPL. The income limits are contained in M04, Appendix 5.

4. Spenddown

Spenddown does not apply to Plan First. However, because an individual enrolled in the Plan First covered group does not receive full Medicaid coverage, if he meets a MN covered group listed in M0320 or M0330, he must be evaluated to determine if he could become eligible for full Medicaid coverage as medically needy (MN) by meeting a spenddown. At application and redetermination, Plan First enrollees who meet the MN covered group and resource requirements are placed on two six-month spenddown budget periods within the 12 month renewal period. They may also be eligible for a retroactive MN spenddown determination. See chapter M13 for spenddown instructions.

D. Entitlement and Enrollment

1. Begin Date

Eligibility in the Plan First covered group begins the first day of the month in which the application is filed, if all eligibility factors are met in the month.

2. Retroactive Coverage

Individuals in this covered group are entitled to retroactive coverage if they meet all the requirements in the retroactive period.

3. Enrollment

The AC for Plan First enrollees is "080."

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.

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:

- LIFC;
- Pregnant Women;
- Child Under Age 19;
- SSI recipients.

2. Creditable Health Insurance Coverage

BCCPTA *individuals* must not have creditable health insurance coverage. Creditable health insurance coverage includes:

- a group health plan;
- health insurance coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;
- Medicare;
- Medicaid;
- armed forces insurance a medical care program of the Indian Health Service (IHS) or of a tribal organization;
- a state health risk pool.

There may be situations where an *individual* has creditable health insurance coverage as defined above, but the coverage does not include treatment of breast or cervical cancer due to a period of exclusion or exhaustion of lifetime benefits, or the woman may have a high deductible. The *individual* is not eligible for Medicaid in the BCCPTA covered group because *of the* creditable health insurance.

C. Financial Eligibility

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

Individuals requesting Medicaid coverage of LTC services must provide verification of their resources and income and must meet all the LTC eligibility requirements in chapter M14.

D. Application Procedures

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

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

Individuals who meet the description of individuals in the LIFC, Pregnant Women, *Child Under Age 19*, or SSI recipients covered groups must complete the appropriate *MA* application for the covered group and must have an *MA* eligibility determination completed prior to determining their eligibility in the BCCPTA covered group. If not eligible in the LIFC,

Pregnant Women, FAMIS Plus, or SSI recipients covered groups, then determine their eligibility in the BCCPTA covered group.

1. Application Form

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

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

2. Application Processing Time Frames

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

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

3. Notices

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

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

E. Entitlement

1. Entitlement Begin Date

Eligibility under this covered group is met the beginning of the month the screening is completed if the individual later has a positive diagnosis as a result of the screening and is determined to be in need of treatment for breast and/or cervical cancer.

Eligible BCCPTA individuals are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. *Coverage is to be provided throughout the person's course of treatment, and no limit is placed upon the number of years an eligible person may be covered as long as physician certifies at renewal that treatment for the breast or cervical condition is still required.*

2. Retroactive Entitlement

Retroactive coverage is applicable to this covered group if the individual was screened by a medical provider operating under the BCCEDP and diagnosed as needing treatment for breast or cervical cancer in the retroactive month(s).

F. Enrollment

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

G. Benefit Package

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

H. Renewal

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

M0330.800 FAMILIES & CHILDREN MEDICALLY NEEDY GROUPS

A. Introduction

An F&C medically needy individual must

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

B. Procedure

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

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

C. Referral to Health Insurance Marketplace

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

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

M0330.801 PREGNANT WOMEN

A. Nonfinancial Eligibility

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

A pregnant woman's Medicaid eligibility is first determined in the CN pregnant women covered group which has no resource limit and has an income limit that is higher than the medically needy income limit. If a pregnant woman is not eligible as a *CN Pregnant Woman* because her income is too high, evaluate as FAMIS MOMS. If the individual is not eligible for FAMIS MOMS, then evaluate as MN. She may spenddown to the lower MN income limit IF her resources are within the MN resource limit.

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

B. Financial Eligibility

1. Assistance Unit

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

2. Resources

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. The resources policy in chapter M06 applies.

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

a. Resources Within The Limit

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

b. Resources Exceed The Limit

If current resources exceed the limit, she is not eligible in this covered group.

