Cheryl Roberts
DIRECTOR

Department of Medical Assistance Services

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

April 1, 2026

Virginia Medical Assistance Eligibility Manual Transmittal
DMAS-38

The following acronyms are contained in this letter:

- CBC – Community Based Care
- CCC+ - Medicaid managed care program serving adults and children with disabilities and complex care needs.
- DDS – Disability Determination Services
- DMAS – Department of Medical Assistance Services
- MCO – Managed Care Organization
- PRTF – Psychiatric Residential Treatment Facility
- TN – Transmittal

TN #DMAS-38 includes policy clarifications, updates and revisions. Unless otherwise noted in the Cover Letter and/or policy, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after April 1, 2026.

The following changes are contained in TN #DMAS-38:

Changed Sections	Changes
Chapter M000	Added Income Limits and Reference section
Subchapter M0310.112 D.2.b.	Although a referral to DDS must still be made before the 18th birthday, Continuous Eligibility protections will apply until the earlier of the month that the child turns 19 or the month that their 12-month protected period ends.
Subchapter M0320.502	CBC services must start within 180 days of the Notice of Action approving LTSS coverage.
Subchapter M0330.400 D.	Individuals who experience a miscarriage are eligible for 12 or 2 month post-pregnancy coverage.
Subchapter M0520.001 B. 4	Replace link to PRTFs Rate Setting
Chapter M18	Remove references to Medallion 4.0 and CCC+ MCO programs. Remove reference to excluding individuals under 21 in PRTF from managed care
Subchapter M2210.100	Individuals who experience a miscarriage are eligible for 12 or 2 month post-pregnancy coverage. Publish converted Chapter 22.
Subchapter M2310.100	Individuals who experience a miscarriage are eligible for 12 or 2 month post-pregnancy coverage. Publish converted Chapter 23.

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

Virginia Medical Assistance Eligibility Manual

Chapter M00
Appendix – Income Charts

Created April 2026

Chapter M00 Appendix Changes

Changed With	Effective Date	Subchapters Changed

TN – Transmittal
UP – Update

Table of Contents

Reference Information – Grouping of Localities 1
Reference Information – Treatment of Income for Children, Families & Children, and Children Covered Groups 3
MAGI Income Charts 5
Families & Children Income 10
Aged, Blind & Disabled (ABD) Income Limits 12
12-Month Extended Medicaid Income Limits 15
FAMIS Income Limits 16
FAMIS Moms Income Limits 18
FAMIS Prenatal Coverage Income Limits 19

REFERENCE INFORMATION – GROUPING OF LOCALITIES

The three locality tables that follow are used in conjunction with the following income charts: MAGI Income Charts, Families & Children Income, and Aged, Blind and Disabled Income Charts.

The information in the tables is associated with Chapters M04, M07 and M08 of the Medical Assistance Eligibility Manual.

Chart Name: Grouping of Localities – Group I
Effective Date: July 1, 2017

Counties – Listed Alphabetically: A - Fra	Counties – Listed Alphabetically: Fre -N	Counties – Listed Alphabetically: O - Y	Cities
Accomack	Frederick	Orange	Bristol
Alleghany	Giles	Page	Buena Vista
Amelia	Gloucester	Patrick	Danville
Amherst	Goochland	Pittsylvania	Emporia
Appomattox	Grayson	Powhatan	Franklin
Bath	Greene	Prince Edward	Galax
Bedford	Greensville	Prince George	Norton
Bland	Halifax	Pulaski	Suffolk
Botetourt	Hanover	Rappahannock	
Brunswick	Henry	Richmond County	
Buchanan	Highland	Rockbridge	
Buckingham	Isle of Wight	Russell	
Campbell	James City	Scott	
Caroline	King George	Shenandoah	
Carroll	King & Queen	Smyth	
Charles City	King William Lancaster	Southampton	
Charlotte	Lee	Spotsylvania	
Clarke	Louisa	Stafford	
Craig	Lunenburg	Surry	
Culpeper	Madison	Sussex	
Cumberland	Mathews	Tazewell	
Dickenson	Mecklenburg	Washington	
Dinwiddie	Middlesex	Westmoreland	
Essex	Nelson	Wise	
Fauquier	New Kent	Wythe	
Floyd	Northampton	York	
Fluvanna	Northumberland		
Franklin	Nottoway		

Chart Name: Grouping of Localities – Group II
Effective Date: July 1, 2017

Counties	Cities
Albemarle	Chesapeake
Augusta	Covington
Chesterfield	Harrisonburg
Henrico	Hopewell
Loudoun	Lexington
Roanoke	Lynchburg
Rockingham	Martinsville
Warren	Newport News
	Norfolk
	Petersburg
	Portsmouth
	Poquoson
	Radford
	Richmond Roanoke
	Salem
	Staunton
	Virginia Beach
	Williamsburg
	Winchester

Chart Name: Grouping of Localities – Group III
Effective Date: July 1, 2017

Counties	Cities
Arlington	Alexandria
Fairfax	Charlottesville
Montgomery	Colonial Heights
Prince William	Falls Church
	Fredericksburg
	Hampton
	Manassas
	Manassas Park
	Waynesboro

REFERENCE INFORMATION – TREATMENT OF INCOME FOR CHILDREN, FAMILIES & CHILDREN, AND CHILDREN COVERED GROUPS

The table below is used in conjunction the following income charts: MAGI Income Charts, Families & Children Income.

The information in the table is associated with Chapters M04 and M07 of the Medical Assistance Eligibility Manual.

Effective Date: July 2025

INCOME	MAGI COVERED GROUPS	MEDICALLY NEEDY; 300% SSI; F&C COVERED GROUPS
Difficulty of Care Payments	*Not counted*	*Counted with appropriate earned income disregards*
Earnings	Counted with no disregards	Counted with appropriate earned income disregards
Social Security Benefits Adult's MAGI household	Benefits received by a parent or stepparent are counted for his eligibility determination, as well as the eligibility determinations of his spouse and children in the home.	Counted if anyone in the Family Unit/Budget Unit receives
Social Security Benefits Child's MAGI household	If the child lives with a parent, only counted if the child is required to file a federal tax return.	Counted if anyone in the Family Unit/Budget Unit receives
Child Support Received	Not counted	Counted – subject to $50 exclusion
Child Support Paid	Not deducted from income	Not deducted from income
Alimony Received	Counted if divorce agreement was finalized prior to January 1, 2019, and the agreement has not been modified.	Counted – subject to $50 exclusion if comingled with child support
Alimony Paid	Deducted from income if divorce agreement was finalized prior to January 1, 2019	Not deducted from income
Worker's Compensation	Not counted	Counted
Veteran's Benefits	Not counted if they are not taxable in IRS Publication 525	Counted
Scholarships, fellowships, grants and awards used for educational purposes	Not counted	Not counted
Student Loan Debt	Effective January 1, 2019, student loan debt forgiven due to death or disability of student is not counted as income.	Not applicable

INCOME	MAGI COVERED GROUPS	MEDICALLY NEEDY; 300% SSI; F&C COVERED GROUPS
Foreign Income (whether or not excluded from taxes)	Counted	Counted
Interest	Counted	Counted
Lump Sums	Income in month of receipt	Income in month of receipt
Lottery & Gambling Winnings	Lottery and gambling winnings of $80,000 or greater, received in a single payout, are counted in the month received and over a period of up to 120 months. Income in month of receipt for other HH members.	Income in month of receipt
Gifts, inheritances, life insurance proceeds	Not counted	Counted as lump sum in month of receipt
Parsonage allowance	Not counted	Counted
Pandemic Unemployment Compensation Payments	Not counted (regular Unemployment Compensation is counted.)	Not counted (regular Unemployment Compensation is counted.)
Federal COVID-19 relief payments	Not counted	Not counted

MAGI INCOME CHARTS

NOTE: The income charts in this section are associated with Chapter M04 – Modified Adjusted Gross Income (MAGI) of the Medical Assistance Eligibility Manual.

Income Chart Name: 5% Federal Poverty Level (FPL) Income Disregard Amounts - All Localities

Effective Date: January 13, 2026

Household Size	Monthly Amount
1	*$67*
2	*$91*
3	*$114*
4	*$138*
5	*$162*
6	*$185*
7	*$209*
8	*$233*
Each additional, add	*$24*

Income Chart Name: Gap-Filling Rule Evaluation 100% Federal Poverty Level (FPL) Income Limits

Effective Date: January 13, 2026

Household size	Annual (Use for Gap-Filling Evaluation)	Monthly
1	*$15,960*	*$1,330*
2	*$21,640*	*$1,804*
3	*$27,320*	*$2,277*
4	*$33,000*	*$2,750*
5	*$38,680*	*$3,224*
6	*$44,360*	*$3,697*
7	*$50,040*	*$4,170*
8	*$55,720*	*$4,644*
Each additional, add	*$5,680*	*$474*

Income Chart Name: Pregnant Women 143% Federal Poverty Level (FPL) Income Limits – All Localities

Effective Date: January 13, 2026

NOTE: A pregnant woman's household is at least two individuals when evaluated in the Pregnant Women covered group.

Household Size	143% FPL Yearly Amount	143% FPL Monthly Amount	148% FPL (143% FPL + 5% FPL Disregard)
2	*$30,946*	*$2,579*	*$2,669*
3	*$39,068*	*$3,256*	*$3,370*
4	*$47,190*	*$3,933*	*$4,070*
5	*$55,313*	*$4,610*	*$4,771*
6	*$63,435*	*$5,287*	*$5,472*
7	*$71,558*	*$5,964*	*$6,172*
8	*$79,680*	*$6,640*	*$6,873*
Each additional, add	*$8,123*	*$677*	*$701*

Income Chart Name: Child Under Age 19 – 143% Federal Poverty Level (FPL) Income Limits – All Localities

Effective Date: January 13, 2026

# of Persons in Household	109% FPL for Determining Aid Category: Monthly Limit	143% FPL: Annual Limit	143% FPL: Monthly Limit	148% FPL (143% FPL + 5% FPL Disregard): Monthly Limit
1	*$1,450*	*$22,823*	*$1,902*	*$1,969*
2	*$1,966*	*$30,946*	*$2,579*	*$2,669*
3	*$2,482*	*$39,068*	*$3,256*	*$3,370*
4	*$2,998*	*$47,190*	*$3,933*	*$4,070*
5	*$3,514*	*$55,313*	*$4,610*	*$4,771*
6	*$4,030*	*$63,435*	*$5,287*	*$5,472*
7	*$4,546*	*$71,558*	*$5,964*	*$6,172*
8	*$5,062*	*$79,680*	*$6,640*	*$6,873*
Each additional, add	*$516*	*$8,123*	*$677*	*$701*

Income Chart Name: Low-Income Families with Children (LIFC) Income Limits
Effective Date: July 1, 2025

NOTE: Refer to Section M0010 in this document for a list of Group I, II and III localities and cities.

