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July 1, 2023

Virginia Medical Assistance Eligibility Manual
Transmittal #DMAS-28

The following acronyms are contained in this letter:

- COVID – Coronavirus Disease
- DHS – Department of Homeland Security
- DMAS – Department of Medical Assistance Services
- LDSS – Local Department of Social Services
- LIFC – Low Income Families with Children
- LTSS – Long-term Services and Supports
- MAGI – Modified Adjusted Gross Income
- PHE – Public Health Emergency
- TN – Transmittal

TN #DMAS-28 includes policy clarifications, updates and revisions. Unless otherwise noted in the Cover Letter and/or policy, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after July 1, 2023.
Note: The Public Health Emergency continued until May 11, 2023, however The Consolidated Appropriations Act of 2023 was implemented which allowed case redeterminations to begin as of April 1.

The following changes are contained in TN #DMAS-28:

Changed Pages	Changes
Subchapter M0320	Update to Medicaid Works Threshold amount
Subchapter M0450; Appendices	Update policy for pregnant woman when gap-filling methodology was used and when to review and income limits
Subchapter M0710; Appendices	Income limits update
Subchapters M0810, S0820, M0820, S0830	Updates from POMS manual (Social Security Program Operations Manual System)

Subchapters M0815 and S1130	COVID-Relief Payments are Disaster Relief
Subchapter M1440	Update of Developmental Disability Waiver Services chart in Appendix 1
Subchapter M1450	Change to penalty period if transferred during COVID-19 continuous Coverage period and update of Life Expectancy Table in Appendix 2
Subchapter M1470.410	Correct amount of Personal Maintenance Allowance from $1508 to $1509 and Appeal updates in Appendix 1
Subchapter M1480.410	Community Spouse PMA and Excess Shelter Standard update
Subchapter M1520.200	An ex parte renewal must be attempted for all MA recipients, including those who have a resource test and/or reported resources; DMAS is not cancelling cases for returned mail (cancel reason 12); If a renewal application is received in the agency, the worker can take action on it even if the scheduled renewal date is in the future; Penalty periods for asset transfers that occurred during PHE are to be imposed IN FULL going forward (other asset transfer penalty periods continue to follow existing policy in M1450); income limits update.
Chapter M16	Appeals updates
M21 Appendix 1	Income limits update
M22 Appendix 1	Income limits update
M23 Appendix 1	Income limits update

Please retain this TN letter for future reference. Should you have questions about information contained in this transmittal, please contact Yolanda Chandler, Director, DMAS Eligibility and Enrollment Services Division, at yolanda.chandler@dmas.virginia.gov or (804) 588-4879.

Sincerely,

Sarah Hatton

Sarah Hatton, M.H.S.A.
Deputy of Administration

Attachment

M0320 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-28	7/1/23	Page 26a
TN #DMAS-27	4/1/23	Pages 11, 24, 25, 27
TN #DMAS-26	1/1/23	Page 11
TN #DMAS-24	7/1/22	Pages 2, 30, 31, 33
TN #DMAS-23	4/1/22	Page 27
TN #DMAS-22	1/1/22	Pages 11, 26a, 27
TN #DMAS-20	7/1/21	Pages 24, 26-29
TN #DMAS-19	4/1/21	Pages 26a, 29
TN #DMAS-18	1/1/21	Pages 11, 22, 26, 27
TN #DMAS-17	7/1/20	Pages 24. 25. 26, 27 Page 26a was added as a runover page.
TN #DMAS-15	1/1/20	Pages 11, 26, 27, 29
TN #DMAS-14	10/1/19	Page 40
TN #DMAS-13	7/1/19	Pages 1, 24-27
TN #DMAS-11	1/1/19	Pages 2a, 11, 35, 37
TN #DMAS-10	10/1/18	Page 1 1a added as a runover page
TN #DMAS-9	7/1/18	Page 2, 17
TN #DMAS-7	1/1/18	Page 2, 3, 4, 11, 26-27.
TN #DMAS-4	4/1/17	Page 26
TN #DMAS-3	1/1/17	Pages 11, 27, 29, 40, 41, 44, 45, 52
TN #DMAS-2	10/1/16	Pages 4, 15, 16, 18, 20, 22, 30, 33, Pages 39- 41, 43-45, 48, 51, 52, 55
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 1, 11, 25-27, 46-49 Page 50 is a runover page.
TN #100	5/1/15	Pages 6, 11, 24, 25-27, 29-30
TN #99	1/1/14	Page 11
TN #98	10/1/13	Pages 1, 54, 55.
UP #9	4/1/12	Pages 11, 26, 32, 34-37, 45, 46, 55
TN #97	9/1/12	Table of Contents Pages 1-56 (all pages)
UP #6	4/1/12	Pages 11, 12, 46a
TN #96	10/1/11	Table of Contents Pages 46f-50b Page 50c deleted
TN #95	3/1/10	Pages 11, 12, 42c, 42d, 50, 53, 69 Pages 70, 71 Page 72 added.
TN #94	9/1/10	Pages 49-50b
UP #3	3/1/10	Pages 34, 35, 38, 40, 42a, Pages 42b, 42f
TN #93	1/1/10	Pages 11-12, 18, 34-35, 38 Pages 40, 42a-42d, 42f-44, 49 Pages 50c, 69-71
UP #2	8/24/09	Pages 26, 28, 32, 61, 63, 66
Update (UP) #1	7/1/09	Pages 46f-48
TN #91	5/15/09	Pages 31-34 Pages 65-68

b. Ongoing eligibility

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

1) For **earnings** accumulated **after** enrollment in MEDICAID WORKS, up to the current 1619(b) income threshold amount will be disregarded if deposited and retained in the WIN Account. The current 1619(b) threshold amount is *$48,092*.

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

Changed With	Effective Date	Pages Changed
TN #DMAS-28	7/1/23	Page 37 Appendices 1,2,3,5,6 and 7

- First, add together income already received for the year. Do not convert the income.
- Next, calculate the projected income for the remainder of the year based on the current monthly income, unless the individual's income is expected to change (e.g. current employment is terminating).
- Add income already received to projected income to obtain the **annual** projected income for the current calendar year.
- Compare the **annual** projected income to the 100% FPL **annual** income limits for the MAGI household size in M04, Appendix 1.
- If the **annual** income is less than or equal to 100% FPL, compare the **annua**l income to the **annual** income limit for the individual's covered group.
- For the individual to be eligible for Medicaid as a result of applying the gap-filling rule, the countable income must be no more than the **annual i**ncome limit for the individual's covered group. The 5% income disregard used for the Medicaid MAGI determination does not apply. See M04 Appendices 2-6 for income limits.

3. Renewals

A renewal of eligibility must be completed in January of the following year and annually thereafter. At the time of initial enrollment, change the renewal date to January of the following year. Evaluate the individual's eligibility using Medicaid/FAMIS MAGI methodology before applying gap-filling methodology. A gap-filling evaluation may not be necessary for future eligibility determinations/renewals since tax dependency status and/or income may have changed.

For a pregnant woman determined eligible based on gap-filling methodology, coverage ends the last day of the 12th month after the end of the month in which the pregnancy ends. Complete a renewal 30 days prior to the end of coverage.

4. Individual Not Eligible Using Gap-filling Methodology

If the individual's household income is determined to be over the Medicaid and FAMIS income limits after the gap-filling rule evaluation **and** he meets a MN covered group, he must be offered the opportunity to be placed on a MN spenddown. If the individual does not provide the necessary verifications for the gap-filling evaluation the application should be denied.

A. 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, which uses tax filers income methodology. The child is determined to not be eligible for the APTC because his countable income is below the lower income threshold (it is too low) for APTC eligibility.

The HIM refers the application 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.

5% FPL INCOME DISREGARD AMOUNTS
ALL LOCALITIES

EFFECTIVE *1/20/23*

Household Size	Monthly Amount
1	*$61*
2	*83*
3	*104*
4	*125*
5	*147*
6	*168*
7	*190*
8	*211*
Each additional, add	*22*

GAP-FILLING RULE EVALUATION
100% FPL
INCOME LIMITS

EFFECTIVE *1/20/23*

Household size	Annual (Use for Gap-filling Evaluation)	Monthly
1	*$14,580*	*$1215*
2	*19,720*	*1644*
3	*24,860*	*2,072*
4	*30,000*	*2,500*
5	*35,140*	*2,929*
6	*40,280*	*3,357*
7	*45,420*	*3,785*
8	*50,560*	*4,214*
Each additional	*5,140*	*429*

PREGNANT WOMEN
143% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/20/23*

Household Size	143% FPL Yearly Amount	143% FPL Monthly Amount	148% FPL (143% FPL + 5% FPL Disregard)
2*	*$28,200*	*$2,350*	*$2,433*
3	*35,550*	*2,963*	*3,067*
4	*42,900*	*3,575*	*3,700*
5	*50,251*	*4,188*	*4,335*
6	*57,601*	*4,801*	*4,969*
7	*64,951*	*5,413*	*5,603*
8	*72,301*	*6,026*	*6,237*
Each additional, add	*7,351*	*613*	*635*

*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 *1/20/23*

# of Persons in House-hold	**109% FPL (for Determining Aid Category)**	**143% FPL**		**148% FPL (143% FPL + 5% FPL Disregard)**
	Monthly Limit	*Annual Limit*	Monthly Limit	Monthly Limit
1	*$1,325*	*$20,850*	*$1,738*	*$1,799*
2	*1,792*	*28,200*	*2,350*	*2,433*
3	*2,259*	*35,550*	*2,963*	*3,067*
4	*2,725*	*42,900*	*3,575*	*3,700*
5	*3,192*	*50,251*	*4,188*	*4,335*
6	*3,659*	*57,601*	*4,801*	*4,969*
7	*4,126*	*64,951*	*5,413*	*5,603*
8	*4,593*	*72,301*	*6,026*	*6,237*
Each add'l, add	*467*	*7,351*	*613*	*635*

LIFC Income Limits

Effective *7/1/2023*

Group I

Household Size	Monthly Amount	Annual Amount
1	*$307*	*$3684*
2	*467*	*5604*
3	*592*	*7104*
4	*717*	*8604*
5	*846*	*10152*
6	*952*	*11424*
7	*1073*	*12876*
8	*1203*	*14436*
Additional	*128*	*1536*

Group II

Household Size	Monthly Amount	Annual Amount
1	*$402*	*$4824*
2	*574*	*6888*
3	*720*	*8640*
4	*860*	*10320*
5	*1011*	*12132*
6	*1140*	*13680*
7	*1277*	*15324*
8	*1413*	*16956*
Additional	*145*	*1740*

Group III

Household size	Monthly Amount	Annual Amount
1	*$603*	*$7236*
2	*805*	*9660*
3	*985*	*11820*
4	*1156*	*13872*
5	*1366*	*16392*
6	*1518*	*18216*
7	*1690*	*20280*
8	*1868*	*22416*
Additional	*174*	*2088*

INDIVIDUALS UNDER AGE 21 INCOME LIMITS

EFFECTIVE *7/1/23*

Group I

Household Size	Monthly Income Limit	Annual Income Limit
1	*$273*	*$3,276*
2	*456*	*5,472*
3	*581*	*6,972*
4	*705*	*8,460*
5	*829*	*9,948*
6	*929*	*11,148*
7	*1,040*	*12,480*
8	*1,179*	*14,148*
Each additional person add	*123*	*1,476*

Group II

Household Size	Monthly Income Limit	Annual Income Limit
1	*$398*	*$4,776*
2	*576*	*6,912*
3	*718*	*8,616*
4	*861*	*10,332*
5	*1,017*	*12,204*
6	*1,252*	*15,024*
7	*1,277*	*15,324*
8	*1,421*	*17,052*
Each additional person add	*143*	*1,716*

Group III

Household Size	Monthly Income Limit	Annual Income Limit
1	*$529*	*$6,348*
2	*707*	*8,484*
3	*855*	*10,260*
4	*1,001*	*12,012*
5	*1,182*	*14,184*
6	*1,303*	*2,606*
7	*1,446*	*17,352*
8	*1,590*	*19,080*
Each additional person add	*144*	*1,728*

PLAN FIRST
200% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/20/2023*

Household Size	200% FPL Yearly Amount	200% FPL Monthly Amount	205% FPL (200% FPL + 5% FPL Disregard)
1	*$29,160*	*$2,430*	*$29,160*
2	*39,440*	*3,287*	*39,440*
3	*49,720*	*4,144*	*49,720*
4	*60,000*	*5,000*	*60,000*
5	*70,280*	*5,857*	*70,280*
6	*80,560*	*6,714*	*80,560*
7	*90,840*	*7,570*	*90,840*
8	*101,120*	*8,427*	*101,120*
Each additional, add	*10,280*	*857*	*10,280*

MAGI ADULTS
133% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/20/2023*

Household Size	***133% FPL Yearly Amount***	**133% FPL Monthly Amount**	**138% FPL (133% FPL + 5% FPL Disregard)**
1	*$19,392*	*$1,616*	*$1,677*
2	*26,228*	*2,186*	*2,269*
3	*33,064*	*2,756*	*2,860*
4	*39,900*	*3,325*	*3,450*
5	*46,737*	*3,895*	*4,042*
6	*53,573*	*4,465*	*4,633*
7	*60,409*	*5,035*	*5,225*
8	*67,245*	*5,604*	*5,815*
Each additional, add	*6,837*	*570*	*592*

M0710 Changes (page 1 of 2)

Changed With	Effective Date	Pages Changed
TN #DMAS-28	7/1/23	Appendix 2 Appendix 3

F&C MEDICALLY NEEDY INCOME LIMITS

EFFECTIVE 7/1/23

GROUP 1			GROUP II		GROUP III	
# of Persons in Family/Budget Unit	**Semi-Annual Income**	**Monthly Income**	**Semi-Annual Income**	**Monthly Income**	**Semi-Annual Income**	**Monthly Income**
1	*$2324.16*	*$387.36*	*$2681.73*	*$446.95*	*$3486.27*	*$581.04*
2	*2958.70*	*493.11*	*3302.13*	*550.35*	*4202.86*	*700.47*
3	*3486.27*	*581.04*	*3843.82*	*640.63*	*4737.77*	*789.62*
4	*3933.24*	*655.54*	*4296.56*	*716.09*	*5184.78*	*864.13*
5	*4380.21*	*730.03*	*4737.58*	*789.59*	*5607.96*	*934.66*
6	*4827.17*	*804.52*	*5184.74*	*864.12*	*6078.68*	*1013.11*
7	*5274.12*	*879.02*	*5,607.96*	*934.66*	*6525.63*	*1087.60*
8	*5810.48*	*968.41*	*6168.06*	*1028.01*	*6972.61*	*1162.10*
9	*6346.42*	*1057.73*	*6768.84*	*1128.14*	*7620.25*	*1270.04*
10	*6972.61*	*1162.10*	*7330.18*	*1221.69*	*8134.73*	*1355.78*
Each add'l person	*600.66*	*100.11*	*600.66*	*100.11*	*600.66*	*100.11*

F&C 100% STANDARD OF ASSISTANCE

EFFECTIVE 7/1/23

(Used as the F&C Deeming Standard)

Group I

Household Size	Income Limit
1	*$302*
2	*459*
3	*582*
4	*706*
5	*831*
6	*936*
7	*1,056*
8	*1,181*
Each additional person add	*126*

