Records / Medicaid State Plan

VA - Medicaid State Plan

Summary News Related Actions

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CMS-10434 OMB 0938-1188

Medicaid State Plan Administration

Organization

Designation and Authority

MEDICAID | Medicaid State Plan | Administration | VA2018MS0008O | VA-18-0011

Package Header

Package ID	VA2018MS0008O	**SPA ID**	VA-18-0011
Submission Type	Official	**Initial Submission Date**	7/23/2018
Approval Date	10/09/2018	**Effective Date**	11/1/2018
Superseded SPA ID	VA-13-0012		
	System-Derived		

A. Single State Agency

1. State Name: Virginia

☒ 2. As a condition for receipt of Federal funds under title XIX of the Social Security Act, the single state agency named here agrees to administer the Medicaid program in accordance with the provisions of this state plan, the requirements of titles XI and XIX of the Act, and all applicable Federal regulations and other official issuances of the Centers for Medicare and Medicaid Services (CMS).

3. Name of single state agency:

Department of Medical Assistance Services

4. This agency is the single state agency designated to administer or supervise the administration of the Medicaid program under title XIX of the Social Security Act. (All references in this plan to "the Medicaid agency" mean the agency named as the single state agency.)

B. Attorney General Certification:

☒ The certification signed by the state Attorney General identifying the single state agency and citing the legal authority under which it administers or supervises administration of the program has been provided.

Name	Date Created
AG Certification_Single State Agency_Attachment 1	7/5/2018 9:37 AM EDT

C. Administration of the Medicaid Program

The state plan may be administered solely by the single state agency, or some portions may be administered by other agencies.

◉ 1. The single state agency is the sole administrator of the state plan (i.e. no other state or local agency administers any part of it). The agency administers the state plan directly, not through local government entities.

○ 2. The single state agency administers portions of the state plan directly and other governmental entity or entities administer a portion of the state plan.

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	System-Derived		

D. Additional information (optional)

Medicaid State Plan Administration

Organization

Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration, Eligibility | VA2024MS0001O | VA-24-0002

Package Header

Package ID	VA2024MS0001O	**SPA ID**	VA-24-0002
Submission Type	Official	**Initial Submission Date**	2/20/2024
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	System-Derived		

A. Eligibility Determinations (including any delegations)

1. The entity or entities that conduct determinations of eligibility for families, adults, and individuals under 21 are:

- [x] a. The Medicaid agency
- [x] b. Delegated governmental agency
  - [x] i. Single state agency under Title IV-A (TANF) (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
  - [x] ii. An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
  - [ ] iii. Other

2. The entity or entities that conduct determinations of eligibility based on age (65 or older), or having blindness or a disability are:

- [x] a. The Medicaid agency
- [x] b. Delegated governmental agency
  - [x] i. Single state agency under Title IV-A (TANF) (in the 50 states or the District of Columbia) or under Title I or XVI (AABD) in Guam, Puerto Rico, or the Virgin Islands
  - [ ] ii. An Exchange that is a government agency established under sections 1311(b)(1) or 1321(c)(1) of the Affordable Care Act
  - [ ] iii. The Social Security Administration determines Medicaid eligibility for:
    - [ ] (1) SSI beneficiaries
    - [ ] (2) Optional state supplement recipients
  - [ ] iv. Other

3. Assurances:

- [x] a. The Medicaid agency is responsible for all Medicaid eligibility determinations.
- [x] b. There is a written agreement between the Medicaid agency and the Exchange or any other state or local agency that has been delegated authority to determine eligibility for Medicaid eligibility in compliance with 42 CFR 431.10(d).
- [x] c. The Medicaid agency does not delegate authority to make eligibility determinations to entities other than government agencies which maintain personnel standards on a merit basis.
- [x] d. The delegated entity is capable of performing the delegated functions.

Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration, Eligibility | VA2024MS0001O | VA-24-0002

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B. Fair Hearings (including any delegations)

☒ The Medicaid agency has a system of hearings that meets all of the requirements of 42 CFR Part 431, Subpart E.

☒ The Medicaid agency is responsible for all Medicaid fair hearings.

1. The entity or entities that conduct fair hearings with respect to eligibility based on applicable modified adjusted gross income (MAGI) are:

☒ a. Medicaid agency

d. Delegated governmental agency

3. For all other Medicaid fair hearings (not related to an eligibility determination based on MAGI):

☒ All other Medicaid fair hearings are conducted at the Medicaid agency or at another state agency authorized under an ICA waiver.

Eligibility Determinations and Fair Hearings

MEDICAID | Medicaid State Plan | Administration, Eligibility | VA2024MS0001O | VA-24-0002

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C. Evidentiary Hearings

The Medicaid agency uses local governmental entities to conduct local evidentiary hearings.

- ○ Yes
- ◉ No

D. Additional information (optional)

Medicaid State Plan Administration

Organization

Organization and Administration

MEDICAID | Medicaid State Plan | Administration, Eligibility | VA2024MS0001O | VA-24-0002

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A. Description of the Organization and Functions of the Single State Agency

1. The single state agency is:

a. A stand-alone agency, separate from every other state agency

b. Also the Title IV-A (TANF) agency

c. Also the state health department

d. Other:

2. The main functions of the Medicaid agency and where these functions are located within the agency are described below. This description should be consistent with the accompanying organizational chart attachment. (If the function is not performed by the Medicaid agency, indicate in the description which other agency performs the function.)

a. Eligibility Determinations

The Title IV-A Agency, the State Department of Social Services, maintains the Virginia Case Management System (VaCMS); the eligibility determination system implemented to evaluate and enroll eligible members directly into the MMIS.

DMAS Eligibility and Enrollment Division Staff perform determinations of eligibility for all non-MAGI individuals and all determinations required outside of the VACMS system, including MAGI and non-MAGI eligibility determinations for incarcerated individuals and those who are returning to the community upon release.

A contractor vendor is responsible for operating the Medicaid call center, Cover Virginia, data entry of MAGI application information into the VaCMS system, the state's eligibility system, and administrative functions of the MAGI and non-MAGI eligibility determination processes for incarcerated individuals and those who are returning to the community upon release. The Eligibility and Enrollment Services Division in the Department of Medical Assistance Services oversees the contracted vendor.

In addition, Virginia's State-Based Exchange (SBE) will evaluate individuals to conduct final eligibility determinations for Medicaid. The SBE is a stand-alone system that operates outside of the Medicaid agency. the state delegates authority to the SBE to make final Medicaid eligibility determinations for families, adults, and individuals under 21. Please see section B below.

b. Fair Hearings (including expedited fair hearings)

The Appeals Division within the State Medicaid agency provides a process by which individuals can appeal adverse decisions made by the Agency or its contractors. The Appeals Division handles all fair hearing requests governed by 42 CFR part 431, subpart E, which includes eligibility denials, actions as defined at 42 CFR 431.201, and other circumstances described at 42 CFR 431.220.

c. Health Care Delivery, including benefits and services, managed care (if applicable)

The Health Care Services Division focuses on the development, implementation, and administration of managed care, pharmacy, and quality assurance services provided to eligible Medicaid recipients.

The Integrated Care Division is responsible for ensuring individuals with complex care needs receive comprehensive care coordination, ensuring access to appropriate quality care that supports the highest possible level of health outcomes. The Division leads the development and implementation of necessary regulations, policies and procedures to promote the most effective and efficient care in the least restrictive environments.

The Division of Aging and Disability Services develops, implements and administers programs designed to improve the lives of the elderly and persons with disabilities. The Division analyzes, develops and promulgates long-term care regulations, policies and procedures, designs and conducts long-term care studies, provides policy and operational support for the long-term care programs of the Agency and develops new home-and-community-based waivers.

The Medical Support Unit is housed within the Office of the Chief Medical Officer and is a federally required critical component of the Medicaid Program. It ensures that medical consultation is available to Agency programs and to Agency administration, as well as to assure that peer review is available to enrolled providers.

d. Program and policy support including state plan, waivers, and demonstrations (if applicable)

The Policy, Regulation, and Member Engagement Division with the State Medicaid Agency provides program and policy support to include planning and innovation efforts in response to state and federal laws and other requirements, agency priorities, industry best practices and stakeholder inputs.

The Eligibility and Enrollment Services Division establishes and maintains the program rules related to financial and non-financial eligibility for the Virginia Medicaid and Family Access to Medical Insurance Security (FAMIS) programs in accordance with federal guidelines.

The Behavioral Health Division reviews the use of existing behavioral health services, reviews options for improving the quality of these services and access to

care, and suggests policy and program improvements related to these services.

The Office of High Needs Supports reviews the use of services for individuals with developmental disabilities, reviews options for improving the quality of these services and access to care, and suggests policy and program improvements related to these services.

The Office of Community Living reviews the use of the CCC Plus Waiver as well as both consumer-directed and agency-directed services within the home and community based waivers. The Office reviews options for improving the quality of these services and access to care, and suggests policy and program improvements related to these services.

The Office of Quality and Population Health focuses on developing, analyzing, reporting, and improving quality measures and outcomes of health care provided to Medicaid members.

e. Administration, including budget, legal counsel

The Department of Medical Assistance Services (DMAS) is operated under the direct supervision of the Director of DMAS who is appointed by the Governor. The Director executes the Department's multi-billion dollar biennium budget, plans and implements medical services through a network of health providers, and represents DMAS with other governmental entities. The principal assistant is the Deputy Director who assists the Director in all aspects of Medicaid planning, development, evaluation and the daily operation of all program functions, in addition to supervising the Support Services Unit.

The Budget Division is responsible for developing and managing the Agency's budget, submitting the Agency's budget to the Department of Planning and Budget (the Agency responsible for managing the entire state government budget) and the federal Centers for Medicare and Medicaid Services.

The Federal Reporting Division is in charge of managing the federal reports that are sent to CMS for financial management.

The Internal Audit Division independently examines and evaluates the ongoing control processes of the Agency and provides counsel and recommendations for improvement whenever such opportunities are identified. The objective of the Division is to provide reasonable assurance to management, within economic limitations and subject to the availability of staff.

The Procurement and Contract Management Division directs the Agency procurement activities and directs the development of Requests for Proposals (RFP) and Invitations for Bids (IFB), contract preparation, solicitation evaluation processes, contractor selection and contract performance reporting.

f. Financial management, including processing of provider claims and other health care financing

The Fiscal Division provides accounting, reporting, and financial management services to the Agency. The accounting functions are in compliance with relevant laws, regulations, fiscal policies and procedures, and professional standards. The Division develops and operates financial systems with sufficient internal control to provide accurate, timely, and meaningful financial and operating information to all interested parties and to protect the Department against theft and other types of loss. The Division is responsible for financial reporting, disbursement, cash management, third party liability, purchasing and support operations, and financial system administration. The Controller performs general administrative functions; develops and maintains fiscal policies and procedures; develops and implements and uses major automated systems; and provides overall planning and guidance for the Division.

The Program Operations Division provides services for medical evaluation of services including an eligibility and enrollment component, payment processing, customer services, and provider training. The Payment Processing Unit within the Program Operations Division evaluates, processes, and adjudicates claims and payments for various providers in specific benefit programs.

The Provider Reimbursement Division (PRD) is responsible for determining the payments for participating providers in Virginia's Department of Medical Assistance Services, including calculating, reviewing, and updating Medicaid capitation and provider payment rates. In addition, PRD calculates and administers supplemental payments to hospitals, nursing care facilities and physicians. An important part of this work includes the settlement and auditing of institutional providers' cost reports and utilizing both regulatory and market information to determine appropriate and allowable payments.

The Office of Value Based Purchasing serves as an Agency expert in the development and implementation of value-based payment policy.

g. Systems administration, including MMIS, eligibility systems

The Information Management Division (IM) is responsible for the development, implementation, and maintenance of all computer software systems within the Agency as well as the procurement, maintenance, and operation of computer equipment. Much of the work is performed in tandem with Agency's fiscal agent. Under DMAS' direction, the fiscal agent designs, develops, and maintains the Agency's Medicaid Management Information System (MMIS).

The Title IV-A Agency, the State Department of Social Services, maintains the Virginia Case Management System (VaCMS); the eligibility determination system implemented to evaluate and enroll eligible members directly into the MMIS.

A contractor vendor is responsible for operating the Medicaid call center, Cover Virginia, data entry of MAGI application information into the VaCMS system, the state's eligibility system, and administrative functions of the MAGI and non-MAGI eligibility determination processes for incarcerated individuals and those who are returning to the community. The Eligibility and Enrollment Services Division in the Department of Medical Assistance Services oversees the contracted vendor.

The Office of Enterprise and Project Management is responsible for the implementation of agency information technology and program related projects.

In addition, Virginia's State-Based Exchange (SBE), the Virginia Health Benefit Exchange, will conduct final eligibility determinations for individuals whose eligibility is determined based on MAGI methodology and who apply through the SBE. The SBE operates a stand-alone eligibility system, separate and apart from the Medicaid agency. The state delegates authority to the SBE to make final Medicaid MAGI-based eligibility determinations for families, adults, and individuals under 21. Please see section B below.

h. Other functions, e.g., TPL, utilization management (optional)

The Office of Data Analytics provide a structured analytics environment that assures data integrity, data consistency, well documented research, and repeatability.

The Program Integrity Division has responsibility for three units: Recipient Audit Unit, External Provider Audit and Policy Unit, and the Prior Authorization and

Utilization Review (PAUR) Unit. The Recipient Audit Unit investigates referrals of fraudulent activity and abuse by Medicaid and FAMIS enrollees. The External Provider Audit and Policy unit oversees a wide variety of audit contracts in addition to providing policy analysis and expertise related to program integrity issues. The PAUR Unit conducts provider audits and also oversees a contractor that provides medical staff who review requests for service authorization and determine if the service is medically necessary under DMAS policy.

3. An organizational chart of the Medicaid agency has been uploaded:

Name	Date Created
overall-org-structure-updated-2023-07-05	7/5/2023 2:14 PM EDT

Organization and Administration

MEDICAID | Medicaid State Plan | Administration, Eligibility | VA2024MS0001O | VA-24-0002

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B. Entities that Determine Eligibility or Conduct Fair Hearings Other than the Medicaid Agency

Title	Description of the functions the delegated entity performs in carrying out its responsibilities:
An Exchange that is a government agency	Virginia's State-Based Exchange (SBE), the Virginia Health Benefit Exchange, will conduct final Medicaid eligibility determinations for groups of individuals whose income eligibility is determined based on MAGI methodology and who apply through the SBE. The SBE will not be assigning an individual who is determined eligible for Medicaid whose income eligibility is determined using MAGI methodology to a specific eligibility group, determining cost sharing (if applicable), or assigning a benefit package. The SBE will transfer eligibility information to the Virginia Case Management system (VaCMS) and these functions will be performed by the single state agency and the Title IV-A agency. The SBE also refers individuals to the single state agency for determination if potentially eligible for non-MAGI Medicaid (e.g., ABD or limited coverage) or if potentially eligible for MAGI coverage by the exchange was unable to make a full determination. The SBE will not be handling appeals.
Single state agency under Title IV-A (TANF)	The Title IV-A agency (State Department of Social Services or DSS) determines eligibility for Title XIX services, including eligibility under MAGI. Eligibility determinations are performed by staff supervised by the State DSS and administered by county and city departments of social services. The duties of the State DSS are as follows: certification by local social services agency superintendents/directors of current public assistance recipients and foster care children of the local social services department, acceptance of applications for medical assistance under Title XIX by the local department of social services of the city or county in which the applicant resides, or by State employees located in designated institutions. This includes determination of initial eligibility, certification of applicants found eligible, recertification on basis of periodic reviews of eligibility, and notification to the Department of Medical Assistance Services and to the applicant/recipient of the initial eligibility decision and any subsequent change in eligibility status. The State DSS is responsible for supervising the local departments of social services in the performance of the eligibility determination function. DMAS oversees the performance of these functions and retains all policy-making and decision-making authority as set forth in 42 CFR 431.10(e).