Group I Income Chart

Household Size	Monthly Amount	Annual Amount
1	*$329*	*$3,948*
2	*$495*	*$5,940*
3	*$632*	*$7,584*
4	*$764*	*$9,168*
5	*$896*	*$10,752*
6	*$1010*	*$12,120*
7	*$1142*	*$13,704*
8	*$1276*	*$15,312*
Additional	*$139*	*$1,668*

Group II Income Chart

Household Size	Monthly Amount	Annual Amount
1	*$429*	*$5,148*
2	*$609*	*$7,308*
3	*$767*	*$9,204*
4	*$913*	*$10,956*
5	*$1,075*	*$12,900*
6	*$1,209*	*$14,508*
7	*$1,355*	*$16,260*
8	*$1,510*	*$18,120*
Additional	*$155*	*$1,860*

Group III Income Chart

Household Size	Monthly Amount	Annual Amount
1	*$642*	*$7,704*
2	*$859*	*$10,308*
3	*$1,048*	*$12,576*
4	*$1,226*	*$14,712*
5	*$1,452*	*$17,424*
6	*$1,613*	*$19,356*
7	*$1,793*	*$21,516*
8	*$1,983*	*$23,796*
Additional	*$188*	*$2,256*

Income Chart Name: Individuals Under 21 Income Limits
Effective Date: July 1, 2025

NOTE: Refer to Section M0010 in this document for a list of Group I, II and III localities and cities.

Group I Income Chart

Household Size	Monthly Amount	Annual Amount
1	*$315*	*$3,780*
2	*$481*	*$5,772*
3	*$618*	*$7,416*
4	*$747*	*$8,964*
5	*$880*	*$10,560*
6	*$986*	*$11,832*
7	*$1,114*	*$13,368*
8	*$1,253*	*$15,036*
Additional	*$135*	*$1,620*

Group II Income Chart

Household Size	Monthly Amount	Annual Amount
1	*$424*	*$5,088*
2	*$611*	*$7,332*
3	*$765*	*$9,180*
4	*$914*	*$10,968*
5	*$1,079*	*$12,948*
6	*$1,209*	*$14,508*
7	*$1,355*	*$16,260*
8	*$1,509*	*$18,108*
Additional	*$153*	*$1,836*

Group III Income Chart

Household Size	Monthly Amount	Annual Amount
1	*$560*	*$6,720*
2	*$752*	*$9,024*
3	*$907*	*$10,884*
4	*$1,062*	*$12,744*
5	*$1,256*	*$15,072*
6	*$1,383*	*$16,596*
7	*$1,534*	*$18,408*
8	*$1,689*	*$20,268*
Additional	*$154*	*$1,848*

Income Chart Name: Plan First 200% Federal Poverty Level (FPL) Income Limits – All Localities

Effective Date: January 13, 2026

Household Size	200% FPL Yearly Amount	200% FPL Monthly Amount	205% FPL (200% FPL + 5% FPL Disregard)
1	*$31,920*	*$2,660*	*$2,727*
2	*$43,280*	*$3,607*	*$3,697*
3	*$54,640*	*$4,554*	*$4,668*
4	*$66,000*	*$5,500*	*$5,638*
5	*$77,360*	*$6,447*	*$6,608*
6	*$88,720*	*$7,394*	*$7,579*
7	*$100,080*	*$8,340*	*$8,549*
8	*$111,440*	*$9,287*	*$9,519*
Each additional, add	*$11,360*	*$947*	*$971*

Income Chart Name: MAGI Adults 133% Federal Poverty Level (FPL) Income Limits – All Localities

Effective Date: January 13, 2026

Household Size	133% FPL Yearly Amount	133% FPL Monthly Amount	138% FPL (133% FPL + 5% FPL Disregard)
1	*$21,227*	*$1,769*	*$22,025*
2	*$28,782*	*$2,399*	*$29,864*
3	*$36,336*	*$3,028*	*$37,702*
4	*$43,890*	*$3,658*	*$45,540*
5	*$51,445*	*$4,288*	*$53,379*
6	*$58,999*	*$4,917*	*$61,217*
7	*$66,554*	*$5,547*	*$69,056*
8	*$74,108*	*$6,176*	*$76,894*
Each additional, add	*$7,555*	*$630*	*$7,839*

FAMILIES & CHILDREN INCOME

Income Chart Name: Families & Children Medically Needy Income Limits
Effective Date: July 1 2025

NOTE: The income charts in this section are associated with Chapter M07 – Families and Children Income of the Medical Assistance Eligibility Manual. Refer to the Reference Information – Grouping of Localities section in this document for a list of Group I, II and III localities and cities.

Group I Income Chart

# of Persons in Family/Budget Unit	Semi-Annual Income	Monthly Income
1	*$2,460.34*	*$410.05*
2	*$3,132.06*	*$522.01*
3	*$3,690.53*	*$615.08*
4	*$4,163.71*	*$693.95*
5	*$4,636.86*	*$772.81*
6	*$5,110.01*	*$851.66*
7	*$5,583.16*	*$930.52*
8	*$6,150.95*	*$1,025.15*
Each additional person	*$635.84*	*$105.97*

Group II Income Chart

# of Persons in Family/Budget Unit	Semi-Annual Income	Monthly Income
1	*$2,838.87*	*$473.14*
2	*$3,495.33*	*$582.55*
3	*$4,069.08*	*$678.18*
4	*$4,542.24*	*$757.04*
5	*$5,015.39*	*$835.89*
6	*$5,488.55*	*$914.75*
7	*$5,961.70*	*$ 993.61*
8	*$6,529.48*	*$1,088.24*
Each additional person	*$635.84*	*$105.97*

Group III Income Chart

# of Persons in Family/Budget Unit	Semi-Annual Income	Monthly Income
1	*$3,690.53*	*$615.08*
2	*$4,449.18*	*$741.53*
3	*$5,015.39*	*$835.89*
4	*$5,488.55*	*$914.75*
5	*$5,961.70*	*$993.61*
6	*$6,434.85*	*$1,072.47*
7	*$6,908.00*	*$1,151.33*
8	*$7,381.18*	*$1,230.19*
Each additional person	*$635.84*	*$105.97*

Income Chart Name: Families & Children 100% Standard of Assistance
Effective Date: July 1 2025

NOTE: Used as the Families and Children Deeming Standard.

Group I Income Chart

Household Size	Income Limit
1	*$324*
2	*$486*
3	*$619*
4	*$752*
5	*$882*
6	*$995*
7	*$1,120*
8	*$1,257*
Each additional person	*$137*

Group II Income Chart

Household Size	Income Limit
1	*$422*
2	*$599*
3	*$755*
4	*$897*
5	*$1,055*
6	*$1,191*
7	*$1,334*
8	*$1,485*
Each additional person	*$153*

Group III Income Chart

Household Size	Income Limit
1	*$632*
2	*$844*
3	*$1,031*
4	*$1,208*
5	*$1,426*
6	*$1,586*
7	*$1,767*
8	*$1,953*
Each additional person	*$185*

AGED, BLIND & DISABLED (ABD) INCOME LIMITS

Last Section Revision Date: January 2026

NOTE: The income charts in this section are associated with Chapter M08 – Aged, Blind and Disabled (ABD) of the Medical Assistance Eligibility Manual. Refer to the Reference Information – Grouping of Localities section in this document for a list of Group I, II and III localities and cities.

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

A. Categorically Needy Overview

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.

B. Categorically Needy Protected Cases Only

Income Chart Name: Categorically Needy Protected Covered Groups Which Use SSI Income Limits
Effective Date: January 2026

Family Unit Size	2025 Monthly Amount	2026 Monthly Amount
1	$967	*$994*
2	$1,450	*$1,490*

Income Chart Name: Individual or Couple Whose Total Food and Shelter Needs are Contributed to the Individual or Couple
Effective Date: January 2026

Family Unit Size	2025 Monthly Amount	***2026 Monthly Amount***
1	$645	*$663*
2	$967	*$994*

C. Categorically Needy 300% of SSI

Income Chart Name: Categorically Needy 300% of SSI
Effective Date: January 2026

NOTE: 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 Unit Size	2025Monthly Amount	2026 Monthly Amount
1	$2,901	*$2,982*

D. ABC Medically Needy

Income Chart Name: Aged, Blind, Disabled (ABD) Medically Needy
Effective Date: July 2025

Group I Income Chart

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

Group II Income Chart

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

Group III Income Chart

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

E. ABD Categorically Needy

Acronym Definitions Used in the Following Income Charts

- **ABD** – Aged, Blind, Disabled
- **FPL** – Federal Poverty Limit
- **QDWI** – Qualified Disabled Working Individuals
- **QI** – Qualifying Individual
- **QMB** – Qualified Medicare Beneficiary
- **SLMB** – Specified Low-Income Medicare Beneficiary
- **SSI** – Social Security Income

The following income charts are for:

- ABD 80% FPL, QMB, SLMB, and QI without Social Security income; all QDWI
  - Effective *1/15/25*
  - All Localities

- ABD 80% FPL, QMB, SLMB, and QI with Social Security income
  - Effective *3/1/25*
  - All Localities

Income Chart Name: Aged, Blind, Disabled (ABD) Categorically Needy for 80% FPL
Effective Date: January 13, 2026 for those without SSI; March 1, 2026 for those with SSI

Family Unit Size	2025 Annual	2025 Monthly	2026 Annual	2026 Monthly
1	$12,520	$1,044	*$12,768*	*$1,064*
2	$16,920	$1,410	*$17,312*	*$1,443*

Income Chart Name: Aged, Blind, Disabled (ABD) Categorically Needy for QMB 100% FPL
Effective Date: January 13, 2026 for those without SSI; March 1, 2026 for those with SSI

Family Unit Size	2025 Annual	2025 Monthly	2026 Annual	2026 Monthly
1	$15,650	$1,305	$15,960	$1,330
2	$21,150	$1,763	$21,640	$1,804

Income Chart Name: Aged, Blind, Disabled (ABD) Categorically Needy for SLMB 120% of FPL
Effective Date: January 13, 2026 for those without SSI; March 1, 2026 for those with SSI

Family Unit Size	2025 Annual	2025 Monthly	2026 Annual	2026 Monthly
1	$18,780	$1,565	$19,152	$1,596
2	$25,380	$2,115	$25,968	$2,164

Income Chart Name: Aged, Blind, Disabled (ABD) Categorically Needy for QI 135% of FPL
Effective Date: January 13, 2026 for those without SSI; March 1, 2026 for those with SSI

Family Unit Size	2025 Annual	2025 Monthly	2026 Annual	2026 Monthly
1	$21,128	$1,761	$21,546	$1,796
2	$28,553	$2,380	$29,214	$2,435

Income Chart Name: Aged, Blind, Disabled (ABD) Categorically Needy for QDWI 200% of FPL
Effective Date: January 13, 2026

Family Unit Size	2025 Annual	2025 Monthly	2026 Annual	2026 Monthly
1	$31,300	$2,609	$31,920	$2,660
2	$42,300	$3,525	$43,280	$3,607

12-MONTH EXTENDED MEDICAID INCOME LIMITS

Last Section Revision Date:

NOTE: The income chart in this section is associated with Chapter M15 – Entitlement Policy & Procedures of the Medical Assistance Eligibility Manual.

