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CHAPTER III

MEMBER ELIGIBILITY

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DETERMINING ELIGIBILITY

The Department of Medical Assistance Services (DMAS) administers Virginia's medical assistance programs: Medicaid and the state's Children's Health Insurance Program (CHIP), called Family Access to Medical Insurance Security (FAMIS). Per state regulations, eligibility determinations for the medical assistance programs are made by the local departments of social services (LDSS) and by the Cover Virginia Central Processing Unit (CPU).

Inquiries from persons who wish to apply for medical assistance should be referred to the LDSS in the locality in which the applicant resides, to the Cover Virginia Call Center at 1-855-242-8282, or the Cover Virginia website at https://coverva.dmas.virginia.gov/. DMAS will not pay providers for services, supplies, or equipment until the applicant's eligibility has been determined. (See "Assistance to Patients Possibly Eligible for Benefits.") A member's eligibility must be reviewed when a change in the member's circumstances occurs. All members are subject to a periodic renewal (redetermination) of eligibility annually, with the following exceptions:

- Effective January 1, 2027, individuals enrolled in the Medicaid Expansion coverage group must renew coverage every six months.
    - American Indian Tribal members who are enrolled in Expansion are not subject to the six-month requirement and must complete the renewal process annually.
- Pregnant members have continuous eligibility through the end of their postpartum period, which is 12 months postpartum, with the exception of FAMIS Prenatal members, whose postpartum coverage period ends 60 days postpartum.

Groups Covered by Medical Assistance

Individuals who apply for Medicaid are evaluated under the covered group or groups they meet. Each covered group has a prescribed income limit, and some covered groups also have an asset or resource limit. The FAMIS programs—FAMIS for Children, FAMIS MOMS and FAMIS Prenatal Coverage for pregnant women—offer coverage similar to Medicaid but have higher income limits.

Individuals may be eligible for full medical assistance coverage, including the payment of Medicare premiums for Medicaid members with Medicare, if they fall into one of the following covered groups and meet the nonfinancial and financial requirements for the group:

- Auxiliary Grants (AG) recipients

- Aged, blind or disabled (ABD) recipients of Supplemental Security Income

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(SSI) and certain former SSI recipients with “protected” status.

- ABD individuals with income less than or equal to 80% of the Federal Poverty Level (FPL) who are age 65 or older, blind, or disabled and/or who are eligible for or enrolled in Medicare.

- Low-Income Families with Children (LIFC; a coverage group for parents with a dependent child under age 18 years in the home who meet certain income limits and other eligibility criteria).

- Pregnant women, and postpartum women through the end of the 12-month postpartum period (Medicaid and FAMIS MOMS).

- Pregnant women otherwise eligible for full-benefit coverage through Medicaid or FAMIS MOMS but for their immigration status, through the FAMIS Prenatal Coverage program. FAMIS Prenatal Coverage members are eligible for the duration of the pregnancy and through the end of the month in which the 60th postpartum day falls.

- Newborns up to age one year born to individuals enrolled in Medicaid, FAMIS, or FAMIS MOMS at the time of birth.

- Children in foster care or subsidized adoptions, and individuals under age 26 who were formerly in foster care until their discharge from foster care at age 18 or older.

- Children under age 19 years (Children’s Medicaid, FAMIS)

- Adults between the ages of 19 and 64 who are not eligible for or enrolled in Medicare (Medicaid Expansion Adults).

- Individuals under age 21 in institutional care.

- Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) — women and men who were certified through the Breast and Cervical Cancer Early Detection Program.

- Individuals who are in long-term care institutions or receiving services under a home and community-based care waiver, or who have elected hospice care.

The following individuals may be eligible for limited Medicaid coverage if they meet the nonfinancial and financial requirements for the covered group:

- Qualified Medicare Beneficiaries (QMBs) with income less than or equal to

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100% of the FPL. This group is eligible for Medicaid coverage of Medicare premiums, deductibles, and coinsurance only.

- Special Low-Income Medicare Beneficiaries (SLMB) with income over 100% and less than or equal to 120% of the FPL. This group is eligible for Medicaid coverage of Medicare Part B premiums only.

- Qualified Individuals (QI) with income over 120% but less than or equal to 135% of the FPL. This group is eligible for Medicaid coverage of the Medicare Part B premiums only.

- Qualified Disabled and Working Individuals (QDWI) with income up to 200% of the FPL. This group is eligible for Medicaid payment of Medicare Part A premiums only.

- Plan First – Individuals with income up to 200% of FPL who are not covered for full Medicaid benefits. Coverage is limited to family planning services only. Applicants must opt in to be evaluated for Plan First coverage if they do not qualify for full Medicaid coverage.