Organization and Administration

MEDICAID | Medicaid State Plan | Administration, Eligibility | VA2024MS0001O | VA-24-0002

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E. Coordination with Other Executive Agencies

The Medicaid agency coordinates with any other Executive agency related to any Medicaid functions or activities not described elsewhere in the Organization and Administration portion of the state plan (e.g. public health, aging, substance abuse, developmental disability agencies):.

Yes

No

Name of agency:	**Description of the Medicaid functions or activities conducted or coordinated with another executive agency:**
Department for Aging and Rehabilitative Services	The Department for Aging and Rehabilitative Services (DARS) coordinates and provides Medicaid services and advocates for resources and services to improve the employment, quality of life, security, and independence of older Virginians, Virginians with disabilities, and their families.
Department for the Blind and Vision Impaired	The Department for the Blind and Vision Impaired (DBVI) coordinates and provides services, to include Medicaid services, to assist citizens who are blind, deaf and blind, or vision impaired in achieving their maximum level of employment, education, and personal independence.
The Department of Health Professions	The Department of Health Professions (DHP) is responsible for the licensure and regulation of healthcare practitioners across 80 professions. Health regulatory boards issue permits and licenses to facilities, to include Medicaid facilities, such as pharmacies.
Department of Behavioral Health and Developmental Services	The Department of Behavioral Health and Developmental Services (DBHDS) licenses services that provide treatment, training, support and habilitation to individuals who have mental illness, developmental disabilities or substance abuse disorders, to individuals receiving services under the Medicaid DD Waiver, or to individuals receiving services in residential facilities for individuals with brain injuries.

Organization and Administration

MEDICAID | Medicaid State Plan | Administration, Eligibility | VA2024MS0001O | VA-24-0002

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F. Additional information (optional)

Medicaid State Plan Administration

Organization

Single State Agency Assurances

MEDICAID | Medicaid State Plan | Administration | VA2018MS0008O | VA-18-0011

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A. Assurances

- [x] 1. The state plan is in operation on a statewide basis, in accordance with all the requirements of 42 CFR 431.50.
- [x] 2. All requirements of 42 CFR 431.10 are met.
- [x] 3. There is a Medical Care Advisory Committee to the agency director on health and medical services established in accordance with 42 CFR 431.12. All requirements of 42 CFR 431.12 are met.
- [x] 4. The Medicaid agency does not delegate, other than to its own officials, the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters.
- [x] 5. The Medicaid agency has established and maintains methods of personnel administration on a merit basis in accordance with the standards described at 5 USC 2301, and regulations at 5 CFR Part 900, Subpart F. All requirements of 42 CFR 432.10 are met.
- [x] 6. All requirements of 42 CFR Part 432, Subpart B are met, with respect to a training program for Medicaid agency personnel and the training and use of sub-professional staff and volunteers.

B. Additional information (optional)

Medicaid State Plan Eligibility

Income/Resource Methodologies

Eligibility Determinations of Individuals Age 65 or Older or Who Have Blindness or a Disability

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0002O | VA-23-0004

Package Header

Package ID	VA2020MS0002O	**SPA ID**	VA-23-0004
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A. Eligibility Determinations of Individuals Who Are Age 65 or Older or Who Have Blindness or a Disability

Eligibility determinations of individuals who are age 65 or older or who have blindness or a disability are based on one of the following:

○ 1. SSA Eligibility Determination State (1634 State)

The state has an agreement under section 1634 of the Social Security Act for the Social Security Administration to determine Medicaid eligibility of SSI beneficiaries. For all other individuals who seek Medicaid eligibility on the basis of being age 65 or older or having blindness or a disability, the state requires a separate Medicaid application and determines financial eligibility based on SSI income and resource methodologies.

○ 2. State Eligibility Determination (SSI Criteria State)

The state requires all individuals who seek Medicaid eligibility on the basis of being age 65 or older or having blindness or a disability, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility based on SSI income and resource methodologies.

◉ 3. State Eligibility Determination (209(b) State)

The state requires all individuals who seek Medicaid eligibility on the basis of being age 65 or older or having blindness or a disability, including SSI beneficiaries, to file a separate Medicaid application, and determines financial eligibility using income and resource methodologies more restrictive than SSI.

B. Additional information (optional)

Medicaid State Plan Eligibility

Income/Resource Methodologies

Non-MAGI Methodologies

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0002O | VA-23-0004

Package Header

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The state will apply the methodologies as described below, and consistent with 42 CFR 435.601, 435.602, and 435.831.

A. Basic Financial Methodology

1. The state applies the income and resource methodologies of the SSI program when determining eligibility for a population based on age (65 or older) or having blindness or a disability, with the exceptions described below in B. through G.

2. The state applies the financial methodologies of either the SSI program or the AFDC program in effect as of July 16, 1996 (whichever is most closely related) when determining eligibility for a population based on age (as a child), pregnancy, or status as a caretaker relative, with the exceptions described below in B. through G.

B. Use of Less Restrictive and More Restrictive Methodologies

1. The state elects to apply income and/or resources methodologies that are less restrictive than those used under the cash assistance programs, in accordance with 42 CFR 435.601(d).

- Yes
- No

2. The less restrictive income and resource methodologies are described on the RU for each applicable eligibility group.

3. The state applies more restrictive financial eligibility requirements to individuals who are age 65 or older or who have blindness or disability. The more restrictive requirements are no more restrictive than those requirements contained in the state's Medicaid plan in effect on January 1, 1972.

4. The more restrictive requirements are described in More Restrictive Methodologies Under 1902(f).

Non-MAGI Methodologies

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0002O | VA-23-0004

Package Header

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	User-Entered		

C. Financial Responsibility of Relatives

1. In determining financial eligibility for an individual, the state does not include income and resources from anyone other than the individual's spouse, and for individuals under age 21 or who have blindness or disability, the individual's parent.

a.The state includes the income and resources of a spouse or parent only when they are living with the individual in the same household, except as follows:

i. In the case of spouses who are age 65 or older or who have blindness or disability and who share the same room in a Medicaid institution, the state:

- ○ (1) Considers these couples either as living together or as living separately for the purpose of counting income and resources, whichever is more advantageous to the couple.
- ◉ (2) Considers these couples as living separately for the purpose of counting income and resources.

ii. Where applicable, the state determines income and resource eligibility consistent with the spousal impoverishment rules of section 1924 of the Act, as described in the Resource Assessment and Eligibility reviewable unit.

b. In the case of individuals under age 21 for whom AFDC is the most closely related cash assistance program, the income and resources of parents and spouses are included only if the individual would have been considered a dependent under the state's approved AFDC state plan in effect as of July 16, 1996.

2. In determining financial eligibility for individuals who are age 65 or older or who have blindness or a disability, the state may apply more restrictive requirements for relative responsibility than specified in B.1., but no more restrictive than the requirements under the Medicaid plan in effect on January 1, 1972. These methodologies are described in More Restrictive Methodologies under 1902(f).

Non-MAGI Methodologies

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0002O | VA-23-0004

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	User-Entered		

D. Family Size

1. The family size of an individual for whom the SSI income and resource methodologies are used (as described in section A) includes the persons identified below:

a. The individual applying, or

b. If the individual lives together with his or her spouse, the individual applying and the spouse, or

c. If the individual lives together with his or her parent(s) and the individual is under 21 or has blindness or a disability, the individual applying and the parent(s).

2. The family size of an individual for whom the AFDC income and resource methodologies are used (as described in section A.), includes the persons who would have been included in the family under the state's July 16, 1996 AFDC state plan, except where the state has elected to use the MAGI-like methodologies (as described in section E).

3. The state defines family size for one or more of the following FPL eligibility groups to include others beyond those identified in D.1. and D.2.

Yes

No

Non-MAGI Methodologies

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0002O | VA-23-0004

Package Header

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	User-Entered		

E. Use of MAGI-like Methodologies

1. The state uses MAGI-like methodologies for one or more populations for whom the most closely related cash assistance program would be the AFDC program in effect as of July 16, 1996.

- (●) Yes
- ( ) No

2. The election to use MAGI-like methodologies is described on the RU for each applicable eligibility group.

3. The MAGI-like methodology is consistent with 42 CFR 435.603(b) through (f) with respect to definitions, household income, and definition of household, except:

a. The agency elects to use the MAGI definition of parent when considering the financial responsibility of relatives, which includes natural or biological parents, as well as adopted parents and stepparents.

- ( ) Yes
- (●) No

b. Less restrictive methodologies can be used, as described in section B.

c. The financial responsibility requirements for relatives are applicable, as described in section C.

d. The countable income deductions for the medically needy are applicable, when the MAGI-like methodologies are applied to the medically needy, as described in section F.

Non-MAGI Methodologies

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0002O | VA-23-0004

Package Header

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F. Countable Income Deductions for the Medically Needy

In determining countable income for individuals who are age 65 or older or who have blindness or a disability, the state deducts:

1. Amounts that are no more restrictive than those used under the Medicaid plan on January 1, 1972, and no more liberal than those used in determining eligibility under SSI or an optional state supplement, and

2. Amounts that are at least the same as those that would be deducted in determining eligibility under the eligibility group for individuals in 209(b) states who are age 65 or older or who have blindness or a disability (described in 42 CFR 435.121).

Non-MAGI Methodologies

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0002O | VA-23-0004

Package Header

Package ID VA2020MS0002O
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G. Additional Information (optional)

Medicaid State Plan Eligibility

Income/Resource Methodologies

More Restrictive Requirements than SSI under 1902(f) - (209(b) States)

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0002O | VA-23-0004

Package Header

Package ID	VA2020MS0002O	**SPA ID**	VA-23-0004
Submission Type	Official	**Initial Submission Date**	2/6/2023
Approval Date	05/02/2023	**Effective Date**	1/1/2023
Superseded SPA ID	16-12, 93-4, 03-14, 01-03		
	User-Entered		

The state applies more restrictive requirements than SSI under the authority of section 1902(f) of the Act, and consistent with 42 CFR 435.121.

A. Use of More Restrictive Requirements

The state applies more restrictive eligibility requirements to individuals who are age 65 or older or who have blindness or disability. The more restrictive requirements are no more restrictive than those requirements contained in the state's Medicaid plan in effect on January 1, 1972. The state does not apply more restrictive requirements if:

1. The requirement conflicts with the requirements of section 1924 of the Act, which governs the eligibility and post-eligibility treatment of income and resources of institutionalized individuals with community spouses;

2. The requirement conflicts with a more liberal requirement which the agency has elected to use under 42 CFR 435.601; or

3. The more restrictive requirement conflicts with a more liberal requirement the state has elected to use under §435.234(c) in determining eligibility for State supplementary payments.

B. Populations with More Restrictive Requirements

The state applies more restrictive requirements for the following populations:

☒ 1. Individuals age 65 or older

☒ 2. Individuals who have blindness

☒ 3. Individuals who have a disability

C. Types of More Restrictive Requirements Used

The state applies more restrictive requirements for the following populations:

1. The state uses more restrictive requirements with respect to income.

☒ 2. The state uses more restrictive requirements with respect to resources.

3. The state uses more restrictive requirements with respect to the definition of disability.

4. The state uses more restrictive requirements with respect to the definition of blindness.

5. The state uses more restrictive requirements with respect to financial responsibility of relatives.

6. The state uses other more restrictive requirements.

More Restrictive Requirements than SSI under 1902(f) - (209(b) States)

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0002O | VA-23-0004

Package Header

Package ID	VA2020MS0002O	**SPA ID**	VA-23-0004
Submission Type	Official	**Initial Submission Date**	2/6/2023
Approval Date	05/02/2023	**Effective Date**	1/1/2023
Superseded SPA ID	16-12, 93-4, 03-14, 01-03		
	User-Entered		

E. More Restrictive Requirements with Respect to Resources

The following more restrictive requirements are used with respect to resources:

☐ 1. The state uses a lower resource standard than the SSI or the Optional State Supplement standard for eligibility groups under Mandatory Coverage and Options for Coverage.

☒ 2. The state uses more restrictive requirements with respect to the treatment of real property.

☒ a. The state uses a more restrictive requirement with respect to the treatment of home property.

Description:

1. Real property contiguous to an individual's residence which does not meet the
home property definitions in 2, the SSI income-producing requirement or the exceptions in 5, and which is saleable according to 6, shall be counted as an available resource. The equity value of the contiguous property shall be added to the value of all other countable resources.
2. Ownership of a dwelling occupied by the applicant as his home does not affect
eligibility. A home shall mean the house and lot used as the principal residence
and all contiguous property as long as the value of the land, exclusive of the lot
occupied by the house, does not exceed $5,000. In any case in which the definition of home as provided here is more restrictive than that provided in the State Plan for Medical Assistance in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value.
The lot occupied by the house shall be a measure of land as designated on a plat or survey or whatever the locality sets as a minimum size for a building lot,
whichever is less. In localities where no minimum building lot requirement exists, a lot shall be a measure of land designated on a plat or survey or one acre, whichever is less.
Contiguous property essential to the operation of the home means:
a. land used for the regular production of any food or goods for the household's consumption only, including:
i. vegetable gardens,
ii. pasture land which supports livestock raised for milk or meat, and land used to raise chickens, pigs, etc. (the amount of land necessary to support such
animals is established by the local extension service; however, in no case shall more land be allowed than that actually being used to support the livestock.),
iii. outbuildings used to process and/or store any of the above;
b. driveways which connect the homesite to public roadways;
c. land necessary to the home site to meet local zoning requirements (e.g. building sites, mobile home sites, road frontage, distance from road, etc.);
d. land necessary for compliance with state or local health requirements (e.g. distance between home and septic tank, distance between septic tanks, etc.);
e. water supply for the household;
f. existing burial plots.
g. outbuilding used in connection with the dwelling, such as garages or tool sheds.
All of the above facts must be fully reevaluated and documented in the case record before the home site determination is made.
3. An institutionalized individual's former residence is counted as an available resource if the recipient is institutionalized longer than six months after the date he was admitted. The former residence is disregarded if it is occupied by the recipient's;
a. spouse,
b. minor dependent child under age 18,

c. dependent child under age 19 if still in school or vocational training,
d. parent or adult child who is disabled according to the Medicaid disability definition, and who was living in the home with the recipient for at least one year prior to the recipient's institutionalization, and who is dependent upon the recipient for his shelter needs.
e. parent who is age 65 or older and who is disabled according to the Medicaid or civil service disability definition and who was living in the home with the recipient for at least one year prior to the recipient's institutionalization and who is dependent upon the recipient for his shelter needs.
4. An applicant or recipient's proportional share of the value of property owned jointly with another person to whom the applicant or recipient is not married as tenants in common or joint tenants with the right of survivorship at common law is counted as a resource unless it is exempt property or is unsaleable.
5. Ownership of other real property generally precludes eligibility.*

☒ b. The state uses other more restrictive requirements related to real property.