Income Chart Name: Twelve Month Extended Medicaid Income Limits – 185% of Federal Poverty Limits: All Localities

Effective *1/17/24*

# of Persons in Family Unit / Budget Unit	185% FPL Monthly Limit
1	*$2,322*
2	*$3,152*
3	*$3,981*
4	*$4,810*
5	*$5,640*
6	*$6,469*
7	*$7,299*
8	*$8,128*
Each additional, add	*$830*

FAMIS INCOME LIMITS

Last Section Revision Date: January 2026

NOTE: The income charts in this section are associated with Chapter M21 – FAMIS of the Medical Assistance Eligibility Manual.

Income Chart Name: FAMIS Income Limits - All Localities
Effective *1/13/26*

# of Persons in FAMIS Household	150% FPL Annual Limit	150% FPL Monthly Limit
1	*$23,940*	*$1,995*
2	*$32,460*	*$2,705*
3	*$40,980*	*$3,415*
4	*$49,500*	*$4,125*
5	*$58,020*	*$4,835*
6	*$66,540*	*$5,545*
7	*$75,060*	*$6,255*
8	*$83,580*	*$6,965*
Each additional, add	*$8,520*	*$710*

# of Persons in FAMIS Household	200% FPL Annual Limit	200% FPL Monthly Limit
1	*$31,920*	*$2,660*
2	*$43,280*	*$3,607*
3	*$54,640*	*$4,554*
4	*$66,000*	*$5,500*
5	*$77,360*	*$6,447*
6	*$88,720*	*$7,394*
7	*$100,080*	*$8,340*
8	*$111,440*	*$9,287*
Each additional, add	*$11,360*	*$947*

# of Persons in FAMIS Household	205% FPL Annual Limit (200% FPL + 5% Disregard as Displayed in VaCMS)
1	*$2,727*
2	*$3,697*
3	*$4,668*
4	*$5,638*
5	*$6,608*
6	*$7,579*
7	*$8,549*

# of Persons in FAMIS Household	205% FPL Annual Limit (200% FPL + 5% Disregard as Displayed in VaCMS)
8	*$9,519*
Each additional, add	*$971*

FAMIS MOMS INCOME LIMITS

NOTE: The income chart in this section is associated with Chapter M22 – FAMIS Moms of the Medical Assistance Eligibility Manual.

Income Chart Name: FAMIS Moms 200% FPL Income Limits - All Localities
Effective: *1/13/26*

Household Size	200% FPL Yearly Amount	200% FPL Monthly Amount	205% FPL (200% FPL + 5% FPL Disregard as Displayed in VaCMS)
2	*$43,280*	*$3,607*	*$3,697*
3	*$54,640*	*$4,554*	*$4,668*
4	*$66,000*	*$5,500*	*$5,638*
5	*$77,360*	*$6,447*	*$6,608*
6	*$88,720*	*$7,394*	*$7,579*
7	*$100,080*	*$8,340*	*$8,549*
8	*$111,440*	*$9,287*	*$9,519*
Each additional, add	*$11,360*	*$947*	*$971*

FAMIS PRENATAL COVERAGE INCOME LIMITS

NOTE: The income charts in this section are associated with Chapter M23 – FAMIS Prenatal Coverage of the Medical Assistance Eligibility Manual.

Income Chart Name: FAMIS Prenatal Coverage 200% FPL Income Limits - All Localities
Effective: *1/13/26*

Enroll Using Aid Category 110

Household Size	143% FPL Yearly Amount	143% FPL Monthly Amount	148% FPL (143% FPL + 5% FPL Disregard)
2	*$30,946*	*$2,579*	*$2,669*
3	*$39,068*	*$3,256*	*$3,370*
4	*$47,190*	*$3,933*	*$4,070*
5	*$55,313*	*$4,610*	*$4,771*
6	*$63,435*	*$5,287*	*$5,472*
7	*$71,558*	*$5,964*	*$6,172*
8	*$79,680*	*$6,640*	*$6,873*
Each additional, add	*$8,123*	*$677*	*$701*

Enroll Using Aid Category 111

Household Size	200% FPL Yearly Amount	200% FPL Monthly Amount	205% FPL (200% FPL + 5% FPL Disregard)
2	*$43,280*	*$3,607*	*$3,697*
3	*$54,640*	*$4,554*	*$4,668*
4	*$66,000*	*$5,500*	*$5,638*
5	*$77,360*	*$6,447*	*$6,608*
6	*$88,720*	*$7,394*	*$7,579*
7	*$100,080*	*$8,340*	*$8,549*
8	*$111,440*	*$9,287*	*$9,519*
Each additional, add	*$11,360*	*$947*	*$971*

Changed With	Effective Date	Pages Changed
TN #DMAS-38	4/1/26	Page 24
TN #DMAS-36	10/1/25	Page 30a ; Appendix 1
TN #DMAS-35	7/1/25	Pages 5 and 28, Appendix 1
TN #DMAS-33	10/1/24	Page 28
TN #DMAS-29	10/1/23	Page 5
TN #DMAS-26	1/1/23	Pages 2, 28b Appendix 1
TN #DMAS-24	7/1/22	Page 36 Page 37 is a runover page.
TN #DMAS-23	4/1/22	Pages 2, 5, 6, 6a
TN #DMAS-22	1/1/22	Page 28
TN #DMAS-20	7/1/21	Page 6 Pages 5 and 5a are runover pages.
TN #DMAS-18	1/1/21	Table of Contents, page ii Pages 26, 27 Appendix 1 was removed. Appendix 2 was renumbered to Appendix 1.
TN #DMAS-17	7/1/20	Page 7 Pages 8 and 9 are runover pages.
TN #DMAS-15	1/1/20	Pages 29, 30
TN #DMAS-14	10/1/19	Pages 24, 26, 27, 40
TN #DMAS-13	7/1/19	Pages 24 Page 24a is a runover page.
TN #DMAS-12	4/1/19	Pages 8, 9, 13
TN #DMAS-10	10/1/18	Table of Contents, page ii Pages 1-4 Page 40 was added.
TN #DMAS-9	7/1/18	Page 35 Appendix 2, Page 1
TN #DMAS-8	4/1/18	Page 9
TN #DMAS-7	1/1/18	Pages 34, Appendix 2, page 1
TN #DMAS-5	7/1/17	Pages 13, 37, 38
TN #DMAS-4	4/1/17	Pages 24, 30a Page 23 is a runover page. Page 24a was added as a runover page.

1. Individual Under Age 19 and Not Receiving Long-term Care

A child under age 19 who is not receiving LTC services and who is claiming to have a disabling condition must have his disability determined by DDS if:

- he is not eligible for FAMIS Plus or FAMIS, or
- it is 90 calendar days prior to his 19th birthday.

Do **NOT** refer a disabled child under age 19 to DDS for the sole purpose of participation in the Health Insurance Premium Payment (HIPP) program

2. Individual Under 21 in LTC

a. Facility-based Care

An individual under age 21 in a nursing facility or intermediate care facility for the intellectually disabled (ICF-ID) must have his disability determined if

- he is not eligible in the Individuals Under 21 covered group, or
- it is 90 calendar days prior to his **21st** birthday.

b. **Home and Community-based Services (HCBS)**

A child who is receiving HCBS waiver services and has not previously had a disability determination must have his disability determined prior to his **18th** birthday because he will no longer be eligible in the F&C 300% SSI covered group (under which parental income is not counted), once he turns 18. The child must be evaluated for coverage as a blind or disabled individual using the income and resource rules applicable to blind/disabled institutionalized individuals. For a child under 19 who is not disabled, MAGI income counting rules require that parental income be included in the eligibility determination.

Ninety days (90) prior to the child turning age 18, the eligibility worker must contact the parent or responsible party and send a verification checklist to request the required documents to start the DDS referral process. Follow the procedure in M0310.112 G below to make a referral to DDS. *Continuous Enrollment protections will apply until the earlier of: the month that the child turns 19 or the month that their 12-month protected period ends.*

Note: The local DSS is not responsible for initiating a DDS referral for a child turning 18 who receives SSI. The child will have a review of continuing disability and SSI eligibility completed by the SSA. The child remains disabled for Medicaid purposes unless and until his disability status is discontinued by SSA.

E. When an LDSS Referral to DDS is Required

1. Disability Determination Has Not Been Made

The DDS must make a determination of disability when the applicant alleges a disability and a disability determination has not been made by SSA or the RRB. The DDS must make a disability determination within a time frame that will allow the LDSS to process the application within 90 days, provided all medical information has been submitted.

M0320 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-38	4/1/26	Page 33
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

M0320.502 ABD RECEIVING MEDICAID WAIVER SERVICES (CBC)

A. Policy

42 CFR 435.217 - The state plan includes the covered group of aged, blind or disabled individuals in the community who

- would be eligible for Medicaid if institutionalized;
- are authorized to receive Medicaid waiver services and have selected the option to receive Medicaid waiver services in lieu of nursing facility services;
- in the absence of the waiver services would require the level of care furnished in a hospital, nursing facility or ICF-MR; and
- have income that does not exceed 300% of the SSI individual payment limit (see M0810.002 A. 3).

Do not wait until the individual starts to receive the waiver services to determine eligibility in this covered group. Determine eligibility in this covered group if the individual is authorized (see subchapter M1420) to receive Medicaid waiver services and has selected the option to receive Medicaid waiver services in lieu of nursing facility services. Presume the individual will receive the services and go on to determine financial eligibility using the policy and procedures in C. below.

If the individual's eligibility was determined as an institutionalized individual prior to the receipt of waiver services, the EW must verify the receipt of Medicaid CBC services within *180* days of the date of the Notice of Action on Medicaid. If Medicaid CBC services did not start within *180* days of the date of the Notice of Action on Medicaid, the individual's continued eligibility must be re-evaluated as a non-institutionalized individual.

B. Financial Eligibility

1. Asset Transfer

The individual must meet the asset transfer policy in subchapter M1450.

2. Resources

a. Resource Eligibility - Unmarried Individual

All of the individual’s resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements in chapter S11 (ABD Resources). Pay close attention to:

1) equity in non-exempt property contiguous to the individual’s home which exceeds $5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property, and
2) ownership of his/her former residence when the individual has been away from his home property for longer than 6 months. Determine if the home property is excluded in M1130.100.

DO NOT DEEM any resources from a blind or disabled child’s parent

Changed With	Effective Date	Pages Changed
TN #DMAS-38	4/1/26	Page 15
TN #DMAS-35	7/1/25	Pages 1 and 9
TN #DMAS-33	10/1/24	Pages 1a, 24
TN #DMAS-32	7/1/24	Page 1a, 4
TN #DMAS-31	4/1/24	Pages 8, 26-28
TN #DMAS-30	1/1/24	Pages 1, 2, 4, 6, 8, 10, 12, 17, 20, 23, 34, 35, 38, 40
TN #DMAS-26	1/1/23	Page 10
TN #DMAS-24	7/1/22	Pages 1, 2, 15, 18, 29, 31, 32 Page 2a was added as a runover page.
TN #DMAS-23	4/1/22	Table of Contents Pages 1, 2, 5, 7, 8, 29, 37, 39, 40
TN #DMAS-20	7/1/21	Pages 1, 13, 14
TN #DMAS-19	4/1/21	Pages 14, 26
TN #DMAS-14	10/1/19	Pages 1, 2, 10a
TN #DMAS-12	4/1/19	Pages 26, 28
TN #DMAS-11	1/1/19	Pages 1, 2, 12, 14-16, 24, 25
TN #DMAS-10	10/1/18	Table of Contents Page 1-2, 30 Page 10a-b were added as runover pages.

