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January 1, 2025

Virginia Medical Assistance Eligibility Manual Transmittal
#DMAS-34

The following acronyms are contained in this letter:

- COLA – Cost of Living Adjustment
- DADS – Division of Aging and Disability Services
- DD Waiver – Developmental Disability Waiver
- DMAS – Department of Medical Assistance Services
- HIPP – Health Insurance Premium Payment Program
- FAMIS – Family Access to Medical Insurance Security
- MSP – Medicare Savings Program
- NADA - National Automobile Dealers Association
- NBD – Non-blind or Disabled
- PMA – Personal Maintenance Allowance
- SBE – State Based Exchange
- SSDI – Social Security Disability Insurance
- SSI – Supplemental Security Insurance
- TN – Transmittal
- VIM – Virginia Insurance Marketplace

TN #DMAS-34 includes policy clarifications, updates and revisions. Unless otherwise noted in the Cover Letter and/or policy, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after January 1, 2025.

The following changes are contained in TN #DMAS-34:

Changed Sections	Changes
Subchapter M0130.200 G.	Update link to HIPP Fact Sheet.
Subchapter M0320	Update COLA and Medicare changes for 2025. Added SSDI income disregard for DD Waiver individuals. **Remove 26a if 1619(b) threshold not received.**
Subchapter M0530	Update the NBD allocation, parental living allowance and deeming standard for 2025.
Subchapter M0810	Update SSI amounts for 2025.

Subchapter M0820	Update Student Earned Income Exclusion for 2025.
Subchapter M1110	Update MSP resource limits for 2025 and some NADA references.
Subchapter M1410.010	Remove duplicate bullet at top of page 3.
Subchapter M1460	Update the home equity limit and Student Earned Income Exclusion for 2025, correct references to DADs and Purchasing. SSDI income deduction for DD Waiver individuals. Clarify worker action when attested income used for patient pay.
Subchapter M1470	Update the PMA, Special Earnings Allowance for 2025, references to Fiscal Division.
Subchapter M1480	Update the home equity limit, the spousal resource standards, the maximum monthly maintenance needs allowance, the personal maintenance allowance, and the special earnings allowance for 2025.
Subchapter M1520.200 C.3	Correct reference to Virginia's Insurance Marketplace (VIM) and the State Based Exchange (SBE).
Subchapter M2340.100.F.	Clarify enrolling infant born to woman receiving FAMIS Prenatal Coverage.

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

Sincerely,

Sarah Hatton

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

Attachment

M0130 Changes
Page 1 of 2

Changed With	Effective Date	Pages Changed
TN #DMAS-34	1/1/25	Pages 9 and 10
TN #DMAS-32	7/1/24	Pages 9 and 10
TN #DMAS-29	10/1/23	Page 12
TN #DMAS-27	4/1/23	Page 6a
TN #DMAS-25	10/1/22	Pages 9,10
TN #DMAS-23	4/1/22	Pages 5, 12
TN #DMAS-21	10/1/21	Page 14
TN #DMAS-20	7/1/21	Page 2 Page 2a is a runover page.
TN #DMAS-18	1/1/21	Pages 4, 8, 13

If the client is eligible for benefits to be used exclusively for the payment of medical expenses (i.e. an insurance settlement), but there is no TPL code for that benefit, the worker must email the information to the DMAS TPL Unit at TPLUnit@dmas.virginia.gov, or send the information to:

DMAS Third Party Liability Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

G. Health Insurance Premium Payment (HIPP) Program

The HIPP program is a cost-savings program for individuals enrolled in Medicaid which may reimburse some or all of the employee portion of the employer group health insurance premium. Eligibility for HIPP is determined by the HIPP Unit at DMAS. Participation in HIPP is voluntary.

The local DSS agency must give each applicant or enrollee who reports that he or someone in his family is employed more than 30 hours each week and is eligible for health insurance coverage under an employer's group health plan must be given a HIPP Fact Sheet, which provides a brief description of the program and the contact information for the HIPP Unit at DMAS. The HIPP Fact Sheet is available at *https://fusion.dss.virginia.gov/Portals/[bp]/Medicaid/Resources%20and%20Job%20Aids/MA%20Fact%20Sheets/HIPP%20Fact%20Sheet%2024_d032_03_0842-04-eng_.doc?ver=2024-07-15-082927-803*. Enrollees and other members of the public may contact the HIPP Unit for additional information at hippcustomerservice@dmas.virginia.gov.

If the health insurance policy holder lives outside of the home, a HIPP Consent Form must be completed by both the policy holder and the parent/authorized representative so the DMAS HIPP Unit can process the HIPP application. If the form is required, the DMAS HIPP Unit will send it to the applicant for completion.

H. Verification of Financial Eligibility Requirements

The eligibility worker must verify the following financial eligibility requirements:

- the value of all countable, non-excluded resources, if the reported values of the resources are not both reasonably compatible with electronic sources AND below the resource limit. In all situations the sources of the resources do not have to match. If the member attests to having resources below the limit and values received from electronic sources are above the limit, additional verification should be requested. Reasonable compatibility for resource evaluation is effective for all case actions as of June 3, 2024.
- asset transfer information for individuals in need of long-term care services, including the date of transfer, asset value, and compensation received.
- earned and unearned income. For all case actions effective August 26, 2022, if the income attested to by the applicant is within 20% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required.

  If the attested income is under the income limit and the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return. If the applicant meets a Medically Needy (MN) covered group, verification of income **is required** to determine spenddown liability.

  If the attested income is over the income limit and the individual does not meet a Medically Needy (MN) covered group, deny the application.

M0320 Changes

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

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

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

a. *Current Title II Benefit= Benefit Before 1/24 COLA 2.5% (1/24 Increase)*
b. *Current Title II Benefit= Benefit Before 1/23 COLA 3.2% (1/23 Increase)*
c. Current Title II Benefit = Benefit Before 1/22 COLA 1.059 (1/22 Increase)
d. Benefit Before 1/22 COLA = Benefit Before 1/21 COLA 1.013 (1/21 Increase)
e. Benefit Before 1/21/ COLA = Benefit Before 1/20 COLA 1.016 (1/20 Increase)

5. Medicare Premiums

a. Medicare Part B premium amounts:

1-1-25 $185.00
1-1-24 $174.70
1-1-23 $164.90
1-1-22 $170.10
1-1-21 $148.50
1-1-20 $144.60

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

b. Medicare Part A premium amount:

1-1-25 $518.00
1-1-24 $505.00
1-1-23 $506.00
1-1-22 $499.00
1-1-21 $471.00
1-1-20 $458.00

Contact a Medical Assistance Program Consultant for amounts for years prior to *2020.*

6. Evaluation

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

b. Ongoing eligibility

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

1) For **earnings** accumulated **after** enrollment in MEDICAID WORKS, up to the current 1619(b) income threshold amount will be disregarded if deposited and retained in the WIN Account. The *2024* 1619(b) threshold amount is *$45,976 (decreased from the 2023 amount)*.

2) Resources accumulated while in MEDICAID WORKS and held in Internal Revenue Service (IRS)-approved retirement accounts, medical or health savings accounts, medical reimbursement (flex) accounts, education accounts, independence accounts, and other similar State-approved accounts are excluded. Examples of these accounts include Archer Medical Savings Accounts, 401(k)/403(b)/457(b)/503(b) accounts, traditional Individual Retirement Accounts (IRAs), Roth IRAs, SEP-IRAs, SIMPLE IRAs, and Thrift Savings Plans. The account must be designated as a WIN Account to be excluded. **Resources accumulated while in MEDICAID WORKS and held in IRS-approved accounts that have been designated as WIN Accounts are also excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees**. The account must be exclusively used to hold resources accumulated while in MEDICAID WORKS (including interest) for the exclusion to continue. Resources can be spent however the individual chooses. Transfers will be evaluated if the individual applies for LTSS.

3) Resources can be spent however the individual chooses. Transfers will be evaluated to determine if a penalty should be calculated if the individual applies for (or is receiving) LTSS.

