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December 1, 2025

Virginia Medical Assistance Eligibility Manual Transmittal
DMAS-37

The following acronyms are contained in this letter:

- COLA – Cost of Living Increase
- DMAS – Department of Medical Assistance Services
- LIFC – Low Income Families & Children
- MA – Medical Assistance
- MSP – Medicare Savings Plan
- NBD – Non-Blind/Disabled
- PMA – Personal Maintenance Allowance
- SSI – Supplemental Security Income
- TN – Transmittal

TN #DMAS-37 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, 2026.

The following changes are contained in TN #DMAS-37:

Changed Sections	Changes
M0120.500 C. 2.	Updates procedure to make a coverage correction request and removes the enrollment email address.
M0130.300 D.3.	Updates procedure to make a coverage correction request and removes the enrollment email address.
M0320	Update COLA and Medicare changes for 2026
M0410.100 M0430.400 M0450.300	Correct examples to reflect that LIFC pregnant individuals count as a household of two (including the unborn child).
M0530	Update the NBD allocation, parental living allowance and deeming standard for 2026
M0810	Update SSI amounts for 2026.

Subchapter M0820	Update Student Earned Income Exclusion for 2026.
Subchapter M1110	Update the MSP resource limits for 2026.
Subchapter M1460	Update the home equity limit and Student Earned Income Exclusion for 2026.
Subchapter M1470	Update the PMA and the Special Earnings Allowance for 2026
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 2026.
M1510.107	Updates procedure to make a coverage correction request and removes the enrollment email address.

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

M0120 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Page 17
TN #DMAS-36	10/1/25	M0120.100
TN #DMAS-35	7/1/25	Pages 2 and 5
TN #DMAS-30	1/1/24	Page 17
TN #DMAS-25	10/1/22	Page 7
TN #DMAS-23	4/1/22	Pages 9, 10, 16, 17, 19
TN #DMAS-18	1/1/21	Pages 11, 17 Page 12 is a runover page. Page 12a was added as a runover page.
TN #DMAS-17	7/1/20	Pages 2, 2a, 5, 7, 8, 13, 16 Page 6 is a runover page. Page 14 was removed. Pages 15-20 were renumbered.
TN #DMAS-14	10/1/2019	Pages 7, 10, 11, 18 Page 20a was deleted.
TN #DMAS-12	4/1/19	Pages 2, 12-13,15, 20a
TN #DMAS-10	10/1/18	Pages 2, 4, 15, 17-20 Page 20a was added as a runover page.
TN #DMAS-8	4/1/18	Page 12
TN #DMAS-6	10/1/17	Page 1
TN #DMAS-5	7/1/17	Page 2a
TN #DMAS-4	4/1/17	Pages 2a, 7, 10, 13
TN #DMAS-3	1/1/17	Page 15
TN #DMAS-2	9/1/16	Pages 2, 15 Page 2a is a runover page.
TN #DMAS-1	6/1/16	Pages 7, 10, 11, 16-20
TN #100	5/1/15	Table of Contents Pages 1, 2, 15, 20 Page 2a and 16 are runover pages.
UP #10	5/1/14	Table of Contents Pages 11, 16-18 Pages 11a and 11b were deleted. Pages 19 and 20 were added.
TN #99	1/1/14	Page 11 Pages 11a and b were added.
TN #98	10/1/13	Table of Contents Pages 1-17
UP #9	4/1/13	Page 13, 15, 16
UP #7	7/1/12	Pages 1, 10-12
TN #96	10/1/11	Table of Contents Pages 6-18
TN #95	3/1/11	Pages 1, 8, 8a, 14
TN #94	9/1/10	Pages 8, 8a
TN #93	1/1/10	Pages 1, 7, 9-16
Update (UP) #1	7/1/09	Page 8
TN #91	5/15/09	Page 10

(AC 035) is limited to outpatient prenatal services; labor and delivery are not covered under HPE for AC 035. HPE coverage for Plan First enrollees AC084 is limited to family planning services only. Transportation to receive covered medical services is covered for all HPE enrollees.

Enrollment as HPE is limited to one HPE period per calendar year for all individuals other than pregnant women. For pregnant women, enrollment is limited to one HPE eligibility period per pregnancy. Children's 12 month continuous eligibility does not apply to children enrolled as HPE.