Name of requirement:	Description:
Real Property	For income-producing property and other nonresidential property, appropriate equity and profit is to be determined by the prorata share owned by an individual in relation to his proportionate share of the equity and profit. The current market value of real property is determined by ascertaining the tax assessed value of the property and applying to it the local assessment rate. Alternatively, for non-commercial real peroperty only, the current market value may be determined through the use of a certified appraisal in lieu of the tax assessed value. The certified appraisal must be completed by an indeividual licensed by the Virginia Real Estate Appraiser Board and the cost of the certified appraisal is to be borne by the applicant/recipient or his designee. The equity value is the current market value less the amount due on any recorded liens against the property. "Recorded" means written evidence that can be substantiated, such as deeds of trust, liens, promissory notes, etc. An applicant or recipient's proportional share of the value of property owned jointly with another person to whom the applicant or recipient is not married as tenants in common or joint tenants with the right of survivorship at common law is counted as a resource unless it is exempt property or is unsaleable. Ownership of other real property generally precludes eligibility. Exceptions to this provision are: (i) when the equity value of the property, plus

Name of requirement:	Description:
	all other resources, does not exceed the appropriate resource limitation; (ii) the property is smaller than the county or city zoning ordinances allow for home sites or building purposes, or the property has less than the amount of road frontage required by the county or city for building purposes and adjoining land owners will not buy the property; or (iii) the property has no access, or the only access is through the exempted home site; or (iv) the property is contiguous to the recipient's home site and the survey expenses required for its sale reduce the value of such property, plus all other resources, below applicable resource limitations; or (v) the property cannot be sold after a reasonable effort to sell it has been made.

☐ 3. The state uses more restrictive requirements with respect to the treatment of lump sums.

☒ 4. The state uses more restrictive requirements with respect to the treatment of personal property.

Description:

Property in the form of an interest in an undivided estate is to be regarded as an asset when the value of the interest plus all other resources exceeds the applicable resource limit unless it is considered unsaleable for reasons other than being an undivided estate. An heir can initiate a court action to partition. If a partition suit is necessary (because at least one other owner of or heir to the property will not agree to sell the property) in order for the individual to liquidate the interest, estimated partition costs may be deducted from the property's value. However, if a partition would not result in the applicant/recipient securing title to property having value substantially in excess of the cost of the court action, the property would not be regarded as an asset.

Prepaid burial plans are counted as resource since the money is refundable to the individual upon his request. Cemetery plots are not counted as resources. Assets which can be liquidated such as cash, bank accounts, stocks, bonds, securities and deeds of trusts are considered resources.

☐ 5. The state uses other more restrictive requirements with respect to resources:

More Restrictive Requirements than SSI under 1902(f) - (209(b) States)

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0002O | VA-23-0004

Package Header

Package ID	VA2020MS0002O	**SPA ID**	VA-23-0004
Submission Type	Official	**Initial Submission Date**	2/6/2023
Approval Date	05/02/2023	**Effective Date**	1/1/2023
Superseded SPA ID	16-12, 93-4, 03-14, 01-03		

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J. Income Deductions

When applying more restrictive requirements, the state deducts SSI payments received by the individual and state supplement payments that meet the conditions specified in 42 CFR 435.232 and 435.234. The state also allows the following individuals to deduct incurred medical and remedial expenses (spend down) to become categorically eligible under the group for individuals in 209(b) states who are age 65 or over or who have blindness or a disability:

1. SSI beneficiaries and eligible spouses of SSI beneficiaries

2. State supplement recipients or individuals who are eligible for but not receiving a state supplementary payment.

3. Individuals who would be eligible for SSI/SSP but for OASDI COLA increases since April, 1977 (42 CFR 435.135)

In determining countable income used for the purpose of calculating spend down for this population, the state deducts OADSI benefits, as follows:

a. All of the OASDI benefits is deducted from income.

b. Part of the OASDI benefits is deducted from income.

c. None of the OASDI benefits is deducted from income.

4. Disabled widows and widowers ineligible for SSI due to increase in OASDI (42 CFR 435.137)

In determining countable income used for the purpose of calculating spend down for this population, the state deducts OADSI benefits, as follows:

a. All of the OASDI benefits is deducted from income.

b. Part of the OASDI benefits is deducted from income.

c. None of the OASDI benefits is deducted from income.

5. Disabled widows and widowers ineligible for SSI due to early receipt of social security (42 CFR 435.138)

In determining countable income used for the purpose of calculating spend down for this population, the state deducts OADSI benefits, as follows:

a. All of the OASDI benefits is deducted from income.

b. Part of the OASDI benefits is deducted from income.

c. None of the OASDI benefits is deducted from income.

6. Adult children with disabilities (1939(a)(2)(D) and 1634(c) of the Act)

In determining countable income used for the purpose of calculating spend down for this population, the state deducts OASDI benefits, as follows:

a. All of the OASDI benefits is deducted from income.

b. Part of the OASDI benefits is deducted from income.

c. None of the OASDI benefits is deducted from income.

More Restrictive Requirements than SSI under 1902(f) - (209(b) States)

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0002O | VA-23-0004

Package Header

Package ID	VA2020MS0002O	**SPA ID**	VA-23-0004
Submission Type	Official	**Initial Submission Date**	2/6/2023
Approval Date	05/02/2023	**Effective Date**	1/1/2023
Superseded SPA ID	16-12, 93-4, 03-14, 01-03		
	User-Entered		

K. Additional Information (optional)

*Cont'd: Exceptions to this provision are: (i) when the equity value of the property, plus all other resources, does not exceed the appropriate resource limitation; (ii) the property is smaller than the county or city zoning ordinances allow for home sites or building purposes, or the property has less than the amount of road frontage required by the county or city for building purposes and adjoining land owners will not buy the property; or (iii) the property has no access, or the only access is through the exempted home site; or (iv) the property is contiguous to the recipient's home site and the survey expenses required for its sale reduce the value of such property, plus all other resources, below applicable resource limitations; or (v) the property cannot be sold after a reasonable effort to sell it has been made, as defined in 7.

6. Reasonable Effort to Sell. Individuals must comply with the Reasonable Effort to Sell Requirements that are included in the DMAS Eligibility Manual, Chapter 11, Item M1130.140 (available at this link: https://www.dmas.virginia.gov/media/5521/m11-1-1-2023.pdf)

Medicaid State Plan Eligibility

Income/Resource Standards

Medically Needy Income Level

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0002O | VA-23-0004

Package Header

Package ID VA2020MS0002O
SPA ID VA-23-0004
Submission Type Official
Initial Submission Date 2/6/2023
Approval Date 05/02/2023
Effective Date 1/1/2023
Superseded SPA ID 01-02, 03-01, 93-04

User-Entered

A. Income Level Used

1. The state employs a single income level for the medically needy, subject to the condition described in A.3.

2. The income level varies based on differences between shelter costs in urban and rural areas.

- (•) Yes
- ( ) No

The areas in which the level varies are:

Name of area:	Description:
Group 1	Lower cost of living areas: Counties: Accomack Alleghany Amelia Amherst Appomattox Bath Bedford Bland Botetourt Brunswick Buchanan Buckingham Campbell Caroline Carroll Charles City Charlotte Clarke Craig Culpeper Cumberland Dickenson Dinwiddie Essex Fauquier Floyd Fluvanna Franklin Frederick Giles Gloucester Goochland Grayson Greene Greensville Halifax Hanover Henry Highland Isle of Wight James City King George

Name of area:	Description:
	King & Queen King William Lancaster Lee Louisa Lunenburg Madison Mathews Mecklenburg Middlesex Nelson New Kent Northampton Northumberland Nottoway Orange Page Patrick Pittsylvania Powhatan Prince Edward Prince George Pulaski Rappahannock Richmond County Rockbridge Russell Scott Shenandoah Smyth Southampton Spotsylvania Stafford Surry Sussex Tazewell Washington Westmoreland Wise Wythe York Cities: Bristol Buena Vista Danville Emporia Franklin Galax Norton Suffolk
Group 2	Middle income areas: Counties: Albemarle Augusta Chesterfield Henrico Loudoun Roanoke Rockingham Warren Cities: Chesapeake Covington Harrisonburg Hopewell Lexington Lynchburg Martinsville Newport News Norfolk Petersburg Portsmouth

Name of area:	Description:
Group 3	Poquoson Radford Richmond Roanoke Salem Staunton Virginia Beach Williamsburg Winchester Urban, higher-cost of living areas: Counties: Arlington Fairfax Montgomery Prince William Cities: Alexandria Charlottesville Colonial Heights Falls Church Fredericksburg Hampton Manassas Manassas Park Waynesboro

3. The state has a separate income level for the individuals who are age 65 or older, or who have blindness or a disability.

- ○ Yes
- ◉ No

4. The level used is:

Group 1

Household size	Standard
1	$356.35
2	$453.65
3	$534.54
4	$603.07
5	$671.60
6	$740.13
7	$808.66
8	$890.90
9	$973.14
10	$1069.09

The state uses an additional incremental amount for larger household sizes.

- ◉ Yes
- ○ No

Incremental Amount:

$92.09

The dollar amounts increase automatically each year

- ◉ Yes
- ○ No

The basis of the increase is:

- ◉ CPI-U
- ○ Other basis

The annual increase occurs in the month and day indicated:

Every 1 of July

Group 2

Household size	Standard
1	$411.18
2	$506.31
3	$589.36

The state uses an additional incremental amount for larger household sizes.

- ◉ Yes
- ○ No

Incremental Amount:

$92.09

The dollar amounts increase automatically each year

Household size	Standard
4	$658.78
5	$726.40
6	$794.96
7	$859.85
8	$945.73
9	$1037.84
10	$1123.91

Group 3

Household size	Standard
1	$534.54
2	$644.42
3	$726.43
4	$794.96
5	$859.85
6	$932.02
7	$1000.55
8	$1069.09
9	$1168.39
10	$1247.27

Generate Consolidated MSP

Yes

No

The basis of the increase is:

CPI-U

Other basis

The annual increase occurs in the month and day indicated:

Every 1 of July

The state uses an additional incremental amount for larger household sizes.

Yes

No

Incremental Amount:

$92.09

The dollar amounts increase automatically each year

Yes

No

The basis of the increase is:

CPI-U

Other basis

The annual increase occurs in the month and day indicated:

Every 1 of July

Medically Needy Income Level

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0002O | VA-23-0004

Package Header

Package ID VA2020MS0002O
SPA ID VA-23-0004
Submission Type Official
Initial Submission Date 2/6/2023
Approval Date 05/02/2023
Effective Date 1/1/2023
Superseded SPA ID 01-02, 03-01, 93-04

User-Entered

B. Basis for Income Level

1. Minimum Income Level

The minimum income level for this eligibility group is the lower of the state's July 1996 AFDC payment standard or the state's income standard for the Parents and Other Caretaker Relatives eligibility group.

2. Maximum Income Level

The maximum income level for this eligibility group is 133 1/3 percent of the higher of the state's 1996 AFDC payment standard or the state's income standard for the Parents and Other Caretaker Relatives eligibility group.

Medically Needy Income Level

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0002O | VA-23-0004

Package Header

Package ID	VA2020MS0002O	**SPA ID**	VA-23-0004
Submission Type	Official	**Initial Submission Date**	2/6/2023
Approval Date	05/02/2023	**Effective Date**	1/1/2023
Superseded SPA ID	01-02, 03-01, 93-04		

User-Entered

C. Additional Information (optional)

Medicaid State Plan Eligibility

Income/Resource Standards

Handling of Excess Income (Spenddown)

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0002O | VA-23-0004

Package Header

Package ID	VA2020MS0002O	**SPA ID**	VA-23-0004
Submission Type	Official	**Initial Submission Date**	2/6/2023
Approval Date	05/02/2023	**Effective Date**	1/1/2023
Superseded SPA ID	VA-93-0004		

User-Entered

If countable income exceeds the income standard, the state must deduct from income medical expenses incurred by the individual or family or financially responsible relatives that are not subject to payment by a third party, in accordance with 42 CFR 435.831 and 42 CFR 435.121.

A. Budget Periods

Income in excess of the appropriate income standard is considered available for payment of medical or remedial care expenses in budget periods that do not exceed six months.

1. In determining income eligibility, countable income is reduced by the amount of incurred medical or remedial care expenses during the budget period specified below:

- ○ a. One budget period of:
- ◉ b. More than one budget period, as described below:

☑ i. Community budget period

Length of budget period:

- ◉ (1) 6 months
- ○ (2) 5 months
- ○ (3) 4 months
- ○ (4) 3 months
- ○ (5) 2 months
- ○ (6) 1 month

☑ ii. Institutional budget period

Length of budget period:

- ○ (1) 6 months
- ○ (2) 5 months
- ○ (3) 4 months
- ○ (4) 3 months
- ○ (5) 2 months
- ◉ (6) 1 month

☐ iii. Other budget period

Handling of Excess Income (Spenddown)

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0002O | VA-23-0004

Package Header

Package ID	VA2020MS0002O	**SPA ID**	VA-23-0004
Submission Type	Official	**Initial Submission Date**	2/6/2023
Approval Date	05/02/2023	**Effective Date**	1/1/2023
Superseded SPA ID	VA-93-0004		
	User-Entered		

B. Types of Eligible Expenses

1. In determining incurred expenses to be deducted from income, the state includes:

a. Medicare, Medicaid, and other health insurance premiums and enrollment fees.

b. Cost sharing, including copayments, coinsurance, and deductibles, imposed by Medicare, Medicaid or other health insurance.

c. Expenses for necessary medical and remedial services recognized by state law but not included in the state plan.

d. Expenses for necessary medical and remedial services included in the state plan, including those that exceed limitations on the amount, duration, and scope of services.

2. The state also includes medical institutional expenses projected to the end of the budget period at the Medicaid reimbursement rate.

Yes

No

3. Incurred expenses subject to payment by a third party are not deducted unless the third party is a public program (other than Medicaid) of a state and the program is financed by the state.

Handling of Excess Income (Spenddown)

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0002O | VA-23-0004

Package Header

Package ID	VA2020MS0002O	**SPA ID**	VA-23-0004
Submission Type	Official	**Initial Submission Date**	2/6/2023
Approval Date	05/02/2023	**Effective Date**	1/1/2023
Superseded SPA ID	VA-93-0004		
	User-Entered		

C. Timeframe of Deduction of Expenses

In determining incurred expenses to be deducted from income, the state deducts:

1. Incurred medical and remedial expenses without regard to the age of the expenses.

2. Payments made during the budget period on eligible expenses incurred at any time, if not previously deducted in establishing eligibility.

3. Unpaid eligible expenses incurred at any time prior to the budget period, which have not been deducted previously in establishing eligibility.

Handling of Excess Income (Spenddown)

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0002O | VA-23-0004

Package Header

Package ID	VA2020MS0002O	**SPA ID**	VA-23-0004
Submission Type	Official	**Initial Submission Date**	2/6/2023
Approval Date	05/02/2023	**Effective Date**	1/1/2023
Superseded SPA ID	VA-93-0004		
	User-Entered		

D. Order of Deduction of Expenses

Incurred medical or remedial care expenses are deducted in the following order:

1. By the type of service, in the following order:

    a. Premiums, deductibles, coinsurance and co-payments.

    b. Expenses for necessary medical or remedial care services that are recognized under state law but not included in the State Plan.

    c. Expenses for necessary medical or remedial care services that are included in the state Plan that exceed agency limitations on amount, duration, or scope of services.

    d. Expenses for necessary medical or remedial care services that are included in the state Plan that are within the agency limitations on amount, duration, or scope of services.

2. In chronological order by the date of the service, or the date cost sharing payments are due.

3. In chronological order by the date the bill is submitted to the state by the individual.

Handling of Excess Income (Spenddown)

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0002O | VA-23-0004

Package Header

Package ID	VA2020MS0002O	**SPA ID**	VA-23-0004
Submission Type	Official	**Initial Submission Date**	2/6/2023
Approval Date	05/02/2023	**Effective Date**	1/1/2023
Superseded SPA ID	VA-93-0004		
	User-Entered		

E. Reasonable Limitations

The state sets reasonable limits on the amount to be deducted for expenses.