Group II

Household Size	Income Limit
1	*$394*
2	*564*
3	*708*
4	*846*
5	*993*
6	*1,119*
7	*1,253*
8	*1,398*
Each additional person add	*143*

Group III

Household Size	Income Limit
1	*$592*
2	*836*
3	*969*
4	*1,138*
5	*1,342*
6	*1,493*
7	*1,661*
8	*1,838*
Each additional person add	*171*

M0810 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-28	7/1/23	Pages 2, 6
TN #DMAS-25	1/1/23	Pages 1, 2
TN #DMAS-24	7/1/22	Page 2
TN #DMAS-23	4/1/22	Page 2
TN #DMAS-22	1/1/22	Pages 1, 2, 3
TN #DMAS-20	7/1/21	Page 2
TN #DMAS-19	4/1/21	Page 2
TN #DMAS-18	1/1/21	Pages 1, 2
TN #DMAS-17	7/1/20	Page 2
TN #DMAS-16	4/1/20	Page 2
TN #DMAS-15	1/1/20	Pages 1, 2
TN #DMAS-14	10/1/19	Pages 20, 25, 27 Page 28 is a runover page.
TN #DMAS-12	4/1/19	Page 2
TN #DMAS-11	1/1/19	Pages 1, 2
TN #DMAS-10	10/1/18	Page 2
TN #DMAS-9	7/1/18	Page 2
TN #DMAS-8	4/1/18	Page 2
TN #DMAS-7	1/1/18	Pages 1, 2
TN #DMAS-5	7/1/17	Page 2
TN #DMAS-4	4/1/17	Page 2
TN #DMAS-3	1/1/17	Pages 1, 2
TN #DMAS-2	10/1/16	Page 2
TN #DMAS-1	6/1/16	Pages 1, 2
UP #11	7/1/15	Page 2
TN #100	5/1/15	Pages 1, 2
UP #10	5/1/14	Page 2
TN #99	1/1/14	Pages 1, 2
TN #98	10/1/13	Page 2
UP #9	4/1/13	Pages 1, 2
UP #7	7/1/12	Page 2
UP #6	4/1/12	Pages 1, 2
TN #95	3/1/11	Pages 1, 2
TN #93	1/1/10	Pages 1, 2
Update (UP) #1	7/1/09	Page 2

3. Categorically Needy 300% of SSI

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

Family Size Unit	2022 Monthly Amount	2023 Monthly Amount
1	$2,523	$2,742

4. ABD Medically Needy

a. Group I	7/1/*22* – 6/30/*23*		7/1/*23*	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	*$2,138.14*	*$356.35*	*$2324.16*	*$387.36*
2	*2,721.95*	*453.65*	*2958.70*	*493.11*

b. Group II	7/1/*22* – 6/30/*23*		7/1/*23*	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	*$2,467.09*	*$411.18*	*$2681.73*	*$446.95*
2	*3,037.88*	*506.31*	*3302.13*	*550.35*

c. Group III	7/1/*22* – 6/30/*23*		7/1/*23*	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	*$3,207.24*	*$534.54*	*$3486.27*	*$581.04*
2	*3,866.55*	*644.42*	*4202.86*	*700.47*

5. ABD Categorically Needy

For:

ABD 80% FPL, QMB, SLMB, & QI <u>without</u> Social Security income; all QDWI; effective 1/20/23

ABD 80% FPL, QMB, SLMB, & QI <u>with</u> Social Security income; effective 3/1/23

All Localities	2022		2023	
ABD 80% FPL	Annual	Annual	Annual	Monthly
1	$10,872	$10,872	$11,664	$972
2	14,648	14,648	15,776	1,315
QMB 100% FPL	Annual	Annual	Annual	Monthly
1	$13,590	$13,590	$14,580	$1,215
2	18,310	18,310	19,720	1,644
SLMB 120% of FPL	Annual	Annual	Annual	Monthly
1	$16,308	$16,308	$17,496	$1,458
2	21,972	21,972	23,664	1,972
QI 135% FPL	Annual	Annual	Annual	Monthly
1	$18,347	$18,347	$19,683	$1,641
2	24,719	24,719	26,622	2,219
QDWI 200% of FPL	Annual	Annual	Annual	Monthly
1	$27,180	$27,180	$29,160	$2,430
2	36,620	36,620	39,440	3,287

M0810.020 FORMS AND AMOUNTS OF INCOME

A. Operating Policies

1. Forms of Income

Income, whether earned or unearned, may be received in the form of cash--currency, checks, money orders, or electronic funds transfers (EFT), such as:

- Social Security checks
- unemployment compensation checks
- payroll checks or currency.

2. Amounts of Income

The value of cash income is generally the amount of the currency or the face value of checks, money orders or EFT's the individual receives. There are some exceptions listed in B. below.

B. References

- Expenses of obtaining income, S0830.100.
- Determining amount of wages, S0820.100.
- Amounts withheld to recover an overpayment, S0830.110.
- Garnishment or seizure, S0810.025.
- Income exclusions, S0810.400.

S0810.025 EFFECT OF GARNISHMENT OR SEIZURE

A. Definition

A **garnishment** or **seizure** is a withholding of an amount from earned or unearned income in order to satisfy a debt or legal obligation.

B. Policy Principles

Amounts withheld from earned or unearned income to satisfy a debt or legal obligation are income for Medicaid purposes.

C. Related Policy

1. Earned Income

Wages are what an individual receives (before any deductions) for working as someone else's employee. See S0820.100.

2. Unearned Income

See S0830.115 for instructions on determining the amount of unearned income if garnishment or other withholding is involved.

3. Deeming or Court Ordered Payments

When the court orders garnishment of income of an ineligible spouse, parent, ineligible child, or eligible alien (sponsored by an ineligible spouse or parent) to pay court-ordered or title IV-D enforced support payments. Ref SI 01320.145.

D. Development and Documentation

Determine the type of garnished or seized income and document the gross amount of the income

M0815 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-28	7/1/23	Page 12
TN #DMAS-20	7/1/21	Pages 11, 12
TN #DMAS-17	7/1/20	Table of Contents Pages 11, 12
Transmittal (TN) #DMAS-7	1/1/18	Page 1

S0815.270 INCOME TAX REFUNDS AND CREDITS

A. Policy

1. General — Any amount refunded on income taxes already paid is **not income**.

2. Tax Withheld Prior to Application Date — Income tax refunds are not income even if the income from which the tax was withheld or paid was received in a period prior to application for Medicaid.

3. Tax Refunds and Blind Work Expenses — Income tax refunds are **not income** even if the income taxes were included as work expenses of the blind. (See S0820.535 B.3.)

4. COVID-19 Relief Payments — COVID-19 relief payments provided under federal law are considered *disaster assistance* tax credits and are not countable as income *or* resources. See M1130.675.

S0815.300 CREDIT LIFE OR CREDIT DISABILITY INSURANCE PAYMENTS

A. Definition of Credit Life/Disability Insurance — Credit life and credit disability insurance policies are issued to or on behalf of borrowers, to cover payments on loans, mortgages, etc. in the event of death or disability. These insurance payments are made directly to loan or mortgage companies, etc. and are not available to the individual.

B. Policy

- Payments made under a credit life or credit disability insurance policy on behalf of an individual are **not income.**
- Food, clothing, or shelter received as the result of a credit life or credit disability payment is **not income.**

C. Example — Frank Fritz, a Medicaid recipient, purchased credit disability insurance when he bought his home. Subsequently Mr. Fritz was in a car accident and became totally disabled. Because of his disability, the insurance company pays off the home mortgage. Neither the payment nor the increased equity in the home is income to Mr. Fritz.

M0820 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-28	7/1/23	Pages 4, 11, 17, 29. Page 12 is a runover page.
TN #DMAS-23	1/1/23	Pages 30, 31
TN #DMAS-22	1/1/22	Pages 30, 31
TN #DMAS-18	1/1/21	Pages 30, 31
TN #DMAS-12	4/1/20	Page 29
TN #DMAS-15	1/1/20	Pages 30, 31
TN #DMAS-14	10/1/19	Pages 10, 11, 13, 22, 24
TN #DMAS-12	4/1/19	Page 21
TN #DMAS-11	1/1/19	Pages 30, 31
TN #DMAS-7	1/1/18	Page 11, 30-32
TN #DMAS-5	7/1/17	Pages 11, 13, 29, 30 Page 12 is a runover page.
TN #DMAS-3	1/1/17	Pages 30, 31
TN #DMAS-1	6/1/16	Pages 30, 31, 47
TN #100	5/1/15	Pages 30, 31, 47 Page 48 is a runover page.
TN #99	1/1/14	Pages 30, 31
UP #9	4/1/13	Pages 30, 31
Update (UP) #6	4/1/12	Pages 30, 31
TN #95	3/1/11	Pages 3, 30, 31
TN #93	1/1/10	Pages 30, 31
TN #91	5/15/09	Table of Contents Pages 29, 30

S0820.102 CAFETERIA PLANS

A. Definitions

A cafeteria plan is a written benefit plan offered by an employer in which:

1. Cafeteria Plans

- all participants are employees; and
- participants can choose, cafeteria-style, from a menu of two or more cash or qualified benefits.

2. Qualified Benefits

A qualified benefit is a benefit that the Internal Revenue Service (IRS), by express provision of Section 125 of Chapter 1 of the Internal Revenue Code (IRC) or IRS regulations, does not consider part of an employee's gross income. Qualified benefits include, but are not limited to:

- accident and health plans (including medical plans, vision plans, dental plans, accident and disability insurance);
- group term life insurance plans (up to $50,000);
- dependent care assistance plans; and
- certain stock bonus plans under section 401(k)(2) of the IRC (but not 401(k)(1) plans).

Cash is **not** a qualified benefit.

3. Salary Reduction

A salary reduction agreement is an agreement between employer and employee whereby the employee, in exchange for the right to participate in a cafeteria plan, accepts a lower salary or forgoes a salary increase.

B. Background

1. IRS Authority

Section 125 of the IRC permits cafeteria plans.

2. Monitoring

IRS relies on employers to ensure that IRS-approved plans continue to meet the requirements of Section 125 of the IRC.

3. Funding

Most cafeteria plans are funded by salary-reduction agreements *however an employer may contribute to fund basic benefit levels under a cafeteria plan without a salary-reduction agreement.*

4. Significance for Tax Purposes

Because Section 125 of the IRC provides that qualified benefits and the amount of a salary-reduction agreement are not part of gross income, they are not subject to Social Security/Medicare and income taxes.

5. Cafeteria Plan Indicators

It can be difficult to tell whether pay*stub* entries represent payroll deductions, which are part of gross wages, or cafeteria-plan itemizations, which are not. The following indicators suggest a cafeteria plan.

a. A payslip / *paystub may* use terms such as:
   - FLEX
   - CHOICES
   - Sec. 125
   - Cafe Plan

M0820.130 EVIDENCE OF WAGES OR TERMINATION OF WAGES

A. Policy

1. Primary Evidence of Wages

The following proofs, in order of priority, are acceptable evidence of wages:

a. Verifications of income *received from or* reasonable compatibility with electronic data sources, including the Virginia Employment Commission (VEC), Federal Data HUB or The Work Number. *A discrepancy in the wage data may be resolved by obtaining other primary or secondary data.*

b. Pay slips--Must contain the individual's name or Social Security number, gross wages, and period of time covered by the earnings.

c. Oral statement from employer, recorded in case record.

d. Written statement from employer.

2. Secondary Evidence of Wages

If primary evidence is not available, the following proofs, in order of priority, are acceptable evidence of wages:

a. W-2 forms, Federal or State income tax forms showing annual wage amounts.

b. Individual's signed allegation of amount and frequency of wages.

3. Acceptable Evidence of Termination of Wages

The following proofs, in order of priority, are acceptable evidence of termination of wages:

a. Verifications from electronic data sources, including the Virginia Employment Commission (VEC).

b. Oral statement from employer, recorded in case record.

c. Written statement from employer.

d. Individual's signed allegation of termination of wages (including termination date and date last paid).

B. Procedure

1. Order of Priority

Seek type "a" evidence before type "b," etc.

2. Pay Slips / *Pay stubs*

a. Stress to the individual that he/she is responsible for providing proof of wages if not available from an electronic source and is expected to retain all pay stubs and provide them as requested.

b. Accept the individual's signed allegation of when earnings were received if it is not shown on the payslip *or pay stub.*

NOTE: Pay slips which do not contain all the required information may be used in conjunction with other evidence; however, any discrepancies must be resolved.

If not all pay slips are available, but the wages attributable to the missing pay slip(s) can be determined by other evidence (e.g., year-to-date totals), it is not necessary to obtain the missing pay slip.

3. Employer Reports

If an employer returns a statement to the EW unsigned, do not recontact the employer for a signature unless the EW questions the statement's validity (e.g., the income verification form was hand-carried to the LDSS by the applicant rather than mailed directly to the LDSS).

4. Evidence Reflects Only an Annual Wage Amount

If the evidence that can be obtained reflects only an **annual** wage amount, divide the annual amount by 12 to get monthly wage amounts.

C. References

- Military pay and allowances, S0830.540.

M0820.155 HOW TO ARRIVE AT AN ESTIMATE

A. Procedure-- General

1. Consider Known Facts

a. Consider any **recent work history,** unless inappropriate to the current situation (e.g., work stopped due to retirement or disability).

b. Try to establish a **logical wage pattern** by reviewing with the recipient, representative, or worker the

- rate of pay,
- hours worked per week *or per time period*, and
- number of pay periods in each month, *or*
- *the scheduled receipt dates (weekly, biweekly, bimonthly).*

c. Be alert to individuals who perform **seasonal work** (e.g., school bus drivers).

d. Take into account any Blind Work Expenses/Impairment Related Work Expenses (**BWE/IRWE)** the individual anticipates he/she will incur.

2. Obtain More Information

Contact the employer by telephone, or by mail **only if you cannot establish an estimate using 1. above.**

3. Determine Estimate

Use the information obtained above and your own judgement to determine an estimate.

To convert to monthly income:

- multiply weekly wage by 4.3; or
- multiply biweekly wage by 2.15, or
- divide biweekly wage by 2 and multiply result by 4.3; or
- multiply semi-monthly wage by 2.

B. Procedure-- Anticipated Decrease in Wages

If a worker anticipates a decrease in wages which is not supported by evidence in the file, tell the individual to inform us as soon as the decrease can be verified. We will make any adjustments at that time. An example of this situation would be a wage cutback which is still being negotiated.

Meanwhile, use your judgement in selecting the verified period on which to base the estimate. For example, it could be the total period just redetermined, or a shorter period if there has been a pertinent change in circumstances such as a transfer.

C. Procedure

1. Verification

a. Verify these payments by examining documents in the individual's possession which reflect:

- *the reason for the payment;*
- the amount of the payment;
- the date(s) received, and
- the frequency of payment, if appropriate.

b. If the individual has no such evidence in his possession, contact the source of the payment.

c. If verification cannot be obtained by the above means, accept any evidence permitted by either S0820.130 A. or S0820.220.

2. Assumption

Assume that any honorarium received is in consideration of services rendered, absent evidence to the contrary. Evidence to the contrary would include a statement or document indicating that part or all of the honorarium is for something other than services rendered (e.g., travel expenses or lodging).