There are no appeal rights for an HPE determination.

1. Eligibility Procedures – Post HPE Enrollment

a) MA Application Not Submitted

If the person does not submit an MA application prior to the end of the HPE coverage period, no further worker action or additional notice not required because the enrollment was for a closed period of coverage.

b) MA Application Submitted

For MA coverage to continue beyond the initial HPE coverage period, the individual must submit a full MA application. MA applications submitted by HPE enrollees are subject to the standard eligibility and entitlement policies. The 7-calendar day processing standard applies to MA applications submitted by pregnant women. The 10-work day requirement applies to applications submitted by BCCPTA individuals enrolled in HPE.

While the LDSS does not determine eligibility for HPE, if an MA application is received and pended in VaCMS, the individual's coverage in the HPE AC may need to be extended or reinstated (if HPE coverage will end during the application processing period) while the application is processed. If HPE coverage needs to be extended/reinstated, alert a VDSS Regional Consultant or *submit a* Coverage Correction Request *through the Coverage Correction Portal (CCP) on the MES website.*, *Home | MES. To access the CCP and User Guides, LDSS, VDSS, CoverVA, and DMAS staff must sign into the MES using their current credentials and then sign into the MMIS with their eCode. The enrollment mailbox has been disabled.*

Example 1: Mary Smith is enrolled in HPE coverage in AC 065 (LIFC) for the period of 3-5-18 through 4-30-18. On 4-20-18, she submits an MA application; however, the 45th processing day will fall after the HPE end date of 4-30-18. Therefore, the worker must have the HPE coverage reinstated in *MES* under the same aid category (AC 065), using the MA application date. The effective date of the reinstatement is 5-1-18, the day after the HPE coverage ends. Once the application has been processed. the worker must act to cancel the HPE coverage, and if the individual remains eligible reinstate coverage in the appropriate AC.

Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Page 12
TN #DMAS-36	10/1/25	M0130.500
TN #DMAS-35	7/1/25	Pages 1, 9, 10 and 15
TN #DMAS-34	1/1/25	Page 9
TN #DMAS-33	10/1/24	TOC, Pages 1, 6, 6a, 12-14 Page 15 is added.
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

D. Application Disposition

1. General Principle

Each application must be disposed of by a finding of eligibility or ineligibility as supported by the facts in the case record, unless the application is withdrawn or terminated (see M0130.400).

If an applicant dies during the application process, his eligibility can only be established for the period during which he was alive.

If an applicant (other than a Medicare beneficiary, HPE, or deceased individual) is ineligible for MA for any reason other than the inability to determine eligibility, a referral to the VIM must be made so that his eligibility for the APTC in conjunction with a Qualified Health Plan (QHP) can be determined. Individuals who have Medicare, who are incarcerated, who are enrolled as HPE, and deceased individuals and are not referred to the VIM.

2. Entitlement and Enrollment

a. Entitlement

Entitlement to medical assistance is based on the application month. However, entitlement cannot begin prior to an individual's date of birth, and cannot continue after an individual's date of death. See section M1510.100 for detailed entitlement policy and examples.

If applicants indicate that they have been receiving MA (Medicaid or Children's Health Insurance Program) coverage in another state prior to moving to Virginia, instruct them to contact the eligibility worker there and request that the coverage be cancelled, if they have not already done so. Individuals are no longer considered residents of the other state once they have moved to and intend to reside in Virginia and are not entitled to receive services paid for by the other state's MA program. Enrollment may begin with the month of application or the earliest month in the application's retroactive period that they met the residency requirement per M0230.

b. Enrollment

MA enrollees must be enrolled in the MES, either through the system interface with the eligibility determination system or by submitting a coverage correction *request through the Coverage Correction Portal (CCP) on the MES website.*, Home | MES.

Note: The MES was implemented in April 2022. Prior to April 2022, the Medicaid Management Information System (MMIS) was used for enrollment and claims processing. References to MMIS in the Medical Assistance Eligibility Manual will be updated as other policy revisions are made.

When an individual who does not have Medicare is eligible for only limited MA benefits, such as Plan First, a referral to the VIM must be made so that eligibility for the APTC in conjunction with a QHP can be determined.

