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July 1, 2026

Virginia Medical Assistance Eligibility Manual Transmittal
DMAS-39

The following acronyms are contained in this letter:

- CBC – Community Based Care
- CCF – Coverage Correction Form
- CCP – Coverage Correction Portal
- DMAS – Department of Medical Assistance Services
- LDSS – Local Department of Social Services
- LTSS – Long Term Services and Supports
- MES – Medicaid Enterprise System
- TN – Transmittal
- VDSS – Virginia Department of Social Services

TN #DMAS-39 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 July 1, 2026.

The following changes are contained in TN #DMAS-39:

Changed Sections	Changes
Chapter M000	Updated Income Limits and Reference section
Chapter M14	Full chapter will be published in new format when TN #DMAS-39 changes are incorporated.
Subchapter M1410.010, M1410.100	The worker must verify that LTSS started within one year of the date on the Notice of Action on Medicaid. If services do not start within 365 days of the Notice of Action on Medicaid, the individual can no longer be considered an institutionalized individual and continued eligibility must be re-evaluated as a non-institutionalized individual.
M1430.100	If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has one year (365 days) from the date on the Notice of Action to begin services.
M1440.010	If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has 365 days from the date on the Notice of Action to begin receiving CBC services.
M1460.220	If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has one year (365 days) from the date on the Notice of Action to begin services.

M1470.001	If VaCMS is not able to process required transactions, a Patient Pay Correction request should be submitted using the Coverage Correction Portal (CCP). The CCP replaces the Word document version of the Coverage Correction Form (CCF), Patient Pay Correction Form, use of the shared e-mail boxes and the requirement to upload coverage and patient pay correction forms to DMIS. **Effective 8/1/2025, all Coverage and Patient Pay Correction Requests must be submitted through the CCP.** To access the CCP and User Guides, LDSS, VDSS, Cover Virginia, and DMAS staff must sign into the MES using their current credentials and then sign into the MMIS with their eCode. The patientpay@dmas.virginia.gov mailbox remains active for questions, but correction requests should be submitted through the CCP. DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into MES.
M1470.230	Claims for incurred medical or remedial care expenses must be submitted within 90 calendar days after the invoice date. **No deductions shall be permitted for medical or remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period.** The "Requests for Adjustments from LTSS providers" section is updated with additional requirements.
M1470.430	Patient Pay correction request procedure updated.
M1470.910	Patient Pay correction request procedure updated.
M1470.930	Patient Pay correction request procedure updated.
M1480.410	Monthly Maintenance Needs Allowance and Excess Shelter Standard updated.
M1520.300	A batch will run in MES to verify or update the date of death with the date received from the Virginia Department of Health.

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

Subchapter M1410: General Rules

Last Subchapter Revision Date: July 2026

M1410 CHANGES

Changed With	Effective Date	Sections Changed
TN #DMAS-39	7/1/26	M1410.010, M1410.100
TN #DMAS-34	1/1/25	M1410.020
TN #DMAS-33	10/1/24	M1410.010
TN #DMAS-31	4/1/24	M1410.300
TN #DMAS-30	1/1/24	M1410.010 and M1410.200
TN #DMAS-29	10/1/23	M1410.300
TN #DMAS-25	10/1/22	M1410.010
TN #DMAS-24	7/1/22	M1410.010, M1410.200, M1410.300
TN #DMAS-21	10/1/21	M1410.200
TN #DMAS-18	1/1/21	M1410.010
TN #DMAS-17	7/1/20	Table of Contents M1410.010, M1410.030, M1410.060, M1410.300
TN #DMAS-14	10/1/19	M1410.300
TN #DMAS-12	4/1/19	M1410.030, M1410.300
TN #DMAS-11	1/1/19	M1410.050
TN #DMAS-10	10/1/18	M1410.050, M1410.060, M1410.100, M1410.200, M1410.300
TN #DMAS-9	7/1/18	M1410.010
TN #DMAS-8	4/1/18	M1410.200
TN #DMAS-7	1/1/18	M1410.050
TN #DMAS-5	7/1/17	M1410.030, M14.040
TN #DMAS-3	1/1/17	M1410.040, M1410.300
TN #DMAS-1	6/1/16	M1410.300
TN #100	5/1/15	M1410.010
TN #99	1/1/14	M1410.200
UP #7	7/1/12	M1410.040
TN #96	10/1/11	M1410.200
TN #95	3/1/11	M1410.300
TN #94	9/1/10	M1410.040, M1410.300
TN #93	1/1/10	M1410.010
TN #91	5/15/09	M1410.300