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

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

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible in an MSP covered group (which has more liberal resource methods and standards).

3. Income

To determine if an individual has income within the 300% of SSI limit, use **gross** income, not countable income. Determine what is income according to chapter S08 and subchapter M1460.

DO NOT subtract the $20 general exclusion or any other income exclusions. The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Effective 12/1/2024, Virginia's state Medicaid plan was updated to disregard Social Security Disability Income (SSDI) when determining eligibility for Long Term Services and Supports (LTSS) for approved Developmental Disability (DD) Waiver recipients. This change does not apply to CCCPlus waiver recipients.

The disregard is not applicable to the post-eligibility calculation of patient pay.

- *SSDI over and above the current SSI payment limit will be disregarded for Medicaid applicants offered a DD waiver slot dependent upon Medicaid eligibility and enrollment.*
- *SSDI over and above the current SSI payment limit will be disregarded at renewal for individuals approved for LTSS through a DD waiver.*
- *SSDI will be countable as applicable for the covered group(s) in which the individual is being re-evaluated if they are no longer approved for a DD waiver, for example no longer meeting the level of care (LOC) requirement.*

VaCMS will automatically disregard the SSDI income of a client who meets the above criteria counting only the SSI maximum income limit for one person. Additionally, the MA institutionalized screen and various elements of the Eligibility summary screen have been updated with this change.

Compare the total gross income to the 300% of SSI limit (see M0810.002 A. 3). If countable income is equal to or less than this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in this covered group. Evaluate his/her eligibility as medically needy.

C. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

If the individual has Medicare Part A, re-calculate the individual's income - subtract appropriate exclusions. Compare the countable income to the QMB and SLMB limits.

1. Dual-eligible As QMB or SLMB *If the individual is also a Qualified Medicare Beneficiary (QMB) or Special Low Income Medicare Beneficiary (SLMB) - the individual has Medicare Part A and has countable income within the QMB or SLMB income limits - the AC is:*

- *022 for an aged individual also QMB;*
- *042 for a blind individual also QMB;*
- *062 for a disabled individual also QMB;*
- *025 for an aged individual also SLMB;*
- *045 for a blind or disabled individual also SLMB.*

2. Not QMB or SLMB *If the individual is NOT a QMB or SLMB - the individual does NOT have Medicare Part A, OR has countable income over the QMB and SLMB income limits - the AC is:*

- *020 for an aged individual NOT also QMB or SLMB;*
- *040 for a blind individual NOT also QMB or SLMB;*
- *060 for a disabled individual NOT also QMB or SLMB.*

D. Ineligible In This Covered Group *If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy spenddown. If the individual is not eligible for Medicaid in this covered group because of resources, determine the individual's eligibility as QMB, SLMB, QDWI or QI if he/she has Medicare Part A.*

living in the home. Count actual resources the parent makes available to the child.

If current resources are within the limit, then determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible for Medicaid in this covered group.

b. Resource Eligibility - Married Individual

If the individual is married and has a community spouse, use the resource policy in subchapter M1480. If the individual is married, but has no community spouse, use the resource policy in subchapter M1460. Evaluate countable resources using ABD resource policy in chapter S11.

If current resources are within the limit, then determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible in an MSP covered group (which has more liberal resource methods and standards).

3. Income

To determine if an individual has income within the 300% of SSI limit, use **gross** income, not countable income. Determine what is income according to chapter S08 and subchapter M1460.

DO NOT subtract the $20 general exclusion or any other income exclusions. The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Effective 12/1/2024, Virginia's state Medicaid plan was updated to disregard Social Security Disability Income (SSDI) when determining eligibility for Long Term Services and Supports (LTSS) for approved Developmental Disability (DD) Waiver recipients. This change does not apply to CCCPlus waiver recipients.

The disregard is not applicable to the post-eligibility calculation of patient pay.

- *SSDI over and above the current SSI payment limit will be disregarded for Medicaid applicants offered a DD waiver slot dependent upon Medicaid eligibility and enrollment.*
- *SSDI over and above the current SSI payment limit will be disregarded at renewal for individuals approved for LTSS through a DD waiver.*
- *SSDI will be countable as applicable for the covered group(s) in which the individual is being re-evaluated if they are no longer approved for a DD waiver, for example no longer meeting the level of care (LOC) requirement.*

VaCMS will automatically disregard the SSDI income of a client who meets the above criteria counting only the SSI maximum income limit for one person. Additionally, the MA institutionalized screen and various elements of the Eligibility summary screen have been updated with this change.

C. Entitlement & Enrollment

Compare the total gross income to the 300% of SSI limit (see M0810.002 A. 3). If countable income is equal to or less than this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in this covered group. Evaluate his/her eligibility as medically needy. Individuals *eligible* in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met. Retroactive coverage does not apply to this covered group because an individual cannot be eligible in this covered group until he/she applies for Medicaid. [The individual cannot have received Medicaid covered waiver services in the retroactive period because he was not receiving Medicaid on or before the date he applied.]

If the individual has Medicare Part A, re-calculate the individual's income - subtract the appropriate exclusions. Compare the countable income to the QMB and SLMB limits.

1. Dual-eligible As QMB or SLMB

If the individual is also a Qualified Medicare Beneficiary (QMB) or Special Low Income Medicare Beneficiary (SLMB) - the individual has Medicare Part A and has countable income within the QMB or SLMB income limits - the AC is:

M0530 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-34	1/1/25	Appendix 1, page 1
TN #DMAS-31	4/1/24	Appendix 1, page 1
TN #DMAS-26	1/1/23	Appendix 1, page 1
TN #DMAS-22	1/1/22	Appendix 1, page 1
TN #DMAS-18	1/1/21	Appendix 1, page 1
TN #DMAS-15	1/1/20	Appendix 1, page 1
TN #DMAS-11	1/1/19	Appendix 1, page 1
TN #DMAS-8	4/1/18	Appendix 1, page 1
TN #DMAS-6	10/1/17	Pages 2, 24, 30
TN #DMAS-3	1/1/17	Appendix 1, page 1
TN #DMAS-2	10/1/16	Pages 23, 24
TN #DMAS-1	6/1/16	Appendix 1, page 1
TN #100	5/1/15	Pages 14, 16, 29, 30 Appendix 1, page 1
TN #99	1/1/14	Appendix 1, page 1
UP #9	4/1/13	Appendix 1, page 1
UP #6	4/1/12	Appendix 1, page 1
Update (UP) #5	7/1/11	Page 14
TN #95	3/1/11	Page 1 Appendix 1, page 1
TN #93	1/1/10	Pages 11, 19 Appendix 1, page 1

Deeming Allocations

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

NBD (Non-blind/disabled) Child Allocation

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

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

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

Parental Living Allowance

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

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

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

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

Deeming Standard

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

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

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

M0810 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-34	1/1/25	Pages 1 and 2
TN #DMAS-32	7/1/24	Page 2
TN #DMAS-31	4/1/24	Pages TOC i, 1, 2
TN #DMAS-29	10/1/23	Pages 6, 9
TN #DMAS-28	7/1/23	Pages 2, 6
TN #DMAS-27	4/1/23	Page 2, 25, 27, 28 Page 25a is a runover page
TN #DMAS-25	1/1/23	Pages 1, 2
TN #DMAS-24	7/1/22	Page 2
TN #DMAS-23	4/1/22	Page 2
TN #DMAS-22	1/1/22	Pages 1, 2, 3
TN #DMAS-20	7/1/21	Page 2
TN #DMAS-19	4/1/21	Page 2
TN #DMAS-18	1/1/21	Pages 1, 2
TN #DMAS-17	7/1/20	Page 2
TN #DMAS-16	4/1/20	Page 2
TN #DMAS-15	1/1/20	Pages 1, 2
TN #DMAS-14	10/1/19	Pages 20, 25, 27 Page 28 is a runover page.
TN #DMAS-12	4/1/19	Page 2
TN #DMAS-11	1/1/19	Pages 1, 2
TN #DMAS-10	10/1/18	Page 2
TN #DMAS-9	7/1/18	Page 2
TN #DMAS-8	4/1/18	Page 2
TN #DMAS-7	1/1/18	Pages 1, 2
TN #DMAS-5	7/1/17	Page 2
TN #DMAS-4	4/1/17	Page 2
TN #DMAS-3	1/1/17	Pages 1, 2
TN #DMAS-2	10/1/16	Page 2
TN #DMAS-1	6/1/16	Pages 1, 2
UP #11	7/1/15	Page 2
TN #100	5/1/15	Pages 1, 2
UP #10	5/1/14	Page 2
TN #99	1/1/14	Pages 1, 2
TN #98	10/1/13	Page 2
UP #9	4/1/13	Pages 1, 2
UP #7	7/1/12	Page 2
UP #6	4/1/12	Pages 1, 2
TN #95	3/1/11	Pages 1, 2
TN #93	1/1/10	Pages 1, 2
Update (UP) #1	7/1/09	Page 2