3. Notification to Applicant

Either a Notice of Action generated by the eligibility determination system or the equivalent form #032-03-006 (available at the DSS Fusion website) must be used to notify the applicant of the specific action taken on the application. The notice must be sent to the authorized representative, if one has been designated.

M0320 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Page 11
TN #DMAS-35	7/1/25	Sections .400 and .500
TN #DMAS-34	1/1/25	Pages 11, 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 = Benefits before 1/25 COLA 2.8% (1/25 increase)*
b. Current Title II Benefit= Benefit Before 1/24 COLA 2.5% (1/24 Increase)
c. Current Title II Benefit= Benefit Before 1/23 COLA 3.2% (1/23 Increase)
d. Current Title II Benefit = Benefit Before 1/22 COLA 1.059 (1/22 Increase)
e. Benefit Before 1/22 COLA = Benefit Before 1/21 COLA 1.013 (1/21 Increase)
f. Benefit Before 1/21/ COLA = Benefit Before 1/20 COLA 1.016 (1/20 Increase)

5. Medicare Premiums

a. Medicare Part B premium amounts:

1-1-26 $202.90
1-1-25 $185.00
1-1-24 $174.70
1-1-23 $164.90
1-1-22 $170.10

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:

1-1-26 $565.00
1-1-25 $518.00
1-1-24 $505.00
1-1-23 $506.00
1-1-22 $499.00

Contact a Medical Assistance Program Consultant for amounts for years prior to *2022.*

6. Evaluation

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

Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Pages 2, 13, 30, 31
TN #DMAS-35	7/1/25	Page 4, 14, 15, 20, 33; Appendices 3, 5, 8
TN #DMAS-34	1/1/25	Pages 16a and 16b, Appendix 1,2,6,7
TN #DMAS-33	10/1/24	Appendix 2
TN #DMAS-32	7/1/24	Pages 2, 4, 5, 8, 16, 16b2, 21, 33, 34, 34a Appendices 3, 5 and 8
TN #DMAS-31	4/1/24	Pages 15 and 16a; Appendices 1, 2, 6 and 7
TN #DMAS-30	1/1/24	Pages 1, 34 Page 34a is a runover page
TN #DMAS-28	7/1/23	Page 37 Appendices 1,2,3,5,6 and 7

- has no resource test (Exception: MAGI Adults requesting coverage of Long-Term Care services are subject to certain asset/resource requirements)

2. MAGI Rules

- MAGI has an income disregard equal to 5% of the federal poverty level (FPL) for the Medicaid or FAMIS individual's household size. The disregard is only given if the individual is not eligible for coverage due to excess income. It is applicable to individuals in both full-benefit and limited-benefit covered groups.
- If the individual meets multiple Medicaid covered groups (and/or FAMIS) his gross income is compared first to the income limit of the group with the highest income limit under which the individual could be eligible.
- If the income exceeds the limit, the 5% FPL disregard can be allowed, and the income again is compared to the income limit.
- When considering tax dependents in the tax filer's household, the tax dependent may not necessarily live in the tax filer's home.
- Under MAGI counting rules, an individual may be counted in more than one household but is only evaluated for eligibility in his household.
- Use non-filer rules when the household does not file taxes.
- Use non-filer rules when the applicant is claimed as a tax dependent by someone outside the applicant's household.
- Non-filer rules may be used in multi-generational household.

3. Eligibility Based on MAGI

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

a. Children under 19

b. Parent/caretaker relatives of children under the age of 18 - Low Income Families With Children (LIFC)

c. Pregnant individuals, including *LIFC,* FAMIS MOMS and FAMIS Prenatal Coverage

d. Individuals Under Age 21

e. Adults between the ages of 19 and 64 not eligible or enrolled in Medicare (effective January 1,2019)

f. Individuals in Plan First.

4. Eligibility NOT Based on MAGI

MAGI methodology is NOT used for eligibility determinations for: individuals for whom the eligibility worker is not required to make an income determination:

A. Two Parents Not Married To Each Other, Both File Taxes; 1 Child-In-Common, One Child Not In Common; Mom Is Pregnant

Jill and Max are both tax filers. Also in the home are Max's son, Mark and their child-in-common, May. Jill is pregnant, expecting 1 baby. Max claims both children on his taxes. All applied for MA.

