COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

JENNIFER S. LEE, M.D.
DIRECTOR

SUITE 1300
600 EAST BROAD
STREET RICHMOND,
VA 23219
804/786/7933
800/343-0634 (TDD)
www.dmas.virginia.gov

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Virginia Medical Assistance Eligibility Manual

Transmittal #DMAS-8

- ABD – Aged, Blind or Disabled
- APTC – Advance Premium Tax Credit
- DMAS – Department of Medical Assistance Services
- F&C – Families and Children
- FAMIS – Family Access to Medical Insurance Security
- FPL – Federal Poverty Level
- LIFC – Low Income Families with Children
- MA – Medical Assistance
- TN – Transmittal
- VA – Veterans Administration

TN #DMAS-8 includes policy clarification, updates and revisions to the MA Eligibility Manual. Unless otherwise noted, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after April 1, 2018.

The following changes are contained in TN #DMAS-8:

Changed Pages	Changes
Subchapter M0120 Page 12	Clarified the treatment of application forms other than the Application for Health Insurance & Help Paying Costs.
Subchapter M0130 Page 13	Clarified that an approval notice must state the next annual renewal date.
Subchapter M0310 Page 9	Clarified that when a parent is in the home, no relative other than a stepparent can be eligible for Medicaid in the LIFC covered group.
Subchapter M0330 Pages 1, 9, 10, 25	On page 1, clarified the F&C covered group hierarchy. On pages 9 and 10, clarified that the definition of a dependent child in M0310.111 is applicable to the LIFC covered group. On page 25, corrected a typographical error.
Chapter M04 Table of Contents Pages 2-6a, 12-14b, 25 Pages 26 and 27 were added. Pages 14c was added as a runover pages. Appendices 1, 2, 6 and 7 Appendix 1, page 2 was added	Revised the Table of Contents. On page 2, added an acronym. On page 3, added the definitions for the APTC and coverage gap/gap-filling rule, and clarified the definition of a caretaker-relative. On page 4, clarified that LIFC is a covered group. On page 5, clarified the exceptions to the tax household composition rules for tax dependents. On pages 6, 6a, 25, 26, and 27, added policy and examples on the gap-filling rule. On pages 12-14b and in Appendix 7, clarified what is and is not countable income. In Appendices 1, 2 and 6, revised the F&C income limits that are based on the FPL, effective January 18, 2018. Appendix 1, page 2 contains the 100% FPL income limits used for the gap-filling rule evaluation.
Subchapter M0530 Appendix 1, page 1	Revised the deeming standards effective January 1, 2018.
Subchapter M0810 Page 2	Revised the ABD income limits that are based on the FPL, effective January 18, 2018.
Subchapter M1120 Page 22a	Clarified the treatment of income or the right to income transferred into a trust established for a disabled individual.
Subchapter M1410 Page 9	Corrected a reference.
Subchapter M1460 Page 18a, 32, 35	On page 18a, clarified that the former home is excluded indefinitely only when it is occupied by a spouse, minor child, disabled adult child, or disabled parent. On page 31, clarified that VA pension payments are not counted as income for the eligibility determination for any group other than MN when the patient is a veteran's dependent child. On page 35, updated the student child earned income exclusion for 2018.

Changed Pages	Changes
Subchapter M1470 Page 2a	Clarified that VA pension payments in excess of $90.00 per month are counted as income for patient pay when the patient is a veteran's dependent child.
Subchapter M1510 Pages 2, 8a, 8b Page 8c was added.	On page 2, removed an obsolete hyperlink. Page 8a is a runover page. On pages 8b and 8c, clarified the procedures for evaluating eligibility after a disability appeal when a case record was purged.
Subchapter M1520 Pages 2, 18 Appendix 2, page 1	On page 2, clarified when income must be verified after a reported change. On page 18, clarified when the 12-month Medicaid extension begins. In Appendix 2, revised the income limits, effective January 18, 2018.
Subchapter M1550 Pages 3	Corrected a reference.
Chapter M16 Page 7	On page 7, removed an obsolete hyperlink.
Chapter M21 Appendix 1, page 1	In Appendix 1, revised the income limits effective January 18, 2018.
Chapter M22 Appendix 1, page 1	In Appendix 1, revised the income limits effective January 18, 2018.

Please retain this TN letter for future reference. Should you have questions about information contained in this transmittal, please contact Cindy Olson, Director, DMAS Eligibility and Enrollment Services Division, at cindy.olson@dmas.virginia.gov or (804) 225-4282.

Sincerely,

Linda Nablo
Chief Deputy Director

Attachment

M0120 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-8	4/1/18	Page 12
TN #DMAS-6	10/1/17	Page 1
TN #DMAS-5	7/1/17	Page 2a
TN #DMAS-4	4/1/17	Pages 2a, 7, 10, 13
TN #DMAS-3	1/1/17	Page 15
TN #DMAS-2	9/1/16	Pages 2, 15 Page 2a is a runover page.
TN #DMAS-1	6/1/16	Pages 7, 10, 11, 16-20
TN #100	5/1/15	Table of Contents Pages 1, 2, 15, 20 Page 2a and 16 are runover pages.
UP #10	5/1/14	Table of Contents Pages 11, 16-18 Pages 11a and 11b were deleted. Pages 19 and 20 were added.
TN #99	1/1/14	Page 11 Pages 11a and b were added.
TN #98	10/1/13	Table of Contents Pages 1-17
UP #9	4/1/13	Page 13, 15, 16
UP #7	7/1/12	Pages 1, 10-12
TN #96	10/1/11	Table of Contents Pages 6-18
TN #95	3/1/11	Pages 1, 8, 8a, 14
TN #94	9/1/10	Pages 8, 8a
TN #93	1/1/10	Pages 1, 7, 9-16
Update (UP) #1	7/1/09	Page 8
TN #91	5/15/09	Page 10

2. BCCPTA Medicaid Application

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application, form #032-03-384, is used only by individuals screened under the Breast and Cervical Cancer Early Detection Program. **This form is not to be given to applicants by the local departments of social services** (M0120, Appendix 2 is provided for reference purposes only).

3. Replaced Application Forms

The following forms were replaced by the streamlined application forms effective October 1, 2013. While agencies should accept and process any of these forms *if they are* submitted, additional information, *such as tax filing information, may* need to be obtained *(see M0120.300 B.4 below).*

- Application for Benefits (#032-03-824)
- The Application/Redetermination for Medicaid for SSI Recipients (#032-03-091)
- The Medicaid Application/Redetermination for Medically Indigent Pregnant Women (#032-03-040)
- The Health Insurance for Children and Pregnant Women (#FAMIS-1)
- The Application for Adult Medical Assistance form (#032-03-0222)
- The Plan First Application (#DMAS-65E)

4. *Renewal Forms Returned After Reconsideration Period*

Renewal forms filed after the end of the 90-day reconsideration period are treated as reapplications. Accept the form and request any additional information needed to determine the individual's eligibility. See M1520.200 C for additional information.

***5*. If Additional Information is Required**

Applicants may apply for MA on any valid application form. Regardless of which application form is used, if additional information is required to determine an applicant's eligibility, *send the applicant the relevant page(s) of the Cover Virginia Application for Health Coverage & Help Paying Costs, and/or Appendices D or E, as appropriate, along with a checklist asking* for the information. Give the applicant at least 10 business days to return *the information and any required* verifications to the agency.

M0120.400 Place of Application

A. Principle

The place of application is ordinarily the office of the local social service department serving the locality in which the applicant resides. Verification of locality residence is not required. MA applications are also taken at designated hospitals and health clinics (Medicaid outstationed sites). If an applicant is homebound and needs assistance with completing the application, the agency, upon request, must arrange to have the application taken where he resides or is a patient.

1. Locality of Residence

Medical assistance applications that are completed and filed online are sent to the LDSS in the applicant's locality of residence or where the individual last lived outside of an institution .

2. Joint Custody Situations

A child whose residence is divided between two custodial parents living in different localities is considered to reside in the locality in which he attends school. If the child is not enrolled in school, the parents must decide which locality is the child's residence for application/ enrollment purposes.

M0130 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-8	4/1/18	Page 13
TN #DMAS-7	1/1/18	Pages 1, 9
TN #DMAS-5	7/1/17	Pages 1, 10
TN #DMAS-4	4/1/17	Page 6
TN #DMAS-3	1/1/17	Pages 5, 7, 11
TN #DMAS-2	10/1/16	Table of Contents Pages 2. 4, 5, 7-10, 12, 13 Page 2a is a runover page. Page 14 was added as a runover page.
TN #DMAS-1	6/1/16	Table of Contents Pages 4, 6, 10, 12 Page 11 is a runover page. Page 13 was added as a runover page.
TN #100	5/1/15	Pages 1, 2-2b, 5, 11 Pages 3, 6 and 2c are runover Pages.
UP #10	5/1/14	Table of Contents Pages 8-12 Page 13 was added.
TN #99	1/1/14	Pages 10-12 Page 13 was added.
TN #98	10/1/13	Table of Contents Pages 1-12
UP #9	4/1/13	Page 3, 5
UP #7	7/1/12	Pages 4, 5
TN #96	10/1/11	Pages 6-8
TN #95	3/1/11	Page 8
TN #94	9/1/10	Pages 2-6, 8
TN #93	1/1/10	Pages 4-6, 8
Update (UP) #2	8/24/09	Pages 8, 9

a. Approvals

As applicable, the notice must state that:

- the application has been approved, including the effective date(s) of coverage *and the date of the next annual renewal*;
- retroactive Medicaid coverage was approved, including the effective dates.
- For approvals of limited coverage, the notice or a separate system-generated notice must state that the application has been referred to the HIM for determination of eligibility for the APTC.

b. Denials

As applicable, the notice must state that:

- the application has been denied, including the specific reason for denial cited from policy;
- retroactive Medicaid coverage was denied, including the specific reason for denial cited from policy.
- When the applicant (other than a Medicare beneficiary or deceased individual) is ineligible for MA for any reason other than the inability to determine eligibility, either the notice or a separate system-generated notice must state that the application has been referred to the HIM for determination of eligibility for the APTC.

c. Delays

The notice must state that there is a delay in processing the application, including the reason.

d. Other Actions

Other actions for which a notice must be sent include when a request for re-evaluation of an application in spenddown status has been completed.

e. Advance Health Care Directive

An Advance Health Care Directive insert is required to be included with an initial notice of eligibility. The insert (available at http://spark.dss.virginia.gov/divisions/bp/me/forms/index.cgi) must be included with the initial approval or denial Notice of Action. This insert is not required when adding a person to an existing case, at redetermination, when a change is reported or when coverage is cancelled.

