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April 1, 2024

Virginia Medical Assistance Eligibility Manual
Transmittal #DMAS-31

The following acronyms are contained in this letter:

- BCCPTA – Breast & Cervical Cancer Prevention & Treatment Act
- DMAS – Department of Medical Assistance Services
- FAMIS – Family Access to Medical Insurance Security Plan
- MAGI – Modified Adjusted Gross Income
- MN – Medically Needy
- POMS - Social Security Administration Program Operations Manual System
- SSI – Supplemental Security Income
- TN – Transmittal
- WIN – Work Incentive Account (for Medicaid Works)

TN #DMAS-31 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 April 1, 2024.

The following changes are contained in TN #DMAS-31:

Changed Pages	Changes
Subchapter M0320.400	Clarify relationship between Medicaid Works and 1619(b) status; update SSI standard and income limits.
Subchapter M0330.109	If individuals are eligible for the Former Coster Care group they are enrolled there instead of other mandatory CN groups.
Subchapter M0330.700	Correct hyperlink to VDH (regarding BCCPTA); add Former Foster Care to mandatory groups
Subchapter M0440.100 Appendices 1,2,6,7	Update tax filing threshold and clarify that difficulty of care payments can include payments for personal care provided by parents to LTSS eligible children; remove references to COVID-19 payments; update FPL income limits effective 1/17/24.
Chapter S08	Add explanation of POMS relationship to Medicaid rules and hyperlink. Update “S” to “M” in table of contents. Update CN income limits.
Subchapter M0810.002	Update CN income limits.
Subchapter S0820.147	Clarify wage verification service policy.

Chapter M11	Add explanation of POMS relationship to Medicaid rules and hyperlink. Update "S" to "M" in table of contents.
Subchapter M1110.210	Add WIN account to excluded resources (continues for one year after no longer participating in Medicaid Works).
Subchapter M1120.210 Subchapter M1120.235	Add WIN account to excluded resources (continues for one year after no longer participating in Medicaid Works).
Subchapter M1130.00 Subchapter M1130.640	Add WIN account to excluded resources (continues for one year after no longer participating in Medicaid Works).
Subchapter M1140.200 Subchapter M1140.260 Subchapter M1140.990	Add WIN account to excluded resources (continues for one year after no longer participating in Medicaid Works).
Subchapter M1410.300	Update CCCPlus to Cardinal Care MCOs
Subchapter M1450.700	Update DMAS division name to Eligibility Policy & Outreach (EPO); add mailbox address.
Subchapter M1460.150	Update home equity limit and student earned income exclusion.
Subchapter M1460.500	Add WIN account to excluded resources (continues for one year after no longer participating in Medicaid Works).
Subchapter M1470.230	Clarify that "old bills" are bills incurred prior to the effective date of LTSS Medicaid eligibility. Replace references to CCC Plus with Cardinal Care.
Subchapter M1470.900	Clarify that Medicaid covered services provided by out of state dental providers cannot be deducted since Virginia now covers these services. Clarify that bills for services provided by providers who do not participate with Virginia Medicaid cannot be deducted from the patient pay responsibility.
M1480.200 B 3b	Correct grammar regarding who is institutionalized.
Subchapter M1480.225	Clarify that that applicant should provide information about any legal proceeding initiated, protective orders in effect etc. when claiming undue hardship.
Subchapter M1510.102	Add exception for PG woman and Child to when spenddown eligibility ends.
Subchapter M1520.400	Clarify that individuals should be screened for eligibly in a MAGI group prior to placing in Extended Medicaid.
Chapter M20	There is now only one level of Low Income Subsidy (LIS) assistance.
Chapter M21	Update FPL income limits effective 1/17/24.
Chapter M22	Update FPL income limits effective 1/17/24.
Chapter M23	Update FPL income limits effective 1/17/24.

Please retain this TN letter for future reference. Should you have questions about information contained in this transmittal, please contact Sara Cariano, Director, DMAS Eligibility Policy & Outreach Division, at sara.cariano@dmas.virginia.gov or (804) 229-1306.

Sincerely,

Sarah Hatton

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

Attachment

M0320 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-31	4/1/24	Pages 11, 24-30
TN #DMAS-30	1/1/24	Page 23
TN #DMAS-29	10/1/23	Pages 1, 25, 26, 26a, 27, 28
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

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

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

a. Current Title II Benefit = *Benefit Before 1/24 COLA*
3.2 (1/24 Increase)

b. Benefit Before 1/24 COLA = Benefit Before 1/23 COLA
8.7 (1/23 Increase)

c. Benefit Before 1/23 COLA = Benefit Before 1/22 COLA
1.059 (1/22 Increase)

d. Benefit Before 1/22 COLA = Benefit Before 1/21 COLA
1.013 (1/21 Increase)

5. Medicare Premiums

a. Medicare Part B premium amounts:

1-1-24 $174.70
1-1-23 $164.90
1-1-22 $170.10
1-1-21 $148.50
1-1-20 $144.60
1-1-19 $135.50

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

b. Medicare Part A premium amount:

1-1-24 $505.00
1-1-23 $506.00
1-1-22 $499.00
1-1-21 $471.00
1-1-20 $458.00
1-1-19 $437.00

Contact a Medical Assistance Program Consultant for amounts for years prior to *2019*.

6. Evaluation

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

B. Financial Eligibility

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

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

The resource requirements in chapter *M*11 and Appendix 2 to chapter *M*11 apply to this covered group.

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

3. Income The income limits are ≤ 80% of the FPL and are in section M0810.002. The income requirements in chapter *M*08 must be met.

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

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

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

E. Enrollment The ABD 80% group AC is:

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

M0320.400 MEDICAID WORKS

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

- at least age 16 and are under age 65, **and**
- who have countable income less than or equal to *138%* FPL ***and***
- who have countable resources less than or equal to $2,000 for an individual and $3,000 for a couple; **and**

- who are working or have a documented date for employment to begin in the future.
- Current participation in the Social Security Administration (SSA) programs Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) will satisfy the condition for disability. Any applicant without SSA documentation of disability should be evaluated by the state's Disability Determination Services program before eligibility can be established.

These individuals can retain Medicaid coverage as long as they remain employed and their earned income is less than or equal to $6,250 per month. MEDICAID WORKS is Virginia's Medicaid Buy-In (MBI) program.

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

An individual with SSI or eligible for Medicaid as a Qualified Severely Impaired Individual (QSII) (1619(b)) meet *the 138% FPL* income requirement for entry into MEDICAID WORKS and must not be discouraged from enrolling in MEDICAID WORKS. An individual who meets the criteria for 1619(b) status may choose to participate in MEDICAID WORKS because of the higher resource limit.

C. Nonfinancial Eligibility

The individual must also meet the following additional nonfinancial criteria:

- The individual must be competitively employed in an integrated setting. Work must occur in a work setting in the community or in a personal business alongside people who do not have disabilities.

  Work performed in a sheltered workshop or similar setting is **not** considered competitive employment in an integrated setting. Contact a Regional Medical Assistance Program Consultant if there is a question about whether the employment meets the criteria for MEDICAID WORKS.

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

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

- All individuals requesting enrollment in MEDICAID WORKS must also sign a MEDICAID WORKS Agreement, available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms. The agreement outlines the individual's responsibilities as an enrollee in the program.

D. Financial Eligibility

1. Assistance Unit

Initial eligibility determination

To qualify for MEDICAID WORKS, the individual must meet the assistance unit policy and procedures in chapter M05 that apply to ABD non-institutionalized individuals. Individuals receiving SSI or who have 1619(b) status also meet the income requirement for entry into MEDICAID WORKS.

Income from a non-ABD spouse, non-applicant/member ABD spouse, or parents is **not** considered deemable income and is not counted for the initial eligibility determination for individuals requesting to participate in MEDICAID WORKS.

Resources from the individual's spouse with whom he lives or, if under age 21, the individual's parents with whom he lives, must be deemed available.

b. Ongoing eligibility

Once the individual is enrolled in MEDICAID WORKS, **the individual is treated as an assistance unit of one.** Spousal and parental resources and income are disregarded for ongoing enrollee eligibility.

2. Resources

a. Initial eligibility determination

For the initial eligibility determination, the resource limit is $2,000 for an individual and $3,000 for a couple. Resources must be evaluated for all individuals, including SSI recipients and QSII/(1619(b) individuals, who wish to qualify for MEDICAID WORKS. The resource requirements in chapter S11 and Appendix 2 to chapter S11 apply for the initial eligibility determination. The individual's countable, nonexempt resources must be verified. All countable resources, must be added together to determine if the individual's countable resources are within the limit.

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 *$45,976*.

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 Accounts are also excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees**. The account must be exclusively used to hold resources accumulated while in MEDICAID WORKS (including interest) for the exclusion to continue. Resources acquired from earnings while enrolled in Medicaid Works can be spent however the individual chooses. Transfers will be evaluated if the individual applies for LTSS.

3) For **all** other resources, the resource requirements in chapter *M*11 and Appendix 2 to chapter *M*11 apply. All of the individual's countable, nonexempt resources must be verified and evaluated.

All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements. The resource limit for resources not excluded in 1) or 2) above is $2,000 for an individual.

Accounts are also excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees. The account must be exclusively used to hold resources accumulated while in MEDICAID WORKS (including interest) for the exclusion to continue.

4) For **all** other resources, the resource requirements in chapter S11 and Appendix 2 to chapter *M*11 apply. All the individual's countable, nonexempt resources must be verified and evaluated.

All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements. The resource limit for resources not excluded in 1) or 2) above is $2,000 for an individual.

3. Income

a. Initial eligibility determination

For the initial eligibility determination on or after *January 20, 2024*, the limit for total countable income (unearned and earned) is less than or equal to 138% of the FPL (*$1732* per month for an individual or *$2268* when the applicant has an ABD spouse who is also applying for or covered by Medicaid). Use the rules in chapter *M*08 to determine income in the month of application. If the recipient is eligible for a SSI cash payment, the Medicaid 138% FPL income eligibility requirement is met.

b. Ongoing eligibility

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

1) The income limit for earned income is $6,250 per month ($75,000 per year) (no change for *2024*) if the funds are deposited in a WIN Account. The policy for determining countable earned income is contained in subchapter *M*0820.