Jill is a tax filer who claims no additional dependents. Her MAGI household is the same as her tax household for Medicaid coverage in the LIFC covered group and includes her unborn child when determining her eligibility as a pregnant woman. Max is a tax filer with two dependent children; his MAGI household is the same as his tax household. Mark is a tax dependent living with his tax filer parent and no exceptions exist; his MAGI household is the same as the tax household. May is a tax dependent, but her parents are not filing jointly so an exception exists and non-filer rules are used for her MAGI household.

The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Jill	2 – Jill and 1 unborn	Tax-filer pregnant woman; no other dependents
Max	3 – Max, Mark and May	Tax filer and two dependent children
Mark	3 – Mark, Max and May	Tax filer rules, tax household rules for person filing for him
May	4 – May, Max, Jill and Mark	Non-filer rules child with parents not filing jointly, non-married parents and half sibling.

B. Tax Filer, Spouse, Their Child, His Child Not Living In the Home

Gerry and Bree are married and file their taxes jointly. Also in the home is their son, Tad age 7, whom they claim as their dependent. They also claim Gerry's daughter, Tansy age 10, who does not live with them. Gerry, Bree and Tad applied for MA.

Gerry and Bree are tax filers who are married, filing jointly claiming two dependent children. Their MAGI household is the same as their tax household.

Tad is a tax dependent child and no tax dependent exceptions exist; Tad's MAGI household is the same as the tax household. The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Gerry	4 – Gerry, Bree, Tad and Tansy	Tax filers and dependent children
Bree	4 – Gerry, Bree, Tad and Tansy	Tax filers and dependent children
Tad	4 – Gerry, Bree, Tad, Tansy	Tax filer and dependents

A. Example #2 Non Tax Filer Three Generation Household (Using Jan. 18, 2018 figures)

Sally Green is age 64, a grandmother who does not expect to file taxes this year. She is neither blind or disabled. She lives with her daughter Jane, age 20 and a full-time student, and her granddaughter Dee (Jane's daughter), age 2. Sally takes care of Dee while Jane is attending school and working at her part-time job. Jane is pregnant with 1 unborn. They live in Hanover, a Group I locality. Sally doesn't have Medicare.

Income:
Sally receives SSA widow's benefits of $1,000 per month.

Jane earns $300 per month or $3,600 annually and is not required to file taxes.

The MAGI non-filer households are:

Person	# - Household Composition	Reason
Sally	1 – Sally	Non-filer grandmother
Jane (PG)	3 – Jane, Jane's unborn child & Dee	Non-filer, her unborn child & non-filer's child < 19
Dee	2 – Dee, Jane	Non-filer child < 19 & non-filer child's parent

Sally's eligibility determination:
Potential covered groups: Plan
First
MAGI Adult
Monthly Income limits:

MAGI Adult income limit for HH of 1=$1,346
Plan First 200% FPL income limit for HH of 1 = $2,024
5% FPL for 1 = $51

HH gross monthly income = $1,000 Sally's SSA benefits
Her gross income of $1,000 is less than the MAGI Adult limit of $1,346 for 1. Sally is eligible for full coverage in the MAGI Adult coverage group.

Jane's eligibility determination:

Potential covered groups: LIFC
MAGI Adult
Medicaid Pregnant Women

Monthly Income limits:
LIFC, Group I for HH of 3 = $381
Pregnant Women 143% FPL for a HH of 3 = $2,477 MAGI Adult income limit for HH of 3=$2,391
5% FPL for 3 = $86

HH monthly income = $300 Jane's income.

Jane is over age 19, not a child and not counted as a dependent for anyone else. Jane's earnings must be counted even though she is not required to file taxes. As her mother (Sally) is not in Jane's tax filing HH, Sally's income is not counted when determining Jane's eligibility. The HH would consist of Jane, *her unborn child* and her daughter Dee.

$300 is less than the LIFC limit for 3 ($381) so the 5% disregard is not applied (it is not necessary). Jane is eligible for Medicaid in the LIFC covered group.

If Jane had been over income for the LIFC covered group, the step to apply the 5% disregard would have been used. If she was found over the LIFC income limit, a review as a Medicaid Pregnant Woman 143% income limit would have been used.

