

BROADCAST DMAS-87

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TO: LDSS Directors and Eligibility Staff and Cover Virginia Staff

FROM: Cindy Olson, Director, Eligibility and Enrollment Services Division,
Department of Medical Assistance Services (DMAS)
John Stanwix, Director, Appeals Division, DMAS

SUBJECT: Continuous Coverage Process During An Appeal

CONTACT: Michael Puglisi at michael.puglisi@dmass.virginia.gov

Under federal law, appellants may receive continued coverage during the State Fair Hearing process under certain circumstances (42 CFR § 431.230). When the Appeals Division of the Department of Medical Assistance Services (DMAS) receives a new appeal request, it must evaluate whether the appellant has requested continued coverage, and if so, if they are eligible under the rules enumerated in the Code of Federal Regulations. Under the Virginia Administrative Code, the Appeals Division will order continued coverage if the appeal has been requested before effective date of termination, or within 10 days of the Notice of Action under appeal, and the issue in question in the appeal is not solely based upon federal or state law or policy (12 VAC 30-110-100).

Under the Appeals Division's processes, the Eligibility Cases Manager approves continued coverage in the Division's Appeals Information Management System (AIMS), and the system automatically generates a document that is addressed and transmitted to the coordinator or point of contact at the applicable local department of social services agency. Upon issuance of this notice, the coordinator at the local agency must reopen coverage in VaCMS in the original aid category within three days. Federal law is clear that coverage must be uninterrupted.

Once coverage is reopened, the worker at the local department of social services (LDSS) agency must transmit a new Notice of Action to inform the appellant that continued coverage has been approved during the appeals process. The notice must be clear that coverage has been reopened solely as a result of the appeal and only for the duration of the appeal process. Finally, the LDSS worker must transmit a copy of the new Notice of Action to the Appeals Division within the three-day timeframe.

Please refer to M1640.100 of the Medical Assistance Eligibility Manual for further details of this process.