3. Expenses of Obtaining Income

DO NOT DEDUCT any expenses of obtaining income from royalties or honoraria that are earned income. (Such expenses are deductible from royalties/honoraria that are unearned income.)

4. Documentation

Document the file by including copies of documents or indicating in the file information provided by the payment source concerning the amount and, if appropriate, frequency of payment.

D. References

- Royalties as unearned income, S0830.510.
- To determine deductible IRWE/BWE, see S0820.535 - .565.

EARNED INCOME EXCLUSIONS

M0820.500 GENERAL

A. Policy

1. General

The source and amount of all earned income must be determined, but not all earned income counts when determining Medicaid eligibility.

2. Other Federal Laws

First, income is excluded as authorized by other Federal laws.

3. *2020* Census Income

Income paid by the U.S. Census Bureau to temporary employees specifically hired for the *2020* census is NOT counted when determining eligibility for medical assistance.

S0830 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-28	7/1/23	Table of Contents, pages i,iv. Pages 8, 9, 23, 83, 84, 86. 87, 124, 124a, 125. Add Pages 32a, 124d, 139-140.
TN #DMAS-25	1/1/23	Pages 24, 24a, 50
TN #DMAS-24	7/1/22	Page 114
TN #DMAS-23	4/1/22	Page 78
TN #DMAS-17	7/1/20	Page 29
TN #DMAS-12	4/1/19	Page 113
TN #DMAS-7	1/1/18	Table of Contents, page iii, iv. Pages 7-8, 17-18, 20, 29, 48, 79a, 82, 124a-124b, 125.
TN #DMAS-4	4/1/17	Table of Contents, page i Pages 24, 24c
TN #DMAS-2	10/1/16	On page 109, updated the format of the header. Neither the date nor the policy was changed.
TN #DMAS-1	3/23/16	Table of Contents, page iii Pages 18, 82
Update #7	7/1/12	Page 24
TN #94	9/1/10	Page 29
TN #93	1/1/10	Table of Contents, page iv Pages 28, 67, 119-120 Pages 122-125
TN #91	5/15/09	Table of Contents, page i Page 29

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M0830 UNEARNED INCOME

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OTHER UNEARNED INCOME EXCLUSIONS

SPECIAL CONSIDERATIONS FOR NATIVE AMERICANS

AMOUNT OF UNEARNED INCOME

S0830.100 EXPENSES OF OBTAINING INCOME

A. Definition

An **expense** as used in this section is one that is an essential factor in obtaining a particular payment(s).

B. Policy

Unearned income does not include that part of a payment which is for an essential expense incurred in getting the payment.

1. Treatment of Expenses

- From a payment received for damages in connection with an accident, we subtract **legal, medical, and other expenses** connected with the accident.

- From a retroactive check from a benefit program other than SSI, we subtract **legal fees** connected with that claim, *which may also include out-of-pocket expenses that are not part of the fee, but are paid by, or billed to, the member.*

2. How to Deduct Expenses-- General

Except as noted in 3. below, expenses are deducted from the first and any subsequent amounts of related income until you have completely eliminated all expenses.

3. Expense Money -- Assumption

You may assume that the following payments for expenses do not exceed the expenses and thus do not result in income:

- payments by a government agency for expenses related to obtaining a service or participating in a program (e.g., $10 expense money provided to jurors); and

- lump sum advances or reimbursements by employers to cover expenses of employment paid by the employee (e.g., employee receives a per diem allowance, school bus driver is paid $100 per month allowance to pay for gas and maintenance).

NOTE: See C.2. below for verification requirements when this assumption is applied.

4. Repayment of Legal Fees When Equal Access to Justice Act Payments are Involved

An attorney who receives duplicate fees under the Equal Access to Justice Act (EAJA) and section 206(b) of the Social Security Act is obligated to return the smaller fee to the recipient. Any such payment to the recipient is income, provided that the amount of the fee previously had been deducted from income.

S0830.210 BENEFITS PAID UNDER TITLE II OF THE SOCIAL SECURITY ACT

A. Policy Principles

1. Retirement, survivors, and disability insurance (RSDI) monthly benefits are unearned income. (See S0830.545 for treatment of lump-sum death payments.)

2. The amount of premiums deducted for Supplementary Medical Insurance (SMI) under Medicare from RSDI benefits is included in unearned income.

3. Unearned income includes the amount withheld to recover an overpayment (unless the exception in S0830.110 applies).

B. Operating Policies

1. Reductions, Deductions, and Rounding

The amount of Title II after reductions, certain deductions, and dollar rounding, but before the collection of any obligations of the beneficiary (e.g., supplementary medical insurance (SMI) premium, Medicare Part D premium or prior overpayment) is unearned income.

2. Worker's Compensation Offset

If a monthly benefit payment has been reduced because of a workers compensation offset, the net amount of the benefit received (plus any SMI/Medicare Part D premium withheld) is unearned income.

3. Prior Overpayment

If all or part of a Title II benefit is being withheld to recover an overpayment, count as income the amount of Title II before deduction for the overpayment unless the exception in S0830.110 applies.

If the exception applies (i.e., the overpayment occurred when the individual was receiving Medicaid and the overpaid amount was included in unearned income at that time), do not include the amount deducted for an overpayment in calculating countable Title II income.

Also do not count as income monies received as a result of a waiver approval when the money was previously withheld to recover a title II overpayment and was counted as income for Medicaid when originally withheld.

4. SMI Premiums

Do not count refunded SMI premiums as unearned income.

The amount of premiums deducted from RDSI benefits for SMI under Medicare or Medicare Part B is unearned income.

Example: An individual's Title II benefits for January 1987 through May 1987 are withheld because of expected work and earnings. He reports In June 1987 that he quit working in February 1987. He paid

S0830.260 STATE ANNUITIES FOR CERTAIN VETERANS

A. Introduction

On June 17, 2008, President Bush signed into law H.R. 6081, the Heroes Earnings Assistance and Relief Tax Act of 2008 (the HEART Act,) which excludes State annuities for certain veterans from income.

B. Definition of a Veteran

The term "veteran" means a person who served in the active military, naval, or air service, and who was discharged or released under conditions other than dishonorable.

C. Exclusion

Effective benefits payable on or after September 1, 2008, a State annuity paid by a State, to a person, and/or a person's spouse, on the basis of the State's determination that the person is a veteran and is blind, disabled, or aged, is excluded from income in the month of receipt.

NOTE: A State annuity payment is not a benefit issued by the Department of Veterans Affairs, such as VA compensation or VA pension.

D. Procedure – Initial and Post Eligibility

If a veteran or a veteran's spouse, alleges the receipt of a State veteran's annuity as outlined in SI 00830.260C, ask the individual to submit evidence that verifies the source of the State annuity.

Acceptable evidence documents in the individual's possession (i.e. award letter from the State), office precedent, or direct contact with the State.

If evidence verifies that the annuity is paid by the State to a veteran or a veteran's spouse under this provision, but not the amount or date(s) of payment, accept the individual's allegation of amount(s) and date(s) of receipt. Exclude the State veteran's annuity payment from income for the month of receipt and without further development.

NOTE: Interest earned on retained payments is not excluded from income, see Dividends and Interest SI 00830.500.

M0830.540 UNIFORMED SERVICES -- PAY AND ALLOWANCES

A. Introduction

Compensation to most members of the Uniformed Services takes the form of earned and unearned income, and often of both cash and in-kind income.

All branches of the Uniformed Services adhere to a single pay system, but that system is complex and varies significantly from branch to branch. Proper and efficient handling of cases require an understanding of:

- how the pay system works;
- what the key terms mean; and
- how Medicaid policies and procedures apply to different forms of compensation.

The policy and procedures in this section are effective September 1, 2008 and are based on the Heroes Earnings Assistance and Relief Tax Act of 2008 (the Heart Act) that changed how we treat certain cash payments to members of the Uniformed Services. Such cash payments are considered earned income .

B. Definitions

1. Uniformed Services

The Uniformed Services are defined by law and include the:

- Army;
- Navy;
- Air Force;
- Marine Corps;
- Coast Guard;
- Reserve and National Guard components of the above;
- Public Health Service commissioned officer corps; and
- National Oceanic and Atmospheric Administration commissioned officer corps.

2. Entitlements

Entitlements are pay, allowances, and other **cash** benefits due a service member. Entitlements can include basic pay, special and incentive pay, allowances, advance pay, and reimbursements for certain work-related expenses.

3. Basic Pay

Basic (or base) pay is the service member's wage. It is based solely on the member's pay grade and length of service.

Basic pay is subject to FICA taxes as well as income tax.

4. Allowances

Allowances are **cash** benefits that compensate the service member, at least in part, for the expenses of housing, food, clothing, and special situations during periods of active duty service. Allowances are not paid for weekend drills of Reserve and National Guard components.

Allowances are not subject to FICA tax and usually are not subject to income taxes.

Often, for accounting purposes, a service branch changes a subcategory of allowance retroactively (e.g., from one type of subsistence allowance to another). The change is explained on the pay slip by showing, as an **entitlement**, the full amount due for the earlier month under the correct subcategory (e.g., leave rations). The full amount previously paid as the entitlement for the earlier month under the incorrect subcategory is shown as a **deduction** (e.g., separate rations). The amounts may be identical or different. (See D.7. for the policy governing these retroactive adjustments.)

5. Subsistence

Subsistence means food and is also referred to as rations. Service members usually receive either free rations from a service facility or an allowance for rations. (The value of free rations does not appear on pay records.)

Effective in 2002, subsistence is paid at a fixed monthly rate for both officers and enlisted persons which applies to all branches of military service.

6. Basic Allowance for Housing (BAH)

The basic allowance for housing (BAH) is an amount of money that a service member receives to pay for housing not provided by the Government. It is a combination of the old basic allowance for quarters (BAQ) and the variable housing allowance (VHA). The BAH was designed to make housing allowances more equitable throughout the services and the ranks, and more in line with civilian cost of living in the areas surrounding military installations.

In some cases, the service branch may pay a BAH to a service member living in free on-base housing, but then deduct the allowance (rather than rent) in the same month. This transaction is merely for accounting purposes and results in a zero-payment transaction. What is actually received is rent-free shelter. The BAH is based on the service person's rank, and has nothing to do with the current market value (CMRV) of the shelter. The CMRV of the shelter must be obtained, for presumed maximum value rebuttal purposes, by determining what the shelter would rent for in the community (i.e., off the military installation).

7. Basic Discount Meal Rate

The Basic Discount Meal Rate (BAS DISC MEAL RATE) is the amount deducted from the service member's pay for subsistence (rations) when a meal card is issued for purchasing food at an on-base dining hall. The meal card is based on a standard daily rate.

8. Continental United States Cost of Living Allowance (CONUS COLA)

The CONUS COLA is paid to members of the Uniformed Services as compensation for a portion of excess costs for non-housing expenses incurred based on the geographical duty location. CONUS COLA is a monthly entitlement based on a 30-day month, the same as BAH. Private sector pay scales tend to reflect local living costs in United States locations, but military pay tables do not. The purpose of the CONUS COLA is to provide compensation for variations in non-housing costs in the continental United States. The CONUS COLA is considered a COLA (wages). It is not considered a special pay, additional pay, or an incremental increase.

11. Allotments

Allotments are deductions, usually voluntary, from a service member's paycheck for special purposes. Allotments are often requested for purposes such as:

- payments to dependents;
- deposits to a savings account;
- charitable contributions; and
- purchasing savings bonds.

12. Pay Grade

The pay grade is an alphanumeric code designating the rank of a service member. Within a pay grade, pay levels vary according to the number of years of service. It also indicates whether that service member is:

- an enlisted member (pay grades E-1 through E-9);
- a warrant officer (W-1 through W-4); or
- a commissioned officer (0-1 through 0-10).

13. Leave and Earnings Statement (LES)

The LES is the monthly pay slip issued to service member. Each service branch has it own version. Item G. below lists common LES abbreviations.

14. *Additional Pay*

Additional pay in any extra increment in pay, other than an increase in basic pay (e.g. COLAs, promotions). Increase in basic pay includes items such as cost-of living adjustment (COLA) and promotions.

C. Process--How the Pay System Works

1. Forms of Compensation

Compensation to members of the Uniformed Services take several forms, chiefly:

- basic (or base) pay;
- special and incentive pay; and
- cash allowances for, and in-kind provision of, subsistence (rations), clothing, and quarters.

2. Amount of Compensation

The amount of compensation, depending on the form it takes, can vary with rank, length of service, location of duty station, family size, and other factors.

3. Paydays

a. First-of-Month Payday

All branches of the Uniformed Services pay full-time service members on the first day of the month for work performed in the previous calendar month.

b. **Mid-Month Payday**

All service branches (other than the Public Health Service) offer full-time members a mid-month payment as partial payment of the net amount due for the full calendar month. The mid-month payment is optional or standard, depending on the service branch:

- Army and Air Force -- Optional
  Navy, Marine Corps, Coast Guard, and National Oceanic and Atmospheric Administration (NOAA) – Standard

c. **Casual Pay**
While away from base, a service member can receive payment of pay and allowances due for the current month. This casual pay is issued at odd times of the month. Casual pay is not an entitlement. It is a manner of paying compensation that is already due.

d. **Reserve and National Guard Paydays**
Part-time service members are paid at different times depending on their periods of service.

4. Apportionment Between Paydays

a. **First-of-Month Payday**

The first-of-month payment represents all net compensation due for the work month less the amount paid earlier in the pay period.

b. **Mid-Month Payday**
The amount paid mid-month (if any) varies according to the rules of the service branch and rank of the service member, as illustrated in the following chart:

SERVICE BRANCH	**AMOUNT PAID MID-MONTH**	
	BASIC PAY, SPECIAL PAY AND ALLOWANCES (EXCEPT SUBSISTENCE)	**SUBSISTENCE ALLOWANCE**
Air Force Navy Marine Corps Coast Guard NOAA	One-half of net amount due for work month.	*Effective 2002, subsistence is paid at a fixed monthly rate for both officers and enlisted persons which applies to all branches of military service.*
Army	Optional percentage (up to 50%) of net amount paid for the month **before** the work month	

5. Pay Slips

The service branches issue a **single** pay slip each month on or after the first-of-month payday. That pay slip shows the gross amount due for the full calendar month and the net amount issued on each payday of the month.

S0830.735 PAYMENT FOR CLINICAL TRIAL PARTICIPANTS

A. Background

On October 5, 2010, the President signed into law the "Improving Access to Clinical Trials Act." This Act provides for the income and resource exclusion of compensation received for participating in clinical trials researching and testing treatment of rare diseases or conditions as defined in Section 5(b)(2) of the "Orphan Drug Act". The income exclusion applies to the first $2,000 per calendar year received by an SSI beneficiary, spouse, or deemor as compensation for participation in clinical trials that meet the criteria detailed in this section. The following provides an understanding of terms used:

B. Glossary of Terms

a. Clinical Trial – A research study designed to answer specific questions about vaccines or new therapies or new ways of using known treatments. Clinical trials (also called medical research or research studies) serve to determine whether new drugs or treatments are both safe and effective.

b. Informed consent form - The document that describes the rights of the clinical trial participants and includes key information about the study, including but not limited to: purpose, duration, required procedures, reasonably foreseeable risks, reasonably expected benefits, contacts, and any compensation or reimbursement information. Department of Health and Human Services (HHS) regulations at 45 C.F.R. 46.116 generally requires the administrators of clinical trials involving human subjects to obtain the participants' signed informed consent.

c. Institutional review board (IRB) is a a committee of physicians, statisticians, researchers, community advocates, and others responsible for ensuring that a clinical trial is ethical and protects the participants. In the United States, an IRB must approve the clinical trial before the trial begins.

d. The "Orphan Drug Act", Public Law 97-414, promotes the development of drugs for rare diseases and conditions.

e. Rare disease or condition, also known as an "orphan" disease, is generally any disease or condition that affects less than 200,000 people in the United States. Certain conditions that affect more than 200,000 people may be considered orphan diseases if they meet other criteria in the "Orphan Drug Act".

f. Types of Clinical Trials – There are five types of trials.