TN – Transmittal

UP – Update

SECTION M1410.010: GENERAL – LONG-TERM CARE

Last Section Revision Date: July 2026

A. Introduction

Chapter M1410 contains the rules that apply to individuals needing long-term services and support (LTSS). The rules are contained in the following subchapters:

- M1410 General Rules
- M1420 Pre-admission Screening
- M1430 Facility Care
- M1440 Community-based Care Waiver Services
- M1450 Transfer of Assets
- M1460 Financial Eligibility
- M1470 Patient Pay – Post-eligibility Treatment of Income
- M1480 Married Institutionalized Individuals' Financial Eligibility

The rules found within this Chapter apply to those individuals applying for or receiving Medicaid who meet the definition of institutionalization.

B. Definitions

The definitions found in this section are for terms used when policy is addressing types of long-term services and support (LTSS), institutionalization, and individuals who are receiving that care.

- **Assisted Living Facility (ALF) / Memory Care Unit** – An assisted living facility (ALF) or memory care unit are not long-term care facilities or a Medicaid medical institution. An ALF or memory care unit may be located within the same setting or campus such as a continuing care or a long-term care facility; however, the level of care differs from that of a Medicaid medical institution.

- **Authorized Representative** – An authorized representative is a person who is authorized to conduct business for an individual. A competent individual must designate the authorized representative in a written statement, which is signed by the individual applicant. The authorized representative of an incompetent or incapacitated individual is the individual's:
  - Spouse
  - Parent
  - Attorney-in fact (person who has the individual's power-of-attorney)
  - Legally appointed guardian
  - Legally appointed conservator (formerly known as the committee)
  - Trustee
  -
- **Group Homes** – Group homes providing services through the Community Living Waiver are not medical institutions.
- **In an Institution** – This refers to an individual who is admitted to live in an institution and receives treatment or services provided there that are appropriate to the individual’s requirements.

- **Independent Living Facility** – A senior living center/senior apartment/retirement community are independent living arrangements or residences and are not medical institutions.

- **Inpatient** – An inpatient is a patient who has been admitted to a medical institution on the recommendation of a physician or dentist and who:
    - receives room, board, and professional services in the institution for a 24-hour period or longer, or
    - is expected by the institution to receive room, board, and professional services in the institution for a 24-hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility, and does not actually stay in the institution for 24 hours.

- **Institution** – An institution is an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

- **Institutionalization** – This means receipt of 30 consecutive days of:
    - care in a medical institution (such as a nursing facility), or
    - Medicaid Home and Community-Based Services (HCBS), or
    - a combination of the two.

The definition of institutionalization is also met when an individual has a signed hospice election that has been in effect for 30 consecutive days.

The 30 days begins with the day of admission to the medical institution or receipt of Medicaid HCBS. The date of discharge into the community (not in LTSS) or death is **NOT** included in the 30 days.

The institutionalization provisions may be applied when the individual is already in a medical facility at the time of the application, or the individual has been authorized to receive LTC or Long-term Services and Supports (LTSS) and it is anticipated that he is likely to receive the services for 30 or more consecutive days. If it is known at the time the application is processed that the individual did not or will not meet the 30 consecutive day requirement, the individual is not to be treated as an institutionalized individual unless community LTSS has been authorized.

The 30-consecutive-days requirement is expected to be met if the authorization for LTSS is provided verbally or in writing. This allows the agency to begin the evaluation of the applicant in the 300% SSI covered group for institutionalized individuals and to use the special rules for married institutionalized individuals who have a community spouse, if appropriate. However, prior to approval of the individual for Medicaid payment of LTSS, the worker must have received the DMAS-96 that was signed by the supervising physician (or an electronic equivalent) or the signed Waiver Level of Care form (or an electronic equivalent). Applicants must be evaluated as non-institutionalized individuals for the months prior to the month in which the completed form is dated.

