March 1, 2010

MEDICAID MANUAL – VOLUME XIII

POLICY UPDATE #3

Medicaid Policy Update #3 contains revised policy regarding citizenship and identity verification and the resource limits for the Qualified Disabled & Working Individuals (QDWI) covered group. The policy revisions contained in Medicaid Policy Update #3 are effective for all eligibility determinations completed on or after March 1, 2010.

Revised Policy

SSA Citizenship and Identity Verification

Beginning in March, the Department of Medical Assistance Services (DMAS) will send data from the Medicaid Management Information System (MMIS) to the Social Security Administration (SSA) on certain active enrollees who have been given a "good faith/reasonable opportunity" period for verifying their citizenship and identity. The data files include only those enrollees who have renewals due within the next two months, new enrollees added to MMIS with the month and enrollees whose current renewal of eligibility is overdue. The IEVS Eligibility Update (SSN Verification) Report has been renamed and will be called the "SSN and Citizenship Update Report." It has been modified to include the names of enrollees whose citizenship cannot be verified by SSA records. The report will be posted each month to SPARK after cutoff.

LDSS Medicaid workers are expected to review the report to see if the report lists any enrollees who were rejected either because their SSN, name or date of birth did not match information in the SSA records or because the SSA could not verify the enrollees' citizenship and identity.

Local workers will review the report for discrepancies and, if the error was typographical or the result of a clerical error, eligibility staff will be required to correct the information in the MMIS or ADAPT so that a new data match with SSA can occur.

If the inconsistency is not the result of a typographical or other clerical error, then the eligibility worker is required to send a written notification to the enrollee informing him of the discrepancy and giving him 90 calendar days from the date of the notice to resolve the discrepancy with the SSA and provide either written verification of the correction OR acceptable documentation of their C&I to the local agency. In the notice, the deadline date by which the enrollee must provide the requested information is required to be included.

Resource Limits for Qualified Disabled & Working Individuals (QDWI)

The resource limits for the Qualified Disabled & Working Individuals (QDWI) covered group are changed back to the resource limits in effect prior to January 1, 2010. The QDWI resource limits are not the same as the Extra Help resource limits and will **not** change each

year when the resource limits for the other Medicare Savings Programs (MSP) change. The resource limits for the MSPs were also moved from Chapter M20 to subchapter S1110.

Electronic Version

Medicaid Policy Update #3 is available electronically on SPARK and the VDSS public web site. It has not been printed for distribution. The electronic version is the transmittal of record. Significant changes to the manual are as follows:

Pages Changed	Significant Changes
M0220 Pages 1-3a	On pages 1-3a, added policy regarding the new reasonable opportunity period and the SSA data match method for documenting citizenship and identity.
M0320 Pages 34, 35, 38, 40, 42a, 42b, 42f	On pages 34, 35, 38, 40, 402a and 42b, changed the reference to the location of the resource limits for the MSPs. On page 43f, updated the resource limits for the QDWI covered group.
S1110 Table of Contents Page 2	Updated the Table of Contents. On page 2, updated the resource limits for the QDWI group and added the resource limits for the MSPs.

Pages Changed	Significant Changes
M20 Table of Contents, page ii Appendix 3, page 1	Updated the Table of Contents. On Appendix 3, page 1, deleted the resource limits for the MSPs. The resource limits for the MSPs were moved to M1110.003.
M21 Pages 2-5	On pages 2 and 3, added policy regarding the reasonable opportunity period and the SSA data match method for documenting citizenship and identity. Pages 4 and 5 are runover pages.
M22 Page 2	On page 2, added policy regarding the SSA data match method for documenting citizenship and identity.

Questions about information contained in Medicaid Policy Update #3 should be directed to Stephanie Sivert, Manager, Medical Assistance Programs, at 804-726-7660 or stephanie.sivert@dss.virginia.gov.