- *Diagnostic trials look for better tests or procedures for diagnosing a particular disease or condition;*
- *Quality of Life trials (or Supportive Care trials) explore ways to improve comfort and the quality of life for individuals with a chronic illness;*
- *Prevention trials look for better ways to prevent disease in people who have never had the disease or to prevent a disease from returning. These approaches may include medicines, vaccines, vitamins, minerals, or lifestyle changes;*
- *Screening trials test the best way to detect certain diseases or health conditions; and*
- *Treatment trials test experimental treatments, new combinations of drugs, or new approaches to surgery or radiation therapy.*

C. Income Exclusion Policy

Effective April 3, 2011, exclude from income the first $2,000 paid during a calendar year to a member, spouse, or deemor as compensation for participation in a clinical trial. but only if the clinical trial meets the following requirements:

- *must be reviewed and approved by an IRB;*
- *must involve research and testing of medical treatments; and*
- *must target a rare disease or condition.*

a. *Do not exclude from income any compensation received prior to April 3, 2011, for participation in clinical trials that meet the criteria in SI 00830.735C.1. Apply regular income counting rules to those payments.*

b. *Payments as reimbursement for expenses incurred while participating in a clinical trial: The income exclusion for clinical trial compensation does not apply to payments received as reimbursement for expenses incurred while participating in a clinical trial.*

c. *Payments to reimburse clinical trial participants for expenses incurred while participating in the trial do not reduce the $2,000 calendar year maximum.*

d. *Exclude reimbursement payments following the instructions in SI 00815.250, Rebates and Refunds. Some examples of reimbursable expenses are travel to and from research location, meals, etc.*

e. *Request the "informed consent form" from the clinical trial participant. The informed consent form provides most of the required information.*

S0830.750 *GIFTS to CHILDREN with LIFE-THREATENING CONDITIONS*

A. Introduction

This section provides policy and procedures applicable when a tax-exempt organization gives a gift to a disabled child with a life-threatening condition; specifically when to count or exclude such gifts as income. For information regarding gifts from non-organizational donors, see SI 00830.520.

B. Definitions

Definitions pertinent to this exclusion

- *Child - Apply the exclusion only to a child who has not attained age 18 and who has a life-threatening condition.*
- *In-kind gift- An in-kind gift is any food, shelter, or other item donated to the child or another individual on the child's behalf. An in-kind gift cannot be cash itself.*
- *Benefit of the child - A gift is for the benefit of the child if the giver intends the gift for the use, welfare, or enjoyment of the child. However, the gift still meets the benefit of the child criteria if it benefits more people than just the disabled child; for example, shared electronics like a computer or television or a family trip. Interpret this definition broadly.*
- *501(c) (3) tax-exempt organization – review the Internal Revenue Code, as it pertains to a 501(c) (3) tax-exempt organization to see if organization qualifies when used for this exemption.*

C. Policy regarding gifts

Eligibility for the exclusion depends on both the giver of the gift and the recipient.

1. *The recipient of the gift must be under age 18 and have a life-threatening condition. The donor must be an organization described in Section 501(c) (3) of the Internal Revenue Code of 1986, which is exempt from taxation under Section 501(a). For more information regarding section 501(c) (3) organizations, see SI 00830.750D.3, in this section.*

2. *Gifts to exclude from income the following gifts or for the benefit of the child:*
   - *Any in-kind gift, not converted to cash; and Cash gifts to the extent that the total cash we exclude under this provision does not exceed $2,000 in any calendar year.*
   - *Cash the individual receives in excess of $2,000 in a calendar year is subject to regular income counting rules. For example, we exclude $2,000 of a $2,500 cash gift and count the remaining $500 as income.*
   - *For instructions regarding how to determine whether to consider a gift card cash or an in-kind gift, see SI 00830.522.*

3. *Gifts to count as income - converted into cash. When an individual converts an in-kind gift to cash, determine whether to count the cash as income in the month of receipt of the converted funds based on whether the gift met the criteria to exclude it under a different resource provision. If the gift would not meet the criteria to exclude it under a different resource provision, count the cash as income in the month of receipt of the converted funds. Consider as a countable resource any funds retained into the month following the month of receipt. Do not apply the $2000 income exclusion to the converted funds.*

   Exception : Apply the income exclusion to the profits from the conver from the conversion if other resource exclusions (i.e., auto exclusion, household goods, and personal effects) would have applied to the gift that the individual converted to cash.

M1130 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-28	7/1/23	Page 66 and 73
TN #DMAS-27	4/1/23	Table of Contents, page ii Pages 77, 78 Page 77b added
TN #DMAS-23	4/1/22	Table of Contents, pages i, ii Pages 47, 48, 79 Page 48a was added. Page 48b was added as a runover page Page 78 is a runover page.
TN #DMAS-20	7/1/21	Table of Contents, page ii Pages 5, 73, 74 Page 74a was added as a runover page.
TN #DMAS-18	1/1/21	Pages 31, 33, 34
TN #DMAS-17	7/1/20	Table of Contents, page ii Pages 73, 74 Page 5 is a runover page.
TN #DMAS-12	4/1/19	Page 13
TN #DMAS-9	7/1/18	Pages 1, 3
TN #DMAS-7	1/1/18	Pages 45,78-79 Appendix 1, pages 3,5
TN #DMAS-5	7/1/17	Pages 13, 15, 78, 79 Page 14 is a runover page.
TN #DMAS-3	1/1/17	Table of Contents, page ii Page 76 Page 77 is a runover page. Pages 78 and 79 were added.
TN #DMAS-1	6/1/16	Pages 4, 14, 15
TN #100	5/1/15	Pages 13, 15, 21, 31, 33, 34 Pages 16 and 32 are runover pages.
UP #9	4/1/13	Table of Contents, page ii Pages 5, 62 Pages 62a was added.
TN#97	9/1/12	Page 14
Update #7	7/1/12	Page 24
TN #96	10/1/11	Table of Contents, page ii Pages 4, 73, 74 Appendix 1, pages 1-14 Appendix 2, page 1 Appendix 4, pages 1-8 added
TN #95	3/1/11	Pages 28, 29, 33
TN #94	9/1/10	Pages 20, 20a, 28-29a
TN #93	1/1/10	Pages 63-65 Pages 70, 74, 75
TN #91	5/15/09	Page 13

S1130.620 DISASTER ASSISTANCE *(including COVID-19 Relief Payments)*

A. Policy

1. The Exclusion--December 1, 1988 and Continuing

Unspent assistance received from the following sources is permanently excluded from resources:

the Disaster Relief and Emergency Assistance Act (P.L. 100-707);

- **another Federal statute because of a presidentially-declared major disaster;**
- **comparable assistance received from a State or local government; or**
  - **from a disaster assistance organization.**

To be excluded from resources, the funds must be excludable from income per S0830.620.

2. Interest on Excluded Funds

Interest earned on funds excluded under this provision is excluded from income and from resources. (For months prior to December 1988, interest was excluded from income and resources for as long as the funds themselves were excluded.)

B. Procedure

1. When to Develop

Develop this exclusion only when an individual alleges the receipt of assistance excludable under this provision and the exclusion would permit eligibility.

2. Evidence of Excludability

Follow the instructions in S0830.620. If the file contains evidence that the disaster assistance is excluded from income, use the same evidence to establish that the assistance is excluded from resources.

3. Document the Determination

Summarize the basis for the exclusion in the case record. Show the amount excluded and the first month and year that the exclusion applies.

C. References

Payments for repair or replacement of lost, damaged, or stolen excluded resources, S1130.630.

Identifying excluded funds that have been commingled with nonexcluded funds, S1130.700.

C. Procedure -- Initial Applications and Posteligibility

1. When to Develop

When an individual would otherwise be ineligible due to excess resources, determine if applying this exclusion would permit eligibility. If the exclusion would permit eligibility, develop per 2. below.

NOTE: If the individual is resources-eligible even without the application of this exclusion, it is not necessary to develop under this section.

2. Development and Documentation

If an individual alleges that his/her resources include unspent relocation assistance payments:

- follow the procedures in S0830.655D.;
- document the date(s), type(s) and amount(s) of such payments(s); and
- obtain a statement as to the date(s) and amount(s) of any account deposits corresponding to the payments.

D. References

Commingled funds, S1130.700.

M1130.675 TAX ADVANCES, REFUNDS AND REBATES RELATED TO EARNED INCOME TAX CREDITS

A. Policy

1. EITC Related Refunds

Effective with resource determinations made for the month of January 1991, an unspent Federal tax refund or payment made by an employer related to Earned Income Tax Credits (EITC's) is excluded from resources **only for the month following the month** the refund or payment is received.

Interest earned on unspent tax refunds related to EITC's is **not** excluded from income or resources by this provision (S0830.500).

B. Procedure--Initial Claims and Post-Eligibility

1. When to Develop

Develop these exclusion*s* only when an individual alleges the receipt of assistance excludable under this provision and the exclusion would permit eligibility.

1440 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-28	7/1/23	Appendix 1, Pages 1-4
TN #DMAS-10	10/1/18	Pages 3, 5
TN #DMAS-7	1/1/18	Page 1. Appendix 1, Page 4.
TN #DMAS-5	7/1/17	Table of Contents Pages 3-9, 11, 12
TN #DMAS-3	1/1/17	Table of Contents Pages 3-12 Appendix 1 was added. Page 2 is a runover page. Pages 13-23 were deleted.
UP #9	4/1/13	Page 5
Update (UP) #7	7/1/12	Table of Contents Pages 2, 14, 15, 18a-18c Pages 19, 20
TN #94	9/1/2010	Table of Contents Pages 13, 16, 18b, 19-22
TN #93	1/1/2010	Pages 14, 16
TN #91	5/15/2009	Table of Contents Page 12 Pages 17-18c

Developmental Disabilities Waivers – Services and Support Options – Updated *July 2023*

(BI = Building Independence Waiver; FI = Family & Individual Supports Waiver; CL = Community Living Waiver)

	BI	FI	CL	Description
Employment and Day *Services*				
Individual Supported Employment	✓	✓	✓	Individual Supported Employment services is provided one-on-one by a job coach *and offers training and support in a competitive job where persons without disabilities are employed.*
Group Supported Employment	✓	✓	✓	Group Supported Employment services *is* continuous *employment-related* support *in a competitive job where persons* without disabilities *are employed.*
Workplace Assistance		✓	✓	Workplace Assistance *is* provided to someone who requires more than typical job coach services to *maintain individual, competitive employment.*
Community Engagement	✓	✓	✓	Community Engagement Services *provides a wide variety of opportunities relationships and natural support in the community, while utilizing the community as a learning environment.*
Community Coaching	✓	✓	✓	Community Coaching is designed for *people* who need one to one support in order build a specific skill or set of skills to address barrier(s) that prevents *that* person from participating in Community Engagement.
Group Day	✓	✓	✓	Group Day Services *include skill-building and support activities to enhance independence and increase community integration. Can occur in a center and the community.*
Services via *consumer and agency directed models*				
Companion Services		✓	✓	*Provides nonmedical care, socialization, or support to adults, ages 18 and older in person's home and/or in the community.*
Personal Assistance Services		✓	✓	Includes monitoring health status, *assisting with maintaining a clean and safe home and providing direct support with personal care needs, at home, in the community, and at work.*
Respite *Services*		✓	✓	Respite services are specifically designed to provide temporary, *short-term care for a person* when his/her primary caregiver *is unavailable.*

	BI	FI	CL	Description
Residential *Services*				
Independent Living Supports	✓			Independent Living Supports are provided to adults (18 and older) *and* offers skill building and support to secure a self-sustaining, independent living situation in the community and/or may provide the support necessary to maintain those skills.
Shared Living	✓	✓	✓	Shared Living *is support to a person who resides in his/her own home/apartment in the community provided by a roommate of the person's choosing. The individual receives a Medicaid reimbursement for the roommate's portion of the total cost of rent, food, and utilities in exchange for the roommate providing minimal supports.*
Supported Living		✓	✓	Supported Living services take place in an apartment/house setting operated by a DBHDS licensed provider and provides *24/7* around the clock availability of staff *support performed* by paid staff who have the ability to respond in a timely manner. *May be provided individually or at the same time to more than one individual living in the home, depending on the required support.*
In-home Support Services		✓	✓	In-Home Supports take place in the person's and/or family's home or community settings. Services are designed to ensure the health, safety and welfare of the person and expand daily living
Sponsored Residential			✓	Sponsored Residential Services take place in a licensed DBHDS *family home where the homeowners are the paid caregivers ("sponsors") who provide support as necessary so that the person can reside successfully in the home and community.*
Group Home Residential			✓	Group Home Residential Services *are provided in a DBHDS licensed home with staff available 24 hours per day to provide a skill building component, along with the provision of general health and safety supports, as needed.*
Crisis *Services*				
Community-Based Crisis Supports	✓	✓	✓	Community-based crisis supports provided in the individual's home and community setting. Crisis staff work directly with and assist the *person* and *his/her* current support provider or family. These services provide temporary intensive support to emergency psychiatric hospitalization, institutional placement or prevent other out-of-home placement.
Center-based Crisis Supports	✓	✓	✓	Center-based crisis supports provide long term crisis prevention and stabilization in a residential setting (Crisis Therapeutic Home) through planned and emergency admissions.
Crisis Support Services	✓	✓	✓	Crisis support services provide intensive supports to stabilize the person who may experience an episodic behavioral or psychiatric crisis in the community which has the potential to jeopardize his/her current community living situation.

	BI	FIS	CL	Description
Medical and Behavioral *Services*				
Skilled Nursing		✓	✓	Skilled Nursing is part-time or intermittent care *provided by an LPN or RN to address or delegate needs that require direct support or oversight of a licensed nurse. Nursing service can occur at the same time as other waiver services.*
Private Duty Nursing		✓	✓	Private Duty Nursing is individual and continuous care (in contrast to part-time or intermittent care) for *people* with a medical condition and/or complex health care need, to enable the *person* to remain at home.
Therapeutic Consultation		✓	✓	Therapeutic consultation services *in consultation with a professional* designed to assist the individual's *staff* and*/or* the individual's family/caregiver, as appropriate, *through* assessments, *development of TC supports plan* and teaching for the purpose of assisting the individual enrolled in the waiver with the designated specialty area. The specialty areas are psychology, behavioral consultation, therapeutic recreation, speech and language pathology, occupational therapy, physical therapy, and rehabilitation engineering.
Personal Emergency Response System (PERS)	✓	✓	✓	PERS is a service that monitors individual's safety in *his/her* home, and provides access to emergency assistance for medical or environmental emergencies through the provision of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the *person's* home telephone system.