M0310 Changes
Page 1 of 2

Changed With	Effective Date	Pages Changed
TN #DMAS-5	4/1/19	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

M0310 Changes
Page 2 of 2

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
TN #99	1/1/14	Pages 6, 7, 21, 24, 25, 27a, 39
TN #98	10/1/13	Pages 2, 4, 27a, 27b, 28, 35, 36, 39
UP #9	4/1/13	Pages 24-27 Appendix 2
TN #97	9/1/12	Table of Contents, page i Pages 1-5a, 10-13 Pages 23, 28, 29, 30a, 31 Pages 33, 36, 38, 39
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
TN #95	3/1/11	Pages 30, 30a
TN #94	9/1/10	Pages 21-27c, 28
TN #93	1/1/10	Page 35 Appendix 5, page 1
Update (UP) #2	8/24/09	Table of Contents Page 39
TN #91	5/15/09	Pages 23-25 Appendix 4, page 1 Appendix 5, page 1

3. 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.

M0330 Changes

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

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.

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 Community-based Care waiver services 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. Effective January 1, 2014, if a child is a former Virginia 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 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 LIFC, but meets the definition of a pregnant woman, evaluate in the pregnant woman/newborn child group.
3. If the individual is not LIFC or pregnant, is in medical institution, has been screened and approved for Community-based Care waiver services or has elected hospice, evaluate in the appropriate F&C 300 % of SSI covered group.
4. Effective January 1, 2014, if the individual is a former Virginia foster care child under 26 years, evaluate is this covered group.
5. 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 individual, evaluate in the BCCPTA covered group.
6. Ifthe 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.
7. If the individual is a pregnant woman but has excess income for coverage in a CN group or FAMIS MOMS (for applications submitted before 12/31/13 only), evaluate as MN.

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.

An 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 is in the home, no relative other than 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.

B. Nonfinancial Requirements

Individuals in this covered group must meet the Medicaid nonfinancial requirements in chapter M02.

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 was 211% FPL through December 31, 2013. The income limit between January 1, 2014, and December 31, 2014, was 100% FPL. Effective January 1, 2015, the income limit 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."

M04 Changes

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

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M04 MODIFIED ADJUSTED GROSS INCOME (MAGI)

be eligible. If the income exceeds the limit, the 5% FPL disregard can be allowed, and the income again is compared to the income limit.

- When considering tax dependents in the tax filer's household, the tax dependent may not necessarily live in the tax filer's home.
- Under MAGI counting rules, an individual may be counted in more than one household but is only evaluated for eligibility in his household.
- Use non-filer rules when the household does not file taxes.
- Use non-filer rules when the applicant is claimed as a tax dependent by someone outside the applicant's household.
- Non-filer rules may be used in multi-generational households.

1. Eligibility Based on MAGI

MAGI methodology is used for eligibility determinations for insurance affordability programs including Medicaid, FAMIS, the Advance Premium Tax Credit (APTC) and cost sharing reductions through the Health Insurance Marketplace for the following individuals:

a. Children under 19
b. Parent/caretaker relatives of children under the age of 18 - Low Income Families With Children (LIFC)
c. Pregnant women
d. Individuals Under Age 21
e. Plan First.

2. Eligibility NOT Based on MAGI

MAGI methodology is NOT used for eligibility determinations for:

a. individuals for whom the agency is not required to make an income determination:

- Supplemental Security Income (SSI) recipients
- Auxiliary Grant recipients
- IV-E foster care or adoption assistance recipients
- Deemed newborns
- BCCPTA (Breast and Cervical Cancer Prevention and Treatment Act) enrollees.

b. individuals who are eligible on the basis of being aged (age 65 or older), blind or disabled;

c. individuals who are eligible only in the 300% of SSI covered group;

d. individuals evaluated as Medically Needy *(MN)*;

5. Special Medical Needs Adoption Assistance Children

A Special Medical Needs Adoption Assistance (AA) child is subject to modified MAGI methodology for the child's initial Medicaid eligibility determination. These children are in their own household apart from parents and siblings. Parents' and siblings' income is not counted for these children.

6. Children in Level C Psychiatric Residential Treatment Facilities (PRTFs)

Children placed in Level C PRTFs are considered absent from their home if their stay in the facility has been 30 consecutive days or more. A child who is placed in a Level C PRTF is considered NOT living with his parents for MAGI purposes as of the first day of the month in which the 30th day of psychiatric residential placement occurs. Long-term care rules do not apply. See M0520.100 B.3.

M0420.100 Definitions

A. Introduction

The definitions below are used in this chapter. Some of the definitions are also in subchapter M0310. Some of the definitions are from the IRC.

B. Definitions

1. Advance Premium Tax Credit (APTC)

is a tax credit that an individual or family with taxable income of at least 100% FPL but no more than 400% FPL can take in advance to lower their monthly health insurance premium. Eligibility for the APTC is determined by the federal HIM using MAGI rules for tax-filer households. Projected annual household income, rather than monthly income, is evaluated.

2. Caretaker Relative

means a non-parent relative of a "dependent" child by blood, adoption, or marriage with whom the child lives, who assumes primary responsibility for the child's care. *When a parent is in the home, no relative other than a stepparent can be eligible for Medicaid in the LIFC covered group.*

3. Child

means a natural, biological, adopted, or stepchild.

4. Coverage Gap and Gap-filling Rule

occurs when the difference in eligibility rules between the APTC and Medicaid/FAMIS creates a situation in which an applicant may appear to be financially ineligible for both the APTC (household income is too low) and Medicaid or FAMIS (household income is too high). The gap-filling rule is applied in such cases to help mitigate the coverage gap.

5. Dependent Child

means a child under age 18, or age 18 and a full-time student in a secondary school, who lives with his parent or caretaker-relative.

6. Family

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

7. Family Size

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

8. Household

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

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

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

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

11. Reasonable Compatibility means the income attested to (declared) by the applicant is within 10% of income information obtained from electronic sources. If the income from both sources meets the 10% requirement, then the attestation is considered verified.

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

If reasonable compatibility does not exist or income data was not available through the Hub, the income will be labeled unverified. If the system indicates that the income is not verified and the attestation is below the medical assistance income level, documentation of income is required.

12. Sibling means a natural, biological, stepsibling or half-sibling.

13. Tax-Dependent means an individual for whom another individual claims a deduction for a personal exemption under section 151 of the Internal Revenue Code of 1986 for a taxable year.

14. Tax-filer Household means individuals who expect to file a Federal tax return and/or who expect to be claimed as a tax dependent for the taxable year in which an initial determination or renewal of eligibility is being made.

M0430.100 MAGI HOUSEHOLD COMPOSITION

A. Introduction The household composition is the basis for the financial eligibility determination for each person in the home who applies for MA. Eligibility is based on the countable income of the household members.

The MAGI rules for household composition represent a major change for Medicaid. Included in the MAGI household composition are:

- stepparents and stepchildren,
- children/siblings with income,
- children ages 21 and older who are claimed as tax dependents, and
- other adult tax dependents.

B. Household Composition Rules Tax filers and tax dependents use the tax household rules with limited exceptions. In most cases, the household is determined by principles of tax dependency.

- Parents, children and siblings are included in the same household.

- Stepparents and parents are treated the same.
- Children and siblings with or without income are included in the same household as the rest of the family.
- Older children are included in the family if claimed as tax dependent by the parents.
- Married couples living together are **always** included in each other's household even if filing separately.
- Married couples that are separated and not living together but file jointly are not included in each other's household.
- Dependent parents may be included in the household if they are claimed for income tax purposes.

1. Tax Filer Household Composition

The tax filer household is determined based on the rules of tax dependency. Parents, children and siblings are included in the same household. The tax filer's household consists of the tax filer and all tax dependents who **are expected to be claimed for the current year**. This could include non-custodial children claimed by the tax filer, but living outside the tax filer's home and dependent parents claimed by the tax filer, but living outside the tax filer's home.

The tax filer household is composed of the individual who expects to file a tax return this year and does not expect to be claimed as dependent by another tax filer. The household consists of the tax filer and all individuals the tax filer expects to claim as a tax dependent.

2. Tax Dependent Household Composition

means all dependents expected to be claimed by another tax filer for the taxable year. Except for Special Medical Needs AA children and children who have been in a Level C PRTF for at least 30 consecutive days, the tax dependent's household consists of the (1) tax dependent, (2) his parents and (3) his siblings living in the home who are also claimed by the same tax filer.

If the tax dependent is living with a tax filer other than a parent or spouse or is living separately from the parent claiming him as a dependent, the tax dependent is included in the tax filer household, but the tax filer is NOT included in the tax dependent's household.