3. Income

Determine MN countable income according to chapter M07. Subtract the appropriate exclusions. Compare the total countable income to the MN income limit for the individual's locality group (see M0710, Appendix 5 for the MN income limits).

4. Income Exceeds MN Limit

Because the MN pregnant woman's income exceeds the 133% FPL limit, it also exceeds the MN limit. She becomes eligible in this MN covered group when she has incurred medical expenses equal to the difference between her income and the MN income limit (spenddown). See chapter M13 for spenddown policy and procedures.

5. Income Changes

Any changes in a medically needy pregnant woman's income that occur after her eligibility has been established, **do not** affect her eligibility as long as she meets the pregnant woman definition, the nonfinancial and MN resource eligibility requirements.

The spenddown liability must be recalculated when an income change is reported prior to eligibility being established.

C. Entitlement

Eligible *women* in this MN group are entitled to full Medicaid coverage beginning the first day the spenddown is met. *Coverage ends on the last day of the spenddown period, as long as the woman's pregnancy did not end while she was enrolled in MN coverage.*

If the woman delivers the child while enrolled in MN coverage, she is entitled to MN coverage as long as she continues to meet the definition of a pregnant woman in M0310.124. Her MN coverage ends on the last day of the month in which the 60th day following the end of the pregnancy occurs, regardless of when the spenddown period ends, without the need for a new application or an additional spenddown period.

Retroactive coverage is applicable to this covered group.

Example 1:

A pregnant woman applied for Medicaid on March 3. Her estimated date of delivery is October 20. Her income exceeds the income limit for 2 persons for Medicaid and FAMIS MOMS. Her resources are within the medically needy resource limit and she is placed on a spenddown for the period March 1 through August 31. She meets the spenddown on May 11 and is enrolled in Medicaid as a medically needy pregnant woman through August 31.

Her income increased in August. Because her income increased after she established eligibility *(on May 11)* but before the date her pregnancy ended, the increase in income does not affect her Medicaid eligibility – *reference M0330.801.B5.* Her income that was verified in March is used to calculate her *for the next consecutive* spenddown *period*. She is placed on spenddown for the period September 1 through February 28, using the same spenddown amount from her previous spenddown and establishes eligibility *unless she is no longer eligible due to non-financial or resource criteria*. Her child is born on October 10. Her Medicaid coverage as a pregnant woman is canceled effective December 31, the last day of the month in which the 60th day after her pregnancy ended occurred. She no longer meets the pregnant woman covered group requirements.

Example 2:

A pregnant woman applied for Medicaid on January 5. Her estimated date of delivery is May 10. Her income exceeds the income limit for 2 persons for Medicaid and FAMIS MOMS. Her resources are within the medically needy resource limit for the retroactive period and ongoing, and she is placed on a retroactive spenddown for the period October 1 through December 31of the previous year and a prospective spenddown for the period January 1 through June 30. She delivered the child and met the spenddown on May 20. She was enrolled in MN coverage effective May 20. Although her spenddown period ends on June 30, her postpartum period does not end until July 31(the end of the month in which the 60th day after her pregnancy ended falls). Therefore, her coverage is cancelled effective July 31.

Note: The eligibility worker must evaluate the individual's eligibility in all other covered groups prior to taking action to cancel the MN coverage.

D. Enrollment

Eligible individuals in this group are enrolled in aid category 097.

M0330.802 NEWBORN CHILDREN UNDER AGE 1

A. Policy

42 CFR 435.301 (b)(1)(iii) - If the state chooses to cover the MN, the State Plan must provide MN coverage to all newborn children born on or after October 1, 1984 to a woman who is eligible as MN and is receiving Medicaid on the date of the child's birth. Coverage must be provided to those newborn children whose mothers were eligible as MN but whose coverage was restricted to Medicaid payment for labor and delivery as an emergency service. The child remains eligible for one year.

B. Nonfinancial Eligibility

A child who meets this covered group:

- is under age of 1 year;
- was born to a mother who is found eligible for Medicaid as medically needy or meets spenddown effective on or before the date of the child's birth.

  If the child's mother was covered by Medicaid as a medically 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.