M0220 Changes

Changed With	Effective Date	Pages Changed
Update (UP) #3	03/01/2010	pages 1-3a
TN #93	01/01/2010	Table of Contents pages 7-8 page 14a pages 14c-14d pages 15-20 page 22a Appendix 1 Appendix 3, page 3 Appendix 4, pages 1 and 2 Appendix 6, page 2
TN #92	05/22/2009	Table of Contents pages 1-6a Appendix 8 (18 pages) pages 4a-4t were removed and not replaced.
TN #91	05/15/2009	page 7 pages 14a, 14b page 18 page 20 Appendix 3, page 3

M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS

M0220.001 GENERAL PRINCIPLES

A. Introduction

This subchapter explains in detail how to determine if an individual is a citizen or alien eligible for full Medicaid benefits (referred to as "full benefit aliens") or emergency services only (referred to as "emergency services aliens"). The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) made major changes to the Medicaid eligibility of non-citizens of the United States. These changes eliminated the "permanently residing under color of law" (PRUCOL) category of aliens. The Medicaid benefits for which an alien is eligible are based upon whether or not the alien is a "qualified" alien as well as the alien's date of entry into the United States.

With some exceptions, the Deficit Reduction Act of 2005 (DRA) required applicants for Medicaid and Medicaid recipients to verify their United States citizenship and identity to be able to qualify for Medicaid benefits. The citizenship and identity *(C&I)* verification requirements became effective July 1, 2006. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) allows additional exemptions from the *C&I* verification requirements *and provides states with the option to verify C&I through the use of an electronic data match with the Social Security Administration (SSA).* It also requires states to enroll otherwise eligible individuals prior to providing *C&I* verification, and grant them a "reasonable opportunity" period after enrollment to provide documentation, if necessary.

The policy and procedures for determining whether an individual is a citizen or a "full-benefit" or "emergency services" alien are contained in the following sections:

M0220.100 Citizenship & Naturalization;
M0220.200 Alien Immigration Status
M0220.300 Full Benefit Aliens
M0220.400 Emergency Services Aliens
M0220.500 Aliens Eligibility Requirements
M0220.600 Full Benefit Aliens Entitlement & Enrollment
M0220.700 Emergency Services Aliens Entitlement & Enrollment

B. Declaration of Citizenship/Alien Status

The Immigration Reform and Control Act (IRCA) requires as a condition of eligibility that the adult applicant who is head of the household (with exceptions below) declare in writing under penalty of perjury whether or not the individual(s) for whom he is applying is a citizen or national of the United States, and if not, that the individual is a lawfully admitted alien. For children under 18 years of age, the declaration is made by an adult family member. The declaration statement is on the application form.

EXCEPTION: An individual who is an "unqualified" alien (as defined in section M0220.410) does NOT complete the declaration.

Individuals who are required to sign the declaration and who fail or refuse to sign are NOT eligible for any Medicaid services.

M0220.100 CITIZENSHIP AND NATURALIZATION

A. Introduction

A citizen or naturalized citizen of the United States meets the citizenship requirement for Medicaid eligibility, and is eligible for all Medicaid services if he meets all other Medicaid eligibility requirements.

B. Citizenship Determination

1. Individual Born in the United States

An individual born in the United States, any of its territories (Guam, Puerto Rico, United States Virgin Islands, or Northern Mariana Islands), American Samoa, or Swain's Island is a United States citizen.

A child born in the United States to non-citizen parents who are in the United States as employees of a foreign country's government may not meet the United States citizen requirement. When a child born in the United States to non-citizen parents is a United States citizen by birth, the child may not meet the Virginia residency requirements in M0230.201 because of the parents' temporary stay in the United States.