GENERAL

M0810.001 INCOME AND ELIGIBILITY

A. Introduction

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

B. Policy Principles

1. Who is Eligible

An individual is eligible for Medicaid if the person:

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

2. General Income Rules

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

M0810.002 INCOME LIMITS

A. Income Limits

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

1. Categorically Needy

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

2. Categorically Needy Protected Cases Only

Categorically-Needy Protected Covered Groups Which Use SSI Income Limits		
Family Unit Size	*2024* Monthly Amount	*2025* Monthly Amount
1	*$943*	*$967*
2	*1,415*	*$1,450*
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size	*2024* Monthly Amount	*Calculation changed, amount not announced for 2025 as of 11/21/2024*
1	*$629*	
2	*$944*	

3. Categorically Needy 300% of SSI

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

Family Size Unit	*2024* Monthly Amount	*2025* Monthly Amount
1	*$2,829*	*$2,901*

4. ABD Medically Needy

a. Group I	7/1/23-6/30/24		7/1/24	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,324.16	$387.36	$2,391.01	$398.50
2	2,925.70	493.11	3,043.80	507.30

b. Group II	7/1/23-6/30/24		7/1/24	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,681.739	$446.95	$ 2,758.87	$ 459.81
2	3,302.13	550.35	3,396.83	566.14

c. Group III	7/1/23-6/30/24		7/1/24	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$3,486.27	$581.04	$3,586.53	$597.76
2	4,202.86	700.47	4,323.80	720.63

5. ABD Categorically Needy

For:

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

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

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

M0820 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-34	1/1/25	Pages 30, 31
TN #DMAS-31	4/1/24	TOC i, Pages 15a, 31
TN #DMAS-29	10/1/23	Pages 3, 4, 11, add 15a, 17, 28, 29
TN #DMAS-28	7/1/23	Pages 4, 11, 17, 29. Page 12 is a runover page.
TN #DMAS-23	1/1/23	Pages 30, 31
TN #DMAS-22	1/1/22	Pages 30, 31
TN #DMAS-18	1/1/21	Pages 30, 31
TN #DMAS-12	4/1/20	Page 29
TN #DMAS-15	1/1/20	Pages 30, 31
TN #DMAS-14	10/1/19	Pages 10, 11, 13, 22, 24
TN #DMAS-12	4/1/19	Page 21
TN #DMAS-11	1/1/19	Pages 30, 31
TN #DMAS-7	1/1/18	Page 11, 30-32
TN #DMAS-5	7/1/17	Pages 11, 13, 29, 30 Page 12 is a runover page.
TN #DMAS-3	1/1/17	Pages 30, 31
TN #DMAS-1	6/1/16	Pages 30, 31, 47
TN #100	5/1/15	Pages 30, 31, 47 Page 48 is a runover page.
TN #99	1/1/14	Pages 30, 31
UP #9	4/1/13	Pages 30, 31
Update (UP) #6	4/1/12	Pages 30, 31
TN #95	3/1/11	Pages 3, 30, 31
TN #93	1/1/10	Pages 30, 31
TN #91	5/15/09	Table of Contents Pages 29, 30

3. Other Earned Income

Then, other income exclusions are applied, in the following order, to the rest of earned income in the month:

a. Federal earned income tax credit payments.

b. Up to $10 of earned income in a month if it is infrequent or irregular.

c. *For 2025, up to $2,350 per month, but not more than $9,460 in a calendar year, of the earned income of a blind or disabled student child.*

For 2024, up to $2,290 per month, but not more than $9,230 in a calendar year, of the earned income of a blind or disabled child.

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

d. Any portion of the $20 monthly general income exclusion which has not been excluded from unearned income in that same month.

e. $65 of earned income in a month.

f. Earned income of disabled individuals used to pay impairment-related work expenses.

g. One-half of remaining earned income in a month.

h. Earned income of blind individuals used to meet work expenses.

i. Any earned income used to fulfill an approved plan to achieve self-support.

4. Unused Exclusion

Earned income is never reduced below zero. Any unused earned income exclusion is never applied to unearned income.

Any unused portion of a monthly exclusion cannot be carried over for use in subsequent months.

5. Couples

The $20 general and $65 earned income exclusions are applied only once to a couple, even when both members (whether eligible or ineligible) have income, since the couple's earned income is combined in determining Medicaid eligibility.

B. References

For exclusions which apply to both earned and unearned income, see:

- S0810.410 for infrequent/irregular income
- S0810.420 $20 general exclusion
- M0810.430 amount to fulfill a plan for achieving self-support

For exclusions applicable only to earned income, see S0820.510 - S0820.570.

M0820.510 STUDENT CHILD EARNED INCOME EXCLUSION

A. Policy

1. General

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

For Months	Up to per month	But not more than in a calendar year
In calendar year 2025	*$2,350*	*$9,460*
In calendar year 2024	$2,290	$9,230
In calendar year 2023	$2,220	$8,950
In calendar year 2022	$2.040	$8,230
In calendar year 2021	$1,930	$7,770

2. Qualifying for the Exclusion

The individual must be:

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

3. Earnings Received Prior to Month of Eligibility

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

4. Future Increases

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

B. Procedure

1. Application of the Exclusion

Apply the exclusion:

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

2. School Attendance and Earnings

Develop the following factors and record them:

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

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

M1110 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-34	1/1/25	Page 2, 10a
TN #DMAS-32	7/1/24	Pages 1 and 18
TN #DMAS-31	4/1/24	TOC, Pages 1, 6, 7
TN #DMAS-30	1/1/24	Page 2
TN #DMAS-27	4/1/23	Pages 6, 7
TN #DMAS-26	1/1/23	Page 2
TN #DMAS-22	1/1/22	Pages 1, 2
TN #DMAS-20	7/1/21	Page 16
TN #DMAS-19	4/1/21	Page 16
TN #DMAS-18	1/1/21	Page 2
TN #DMAS-17	7/1/20	Page 1
TN #DMAS-15	1/1/20	Page 2
TN #DMAS-12	4/1/19	Pages 10-10a
TN #DMAS-11	1/1/19	Page 2
TN #DMAS-3	1/1/18	Page 2
TN #DMAS-4	4/1/17	Pages 10, 10a
TN #DMAS-3	1/1/17	Pages 2, 7, 10, 11 Page 10a was added as a runover page.
TN #100	5/1/15	Page 2
TN #99	1/1/14	Page 2
UP #9	4/1/13	Page 2
UP #6	4/1/12	Page 2
TN #96	10/1/11	Page 2
TN #95	3/1/11	Page 2
Update (UP) #3	3/2/10	Table of Contents page 2
TN #93	1/1/10	Page 2
TN #91	5/15/09	Pages 14-16

M1110.003 RESOURCE LIMITS

A. Introduction

The resource limit is the maximum dollar amount of countable assets an individual, couple, or family may own and still meet the established criteria for Medical Assistance in an ABD category. These amounts are established by law.

B. Policy Principles

1. Resource Ineligibility

An individual (or couple) with countable resources in excess of the applicable limit is not eligible for Medicaid.