For example, a married pregnant woman applies for Medicaid on October 10. She received a medical service in the retroactive period. Her expected delivery date is January 15. She and her husband have been unemployed since June 23. Her husband began earning $3,000 a month on October 9; she remains unemployed. Since they had no income during the retroactive period, she is found eligible for retroactive coverage effective July 1.

Because her available income (from her husband) changed after she established eligibility on July 1, the change in income does not affect her eligibility and she remains eligible for Medicaid in October and subsequent months until she no longer meets the pregnant woman definition or other nonfinancial requirements.

b. Newborn

Income changes do NOT affect the certain newborn's eligibility for the first year of the child's enrollment as a certain newborn.

The mother's failure to complete a renewal of her own eligibility and/or the eligibility of other children in the household does NOT affect the eligibility of the certain newborn.

5. Income Exceeds Limit

If the pregnant woman's income exceeds the 143% FPL limit, she is not eligible in this covered group. Determine her eligibility for FAMIS MOMS. If the pregnant woman is not eligible for FAMIS MOMS, evaluate her eligibility as MN (see M0330.801). Ineligible women, other than incarcerated women, must be referred to the Health Insurance Marketplace for evaluation for the APTC.

D. Entitlement

Eligible pregnant women 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 woman was pregnant during the retroactive month(s).

The newborn's Medicaid coverage begins the date of the child's birth. A renewal must be completed for the newborn in the last month in which the child meets the Newborn Children Under Age 1 covered group and must include SSN or proof of application, as well as verification of income.

Eligible pregnant women and newborns are entitled to all Medicaid covered services as described in chapter M18.

After her eligibility is established as a pregnant woman, the woman's Medicaid entitlement continues for 12 months following the end of the month in which her pregnancy ends *(including by miscarriage)*, regardless of income changes. Medicaid coverage ends the last day of the 12th month.

If a Medicaid or FAMIS MOMS recipient who applied effective November 1, 2021 [or a CHIPRA214 (lawfully residing individual) who applied effective April 1, 2022] whose pregnancy has ended reapplies for coverage after July 1, 2022, she is entitled to the remainder of the 12 month post-partum period she would have received had her coverage not been canceled.

E. Enrollment

The AC for pregnant women who are not incarcerated is 091. The AC for pregnant women who are incarcerated is 109. The AC for newborns born to women who were enrolled in Medicaid is 093.

M0520 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-38	4/1/26	Page 2
TN #DMAS-33	10/1/24	Page 4
TN #DMAS-19	4/1/21	Page 2
TN #DMAS-12	4/1/19	Page 1, 2
TN #DMAS-10	10/1/18	Page 2
TN #DMAS-3	1/1/17	Table of Contents Pages 3, 5-35 Pages 36-38 were removed.
TN #100	5/1/15	Page 2
TN #98	10/1/13	Title Page Table of Contents Pages 1,2,9
UP #7	7/1/12	Table of Contents Pages 2-5
Update (UP) #4	7/1/10	Pages 2, 2a

4. Psychiatric Residential Treatment Facilities (PRTFs)

Children residing in a PRTF (formerly called a Level C PRTF) are not temporarily absent from home. They are indefinitely absent from home and are not living with their parents or siblings for Medicaid purposes, if their stay in the facility has been 30 calendar days or longer. Long-term care rules do not apply to these children.

If the child is placed in a PRTF, verify that the facility is on the *DMAS* website at *Rate Setting*. *Scroll down and c*lick on ***Behavioral Health; PRTF/ARTS; Rates Effective July 1, 2025***. If the facility is not a PRTF facility, the child is NOT considered living away from his parents.

5. Medical Facilities

Children in medical institutions (facilities) are temporarily absent from home if their stay in the medical facility is less than 30 consecutive days. If the stay has been, or is expected to be, 30 or more consecutive days, go to section M1410.010 to determine if the child is institutionalized in long-term care. A child who is institutionalized in a medical facility or Medicaid waiver services is NOT considered living with his or her parents for Medicaid eligibility purposes.

6. Parent/ Caretaker-Relative Living in the Home

A parent/caretaker-relative who is absent from the home is considered living with a child in the household if the absence is temporary and the parent/caretaker-relative intends to return home when the purpose of the absence (such as military service, vacation, education, medical care or rehabilitation) is complete.

C. Procedure

This section contains an overview of the F&C family unit and budget unit rules. The detailed policy and procedures are contained in the following sections:

- M0520.010 Definitions;
- M0520.100 Family Unit Rules;
- M0520.200 Budget Unit Rules;
- M0520.300 Deeming From Spouse;
- M0520.400 Deeming From Parent;
- M0520.500 Changes In Status;
- M0520.600 Pregnant Woman Budget Unit;
- M0520.700 Individual Under Age 21 Family Unit.

Virginia Medical Assistance Eligibility Manual

Chapter M18
Medical Services

Chapter M18 Changes

Date Converted to New Template: October 2025

Changed With	Effective Date	Subchapters Changed
TN #DMAS-26	1/1/23	Pages 6a, 7 and 8
TN #DMAS-22	1/1/22	Page 8 Page 7 is a runover page.
TN #DMAS-20	7/1/21	Page 7 Page 8 is a runover page.
TN #DMAS-12	04/01/2019	Page 3, 5
TN #DMAS -11	01/01/2019	Page 3
TN #DMAS-10	10/1/18	Pages 3-5
TN #DMAS-6	10/1/17	Table of Contents Pages 3-5 Page 6 is a runover page. Page 6a was added.
TN #100	5/1/15	Table of Contents Pages 1-9 Pages 10-17 were deleted. Appendix 1 was removed.
UP #9	4/1/13	Page 3
UP #7	7/1/12	Page 12
TN #96	10/01/11	Pages 3, 4, 16
TN #95	3/1/11	Page 9
TN #94	9/1/10	Page 12
TN #93	1/1/10	Pages 4, 5
TN #91	5/15/09	Page 2 Pages 5, 6 Page 8

TN – Transmittal

UP – Update

Table of Contents

Subchapter M1810: Medicaid Eligibility Card 1
M1810 Changes 1
Section M1810.100: Medicaid Eligibility Card 2
Subchapter M1820: Service Providers 4
M1820 Changes 4
Section M1820.100: Service Providers 5
Subchapter M1830: Managed Care 6
M1830 Changes 6
Section M1830.100: Managed Care 7
Subchapter M1840: Utilization Review and Client Medical Management 11
M1840 Changes 11
Section M1840.100: Utilization Review and Client Medical Management 12
Subchapter M1850: Covered Services 13
M1850 Changes 13
Section M1850.100: Covered Services 14
Subchapter M1860: Services Received Outside Virginia 17
M1860 Changes 17
Section M1860.100: Services Received Outside Virginia 18

Subchapter M1810: Cardinal.Care.**Medicaid Eligibility Card**

Last Subchapter Revision Date: 4/1/2026

M1810 CHANGES

Changed With	Effective Date	Sections Changed
TN #DMAS-38	4/1/26	M1810.100

TN – Transmittal
UP – Update

SECTION M1810.100: CARDINAL.CARE.MEDICAID ELIGIBILITY CARD

Last Section Revision Date: April 2026

A. *Cardinal Care* Medicaid Card Issuance

A *Cardinal Care* Medicaid card is issued to an individual who has been found eligible for Medicaid and is enrolled with the Department of Medical Assistance Services (DMAS). The card is plastic with the enrollee's name, gender and birth date on the front, and a strip on the back that providers can "swipe" to *determine* the type of coverage and the begin date of coverage. The card is intended to be permanent. Presentation of the card to the Medicaid-enrolled (certified) provider of medical services authorizes the provider to bill Medicaid for the needed services, if such services are covered by the Medical Assistance Program and DMAS has pre-authorized the service, when pre-authorization is required.

EXCEPTION: The following recipients do not receive a *Cardinal Care* Medicaid card:

- individuals eligible for Medicare premium payment only,
- individuals enrolled in a closed period of coverage in the past with no ongoing coverage, and
- incarcerated individuals eligible for Medicaid payment of inpatient hospitalization services only.

B. Use of the *Cardinal Care* Medicaid Card

1. **General**

   Local social services departments must provide recipients with information concerning use of the *Cardinal Care* Medicaid card. This includes information that misuse of the card is fraud and can result in prosecution. Examples of misuse include:

   - using the card following cancellation of eligibility,
   - alteration of names, dates, or other information to secure medical care to which the individual is not entitled, and
   - knowingly permitting another person to use an individual's card to secure medical care.

2. **Foster Care Children in Institutional Facilities**

   The local department of social services (LDSS) should use the local department's address when enrolling a foster care child whose custody is held by the local department of social services and who is placed in an institution. Upon receipt of

the Medicaid card, it should be sent to the appropriate institution for use on the child's behalf. The local department has the responsibility of advising the child caring institution of the medical and dental services covered by Medicaid.

3. **Nursing Facility Patients**

   Patients in nursing facilities receive *Cardinal Care* Medicaid cards. The nursing facility also receives a computer-generated list at the first of the month which lists all eligible Medicaid patients in that facility.

   This report reflects only those Medicaid-eligible patients for whom the nursing facility has submitted an "admission packet."

   DMAS staff enters the patient information into the system and assigns a patient control number to the facility for use in billing Medicaid for the patient's care.

   When a patient dies or is discharged from the facility, the facility is responsible for notifying DMAS and the LDSS of the date of discharge or death. Long-term *Services and Supports* (LT*SS*) providers have been instructed to notify the LDSS of death or discharge via the Medicaid Long-term Care Communication Form (DMAS-225).

Subchapter M1820: Service Providers

Last Subchapter Revision Date: April 2026

M1820 CHANGES

Changed With	Effective Date	Sections Changed
TN #DMAS-38	4/1/26	M1820.100

TN – Transmittal

UP – Update

SECTION M1820.100: SERVICE PROVIDERS

Last Section Revision Date: April 2026

A. Enrollment Requirement

Providers of medical services must be enrolled by DMAS to receive Medicaid payment for their services. Lists of enrolled providers are available to local departments of social services and enrollees from DMAS and are available online at www.dmas.virginia.gov.

B. Out-of-State Providers

1. **Covered Services**

   Medicaid will cover medical services rendered by out-of-state providers when the use of such providers is:

   - the general custom of the eligible individual (e.g., a recipient living near the border of another state),
   - needed by a non IV-E Foster Care child placed outside Virginia,
   - necessitated when an eligible person is temporarily outside Virginia and has a medical emergency, or
   - indicated because of referral to an out-of-state facility when preauthorized by DMAS.