- ○ Yes
- ◉ No

Handling of Excess Income (Spenddown)

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0002O | VA-23-0004

Package Header

Package ID	VA2020MS0002O	**SPA ID**	VA-23-0004
Submission Type	Official	**Initial Submission Date**	2/6/2023
Approval Date	05/02/2023	**Effective Date**	1/1/2023
Superseded SPA ID	VA-93-0004		

User-Entered

F. Spenddown Payments Made by Individuals

The state permits individuals to pay-in their spenddown liability.

- Yes
- No

Handling of Excess Income (Spenddown)

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0002O | VA-23-0004

Package Header

Package ID	VA2020MS0002O	**SPA ID**	VA-23-0004
Submission Type	Official	**Initial Submission Date**	2/6/2023
Approval Date	05/02/2023	**Effective Date**	1/1/2023
Superseded SPA ID	VA-93-0004		
	User-Entered		

G. Additional Information (optional)

Medicaid State Plan Eligibility

Income/Resource Standards

Medically Needy Resource Level

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0002O | VA-23-0004

Package Header

Package ID	VA2020MS0002O	**SPA ID**	VA-23-0004
Submission Type	Official	**Initial Submission Date**	2/6/2023
Approval Date	05/02/2023	**Effective Date**	1/1/2023
Superseded SPA ID	VA-93-0004		
	User-Entered		

A. Medically Needy Resource Level Structure

1. The state employs a single resource level for the medically needy, subject to the condition described in A.3.

2. The resource level is equal to or higher than the lowest resource standard used under the most closely related cash assistance program.

3. The state has a separate resource level for the individuals who are age 65 or older, or who have blindness or a disability that is more restrictive than the resource level used for other medically needy populations.

- ○ Yes
- ◉ No

Medically Needy Resource Level

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0002O | VA-23-0004

Package Header

Package ID VA2020MS0002O
Submission Type Official
Approval Date 05/02/2023
Superseded SPA ID VA-93-0004
User-Entered

SPA ID VA-23-0004
Initial Submission Date 2/6/2023
Effective Date 1/1/2023

B. Resource Level Used

The level used is:

Household size	Standard
1	$2000.00
2	$3000.00
3	$3100.00
4	$3200.00
5	$3300.00
6	$3400.00
7	$3500.00
8	$3600.00
9	$3700.00
10	$3800.00

The state uses an additional incremental amount for larger household sizes.

Yes

No

Incremental Amount:

$100.00

Medically Needy Resource Level

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0002O | VA-23-0004

Package Header

Package ID	VA2020MS0002O	**SPA ID**	VA-23-0004
Submission Type	Official	**Initial Submission Date**	2/6/2023
Approval Date	05/02/2023	**Effective Date**	1/1/2023
Superseded SPA ID	VA-93-0004		
	User-Entered		

C. Additional Information (optional)

Medicaid State Plan Eligibility

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0001O | VA-23-0003

Package Header

Package ID VA2023MS0001O
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System-Derived

Mandatory Coverage

A. The state provides Medicaid to mandatory groups of individuals. The mandatory groups covered are:

Families and Adults

Eligibility Group Name	Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Infants and Children under Age 19	☐		○	CONVERTED
Parents and Other Caretaker Relatives	☐		○	CONVERTED
Pregnant Women	☐		○	CONVERTED
Deemed Newborns	☐		○	NEW
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care	☐		○	NEW
Former Foster Care Children	☐	☐	○	APPROVED
Transitional Medical Assistance	☐		○	NEW
Extended Medicaid due to Spousal Support Collections	☐		○	NEW

Aged, Blind and Disabled

Eligibility Group Name	Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals in 209(b) States Who Are Age 65 or Older or Who have Blindness or a Disability	☐		●	NEW
Closed Eligibility Groups	☐		○	NEW
Individuals Deemed To Be Receiving SSI	☐		○	NEW
Working Individuals under 1619(b)	☐		○	NEW
Qualified Medicare Beneficiaries	☐		○	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Qualified Disabled and Working Individuals		☐	☐	○	NEW
Specified Low Income Medicare Beneficiaries		☐	☐	○	NEW
Qualifying Individuals		☐	☐	○	NEW

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0001O | VA-23-0003

Package Header

Package ID VA2023MS0001O
SPA ID VA-23-0003
Submission Type Official
Initial Submission Date 3/9/2023
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System-Derived

B. The state elects the Adult Group, described at 42 CFR 435.119.

Yes No

Families and Adults

Eligibility Group Name	Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Adult Group	☐		●	APPROVED

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Former Foster Care Children

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0001O | VA-23-0003

Individuals under the age of 26, who were in foster care and on Medicaid when they turned age 18 or aged out of foster care.

Package Header

Package ID	VA2023MS0001O	**SPA ID**	VA-23-0003
Submission Type	Official	**Initial Submission Date**	3/9/2023
Approval Date	05/31/2023	**Effective Date**	1/1/2023
Superseded SPA ID	VA-17-0021		
	System-Derived		

The state covers the mandatory former foster care children group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are under age 26

2. Were in foster care upon attaining age 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act (up to age 21).

3. Are described under either Section B. or C.

B. Individuals Covered

For individuals who turn 18 before January 1, 2023:

1. The state covers individuals who:

a. Upon attaining age 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act (up to age 21) were:

i. In foster care under the responsibility of the state or a Tribe within the state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program); and

ii. Enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration; and

b. Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

2. In addition to B.1., the state elects to cover individuals who were in foster care under the responsibility of the state or a Tribe within the state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program) when they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act, and meet the following criteria:

☒ a. They were enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.

☒ b. They were placed by the state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project when they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.

☐ c. They were placed by the state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project at any time during the foster care period in which they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.

C. Individuals Covered

For individuals who turn 18 on or after January 1, 2023:

1. The state covers individuals who:

a. Upon attaining age 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act (up to age 21) were:

i. In foster care under the responsibility of any state or a Tribe within any state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program); and

ii. Enrolled in Medicaid under a state's Medicaid state plan or 1115 demonstration; and

b. Are not enrolled in mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

2. In addition to C.1., the state elects to cover individuals who were in foster care under the responsibility of any state or a Tribe within any state (including children who were cared for through a grant to a state under the unaccompanied refugee minor program) when they turned 18 or a higher age at which that state's or Tribe's foster care assistance ends under title IV-E of the Act, and meet the following criteria:

☒ a. They were enrolled in Medicaid under a state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they turned 18 or a higher age at which a state's or Tribe's foster care assistance ends.

☒ b. They were placed by a state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project when they turned 18 or a higher age at which a state's or Tribe's foster care assistance ends.

☐ c. They were placed by a state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project at any time during the foster care period in which they turned 18 or a higher age at which a state's or Tribe's foster care assistance ends.

Former Foster Care Children

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0001O | VA-23-0003

Package Header

Package ID VA2023MS0001O
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D. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Adult Group

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0006O | VA-18-0004

Non-pregnant individuals age 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.

Not Started | In Progress | Complete

Package Header

Package ID VA2018MS0006O
SPA ID VA-18-0004
Submission Type Official
Initial Submission Date 6/8/2018
Approval Date 10/05/2018
Effective Date 1/1/2019
Superseded SPA ID N/A

The state covers the Adult Group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Have attained age 19 but not age 65

2. Are not pregnant

3. Are not entitled to or enrolled for Part A or B Medicare benefits

4. Are not otherwise eligible for and enrolled for mandatory coverage under the state plan in accordance with 42 CFR 435, subpart B.

5. Note: In 209(b) states, individuals receiving SSI or deemed to be receiving SSI who do not qualify for mandatory Medicaid eligibility due to more restrictive requirements may qualify for this eligibility group if otherwise eligible.

B. Financial Methodologies

MAGI-based methodologies are used in calculating household income. Please refer as necessary to MAGI-Based Methodologies, completed by the state.

C. Income Standard Used

The amount of the income standard for this group is 133% FPL.

D. Coverage of Dependent Children

Parents or caretaker relatives living with a child under the age specified below are not covered unless the child is receiving benefits under Medicaid, CHIP or through the Exchange or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.

1. Under age 19, or
2. A higher age of children, if any covered under the Reasonable Classifications of Children eligibility group (42 CFR 435.222) on March 23, 2010:
    a. Under age 20
    b. Under age 21

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0006O | VA-18-0004

Package Header

Package ID	VA2018MS0006O	**SPA ID**	VA-18-0004
Submission Type	Official	**Initial Submission Date**	N/A
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Superseded SPA ID	N/A		

E. Additional Information (optional)

Medicaid State Plan Eligibility

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
Submission Type	Official	**Initial Submission Date**	1/8/2024
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Superseded SPA ID	VA-23-0004		
	System-Derived		

A. Options for Coverage

The state provides Medicaid to specified optional groups of individuals.

(•) Yes ( ) No

The optional eligibility groups covered in the state plan are (elections made in this screen may not be comprehensive during the transition period from the paper-based state plan to MACPro):

Families and Adults

Eligibility Group Name	Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Optional Coverage of Parents and Other Caretaker Relatives	☐	☐	○	NEW
Reasonable Classifications of Individuals under Age 21	☑	☐	○	CONVERTED
Children with Non-IV-E Adoption Assistance	☑	☐	○	CONVERTED
Independent Foster Care Adolescents	☐	☐	○	NEW
Optional Targeted Low Income Children	☐	☐	○	NEW
Individuals above 133% FPL under Age 65	☐	☐	○	NEW
Individuals Needing Treatment for Breast or Cervical Cancer	☑	☐	○	NEW
Individuals Eligible for Family Planning Services	☑	☐	○	CONVERTED
Individuals with Tuberculosis	☐	☐	○	NEW

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Electing COBRA Continuation Coverage				○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Individuals Eligible for but Not Receiving Cash Assistance				○	NEW
Individuals Eligible for Cash Except for Institutionalization		☐	☐	○	APPROVED
Individuals Receiving Home and Community-Based Waiver Services under Institutional Rules		☐		●	NEW
Optional State Supplement Beneficiaries		☐		○	NEW
Individuals in Institutions Eligible under a Special Income Level		☐	☐	○	APPROVED
PACE Participants		☐		○	NEW
Individuals Receiving Hospice		☐		○	NEW
Children under Age 19 with a Disability				○	NEW
Age and Disability-Related Poverty Level		☐	☐	●	APPROVED
Work Incentives				○	NEW
Ticket to Work Basic		☐	☐	●	APPROVED
Ticket to Work Medical Improvements				○	NEW
Family Opportunity Act Children with a Disability				○	NEW
Individuals Receiving State Plan Home and Community-Based Services				○	NEW
Individuals Receiving State Plan Home and Community-Based Services Who Are Otherwise Eligible for HCBS Waivers				○	NEW

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID VA2023MS0003O
SPA ID VA-24-0004
Submission Type Official
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System-Derived

B. Medically Needy Options for Coverage

The state provides Medicaid to specified groups of individuals who are medically needy.

(•) Yes ( ) No

The medically needy eligibility groups covered in the state plan are:

1. Mandatory Medically Needy:

Families and Adults

Eligibility Group Name	Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Pregnant Women	☐	☐	○	NEW
Medically Needy Children under Age 18	☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name	Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Protected Medically Needy Individuals Who Were Eligible in 1973	☐	☐	○	NEW

2. Optional Medically Needy:

Families and Adults

Eligibility Group Name	Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Reasonable Classifications of Individuals under Age 21	☐	☐	○	NEW
Medically Needy Parents and Other Caretaker Relatives	☐	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name	Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Medically Needy Populations Based on Age, Blindness or Disability	☐	☐	○	APPROVED

Optional Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
Submission Type	Official	**Initial Submission Date**	1/8/2024
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	System-Derived		

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Individuals Eligible for Cash Except for Institutionalization

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Individuals who would be eligible for federal cash assistance or an optional state supplement, except for institutionalization.

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
Submission Type	Official	**Initial Submission Date**	1/8/2024
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	User-Entered		

The state covers the optional Individuals Eligible for Cash Except for Institutionalization eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are in a medical institution.

2. Would meet the eligibility requirements for at least one of the following cash assistance programs, but for the lower income standards used to determine eligibility for institutionalized individuals:

☒ a. SSI

☒ b. Optional State Supplement

☒ c. AFDC

Individuals Eligible for Cash Except for Institutionalization

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID VA2023MS0003O
SPA ID VA-24-0004
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Superseded SPA ID New
User-Entered

B. Individuals Covered

1. The state covers all individuals who meet the characteristics described in section A.

Yes

No

2. The state covers the following populations:

- [x] a. Individuals age 65 or older
- [x] b. Individuals who have blindness
- [x] c. Individuals who have a disability
- [x] d. All children under a specified age limit:
  - i. Under age 21
  - ii. Under age 20
  - iii. Under age 19
  - iv. Under age 18
- [x] e. Reasonable classifications of children

Name of classification	Age Range
Individuals placed in foster care homes by public agencies	Under age 21
Individuals placed in private institutions by public agencies	Under age 21
Individuals in adoptions subsidized in full or part by a public agency	Under age 21
Individuals in nursing facilities, if nursing facility services are provided under this plan	Under age 21
Also individuals in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF-IID), if these services are provided under this plan.	Under age 21
Department of Juvenile Justice Children	Under age 21

Name: Department of Juvenile Justice Children
Description: Children are in the custody of DJJ.
Age Covered: Under age 21

- [x] f. Parents and other caretaker relatives
- [x] g. Pregnant women
- [ ] h. Other population

Individuals Eligible for Cash Except for Institutionalization

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
Submission Type	Official	**Initial Submission Date**	1/8/2024
Approval Date	04/04/2024	**Effective Date**	1/1/2024
Superseded SPA ID	New		
	User-Entered		

C. Financial Methodologies

1. In calculating household income and resources for individuals who are seeking eligibility on the basis of being age 65 or older or having blindness or disability, SSI methodologies are used. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

- ○ a. SSI methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.
- ◉ b. More restrictive requirements than SSI. Please refer as necessary to More Restrictive Requirements than SSI under 1902(f), completed by the state.

2. In calculating household income and resources for populations for which AFDC is the most closely related program, the following methodology(ies) are used:

- ◉ a. MAGI-like methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.
- ○ b. AFDC methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

3. Less restrictive methodologies are used in calculating countable income.

- ○ Yes
- ◉ No

4. Less restrictive methodologies are used in calculating countable resources.

- ◉ Yes
- ○ No

The less restrictive resource methodologies are:

☒ The state uses a less restrictive methodology with respect to resources set aside for burial.

☒ Specified methodology for the treatment of resources set aside for burial:

Name of methodology:	Description:
Burial expenses	Resources set aside to meet the burial expenses of an applicant/recipient or that individual's spouse are excluded from countable assets. In determining eligibility for benefits for medically needy individuals, disregarded from countable resources is an amount not in excess of $3,500 for the individual and an amount not in excess of $3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by: A. the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources; and B. the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses.

☒ The state uses a less restrictive methodology with respect to the treatment of motor vehicles.

☒ The value of a countable motor vehicle is totally disregarded, without limits or conditions.

One motor vehicle

More than one motor vehicle

☒ Household goods and services are disregarded as a resource.

Description of disregard: The value of all household goods and personal effects are disregarded as resources.