2. Resource Limits

ABD Eligible Group	One Person	Two People
Categorically Needy Medically Needy	$2,000	$3,000
ABD with Income ≤ 80% FPL	$2,000	$3,000
QDWI	$4,000	$6,000
QMB SLMB QI	**Calendar Year** **2023** $9,090 **2024** $9,430 ***2025*** *$9,660*	**Calendar Year** **2023** $13,630 **2024** $14,130 ***2025*** *$14,470*

3. Change in Marital Status

A change in marital status can result in a change to the applicable resource limit. The resource limit change is effective with the month that we begin treating both members of a couple as individuals. For example, separation from an ineligible spouse can change the limit from $3,000 to $2,000. See M1110.530 B.

4. Reduction of Excess Resources

Month of Application

Excess resources throughout the month of application causes ineligibility for the application month. Reduction of excess resources within the application month can cause resource eligibility for that month.

The cost of the appraisal must be paid by either the applicant/recipient or the individual acting on the applicant or recipient's behalf. Certified appraisals documenting the value of the property must contain the name and license number of the individual conducting the appraisal. A copy of the appraisal must be scanned into the VaCMS case record or placed in the hard case record.

If tax assessment and appraisal are both provided, use the value that is most beneficial to the applicant.

License validity for appraisers in Virginia, if necessary, can be verified through the "License Lookup" tool on the Department of Professional and Occupational Regulation's website at www.dpor.virginia.gov or by calling the Real Estate Appraiser staff at 804-367-2039. A copy of the appraisal must be scanned into the VaCMS case record or placed in the hard case record.

If tax assessment and appraisal are both provided, use the value that is most beneficial to the applicant.

- *Countable motor vehicles:*

  a. *Online at Get New Car Prices & Used Car Values | Find Real-world Car Costs (jdpower.com) (J. D. Powers bought NADA and now provides this information).*
  b. *If the vehicle is not listed on the J.D. Powers website, the value which is assessed for tax purposes, or*
  c. *If the methods listed above are not available:*
     - *a statement from a licensed dealer, or*
     - *the statement of the applicant/recipient*
  d. *Information from other websites such as khb.com, carvana.com or edmunds.com.*

b. Equity value (EV) is the CMV of a resource minus any encumbrance on it.

c. An encumbrance is a legally binding debt against a specific property. Such a debt reduces the value of the encumbered property but does not have to prevent the property owner from transferring ownership (selling) to a third party. However, if the owner of encumbered property does sell it, the creditor will nearly always require a debt satisfaction from the proceeds of sale.

M1410 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-34	1/1/25	Page 3
TN #DMAS-33	10/1/24	Page 2a
TN #DMAS-31	4/1/24	Page 12
TN #DMAS-30	1/1/24	Pages 2 and 9
TN #DMAS-29	10/1/23	Page 11
TN #DMAS-25	10/1/22	Page 2a
TN #DMAS-24	7/1/22	Pages 2, 9, 13
TN #DMAS-21	10/1/21	Page 9
TN #DMAS-18	1/1/21	Page 1
TN #DMAS-17	7/1/20	Table of Contents Pages 1, 4, 8, 11-13 Pages 4a and 7 were removed. Pages 8-14 were renumbered 7-13.
TN #DMAS-14	10/1/19	Pages 10, 12-14
TN #DMAS-12	4/1/19	Page 4, 10-11 Page 4a was added as a runover page.
TN #DMAS-11	1/1/19	Pages 6, 7
TN #DMAS-10	10/1/18	Pages 8-14
TN #DMAS-9	7/1/18	Page 1
TN #DMAS-8	4/1/18	Page 9
TN #DMAS-7	1/1/18	Page 7
TN #DMAS-5	7/1/17	Pages 4-7
TN #DMAS-3	1/1/17	Pages 6, 7, 12-14
TN #DMAS-1	6/1/16	Pages 12-14
TN #100	5/1/15	Page 2
TN #99	1/1/14	Page 10
Update #7	7/1/12	Pages 6, 7
TN #96	10/1/11	Page 11, 12
TN #95	3/1/11	Pages 13, 14 Page 15 was removed.
TN #94	9/1/10	Pages 6, 7, 13
TN #93	1/1/10	Pages 1, 7, 9, 12
TN #91	5/15/09	Pages 11-14

M1410.020 NON-FINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

To be eligible for Medicaid payment of long-term care, an individual must be eligible for Medicaid. The Medicaid non-financial eligibility requirements in chapter M02 apply to all Medicaid applicants and recipients, including those individuals in long-term care. The non-financial requirements and the location of the manual policy for each requirement are:

B. Citizenship/ Alienage

The citizenship and alien status policy is found in M0220.

C. Virginia Residency

The Virginia state resident policy for patients in medical institutions is found in subchapter M1430.101; the state resident policy for CBC patients is found in M0230.

D. Social Security Number

The social security number policy is found in M0240.

E. Assignment of Rights

The assignment of rights and support cooperation policy is found in M0250.

F. Application for Other Benefits

The application for other benefits policy is found in M0270.

G. Institutional Status

The institutional status policy for facility patients is in subchapter M1430.100. The institutional status policy for CBC waiver services patients is found in subchapter M1440.010.

H. Covered Group (Category)

The Medicaid covered groups eligible for long-term care services are listed in subchapter M1460. The category requirements for the covered groups are found in chapter M03.

M1410.030 FACILITY CARE

A. Introduction

Medicaid covers care provided in a medical institution to persons whose physical or mental condition requires nursing supervision and assistance with activities of daily living. Some institutions have both medical and residential sections. An individual in the medical section of the institution is a patient in a medical facility; however, an individual in the residential portion of the institution is a resident of a residential facility NOT a patient in a medical facility.

This section contains descriptions of the types of **facilities** (medical institutions) in which Medicaid provides payment for services received by eligible patients. See subchapter M1430 for specific policy and procedures which apply to patients in facilities.

M1460 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-34	1/1/25	Pages 3, 29, 35 Page 26a is added
TN #DMAS-33	10/1/24	Pages 4, 23, 24
TN #DMAS-32	7/1/24	Page 4a
TN #DMAS-31	4/1/24	Page 3, 35
TN #DMAS-30	1/1/24	Pages 11 and 19
TN #DMAS-26	1/1/23	Pages 3, 35
TN #DMAS-24	7/1/22	Pages 11, 47, 48
TN #DMAS-23	4/1/22	Pages 12, 23
TN #DMAS-22	1/1/22	Pages 3, 35
TN #DMAS-18	1/1/21	Pages 3, 35
TN #DMAS-15	1/1/20	Pages 3, 35
TN #DMAS-14	10/1/19	Pages 4, 29
TN #DMAS-13	7/1/19	Page 42
TN #DMAS-11	1/1/19	Pages 3-5, 10, 26, 31
TN #DMAS-10	10/1/18	Table of Contents, page i Pages 1-3, 4b, 5, 6, 9, 10, 13, 15, 17a, 18, 18a, 26, 27, 30a, 37, 38 Pages 8a, 11, 19, 30, 39 and 40 are runover pages.
TN #DMAS-8	4/1/18	Pages 18a, 32, 35
TN #DMAS-7	1/1/18	Pages 3, 7
TN #DMAS-3	1/1/17	Pages 3, 4, 4b, 24, 25, 29
TN #DMAS-2	10/1/16	Page 35
TN #DMAS-1	6/1/16	Table of Contents, page i Pages 3, 8a, 17, 32
TN #100	5/1/15	Table of Contents, page i Pages 1, 2, 5, 6, 10, 15, 16-17a, 25,41-51
TN #99	1/1/14	Pages 3, 35
UP #9	4/1/13	Table of Contents Pages 3, 35, 38, 41, 42, 50, 51
TN #97	9/1/12	Table of Contents Pages 1, 4-7, 9-17 Page 8a was deleted. Pages 18a-20, 23-27, 29-31 Pages 37-40, 43-51 Pages 52 and 53 were deleted
UP #6	4/1/12	Pages 3, 35
TN #96	10/1/11	Pages 3, 20, 21
TN #95	3/1/11	Pages 3, 4, 35
TN #94	9/1/10	Page 4a
TN #93	1/1/10	Pages 28, 35
TN #91	5/15/09	Pages 23, 24

11. Old Bills

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

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

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

12. Projected Expenses

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

13. Spenddown Liability

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

M1460.150 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LTSS

A. Applicability

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

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

B. Policy

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

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

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

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

***1.* Home Equity Limit**

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

- Effective January 1, 2023: $688,000
- Effective January 1, 2024: $713,000
- *Effective January 1, 2025: $730,000*

7. Credit Life/Disability Payments

(S0815.300) Payments made under a credit life or credit disability insurance policy on behalf of an individual are not income.