Medically Needy Covered Groups and Spenddown

Through a process known as "spenddown," Medicaid provides a limited period of full coverage for certain groups of "Medically Needy" individuals who meet all the Medicaid eligibility requirements but have excess income for full benefit Medicaid. Individuals to whom spenddown may apply include:

- ABD individuals
- Pregnant women and their newborn children
- Children under age 18
- Individuals under age 21 in institutional care, under supervision of the Department of Juvenile Justice, foster care, or subsidized adoptions
- Individuals in long-term care institutions and those receiving services under a home and community-based care waiver or who have elected hospice care.

To be eligible for Medicaid, the individual must have incurred allowable medical expenses that at least equal the spenddown liability. If the individual's allowable medical expenses equal the spenddown liability amount before the end of a budget period (six-month period for non-institutionalized individuals or a one month period for institutionalized individuals), the applicant may receive a limited period of Medicaid coverage which will stop at the end of the budget period. The spenddown liability is the difference between the individual's income and the medically needy income limit for the individual's locality, multiplied by the number of months in the individual's spenddown period. Eligibility must be redetermined in order to establish eligibility in subsequent budget periods.

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An individual placed on a spenddown does **not** have full Medicaid coverage until the spenddown is met, however they may be eligible for limited Medicaid coverage or Plan First during the spenddown period. Medicaid cannot pay medical expenses incurred prior to the date the spenddown is met.

Eligible Noncitizens and Emergency Medicaid Services

To be eligible for full Medicaid or FAMIS benefits, an individual must be a resident of Virginia and a U.S. citizen, or a noncitizen qualified for full benefits. Included in this definition are lawfully residing immigrants who are pregnant or within the first 12 months postpartum and lawfully residing immigrant children under the age of 19. In addition, the FAMIS Prenatal Coverage program offers prenatal coverage, through 60 days postpartum, for uninsured pregnant women up to 200% FPL who do not meet immigration status criteria but are otherwise eligible for Medicaid or FAMIS MOMS.

Individuals who do not qualify for full Medicaid benefits due to their Immigration status may be eligible for Medicaid coverage of emergency services if they meet all other nonfinancial and financial eligibility requirements for full Medicaid coverage.

Individuals may apply for Emergency Services Medicaid through the same application processes used to apply for Medicaid.

For more information, please see the Emergency Medicaid Services Supplement that is attached to the Physician-Practitioner, Hospital, and Transportation Manuals.

Medicaid Eligibility for Institutionalized Individuals

An institutionalized individual is defined as one who is receiving long-term services and supports (LTSS) as an inpatient in a medical institution or nursing facility or in the home or community setting. Home and community-based services (HCBS) include waiver services such as personal care, adult day health care, respite care, and the Program for All Inclusive Care for the Elderly (PACE).

To be approved for Medicaid-covered LTSS, the individual must be institutionalized in a nursing or other medical facility or have been assessed and authorized for HCBS and be eligible for Medicaid in a full-benefit covered group.

If an individual is not eligible for Medicaid in any other full-benefit covered group, the individual's eligibility in one of the special income covered groups is determined. The policy for these groups allows a different method of determining income and resource eligibility, a higher income limit of 300% of the SSI payment for one person.

A married institutionalized individual's spouse at home is referred to as the

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community spouse. The community spouse is able to retain a specified amount of resources to continue to meet maintenance needs in the community. Some of the institutionalized spouse's monthly income may also be allocated to the community spouse if certain criteria are met. At the time of application for Medicaid, the LDSS completes a resource assessment, producing a compilation of a couple's combined countable resources at the time one spouse became institutionalized and a calculation of a spousal share (the amount of shared resources that can be allocated to the community spouse). An institutionalized spouse with a community spouse may also request a resource assessment without submitting a Medicaid application to assist with financial planning.

Most individuals receiving LTSS have an obligation toward the cost of their care, known as the patient pay. MAGI adults do not have a patient pay responsibility.

FAMILY ACCESS TO MEDICAL INSURANCE SECURITY (FAMIS)

FAMIS Children

FAMIS is Virginia's Title XXI Children's Health Insurance Program (CHIP) and is a comprehensive health insurance program for children from birth through age 18 who are not covered under other creditable health insurance and whose income is over the Medicaid income limit but no more than 200% of the FPL.

When children are initially enrolled in FAMIS they will have brief coverage in fee-for-service (FFS), with a Medicaid look-alike benefit package, before transitioning to a managed care organization (MCO). Once in managed care, FAMIS children are eligible for benefits similar to those covered for children under the State Plan for Medical Assistance, with some exceptions.

FAMIS MOMS

The FAMIS MOMS program covers uninsured pregnant women whose income is over the Medicaid income limit but no more than 200% of the FPL. This coverage extends through 12 months postpartum. FAMIS MOMS provides the same benefits to pregnant women as Medicaid, including dental services.