☒ A specified type of resource is disregarded:

Name of resource type:	Description:
Life insurance less than $1500	Life, retirement, and other related types of insurance policies with face values totaling $1,500, or less on any one person 21 years old and over are not considered resources. When the face values of such policies of any one person exceeds $1,500, the cash surrender value of the policies is counted as a resource.
Cemetery plots	Cemetery plots are not counted as resources regardless of the number owned.
Life rights	Life rights to real property are not counted as a resource. The purchase of a life right in another individual's home is subject to transfer of asset rules.
Reasonable effort to sell.	Once the applicant has demonstrated that his property is unsaleable by following the procedures in 3 below, the property is disregarded in determining eligibility starting the first day of the month in which the most recent application was filed, or up to three months prior to this month of application if retroactive coverage is requested and the applicant met all other eligibility requirements in the period. A recipient must continue his reasonable efforts to sell the property as required in 4 below. 2. Reasonable Effort to Sell. For purposes of this section "current market value" is defined as the current tax assessed value. If the property is listed by a realtor, then the realtor may list it at an amount higher than the tax assessed value. In no event, however, shall the realtor's list price exceed 150% of the assessed value. 3. A reasonable effort to sell is considered to have been made: a. As of the date the property becomes subject to a realtor's listing agreement if (i) it is listed at a price at current market value, and (ii) the listing realtor verifies that it is unlikely to sell within 90 days of listing given the particular circumstances involved (e.g., owner's fractional interest; zoning restrictions; poor topography; absence of road frontage or access; absence of improvements; clouds on title, right of way or easement; local market conditions) OR

Name of resource type:	Description:
	b. When at least two realtors refuse to list the property. The reason for refusal must be that the property is unsaleable at current market value. Other reasons for refusal are not sufficient, OR c. When the applicant has personally advertised his property at or below current market value for 90 days by use of a "Sale By Owner" sign located on the property and by other reasonable efforts such as newspaper advertisements, or reasonable inquiries with all adjoining land-owners or other potential interested purchasers. 4. Notwithstanding the fact that the recipient made a reasonable effort to sell the property and failed to sell it, and although the recipient has become eligible, the recipient must make a continuing reasonable effort to sell by: a. Repeatedly renewing any initial listing agreement until the property is sold. If the list price was initially higher than the tax-assessed value, the listed sales price must be reduced after 12 months to no more than 100% of the tax-assessed value. b. In the case where at least 2 realtors have refused to list the property, the recipient must personally try to sell the property by efforts described in 2c above, for 12 months. c. In the case of recipient who has personally advertised his property for a year without success (the newspaper advertisements, "for sale" sign, do not have to be continuous; these efforts must be done for at least 90 days within a 12 month period), the recipient must then (i) subject his property to a realtor's listing agreement at price or below current market value; or (ii) meet the requirements of 2b above which are that the recipient must try to list the property and at least two realtors refuse to list it because it is unsaleable at current market value; other reasons for refusal to list are not sufficient. 5. If the recipient has made a continuing effort to sell the property for 12 months, then the recipient may sell the property between 75% and 100% of its tax assessed value and such sale shall not result in disqualification under the transfer of property rules. If the recipient requests to sell his property at less than 75% of assessed value, he must submit documentation from the listing realtor, or knowledgeable source if the property is not listed with a realtor, that the requested sale price is the best price the recipient can expect to receive for the property at this time. Sale at such a

Name of resource type:	Description:
	documented price shall not result in disqualification under the transfer of property rules. The proceeds of the sale will be counted as a resource in determining continuing eligibility. *
Payments for involuntary sterilization.	The Commonwealth shall disregard as resources amounts received as payment for involuntary sterilization under the Virginia Eugenical Sterilization Act, beyond the allowable nine-month exclusion by the SSI program's resource methodologies.
Disregard excess resources due to COVID-19	Income that would have otherwise been part of an individual's liability for his or her institutional or home and community based waiver services based on the application of the post-eligibility treatment of income (PETI) rules, but which became countable resources on or after March 18, 2020, will be disregarded until the individual's second Medicaid renewal that follows the end of the COVID-19 public health emergency.
Work Incentive Account (WIN accounts)	Resources accumulated in the Work Incentive Account (WIN) shall be disregarded in determining eligibility for one year after the individual leaves the Medicaid buy-in program, unless the WIN account is an IRS-recognized account, in which case the disregard of the account will not be time-limited (subject to the account meeting the conditions described in the "Ticket to Work Basic" section of the state plan). IRS-recognized WIN accounts are: retirement accounts (e.g., 401(k)/403(b)/457(b)/503(b) accounts, traditional Individual Retirement Accounts (IRAs), Roth IRAs, SEP-IRAs, SIMPLE IRAs, and Thrift Savings Plans), medical savings accounts (e.g., Archer Medical Savings Account), medical reimbursement accounts (e.g., Health Savings Accounts), education accounts (e.g., 529 Plans) and independence accounts (e.g., Fostering Independence Account).

☒ A beneficiary of a "qualified state long-term care insurance partnership" policy (partnership policy), as defined in section 1917(b)(1)(C) of the Social Security Act and 45 CFR 144.200 et seq., is provided a resource disregard, equal to the amount of the insurance benefit payments made to or on behalf of the individual from the partnership policy.

Individuals Eligible for Cash Except for Institutionalization

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
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Superseded SPA ID	New		
	User-Entered		

D. Income Standard Used

The income standard used is the standard of the most closely related cash assistance program.

E. Resource Standard Used

The resource standard used is the standard of the most closely related cash assistance program.

Individuals Eligible for Cash Except for Institutionalization

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
Submission Type	Official	**Initial Submission Date**	1/8/2024
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Superseded SPA ID	New		

User-Entered

F. Additional Information (optional)

When an SSI recipient has real property not excluded by our rules then all recipient resources must be verified and evaluated to determine if the SSI recipient meets Medicaid resource requirements.

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Individuals in Institutions Eligible under a Special Income Level

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Individuals who are in medical institutions for at least 30 consecutive days who are eligible under a special income level.

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
Submission Type	Official	**Initial Submission Date**	1/8/2024
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	System-Derived		

The state covers Individuals in Institutions Eligible under a Special Income Level in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Have been in a medical institution for at least 30 consecutive days.

2. Have income at or below a standard described in section D.

Individuals in Institutions Eligible under a Special Income Level

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
Submission Type	Official	**Initial Submission Date**	1/8/2024
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Superseded SPA ID	VA-23-0004		
	System-Derived		

B.Individuals Covered

1. The state covers all individuals who meet the characteristics described in section A.

Yes

No

Individuals in Institutions Eligible under a Special Income Level

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID VA2023MS0003O
SPA ID VA-24-0004
Submission Type Official
Initial Submission Date 1/8/2024
Approval Date 04/04/2024
Effective Date 1/1/2024
Superseded SPA ID VA-23-0004
System-Derived

C. Financial Methodologies

○ 1. The methodologies of the most closely related cash assistance program are used in calculating income and resources, except that income disregards are not applied. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

◉ 2. More restrictive requirements than the most closely related cash assistance program are used in calculating countable income and/or resources, except that income disregards are not applied. Please refer as necessary to More Restrictive Requirements than SSI under 1902(f), completed by the state.

3. Less restrictive methodologies are used in calculating countable resources.

◉ Yes

○ No

The less restrictive resource methodologies are:

☒ The state uses a less restrictive methodology with respect to resources set aside for burial.

☒ Specified methodology for the treatment of resources set aside for burial:

Name of methodology:	Description:
Burial expenses	Resources set aside to meet the burial expenses of an applicant/recipient or that individual's spouse are excluded from countable assets. In determining eligibility for benefits for medically needy individuals, disregarded from countable resources is an amount not in excess of $3,500 for the individual and an amount not in excess of $3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by: A. the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources; and B. the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses.

☒ The state uses a less restrictive methodology with respect to the treatment of motor vehicles.

☒ The value of a countable motor vehicle is totally disregarded, without limits or conditions.

◉ One motor vehicle

○ More than one motor vehicle

☒ Household goods and services are disregarded as a resource.

Description of disregard: The value of all household goods and personal effects are disregarded as resources.

☒ A specified type of resource is disregarded:

Name of resource type:	Description:
Work Incentive Account (WIN accounts)	Resources accumulated in the Work Incentive Account (WIN) shall be disregarded in determining eligibility for one year after the individual leaves the Medicaid buy-in program, unless the WIN account is an IRS-recognized account, in which case the disregard of the account will not be time-limited (subject to the account meeting the conditions described in the "Ticket to Work Basic" section of the state plan). IRS-recognized WIN accounts are: retirement accounts (e.g., 401(k)/403(b)/457(b)/503(b) accounts, traditional Individual Retirement Accounts (IRAs), Roth IRAs, SEP-IRAs, SIMPLE IRAs, and Thrift Savings Plans), medical savings accounts (e.g., Archer Medical Savings Account), medical reimbursement accounts (e.g., Health Savings Accounts), education accounts (e.g., 529 Plans) and independence accounts (e.g., Fostering Independence Account).
Reasonable effort to sell.	Once the applicant has demonstrated that his property is unsaleable by following the procedures in 3 below, the property is disregarded in determining eligibility starting the first day of the month in which the most recent application was filed, or up to three months prior to this month of application if retroactive coverage is requested and the applicant met all other eligibility requirements in the period. A recipient must continue his reasonable efforts to sell the property as required in 4 below. 2. Reasonable Effort to Sell. For purposes of this section "current market value" is defined as the current tax assessed value. If the property is listed by a realtor, then the realtor may list it at an amount higher than the tax assessed value. In no event, however, shall the realtor's list price exceed 150% of the assessed value. 3. A reasonable effort to sell is considered to have been made: a. As of the date the property becomes subject to a realtor's listing agreement if (i) it is listed at a price at current market value, and (ii) the listing realtor verifies that it is unlikely to sell within 90 days of listing given the particular circumstances involved (e.g., owner's fractional interest; zoning restrictions; poor topography; absence of road frontage or access; absence of improvements; clouds on title, right of way or easement; local market conditions) OR b. When at least two realtors refuse to list the property. The reason for refusal must be that the property is unsaleable at current market value.

Name of resource type:	Description:
	Other reasons for refusal are not sufficient, OR c. When the applicant has personally advertised his property at or below current market value for 90 days by use of a "Sale By Owner" sign located on the property and by other reasonable efforts such as newspaper advertisements, or reasonable inquiries with all adjoining land-owners or other potential interested purchasers. 4. Notwithstanding the fact that the recipient made a reasonable effort to sell the property and failed to sell it, and although the recipient has become eligible, the recipient must make a continuing reasonable effort to sell by: a. Repeatedly renewing any initial listing agreement until the property is sold. If the list price was initially higher than the tax-assessed value, the listed sales price must be reduced after 12 months to no more than 100% of the tax-assessed value. b. In the case where at least 2 realtors have refused to list the property, the recipient must personally try to sell the property by efforts described in 2c above, for 12 months. c. In the case of recipient who has personally advertised his property for a year without success (the newspaper advertisements, "for sale" sign, do not have to be continuous; these efforts must be done for at least 90 days within a 12 month period), the recipient must then (i) subject his property to a realtor's listing agreement at price or below current market value; or (ii) meet the requirements of 2b above which are that the recipient must try to list the property and at least two realtors refuse to list it because it is unsaleable at current market value; other reasons for refusal to list are not sufficient. 5. If the recipient has made a continuing effort to sell the property for 12 months, then the recipient may sell the property between 75% and 100% of its tax assessed value and such sale shall not result in disqualification under the transfer of property rules. If the recipient requests to sell his property at less than 75% of assessed value, he must submit documentation from the listing realtor, or knowledgeable source if the property is not listed with a realtor, that the requested sale price is the best price the recipient can expect to receive for the property at this time. Sale at such a documented price shall not result in disqualification under the transfer of property rules. The proceeds of the sale will be

Name of resource type:	Description:
	counted as a resource in determining continuing eligibility. *
Life insurance less than $1500	Life, retirement, and other related types of insurance policies with face values totaling $1,500, or less on any one person 21 years old and over are not considered resources. When the face values of such policies of any one person exceeds $1,500, the cash surrender value of the policies is counted as a resource.
Cemetery plots	Cemetery plots are not counted as resources regardless of the number owned.
Life rights	Life rights to real property are not counted as a resource. The purchase of a life right in another individual's home is subject to transfer of asset rules.
Payments for involuntary sterilization.	The Commonwealth shall disregard as resources amounts received as payment for involuntary sterilization under the Virginia Eugenical Sterilization Act, beyond the allowable nine-month exclusion by the SSI program's resource methodologies.
Disregard excess resources due to COVID-19	Income that would have otherwise been part of an individual's liability for his or her institutional or home and community based waiver services based on the application of the post-eligibility treatment of income (PETI) rules, but which became countable resources on or after March 18, 2020, will be disregarded until the individual's second Medicaid renewal that follows the end of the COVID-19 public health emergency.

☒ A beneficiary of a "qualified state long-term care insurance partnership" policy (partnership policy), as defined in section 1917(b)(1)(C) of the Social Security Act and 45 CFR 144.200 et seq., is provided a resource disregard, equal to the amount of the insurance benefit payments made to or on behalf of the individual from the partnership policy.

Individuals in Institutions Eligible under a Special Income Level

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
Submission Type	Official	**Initial Submission Date**	1/8/2024
Approval Date	04/04/2024	**Effective Date**	1/1/2024
Superseded SPA ID	VA-23-0004		
	System-Derived		

D. Income Standard Used

The income standard for this group is:

- (•) 1. 300% of the SSI Federal Benefit Rate (FBR) for an individual
- ( ) 2. Other lower income level

Individuals in Institutions Eligible under a Special Income Level

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
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Superseded SPA ID	VA-23-0004		
	System-Derived		

E.Resource Standard Used

The resource standard for this group is the one used for the most closely-related cash assistance program.

Individuals in Institutions Eligible under a Special Income Level

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
Submission Type	Official	**Initial Submission Date**	1/8/2024
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Superseded SPA ID	VA-23-0004		
	System-Derived		

F.Additional Information (optional)

Reasonable effort to sell, continued:
6. Once the applicant has demonstrated that his property is unsaleable by following the procedures in 2 above, the property is disregarded in determining eligibility starting the first day of the month in which the most recent application was filed, or up to three months prior to this month of application if retroactive coverage is requested and the applicant met all other eligibility requirements in the period. A recipient must continue his reasonable efforts to sell the property as required in 3 above.

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Age and Disability- Related Poverty Level

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Individuals who are age 65 or older or who have a disability, with income no higher than 100% FPL.

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
Submission Type	Official	**Initial Submission Date**	1/8/2024
Approval Date	04/04/2024	**Effective Date**	1/1/2024
Superseded SPA ID	VA-23-0004		
	System-Derived		

The state covers the optional Age and Disability-Related Poverty Level eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Meet at least one of the following condition(s):

    a. Are age 65 or older; or

    b. Have a disability.

2. Have income and resources at or below the standard for this group.

Age and Disability- Related Poverty Level

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
Submission Type	Official	**Initial Submission Date**	1/8/2024
Approval Date	04/04/2024	**Effective Date**	1/1/2024
Superseded SPA ID	VA-23-0004		
	System-Derived		

B. Individuals Covered

1. The state covers all individuals who meet the characteristics described in section A.

- (•) Yes
- ( ) No

Age and Disability- Related Poverty Level

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID VA2023MS0003O
SPA ID VA-24-0004
Submission Type Official
Initial Submission Date 1/8/2024
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Effective Date 1/1/2024
Superseded SPA ID VA-23-0004
System-Derived

C. Financial Methodologies

1. SSI methodologies are used in calculating household income and resources. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

- [ ] Yes
- [ ] No

a. The state uses the same less restrictive income methodologies for all individuals covered.

- [ ] Yes
- [ ] No

The less restrictive income methodologies are:

- [x] Census Bureau wages are disregarded.

Description of disregard: All census income is disregarded.

- [x] The following less restrictive methodologies are used:

Name of methodology:	Description:
Disregard of in-kind support and maintenance.	The Commonwealth of Virginia shall disregard the value of in-kind support and maintenance when determining eligibility. In-kind support and maintenance means food, clothing, or shelter or any combination of these provided to an individual.