The worker must verify that LTSS started within *one year* of the date on the Notice of Action on Medicaid. If services do not start within *365* days of the Notice of Action on Medicaid, the individual can no longer be considered an institutionalized individual and continued eligibility must be re-evaluated as a non-institutionalized individual. CBC Waiver applicants cannot receive Medicaid payment of CBC services prior to the date the DMAS-96 was signed by the supervising physician. For applicants for whom a Waiver Level of Care form is the appropriate authorization document, Medicaid payment of CBC services cannot begin prior to the date the form has been signed. For purposes of this definition, continuity is broken by 180 or more consecutive day's absence from a medical institution or by non-receipt of waiver services. For applicants in a nursing facility, if it is known at the time of application processing that the individual left the nursing facility and did not stay for 30 consecutive days or begin receiving another type of LTSS, the individual is evaluated as a non-institutionalized individual. Medicaid recipients without a community spouse who request Medicaid payment of LTSS, except MN individuals, and are in the nursing facility for less than 30 consecutive days will have a patient pay determination (see M1470.320).

- **Long-term Care** – Long-term is medical treatment and services directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or lessening of illness, disability or pain which have been received, or are expected to be received, for longer than 30 consecutive days.
- **Medical Institution (Facility)** – is an institution (facility) that:
  - is organized to provide medical care, including nursing and convalescent care,
  - has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,
  - is authorized under state law to provide medical care, and
  - is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

An acute care hospital is a medical institution.

- **Patient** – A patient is an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or lessening of illness, disability, or pain, is a patient.

SECTION M1410.100: LONG-TERM CARE APPLICATIONS

Last Section Revision Date: July 2026

A. Introduction

The general application requirements applicable to all Medicaid applicants/ recipients found in chapter M01 also apply to applicants/recipients who need LTSS services. This section provides those additional or special application rules that apply only to persons who meet the institutionalization definition.

B. Responsible Local Agency

The local social services department in the Virginia locality where the institutionalized individual (patient) last resided outside an institution retains responsibility for receiving and processing the application.

If the patient did not reside in Virginia prior to admission to the institution, the local social services department in the county/city where the institution is located has responsibility for receiving and processing the application.

Home and Community-Based Services (HCBS) applicants apply in their locality of residence.

C. Procedures

1. **Application Completion** – A signed application is received. A face-to-face interview with the applicant or the person authorized to conduct the applicant's business is not required, but is strongly recommended, in order to correctly determine eligibility.

2. **Pre-admission Screening** – Notice from pre-admission screener is received by the local department of social services (LDSS).

   NOTE: Verbal communications by both the screener and the local DSS Eligibility Worker (EW) may occur prior to the completion of screening. Also, not all LTC cases require preadmission screening; see M1420.

3. **Processing** – EW completes the application processing. Processing includes receipt of required verifications, completion of the non-financial and financial eligibility determinations, and necessary case record documentation. See chapter M15 for the processing procedures.

   An individual's eligibility is determined as an institutionalized individual if the individual is in a medical facility or has been authorized for Medicaid LTSS. For any month in the retroactive period, an individual's eligibility can only be determined as an institutionalized individual if the individual met the definition of institutionalization in that month (i.e., the individual had been a patient in a medical institution—including nursing facility or an ICF-ID—for at least 30 consecutive days).

   If it is known at the time the application is processed that the individual did not or will not receive LTSS (i.e., the applicant has died since making the application) do not determine eligibility as an institutionalized individual.

If the individual's eligibility was determined as an institutionalized individual prior to the receipt of waiver services, the EW must verify that LTSS started within *365* days of the date of the Notice of Action on Medicaid. If LTSS did not start within *one year* of the date of the Notice of Action on Medicaid, the individual's continued eligibility must be re-evaluated as a non-institutionalized individual.

4. **Notices** – See section M1410.300 for the required notices.

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Subchapter M1430: Facility Care

Last Subchapter Revision Date: January 2024

M1430 CHANGES

Changed With	Effective Date	Sections Changed
TN #DMAS-39	7/1/26	M1430.100
TN #DMAS-30	1/1/24	M1430.100
TN #DMAS-26	10/1/22	M1430.000, M1430.010
TN #DMAS-24	7/1/22	M1430.100
TN #DMAS-20	7/1/21	Table of Contents M1430.010 Appendix 1 was removed.
TN #DMAS-19	4/1/21	M1430.010
TN #DMAS-10	10/1/18	M1430.100, M1430.101, Appendix 1
TN #DMAS-7	1/1/18	M1430.010, M1430.101, Appendix 1
TN #93	1/1/10	Appendix 1, M1430.010
UP #1	7/1/09	Appendix 1, M1430.010

TN – Transmittal
UP – Update

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SECTION M1430.100: BASIC ELIGIBILITY REQUIREMENTS

Last Section Revision Date: July 2026

A. Overview

To be eligible for Medicaid payment of long-term care, an individual must be eligible for Medicaid. The Medicaid non-financial eligibility requirements in Chapter M02 apply to all individuals in long-term care. The eligibility requirements and the location of the manual policy are listed below in this section.