8. Loan Proceeds

(S0815.350) Proceeds of a bona fide loan are not income to the borrower because of the borrower's obligation to repay.

9. Third Party Payments

a. Payments made by another individual

(S0815.400) Payment of an individual's bills (including Medicare supplementary medical insurance or other medical insurance premiums) by a third party directly to the supplier is not income.

Payments made directly to the service provider by another person for the individual's private room or "sitter" in a medical facility are **not** income to the individual.

EXCEPTION: For F&C covered groups **except** the 300% SSI group: If the person paying the bill(s) is the child's absent father and the Division of Child Support Enforcement (DCSE) has not established an obligation for the absent parent, the amount(s) paid by the absent parent for the child is counted as income.

b. Long-term care (LTC) insurance payments

Institutionalized individuals who have LTC insurance coverage must have the LTC insurance coverage information entered into the recipient's TPL file in VaCMS. The insurance policy type is "H" and the coverage type is "N."

If the patient receives the payment from the insurance company, it is not counted as income. The patient should assign it to the provider. If the patient cannot do this, or the policy prohibits assignment, the payment should be given directly to the provider. The provider should report the payment as a third party payment on its claim form. If the patient received the payment and cannot give it to the provider for some reason, then the patient should send the insurance payment to:

<u>This address is for USPS mail only:</u>
Commonwealth of VA COV - DMAS
PO Box 780209
Philadelphia, PA 19178-0209

<u>This address is only for overnight mail by special carriers:</u>
Lockbox Services #780209
Commonwealth of VA COV DMAS
2005 Market Street, 5th Floor
Philadelphia, PA 19103-7042

Along with the check, submit some type of documentation to explain why the funds are being sent to DMAS.

10. Replacement Income

(S0815.450) If an individual's income is lost, stolen, or destroyed and the individual receives a replacement, the replacement is not income if the original payment was counted in determining the individual's Medicaid eligibility.

11. Erroneous Payments

(S0815.460) A payment is not income when the individual is aware that he is not due the money and returns the check uncashed or otherwise refunds all of the erroneously received money.

*To determine if an individual has income within the 300% of SSI limit, use **gross** income, not countable income. Determine what is income according to chapter S08 and subchapter M1460.*

DO NOT subtract the $20 general exclusion or any other income exclusions. The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Effective 12/1/2024, Virginia's state Medicaid plan was updated to disregard Social Security Disability Income (SSDI) when determining eligibility for Long Term Services and Supports (LTSS) for approved Developmental Disability (DD) Waiver recipients. This change does not apply to CCCPlus waiver recipients.

The disregard is not applicable to the post-eligibility calculation of patient pay.

- *SSDI over and above the current SSI payment limit will be disregarded for Medicaid applicants offered a DD waiver slot dependent upon Medicaid eligibility and enrollment.*
- *SSDI over and above the current SSI payment limit will be disregarded at renewal for individuals approved for LTSS through a DD waiver.*
- *SSDI will be countable as applicable for the covered group(s) in which the individual is being re-evaluated if they are no longer approved for a DD waiver, for example no longer meeting the level of care (LOC) requirement.*

VaCMS will automatically disregard the SSDI income of a client who meets the above criteria counting only the SSI maximum income limit for one person. Additionally, the MA institutionalized screen and various elements of the Eligibility summary screen have been updated with this change.

Compare the total gross income to the 300% of SSI limit (see M0810.002 A. 3). If countable income is equal to or less than this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in this covered group. Evaluate his/her eligibility as medically needy.

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

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

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

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

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

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

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

a. *For 2025, up to $2,350 per month, but no more than $9,460 in a calendar year, of the earned income of a blind or disabled child.*

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

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

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

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

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

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

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

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

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

Changed With	Effective Date	Pages Changed
TN #DMAS-34	1/1/25	Pages 1, 2, 19, 20, 24
TN #DMAS-33	10/1/24	Pages 1, 2, 2a
TN #DMAS-32	7/1/24	Pages 1, 2, 5, 12, 15, 18-20, 28-30, 44, 54, and 55
TN #DMAS-31	4/1/24	Page 10, 12a, 14 and 14a
TN #DMAS-30	1/1/24	Page 20
TN #DMAS-29	10/1/23	Pages 46-48
TN #DMAS-28	7/1/23	Page 19, Appendix 1
TN #DMAS-27	4/1/23	Page 15
TN #DMAS-26	1/1/23	Pages 19, 20
TN #DMAS-25	10/1/22	Page 20
TN #DMAS-24	7/1/22	Pages 1, 15, 28a, 44, 48-50 Page 14a is a runover page.
TN #DMAS-22	1/1/22	Pages 19, 20
TN #DMAS-21	10/1/21	Page 17
TN #DMAS-20	7/1/21	Pages 11, 20, 26
TN #DMAS-19	4/1/21	Pages 7, 8, 22, 23
TN #DMAS-18	1/1/21	Pages 19, 20
TN #DMAS-17	7/1/20	Table of Contents, page ii Pages 1, 14, 28a, 47, 48, 50, 55 Appendix 1, page 1
TN #DMAS-15	1/1/20	Pages 19, 20

M1470.000 PATIENT PAY-POST-ELIGIBILITY TREATMENT OF INCOME

M1470.001 OVERVIEW

A. Introduction

"Patient pay" is the amount of the long-term care (LTC) patient's income which must be paid as *the* share of the LTC services cost. This subchapter provides basic rules regarding the post-eligibility determination of the amount of the LTC patient's income which must be paid toward the cost of care. **MAGI Adults have no responsibility for patient pay.** If an individual receiving LTC, also called long-term *services* and *supports* (LTSS), loses eligibility in the MAGI Adults covered group and is eligible in another full coverage group, patient pay policy will apply.

B. Policy

The state's Medicaid program must reduce its payment to the LTC provider by the amount of the eligible patient's monthly income, after allowable deductions. Patient pay is calculated *using actual verified income* after an individual has been determined eligible for Medicaid and for Medicaid LTC services. A Medicaid recipient who is admitted to a nursing facility, facility for individuals with intellectual disability (ICF-ID) or Medicaid waiver services for less than 30 calendar days must have a patient pay determined for the month(s) in which the recipient is in the facility or waiver services**.** The provider collects the patient pay from the patient or *the* authorized representative. Patient pay information is fed to the Automated Response System (ARS) and the MediCall Systems for provider verification of patient pay. These systems report the amount of patient pay and the date of service to the provider responsible for collecting patient pay.

C. VaCMS Patient Pay Process

The patient pay calculation is completed in VaCMS. Refer to the VaCMS Help feature for information regarding data entry. The patient pay must be updated in the system whenever the patient pay changes, but at least once every 12 months. If VaCMS is not able to process required transactions, a Patient Pay Correction form (DMAS 9PP), available at https://fusion.dss.virginia.gov/bp/BP- Home/Medical-Assistance/Forms, should be submitted to patientpay@dmas.virginia.gov. If attested income was used to determine eligibility, actual income must be verified to calculate patient pay. A *comment should be added to* the Notice of Action at approval *requesting verification of income if not already known to the agency.*

D. Patient Notification

The patient or the authorized representative is notified of the patient pay amount on the Notice of Patient Pay Responsibility. VaCMS will generate and send the Notice of Patient Pay Responsibility. M1470, Appendix 1 contains a sample Notice of Patient Pay Responsibility generated by VaCMS. DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into the Medicaid Enterprise System (MES, formerly MMIS).