3. Less restrictive methodologies are used in calculating countable resources.

- [ ] Yes
- [ ] No

a. The state uses the same less restrictive resource methodologies for all individuals covered.

- [ ] Yes
- [ ] No

The less restrictive resource methodologies are:

- [x] The state uses a less restrictive methodology with respect to resources set aside for burial.
  - [x] Specified methodology for the treatment of resources set aside for burial:

	Name of methodology:	Description:
	Burial expenses	Resources set aside to meet the burial expenses of an applicant/recipient or that individual's spouse are excluded from countable assets. In determining eligibility for benefits for medically needy individuals, disregarded from countable resources is an amount not in excess of $3,500 for the individual and an amount not in excess of $3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by: A. the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources; and B. the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses.

☒ The state uses a less restrictive methodology with respect to the treatment of motor vehicles.

☒ The value of a countable motor vehicle is totally disregarded, without limits or conditions.

- ◉ One motor vehicle
- ○ More than one motor vehicle

☒ Household goods and services are disregarded as a resource.

Description of disregard: The value of all household goods and personal effects are disregarde

d as resources.

☒ A specified type of resource is disregarded:

Name of resource type:	Description:
Life insurance less than $1500	Life, retirement, and other related types of insurance policies with face values totaling $1,500, or less on any one person 21 years old and over are not considered resources. When the face values of such policies of any one person exceeds $1,500, the cash surrender value of the policies is counted as a resource.
Cemetery plots	Cemetery plots are not counted as resources regardless of the number owned.
Life rights	Life rights to real property are not counted as a resource. The purchase of a life right in another individual's home is subject to transfer of asset rules.
Reasonable effort to sell.	Once the applicant has demonstrated that his property is unsaleable by following the procedures in 3 below, the property is disregarded in determining eligibility starting the first day of the month in which the most recent application was filed, or up to three months prior to this month of application if retroactive coverage is requested and the applicant met all other eligibility requirements in the period. A recipient must continue his reasonable efforts to sell the property as required in 4 below. 2. Reasonable Effort to Sell. For purposes of this section "current market

Name of resource type:	Description:
	value" is defined as the current tax assessed value. If the property is listed by a realtor, then the realtor may list it at an amount higher than the tax assessed value. In no event, however, shall the realtor's list price exceed 150% of the assessed value. 3. A reasonable effort to sell is considered to have been made: a. As of the date the property becomes subject to a realtor's listing agreement if (i) it is listed at a price at current market value, and (ii) the listing realtor verifies that it is unlikely to sell within 90 days of listing given the particular circumstances involved (e.g., owner's fractional interest; zoning restrictions; poor topography; absence of road frontage or access; absence of improvements; clouds on title, right of way or easement; local market conditions) OR b. When at least two realtors refuse to list the property. The reason for refusal must be that the property is unsaleable at current market value. Other reasons for refusal are not sufficient, OR c. When the applicant has personally advertised his property at or below current market value for 90 days by use of a "Sale By Owner" sign located on the property and by other reasonable efforts such as newspaper advertisements, or reasonable inquiries with all adjoining land-owners or other potential interested purchasers. 4. Notwithstanding the fact that the recipient made a

Name of resource type:	Description:
	reasonable effort to sell the property and failed to sell it, and although the recipient has become eligible, the recipient must make a continuing reasonable effort to sell by: a. Repeatedly renewing any initial listing agreement until the property is sold. If the list price was initially higher than the tax-assessed value, the listed sales price must be reduced after 12 months to no more than 100% of the tax-assessed value. b. In the case where at least 2 realtors have refused to list the property, the recipient must personally try to sell the property by efforts described in 2c above, for 12 months. c. In the case of recipient who has personally advertised his property for a year without success (the newspaper advertisements, "for sale" sign, do not have to be continuous; these efforts must be done for at least 90 days within a 12 month period), the recipient must then (i) subject his property to a realtor's listing agreement at price or below current market value; or (ii) meet the requirements of 2b above which are that the recipient must try to list the property and at least two realtors refuse to list it because it is unsaleable at current market value; other reasons for refusal to list are not sufficient. 5. If the recipient has made a continuing effort to sell the property for 12 months, then the

Name of resource type:	Description:
	recipient may sell the property between 75% and 100% of its tax assessed value and such sale shall not result in disqualification under the transfer of property rules. If the recipient requests to sell his property at less than 75% of assessed value, he must submit documentation from the listing realtor, or knowledgeable source if the property is not listed with a realtor, that the requested sale price is the best price the recipient can expect to receive for the property at this time. Sale at such a documented price shall not result in disqualification under the transfer of property rules. The proceeds of the sale will be counted as a resource in determining continuing eligibility. *
Payments for involuntary sterilization.	The Commonwealth shall disregard as resources amounts received as payment for involuntary sterilization under the Virginia Eugenical Sterilization Act, beyond the allowable nine-month exclusion by the SSI program's resource methodologies.
Disregard excess resources due to COVID-19	Income that would have otherwise been part of an individual's liability for his or her institutional or home and community based waiver services based on the application of the post-eligibility treatment of income (PETI) rules, but which became countable resources on or after March 18, 2020, will be disregarded until the individual's second Medicaid renewal

Name of resource type:	Description:
Work Incentive Account (WIN accounts)	that follows the end of the COVID-19 public health emergency. Resources accumulated in the Work Incentive Account (WIN) shall be disregarded in determining eligibility for one year after the individual leaves the Medicaid buy-in program, unless the WIN account is an IRS-recognized account, in which case the disregard of the account will not be time-limited (subject to the account meeting the conditions described in the "Ticket to Work Basic" section of the state plan). IRS-recognized WIN accounts are: retirement accounts (e.g., 401(k)/403(b)/457(b)/503(b) accounts, traditional Individual Retirement Accounts (IRAs), Roth IRAs, SEP-IRAs, SIMPLE IRAs, and Thrift Savings Plans), medical savings accounts (e.g., Archer Medical Savings Account), medical reimbursement accounts (e.g., Health Savings Accounts), education accounts (e.g., 529 Plans) and independence accounts (e.g., Fostering Independence Account).

☒ A beneficiary of a "qualified state long-term care insurance partnership" policy (partnership policy), as defined in section 1917(b)(1)(C) of the Social Security Act and 45 CFR 144.200 et seq., is provided a resource disregard, equal to the amount of the insurance benefit payments made to or on behalf of the individual from the partnership policy.

Age and Disability- Related Poverty Level

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
Submission Type	Official	**Initial Submission Date**	1/8/2024
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Superseded SPA ID	VA-23-0004		
	System-Derived		

D. Income Standard Used

The income standard for this eligibility group is:

- ○ 1. 100% FPL
- ◉ 2. A lower percent of the FPL:

80.00% FPL

Age and Disability- Related Poverty Level

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
Submission Type	Official	**Initial Submission Date**	1/8/2024
Approval Date	04/04/2024	**Effective Date**	1/1/2024
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	System-Derived		

E. Resource Standard Used

The resource standard used is:

1. The resource limit for the SSI program; or
2. The resource limit used in the state's medically needy program, if higher.

Age and Disability- Related Poverty Level

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
Submission Type	Official	**Initial Submission Date**	1/8/2024
Approval Date	04/04/2024	**Effective Date**	1/1/2024
Superseded SPA ID	VA-23-0004		
	System-Derived		

F. Additional Information (optional)

Reasonable effort to sell, continued:
6. Once the applicant has demonstrated that his property is unsaleable by following the procedures in 2 above, the property is disregarded in determining eligibility starting the first day of the month in which the most recent application was filed, or up to three months prior to this month of application if retroactive coverage is requested and the applicant met all other eligibility requirements in the period. A recipient must continue his reasonable efforts to sell the property as required in 3 above.

Medicaid State Plan Eligibility

Eligibility Groups - Options for Coverage

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Individuals between ages 16 and 64 with a disability, who have earned income.

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
Submission Type	Official	**Initial Submission Date**	1/8/2024
Approval Date	04/04/2024	**Effective Date**	1/1/2024
Superseded SPA ID	13-20, 93-04, 06-08		
	User-Entered		

The state covers the optional Ticket to Work basic eligibility group in accordance with the following provisions:

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
Submission Type	Official	**Initial Submission Date**	1/8/2024
Approval Date	04/04/2024	**Effective Date**	1/1/2024
Superseded SPA ID	13-20, 93-04, 06-08		
	User-Entered		

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are at least age 16 but less than 65 years of age.

2. Have earned income.

3. But for earned income, meet the SSI definition of disability.

4. Have income and resources that do not exceed the standards established by the state.

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID VA2023MS0003O
SPA ID VA-24-0004
Submission Type Official
Initial Submission Date 1/8/2024
Approval Date 04/04/2024
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Superseded SPA ID 13-20, 93-04, 06-08
User-Entered

B. Financial Methodologies

1. SSI methodologies are used in calculating household income and resources.

Yes

No

Please refer as necessary to Non-MAGI Methodologies, completed by the state.

2. Less restrictive methodologies are used in calculating countable income.

Yes

No

The less restrictive income methodologies are:

☒ Census Bureau wages are disregarded.

Description of disregard: All census income is disregarded.

☒ A specified type of income is disregarded:

Name of income type:	Description:
Disregard of in-kind support and maintenance	The Commonwealth of Virginia shall disregard the value of in-kind support and maintenance when determining eligibility. In-kind support and maintenance means food, clothing, or shelter or any combination of these provided to an individual.
Earned Income	$6,250 a month in earned income is disregarded. This disregard is conditional on the income being placed in a WIN account.
Spousal income	No spousal income is deemed to the individual. All spousal income is disregarded.
Parental Income	No parental income is deemed to the individual. All parental income is disregarded.
COLA increases deposited to WIN account	The Commonwealth shall disregard any increase in the amount of earned income in Social Security Disability Insurance (SSDI) payment resulting from employment as a worker with disabilities eligible for assistance under §1902(a)(10)(A)(ii)(XVI) of the Act or as a result of a COLA adjustment to the SSDI payment, if this additional amount of unearned income in SSDI payment from work and/or COLA is deposited into the individual's designated WIN account.
Unemployment	The Commonwealth shall disregard any amount of unearned income of an enrollee as a result of the receipt of unemployment

Name of income type:	Description:
	insurance benefits due to loss of employment through no fault of his own, if this unearned income from unemployment insurance payments is deposited into the individual's designated WIN account. This disregard shall only apply while an enrollee is in the six month safety net, or "grace" period.

3. Less restrictive methodologies are used in calculating countable resources.

- (•) Yes
- ( ) No

The less restrictive resource methodologies are:

- [x] Resources from household members are disregarded.
  - [x] Resources of the spouse are disregarded. — **Description:** No spousal resources are deemed to the applicant.
  - [x] Resources of parents are disregarded. — **Description:** No parental resources are deemed to the applicant.
- [x] The state uses a less restrictive methodology with respect to resources set aside for burial.
  - [x] A higher amount is disregarded: — **Amount:** $3500.00
  - [x] Specified methodology for the treatment of resources set aside for burial:

Name of methodology:	Description:
Burial expenses	Resources set aside to meet the burial expenses of an applicant/recipient or that individual's spouse are excluded from countable assets. In determining eligibility for benefits for medically needy individuals, disregarded from countable resources is an amount not in excess of $3,500 for the individual and an amount not in excess of $3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by: A. the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources; and B. the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses.

- [x] The state uses a less restrictive methodology with respect to the treatment of motor vehicles.
  - [x] The value of a countable motor vehicle is totally disregarded, without limits or conditions.
    - (•) One motor vehicle
    - ( ) More than one motor vehicle
- [x] The state uses a less restrictive methodology with respect to the treatment of resources set aside in specified types of accounts.
  - [x] Specified types of accounts:

Name of account:	Description:
WIN (Work Incentive Account)	Any checking or savings accounts, or certain IRS-recognized accounts, that the member designates. "IRS-recognized" accounts in this context refers to: retirement accounts (e.g., 401(k)/403(b)/457(b)/503(b) accounts, traditional Individual Retirement Accounts (IRAs), Roth IRAs, SEP-IRAs, SIMPLE IRAs, and Thrift Savings Plans); medical savings accounts (e.g., Archer Medical Savings Account); medical reimbursement accounts (e.g., Health Savings Accounts); education accounts (e.g., 529 Plans); and independence accounts (e.g., Fostering Independence Account). The maximum amount that will be disregarded in a WIN account will be the relevant year's section 1619(b) threshold for Virginia, plus any interest a member has accrued on their designated WIN account; e.g., in 2024, the maximum WIN-account disregard will be $45,976 plus any interest the member has accrued on the account. To be eligible for this resource disregard, WIN Accounts are subject to the following provisions: a. Deposits to this account shall derive solely from the individual's income earned after electing to enroll in the Medicaid Buy-In (MBI) program. b. The account will be held separate from non-exempt resources in accounts for which prior approval has been obtained from the Department, and for which the owner authorizes regular monitoring and/or reporting including deposits, withdrawals, and other information deemed necessary by the Department for the proper administration of this provision. c. WIN accounts shall be disregarded for one year after the individual leaves the Medicaid buy-in program, unless the WIN account is an IRS-recognized account, in which case the disregard of the account will not be time-limited (subject to the account meeting the conditions described above).

☒ Household goods and services are disregarded as a resource.

Description of disregard: The value of all household goods and personal effects are disregarded as resources.

☒ A specified type of resource is disregarded:

Name of resource type:	Description:
Payments made for involuntary sterilization.	The Commonwealth shall disregard as resources amounts received as payment for involuntary sterilization under the Virginia Eugenical Sterilization Act, beyond the allowable nine-month exclusion

Name of resource type:	Description:
	by the SSI program's resource methodologies.
Cemetery plots	Cemetery plots are not counted as resources regardless of the number owned.
Life Rights	Life rights to real property are not counted as a resource. The purchase of a life right in another individual's home is subject to transfer of asset rules.
Reasonable Effort to Sell	A. For purposes of this section "current market value" is defined as the current tax assessed value. If the property is listed by a realtor, then the realtor may list it at an amount higher than the tax assessed value. In no event, however, shall the realtor's list price exceed 150% of the assessed value. B. A reasonable effort to sell is considered to have been made: 1. As of the date the property becomes subject to a realtor's listing agreement if a. it is listed at a price at current market value, and b. the listing realtor verifies that it is unlikely to sell within 90 days of listing given the particular circumstances involved (e.g., owner's fractional interest; zoning restrictions; poor topography; absence of road frontage or access; absence of improvements; clouds on title, right of way or easement; local market conditions) OR 2. When at least two realtors refuse to list the property. The reason for refusal must be that the property is unsaleable at current market value. Other reasons for refusal are not sufficient, OR 3. When the applicant has personally advertised his property at or below current market value for 90 days by use of a "Sale By Owner" sign located on the property and by other reasonable efforts such as newspaper advertisements, or reasonable inquiries with all adjoining land-owners or other potential interested purchasers. C. Notwithstanding the fact that the recipient made a reasonable effort to sell the property and failed to sell it, and although the recipient has become eligible, the recipient must make a continuing reasonable effort to sell by: 1. Repeatedly renewing any initial listing agreement until the property is sold. If the list price was initially higher than the tax-assessed value, the listed sales price must be reduced after 12 months to no more than 100% of the tax-assessed value. 2. In the case where at least 2

Name of resource type:	Description:
	realtors have refused to list the property, the recipient must personally try to sell the property by efforts described in B(3) above, for 12 months. 3. In the case of recipient who has personally advertised his property for a year without success (the newspaper advertisements, "for sale" sign, do not have to be continuous; these efforts must be done for at least 90 days within a 12 month period), the recipient must then a. subject his property to a realtor's listing agreement at price or below current market value; or b. meet the requirements of B(2) above which are that the recipient must try to list the property and at least two realtors refuse to list it because it is unsaleable at current market value; other reasons for refusal to list are not sufficient. D. If the recipient has made a continuing effort to sell the property for 12 months, then the recipient may sell the property between 75% and 100% of its tax assessed value and such sale shall not result in disqualification under the transfer of property rules. If the recipient requests to sell his property at less than 75% of assessed value, he must submit documentation from the listing realtor, or knowledgeable source if the property is not listed with a realtor, that the requested sale price is the best price the recipient can expect to receive for the property at this time. Sale at such a documented price shall not result in disqualification under the transfer of property rules. The proceeds of the sale will be counted as a resource in determining continuing eligibility. E. Once the applicant has demonstrated that his property is unsaleable by following the procedures in Section "B", the property is disregarded in determining eligibility starting the first day of the month in which the most recent application was filed, or up to three months prior to this month of application if retroactive coverage is requested and the applicant met all other eligibility requirements in the period. A recipient must continue his reasonable efforts to sell the property as required in Section C above.
Life insurance less than $1500	Life, retirement, and other related types of insurance policies with face values totaling $1,500, or less on any one person 21 years old and over are not considered resources. When the face values of such policies of any one person

Name of resource type:	Description:
	exceeds $1,500, the cash surrender value of the policies is counted as a resource.