1. Continued Eligibility When Mother Becomes Ineligible

Any child born to an eligible pregnant woman will continue to be eligible in this covered group **up to age 1.**

EXAMPLE #4: A pregnant woman applied for Medicaid on October 24, 2008. Her estimated date of conception is March 24, 2008, and her due date is December 20, 2008. Her income exceeds the CN limit for 2 persons. Her resources are within the medically needy resource limit and she is placed on a spenddown for the period October 1, 2008 through March 31, 2009. She meets the spenddown on November 15, 2008, and is enrolled in Medicaid as MN effective November 15, 2008 through March 31, 2009.

Her child is born on November 30, 2008, and is enrolled in Medicaid as an MN newborn. The mother's Medicaid coverage is canceled effective January 31, 2009, the last day of the month in which the 60th day occurred after her pregnancy ended. The newborn's Medicaid coverage continues through November 30, 2009, the end of the month in which he turns one year old. *A renewal of the child's coverage must be completed for his coverage to continue past age one.*

2. Covered Group Eligibility Ends

The child no longer meets this covered group effective:

a. the end of the month in which the child reaches age 1 year; or

b. the end of the month in which the child no longer resides in Virginia.

B. Financial Eligibility

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

C. Entitlement & Enrollment

Eligible newborns in this MN group are entitled to full Medicaid coverage beginning the date of the child's birth. Retroactive coverage is applicable to this covered group, but coverage cannot begin prior to the date of the child's birth. *A renewal must be completed for the newborn before system cut-off in the last month in which the child meets the Newborn Children Under Age 1 covered group and must include SSN or proof of application, as well as verification of income and resources.*

Eligible children in this group are enrolled in aid category 099.

M0330.803 CHILDREN UNDER AGE 18

A. Nonfinancial Eligibility

42 CFR 435.301(b)(1)(ii) - If the state chooses to cover the medically needy, the State Plan must provide medically needy coverage to all children under 18 years of age who, except for income and resources, would be eligible for Medicaid as categorically needy.

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

A child under age 18's Medicaid eligibility is first determined in the Child Under Age 19 covered group *and for FAMIS*, which *have* no resource limits and *have* income limits that are higher than the medically needy income limit. If a child under age 18 is not eligible *for Medicaid in the Child Under 19 covered group or for FAMIS* because the child's countable income is too high, *and* the child's resources are within the MN resource limit, *evaluate the child's in the MN Children Under Age 18 covered group.*

B. Financial Eligibility

1. Assistance Unit

The assistance unit policy and procedures in chapter M05 apply to this covered group. If not institutionalized, count or deem any resources and income from the child's spouse and/or parent with whom he/she lives.

2. Resources

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. The resources policy in chapter M06 applies.

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

a. Resources Within The Limit

If the child's resources are within the MN limit, go on to determine income eligibility.

b. Resources Exceed The Limit

If the child's resources are NOT within the limit, the child is NOT eligible for Medicaid because of excess resources.

3. Income

Determine MN countable income according to chapter M07. Subtract the appropriate exclusions. Compare the total countable income to the MN income limit for the child's locality group (see section M0710, Appendix 5 for the MN income limits).

4. Income Exceeds MN *and FAMIS* Limit*s*

Because the Child Under Age 19 and FAMIS income limits are higher than the MN income limits, the child becomes eligible in the MN children under age 18 covered group when the child has incurred medical expenses equal to the difference between his/her income and the MN income limit (spenddown). See chapter M13 for spenddown policy and procedures.

5. Income is under the MN and FAMIS Limits

Because of the differences between the Child Under 19 covered group/FAMIS (MAGI) and MN (non-MAGI) income-counting rules, such as the treatment of a stepparent's income, a child may be ineligible for Medicaid as a Child Under 19 or for FAMIS coverage but have countable income under the income limit for MN coverage. In this case, the child's spenddown liability is $0.00 (zero dollars). Even if the spenddown liability is $0.00, MN coverage cannot be open-ended. Enroll the child in two back-to-back six-month periods of coverage, without the need for a new application. Complete a renewal following the procedures in M1520 at the end of the second spenddown period. Continue to enroll the child in two consecutive six-month periods of coverage per year as long as he continues to be eligible as MN at renewal.

C. Entitlement & Enrollment

Children who become eligible after meeting a spenddown are entitled to full medically needy Medicaid coverage beginning the day the spenddown was met. Retroactive coverage is applicable to this covered group.

Eligible children in this group are *enrolled in* aid category 088.