The provider is the only entity with the authority to take action when residents do not pay their patient pay amount. If a resident, or his authorized representative is negligent in paying his patient pay amount to the provider, the provider will provide written documentation regarding the requirement to pay the patient pay amount to the resident or authorized representative and follow the provider's collection procedures to collect the funds. The provider will report the resident's negligence in paying the patient pay amount to the LDSS.

The provider's failure to collect the patient pay, or the patient's failure to pay the patient pay, does not itself affect the patient's Medicaid eligibility. However, the

EW must review the patient's resources each month to determine if the resources are within the Medicaid limit.

If the individual resides in a nursing facility and the above attempts to collect the patient pay amount are unsuccessful, DMAS has advised that the facility may take one of the following options:

1. Facility Option #1

The facility will notify the LDSS no later than 120 calendar days from the due date of the payment. The facility will include in this notification a copy of the third collection statement, a written notification of the situation, documentation of contacts made with the resident or authorized representative, and the reasons why payment has not been made.

The LDSS will take the following steps:

- Upon receipt of the written notice from the facility, the local DSS will review the case to determine if the individual's resources are within Medicaid eligibility limits or if a transfer of assets has occurred.

- If the individual alleges that he does not receive sufficient income to pay his patient pay, the eligibility worker will review the patient pay amount and make any necessary adjustments.

2. Facility Option #2

Discharge or transfer the resident, including transferring the resident within the facility, except as prohibited by the Virginia State Plan for Medical Assistance Services.

Prior to discharge or transfer, the facility must provide reasonable and appropriate notice of the required patient pay, and the resident or authorized representative must be given at least 30 *calendar* days written notice prior to the discharge or transfer, which shall include appeal rights. If the resident or authorized representative does not agree with this action, *they* may submit an appeal request to DMAS. The individual will be allowed to continue residing in the facility during the appeal process.

M1470.100 AVAILABLE INCOME FOR PATIENT PAY

A. Gross Income

Eligibility can be determined using reasonable compatibility, but income must be verified to establish patient pay. Gross monthly income is considered available for patient pay. Gross monthly income includes the same income sources used to determine an individual's eligibility in the 300% SSI income group. It includes types and amounts of income which are excluded when determining medically needy eligibility. Patient pay is a post-eligibility determination. If actual income was not obtained while determining eligibility the worker *must add a* request *for income* verification *to calculate patient pay* by adding a comment on the notice. If the verified income affects eligibility for the individual, process as a change. *If no additional verification is received, the estimated patient pay remains a liability for the individual.*

M1470.410 MEDICAID CBC - PERSONAL MAINTENANCE ALLOWANCE

A. Individuals

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

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

1. Basic Maintenance Allowance

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

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

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

The PMA is:

- January 1, 2022 through December 31, 2022: $1,388
- January 1, 2023 through December 31, 2023: $1,509
- January 1, 2024 through December 31, 2024: $1,556
- *January 1, 2025 through December 31, 2025: $1,596*

Contact a Medical Assistance Program Consultant for the PMA in effect for years prior to 2022.

2. Guardianship Fee

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

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

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

3. Special Earnings Allowance for Recipients in CCC Plus, CL, IS and BI Waivers

Deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

a. for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (*$2,901 in 2025*) per month.

b. for individuals employed at least 4 but less than 20 hours per week, all earned income up to 200% of SSI (*$1,934 in 2025*) per month.

4. Example – Special Earnings Allowance (Using January 2018 figures)

A working patient receiving CCC Plus Waiver services is employed 18 hours per week. Income is gross earnings of $1228.80 per month and SSA of $300 monthly. Special earnings allowance is calculated by comparing gross earned income ($1128.80) to the 200% of SSI maximum ($1,500.00). Gross earned income is less than 200% of SSI; therefore, entitled to a special earnings allowance. Personal maintenance allowance is computed as follows:

$ 1,238.00 CBC basic maintenance allowance
+ 1,128.80 special earnings allowance
$ 2,360.80 PMA

Because the PMA may not exceed 300% of SSI, the PMA for the patient in this example must be reduced to $2,250.00.

B. Couples

The Medicaid CBC waivers do not specify personal maintenance allowances for a married couple living together when both spouses receive Medicaid CBC because each spouse is considered an individual for patient pay purposes. The individual maintenance allowance in section M1470.410 applies to each spouse in a couple when each receives Medicaid CBC.

M1470.420 DEPENDENT CHILD ALLOWANCE

A. Unmarried Individual, or Married Individual With No Community Spouse

For an unmarried Medicaid CBC patient, or a married Medicaid CBC patient without a community spouse, who has a dependent child(ren) under age 21 years in the community:

- Calculate the difference between the appropriate MN income limit for the **child's** home locality for the number of children in the home and the child(ren)'s gross monthly income. If the children are living in different homes, the children's allowances are calculated separately using the MN

- The result is the dependent child allowance. If the result is greater than $0, deduct it from the patient's income as the dependent child allowance. If the result is $0 or less, do not deduct a dependent child allowance.

Do not deduct an allowance if the child(ren)'s monthly income exceeds the MN income limit in the child's home locality for the number of dependent children in the home. Do not deduct an allowance for any other family member.

5. LTC Insurance

a. Deduct LTC premium in admission month only

When an individual has an LTC insurance policy that covers long-term care services received in the home, the individual stops paying premiums beginning the month after he is admitted to the home-based LTC. The premium paid for the policy in the LTC admission month can be deducted from the admission month's patient pay only. The LTC insurance premium is not deducted from patient pay for the months following the admission month.

b. LTC insurance benefits

LTC insurance benefits are treated as TPL. If the individual receives the payment from the insurance company, the payment is not income for patient pay or eligibility determinations. The individual should assign it to the waiver services provider. If the individual cannot do this, or the policy prohibits assignment, the LTC insurance payment should be given directly to the provider. The provider should report the payment as a third party payment on its claim form.

If the provider is unable to accept payment directly from the individual, the individual must send the insurance payment to:

This address is for USPS mail only:
Commonwealth of VA COV - DMAS
PO Box 780209
Philadelphia, PA 19178-0209

This address is only for overnight mail by special carriers:
Lockbox Services #780209
Commonwealth of VA COV DMAS
2005 Market Street, 5th Floor
Philadelphia, PA 19103-7042

Along with the check, submit some type of documentation to explain why the funds are being sent to DMAS.

C. Noncovered Medical/Dental Services

Deductions for the cost of a patient's medically necessary medical or dental services not covered by Medicaid, other insurance (such as Medicare), or another person are subtracted from income to determine patient pay.

See M1470.430 B.3 for the procedures used to deduct Medicare Part D prescription drug co-pays for patients who have Medicare.

DMAS approval **is not** required for deductions of noncovered services from patient pay when the individual receives CBC services, regardless of the amount of the deduction.

1. Zero Patient Pay Procedures

If deductions from patient pay cannot be allowed because the recipient has no income remaining after deducting the personal maintenance allowance, dependent child allowance(s) and health insurance premiums, or the recipient has no income available for patient pay, deny the request.

Notify the patient or the patient's representative using the Notice of Action.

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

Changed With	Effective Date	Pages Changed
TN #DMAS-34	1/1/25	Pages 7, 18c, 66, 69, 70
TN #DMAS-33	10/1/24	Pages 16, 66
TN #DMAS-32	7/1/24	Pages 6, 8a, 8b, 15, 17, 18, 18a, 18c, 21, 30, 31, 47, 52, 52a, 55, 56, 60, 65, 66, 68, 73, 74, 77, 78, 82, 86, 87, 91
TN #DMAS-31	4/1/24	Page 8a, 17
TN #DMAS-30	1/1/24	Pages 3, 7, 18c, 66, 69, 70
TN #DMAS-29	10/1/23	Page 66
TN #DMAS-26	1/1/23	Pages 7, 18c, 66, 69, 70
TN #DMAS-25	10/1/22	Page 66
TN #DMAS-24	7/1/22	Pages 8a, 8b, 13, 50b, 51, 55, 57, 66, 87, 89, 91
TN #DMAS-22	1/1/22	Pages 7, 18c, 66, 69, 70
TN #DMAS-21	10/1/21	Page 66
TN #DMAS-20	7/1/21	Pages 66, 70
TN #DMAS-18	1/1/21	Page 7, 18c, 66, 69, 70, 92
TN #DMAS-17	7/1/20	Pages 8b, 9, 14, 66, 77, 92
TN #DMAS-15	1/1/20	Pages 1, 7, 18c, 66, 69, 70

27. Spousal Share means ½ of the couple's combined countable resources at the beginning of the **first** continuous period of institutionalization, as determined by a resource assessment.