FAMIS Prenatal Coverage

Effective July 1, 2021, prenatal coverage is available through the FAMIS Prenatal Coverage program for uninsured pregnant women who meet all other eligibility criteria for Medicaid and FAMIS MOMS but do not meet immigration status rules. FAMIS Prenatal Coverage is available through the end of the calendar month in which the 60th postpartum day falls.

12-MONTHS CONTINUOUS ELIGIBILITY FOR CHILDREN

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It is mandatory for states to provide 12 months of continuous eligibility (CE) for children under age 19 in Medicaid and CHIP (FAMIS), with limited exceptions. CE means the child remains enrolled for a protected 12-month period, during which their coverage cannot be reduced or terminated regardless of changes in circumstance. Changes in circumstance that do not impact eligibility until the end of the child's CE period include, but are not limited to, an increase in household income, loss of Supplemental Security Income (SSI), or a FAMIS-enrolled child obtaining other qualifying health coverage.

Exceptions to the CE requirement are listed below:

- The child turns age 19. Coverage under a children's eligibility group will end at the end of the month in which the individual turns 19. The individual will be evaluated for ongoing coverage as an adult and enrolled if eligible.
- The child moves out of Virginia. Coverage ends at the end of the month in which the child ceases to be a Virginia resident.
- The child or their representative requests termination of the child's coverage.
- The agency determines that eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the child/child's representative.
- Death of the enrolled child.

Medicaid-enrolled children may not be moved into FAMIS during the 12-month continuous eligibility period as this is a reduction of coverage. FAMIS-enrolled children may be moved into Medicaid during a CE period but must be given a new 12-month CE period beginning when the change occurs.

MEMBER ELIGIBILITY CARD

A white plastic eligibility card with the Cardinal Care logo on front is issued to members enrolled in either Medicaid, FAMIS, or Plan First coverage to present to participating providers. A sample of an eligibility card is included under "Exhibits" at the end of this chapter.

Eligibility must be confirmed each time service is rendered. Verification can occur through a verification vendor, the voice response system or the web-based verification system. LDSS and Cover Virginia do not provide verification of eligibility to providers.

Most individuals have coverage under a Virginia Medicaid/FAMIS contracted managed care organization (MCO) and should not receive services outside their network without a referral and authorization from the MCO. These members will have an MCO card from their assigned MCO provider with the Cardinal Care logo in

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addition to the Medicaid/FAMIS Cardinal Care logo card. Both cards should be presented to the provider when requesting services or medications. The verification response will advise if the member has restrictions such as a contracted MCO enrollment, or a primary payer.

The provider must determine if the service is within the dates of eligibility. These dates must be checked prior to rendering any service. Benefits are available only for services performed during the indicated period of eligibility; Medicaid/FAMIS will not pay for care or services rendered before the beginning date or after the end date of eligibility.

Name of Eligible Person

An eligibility card is issued to each person eligible for full Medicaid/FAMIS benefits and QMBs. Check the name against another proof of identification if there is any question that the card does not belong to the member. Cards with “Do Not Use” or other non-names should not be accepted.

Member's Eligibility Number

The **member's** complete eligibility number is embossed on the front of the eligibility card. Eligibility numbers are distinct and permanent. When a member relocates or moves into another case, or has a break in eligibility, they keep the same number and the same card. This number serves as a “key” in verifying current eligibility status.

All 12 digits must be entered on Medicaid forms for billing purposes.

Bank Identifier

The six numbers on the plastic card represent the Bank Identifier Number (BIN), which is required for pharmacy benefit cards under the National Council of Prescription Drug Programs (NCPDP).

Date of Birth

The date of birth indicates the member's age and identifies eligibility for those services with age restrictions. The date of birth should be checked prior to rendering any services. The provider should verify the age of the member. If the provider has a question as to the age of the member, means of identification other than the Medicaid/FAMIS card should be examined.

Card #

The sequential number of the member’s card is given. If a card is lost or stolen and

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another is issued, the prior card will be de-activated.

VERIFICATION OF MEMBER ELIGIBILITY

It is the obligation of the provider of care to determine the identity of the person named on the eligibility card and the current eligibility status, to include program type or MCO enrollment. Possession of a card does not mean the holder is currently eligible for benefits. .

Program/Benefit Package Information

Members' benefits vary depending upon the program in which they are enrolled. The eligibility verification will provide information on which program the member is participating in. Examples of these programs include Cardinal Care, Medicaid fee-for-service, FAMIS MCO, CCC Plus Waiver, FAMIS fee-for-service and Medicare premium payment.

Limited Benefit Programs for Which Members Receive Eligibility Cards

The Medicare Catastrophic Coverage Act of 1988 and other legislation require State Medicaid Programs to expand the coverage of services to QMBs. There are two levels of coverage for QMBs, based on financial eligibility.