2. Individual Born Outside the U.S.

a. Individual Born to or Adopted by U.S. Citizen Parents

A child or individual born outside the United States to U.S. citizen parents (the mother, if the child was born out-of-wedlock) automatically becomes a citizen by birth. A child under age 18 years who is a lawful permanent resident, who is currently residing permanently in the U.S. in the legal and physical custody of a U.S. citizen parent, and who meets the requirements applicable to adopted children under immigration law automatically becomes a citizen when there is a final adoption of the child, and does not have to apply for citizenship.

b. Individual Born to Naturalized Parents

A child born outside the United States to alien parents automatically becomes a citizen after birth, if his parents (the mother, if the child was born out-of-wedlock) are naturalized before he becomes 16 years of age.

c. Naturalized Individual

A child or individual born outside the U.S. and not automatically a citizen as in a) or b) above must have been naturalized to be considered a citizen.

C. Verification

1. Requirements

The DRA requires that *satisfactory documentation of citizenship and identity must be obtained for all Medicaid enrollees who claim to be U.S. citizens. Medicaid enrollees who claim U.S. citizenship must have a declaration of citizenship AND documentary evidence of citizenship and identity in their case records.*

2. Exceptions to Verification Requirements

The following groups of individuals are NOT required to provide verification of *C&I*. Document in the case record why an individual is exempt from verifying *C&I*:

a. All foster care children and IV-E Adoption Assistance children;

b. Individuals born to mothers who were eligible for Medicaid *in any state* on the date of the individuals' birth;

c. Individuals entitled to or enrolled in Medicare, individuals receiving Social Security benefits on the basis of a disability and SSI recipients currently entitled to SSI payments. Former SSI recipients are not included in the exemption. The local department of social services (LDSS) must have verification from the Social Security Administration (such as a SVES response) of an individual's Medicare enrollment, benefits entitlement or current SSI recipient status.

When an individual loses an exception status and his *C&I* has not previously been verified, the individual must be given a reasonable opportunity to provide C&I.

NOTE: A parent or caretaker who is applying for a child, but who is NOT applying for Medicaid for himself, is NOT required to verify his or her *C&I*.

3. Verification Required One Time

Once verification of *C&I* has been provided, it is not necessary to obtain verification again. Documentary evidence may be accepted without requiring the individual to appear in person. *C&I* documentation must be stored in the case record.

4. Reasonable Opportunity to Provide Verification

If an individual meets all other Medicaid eligibility requirements and declares that he is a citizen, *a reasonable opportunity period must be given to obtain documentation of C&I. Do not delay or deny the application for proof of C&I. If the applicant meets all other Medicaid eligibility requirements, approve the application and enroll the applicant in Medicaid, but specify on the Notice of Action that the individual may have to provide documentation of C&I if it cannot be obtained by other means.*

The individual remains eligible for Medicaid during the reasonable opportunity period. The same reasonable opportunity period requirements apply should an individual lose his exemption from providing *C&I* verification.

D. Procedures for Documenting C&I

CHIPRA allows the option for verification of C&I for individuals newly enrolled in Medicaid or Family Access to Medical Insurance Security Plan (FAMIS) using a data match with SSA to confirm the consistency of a declaration of citizenship with SSA records in lieu of presentation of original documentation. This option, implemented in March 2010, allows for a monthly exchange of data between the Medicaid Management Information System (MMIS) and SSA for the documentation of C&I for individuals enrolled in the Medicaid and FAMIS programs.

1. MMIS Data Matches SSA

If the information in the MMIS matches the information contained in the SSA files, the MMIS will be updated to reflect the verification of C&I.

No further action is needed on the part of the eligibility worker, and the enrollee will not be required to provide any additional documentation, if the SSA match code in MMIS shows that SSA verified the individual's C&I.

2. *MMIS Data Does Not Match SSA*

If the information in the MMIS does not match the information in the SSA files, a discrepancy report will be generated monthly listing the inconsistent information. Eligibility staff are expected to review the report to see if the report lists any enrollees who were rejected because their SSN, name or date of birth did not match information in the SSA records or because the SSA could not verify the enrollee's citizenship and identity. Eligibility workers must review the information in the MMIS or ADAPT to determine if a typographical or other clerical error occurred. If it is determined that the discrepancy was the result of an error, steps must be taken to correct the information in the MMIS or ADAPT so that a new data match with SSA can occur in the future.