28. Spouse means a person who is legally married to another person under Virginia law.

29. Waiver Services means Medicaid-reimbursed home or community-based services covered under a 1915© waiver approved by the Secretary of the United States Department of Health and Human Services.

M1480.015 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LONG-TERM CARE

A. Applicability

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

For Medicaid applicants or enrollees approved for LTSS on or after July 1, 2006, the amount of equity in the home at the time of the initial LTC determination and at each renewal must be evaluated. For the purposes of the home equity evaluation, the definition of the home in M1130.100 A.2 is used; the home means 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.

B. Policy

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

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

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

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

***1.* Home Equity Limit**

The applicable home equity limit is based on the date of the application or request for LTSS coverage. Effective January 1, 2011, the home equity limit is subject to change annually. The home equity limit is:

- Effective January 1, 2022: $636,000
- Effective January 1, 2023: $688,000
- Effective January 1, 2024: $713,000
- *Effective January 1, 2025: $730,000*

2. Reverse Mortgages

Reverse mortgages **do not** reduce equity value until the individual begins receiving the reverse mortgage payments from the lender.

2. After Eligibility is Established

Once an institutionalized spouse has established Medicaid eligibility as an institutionalized spouse, count only the institutionalized spouse's resources when determining the institutionalized spouse's Medicaid eligibility. Do not count or deem the community spouse's resources available to the institutionalized spouse.

If an institutionalized spouse's Medicaid coverage was cancelled and reapplies as an institutionalized individual, use only the resources of the institutionalized spouse for *the applicant's* eligibility determination.

M1480.231 SPOUSAL RESOURCE STANDARDS

A. Introduction

This section provides the amounts and the effective dates of the standards used to determine an institutionalized spouse's initial and ongoing resource eligibility. Use the standard in effect on the date of the institutionalized spouse's Medicaid application. Definitions of the terms are found in section M1480.010.

B. Spousal Resource Standard

$31,584	*1-1-25*
$30,828	1-1-24
$29,724	1-1-23
$27,480	1-1-22

C. Maximum Spousal Resource Standard

$157,920	*1-1-25*
$154,140	1-1-24
$148,620	1-1-23
$137,400	1-1-22

M1480.232 INITIAL ELIGIBILITY DETERMINATION PERIOD

A. Policy

The initial eligibility determination period begins with the month of application. If the institutionalized spouse is eligible for the month of application, the initial eligibility determination period will both begin and end with that month.

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

M1480.400 PATIENT PAY

A. Introduction

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

B. Married With Institutionalized Spouse in a Facility

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

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

A. Introduction

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

B. Monthly Maintenance Needs Allowance

$2,177.50	7-1-21
$2,288.75	7-1-22
$2,465	7-1-23
$2,555	7-1-24

C. Maximum Monthly Maintenance Needs Allowance

$3,435.00	1-1-22
$3,715.50	1-1-23
$3,853.50	1-1-24
$3,948.00	*1-1-25*

D. Excess Shelter Standard

$653.25	7-1-21
$686.63	7-1-22
$739.50	7-1-23
$766.50	7-1-24

E. Utility Standard Deduction (SNAP)

$414.00	1 - 3 household members	10-1-23
$524.00	4 or more household members	10-1-23
$369.00	1 - 3 household members	10-1-24
$467.00	4 or more household members	10-1-24

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

A. Policy

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

$875 gross earned income
- 75 first $75 per month
800 remainder
÷ 2
400 ½ remainder
+ 75 first $75 per month
$475 which is > $190

His personal needs allowance is calculated as follows:

$ 40.00 basic personal needs allowance
+190.00 special earnings allowance
+ 17.50 guardianship fee (2% of $875)
$247.50 personal needs allowance

2. Medicaid CBC Waiver Services and PACE

a. Basic Maintenance Allowance

For the Commonwealth Coordinated Care Plus (CC Plus) Waiver (formerly the Elderly or Disabled with Consumer Direction Waiver and the Technology-Assisted Individuals Waiver), Community Living (CL) Waiver (formerly Intellectual Disabilities Waiver), Family and Individual Supports (IS) Waiver (formerly Individual and Family Developmental Disabilities Support Waiver), Building Independence (BI) Waiver (formerly Day Support Waiver), or PACE, deduct the appropriate maintenance allowance for one person as follows:

- January 1, 2022 through December 31, 2022: $1,388
- January 1, 2023 through December 31, 2023: $1,509
- January 1, 2024 through December 31, 2024: $1,556
- *January 1, 2025 through December 31, 2025: $1,596*

Contact a Medical Assistance Program Consultant for the amount in effect for years prior to 20*22*.

b. Guardian Fee

Deduct the actual fee a guardian or conservator charges, up to a maximum of 5% of the patient's actual gross income (including amounts not counted as income and excluded amounts) for guardianship fees, IF:

* the patient has a legally appointed guardian or conservator AND
* the guardian or conservator charges a fee.

Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

NOTES: No deduction is allowed for representative payee or "power of attorney" fees or expenses. No deduction is allowed if the patient's guardian receives a payment for providing guardianship services from a public agency or organization that receives funding for guardianship services. The guardianship filing fees CANNOT be deducted from the individual's income.

c. Special Earnings Allowance For CCC Plus, CL, IS, and BI Waivers

[EXAMPLE #19 was deleted]

For the CCC Plus, CL, IS, and BI waivers, deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

- for individuals employed 20 hours or more per week, all earned income up to 300% of SSI (*$2,901* in 202*5*) per month.

- for individuals employed at least 4 but less than 20 hours per week, all earned income up to 200% of SSI (*$1,934* in 202*5*) per month.

The total of the basic maintenance allowance, the guardianship fee and the special earnings allowance cannot exceed 300% SSI.

EXAMPLE #20: (Using January 2000 figures)

A working patient in the CL Waiver is employed 18 hours per week. He has gross earnings of $928.80 per month and SS of $300 monthly. His special earnings allowance is calculated first:

$	928.80	gross earned income
-	1,024.00	200% SSI maximum
$	0	remainder

$928.80 = special earnings allowance

His personal maintenance allowance is calculated as follows:

$	512.00	maintenance allowance
+	928.80	special earnings allowance
	$1,440.80	personal maintenance allowance

Changed With	Effective Date	Pages Changed
TN #DMAS-33	1/1/25	Page 9
TN #DMAS-33	10/1/24	Change List; Pages 1, 2a, 4a – 6, 10 – 11, 12a

1. Renewal Completed

Notify the enrollee in writing of the findings of the renewal and the action taken. When eligibility continues, use the Notice of Action, and include the month and year of the next scheduled renewal. When the individual is no longer eligible, use the Advance Notice of Proposed Action and include spenddown information, if applicable. When there is a reduction of benefits, use the Advance Notice of Proposed Action and include the month and year of the next scheduled renewal.

2. Renewal Not Completed

If information necessary to redetermine eligibility is not available through online information systems that are available to the agency and the enrollee has been asked but has failed to provide the information, the renewal must be denied and the coverage cancelled due to the inability to determine continued eligibility. Action cannot be taken to cancel coverage until after the deadline for the receipt of verifications has passed, except for situations when the deadline falls on a weekend or holiday.