- **Application for Other Benefits** – The application for other benefits policy is found in M0270.
- **Assignment of Rights** – The assignment of rights and support cooperation policy is found in M0250.
- **Citizenship/Alienage** – The citizenship and noncitizen status policy is found in M0220.
- **Covered Group (Category)** – The Medicaid covered groups eligible for LTC services, also called long-term services and supports (LTSS), are listed

in M1460. The requirements for the covered groups are found in chapter M03.

- **Financial Eligibility** – An individual who has been a patient in a medical institution (such as a nursing facility) for at least 30 consecutive days of care or who has been authorized for LTSS is treated as an institutionalized individual for the Medicaid eligibility determination. Financial eligibility for institutionalized individuals is determined as a one-person assistance unit separated from his/her legally responsible relative(s).

The 30-consecutive-days requirement is expected to be met if authorization for LTSS is provided verbally or in writing. If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has *one year (365 days)* from the date on the Notice of Action to begin services.

For unmarried individuals, and for married individuals without community spouses other than MAGI Adults, the resource and income eligibility criteria in subchapter M1460 is applicable.

MAGI Adults in LTC are evaluated using the resource policy in M1460 and the MAGI income policy in M04. Only certain resource eligibility requirements are applicable to individuals in the Modified Adjusted Gross Income (MAGI) Adult covered group who are institutionalized.

For married individuals with community spouses, other than MAGI Adults, the resource and income eligibility criteria in subchapter M1480 is applicable.

The asset transfer policy in M1450 applies to all facility patients, including MAGI Adults.

- **Institutional Status** – The institutional status requirements specific to long-term care in a facility are in subchapter M0280.
- **Social Security Number** – The social security number policy is found in M0240.
- **Virginia Residency** – The Virginia state resident policy specific to facility patients is found in subchapter M0230 and section M1430.101 below.

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Subchapter M1440: Community-Based Care Waiver Services

Last Subchapter Revision Date: July 2026

M1440 CHANGES

Changed With	Effective Date	Sections Changed
TN #DMAS-39	7/1/26	M1440.010
TN #DMAS-33	10-1-24	Appendix 1
TN #DMAS-30	1/1/24	M1440.100
TN #DMAS-28	7/1/23	Appendix 1
TN #DMAS-10	10/1/18	M1440.100, M1440.101
TN #DMAS-7	1/1/18	M1440.001, Appendix 1
TN #DMAS-5	7/1/17	Table of Contents PM1440.101, M1440.103, M1440.104, M1440.105, M1440.106M M1440.203, M1440.205
TN #DMAS-3	1/1/17	Table of Contents M1440.101-M1440.205 Appendix 1 was added.
UP #9	4/1/13	M1440.020
UP #7	7/1/12	Table of Contents M1440.010, 14, 15, 18a-18c Pages 19, 20
TN #94	9/1/2010	Table of Contents Pages 13, 16, 18b, 19-22
TN #93	1/1/2010	Pages 14, 16
TN #91	5/15/2009	Table of Contents Page 12 Pages 17-18c

TN – Transmittal
UP – Update

SECTION M1440.010: BASIC ELIGIBILITY REQUIREMENTS

Last Section Revision Date: July 2026

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D. Financial Eligibility

An individual who has been screened and approved for CBC services is treated as an institutionalized individual for the Medicaid eligibility determination. Financial eligibility is determined as a one-person assistance unit separated from his legally responsible relative(s) with whom he lives.

If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has *365* days from the date on the Notice of Action to begin receiving CBC services.

For unmarried individuals, and for married individuals without community spouses other than MAGI Adults, the resource and income eligibility criteria in subchapter M1460 is applicable. MAGI Adults in LTC are evaluated using the resource policy in M1460 the MAGI income policy in M04. Only certain resource eligibility requirements are applicable to individuals in the Modified Adjusted Gross Income (MAGI) Adult covered group who are institutionalized.