	BI	FI	CL	Description
Additional *Services*				
Assistive Technology	✓	✓	✓	Assistive technology is specialized medical equipment, supplies, devices, controls, and appliances*, not covered by insurance* which enable individuals to increase their *independence in* their environment *and community.*
Benefits Planning	✓	✓	✓	*A service that assists recipients of DD Waiver and social security to understand their personal benefits and explore their options regarding employment.*
Community Guide				*Direct assistance (1:1) to persons in navigating and utilizing community resources. Provides information and assistance that help the person in problem solving, decision making, and developing supportive community relationships and other resources that promote implementation of the person-centered plan.*
Electronic Home-Based Services	✓	✓	✓	Electronic Home-Based Services are goods and services based on *current* technology *to enable a person to safely live and participate in the community while decreasing the need for support staff services.* This includes purchases of electronic devices, software, services, and supplies not otherwise provided through this waiver or through the State Plan, that would allow individuals to access greater independence and self-
Environmental Modifications	✓	✓	✓	Environmental modifications physical adaptations to the *person's* primary home *or* primary vehicle that are necessary to ensure the health and welfare of the *person* or enable the individual to function with greater independence.
Individual and Family/Caregiver Training	✓	✓	✓	Training and counseling to individual, families and caregivers to improve supports or educate the person to gain a better understanding of his/her *abilities* or increase his/her self-determination/self-advocacy abilities.
Transition Services	✓	✓	✓	Transition services are nonrecurring set-up expenses for *persons* who are transitioning from an institution or provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.
Employment and Community Transportation	✓	✓	✓	*Promotes the individual's independence and participation in the life of his or her community. Transportation to waiver and other community services or events, activities and resources, inclusive of transportation to employment or volunteer sites, homes of family or friends, civic organizations or social clubs, public meetings or other civic activities, and spiritual activities or events as specified by the service plan and when no other means of access is available.*
Peer Mentor Supports	✓	✓	✓	*Designed to foster connections and relationships which build individual resilience. This service is delivered by people with developmental disabilities who are or have received services, have shared experiences with the person, and provide support and guidance to him/her.*

M1450 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-28	7/1/23	Page 35 and Appendix 2
TN #DMAS-26	1/1/23	Page 46
TN #DMAS-25	10/1/22	Page 36
TN #DMAS-17	7/1/20	Page 45
TN #DMAS-15	1/1/20	Page 46
TN #DMAS-14	10/1/19	Pages 19, 41, 42, 46
TN #DMAS-10	10/1/18	Pages 1, 2 Appendix 3, page 2 Page 24a was added back; it was inadvertently removed in a previous transmittal. Page 2a was added as a runover page.
TN #DMAS-9	7/1/18	Page 35-36a, 37-38, 43
TN #DMAS-7	1/1/18	Page 4, 24, 36, 36a, 37, 41, 42 Appendix 1, Page 1.
TN #DMAS-5	7/1/17	Table of Contents Pages 13, 35, 41-44 Page 43a was renumbered. Pages 45 and 46 were added as runover pages.
TN #DMAS-3	1/1/17	Pages 30, 40-42, 44
TN #DMAS-1	6/1/16	Pages 13, 15, 35 Pages 14 and 16 are runover pages.
TN #100	5/1/15	Table of Contents Pages 17-19, 36, 37 Page 35 is a runover page.
TN #99	1/1/14	Page 7, 10, 21
UP #7	6/1/12	Table of Contents Pages 37-43 Page 43a was added.
TN #96	10/1/11	Table of Contents Pages 4-8 Pages 15, 16, 25, 26 Pages 31-38 Page 31a removed.
TN #95	3/1/11	Pages 4, 24, 32, 36, 37, 37a, Pages 39, 42, 43
TN #94	9/1/10	Table of Contents Pages 36-37a, 39-44
TN #93	1/1/10	Table of Contents Pages 3, 17-18, 29 Appendix 2, page 1
TN #91	5/15/09	Pages 41, 42

M1450.630 PENALTY PERIOD CALCULATION

A. Policy

When a transfer of assets affects eligibility, the penalty period begins when the individual would otherwise be eligible for Medicaid payment for LTSS (long term services and support) if not for the penalty period. The penalty period includes the fractional portion of the month, rounded down to a day. Penalty periods for multiple transfers cannot overlap.

As long as an individual in a penalty period meets a full or limited-benefit Medicaid covered group and all nonfinancial and financial requirements for that covered group, he is eligible for all services covered under that group EXCEPT the Medicaid payment of LTSS. Individuals in nursing and other medical facilities or who have been screened and approved for HCBS (home and community based services), meet the 300% SSI covered group during a penalty period because they meet the definition of an institutionalized person.

An individual with a penalty period who does not meet the 300% SSI covered group may meet other covered groups. See M1450.630 B.5.

B. Penalty Begin Date

For individuals not receiving LTSS at the time of transfer, the penalty period begins the first day of the month in which the individual would otherwise be eligible for Medicaid payment for LTSS, except for the imposition of a penalty period. This includes the application retroactive period for nursing facility patients who have been in the facility during the retroactive period.

For individuals who are receiving Medicaid payment for LTSS at the time of transfer, the penalty period begins the month following the month of transfer *unless the transfer took place during the COVID-19 Emergency continuous eligibility period. See M1520.200.*

1. Medicaid LTSS Not Received at Time of Transfer

If the individual is not receiving Medicaid-covered LTSS at the time of the asset transfer, the penalty period begins the first day of the month in which the individual would otherwise be eligible for Medicaid payment for LTSS but for the application of the penalty period, as long as the date does not fall into another period of ineligibility imposed for any reason.

2. Receiving Medicaid LTSS Services at Time of Transfer

If the individual is receiving Medicaid LTSS at the time of the asset transfer, the penalty period begins the first day of the month following the month in which the asset transfer occurred as long as the individual would otherwise be eligible for Medicaid payment for LTSS but for the application of the penalty period.

A referral to the DMAS Enrollee Audit Unit (RAU) must be made for the months in the penalty period during which the individual received Medicaid LTSS services. See Chapter M17 for instructions on RAU referrals.

LIFE EXPECTANCY TABLE*

If the exact age is not on the chart, use the next lower age. For example, if an individual is age 47 at the time of the asset transfer, use the life expectancy that corresponds to age 40 on the chart.

AGE	Life Expectancy MALE	Life Expectancy FEMALE	AGE	Life Expectancy MALE	Life Expectancy FEMALE
0	*74.12*	*79.78*	74	*11.05*	*12.94*
10	*64.67*	*70.27*	75	*10.46*	*12.26*
20	*54.97*	*60.41*	76	*9.88*	*11.60*
30	*45.86*	*50.79*	77	*9.32*	*10.95*
40	*36.97*	*41.38*	78	*8.77*	*10.31*
50	*28.33*	*32.24*	79	*8.25*	*9.70*
60	*20.47*	*23.67*	80	*7.74*	*9.10*
61	*19.74*	*22.85*	81	*7.25*	*8.53*
62	*19.03*	*21.04*	82	*6.77*	*7.98*
63	*18.32*	*21.24*	83	*6.31*	*7.44*
64	*17.63*	*20.45*	84	*5.88*	*6.93*
65	*16.94*	*19.66*	85	*5.47*	*6.44*
66	*16.26*	*18.88*	86	*5.07*	*5.99*
67	*15.58*	*18.10*	87	*4.70*	*5.55*
68	*14.91*	*17.34*	88	*4.35*	*5.15*
69	*14.24*	*16.58*	89	*4.02*	*4.76*
70	*13.59*	*15.82*	90	*3.72*	*4.41*
71	*12.94*	*15.08*	95	*2.57*	*3.05*
72	*12.30*	*14.36*	100	*1.93*	*2.23*
73	*11.67*	*13.64*	110	*1.05*	*1.12*

**Data from www.ssa.gov Actuarial Life Table, 2020, as used in the 2023 Trustees Report*

M1470 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-28	7/1/23	Page 19, Appendix I
TN #DMAS-27	4/1/23	Page 15
TN #DMAS-26	1/1/23	Pages 19, 20
TN #DMAS-25	10/1/22	Page 20
TN #DMAS-24	7/1/22	Pages 1, 15, 28a, 44, 48-50 Page 14a is a runover page.
TN #DMAS-22	1/1/22	Pages 19, 20
TN #DMAS-21	10/1/21	Page 17
TN #DMAS-20	7/1/21	Pages 11, 20, 26
TN #DMAS-19	4/1/21	Pages 7, 8, 22, 23
TN #DMAS-18	1/1/21	Pages 19, 20
TN #DMAS-17	7/1/20	Table of Contents, page ii Pages 1, 14, 28a, 47, 48, 50, 55 Appendix 1, page 1
TN #DMAS-15	1/1/20	Pages 19, 20
TN #DMAS-14	10/1/19	Table of Contents, page i Pages 1, 14, 28a, 31, 32, 43, 47, 48, 50 Appendix 1, page 2 Page 14a was added as a runover page.

M1470.410 MEDICAID CBC - PERSONAL MAINTENANCE ALLOWANCE

A. Individuals

For the month of entry and subsequent months, deduct from the patient's gross monthly countable income a personal maintenance allowance (PMA). The amount of the allowance depends upon under which Medicaid CBC waiver the patient receives LTC services.

The total amount of the PMA cannot exceed 300% SSI.

1. Basic Maintenance Allowance

Patients receiving Medicaid CBC under the following waivers are allowed a monthly basic PMA:

- Commonwealth Coordinated Care Plus (CCC Plus) Waiver (formerly the Elderly or Disabled with Consumer-Direction Waiver and the Technology-Assisted Individuals Waiver),
- Community Living (CL) Waiver (formerly Intellectual Disabilities Waiver),
- Family and Individual Supports (IS) Waiver (formerly Individual and Family Developmental Disabilities Support Waiver), and
- Building Independence (BI) Waiver (formerly Day Support Waiver).

Individuals enrolled in the Program for All Inclusive Care for the Elderly (PACE) are also allowed the basic PMA.

The PMA is:

- January 1, 2021 through December 31, 2021: $1,311
- January 1, 2022 through December 31, 2022: $1,388
- *January 1, 2023 through December 31, 2023: $1,509*

Contact a Medical Assistance Program Consultant for the PMA in effect for years prior to *2021*.

2. Guardianship Fee

Deduct an amount up to 5% of the patient's gross monthly income (including amounts not counted as income and excluded income) for guardianship fees, if the patient has a legally appointed guardian or conservator AND the guardian or conservator charges a fee. The guardianship **filing** fees CANNOT be deducted from the individual's income. Document how it was determined that the guardian/conservator charges a fee and the amount of the fee.

No deduction is allowed if the patient's guardian receives a payment for providing guardianship services from a public agency or organization that receives funding for guardianship services.

No deduction is allowed for representative payee or "power of attorney" fees or expenses.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

Patient pay may be the lesser of the SDL amount, contributable income amount (income remaining after deductions plus the SDL), remaining income or the Medicaid Rate, whichever is applicable to the individual's circumstances.

Patient pay will not exceed the Medicaid Rate.

You must report any changes in income or resources to the local agency. Failing to report changes or providing false or misleading information may result in your prosecution for fraud.

If you have Medicare Part A coverage, and were admitted to a nursing facility under "Skilled Care", the patient pay amount you owe for the first 100 days may be less than the amount shown on this notice. The nursing facility will determine how many days are covered by Medicare and will send you a bill. Once Medicare stops paying, you will be responsible for the full patient pay amount shown on this notice.

Appeal Information
If you disagree with this action, you have the right to file an appeal. You or your authorized representative must send a written appeal request within 35 days of receipt of this notification. If you file an appeal before the effective date of this action, the patient pay will remain unchanged during the appeal process. However, if the Appeals Division upholds this action, you may be required to reimburse the Medicaid Program for the excess cost of services paid on your behalf during the appeal period.

Applicant/enrollees are encouraged to file an appeal request through the DMAS appeals portal at https://www.dmas.virginia.gov/appeals/. It is also acceptable to file an appeal by other means, using the "Virginia Medicaid/FAMIS Appeal Request Form," which is available from DMAS at https://www.dmas.virginia.gov/appeals/.

The appeal request should identify the action under appeal, the reason for the appeal, and include a copy of the notice of action. The submission should also include acceptable proof of authorization to act on behalf of an applicant or enrollee if an authorized representative is filing on their behalf. Appeals filed more than 35 days after the date on the notice of action should include a good cause statement explaining the reason for filing an untimely appeal. Finally, appellants and their representatives may include any other documentation that they wish the hearing officer to consider.

How to File an Appeal Request
1. Electronically. Via the Appeals Information Management System (AIMS) portal at https://www.dmas.virginia.gov/appeals/ or email an appeal request to appeals@dmas.virginia.gov
2. By fax. Fax an appeal request to DMAS at (804) 452-5454
3. By mail or in person. Send or bring an appeal request to:

Department of Medical Assistance Services
Appeals Division
600 East Broad Street
Richmond, Virginia 23219

4. By phone. Call the Appeals Division at (804) 371-8488 (TTY: 1-800-828-1120).

Changed With	Effective Date	Pages Changed
TN #DMAS-28	7/1/23	Page 66
TN #DMAS-26	1/1/23	Pages 7, 18c, 66, 69, 70
TN #DMAS-25	10/1/22	Page 66
TN #DMAS-24	7/1/22	Pages 8a, 8b, 13, 50b, 51, 55, 57, 66, 87, 89, 91
TN #DMAS-22	1/1/22	Pages 7, 18c, 66, 69, 70
TN #DMAS-21	10/1/21	Page 66
TN #DMAS-20	7/1/21	Pages 66, 70
TN #DMAS-18	1/1/21	Page 7, 18c, 66, 69, 70, 92
TN #DMAS-17	7/1/20	Pages 8b, 9, 14, 66, 77, 92
TN #DMAS-15	1/1/20	Pages 1, 7, 18c, 66, 69, 70 Page 2 is a runover page.
TN #DMAS-14	10/1/19	Pages 8a, 8b, 12, 15, 16, 18, 20, 21, 30, 32, 51

After eligibility is established, the usual reporting and notification processes apply. Send written notice for the month(s) during which the individual establishes Medicaid eligibility. VaCMS will generate the "Notice of Patient Pay Responsibility" and it will be sent to the individual or his authorized representative.

M1480.400 PATIENT PAY

A. Introduction

This section contains the policy and procedures for determining an institutionalized spouse's (as defined in section M1480.010 above) patient pay in all covered groups.

B. Married With Institutionalized Spouse in a Facility

For a married long-term services and support (LTSS) patient with an institutionalized spouse in a facility, **NO** amount of the patient's income is deducted for the spouse's needs in the patient pay calculation.

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

Introduction

This subsection contains the standards and their effective dates that are used to determine the community spouse's and other family members' income allowances. The income allowances are deducted from the institutionalized spouse's gross monthly income when determining the monthly patient pay amount. Definitions of these terms are in section M1480.010 above.