   If the individual is self-employed, net earnings from self-employment (NESE) must be demonstrated through documentation of Internal Revenue Service (IRS) filings, quarterly estimated taxes, business records, and/or business plans. The individual's signed allegation of self-employment is acceptable if no other evidence of NESE can be obtained. Follow the policy in *M*0820.220 for determining NESE.

2) The income limit for unearned income remains less than or equal to 138% of the FPL. The policy for determining countable unearned income is contained in subchapter *M*0830.

3) Any increase in an enrollee's Social Security Disability benefits resulting from employment as a MEDICAID WORKS participant OR as a result of a COLA adjustment to the Social Security Disability benefits will not be counted as long as the increase is regularly deposited upon receipt into the individual's WIN account.

4) Unemployment insurance benefits received due to loss of employment through no fault of the individual's own are not counted during the six-month safety net period (see M0320.400 G) as income as long as the payments are regularly deposited upon receipt into the individual's WIN account.

4. Income Exceeds 138% FPL at Eligibility Determination

Spenddown does not apply to the Medicaid Works covered group. Therefore, admission into MEDICAID WORKS is not available to individuals whose income exceeds 138% of the FPL. Evaluate the individual's eligibility in all other Medicaid covered groups.

E. Good Cause

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

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

G. Safety Net

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

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

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

Resources accumulated while in MEDICAID WORKS and retained in an IRS-approved account described in M0320.400 D. 2. b. 2) that has been designated as a WIN Account are excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees.

H. Benefit Package

Individuals enrolled in MEDICAID WORKS are entitled to the standard benefits available to full-benefit Medicaid enrollees (see Chapter M18), as well as Personal Assistance Services; MEDICAID WORKS enrollees do **not** have a patient pay. Intensive Behavioral Dietary Counseling is also covered for MEDICAID WORKS enrollees when a physician determines that the service is medically necessary.

I. Entitlement and Enrollment

Entitlement for MEDICAID WORKS is dependent upon meeting the requirements listed above.

There is no retroactive coverage under MEDICAID WORKS. The application date in the Virginia Case Management System (VaCMS) is the date the individual signed the MEDICAID WORKS Agreement. Coverage shall begin on the first day of the month following the month in which all requirements are met. If the applicant has a future start date for employment, the effective date of eligibility shall be no earlier than the first day of employment. However, unless employment begins on the first day of the month, MEDICAID WORKS enrollment will begin on the first of the following month.

The AC for MEDICAID WORKS is 059. Use the following procedures to enroll the individual in VaCMS:

New Application – Applicant is Disabled and enrolled in Medicaid

1. For the month of application and any retroactive months in which the person is eligible, enroll the individual in the appropriate AC in a closed period of coverage, beginning the first day of the month in which eligibility exists. The cancel date is the last day of the month in which the MEDICAID WORKS Agreement was signed. Use Cancel Code 042.
2. Reinstate the individual's coverage in MEDICAID WORKS using AC 059 beginning the first day of the following month (the first day of the month following the month in which the MEDICAID WORKS Agreement is signed). Use the same application date (the actual date of the initial application) that was used for the month of application.

DMAS approval is not required for participation in MEDICAID WORKS; however, information must be sent to DMAS after the individual is enrolled for tracking purposes. Use the MEDICAID WORKS Email Cover Sheet available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms., and **email** it together with the following information to DMAS at *MedicaidWorks@dmas.virginia.gov*:

- the signed MEDICAID WORKS Agreement,
- the Work Incentive Account (WIN) information (a bank account statement or verification from the bank that the account was opened), and
- one of the following verifications of employment:
  - a pay stub showing current employment or
  - an employment letter with start date or
  - self-employment document(s).

Current Enrollee

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

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

Eligibility for MEDICAID WORKS continues ~~as long as~~ *if* the enrollee continues to:

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

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

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

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

M0320.500 300% of SSI INCOME LIMIT GROUPS

A. Introductions

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

B. Covered Groups

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

M0330 Changes
Page 1 of 2

Changed With	Effective Date	Pages Changed
TN #DMAS-31	4/1/24	Pages 8, 26-28
TN #DMAS-30	1/1/24	Pages 1, 2, 4, 6, 8, 10, 12, 17, 20, 23, 34, 35, 38, 40
TN #DMAS-26	1/1/23	Page 10
TN #DMAS-24	7/1/22	Pages 1, 2, 15, 18, 29, 31, 32 Page 2a was added as a runover page.
TN #DMAS-23	4/1/22	Table of Contents Pages 1, 2, 5, 7, 8, 29, 37, 39, 40
TN #DMAS-20	7/1/21	Pages 1, 13, 14
TN #DMAS-19	4/1/21	Pages 14, 26
TN #DMAS-14	10/1/19	Pages 1, 2, 10a
TN #DMAS-12	4/1/19	Pages 26, 28
TN #DMAS-11	1/1/19	Pages 1, 2, 12, 14-16, 24, 25
TN #DMAS-10	10/1/18	Table of Contents Page 1-2, 30 Page 10a-b were added as runover pages.

2. Resources

There is no resource test for the Adoption Assistance Children With Special Needs for Medical or Rehabilitative Care covered group.

3. Income

Adoption assistance children in residential facilities do not have a different income limit. The income limit for Individuals Under Age 21 for one person in the child's locality is used to determine eligibility in the Adoption Assistance Children With Special Needs for Medical or Rehabilitative Care covered group. See M04, Appendix 4.

For a Virginia adoption assistance child with special needs for medical or rehabilitative care living outside the State of Virginia, the income limit for the unit is the income limit for the Virginia locality that signed the adoption assistance agreement.

The adoption subsidy payment is excluded when determining the child's financial eligibility.

If the child's countable income exceeds the income limit for Individuals Under Age 21, evaluate the child in the Adoption Assistance Children With Special Needs for Medical or Rehabilitative Care MN covered group (see M0330.805). Ineligible individuals must be referred to the Health Insurance Marketplace for evaluation for the APTC.

5

D. Entitlement & Enrollment

Entitlement to Medicaid begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

Children under 19 receive 12 months of continuous eligibility unless they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.

The AC for individuals in the Adoption Assistance Children With Special Needs for Medical or Rehabilitative Care covered group is "072."

M0330.109 FORMER FOSTER CARE CHILDREN UNDER AGE 26

A. Policy

P.L. 111-148 (The Affordable Care Act) - The federal Medicaid law requires the State Plan to cover individuals who were formerly in Title IV-E or non-IV-E foster care or the Unaccompanied Refugee Minors Program (URM) when the individual:

- was in the custody of a local department of social services in Virginia, another state, or a U.S. Territory, and receiving Medicaid until his discharge from foster care upon turning 18 years or older, or
- was in the URM program in Virginia or another state and receiving Medicaid until his discharge upon turning 18 years or older, *and*
- is under age 26 years.

A child age 18 and over who is in an Independent Living arrangement or in the Fostering Futures Program with a local department of social services may be eligible in this covered group.

M0330.700 BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT (BCCPTA)

A. Policy

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000 (P.L. 106-354) provides for payment of medical services, including long-term care (LTC) (see Chapter M14) for certain women and men with breast cancer or women with cervical cancer

Individuals eligible for the BCCPTA program must be age 18 through 64. They must have been screened and certified as needing treatment for breast or cervical cancer (including pre-cancerous conditions) by a medical provider operating under the Center for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program (BCCEDP) and referred to LDSS for a Medicaid eligibility determination. These individuals must not have creditable health insurance coverage for treatment of breast or cervical cancer.

Virginia's BCCEDP program, Every Woman's Life, is administered by the Virginia Department of Health. Screening locations can be found at *Free Breast and Cervical Screenings - Free Breast and Cervical Screenings (virginia.gov)*. Information can also be obtained by calling 1-866-395-4968.

Through an agreement between Virginia and the District of Columbia (D.C.), residents of northern Virginia (the cities of Alexandria, Fairfax, Falls Church, Manassas, Manassas Park and the counties of Arlington, Fairfax, Loudoun and Prince William) are allowed to be screened and diagnosed for breast or cervical cancer and pre-cancerous conditions through the DC Center for Disease Control and Prevention's "Project Wish" program. Individuals who are screened and certified as needing treatment for breast or cervical cancer through Project Wish may be eligible for Virginia Medicaid, provided they meet the requirements of the BCCPTA covered group. These individuals will receive a Virginia BCCPTA Application Form from the DC providers and will be instructed to submit the application directly to the local department of social services in their home locality.

Individuals diagnosed with cancer by a provider who is not operating under the BCCEDP are not eligible in this covered group. Every Woman's Life is responsible for determining if an individual was diagnosed by a BCCEDP provider. Refer individuals who indicate to the local agency that they received a breast or cervical cancer diagnosis but do not provide the BCCPTA Application Form to Every Woman's Life (see above for contact information).

B. Nonfinancial Eligibility

1. Required Nonfinancial Requirements

BCCPTA individuals must meet the Medicaid nonfinancial requirements in chapter M02.

In addition, BCCPTA individuals must not be eligible for Medicaid under the following mandatory categorically needy covered groups:

- LIFC;
- Pregnant Women;
- Child Under Age 19;
- SSI recipients;
- *Former Foster Care.*

2. Creditable Health Insurance Coverage

BCCPTA individuals must not have creditable health insurance coverage. Creditable health insurance coverage includes:

- a group health plan;
- health insurance coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;
- Medicare;
- Medicaid;
- armed forces insurance a medical care program of the Indian Health Service (IHS) or of a tribal organization;
- a state health risk pool.

There may be situations where an individual has creditable health insurance coverage as defined above, but the coverage does not include treatment of breast or cervical cancer due to a period of exclusion or exhaustion of lifetime benefits, or the woman may have a high deductible. The *individual* is not eligible for Medicaid in the BCCPTA covered group because *of the* creditable health insurance.

C. Financial Eligibility

There are no Medicaid financial requirements for the BCCPTA covered group. The BCCEDP has income and resource requirements that are used to screen individuals for this program.