For married individuals with community spouses, other than MAGI Adults, the resource and income eligibility criteria in subchapter M1480 is applicable.

The asset transfer policy in M1450 applies to all CBC waiver services recipients.

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Subsection M1460.220: 330% of SSI Payment Limit Group

Last Subsection Revision Date: July 2026

A. Description

These are ABD or F&C individuals in medical facilities or who receive Medicaid CBC waiver services, who meet the appropriate CN resource requirements and resource limit and whose income is less than or equal to 300% of the SSI payment limit for an individual.
Individuals who have been authorized for Medicaid LTC or Long-term Services and Supports (LTSS) may be evaluated in this covered group. If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has *one year* (*365* days) from the date on the Notice of Action to begin services.

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Subchapter M1470: Patient Pay – Post-eligibility Treatment of Income

Last Subchapter Revision Date: 7/1/26

M1470 CHANGES

Changed With	Effective Date	Sections Changed
TN #DMAS-39	7/1/26	M1470.001, M1470.230, M1470.430, M1470.910, M1470.930
TN #DMAS-37	1/1/26	M1470.410
TN #DMAS-36	10/1/25	M1470.430, M1470.600, M1470.1100
TN #DMAS-35	7/1/25	M1470.001 and M1470.910
TN #DMAS-34	1/1/25	M1470.001, M1470.100, M1470.230, M1470.410, M1470.420, M1470.430

TN #DMAS-33	10/1/24	M1470.001, M1470.100
TN #DMAS-32	7/1/24	M1470.001, M1470.100, M1470.100, M1470.230, M1470.300, M1470.41020, M 1470.4300, M1470.900, M1470.1100, and M1470.1210
TN #DMAS-31	4/1/24	M1470.230, M1470.240
TN #DMAS-30	1/1/24	M1470.420
TN #DMAS-29	10/1/23	M1470.900, M1470.910
TN #DMAS-28	7/1/23	M1470.410, Appendix 1
TN #DMAS-27	4/1/23	M1470.300
TN #DMAS-26	1/1/23	M1470.410
TN #DMAS-25	10/1/22	M1470.410
TN #DMAS-24	7/1/22	M1470.001, M1470.240, M1470.430, M1470.920, M1470.930
TN #DMAS-22	1/1/22	M1470.410
TN #DMAS-21	10/1/21	M1470.320
TN #DMAS-20	7/1/21	M1470.230, M1470.410, M1470.430
TN #DMAS-19	4/1/21	M1470.230, M1470.430
TN #DMAS-18	1/1/21	M1470.410, M1470.420
TN #DMAS-17	7/1/20	Table of Contents, page ii M1470.001, M1470.230, M1470.430, M1470.900, M1470.910, M1 470.1010, M14701210 Appendix 1, page 1
TN #DMAS-15	1/1/20	M1470.410, M1470.420
TN #DMAS-12	4/1/19	M1470.230, M1470.430
TN #DMAS-10	10/1/18	M1470.230, M1470.430
TN #DMAS-9	7/1/18	M1470.230, M1470.430

SECTION M1470.001: PATIENT PAY OVERVIEW

Last Section Revision Date: JULY 2026

A. Introduction

"Patient pay" is the amount of the long-term care (LTC) patient's income which must be paid as the share of the LTC services cost. This subchapter provides
basic rules regarding the post-eligibility determination of the amount of the LTC patient's income which must be paid toward the cost of care. **MAGI Adults, Hospice recipients receiving services outside a facility and individuals participating in the Medicaid Works program have no responsibility for patient pay (see M03 for more information).** If an individual receiving LTC, also called long-term services and supports (LTSS), loses eligibility in one of these covered groups and is eligible in *a* different full coverage group, patient pay policy will apply.

B. Policy

The state's Medicaid program must reduce its payment to the LTC provider by the amount of the eligible patient's monthly income, after allowable deductions. Patient pay is calculated using actual verified income after an individual has been determined eligible for Medicaid and for Medicaid LTC services. A non-Medically Needy Medicaid recipient who is admitted to a nursing facility, facility for individuals with intellectual disability (ICF-ID) or Medicaid waiver services for less than 30 calendar days must have a patient pay determined for the month(s) in which the recipient is in the facility or waiver services**.** Medically Needy Medicaid does not cover services in ICF-ID or other facilities for less than 30 days. See M1470.320. The provider collects the patient pay from the patient or the
authorized representative. Patient pay information is fed to the Automated Response System (ARS) and the MediCall Systems for provider verification of patient pay. These systems report the amount of patient pay and the date of service to the provider responsible for collecting patient pay.

