
**DEPARTMENT
POLICY****Medicaid Only**

Special N/Support (SNS) is an automatic coverage group. When ineligibility for LIF results wholly or in part from spousal support payments, the individual may continue eligible for Medicaid for four months.

Individuals receiving Medicaid on this basis are referred to as Special N/Support beneficiaries.

Special N/Support eligibility can be considered only after LIF.

**INITIAL SPECIAL N/
SUPPORT
ELIGIBILITY**

LIF must be transferred to Special N/Support when all of the following criteria are met.

- The LIF group is **not** eligible for continued Medicaid as Transitional MA.
- At least one LIF group member was a LIF beneficiary in three of the six calendar months before the month in which LIF will terminate.
- LIF ineligibility resulted from excess earned income and countable spousal support income.

A new or updated application for healthcare coverage is not required to transfer to Special N/Support.

**Special N/Support
Group**

The Special N/Support group is those persons who were in the LIF group at the time of transfer to Special N/Support.

Four-Month Period

The four-month period begins with the calendar month following the month in which LIF terminates. For example, coverage begins August 1 if LIF terminates in July. In this example, the four-month period would end November 30.

CONTINUED ELIGIBILITY

During the four-month period, each Special N/Support group member remains eligible unless it is reported that a member does not meet the Medicaid requirements in :

- BEM 220, Residence.
- BEM 257, Third Party Resource Liability.
- BEM 265, Institutional Status.

If Special N/Support eligibility is lost during the four-month period based on BEM 220, 257, or 265, but the reason for ineligibility ceases, SNS eligibility exists again. Eligibility restarts the month ineligibility ceased and continues for the remainder of the 4 month period. The individual is responsible for reporting the change that re-establishes eligibility.

Note: Newborns eligible under BEM 145 may be added to the Special N/Support case but are **not** Special N/Support recipients.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories. See BAM 115 and 220.

LEGAL BASE

MA

Social Security Act, Section 1902(a)(10)(A)(i)(I), 1931

JOINT POLICY DEVELOPMENT

Medicaid, Transitional Medical Assistance (TMA), and Maternity Outpatient Medical Services (MOMS) policy has been developed jointly by the Department of Community Health (DCH) and the Department of Human Services (DHS).