QMB Coverage Only—Members in this group are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit, less the member's copayment on allowed charges for all Medicare-covered services. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY--QMB." The Medicare coinsurance is limited to the Medicaid fee when combined with the Medicare payment.

QMB Extended Coverage—Members in this group are dually-eligible for full Medicaid coverage and Medicare. They are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit on allowed charges for all Medicare-covered services plus coverage of all other Medicaid-covered services listed in Chapter I of this manual. This group's Medicaid verification provides the message, "QUALIFIED MEDICARE BENEFICIARY--QMB EXTENDED." These members are responsible for copays for pharmacy services, health department clinic visits, and vision services.

SLMBs and QIs do not receive member eligibility cards because they are not eligible for the payment of medical services rendered.

Plan First—Men and women enrolled in Plan First can receive limited Medicaid covered family planning services only, and they receive a Plan First identification card. This group's Medicaid verification provides the message, "limited benefits

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only." See the Plan First Manual for more information.

All Others—Members without ANY of these messages at time of verification will be eligible for those covered services listed in Chapter I of this manual.

Special Indicator Code (formerly Copayment Code – Copayments are no longer charged for Medicaid and FAMIS eligible members)

The Special Indicator Code indicates eligibility for certain additional services. These codes are:

Code	Message
A	Under 21.
B	Individuals Receiving Long-Term Care Services, Home or Community-Based Waiver Services, or Hospice Care
C	All Other Members

Insurance Information

The "Insurance Information" in the verification response indicates any type of insurance coverage the member has in addition to Medicaid. This information includes specific insurance companies, dates of coverage, policy numbers, and a code that specifies the particular type of coverage of the policy. These items are:

Carrier Code	A three-digit code indicating the name of the insurance carrier, e.g. 001 for Medicare (See Insurance Company Code List for these code numbers in "EXHIBITS" at the end of this chapter.) If the carrier code is 003 (not listed), call the member's local eligibility worker for assistance in obtaining the name of the insurance carrier.
Begin Date	The first date on which this insurance policy was effective
Type Code	An alpha character describing the type of coverage provided by the policy, such as a "D" for dental coverage. (See the Type of Coverage Code List under "EXHIBITS" at the end of this chapter for a list of these codes.)
Policy Number/ Medicare Code	The specific policy or Medicare number for the insurance identified by the Carrier Code

Only insurance information for active policies during the period for which eligibility is

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requested is provided at verification. If the member reports insurance information different from what is on the card, refer the member to their LDSS eligibility worker to correct the data so bills will be processed correctly.

Under the assignment of benefits regulations, DMAS can act on behalf of the member (subscriber) and recover third-party payment from the primary carrier. Workers' Compensation and other liability insurances (e.g., automobile liability insurance or home accident insurance) **are always considered as primary carriers** for cases where coverage is applicable to the injury being treated. Because the member's eligibility card cannot indicate this coverage, it is necessary that cause-of-injury information be obtained from the member.

Primary Care Providers (PCPs) for the Client Medical Management Program

A primary care designation or restriction is imposed by the Member Monitoring Unit of DMAS as a result of high utilization of services by the member causing unnecessary or duplicate services. Eligibility verification will list the names of designated primary care providers (physician and/or pharmacy). The designated providers must agree to the relationship prior to the designation appearing on the member's card. Unless it is an emergency, do not provide services without contacting the primary care provider first for authorization.

MANAGED CARE PROGRAMS

Most Medicaid members are enrolled in one of the Department's managed care programs (Cardinal Care and PACE). Each program has specific eligibility requirements and health plan assignment criteria for its members. For more information, please contact the individual's managed care plan/PACE provider directly.

Contact and/or eligibility and assignment information for managed care plans can be found on the DMAS website for each program as follows:

- Cardinal Care: https://dmas.virginia.gov/for-providers/managed-care/cardinal-care-managed-care/
- Program of All-Inclusive Care for the Elderly (PACE) https://www.dmas.virginia.gov/for-providers/long-term-care/programs-and-initiatives/program-of-all-inclusive-care

MEMBER WITHOUT AN ELIGIBILITY CARD

A member who seeks services should be considered responsible for all charges incurred unless eligibility is verified. The provider can verify eligibility without the

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card using two other identification keys, including name, Social Security Number, and date of birth. These can be used to access the MediCall automated System, the verification vendors, and the web verification system (ARS). See Chapter I for further information about verification methods. LDSS do not provide verification of eligibility to providers.

ASSISTANCE TO PATIENTS POSSIBLY ELIGIBLE FOR BENEFITS

If a patient is unable to pay for services rendered, the provider may refer the patient or the patient's authorized representative to the LDSS in the locality in which the applicant resides or to the Cover Virginia Call Center at 1-855-242-8282 to complete an application for Medicaid. In most cases, a member's eligibility begins the first of the month in which the individual applies for coverage; however, Medicaid assumes no financial responsibility for services rendered prior to the effective date of a member's eligibility.