☒ A beneficiary of a "qualified state long-term care insurance partnership" policy (partnership policy), as defined in section 1917(b)(1)(C) of the Social Security Act and 45 CFR 144.200 et seq., is provided a resource disregard, equal to the amount of the insurance benefit payments made to or on behalf of the individual from the partnership policy.

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
Submission Type	Official	**Initial Submission Date**	1/8/2024
Approval Date	04/04/2024	**Effective Date**	1/1/2024
Superseded SPA ID	13-20, 93-04, 06-08		
	User-Entered		

C. Income Standard Used

The income standard for this group is:

1. No income standard
2. A percentage of the federal poverty level:

FPL 138.00%

3. A percentage of the SSI Federal Benefit Rate:
4. A dollar amount
5. Other

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
Submission Type	Official	**Initial Submission Date**	1/8/2024
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Superseded SPA ID	13-20, 93-04, 06-08		
	User-Entered		

D. Resource Standard Used

The resource standard for this group is:

- ○ 1. No resource standard
- ◉ 2. SSI resource standard
- ○ 4. A dollar amount higher than the SSI resource standard

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
Submission Type	Official	**Initial Submission Date**	1/8/2024
Approval Date	04/04/2024	**Effective Date**	1/1/2024
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	User-Entered		

E. Premiums and Cost Sharing

Requirements for premiums and cost sharing for this group are found in the premium and cost sharing sections of the state plan.

Ticket to Work Basic

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
Submission Type	Official	**Initial Submission Date**	1/8/2024
Approval Date	04/04/2024	**Effective Date**	1/1/2024
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	User-Entered		

F. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility Groups - Medically Needy

Medically Needy Populations Based on Age, Blindness or Disability

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Individuals who are age 65 or older or who have blindness or a disability who do not qualify as categorically needy.

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
Submission Type	Official	**Initial Submission Date**	1/8/2024
Approval Date	04/04/2024	**Effective Date**	1/1/2024
Superseded SPA ID	VA-23-0004		
	System-Derived		

The state covers the optional Medically Needy Populations Based on Age, Blindness or Disability eligibility group in accordance with the following provisions:

A. Characteristics

Individuals qualifying under this eligibility group must meet the following criteria:

1.Meet at least one of the following:

a. Are age 65 or older;

b. Have blindness; or

c. Have a disability.

2. Are not otherwise eligible for categorically needy coverage under the state plan.

3. Have income at or below the medically needy income level and resources at or below the medically needy resource level.

Medically Needy Populations Based on Age, Blindness or Disability

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID VA2023MS0003O
SPA ID VA-24-0004
Submission Type Official
Initial Submission Date 1/8/2024
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Superseded SPA ID VA-23-0004
System-Derived

B. Individuals Covered

The state covers the following populations:

- [X] 1. Individuals age 65 or older
- [X] 2. Individuals with blindness
- [X] 3. Individuals who have a disability

Medically Needy Populations Based on Age, Blindness or Disability

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID VA2023MS0003O
SPA ID VA-24-0004
Submission Type Official
Initial Submission Date 1/8/2024
Approval Date 04/04/2024
Effective Date 1/1/2024
Superseded SPA ID VA-23-0004
System-Derived

C. Financial Methodologies

1. The state uses the same financial methodology for all individuals covered.

Yes

No

2. The financial methodology used is:

a. SSI methodologies. Please refer as necessary to Non-MAGI Methodologies, completed by the state.

b.More restrictive requirements than SSI. Please refer as necessary to More Restrictive Requirements than SSI under 1902(f), completed by the state.

c. Less restrictive methodologies are used in calculating countable income.

Yes No

The less restrictive income methodologies are:

☒ Census Bureau wages are disregarded.

Description of disregard: All census income is disregarded.

☒ The following less restrictive methodologies are used:

Name of methodology:	Description:
Disregard of in-kind support and maintenance.	The Commonwealth of Virginia shall disregard the value of in-kind support and maintenance when determining eligibility. In-kind support and maintenance means food, clothing, or shelter or any combination of these provided to an individual.
Disregard of income.	The Commonwealth will disregard all earned income of a child under the age of 19 years who is a student. This applies only to medically needy children.

d. Less restrictive methodologies are used in calculating countable resources.

Yes No

The less restrictive resource methodologies are:

☒ The state uses a less restrictive methodology with respect to resources set aside for burial.

☒ Specified methodology for the treatment of resources set aside for burial:

	Name of methodology:	Description:
	Burial expenses	Resources set aside to meet the burial expenses of an applicant/recipient or that individual's spouse are excluded from countable assets. In determining eligibility for benefits for medically needy individuals, disregarded from countable resources is an amount not in excess of $3,500 for the individual and an amount not in excess of $3,500 for his spouse when such resources have been set aside to meet the burial expenses of the individual or his spouse. The amount disregarded shall be reduced by: A. the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources; and B. the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting the individual's or his spouse's burial expenses.

☒ The state uses a less restrictive methodology with respect to the treatment of motor vehicles.

☒ The value of a countable motor vehicle is totally disregarded, without limits or conditions.

- ◉ One motor vehicle
- ○ More than one motor vehicle

☒ Household goods and services are disregarded as a resource.

Description of disregard: The value of all household goods and personal effects are disregarde

d as resources.

☐ A specified type of resource is disregarded:

Name of resource type:	Description:
Life insurance less than $1500	Life, retirement, and other related types of insurance policies with face values totaling $1,500, or less on any one person 21 years old and over are not considered resources. When the face values of such policies of any one person exceeds $1,500, the cash surrender value of the policies is counted as a resource.
Cemetery plots	Cemetery plots are not counted as resources regardless of the number owned.
Life rights	Life rights to real property are not counted as a resource. The purchase of a life right in another individual's home is subject to transfer of asset rules.
Reasonable effort to sell.	Once the applicant has demonstrated that his property is unsaleable by following the procedures in 3 below, the property is disregarded in determining eligibility starting the first day of the month in which the most recent application was filed, or up to three months prior to this month of application if retroactive coverage is requested and the applicant met all other eligibility requirements in the period. A recipient must continue his reasonable efforts to sell the property as required in 4 below. 2. Reasonable Effort to Sell. For purposes of this section "current market

Name of resource type:	Description:
	value" is defined as the current tax assessed value. If the property is listed by a realtor, then the realtor may list it at an amount higher than the tax assessed value. In no event, however, shall the realtor's list price exceed 150% of the assessed value. 3. A reasonable effort to sell is considered to have been made: a. As of the date the property becomes subject to a realtor's listing agreement if (i) it is listed at a price at current market value, and (ii) the listing realtor verifies that it is unlikely to sell within 90 days of listing given the particular circumstances involved (e.g., owner's fractional interest; zoning restrictions; poor topography; absence of road frontage or access; absence of improvements; clouds on title, right of way or easement; local market conditions) OR b. When at least two realtors refuse to list the property. The reason for refusal must be that the property is unsaleable at current market value. Other reasons for refusal are not sufficient, OR c. When the applicant has personally advertised his property at or below current market value for 90 days by use of a "Sale By Owner" sign located on the property and by other reasonable efforts such as newspaper advertisements, or reasonable inquiries with all adjoining land-owners or other potential interested purchasers. 4. Notwithstanding the fact that the recipient made a

Name of resource type:	Description:
	reasonable effort to sell the property and failed to sell it, and although the recipient has become eligible, the recipient must make a continuing reasonable effort to sell by: a. Repeatedly renewing any initial listing agreement until the property is sold. If the list price was initially higher than the tax-assessed value, the listed sales price must be reduced after 12 months to no more than 100% of the tax-assessed value. b. In the case where at least 2 realtors have refused to list the property, the recipient must personally try to sell the property by efforts described in 2c above, for 12 months. c. In the case of recipient who has personally advertised his property for a year without success (the newspaper advertisements, "for sale" sign, do not have to be continuous; these efforts must be done for at least 90 days within a 12 month period), the recipient must then (i) subject his property to a realtor's listing agreement at price or below current market value; or (ii) meet the requirements of 2b above which are that the recipient must try to list the property and at least two realtors refuse to list it because it is unsaleable at current market value; other reasons for refusal to list are not sufficient. 5. If the recipient has made a continuing effort to sell the property for 12 months, then the

Name of resource type:	Description:
	recipient may sell the property between 75% and 100% of its tax assessed value and such sale shall not result in disqualification under the transfer of property rules. If the recipient requests to sell his property at less than 75% of assessed value, he must submit documentation from the listing realtor, or knowledgeable source if the property is not listed with a realtor, that the requested sale price is the best price the recipient can expect to receive for the property at this time. Sale at such a documented price shall not result in disqualification under the transfer of property rules. The proceeds of the sale will be counted as a resource in determining continuing eligibility. *
Payments for involuntary sterilization.	The Commonwealth shall disregard as resources amounts received as payment for involuntary sterilization under the Virginia Eugenical Sterilization Act, beyond the allowable nine-month exclusion by the SSI program's resource methodologies.
Disregard excess resources due to COVID-19	Income that would have otherwise been part of an individual's liability for his or her institutional or home and community based waiver services based on the application of the post-eligibility treatment of income (PETI) rules, but which became countable resources on or after March 18, 2020, will be disregarded until the individual's second Medicaid renewal

Name of resource type:	Description:
Work Incentive Account (WIN accounts)	that follows the end of the COVID-19 public health emergency. Resources accumulated in the Work Incentive Account (WIN) shall be disregarded in determining eligibility for one year after the individual leaves the Medicaid buy-in program, unless the WIN account is an IRS-recognized account, in which case the disregard of the account will not be time-limited (subject to the account meeting the conditions described in the "Ticket to Work Basic" section of the state plan). IRS-recognized WIN accounts are: retirement accounts (e.g., 401(k)/403(b)/457(b)/ 503(b) accounts, traditional Individual Retirement Accounts (IRAs), Roth IRAs, SEP-IRAs, SIMPLE IRAs, and Thrift Savings Plans), medical savings accounts (e.g., Archer Medical Savings Account), medical reimbursement accounts (e.g., Health Savings Accounts), education accounts (e.g., 529 Plans) and independence accounts (e.g., Fostering Independence Account).

☒ A beneficiary of a "qualified state long-term care insurance partnership" policy (partnership policy), as defined in section 1917(b)(1)(C) of the Social Security Act and 45 CFR 144.200 et seq., is provided a resource disregard, equal to the amount of the insurance benefit payments made to or on behalf of the individual from the partnership policy.

Medically Needy Populations Based on Age, Blindness or Disability

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
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	System-Derived		

D. Income Standard Used

The income standard used for this group is described in the Medically Needy Income Level RU.

Medically Needy Populations Based on Age, Blindness or Disability

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
Submission Type	Official	**Initial Submission Date**	1/8/2024
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E. Resource Standard Used

The resource standard used for this group is described in the Medically Needy Resource Level RU.

Medically Needy Populations Based on Age, Blindness or Disability

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
Submission Type	Official	**Initial Submission Date**	1/8/2024
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	System-Derived		

F. Spenddown

The state allows individuals to deduct incurred medical and remedial expenses (spend down) to become eligible under this group. Spenddown is defined in the Handling of Excess Income (Spenddown) RU.

Medically Needy Populations Based on Age, Blindness or Disability

MEDICAID | Medicaid State Plan | Eligibility | VA2023MS0003O | VA-24-0004

Package Header

Package ID	VA2023MS0003O	**SPA ID**	VA-24-0004
Submission Type	Official	**Initial Submission Date**	1/8/2024
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	System-Derived		

G. Additional Information (optional)

Medicaid State Plan Eligibility

Non-Financial Eligibility

Citizenship and Non-Citizen Eligibility

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0001O | VA-21-0005

Package Header

Package ID	VA2020MS0001O	**SPA ID**	VA-21-0005
Submission Type	*Official*	**Initial Submission Date**	1/20/2021
Approval Date	04/16/2021	**Effective Date**	4/1/2021
Superseded SPA ID	VA-13-0014		
	User-Entered		

☐ The state provides Medicaid to citizens and nationals of the United States and certain non-citizens who meet all other Medicaid eligibility requirements under the state plan, consistent with requirements of 42 CFR 435.406, including during a reasonable opportunity period pending verification of their citizenship, national status or satisfactory immigration status.

A. Citizens, Nationals and Eligible Non-Citizens

The state provides Medicaid eligibility to otherwise eligible individuals:

1. Who are citizens or nationals of the United States; or

2. Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641) or who are non-citizens treated as refugees under other federal statutes for purposes of Medicaid eligibility, subject to the requirements at 8 U.S.C. §1612(b)(2), and are not restricted by section 403 of PRWORA (8 U.S.C. §1613); or who are non-citizens whose eligibility is required by 8 U.S.C. 1612(b)(2)(E) and (F); and

3. Who have declared themselves to be citizens or nationals of the United States, or non-citizens having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), 1902(ee) of the SSA and 42 CFR 435.406, 911, and 956.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

a. The agency provides for an extension of the reasonable opportunity period for non-citizens if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

- (•) Yes
- ( ) No

☒ b. When a reasonable opportunity period is provided, the agency furnishes benefits to otherwise eligible individuals on the following date:

The date benefits are furnished is:

- (•) i. The date of the application containing the declaration of citizenship or immigration status.
- ( ) ii. The first day of the month of application.

Citizenship and Non-Citizen Eligibility

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0001O | VA-21-0005

Package Header

Package ID VA2020MS0001O
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User-Entered

B. Optional Coverage of Qualified Non-Citizens

The state provides Medicaid coverage to all otherwise-eligible Qualified Non-Citizens whose eligibility is not restricted by section 403 of PRWORA (8 U.S.C. §1613).

Yes

No

Indicate which requirements apply:

1. The state requires Lawful Permanent Residents to have 40 qualifying work quarters under Title II of the Social Security Act.