If the inconsistency is not the result of a typographical or other clerical error, the eligibility worker must then send a written notification to the enrollee that informs the enrollee of the discrepancy and gives him 90 calendar days from the date of the notice to either resolve the discrepancy with the SSA and to provide written verification of the correction, OR provide acceptable documentation of C & to the LDSS. The notice must specify the date of the 90th day, and must state that, if the requested information is not provided by the 90th day, the individual's Medicaid coverage will be canceled. Include with the notice the "Proof of U.S. Citizenship and Identity for Medicaid" document available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/citizenship/index.cgi#forms.

Acceptable forms of documentation for C &I are also included in Appendix 8 to this subchapter.

If written documentation from the SSA is received within 90 days, update the MMIS accordingly so that the enrollee's information will be selected for a future data match.

If the individual provides acceptable documentation of C&I within the 90 days, update the appropriate fields in MMIS with the appropriate codes. No further match will be done with the SSA files.

If the individual does not provide the information necessary to meet the C&I documentation requirements, action must be taken to send an advance notice and cancel coverage at the end of the month in which the 90th day occurs.

3. *Subsequent Applications*

If the individual who lost coverage for failure to provide C&I documentation files a subsequent application, a new reasonable opportunity period is ***not*** *granted. The individual must provide acceptable documentation of C&I prior to approval. of the re-application.*

M0320 Changes

Changed With	Effective Date	Pages Changed
UP #3	03/01/2010	pages 34, 35, 38, 40, 42a, pages 42b, 42f
TN #93	01/01/2010	pages 11-12, 18, 34-35, 38 pages 40, 42a-42d, 42f-44, 49 pages 50c, 69-71
UP #2	08/24/2009	pages 26, 28, 32, 61, 63, 66
Update (UP) #1	07/01/2009	pages 46f-48
TN #91	05/15/2009	pages 31-34 pages 65-68

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 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. 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.

M0320.206 QMB (QUALIFIED MEDICARE BENEFICIARY)

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 limits.

B. Nonfinancial Eligibility

The Qualified Medicare Beneficiary must meet all the nonfinancial eligibility requirements in chapter M02.

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 M0320.209 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 medically indigent QMB determination; the other is for the ABD spouse's CN or MN covered group.

2. Resources

The asset transfer rules in subchapter M1450 must be met by the medically indigent Medicare beneficiary.

The resource requirements in chapter S11 and Appendix 2 to chapter S11 must be met by the medically indigent 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 Medicare Savings Programs (MSPs). See *section M1110.003* for the current resource limits.

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 classification and 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.

M0320.207 SLMB (SPECIAL LOW INCOME MEDICARE BENEFICIARY)

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 (M0320.206 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 federal poverty limits) but is less than 120% of the poverty limits.

B. Nonfinancial Eligibility

The SLMB must meet all the nonfinancial eligibility requirements in chapter M02.

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.

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 limit 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 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 SLMB income eligibility.

4. Income Equals or Exceeds SLMB Limit

Spenddown does not apply to the medically indigent 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 spenddown*s* 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. Recipient's AC Changes To SLMB

An enrolled recipient's *AC* cannot be changed to AC "053" using a "change" transaction in the MMIS. If a Medicaid recipient becomes ineligible for full-coverage Medicaid or QMB-only coverage because

2. Qualified Individual (QI)

A Qualified Individual (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 federal poverty limit) but is less than the QI limit (135%of the poverty limit).

B. Nonfinancial Eligibility

QIs must meet all the nonfinancial eligibility requirements in chapter M02.

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 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 QI; he/she may be eligible as a Qualified Disabled and Working Individual (QDWI). See M0320.209 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 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 Qualified Individuals.

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 medically indigent QI determination; the other is for the ABD spouse's CN, CNNMP or MN covered group.

2. Resources

The asset transfer rules in subchapter M1450 must be met by the QI.