Retroactive Coverage

Effective January 1, 2027, an individual may request an evaluation for retroactive coverage of medical expenses that were incurred prior to the month of application.

- Individuals eligible for Medicaid Expansion may be evaluated for retroactive coverage one month prior to the month of application.
- Individuals eligible for all other Medicaid coverage groups may be evaluated for retroactive coverage up to two months prior to the month of application.
- FAMIS retroactive coverage is limited to children for whom an application is submitted within the two months following the month of birth.

Once a patient is found eligible, providers shall bill Medicaid for covered services, and upon receipt of payment from Medicaid, must reimburse the patient for anyout-of-pocket expenses; Medicaid cannot reimburse members for out-of-pocket expenses.

MEDICAID APPLICATIONS – AUTHORIZED REPRESENTATIVE POLICY

A Medicaid applicant must sign the application form unless the application is filed and signed by the applicant's legal guardian or conservator, attorney-in-fact, or other person who is authorized to apply on the applicant's behalf. If the applicant is unable to sign their name but can make a mark, the mark must be designated "his/her mark" and witnessed by one person.

A child under age 18 cannot legally sign a Medicaid application for himself or herself unless the child is legally emancipated from their parents. If a child is not legally emancipated, the parent or legal guardian**, or** an authorized representative designated by the parent or legal guardian, or a caretaker relative with whom the child lives must sign the application. Exception: A minor child under 18 years of age

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may apply for Medicaid on behalf of their own child.

A legally competent individual age 18 or older may authorize anyone age 18 or older to file a Medicaid application on their behalf provided that the authorization is in writing, identifies the individual or organization authorized to conduct business on their behalf, and is signed by the individual giving the authorization.

When an individual has been determined by a court to be legally incompetent or legally incapacitated, the individual's legally appointed guardian or conservator is the individual's authorized representative and can apply for Medicaid on the individual's behalf. If an individual does not have a legal guardian or authorized representative and is mentally unable to sign an application or designate a representative, the individual's spouse will be considered the authorized representative for Medicaid purposes. In situations where the individual is not married, is estranged from their spouse, or the spouse is unable to represent him or her, a relative of the individual who is willing to take responsibility for the individual's Medicaid business may be considered their authorized representative. Relatives who may be considered authorized representatives in this situation are, in the following order of preference: the individual's adult child; parent; adult sibling; adult niece or nephew; or adult aunt or uncle.

If it is determined that an individual cannot sign an application and does not have an attorney-in-fact or authorized representative, a Medicaid application may be filed by someone other than an authorized person provided the individual's inability to sign the Medicaid application is verified by a written statement from the individual's doctor. The statement must indicate that the individual is unable to sign and file a Medicaid application because of their diagnosis or condition. The application will be pended until it can be appropriately signed if it is determined that court action has been initiated to have a guardian or committee appointed for the individual or until an Adult Protective Services investigation concludes that guardianship proceedings will not be initiated. Under no circumstances can an employee of, or an entity hired by, a medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of an individual who cannot designate an authorized representative.

An application may be filed on behalf of a deceased person by their guardian or conservator, attorney-in-fact, executor or administrator of their estate, surviving spouse, or a surviving family member, in the following order of preference: adult child, parent, adult sibling, adult niece or nephew, or adult aunt or uncle. The application must be filed within the appropriate retroactive time periods (see section titled: Assistance to Patients Possibly Eligible for Benefits) subsequent to the month of the individual's death. Under no circumstances can an employee of, or an entity hired by, a medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of a deceased individual.

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~~**NON-MEDICAID PATIENT RELATIONSHIP**~~

~~Medicaid-eligible members who elect to be treated as private patients or who decline to verify their Medicaid eligibility with providers will be treated as private pay patients by the provider and by DMAS. Providers are required to furnish supporting documentation whenever patients fall into either of these categories.~~

NEWBORN INFANT ELIGIBILITY

All newborn days, including claims for "well babies," must be submitted separately. "Well baby" days cannot be processed as part of the mother's per diem, and no information related to the newborn must appear on the mother's claim.

A newborn is automatically considered eligible for Medicaid or FAMIS through age 1 year if the newborn's mother was eligible for full coverage Medicaid or enrolled in FAMIS or FAMIS MOMS at the time she gave birth. A medical assistance application must be filed for any child whose mother was not eligible for Medicaid or enrolled in FAMIS/FAMIS MOMS at the time of the child's birth.

A streamlined way to report the birth of the newborn is through the Medicaid MES/FAS Web Provider Portal http://vamedicaid.dmas.virginia.gov/ under the link "E-213". Any provider approved for access to the Portal may report the newborn's birth. To review the newborn's Member ID number, access the portal 30 days after submitting the E-213.