A Special Medical Needs AA child or a child who has been in a Level C PRTF for at least 30 consecutive days is in his own household with no parents or siblings.

Exceptions to the tax household composition rules apply when:

- individuals other than biological, adopted or stepchildren are claimed as tax dependents,
- children are claimed by non-custodial parents,
- *children live with both parents and expect to be claimed as a tax dependent by one parent, but parents (married or unmarried) do not expect to file jointly,*
- the tax dependent is a Special Medical Needs AA child or a child who has been in a Level C PRTF for at least consecutive 30 days.

3. Non Filer Household Composition

The Non Tax Filer household rules mirror the tax filer rules to the maximum extent possible.

- The household consists of parents and children under age 19. Exception: A Special Medical Needs AA child or a child who has been in a Level C PRTF for at least 30 consecutive days is in his own household with no parents or siblings.
- Non-filer rules are used when a child is claimed as a tax dependent of someone not living in the home.
- Non-filer rules are used in the case of a multi-generational household where the tax dependent is also the parent of a child.
- Children under age 19 living with a relative other than a parent are included only in their own household.
- Spouses, parents, stepparents and children living together are included in the same household. Exception: A Special Medical Needs AA child or a child who has been in a Level C PRTF for at least 30 consecutive days is in his own household with no parents or siblings.
- For non-filers, a "child" is defined as under age 19.

4. Married Couple

In the case of a married couple living together, the spouse is always included in the household of the other spouse, regardless of their tax filing status. This includes a tax dependent living with both a tax filer parent AND the dependent's spouse. The tax dependent's household includes his spouse, the tax filer, any other parent in the home, and any siblings in the home who are also claimed by the same tax filer.

5. Tax Filer is Under Age 19

If the tax filer is under age 19, lives in the home with his parent(s) AND is not expected to be claimed as a dependent by anyone, the parent(s) are included in the child's household.

6. Gap-filling Rule

States are required to use household income, as calculated by the federal HIM for the APTC eligibility determination, to determine eligibility for Medicaid or FAMIS if both of the following conditions apply:

- *Current monthly household income, using Medicaid/FAMIS MAGI-based methods is over the applicable income limit (including the 5% FPL disregard), and*
- *Projected annual household income, using MAGI methods applied by the HIM for the purposes of APTC eligibility, is below 100% FPL (i.e. the lower income threshold for APTC eligibility). See M04, Appendix 1.*

This requirement is referred to the gap-filling rule.

If it is necessary to apply the gap-filling rule but the eligibility and enrollment system is unable to determine eligibility using the gap-filling evaluation, the evaluation must be completed outside the system and documented in the electronic record. Follow the Interim Business Processes (IBP) for the Gap-Filling Rule in VaCMS for enrollment instructions.

Application of the Gap-filling Rule

- *The gap-filling rule does not establish a special eligibility group. The individual must meet a covered group and all non-financial eligibility criteria.*
- *The individual must be claimed as a tax dependent (including those who meet a tax dependent household exception in M0430.100 B.2). APTC methodology does not apply to non-filer households.*
- *If the individual is determined to be over the Medicaid and FAMIS income limits after using the gap-filling rule and he meets a MN covered group, he must be offered the opportunity to be placed on a MN spenddown.*
- *Applying the gap-filling may not be necessary for future eligibility determinations/renewals since tax dependency status may have changed.*

See M0450.400 for gap-filling rule evaluation procedures and examples.

M0430.200 TAX FILER HOUSEHOLD EXAMPLES

A. Married Parents and Their Tax Dependent Children

Sam and Sally are a married couple. They file taxes jointly and claim their two children Susie and Sarah as tax dependents. All of them applied for MA.

The MAGI household is the same as their tax household because the tax filers are a married couple filing jointly and claiming their dependent children. No additional individuals live in the home.

Ask the following questions for each tax dependent to determine if exceptions exist:

- Is Susie the tax dependent of someone other than a spouse or a biological, adopted, or stepparent? No, also applies to Sarah
- Is Susie a child living with both parents, but the parents do not expect to file a joint tax return? No, also applies to Sarah
- Is Susie a child who expects to be claimed by a non-custodial parent? No, also applies to Sarah

The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Sam	4 - Sam, Sally, Susie, Sarah	Tax-filer & dependents
Sally	4 – Sally, Sam, Susie, Sarah	Tax filer & dependents
Susie	4 – Susie, Sam, Sally, Sarah	Tax dependent, tax-filer parents and other tax dependent
Sarah	4 - Sarah, Sam. Sally, Susie	Tax dependent, tax-filer parents and other tax dependent

and the attestation is below the medical assistance income level, documentation of income is required.

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

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

A. MAGI Income Rules

1. Income That is Counted

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

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

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

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

c. Income of a child under 19 in a non-filer household who is NOT living with a parent or parents and who is not required to file taxes because the tax filing threshold is not met. Any Social Security benefits the child may have do not count in determining whether or not the tax filing threshold is met.

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

e. *Foreign income is counted.*

f. Stepparent income is counted.

g. *Alimony **received** is counted with no exclusions.*

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

2. Income That is Not Counted

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

b. Workers Compensation is not counted.

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

d. Veterans benefits which are **not** taxable in IRS pub 907 are not counted:

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

e. Alimony **paid** to a separated or former spouse outside the home is deducted from countable income. *Child support paid is **not** deducted from income.*

f. Interest paid on student loans is deducted from countable income.

g. *Gifts, inheritances, and* proceeds from life insurance are not counted.

i. A parsonage allowance is not counted.

j. *Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are not counted.*

3. Income From Self-employment

An individual reporting self-employment income must documentation of business expenses and income, such as IRS Form 1040 for the adjusted gross income, Schedule C (business expenses), Schedule E (expenses from rental income) and Schedule F (expenses from farming). If the individual alleges that his current income is not accurately represented by tax records, obtain additional information (such as business records) that documents current income.

Business expenses are expenses directly related to producing goods or services and without which the goods or services could not be produced. Allowable business expenses include, but are not limited to, the following:

- payments on the interest of the purchase price of, and loans for, capital assets such as real property, equipment, machinery and other goods of a durable nature;
- insurance premiums;
- legal fees;
- expenses for routine maintenance and repairs;
- advertising costs;
- bookkeeping costs.
- depreciation and capital losses. If the losses exceed income, the resulting negative dollar amount offsets other countable income.

Expenses that are not deducted for MAGI purposes include the following: payments on the principal of the purchase price of, and loans for, capital assets, such as real property, equipment, machinery and other goods of a durable nature; the principal and interest on loans for capital improvements of real property; net losses from previous periods; federal, state, and local taxes; personal expenses, entertainment expenses, and personal transportation; and money set aside for retirement purposes.

4. Private Accident/Health Plan Benefits

Private accident, health plan, and disability benefits are benefits paid from a plan provided by an employer or purchased by the individual. Social Security benefits and Supplemental Security Income (SSI) are not private benefits.

Benefits received for personal injury or sickness through an accident or health plan that is paid for by an employer are countable income.

If the individual pays the entire cost of the accident or health plan, benefits received from the plan are NOT income.

If both the employer and the individual pay for the plan, only the benefits received through the employer's payments are income.

5. American Indian-Alaska Native Payments

In addition, the following payments to American Indian/Alaska Natives are not counted as income:

a. distributions received from the Alaska Native Corporations and Settlement Trusts (Public Law 100-241),

b. distributions from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the Supervision of the Interior,

c. distribution and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extractions and harvest from:

- rights of any lands held in trust located within the most recent boundaries of a prior Federal reservation or under the supervision of the Secretary of the Interior,
- federally protected rights regarding off-reservation hunting, fishing, gathering or usage of natural resources,
- distributions resulting from real property ownership interests related to natural resources and improvements,
- located on or near a reservation of within the most recent boundaries of a prior Federal reservation, or
- resulting from the exercise of federally-protected rights relating to such property ownership interests.

d. payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or right or rights that support subsistence or a traditional lifestyles according to applicable Tribal Law or custom.

e. Student financial assistance provided under the Bureau of Indian Affairs Education Program.

B. Monthly Income Determinations

Medicaid and FAMIS income eligibility is determined using current monthly income. Sources and amounts of income that are verified electronically and are reasonably compatible do not require additional verification.

When income cannot be verified electronically **or** the information reported is not reasonably compatible (see M0420.100 for the definition), the individual must be asked to provide current verification of the household income so a point-in-time income eligibility determination can be made.

C. Steps for Calculating MAGI

For non-filers or any other individuals whose income cannot be verified by the Hub, use the following steps for calculating an individual's MAGI. Subtract any deductions listed below if they are reported by the individual.

For tax filers whose income is verified in the Hub, the steps below are not followed: no MAGI calculation is required.

Adjusted Gross Income (AGI) Line 4 on Internal Revenue Service (IRS) Form 1040 EZ Line 21 on IRS Form 1040A Line 37 on IRS Form 1040	**Include:** • Wages, salaries, tips, etc • Taxable interest • Taxable amount of pension, annuity or Individual Retirement Account (IRA) distributions and Social Security benefits • Business Income, farm income, capital gain, other gains (or loss) • Unemployment Compensation • Ordinary dividends • Alimony received • Rental real estate, royalties, partnerships • S corporations, trusts, etc. • Taxable refunds, credits, or offset of state and local income taxes • Other income	**Deduct:** • Certain self-employment expenses • Student loan interest deduction • Educator expenses • IRA deduction • Moving expenses • Penalty on early withdrawal of savings • Health savings account deduction • Alimony paid *(but not child support paid)* • Domestic production activities deduction • Certain business expenses of reservists, performing artists, and fee-basis government officials

Note: Check the IRS website for detailed requirements for the income and deduction categories above. Do not include Veteran's disability payments, Worker's Compensation or child support received. Pre-tax contributions, such as those for child care, commuting, employer-sponsored health insurance, flexible spending accounts and retirement plans such as 401(k) and 403(b), are not included in AGI but are not listed above because they are already subtracted out of W-2 wages and salaries.