2. **Provider Enrollment**

   In instances where an out-of-state provider is not currently enrolled as a DMAS provider, DMAS will accept the provider's initial billing and will contact the provider to determine the provider's wish to become enrolled so that subsequent services can be paid through the computerized Medicaid claims processing system. *New Enrollment webpage can be accessed to enroll the provider online.*

Subchapter M1830: Managed Care

Last Subchapter Revision Date: April 2026

M1830 CHANGES

Changed With	Effective Date	Sections Changed
TN #DMAS-38	4/1/26	M1830.100

TN – Transmittal

UP – Update

SECTION M1830.100: MANAGED CARE

Last Section Revision Date: April 2026

A. General Information

DMAS provides Medicaid coverage to enrollees primarily through two delivery systems: fee-for-service (FFS) and managed care. FFS benefits are administered by DMAS through participating providers within the traditional Medicaid program rules. Most Virginia Medicaid enrollees including individuals with other forms of health insurance (TPL) are required to receive medical care through a managed care organization.

B. *Cardinal Care*

The *Cardinal Care* managed care program is administered through DMAS' contracted managed care organizations (MCOs). *On October 1, 2023, Virginia Medicaid combined the two managed care programs of Medallion 4.0 and Commonwealth Coordinated Care Plus (CCC Plus) into Cardinal Care Managed Care (CCMC). CCMC continues to offer members the same programs and services and does not reduce or change any existing coverage. CCMC are categorized in two benefit plans/populations:*

- *Acute (previously Medallion 4.0) and MLTSS (previously CCC Plus).*
    - *Provides services to qualified members in the areas of maternity care, including early prenatal care, case management, and postpartum care; care for infants and children (including foster care), including early intervention services, immunizations, screening, and preventive care; and wellness, behavioral health, community mental health services, behavioral therapy, family planning and chronic disease support for adults.*
- *MLTSS (Managed Long-term Services and Supports):*
    - *Designed to assist individuals with health or personal needs, activities of daily living, and instrumental activities of daily living over a period. LTSS can be provided at home, in the community, or in various types of facilities, including Nursing Facilities.*
    - *MLTSS is meant for members who cannot perform daily living tasks, private care can come to members' homes or communities to provide additional services.*

Some enrollees in the groups below are *served through Fee for Service* because they meet exclusionary criteria. The following is a **partial** list of enrollees excluded from managed care enrollment:

- Enrollees who meet a spenddown and are enrolled for a closed period of coverage
- Enrollees who are participating in Plan First

- Enrollees who have an eligibility period that is less than three months or who have an eligibility period that is only retroactive
- *Limited covered groups – Plan First, Qualified Medicare Beneficiaries (QMB) only, Special Low-income Medicare Beneficiaries (SLMB), and Qualified Individuals (QI)*
- *Enrollees in specialized settings – intermediate care facilities for individuals with intellectual disability (ICF-ID), Veterans' nursing facilities, psychiatric residential treatment facilities (PRTF), the Virginia Home, and the Piedmont, Catawba and Hancock state facilities*
- *Enrollees in hospice care (CCC Plus who elect hospice will remain in CCC Plus.)*
- *Enrollees in other programs – Medicaid or FAMIS Medallion 4.0 managed care, and the Program for All-inclusive Care for the Elderly (PACE)*

All *Cardinal Care* health plans offer enhanced benefits to members including, but not limited to:

- Boys and Girls Club membership (6-18 olds)
- Cell phone
- Centering pregnancy program
- Free meal delivery after inpatient hospital stays
- GED for Foster Care
- Sports physical at no cost (under age 21)
- Swimming lessons for members six (6) years and younger
- Vision for adults

NOTE: Not all health plans will offer all of the same enhanced benefits

Enrollees excluded from mandatory managed care enrollment shall receive Medicaid services under the current fee-for-service system. When enrollees no longer meet the criteria for exclusion, they shall be required to enroll in the appropriate managed care program.

Enrollees and their families may contact the Managed Care *Cardinal Care* Helpline at 1-800-643-2273 for information and assistance.

C. Managed Care Helpline

Eligible individuals can enroll in an MCO or obtain additional information, as well as assistance with coverage issues, by calling the Managed Care *Cardinal Care* Helpline at 1-800-643-2273 (TTY/TDD 1-800-817-6608). The Helpline is available Monday through Friday from 8:30 a.m. until 6:00 p.m. Information is available online at www.virginiamanagedcare.com.

D. Family Access to Medical Insurance Security Plan (FAMIS) Managed Care

FAMIS benefits are *also* administered through *Cardinal Care (*DMAS contracted MCOs) or through FAMIS fee-for-service.

In all areas of the Commonwealth, FAMIS enrollees have the choice between *5* MCOs. When a child is first enrolled in FAMIS, *they are* able to access health care through the FAMIS fee-for-service program. Within 1 or 2 months after FAMIS enrollment, the child will be enrolled with a *Cardinal Care* MCO.

FAMIS benefits are slightly different than the benefits that children enrolled in Medicaid receive.

FAMIS enrollees may receive nurse practitioner services, nurse midwife services, and private duty nursing services. Skilled nursing services provided by a Local Education Association (LEA) include medical evaluations or assessments, state mandated health screenings, and other services that are determined to be necessary to assess, monitor, and provide nursing interventions to prevent or maintain health or a medical condition, under the scope of a licensed school nurse (RN or LPN working under the supervision of an RN).

Additionally, FAMIS enrollees are eligible for up to 180 days of Nursing Facility services in accordance with the base benchmark plan.

The following is a partial list of services (while covered under Medicaid) are **NOT** covered under FAMIS.

- Early and Period Screening Diagnosis and Treatment (EPSDT) services are not covered for FAMIS MCO members. Many of the services that are covered as EPSDT services by Medicaid are covered under FAMIS MCO's well child and immunization benefits. EPSDT services **are** covered for FAMIS FFS members because they receive the Medicaid benefit package.
- Psychiatric treatment in free standing facilities is not covered under FAMIS. However, psychiatric treatment is covered when provided in a psychiatric unit of an acute hospital.
- Routine transportation to and from medical appointments is not covered for FAMIS enrollees. Children enrolled in FAMIS FFS may receive non-emergency transportation services. Emergency transportation is covered for *all* FAMIS enrollees.
- Intensive in-home, therapeutic day treatment, mental health crisis intervention, and case management for children at risk of or experiencing a serious emotional disturbance are covered under FAMIS. Other community mental health rehabilitation services are not covered.

Eligible FAMIS individuals can enroll in an MCO or obtain additional information, as well as assistance with coverage issues, by calling Cover Virginia at 1-855-242-8282, Monday through Friday from 8:00 a.m. until 7:00 p.m. and Saturdays from 9:00 a.m. – noon. Information is also available online at *Home | CoverVA*.

A summary of FAMIS covered services can be found online at: *Medicaid for Children and FAMIS | CoverVA*

E. Enrollment Corrections/Changes

DMAS pays a capitation rate for every month an individual is enrolled in managed care regardless of whether the individual receives *Cardinal Care* during the month. If an individual is incorrectly enrolled in a Medicaid managed care program, the eligibility worker must refer the case to DMAS at the following address for possible recovery of expenditures (see chapter M1700):

Recipient Audit Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Subchapter M1840: Utilization Review and Client Medical Management

Last Subchapter Revision Date: October 2017

M1840 CHANGES

Changed With	Effective Date	Sections Changed

TN – Transmittal
UP – Update

SECTION M1840.100: UTILIZATION REVIEW AND CLIENT MEDICAL MANAGEMENT

Last Section Revision Date: October 2017

A. Utilization Review

Federal regulations require the Department of Medical Assistance Services (DMAS) to regularly review recipients' use and need for the covered medical services they receive. Regulations require that Medicaid pay only for medically necessary covered medical services. Medicaid cannot pay for duplicate services since they are not necessary.

DMAS staff in the Program Integrity Division reviews provider claims and recipient utilization histories for medical necessity. If it is determined that services were not medically necessary, providers are obligated to reimburse DMAS for any Medicaid payment they have received.

B. Client Medical Management (CMM) Program

An enrollee’s utilization of Medicaid cards for physicians' services and pharmaceutical services is monitored regularly by DMAS. Whenever the utilization of one or both of these services is unusually high, the services will be reviewed for medical necessity. If some services are considered not medically necessary, recipients who are not enrolled in a managed care program will be placed in the CMM Program and required to select a primary physician and/or pharmacy or both.

Individuals identified as high utilizers will receive a letter of notification with instructions about selecting primary providers and identifying those providers to DMAS. Individuals who do not respond to the letter within the specified time will have their primary physician and pharmacy designated by DMAS.

For recipients who have been placed in the CMM Program, Medicaid payment for physicians' services will be limited to those services rendered by the primary physician (including a physician providing services to the patients of the primary physician when the primary physician is not available), physicians seen on referral from the primary physician, and emergency medical services.

Prescriptions may be filled by a non-designated pharmacy only in emergency situations when the designated pharmacy is closed or cannot readily obtain the drug.

Subchapter M1850: Covered Services

Last Subchapter Revision Date: January 2023

M1850 CHANGES

Changed With	Effective Date	Sections Changed

TN – Transmittal

UP – Update

SECTION M1850.100: COVERED SERVICES

Last Section Revision Date: January 2023

A. General Information

Information on Medicaid covered services is provided to assist the eligibility worker in responding to general inquiries from applicants/recipients. Individuals who have problems with bills or services from providers of care should be referred as follows:

- Refer FFS Medicaid enrollees to the DMAS Recipient Helpline at 804-786-6145. Refer individuals who need assistance with transportation to the DMAS transportation broker at 1-866-386-8331.
- Refer individuals enrolled in managed care to the Managed Care Helpline at 1-800-643-2273 or directly to their MCO. Individuals in managed care who need assistance with transportation must contact their MCO directly.

B. Copayments

1. **Medicaid Enrollees without Medicare**

   Medicaid covered services *no longer* have a "copayment," which is the portion of the cost of the service for which the recipient is responsible.

2. **Medicare Beneficiaries**

   Medicaid covers the Medicare copayment for individuals with Medicare and full-benefit Medicaid (dual eligibles) and Qualified Medicare Beneficiaries (QMB). However, a provider is allowed to collect the Medicare copayment at the time of service. If the provider requires the individual to pay the Medicare copayment, the individual must be reimbursed or credited the difference between the Medicare and Medicaid copayments once the provider receives payment of the Medicaid claim.