The newborn's birth can also be reported by calling CoverVA (1-833-5CALLVA/ 833-522-5582) or by reporting to the local department of social services in the locality where the member resides.

See Chapter I for more information on eligibility verification.

MEDICAID ELIGIBILITY FOR HOSPICE SERVICES

To be eligible to elect hospice as a Medicaid benefit, an individual must be entitled to Medicaid benefits and be certified as terminally ill. "Terminally ill" is defined as having a medical prognosis that life expectancy is six months or less. If the individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected or revoked concurrently under both programs.

GUIDELINES ON INSTITUTIONAL STATUS

Individuals Residing in an Institution for Mental Diseases (IMD)

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Federal regulations in 42 CFR 435.1009 prohibit federal financial participation in Medicaid services provided to individuals under age 65 years who are patients in an IMD, unless they are under age 22 and are receiving inpatient psychiatric services. An IMD is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, to persons with mental health conditions. A psychiatric residential treatment facility for children and adolescents is an IMD. An Intermediate Care Facility for the Intellectually Disabled (ICF-ID) is not an IMD.

Inmates of a Public Institution

Inmates of public institutions fall into three groups:

- individuals living in ineligible public institutions;
- incarcerated adults; and
- juveniles in detention.

An individual is an inmate of a public institution from the date of admission to the public institution until discharge, or from the date of actual incarceration in a prison, county or city jail or juvenile detention facility until permanent release, bail, probation or parole. An individual is considered incarcerated until permanent release, bail, probation or parole.

An individual who lives in a public residential facility that serves more than 16 residents is NOT eligible for Medicaid. The following are ineligible public institutions:

- public residential institutions with more than 16 beds
- residential facilities located on the grounds of, or adjacent to, a public institution with more than 16 beds.

Incarcerated Individuals

Incarcerated individuals (adults and juveniles) who are hospitalized can be eligible for Medicaid payment limited to services received during an inpatient hospitalization of 24 hours or longer, provided they meet all other Medicaid eligibility requirements.

Incarcerated individuals include:

- individuals under the authority of the Virginia Department of Corrections (DOC) or Virginia Department of Juvenile Justice (DJJ), and

- individuals held in regional and local jails, including those on work release.

Individuals are not eligible for full benefit Medicaid coverage while they are living in a correctional facility, regional or local jail or juvenile facility.

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An individual in prison or jail who transfers temporarily to a halfway house or residential treatment facility prior to a formal probation release order is still an inmate of a public institution and can only be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

Individuals released from jail under a court probation order due to a medical emergency are NOT inmates of a public institution because they are no longer incarcerated.

Once an individual is released from the correctional facility, they can receive full benefit Medicaid coverage, provided they meet all Medicaid eligibility requirements.

Juveniles

In determining whether a juvenile (individual under age 21 years) is incarcerated, the federal Medicaid regulations distinguish between the nature of the detention, pre- and post- disposition situations, and types of facilities.

a. Prior to Court Disposition

   The following juveniles can be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

   - juvenile who is in a detention center due to criminal activity
   - juvenile who has criminal charges pending (no court disposition has been made) who is ordered by the judge to go to a treatment facility, then come back to court for disposition when the treatment is completed

b. After Court Disposition

   Juveniles who are on probation with a plan of release which includes residence in a detention center are inmates of a public institution. If they go to any of the secure juvenile correctional facilities, they are inmates of a public institution and can only be eligible for Medicaid payment limited to inpatient hospitalization. A list of secure detention facilities in Virginia is available on the Department of Juvenile Justice's web site:
   https://www.djj.virginia.gov/documents/ppi/Juvenile-Detention-Centers-and-Homes-Contacts.pdf

   If they go to a non-secure group home, they can be eligible for Medicaid or FAMIS because a non-secure group home is not a detention center.

   A juvenile who is in a detention center due to care, protection or in the best interest of the child can be eligible for full benefit Medicaid or Family Access to

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Medical Insurance Security (FAMIS) coverage.

c. Type of Facility

The type of facility, whether it is residential or medical and whether it is public or private, must be determined. A juvenile who resides in an ineligible public residential facility is not eligible for full-benefit Medicaid. The child can be eligible for Medicaid coverage limited to inpatient hospitalization if they are admitted to a medical facility for inpatient services.

Who is Not an Inmate of a Public Institution

An individual is NOT an inmate of a public institution if:

- the individual is in a public educational or vocational training institution for purposes of securing education or vocational training OR
- the individual is in a public institution for a temporary period pending other arrangements appropriate to his needs. Individuals in public institutions for a temporary period include:
  - individuals admitted under a Temporary Detention Order (TDO)
  - individuals arrested then admitted to a medical facility
  - inmates out on bail
  - individuals on probation (including a juvenile on conditional probation or probation in a secure treatment center), parole, or conditional release
  - juveniles in a detention center due to care, protection or in their best interest.