B. Monthly Maintenance Needs Allowance	\$2,177.50	7-1-21
	\$2,288.75	7-1-22
	$2,465.00	*7-1-23*
C. Maximum Monthly Maintenance Needs Allowance	\$3,259.50	1-1-21
	\$3,435.00	1-1-22
	\$3,715.50	1-1-23
D. Excess Shelter Standard	\$653.25	7-1-21
	\$686.63	7-1-22
	$739.50	*7-1-23*

E. Utility Standard Deduction (SNAP)	\$322.00	1 - 3 household members	10-1-21
	\$402.00	4 or more household members	10-1-21
	\$374.00	1 - 3 household members	10-1-22
	\$473.00	4 or more household members	10-1-22

M1480.420 PATIENT PAY FOR ABD 80% FPL AND 300% SSI INSTITUTIONALIZED SPOUSE

A. Policy

After a 300% SSI or ABD 80% FPL institutionalized spouse has been found eligible for Medicaid, determine his patient pay (post-eligibility treatment of income).

Changed With	Effective Date	Pages Changed
TN #DMAS-28	7/1/23	Pages 1, 2, 2a, 4, 7, 8, 8a, 12, 13, 14 ; Appendix 2
TN #DMAS-27	4/1/23	Page 1, 15, 24a
TN #DMAS-26	1/1/23	Pages 15 and 24a
TN #DMAS-24	7/1/22	Pages 1, 3, 10 Pages 2 and 11 are a runover pages.
TN #DMAS-23	4/1/22	Pages 10, 11, 12, 13, 26, 27, 30 Appendix 2, page 1
TN #DMAS-22	1/1/22	Page 14
TN #DMAS-21	10/1/21	Pages 6, 12
TN #DMAS-20	7/1/21	Pages 2, 3. 5. 6, 13, 14 Page 2a is a runover page. Page 6a was added as a runover page
TN #DMAS-19	4/1/21	Appendix 2
TN #DMAS-18	10/1/19	Pages 1, 4, 4a, 5, 11, 13 Content that was inadvertedly deleted in a previous transmittal was restored. No policy was revised.
TN #DMAS-17	7/1/20	Pages 2, 4, 25, 30 Page 3 is a runover page.
TN #DMAS-16	4/1/20	Pages 3, 4, 7, 9 Appendix 2 Pages 3a and 4 were renumbered to pages 4 and 4a. Page 4a is a runover page.
TN #DMAS-15	1/1/20	Pages 8, 8a
TN #DMAS-14	10/1/19	Pages 2, 3, 4, 6a, 8, 9, 10, 13 Page 4a is a runover page. Page 10a was added as a runover page. Page 7a was deleted.
TN #DMAS-13	7/1/19	Page 14
TN #DMAS-12	4/1/19	Table of Contents Pages 2, 5, 6, 6a, 7, 8, 8a, 11, 12, 15-18, 20 Appendix 2 Page 24a was added. Pages, 19, 21-24, 25 are runover pages.

M1520.000 MEDICAL ASSISTANCE ELIGIBILITY REVIEW

M1520.001 GENERAL PRINCIPLE

A. Policy

A MA recipient's eligibility must be partially reviewed whenever the agency becomes aware of any change in the enrollee's circumstances that might affect the enrollee's continued eligibility. The timeframe for acting on a change is 30 calendar days from the date the change is reported or the agency becomes aware of the change.

Exception: Children meeting the definition of a newborn in M0330.802 or M2240.100.F are to be enrolled as soon as possible upon report of the birth.

An annual review of all of the enrollee's eligibility requirements is called a "redetermination" or "renewal." A renewal of the enrollee's eligibility must be completed at least once every 12 months. The renewal can be initiated in the 10th month to ensure timely completion of the renewal.

When an enrollee no longer meets the requirements for his current covered group, prior to cancelling his coverage, evaluate the enrollee in all covered groups for which he may meet the definition. If the enrollee is not eligible for full benefit Medicaid coverage and is not eligible in any other limited-benefit covered group (i.e. the Medicare Savings Programs), evaluate the enrollee for Plan First, unless he has declined that coverage.

B. Procedures For Partial Review and Renewals

The policy and procedures in this subchapter are contained in the following sections:

- Partial reviews – M1520.100;
- Renewals – M1520.200;
- Canceling coverage or Reducing the level of benefits – M1520.300;
- Extended Medicaid coverage – M1520.400;
- Transferring cases within Virginia – M1520.500.

C. Public Health Emergency *(COVID)*

On January 31, 2020, a public health emergency (PHE) was declared by the U.S. Department of Health and Human Services as a result of the continued consequences of the Coronavirus Disease 2019 (COVID-19) pandemic. Under the direction of the Centers for Medicare and Medicaid Services (CMS), state Medicaid agencies have not taken action to cancel or reduce medical assistance coverage for enrolled individuals, regardless of eligibility changes, unless the individual dies, moves out of the state, or requests cancelation of coverage. *This was referred to as Medicaid continuous coverage. On May 11, 2023 Congress ended the federal COVID-19 public health emergency.*

The Consolidated Appropriations Act of 2023 was enacted on 12/29/2022. This policy took effect on April 1, 2023 and affected Medicaid continuous coverage. This outlined case closures or cancellations for those enrollees no longer eligible for Medicaid coverage would be effective as of April 30, 2023.

CMS provided post-pandemic guidance known as "Unwinding" and procedures were developed and implemented for agencies to begin the redetermination process of the majority of Medicaid enrollees.

These procedures began in March 2023 via an electronic Ex Parte process. A schedule of when redeterminations were to be processed was constructed and provided to all agencies. This was in order to handle the processing in a logical manner as the CMS instruction was that no more than one ninth of redeterminations could be initiated within any month.

Information was shared with the agencies that are involved with the processing of redeterminations. Broadcasts were available in Fusion and trainings were held for those involved.

M1520.100 PARTIAL REVIEW

A. Enrollee's Responsibility

Enrollees must report changes in circumstances that 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 be reported to the DMAS HIPP Unit within the 10-day timeframe.

B. Eligibility Worker's Responsibility

The eligibility worker is responsible 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 services and supports (LTSS), if possible, use available online systems information to verify the reported change. If the online-information is compatible with the reported change, determine eligibility based upon the information available.

If verifications must be obtained from the enrollee, send a verification checklist, and allow at least 10 calendar days for the information to be returned. If information is not provided by the deadline and continued eligibility cannot be determined, send advance notice to the enrollee/ authorized representative stating the cancellation date and the reason. Document the information and evaluation in the VaCMS case record. If requested verifications are received after the deadline due to circumstances beyond the individual's control (e.g. a postal system delay), reopen the case, and complete processing of the change.

When an enrollee reports a change or the agency receives information indicating a change in the 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.

The following changes must be verified:

- A decrease in income or termination of employment that causes the individual to move from limited Medicaid coverage to full Medicaid coverage,
- An increase in income that causes the individual to move from Medicaid to FAMIS, or to need a Medically Needy spenddown calculation.

If a reported change is not compatible with information obtained from online system searches, obtain verification from enrollee or authorized representative. The agency may not deny an increase in benefits, terminate coverage, or reduce benefits for any individual unless the agency has sought additional information from the individual and provided proper notification.

When a change is reported that impacts eligibility or a renewal is completed and the enrollee is no longer eligible, the Advance Notice of Proposed Action must be sent to the enrollee, before the enrollee's benefits can be reduced or his eligibility can be terminated (see M1520.301). Send the notice to the authorized representative if one has been designated.

1. Asset Transfers during the PHE

When an enrollee reports an uncompensated asset transfer that took place during the COVID-19 Continuous Eligibility Period (sometimes termed the PHE- Public Health Emergency) before April 1, 2023, the transfer should be evaluated and a penalty period calculated. The option to claim undue hardship must be given to the member. ***If Undue Hardship is denied or not requested, apply the FULL penalty period going forward (after the 10 day advance notice period)****, send notice to the client and a 225 (LTSS Communication form) to the provider.*

2. Negative Action requires a Notice

Adequate notice using the Notice of Action must be provided when an enrollee dies, enters an ineligible institution, is incarcerated and no longer meets a covered group, moves out of Virginia, requests termination of his coverage, or is unable to be located by the local agency.

3. Changes That Do Not Require Partial Review

Document changes in an enrollee's situation, such as the receipt of the enrollee's Social Security number (SSN), that do not require a partial review in the case record and take action any necessary action on the enrollee's coverage.

Example: An 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

No partial review is required for a change in income (earned, unearned or self-employment) if the eligible individual's coverage remains within the equivalent coverage group (and there is no patient pay associated with the EDG).

Example: The individual is enrolled in a full coverage aid category prior to the reported change and remains in full coverage after the change. No verification is required as coverage remains within the equivalent coverage group after income change.

D. Child Moves From *Case* Home

When an enrolled child moves out of the home *in which he was living at application or last renewal* but is still living in Virginia, do not cancel MA coverage solely on the basis of the move, and do not require a new application. Complete a partial review to determine the child's continuing eligibility if any changes in income, such as the child becoming employed, are reported.

1. Case Management

The necessary case management actions depend on the child's age and whether or not the child has moved to an arrangement in which an authorized representative is necessary.

a. Child Age 18 years or Under 18 and Living with a Relative

If the child is age 18, he may be placed in his own MA case if he was previously on a case with other enrollees. If the child is under age 18 and moved in with an adult relative, the child may be placed on a case with the relative and the relative authorized to conduct MA business on behalf of the child.

b. Child Under Age 18 years Living with Non-relative

When a child under age 18 moves to the home of a non-relative adult without legal custody, the non-relative adult does not have to be an authorized representative to report changes in the child's situation. However, the worker cannot discuss the case or send the non-relative adult a copy of the child's MA card unless the person is authorized to handle the MA business for the child. Follow the procedures in M1520.100 D.2 through D.4 below.

2. Enrollment

a. Case Number

The child's member ID number does not change, but the child's Member ID number must be moved to a case number in the child's name as case head, if the person with whom the child is living does NOT have authority to act on the child's behalf.

b. Demographics Comment Screen

In VaCMS, enter a comment that will inform staff that information from the case cannot be shared with (the name of the person with whom the child lives) because he/she is NOT authorized to receive the information.

B. Renewal Procedures

Renewals may be completed in one of the following ways:

- ex parte,
- using a paper form,
- online,
- telephonically by calling the Cover Virginia Call Center.

1. Ex Parte Renewals

An ex parte renewal is an internal review of eligibility based on information available to the agency. Conduct renewals of ongoing Medicaid eligibility through the ex parte renewal process *for all covered groups, including covered groups with a resource test and individuals receiving LTSS. If an automated ex parte renewal cannot be attempted, a manual ex parte renewal must be attempted and documented in VaCMS.*

a. MAGI-based Cases

For cases subject to Modified Adjusted Gross Income (MAGI) methodology, an ex parte renewal should be completed when income verification is available through the federal Hub. An individual may authorize the use of Internal Revenue Services (IRS) data for up to five years on the application form and at each renewal. In order for the federal Hub to be used for income, there must be a valid authorization in the electronic or paper case record.

The agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family, and must make efforts to align renewal dates for all programs. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information, information from SSA through SVES or SOLQ-I and information from child support and child care files. Verification of income from available sources, including the VEC, may be used if it is dated within the previous 12 months. See M0130.001.B.3.

The eligibility worker is to take every opportunity to renew Medicaid eligibility when information is reported/verified that will allow a renewal of eligibility to be completed. For example, when an ongoing Medicaid enrollee applies for SNAP or TANF or reports a change in income, use the income information obtained to complete an early ex parte Medicaid renewal and extend the Medicaid renewal for another 12 months.

The agency must include in each applicant's case record facts to support the agency's decision on the case. The eligibility worker must document the date and method used to obtain the verification information (viewed pay stub dated xx/xx/xxxx, telephone call on xx/xx/xxxx date, etc.), the type of verification, the source and a description of the information. If the renewal is not processed and documented electronically, the documentation must be placed and maintained in the case record.

b. SSI Medicaid Enrollees

An ex parte renewal for an SSI recipient (including *a LTSS* recipient) can be completed by verifying the individual's continued receipt of SSI through SVES or SOLQ-I, checking AVS and other electronic verification sources, and documenting the case record. For a 1619(b) individual, check the Medicaid Test Indicator field in SVES or SOLQ-I to verify there is a code of A, B or F.

If the individual is no longer an SSI recipient or no longer has 1619(b) status *a manual ex parte renewal must still be attempted. If the ex parte renewal is unsuccessful or results in negative action,* a contact-based renewal must be completed and necessary verifications obtained to evaluate the individual's eligibility in all other covered groups prior to canceling his Medicaid coverage.

c. All other Medicaid Enrollees

Evaluation for continued Medical Assistance for all covered groups must be attempted using the ex parte renewal process, including covered groups with a resource test and individuals receiving LTSS. If a case drops out of the automated ex parte renewal process, a manual ex parte renewal must be attempted and documented in VaCMS.

d. Continuing Eligibility Not Established Through Ex Parte Process

If the ex parte renewal results in the individual no longer being eligible for coverage, the individual must be given the opportunity to submit current income information and verifications. Follow the steps in M1520.200 B.2 below for completing a paper-based renewal.

2. Paper Renewals

When an ex parte renewal cannot be completed and the enrollee has not completed a renewal telephonically or online, send the enrollee a pre-filled paper Administrative Renewal form to sign and return. If an authorized representative has been designated, the renewal form is sent to the authorized representative.

The form needs to be sent to the enrollee in time to allow for the return and processing periods prior to the system cut-off in the 12th month of eligibility. The enrollee must be allowed 30 days to return the renewal form and any necessary verifications; Administrative Renewal forms are pre-filled with the return date. The specific information requested and the deadline for receipt of the verification must be documented in the case record.

If the enrollee submits a completed application form, accept it as a renewal form and obtain any additional information needed to complete the renewal.

If a paper or electronic renewal application is submitted by the enrollee, the renewal should be evaluated even if the scheduled renewal date is in the future.

New or revised information provided by the enrollee must be entered into the system. The enrollee is responsible for reporting any changes. If the enrollee does not check either "yes" or "no" in response to a particular question, there is considered to be no change with regard to that question.

Verifications must be copied or scanned into VaCMS using the Document Management Imaging System (DMIS) and preserved for the record. Notes by the eligibility worker that the verifications were viewed are not sufficient.

Renewals must be completed prior to cut-off in the 12th month of eligibility or within 30 calendar days from the receipt of the renewal, whichever is later.

When an individual does not return the renewal form and action is taken to cancel coverage, a three-month reconsideration period applies (see M1520.200 C.4).

Note: Follow Auxiliary Grants (AG) policy regarding the appropriate renewal form to use for AG/Medicaid enrollees.

3. Online and Telephonic Renewals

Enrollees may opt to complete a renewal online using CommonHelp or by telephone through the Cover Virginia Call Center.

Renewals completed through CommonHelp are electronically signed by the enrollee or authorized representative. For cases in VaCMS, renewals completed through CommonHelp will automatically be entered into VaCMS for the worker to complete processing. For non-VaCMS cases, the renewal must be completed manually. It is not necessary to print a renewal completed through CommonHelp for the case record because it will be maintained electronically; however, the evaluation of eligibility and verifications must documented in the VaCMS case record. If the enrollee reports having no income ($0 income), follow the procedures in M1520.200 B.1.b).