Yes

No

2. The state limits eligibility to 7 years for the following non-citizens:

a. Non-citizens admitted to the U.S. as a refugee under section 207 of the Immigration and Nationality Act (INA)

b. Non-citizens granted asylum under section 208 of the INA

c. Non-citizens whose deportation is withheld under section 243(h) or 241(b)(3) of the INA

d. Non-citizens granted status as a Cuban-Haitian Entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980

e. Non-citizens admitted to the U.S. as Amerasian immigrants

f. Non-citizens treated as refugees under other federal statutes for purposes of Medicaid eligibility

Yes

No

Citizenship and Non-Citizen Eligibility

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0001O | VA-21-0005

Package Header

Package ID	VA2020MS0001O	**SPA ID**	VA-21-0005
Submission Type	Official	**Initial Submission Date**	1/20/2021
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Superseded SPA ID	VA-13-0014		
	User-Entered		

C. Coverage of Lawfully Residing Individuals

The state elects the option to provide Medicaid coverage to otherwise eligible individuals, lawfully residing in the United States, as provided in section 1903(v)(4) of the Act.

- (●) Yes
- ( ) No

- [X] 1. Pregnant women
- [X] 2. Individuals under a specified age:
  - ( ) a. Individuals under age 21
  - ( ) b. Individuals under age 20
  - (●) c. Individuals under age 19

3. An individual is considered to be lawfully residing in the United States if he or she is lawfully present and otherwise meets the eligibility requirements in the state plan.

4. An individual is considered to be lawfully present in the United States if he or she is:

a. A qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);

b. A non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));

c. A non-citizen who has been paroled into the United States in accordance with 8 U.S.C.1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

d. A non-citizen who belongs to one of the following classes:

i. Granted temporary resident status in accordance with 8 U.S.C.1160 or 1255a, respectively;

ii. Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;

iii. Granted employment authorization under 8 CFR 274a.12(c);

iv. Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;

v. Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

vi. Granted Deferred Action status;

vii. Granted an administrative stay of removal under 8 CFR 241;

viii.Beneficiary of approved visa petition who has a pending application for adjustment of status;

e. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C.1231,or under the Convention Against Torture who:

i. Has been granted employment authorization; or

ii. Is under the age of 14 and has had an application pending for at least 180 days;

f. Has been granted withholding of removal under the Convention Against Torture;

g. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C.1101(a)(27)(J);

h. Is lawfully present in American Samoa under the immigration laws of American Samoa; or

i. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b)).

j. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (a) through (i) of this definition.

- [X] k. Other

Description:

Description: Exceptions: • Individuals granted an administrative stay of removal under 8 CFR 241, described under C.4.d.vii., above, are not considered to be lawfully present; • Individuals granted employment authorization under 8 CFR 274a.12(c)(35) and (c)(36), described under paragraph C.4.d.iii, are not considered to be lawfully present unless they have an immigration status considered lawfully present under paragraph 4.a. through i.

Citizenship and Non-Citizen Eligibility

MEDICAID | Medicaid State Plan | Eligibility | VA2020MS0001O | VA-21-0005

Package Header

Package ID	VA2020MS0001O	**SPA ID**	VA-21-0005
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D. Emergency Coverage

☒ The state assures that it provides limited Medicaid services for treatment of an emergency medical condition, not related to an organ transplant procedure, as defined in 1903(v)(3) of the Social Security Act and implemented at 42 CFR 440.255, to the following individuals who meet all Medicaid eligibility requirements, except documentation of citizenship or satisfactory immigration status and/or present an SSN:

1. Qualified non-citizens subject to the 5 year waiting period described in 8 U.S.C. 1613(a)

2. Non-qualified non-citizens, unless covered as a lawfully residing child or pregnant woman by the state under the option in accordance with 1903(v)(4) and implemented at 435.406(b).

3. Qualified non-citizens for whom the state has elected to limit coverage, in accordance with 8 U.S.C. 1612(b)(2)(A), as amended, or (B).

E. Additional Information (optional)

Medicaid State Plan Eligibility

General Eligibility Requirements

Application

MEDICAID | Medicaid State Plan | Eligibility | VA2022MS0001O | VA-22-0001

Package Header

Package ID VA2022MS0001O
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Submission Type Official
Initial Submission Date 8/25/2022
Approval Date 01/09/2023
Effective Date 7/1/2022
Superseded SPA ID VA-18-0015
System-Derived

A. MAGI Paper Application

The state uses the following paper application(s) for individuals applying for coverage based on the applicable modified adjusted gross income (MAGI) standard.

1. The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

2. One or more alternative single, streamlined applications developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary

Name

Standard Application and Single Page Supplement

The paper application(s) has been uploaded.

Document Name	Date Created
English Application Single Page Supplement 12_22_22	12/22/2022 5:10 PM EST
English MAGI Standard Application 122222	12/22/2022 5:10 PM EST

3. One or more alternative applications used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single streamlined application used only for insurance affordability programs to individuals seeking assistance only through such programs

4. Other alternative applications, provided that the agency makes readily available the single streamlined application used only for insurance affordability programs to individuals seeking assistance only through such programs

Application

MEDICAID | Medicaid State Plan | Eligibility | VA2022MS0001O | VA-22-0001

Package Header

Package ID	VA2022MS0001O	**SPA ID**	VA-22-0001
Submission Type	Official	**Initial Submission Date**	8/25/2022
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Superseded SPA ID	VA-18-0015		
	System-Derived		

B. MAGI Online Application

The state uses the following online application(s) for individuals applying for coverage based on the applicable MAGI standard.

- ○ 1. The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act
- ◉ 2. One or more alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary

Name

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Screenshots or other documentation of the online application(s) has been uploaded.

Document Name	Date Created
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- ☐ 3. One or more alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single application used only for insurance affordability programs to individuals seeking assistance only through such programs
- ☐ 4. Other alternative applications, provided that the agency makes readily available the single streamlined application used only for insurance affordability programs to individuals seeking assistance only through such programs

Application

MEDICAID | Medicaid State Plan | Eligibility | VA2022MS0001O | VA-22-0001

Package Header

Package ID	VA2022MS0001O	**SPA ID**	VA-22-0001
Submission Type	Official	**Initial Submission Date**	8/25/2022
Approval Date	01/09/2023	**Effective Date**	7/1/2022
Superseded SPA ID	VA-18-0015		
	System-Derived		

C. Basis Other than MAGI - Paper Application

The state uses the following paper application(s) for individuals applying for coverage on a basis other than the applicable MAGI standard:

☒ 1. The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary

☐ 2. One or more applications designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary

☐ 3. One or more applications used to apply for multiple human service programs

☐ 4. Other alternative applications

Application

MEDICAID | Medicaid State Plan | Eligibility | VA2022MS0001O | VA-22-0001

Package Header

Package ID	VA2022MS0001O	**SPA ID**	VA-22-0001
Submission Type	Official	**Initial Submission Date**	8/25/2022
Approval Date	01/09/2023	**Effective Date**	7/1/2022
Superseded SPA ID	VA-18-0015		
	System-Derived		

D. Other than MAGI - Online Application

The state uses the following online application(s) for individuals applying for coverage who may be eligible on a basis other than the applicable MAGI standard:

- [x] 1. The single, streamlined application developed by the Secretary or one of the alternate online forms developed by the state and approved by the Secretary, and supplemental online forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary
- [ ] 2. One or more application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary
- [ ] 3. One or more application used to apply for multiple human service programs
- [ ] 4. Other alternative applications

Application

MEDICAID | Medicaid State Plan | Eligibility | VA2022MS0001O | VA-22-0001

Package Header

Package ID	VA2022MS0001O	**SPA ID**	VA-22-0001
Submission Type	Official	**Initial Submission Date**	8/25/2022
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Superseded SPA ID	VA-18-0015		
	System-Derived		

E. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility and Enrollment Processes

Presumptive Eligibility

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0007O | VA-18-0010

Package Header

Package ID	VA2018MS0007O	**SPA ID**	VA-18-0010
Submission Type	Official	**Initial Submission Date**	6/22/2018
Approval Date	12/17/2018	**Effective Date**	1/1/2019
Superseded SPA ID	VA-14-0007		
	User-Entered		

The state provides Medicaid services to individuals during a presumptive eligibility period following a determination by a qualified entity.

Presumptive eligibility covered in the state plan includes:

Eligibility Groups

Eligibility Group Name	Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Presumptive Eligibility for Children under Age 19	☐	☐	○	NEW
Parents and Other Caretaker Relatives - Presumptive Eligibility	☐	☐	○	NEW
Presumptive Eligibility for Pregnant Women	☐	☐	○	NEW
Adult Group - Presumptive Eligibility	☐	☐	○	NEW
Individuals above 133% FPL under Age 65 - Presumptive Eligibility	☐	☐	○	NEW
Individuals Eligible for Family Planning Services - Presumptive Eligibility	☐	☐	○	NEW
Former Foster Care Children - Presumptive Eligibility	☐	☐	○	NEW
Individuals Needing Treatment for Breast or Cervical Cancer - Presumptive Eligibility	☐	☐	○	NEW

Hospitals

Eligibility Group Name	Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Presumptive Eligibility by Hospitals	☑	☑	○	APPROVED

Presumptive Eligibility

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0007O | VA-18-0010

Package Header

Package ID	VA2018MS0007O	**SPA ID**	VA-18-0010
Submission Type	Official	**Initial Submission Date**	6/22/2018
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Superseded SPA ID	VA-14-0007		
	User-Entered		

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Presumptive Eligibility

Presumptive Eligibility by Hospitals

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0007O | VA-18-0010

Package Header

Package ID	VA2018MS0007O	**SPA ID**	VA-18-0010
Submission Type	Official	**Initial Submission Date**	6/22/2018
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Superseded SPA ID	VA-14-0007		
	System-Derived		

☒ The state provides an assurance that it has policies and procedures in place to enable qualified hospitals to determine presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

☒ The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

A. Qualifications of Hospitals

A qualified hospital is a hospital that:

1. Participates as a provider under the state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

2. Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

3. Assists individuals in completing and submitting the full application and understanding any documentation requirements.

◉ Yes ○ No

Presumptive Eligibility by Hospitals

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0007O | VA-18-0010

Package Header

Package ID VA2018MS0007O
SPA ID VA-18-0010
Submission Type Official
Initial Submission Date 6/22/2018
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Effective Date 1/1/2019
Superseded SPA ID VA-14-0007

System-Derived

B. Eligibility Groups or Populations Included

The eligibility groups or populations for which hospitals determine eligibility presumptively are:

1. Pregnant Women
2. Infants and Children under Age 19
3. Parents and Other Caretaker Relatives
4. Adult Group, if covered by the state
5. Individuals above 133% FPL under Age 65, if covered by the state
6. Individuals Eligible for Family Planning Services, if covered by the state
7. Former Foster Care Children
8. Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state

The state limits qualified hospitals for this group to providers who conduct screenings for breast and cervical cancer under the state's Centers for Disease Control and Prevention's National Breast and Cervical Cancer Early Detection Program.

Yes No

9. Other Medicaid state plan eligibility groups:
10. Demonstration populations covered under section 1115

Presumptive Eligibility by Hospitals

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0007O | VA-18-0010

Package Header

Package ID	VA2018MS0007O	**SPA ID**	VA-18-0010
Submission Type	Official	**Initial Submission Date**	6/22/2018
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Superseded SPA ID	VA-14-0007		
	System-Derived		

C. Standards for Participating Hospitals

The state establishes reasonable standards for qualified hospitals making presumptive eligibility determinations.

(●) Yes ( ) No

[X] The state has a standard requiring that a percentage of individuals who are determined presumptively eligible submit a regular application, as described at 42 CFR 435.907, before the end of the presumptive eligibility period.

Percentage of individuals submitting a regular application:

85.00%

[X] The state has a standard requiring that a percentage of individuals who are determined presumptively eligible be determined eligible for Medicaid based on the submission of an application before the end of the presumptive eligibility period.

Percentage of individuals found eligible for Medicaid

70.00%

D. Presumptive Eligibility Period

1. The presumptive period begins on the date the determination is made.
2. The end date of the presumptive period is the earlier of:
   - The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or
   - The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.
3. Periods of presumptive eligibility are limited as follows:

(●) a. No more than one period within a calendar year.

( ) b. No more than one period within two calendar years.

( ) c. No more than one period within a six-month period, starting with the effective date of the initial presumptive eligibility period.

( ) d. No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

( ) e. Other reasonable limitation:

Presumptive Eligibility by Hospitals

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0007O | VA-18-0010

Package Header

Package ID VA2018MS0007O
SPA ID VA-18-0010
Submission Type Official
Initial Submission Date 6/22/2018
Approval Date 12/17/2018
Effective Date 1/1/2019
Superseded SPA ID VA-14-0007
System-Derived

E. Application for Presumptive Eligibility

☒ 1. The state uses a standardized screening process for determining presumptive eligibility.

2. The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS. A copy of the single streamlined application with questions necessary for a PE determination highlighted or denoted is included.

3. The state uses a separate paper application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

☒ 4. The state uses an online portal or electronic screening tool for presumptive eligibility approved by CMS. Screenshots of the tool included.

Name	Date Created	
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F. Presumptive Eligibility Determination

The presumptive eligibility determination is based on the following factors:

1. The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)

2. Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.

a. A reasonable estimate of MAGI-based income is used to determine household income.

b. Gross income is used to determine household size.

c. Other income methodology

☒ 3. State residency

☒ 4. Citizenship, status as a national, or satisfactory immigration status

Presumptive Eligibility by Hospitals

MEDICAID | Medicaid State Plan | Eligibility | VA2018MS0007O | VA-18-0010

Package Header

Package ID	VA2018MS0007O	**SPA ID**	VA-18-0010
Submission Type	Official	**Initial Submission Date**	6/22/2018
Approval Date	12/17/2018	**Effective Date**	1/1/2019
Superseded SPA ID	VA-14-0007		
	System-Derived		

G. Qualified Entity Requirements

[X] 1. The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals.

2. A copy of the training materials has been uploaded for review during the submission process.

Name	Date Created	
S21 HPE Training with 40 quarter reference 12.11.18.Revisedpptx	12/14/2018 9:53 AM EST	
Immigration Status dropdown menus expanded_12.11.2018	12/14/2018 9:55 AM EST	

H. Additional Information (optional)

Medicaid State Plan Eligibility

Eligibility and Enrollment Processes

Continuous Eligibility for Children

MEDICAID | Medicaid State Plan | Administration, Eligibility | VA2024MS0001O | VA-24-0002

Package Header

Package ID	VA2024MS0001O	**SPA ID**	VA-24-0002
Submission Type	Official	**Initial Submission Date**	2/20/2024
Approval Date	04/19/2024	**Effective Date**	1/1/2024
Superseded SPA ID	N/A		

User-Entered

The state provides continuous eligibility for children in accordance with the following provisions:

A. Mandatory Continuous Eligibility for Hospitalized Children

The state provides Medicaid to a child eligible for and enrolled under the Infants and Children under Age 19 (42 CFR 435.118) eligibility group until the end of an inpatient stay for which inpatient services are covered, if the child:

1. Was receiving inpatient services covered by Medicaid on the date the child becomes ineligible under the eligibility group based on the child's age; and

2. Would remain eligible but for attaining such age.

B. Mandatory Continuous Eligibility for Children

The state provides continuous eligibility to all children under age 19 and that:

1. The continuous eligibility period begins on the effective date of the child's most recent determination or redetermination of eligibility, and ends the last day of the earlier of the following periods:

a. The month that the child turns 19 years old;

b. 12 months.

2. Continuous eligibility is provided to children eligible under all mandatory and optional eligibility groups (excluding Medically Needy) who would otherwise lose eligibility because of any change in circumstances, unless:

a. The child dies;

b. The child or the child's representative voluntarily requests a termination of the child's eligibility;

c. The child ceases to be a resident of the state;

d. The Medicaid agency determines that eligibility was determined incorrectly at the most recent determination or redetermination of eligibility because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or

e. The child attains the maximum age specified in B.

C. Additional Information (optional)

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