3. Covered Services

The services listed below are covered:

- Behavioral health services, including clinic services, outpatient psychiatric services, mental health case management, psychosocial rehabilitation, mental health skill building, therapeutic day treatment for children and adolescents, intensive in-home services for children and adolescents, mental health partial hospitalization, mental health intensive outpatient, assertive community treatment, applied behavior analysis, multisystemic therapy, functional family therapy, mobile crisis response, community stabilization, 23-hour crisis stabilization, residential crisis stabilization unit services, therapeutic group homes and psychiatric residential treatment services

- Case management services
- Certified pediatric nurse and family nurse practitioner services
- Clinical psychologist services
- Community-based services for individuals with intellectual disabilities, including day health rehabilitation services and case management
- Dental services for children enrolled in Medicaid and FAMIS, pregnant women enrolled in Medicaid, FAMIS MOMS, and FAMIS Prenatal Coverage, and effective July 1, 2021, all other adults with **full** Medicaid benefits
- *Dialysis services*
- Early Periodic Screening, Diagnostic and Treatment (EPSDT) services
- Emergency hospital services
- Family planning services
- Federally Qualified Health Center clinic services
- Home and community-based care waiver services (see subchapter M1440)
- Home health services: nurse, aide, supplies, treatment, physical therapy, occupational therapy, and speech therapy services
- Hospice services
- Inpatient hospital services
- Intensive Behavioral Dietary Counseling, for individuals in MEDICAID WORKS
- Intermediate care facility services for the intellectually disabled (ICF-ID)
- Laboratory and x-ray services
- Medicare premiums: Hospital Insurance (Part A); Supplemental Medical Insurance (Part B) for the Categorically Needy (CN) and Medically Needy (MN)
- Nurse-midwife services
- Nursing facility care
- Other clinic services: services provided by rehabilitation agencies, ambulatory surgical centers, renal dialysis clinics, and local health departments
- Outpatient hospital services
- Personal assistance services, for individuals in Medicaid Works
- Physical therapy and related services

- Physician services
- Podiatrist services
- *Pregnancy related services*
- Prescribed drugs
- Prosthetic devices
- Rural Health Clinic services
- Skilled nursing facility services for individuals under age 21 years
- Substance abuse services
- Transplant services
- Transportation to receive medical services
- Vision services

Subchapter M1860: Services Received Outside Virginia

Last Subchapter Revision Date: May 2015

M1860 CHANGES

Changed With	Effective Date	Sections Changed

TN – Transmittal
UP – Update

SECTION M1860.100: SERVICES RECEIVED OUTSIDE VIRGINIA

Last Section Revision Date: May 2015

A. General

Medicaid must pay for covered medical services received by any eligible person who is temporarily absent from Virginia if the medical service provider agrees to accept Medicaid payment.

B. Out-of-State Institutional Placements

Virginia Medicaid will cover an enrollee who is placed in an LTC facility in another state only if the placement is preauthorized by the DMAS Long Term Care Section.

A child in IV-E Foster Care who is placed in an institution outside Virginia is eligible for Medicaid through the state in which he resides. A child in non-IV-E Foster Care is eligible for Virginia Medicaid when the child is in an institution outside Virginia, since the child is considered to be a resident of the locality which holds custody.

Chapter M22
FAMIS MOMS

Chapter M22 Changes

Date Converted to New Template: October 2025

Changed With	Effective Date	Sections Changed
TN #DMAS-38	4/1/26	M2210.100
TN #DMAS-34	1/1/25	Appendix 1
TN #DMAS-31	4/1/24	Appendix 1
TN #DMAS-28	7/1/23	Appendix 1
TN #DMAS-24	7/1/22	Pages 1, 2, 5, 6
TN #DMAS-23	4/1/22	Page 6 Appendix 1, page 1
TN #DMAS-20	7/1/21	Page 2
TN #DMAS-19	4/1/21	Appendix 1, page 1
TN #DMAS-18	1/1/21	Page 6
TN #DMAS-16	4/1/20	Appendix 1, page 1
TN #DMAS-14	10/1/19	Page 5
TN #DMAS-12	4/1/19	Appendix 1, page 1
TN #DMAS-8	4/1/18	Appendix 1, page 1
TN #DMAS-6	10/1/17	Page 7 Appendix 1, page 1
TN #DMAS-4	4/1/17	Appendix 1, page 1
TN #DMAS-1	6/1/16	Page 4 Appendix 1, page 1
TN #100	5/1/15	Table of Contents Pages 1, 2, 5, 6, 7 Appendix 1 Pages 3 and 4 are runover pages.
TN #98	10/1/13	Table of Contents Pages 1-7 Appendix 1 Pages 8-10 were deleted.
UP #9	4/1/13	Appendix 1
UP #8	10/1/12	Pages 2, 3 Page 3a deleted
UP #7	7/1/12	Pages 2, 3
UP #6	4/1/12	Appendix 1
TN #96	10/1/11	Pages 3, 3a

Changed With	Effective Date	Sections Changed
TN #95	3/1/11	Pages 4-6 Appendix 1
UP #4	7/1/10	Page 10
TN #94	9/1/10	Page 3
UP #3	3/01/10	Page 2
TN #93	1/1/10	Pages 2-10
UP #2	8/24/09	Page 3
UP #1	7/1/09	Pages 1, 2, 7 Appendix 1, page 1

TN – Transmittal

UP – Update

Table of Contents

Subchapter M2210: FAMIS Moms 1
M2210 Changes 1
Section M2210.100: FAMIS MOMS General Information 2
Subchapter M2220: Nonfinancial Eligibility 3
M2220 Changes 3
Section M2220.100: Nonfinancial Eligibility Requirements 4
Subsection M2220.200: Health Insurance Coverage 6
Subsection M2220.300: No Child Support Cooperation Requirements 8
Subchapter M2230: Financial Eligibility 9
M02230 Changes 9
Section M2230.100: Financial Eligibility 10
Subchapter M2240: Application and Case Handling Procedures 11
M2240 Changes 11
Section M2240.100: Application and Case Handling Procedure 12
Subchapter M2250: Adverse Actions 14
M2250 Changes 14
Section M2250.100: Review of Adverse Actions 15
Appendix 1: FAMIS MOMS Income Limits 16

Subchapter M2210: FAMIS Moms

Last Subchapter Revision Date: April 2026

M2210 CHANGES

Changed With	Effective Date	Sections Changed
TN #DMAS-38	April 2026	M2210.100
TN #DMAS-24	July 2022	M2210

TN – Transmittal

UP – Update

SECTION M2210.100: FAMIS MOMS GENERAL INFORMATION

Last Section Revision Date: April 2026

A. Introduction

The 2005 Appropriation Act directed the Department of Medical Assistance Services (DMAS) to expand medical coverage to uninsured pregnant women who are ineligible for Medicaid and have income in excess of the Medicaid limits, but whose family income is less than or equal to 200% of the federal poverty level (FPL). The Family Access to Medical Insurance Security (FAMIS) MOMS program was subsequently established. FAMIS MOMS was closed to new applications from January 1, 2014 until November 30, 2014. Enrollment in the program resumed on December 1, 2014.

Eligibility for FAMIS MOMS is determined by either the local DSS, including a VDSS outstationed site, or the Cover Virginia Central Processing Unit (CPU). Applications processed by the Cover Virginia CPU will be transferred to the appropriate local DSS for case maintenance.

Eligible women are enrolled for benefits effective the first day of the application month if all eligibility requirements are met in that month. There is no retroactive coverage in FAMIS MOMS. Pregnant women found eligible for FAMIS MOMS receive the same benefits as Medicaid pregnant women, including comprehensive dental services. An eligible woman will receive coverage through her pregnancy and for 12 months following the end of the month in which her pregnancy ends *(including by miscarriage)*, regardless of income changes.

B. Policy Principles

FAMIS MOMS covers uninsured low-income pregnant women who are not eligible for Medicaid due to excess income, and whose countable income is less than or equal to 200% of the FPL.

A pregnant woman is eligible for FAMIS MOMS if <u>all</u> of the following are met:

- She is not eligible for Medicaid and has income in excess of the Medicaid limits.
- She is a resident of Virginia.
- She is uninsured.
- She is not an inmate of a public institution.
    A. She is **not** an inpatient in an institution for mental diseases at the time of application/re-evaluation.
- She has countable family income less than or equal to 200% FPL.

Subchapter M2220: Nonfinancial Eligibility

Last Subchapter Revision Date: July 2022

M2220 CHANGES

Changed With	Effective Date	Sections Changed
TN #DMAS-24	July 2022	M2220

TN – Transmittal

UP – Update

SECTION M2220.100: NONFINANCIAL ELIGIBILITY REQUIREMENTS

Last Section Revision Date: July 2022

A. Policy

The pregnant woman must meet, with certain exceptions, the Medicaid nonfinancial eligibility requirements in Chapter M02 and the nonfinancial eligibility requirements imposed by FAMIS.

B. M02 Applicable Requirements

The Medicaid nonfinancial eligibility requirements in Chapter M02 that must be met are:

- citizenship or noncitizen status, with the exception noted in M2220.100 C below,
- Virginia residency requirements,
- Provision of a Social Security Number (SSN) or proof of application for an SSN;
- assignment of rights,
    B. application for other benefits, and
- institutional status requirements regarding inmates of a public institution.

C. FAMIS MOMS Noncitizen Status Requirements

Lawfully residing pregnant women meet the FAMIS noncitizen requirements without regard to their date of arrival or length of time in the U.S. The lawfully residing noncitizen groups are contained in section M0220.314.

EXCEPTION to M02:

FAMIS MOMS does not provide emergency services only coverage for noncitizens who are not lawfully residing in the U.S., such as illegal noncitizens or those whose lawful admission status has expired. These noncitizens are not eligible for FAMIS MOMS but may be eligible for FAMIS Prenatal Coverage if they apply for coverage no later than the month their child is born. **Use Chapter M23 to evaluate the pregnant woman for eligibility under FAMIS Prenatal Coverage.**

D. FAMIS MOMS Covered Group Requirements

1. **Declaration of Pregnancy**

   The woman's pregnancy is declared on the application and requires no further verification unless the agency has received conflicting information. See M0310.124 for the definition of a pregnant woman.

2. **Must be Uninsured**

The pregnant woman must be uninsured; that is, she must not be covered under any creditable health insurance plan offering hospital and medical benefits. If a pregnant woman has creditable health insurance that does not cover pregnancy, labor and/or delivery services, the pregnant woman is ineligible for FAMIS MOMS because she is insured. *If the pregnant woman obtains health insurance coverage after enrollment, she remains eligible for FAMIS MOMS coverage*.

3. **IMD Prohibition**

   The pregnant woman cannot be in inpatient in an institution for the treatment of mental diseases (IMD) *at the time of application/reevaluation*.

Subsection M2220.200: Health Insurance Coverage

Last Subsection Revision Date: May 2015

A. Introduction

The intent of FAMIS MOMS is to provide health coverage to low-income uninsured pregnant women. A pregnant woman who has creditable health insurance coverage is not eligible for FAMIS MOMS.

B. Definitions

- **Creditable Coverage** – For the purposes of FAMIS MOMS, creditable coverage means coverage of the individual under any of the following:
    - Church plans and governmental plans
    - Health insurance coverage, either group or individual insurance
    - Military-sponsored health care
    - A state health benefits risk pool
    - The federal Employees Health Benefits Plan
    - Medicare
    - A public health plan
    - Any other health benefit plan under section 5(e) of the Peace Corps Act

  The definition of creditable coverage includes short-term limited coverage.