Individuals requesting Medicaid coverage of LTC services must provide verification of their resources and income and must meet all the LTC eligibility requirements in chapter M14.

D. Application Procedures

The application procedures for individuals who meet the BCCPTA non-financial requirements have been streamlined to facilitate the prompt enrollment and immediate access to services for individuals who need treatment for breast or cervical cancer. In addition to the nonfinancial information required to evaluate eligibility in the BCCPTA covered group, the following information is needed for enrollment in Medicaid:

- name,
- address,
- sex and race,
- date of birth,
- country of origin and entry date, if an alien.

Individuals who meet the description of individuals in the LIFC, Pregnant Women, Child Under Age 19, or SSI recipients covered groups must complete the appropriate MA application for the covered group and must have an MA eligibility determination completed prior to determining their eligibility in the BCCPTA covered group. If not eligible in *a mandatory coverage group,*

then determine their eligibility in the BCCPTA covered group.

1. Application Form

This covered group has a special application, BCCPTA Medicaid Application (form #032-03-384), **that must be initiated by a BCCEDP provider**, including those affiliated with Project Wish operating in the District of Columbia. The application includes the BCCEDP certification of the individual's need for treatment and the information needed to determine the nonfinancial eligibility in the BCCPTA covered group. Appendix 7 to subchapter M0120 contains a sample of the BCCPTA Medicaid Application form.

If eligibility in another Medicaid covered group must first be determined, the applicant must be given the appropriate Medicaid application.

2. Application Processing Time Frames

BCCPTA Medicaid applications filed by individuals who do not meet the description of an individual in the LIFC, Pregnant Women, FAMIS Plus, or SSI recipients covered groups must be processed within 10 working days of the agency's receipt of the signed application.

BCCPTA Medicaid applications filed by individuals who meet the description of an individual in *one of the mandatory* covered groups must be processed as soon as possible, but no later than 45 calendar days of the agency's receipt of the signed application.

3. Notices

If the BCCPTA Medicaid application is the only application required and no additional information is required, the eligibility decision must be made immediately and applicant must be notified of the decision within 10 working days of the agency's receipt of the application.

If a decision cannot be made within 10 working days of receipt of the BCCPTA application, the worker must send a "Notice of Action on Medicaid", form #032-03-008, on the 10th day stating why action has not been taken, specifying what information is needed and a deadline for submitting the information.

E. Entitlement

1. Entitlement Begin Date

Eligibility under this covered group is met the beginning of the month the screening is completed if the individual later has a positive diagnosis as a result of the screening and is determined to be in need of treatment for breast and/or cervical cancer.

Eligible BCCPTA individuals are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Coverage is to be provided throughout the person's course of treatment, and no limit is placed upon the number of years an eligible person may be covered as long as physician certifies at renewal that treatment for the breast or cervical condition is still required.

2. Retroactive Entitlement

Retroactive coverage is applicable to this covered group if the individual was screened by a medical provider operating under the BCCEDP and diagnosed as needing treatment for breast or cervical cancer in the retroactive month(s).

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Changed With	Effective Date	Pages Changed
TN #DMAS-31	4/1/24	Pages 15 and 16a; Appendices 1, 2, 6 and 7
TN #DMAS-30	1/1/24	Pages 1, 34 Page 34a is a runover page
TN #DMAS-28	7/1/23	Page 37 Appendices 1,2,3,5,6 and 7

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

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

B. MAGI Income Rules

1. Income That is Counted

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

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

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

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

For children and tax dependents, Social Security income only counts toward the total household income if the individual is required to file a federal tax return. Any Social Security benefits the child or dependent may receive do not count as unearned income in determining whether the tax filing threshold is met.

c. Income of a child under 19 in a non-filer household who is NOT living with a parent or parents and who is not required to file taxes because the tax filing threshold is not met.

When determining the total household income of a child who is NOT living with a parent (for example, living with a grandparent) or an individual being claimed by a non-parent, the dependent's income is always counted in determining their own eligibility, even if the income is below the tax filing threshold.

Effective, January 1, *2024*, the Tax Filing Threshold for MAGI income counting purposes *for children* is *$1,250* in unearned income and *$13,850* in earned income. Social Security benefits do not count as unearned income in determining whether the tax filing threshold is met. *If the dependent is married, 65 or over or blind, please see 2023 Publication 501 (irs.gov)*

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

e. Foreign income is counted.

f. Stepparent income is counted.

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

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

h. A parsonage allowance is not counted.

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

j. <u>Student loans</u>

Effective January 1, 2019, student loan debt forgiven due to death or disability of student is not counted as income.

Amounts that an employer paid in 2020 for an employee's student loan principal and interest are not counted in the employee's MAGI.

k. Difficulty of Care Payments, which include (1) payments designated by the payer as compensation for providing additional care that is required for a physically, mentally or emotionally disabled qualified foster care individual living in the provider's home and (2) payments to care providers *(including parents providing personal care to a child)* who provide care under a Medicaid home and-community-based Waiver to an individual in the care provider's home. The care provider's home is the residence in which the care provider resides and regularly performs the routines of the care provider's life. If the care provider moves into an individual's home to care for that individual and performs the routines of the care provider's life in that residence, it is considered the care provider's home.

l. General Welfare Payments for Indian Tribes are not countable To qualify under the general welfare exclusion, the payments must be made pursuant to a governmental program for the promotion of the general welfare based on need and not represent compensation for services (See https://www.irs.gov/pub/irs-drop/n-12-75.pdf)

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

5% FPL INCOME DISREGARD AMOUNTS
ALL LOCALITIES

EFFECTIVE *1/17/2024*

Household Size	**Monthly Amount**
1	*$63*
2	*$86*
3	*$108*
4	*$130*
5	*$153*
6	*$175*
7	*$198*
8	*$220*
Each additional, add	*$23*

GAP-FILLING RULE EVALUATION
100% FPL
INCOME LIMITS

EFFECTIVE *1/17/24*

Household size	Annual (Use for Gap-filling Evaluation)	Monthly
1	*$15,060*	*$1,255*
2	*$20,440*	*$1,704*
3	*$25,820*	*$2,152*
4	*$31,200*	*$2,600*
5	*$36,580*	*$3,049*
6	*$41,960*	*$3,497*
7	*$47,340*	*$3,945*
8	*$52,720*	*$4,394*
Each additional	*$5,380*	*$449*

PREGNANT WOMEN
143% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/17/24*

Household Size	143% FPL Yearly Amount	143% FPL Monthly Amount	148% FPL (143% FPL + 5% FPL Disregard)
2*	*$21,536*	*$1,795*	*$1,858*
3	*$29,230*	*$2,436*	*$2,521*
4	*$36,923*	*$3,077*	*$3,185*
5	*$44,616*	*$3,718*	*$3,848*
6	*$52,310*	*$4,360*	*$4,512*
7	*$60,003*	*$5,001*	*$5,176*
8	*$67,697*	*$5,642*	*$5,839*
Each additional, add	*$75,390*	*$6,283*	*$6,503*

*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 *1/17/24*

# 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	*$1,368*	*$21,536*	*$1,795*	*$1,858*
2	*$1,857*	*$29,230*	*$2,436*	*$2,521*
3	*$2,346*	*$36,923*	*$3,077*	*$3,185*
4	*$2,834*	*$44,616*	*$3,718*	*$3,848*
5	*$3,323*	*$52,310*	*$4,360*	*$4,512*
6	*$3,812*	*$60,003*	*$5,001*	*$5,176*
7	*$4,301*	*$67,697*	*$5,642*	*$5,839*
8	*$4,789*	*$75,390*	*$6,283*	*$6,503*
Each add'l, add	*$489*	*$7,694*	*$642*	*$664*

PLAN FIRST
200% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/17/24*

Household Size	200% FPL Yearly Amount	200% FPL Monthly Amount	205% FPL (200% FPL + 5% FPL Disregard) Monthly Amount
1	*$30,120*	*$2,510*	*$2,573*
2	*$40,880*	*$3,407*	*$3,492*
3	*$51,640*	*$4,304*	*$4,411*
4	*$62,400*	*$5,200*	*$5,330*
5	*$73,160*	*$6,097*	*$6,250*
6	*$83,920*	*$6,994*	*$7,169*
7	*$94,680*	*$7,890*	*$8,088*
8	*$105,440*	*$8,787*	*$9,007*
Each additional, add	*$10,760*	*$897*	*$920*

MAGI ADULTS
133% FPL
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/17/24*

Household Size	133% FPL Yearly Amount	133% FPL Monthly Amount	138% FPL (133% FPL + 5% FPL Disregard)
1	*$20,030*	*$1,670*	*$1,732*
2	*$27,186*	*$2,266*	*$2,351*
3	*$34,341*	*$2,862*	*$2,970*
4	*$41,496*	*$3,458*	*$3,588*
5	*$48,652*	*$4,055*	*$4,207*
6	*$55,807*	*$4,651*	*$4,826*
7	*$62,963*	*$5,247*	*$5,445*
8	*$70,118*	*$5,844*	*$6,063*
Each additional, add	*$7,156*	*$597*	*$619*

M0530 Changes

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TN #DMAS-8	4/1/18	Appendix 1, page 1
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TN #DMAS-1	6/1/16	Appendix 1, page 1
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TN #99	1/1/14	Appendix 1, page 1
UP #9	4/1/13	Appendix 1, page 1
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Update (UP) #5	7/1/11	Page 14
TN #95	3/1/11	Page 1 Appendix 1, page 1
TN #93	1/1/10	Pages 11, 19 Appendix 1, page 1

Deeming Allocations

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

NBD (Non-blind/disabled) Child Allocation

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

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

2024: $1,415 - $943 = $472
2023: $1,371 - $914 = $457
2022: $1,261 - $841 = $420
2021: $1,191 - $794 = $397

Parental Living Allowance

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

SSI payment for one person = *$943 for 2024*; $914 for 2023; $841 for 2022.

The living allowance for both parents living with the child is the SSI payment for a couple.

SSI payment for both parents = *$1,415 for 2024*; $1,371 for 2023; $1,261 for 2022.