C. VaCMS Patient Pay Process

The patient pay calculation is completed in VaCMS. Refer to the VaCMS Help feature for information regarding data entry. The patient pay must be updated in the system whenever the patient pay changes, but at least once every 12 months.
If VaCMS is not able to process required transactions, a Patient Pay Correction *request should be submitted using the Coverage Correction Portal (CCP).*

The CCP replaces the Word document version of the Coverage Correction Form (CCF), Patient Pay Correction Form, use of the shared e-mail boxes and the requirement to upload coverage and patient pay correction forms to DMIS. Effective 8/1/2025, all Coverage and Patient Pay Correction Requests must be submitted through the CCP.

To access the CCP and User Guides, LDSS, VDSS, Cover Virginia, and DMAS staff must sign into the MES using their current credentials and then sign into the MMIS with their eCode.

The patientpay@dmas.virginia.gov mailbox remains active for questions, but correction requests should be submitted through the CCP. DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into MES.

If attested income was used to determine eligibility, actual income must be verified to calculate patient pay. If actual income was not obtained while determining eligibility the worker must request income verification to calculate patient pay by adding a comment on the notice. If the verified income affects eligibility for the individual, process as a change. If no additional verification is received, the estimated patient pay remains a liability for the individual.

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Subsection M1470.230: Facility – Noncovered Medical Expenses

Last Subsection Revision Date: July 2026

A. Policy

Amounts for incurred medical and dental expenses not covered by Medicaid or another third party are deducted from the patient's gross monthly income when determining patient pay.

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4. **Documentation Required**

a. **Requests for Adjustments from A Patient or Authorized Representative** – Request the following documentation from the patient or his representative:

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

The local agency can make the adjustment for services identified in subsection C. 2. b. through d.1), above providing the cost of the service does not exceed $500. If the cost of the service is not identified in subsection C. 2. b. through d.1), or exceeds $500, send the documentation to DMAS to obtain approval and the allowable amount of the adjustment (reimbursement is limited to the prevailing Medicaid or Medicare rate).

Claims for incurred medical or remedial care expenses must be submitted within 90 calendar days after the invoice date.

No deductions shall be permitted for medical or remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period.

b. **Requests for Adjustments from LTC Providers**

If the request for an adjustment to patient pay to deduct one of the above expenses is made by a nursing facility, ICF-MR, long-stay hospital, or Department of Behavioral Health and Developmental Services (DBHDS) facility, the request must be accompanied by:

- *A completed DMAS-225;*
- the recipient's correct Medicaid ID number,
- the current physician's order for the non-covered service (not required for replacement of hearing aid batteries or eyeglass frames or for repair of hearing aids or eyeglasses),
- *Service description and medical justification for the service being requested;*

- actual cost information,
- documentation that the recipient continues to need the equipment for which repair, replacement, or battery is requested, and
- a statement of denial or noncoverage by other insurance. *The NF must obtain verification that the requested service or item is not covered by any other source. Either an official denial from a third-party carrier or a written statement by the NF staff that the insurance company was contacted, and the item or service is, in fact, non-covered is acceptable. In either case, the statement must include identification of the third party payer(s), the policy number, and the name of the insured, the date that the third party payer was contacted, and the full name of the third-party payer contact person.*
- *For hearing aid, wheelchair, and communication device requests, the Minimum Data Sheet (MDS) must also be included or alternative similar documentation if the individual resides in an ICF/IID or LSH.*

If the request from a facility does not include all the above documentation, return the request to the facility asking for the required documentation.

When the cost of the service cannot be authorized by the local department of social services and/or exceeds $500, send the request and the documentation to DMAS to obtain approval for the adjustment and the allowable amount of the adjustment (reimbursement is limited to the prevailing Medicaid or Medicare rate). DMAS must be notified of the name and address of the recipient's spouse, POA or guardian so that proper notification of the decision can be given.

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Subsection M1470.430: Medicaid CBC – Noncovered Medical Expenses

Last Subsection Revision Date: July 2026

A. Policy

Amounts for incurred medical and dental expenses not covered by Medicaid or another third party, including services or benefits provided as part of an enrollee's managed care organization, are deducted from the patient's gross monthly income when determining patient pay.