- **Employer-Sponsored Dependent Health Insurance** – Employer-sponsored dependent health insurance means the employer pays a portion of the premium payment. COBRA coverage in which the employer makes no contribution to the payment of the premium is not employer- sponsored insurance.

- **Health Benefit Plan** – "Health benefit plan" is defined in the Virginia Bureau of Insurance Regulations (14VAC5-234-30) and means:
    - Any accident and health insurance policy or certificate
    - Health services plan contract
    - Health maintenance organization subscriber contract
    - Plan provided by a Multiple Employer Welfare Arrangement (MEWA)

  Health benefit plan does NOT mean:
    - Medicaid,
    - accident only,
    - credit or disability insurance,
    - long-term care insurance,
    - dental only or vision only insurance,
    - specified disease insurance,
    - hospital confinement indemnity coverage,

- limited benefit health coverage,
- coverage issued as a supplement to liability insurance,
- insurance arising out of workers' compensation or similar law
- automobile medical payment insurance, or
- insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

- **Insured** – means having creditable health insurance coverage or coverage under a health benefit plan. A woman is considered to be insured if she is covered by a creditable health insurance plan, even if the policy or plan does not cover pregnancy-related services.

C. **Uninsured** – means having no insurance; having insurance that is not creditable; having coverage which is not defined as a health benefit plan, or having a health insurance plan that does not have a network of providers in the area where the pregnant woman resides.

C. Policy

1. Must be Uninsured

A nonfinancial requirement of FAMIS MOMS is that the pregnant woman be uninsured. A pregnant woman **cannot:**

- have creditable health insurance coverage, or
- have coverage under a group health plan (TRICARE, federal employee benefit plan, private group insurance such as Anthem, etc.) or Medicare.

2. Prior Insurance

Prior insurance coverage is not a factor as long as the pregnant woman is uninsured during the month for which FAMIS MOMS eligibility is being determined.

Subsection M2220.300: No Child Support Cooperation Requirements

Last Subsection Revision Date: June 2016

A. Policy

There are no requirements for FAMIS MOMS applicants or recipients to cooperate in pursuing support from an absent parent.

Subchapter M2230: Financial Eligibility

Last Subchapter Revision Date: June 2016

M02230 CHANGES

Changed With	Effective Date	Sections Changed
TN #DMAS-1	June 2016	M2230

TN – Transmittal
UP – Update

SECTION M2230.100: FINANCIAL ELIGIBILITY

Last Section Revision Date: June 2016

A. Financial Eligibility

1. Income

Modified Adjusted Gross Income (MAGI) methodology contained in Chapter M04 is used for the FAMIS MOMS income evaluation. To the maximum extent possible, attested income must be verified by information obtained from electronic data sources, such as the federal hub or another reliable data source, prior to requesting paystubs or employer statements. For all case actions effective October 26, 2019, if the income attested to by the applicant is within 10% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required. If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return.

The FAMIS MOMS income limit is 200% of the FPL (see Appendix 1 to this chapter) for the number of individuals in the pregnant woman's MAGI household composition as defined in M04. The pregnant woman is counted as herself plus the number of children she is expected to deliver. Per MAGI policy in chapter M04, a 5% FPL income disregard is applicable.

2. Resources

Resources are not evaluated for FAMIS MOMS.

3. No Spenddown

Spenddown does not apply to FAMIS MOMS. If countable income exceeds the FAMIS MOMS income limit, the pregnant woman is not eligible for the FAMIS MOMS program. She must be referred to the Health Insurance Marketplace and be given the opportunity to have a MN Medicaid evaluation.

Subchapter M2240: Application and Case Handling Procedures

Last Subchapter Revision Date: July 2022

M2240 CHANGES

Changed With	Effective Date	Sections Changed
TN #DMAS-24	July 2022	M2240

TN – Transmittal
UP – Update

SECTION M2240.100: APPLICATION AND CASE HANDLING PROCEDURE

Last Section Revision Date: July 2022

A. Application Requirements

The policies in subchapters M0120 and M0130 apply.

B. Eligibility Determination

1. **Pregnant *Individual* Under Age 19**

   Process an application by a pregnant individual under age 19 in the following order:

   a. Determine eligibility for Medicaid as a pregnant woman; if not eligible because of excess income, go to item b.

   b. Determine eligibility for FAMIS MOMS; if not eligible because of excess income, go to item c.

   c. If she is not eligible for FAMIS MOMS because of excess income, she must be referred to the Health Insurance Marketplace and given the opportunity to have a Medically Needy evaluation completed.

2. **Seven-Calendar Day Processing**

   Applications for pregnant women must be processed as soon as possible, but no later than seven calendar days from the date the signed application was filed. If all necessary verifications are not received, the application continues to pend until the 45-day processing time limit is met.

3. **Notice Requirements**

   The applicant/recipient must be notified in writing of the required information and the deadline by which the information must be received.

   The agency must have all necessary verifications within seven calendar days in order to determine eligibility. If the agency does not receive the verifications within the seven calendar days, the worker must send the applicant written notice on the seventh day. The notice must state why action on the application could not be taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 calendar days to submit the verification.

   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 MOMS 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 and Enrollment

1. ***Dates* of Coverage**

   Pregnant women determined eligible for FAMIS MOMS are enrolled for benefits effective the first day of the application month, if all eligibility requirements are met in that month. FAMIS MOMS coverage ends the last day of the 12th month after the end of the month in which the pregnancy ends.

2. **No Retroactive Coverage**

   There is no retroactive coverage in the FAMIS MOMS program.

3. **Aid Category**

   The FAMIS MOMS aid category (AC) is "005."

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 both Medicaid and FAMIS MOMS, as well as a referral to the Health Insurance Marketplace, if applicable.

If the pregnant woman is ineligible for both Medicaid and FAMIS MOMS due to excess income, she must be sent a written notice that she is not eligible for either program and that her case has been referred to the Health Insurance Marketplace. She must also be given the opportunity to have a Medicaid medically needy evaluation completed. Send the notice and a request for information about her resources to the pregnant woman and advise her that if the resource information is returned within 10 days the original application date will be honored.

F. Application Not Required for Newborn

The newborn child born to a FAMIS MOMS enrollee is deemed eligible for FAMIS coverage until the child's first birthday. Follow the procedures for enrolling a newborn in M0330.802, using the appropriate AC as follows:

- AC 010 = mother's income > 143% FPL but ≤ 150% FPL
- AC 014 = mother's income > 150% FPL but ≤ 200% FPL

Act on the enrollment of a deemed newborn as soon as feasible when the birth is reported to the local DSS office or to DMAS.

Subchapter M2250: Adverse Actions

Last Subchapter Revision Date:

M2250 CHANGES

Changed With	Effective Date	Sections Changed
TN #DMAS-6	October 2017	M2250

TN – Transmittal

UP – Update

SECTION M2250.100: REVIEW OF ADVERSE ACTIONS

Last Section Revision Date: October 2017

An applicant for FAMIS MOMS may request a review of an adverse determination regarding eligibility for FAMIS MOMS. FAMIS MOMS follows the procedures established by Medicaid for client appeals (see Chapter M16).

The payment of medical services on the part of any pregnant woman or any right to participate in the program is not subject to review if the reason for denial or cancellation is that funds for the FAMIS MOMS program are exhausted.

Appendix 1: FAMIS MOMS Income Limits

The following income chart has been moved to Chapter M00 - Appendix - Income Charts:

- FAMIS Moms 200% FPL Income Limits – All Localities

Virginia Medical Assistance Eligibility Manual

Chapter M23
FAMIS Prenatal Coverage

Chapter M23 Changes

Date Converted to New Template: February 2026

Changed With	Effective Date	Sections 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

TN – Transmittal
UP - Update

Table of Contents

Subchapter M2310: FAMIS Prenatal Coverage 1
M2310 Changes 1
Section M02310.100: FAMIS Prenatal Coverage General Information 2
Subchapter M2320: Nonfinancial Eligibility 4
M2320 Changes 4
Section M02320.100: Nonfinancial Eligibility Requirements 5
Subsection M02320.200: Health Insurance Coverage 7
Subsection M02320.300: No Child Support Cooperation Requirements 9
Subchapter M2330: Financial Eligibility 10
M2330 Changes 10
Section M02330.100: Financial Eligibility 11
Subchapter M2340: Application and Case Handling Procedures 12
M2340 Changes 12
Section M02340.100: Application and Case Handling Procedures 13
Subchapter M2350: Adverse Actions 17
M2350 Changes 17
Section M02350.100: Review of Adverse Actions 18
Appendix 1: FAMIS Prenatal Coverage Income Limits 19

Subchapter M2310: FAMIS Prenatal Coverage

Last Subchapter Revision Date: April 2026

M2310 CHANGES

Changed With	Effective Date	Sections Changed
TN #DMAS-38	April 2026	M2310.100
TN #DMAS-30	January 2024	M2310

TN – Transmittal
UP – Update

SECTION M02310.100: FAMIS PRENATAL COVERAGE GENERAL INFORMATION

Last Section Revision Date: April 2026

A. Introduction

The 2021 Special Sessions I Appropriations Act directed the Department of Medical Assistance Services (DMAS) to amend the Family Access to Medical Insurance Security Plan (FAMIS) and expand medical coverage to uninsured pregnant women and their unborn children:

- who are ineligible for full-benefit Medicaid or FAMIS Moms due to the woman's immigration status, and
- whose Modified Adjusted Gross Income (MAGI) household income is less than or equal to 200% of the federal poverty level (FPL).

FAMIS Prenatal Coverage is effective beginning July 1, 2021.

Eligibility for FAMIS Prenatal Coverage is determined by either the local DSS, including a VDSS out stationed site, or the Cover Virginia Central Processing Unit (CPU). Applications processed by the Cover Virginia CPU will be transferred to the appropriate local DSS for case maintenance.

Eligible women are enrolled for benefits effective the first day of the application month if all eligibility requirements are met in that month. There is no retroactive coverage in FAMIS Prenatal Coverage. If the woman applies for coverage after the month in which the child is born but within the application's retroactive period, she may be eligible for Medicaid coverage of the labor and delivery as emergency services if the woman's countable MAGI household income is within the Medicaid limit. See M0220.400.

Pregnant women found eligible for FAMIS Prenatal Coverage receive the same benefits as Medicaid and FAMIS MOMS pregnant women, including comprehensive dental services.

An eligible woman will receive coverage through her pregnancy and the end of the month in which the 60th day following the end of the pregnancy occurs *(including by miscarriage)*. An infant born to a woman enrolled in FAMIS Prenatal Coverage will receive ongoing coverage beginning on the date of the infant's birth and ending 12 months after the child's birth month. The infant's coverage will be in Medicaid or FAMIS, based on the mother's MAGI household unit income at the time of application. The infant's birth is evaluated as a case change; an application does not need to be submitted for the infant.

B. Policy Principles

FAMIS Prenatal Coverage covers uninsured low-income pregnant women who are not eligible for Medicaid or FAMIS MOMS due to the woman's immigration status and whose countable income is less than or equal to 200% of the FPL.