Deeming Standard

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

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

2024: $1,415 - $943 = $472
2023: $1,371 - $914 = $457
2022: $1,261 - $841 = $420
2021: $1,191 - $794 = $397

M08 TOC Changes

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GENERAL

M0810.001 INCOME AND ELIGIBILITY

A. Introduction

The following sections explain how to treat income *to determine eligibility in the Aged, Blind and Disabled covered groups* in the Medicaid program. *Virginia Medicaid follows Social Security Administration rules from the SSI section of the Program Operations Manual System (POMS)* [SSA's Policy Information Site - POMS]. *Some of the rules are adapted due to state laws and regulations. We have noted in each section if the section follows SSA policy without deviation by adding "per POMS'*. This chapter explains how we count income.

B. Policy Principles

1. Who is Eligible

An individual is eligible for Medicaid if the person:

- meets a covered group; and
- meets the nonfinancial requirements; and
- meets the covered group's resource limits; and
- meets the covered group's income limits.

2. General Income Rules

- Count income on a monthly basis.
- Not all income counts in determining eligibility.
- If an individual's countable income exceeds a classification's monthly limit, a medically needy spenddown may be established, if appropriate.

M0810.002 INCOME LIMITS

A. Income Limits

The Medicaid covered group determines which income limit to use to determine eligibility.

1. Categorically Needy

Supplemental Security Income (SSI) and State Supplement (Auxiliary Grant) recipient's money payments meet the income eligibility criteria in the ABD Categorically Needy covered group.

2. Categorically Needy Protected Cases Only

Categorically-Needy Protected Covered Groups Which Use SSI Income Limits		
Family Unit Size	2023 Monthly Amount	*2024* Monthly Amount
1	$914	*$943*
2	1,371	*$1,415*
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size	2023 Monthly Amount	*2024* Monthly Amount
1	$589	*$629*
2	$894	*$944*

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	2023 Monthly Amount	*2024* Monthly Amount
1	$2,742	*$2,829*

4. ABD Medically Needy

a. Group I	7/1/21 – 6/30/23		7/1/23	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,138.14	$356.35	$2,324.16	$387.36
2	2,721.95	453.65	2,925.70	493.11

b. Group II	7/1/21 – 6/30/23		7/1/23	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,467.09	$411.18	$2,681.739	$446.95
2	3,037.88	506.31	3,302.13	550.35

c. Group III	7/1/21 – 6/30/23		7/1/23	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$3,207.24	$534.54	$3,486.27	$581.04
2	3,866.55	644.42	4,202.86	700.47

5. ABD Categorically Needy

For:

ABD 80% FPL, QMB, SLMB, & QI without Social Security income; all QDWI; effective *1/17/24*

ABD 80% FPL, QMB, SLMB, & QI with Social Security income; effective *3/1/24*

All Localities	2023		*2024*	
ABD 80% FPL	Annual	Monthly	Annual	Monthly
1	$11,664	$972	*$12,048*	*$1,004*
2	15,776	1,315	*16,352*	*1,363*
QMB 100% FPL	Annual	Monthly	Annual	Monthly
1	$14,580	$1,215	*$15,060*	*$1,255*
2	19,720	1,644	*20,440*	*1,704*
SLMB 120% of FPL	Annual	Monthly	Annual	Monthly
1	$17,496	$1,458	*$18,072*	*$1,506*
2	23,664	1,972	*24,528*	*2,044*
QI 135% FPL	Annual	Monthly	Annual	Monthly
1	$19,683	$1,641	*$20,331*	*$1,695*
2	26,622	2,219	*27,594*	*2,300*
QDWI 200% of FPL	Annual	Monthly	Annual	Monthly
1	$29,160	$2,430	*$30,120*	*$2,510*
2	39,440	3,287	*40,880*	*3,407*

M0815 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-31	4/1/24	TOC page i
TN #DMAS-20	7/1/21	Pages 11, 12
TN #DMAS-17	7/1/20	Table of Contents Pages 11, 12
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TN #DMAS-29	10/1/23	Pages 3, 4, 11, add 15a, 17, 28, 29
TN #DMAS-28	7/1/23	Pages 4, 11, 17, 29. Page 12 is a runover page.
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*M*0820.147 WAGE VERIFICATION COMPAN*IES*

A. Introduction

Employment and wage verification companies generally maintain an up-to-date database of wage information for employers who subscribe to the service. They provide an efficient means to verify wages. Obtaining information from wage verification companies may reduce time-consuming contacts with participating employers when pay stubs are not readily available.

- Consider wage information from The Work Number *or the Federal Data HUB* as valid wage verification, unless the evidence contains missing or discrepant information.
- If you discover a discrepancy in the wage data, resolve the discrepancy by obtaining additional primary or secondary evidence.
- Applicant/Member can provide consent for the worker to access all approved online resources when applying.

IMPORTANT: Application/Members are not required to provide this authorization. Do not request information from *wage verification sources* for individuals who refuse to provide or who have revoked wage and employment information authorization. It will be the applicant/members responsibility to provide the required verifications.

Wage verification companies do not always provide cafeteria plan information and income from tips.

If evidence on the record (e.g., the Wages page, prior pay stubs, etc.) or evidence from the wage verification company indicates that a cafeteria plan may exist, and the wage evidence does not provide exact amounts and evidence on record or evidence from the wage verification company indicates unreported tips, obtain additional primary or secondary evidence.

B. Documentation

Document evidence from a wage verification company as follows:

- Document verified wages in case record.
- Download the verified wage information in the electronic record.
- If a discrepancy exists between the information provided by the wage verification company and other wage evidence obtained, you must resolve the discrepancy by obtaining other wage evidence.

S0820.510 STUDENT CHILD EARNED INCOME EXCLUSION

A. Policy

1. General

For a blind or disabled child who is a student regularly attending school, earned income is excluded under this provision, limited to the maximum amounts shown below.

For Months	Up to per month	But not more than in a calendar year
In calendar year 2024	*$2,290*	*$9,230*
In calendar year 2023	$2,220	$8,950
In calendar year 2022	$2.040	$8,230
In calendar year 2021	$1,930	$7,770

2. Qualifying for the Exclusion

The individual must be:

- a child under age 22; and
- a student regularly attending school.

3. Earnings Received Prior to Month of Eligibility

Earnings received prior to the month of eligibility do not count toward the yearly limit.

4. Future Increases

The monthly and yearly limits will be adjusted annually based on increases in the cost of living index. Under this calculation, these amounts will never be lower than the previous year's amounts. However, there may be years when no increases result from the calculation.

B. Procedure

1. Application of the Exclusion

Apply the exclusion:

- consecutively to months in which there is earned income until the exclusion is exhausted or the individual is no longer a child; and
- only to a student child's own income.

2. School Attendance and Earnings

Develop the following factors and record them:

- whether the child was regularly attending school in at least 1 month of the current calendar quarter, or expects to attend school for at least 1 month in the next calendar quarter, and
- the amount of the child's earned income (including payments from Neighborhood Youth corps, Work-Study, and similar programs).

Verify wages of a student child even if they are alleged to be $65 or less per month.

M0830 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-31	4/1/24	TOC pages i, ii
TN #DMAS-28	7/1/23	Table of Contents, pages i,iv. Pages 8, 9, 23, 83, 84, 86. 87, 124, 124a. Add Pages 32a, 123a, 123b, 124b.
TN #DMAS-27	4/1/23	Pages 7, 124a
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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
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Changed With	Effective Date	Pages Changed
TN #DMAS-31	4/1/24	TOC, Pages 1 and 7
TN #DMAS-30	1/1/24	Page 2
TN #DMAS-27	4/1/23	Pages 6, 7
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TN #DMAS-4	4/1/17	Pages 10, 10a
TN #DMAS-3	1/1/17	Pages 2, 7, 10, 11 Page 10a was added as a runover page.
TN #100	5/1/15	Page 2
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M1110.001 ROLE OF RESOURCES

A. Introduction

As a program based on need, Medicaid uses the value of a person's countable resources as one of two financial criteria in determining eligibility. The other criterion is income. *The following sections explain how to treat resources to determine eligibility in the Aged, Blind and Disabled covered groups in the Medicaid program. Virginia Medicaid follows Social Security Administration rules from the SSI section of the Program Operations Manual System (POMS) SSA's Policy Information Site - POMS. Some of the rules are adapted due to state laws and regulations. We have noted in each section if the section follows SSA policy without deviation by adding "per POMS'. This chapter explains how we count resources.*

B. Policy Principles

1. Monthly Determina-tions

Eligibility with respect to resources is a determination made for each calendar month, beginning with the month of application or, if retroactive eligibility is being determined, the third month prior to the month in which the application is submitted. Resource eligibility exists for the full month if countable resources were at or below the applicable resource limit for any part of the month.

2. Countable Resources

Not everything a person owns (i.e., not every asset) is a resource and not all resources count against the resource limit. *The location of a resource does not by itself exclude the resource. "*The Social Security Act and other Federal statutes require the exclusion of certain types and amounts of resources. Any assets that are resources but not specifically excluded are "countable." See:

- M1110.003 B.2. for the resource limits;
- S1110.100 for the distinction between assets and resources; and
- S1110.210 for a listing of exclusions.

3. Whose Resources Can Count

Medicaid law specifies that resources are only considered available between spouses and from parents to their children under age 21, and for certain blind and disabled children ages 18 to 21.

See M1110.530 for blind and disabled children age 18 to 21.

4. Whose Resources Can Not Count

Medicaid law will not allow certain resources to be considered in determining eligibility. Do not count resources:

- From a step-parent.
- From siblings.
- From spouse or parent living apart unless it is a voluntary financial contribution. (Exception for Long-term care)
- From an alien sponsor.