If a paper or electronic renewal application is submitted by the enrollee, the renewal should be processed even if the scheduled renewal date is in the future. If the case is in a current certification period, the renewal should be evaluated for possible changes.

Telephonic renewals may be taken only by the Cover Virginia Call Center. Telephonic renewals cannot be taken directly by the local agency because a telephonic signature is required.

C. Disposition of Renewal

The enrollee must be informed in writing of the findings of the renewal and the action taken using the Notice of Action when continued eligibility exists. Advance written notice must be used when there is a reduction of benefits or termination of eligibility (see M1520.300).

If the recipient does not have an SSN, or if the Hub, SOLQ-I, or SVES does not return information showing that the recipient is deceased, contact the parent/caretaker relative or authorized representative to obtain the date of death. Information from a medical professional/facility is also acceptable.

The worker must document the VaCMS case record. Send adequate notice of cancellation to the estate of the enrollee at the enrollee's last known address and to any authorized representative(s) using the Notice of Action on Medicaid.

Cancel the enrollee's coverage, using the date of death as the effective date of cancellation.

4. Enrollee Enters an IMD

When an enrollee enters an institution for the treatment of mental diseases (IMD), **do not** cancel coverage. DMAS will coordinate with the Centers for Medicare and Medicaid Services (CMS) to ensure that no unauthorized FFP occurs

If an enrollee becomes incarcerated, a partial review must be completed to determine if he continues to meet the requirements for coverage in a full-benefit CN covered group. If he continues to be eligible, cancel the existing coverage and reinstate in AC 109 for ongoing coverage the date of incarceration. If the individual no longer meets the requirements for a full benefit CN covered group, cancel the coverage, effective the day prior to entering incarceration. See M0140.000.

5. End of Spenddown Period

When eligibility terminates at the end of a six-month spenddown period, advance notice is not required. The individual is notified of the limited period of spenddown eligibility on the Notice of Action sent at the time the spenddown application is approved. Explanation of this limitation and information relative to re-application is provided at the time of the spenddown eligibility determination and enrollment.

6. Reason "012" Cancellations

DMAS staff are no longer performing cancellations due to returned mail. *Cancellations for other reasons (such as aging out of the current aid category)* are reported in the monthly System Cancellation Report (RS-O-112) available in the Data Warehouse Medicaid Management Reports. The report is issued between the 21st and 25th day of each month and is to be monitored so that appropriate follow up may be made.

TWELVE MONTH EXTENDED MEDICAID INCOME LIMITS 185% of FEDERAL POVERTY LIMITS EFFECTIVE *1-20-23* ALL LOCALITIES

# of Persons in Family Unit/Budget Unit	185% FPL Monthly Limit
1	*$2,248*
2	*3,041*
3	*3,833*
4	*4,625*
5	*5,418*
6	*6,210*
7	*7,003*
8	*7,795*
Each additional person add	*793*

M16 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-28	7/1/23	Table of Contents Pages 1-9, 11 Page 13 was added
TN #DMAS-20	7/1/21	Table of Contents Pages 1-10 Pages 11 and 12 were added.
N/A	10/15/20	Pages 3, 8 Page 8a was added as a runover page.
TN DMAS-12	4/1/19	Page 7
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

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M16 APPEALS PROCESS

M1600.00 APPEALS PROCESS

M1610.100 PURPOSE AND SCOPE

A. Legal Base

The Social Security Act requires that the State Plan for Medical Assistance provide individuals affected by the administration of the Medical Assistance Program an opportunity for a fair hearing. The act establishes the right of any individual to appeal and receive a fair hearing before the administering agency, the Department of Medical Assistance Services (DMAS), when DMAS or any of its designated agents:

- takes an action to terminate, deny, suspend, or reduce benefits,
- fails to take an application for medical assistance,
- fails to act on an application for medical assistance with reasonable promptness, or
- takes any other action that adversely affects receipt of medical assistance.

This chapter applies to client appeals resulting from eligibility determinations made by the Virginia Department of Social Services, its local offices, the Department of Medical Assistance Services, Cover Virginia, and agents *or contractor(s)*.

Many Medicaid members are enrolled with a Managed Care Organization (MCO). The MCO appeals process differs from the Eligibility appeals process and the procedures contained within this chapter do not apply to MCO appeals.

B. Participants

The DMAS Appeals Division provides the Hearing Officer who makes arrangements for the fair hearing. The Appeals Division is separate and apart from operational divisions and units within and outside of DMAS. The Division provides a neutral forum for appeals. The Hearing Officer is an impartial decision-maker who will conduct hearings, decide on questions of evidence, procedure and law, and render a written final decision. The Hearing Officer is one who has not been directly involved in the initial adverse action which is the issue of the appeal.

The Agency or Contractor taking the action being appealed and the appellant (the individual appealing some aspect of entitlement to medical assistance or its scope of services) or their representative must participate in the hearing. Most hearings will be conducted by telephone.

Appeals that result from a self-directed application in the eligibility and enrollment system are handled by the local department of social services (LDSS) that houses *the* processed application.

C. Ex Parte Communication

Ex parte communication with the Hearing Officer is strictly prohibited. Ex parte communication is any off-the-record communication (oral or written) between the Hearing Officer and an interested party outside the presence of the other parties to the proceeding during the life of the appeal proceeding.

The Hearing Officer cannot discuss the substantive issues of an appeal with anyone outside of the hearing. Therefore, it is not appropriate to contact the Hearing Officer to discuss the Agency's action prior to or after the hearing.

Any information provided to the Hearing Officer must be provided to all parties of the proceeding. However, as noted in M1620.100, it is appropriate to notify all parties to the appeal when an action is taken by an Agency to resolve the issue of the appeal. Communication is also allowed for administrative reasons such as scheduling hearings, canceling hearings, and indicating a desire to withdraw an appeal.

D. Notification and Rights

At the time of application or redetermination, and at the time of any action or proposed action affecting eligibility for medical assistance, medical services or patient pay, every applicant for and enrollee of medical assistance shall be informed in writing of the right to a hearing. Appellants shall also be notified of the method by which they may obtain a hearing, and of their right to represent themselves at the hearing or to be represented by an authorized representative such as an attorney, relative, friend, or other spokesperson.

M1620.100 LOCAL AGENCY CONFERENCE

A. Definition and Scope

The Local Agency Conference *(also known as the 'pre-hearing conference")* is an informal process outside of the standard appeal process and does not involve the DMAS Appeals Division. At the conference, the Agency must:

- *explain at the outset that the Local Agency Conference is an informal discussion between the local agency representative and the applicant/enrollee that does not involve the DMAS Appeals Division;*
- *state that the purpose is to describe the reason for the action, give the individual the opportunity to discuss their position/ask questions, and allow the individual to submit documents if they choose;*
- allow the applicant/enrollee to represent themselves or be represented by an authorized representative such as a legal counsel, a friend, or a relative.
- give the applicant/enrollee an explanation of the action;
- allow the applicant/enrollee to present any information to support their disagreement with the action;
- *make clear at the conclusion of the Local Agency Conference that if the applicant/enrollee disagrees with the results of the Local Agency Conference, the standard appeal process remains available;*
- *tell applicants/enrollees who have not yet filed an appeal that the appeal filing timeframes are applicable (30 days from the date of the notice with an additional allowance of five days for mailing – 35 days total from the date of the originating written notice of action) and inform them of the methods to request an appeal; and*

- *tell applicants/enrollees who have already requested an appeal that they may continue the standard appeal process, can submit additional documents directly to DMAS, and should monitor their correspondence for notification of a hearing date.*

B. Time Limits

A dissatisfied applicant or enrollee must be given the opportunity to request a Local Agency Conference. If a conference is requested, it must be scheduled within 10 business days of receiving the request. *The Agency may proactively offer a Local Agency Conference at any point prior to a scheduled hearing, but the applicant/enrollee is not required to participate.*

C. The Conference and Right to Appeal

The Local Agency Conference must not be used as a barrier to the *applicant/enrollee's* right to a fair hearing. Participation in a conference does not extend the *35*-day time limit for requesting an appeal.

D. Failure to Request a Conference

The applicant's or enrollee's failure to request a conference does not affect the right to appeal within 30 days of the Notice of Action on Benefits and does not affect the right to continued *coverage* if the appeal is *submitted* to the DMAS Appeals Division prior to the effective date of the action.

E. Agency Case Review

An Agency representative should review the case before contacting the applicant/enrollee for a Local Agency Conference:

- *If errors are identified, the Agency representative should correct the case, re-determine eligibility, send a new notice of action to the applicant/enrollee, and upload the notice of action to the Appeals Information Management System portal.*

- *If no errors are identified the Agency representative should be prepared to provide an explanation for the adverse action during the Local Agency Conference.*

F. Decision Notification

The Local Agency Conference may or may not result in a change in the Agency's decision to take the action in question; however, an Agency may reverse its decision at any time between making the original decision and when a decision is rendered by the Hearing Officer.

If the Agency decides not to take the adverse action indicated on the notice, the Agency must inform the *applicant/enrollee* in writing. The Agency must send a new notice of action regarding the changed action *to the appellant/enrollee. The Agency must upload the new notice of action to the Appeals Information Management System portal.*

If the Agency's decision is to stand by its action, the applicant/enrollee must be informed, but written notice of this decision is not required.

M1630.100 APPEAL REQUEST PROCEDURES

A. Appeal Definition

An appeal is a request for a fair hearing. The request must be a clear expression by an applicant or enrollee, their legal representative (such as a guardian, conservator, or person having power of attorney), or authorized representative acting at their request, of a desire to present their case to a higher authority.

B. Appeal Request

Applicant/enrollees are encouraged to file and appeal request through the DMAS appeals portal at **https://www.dmas.virginia.gov/appeals/**. *It is also acceptable to file an appeal by other means,* using the "Virginia Medicaid/FAMIS Appeal Request Form," which is available from DMAS at **https://www.dmas.virginia.gov/appeals/**.

The appeal request should identify the action under appeal, the reason for the appeal, and include a copy of the notice of action. The submission should also include acceptable proof of authorization to act on behalf of an applicant or enrollee if an authorized representative is filing on their behalf. Appeals filed more than 35 days after the date on the notice of action should include a good cause statement explaining the reason for filing an untimely appeal. Finally, appellants and their representatives may include any other documentation that they wish the hearing officer to consider.

***C.* How to File an Appeal Request**

1. *Electronically. Via the Appeals Information Management System (AIMS) portal at* ***https://www.dmas.virginia.gov/appeals/*** ***or*** *email an appeal request to* ***appeals@dmas.virginia.gov***
2. **By fax**. Fax an appeal request to DMAS at **(804) 452-5454**
3. **By mail** or **in person.** Send or bring an appeal request to:
   Department of Medical Assistance Services
   Appeals Division
   600 East Broad Street
   Richmond, Virginia 23219
4. **By phone.** Call the Appeals Division at (**804) 371-8488** (**TTY: 1-800-828-1120**).

C. Assuring the Right to Appeal

The right to appeal must not be limited or interfered with in any way. When requested to do so, the Agency must assist the applicant/enrollee in preparing and submitting a request for a fair hearing. The Agency may not discourage an applicant/enrollee from requesting an appeal and may not pressure an appellant to withdraw an appeal that they have already filed.

D. Appeal Time Standards

A request for an appeal must be made within *35* days of the *notice of action (thirty days from the date of the notice with an additional allowance of five day for the mailing – 35 days total from the date of the originating written notice of action).* that Medicaid coverage or medical services has been denied, terminated, reduced, adversely affected, *or that an application or request for coverage* has not been acted upon with reasonable promptness.

Notification is presumed received by the applicant/enrollee within five days of the date the notice was mailed, unless the applicant/enrollee demonstrates that the notice was not received in the five-day period through no fault of *their* own.

An appeal request shall be deemed to be filed timely if it is mailed, faxed, electronically transmitted, or otherwise delivered to the DMAS Appeals Division before the end of last day of filing (30 days plus five mailing days after the date the Agency mailed the notice of adverse action). The date of filing will be determined by:

- the postmark date,
- the date of an internal DMAS receipt date-stamp, or the date the request was faxed or hand-delivered.

In computing the time period, the day of the act or event from which the period of time begins to run shall be excluded, and the last day included. If the time limit would expire on a weekend or state or federal holiday, it shall be extended until the next regular business day.

The DMAS Appeals Division will, at its discretion, grant an extension of the time limit for requesting an appeal if failure to comply with the time limit is due to a good cause such as illness of the appellant or their representative, failure to have been notified of the right to appeal, delay due to the postal service or to an incorrect address, *filing the appeal with another government agency in good faith,* or other unusual or unavoidable circumstances.

M1640.100 CONTINUED COVERAGE PENDING APPEAL DECISION

A. Appeal Validation

Following receipt of a written request for a hearing, the DMAS Appeals Division will determine whether the request is valid. A valid appeal is one that involves an action over which the DMAS Appeals Division has hearing authority, and that is received within the required time limit or extended time limit. During the process of validating an appeal request, a representative of the DMAS Appeals Division may contact the Agency to request a copy of the notice of the adverse action. Upon receipt of such a request, the Agency must immediately send a copy of the notice to the DMAS Appeals Division.

When an appeal is determined to be valid, the DMAS Appeals Division will send official notification to the Agency and identify the issue and Hearing Officer.

B. Coverage May Continue

When an appeal is received and validated, the DMAS Appeals Division decides if Medicaid coverage must continue and notifies the Agency. The Agency should not continue coverage due to the appeal until it has been contacted by the Appeals Division. Upon being informed, by telephone or correspondence, that the enrollee is eligible to receive continued coverage, the Agency must reinstate coverage immediately.

An enrollee's Medicaid coverage must continue until a final appeal decision is made when an appeal hearing is requested prior to the effective date of the action stated on the *Notice of Action*, or when the appeal is requested after the effective date but within 10 days of the *Notice of Action.*

In the case of a patient pay adjustment, the patient pay obligation must return to the amount that was effective prior to the change shown on the Notice of Obligation for Long Term Care Costs that is the subject of the appeal.

C. When Continued Coverage Does Not Apply

Coverage **will not** continue through the date of the appeal decision when:

- an appeal hearing is requested after the effective date of action, or more than 10 days after the Notice of Action if the appellant is given less than 10 days of advanced notice; or the sole issue under appeal is one of Federal or State law or policy, and the Agency promptly informs the appellant that services will be terminated or reduced pending the appeal hearing decision.

D. Recovery of Continued Coverage Costs

When the Hearing Officer determines the appellant is not eligible for coverage, the cost of medical care received during the period of continued coverage may be recovered by DMAS, to the extent they were furnished solely by reason of this section. (See M1670.100)

M1650.100 PRE-HEARING ACTIONS

***A.* Invalidation**

A request for an appeal may be invalidated if it was not filed within the time limit imposed or if it was not filed by the applicant/enrollee or an authorized representative. The Hearing Officer shall issue *the appropriate* final decision.

***1.* Appeal Not Filed Timely**

If DMAS determines that the appellant has failed to file a timely appeal, DMAS shall notify the appellant or the appellant's representative of the opportunity to show good cause for the late appeal.

If there is no response, or if after evaluating the response, the Hearing Officer determines that the reason for failing to file a timely appeal does not meet good cause criteria, the appeal request will be considered invalid and the Hearing Officer will issue the appropriate final decision.