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 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 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.

5. Income Equals or Exceeds QI Limit

Spenddown does not apply to the medically indigent income limits. If the individual's income is equal to or exceeds the QI limit (135% of FPL), **he/she is not eligible as QI** and cannot spenddown to the QI limit.

D. QI Entitlement

Coverage under this group cannot begin earlier than January 1 of the calendar year.

QIs are eligible for retroactive coverage as a QI. Retroactive eligibility cannot begin earlier than January 1 of the current calendar year.

income is within CNNMP, 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 medically indigent QDWI determination; the other is for the ABD spouse's covered group.

2. Resources

The asset transfer rules in subchapter M1450 must be met by the medically indigent Medicare beneficiary.

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 medically indigent 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.

S1110 Changes

Transmittal Number	Effective Date	Pages Changed
UP #3	03/02/2010	Table of Contents page 2
TN #93	01/01/2010	page 2
TN #91	05/15/2009	pages 14-16

TABLE OF CONTENTS

S1110.000 RESOURCES, GENERAL

M1110.003 RESOURCE LIMITS

A. Introduction

The resource limit is the maximum dollar amount of countable assets an individual, couple, or family may own and still meet the established criteria for Medical Assistance in an ABD category. These amounts are established by law.

C

B. Policy Principles

1. Resource Ineligibility

An individual (or couple) with countable resources in excess of the applicable limit is not eligible for Medicaid.

2. Resource Limits

ABD Eligible Group	One Person	Two People
Categorically Needy Cat-Needy Nonmoney Payment Medically Needy	$2,000	$3,000
ABD With Income ≤ 80% FPL	$2,000	$3,000
QDWI	*$4,000*	*$6,000*
QMB SLMB QI	$6,600	$9,910

3. Change in Marital Status

A change in marital status can result in a change to the applicable resource limit. The resource limit change is effective with the month that we begin treating both members of a couple as individuals. For example, separation from an ineligible spouse can change the limit from $3,000 to $2,000. See M1110.530B.

4. Reduction of Excess Resources

Month of Application

Excess resources throughout the month of application causes ineligibility for the application month. Reduction of excess resources within the application month can cause resource eligibility for that month.

M20 Changes

Changed With	Effective Date	Pages Changed
Update (UP) #3	03/01/2010	Table of Contents, page ii Appendix 3, page 1
TN #93	01/01/2010	Table of Contents, page ii pages 3, 5, 6, 7, 10, 11, 15 Appendix 1, page 1 Appendix 2, page 1 Appendix 3, page 1 Appendix 4, page 1

EXTRA HELP INCOME LIMITS
ALL LOCALITIES
EFFECTIVE 1/23/09
MONTHLY GUIDELINES

FAMILY SIZE	PERCENT OF FEDERAL POVERTY LEVEL (FPL)				
	100%	135%	140%	145%	150%
1	$902.50	$1,218.38	$1,263.50	$1,308.63	$1,353.75
2	1,214.17	1,639.13	1,699.83	1,760.54	1,821.25
3	1,525.83	2,059.88	2,136.17	2,212.46	2,288.75
4	1,837.50	2,480.63	2,572.50	2,664.38	2,756.25
5	2,149.17	2,901.38	3,008.83	3,116.29	3,223.75
6	2,460.83	3,322.13	3,445.17	3,568.21	3,691.25
7	2,772.50	3,742.88	3,881.50	4,020.13	4,158.75
8	3,084.17	4,163.63	4,317.83	4,472.04	4,626.25

For family units of more than 8 members, contact a Medical Assistance Program Consultant.