B. Description—List of Resource Exclusions

Exclusion	Reference	No Limit on Value and/or Length of Time	Limit on Value and/or Length of Time
Life insurance, depending on its face value	M1130.300		X
Burial space or plot held for an eligible individual, his/her spouse, or member of his/her immediate family	M1130.400	X	
Burial funds for an individual and/or his/her spouse	M1130.410		X
Certain prepaid burial contracts	M1130.420		X
Household Goods and Personal Effects	M1130.430	X	
Property essential to self-support	M1130.500-.504		X
Resources of a blind or disabled person which are necessary to fulfill an approved plan for achieving self-support	M0810.430 M1130.510		X
Retained retroactive SSI or RSDI benefits	M1130.600		X
Radiation Exposure Compensation Trust Fund payments	M1130.680	X	
German reparations payments made to World War II Holocaust survivors	M0830.710 M1130.610	X	
Austrian social insurance payments	M0830.715 M1130.615	X	
Japanese-American and Aleutian restitution payments	M0830.720	X	
Federal disaster assistance received because of a Presidentially declared major disaster, including accumulated interest	M0830.620 M1130.620	X	
Cash (including accrued interest) and in-kind replacement received from any source at any time to replace or repair lost, damaged, or stolen excluded resources	M0815.200 M1130.630		X
Certain items excluded from both income and resources by other Federal statutes	M0830.055 M1130.640	Varies	
Agent Orange settlement payments to qualifying veterans and survivors	M0830.730 M1130.660	X	
Victim's compensation payments	M0830.660 M1130.665		X
Tax refunds related to Earned Income Tax Credits	M0820.570 M1130.675		X
Achieving a Better Life Experience (ABLE) accounts	M1130.740		X
Post-PHE Excluded Resources	M1130.720		*X*
Work Incentive Account (WIN)	*M0320.400*		*X*

C. References

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M1120 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-31	4/1/24	Table of Contents
TN #DMAS-18	1/1/21	Table of Contents Pages 27, 28, 29 Pages 28a through 28d were added. Pages 28 d is a runover page
TN #DMAS-11	1/1/19	Page 29
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TN #DMAS-5	7/1/17	Pages 15, 17, 18
TN #DMAS-2	10/1/16	On page 6, updated the format of the header. Neither the date nor the policy was changed.
TN #96	10/1/11	Table of Contents Pages 24-26
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M1130 Changes

Changed With	Effective Date	Pages Changed
TN# DMAS-31	4/1/24	Table of Contents pages i, ii, Page 59
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
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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
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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
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5. Change of Intent

If, after property has been excluded because an individual intends to resume self- support activity, the individual decides not to resume such activity, the exclusion ceases to apply as of the date of the change of intent. Thus, unless excluded under another provision, the property is a resource for the following month.

D. Procedure -- Disabling Condition

1. Individual's Statement

If an individual alleges that self-support property is not in current use because of a disabling condition, obtain the individual's signed statement as to:

- the nature of the condition;
- the date *they* ceased the self-support activity; and
- when *they* intend to resume the activity, if at all.

2. Special Review

Prepare a special review as to whether up to an additional 12 months will be allowed for resuming use of the property.

NOTE: Medical review is not an indicator of an individual's intent or ability to do at least some work.

*M*1130.510 RESOURCES SET ASIDE AS PART OF A PLAN FOR ACHIEVING SELF-SUPPORT *OR WIN ACCOUNTS*

A. Introduction

A plan for achieving self-support (PASS) allows blind and disabled (but not aged) individuals to set aside income and/or resources necessary for the achievement of his ~~its~~ goals.
A Work Incentive Account (WIN) allows blind and disabled individuals to work and set aside income while also being eligible as an SSI OR SSDI recipient.

B. Policy Principle

Resources set aside as part of an approved PASS are excluded.

WIN accounts are excluded up to the SSI Threshold amount if an individual is enrolled in Medicaid Works.

B. Development and Documentation

PASS resources are determined by SSI. See M0810.430 for additional information about PASS. *See M0230.400 for additional information on WIN accounts.*

M1410 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-31	4/1/24	Page 12
TN #DMAS-30	1/1/24	Pages 2 and 9
TN #DMAS-29	10/1/23	Page 11
TN #DMAS-25	10/1/22	Page 2a
TN #DMAS-24	7/1/22	Pages 2, 9, 13
TN #DMAS-21	10/1/21	Page 9
TN #DMAS-18	1/1/21	Page 1
TN #DMAS-17	7/1/20	Table of Contents Pages 1, 4, 8, 11-13 Pages 4a and 7 were removed. Pages 8-14 were renumbered 7-13.
TN #DMAS-14	10/1/19	Pages 10, 12-14
TN #DMAS-12	4/1/19	Page 4, 10-11 Page 4a was added as a runover page.
TN #DMAS-11	1/1/19	Pages 6, 7
TN #DMAS-10	10/1/18	Pages 8-14
TN #DMAS-9	7/1/18	Page 1
TN #DMAS-8	4/1/18	Page 9
TN #DMAS-7	1/1/18	Page 7
TN #DMAS-5	7/1/17	Pages 4-7
TN #DMAS-3	1/1/17	Pages 6, 7, 12-14
TN #DMAS-1	6/1/16	Pages 12-14
TN #100	5/1/15	Page 2
TN #99	1/1/14	Page 10
Update #7	7/1/12	Pages 6, 7
TN #96	10/1/11	Page 11, 12
TN #95	3/1/11	Pages 13, 14 Page 15 was removed.
TN #94	9/1/10	Pages 6, 7, 13
TN #93	1/1/10	Pages 1, 7, 9, 12
TN #91	5/15/09	Pages 11-14

b. Where to Send the DMAS-225.

If the individual is enrolled in a *Cardinal Care managed care organization* (MCO), send the DMAS-225 to the individual's MCO. If known, send it to the individual's care coordinator. Contact information for the *Cardinal Care* MCOs is available at *MCO Member Contact Information - Updated August 1, 2023 (virginia.gov)*.

If the individual is not in managed care, send the DMAS-225 as indicated below:

1) For hospice services patients, including hospice patients in a nursing facility or those who are also receiving CBC services, send the original form to the hospice provider.
2) For facility patients, send the original form to the nursing facility.
3) For PACE or adult day health care recipients, send the original form to the PACE or adult day health care provider.
4) For Medicaid CBC, send the original form to the following individuals
   - the case manager at the Community Services Board, for the Family and Individual Supports (formerly Developmental Disabilities) Waivers;
   - the case manager (support coordinator), for the FIS (DD) Waiver,
   - the personal care provider, for agency-directed CCC Plus Waiver personal care services and other services. If the patient receives both personal care and adult day health care, send the DMAS-225 to the personal care provider.
   - the service facilitator, for consumer-directed CCC Plus Waiver services,
   - the case manager, for any enrollee with case management services, and
   - the case manager at DMAS, for CCC Plus Waiver Private Duty Nursing (PDN) services), at the following address:

     Office *of* Community Living
600 E. Broad St,
Richmond, VA 23219

Retain a copy of the completed DMAS-225 in the case record.

4. Advance Notices of Proposed Action

The recipient must be notified in advance of any adverse action that will be taken on his/her Medicaid eligibility or patient pay.

M1450 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-31	4/1/24	Pages 42 and 46
TN #DMAS-29	10/1/23	Page 37
TN #DMAS-28	7/1/23	Page 35 and Appendix 2
TN #DMAS-27	4/1/23	Page 44
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

- calculation and duration of the penalty period(s) being imposed;
- a brief summary of the applicant/recipient's current eligibility status and living arrangements (nursing facility or community); and
- other documentation provided by the applicant/recipient.

Email the documentation to DMAS at *DMASEvaluation@dmas.virginia.gov or mail to:*

DMAS, *Eligibility Policy and Outreach Division*
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

A copy of all documentation submitted with the undue hardship claim must be retained in the case record.

d. When Applicant/Recipient Was Victim

If the applicant/recipient was a victim of an individual who is not the individual's attorney in fact, guardian, conservator or trustee and undue hardship is claimed, the **agency** must provide a statement documenting the facts and what actions were taken by the agency with regard to their findings. If the transfer was by a court-appointed guardian or conservator, documentation of any bond insurance that would cover the loss must be provided.

e. Undue Hardship Not Claimed or Not Granted by DMAS

If undue hardship is not claimed or if a penalty period must be imposed per DMAS, follow the procedures in M1450.800 through M1450.830 for notifying the individual and DMAS of the action. The individual must be informed that a denial of a claim for undue hardship may be appealed in accordance with the provisions of 12 VAC 30-110. If the individual meets all other eligibility requirements, he is eligible for Medicaid payment of all covered services other than LTC.

2. DMAS

DMAS will review the documentation provided with the undue hardship claim to determine if an undue hardship may be granted and send written notification to the eligibility worker. If additional information is needed to clarify the documentation received with the Undue Hardship claim, DMAS will notify the agency and provide a time frame for submitting the documentation. A copy of the decision must be retained in the individual's case record.

3. Subsequent Claims

If DMAS is unable to approve an undue hardship request because sufficient supporting documentation was not submitted, the claim must be denied and the penalty period must begin. Once a claim is denied, no further decision related to the same asset transfer will be made by DMAS unless the individual experiences a change in circumstances **while still in the penalty period**, such as receiving a discharge notice, that would result in the individual being removed from the institution or becoming unable to receive life-sustaining medical care, food, clothing, shelter or other necessities of life.

C. Send DMAS Notice

The agency worker must send a copy of the DMAS-225 to:

Department of Medical Assistance Services
Eligibility Policy and Outreach Division

600 E. Broad St., Suite 1300
Richmond, VA 23219.

Or email to *Patientpay@dmas.virginia.gov*. The copy of the DMAS-225 must be signed and dated by the worker and must show the worker number and the local agency's FIPS code.

Any information the agency receives about the individual's subsequent receipt of compensation which shortens the penalty period must be sent to the DMAS at the above address.