***2.* Factual Dispute of Timeliness**

If a factual dispute exists about the timeliness of the request for an appeal, the Hearing Officer shall receive testimony and evidence at the hearing prior to receiving testimony and evidence about the substantive issue of the appeal. A decision on the timeliness issue will be made prior to a determination of whether to make a decision about the substantive issue of the appeal.

***3.* When Individual Filing Appeal Is Not the Appellant**

If the individual filing the appeal is not the appellant or an authorized representative of the appellant, DMAS will request that the appellant and/or representative provide proof of authorization to represent the appellant. If proof is not provided, the appeal request will be considered invalid and the Hearing Officer will issue the appropriate final decision.

B. Administrative Dismissal

A request for an appeal may be administratively dismissed without a hearing if the appellant has no right to a hearing. The Hearing Officer shall issue a final decision.

***1.* No Adverse Action Taken**

If DMAS learns that no adverse action was taken prior to the date of the appeal request, the Hearing Officer will issue a final decision dismissing the appeal.

2. **Disability Decision Rescinded By DDS**

If the appellant's Medicaid application is returned to a pending status because the Disability Determination Services analyst rescinds the denial of disability*, the Hearing Officer will issue a final decision dismissing the appeal.*

C. Withdrawal

If the appellant requests that the appeal be withdrawn*,* the Hearing Officer will send the appellant a letter acknowledging the withdrawal and no further action will be taken on the appeal. A copy of the letter will be sent to the Agency.

- The appellant must provide the Appeals Division with a statement clearly indicating that they wish to withdraw their appeal. *Appellants or authorized representatives who have established access to the Appeals Information Management System portal may withdraw their appeal electronically within the portal. Otherwise,* the statement or form must be mailed, e-mailed, or faxed to the DMAS Appeals Division.

- In lieu of a written statement, the appellant may make a recorded verbal statement clearly indicating that they wish to withdraw their appeal by calling the Appeals Division at **(804) 371-8488.** Verbal notification to the LDSS by the appellant to withdraw an appeal is **not** sufficient.

D. Failure to Appear

If the appellant or their representative fails to appear at the scheduled hearing, and does not reply within 10 days to the Hearing Officer's request for an explanation that meets good cause criteria, or if the appellant does reply and the Hearing Officer decides that the reply does not meet good cause criteria, the appeal will be closed as "abandoned," and the Hearing Officer will issue a final decision.

E. Administrative Resolution

If, upon reevaluation by the LDSS, the appellant's coverage is reinstated to the full amount of coverage that was in effect prior to closure or reduction of benefits, the appeal will be closed as administratively resolved, and the Hearing Officer will issue a final decision.

NOTE: The Agency should not assume that any new Notice of Action automatically ends the appeal. The Agency must send any new Notices to the Appeals Division, and the Appeals Division will decide whether the appeal is administratively resolved. The Agency will receive a copy of final letters for administrative closures.

F. Judgment on the Record

If the Hearing Officer determines from the record that the Agency's action was clearly in error and that the case should be resolved in the appellant's favor, he shall issue a judgment on the record instead of holding a hearing. The Hearing Officer will provide the Agency with a clear explanation of the reason(s) for issuing a judgment on the record and which actions must be taken by the Agency to correct the case. The decision to issue a judgment on the record is at the Hearing Officer's discretion

G. Remand to the Agency Prior to the Hearing

If the Hearing Officer determines from the record that the case might be resolved in the appellant's favor if the Agency obtains and develops additional information, documentation, or verification, they may remand the case to the Agency for action consistent with the Hearing Officer's written instructions. The Agency must complete the remand evaluation within 30 days or 45 days as applicable.

H. Defective Notices

If the appealed Notice of Action is defective on its face, the Hearing Officer may remand the appeal to the Agency for the issuance of a legally compliant Notice.

For Notices reducing or terminating existing coverage or services, the Hearing Officer will issue a decision that finds in favor of the appellant by ordering the Agency/contractor to reinstate the existing level of coverage or services at issue for a period of at least 30 calendar days; and
Requires the Agency/contractor to issue a new compliant notice prior to the end of the 30 calendar day period by reviewing the same application or service authorization request. If the Agency/contractor requires additional information to process the application or service authorization request, they must ensure that the information is requested and obtained in order to timely issue the new compliant notice.

For Notices concerning new applications for eligibility or requests for new services, the Hearing Officer may issue a decision remanding the Notice to the entity that issued it and order that, within a reasonable period determined by the Hearing Officer, a new compliant Notice be issued to the member on the same eligibility application or service authorization request. If the Agency/contractor requires additional information to process the application or service authorization request, they must ensure that the information is requested and obtained in order to timely issue the new compliant notice. Alternatively, the appellant will be given the option to waive the deficient notice and continue with the State Fair Hearing process.

M1660.100 SCHEDULING THE HEARING

A. Scheduling and Location

The Hearing Officer will select a date and time for the hearing. Typically, hearings are scheduled at least three weeks in advance.

Hearings will be *conducted by telephone* unless the appellant requests a face-to-face hearing. Appellants may request to participate in their hearing at the local Agency rather than appearing telephonically.

Hearings regarding actions taken *by other agents* or contractors will be conducted telephonically.

B. Confirmation Letter

The schedule letter is mailed to the appellant and representative, and a copy is *provided* to the Agency *via the Appeals Information Management System Portal.*

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 Appeals Division as soon as possible and request an alternate date and time for the hearing.

M1670.100 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. There is a form for the Agency Appeal Summary (form #032-03-805) available on Fusion.

When preparing the Agency Appeal Summary, the Agency must consider all documents submitted up until that point, even if the information/documents were submitted for the first time during the appeal process, as discussed below at M1680.100 (A)(5). The Agency Appeal Summary must thoroughly explain the facts, policy, and other relevant information that support the Agency's position on the appeal. The Agency must submit all documents relevant to the Agency's determination with the Agency Appeal Summary.

If new documentation submitted by the appellant during the appeals process would not result in a finding of *medical assistance* eligibility, then the Agency or Contractor must produce an appeal summary explaining why the new documentation did not result in a finding of eligibility and should attend the hearing prepared to explain why the Agency or Contractor maintains its position on the appeal.

B. Send to Appeals Division and Appellant

The Agency must *transmit* one copy of the Agency Appeal Summary and all relevant documentation to the following parties by the due date specified by the Appeals Division at the time of the notification *and in the following manner:*

- Department of Medical Assistance Services, Appeals Division - Electronically via the *Appeals Information Management System* at portal at www.dmas.virginia.gov/appeals. Use of the *Appeals Information Management System* portal is the *required* method for filing the appeal summary with DMAS.

- The appellant or their authorized representative, if the appellant has designated a representative for the appeal, *via U.S. Mail.*

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.

C. Deadline for Submission

In most cases, the Agency Appeal Summary must be submitted to the DMAS Appeals Division and the appellant or their authorized representative within 21 days after the Agency or Contractor is notified of the appeal. The only exception is when the Appeals Division certifies an expedited appeal.

Further, a de novo hearing is a hearing that starts over from the beginning. This means the Hearing Officer must allow the appellant to develop the record fully. The record will consist of any relevant evidence, documentation, and testimony, regardless of whether it was available at the time of the adverse determination. The Hearing Officer's decision will be based solely on the record developed during the de novo hearing process, and it will include an explanation of how the facts apply to the relevant laws, regulations, and policies.

Agencies and Contractors will receive a copy of any new documentation that has been submitted to the DMAS Appeals Division during the appeal process to determine whether it is possible to approve MA coverage. If the Agency or Contractor receives new documentation from the appellant independently during the appeal process, copies of such documentation must be sent to the DMAS Appeals Division. The Agency or Contractor can use new documentation to determine that the appellant is eligible for coverage. If the Agency or Contractor determines that the appellant is eligible, then they shall issue a new *Notice of Action* and provide it to all parties to the appeal. The Hearing Officer must then decide whether it is appropriate to resolve the appeal based upon the new *Notice of Action.*

If the new documentation submitted by the appellant would not result in a finding of MA eligibility, then the Agency or Contractor must produce an appeal summary explaining why the new documentation did not result in a finding of eligibility and must attend the hearing prepared to explain why the Agency or Contractor maintains its position on the appeal.

After the hearing, the DMAS Hearing Officer will issue a decision as to whether or not the appellant is approved for coverage based upon all of the documentation, evidence, and testimony provided by the appellant and the Agency or Contractor.

B. Hearing Officer Evaluation and Decision

1. Evaluation

Following the hearing, the Hearing Officer will prepare a decision taking into account the Agency Appeal Summary, evidence provided by the appellant or their representative, testimony, and additional information provided by the parties. The Hearing Officer will evaluate all evidence, research laws, regulations and policy, and will decide if the applicant or recipient is approved for coverage.

2. Hearing Officer Decision

Examples of the Hearing Officer's decisions include:

a. Sustain

When the Hearing Officer's decision is consistent with the Agency's action, the decision is "sustained."

M21 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-28	7/1/23	Appendix 1
TN #DMAS-25	10/1/22	Page 6
TN #DMAS-24	7/1/22	Page 7
TN #DMAS-23	4/1/22	Appendix 1, page 1
TN #DMAS-21	10/1/21	Pages 4, 5
TN #DMAS-20	7/1/21	Page 2
TN #DMAS-19	4/1/21	Appendix 1, page 1
TN #DMAS-16	4/1/20	Appendix 1, page 1
TN #DMAS-14	10/1/19	Pages 4-6
TN #DMAS-12	4/1/19	Appendix 1, page 1
TN #DMAS-9	7/1/18	Page 5
TN #DMAS-8	4/1/18	Appendix 1, page 1
TN #DMAS-4	4/1/17	Appendix 1, page 1
TN #DMAS-2	1/1/17	Appendix 1, page 1
TN #DMAS-2	10/1/16	Page 3
TN #DMAS-1	6/1/16	Appendix 1, page 1
TN #100	5/1/15	Table of Contents Pages 1-7 Appendices 1 Pages 8-10 and Appendices 2 and 3 were deleted.
UP #10	5/1/14	Pages 1-3 Appendix 1
TN #99	1/1/14	Pages 1-3 Appendix 1
TN # 98	10/1/13	Table of Contents Pages 1-10 Pages 10a and 11-16 were deleted.
UP #9	4/1/13	Pages 3, 4
UP #8	10/1/12	Table of Contents Pages 2-4 Appendix 3 deleted
TN #97	9/1/12	Pages 3, 4
UP #7	7/1/12	Pages 3, 4 Appendix 2, pages 1 Appendix 3, pages 1 and 2
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	Pages 3, 8
TN #95	3/1/11	Table of Contents Pages 5, 6, 14, 15, Page 16 added Appendix 1
TN #94	9/1/10	Page3 Appendix 3, pages 1 and 2
UP #3	3/1/10	Pages 2-5
TN #93	1/1/10	Page 2-4, 8
Update (UP) #2	8/24/09	Page 4

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

EFFECTIVE *1/20/23*

# 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	*$21,870*	*$1,823*	*$29,160*	*$2,430*	*$29,160*
2	*29,580*	*2,465*	*$39,440*	*$3,287*	*$3,370*
3	*37,290*	*3,108*	*49,720*	*4,144*	*4,248*
4	*45,000*	*3,750*	*60,000*	*5,000*	*5,125*
5	*52,710*	*4,393*	*70,280*	*5,857*	*6,004*
6	*60,420*	*5,035*	*80,560*	*6,714*	*6,882*
7	*68,130*	*5,678*	*90,840*	*7,570*	*7,760*
8	*75,840*	*6,320*	*101,120*	*8,427*	*8,638*
Each add'l, add	*7,710*	*643*	*10,280*	*857*	*889*

M22 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-28	7/1/23	Appendix 1
TN #DMAS-24	7/1/22	Pages 1, 2, 5, 6
TN #DMAS-23	4/1/22	Page 6 Appendix 1, page 1
TN #DMAS-20	7/1/21	Page 2
TN #DMAS-19	4/1/21	Appendix 1, page 1
TN #DMAS-18	1/1/21	Page 6
TN #DMAS-16	4/1/20	Appendix 1, page 1
TN #DMAS-14	10/1/19	Page 5
TN #DMAS-12	4/1/19	Appendix 1, page 1
TN #DMAS-8	4/1/18	Appendix 1, page 1
TN #DMAS-6	10/1/17	Page 7 Appendix 1, page 1
TN #DMAS-4	4/1/17	Appendix 1, page 1
TN #DMAS-1	6/1/16	Page 4 Appendix 1, page 1
TN #100	5/1/15	Table of Contents Pages 1, 2, 5, 6, 7 Appendix 1 Pages 3 and 4 are runover Pages.
TN #98	10/1/13	Table of Contents Pages 1-7 Appendix 1 Pages 8-10 were deleted.
UP #9	4/1/13	Appendix 1
UP #8	10/1/12	Pages 2, 3 Page 3a deleted
UP #7	7/1/12	Pages 2, 3
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	Pages 3, 3a
TN #95	3/1/11	Pages 4-6 Appendix 1
UP #4	7/1/10	Page 10
TN #94	9/1/10	Page 3
UP #3	3/01/10	Page 2
TN #93	1/1/10	Pages 2-10
UP #2	8/24/09	Page 3
Update (UP) #1	7/1/09	Pages 1, 2, 7 Appendix 1, page 1

FAMIS MOMS
200% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/20/23*

Household Size	200% FPL Yearly Amount	200% FPL Monthly Amount	205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)
2	*$39,440*	*$3,287*	*$3,370*
3	*49,720*	*4,144*	*4,248*
4	*60,000*	*5,000*	*5,125*
5	*70,280*	*5,857*	*6,004*
6	*80,560*	*6,714*	*6,882*
7	*90,840*	*7,570*	*7,760*
8	*101,120*	*8,427*	*8,638*
Each additional, add	*10,280*	*857*	*889*

M23 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-28	7/1/23	Appendix 1
TN #DMAS-25	10/1/22	Pages 5 & 6. Adjust pages 7-8.
TN #DMAS-24	7/1/22	Page 6
TN #DMAS-23	4/1/22	Page 6 Appendix 1, page 1
TN #DMAS-21	10/1/21	Pages 6, 7

FAMIS PRENATAL COVERAGE
200% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/20/23*

	Enroll Using Aid Category 110			Enroll Using Aid Category 111		
Household Size	**143% FPL Yearly Amount**	**143% FPL Monthly Amount**	**148% FPL (143% FPL + 5% FPL Disregard)**	**200% FPL Yearly Amount**	**200% FPL Monthly Amount**	**205% FPL (200% FPL + 5% FPL Disregard)**
2	*$28,200*	*2,350*	*$2,433*	*$39,440*	*$3,287*	*$3,370*
3	*35,550*	*2,963*	*3,067*	*49,720*	*4,144*	*4,248*
4	*42,900*	*3,575*	*3,700*	*60,000*	*5,000*	*5,125*
5	*50,251*	*4,188*	*4,335*	*70,280*	*5,857*	*6,004*
6	*57,601*	*4,801*	*4,969*	*80,560*	*6,714*	*6,882*
7	*64,951*	*5,413*	*5,603*	*90,840*	*7,570*	*7,760*
8	*72,301*	*6,026*	*6,237*	*101,120*	*8,427*	*8,638*
Each additional, add	*7,351*	*613*	*635*	*10,280*	*857*	*889*