Add (+) back certain income	• Non-taxable Social Security benefits (line 20a minus 20b on Form 1040) • Tax –exempt interest (Line 8b on Form 1040) • Foreign earned income and housing expenses for Americans living abroad (calculated in IRS Form 2555)

Exclude (-)from income	• Social Security benefits received by a child are not countable for his eligibility when a parent is in the household, unless the child is required to file taxes. • Scholarships, awards, or fellowship grants used for education purposes and not for living expenses • Certain American Indian and Alaska Native income derived from distributions, payments, ownership interests, real property usage rights and student financial assistance • *Gifts, inheritances, and* proceeds from life insurance • An amount received as a lump sum is counted only in the month received. • *Parsonage allowance*

M0450.100 STEPS FOR DETERMINING MAGI-BASED ELIGIBILITY

A. Determine Household Composition

1. Does the individual expect to file taxes?

a. If No - Continue to Step 2

b. If Yes - Does the individual expect to be claimed as a tax dependent by anyone else?

1) If No - the household consists of the tax filer, a spouse living with the tax filer, and all persons whom the tax filer expects to claim as a tax dependent. For a tax filer under age 19, parents living in the home are also in the individual's household.

2) If Yes - Continue to Step 2

2. Does the Individual Expect to be Claimed As a Tax Dependent?

a. If No - Continue to Step 3

b. If Yes - Does the individual meet any of the following exceptions?

1) the individual expects to be claimed as a tax dependent of someone other than a spouse or a biological, adopted, or stepparent;

2) the individual is a child (under age 19) living with both parents, but the parents do not expect to file a joint tax return; or

3) the individual is a child who expects to be claimed by a non-custodial parent?

i. If no - the household is the household of the tax filer claiming her/him as a tax dependent.

ii. Is the individual married? If yes – does the household also include the individual's spouse?

iii. If yes - Continue to Step 3.

4) the child is a Special Medical Needs AA child?

If yes, continue to Step 3 below.

3. Individual Is Neither Tax Filer Nor Tax Dependent Or Meets An Exception In 2. b Above

For individuals, other than Special Medical Needs AA children, who neither expect to file a tax return nor expect to be claimed as a tax dependent, as well as tax dependents who meet one of the exceptions in 2.b above, the household consists of the individual and, if living with the individual:

- the individual's spouse;
- the individual's natural, adopted and step children under the age 19; and
- In the case of individuals under age 19, the individual's natural, adopted and stepparents and natural, adoptive and stepsiblings under age 19.

The household of a Special Medical Needs AA child consists only of the child.

Dee's eligibility determination:

Potential covered groups:

Child < Age 19
FAMIS

Monthly Income limits:

Child < Age 19 143% FPL for a HH of 2 = $1,849
FAMIS, 200% FPL for HH of 2 = $2,585
5% FPL for 2 = $65

HH monthly income:

$300 (Jane's gross earnings)

$300 is less than the Medicaid Child < Age 19 143% FPL income limit for 2 ($1,849) so Dee is eligible for Medicaid in the Child < Age 19 covered group. The 5% disregard is not applied because it is not necessary; her gross HH income is within the Medicaid Child < Age 19 income limit.

M0450.400 GAP-FILLING RULE EVALUATION

A. When to Complete Gap-filling Evaluation

Complete a gap-filling evaluation to determine eligibility for Medicaid or FAMIS whenever both of the following conditions apply:

- *Current monthly household income, using Medicaid/FAMIS MAGI-based methods including the 5% FPL disregard, is over the applicable income limit, and*
- *Projected annual household income, using MAGI methods applied by the HIM for the purposes of APTC eligibility, is below 100% FPL (i.e. the lower income threshold for APTC eligibility). See M04, Appendix 1.*

If the eligibility and enrollment system is unable to determine eligibility using the gap-filling evaluation, the evaluation must be completed outside the system and documented in the electronic record. If the individual is eligible, the coverage must be entered directly into MMIS.

B. Household Income Calculation

Under the gap-filling rule, financial eligibility for Medicaid and FAMIS is determined using household income as calculated by the federal HIM for APTC purposes.

- *Medicaid/FAMIS-specific household composition rules (e.g. tax dependent exceptions), income counting rules (e.g. for lump sum payments), and evaluation period (e.g. current monthly income) are not used.*

- *Financial eligibility for the APTC is based on annual income for the calendar year in which benefits are sought. This means that the individual's prior income, or lack of income, for the calendar year, is included in the calculation of financial eligibility.*

- *The individual does not need to apply for the APTC prior to applying for Medicaid or having the gap-filling evaluation completed. However, if the local agency knows the determination of annual income made by the HIM, it may use that information for the purposes of applying the gap filling rule.*

C. Example Situation – Coverage Gap and Gap Filling Rule

A 10-year-old child lives with both parents, who are not married, and the child is expected to be claimed as a tax dependent by one parent. His parents apply for the APTC through the federal HIM. The HIM only processes applications for tax filers because the APTC only applies to tax filing households. The child is determined to not be eligible for the ATPC because his countable income is below the lower income threshold (it is too low) for APTC eligibility

The HIM makes an application referral to Virginia for a Medicaid/FAMIS eligibility determination. The child meets a tax dependent exception in M0430.100 B.2 (he lives with both parents, is claimed as a tax dependent by one parent, and the parents do not expect to file jointly). The child's eligibility for Medicaid or FAMIS is determined using non-filer methodology. Because he is under 19 and both parents are in his household, the income of both parents is counted. His household income with the 5% FPL disregard is over the limit for both Medicaid and FAMIS.

Since the child does not qualify for the APTC because his countable income is under the lower financial threshold for the APTC AND he has excess income using non-filer rules household composition/ income rules, the gap-filling rule must be applied.

D. Example – Gap Filling Evaluation

Maria and Tony are an unmarried couple who live with their 12-year-old daughter, Anita. Maria and Tony are both employed. Anita is claimed as a tax dependent by Maria, who works part time. Maria applies for Medicaid only for Anita. Because Anita lives with both parents, but the parent's file taxes separately and only one parent claims her as a tax dependent, Anita meets a tax dependent exemption. Her eligibility must be evaluated using non-filer rules.

Because she is under age 19, Anita's MAGI household consists of Anita and both parents. Both Maria's and Tony's income is counted for Anita's eligibility. Her countable income, including with the 5% FPL disregard, is over the limits for both Medicaid and FAMIS.

The eligibility worker notes that a potential gap-filling situation exists. The worker evaluates Anita's eligibility for Medicaid or FAMIS using the APTC rules. Under the APTC rules, Anita's household consists of Anita (tax dependent) and Maria (tax filer); Tony is not in Anita's household because he does not claim Anita on his taxes. Maria's income from her part time job is under 100% FPL. Therefore, Anita is eligible for Medicaid under the gap-filling rule. The eligibility worker enrolls Anita in Medicaid.

The following tables show the household formation and income used.

For the Medicaid/FAMIs evaluation:

Person	*# - MAGI Household Composition Non-filer rules*	*Income to count for Medicaid/FAMIS eligibility*
Anita	*3 – Anita, Maria, Tony*	*Maria, Tony*

For the gap-filling evaluation

Person	*# - ATPC Household Composition*	*Income to count for Medicaid/FAMIS eligibility*
Anita	*2 – Maria, Anita*	*Maria, and (non-excluded) income from Anita*

5% FPL DISREGARD **EFFECTIVE *1/18/18***	
Household Size	**Monthly Amount**
1	$51 *(no change)*
2	*69*
3	*87*
4	*105*
5	*123*
6	*141*
7	*159*
8	*177*
Each additional, add	18 *(no change)*

GAP-FILLING RULE EVALUATION
100% FPL
INCOME LIMITS

EFFECTIVE 1/18/18

Household size	*Annual*	*Monthly*
1	*$12,140*	*$1,012*
2	*16,460*	*1,372*
3	*20,780*	*1,732*
4	*25,100*	*2,092*
5	*29,420*	*2,452*
6	*33,740*	*2,812*
7	*38,060*	*3,172*
8	*42,380*	*3,532*
Each additional	*4,320*	*360*

PREGNANT WOMEN
143% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/18/18*

Household Size	143% FPL Monthly Amount	149% FPL (143% FPL + 5% FPL Disregard as Displayed in VaCMS)
2*	*$1,962*	*$2,031*
3	*2,477*	*2,564*
4	*2,992*	*3,027*
5	*3,506*	*3,629*
6	*4,021*	*4,162*
7	*4,536*	*4,695*
8	*5,051*	*5,228*
Each additional, add	*515*	*533*

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

CHILD UNDER AGE 19
143% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/18/18*

# of Persons in House-hold	**109% FPL (for Determining Aid Category)**	**143% FPL**	**149% FPL (143% FPL + 5% FPL Disregard as Displayed in VaCMS)**
	Monthly Limit	Monthly Limit	Monthly Limit
1	*$1,103*	*$1,447*	*$1,498*
2	*1,496*	*1,962*	*2,031*
3	*1,888*	*2,477*	*2,564*
4	*2,280*	*2,992*	*3,027*
5	*2,673*	*3,506*	*3,629*
6	*3,065*	*4,021*	*4,162*
7	*3,458*	*4,536*	*4,695*
8	*3,850*	*5,051*	*5,228*
Each add'l, add	*393*	*515*	*533*