M1460 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-31	4/1/24	Page 3, 35
TN #DMAS-30	1/1/24	Pages 11 and 19
TN #DMAS-26	1/1/23	Pages 3, 35
TN #DMAS-24	7/1/22	Pages 11, 47, 48
TN #DMAS-23	4/1/22	Pages 12, 23
TN #DMAS-22	1/1/22	Pages 3, 35
TN #DMAS-18	1/1/21	Pages 3, 35
TN #DMAS-15	1/1/20	Pages 3, 35
TN #DMAS-14	10/1/19	Pages 4, 29
TN #DMAS-13	7/1/19	Page 42
TN #DMAS-11	1/1/19	Pages 3-5, 10, 26, 31
TN #DMAS-10	10/1/18	Table of Contents, page i Pages 1-3, 4b, 5, 6, 9, 10, 13, 15, 17a, 18, 18a, 26, 27, 30a, 37, 38 Pages 8a, 11, 19, 30, 39 and 40 are runover pages.
TN #DMAS-8	4/1/18	Pages 18a, 32, 35
TN #DMAS-7	1/1/18	Pages 3, 7
TN #DMAS-3	1/1/17	Pages 3, 4, 4b, 24, 25, 29
TN #DMAS-2	10/1/16	Page 35
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 3, 8a, 17, 32
TN #100	5/1/15	Table of Contents, page i Pages 1, 2, 5, 6, 10, 15, 16-17a, 25,41-51
TN #99	1/1/14	Pages 3, 35
UP #9	4/1/13	Table of Contents Pages 3, 35, 38, 41, 42, 50, 51
TN #97	9/1/12	Table of Contents Pages 1, 4-7, 9-17 Page 8a was deleted. Pages 18a-20, 23-27, 29-31 Pages 37-40, 43-51 Pages 52 and 53 were deleted
UP #6	4/1/12	Pages 3, 35
TN #96	10/1/11	Pages 3, 20, 21
TN #95	3/1/11	Pages 3, 4, 35
TN #94	9/1/10	Page 4a
TN #93	1/1/10	Pages 28, 35
TN #91	5/15/09	Pages 23, 24

11. Old Bills

Old bills are unpaid medical, dental, or remedial care expenses which:

- were incurred prior to the Medicaid application month and the application's retroactive period,
- were not fully deducted from (counted in) any previous sp3enddown budget period where the spenddown was met, and
- remain a liability to the individual.

EXCEPTION: Bills paid by a state or local program and which meet the definition of "old bills" are treated as old bills even though they are not the individual's liability.

12. Projected Expenses

Expenses for services that have not yet been incurred but are reasonably expected to be incurred are projected expenses.

13. Spenddown Liability

The spenddown liability is the amount by which the individual's countable income exceeds the MNIL for the budget period.

M1460.150 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LTSS

A. Applicability

The policy in this section applies to nursing facility and CBC/PACE patients, including MAGI Adults effective January 1, 2019, who meet the requirements for LTC services, now called long term services and supports (LTSS), on or after January 1, 2006. This includes individuals who filed reapplications after a break in Medicaid eligibility. It does **not apply** to Medicaid recipients who were approved for LTSS prior to January 1, 2006, and who maintain continuous Medicaid eligibility.

For Medicaid applicants or enrollees approved for LTSS on or after July 1, 2006, the amount of equity in the home at the time of the initial LTSS determination and at each renewal must be evaluated.

B. Policy

Individuals with equity value (tax assessed value minus encumbrances) in home property that exceeds the limit are NOT eligible for Medicaid payment of LTSS unless the home is occupied by

- a spouse,
- a dependent child under age 21 years, or
- a blind or disabled child of any age.

If substantial home equity exists, the individual is not evaluated for or eligible for the Medicaid payment of LTSS. Do not evaluate asset transfers.

An individual with excess home equity is not eligible in the 300% of SSI covered group, but may be eligible for Medicaid payment of covered services other than LTSS if he is eligible in another covered group. Evaluate eligibility for an individual with substantial home equity in other covered groups.

1. Home Equity Limit

The applicable home equity limit is based on the date of the application or request for LTC coverage. The home equity limit is:

- Effective January 1, 2022: $636,000
- Effective January 1, 2023: $688,000
- *Effective January 1, 2024: $713,000*

6. Domestic Travel Tickets

Gifts of domestic travel tickets [1612(b)(15)].

7. Victim's Compensation

Victim's compensation provided by a state.

8. Tech-related Assistance

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

9. $20 General Exclusion

$20 a month general income exclusion for the unit.

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

10. PASS Income

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

11. Earned Income Exclusions

The following earned income exclusions are not deducted for the 300% SSI group:

a. *For 2024, up to $2,290 per month, but no more than $9,230 in a calendar year, of the earned income of a blind or disabled child.*

   For 2023, up to $2,220 per month, but not more than $8,950 in a calendar year, of the earned income of a blind or disabled student child.

   For 2022, up to $2.040 per month, but not more than $8,230 in a calendar year, of the earned income of a blind or disabled student child.

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

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

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

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

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

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

12. Child Support

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

M1470 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-31	4/1/24	Page 10
TN #DMAS-30	1/1/24	Page 20
TN #DMAS-29	10/1/23	Pages 46-48
TN #DMAS-28	7/1/23	Page 19, Appendix 1
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

Notify the patient or the patient' authorized representative of the denial of the request using the Notice of Action.

If a noncovered service is already being deducted, leaving no patient pay, and a new deduction for another noncovered service has been approved, notify the patient or his authorized representative that the deduction for the new noncovered service will be made after the first noncovered service deductions are completed.

2. Allowable Non-covered Expenses

When a patient has income available for patient pay, the following can be deducted as noncovered expenses:

a. Old Bills

"Old bills" are deducted from patient pay as noncovered expenses. "Old bills" are unpaid medical, dental or remedial care expenses which:

- were incurred prior to the Medicaid *full coverage effective date*, or the service was not a Medicaid- covered service;
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met; **and**
- remain a liability to the individual.
- **"Old bills" do not require approval from DMAS in order to be deducted in the patient pay calculation even when the amount of the "old bill" exceeds $500.**

b. Services Provided By A Non-participating Provider

Medical and dental services that are covered by Medicaid, but that the *Medicaid* enrollee receive*s* from a provider who does not participate in Virginia Medicaid, *CANNOT be* deducted from patient pay as non-covered services.

c. Covered Services Outside of Medicaid's Scope

Medically necessary medical and dental services exceeding Medicaid's amount, duration, or scope can be deducted from patient pay. Scope includes benefits or services provided by the enrollee's MCO (managed care organization).

d. Other Allowable Noncovered Services

1) The following medically necessary medical and dental services that are NOT covered by Medicaid or by benefits provided by the enrollee's MCO can be deducted from patient pay by the local department of social services without DMAS approval when the cost does NOT exceed $500. **If the service is not identified in the list below and/or the cost of the service exceeds $500, send the request**

3a. Managed Care Organizations and CCC Plus (effective January. 1, 2018)

As of January 1, 2018, the majority of Medicaid-eligible individuals who receive long-term service and support (LTSS) are covered under the CCC Plus program through one of six (6) managed care organizations (MCO). As part of the CCC Plus program, each health plan offers enhanced benefits, such as adult dental services or hearing aids, outside of the required contracted Medicaid services. Some of these enhanced benefits are frequently submitted to the LDSS as patient pay adjustment.

If there are other coverage sources available for these services or items, Medicaid policy requires the request for coverage first be submitted to those sources and exhausted there, before the LDSS/DMAS may consider or approve a patient pay adjustment.

A process is in development to develop a procedure for distinguishing MCO enhanced benefit services from allowable patient pay deductions. Until further notice, providers and nursing facilities will continue sending all patient pay adjustment requests to the patient's LDSS eligibility worker.

Eligibility workers will review and process patient pay adjustment requests without requiring submission of the request to the individual's CCC Plus plan.

4. Documentation Required

a. Requests For Adjustments From A Patient or Authorized Representative

Request the following documentation from the patient or his representative:

- a copy of the bill;
- if applicable, the amount owed that was not covered by the patient's insurance;
- proof that the service was medically necessary. Proof may be the prescription, doctor's referral, or a statement from the patient's doctor or dentist. Proof applies to a physician, doctor, or dentist's current, and not "standing", order(s).

Do not send requests for adjustments to DMAS when the patient has no available income for patient pay. Refer to M1470.230 C.5.c for notification procedures to be followed by the local worker.

When a request for an adjustment is approved or denied by DMAS, the local DSS worker will receive a copy of the letter sent to the recipient by DMAS:

1) If approved, adjust the patient pay using the VaCMS Patient Pay process.

2) If the adjustment request is denied, DMAS prepares the notification.

b. DMAS Approval Not Required

Determine if the expense is deducted from patient pay using the following sequential steps:

1) Upon receipt of the requested documentation, determine the amount of the bill that is a valid deduction. Do not deduct more than the available income that remains after the personal needs, dependent child allowance(s), and health insurance premiums are deducted.

   If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service is requested, deduct the new noncovered services after the first noncovered service deductions have been completed.

2) Subtract the deduction for the month following the month the change is reported. If the deduction exceeds the available income, the remaining balance can be carried over to the following month(s).

c. Notice Procedures

Upon the final decision to allow the deduction, use the VaCMS Patient Pay process to adjust the patient pay. VaCMS will generate and send the Notice of Patient Pay Responsibility.

6. *Cardinal Care* Managed Care Organizations (effective *October 1,2023*)

As of *October 1, 2023*, the majority of Medicaid-eligible individuals who receive long-term care (LTC) services are covered under *Cardinal Care* through one of six (6) managed care organizations (MCOs). As part of *Cardinal Care*, each health plan offers enhanced benefits outside of the required contracted Medicaid services. Some of these enhanced benefits are frequently submitted to the LDSS as patient pay adjustment.

If there are other coverage sources available for these services or items, Medicaid policy requires the request for coverage first be submitted to those sources and exhausted there, before the LDSS/DMAS may consider or approve a patient pay adjustment.

A process is in development to develop a process for distinguishing MCO enhanced benefit services from allowable patient pay deductions. Until further notice, providers and nursing facilities will continue sending all patient pay adjustment requests to the patient's LDSS eligibility worker.

Eligibility workers will review and process patient pay adjustment requests without requiring submission of the request to the individual's *Cardinal Care* plan.

M1470.240 FACILITY - HOME MAINTENANCE DEDUCTION

A. Policy

A single institutionalized individual can be allowed a deduction for the cost of maintaining a home for not more than six months if a physician has certified he or she is likely to return home within that period.

Home maintenance means that the individual has the responsibility to pay shelter costs on his former place of residence in Virginia, such as rent, mortgage, utilities, taxes, room and board, or assisted living facility (ALF) payments, and that the home, apartment, room or bed is being held for the individual's return to his former residence in Virginia. Individuals who have no responsibility to pay shelter costs are not permitted a home maintenance deduction. If responsibility for shelter costs is questionable, documentation must be requested and provided.