APPEALS OF ADVERSE ACTIONS

An appeal is a request for a review of an adverse decision taken by DMAS, a DMAS contractor, or another agency on behalf of DMAS. There are two types of appeals – a provider appeal, which may be filed by a provider or their authorized representative, and a client appeal, which may be filed by an individual or an authorized representative on the individual's behalf. The client appeals process is described below. The provider appeals process is described in Chapter II.

CLIENT APPEALS

Definitions

Administrative Dismissal – The dismissal of a client appeal on various grounds, such as lack of a signed authorized representative form, or the lack of a final adverse action from the Medicaid Managed Care Organization ("MCO"), other DMAS Contractor, or other agency acting on behalf of DMAS.

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Adverse Action – means the denial or termination of enrollment or reduction in coverage, or the partial approval, denial, reduction, suspension, or termination of a service.

Adverse Benefit Determination – Pursuant to 42 C.F. R. § 438.400, means, in the case of an MCO, any of the following: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) The reduction, suspension, or termination of a previously authorized service; (iii) The denial, in whole or in part, of payment for a service; (iv) The failure to provide services in a timely manner, as defined by the State; (v) The failure of an MCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances an appeals; (vi) For a resident of a rural area with only one MCO, the denial of a member's request to exercise their right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. The denial, in whole or in part, of payment for a service solely because the claim does not meet the definition of a "clean claim" at 42 C.F.R. § 447.45(b) is not an adverse benefit determination.

Appeal – means:

1. For non-members, defined as a request for review of an adverse action by DMAS, a DMAS Contractor, or another agency acting on behalf of DMAS.

2. For members enrolled in an MCO, in accordance with 42 C.F.R. § 438.400, defined as a request for review of an MCO's internal appeal decision to uphold the MCO's adverse benefit determination. For members enrolled in an MCO, an appeal may only be requested after exhaustion of the MCO's one-step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

3. For members receiving fee-for-service ("FFS") services, defined as a request for review of a DMAS adverse action or DMAS Contractor's decision to uphold the Contractor's adverse action. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

Internal Appeal – means a request to the MCO by a member, a member's authorized representative or provider, acting on behalf of the member and with the member's written consent, for review of the MCO's adverse benefit determination. The internal appeal is the only level of appeal with the MCO and must be exhausted

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by a member or deemed exhausted according to 42 C.F.R. § 438.408(c)(3) before the member may initiate a State fair hearing.

Representative (or Authorized Representative) - means an individual who has been authorized to represent someone who received an adverse action. The authorized representative can be anyone such as a family member, friend, neighbor, provider, etc. However, the authorization for someone to serve as a representative for an individual 18 years of age or older must be in writing and submitted to the DMAS Appeals Division to process the appeal. This includes authorization for a provider to represent a member when the services at issue have not been rendered. Written authorization can include a power of attorney, proof of guardianship, or other legal documents establishing the representation. DMAS also has an authorized representative form available on its website at: https://www.dmas.virginia.gov/appeals.

State Fair Hearing – means the Department's *de novo* evidentiary hearing process for client appeals. Any adverse action by DMAS, a DMAS Contractor, or other agency acting on behalf of DMAS or internal appeal decision rendered by the MCO may be appealed by the member to the Department's Appeals Division. The Department conducts *de novo* evidentiary hearings in accordance with regulations at 42 C.F.R. § 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

There are three types of client appeals, each of which is described below. The first two types, MCO and FFS, involve individuals who are enrolled in Medicaid or a Medicaid program and receiving services either through an MCO or through fee-for-service. The third type, non-member, involves individuals who are seeking to become enrolled in Medicaid or a Medicaid program.

Member Appeals (MCO)

A member, an attorney, a provider authorized to represent a member, or another authorized representative on behalf of the member have the right to appeal adverse benefit determinations to the Department. However, the MCO's internal appeal process must be exhausted, or deemed exhausted (due to the failure of the MCO to adhere to the notice and timing requirements), prior to a member filing an appeal with the DMAS Appeals Division.

Any member, member's attorney, or member's authorized representative wishing to appeal an adverse benefit determination must first file an internal appeal with the MCO **within 60 calendar days** from the date on the notice of adverse benefit determination. The internal appeal request may be submitted orally or in writing. For individuals with special needs or who do not understand English, the appeal rights must be provided in such a manner as to make it understandable by the individual.

A member may request continuation of services during the MCO's internal appeal

and DMAS' State fair hearing. If an appeal is filed before the effective date of the action or within 10 days of the date the notice of adverse benefit determination was mailed, services may continue during the appeal process. If the final resolution of the appeal upholds the MCO's action and services to the member were continued while the internal appeal or State fair hearing was pending, the MCO may recover the cost of the continuation of services from the member.