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5. Procedures

a. **Determine Deduction** – When the individual receives CBC services, DMAS approval **is not required** for deductions of noncovered services from patient pay, regardless of the amount of the deduction.

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

1. Upon receipt of the requested documentation, determine the amount of
the bill that is a valid deduction. Do not deduct more than the availab le income that remains after the personal needs, dependent child allowance(s), and health insurance premiums are deducted.
If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service is requeste d, deduct the new noncovered services after the first noncovered service deductions have been completed.
2. Subtract the deduction for the current month. If the deduction ex ceeds the available income, the remaining balance can be carried over to the following month(s).

b. **Notice Procedures** – Upon the final decision to allow the deduction, use the VaCMS Patient Pay
process to adjust the patient pay. VaCMS will generate and send the Notic e of Patient Pay Responsibility. If VaCMS is not able to process required transactions, a Patient Pay Correction *request should be submitted using the Coverage Correction Portal (CCP)*.

The CCP replaces the Word document version of the Coverage Correction Form (CCF), Patient Pay Correction Form, use of the shared e-mail boxes and the requirement to upload coverage and patient pay correction forms to DMIS. Effective 8/1/2025, all Coverage and Patient Pay Correction Requests must be submitted through the CCP.

To access the CCP and User Guides, LDSS, VDSS, Cover Virginia, and DMAS staff must sign into the MES using their current credentials and then sign into the MMIS with their eCode.

The patientpay@dmas.virginia.gov mailbox remains active for questions, but correction requests should be submitted through the CCP. DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into MES.

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Subsection M1470.910: Retroactive Adjustment for Prior Months

Last Subsection Revision Date: July 2026

A. Retroactive Adjustment

If a change was reported timely and the patient pay for prior months is incorrect, adjust the patient pay for the prior months only in the following situations:

- A deceased individual had health insurance premiums or noncovered medical expenses that should have reduced patient pay, or
- A community spouse is owed money for a spousal allowance and the institutionalized spouse is deceased or no longer in long-term care. However, if the community spouse had decreased income and did not report the change in a timely manner, do not adjust the patient pay.
- Patient pay may be reduced in the past when there is no other way to make the member whole (e.g., ongoing patient pay is zero). The reduction must be for the most recent months and must be approved and completed by DMAS. If VaCMS is not able to process required transactions, a Patient Pay Correction *request should be submitted using the Coverage Correction Portal (CCP). To access the CCP and User Guides, LDSS, VDSS, Cover Virginia, and DMAS staff must sign into the MES using their current credentials and then sign into the MMIS with their eCode. The patientpay@dmas.virginia.gov mailbox remains active for questions, but correction requests should be submitted through the CCP. DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into MES*.
- If an individual has moved from NF to CBC, adjust the patient pay effective the month after the change.

In these situations, adjust the patient pay retroactively using the VaCMS Patient Pay process for the prior months in which the patient pay was incorrect. **In all other situations when a change is reported timely, do not adjust the patient pay retroactively.**

B. Notification Requirements

VaCMS automatically generates and sends the Notice of Patient Pay Responsibility. DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into MES

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Subsection M1470.930: Death or Discharge from LTC

Last Subsection Revision Date: July 2026

A. Policy

The LTC provider may not collect an amount of patient pay that is more than the Medicaid rate for the month. When a patient dies or is discharged from LTC to another living arrangement that does not include LTC services, do not recalculate patient pay for the month in which the patient died or was discharged. The provider is responsible for collecting an

amount of patient
pay for the month of death or discharge that does not exceed the Medicaid rate for the month.

B. Procedure

Refer to the VaCMS Help feature for procedures regarding death or discharge from LTC. Send a DMAS-225 to the provider regarding the eligibility status of the patient. Send a notice to the patient or the patient's representative that reflects the reduction or termination of services. If VaCMS is not able to process required transactions or additional correction is needed, a Patient Pay Correction *request should be submitted using the Coverage Correction Portal (CCP). To access the CCP and User Guides, LDSS, VDSS, Cover Virginia, and DMAS staff must sign into the MES using their current credentials and then sign into the MMIS with their eCode. The patientpay@dmas.virginia.gov mailbox remains active for questions, but correction requests should be submitted through the CCP.*

DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into MES.