PLAN FIRST
200% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/18/18*

Household Size	200% FPL Monthly Amount	205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)
1	*$2,024*	*$2,075*
2	*2,744*	*2,813*
3	*3,464*	*3,551*
4	*4,184*	*4,289*
5	*4,904*	*5,027*
6	*5,624*	*5,765*
7	*6,344*	*6,503*
8	*7,064*	*7,241*
Each additional, add	*720*	*738*

TREATMENT OF INCOME FOR FAMILIES & CHILDREN COVERED GROUPS

INCOME	MAGI COVERED GROUPS	MEDICALLY NEEDY AND 300% SSI F&C COVERED GROUPS
Earnings	Counted with no disregards	Counted with appropriate earned income disregards
Social Security Benefits Adult's MAGI household	Benefits received by a parent or stepparent are counted for his eligibility determination, as well as the eligibility determinations of his spouse and children in the home.	Counted if anyone in the Family Unit/Budget Unit receives
Social Security Benefits Child's MAGI household	Benefits received by a child with at least one parent/stepparent in household are not countable unless the child is required to file taxes. When the child is in his own household, benefits are always countable.	Counted if anyone in the Family Unit/Budget Unit receives
Child Support Received	Not counted	Counted – subject to $50 exclusion
Child Support Paid	Not deducted from income	Not deducted from income
Alimony Received	Counted	Counted – subject to $50 exclusion if comingled with child support
Alimony Paid	Deducted from income	Not deducted from income
Worker's Compensation	Not counted	Counted
Veteran's Benefits	Not counted *if they are **not** taxable in IRS pub 907*	Counted
Scholarships, fellowships, grants and awards used for educational purposes	Not counted	Not counted
Foreign Income (whether or not excluded from taxes)	Counted	Counted
Interest (whether or not excluded from taxes)	Counted	Counted
Lump Sums	Income in month of receipt	Income in month of receipt
Gifts, inheritances, life insurance proceeds	Not counted	Counted as lump sum in month of receipt
Parsonage allowance	Not counted	Counted

M0530 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-8	4/1/18	Appendix 1, page 1
TN #DMAS-6	10/1/17	Pages 2, 24, 30
TN #DMAS-3	1/1/17	Appendix 1, page 1
TN #DMAS-2	10/1/16	Pages 23, 24
TN #DMAS-1	6/1/16	Appendix 1, page 1
TN #100	5/1/15	Pages 14, 16, 29, 30 Appendix 1, page 1
TN #99	1/1/14	Appendix 1, page 1
UP #9	4/1/13	Appendix 1, page 1
UP #6	4/1/12	Appendix 1, page 1
Update (UP) #5	7/1/11	Page 14
TN #95	3/1/11	Page 1 Appendix 1, page 1
TN #93	1/1/10	Pages 11, 19 Appendix 1, page 1

Deeming Allocations

The deeming policy determines how much of a legally responsible relative's income is deemed to the applicant/recipient. The allocation amount increases automatically whenever the SSI payment limit increases.

NBD (Non-blind/disabled) Child Allocation

The NBD child allocation is equal to the difference between the SSI payment for two persons and the SSI payment for one person.

SSI payment for couple - SSI payment for one person = NBD child allocation

2018: $1,125 - $750 = $375
2017: $1,103 - $735 = $368

Parental Living Allowance

The living allowance for one parent living with the child is the SSI payment for one person.

SSI payment for one person = *$750 for 2018*; $735 for 2017.
The living allowance for both parents living with the child is the SSI payment for a couple.

SSI payment for both parents = *$1,125 for 2018*; $1,103 for 2017.

Deeming Standard

The NABD (non-age/blind/disabled) spouse deeming standard is the difference between the SSI payment for two persons and the SSI payment for one person.

SSI payment for couple - SSI payment for one person = deeming standard

2018: $1,125 - $750 = $375
2017: $1,103 - $735 = $368

M0810 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-8	4/1/18	Page 2
TN #DMAS-7	1/1/18	Page 1, 2
TN #DMAS-5	7/1/17	Page 2
TN #DMAS-4	4/1/17	Page 2
TN #DMAS-3	1/1/17	Pages 1, 2
TN #DMAS-2	10/1/16	Page 2
TN #DMAS-1	6/1/16	Pages 1, 2
UP #11	7/1/15	Page 2
TN #100	5/1/15	Pages 1, 2
UP #10	5/1/14	Page 2
TN #99	1/1/14	Pages 1, 2
TN #98	10/1/13	Page 2
UP #9	4/1/13	Pages 1, 2
UP #7	7/1/12	Page 2
UP #6	4/1/12	Pages 1, 2
TN #95	3/1/11	Pages 1, 2
TN #93	1/1/10	Pages 1, 2
Update (UP) #1	7/1/09	Page 2

3. Categorically Needy 300% of SSI

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

Family Size Unit	2018 Monthly Amount	2017 Monthly Amount
1	$2,250	$2,205

4. ABD Medically Needy

a. Group I	7/1/2017		7/1/2016 – 6/30/17	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$1,867.21	$311.20	$1,861.63	$310.27
2	2,377.24	396.20	2,370.20	395.03

b. Group II	7/1/2017		7/1/2016 – 6/30/17	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,154.48	$359.08	$2,148.04	$358.00
2	2,653.01	442.16	2,645.09	440.84

c. Group III	7/1/2017		7/1/2016 – 6/30/17	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,800.83	$466.80	$2,792.45	$465.40
2	3,376.83	562.80	3,366.75	561.12

5. ABD Categorically Needy

All Localities	*2018*		2017	

For:

ABD 80% FPL, QMB, SLMB, & QI <u>without</u> Social Security income; all QDWI; effective *1/18/18*

ABD 80% FPL, QMB, SLMB, & QI <u>with</u> Social Security income; effective *3/1/18*

ABD 80% FPL	Annual	Monthly	Annual	Monthly
1	*$9,712*	*$810*	$9,648	$804
2	*13,168*	*1,098*	12,992	1,083
QMB 100% FPL	Annual	Monthly	Annual	Monthly
1	*$12,140*	*$1,012*	$12,060	$1,005
2	*16,460*	*1,372*	16,240	1,354
SLMB 120% of FPL	Annual	Monthly	Annual	Monthly
1	*$14,568*	*$1,214*	$14,472	$1,206
2	*19,752*	*1,646*	19,488	1,624
QI 135% FPL	Annual	Monthly	Annual	Monthly
1	*$16,389*	*$1,366*	$16,281	$1,357
2	*22,221*	*1,852*	21,924	1,827
QDWI	Annual	Monthly	Annual	Monthly
200% of FPL	*$24,280*	*$2,024*	$24,120	$2,010
1	*32,920*	*2,744*	32,480	2,707
2				

M1120 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-8	4/1/18	Page 22a
TN #DMAS-7	1/1/18	Table of Contents i, pages 3, 22a, 30
TN #DMAS-5	7/1/17	Pages 15, 17, 18
TN #DMAS-2	10/1/16	On page 6, updated the format of the header. Neither the date nor the policy was changed.
TN #96	10/1/11	Table of Contents pages 24-26
TN #93	1/1/2010	page 22

3. Transfers of Income into a Trust Established for a Disabled Individual

The treatment of income transferred into a *trust established for a disabled individual or pooled trust* as described in M1120.202 is dictated *for Medicaid eligibility purposes* by federal rules for the treatment of *transferring* such income *into* a Qualified Income Trust, also referred to as a Miller Trust. *Although* Virginia **does not** recognize Miller trusts, *the Medicaid income exclusion provided for in a Miller trust* is equally applicable *in states that do not have Miller Trusts to trusts established for disabled individuals*.

Under Miller Trust rules, income received and placed into a trust established for a disabled individual or pooled trust is not counted in determining the individual's income eligibility. Additionally, if the ***right*** *to income is transferred to the trust, the income is not counted because it does not meet the Supplemental Security Income (SSI) and Medicaid definitions of income.*

Transfers of income and the right to income into a trust established for a disabled individual or pooled trust are not considered uncompensated transfers of assets when the individual is under age 65.

M1410 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-8	4/1/18	Page 9
TN #DMAS-7	1/1/18	Page 7
TN #DMAS-5	7/1/17	Pages 4-7
TN #DMAS-3	1/1/17	Pages 6, 7, 12-14
TN #DMAS-1	6/1/16	Pages 12-14
TN #100	5/1/15	Page 2
TN #99	1/1/14	Page 10
Update #7	7/1/12	Pages 6, 7
TN #96	10/1/11	Page 11, 12
TN #95	3/1/11	Pages 13, 14 Page 15 was removed.
TN #94	9/1/10	Pages 6, 7, 13
TN #93	1/1/10	Pages 1, 7, 9, 12
TN #91	5/15/09	Pages 11-14

M1410.060 POST-ELIGIBILITY TREATMENT OF INCOME (PATIENT PAY)

A. Introduction

Medicaid-eligible individuals must pay a portion of their income to the LTC provider; Medicaid pays the remainder of the cost of care. The portion of their income that must be paid to the provider is called "patient pay."

B. Patient Pay

The policies and procedures for patient pay determination are found in subchapter M1470 of this chapter for individuals who do not have community spouses and in subchapter M1480 for individuals who have community spouses.

M1410.100 LONG-TERM CARE APPLICATIONS

A. Introduction

The general application requirements applicable to all Medicaid applicants/ recipients found in chapter M01 also apply to applicants/recipients who need LTC services. This section provides those additional or special application rules that apply only to persons who meet the institutionalization definition.

B. Responsible Local Agency

The local social services department in the Virginia locality where the institutionalized individual (patient) last resided outside an institution retains responsibility for receiving and processing the application.

If the patient did not reside in Virginia prior to admission to the institution, the local social services department in the county/city where the institution is located has responsibility for receiving and processing the application.