EXTRA HELP RESOURCE LIMITS – EFFECTIVE 1/1/10

	Extra Help			
	1	2	3	4
Income	< $1,353.75	< $1,821.25	< $2,288.75	< $2,756.25
Resource Limit	$11,010	$22,010 (C)	$11,010 (S) $22,010 (C)	$11,010 (S) $21,010 (C)

M21 Changes

Changed With	Effective Date	Pages Changed
UP #3	03/01/2010	pages 2-5
TN #93	01/01/2010	page 2-4, 8
Update (UP) #2	08/24/2009	page 4

- he is uninsured;
- he is **not** a member of a family eligible for health benefits coverage under the State Employee Health Insurance Plan on the basis of a family member's employment with a State agency (see Appendix 2 to this chapter);
- he is **not** a member of a family who has dropped health insurance coverage on him within 4 months of the application without good cause;
- he is **not** an inmate of a public institution;
- he is **not** an inpatient in an institution for mental diseases;
- he meets the Medicaid Nonfinancial Eligibility Requirements in Chapter M02 with certain exceptions; and
- he has gross family income less than or equal to 200% FPL.

M2120.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

The child must meet, with certain exceptions, the Medicaid Nonfinancial Eligibility Requirements in chapter M02 and the nonfinancial eligibility requirements imposed by FAMIS.

B. M02 Requirements

The Medicaid Nonfinancial Eligibility Requirements in Chapter M02 that must be met are:

- citizenship and alienage requirements, including Afghan and Iraqi special immigrants in M0220.313 A, with the exceptions noted in M2120.100 C.1. below;
- Virginia residency requirements;
- institutional status requirements regarding inmates of a public institution.

C. M02 Exceptions

The exceptions to the Medicaid Nonfinancial Eligibility Requirements in Chapter M02 are**:**

1. Citizenship & Identity Verification Required

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 mandates that effective January 1, 2010, all applicants for coverage in a Title XXI program must provide verification of citizenship and identity *(C&I).* If the child is a United States (U.S.) citizen, the child must meet the U.S. citizenship requirements in M0220.001.

Verification of citizenship is required; declaration of the child's U.S. citizenship is no longer accepted. However, like Medicaid, a reasonable

opportunity period must be given to the applicant. The *C&I* verification requirements in M0220.100 apply to FAMIS, *including use of the Social Security Administration (SSA) data match when a Social Security number (SSN) has been provided. If an SSN has not been provided for the child, a reasonable opportunity to provide acceptable documentation of C&I must be given. The reasonable opportunity period will last until the time of the first annual renewal.*

If the child is not a U.S. citizen, the child must meet the FAMIS alienage requirements.

2. Alienage Requirements

Alien status must be verified. Refer to sections M0220.200, M0220.201 and M0220.202 for information about verifying alien status.

FAMIS alienage requirements are different from the Medicaid alienage requirements. Qualified aliens who entered the U.S. before August 22, 1996 meet the alienage requirements and are not subject to time limitations.

a. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **without regard to time limitations**:

- refugees or Cuban-Haitian Entrants (see M0220.310 A. 2 and 7),
- asylees (see M0220.310 A. 4),
- veteran or active military (see M0220.311),
- deportation withheld (see M0220.310 A. 6), and
- victims of a severe form of trafficking (see M0220.313 B.5).

b. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **after five years of residence in the United States:**

- lawful permanent residents (LPR),
- conditional entrants-aliens admitted pursuant to 8 U.S.C.1153(a)(7),
- aliens, other than Cuban-Haitian Entrants, paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA, and
- battered aliens, alien parents of battered children, alien children of battered parents.

3. Legal Immigrant Children < 19 Not Applicable

The legal immigrant children policy in M0220.314 does NOT apply to the FAMIS program.

4. No Emergency Services Only For Unqualified Aliens

Unqualified aliens, including illegal and non-immigrant aliens, do not meet the alienage requirements and are not eligible for FAMIS.

5. Alien Eligibility Chart — Appendix 3, FAMIS Alien Eligibility Chart, lists alien groups that meet or do not meet the alienage requirements.

6. SSN — A Social Security number (SSN) or proof of application for an SSN (M0240) is **not** a requirement for FAMIS.

7. Assignment of Rights — Assignment of rights to payment for medical care from any liable third party is a condition of eligibility for the child.