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Subchapter M1480: Married Institutionalized Individuals' Eligibility and Patient Pay

Last Subchapter Revision Date: July 2026

M1480 CHANGES

Changed With	Effective Date	Sections Changed
TN #DMAS-39	7/1/26	M1480.410
TN #DMAS-37	1/1/26	M1480.015, M1480.231, M1480.410, M1480.430
TN #DMAS-36	10/1/25	M1480.410
TN #DMAS-35	7/1/25	M1480.000, M1480.410
TN #DMAS-34	1/1/25	M1480.015, M1480.231, M1480.410, M1480.430
TN #DMAS-33	10/1/24	M1480.220, M1480.410
TN #DMAS-32	7/1/24	M1480.010, M1480.200, M1480.220, M1480.225, M1480.231, M1480.232, M1480.240, M1480.241, M1480.260, M1480.320, M1480.330, M1480.330, M1480.335, M1480.342, M1480.350, M1480.420, M1480.430, M1480.440, M1480.450, M1480.460, M1480.470, M1480.430
TN #DMAS-31	4/1/24	M1480.200, M1480.225

TN #DMAS-30	1/1/24	M1480.010, M1480.015, M1480.231, M1480.410, M1480.430
TN #DMAS-29	10/1/23	M1480.410
TN #DMAS-26	1/1/23	M1480.015, M1480.231, M1480.410, M1480.430
TN #DMAS-25	10/1/22	M1480.420
TN #DMAS-24	7/1/22	M1480.200, M1480.210, M1480.310, M1480.315, M1480.330, M1480.340, M1480.400, M1480.470, M1480.470, m1480.430
TN #DMAS-22	1/1/22	M1480.015, M1480.231, M1480.410, M1480.430
TN #DMAS-21	10/1/21	M1480.410
TN #DMAS-20	7/1/21	M1480.410, M1480.430
TN #DMAS-18	1/1/21	M1480.015, M1480.231, M1480.410, M1480.430, M1480.510
TN #DMAS-17	7/1/20	M1480.015, M1480.231, M1480.410, M1480.440, M1480.510
TN #DMAS-15	1/1/20	M1480.000, M1480.015, M1480.231, M1480.410, M1480.430
TN #DMAS-13	7/1/19	M1480.410

Subsection M1480.410: Maintenance Standards and Allowances

Last Subsection Revision Date: July 2026

A. Introduction

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

B. Monthly Maintenance Needs Allowance

$2,705	*7-1-26*
$2,643.75	7-1-25
$2,555	7-1-24
$2,465	7-1-23
$2,288.75	7-1-22

C. Maximum Monthly Maintenance Needs Allowance

$4,066.50	1-1-26
$3,948.00	1-1-25
$3,853.50	1-1-24
$3,715.50	1-1-23
$3,435.00	1-1-22

D. Excess Shelter Standard

$811.50	*7-1-26*

$793.13	7-1-25
$766.50	7-1-24
$739.50	7-1-23
$686.63	7-1-22

E. Utility Standard Deduction (SNAP)

$375.00	10-1-25	1 - 3 household members
$476.00	10-1-25	4 or more household members
$369.00	10-1-24	1 - 3 household members
$467.00	10-1-24	4 or more household members

SECTION M1520.300: MA CANCELLATION OR SERVICES REDUCTION

Last Section Revision Date: July 2026

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3. Death of Enrollee –

The eligibility worker must take the following action when it is determined that an enrollee is deceased:

N. The Social Security Administration will verify that an individual is dead, but not the date of death. A match with Social Security Administration data occurs when the individual's information is sent through the Hub in VaCMS.

O. Accept the date of death reported to the agency from a family representative or medical provider as accurate. If there is conflicting information regarding the date of death, contact the parent/caretaker relative or authorized representative to obtain the date of death. Information from a medical professional/facility is also acceptable. If the worker is unable to determine the actual date of death, use the date that a HUB inquiry verifies that the member is deceased. *A batch will run in MES to verify or update the date of death with the date received from the Virginia Department of Health*.

P. The worker must document the VaCMS case record. Send adequate notice of cancellation to the estate of the enrollee at the enrollee's last known address and to any authorized representative(s) using the Notice of Action on Medicaid.

Q. Cancel the enrollee's coverage, using the date of death (or the date of the HUB inquiry) as the effective date of cancellation.