Dee's eligibility determination:

Potential covered groups: Child
< Age 19
FAMIS

Monthly Income limits:
Child < Age 19 143% FPL for a HH of 2 = $1,962 FAMIS, 200% FPL for HH of 2 = $2,585
5% FPL for 2 = $65

HH monthly income:
$300 (Jane's gross earnings)

As HH income $300 is less than the Medicaid Child < Age 19 143% FPL income limit for 2 ($1,962), Dee is eligible for Medicaid. The 5% disregard is not necessary since she qualified in this aid category.

M0530 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Appendix 1, page 1
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

2026: $1,491- $994 = $497
2025: $1,450 - $967 = $483
2024: $1,415 - $943 = $472
2023: $1,371 - $914 = $457
2022: $1,261 - $841 = $420

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 = *$994 for 2026;* $967 for 2025; $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 = *$1,491 for 2026;* $1,450 for 2025; $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

2026: $1,491 - $994 = $497
2025: $1,450 - $967 = $483
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-37	1/1/26	Pages 1, 2
TN #DMAS-35	7/1/25	Pages 1, 2 and 25
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	*2025 Monthly Amount*	*2026 Monthly Amount*
1	*$967*	*$994*
2	*1,450*	*$1,491*
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size	*2025 Monthly Amount*	*2026 Monthly Amount*
1	*$645*	*$663*
2	*$967*	*$994*

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	*2025 Monthly Amount*	*2026 Monthly Amount*
1	*$2,901*	*$2,982*

4. ABD Medically Needy

a. Group I	7/1/24-6/30/25		7/1/25	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$2,391.01	$398.50	$2,460.34	$410.05
2	3,043.80	507.30	3,132.06	522.01

b. Group II	7/1/24-6/30/25		7/1/25	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$ 2,758.87	$ 459.81	$ 2,838.87	$ 473.14
2	3,396.83	566.14	3,495.33	582.55

c. Group III	7/1/24-6/30/25		7/1/25	
Family Unit Size	Semi-annual	Monthly	Semi-annual	Monthly
1	$3,586.53	$597.76	$3,690.53	$615.08
2	4,323.80	720.63	4,449.18	741.53

5. ABD Categorically Needy

For:

ABD 80% FPL, QMB, SLMB, & QI <u>without</u> Social Security income; all QDWI; effective 1/15/25

ABD 80% FPL, QMB, SLMB, & QI <u>with</u> Social Security income; effective 3/1/25

All Localities	2024		2025	
ABD 80% FPL	Annual	Monthly	Annual	Monthly
1	$12,048	$1,004	$12,520	$1,044
2	16,352	1,363	16,920	1,410
QMB 100% FPL	Annual	Monthly	Annual	Monthly
1	$15,060	$1,255	$15,650	$1,305
2	20,440	1,704	21,150	1,763
SLMB 120% of FPL	Annual	Monthly	Annual	Monthly
1	$18,072	$1,506	$18,780	$1,565
2	24,528	2,044	25,380	2,115
QI 135% FPL	Annual	Monthly	Annual	Monthly
1	$20,331	$1,695	$21,128	$1,761
2	27,594	2,300	28,553	2,380
QDWI 200% of FPL	Annual	Monthly	Annual	Monthly
1	$30,120	$2,510	$31,300	$2,609
2	40,880	3,407	42,300	3,525

M0820 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Pages 30, 31
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 2026, up to $2,410 per month, but not more than $9,730 in a calendar year, of the earned income of a blind or disabled child.*

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.

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 2026	*$2,410*	*$9,730*
In calendar year 2025	$2,350	$9,460
In calendar year 2024	$2,290	$9,230
In calendar year 2023	$2,220	$8,950

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-37	1/1/26	Page 2
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** **2024** $9,430 **2025** $9,660 ***2026*** *$9,950*	**Calendar Year** **2024** $14,130 **2025** $14,470 ***2026*** *$14,910*

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.

M1460 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Pages 3, 35
TN #DMAS-36	10/1/25	Pages 2, 17, 41, 42, 44, 46
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, 2024: $713,000
- Effective January 1, 2025: $730,000
- *Effective January 1, 2026: $752,000*

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

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

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

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

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

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

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

a. *For 2026, up to $2,410 per month, but not more than $9,730 in a calendar year, of the earned income of a blind or disabled Student child.*
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.