Community-Based Care (CBC) applicants apply in their locality of residence.

ABD patients in state Department of Behavioral Health and Developmental Services (DBHDS) facilities for more than 30 days have eligibility determined by Medicaid technicians located in the state DBHDS facilities. When an enrolled ABD Medicaid recipient is admitted to a state DBHDS facility, the local department of social services transfers the case to the Medicaid technician after the recipient has been in the facility for 30 days or more. See section M1520.*500* for case transfer policy.

C. Procedures

1. Application Completion

A signed application is received. A face-to-face interview with the applicant or the person authorized to conduct his business is not required, but is strongly recommended, in order to correctly determine eligibility.

2. Pre-admission Screening

Notice from pre-admission screener is received by the local Department of Social Services (DSS).

NOTE: Verbal communications by both the screener and the local DSS Eligibility Worker (EW) may occur prior to the completion of screening. Also, not all LTC cases require pre-admission screening; see M1420.

M1460 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-8	4/1/18	Pages 18a, 32, 35
TN #DMAS-7	1/1/18	Pages 3, 7
TN #DMAS-3	1/1/17	Pages 3, 4, 4b, 24, 25, 29
TN #DMAS-2	10/1/16	Page 35
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 3, 8a, 17, 32
TN #100	5/1/15	Table of Contents, page i Pages 1, 2, 5, 6, 10, 15, 16-17a, 25,41-51
TN #99	1/1/14	Pages 3, 35
UP #9	4/1/13	Table of Contents Pages 3, 35, 38, 41, 42, 50, 51
TN #97	9/1/12	Table of Contents Pages 1, 4-7, 9-17 Page 8a was deleted. Pages 18a-20, 23-27, 29-31 Pages 37-40, 43-51 Pages 52 and 53 were deleted
UP #6	4/1/12	Pages 3, 35
TN #96	10/1/11	Pages 3, 20, 21
TN #95	3/1/11	Pages 3, 4, 35
TN #94	9/1/10	Page 4a
TN #93	1/1/10	Pages 28, 35
TN #91	5/15/09	Pages 23, 24

NOTE: If the individual's resources exceed the resource limit, and the individual has Medicare Part A, evaluate for eligibility as QMB, SLMB, or QI (limited coverage) which have a higher resource limit.

2. F&C Covered Groups

An institutionalized individual is an assistance unit of 1 person, considered living separately from his family. No resources are deemed available from a child's parent(s).

NOTE: A pregnant woman's assistance unit includes the number of unborn children with which she is pregnant.

Use the resource policy and procedures in chapter M06 for the resource determination.

M1460.520 RETROACTIVE RESOURCE DETERMINATION

A. Policy

When an applicant reports that he received a medical service within the retroactive period, evaluate Medicaid eligibility for that period.

Evaluate resource eligibility for each month using resources available during that month.

B. Reduction of Resources

An individual cannot retroactively reduce resources. If countable resources exceeded the resource limit **throughout** a retroactive month, the individual is **not** eligible for that month. However, if an applicant reduces excess resources **within** a retroactive month, he may be eligible in the month in which the value of his resources is reduced to or below the Medicaid resource limit.

In order to reduce resources, liquid resources such as bank accounts and prepaid burial accounts must actually have been expended. Non-liquid resources must have been liquidated and the money expended.

M1460.530 HOME OWNERSHIP (NOT APPLICABLE TO ABD 80% FPL GROUP)

A. Policy

The policy in this section does not apply to the ABD 80% FPL group. See Appendix 2 to chapter S11 for home ownership resource policy for the ABD 80% FPL group.

The institutionalized individual's former home in which he has an ownership interest, and which he occupied as his residence before becoming institutionalized, is not a countable resource for the first six months **following** admission to a medical facility or nursing facility. The former home is excluded indefinitely when it is occupied by a spouse, minor child, disabled adult child, or disabled parent.

B. Definitions for This Section

1. Dependent

A dependent child or parent is one who may be claimed as a dependent for tax purposes under the Internal Revenue Service's Code by either the institutionalized individual or his spouse.

b. Payments for unusual medical expenses.

c. Payments made as part of a VA program of vocational rehabilitation.

d. VA clothing allowance.

e. Any pension paid to a nursing facility patient who is

- a veteran with no dependents,
- a veteran's surviving spouse who has no child, or
- *a veteran's dependent child.*

NOTE: Refer to section M1470.100 for counting VA pension payments as income for post-eligibility determinations. This applies to all LTC recipients, including those patients who reside in state veterans' care centers.

f. Any portion of a VA educational benefit which is a withdrawal of the veteran's own contribution is a conversion of a resource and is not income.

2. VA Augmented Benefits

An absent dependent's portion of an augmented VA benefit received by the individual on or after 11-17-94 is NOT income to the individual when determining his eligibility in any covered group EXCEPT an F&C MN covered group.

VA Augmented benefits are COUNTED as income when determining eligibility in the F&C MN covered groups.

3. Return of Money

(S0815.250) A rebate, refund, or other return of money that an individual has already paid is NOT income to the individual when determining his eligibility in any covered group EXCEPT an F&C MN covered group. The key idea is a return of the individual's own money. Some "rebates" do not fit this category, such as a cooperative operating as a jointly owned business pays a "rebate" as a return on a member's investment; this "rebate" is unearned income similar to a dividend.

4. Death Benefits

Death benefits **equal** to cost of last illness and burial are NOT income in all covered groups EXCEPT the F&C MN covered groups.

Any amount of the death benefit that **exceeds** the costs of last illness and burial **is counted as income** for eligibility and patient pay **in all covered groups**.

5. Austrian Social Insurance

Austrian Social Insurance payments that meet the requirements in S0830.715 are NOT income in all covered groups EXCEPT the F&C MN covered groups.

6. Native American Funds

a. Seneca Nation Settlement Act [ref. P.L. 101-503]

b. Yakima Indian Nation [ref. P.L. 99-433]

c. Papago Tribe of Arizona [ref. P.L. 97-408]

d. Shawnee Indians [ref. P.L. 97-372]

6. Domestic Travel Tickets Gifts of domestic travel tickets [1612(b)(15)].

7. Victim's Compensation Victim's compensation provided by a state.

8. Tech-related Assistance Tech-Related Assistance for Individuals with Disabilities [ref. P.L. 100-407].

9. $20 General Exclusion $20 a month general income exclusion for the unit.

EXCEPTION: Certain veterans (VA) benefits are not subject to the $20 income exclusion. Refer to subchapter S0830 for complete explanation of which VA payments are entitled to the $20 general exclusion.

10. PASS Income Any unearned income used to fulfill an SSI approved plan to achieve self-support (PASS). See item 12 below for earned income used to fulfill a PASS [1612(b) (4)(A) & (B)].

11. Earned Income Exclusions The following earned income exclusions are not deducted for the 300% SSI group:

a. For 2018, up to *$1,820* per month, but not more than *$7,350* in a calendar year, of the earned income of a blind or disabled student child.

For 2017, up to $1,790 per month, but not more than $7,200 in a calendar year, of the earned income of a blind or disabled student child..

b. Any portion of the $20 monthly general income exclusion which has not been excluded from unearned income in that same month [1612(b) (2)(A)].

c. $65 of earned income in a month [1612(b) (4)(C)].

d. IRWE - earned income of disabled individuals used to pay impairment-related work expenses [1612(b) (4)(B)].

e. One-half of remaining earned income in a month [1612(b) (4)(C)].

f. BWE - Earned income of blind individuals used to meet work expenses [1612(b) (4)(A)].

g. Earned income used to fulfill an SSI approved plan to achieve self-support (PASS) [1612(b) (4)(A) & (B)].

12. Child Support Child support payments received from an absent parent for a blind or Disabled child [1612(b) (9)].

M1470 Changes

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

1. 300% SSI Group

If the individual is eligible in the 300% SSI group, to determine patient pay start with the gross monthly income calculated for eligibility. Then add and deduct any amounts that are listed in subsection C. below.

2. Groups Other Than 300% SSI Group

If the individual is eligible in a covered group other than the 300% SSI group, determine the individual's patient pay income using subsections B. and C. below.

B. Income Counted For Patient Pay

All countable sources of income for the 300% SSI group listed in section M1460.611 are considered income in determining patient pay. Any other income NOT specified in C. below is counted as income for patient pay.

1. Aid & Attendance and VA Pension Payments

Count the total VA Aid & Attendance payments and/or VA pension payments in excess of $90.00 per month as income for patient pay when the patient is:

- a veteran who does not have a community spouse or dependent child,
- a deceased veteran's surviving spouse who does not have a dependent child, or
- *a veteran's dependent child.*

Do not count any VA Aid & Attendance payments and/or VA pension payments when the patient is:

- a veteran who has a community spouse or dependent child, or
- a deceased veteran's surviving spouse who has a dependent child.

NOTE: This applies to all LTC recipients, including patients who reside in a Veterans Care Center.

2. Non-Refundable Advance Payments To LTC Providers

Advance payments and pre-payments paid by a recipient to the LTC provider that will not be refunded are counted as income for patient pay. M1470.1100 contains instructions for calculating the patient pay when an advance payment has been made to reduce resources within a month.

C. Income Excluded For Patient Pay

Income from sources listed in subchapter M1460.610 "What is Not Income" is not counted when determining patient pay, **EXCEPT** for the VA Aid & Attendance and VA pension payments to veterans which are counted in the patient pay calculation (see B. above). Additional types of income excluded from patient pay are listed below.

1. SSI & AG Payments

All SSI and Auxiliary Grants (AG) payments are excluded from income when determining patient pay.