D. FAMIS Nonfinancial Requirements — The child must meet the following FAMIS nonfinancial requirements:

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

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

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

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

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

M2120.200 HEALTH INSURANCE COVERAGE

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

B. Definitions

1. Creditable Coverage — For the purposes of FAMIS, creditable coverage means coverage of the individual under any of the following:

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

- a public health plan; and
- any other health benefit plan under section 5(e) of the Peace Corps Act.

The definition of creditable coverage includes short-term limited coverage.

2. Family Member

When determining whether the child is eligible for coverage under a State Employee Health Insurance Plan, or whether the discontinuance of health insurance affects the child's eligibility, family member means:

- parent(s) with whom the child is living, and
- a stepparent with whom the child is living if the stepparent claims the child as a dependent on his federal tax return.

3. Health Benefit Plan

"Health benefit plan" is defined in the Virginia Bureau of Insurance Regulations (14VAC5-234-30) and means:

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

Health benefit plan does not mean:

- Medicare, Medicaid, FAMIS Plus, or State/Local Hospitalization;
- accident only;
- credit or disability insurance;
- long-term care insurance;
- dental only or vision only insurance;
- specified disease insurance;
- hospital confinement indemnity coverage;
- limited benefit health coverage;
- coverage issued as a supplement to liability insurance;
- insurance arising out of workers' compensation or similar law;
- automobile medical payment insurance; or
- insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

4. Insured

means having creditable health insurance coverage or coverage under a health benefit plan.

5. Uninsured

means having no insurance; having insurance that is not creditable; having coverage which is not defined as a health benefit plan, or having a health insurance plan that does not have a network of providers in the area where the child resides.

C. Policy

A nonfinancial requirement of FAMIS is that the child be uninsured. A child **cannot:**

- have creditable health insurance coverage;

M22 Changes

Changed With	Effective Date	Pages Changed
UP #3	03/01/10	page 2
TN #93	01/01/10	pages 2-10
UP #2	08/24/09	page 3
Update (UP) #1	07/01/09	pages 1, 2, 7 Appendix 1, page 1

- she is **not** an inpatient in an institution for mental diseases; and
- she has countable family income less than or equal to 200% FPL.

M2220.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

A. Policy

The pregnant woman must meet, with certain exceptions, the Medicaid nonfinancial eligibility requirements in Chapter M02 and the nonfinancial eligibility requirements imposed by FAMIS.

B. M02 Applicable Requirements

The Medicaid nonfinancial eligibility requirements in Chapter M02 that must be met are:

- citizenship or alien status;
- Virginia residency requirements;
- assignment of rights;
- application for other benefits;
- institutional status requirements regarding inmates of a public institution.

C. FAMIS Nonfinancial Requirements

The FAMIS nonfinancial eligibility requirements are**:**

1. Citizenship & Identity Verification Required

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 mandates that, effective January 1, 2010, all applicants for coverage in a Title XXI program must provide verification of citizenship and identity *(C&I).* If the pregnant woman is a United States (U.S.) citizen, *she* must meet the U.S. citizenship requirements in M0220.100. Verification *of citizenship* **is** required; declaration of the woman's U.S. citizenship is **no longer** accepted. However, *as with* Medicaid, *a reasonable opportunity period must be given.*

The *C&I* verification requirements in M0220.100 apply to FAMIS MOMS, *including the use of the Social Security Administration (SSA) data match when a Social Security Number (SSN) has been provided. If an SSN has not been provided, a reasonable opportunity to provide acceptable documentation of C&I must be given.*

If not a U.S. citizen, the pregnant woman must meet the alienage requirements.

2. Alienage Requirements

FAMIS MOMS alienage requirements are the same as the FAMIS alienage requirements.

a. Citizens and qualified aliens who entered the U.S. before August 22, 1996 meet the citizenship/alienage requirements.

b. The following qualified aliens who entered the U.S. on or after August 22, 1996 meet the alienage requirements **without any time limitations**