EXCEPTION: For an individual admitted to a nursing facility from an ALF, deduct a home maintenance allowance for the month of entry even if the admission to the nursing facility is not temporary.

Only one spouse of an institutionalized married couple (both spouses are in a medical facility) is allowed the deduction to maintain a home for up to six months, if a physician certifies that he is likely to return home within that period.

M1480 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-31	4/1/24	Page 8a
TN #DMAS-30	1/1/24	Pages 3, 7, 18c, 66, 69, 70
TN #DMAS-29	10/1/23	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

M1480.200 RESOURCE ASSESSMENT RULES

A. Introduction

A resource assessment must be completed when an institutionalized spouse with a community spouse applies for Medicaid coverage of long term care services and may be requested without a Medicaid application.

A resource assessment is strictly a:

- compilation of a couple's reported resources that exist(ed) at the first moment of the first day of the month in which the first continuous period of institutionalization began on or after September 30, 1989.
- calculation of the couple's total countable resources at that point, and
- calculation of the spousal share of those total countable resources.

A resource assessment does not determine resource eligibility but is the first step in a multi-step process. A resource assessment determines the spousal share of the couple's combined countable resources.

B. Policy Principles

1. Applicability

The resource assessment and resource eligibility rules apply to individuals who began a continuous period of institutionalization on or after September 30, 1989 and who are likely to remain in the medical institution for a continuous period of at least 30 consecutive days, or have been authorized for Medicaid CBC waiver services, or have elected hospice services.

The resource assessment and resource eligibility rules do **NOT** apply to individuals who were institutionalized before September 30, 1989, **unless** they leave the institution (or Medicaid CBC waiver services) for at least 30 consecutive days and are then re-institutionalized for a new continuous period that began on or after September 30, 1989.

Resource Assessment policy does not apply to individuals eligible in the MAGI Adult covered group. However, a resource assessment may be needed when a married individual FORMERLY received LTSS as a MAGI Adult, and needs to be re-evaluated for LTSS in a non-MAGI group. If the individual is currently married but was not married on the first day of the first continuous period of institutionalization, no resource assessment is needed.

2. Who Can Request

A resource assessment without a Medicaid application can be requested by the institutionalized individual in a medical institution, his community spouse, or an authorized representative. See section M1410.100.

3. When to Do A Resource Assessment

a. Without A Medicaid Application

A resource assessment without a Medicaid application may be requested when a spouse is admitted to a **medical institution**. Do not do a resource assessment **without** a Medicaid application unless the individual is in a medical institution.

b. With A Medicaid Application

The spousal share is used in determining the institutionalized individual's resource eligibility. A resource assessment must be completed when a married institutionalized individual *has* a community spouse *and*

On the Medicaid Resource Assessment form the worker lists the couple's resources as of December 1, 1995 as follows:

Resource	Owner	Countable	Countable Value
Home	Mr & Mrs	No	0
Savings	Mr & Mrs	Yes	$100,000
CD	Mr	Yes	$31,000

$131,000 Total Value of Couple's Countable Resources
$ 65,500 Spousal Share

In the eligibility evaluation, the worker uses the spousal share amount ($65,500) as one factor to determine the spousal protected resource amount (PRA) that is subtracted from the couple's current resources to determine the institutionalized spouse's resource eligibility.

F. Notice Requirements

Do not send the Notice of Medicaid Resource Assessment when a resource assessment is completed as a part of a Medicaid application.

Include a copy of the Medicaid Resource Assessment form with the Notice of Action on Medicaid that is sent when the eligibility determination is completed.

M1480.225 INABILITY TO COMPLETE THE RESOURCE ASSESSMENT-UNDUE HARDSHIP

A. Policy

Federal law states that a resource assessment must be completed on all Medicaid applications for institutionalized individuals who have a community spouse. On occasion, however, it is difficult to comply with this requirement because the applicant is unable to establish his marital status or locate a separated spouse, or the community spouse refuses or fails to provide information necessary to complete the resource assessment. In situations where the applicant is unable to provide information necessary to complete the resource assessment, undue hardship can be claimed if each of the following criteria is met:

1. The applicant establishes by affidavit specific facts sufficient to demonstrate (a) that he has taken all steps reasonable under the circumstances to locate the spouse, to obtain relevant information about the resources of the spouse, and to obtain financial support from the spouse *(including information about any legal proceedings initiated, protective orders in effect, etc.)*; and (b) that he has been unsuccessful in doing so;

   Absent extraordinary circumstances, determined by DMAS, the requirements of A.1 (a) cannot be met unless the applicant and spouse have lived separate and apart without cohabitation and without interruption for at least 36 months.

2. Upon such investigation as DMAS may undertake, no *relevant* facts are revealed that refute the statement contained in the applicant's affidavit, as required by paragraph A.1.

M1510 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-31	4/1/24	Pages 7 and 8
TN #DMAS-30	1/1/24	Page 1, 2a, 8a,
TN #DMAS-24	7/1/22	Pages 8, 9a, 12-14
TN #DMAS-22	1/1/22	Page 8a Page 8 is a runover page.
TN #DMAS-21	10/1/21	Page 9a
TN #DMAS-19	4/1/21	Pages 6, 8
TN #DMAS-18	1/1/21	Pages 2b, 9, 12
TN #DMAS-17	7/1/20	Page 15
TN #DMAS-16	4/1/20	Pages 5, 6, 12, 13 Pages 14 and 15 are runover pages.
TN #DMAS-14	10/1/19	Pages 2b, 4, 5-7
TN #DMAS-12	4/1/19	Pages 7, 9a. Page 7a is a runover page.
TN #DMAS-11	1/1/19	Page 7

If the patient is discharged from the facility and the patient meets all eligibility factors, the agency will enroll the patient effective the date of discharge.

EXAMPLE #6b: Mr. A is a 50 year old patient at Central State Hospital (an IMD). He receives Social Security disability benefits. The CSB sends his local agency a Medicaid application which is received on August 18. The facility's statement notes that he will be discharged on September 17 to ABC Nursing Home, a nursing facility. The agency completes the determination on August 27 and finds that he will be eligible once he is discharged to the nursing facility.

The agency does not enroll Mr. A until the discharge is confirmed. The CSB case manager calls the agency on September 21 and informs the agency that the patient was discharged to the ABC Nursing Home on September 18. The patient is enrolled in Medicaid with a begin date of September 18.

4. Offenders (Incarcerated Individuals)

Individuals who meet all Medicaid eligibility requirements, including eligibility in a **full benefit** CN covered group, are eligible for Medicaid coverage limited to inpatient hospitalization while incarcerated. Enroll eligible MAGI Adults in aid category AC 108 and all other offenders in aid category AC 109 regardless of their covered group.

See M0140.000 regarding incarcerated individuals and M1520.102 for ongoing entitlement.

5. MAGI Adult Turns 65 or Eligible for Medicare

When an individual enrolled in the Modified Adjusted Gross Income MAGI Adults covered group turns 65 years old, begins to receive Medicare or is eligible to receive Medicare, he is no longer eligible in the MAGI Adults covered group. Evaluate the individual for eligibility in an Aged, Blind or Disabled covered group. If the individual is not eligible in any other covered group, cancel his coverage following the policy in M1510.102 B below.

B. Coverage End Date

Medicaid entitlement ends the last day of the month in which the recipient fails to meet all of the Medicaid eligibility requirements, unless the recipient is a CN pregnant woman or is age 22 or over, but under age 65 and was admitted to an IMD.

Medicaid coverage is canceled on the last day of the month in which the agency determines that the recipient no longer meets the eligibility requirements IF the agency can send an advance notice to the recipient at least 11 days before the last day of the month. If the agency cannot send the notice at least 11 days before the end of the month, coverage is canceled effective the last day of the next month.

1. CN Pregnant Woman

After eligibility is established, a pregnant woman in any CN covered group continues to be eligible for Medicaid during the remainder of her pregnancy and for 12 months following the end of the month in which her pregnancy ends, regardless of any changes in family income, as long she continues to meet all non-financial criteria. If the woman becomes pregnant while she is in the 12 month coverage period, she is entitled to an additional 12 months of coverage following the end of the second pregnancy.

2. Individual Admitted to Ineligible Institution Other than an IMD

Cancel coverage as soon as possible after learning of the enrollee's admission to an ineligible institution. **DO NOT cancel coverage retroactively.** Cancel coverage effective the current date (date the worker enters the cancel transaction in the system)." **An Advance Notice of Proposed Action is not required.** Send a Notice of Action to the enrollee or his authorized representative informing him of the cancel date and the reason.

Note: An individual of any age who is **enrolled in Medicaid** at the time of admission to an **IMD** may remain enrolled in Medicaid. **Do not cancel coverage**. The Department of Medical Assistance Services (DMAS) will coordinate with the Centers for Medicare and Medicaid Services (CMS) to ensure that no unauthorized FFP occurs for individuals age 22 years or over but under age 65 years.

3. Spenddown Enrollees

Medicaid entitlement ends on the last day of the last month in the spenddown budget period, unless the individual's or family's circumstances change before that date. *Exceptions:*

a. Medically Needy Pregnant Woman
Pregnant woman who meet a spenddown are entitled to MN coverage for 12 months following the end of the month in which the pregnancy ends.

b. *Medically Needy child*
After meeting s spenddown children under 19 receive 12 months of continuous eligibility unless they reach age 19; are no longer Virginia residents; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.

C. Ongoing Entitlement After Resources Are Reduced

When an applicant has excess resources throughout the application month, he is not eligible for Medicaid for the month of application. An applicant who reduces excess resources during the month of application or a subsequent month before action is taken on the application may become eligible in the month in which the value of his resources is reduced to, or below, the Medicaid resource limit. In order to reduce resources, the resources must actually be expended and the expenditure documented. (For example: a receipt, a canceled check, or a bank statement).

Reduction of resources is an asset transfer and must be evaluated under asset transfer policy (subchapter M1450). When excess resources are reduced, entitlement to ongoing Medicaid may begin no earlier than the first day of the month in which the resources were reduced to the Medicaid limit. When retroactive coverage is requested, policy in M1510.101 above must be followed.