2. Certain Interest Income

a. Interest or dividends accrued on excluded funds which are set aside for burial are not income for patient pay.

b. Interest income when the total interest accrued on all interest-bearing accounts is less than or equal to $10 monthly is not income for patient pay. Interest income that is not accrued monthly must be converted to a monthly amount to make the determination of whether it is excluded.

- Verify interest income at application and each scheduled redetermination.

M1510 Changes

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

4. PARIS Match Data

The Public Assistance Reporting Information System (PARIS) is a Federal computer matching initiative that the Virginia Department of Social Services (VDSS) participates in quarterly. VDSS participates in the data exchange with all active Medicaid enrollees and they are matched for the receipt of Veterans benefits and enrollment in multiple states' Medicaid programs. Each public assistance report is matched by social security number.

If a PARIS match is found, the worker will receive an alert in the Virginia Case Management System (VaCMS). The worker must evaluate all matches for current and ongoing eligibility and take appropriate case action within 30 days. Multiple matches must be assessed as a whole for the entire case. Workers must document findings in VaCMS under Case Comments. Procedures for researching and reporting PARIS matched individuals are found in the PARIS User Guide *available on the VDSS intranet.*

Once the evaluation of the match is completed and the case comments are documented, complete and send the Notice of Recipient Fraud/Non-Fraud Recovery (form #DMAS 751R), *located on the VDSS intranet*, to

Department of Medical Assistance Services
Recipient Audit Unit,
600 E. Broad Street, Suite 1300,
Richmond, Virginia 23219

The form may be faxed to 804-452-5472 or emailed to recipientfraud@dmas.Virginia.gov.

The DMAS Program Integrity Division will conduct steps to complete the match and Benefit Impact Screen (BIS).

M1510.103 HOSPITAL PRESUMPTIVE ELIGIBILITY

A. Policy

Individuals enrolled on the basis of Hospital Presumptive Eligibility (HPE) are covered by Medicaid beginning with the date of the HPE determination through the last day of the following month or the date MA eligibility is determined by an LDSS, whichever comes first. For their coverage to continue beyond the HPE enrollment period, they must submit a full MA application to the LDSS. If the individual does not submit an MA application, no further action is necessary on the part of the LDSS. See M0120.500 C. for additional information.

B. Procedures

When an HPE enrollee submits a full MA application and it is pended in VaCMS, the individual's coverage in the HPE AC is extended by the eligibility worker, as necessary, while the application is processed.

The 10-working day processing standard applies to applications submitted by pregnant women and BCCPTA individuals enrolled in HPE.

1. Enrollment

When an individual is determined eligible for MA coverage, his MA coverage under the appropriate MA AC includes any days to which he is entitled that are not already covered by HPE. If the individual submitted the MA application in the same month HPE coverage began and HPE began on any day other than the first day of the month, his MA coverage begins the first day of that month and the eligibility worker enrolls him in a closed period of coverage in the appropriate MA AC beginning with the first day of the month and ending the day before the HPE begin date. The worker is to enroll the eligible individual in ongoing coverage in the appropriate MA AC beginning the first day of the month after the effective date of the HPE coverage cancellation.

2. Individuals Enrolled in HPE as Pregnant Women or in Plan First

If an individual who was enrolled in HPE with partial coverage as a pregnant woman or in Plan First is determined eligible for full MA coverage in the period covered by HPE, cancel HPE coverage retroactively and reinstate in full coverage for the retroactive months and ongoing, if eligible.

3. Retroactive Entitlement

An individual's eligibility for retroactive coverage for the three months prior to the month of the MA application is determined when the individual had a medical service within the three months prior to the month of the full MA application. If the individual had full coverage while enrolled as HPE, only enroll him for the portion of the retroactive period that he was not enrolled as HPE.

4. HPE Enrollee Not Eligible for Ongoing Coverage

If the applicant is determined to not be eligible for ongoing MA coverage, his entitlement to HPE coverage ends. Cancel the HPE coverage effective the current date (i.e. day of the eligibility determination).

Send a Notice of Action indicating that the individual's MA application was denied and that his HPE coverage was cancelled with the effective date. The individual receives notice of the HPE coverage period from the hospital at the time of the HPE enrollment; advance notice of the HPE cancellation is not required. There are no appeal rights for HPE.

M1510.104 DISABILITY DENIALS

A. Policy

When an individual concurrently applies for SSI or SS and Medicaid as disabled, and either the DDS or the Social Security Administration (SSA) denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.

When an individual applies for Medicaid as disabled or concurrently applies for SS/SSI and Medicaid as disabled, and DDS denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.

B. Procedures

1. Subsequent SSA/SSI Disability Decisions

The SSA disability decision takes precedence over a DDS decision (DDS will make a decision before SSA if SSA does not take action within the 90-day Medicaid application processing time). If SSA denies disability and the decision is appealed and 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.

2. Use Original Application

The original application is used as long as the application was denied because the individual was not disabled and the subsequent disability onset month is no later than 90 days from the month of application.

3. Entitlement

If the re-evaluation determines that the individual is eligible, the individual's Medicaid entitlement is based on the Medicaid application date including the retroactive period if *available documentation verifies that* all eligibility requirements were met during the retroactive period. However, eligibility as a disabled individual cannot begin prior to the disability onset date when the disability onset date falls after the application date.

4. Renewal

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 a *renewal* to determine whether or not the individual remains eligible.

5. Original Application Was Purged

Closed cases may be purged after at least three years from the application date have passed (see M0130.400). If the case record was purged, in the absence of agency knowledge regarding the original application date (e.g. an application log), accept the individual's attestation of the application date.

Send the individual two application forms. Instruct the individual to complete one application according to his circumstances at the time of the attested original application date and the other application according to his current circumstances. Request verifications for the attested original application month and retroactive period, as well as the current application according to the renewal policy in M1520.200 A, in order to evaluate ongoing eligibility

If verifications from the attested application month and retroactive period cannot be obtained, eligibility cannot begin until the earliest month that the individual was both disabled and his eligibility can be verified.

6. Spenddown

If, based upon the re-evaluation, the individual is determined not eligible but met the requirements in Chapter M13 for placement on a spenddown, a first prospective and additional 6 month spenddown budget period*(s)* are 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.

M1520 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-8	4/1/18	Pages 2, 18 Appendix 2
TN #DMAS-7	1/1/18	Pages 2, 3, 3a, 5, 6, 7 Pages 6a and 7a are runover pages.
TN #DMAS-5	7/1/17	Pages 1, 2, 6, 8 Pages 3, 7, 7a and 9 are runover pages.
TN #DMAS-4	4/1/17	Pages 25-27 Appendix 2, page 1 Pages 28-30 were added.
TN #DMAS-3	1/1/17	Pages 1, 2, 4, 6, 7, 8, 14, 26
TN #DMAS-2	10/1/16	Pages 1, 3, 6, 8, 12, 14, 15 Pages 19-24
TN #DMAS-1	6/1/16	Pages 3, 6, 7, 9, 11-14, 17 Appendix 2, page 1 Pages 3a and 7a were added. Page 8 is a runover page.
TN #100	5/1/15	Table of Contents Pages 1-27 (entire subchapter –pages 28-34 were deleted) Appendices 1 and 2 were added.
TN #99	1/1/14	Table of Contents Pages 1-34 (entire subchapter)
UP #9	4/1/13	Pages 7b and 10a
TN #97	9/1/12	Page 1
UP #7	7/1/12	Pages 1, 7, 7c, 7g
TN #96	10/1/11	Table of Contents Pages 1-7g Pages 11-13 Pages 21-24
TN #95	3/1/11	Pages 6a, 7, 21, 22
TN #94	9/1/10	Table of Contents Pages 3, 4b, 5, 6-6a, 10 Appendix 1 was removed.
UP #4	7/1/10	Page 4
TN #93	1/1/10	Pages 3, 4b, 5-6, 10, 15 Pages 21, 22
Update (UP) #2	8/24/09	Pages 1, 2, 13, 14, 17, 18
Update (UP) #1	7/01/09	Page 3

M1520.100 PARTIAL REVIEW

A. Enrollee's Responsibility

Enrollees must report changes in circumstances which may affect eligibility and/or patient pay within 10 days from the day the change is known. For enrollees participating in the Health Insurance Premium Payment (HIPP) Program, changes that may affect participation in HIPP must also be reported to the DMAS HIPP Unit within the 10-day timeframe.

B. Eligibility Worker's Responsibility

The eligibility worker has a responsibility for keeping a record of changes that may be anticipated or scheduled, and for taking appropriate action on those changes.

Appropriate agency action on a reported change must be taken within 30 days of the report. If the enrollee reports any changes requiring verifications, such as changes in income or resources, or an asset transfer for enrollees receiving long-term-care (LTC) services, *if possible, use online systems information verifications that are available to the agency. If it is necessary to obtain verifications from the enrollee*, send the enrollee a checklist requesting the necessary verifications, and allow at least 10 calendar days for the information to be returned. Document the information and evaluation in the VaCMS case record.

1. Changes That Require Partial Review of Eligibility

When changes in an enrollee's situation are reported by the enrollee or when the agency receives information indicating a change in an enrollee's circumstances (i.e. Supplemental Security Income [SSI] purge list, reported transfer of assets), the worker must take action to partially review the enrollee's continued eligibility.

A reported decrease in income or termination of employment must be verified when the change in income causes the individual to move from a limited-benefit covered group to another limited-benefit covered group, or to a full-benefit covered group. For terminated employment, verify the date of termination and the date the last paycheck was received.

A reported increase in income and/or resources can be acted on without requiring verification, unless the increase causes the individual from Medicaid to FAMIS *or the individual meets a Medically Needy covered group and is eligible to be placed on a spenddown*.