Member appeals to DMAS are conducted in accordance with 42 C.F.R. § 431 Subpart E and the Department's Client Appeals regulations at Virginia Administrative Code 12 VAC 30-110-10 through 12 VAC 30-110-370.

If a member is dissatisfied with the MCO's internal appeal decision, the member or member's authorized representative may appeal to DMAS. Standard appeals of the MCO's internal appeal decision may be requested orally or in writing to DMAS. Expedited appeals of the MCO's internal appeal decision may be filed by telephone or in writing. The appeal may be filed at any time after the MCO's appeal process is exhausted and extending through **120 days after receipt** of the MCO's appeal decision. Appeal requests may be sent to the DMAS Appeals Division through one of the following methods:

- Through the Appeals Information Management System ("AIMS") at https://www.dmas.virginia.gov/appeals/. From there, you can fill out a client appeal request, submit documentation, and follow the process of your appeal.

- Through mail, email, or fax. You can download a Medicaid Client Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the client appeal. The request can be submitted by:
    - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
    - Email to appeals@dmas.virginia.gov; or
    - Fax to (804) 452-5454

- By phone at (804) 371-8488 or in-person at the Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219.

The Department's State fair hearing decision may be appealed to the appropriate circuit court by the member in accordance with the Administrative Process Act at Va. Code § 2.2-4025, *et. seq*. and the Rules of Court.

Member Appeals (FFS)

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12 VAC 30-110-10 through 370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Adverse actions may be

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appealed by the Medicaid member or by an attorney, by a provider authorized to represent the member, or other authorized representative on behalf of the member. Adverse actions include terminations of enrollment, or partial approvals, denials, reductions, suspensions, and terminations of service. Also, failure to act on a request for services within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was mailed, services may continue during the appeal process. However, if the adverse action is upheld by the hearing officer, the member may be required to repay DMAS or the DMAS Contractor for all services received during the appeal period. For this reason, the member may choose not to receive continued services. The DMAS contractor will be notified by DMAS to reinstate services if continuation of services is applicable. If coverage is continued or reinstated due to an appeal, DMAS or the DMAS contractor may not terminate or reduce services until a decision is rendered by the hearing officer.

Appeals may be requested orally or in writing by the member, the member's attorney, or the member's authorized representative. Appeals filed orally or electronically must be received within 30 days of receipt of the notice of adverse action. Appeals sent by mail must be postmarked within 30 days of receipt of the notice of adverse action. Forms are available on the internet at https://www.dmas.virginia.gov/appeals or by calling (804) 371-8488.

A copy of the notice or letter about the action should be included with the appeal request. Appeal requests may be sent to the DMAS Appeals Division through one of the following methods:

- Through AIMS at https://www.dmas.virginia.gov/appeals/. From there you can fill out a client appeal request, submit documentation, and follow the process of your appeal.

- Through mail, email, or fax. You can download a Medicaid Client Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the client appeal. The request can be submitted by:
    - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
    - Email to appeals@dmas.virginia.gov; or
    - Fax to: (804) 452-5454

- By phone at (804) 371-8488 or in-person at the Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219.

The Department's state fair hearing decision may be appealed to the appropriate

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Circuit Court by the member in accordance with the Administrative Process Act at Va. Code § 2.2-4025, *et. seq*. and the Rules of Court.

NON-MEMBER APPEALS

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12 VAC 30-110-10 through 370, require that written notification be provided to individuals when DMAS, its contractors, or another agency on behalf of DMAS, takes an action that affects the non-member. Adverse actions may be appealed by the non-member, an attorney, a provider authorized to represent the member, or other authorized representative on behalf of the member. Adverse actions include denials of enrollment in the Medicaid program or denial of services that would result in enrollment in a Medicaid program. Also, failure to act within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

Appeals may be requested orally or in writing by the member, the member's attorney, or the member's authorized representative. Appeals filed orally or electronically must be received within 30 days of receipt of the notice of adverse action. Appeals sent by mail must be postmarked within 30 days of receipt of the notice of adverse action. Forms are available on the internet at https://www.dmas.virginia.gov/appeals or by calling (804) 371-8488. A copy of the notice or letter about the action should be included with the appeal request. Appeal requests may be sent to the DMAS Appeals Division through one of the following methods:

- Through AIMS at https://www.dmas.virginia.gov/appeals/. From there you can fill out a client appeal request, submit documentation, and follow the process of your appeal.

- Through mail, email, or fax. You can download a Medicaid Client Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the client appeal. The request can be submitted by:
    - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
    - Email to appeals@dmas.virginia.gov; or
    - Fax to (804) 452-5454

- By phone at (804) 371-8488 or in-person at the Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219.

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The Department's State fair hearing decision may be appealed to the appropriate circuit court by the member in accordance with the Administrative Process Act at Va. Code § 2.2-4025, *et. seq*. and the Rules of Court.

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