Changed With	Effective Date	Pages Changed
TN #DMAS-31	4/1/24	Pages 15 and 16
TN #DMAS-30	1/1/24	Pages 3, 10, 10a, 13, 14, 18
TN #DMAS-29	10/1/23	Pages 3, 4, 7, 8, 12, 14, 15
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

8. Enrollee Requests Cancellation

An enrollee may request cancellation of his and/or his children's medical assistance coverage at any time. The request can be verbal or written. Documentation of a written withdrawal request must be placed in the case record. A verbal request for withdrawal can be accepted only from the enrollee or case head, or his authorized representative. A verbal request must be documented in the case record with the date and time the withdrawal request was received, the name of the person who made the withdrawal request, and the name of the agency staff person who took the call.

When the enrollee requests cancellation of Medicaid, the local department must send adequate notice using the Notice of Action to the enrollee no later than the effective date of cancellation.

On the notice:

- check the "other" block and list the reason as "Medicaid coverage cancelled at the enrollee's request,"
- include the effective date of cancellation and instruct the enrollee to discontinue using the card after that date, and
- instruct the enrollee to retain the Medicaid card for future use in case coverage is reinstated within the next 12 months (the system will generate a new card after 12 months).

M1520.400 EXTENSIONS OF MEDICAID COVERAGE

A. Policy

Medicaid families may be eligible for an extended period of Medicaid coverage when the family meets all the requirements for the Low Income Families with Children (LIFC) covered group except income.

LIFC families who received Medicaid in three of the last six months and who became ineligible for Medicaid due to increased income from spousal support may be eligible for a four-month extension.

LIFC families who received Medicaid in three of the last six months and who became ineligible for Medicaid due to an increase in earnings may be eligible for a twelve-month extension. Earnings could increase because of a new job, a raise in the rate of pay or more hours are being worked.

Prior to evaluating the case for the Medicaid extensions, review the household's eligibility in the MAGI covered groups. If eligible, update the renewal date. If anyone in the household is ineligible in a MAGI group, evaluate eligibility for the Medicaid extensions.

MAGI methodology for the formation of households does not apply to individuals in Extended Medicaid. The family unit policies in M0520 apply to Extended Medicaid.

If ineligible *in a MAGI group or* the Medicaid extensions, individuals must be must be evaluated for eligibility *in any other applicable* covered groups. If a child under 18 is ineligible, the child must be given an opportunity for a

medically needy determination prior to the worker taking action to cancel the Medicaid coverage. Unless the child has Medicare, a referral to the *Marketplace* must be made *if the coverage is closed*.

B. Procedure

The policy and procedures for the four-month extension are in section M1520.401 below.

The policy and procedures for the twelve-month extension are in section M1520.402 below.

M1520.401 FOUR-MONTH EXTENSION

A. Policy

An LIFC Medicaid family is entitled to four additional months of Medicaid coverage after the family loses Medicaid LIFC eligibility when the following conditions are met:

- The parent or caretaker-relative received Medicaid as LIFC in at least three of the six months immediately preceding the month in which they became ineligible for LIFC;
- The parent or caretaker-relative lost eligibility solely or partly due to receipt of or increased **countable** spousal support income; and
- All other Medicaid eligibility factors except income are met.

Effective January 1, 2019, alimony or spousal support is not countable as income. Alimony received prior to January 1, 2019 is countable.

An individual whose divorce decree was finalized prior to January 1, 2019, has the option with the IRS to adopt the new rule by modifying the divorce agreement. A copy of the modified divorce agreement must be provided to the eligibility worker; otherwise, the alimony or spousal support continues to be countable.

B. Procedures

1. Received in Error

For purposes of this subsection, "received Medicaid as LIFC" does not include received Medicaid erroneously. Therefore, a family who received Medicaid erroneously during three or more of the six months before the month of ineligibility does **not** qualify for the Medicaid extension and must be evaluated for eligibility in other covered groups.

2. New Family Member

A new member of the family, other than a newborn, is eligible for Medicaid under this provision if he/she was a member of the family in the month the unit became ineligible for LIFC Medicaid. A newborn born to an eligible member of the family at any time during the 4-month extension is eligible under this provision because the baby meets the CN newborn child under age 1 covered group.

3. Moves Out of State

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

M20 Changes

Changed With	**Effective Date**	**Pages Changed**
TN #DMAS-31	4/1/24	Page 1
TN #96	10/1/11	Table of Contents pages 1, 2 Pages 3-18 and Appendices 1-9 were removed.
Update (UP) #3	3/01/10	Table of Contents, page ii Appendix 3, page 1
TN #93	1/1/10	Table of Contents, page ii pages 3, 5, 6, 7, 10, 11, 15 Appendix 1, page 1 Appendix 2, page 1 Appendix 3, page 1 Appendix 4, page 1

M2000.000 EXTRA HELP - MEDICARE PART D LOW-INCOME SUBSIDY

M2010.100 EXTRA HELP GENERAL INFORMATION

A. Introduction

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173) amended Title XVIII of the Social Security Act by establishing Medicare Part D, the Voluntary Prescription Drug Benefit Program for individuals who are entitled to Medicare Part A and/or enrolled in Medicare Part B.

B. Medicaid and Medicare Part D Prescription Drug Coverage

For the purposes of Medicare Part D, individuals who are eligible for both Medicare and Medicaid benefits are considered dually eligible. Effective January 1, 2006, Medicaid does not provide prescription drug coverage for dually eligible individuals. These individuals receive their prescription drug coverage through Medicare Part D. Medicaid will only cover prescription medication that cannot be covered by Medicare under the MMA, including some controlled medications.

Medicare beneficiaries who are not eligible for Medicaid and who choose to participate in Medicare Part D are subject to cost-sharing obligations, including monthly premiums, deductibles, and copayments.

C Extra Help Low Income Subsidy

Extra Help is the subsidy provided under Medicare Part D that reduces out-of-pocket expenses for Medicare Part D enrollees who, based on their income and resources, are determined to be low-income. Extra Help is the public name for the subsidy program; the Social Security Administration (SSA) generally refers to the subsidy as Low-Income Subsidy (LIS) in its contacts with state Medicaid programs. *As of January 1, 2024, there is only one level of the LIS* - the full subsidy. The individual's income and resources determine *eligibility for* the subsidy.

1. Dually Eligible Individuals Have Full LIS – No Premiums, Deductibles or Copays

Dually eligible individuals are automatically eligible for the LIS and are enrolled using data matches from the Department of Medical Assistance Services (DMAS) and the Centers for Medicare and Medicaid Services (CMS). Under the full LIS, dually eligible individuals have no Medicare Part D premiums, deductibles, or threshold costs. All dually eligible individuals except those in nursing facilities have copayments ranging from $1 to $5 per prescription.

2. Non Dually Eligible Individuals

Medicare beneficiaries who are not eligible for Medicaid must apply for the subsidy and be determined eligible in order to receive assistance with their Medicare Part D cost-sharing obligations. More information about the benefits available under the LIS for non-dually eligible individuals is available on-line at *Apply for Medicare Part D Extra Help program | SSA*.

D. LIS Medicaid Applications

Effective January 1, 2011, all applications for the Extra Help LIS made to SSA are also considered applications for Medicaid. The SSA transmits data on all LIS applicants residing in Virginia to the Virginia Department of Social Services. A pre-populated Application for Adult Medical Assistance is generated by the Medicaid LIS system for individuals who are not currently enrolled in Medicaid and transmitted to the appropriate local agency. See M0120.300 B.10 for additional information about LIS Medicaid applications.

M21 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-31	4/1/24	Appendix 1
TN #DMAS-30	1/1/24	Pages 1, 3, 7
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 *1/17/24*

# 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	*$22,590*	*$1,883*	*$30,120*	*$2,510*	*$2,573*
2	*30,660*	*2,555*	*40,880*	*3,407*	*3,492*
3	*38,730*	*3,228*	*51,640*	*4,304*	*4,411*
4	*46,800*	*3,900*	*62,400*	*5,200*	*5,330*
5	*54,870*	*4,573*	*73,160*	*6,097*	*6,250*
6	*62,940*	*5,245*	*83,920*	*6,994*	*7,169*
7	*71,010*	*5,918*	*94,680*	*7,890*	*8,088*
8	*79,080*	*6,590*	*105,440*	*8,787*	*9,007*
Each add'l, add	*8,070*	*673*	*10,760*	*897*	*920*

M22 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-31	4/1/24	Appendix 1
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 *1/17/24*

Household Size	200% FPL Yearly Amount	200% FPL Monthly Amount	205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)
2	*$30,120*	*$2,510*	*$2,573*
3	*$40,880*	*$3,407*	*$3,492*
4	*$51,640*	*$4,304*	*$4,411*
5	*$62,400*	*$5,200*	*$5,330*
6	*$73,160*	*$6,097*	*$6,250*
7	*$83,920*	*$6,994*	*$7,169*
8	*$94,680*	*$7,890*	*$8,088*
Each additional, add	*$105,440*	*$8,787*	*$9,007*

M23 Changes

Changed With	**Effective Date**	**Pages Changed**
TN #DMAS-31	4/1/24	Appendix 1
TN #DMAS-30	1/1/24	Pages 1, 6, 7, 8
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 *1/17/24*

	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	*$29,230*	*$2,436*	*$2,521*	*$3,407*	*$41,902*	*$3,492*
3	*$36,923*	*$3,077*	*$3,185*	*$4,304*	*$52,931*	*$4,411*
4	*$44,616*	*$3,718*	*$3,848*	*$5,200*	*$63,960*	*$5,330*
5	*$52,310*	*$4,360*	*$4,512*	*$6,097*	*$74,989*	*$6,250*
6	*$60,003*	*$5,001*	*$5,176*	*$6,994*	*$86,018*	*$7,169*
7	*$67,697*	*$5,642*	*$5,839*	*$7,890*	*$97,047*	*$8,088*
8	*$75,390*	*$6,283*	*$6,503*	*$8,787*	*$108,076*	*$9,007*
Each additional, add	*$7,694*	*$642*	*$664*	*$897*	*$11,029*	*$920*