2. Changes That Do Not Require Partial Review

When changes in an enrollee's situation are reported or discovered, such as the enrollee's Social Security number (SSN) and card have been received, the worker must document the change in the case record and take action appropriate to the reported change in the appropriate computer system(s).

Example: The MA enrollee who did not have an SSN, but applied for one when he applied for MA, reports by calling the worker that he received his SSN. The worker records the telephone call and the enrollee's newly assigned SSN in the case record, verifies the SSN via SPIDeR and enters the enrollee's verified SSN in the eligibility determination/enrollment systems.

3. HIPP

The eligibility worker must provide the enrollee with a copy of the HIPP FACT Sheet when it is reported that he or a family member is employed more than 30 hours per week and is eligible for coverage under an employer's group health plan. The HIPP Fact Sheet is available *on the VDSS intranet*. The eligibility worker must report to the HIPP Unit at DMAS any changes in an enrollee's situation

4. No Fraud

The family has not been determined to be ineligible for LIFC Medicaid at any time during the last six months in which the family received LIFC Medicaid because of fraud.

C. Entitlement & Enrollment

The AC for enrollees in the family receiving the twelve-month extension is "081" for an LIFC family with one parent or caretaker-relative or "083" for a two-parent family.

Entitlement does not continue for any member of the family who moves to another state.

1. Determining Extension Period

a. *Establishing Initial Month of Eligibility*

Medicaid coverage will continue for six months beginning with the first month *following the month* in which the family is *no longer* eligible for LIFC Medicaid because of excess income due to the increased earnings of the parent or caretaker/relative.

If the new/increased earnings *are* not reported timely, *or the agency does not take action timely, the extension period still begins the same month it would have begun had the new/increased earnings been reported or acted on timely.*

Extension for an additional six-month period is possible if the reporting and financial requirements below are met.

For example, if the increased earnings were received in April, but were not reported or discovered until a review of eligibility in June, the 12-month *extension* period *still* begins with May. The screening period to determine if the family received LIFC Medicaid in at least three of the six months immediately preceding the month in which the family became ineligible for LIFC Medicaid *is* November *through* April.

b. Simultaneous Income Changes

In situations where a case has simultaneous income changes which cause LIFC Medicaid ineligibility, such as new or increased earned income plus an increase in spousal support, the eligibility worker must determine if the case would have been ineligible due to new or increased earnings. This requires that the eligibility worker recalculate the LIFC income eligibility only considering the increased earned income.

1) If the family would have been ineligible solely due to the increase in earned income, it will be considered the reason for LIFC Medicaid ineligibility and the family is eligible for the twelve-month Medicaid extension.

2) If, however, the family would have continued to be eligible for LIFC Medicaid if the only change had been increased earnings, the other changes which occurred simultaneously will be the reason for LIFC Medicaid ineligibility. The family is **not** eligible for the twelve-month Medicaid extension. If the reason for LIFC Medicaid ineligibility was due to the receipt of or increase in spousal support, evaluate the family's eligibility for the four-month extension in M1520.401.

TWELVE MONTH EXTENDED MEDICAID INCOME LIMITS 185% of FEDERAL POVERTY LIMITS EFFECTIVE *1-18-18* ALL LOCALITIES

# of Persons in Family Unit/Budget Unit	185% FPL Monthly Limit
1	*$1,872*
2	*2,538*
3	*3,204*
4	*3,870*
5	*4,536*
6	*5,202*
7	*5,868*
8	*6,534*
Each additional person add	*666*

M1550 Transmittal Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-8	4/1/18	Page 3
TN #DMAS-7	1/1/18	Page 1 Appendix 1, page 1.
TN #DMAS-4	4/1/17	Appendix 1,page 1
TN #DMAS-3	1/1/17	Pages 4-6, 8, 9
TN #100	5/1/15	Appendix 1,page 1
UP #9	4/1/13	Appendix 1, page 1
Update (UP) #7	7/1/12	Appendix 1, page 1
TN #96	10/1/11	Appendix 1, page 1
TN #93	1/1/10	Title page Table of Contents Pages 1-9 Appendix 1, page 1
TN #91	5/15/09	Appendix 1

M1550.400 CASE HANDLING PROCEDURES

A. Introduction

Effective July, 1994, the Aged, Blind or Disabled (ABD) Medicaid cases handle by local departments of social services and cases of patients in DBHDS facilitie will be transferred between the facility and the local DSS agency when the individual leaves a community to enter a DBHDS facility or leaves the DBHDS facility to live in a community. Case transfer policy in M1520.*500* is applicable

NOTE: Transfer procedures are applicable only to individuals who are eligible in an ABD covered group. The Medicaid case of a child eligible in a Families and Children (F&C) covered group who is a patient in a DBHDS facility is the responsibility of the local department of social services (LDSS) in which the child last resided. If the child is not currently a Medicaid recipient, an application for Medicaid may be made with the LDSS in the locality in which the child last resided.

Persons between the ages of 21 (or 22 if treatment began before age 21) and 65 are not eligible for Medicaid while they are patients in an institution for treatment of mental diseases (IMD) or tuberculosis.

B. Procedures

Use the policy and procedures contained in the subchapters below when an individual is:

- admitted to a DBHDS facility (M1550.401),
- discharged from a DBHDS facility to a community living arrangement (M1550.402),
- discharged from a DBHDS facility to an assisted living facility (ALF) (M1550.403), and
- discharged from a DBHDS facility to a nursing facility or Medicaid Community-based Care (CBC) waiver services (M1550.404).

M1550.401 ADMISSION TO DBHDS FACILITIES

A. Introduction

When a Medicaid recipient is admitted to a DBHDS facility from a community living arrangement, follow the procedures in this section. The procedures for an ABD recipient differ from those for an F&C recipient

B. Local Social Services

1. ABD Recipient

When an ABD recipient has been admitted to a DBHDS facility, the eligibility worker must determine if it is appropriate to transfer the case. Do not transfer the Medicaid case of an individual between the ages of 21 and 65 if the individual is admitted to an IMD since he or she cannot be Medicaid eligible while in the institution. The Medicaid case of such an individual must be closed.

M16 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-8	4/1/18	Page 7
TN #DMAS-4	4/1/17	Page 7 Pages 8-10 are runover pages.
TN #DMAS-2	10/1/16	Page 3
TN #DMAS-1	6/1/16	Page 1
TN #100	5/1/15	Page 3
Update #9	4/1/13	Page 8

The schedule letter contains information about summary due dates and other pertinent information.

If the agency representative cannot be available on the date and time selected by the Hearing Officer, he/she must notify the DMAS as soon as possible and request an alternate date and time for the hearing.

M1670.100 LOCAL AGENCY APPEAL SUMMARY

A. Agency Appeal Summary Form

Upon notification that a fair hearing has been requested, the agency must complete an "Agency Appeal Summary," form #032-03-805 available *on the VDSS intranet.*

The Agency Appeal Summary must address the issue(s) on the Notice of Action that the appellant has appealed. The Agency Appeal Summary must also include all relevant information that describes and supports the agency's action. The agency must submit all documents relevant to the agency's determination with the Agency Appeal Summary.

B. Send to Appeals Division and Appellant

The agency must send one copy of the Agency Appeal Summary form and all relevant documentation to the following parties by the due date specified by the Appeals Division at the time of the notification:

- Department of Medical Assistance Services
  Appeals Division, 6th Floor
  600 East Broad Street
  Richmond, Virginia 23219

- The appellant or his authorized representative, if the appellant has designated a representative for the appeal.

The agency must keep a copy of the Agency Appeal Summary and all relevant documentation, including applications, notices, and DMAS appeal decisions for its records.

M1680.100 THE HEARING PROCEDURE

A. Hearing Procedure

The hearing will be conducted in an informal manner. Formal rules of evidence do not apply in these proceedings. The appellant is entitled to guarantees of fair hearings established in Goldberg v. Kelly, 397 US 245 (1970). The proceedings will be governed by the following rules:

1. Record

The Hearing Officer will swear-in all hearing participants who will be presenting evidence or facts and will record the hearing proceedings.

2. Appellant

The appellant will present his own case or have it presented by an authorized representative. He will be allowed to bring witnesses, establish all pertinent facts and circumstances, advance any testimony or evidence, and question witnesses.

M21 Changes

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

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

EFFECTIVE *1/18/18*

# of Persons in FAMIS House-hold	**FAMIS 150% FPL**		**FAMIS 200% FPL**		
	Annual Limit	Monthly Limit	Annual Limit	Monthly Limit	205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)
1	*$18,210*	*$1,518*	*$24,280*	*$2,024*	*$2,075*
2	*24,690*	*2,058*	*32,920*	*2,744*	*2,813*
3	*31,170*	*2,598*	*41,560*	*3,464*	*3,551*
4	*37,650*	*3,138*	*50,200*	*4,184*	*4,289*
5	*44,130*	*3,678*	*58,840*	*4,904*	*5,027*
6	*50,610*	*4,218*	*67,480*	*5,624*	*5,765*
7	*57,090*	*4,758*	*76,120*	*6,344*	*6,503*
8	*63,570*	*5,298*	*84,760*	*7,064*	*7,241*
Each add'l, add	*6,480*	*540*	*8,640*	*720*	*738*

M22 Changes

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

FAMIS MOMS
200% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/18/18*

Household Size	200% FPL Monthly Amount	205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)
2	*$2,744*	*$2,813*
3	*3,464*	*3,551*
4	*4,184*	*4,289*
5	*4,904*	*5,027*
6	*5,624*	*5,765*
7	*6,344*	*6,503*
8	*7,064*	*7,241*
Each additional, add	*720*	*738*