M0330.804 INDIVIDUALS UNDER AGE 21

A. Policy

42 CFR 435.308(b) - A state may choose to provide medically needy coverage to reasonable classifications of individuals under 21 years of age who are not eligible for coverage as categorically needy but who meet the medically needy resource and income requirements.

Virginia has chosen to cover the following reasonable classifications of individuals under age 21:

- Non-IV-E Foster Care children
- Department of Juvenile Justice (DJJ) children,
- Non-IV-E Adoption Assistance children,
- Children in intermediate care nursing facilities (ICF), and
- Children in an ICF-*ID*.

NOTE: the ICF- *ID* services are **not** covered for medically needy individuals, but other Medicaid covered services such as prescription drugs, physicians, inpatient and outpatient hospital services are covered for medically needy patients in ICF- *IDs*.

B. Nonfinancial Eligibility

The individual must be under age 21 and meet the nonfinancial requirements in chapter M02. The child meets the age requirement until the end of the month in which the child turns age 21.

C. Reasonable Classifications

The individual under age 21 must meet one of the following classifications:

1. Non IV-E Foster Care

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

c. Children Living In Public Institutions

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

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

d. Child in Independent Living Arrangement

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

2. Non-IV-E Adoption Assistance

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

Non IV-E adoption assistance children who have "special medical needs" have additional requirements. See section M0330.805 for the medically needy Special Medical Needs Adoption Assistance requirements.

3. In ICF or ICF-*ID*

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

D. Assistance Unit

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

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

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

b. Adoptive Placement

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

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

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

d. **Child in ICF or ICF- *ID***

A child in an ICF or an ICF- *ID* is an institutionalized individual in a medical facility when he meets the definition of "institutionalized individual" in section M1410.010 B.2. When he meets the institutionalized individual definition, he is an assistance unit of one person.

E. Resources

The resource limit and requirements are found in chapter M06.

If the resources exceed the limit, the child is not eligible for Medicaid. If the child is under age 19, determine the child's eligibility as FAMIS Plus because that classification has no resource limits.

F. Income

The MN income requirements are found in subchapter M0710.

***1.* Income Limits**

For the MN Individuals Under Age 21 covered group, the income limit is the medically needy income limit found in chapter M0710, Appendix 5.

The foster care or adoption subsidy payment is excluded when determining the unit's income eligibility.

Foster care or adoption assistance children in residential facilities do not have a different income limit. For a foster care/adoption assistance child living outside the State of Virginia, the MN income limit for the unit is the income limit for the Virginia locality which holds custody, pays the adoption subsidy, or signed the adoption assistance agreement.

***2.* Income Exceeds MN Income Limit**

If the unit's resources are within the medically needy limit, but the income exceeds the medically needy income limit, the unit is placed on a spenddown. All medical expenses of the unit members are used to meet the spenddown. Once the spenddown is met, only the child and family members who meet an MN covered group and who applied for Medicaid are enrolled in Medicaid.

G. Entitlement & Enrollment

1. Entitlement

Entitlement to Medicaid begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. If the individual is eligible after meeting a spenddown, entitlement begins the date the spenddown was met and ends after the last day of the spenddown period.

Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

2. Enrollment

The aid category for medically needy individuals in the MN covered group of Individuals Under Age 21 are:

- 086 for an MN Non-IV-E foster care, MN Non-IV-E adoption assistance,
- 085 for an MN Juvenile Justice Department child;
- 098 for an MN child under age 21 in an ICF or ICF- *ID*.

M0330.805 SPECIAL MEDICAL NEEDS ADOPTION ASSISTANCE

A. Policy

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

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

If the child was not enrolled in Medicaid and would not have been eligible for Medicaid prior to the adoption assistance agreement being entered into, the child is **not** eligible for Medicaid in the MN covered group of "special medical needs adoption assistance children." The child may be eligible in the MN Non-IV-E Adoption Assistance classification of Individuals Under Age 21 in section *M0330.804*.

B. Nonfinancial Eligibility

The child must

- be under age 21,
- meet the "special medical needs" adoption assistance definition in M0310.102, and
- meet the nonfinancial requirements in chapter M02.

C. Financial Eligibility

1. Assistance Unit

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

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

2. Resources

The resource limits and requirements are found in chapter M06.

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

3. Income

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

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

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

D. Entitlement & Enrollment

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

The AC for individuals in the MN covered group of special medical needs adoption assistance children is "086."