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

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

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

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

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

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

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

M1470 Changes
Page 2 of 2

Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Page 19
TN #DMAS-36	10/1/25	Pages 26, 32, 54
TN #DMAS-35	7/1/25	Pages 1 and 48
TN #DMAS-34	1/1/25	Pages 1, 2, 10, 11, 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

M1470.410 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
- *January 1, 2026 through December 31, 2026: $1,641*

Contact a Medical Assistance Program Consultant for the PMA in effect for years prior to 202*3.*

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.

Changed With	Effective Date	Pages Changed
TN #DMAS-37	1/1/26	Pages 7, 18c, 66, 69, 70
TN #DMAS-36	10/1/25	Page 66
TN #DMAS-35	7/1/25	Pages 1 and 66
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, 2023: $688,000
- Effective January 1, 2024: $713,000
- Effective January 1, 2025: $730,000
- *Effective January 1, 2026: $752,000*

***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

$32,532	*1-1-26*
$31,584	1-1-25
$30,828	1-1-24
$29,724	1-1-23

C. Maximum Spousal Resource Standard

$162,660	*1-1-26*
$157,920	1-1-25
$154,140	1-1-24
$148,620	1-1-23

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	$2,288.75	7-1-22
	$2,465	7-1-23
	$2,555	7-1-24
	$2,643.75	7-1-25
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
	$4,066.50	*1-1-26*
D. Excess Shelter Standard	$686.63	7-1-22
	$739.50	7-1-23
	$766.50	7-1-24
	$793.13	7-1-25

E. Utility Standard Deduction (SNAP)	$369.00	1 - 3 household members	10-1-24
	$467.00	4 or more household members	10-1-24
	$375.00	1 - 3 household members	10-1-25
	$476.00	4 or more household members	10-1-25

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, 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
- *January 1, 2026 through December 21, 2026: $1,641*

Contact a Medical Assistance Program Consultant for the amount in effect for years prior to 20*23*.

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 (*$2,982 in 2026*) per month.

- for individuals employed at least 4 but less than 20 hours per week, all earned income up to 200% of SSI (*$1,988 in 2026*) 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-37	1/1/26	Page 9a
TN #DMAS-33	10/1/24	Pages 9a, 10, 12-15
TN #DMAS-32	7/1/24	Page 2b
TN #DMAS-31	4/1/24	Pages 7 and 8
TN #DMAS-30	1/1/24	Page 1, 2a, 8a,
TN #DMAS-24	7/1/22	Pages 8, 9a, 12-14
TN #DMAS-22	1/1/22	Page 8a Page 8 is a runover page.
TN #DMAS-21	10/1/21	Page 9a
TN #DMAS-19	4/1/21	Pages 6, 8
TN #DMAS-18	1/1/21	Pages 2b, 9, 12
TN #DMAS-17	7/1/20	Page 15
TN #DMAS-16	4/1/20	Pages 5, 6, 12, 13 Pages 14 and 15 are runover pages.
TN #DMAS-14	10/1/19	Pages 2b, 4, 5-7
TN #DMAS-12	4/1/19	Pages 7, 9a. Page 7a is a runover page.
TN #DMAS-11	1/1/19	Page 7

M1510.107 Enrollment Changes

~~D~~. Enrollment Changes

VaCMS is the MA eligibility system of record, however some enrollment functions can only be handled by the DMAS Eligibility and Enrollment Unit. The VaCMS and MES [Medicaid Enterprise System (formerly MMIS)] systems **must** reflect correct coverage. Appropriate change requests include (but are not limited to):

- Coverage corrections unable to be handled through VaCMS
- Duplicate linking
- Erroneous death cancellations
- Same day void.

There may be instances when VaCMS should be able to successfully update the enrollment system but does not. When this occurs, the eligibility worker must follow the steps as listed below:

- First attempt to make the correction in VaCMS with the help of supervisors or other agency resources. If not successful;
    - Contact the VDSS Regional Practice Consultant (RC) for assistance. The RC will help the local worker make the correction in VaCMS.
- If either the agency resources or RC is unable to correct the enrollment in VaCMS, they can instruct the worker to submit a coverage correction to DMAS *by submitting a coverage correction request through the Coverage Correction Portal (CCP) on the MES website., Home | MES.*