3. Referral to *Virginia's* Insurance Marketplace (*V*IM)

Unless the individual has Medicare, a referral to the *V*IM—also known as the *State Based Exchange (SBE)*--must be made when an individual's coverage is cancelled so that the individual's eligibility for the Advance Premium Tax Credit (APTC) in conjunction with a Qualified Health Plan (QHP) can be determined. If the individual's renewal was not processed in VaCMS, his case must be entered in VaCMS in order for the *V*IM referral to be made.

4. Renewal Filed During the Three-month Reconsideration Period

If the individual's coverage is cancelled because the individual did not return the renewal form (or complete an online or telephonic renewal) or requested verifications, the Affordable Care Act (ACA) requires a reconsideration period of 90 days be allowed for an individual to file a renewal or submit verifications. For MA purposes, the 90 days is counted as three calendar months. The individual must be given the entire reconsideration period to submit the renewal form and any required documentation. When the renewal or verifications are provided within the 90 day reconsideration period, process the renewal as soon as possible but at least within 30 calendar days from receipt.

The reconsideration period applies to renewals for all covered groups.

If the individual files a renewal or returns verifications at any time during the reconsideration period and is determined to be eligible, reinstate the individual's coverage back to the date of cancellation.

For individuals who were enrolled as Qualified Medicare Beneficiaries (QMB) at the time of cancellation, reinstate coverage back to the date of cancellation.

If an individual began receiving Medicare during the reconsideration period and is eligible as QMB, the QMB coverage is effective the month **in which Medicare began**. Evaluate eligibility for the other months of the reconsideration period in other possible covered groups, including Medically Needy.

Send a Notice of Action informing him of the reinstatement, his continued coverage and the next renewal month and year. See M1520, Appendix 1 for the Renewal Process Reference Guide.

If the individual is not eligible, send a Notice of Action indicating the correct reason for the cancellation (e.g. countable income exceeds the limit). Renewal forms filed after the end of the reconsideration period are treated as reapplications.
Accept the form and request any additional information needed to determine the individual's eligibility.

M23 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-34	1/1/25	Pages 6 & 7 Page 7a is added
TN #DMAS-33	10/1/24	Page 7
TN #DMAS-31	4/1/24	Appendix 1
TN #DMAS-30	1/1/24	Pages 1, 6, 7, 8
TN #DMAS-28	7/1/23	Appendix 1
TN #DMAS-25	10/1/22	Pages 5 & 6. Adjust pages 7-8
TN #DMAS-24	7/1/22	Page 6
TN #DMAS-23	4/1/22	Page 6 Appendix 1, page 1
TN #DMAS-21	10/1/21	Pages 6, 7

Once all necessary verifications for the pregnant woman are received, an eligibility determination must be made immediately and the applicant must be notified of the decision.

C. Case Setup Procedures for Approved Cases

A woman enrolled as FAMIS Prenatal Coverage may have the same base case number in the Medicaid Enterprise System (MES—formerly the Virginia Medicaid Management Information System [MMIS]) as Medicaid enrollees.

D. Entitlement & Enrollment

1. Begin Date of Coverage

Pregnant women determined eligible for FAMIS Prenatal Coverage are enrolled for benefits effective the first day of the application month, if all eligibility requirements are met in that month.

2. No Retroactive Coverage

There is no retroactive coverage in the FAMIS Prenatal Coverage program.

3. Aid Categories

The FAMIS Prenatal Coverage aid categories (AC)* are:

- 110 for pregnant women with income ≤143% FPL
- 111 for pregnant women with income >143% FPL but ≤ 200% FPL.

Note: A change in the MMIS enrollment system was effective July 1, 2022 to display the FAMIS Prenatal aid categories AC110 / AC111. Anyone enrolled prior to July 1, 2022 will remain in aid category AC005 *until renewal* if eligibility is not run and updated to the new AC.

4. Coverage Period

After her eligibility is established as a pregnant woman, the woman's FAMIS Prenatal Coverage entitlement continues through her pregnancy and the 60-day period following the end of her pregnancy regardless of income changes. Her coverage ends the last day of the month in which the 60th postpartum day occurs. The 12-month coverage period for pregnant women in Medicaid and FAMIS MOMS is not applicable to FAMIS Prenatal Coverage.

E. Notification Requirements

Written notice must be sent to the pregnant woman informing her of the action taken on the application. The notice must include the eligibility determination results for FAMIS Prenatal Coverage.

If the woman is not eligible for FAMIS Prenatal Coverage and has no documentation of immigration status, DO NOT make a referral to the Health Insurance Marketplace.

F. Enrolling Infant Born to a Woman in FAMIS Prenatal Coverage

For women assigned to AC 110 under a fee for service (FFS) arrangement, her labor and delivery services are paid as emergency services, and the newborn is considered a deemed-eligible newborn. When the birth of the child born to a women enrolled in FAMIS Prenatal Coverage is reported, review the available systems to determine if the mother is assigned to AC110 under FFS. If so, the child is enrolled as a deemed newborn in AC 093 and is eligible for 12 months of continuous
coverage. An infant born to a woman in FAMIS Prenatal Coverage who is assigned to AC 111 and/or enrolled in managed care must be evaluated for ongoing coverage. The infant is not considered a deemed-eligible newborn but has rather been enrolled prenatally through the mother's enrollment in FAMIS Prenatal

Coverage, and the *enrollment is treated as a change in circumstances. If the newborn's eligibility can be verified with information known to the agency, enroll the child effective the date of the birth with a 12-month certification period. If the child's eligibility can't be verified,* the infant's birth is treated as an "add a person" case change in the enrollment system and given a 12 month certification period starting with the mother's first month of enrollment.

To enroll the infant, the worker must have the information below. Use existing case data if possible. If additional information is needed, send a request for verification. *The newborn is protected by continuous eligibility until the end of their certification period. If a verification request is sent and returned, process it as a change in circumstances. If the child remains eligible, give them a new 12-month certification period. If the verification request is not returned or the information provided indicates that the child is ineligible, do not disenroll them. Eligibility will be reviewed through the annual redetermination process at the end of their current certification period.*

1. Required Information

- Name, date of birth, sex (gender)
- Information about the infant's MAGI household and income, if not available in the case record

Unless the agency has information about the infant's father living in the home (i.e. for another program), use only the mother's reported income to enroll the infant. Do not request information about the father or the father's income unless the agency has *current* information about the father living in the home and his income. *Information on file can be used if less than six months old.*

Note: The infant is not required to provide an SSN or proof of application for an SSN in order to be enrolled. Follow the procedures in M0240.200 B.3 90 days following the infant's enrollment to determine if an SSN has been assigned. If the SSN number has not yet been issued at 90 days, obtain the SSN or proof of application for an SSN at the first renewal of the infant's coverage.

2. Enrollment and Aid Category

Update the case with the new infant's information, enrolling the child as a Medicaid child under 19 or in FAMIS, as appropriate based on the mother's countable income at the time of application. Use the appropriate AC below to enroll the infant:

- Medicaid AC 090 for income > 109% FPL $\leq$ 143% FPL
- Medicaid AC 091 for income $\leq$ 109% FPL
- FAMIS AC 006 for income > 150% FPL and $\leq$ 200% FPL
- FAMIS AC 008 for income > 143% FPL and $\leq$ 150% FPL

3. Renewal

The infant's first renewal is due 12 months from the month of the child's enrollment.

G. Examples

Example 1: Rose is pregnant and is carrying one unborn child. She was born outside the U.S. She applies for Medicaid on October 27, 2021. She reported on the application that she visited the emergency room in August 2021. The retroactive period for her application is July – September 2021.

Rose is unable to verify that she is lawfully residing in the U.S.; therefore, she cannot be eligible for full-benefit Medicaid or FAMIS Moms and is evaluated for FAMIS Prenatal Coverage. Her verified countable monthly income is $1,756 per month, which is under the income limit for FAMIS Prenatal Coverage for her MAGI household size of two. She is approved for FAMIS Prenatal coverage and enrolled effective October 1, 2021, in AC 110, based on her countable income of under 143% FPL (see M23, Appendix 1). She is enrolled in Managed Care, so her infant will not be considered a deemed-eligible newborn.