A pregnant woman **of any age** is eligible for FAMIS Prenatal Coverage if all of the following are met:

- she applies for coverage while pregnant or in the month of the birth of her infant child,
- she does not meet the definition of a **lawfully residing noncitizen pregnant woman in M0220.314**,
- she is a resident of Virginia,
- she is uninsured,
- she is not an inmate of a public institution,
- she is not an inpatient in an institution for mental diseases, and
- she has countable MAGI household income less than or equal to 205% FP (200% FPL plus 5% FPL disregard).

Subchapter M2320: Nonfinancial Eligibility

Last Subchapter Revision Date: July 2021

M2320 CHANGES

Changed With	Effective Date	Sections Changed
TN #DMAS-20	July 2021	M2320

TN – Transmittal

UP – Update

SECTION M02320.100: NONFINANCIAL ELIGIBILITY REQUIREMENTS

Last Section Revision Date: July 2021

A. Policy

The pregnant woman must meet, with certain exceptions, the Medicaid nonfinancial eligibility requirements in Chapter M02 and must be uninsured.

B. M02 Applicable Requirements

The Medicaid nonfinancial eligibility requirements in Chapter M02 that must be met are:

- Virginia residency requirements (M0230)
- Assignment of rights (M0250)
- Application for other benefits (M0270)
- Institutional status requirements regarding inmates of a public institution (M0280).

The Social Security Number (SSN) requirement does not apply to the pregnant woman.

C. Noncitizen Status and FAMIS Prenatal Coverage

FAMIS Prenatal Coverage is limited to a pregnant woman of any age who **does not** meet the lawfully residing noncitizen status requirement for pregnant women for full-benefit coverage in M0220.314 and who applies for coverage while pregnant or no later than the month in which the infant is born.

A pregnant woman who does not meet the lawfully residing noncitizen status requirement and who applies for coverage after the month in which the child is born but within the application's retroactive period may be eligible for Medicaid coverage of the labor and delivery as emergency services if the woman's countable MAGI household income is within the Medicaid or limit or she is eligible as Medically Needy. See M0220.400.

D. FAMIS Prenatal Coverage Covered Group Requirements

1. **Declaration of Pregnancy**

   The woman's pregnancy and the number of unborn children are declared on the application and require no further verification unless the agency has received conflicting information. See M0310.124 for the definition of a pregnant woman.

2. **Must be Uninsured**

   The pregnant woman must be uninsured; that is, she must not be covered under any creditable health insurance plan offering hospital and medical benefits. If a pregnant woman has creditable health insurance that does not cover pregnancy,

labor and/or delivery services, the pregnant woman is ineligible for FAMIS Prenatal Coverage because she is insured.

3. **IMD Prohibition**

   The pregnant woman cannot be an inpatient in an institution for mental diseases (IMD).

Subsection M02320.200: Health Insurance Coverage

Last Subsection Revision Date: July 2021

A. Introduction

A pregnant woman who has creditable health insurance coverage is not eligible for FAMIS Prenatal Coverage.

FAMIS Prenatal coverage provides the same coverage as FAMIS MOMS, including coverage of prenatal care, other medical care, dental care, and transportation to received covered services. Pregnant women enrolled in FAMIS Prenatal Coverage will receive care through a managed care organization (see M1830.100).

B. Definitions

- **Creditable Coverage** – For the purposes of FAMIS Prenatal Coverage, creditable coverage means coverage of the individual under any of the following:
    - Church plans and governmental plans
    - Health insurance coverage, either group or individual insurance;
    - Military-sponsored health care
    - A state health benefits risk pool
    A. The federal employees' health benefits plan; Medicare
    - A public health plan
    - Any other health benefit plan under section 5(e) of the peace corps act

    The definition of creditable coverage includes short-term limited coverage.

- **Employer-sponsored Dependent Health Insurance** – means the employer pays a portion of the premium payment. COBRA coverage in which the employer makes no contribution to the payment of the premium is not employer-sponsored insurance.

- **Health Benefit Plan** – is defined in the Virginia Bureau of Insurance Regulations (14VAC5-234-30) and means:
    - any accident and health insurance policy or certificate,
    - health services plan contract,
    B. health maintenance organization subscriber contract, or
    - plan provided by a Multiple Employer Welfare Arrangement (MEWA)."

    Health benefit plan does NOT mean:
    - Medicaid,
    - accident only,
    - credit or disability insurance,
    - long-term care insurance,
    - dental only or vision only insurance,

- specified disease insurance,
- hospital confinement indemnity coverage,
- limited benefit health coverage,
- coverage issued as a supplement to liability insurance,
- insurance arising out of workers' compensation or similar law,
- automobile medical payment insurance, or
- insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

- **Insured** – means having creditable health insurance coverage or coverage under a health benefit plan. A woman is considered to be insured if she is covered by a creditable health insurance plan, even if the policy or plan does not cover pregnancy-related services.

- **Uninsured** – means having no insurance; having insurance that is not creditable; having coverage which is not defined as a health benefit plan, or having a health insurance plan that does not have a network of providers in the area where the pregnant woman resides.

C. Policy

1. **Must be Uninsured**

   A nonfinancial requirement of FAMIS Prenatal Coverage is that the pregnant woman be uninsured. A pregnant woman **cannot:**

   - have creditable health insurance coverage, or
   - have coverage under a group health plan (TRICARE, federal employee benefit plan, private group insurance such as Anthem, etc.) or Medicare.

2. **Prior Insurance**

   Prior insurance coverage is not a factor as long as the pregnant woman is uninsured during the month for which FAMIS Prenatal Coverage eligibility is being determined.

Subsection M02320.300: No Child Support Cooperation Requirements

Last Subsection Revision Date: July 2021

A. Policy

There are no requirements for FAMIS Prenatal Coverage applicants or members to cooperate in pursuing support from an absent parent.

Subchapter M2330: Financial Eligibility

Last Subchapter Revision Date: October 2022

M2330 CHANGES

Changed With	Effective Date	Sections Changed
TN #DMAS-25	October 2022	M2330

TN – Transmittal

UP – Update

SECTION M02330.100: FINANCIAL ELIGIBILITY

Last Section Revision Date: October 2022

A. Financial Eligibility

1. Income

MAGI methodology contained in Chapter M04 is used for the FAMIS Prenatal Coverage income evaluation. To the maximum extent possible, attested income must be verified by information obtained from electronic data sources, such as the federal hub or another reliable data source, prior to requesting paystubs or employer statements. 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 reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return. If the documentation is delayed in the mail due to no fault of the applicant, accept delayed documentation and complete application processing.

The FAMIS Prenatal Coverage income limit is 200% of the FPL (see Appendix 1 to this chapter) for the number of individuals in the pregnant woman's MAGI household composition as defined in M04. The pregnant woman is counted as herself plus the number of children she is expected to deliver. Per MAGI policy in chapter M04, a 5% FPL income disregard is applicable.

2. Resources

Resources are not evaluated for FAMIS Prenatal Coverage.

3. No Spenddown

Spenddown does not apply to FAMIS Prenatal Coverage. If countable income exceeds the FAMIS Prenatal Coverage income limit, the pregnant woman is not eligible for the FAMIS Prenatal Coverage program. If the woman has no documentation of immigration status, DO NOT make a referral to the Health Insurance Marketplace.

Subchapter M2340: Application and Case Handling Procedures

Last Subchapter Revision Date: January 2025

M2340 CHANGES

Changed With	Effective Date	Sections Changed
TN #DMAS-34	January 2025	M2340

TN – Transmittal
UP – Update

SECTION M02340.100: APPLICATION AND CASE HANDLING PROCEDURES

Last Section Revision Date: January 2025

A. Application Requirements

The policies in subchapters M0120 and M0130 apply.

B. Eligibility Determination

1. **Seven-Calendar Day Processing**

   Applications for pregnant women must be processed as soon as possible, but no later than seven calendar days from the date the signed application was filed. If all necessary verifications are not received, the application continues to pend until the 45 day processing time limit is met.

2. **Notice Requirements**

   The applicant/recipient must be notified in writing of the required information and the deadline by which the information must be received.

   The agency must have all necessary verifications within seven calendar days in order to determine eligibility. If the agency does not receive the verifications within the seven calendar days, the worker must send the applicant written notice on the seventh day. The notice must state why action on the application could not be taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 calendar days to submit the verification.

   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 and 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.

Because she received an emergency service during the retroactive period and her income is under the Medicaid limit for a pregnant woman, she is evaluated for Emergency Services coverage.

Rose's son, AJ, is born on February 25, 2022, and is enrolled in AC 090 beginning February 25, 2022. His Medicaid renewal is due in February 2023. Rose's FAMIS Prenatal Coverage ends on April 30, 2022.

EXAMPLE #2: Jo lives with her husband Al and daughter Em, who was born on October 31, 2021. Jo was born outside the U.S. She applies for Medical Assistance on November 25, 2021 and requests retroactive coverage for her pregnancy. She does not request coverage for her husband.

Jo 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. Because Jo applied for coverage the month after her infant's birth, she cannot be eligible for FAMIS Prenatal Coverage.

Jo's MAGI household consists of three people—Jo, her infant, and her husband. The verified countable monthly income for the household is $3,473.

Jo's countable income is over the limit of 143% FPL for Medicaid and has excess resources for Medically Needy eligibility; therefore, she cannot be approved for Medicaid coverage of emergency services for the labor and delivery.

Em is determined to be eligible for FAMIS, which covers an eligible child who was born within the 3 months prior to the application month. Em is enrolled effective October 31, 2021, in AC 006. Her renewal is due in October 2022.

The eligibility worker sends a Notice of Action indicating Jo is not eligible for Medicaid or FAMIS Prenatal Coverage and Em has been enrolled in FAMIS.

Subchapter M2350: Adverse Actions

Last Subchapter Revision Date: January 2025

M2350 CHANGES

Changed With	Effective Date	Sections Changed
TN #DMAS-34	January 2025	M2350

TN – Transmittal

UP – Update

SECTION M02350.100: REVIEW OF ADVERSE ACTIONS

Last Section Revision Date: January 2025

An applicant for FAMIS Prenatal Coverage may request a review of an adverse determination regarding eligibility for FAMIS Prenatal Coverage. FAMIS Prenatal Coverage follows the procedures established by Medicaid for client appeals (see Chapter M16).

The payment of medical services on the part of any pregnant woman or any right to participate in the program is not subject to review if the reason for denial or cancellation is that funds for the FAMIS Prenatal Coverage program are exhausted.

APPENDIX 1: FAMIS PRENATAL COVERAGE INCOME LIMITS

The following income charts have been moved to Chapter M00 – Appendix – Income Charts:

C. FAMIS Prenatal Coverage 200% FPL Income Limits - All Localities
- Enroll Using Aid Category 110
  - 143% FPL Yearly Amount
  - 143% FPL Monthly Amount
  - 148% FPL (143% FPL + 5% FPL Disregard)
- Enroll Using Aid Category 111
  - 200% FPL Yearly Amount
  - 200% FPL Monthly Amount
  - 205% FPL (200% FPL + 5% FPL Disregard)